U.S. Department of Health and Human Services

Minutes of the Interdepartmental Substance Use Disorders Coordinating Committee
Full Committee Meeting

June 5, 2023
9:30 a.m. to 11:47 a.m. (Eastern Time Zone)
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857

(Via Zoom)

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Call to Order, Committee Roll Call, and Consideration of Minutes

Tracy Goss, Designated Federal Officer (DFO), Interdepartmental Substance Use Disorders Coordinating Committee (ISUDCC), called the meeting to order at 9:30 a.m. via Zoom. She established a quorum following the roll call.

Federal ISUDCC Members or Designees Present

- Miriam E. Delphin-Rittmon, Ph.D., Assistant Secretary for Mental Health and Substance Use, Substance Abuse and Mental Health Services Administration (SAMHSA)
- Yngvild K. Olsen, M.D., MPH, Director, Center for Substance Abuse Treatment (CSAT), SAMHSA
- Ruth Ryder, Deputy Assistant Secretary for the Office of Policy and Programs – Formula Grants, Office of Elementary and Secondary Education, Department of Education (ED)
- June Sivilli, Senior Advisor, Office of Public Health, Office of National Drug Control Policy (ONDCP)
- Wilson Compton, M.D., National Institute on Drug Abuse (NIDA), National Institutes of Health (NIH)
- Patricia Powell, Ph.D., Deputy Director, National Institute on Alcohol Abuse and Alcoholism (NIAAA), NIH
- Marta Sokolowska, Ph.D., Associate Director for Controlled Substances, Office of the Center Director/CDER, Food and Drug Administration (FDA)
- Dele Solaru, PharmD, MBA, Chief Pharmacy Officer, Office of Personnel Management (OPM)
- Kellie Kubena, Deputy Innovation Officer, Rural Development, Department of Agriculture (USDA)
- Christopher Jones, PharmD, DrPH, MPH, Acting Director, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC)

Federal ISUDCC Members Not Present

- U.S. Department of Justice (DOJ)
- U.S. Department of Labor (DOL)
- U.S. Department of Housing and Urban Development (HUD)
- U.S. Department of Veterans Affairs (VA)
- Social Security Administration (SSA)

Non-Federal ISUDCC Members Present

- Chad Audi, Ph.D., President and CEO, Detroit Rescue Mission Ministries
- Caleb Banta-Green, Ph.D., MPH, MSW, Principal Research Scientist, Alcohol & Drug Abuse Institute, University of Washington

- Jamie Chrisman Low, M.Ed., NCC, Recovery Consultant, Statewide Recovery Community, Network Weaver, Certified Peer Support Specialist
- Susan Dawson, Ed.D., PMHNP-BC, Psychiatric Nurse Practitioner, Assisted Recovery Center of America, and State Targeted Response Team for the Opioid Crisis Trainer for Professionals
- Judy Goforth Parker, Ph.D., A.P.R.N., F.A.C.H.E., Commissioner of Health Policy, Chickasaw Nation
- Sara A. Goldsby, MSW, MPH, Director, South Carolina Department of Alcohol and Other Drug Abuse Services
- Sheryl Ryan, M.D., FAAP, Division Chief, Professor of Pediatrics, Adolescent Medicine and Eating Disorders, Penn State Health
- Amanda S., Patient, and Advocate
- Cynthia Seivwright, MA, CQIA
- Daniel Sledge, BA, LP, Lead Outreach Paramedic, Wilco EMS-MOT
- Richard Spoth, Ph.D., Director, Partnerships in Prevention Science Institute, Iowa State University
- Luis R. Torres, Ph.D., Founding Dean and Professor, School of Social Work, The University of Texas Rio Grande Valley

- Non-Federal ISUDCC Members Not Present
- Honorable Nancy L. Butts, President Judge, Lycoming County Court of Common Pleas, Williamsport, PA
- Meredith Canada, MSW, MPA, LCSW, Public Health Analyst, Indiana High-Intensity Drug Trafficking Area Overdose Response Strategy
- Nicholas Estabrook, Addictive Disease Recovery Support Specialist, Department of Behavioral Health and Development Disabilities
- Erik P. Hess, M.D. MSc, Professor and Vice Chair for Research, Department of Emergency Medicine, the University of Alabama at Birmingham School of Medicine

The DFO entertained a motion to adopt the minutes from the ISUDCC meeting on December 20, 2022. She noted the minutes were certified in accordance with the Federal Advisory Committee Act regulations and included edits. Dr. Dawson moved to adopt the minutes. The DFO then called for discussion, and following none, she asked for a vote to adopt the minutes. Dr. Audi so moved, and Dr. Goforth Parker seconded the motion. The minutes were adopted by unanimous vote.

