

Policy Recommendations for Addressing the Opioid Crisis in the District of Columbia

Final Report – February 2020

Submitted to the Executive Office of the Mayor

The Pew Charitable Trusts

Executive Summary

The Pew Charitable Trusts (Pew) is an independent, nonpartisan research and policy organization dedicated to serving the public. With funding from the Bloomberg Philanthropies, and in partnership with the Bloomberg School of Public Health at Johns Hopkins University, Pew's substance use prevention and treatment initiative works with states to develop and implement programmatic and policy solutions for reducing the opioid fatality rate through treatment, overdose prevention, and recovery support.

In response to the District's invitation for technical assistance, Pew developed a vision for a substance use system of care that prioritizes access to medications for opioid use disorder, embraces overdose prevention strategies to save lives, and supports recovery. Pew also assessed the District's treatment system to understand the areas in which this vision is being fulfilled and areas where improvements would help fulfill this vision.

To inform the development of this vision and to conduct this assessment, Pew conducted more than 150 meetings with stakeholders in the District, including people with lived experience, providers, staff at community-based organizations, and agency staff. Pew also engaged with the Opioid Strategic Groups charged with implementing *Live.Long.DC.*, the District's strategic plan for addressing the opioid crisis, to better understand ongoing efforts. Finally, Pew reviewed existing District laws and regulations.

This final report consists of ten recommendations organized by aspects of the vision developed by Pew and informed by stakeholders, which include:

- Accessing the treatment system;
- Integrating care and supporting care transitions;
- Ensuring quality;
- Preventing fatal overdoses; and
- Supporting recovery.

From this assessment, as well as a review of evidence-based and emerging practices from other states, Pew developed recommendations that build on current efforts to address the opioid crisis.

Recommendations

Accessing the treatment system

Recommendation 1: The Department of Behavioral Health should create a “no wrong door” approach to entering the treatment system by 1) requiring all contracted substance use disorder treatment facilities to provide assessment and referral services and 2) creating a process for primary care and mental health providers to provide assessment and referral services.

Recommendation 2: The Council should fund the Department of Behavioral Health to pilot a 24/7 assessment, medication initiation, and referral site at an existing substance use disorder provider.

Recommendation 3: The Deputy Mayor for Health and Human Services, with support from the Department of Behavioral Health, should coordinate District-funded outreach services to people who use drugs.

Integrating care and supporting care transitions

Recommendation 4: The Mayor should direct the Department of Health Care Finance, with support from the Department of Behavioral Health, to develop and implement a plan for enhancing Medicaid health homes' ability to coordinate care for Medicaid enrollees with opioid use disorder.

Recommendation 5: The Council should fund the Department of Behavioral Health, in collaboration with DC Health, to establish a one-time grant to support the co-location of primary care providers in opioid treatment programs.

Recommendation 6: The Department of Behavioral Health should create a co-occurring certification that can be added to an existing mental health or substance use disorder certification. In support of this, the Department of Health Care Finance should ensure that providers with this certification can bill for co-occurring services.

Ensuring quality

Recommendation 7: The Council should require all residential substance use disorder treatment facilities to provide on-site access to all three FDA-approved medications for opioid use disorder, either directly or through a contract with an outside provider.

Preventing fatal overdoses

Recommendation 8: The Council should amend the District's 911 Good Samaritan law to ensure legal protections for overdose bystanders to encourage more individuals to call for help in the event of an overdose. Additional training should be made available to people who use drugs and first responders regarding amendments to this law.

Recommendation 9: To improve DC's naloxone distribution, the Council should remove the legal requirement that staff of community-based organizations receive training from DC Health to distribute naloxone. If this requirement is not removed, the Council should require DC Health to certify facilities and organizations for naloxone distribution and training.

Supporting recovery

Recommendation 10: The Interagency Council on Homelessness should encourage non-profit hospitals in the District to fund supportive housing by providing matching dollars. In support of this effort, the Department of Health Care Finance and the Interagency Council on Homelessness should finalize efforts to allow providers to bill Medicaid for eligible housing support services.

Acknowledgements

Pew thanks the many individuals who contributed to this report by sharing their experiences and views of the District's treatment system, including staff within District agencies and community-based organizations, providers, and more. Without their insights, this report would not have been possible.

Special thanks are due to members of the Chosen Few, who ensured that this report reflected the experiences of those with opioid use disorder in the District, and to Sharon Hunt, Deputy Director of the Community Services Administration within the Department of Behavioral Health, for the time she spent helping Pew understand the District's treatment system and connect with key stakeholders.

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Introduction

The opioid crisis in DC

In 2017, the District of Columbia had the fourth highest overdose fatality rate in the country.¹ More than 1,000 people died over the last five years due to an opioid overdose.² While deaths declined from 279 in 2017 to 213 in 2018, as of October 2019 deaths increased again, rising to 220.³

These high fatality rates are associated with the presence of fentanyl and fentanyl analogs in the drug supply. Fentanyl is a synthetic opioid that is 50-100 times more potent than morphine, and often mixed with heroin in the illegal drug market.⁴ In 2018, 86 percent of people who died of an opioid overdose had fentanyl in their system,⁵ and over half of the heroin samples tested by the Department of Forensic Sciences contained these compounds.⁶ Many of those who have overdosed were long-time heroin users – from 2014 to 2018, 59 percent of people who overdosed had been using heroin for over 25 years and 88 percent had been using for 10 years or more.⁷

Opioid deaths are not equally distributed across the District's population. From 2014 to 2018, the majority of those who died were men (74 percent) between the ages of 40 and 69 years old (80 percent)⁸, although partial data from 2019 show that deaths are increasing among people aged 20-29.⁹ 82 percent of people who died in 2019 were black,¹⁰ despite black residents making up just 46 percent of the population.¹¹ These deaths are also geographically concentrated in the most disadvantaged parts of the District – over the last six years, Wards 7 and 8 consistently lost the most residents to opioid overdoses.¹² Because of this, the District's continuing efforts to address the opioid crisis in DC are an important part of addressing health inequities.

Ongoing efforts

The recommendations in this report are offered in the context of multiple ongoing efforts to reduce opioid fatalities in DC. In December 2018, the District released *Live.Long.DC.*, a strategic plan for addressing the opioid crisis. This plan consists of 50 strategies in a range of areas, from preventing opioid use and disrupting the drug market to treatment, harm reduction, and recovery support services. Just a few of the strategies implemented under this plan to date include:

- Screening patients in emergency departments for substance use disorder (SUD) and starting them on medication treatment if desired and appropriate (see text box on page 3);
- Establishing an opioid fatality review board that will allow the District to understand where and when an intervention could have potentially prevented a death, and make changes in the treatment system to prevent further overdoses;
- Training additional substance use peer recovery coaches and peer support specialists so that more people with opioid use disorder (OUD) can get help from someone who understands their experience; and
- Expanding access to medications for OUD in the DC Jail.

The District is also making changes to how Medicaid supports treatment for OUD. In November, the federal Centers for Medicare & Medicaid Services (CMS) approved the District's 1115 waiver, which will allow DC to use Medicaid funds to pay for residential substance use and mental health treatment for non-elderly enrollees and add coverage for a variety of other services for people with SUD, including

recovery support services, some of which can be provided by peers, supported employment to help people with SUD obtain and maintain jobs, and reimbursement for transition planning services when someone leaves an inpatient or residential treatment facility.¹³

The Council has also acted to address the crisis. The Opioid Overdose Treatment and Prevention Omnibus Act of 2018 included a number of reforms, including:

- Requiring hospitals to develop protocols for identifying, treating, discharging and referring patients with OUD;
- Requiring the DC jail to continue medications for OUD for people who enter the jail on this treatment;
- Removing drug checking equipment from the drug paraphernalia law, including fentanyl testing strips, which indicate whether fentanyl is present in a substance; and
- Removing a prohibition against syringe service programs from operating within 1,000 feet of a school.¹⁴

This report is meant to build on all of these efforts.

Medications for the treatment of OUD

The Food and Drug Administration has approved three medications for the treatment of OUD: buprenorphine, methadone, and naltrexone. The medications work to relieve the symptoms of opioid withdrawal or block the effects of opioids.* Compared to placebo or treatment without medications, people who use medications to treat their OUD are less likely to use illicit opioids.† Use of medications for OUD is associated with reductions in fatal overdoses‡ and reductions in the transmission of infectious diseases, including HIV and hepatitis C.§ Though counseling in addition to medication may be appropriate for some patients, medication alone has proven to be effective for many.** Because of this, medications should be prescribed even when behavioral therapies are unavailable.††

Sources

* American Society of Addiction Medicine, “The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use” (2015), <http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24>.

† Richard P. Mattick et al., “Methadone Maintenance Therapy Versus No Opioid Replacement Therapy for Opioid Dependence,” *Cochrane Database of Systematic Reviews* 3 (2009): CD002209, <http://www.ncbi.nlm.nih.gov/pubmed/19588333>; Sandra D. Comer et al., “Injectable, Sustained-Release Naltrexone for the Treatment of Opioid Dependence: A Randomized, Placebo-Controlled Trial,” *Archives of General Psychiatry* 63, no. 2 (2006): 210–8, <http://archpsyc.jamanetwork.com/article.aspx?articleid=209312>; Paul J. Fudala et al., “Office-Based Treatment of Opiate Addiction With a Sublingual-Tablet Formulation of Buprenorphine and Naloxone,” *New England Journal of Medicine* 349, no. 10 (2003): 949–58, <http://www.ncbi.nlm.nih.gov/pubmed/12954743>.

‡ Robert P. Schwartz et al., “Opioid Agonist Treatments and Heroin Overdose Deaths in Baltimore, Maryland, 1995–2009,” *American Journal of Public Health* 103, no. 5 (2013): 917–22, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3670653>.

§ Ibid.; Judith I. Tsui et al., “Association of Opioid Agonist Therapy With Lower Incidence of Hepatitis C Virus Infection in Young Adult Injection Drug Users,” *JAMA Internal Medicine* 174, no. 12 (2014): 1974–81, <http://archinte.amanetwork.com/article.aspx?articleid=1918926>; David S. Metzger et al., “Human Immunodeficiency Virus Seroconversion Among Intravenous Drug Users In-and-Out-of-Treatment: An 18-Month Prospective Follow-Up,” *Journal of Acquired Immune Deficiency Syndromes* 6, no. 9 (1993): 1049–56, <http://www.ncbi.nlm.nih.gov/pubmed/8340896>.

** R.P. Schwartz et al., “A Randomized Controlled Trial of Interim Methadone Maintenance,” *Arch Gen Psychiatry* 63, no. 1 (2006): 102–9, <https://www.ncbi.nlm.nih.gov/pubmed/16389204> and S.C. Sigmon et al., “Interim Buprenorphine Vs. Waiting List for Opioid Dependence,” *N Engl J Med* 375, no. 25 (2016): 2504–05, <https://www.ncbi.nlm.nih.gov/pubmed/28002704>.

†† National Academies of Sciences, Engineering, and Medicine, “Medications for Opioid Use Disorder Save Lives” (The National Academies Press, 2019), <https://doi.org/10.17226/25310>.

Scope of the report

The District invited Pew to articulate a vision for a publicly-financed adult substance use treatment system of care that prioritizes access to medication for OUD, embraces overdose prevention strategies to save lives, and supports recovery. Pew was also asked to assess the District’s treatment system to understand the areas in which this vision is being fulfilled and make recommendations for improvement.

To inform the development of this vision and to conduct this assessment, Pew conducted four roundtables to gain the perspectives of people with lived experience and three types of providers – federally qualified health centers (FQHCs), substance use treatment providers, and mental health treatment providers. Pew also met one-on-one with a variety of additional stakeholders, including providers, payers, Councilmembers, and staff from District agencies. In total, Pew conducted more than 150 meetings. Pew also engaged with the Opioid Strategic Groups charged with implementing *Live.Long.DC* to better understand ongoing efforts and reviewed existing District laws and regulations.

From this assessment, Pew developed a vision for the District's treatment system and 10 recommendations for how to achieve this vision in the following areas:

- Accessing the treatment system;
- Integrating care and supporting care transitions;
- Ensuring quality;
- Preventing fatal overdoses; and
- Supporting recovery.

One theme that emerged early in this system assessment was that the District has robust SUD treatment infrastructure. Waiting lists for specialty substance use services, such as residential beds, are rare and per capita, DC has the ninth highest number of providers with the federal waiver required to prescribe buprenorphine, one of the three medications for OUD.¹⁵ There are also signs of progress in expanding access to treatment. While in 2011, there were 21.7 buprenorphine prescriptions per 1,000 Medicaid enrollees 12 and older, by 2018, the prescribing rate had more than doubled to 58.4 per 1,000.¹⁶

Rather than increasing treatment capacity, this report focuses on how the District can better coordinate existing resources to engage more people in treatment. The Department of Health Care Finance (DHCF) estimated that in 2017, only one-third of Medicaid enrollees with a SUD received any treatment,¹⁷ and a nationwide analysis of buprenorphine prescribing rates ranked DC as 32nd.¹⁸

By request of the Mayor's office, Pew's scope of work did not include an examination of treatment in and surrounding the criminal justice system. However, many of the recommendations in this report will improve care for people with criminal justice involvement by making it easier to access comprehensive services.

Likewise, although this report focuses on addressing the opioid crisis, it offers changes to the substance use treatment system that will benefit people who use other drugs. For example, creating additional avenues to access treatment will help more people get treatment when they are ready for it, regardless of the drugs they use.

A vision for the adult opioid use disorder treatment system

The District of Columbia has a high quality, easy to access, integrated public OUD treatment system that addresses the changing needs of the whole person and supports recovery. The treatment system embraces the following principles:

Accessing the treatment system

DC actively works to engage people with opioid use disorder in treatment. When they're ready, patients can access appropriate care immediately, with as few financial or administrative barriers as possible. Additionally, the District can implement policies that will provide active outreach to people who are not in treatment.

Integrating care and supporting care transitions

People with opioid use disorder receive support in addressing their health needs across multiple domains – mental health, substance use disorder treatment, physical health care, and social determinants of health. As their treatment needs change, they can seamlessly access the appropriate type of care.

Ensuring quality

Opioid use disorder treatment services at the system and provider level are high quality, defined as care that is safe, effective, patient-centered, timely, efficient, and equitable.

Preventing fatal overdoses

In addition to improving the treatment system and expanding access to care, DC pursues policies that reduce the risk of fatal overdoses to keep residents alive, wherever they are on their journey to recovery.

Supporting recovery

People with opioid use disorder receive support for their recovery through a treatment system that addresses their individual needs, including social determinants of health, so they can reach their full potential.

Accessing the treatment system

Vision: DC actively works to engage people with opioid use disorder in treatment. When they're ready, patients can access appropriate care immediately, with as few financial or administrative barriers as possible. Additionally, the District can implement policies that will provide active outreach to people who are not in treatment.