Welcome and Opening Remarks

Miriam E. Delphin-Rittmon, Ph.D., ISUDCC Chair, Assistant Secretary for Mental Health and Substance Use

Dr. Delphin-Rittmon welcomed the committee members and presented an overview of the day's meeting, which included updates on the newly established workgroups focused on integrating harm reduction into the prevention, treatment, and recovery continuum of care. She thanked the members for contributing their time and expertise to the workgroups, as well as the staff for their time in helping to facilitate them.

Dr. Delphin-Rittmon noted that following the working group reports there would be a discussion of the reauthorization of the ISUDCC. She provided a short overview of the ISUDCC, including that it is required under the SUPPORT Act, Section 7022, which stipulates that the ISUDCC shall terminate on May 6, 2025. The members' terms would also end at that time. SAMHSA is seeking the members' thoughts regarding if they should request reauthorization and, if so, what shape that might take. She then turned the meeting to Dr. Yngvild K. Olsen to introduce the working group report outs.

ISUDCC Working Group Report Outs
Yngvild Olsen, M.D., MPH, Director, Center for Substance Abuse Treatment

Dr. Olsen provided a brief overview of the working groups. Since their inception, the groups have been holding meetings and making progress. The ISUDCC Advisory Committee must deliberate on any advice, recommendations, or work products from each workgroup. Therefore, each group reports on its progress and seeks committee input. Dr. Olsen anticipates final products being available for review by the end of the calendar year.

ISUDCC Prevention Working Group Report Out
Chase Holleman, LCSW, LCAS, Public Health Advisor, Center for Substance Abuse Prevention

Chase Holleman presented an overview of the prevention working group's purpose, proposing recommendations on how the Federal Government, in particular, SAMHSA, can further integrate and coordinate harm reduction approaches and strategies across the area of prevention, specifically. He then provided a list of the federal and non-federal working group members.

Chase Holleman pointed out that conversations about harm reduction can be rather nebulous but listed the specific objectives of the working group, which include:

- Systems development: identifying gaps, including pressing needs at the local level; identifying barriers to integration/coordination/interdigitation of prevention and harm reduction at the federal, state, and local levels; and identifying best practices and resources.
- Service Delivery Models: identifying barriers to integration/coordination/interdigitation at federal, state, and local levels; identifying best practices and resources; identifying relational components of harm reduction and how they can integrate the expertise and autonomy of people with lived experience; and reimbursement for harm reduction services.

- Workforce development: identifying gaps, including training needs for integrated prevention/harm reduction, and identifying best practices and resources.
- Research: developing systems and best practices for care under real-world conditions and ensuring that healthcare providers and patients receive evidence-based clinical practices.
- Federal Programs: identifying practice and policy recommendations integrating the expertise and autonomy of people with lived experience and identifying barriers to integration/coordination/interdigitation of prevention and harm reduction at federal, state, and local levels.

Chase Holleman ended the presentation by listing the key discussion items the working group focuses on. They include identifying individual guiding themes and conducting a group review of a youth/family policy brief from the Indian Health Service. It is designed to guide the tone and provide an opportunity to share context on communicating recommendations. This led the group to recognize that existing prevention research is plentiful, can support proposed idea development, and is necessary for more refinement of the harm reduction aim. The group identified leading keywords for focus: youth and family, primary prevention, interagency coordination, adverse childhood experiences, etc. Finally, Chase Holleman shared recurrent themes for the working group: social determinants of health, value of family within harm reduction strategies, whole person health benefits (as primary prevention), adequately funding prevention activities. The group acknowledged the tension between prevention and harm reduction. Since there are finite amounts of funding and resources, the group focused on working collaboratively to develop policy recommendations that include prevention and harm reduction.

Following the presentation, Dr. Spoth underscored the nebulous nature of prevention and harm reduction and the tension. Guidance about thinking through the relationship between prevention and harm reduction would be welcome. Dr. Compton noted that the heart of the tension between harm reduction and prevention interdigitation is complicated because harm reduction is inherently about disease and death prevention, not about primary drug use prevention or minimizing first exposure to substances. The group welcomes insights from others regarding how to balance those goals without losing the importance of both pieces.