Background

Washington, DC has prioritized “equitable and timely access to high-quality substance use disorder treatment and recovery support services” in its opioid strategic plan, *Live.Long.DC*,¹⁹ and acted to achieve this goal. These steps include creating a pilot that links SUD patients to treatment following an emergency room visit, revising prior authorization requirements for medications for OUD (see text box on page 3),²⁰ and expanding the number of sites at which patients can access treatment.

The focus on timely access to treatment is important. Since methadone and buprenorphine treat the symptoms caused by withdrawal, any delays in starting people on these medications will increase the chance that someone will relapse and once again use illicit substances. Surveys of people who use drugs (PWUD) show that lack of available treatment slots and related wait times dissuade potential patients from seeking treatment for SUD.²¹ One survey demonstrated that more than 50 percent of SUD patients cited wait time as the largest barrier to treatment engagement.²² A study conducted in St. Louis, MO found that – among adults referred for residential and outpatient substance use treatment – patients who had been retained in treatment had a shorter waiting time between assessment and intake (3.2 days) than those who fallen out of treatment (5.3 days).²³ Similarly, a study of nearly 5,000 admissions to outpatient substance use treatment found that longer wait times between assessment and admission to treatment decreased the probability of individuals remaining in treatment (as measured by attending a fourth treatment session).²⁴

Conversely, initiating treatment “on demand,” or upon presentation to a clinic, results in positive outcomes, as shown by the examples below:

- *California*: An evaluation of San Francisco’s “treatment on demand” clinic found that the program increased the number of admissions by 15 percent in a one-year period.²⁵
- *Connecticut*: An analysis of an opioid treatment program (OTP) found after adopting “treatment-on-demand” that average wait times for starting treatment decreased from 21 days to same-day without impacts on retention, non-medical opioid use, or mortality. The study concluded that the implementation improved financial sustainability.²⁶
- *Florida*: An evaluation of an outpatient clinic found that wait times decreased from 33 days to zero within two weeks of adopting a treatment-on-demand model similar to that of San Francisco. Consequently, the rate of preadmission dropout fell from 54 percent to less than one percent.²⁷

DC has also prioritized conducting peer-led outreach to PWUD to proactively engage more people in treatment. This approach has been used for twenty years to link intravenous drug users with HIV to treatment and to reduce risk behavior,²⁸ and has more recently been adapted to help connect PWUD to substance use treatment. A study in the Chicago area found that this approach can be successful. Of more than 1,600 encounters, half led to an individual agreeing to linkage to medications for OUD. Of those, most (86 percent) showed up to the intake appointment and initiated medication.²⁹

Although the District has already made investments in reducing barriers to care and linking more people to treatment, Pew identified three opportunities to build on this work:

- Further increasing the number of access points for patients to receive care;
- Making treatment available after-hours for those seeking it; and
- Coordinating DC's outreach services to identify and refer more SUD patients to treatment;

This section of the report details how the District can make these improvements.

Recommendations

Recommendation 1: The Department of Behavioral Health should create a “no wrong door” approach to entering the treatment system by 1) requiring all contracted substance use disorder treatment facilities to provide assessment and referral services and 2) creating a process for primary care and mental health providers to provide assessment and referral services.

Problem

People with SUD in the District have limited entry points to the publicly funded treatment system.

Background

As discussed above, treatment systems that have fewer logistical barriers to accessing care get better results. One way to address these barriers is to create multiple sites where people can enter treatment.

Until recently, the Assessment and Referral Center (ARC) was the primary point-of-entry for SUD patients in the District to initiate treatment at OTPs (which provide methadone), residential facilities, and other specialty sites. Patients seeking care at one of these locations needed to go to the ARC between 7am and 6pm on a weekday to receive an assessment of their SUD, and a referral to the appropriate level of care (see text box below). Patients and providers reported that wait times were often several hours, and the Department of Behavioral Health (DBH) itself advises that patients arrive no later than 3:30pm to receive same-day services. In the evening and on weekends, patients could go to the Psychiatric Institute of Washington, which provides detoxification services only. While this provided another way to enter care, detoxification is unnecessary for all patients, many of whom can directly begin treatment with medication without going through medically-managed withdrawal.

What are the American Society of Addiction Medicine (ASAM) Levels of Care?

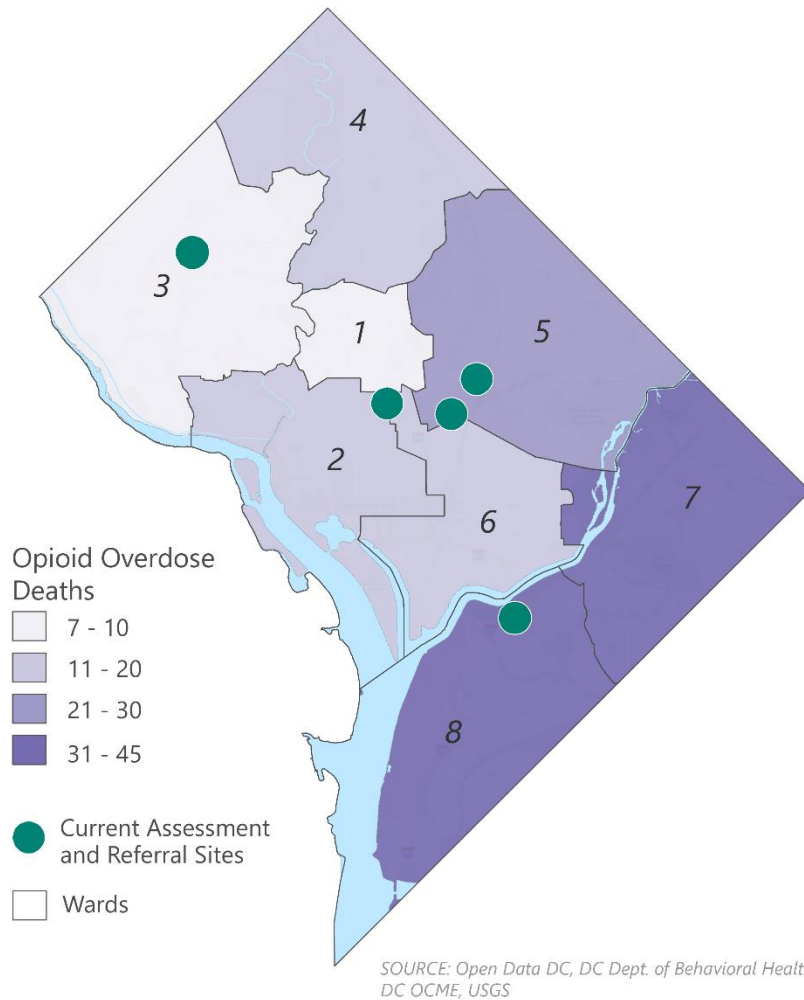
ASAM has put forth a set of guidelines for the treatment of patients with SUD, known as the *ASAM Criteria*. These guidelines divide treatment into four levels of care that provide varying treatment intensity, ranging from outpatient services (level 1) to medically managed intensive inpatient services (level 4). Within the varying levels of care, there are sub-levels to further distinguish the intensity of services offered.* The *ASAM Criteria* also include guidelines for providing treatment for co-occurring services within these varying treatment settings.† DC, like many states, uses the ASAM levels of care to organize the District’s substance use treatment services.

*The American Society of Addiction Medicine, “What are the ASAM Levels of Care?” May 13, 2015 (accessed October 11, 2019), <https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/>.

† D. Mee-Lee et al., *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Addictions* (Carson City, NV: The Change Companies, 2013).

To address these problems, DBH has certified other SUD treatment facilities to conduct assessment and referral, which has resulted in four additional sites. However, as of November 2019, there is no assessment and referral site in Ward 7, which has the District’s second highest overdose rate (see map below). Additionally, non-SUD providers, such as primary care offices, have no method of directly referring patients to the appropriate treatment.

Figure 1: Current adult assessment and referral sites and fatal overdoses by ward



Notes: This map includes the Psychiatric Institute for Washington as an assessment and referral site because it has traditionally been available to patients seeking treatment outside of business hours. The dot in Ward 8 represents two assessment and referral sites located in the same office building. Assessment and referral sites are current as of November 2019.

Sources: District of Columbia Department of Behavioral Health, Certified Provider Listing, accessed May 14, 2019, last modified May, 2019; District of Columbia Office of the Chief Medical Examiner, "Opioid-Related Fatal Overdoses: January 1, 2014 to July 31, 2019" (2019), https://ocme.dc.gov/sites/default/files/dc/sites/ocme/agency_content/OCME%20Opioid%20related%20Fatal%20Overdoses%20AUGUST.PDF.

During Pew's system assessment, stakeholders commented that the limited number of access points has resulted in a variety of challenges for patients seeking treatment:

- One provider said that the additional trip between referral and receiving treatment increased the probability of patient dropout – for example, if a primary care facility determines a patient requires methadone treatment, he or she must be sent to an assessment and referral site

before being sent to an OTP. Several providers shared with Pew that they had high no-show rates of patients referred by the ARC.

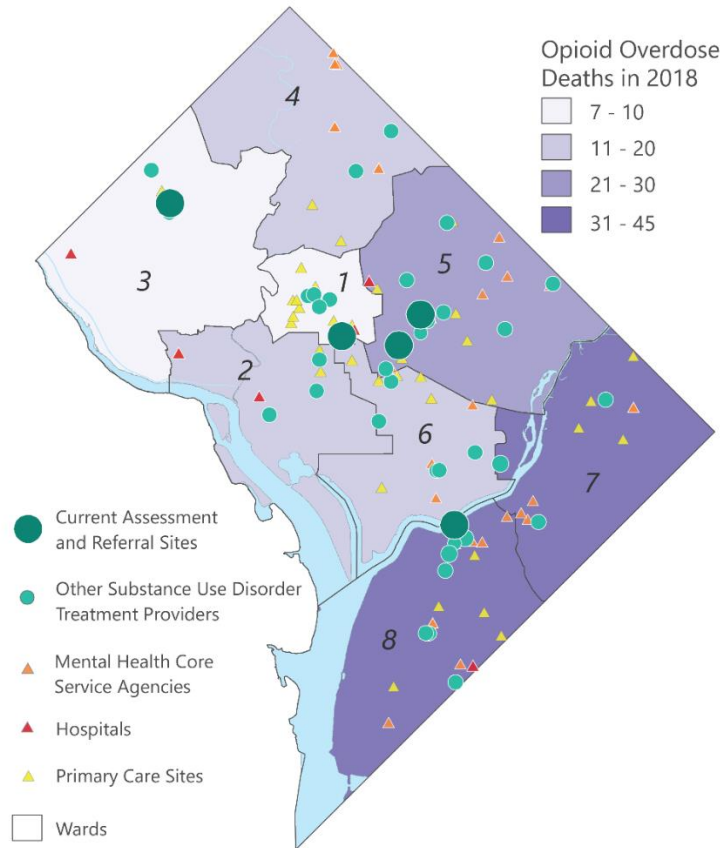
- Stakeholders also reported to Pew that if a patient was not seen at the ARC early in the day, he or she would have to wait until the next day to begin methadone treatment because the OTPs could only initiate treatment during certain hours.
- Some patients expressed frustration regarding the need to travel to multiple sites before receiving care.

A “no wrong door” model of access can address DC’s current challenges with treatment system entry. In this system, SUD providers can assess, refer, or start patients on treatment (when appropriate) in a variety of health facilities. To minimize wait times and improve access to treatment, many states and jurisdictions have adopted this model:

- Denver has adopted a “no wrong door” approach that involves assessment and referral of any SUD in the emergency room, residential facilities, jails, inpatient settings, FQHCs, and OTPs.³⁰
- Nevada allows screening for SUD to take place at office-based treatment programs, FQHCs, obstetric and neonatal service clinics, certified community behavioral health providers, and other provider types. Providers refer more complex cases to Integrated Opioid Treatment and Recovery Centers.³¹
- In Los Angeles County, people seeking treatment can access services through a helpline, client navigation services offered various government and community facilities (at the city, county, and state level), or by going directly to providers.³²
- In New Jersey, treatment providers screen and assess Medicaid beneficiaries using a standardized patient placement tool. The state then uses an independent entity to review placement decisions.³³
- Vermont submitted a state plan amendment last year that clarifies that Medicaid assessment services may be provided in primary care, specialty providers, hospitals, and clinic settings. The plan also sets out the types of professionals who may provide these services.³⁴

The “no wrong door” model allows providers to directly assess and refer their patients without additional administrative or logistical barriers. It builds on DBH’s current direction, by allowing all substance use treatment providers to assess and refer patients and providing a pathway for other providers, such as primary care, mental health clinics, and hospitals, to make direct referrals to treatment. The map below illustrates that the number of potential treatment entry points increases dramatically under the proposed changes.

Figure 2: Potential adult treatment entry points increase under proposed changes, and fatal overdose by ward



SOURCE: Open Data DC, DC Dept. of Behavioral Health, DC OCME, USGS

Notes: This map includes the Psychiatric Institute for Washington as an assessment and referral site because it has traditionally been available to patients seeking treatment outside of business hours. The marker for the current A&R site in Ward 8 represents two sites located in the same office building. Potential assessment and referral sites are all certified adult substance use treatment providers not currently offering these services. The true number of assessment and referral sites will be determined by the number of providers DBH contracts with for these services.

Mental Health Core Service Agencies are publicly-funded mental health facilities in the District. These facilities and primary care sites would conduct assessment and referral under the “no wrong door” access model.

The hospitals included in this map are adult acute-care hospitals. Due to data limitations, primary care sites include only FQHCs. This map also does not show free-standing mental health clinics. Because of these data limitations, the true number of potential treatment entry points is greater than illustrated here.

Sources: District of Columbia Department of Behavioral Health, Certified Provider Listing, accessed May 14, 2019, last modified May, 2019; District of Columbia Office of the Chief Medical Examiner, “Opioid-Related Fatal Overdoses: January 1, 2014 to July 31, 2019” (2019), https://ocme.dc.gov/sites/default/files/dc/sites/ocme/agency_content/OCME%20Opioid%20related%20Fatal%20Overdoses%20AUGUST.PDF. Government of the District of Columbia, “Open Data DC,” accessed November 12, 2019.

Solution

DBH should contract with all SUD providers to assess, refer, and if appropriate, initiate treatment for patients upon presentation and create a process for other providers, such as primary care and mental health, to also conduct assessment and referral services. This change would create more points-of-entry into the treatment system for patients seeking care. It would also reduce the number of trips and transitions between facilities, likely decreasing the probability that patients will drop out of treatment.

SUD Providers

DBH should require all contracted SUD providers to assess, refer, and if appropriate, initiate treatment for patients upon presentation. DBH and DHCF should then use retrospective utilization management strategies to ensure that patients are being referred to the appropriate level of care and that providers are not making inappropriate referrals to their own treatment services. The risk of being denied payment for services already rendered will create incentives for providers to make appropriate referrals. DBH and DHCF should also coordinate to evaluate the model by tracking metrics such as the number of new patients initiated, and the number of patients retained in treatment after 30 days.

Non-SUD Providers

DBH should create a process that allows mental health providers and primary care providers to conduct comprehensive SUD patient assessments and directly refer them SUD providers as necessary. Due to some regulatory barriers, it will take a multiple-step process for DBH to reach this goal.

1. In the short term, DBH should ensure that primary care providers and mental health providers can screen patients for SUD and refer them to SUD providers as necessary. These providers are currently equipped to conduct brief screens and can bill Medicaid for them, but lack information on treatment availability. DBH should provide a directory of SUD treatment facilities and the services offered to support referrals.
2. Within one year, DBH and DHCF should coordinate to enable non-SUD providers to perform comprehensive SUD assessments, which are more time- and labor-intensive than screenings.
 - **Regulatory changes:** Currently, only SUD providers are permitted to bill Medicaid for comprehensive assessments. DBH should revise rules to allow non-SUD providers to do so.
 - **Billing:** FQHCs currently receive a bundled payment for providing behavioral health services to patients. SUD assessments and referral are not currently included in the payment structure. To encourage FQHCs to perform this vital service, Medicaid should determine whether the current rate structure sufficiently reimburses these facilities to conduct more comprehensive SUD assessment. According to provider and agency stakeholders, SUD assessments are more time- and labor-intensive than screenings. These facilities may require more funding to provide these kinds of assessments. The amount of time and work an SUD assessment requires is reflected in the current DC Medicaid fee schedule: a comprehensive assessment carries a \$345.63 fee.³⁵
 - **Standardized assessment:** To ensure that these assessments are of a requisite standard, DBH and DHCF should require that non-SUD providers are performing the same certified

assessment that SUD providers are currently performing. To assist non-SUD providers to reach that standard, DBH should provide additional technical assistance.

- **Referral tool:** To facilitate the assessment and referral process, DBH should provide non-SUD providers with an online referral and treatment locator tool that identifies capacity at SUD provider facilities. This tool could display treatment site and provider-specific information, such as services offered and available treatment slots with online appointment capability to ensure real-time referral functionality. DBH could also use the tool to understand treatment capacity, utilization, and possible unmet need in real time. To create this tool, DBH could either procure a product available on the market, add this functionality to the existing health information exchange, or contract with a technology company to create a tool specific to the District. Potential funding sources for this tool include the Substance Use Block Grant. In order to share information, the tool should incorporate patient consents consistent with federal privacy rules.

To inform patients of these delivery system changes, DBH should also launch a public awareness campaign about these new treatment entry points for patients. This could include disseminating informational material and instructing community-based facilities and outreach teams to inform PWUD that treatment can begin at new entry points.

DBH and DHCF should also coordinate to evaluate the model by tracking metrics such as the number of new patients initiated, and the number of patients retained in treatment after 30 days.

Recommendation 2: The Council should fund the Department of Behavioral Health to pilot a 24/7 assessment, medication initiation, and referral site at an existing substance use disorder provider.

Problem

People with SUD in the District have limited options for entering the treatment system after standard business hours, creating a potential barrier for treatment.

Background

To effectively engage people in care, it is important to have treatment available when they are ready and before withdrawal symptoms occur. As discussed above, delays between seeking and beginning care are associated with treatment dropout,³⁶ and surveys of PWUD show that wait times dissuade potential patients from seeking treatment.³⁷ Programs that offer treatment on demand overcome these barriers and have high rates of treatment initiation and retention.³⁸

Expanding the number of assessment and referral sites in the District will help patients engage in treatment faster, but these sites operate during standard business hours. Additional resources are needed for people who work during the day and those who receive overnight outreach services and may decide they are ready for treatment during those encounters.

As of November 2019, individuals seeking care for SUD after-hours in DC have two options for treatment: emergency departments or an inpatient detoxification facility. Neither of these options fully meets the needs of people who want treatment. Space in the detox facility is limited, and not all patients require detoxification, while emergency departments are often overcrowded³⁹ and best utilized for individuals requiring immediate medical attention.

Therefore, it is important to create a treatment entry point that is available 24/7. Such a facility can assess patients, begin them on medication for OUD if appropriate, and refer them to follow-up care in the appropriate setting the next day.

Similar facilities operate in Arizona. A clinic in north Phoenix saw 1,400 patients during a 24-hour period in June 2018 and has begun to expand, citing a steady rate of 250 initiations per month.⁴⁰ At the Phoenix facility, 37 percent of all client intakes in October 2017 occurred between 7pm and 7am.⁴¹ In a survey of patients, the most frequent answer for why patients chose the clinic was that it had hours that best accommodated them.⁴²

The establishment of a 24/7 clinic that provides treatment on demand would complement the outreach services already offered in DC. If patients are ready for treatment, outreach teams could immediately transport them to the site to initiate treatment.

Solution

The Council should fund DBH to pilot a 24/7 assessment, medication initiation, and referral center for a two-year period. Funding will be needed because of the possibility that patient volume will not be sufficient to support this site through Medicaid billing. The center should offer all three medications for OUD, which would require the site be operated by an OTP or in partnership with one. The site should also offer care coordination and referral services for patients. This pilot should operate out of an existing health facility that isn't a hospital to avoid the risk that this site becomes a separate emergency room for patients with OUD, rather than a walk-in, outpatient treatment facility. Patients should have the option of continuing care at this facility if appropriate or receiving a referral to a treatment provider who better meets their needs.

DBH should conduct ongoing evaluation of the pilot, with an interim evaluation report occurring at one year, to determine its effectiveness and whether it should receive ongoing local funding. Suggested measures include:

- Patient volume;
- Rate of patients initiated at the site who have made their second appointment;
- Number of patients retained in care for 30 days;
- Time of day of initiation; and
- Whether it was their first attempt at treatment.

If the pilot increases treatment initiation and has sufficient patient volume to operate with a reasonable subsidy, the Mayor and Council should fund it on an ongoing basis.

Recommendation 3: The Deputy Mayor for Health and Human Services, with support from the Department of Behavioral Health, should coordinate District-funded outreach services to people who use drugs.

Problem

Outreach efforts for people with SUD are uncoordinated, resulting in duplication of services and the potential of missing key populations.

Background

Outreach services, for the purposes of this report, are teams of peers, social, or community health workers providing harm reduction services, education, case management, health services, or referral in non-clinical settings. Though literature on this subject is limited, existing evaluations of outreach programs highlight the potential of this work to both increase referrals and reduce emergency department visits.⁴³ One literature review found that outreach services improved health and housing outcomes for single adults with mental health and substance use issues.⁴⁴

DC is currently funding outreach services through several agencies, including DBH, DC Health, and the Department of Human Services (DHS). Outreach teams take a variety of approaches. Some focus on connecting people to SUD treatment, while others provide a wider range of services, including syringe exchange, naloxone distribution, and referral to homeless shelters.

Staff from these agencies and outreach providers reported that these efforts would be more efficient if they were better coordinated. This would facilitate more opportunities to provide complementary services, avoid duplicate site visits, and ensure coverage of vulnerable areas. There is also currently no systematic approach to collecting data from outreach programs, creating a missed opportunity to understand the approaches that are most effective at linking PWUD to services and treatment.

Coordinating outreach services and deployment schedules could improve the efficiency and effectiveness of DC's current outreach programs, as well as provide an opportunity for improved data collection from these teams. Data collected during outreach would not only strengthen DC's efforts to monitor and address an underserved population but would also contribute to the broader literature on outreach services.

DBH has recognized that coordinating outreach services is necessary and conducted a cross-agency meeting of outreach teams for December 2019. However, ongoing coordination is needed to most effectively provide these services.

Solution

As the Office of the Deputy Mayor of Health and Human Services oversees the activities and funding for DBH, DC Health, and DHS, this body should coordinate these outreach efforts with support from DBH. The Deputy Mayor's office should act as a convener for outreach teams and their respective project managers in each agency. DBH should serve as a subject matter expert for outreach. DBH's role in this process should include:

- Ensuring deployment areas and schedules meet the needs of PWUD, using timely, location-based data on overdoses from the District of Columbia Fire and Emergency Medical Services Department, drug seizure data provided by the Division of Forensic Sciences and the Metropolitan Police Department, and other relevant data sources including information provided to outreach workers by PWUD.
- Facilitating the sharing of promising practices for conducting outreach to PWUD;
- Exploring possibilities for complementary service provision across teams;
- Coordinating with the Department of Forensic Science to provide outreach teams information regarding drug composition that can be shared with PWUD; and
- Establishing a standardized approach to collecting outreach data.

The Deputy Mayor's office and DBH should work with the Lab @ DC to conduct rapid cycle evaluations to identify the most effective outreach approaches. DBH should then help outreach teams implement these evidence-based approaches.

Integrating care and supporting care transitions

Vision: People with opioid use disorder receive support in addressing their health needs across multiple domains – mental health, substance use disorder treatment, physical health care, and social determinants of health. As their treatment needs change, they can seamlessly access the appropriate type of care.

Background

People with OUD often have other conditions, such as diabetes, hypertension, hepatitis C,⁴⁵ other SUDs, and mental illness.⁴⁶ These co-occurring conditions require a health system that can meet multiple patient needs at once. In some cases, these needs can be met in integrated settings that address both physical and behavioral health or co-occurring mental health and substance use disorder treatment. In other cases, providers must coordinate with one another to address these various health problems. For people with SUD, care coordination can decrease the use of substances, overdoses, police contacts, and visits to the emergency department.⁴⁷

Given these benefits, care coordination is one of four components identified in effective models of OUD treatment in primary care.⁴⁸ According to CMS, care coordination includes the development of individualized treatment plans, monitoring patient outcomes and facilitating behavioral health services.⁴⁹ The Agency for Healthcare Research and Quality (AHRQ) says, “(c)are coordination involves deliberately organizing patient care activities and sharing information among all the participants concerned with a patient’s care.” It requires providers to ask about patients’ needs and preferences ahead of time and communicate this knowledge to the right people in a timely fashion.⁵⁰

OUD, like other chronic conditions, requires continuous care. However, nationally, many people leaving detoxification and residential facilities receive no follow-up care, leaving them vulnerable to relapse.⁵¹ In interviews with stakeholders, many outpatient providers and people with lived experience reported that this is a widespread problem in DC. Federal data confirms this: in 2017, just half of all District Medicaid beneficiaries with OUD who received inpatient or residential SUD treatment services received a community-based service within 30 days of discharge.⁵² Coordination between residential and outpatient treatment providers, including those located in primary care settings, can solve this problem.

The District has made strides towards better integrating and coordinating care for people with OUD. For example:

- All but one of the District’s FQHC provider organizations have at least one physician or advanced practice nurse with the federal waiver required to prescribe buprenorphine, allowing patients to receive both primary care and OUD treatment in the same place. The recently approved Medicaid 1115 waiver should also improve care transitions by reimbursing community behavioral health providers for care transition planning.⁵³
- As part of *Live.Long.DC*, Mary’s Center, one of the District’s FQHCs, has launched Project ECHO for other health centers in the District. This program uses a virtual learning environment to

increase primary care provider expertise and comfort in treating OUD and strengthens the integration of treatment for this condition into primary care settings.⁵⁴

- Hospitals are now starting people on medications in the emergency department and referring them to community services, which will help people transition to treatment.⁵⁵

To coordinate care, providers need information about the services their patients are receiving across settings. To date, it has been difficult for District providers to share SUD treatment information for two reasons. First, the health IT system used by DBH-contracted SUD providers, DataWITS, does not have any functionality to support data sharing across providers. Second, a federal regulation, 42 CFR Part 2, restricts the sharing of a patient's SUD treatment without their consent⁵⁶ and storing this consent is not currently possible within the District's HIE. CMS recently awarded DHCF a grant that will address both problems.⁵⁷ This initiative will further support an integrated, coordinated treatment system.

Pew's assessment of the District's treatment system identified three key pieces missing from the vision articulated above:

1. Medicaid's care coordination approach was not explicitly designed to meet the needs of enrollees with OUD.
2. Patients receiving medication in two of the District's three OTPs do not have access to co-located primary care.
3. Few behavioral health facilities in the District are certified to provide both mental health and SUD treatment services, creating gaps in care for those with co-occurring mental illness and SUD.

This section of the report offers recommendations to address these challenges and help the District achieve a system of integrated and coordinated care.

Recommendations

Recommendation 4: The Mayor should direct the Department of Health Care Finance, with support from the Department of Behavioral Health, to develop and implement a plan for enhancing Medicaid health homes' ability to coordinate care for Medicaid enrollees with opioid use disorder.

Problem

People with OUD have multiple health needs yet receive care in a fragmented health system that silos mental health, substance use, and physical health care.

Background

The District's Medicaid plan includes two health home programs that offer people with chronic conditions care coordination services that address their primary, acute, behavioral health, and long-term care needs, such as help transitioning between treatment settings and referrals to community and social support services. Health homes receive an extra payment in exchange for providing these services.⁵⁸

DC's first health home program, My DC Health Home, is for Medicaid enrollees with severe mental illness. Staff at community mental health providers serve as care teams for these enrollees.⁵⁹ The second health home program, My Health GPS, serves people with multiple chronic conditions, which can

include SUDs. Under this program, primary care providers, such as community health centers, provide care coordination services.⁶⁰

Although neither of these programs were designed specifically to serve people with OUD or other SUDs, patients with these conditions can be enrolled if they meet all the conditions of participation. In fiscal year 2016, 17 percent of all Medicaid enrollees eligible for My Health GPS had a SUD.⁶¹ However, only about 10 percent of all eligible individuals were enrolled in this health home,⁶² and in 2017, just two percent of District Medicaid enrollees treated for SUD received any care coordination services, defined as services that provide a single point of contact with health and social services and promote continuity of care.⁶³

Stakeholder interviews revealed challenges in the District’s health homes that make it difficult for participating providers to coordinate care for enrollees with SUD, including:

- **Patient enrollment:** Several providers reported that they did not know how to enroll eligible patients in the program.
- **Insufficient communication with SUD treatment providers:** While DHCF is working to improve data sharing among providers, community-based providers informed Pew that they frequently do not know when or where their patients are receiving residential treatment. This means that these providers cannot coordinate care for physical health conditions during a residential stay or facilitate transitions from residential to community-based treatment.
- **Peers are not part of care teams:** The state plan amendments for both health homes are unclear regarding whether peers can provide health home services.⁶⁴ Peers help patients with SUD attain community supports and resources related to social services such as housing and employment.⁶⁵ They also use their shared lived experience of recovery from a SUD to offer emotional support.⁶⁶ Peer support services are effective in reducing relapse rates, increasing treatment retention, and increasing satisfaction with treatment.⁶⁷
- **Perceived high administrative burden:** Providers reported spending hours documenting health home encounters for reimbursement, which detracted from time spent with patients.
- **Rate structure:** Some My Health GPS providers observed that the rates for providing care coordination services were insufficient to address the complex health needs of patients with SUD because of the time it takes to serve these patients. For providing health home services, My Health GPS reimburses providers at two rates: a higher rate for “high acuity” patients, and a lower one for “lower acuity” patients. Under the health home payment methodology, frequent ED use and/or frequent inpatient hospitalizations determine acuity.⁶⁸

As of December 2019, health home providers receive \$46.25 per member per month (PMPM) for services provided to the low acuity group.⁶⁹ The rate for the high acuity group is \$137.40 PMPM.⁷⁰ Both providers and agency staff reported that people with OUD were most often assigned to the low acuity group.