Dr. Powell noted that harm reduction in one generation may be prevention in another. She noted that in the current system, children often fall through the cracks. She questioned how this could be supported as a mission of the group. Dr. Jones responded that it is necessary to determine how traditional prevention and harm reduction communities can work together. There is a multigenerational impact from exposure from parental substance use and focusing prevention on children without considering what is happening in the home or community is a missed opportunity.

Dr. Spoth also noted that one point of clarity regarding the intersection of prevention and harm reduction is selective prevention, working with children of parents struggling with drug

addiction. This could be one area of focus. He also emphasized the need to strengthen coalitions so those working on prevention programs work more closely with the harm reduction community to facilitate more selective prevention strategies to work with children and families. Dr. Torres commented that another place where harm reduction and prevention intersect is attempting to reduce harm during initial exploration. Dr. Goforth Parker added that prevention best practices and successes would be excellent resources.

ISUDCC Treatment Working Group Report Out

Caleb Banta-Green, Ph.D., MPH, MSW, Principal Research Scientist, Alcohol & Drug Abuse Institute, University of Washington

Dr. Banta-Green began his presentation with an overview of the recent laws passed in New York State for expanded harm reduction services and in Washington State that expanded access for drug checking services and safer smoking supplies. Dr. Banta-Green first reviewed the foundational concepts of the working group, which include:

- Recognizing and respecting the autonomy and agency of people who use drugs and shifting the focus from a punitive or coercive approach to one that promotes individual choice, dignity, and empowerment.
- Promoting the integration of harm reduction services to include, at a minimum, providing harm reduction education, naloxone distribution, and access to sterile syringes within treatment settings and across the continuum of care for behavioral health; and
- Embracing the services and principles of harm reduction and fostering community engagement and participatory decision-making processes to ensure that the perspectives and voices of people who use drugs are heard and incorporated into policy and program development.

He noted that agency and autonomy are critical but often not felt by people in behavioral health systems. Although not easy, it is essential for governmental agencies to promote the integration of harm reduction since they are the experts. Finally, Dr. Banta-Green emphasized that more is needed than to present harm reduction as a new concept, but that it must transform new work and be driven by community agencies with decades of experience doing this kind of work. He also said that people with lived experience must have their voices heard and stay engaged.

Dr. Banta-Green next described the recommended "pillars of harm reduction," which are:

- Systems Development: Health Hub Model, Recovery Oriented Systems of Care, Addiction Recovery Medical Home- alternative Payment Model, and a "community first" model which prioritizes "people helping people" and promotes dignity, humanity, health equity, and social determinants of health.
- Service Delivery: Acceptance across delivery settings, integration of the expertise and autonomy of people with lived experience, increased supplies and service

availability/delivery, reimbursement and payment for harm reduction services, program performance measures that account for quality over quantity, and assessment protocols that are not punitive (e.g., a diagnostic and medical necessity assessment that takes less than 15 minutes).

- Workforce Development: Staff training, education, and incentivization; integration of peer support (including a career ladder, competitive wages, and benefits); prioritizing patient-provider collaboration (autonomous goal setting and shared decision making); and promoting equitable employment (i.e., removing barriers for people with lived experience such as drug testing, background checks, etc.)
- Research: Developing systems and best practices for care under real-world conditions, stepping back and addressing the research to practice gap, including harm reduction providers and educators in the development of harm reduction research (reinforcing the move from "fringe" to "legitimate"); and moving this to the center of what we do and take it to scale in a transformative way.
- Federal Programs: Expanded supportive messaging from federal entities; support with discretionary funds accessible to a variety of organizations, including grassroots, that prioritizes those with demonstrated history of harm reduction service delivery; measures of programmatic compliance which consider quality and fidelity evidence-based practices and best practices in service delivery; reduction in documentation burden (e.g., data collection tools that are validated); transparency of payment models, reimbursement guidelines, covered services, etc.; reimbursement rates that support staffing, billing infrastructure, etc. without forcing agencies to function at a fiscal loss; and practice and policy recommendations integrating the expertise and autonomy of people with lived experience.