As shown in the table below, this rate is lower than those established in other states with opioid-specific health homes.

Table 1: Sample rates for opioid health homes

State	Rate (PMPM)
Maryland	\$100.85
Rhode Island	\$214
Vermont	\$148.01 or \$163.75 (rate is dependent on setting)

Source: L. Clemans-Cope et al., “Experiences of Three States Implementing the Medicaid Health Home Model to Address Opioid Use Disorder—Case Studies in Maryland, Rhode Island, and Vermont,” *Journal of Substance Abuse Treatment* 83 (2017): 27-35, <http://www.sciencedirect.com/science/article/pii/S0740547217301952>.

To better serve patients with OUD in enrolled in health homes, DHCF is providing education and technical assistance to My Health GPS providers as part of a grant awarded to the District by CMS.⁷¹ However, this technical assistance will not fully address the challenges identified above. Addressing these problems would fulfill the intent of Goal 5 of *Live.Long.DC*, which calls for improved care coordination, including linkages to treatment and social support services and an emphasis on physical health and mental well-being in substance use treatment programming.⁷²

This recommendation offers improvements to how the District operates its health homes so they can better serve Medicaid enrollees with OUD. While these changes will directly assist primary care providers and mental health agencies serving as health homes, recommendation 5 will bring care coordination services into OTPs by creating partnerships between methadone programs and health home providers.

Solution

The Mayor should direct DHCF and DBH to develop and implement a plan to strengthen the ability of Medicaid health home providers to respond to the needs of patients with OUD and other SUDs. The agencies should complete this plan by October 2020 so that any costs associated with implementing the plan can be incorporated into the fiscal year 2022 budget.

This plan should address the following areas for both health homes, except when it is noted that the recommendation applies to only one of the programs:

- **Patient enrollment:** Patients with SUD were not the primary target of DCHF and DBH’s enrollment strategies when the health homes were launched. The agencies should develop a strategy to enroll additional eligible patients with SUD into health homes, including the identification and enrollment of eligible Medicaid enrollees during intake at substance use treatment facilities and prior to release from the DC jail. DHCF should also educate My Health GPS providers on how to identify and enroll eligible patients.
- **Care transitions:**
 - a. **From inpatient and residential settings:** Currently, DHCF requires providers participating in both health homes to provide comprehensive transitional care from emergency departments and inpatient hospitalizations.⁷³ DHCF and DBH should develop a plan for how health homes should offer similar services when patients leave inpatient and residential SUD settings. To support this, DHCF and DBH should consider:
 - i. Providing technical assistance to SUD providers on connecting to the electronic health information exchange. DHCF recently published emergency rules for

enacting the 1115 waiver that require inpatient and residential SUD providers to participate in the Health Information Exchange (HIE).⁷⁴ Once these providers are participating, alerts can be sent to health homes when a patient is admitted, much like the alerts that are currently generated for hospital stays.

- ii. Requiring SUD providers to ask patients for consent at intake to share information with their health home providers. Once DHCF implements the HIE rules described above, these consents can be documented in the HIE. Until that technology is available, providers can obtain and document these consents with a paper form.
- b. **From health homes to SUD providers:** Patients should receive warm handoffs to SUD treatment providers, such as OTPs and residential treatment. These handoffs may include a peer accompanying the patient during an intake appointment and the provision of transportation services.
- **Health home teams:** DHCF and DBH should allow trained and certified peers to be a part of health home teams so that patients can receive these services. In doing so, DHCF and DBH clearly articulate the duties which peers can perform.
- **Helping providers succeed:**
 - a. **Administrative burden:** Health home providers, particularly those participating in My Health GPS, noted that participating in the health home programs created a large administrative burden that detracted from time spent managing patients and delivering care. DBH and DHCF should continue efforts to engage with providers to better understand these challenges and make administrative changes to reduce this burden, in accordance with CMS requirements.
 - b. **Rate structure:** As discussed above, in My Health GPS, the rate providers often receive for patients with OUD (\$46.25 PMPM) is lower than the rates providers receive in some states with opioid-specific health homes (at least \$100 PMPM).⁷⁵ Given that DC has a higher rate available for high acuity health home enrollees, DHCF should re-examine how acuity is determined to ensure that patients with OUD are correctly placed. While they may have low rates of engagement with health care services, including the emergency department and hospitalizations, people with OUD often have complex health needs including co-occurring mental illness, multiple chronic conditions, and other substance use disorders.⁷⁶ These needs may make the higher acuity rate appropriate for this patient cohort.
 - c. **Capacity building:** Both current and potential health home providers may need help to build the capacity to effectively provide health home services. Areas where assistance may be needed include outreach to new patients, training staff, and developing workflows which include health home services. DBH and DHCF should continue to engage with providers to better understand these needs and provide assistance as necessary.

To develop this plan, DHCF and DBH should hold listening sessions with patients and providers to ensure that their voices are represented. Upon developing the plan, DHCF should submit the necessary Medicaid state plan amendments, revise regulations as needed, and implement the plan.

To pay for one-time expenses associated with these changes, DBH should re-direct federal State Opioid Response grant funds that had been set aside for a hub and spoke system, since these changes will fulfill the same goals.

When implementing this plan, DHCF and DBH should measure the effectiveness of health homes in serving patients with OUD. These measures should include:

- The eligibility and enrollment rates of Medicaid enrollees with OUD in these health homes.
- The effectiveness of these health homes in addressing OUD. In November 2019, CMS published an informational bulletin containing reporting measures for SUD-focused health homes and urged states to also adopt them for non-SUD focused health homes. These measures examine the use of medications for OUD and follow-up care from the emergency department after visits for SUD.⁷⁷ DC should use these and other measures to evaluate how health homes are meeting the treatment needs of their enrollees.
- The effectiveness of these health homes in addressing the other health needs of enrollees with OUD. These measures could include the rates of hospital and emergency department admissions for ambulatory-care sensitive conditions or measures relating to specific chronic diseases.

Recommendation 5: The Council should fund the Department of Behavioral Health, in collaboration with DC Health, to establish a one-time grant to support the co-location of primary care providers in opioid treatment programs.

Problem

Residents with OUD treated at two of the District's three OTPs do not receive integrated substance use treatment and medical care.

Background

OUD is associated with increased risk of other health problems. A study of adults in Durham County, North Carolina found that having OUD was associated with an increased likelihood of having hypertension, arthritis, diabetes, chronic kidney disease, asthma, chronic obstructive pulmonary disease, ischemic heart disease, cancer, and hepatitis B or C.⁷⁸ Intravenous drug use also increases the risk of infectious diseases, including hepatitis B and C, HIV, and endocarditis.⁷⁹ Rates of co-occurring mental health disorders are also high. One estimate found that approximately 64 percent of adults with OUD also had any mental illness, and about 27 percent had a serious mental illness, defined as one that substantially interferes with or limits major life activities.⁸⁰

The same population most affected by the District's opioid crisis also disproportionately face other health challenges. In Wards 7 and 8, which have the highest opioid overdose fatality rates,⁸¹ approximately 22 percent and 26 percent of adults, respectively, report being in "fair or poor health." District wide, just 13 percent of adults report "fair or poor health" status.⁸² Moreover, these two wards have the highest rates of several chronic conditions, including asthma, chronic obstructive pulmonary disease, and diabetes.⁸³

However, primary care utilization by Medicaid enrollees in the District is low. According to the 2018 Primary Care Needs Assessment, only about half of adults aged 35-64 had any primary care visits during a 12-month period from June 2015-May 2016.⁸⁴ However, more than 90 percent of patients served in

OTPs were retained in care in fiscal year 2018, indicating that patients connected to these providers return regularly.⁸⁵

Offering primary care services at the same site as substance use treatment can improve engagement in primary care. In a randomized trial, more than 90 percent of patients who were offered medical care on-site at their OTP received treatment for their medical conditions, compared to only 35 percent of patients who received referrals to care.⁸⁶ A longitudinal study found that patients who used an OTP's on-site medical clinic as their usual source of care had more outpatient visits and fewer emergency department visits and hospitalizations than patients who did not receive medical services at the OTP.⁸⁷

The District's 2017 Health Systems Plan, which guides the District's development of health services, identified integrating behavioral and physical health care as an important goal.⁸⁸ However, as of 2019 only one of the District's three OTPs, PIDARC, is co-located with a primary care clinic. This is a missed opportunity for improving the health of individuals with OUD. In interviews with Pew, staff from other OTPs reported that they are interested in adding primary care services, as many patients do not follow through on referrals to off-site care, but they identified the start-up costs of integrating physical health care as the main barrier to doing so.

Solution

DBH, in collaboration with DC Health, should offer a one-time grant to support the two OTPs without co-located primary care – the United Planning Organization Comprehensive Treatment Center and the Behavioral Health Group Washington DC Treatment Center – in partnering with a primary care provider to offer comprehensive primary care services on-site. Following the establishment of these services through the grant, routine insurance billing will sustain them. This grant will ensure that patients can access similar services regardless of the methadone treatment provider they choose.

The District should structure this grant in two phases. In phase 1, the OTPs would receive financial support and technical assistance for developing a plan for primary care integration. This plan should include details such as: the collaborating primary care entity; the services that will be available, how, and where primary care services will be provided, including the role of telehealth; how the primary care provider and the treatment provider will collaborate on a single care plan; and other aspects of integration identified by DBH and DC Health. To ensure that OTP patients receive care coordination services, the partnering entity should be a Medicaid health home.

Once DBH and DC Health approve the plan, phase 2 of the grant would cover capital costs associated with providing care on-site, including changes to the physical space and upgrades to health IT systems to allow information sharing across the co-located providers. Because states cannot use this grant or the Substance Abuse Block Grant to pay for capital expenditures,⁸⁹ the Council will need to fund phase 2 in the budget. This funding should be made available at the beginning of fiscal year 2021, with the expectation that co-location is completed during that fiscal year.

As a condition for receiving this funding, DBH should require OTPs to add buprenorphine and naltrexone to their medication offerings to ensure that the OTP can meet patients' full OUD treatment needs.

The District should evaluate this approach, and if it is successful, consider its application to other outpatient behavioral health settings, such as mental health core service agencies. Measures should

include the number of primary care claims by OTP patients before and after the implementation of co-located primary care, and changes in emergency department and hospital utilization.

Recommendation 6: The Department of Behavioral Health should create a co-occurring certification that can be added to an existing mental health or substance use disorder certification. In support of this, the Department of Health Care Finance should ensure that providers with this certification can bill for co-occurring services.

Problem

The District's treatment system does not provide a full range of services for people with co-occurring SUD and mental illness.

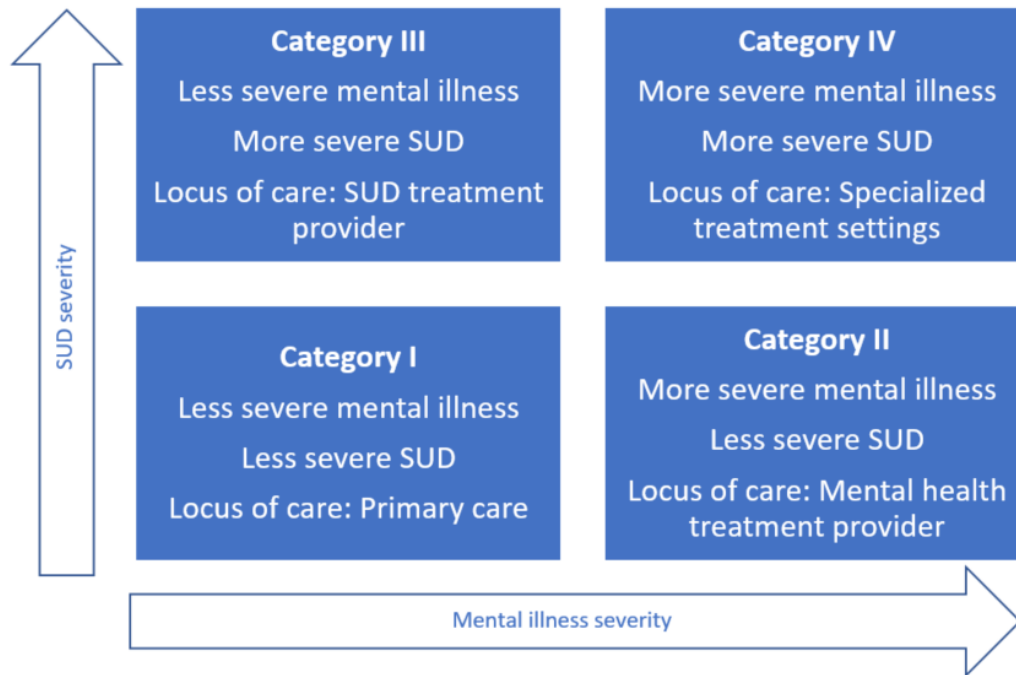
Background

Co-occurring mental illness and SUD are common. In fiscal year 2018, 16 percent of all District Medicaid enrollees with a behavioral health diagnosis had co-occurring serious mental illness and SUD.⁹⁰

Nationally, as mentioned above, more than half of adults with OUD also have any mental illness, and approximately one quarter have a serious mental illness, defined as one that substantially interferes with or limits major life activities.⁹¹

Given these high rates of co-occurring disorders, integrated SUD and mental health treatment has emerged as an important component of behavioral health systems. The Substance Abuse and Mental Health Services Agency (SAMHSA) defines integrated treatment as "a means of coordinating substance abuse and mental health interventions to treat the whole person more effectively." It can be delivered in a variety of settings, depending on the patient's treatment needs. SAMHSA categorizes co-occurring disorders into four quadrants with appropriate treatment settings (Figure 3).⁹²

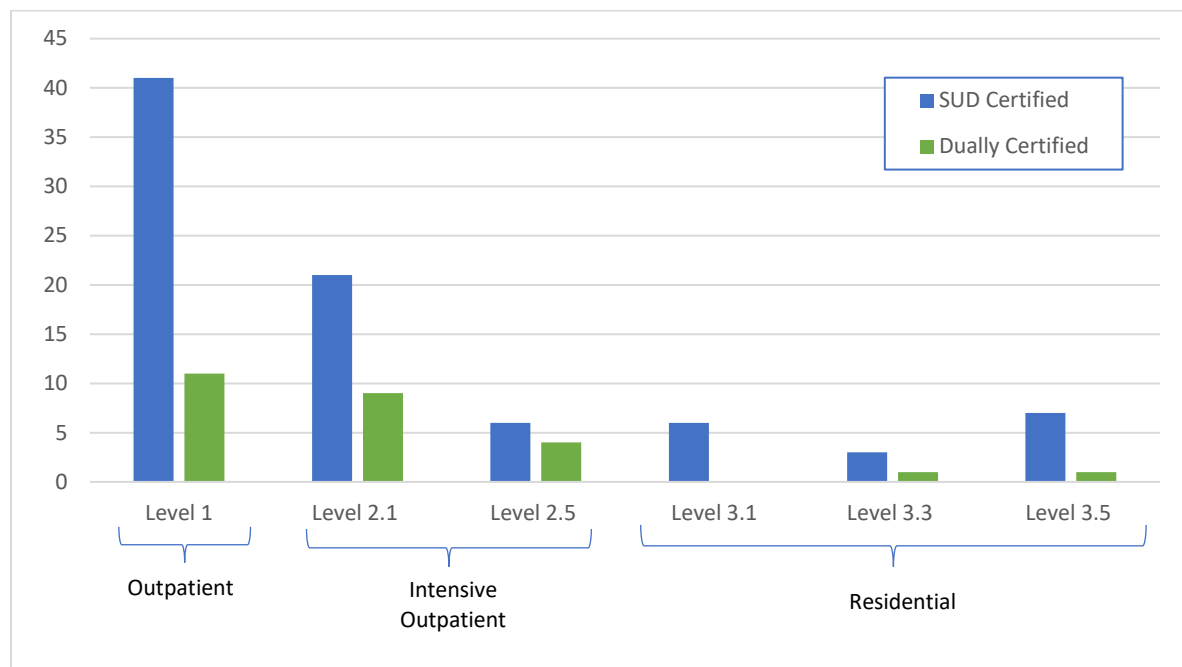
Figure 3: Level of care quadrants for co-occurring disorders



Source: Adapted from Substance Abuse and Mental Health Services Administration, “TIP 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders” (2013), <https://store.samhsa.gov/file/23170/download?token=FBHtrcSs&filename=SMA13-3992.pdf&sku=SMA13-3992>.

Yet few of the District’s SUD treatment facilities are dually certified to offer both mental health and SUD treatment, which would allow them to effectively treat patients in category III, as illustrated above.⁹³ As shown in Figure 2, this gap is particularly evident in the residential treatment continuum (ASAM levels 3.1-3.7 – see text box on page 8).

Figure 2: Number of dually-certified SUD treatment facilities in Washington, DC by ASAM level of care



Source: Pew analysis of District of Columbia Department of Behavioral Health, “Certified Provider Listing”, (May 14, 2019).

One reason for this is that the District has separate sets of regulations for SUD and mental health treatment providers.⁹⁴ According to interviews with providers, the burden of complying with both sets of regulations is the main barrier to obtaining both certifications. The two sets of regulations were originally created by separate agencies and have few parallels. For example, while the mental health regulations include detailed guidance on staffing and provider qualifications, the SUD regulations are less detailed in this area. This means that for a SUD provider to add any mental health services, they may have to significantly alter their staffing structure, despite the ASAM criteria providing guidance on how SUD treatment facilities can add co-occurring capabilities without becoming full-fledged mental health treatment facilities.⁹⁵ Additionally, the regulations do not establish the standards of care for co-occurring services. Instead, they simply require SUD providers to coordinate with mental health providers.⁹⁶ This leaves treatment facilities without guidance on how to treat patients with both mental illness and SUD.

Solution

By September 2020, DBH should publish final rules establishing standards for co-occurring treatment that are in line with clinical practices such as those identified by SAMHSA Treatment Improvement Protocol 42,⁹⁷ the ASAM Criteria,⁹⁸ and the SAMHSA Dual Diagnosis Capability in Mental Health Treatment Toolkit.⁹⁹ These rules should also provide a method by which a currently certified mental health or substance use provider can receive the co-occurring certification without needing to receive a full certification for mental health or substance use treatment, as applicable.

While drafting these rules, DBH should plan to minimize the time and effort required of providers to obtain a co-occurring certification. While quality should be ensured, and DBH should ensure that patient

assessment and placement decisions take into consideration the severity of a patient's SUD and mental illness, obtaining this certification should be less of an administrative burden than obtaining a full additional mental health or SUD certification.

DHCF should ensure that providers with this certification can bill Medicaid for co-occurring services. This may require submitting a state plan amendment to CMS adding these services as a benefit. Enhanced rates may be necessary to support the higher skill level needed to provide these services. For example, New Jersey has established rates specifically for co-occurring services.¹⁰⁰

DBH should collaborate with DHCF to evaluate these changes. Measures should include:

- The number of facilities with a co-occurring certification;
- The number of patients with co-occurring SUD and mental illness with an integrated care plan; and
- Utilization of co-occurring services.

Ensuring quality

Vision: Opioid use disorder treatment services at the system and provider level are high quality, defined as care that is safe, effective, patient-centered, timely, efficient, and equitable.

Background

Like any health service, behavioral health treatment should be high quality. In the landmark report *Crossing the Quality Chasm*, The Institute of Medicine identified six priority areas for ensuring quality care: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.¹⁰¹ While that report focused on physical health care, later work affirmed the appropriateness of these priority areas for behavioral health.¹⁰²

The District has taken several important steps to ensuring the quality of treatment provided. One important aspect of this is measuring provider performance. Through the Results Based Accountability initiative, DBH has developed metrics for the department's contracted providers that will be used to evaluate the care they deliver. *Live.Long.DC.* is taking this work a step further by exploring ways to tie payment to performance.¹⁰³

DC has also ensured that Medicaid pays for medications for the treatment for OUD, which are the most effective forms of treatment (see text box on page 3).¹⁰⁴ All three FDA-approved medications for treating the condition are covered, and buprenorphine prescriptions up to 24 mg/day and injectable naltrexone are available without prior authorization.¹⁰⁵ Patients are increasingly accessing these medications. For example, from 2011 to 2018, the number of buprenorphine prescriptions per 1,000 Medicaid enrollees ages 12 and older increased by 170 percent.¹⁰⁶ Naltrexone prescriptions also increased over the same period, though not as dramatically.¹⁰⁷

In residential treatment settings, however, access to these medications remains restricted, reducing the quality of care provided. This report makes one recommendation for improving quality by addressing this issue.

Recommendations

Recommendation 7: The Council should require all residential substance use disorder treatment facilities to provide on-site access to all three FDA-approved medications for opioid use disorder, either directly or through a contract with an outside provider.

Problem

None of the nine residential treatment facilities in the District initiate patients on medications for OUD (see text box on page 3).

Background

In Fiscal Year 2018, residential substance use treatment accounted for more than half of substance use expenditures in the District's publicly-funded treatment system.¹⁰⁸

Despite the high utilization of residential services in the District's SUD treatment system, none of the nine facilities start patients on medication. While all facilities state that they accept patients currently on medication, Pew heard from people in the District with OUD that these facilities sometimes confiscate previously-prescribed buprenorphine.

Solution

The District should use a two-phase approach to require residential treatment facilities to provide medications for OUD.

Phase 1

In November 2019, DHCF published emergency and proposed rules requiring residential treatment providers to either provide medications directly or facilitate access to medication through transportation as a condition of receiving Medicaid reimbursement. This requirement takes effect January 1, 2020.¹⁰⁹

DHCF should amend these rules to clarify that residential treatment providers must facilitate both the initiation and maintenance of medications for OUD when clinically appropriate, and that patients must have access to all forms of FDA-approved medication.

DHCF should then enforce these rules through 2020.

Phase 2

In 2020, the Council should pass a law requiring all residential facilities to provide buprenorphine and naltrexone on-site and have an agreement with at least one OTP regarding methadone dosing during residential stays. This law should direct DBH to revise certification regulations for ASAM levels 3.1 and above to require:

- The initiation and maintenance of buprenorphine and naltrexone on-site, either by clinicians directly employed by the facility or in partnership with another provider;
- An agreement with at least one OTP regarding methadone initiation and dosing which can be provided through transportation or other arrangements;
- Facility policies allowing patients to bring previously prescribed buprenorphine with them to the residential facilities and allowing patients to obtain refills;
- Facility policies against tapering medication, unless determined to be medically necessary or desired by the patient; and
- Annual reports on facility compliance with these regulations, the total number of unduplicated patients served, the number with OUD, and the number using each of the three medications.

To give facilities time to plan for these changes, the regulations should take effect one year from their adoption. If facilities are not able to comply by this date, DBH should require them to submit a plan for coming into compliance within six months. DBH would then approve the plan or require revisions to ensure the facility will be able to provide medications on-site.

Once implementation begins, DBH should monitor compliance through site visits and using Medicaid claims data to determine whether people in residential care are also filling prescriptions for medication. A high percentage of people with OUD should have simultaneous claims for residential treatment and medication. However, the expectation should not be that all patients have these simultaneous claims

because some will prefer not to use these medications. If residential facilities are not providing medication, DBH should follow existing policies regarding compliance issues, up to and including decertification, if necessary.

Preventing fatal overdoses

Vision: In addition to improving the treatment system and expanding access to care, DC pursues policies that reduce the risk of fatal overdoses to keep residents alive, wherever they are on their journey to recovery.

Background

While it is critical for any substance use treatment system to ensure that PWUD can quickly access high quality, integrated care, it is also important to recognize that not everyone who uses drugs is ready for treatment. SUD is also a chronic, recurring disease, like hypertension and asthma, which means that people in treatment or recovery commonly use again.¹¹⁰ For these reasons, it is important to have policies in place that prevent fatal overdoses.

The District has already implemented multiple laws and programs that do just that:

- In 2012, the Council passed a Good Samaritan Law that protects both people who overdose and those who seek medical assistance for them from a variety of legal consequences.¹¹¹
- In 2016, the Council passed a law allowing community-based organizations and pharmacists to distribute naloxone, a drug that reverses opioid overdose by restoring normal respiration.¹¹² In 2019, DC Health built on these efforts by providing free naloxone at select pharmacies throughout the District¹¹³ and partnering with faith-based organizations to train their congregations on naloxone administration.¹¹⁴
- In 2018, the Council decriminalized the possession and use of drug checking supplies.¹¹⁵ Supplies such as fentanyl test strips allow PWUD to better understand the makeup of the substances they are using and take steps to use more safely. These steps can include using less of the substance, using more slowly, or doing a tester shot.¹¹⁶

Pew identified two additional opportunities to build on this work and save more lives.

Recommendations

Recommendation 8: The Council should amend the District's 911 Good Samaritan law to ensure legal protections for overdose bystanders to encourage more individuals to call for help in the event of an overdose. Additional training should be made available to people who use drugs and first responders regarding amendments to this law.

Problem

DC has the fourth-highest overdose death rate in the country.¹¹⁷ During Pew's system assessment, people in recovery and PWUD expressed hesitancy to call emergency services due to fear of legal involvement.

Background

Throughout Pew's system assessment, individuals in recovery and current users expressed concern that they will experience legal consequences when police arrive on the scene of an overdose. Such concerns

are common among PWUD. In fact, a 2005 Baltimore study found that fear of arrest was associated with not calling 911, even though arrest was largely uncommon.¹¹⁸ A more recent study in Baltimore found that PWUD remain widely fearful of arrest for drug or paraphernalia possession, outstanding warrants, and/or trespassing.¹¹⁹

In an effort to allay these concerns, 46 states and the District had passed 911 Good Samaritan laws as of January 2019.¹²⁰ These laws encourage PWUD to call for help in the event of a suspected overdose by protecting them from drug-related charges, and are associated with reductions in opioid overdose mortality.¹²¹ The CDC recommends offering protection from criminal charges, supervision violation, warrant searches, and property seizure to all individuals at the scene of an overdose, including the overdose victim, the person that seeks care, the person administering naloxone, and all other bystanders.¹²² By removing the legal risks to bystanders, they are no longer “forced to weigh their own wellbeing against the wellbeing of the person who is in crisis in front of them.”¹²³ Prominent harm reduction organizations, such as the Drug Policy Alliance, also recommend that 911 Good Samaritan laws be as broadly applied as possible with respect to what immunity they provide and to whom.¹²⁴

DC’s 911 Good Samaritan law provides broad legal protection against possession of controlled substances or paraphernalia, under-age alcohol consumption, and violations of probation or parole. However, these protections apply only to victims of overdose, individuals that seek care for someone experiencing an overdose, and individuals administering naloxone; the protections notably omit bystanders.¹²⁵ Various stakeholders in DC reported to Pew that arresting individuals at the scene of an overdose is uncommon. However, because DC’s law doesn’t explicitly prohibit arresting bystanders, the decision is left to the discretion of the officer at the scene and contributes to the fear of arrest among PWUD. Amending DC’s 911 Good Samaritan law to expand existing legal protections to bystanders could increase trust among PWUD that they will not experience legal consequences when calling for help.

Vermont’s 911 Good Samaritan law provides an example of how states can offer immunity to all overdose bystanders, even if they do not seek medical attention for themselves or someone else.¹²⁶ DC’s law would be in accordance with CDC’s guidance if it applied its already strong legal protections to everyone at the scene of an overdose, rather than specific individuals.

It is also important for key populations, such as PWUD and first responders, to be aware of and understand the 911 Good Samaritan law in their jurisdiction.¹²⁷ A survey of first responders in Washington state demonstrated that only 16 percent of police officers were aware of the protections their 911 Good Samaritan law offered.¹²⁸ Similarly, two-thirds of participants at a needle exchange program in Baltimore were unaware of their state’s Good Samaritan law.¹²⁹

Familiarity with Good Samaritan laws makes it more likely for PWUD to call for help.¹³⁰ Many states provide targeted education for these populations in an effort to enhance the effectiveness of these laws: Maryland’s Behavioral Health Administration has produced a set of flyers, posters, and promotional videos that are displayed and distributed to PWUD at community-based organizations.¹³¹ The Harm Reduction Coalition has provided detailed descriptions of state-specific 911 Good Samaritan laws to police departments in North Carolina, South Carolina, Georgia, and New York.¹³² Online trainings have also been shown to be effective in enhancing police officers’ knowledge of these laws.¹³³

Solution

DC should amend its 911 Good Samaritan law to grant legal protections to all individuals at the scene of an overdose to encourage individuals to call for medical aid. The same protections the law currently offers to overdose victims and the person who calls for help should extend to these bystanders.

To complement these changes, DC Health should produce and distribute informational material to community-based organizations, syringe exchanges, drug treatment facilities, and correctional facilities to raise awareness among PWUD of changes to the Good Samaritan law. The District's outreach providers could also distribute these materials. Similarly, DBH should coordinate with the DC Metropolitan Police Department to create new training modules that include details on the updated law as a part of ongoing officer training.

Lastly, DC's overdose law recommends a list of metrics that the Mayor may include in an annual report to the Council. One of the metrics is "police arrests made in response to seeking health care for a person experiencing an overdose."¹³⁴ This reporting is currently not mandatory but making it so would allow the District to track the effectiveness of the 911 Good Samaritan Law.

Recommendation 9: To improve DC's naloxone distribution, the Council should remove the legal requirement that staff of community-based organizations receive training from DC Health to distribute naloxone. If this requirement is not removed, the Council should require DC Health to certify facilities and organizations for naloxone distribution and training.

Problem

Community based organizations report difficulty meeting DC Health requirements for distributing naloxone to PWUD.