Dr. Banta-Green ended his presentation by identifying the following steps, including identifying stakeholders, prioritizing recommendations, and "building out" the top recommendations to include not just "what" but "how" and "who."

Following the presentation, Dr. Goforth Parker complimented using pillars to make the often-overwhelming concepts and ideas more manageable. Dr. Spoth noted the parallels between the two working group presentations regarding how to pay for activities and services. He also said that the pillars could also provide a framework for prevention.

ISUDCC Recovery Working Group Report Out

Enid Osborne, Ph.D., Public Health Analyst, Center for Substance Abuse Treatment

Dr. Osborne reviewed the purpose of the workgroup and listed federal, non-federal and staff members. She noted that because attendance has been lower than wished, the working group invited additional members: Greg Williams, a recovery expert, and an individual from the Treatment workgroup with lived experience, Amanda S.

She detailed the working group objectives, focusing on the marriage between harm reduction and recovery. The objectives include:

- Systems development: Identification of gaps, including pressing needs at the local level; identification of barriers to integration/coordination/interdigitation of recovery and harm reduction at federal, state, and local levels; and identification of best practices and resources.
- Service Delivery Models: identification of barriers to integration/coordination/interdigitation at federal, state, and local levels; identification of best practices and resources; relational components of harm reduction and how they can integrate the expertise and autonomy of people with lived experience; and reimbursement for harm reduction services.
- Workforce development: Identifying gaps, including training needs for integrated recovery/harm reduction, and identifying best practices and resources.
- Research: Developing systems and best practices for care under real-world conditions and ensuring that healthcare providers and patients are provided with evidence-based clinical practices.
- Federal Programs: Practice and policy recommendations integrating the expertise and autonomy of people with lived experience and identifying barriers to integration/coordination/interdigitation of recovery and harm reduction at federal, state, and local levels.

Workgroup members utilized their lived and professional experience with substance use prevention, treatment, recovery, and harm reduction as the foundation for conversations. Dr. Osborne noted that for recovery, harm reduction is part of the process and the conversation and seeks to lessen the consequences. Discussion topics included:

- Focus on systems development and service delivery: Professional and lived experience pertaining to substance use prevention, treatment, recovery, and harm reduction. Funding – service delivery and data collection – is not contiguous.
- Identification of gaps and barriers: Role clarity to address the tension between recovery and treatment. What are peers allowed/not allowed to do? Lack of ongoing collaboration resulting in "turf wars." Stigma and misinformation associated with harm reduction as a barrier to expansion and integration with recovery and recovery supports.
- Identification of best practices, resources, and opportunities for integration/development/delivery: Statewide peer networks, states with IC/RC and NAADAC certification to identify pathways for reciprocity; adolescent and young adults in harm reduction; national harm reduction centers/approaches, including substance use disorder/mental health, HIV/AIDS/Other infectious disease groundwork (Syndemic approach); RCO/RCC training and distribution of naloxone; Harm Reduction Specialist

training and certification; linkages to care between harm reduction and RCOs/RCCs; and opportunities to encourage collaboration between HROs and RCOs.

The recovery working group also listed preliminary recommendations, including role clarity for peer support workforce, including specializations; identifying a clear role of recovery in harm reduction work, a focus on supporting peers in harm reduction work; parity for reimbursement levels and models in primary care and behavioral health care; the need for best practices and resources for peer support, including model standards for peer support training which are targeted for summer 2023 from the Office of Recovery; changing the IOM model to include harm reduction; encouraging local pharmacies to distribute information about local harm reduction and recovery resources; financing research on funding for harm reduction and recovery from SAMHSA, state, child welfare, public health, Medicaid and Medicare, private insurance, etc. to include funding for Community Health Workers; promoting parity by increasing funding provided at the local level for braiding and building systems of care (guidance is recommended for localities on braiding/blending funding for better outcomes for those with substance use disorder); defining recovery supports and providing funding for harm reduction; a SAMHSA policy academy for state financing for substance use disorder care (must include Centers for Medicare & Medicaid Services); rapid treatment access for all healthcare entities; funding and providing avenues for increasing collaboration between HROs and RCOs; and creating campaigns aimed at reducing stigma and misinformation within harm reduction and recovery communities.