Background

Naloxone is a safe, effective drug that reverses opioid overdose by restoring normal respiration.¹³⁵ There are three FDA formulations: injectable, auto injectable, and nasal spray. First responders typically use injectable formulations of naloxone while the auto injectable, and nasal spray are relatively easy to use and can be administered by lay people.¹³⁶

The CDC has recommended providing naloxone to people most likely to witness an overdose – first responders and PWUD.¹³⁷ Evaluations of naloxone distribution programs demonstrate that most overdose reversals – in some cases as high as 90 percent – are administered by PWUD.¹³⁸ It is therefore vital to ensure that naloxone is distributed to this population in particular.

In 2016, the Council passed legislation mandating that anyone interested in distributing or administering the medication must receive training from DC Health as a requirement to receive free naloxone from the city.¹³⁹ According to interviews Pew held with groups who provide care to PWUD, homeless shelters and community-based facilities have experienced difficulties ensuring staff receive the mandated training. Stakeholders reported that DC Health's training capacity had not met demand, as courses were often booked months in advance. This has resulted in facilities that serve people at risk of experiencing or witnessing an overdose having long periods of time where no staff were legally qualified to distribute naloxone because of staff waiting for training openings or staff turnover.

In recognition of this problem, DC Health has developed "train the trainer" courses and an online training module. Studies show that training, familiarity, and comfort are important components of

effective naloxone distribution.¹⁴⁰ However, naloxone distribution that is conditional on mandatory training requirements is not a common practice in other states or jurisdictions.¹⁴¹ The benefits of having naloxone widely available vastly outweigh the risks, as it has no negative health effects when administered to people with no opioids in their system¹⁴² and does not increase risk-taking behavior.¹⁴³ Further, there are no significant differences in overdose reversals when naloxone is administered by trained individuals compared to when it is administered by untrained ones.¹⁴⁴

Finally, as of October 2019, DC Health's online curriculum for naloxone training has an estimated completion time of ninety minutes.¹⁴⁵ While the module contains interesting background information, The National Drug Court Institute and the Harm Reduction Coalition recommend that basic training should be limited to the following:

- Risks for opioid overdose;
- Recognizing the signs of an opioid overdose;
- Steps of overdose response – try to wake the person up, call 911, give naloxone, give rescue breathing if able, administer a second dose if no change has occurred in three to five minutes, until the person wakes up or medical help arrives;
- How to administer naloxone;
- How to perform rescue breathing if able;
- Local 911 Good Samaritan laws.¹⁴⁶

The National Drug Court Institute also states that trainings under 15 minutes are suitable for most individuals.¹⁴⁷

Solution

Given the safety and efficacy of naloxone when administered by laypeople, and the District's high overdose rate, the Council should remove the requirement that individuals receive training from DC Health to distribute naloxone.

If the Council declines to remove this requirement, it should amend DC Law 21-186 to allow DC Health to certify facilities and organizations that primarily serve populations at-risk of experiencing or witnessing an overdose to distribute naloxone, such as harm reduction organizations and homeless shelters. Any facility or organization that currently distributes naloxone should be certified to dispense it going forward without requiring additional training. New facilities or organizations interested in dispensing naloxone should enroll their team members in initial trainings provided by DC Health or another organization acceptable to DC Health to become certified. After this initial training, the facility should be certified to distribute naloxone without being held to the individual requirements for new staff, as current staff can educate new hires as needed.

DC Health should continue to offer in-person training, online training, and train-the-trainer courses to interested individuals. By certifying institutions rather than individuals, DC Health can ensure staff receive sufficient training while reducing the likelihood of gaps in naloxone provision.

DC Health should also revise the online training to be in line with recommendations from the National Drug Court Institute and the Harm Reduction Coalition, which provides similar guidance (see Figure 3).

Much like businesses regularly display posters about performing the Heimlich maneuver, facilities can post materials like the flier below to remind clients and staff about the proper use of naloxone.

Figure 4: The Harm Reduction Coalition's essential training for responding to an overdose

Emergency Response for Opioid Overdose

nasal naloxone

harm reduction COALITION

Try to wake the person up

- Shake them and shout.
- If no response, grind your knuckles into their breast bone for 5 to 10 seconds.

Call 911

If you report an overdose, New York State law protects you and the overdosed person from being charged with drug possession, even if drugs were shared.

Administer nasal naloxone

- Assemble nasal naloxone.
- Spray half up each nostril.
- Repeat after 2 to 5 minutes if still not conscious.

Check for breathing

Give CPR if you have been trained, or do rescue breathing:

- Tilt the head back, open the mouth, and pinch the nose.
- Start with 2 breaths into the mouth. Then 1 breath every 5 seconds.
- Continue until help arrives.

Stay with the person

- Naloxone wears off in 30 to 90 minutes.
- When the person wakes up, explain what happened.
- If you need to leave, turn the person on his or her side to prevent choking.

Source: The Harm Reduction Coalition

Supporting recovery

Vision: People with opioid use disorder receive support for their recovery through a treatment system that addresses their individual needs, including social determinants of health, so they can reach their full potential.

Background

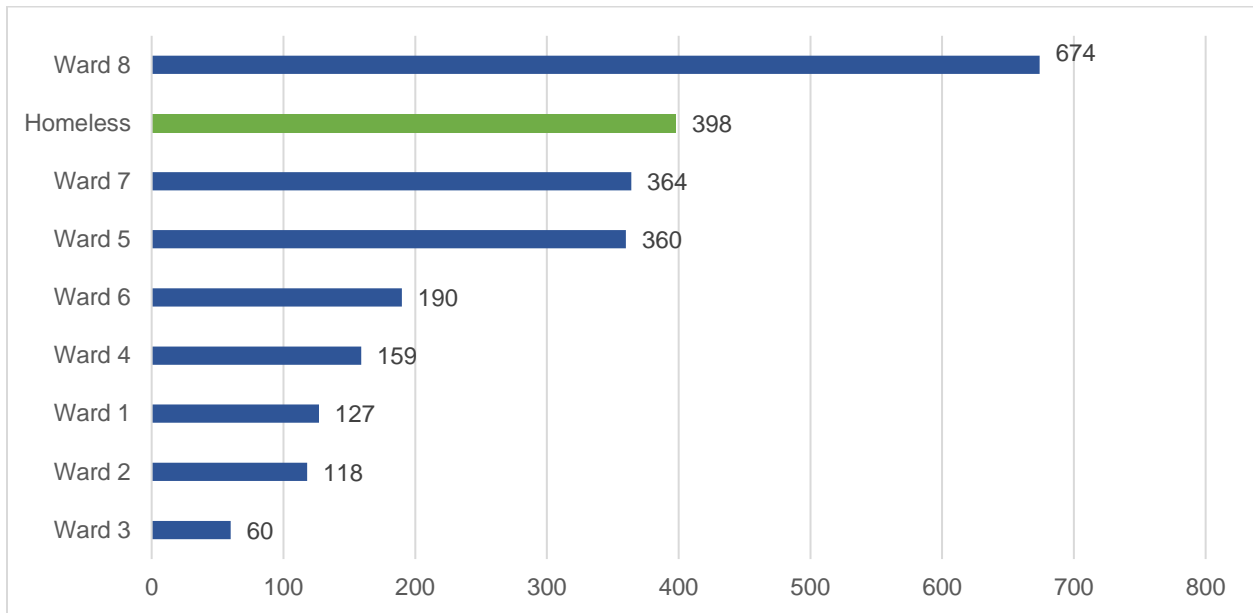
SAMHSA defines recovery as “a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential.”¹⁴⁸ The District has taken steps to help people with a SUD engage with this process. For example:

- **Peer supports:** For many people with a SUD, working with a peer is an important part of recovery. The use of peers reduces relapse rates, improves relationships and social supports, improves satisfaction with the treatment experience, and increases treatment retention.¹⁴⁹ The District has invested in ensuring peer services are available. In fiscal year 2019, DBH certified 132 individuals to provide peer services to people with SUD.¹⁵⁰ Through the 1115 waiver approved by CMS in 2019, the District will be able to use Medicaid funds to pay for recovery support services which can be delivered by peers.¹⁵¹
- **Employment:** For many PWUD, gaining and maintaining employment is another important part of recovery. Pew heard directly from people with lived experience, as well as providers serving them, that many people with OUD in the District want to work but face challenges gaining employment. To help them accomplish this goal, the District’s Medicaid 1115 waiver is implementing supported employment services for people with SUD to help them prepare for, obtain, and maintain a job.¹⁵²

Pew’s system assessment identified housing, one of the four pillars that support recovery according to SAMHSA,¹⁵³ as an area where additional progress is needed. Although the District provides housing for many people through DBH,¹⁵⁴ serving 2,282 people in fiscal year 2018,¹⁵⁵ the need for housing is greater than the supply. In interviews, both people with lived experience and providers serving these patients told Pew that a lack of housing was the biggest barrier to recovery in the District.

Data confirm that there is a large, unmet need for housing among people who use opioids. As shown in the chart below, if homelessness is counted as a ward, it has the second highest number of residents with OUD.

Figure 5: Primary residence of people with OUD in the DBH treatment system (Fiscal year 2018)



Note: These numbers only include individuals receiving treatment within the DBH treatment system. They do not include those receiving treatment outside of this system, such as from a primary care provider, or those not in treatment.

Source: S. Humphrey, "Consumer Data Overview: Opioid Usage FY 2018" (Department of Behavioral Health Applied Research and Evaluation Unit), (2019).

The recommendation below is aimed at addressing the need for housing among individuals with OUD in DC.

Recommendations

Recommendation 10: The Interagency Council on Homelessness should encourage non-profit hospitals in the District to fund supportive housing by providing matching dollars. In support of this effort, the Department of Health Care Finance and the Interagency Council on Homelessness should finalize efforts to allow providers to bill Medicaid for eligible housing support services.

Problem

Many people who misuse opioids in the District are experiencing homelessness, which increases their risk for overdose and relapse

Background

People with OUD with stable housing are less likely to overdose and relapse. A Baltimore study of people who inject drugs found that individuals who were experiencing homelessness were more likely to experience an overdose than those who were not.¹⁵⁶ Another Baltimore study found that among those who previously injected drugs, those who were experiencing homelessness were more likely to relapse.¹⁵⁷ Providing housing to people experiencing homelessness delivers many health care benefits,

including reducing the use of emergency departments and hospitalization, and related costs.¹⁵⁸ Among people with HIV, it also reduces the risk of drug use and needle sharing.¹⁵⁹

The District has made strides towards housing people with OUD, as well as individuals with other needs. As noted above, DBH directly houses many consumers with the condition. The District has also adopted a housing first approach, which provides housing and supportive services without conditions on sobriety or treatment participation.¹⁶⁰ A systematic review of the literature on housing first found that these programs are associated with improved housing retention compared to programs that require treatment.¹⁶¹ Adoption of housing first means that more people with OUD are eligible for housing services.

Mayor Bowser and the Council have also continued to add housing units through the budget. For example, the FY 2020 budget added 615 permanent supportive housing (PSH) units for individuals to the District's inventory (see text box below).¹⁶² However, the Way Home Campaign, a coalition of non-profits and businesses working to end chronic homelessness in DC, estimates that the District requires an additional 1,336 supportive housing units.¹⁶³

Permanent Housing Services in the District

DC provides permanent housing for chronically homeless childless adults through permanent supportive housing. The federal Department of Housing and Urban Development defines a chronically homeless individual as someone with a disability, including SUD, who has experienced homelessness for the last 12 months or at least four times in the past three years for a total of 12 months.

Permanent supportive housing provides chronically homeless individuals with both a long-term housing subsidy and long-term support services to help them maintain housing stability. Support services may include connections to behavioral health treatment and medical care, or help addressing other needs. As of 2018, 3,729 permanent supportive housing units were available for individuals in DC.

Sources: Homeless Emergency Assistance and Rapid Transition to Housing: Defining "Chronically Homeless", 80, no. 233 Fed. Reg. 75791-806 (December 4, 2015), <https://files.hudexchange.info/resources/documents/Defining-Chronically-Homeless-Final-Rule.pdf>; District of Columbia Interagency Council on Homelessness, "Homeward DC: 2015-2020," https://ich.dc.gov/sites/default/files/dc/sites/ich/page_content/attachments/ICH-StratPlan2.11%20web.pdf; Metropolitan Washington Council of Governments, "Homelessness in Metropolitan Washington: Results and Analysis from the Annual Point-in-Time (PIT) Count of Persons Experiencing Homelessness" (May 2019), <https://www.mwcog.org/file.aspx?D=u3Aiy5tb7aCrPyRHDpHT5SHT1i65a5KIkIza9ImotKE%3d&A=MbWQyXHUL>

To close the gap, the District is embracing creative solutions, such as leveraging private investment in affordable housing. In 2019, the Mayor and the Greater Washington Community Foundation announced the Partnership to End Homelessness, which is leveraging private investment to build deeply affordable housing in the District, defined as housing for households earning 0-30 percent of area median income, and PSH. The Partnership will provide affordable capital and grants to affordable housing developers, and grants to nonprofit providers in the homeless services system, including PSH providers.¹⁶⁴

Hospitals can be an additional partner for the District. Hospitals are playing an increasing role in addressing social determinants of health, including housing. According to the American Hospital Association, “Housing is one upstream determinant of health that hospitals and health systems are focused on more and more. Access to safe, affordable, and stable housing is key for good health.”¹⁶⁵

One reason for this investment is that in exchange for their favored tax status, non-profit hospitals are required to demonstrate that they provide “community benefits,” defined by the Internal Revenue Service to include, among others, un- and under-compensated care, and community health improvement activities.¹⁶⁶ These activities can also include investments in housing.¹⁶⁷ The community benefit requirements apply to the District’s five non-profit hospitals (Children’s National Medical Center, Howard University Hospital, MedStar Georgetown, MedStar Washington Hospital Center, and Sibley Memorial Hospital).

Hospital executives invest in housing to reduce unnecessary emergency department use and avoidable hospital admissions,¹⁶⁸ as housing interventions have been found to reduce emergency room utilization.¹⁶⁹ People from District hospitals told Pew that they are often unable to discharge patients experiencing homelessness from the hospital because they are in poor health and would be unable to recover from their illness in an unsheltered condition. Rather than discharging these individuals, they remain in inpatient or emergency beds, which contributes to crowding in these facilities and places a financial burden on the hospitals as they are unable to bill Medicaid for boarding these patients.

In light of community benefit requirements, and the potential to reduce costly utilization, hospitals across the country have invested in housing in various ways. For example, University of Illinois Hospital in Chicago helps patients experiencing homelessness find housing and contributes to paying for PSH units. The hospital projects that their financial contributions will result in an additional 750 affordable housing units in Chicago.¹⁷⁰ In 2016, five Portland, OR hospitals and a nonprofit health plan committed a combined \$21.5 million to build an additional 382 housing units.¹⁷¹

The state of New Jersey has taken a proactive approach to encouraging these investments. In 2019, the New Jersey Housing and Mortgage Finance Agency set aside \$12 million to match hospital contributions to fund housing units. As of July 2019, one hospital had participated in the program and the agency anticipates additional partnerships.¹⁷² By doubling the impact of hospital expenditures, this approach creates incentives for hospital participation.

Solution

Pew recommends that, like New Jersey, the District encourage hospitals to invest in housing by setting aside funding to match hospital contributions to providing additional supportive housing. The amount should be sufficient to house a significant number of people experiencing homelessness but should not be expected to fill the entire funding gap.

To ensure that these funds are efficiently bundled together to create new housing units, hospital contributions should be made to and managed by the Partnership to End Homelessness at the Greater Washington Community Foundation, which has the capacity to work with both funders and the affordable housing developers who would receive the funds.

Finally, while Medicaid dollars cannot be used for rent payments, support services are eligible for Medicaid payment, including housing transition services to help tenants find and move into housing and

tenancy sustaining services such as help understanding and navigating landlord-tenant relationships.¹⁷³ DHCF and the ICH should finalize efforts to enable housing providers to bill Medicaid for eligible services. Identified as a goal in *Homeward DC*,¹⁷⁴ the District's strategic plan for addressing homelessness, using Medicaid to pay for housing services saves money for states by taking advantage of the federal match.

Multiple jurisdictions have obtained Medicaid financing for these services:

- Philadelphia partnered with the Pennsylvania Medicaid agency to provide housing and supports to residents with behavioral health needs experiencing homelessness. Over an eight-year period, 89 percent of program participants remained in stable housing. Obtaining the Medicaid match allowed the city to make housing dollars go further.¹⁷⁵
- Following Hurricane Katrina, Louisiana used federal Medicaid dollars as one of multiple funding sources for PSH,¹⁷⁶ with the goal of creating 3,000 housing units.¹⁷⁷ 94 percent of households who have received PSH since 2008 have remained housed.¹⁷⁸
- Maricopa County, AZ used Medicaid funds to provide PSH in 3,400 units and to make local dollars go further. The federal Department of Housing and Urban Development (HUD) requires states to contribute matching funds towards HUD housing vouchers. Maricopa County was able to use the value of the Medicaid services provided to meet this match requirement.¹⁷⁹

Endnotes

- ¹ L. Scholl et al., “Drug and Opioid-Involved Overdose Deaths – United States, 2013-2017,” *Morbidity and Mortality Weekly Report* 67, no. 5152 (2019), https://www.cdc.gov/mmwr/volumes/67/wr/mm675152e1.htm?s_cid=mm675152e1_w.
- ² District of Columbia Office of the Chief Medical Examiner, “Opioid-Related Fatal Overdoses: January 1, 2014 to October 28, 2019” (2020), https://ocme.dc.gov/sites/default/files/dc/sites/ocme/agency_content/Opioid%20related%20Overdoses%20Deaths%20Jan%201.16.2020-FINAL.pdf
- ³ Ibid.
- ⁴ Centers for Disease Control and Prevention, “Fentanyl,” accessed Nov. 14, 2019, <https://www.cdc.gov/drugoverdose/opioids/fentanyl.html>.
- ⁵ District of Columbia Office of the Chief Medical Examiner, “Opioid-Related Fatal Overdoses.”
- ⁶ District of Columbia Department of Forensic Sciences, “DFS/FCU Metrics,” https://livelong.dc.gov/sites/default/files/dc/sites/opioid/page_content/attachments/SLIDES-METRIC-DFS-FCU.pdf.
- ⁷ District of Columbia Department of Behavioral Health, “*Live.Long.DC.*: Washington, Dc's Strategic Plan to Reduce Opioid Use, Misuse, and Related Deaths” (2019), https://livelong.dc.gov/sites/default/files/dc/sites/opioid/page_content/attachments/LIVE-LONG-DC-WashingtonDCsOpioidStrategicPlan-MarchRevision.pdf.
- ⁸ Ibid.
- ⁹ District of Columbia Office of the Chief Medical Examiner, “Opioid-Related Fatal Overdoses.”
- ¹⁰ Ibid.
- ¹¹ U.S. Census Bureau, “Quick Facts: District of Columbia,” accessed Nov. 11, 2019, <https://www.census.gov/quickfacts/DC>.
- ¹² District of Columbia Office of the Chief Medical Examiner, “Opioid-Related Fatal Overdoses.”
- ¹³ District of Columbia Department of Health Care Finance, “District of Columbia Section 1115 Medicaid Behavioral Health Transformation Demonstration Program” (2019), https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/1115%20Final%20Demonstration%20Application%206.3.19%20.pdf.
- ¹⁴ Opioid Overdose Treatment and Prevention Omnibus Act of 2018, Law 22-288, Council of the District of Columbia (2018), <https://code.dccouncil.us/dc/council/laws/22-288.html>.
- ¹⁵ Substance Abuse and Mental Health Services Administration reported Buprenorphine Waivered Practitioners with Drug Enforcement Administration X-license, November 2017.
- ¹⁶ L. Clemans-Cope et al., “State Variation in Medicaid Prescriptions for Opioid Use Disorder from 2011 to 2018” (Urban Institute, 2019), https://www.urban.org/sites/default/files/publication/100817/2019.08.19_av_state_medicaid_rx_oud_final_v3_4.pdf.
- ¹⁷ District of Columbia Department of Health Care Finance, “District of Columbia Section 1115 Medicaid Behavioral Health Transformation Demonstration Program.”
- ¹⁸ Clemans-Cope et al., “State Variation in Medicaid Prescriptions.”
- ¹⁹ District of Columbia Department of Behavioral Health, “*Live.Long.DC.*”
- ²⁰ District of Columbia Department of Health Care Finance, “Policy #19-001: Removal of Prior Authorization Requirements for Medication-Assisted Treatment” (2019), https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Policy%20%2319-001%20Removal%20of%20Prior%20Auth.%20Req.%20for%20Medication-Assis_0.pdf.
- ²¹ P.W. Appel et al., “Barriers to Enrollment in Drug Abuse Treatment and Suggestions for Reducing Them: Opinions of Drug Injecting Street Outreach Clients and Other System Stakeholders,” *The American Journal of Drug and Alcohol Abuse* 30, no. 1 (2004): 129-53.; C. Redko, Rapp, Richard C., Carlson, Robert G. , “Waiting Time as a Barrier to Treatment Entry: Perceptions of Substance Users,” *Journal of Drug Issues* 36, no. 4 (2006): 831-52, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2396562/pdf/nihms29639.pdf>.

-
- ²² Redko, "Waiting Time as a Barrier to Treatment Entry."
- ²³ R.E. Claus and L.R. Kindleberger, "Engaging Substance Abusers after Centralized Assessment: Predictors of Treatment Entry and Dropout," *Journal of Psychoactive Drugs* 34, no. 1 (2002): 25-31, <https://doi.org/10.1080/02791072.2002.10399933>.
- ²⁴ K.A. Hoffman et al., "Days to Treatment and Early Retention among Patients in Treatment for Alcohol and Drug Disorders," *Addictive Behaviors* 36, no. 6 (2011): 643-47, <https://www.ncbi.nlm.nih.gov/pubmed/21324608>
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3070832>.
- ²⁵ J. Guydish, Ph.D.; Moore, Lisa, Ph.D.; Gleghorn, Alice, Ph.D.; Davis, Thomas; Sears, Clare; Harcourt, John "Drug Abuse Treatment of Demand in San Francisco: Preliminary Findings," *Journal of Psychoactive Drugs* 32, no. 4 (2000), <https://doi.org/10.1080/02791072.2000.10400237>.
- ²⁶ L.M.F. Madden, Scott O; Eggert, Kathryn F; Quanbeck, Andrew R; Freeman, Robert M; Ball, Samuel A; Schottenfeld, Richard A; Shi, Julia M; Savage, Mary Ellen; Barry, Declan T, "An Investigation of an Open-Access Model for Scaling up Methadone Maintenance Treatment," *Addiction* 113 (2018): 1450-58, <https://doi.org/10.1111/add.14198>.
- ²⁷ C.L. McCormick et al., "Improved Patient Outcomes and Reduced Wait Times: Transforming a Va Outpatient Substance Use Disorder Program," *Federal practitioner: for the health care professionals of the VA, DoD, and PHS* 36, no. 7 (2019): 332-38, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6654166/>.
- ²⁸ R.H. Needle et al., "Effectiveness of Community-Based Outreach in Preventing Hiv/Aids among Injecting Drug Users," *International Journal of Drug Policy* 16 (2005): 45-57, <http://www.sciencedirect.com/science/article/pii/S0955395905000964>.
- ²⁹ D.M. Scott CK, Grella CE, Kurz R, Sumpter J, Nicholson L, Funk RR, "A Community Outreach Intervention to Link Individuals with Opioid Use Disorders to Medication-Assisted Treatment," *Journal for Substance Abuse Treatment* (July 10, 2019), <https://doi.org/10.1016/j.jsat.2019.07.001>.
- ³⁰ D.C.S. Sanchez, Scott; Hurley, Hermione; Gaffaney, Michelle, "Anywhere, Anytime: Model for Universal Access to Opioid Medication Assisted Treatment" (Denver Health and the American Society of Addiction Medicine, 2019).
- ³¹ N. Powell, "Integrated Opioid Treatment and Recovery Centers (IOTRCs) – No Wrong Door," CASAT on Demand, accessed October 22, 2019, March 7th, 2019, <https://casatondemand.org/2019/03/07/integrated-opioid-treatment-and-recovery-centers-iotrcs-no-wrong-door/>.
- ³² J.M. Connolly, Division Director, Los Angeles County Department of Public Health Substance Abuse Prevention and Control, "Los Angeles County's Substance Use Disorder (SUD) System of Care", <http://www.itup.org/wp-content/uploads/2019/07/Presentation-John-Connolly.pdf>.
- ³³ New Jersey Department of Human Services, Division of Medical Assistance and Health Services, "NJ FamilyCare Comprehensive Demonstration Implementation Protocol for the Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) Program" (2018), https://www.nj.gov/humanservices/dmahs/home/Comprehensive_Demonstration_Implementation_Protocol_OU_D-SUD_Program.pdf.
- ³⁴ C. Gustafson, "Vermont State Plan Amendment (SPA) 19-0001" (Department of Vermont Health Access, 2019), <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/VT/VT-19-0001.pdf>.
- ³⁵ D.C. Medicaid, "Interactive Fee Schedule Response - Procedure Code: H0001," DC.gov, accessed Dec. 10, 2019, <https://www.dc-medicaid.com/dcwebportal/nonsecure/getFeeScheduleInquiry>.
- ³⁶ Claus and Kindleberger, "Engaging Substance Abusers after Centralized Assessment: Predictors of Treatment Entry and Dropout."; Hoffman et al., "Days to Treatment and Early Retention among Patients in Treatment for Alcohol and Drug Disorders."
- ³⁷ Appel et al., "Barriers to Enrollment in Drug Abuse Treatment and Suggestions for Reducing Them."; Redko, "Waiting Time as a Barrier to Treatment Entry."
- ³⁸ Guydish, "Drug Abuse Treatment of Demand in San Francisco: Preliminary Findings."; Madden, "An Investigation of an Open-Access Model for Scaling up Methadone Maintenance Treatment."; McCormick et al., "Improved Patient Outcomes and Reduced Wait Times: Transforming a Va Outpatient Substance Use Disorder Program."

-
- ³⁹ E.A. Hooker, P.J. Mallow, and M.M. Oglesby, "Characteristics and Trends of Emergency Department Visits in the United States (2010-2014)," *Journal of Emergency Medicine* 56, no. 3 (2019): 344-51, <https://doi.org/10.1016/j.jemermed.2018.12.025>; C.W. Burt, L.F. McCaig "Staffing, capacity, and ambulance diversion in emergency departments: United States, 2003-04" *Adv Data*, 376 (2006), pp. 1-23, <https://www.ncbi.nlm.nih.gov/pubmed/17037024>.
- ⁴⁰ S. Innes, "Desperate to Give up Opioids, Patients Flock to 24/7 Methadone Clinic in Phoenix," AZ Central, last modified February 8th, 2019, accessed September 19th, 2019, February 5th, 2019, <https://www.azcentral.com/in-depth/news/local/arizona-health/2019/02/05/leaders-phoenix-only-24-7-methadone-clinic-overwhelmed-volume-patients-needing-help/1116255002/>.
- ⁴¹ N. Stavros, Chief Executive Officer, Community Medical Services, email to The Pew Charitable Trusts, Sept. 10, 2019.
- ⁴² Ibid.
- ⁴³ Scott CK, "A Community Outreach Intervention to Link Individuals with Opioid Use Disorders to Medication-Assisted Treatment.;" K.M. Wayne et al., "Implementing Peer Recovery Services for Overdose Prevention in Rhode Island: An Examination of Two Outreach-Based Approaches," *Addictive Behaviors* 89 (2019): 85-91, <https://www.ncbi.nlm.nih.gov/pubmed/30278306>.
- ⁴⁴ J.B. Olivet, Elena; Elstad, Emily; Kenney, Rachael; Jassil, Lauren, "Outreach and Engagement in Homeless Services: A Review of the Literature," *The Open Health Services and Policy Journal* 3 (2010): 53-70, <https://pdfs.semanticscholar.org/e228/6201dd16cb582ae7d0315fda778cbcd9d19f.pdf>.
- ⁴⁵ L.-T. Wu, H. Zhu, and U.E. Ghitza, "Multicomorbidity of Chronic Diseases and Substance Use Disorders and Their Association with Hospitalization: Results from Electronic Health Records Data," *Drug and Alcohol Dependence* 192 (2018): 316-23, <http://www.sciencedirect.com/science/article/pii/S0376871618306458>.
- ⁴⁶ C.M. Jones and E.F. McCance-Katz, "Co-Occurring Substance Use and Mental Disorders among Adults with Opioid Use Disorder," *Drug and Alcohol Dependence* 197 (2019): 78-82, <http://www.sciencedirect.com/science/article/pii/S0376871618305209>.
- ⁴⁷ R. Rawson et al., "Assessment of Medication for Opioid Use Disorder as Delivered within the Vermont Hub and Spoke System," *Journal of Substance Abuse Treatment* 97 (2019): 84-90, <http://www.sciencedirect.com/science/article/pii/S0740547218304252>; J.A. Schaefer, R.C. Cronkite, and K.U. Hu, "Differential Relationships between Continuity of Care Practices, Engagement in Continuing Care, and Abstinence among Subgroups of Patients with Substance Use and Psychiatric Disorders," *Journal of Studies on Alcohol and Drugs* 72, no. 4 (2011): 611-21, <https://www.jsad.com/doi/abs/10.15288/jsad.2011.72.611>.
- ⁴⁸ P.T. Korthuis et al., "Primary Care-Based Models for the Treatment of Opioid Use Disorder: A Scoping Review," *Annals of Internal Medicine* 166, no. 4 (2017): 268-78, <https://doi.org/10.7326/M16-2149>.
- ⁴⁹ Centers for Medicare & Medicaid Services, "Medicare Learning Network Fact Sheet: Behavioral Health Integration Services" (2019), <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf>.
- ⁵⁰ Agency for Healthcare Research and Quality, "Care Coordination," last modified August 2018, accessed September 25, 2019, June 2014, <https://www.ahrq.gov/ncepcc/care/coordination.html>.
- ⁵¹ H. Padwa et al., "Organizing Publicly Funded Substance Use Disorder Treatment in the United States: Moving toward a Service System Approach," *Journal of Substance Abuse Treatment* 69 (2016): 9-18, <http://www.sciencedirect.com/science/article/pii/S0740547215300830>.
- ⁵² See Appendix Table D.9 in U.S. Department of Health and Human Services, "T-MSIS Substance Use Disorder (SUD) Data Book: Treatment of SUD in Medicaid, 2017" (2019), <https://www.medicaid.gov/medicaid/data-and-systems/downloads/macbis/sud-data-book.pdf>.
- ⁵³ District of Columbia Department of Health Care Finance, "District of Columbia Section 1115 Medicaid Behavioral Health Transformation Demonstration Program."
- ⁵⁴ District of Columbia Department of Behavioral Health, "Live.Long.DC.;" District of Columbia Primary Care Association, "DCPCA Connections," September 2019, <https://myemail.constantcontact.com/DCPCA-Connections---September-2019-Edition.html?soid=1114178458914&aid=TAezDXqnfSA>.
- ⁵⁵ District of Columbia Department of Behavioral Health, "Live.Long.DC.."