Council Discussion

Dr. Banta-Green noted that things are evolving but slowly regarding harm reduction and prevention, and there is continued tension with adolescents. The traditional notion that to talk about sex and drugs normalizes them has been disproven. It is critical to treat these issues simultaneously and be explicit about them. There is a lot of reluctance from those on the behavioral health side about medications for substance use disorder (SUD) stemming from a misunderstanding of what SUD is and the recovery supporting and harm reduction benefits of medications. In response, Dr. Delphin-Rittmon emphasized the importance of an early harm reduction piece. Dr. Banta-Greene described wrapping up 30 qualitative interviews with people using fentanyl. When available, Dr. Delphin-Rittmon requested the research to share with the committee.

Dr. Compton mentioned that there is room for research to help understand what harm-reduction messaging around use of drug checking technology or the availability of Naloxone or other classic harm reduction techniques do for prevention messaging for teenagers in particular. The systems and service delivery changes Dr. Banta-Green highlighted are needed for prevention – particularly how primary prevention for early childhood is funded, supported, and implemented. Dr. Spoth noted that there had been advances in understanding how to construct prevention

systems, and the literature provides a basis for thinking through how to construct further support for prevention delivery systems across the spectrum of types of levels of prevention.

Sara Goldsby noted that the information from the recovery working group was relevant to South Carolina, where many peers are being used in harm reduction work. The struggle is in defining the peer support specialists' role in harm reduction work, including boundaries. More structure and support are needed in supporting peers who feel vulnerable as they are asked to get involved in more harm reduction activities, including best practices that can be implemented immediately. In response, Dr. Delphin-Rittmon mentioned that there may be room for an environmental scan to see what best practices are being used and how to catalog them to be more useful and meaningful.

Cynthia Seivwright reiterated that the role of peer recovery support specialists in harm reduction puts the individual at risk. Peer recovery support specialists are easier to use than treatment specialists, so an unintentional system has been created that may not be the best because of the undefined roles of the peer recovery support specialists. Dr. Delphin-Rittmon mentioned that funding for peer support specialists and their supervision has been discussed. Individuals engaged in harm reduction also need supervision, so role clarification is needed. She would take these concerns to the Recovery Office.

June Sivilli pointed out that harm reduction is new and not a system in itself. Instead, we are trying to plug disparate services and providers into a system that only partially connects. To receive government reimbursement, it needs to fit into the system. She noted the importance of including outside groups in the harm reduction discussion regarding reimbursement, particularly federal partners that need to be added to participating in the current ISUDCC meeting, such as HUD, CMS, etc., since they are critical to integrating harm reduction services. Dr. Delphin-Rittmon shared that there are ongoing meetings with many agencies not represented in the current ISUDCC meeting and that information will be shared across meetings and groups.

Jamie Chrisman Low noted that one huge stride toward better understanding harm reduction is understanding that peers can be employed in prevention, treatment, and recovery across the continuum. More than one state has a harm reductionist certification, and if peers could achieve that certification, the most qualified could be deployed. She is taking this to her Single State Authority and peer certification commission.

Dr. Olsen noted the synergies between the different working groups and that final recommendations should be holistic as part of the committee's vision and goals. She also mentioned that, outside the statutory list of entities around harm reduction, the question of funding could be looked at on an ad hoc basis. She supported the idea of an environmental scan around the role of harm reductionist qualifications and the services individuals can provide. Finally, she acknowledged a community approach that is family- and community-centered and

engages individuals in the community more deliberately regarding treatment, recovery, and prevention.

Dr. Olsen then requested a formal vote to approve the materials the three working groups and for their continued work in the directions laid out in their reports. Before a motion was made, Sara Goldsby asked that the prevention report include her as a member. Dr. Olsen then asked for a motion with the one amendment requested by Sara Goldsby. The motion was made by Dr. Ryan and seconded by Dr. Goforth Parker and Dr. Torres. There was no discussion, and the motion was carried unanimously.

ISUDCC Reauthorization
Yngvild Olsen, M.D., MPH, Director, Center for Substance Abuse Treatment

Dr. Olsen noted that the ISUDCC will sunset on May 6, 2025. A request for reauthorization must be submitted soon if the work is to be continued. She noted the progress the ISMICC has made regarding reauthorization that continues their work for an additional six years. ISMICC members agreed to extend for six months while new members were appointed. Dr. Olsen asked for committee input regarding similar steps for the ISUDCC.

Several members voiced support for reauthorization, including Dr. Torres, Sara Goldsby, Dr. Banta-Green, and Dr. Jones, who presented specific comments. They cited the importance of maintaining the momentum of the work to ensure that federal agencies are coordinated on this issue. Dr. Banta-Green asked what the timeline would be to get feedback from the government since this historically can take years. Dr. Jones responded that there are activities that do not need authorization and that the continuing discussions are helping to move in the right direction. Dr. Delphin-Rittmon asked for a motion for reauthorization of the ISUDCC. Dr. Audi moved to support the reauthorization, which Dr. Torres seconded. There was no discussion, and the motion was carried unanimously.

Section 1262 (Mainstreaming Addiction Treatment [MAT] Act) and Section 1263 (Medication Access and Training Expansion [MATE] Act) of the Consolidated Appropriations Act, 2023 (PL 117-328)
Yngvild Olsen, M.D., MPH, Director, Center for Substance Abuse Treatment

Dr. Olsen provided a short history of the Consolidated Appropriations Act, which was signed into law on December 29, 2022. Along with funding provisions, Section 1262 of this Act removes the need for practitioners qualified to prescribe controlled medications to first obtain a special waiver to prescribe buprenorphine for the treatment of opioid use disorder. This change also aligns with the Department of Health and Human Services Overdose Prevention Strategy.

With certain exceptions, Section 1263 of the Act also requires a non-addiction medicine/addiction psychiatry board-certified practitioner applying for or renewing a Drug

Enforcement Administration (DEA) license to prescribe controlled medications to receive eight hours of education on substance use disorders. SAMHSA is coordinating with DEA regarding these requirements. Dr. Olsen reviewed the language from Section 1263 regarding the training requirement and noted that practitioners should be aware of their state's requirements because they may differ from the federal law. Starting on June 27, 2023, providers need to ensure they comply with one of the three options in the Act to satisfy the new training requirement related to DEA registration.

Dr. Olsen reviewed the benefits of methadone and buprenorphine treatment. Mortality studies have demonstrated that expanding treatment contributes to a 37% to 80% reduction in overdose mortality. She also cited a study of Medicaid beneficiaries with opioid use disorder that found that treatment that includes medications is associated with reduced inpatient hospital admissions and outpatient emergency department visits.

Dr. Olsen then provided a brief history of the X-waiver, noting that 2000 saw the first time since 1914 that Congress passed into law the ability for practitioners (originally physicians only) to be granted permission to treat opioid use disorder with controlled medications outside of an Opioid Treatment Program. However, less than 10% of DEA registered practitioners took the opportunity to get waivered to do so. In April 2021, revised practice guidelines for training were released, designed to improve those numbers. At the end of 2022, there were 130,000 waivered practitioners out of approximately 1.8 million DEA-registered practitioners, demonstrating the large opportunity that exists for growth in the treatment of OUD.

Section 1263 also identifies organizations that can provide the required training. Currently, a handful of training organizations and accrediting bodies not named in the Act are working with SAMHSA and the DEA to figure out how to have their trainings and activities approved. SAMHSA is listening to and assessing how best to address these concerns.

Since the December 2022 removal of the DATA waiver, SAMHSA has been working with DEA to address barriers and get the message out. SAMHSA no longer accepts Notices of Intent (waiver applications), for example, and have highlighted that on a dedicated webpage. All practitioners who have a current DEA registration that includes Schedule III authority may now prescribe buprenorphine for opioid use disorder if permitted by applicable state law, and SAMHSA encourages them to do so. States that still have references to the data waiver or limitations in this area are working to align their state regulations with this policy change. SAMHSA has guidance and FAQs on its website.

Dr. Olsen listed how SAMHSA works to reduce barriers to accessing effective treatment for substance use disorders. To achieve this goal, SAMHSA has implemented several measures, including:

- Communicating with practitioners through FAQs, publications, and the SAMHSA website to provide relevant information and resources.
- Collaborating with federal partners, particularly the DEA, to address regulatory challenges and streamline processes.
- Offering training and technical assistance through initiatives such as the Provider's Clinical Support System, publications, and technical assistance provided via SAMHSA-funded platforms.
- Engaging with professional associations to encourage prescribing and adopting evidence-based treatments.
- Working on follow up from the Buprenorphine Pharmacy Access Summit that was held in August 2022 to discuss and promote increased access to this life-saving medication.

Finally, Dr. Olsen shared that SAMHSA has put together a list of recommended, voluntary elements for MATE-required SUD training in three buckets that, together, span screening, assessment, interventions, medications, harm reduction approaches, and shared decision-making that involves other skills in communication, awareness of all social determinants of health, and co-occurring conditions. The goal is for practitioners to gain awareness so that when taking care of an individual, they understand that there are other pieces that should be considered. These recommended elements can be found on SAMHSA's website.

Following her presentation, Dr. Olsen opened up the floor for discussion. Dr. Dawson asked if DATA 2000 training qualifies or if providers must complete a new eight-hour course. Dr. Olsen responded that the eight hours of training under the old requirement counts and outlined other ways to meet the requirement. New FAQs posted at the end of April list the training entities included in Section 1263. Dr. Olsen responded to Dr. Banta-Green's question about educating pediatricians on medications for opioid use disorder (MOUD), noting that there is new funding to focus on MOUD and recovery supports for adolescent and transitional aged youth with OUD. Sara Goldsby asked about federal programs supporting primary care and how they can focus on support and expectations of those providers in delivered programs, especially in rural communities. Dr. Dawson noted the stigma of mental health diagnoses and that primary care pediatric and non-mental health providers have difficulty understanding the behavioral health aspects, so integrating mental health provider skills into primary care instruction would be beneficial. In response, Dr. Olsen said that supporting primary care practitioners goes back to the harm reduction approaches and expectations, ensuring providers know where their resources are in their communities. More support and different models would be helpful. Dr. Compton complimented SAMHSA on its efforts to identify what the training base knowledge should be to provide medications, as well as telehealth regulations. Dr. Delphin-Rittmon responded that there has been a lot of advocacy around those issues, and DEA received over 3,000 comments on the proposed buprenorphine regulations and 35,000 on the telemedicine regulations.

June Sivilli shared that in March ONDCP launched a Cascade of Care initiative that includes efforts to increase screening and expand the workforce that builds on SAMHSA's work. ONDCP, in collaboration with federal partners including SAMHSA, is developing core curricula for all health professions in medical schools so that all health providers understand early in their careers that SUD can be treated as a disease and address stigma. She also noted that ONDCP is working with federal partners to increase training for all health providers as an ongoing effort. Dr. Olsen then shared messages from the chat, including Dr. Banta-Green's question about methadone dosing. Other questions referenced fentanyl and revisions to opioid treatment programs. Dr. Olsen said that finalizing the 42 CFR Part 8 OTP rule revision is in process. Dr. Ryan reported on Pennsylvania's Project Echo program, which is a peer-to-peer learning collaborative. Amanda S asked how SAMHSA is working to protect vulnerable buprenorphine patients from providers and bad actors. Dr. Olsen responded that there is a spectrum of providers and mechanisms for patient complaints within states that are the first step to ensuring people are not being taken advantage of. The Federal Government also has those kinds of resources. Adopting harm reduction approaches with individuals as the center need to be advanced across the health care system.

Public Comment

The DFO noted that there was one written submission for public comment from Dr. Jim Christina, CEO and Executive Director of the American Podiatric Medical Association (APMA), the national organization representing doctors of podiatric medicine. Speaking on behalf of the members, Dr. Christina voiced concern that the APMA was not listed as an approved entity to provide training in the MATE Act and the Council for Podiatric Medical Education (CPME) as an approved accrediting body. They are also disappointed that SAMHSA did not add the APMA or CPME to the MATE Act as approved entities since it is perceived as a burden to podiatric physicians. They request that the ISUDCC recommend that SAMHSA designate APMA as an approved training provider and specify that other organizations approved by CPME to provide continuing medical education are also approved to provide the training.

Final Comments/Adjourn

Dr. Delphin-Rittmon thanked the members for their input and acknowledged the committee's activities to advance the integration of harm reduction across the continuum of substance use disorder prevention, treatment, and recovery.

The DFO asked for a motion to adjourn. Dr. Torres was so moved. Dr. Audi seconded the motion, and it was unanimously approved. The meeting adjourned at 11:47 p.m.

August 25, 2023

_____ _____/Miriam Delphin-Rittmon, Ph.D./_____

Date Miriam E. Delphin-Rittmon, Ph.D.
Assistant Secretary for Mental Health and Substance Use

ISUDCC will formally consider minutes at its next meeting, and any corrections or notations will be incorporated into the minutes of that meeting.