-
- ⁵⁶ Legal Action Center, “Frequently Asked Questions: Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE)” (Substance Abuse and Mental Health Services Administration and United States Department of Health and Human Services Office of the National Coordinator), <https://www.samhsa.gov/sites/default/files/faqs-applying-confidentiality-regulations-to-hie.pdf>.
- ⁵⁷ S. Hunt, Deputy Director, Community Services Administration, DC Department of Behavioral Health, email to The Pew Charitable Trusts, Oct. 2, 2019.
- ⁵⁸ Centers for Medicare & Medicaid Services, “Health Homes,” accessed Nov. 8, 2019, <https://www.medicare.gov/medicaid/ltss/health-homes/index.html>.
- ⁵⁹ District of Columbia Department of Health Care Finance, “Health Homes for Persons with Severe Mental Illness - My Health Home,” accessed Nov. 8, 2019, <https://dhcf.dc.gov/page/health-homes-persons-severe-mental-illness-my-health-home>.
- ⁶⁰ District of Columbia Department of Health Care Finance, “Health Home for Persons with Multiple Chronic Conditions - My Health GPS,” accessed Nov. 8, 2019, <https://dhcf.dc.gov/page/health-home-persons-multiple-chronic-conditions-my-health-gps>.
- ⁶¹ District of Columbia Department of Health Care Finance, “Data Snapshot: A Descriptive Analysis of District of Columbia My Health GPS Medicaid Health Home Enrollees with Multiple Chronic Conditions” (2018), <https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Data%20snapshot%20on%20My%20Health%20GPS%20enrollees%2010.19.18.pdf>.
- ⁶² Ibid.
- ⁶³ See Table C.1.i in U.S. Department of Health and Human Services, “T-MSIS Substance Use Disorder (SUD) Data Book: Treatment of SUD in Medicaid, 2017.”
- ⁶⁴ District of Columbia Department of Health Care Finance, “State Plan Amendment Transmittal #17-0003” (2017), https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/My%20Health%20GPS%20Approved%20SPA%2CTechnical%20Correction.pdf; District of Columbia Department of Health Care Finance, “State Plan Amendment #18-0006” (2018), <https://www.medicare.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/DC/DC-18-0006.pdf>.
- ⁶⁵ A.B. Laudet and K. Humphreys, “Promoting Recovery in an Evolving Policy Context: What Do We Know and What Do We Need to Know About Recovery Support Services?,” *Journal of Substance Abuse Treatment* 45, no. 1 (2013): 126-33, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3642237/>.
- ⁶⁶ Substance Abuse and Mental Health Services Administration, “Value of Peers, 2017” (2017), https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tac/value-of-peers-2017.pdf.
- ⁶⁷ S. Reif et al., “Peer Recovery Support for Individuals with Substance Use Disorders: Assessing the Evidence,” *Psychiatric Services* 65, no. 7 (2014): 853-61, <https://doi.org/10.1176/appi.ps.201400047>.
- ⁶⁸ District of Columbia Department of Health Care Finance, “State Plan Amendment #18-0007” (2018), https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/2a.%20SWIFT%20082020184016%20DC%20SPA%2018-0007%20Approval%20letter-CMS%20179-SPA%20pages.pdf.
- ⁶⁹ District of Columbia Department of Health Care Finance, Interactive Fee Schedule, accessed December 10, 2019, <https://www.dc-medicare.com/dcwebportal/nonsecure/feeScheduleInquiry>.
- ⁷⁰ Ibid.
- ⁷¹ Hunt, email.
- ⁷² District of Columbia Department of Behavioral Health, “*Live.Long.DC.*”
- ⁷³ District of Columbia Department of Health Care Finance, “State Plan Amendment #18-0006.”; District of Columbia Department of Health Care Finance, “State Plan Amendment #18-0007.”
- ⁷⁴ District of Columbia Department of Health Care Finance, Notice of Proposed Rulemaking: Rules on the Section 1115 Behavioral Health Transformation Demonstration Program, Ch. 29-86 Behavioral Health Transformation Demonstration Program (2019), <https://www.dcregs.dc.gov/Common/NoticeDetail.aspx?NoticeId=N0087640>.
- ⁷⁵ L. Clemans-Cope et al., “Experiences of Three States Implementing the Medicaid Health Home Model to Address Opioid Use Disorder—Case Studies in Maryland, Rhode Island, and Vermont,” *Journal of Substance Abuse Treatment* 83 (2017): 27-35, <http://www.sciencedirect.com/science/article/pii/S0740547217301952>; District of Columbia Department of Health Care Finance, Interactive Fee Schedule.

-
- ⁷⁶ Jones and McCance-Katz, "Co-Occurring Substance Use and Mental Disorders among Adults with Opioid Use Disorder."; Wu, Zhu, and Ghitza, "Multicomorbidity of Chronic Diseases and Substance Use Disorders and Their Association with Hospitalization."
- ⁷⁷ Centers for Medicare & Medicaid Services, "CMCS Informational Bulletin: New Reporting Measures for Substance Use Disorder (SUD)-Focused Health Homes" (2019), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib112719.pdf>.
- ⁷⁸ Wu, Zhu, and Ghitza, "Multicomorbidity of Chronic Diseases and Substance Use Disorders and Their Association with Hospitalization."
- ⁷⁹ Centers for Disease Control and Prevention, "Infectious Diseases, Opioids, and Injection Drug Use," last modified July 19, 2018, accessed August 26, 2019, <https://www.cdc.gov/pwld/opioid-use.html>.
- ⁸⁰ Jones and McCance-Katz, "Co-Occurring Substance Use and Mental Disorders among Adults with Opioid Use Disorder."
- ⁸¹ District of Columbia Department of Behavioral Health, "*Live.Long.DC.*"
- ⁸² DC Health, "District of Columbia Primary Care Needs Assessment" (2018), https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/DC%20Primary%20Care%20Needs%20Assessment%202018.pdf.
- ⁸³ DC Health, "District of Columbia Behavioral Risk Factor Surveillance System (Brfss): 2017 Annual Report" (2019), <https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/BRFSS%202017%20Annual%20Report%20Final.pdf>.
- ⁸⁴ DC Health, "District of Columbia Primary Care Needs Assessment."
- ⁸⁵ S. Humphrey, Department of Behavioral Health Applied Research and Evaluation Unit, "Consumer Data Overview: Opioid Usage Fy 2018" (2019).
- ⁸⁶ A. Umbricht-Schneiter et al., "Providing Medical Care to Methadone Clinic Patients: Referral Vs on-Site Care," *American Journal of Public Health* 84, no. 2 (1994): 207-10, <https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.84.2.207>.
- ⁸⁷ M.N. Gourevitch et al., "On-Site Medical Care in Methadone Maintenance: Associations with Health Care Use and Expenditures," *Journal of Substance Abuse Treatment* 32, no. 2 (2007): 143-51, <http://www.sciencedirect.com/science/article/pii/S0740547206002443>.
- ⁸⁸ DC Health, "Health Systems Plan" (2017), https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/DC%20Health%20Systems%20Plan%202017_0.pdf.
- ⁸⁹ Substance Abuse and Mental Health Services Administration, "State Opioid Response Funding Opportunity Announcement No. Ti-18-015" (2018), <https://www.samhsa.gov/sites/default/files/grants/pdf/sorfofinal.6.14.18.pdf>; Department of Health and Human Services, Title 45 Public Welfare - Block Grants - Substance Abuse Prevention and Treatment Block Grant - Restrictions on Expenditure of Grant, §96.135 (1993), https://www.ecfr.gov/cgi-bin/text-idx?SID=ec70260c0bad1dbed68720fe98a3e90c&mc=true&node=sp45.1.96.l&rgn=div6#se45.1.96_1135.
- ⁹⁰ District of Columbia Department of Health Care Finance, "District of Columbia Section 1115 Medicaid Behavioral Health Transformation Demonstration Program."
- ⁹¹ Jones and McCance-Katz, "Co-Occurring Substance Use and Mental Disorders among Adults with Opioid Use Disorder."
- ⁹² Substance Abuse and Mental Health Services Administration, "Tip 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders" (2013), <https://store.samhsa.gov/file/23170/download?token=FBHtrcSs&filename=SMA13-3992.pdf&sku=SMA13-3992>.
- ⁹³ Pew analysis of District of Columbia Department of Behavioral Health, Certified Provider Listing, accessed May 14, 2019, last modified May, 2019.
- ⁹⁴ District of Columbia Department of Behavioral Health, Chapter 22-A34 - Mental Health Rehabilitation Services Provider Certification Standards, <https://www.dcregs.dc.gov/Common/DCMR/RuleList.aspx?ChapterNum=22-A34>; District of Columbia Department of Behavioral Health, Chapter 22-A63, Certification Standards for Substance Use

Disorder Treatment and Recovery Providers,

<https://www.dcregs.dc.gov/Common/DCMR/RuleList.aspx?ChapterNum=22-A63>.

⁹⁵ District of Columbia Department of Behavioral Health, Chapter 22-A63; District of Columbia Department of Behavioral Health, Ch. 22-A34.

⁹⁶ District of Columbia Department of Behavioral Health, Chapter 22-A63.

⁹⁷ Substance Abuse and Mental Health Services Administration, “TIP 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders.”

⁹⁸ D. Mee-Lee et al., *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Addictions* (Carson City, NV: The Change Companies, 2013).

⁹⁹ Substance Abuse and Mental Health Services Administration, “Dual Diagnosis Capability in Mental Health Treatment Toolkit Version 4.0” (2011), <https://www.centerforebp.case.edu/client-files/pdf/ddcmhttoolkit.pdf>.

¹⁰⁰ New Jersey Division of Mental Health and Addiction Services, “FFS Rates - Mental Health Treatment” (2016), https://www.nj.gov/humanservices/dmhas/initiatives/managed/FFS_Rates_Only_June292016.pdf.

¹⁰¹ Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, DC: The National Academies Press, 2001), <https://doi.org/10.17226/10027>.

¹⁰² Institute of Medicine, *Improving the Quality of Health Care for Mental and Substance-Use Conditions* (Washington, DC: The National Academies Press, 2006), <https://doi.org/10.17226/11470>.

¹⁰³ District of Columbia Department of Behavioral Health, “Live.Long.DC..”

¹⁰⁴ Behavioral Health Coordinating Committee Prescription Drug Abuse Subcommittee at the U.S. Department of Health and Human Services, “Addressing Prescription Drug Abuse in the United States Current Activities and Future Opportunities” (2013),

https://www.cdc.gov/drugoverdose/pdf/hhs_prescription_drug_abuse_report_09.2013.pdf; American Society of Addiction Medicine, “The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use” (2015), <http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24>.

¹⁰⁵ District of Columbia Department of Health Care Finance, “Policy #19-001: Removal of Prior Authorization Requirements for Medication-Assisted Treatment.”; Kaiser Family Foundation, “Medicaid’s Role in Addressing the Opioid Epidemic” (2019), <https://www.kff.org/infographic/medicaids-role-in-addressing-opioid-epidemic/>.

¹⁰⁶ Clemans-Cope et al., “State Variation in Medicaid Prescriptions.”

¹⁰⁷ Urban Institute, “Tracking Medicaid-Covered Prescriptions to Treat Opioid Use Disorder,” last modified Nov. 19, 2019, accessed Oct. 15, 2019, <https://www.urban.org/policy-centers/health-policy-center/projects/tracking-medicare-covered-prescriptions-treat-opioid-use-disorder>.

¹⁰⁸ District of Columbia Department of Behavioral Health, “Mental Health and Substance Use Report on Expenditures and Services (MHEASURES)” (2019), <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/MHEASURES%20FY18.pdf>.

¹⁰⁹ District of Columbia Department of Health Care Finance, Chapter 86, Behavioral Health Transformation Demonstration Program (2019),

https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Chpt-86-Behavioral%20Health%20Transformation%20Demo%20Program%20Rulemaking.pdf.

¹¹⁰ National Institute on Drug Abuse, “Treatment and Recovery,” last modified July 2018, accessed Dec. 2, 2019, <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery>.

¹¹¹ Code of the District of Columbia § 7–403. Seeking Health Care for an Overdose Victim. (2013), <https://code.dccouncil.us/dc/council/code/sections/7-403.html>; Good Samaritan Overdose Prevention Amendment Act of 2012. D.C. Law 19-243 (2012); District of Columbia.

<https://code.dccouncil.us/dc/council/laws/19-243.html>.

¹¹² Code of the District of Columbia § 7–404. Prescribing Authority of Opioid Antagonist for Overdose Victim and 3rd Parties. (2016), <https://code.dccouncil.us/dc/council/code/sections/7-404.html>; National Institute on Drug Abuse, “Naloxone for Opioid Overdose: Life-Saving Science,” last modified March 2017, accessed Nov. 14, 2019, <https://www.drugabuse.gov/publications/naloxone-opioid-overdose-life-saving-science/naloxone-opioid-overdose-life-saving-science>.

-
- ¹¹³ DC Health, “DC Will Offer Overdose-Reversing Drug, Naloxone, for Free at Select Pharmacies Beginning August 31, 2019,” news release, Aug. 30, 2019, <https://dchealth.dc.gov/release/dc-will-offer-overdose-reversing-drug-naloxone-free-select-pharmacies-beginning-august-31>.
- ¹¹⁴ District of Columbia Department of Behavioral Health, “*Live.Long.DC*. Accomplishments and Progress - September 2019” (2019), [https://livelong.dc.gov/sites/default/files/u23/LLDC%20Accomplishments website September%202019.pdf](https://livelong.dc.gov/sites/default/files/u23/LLDC%20Accomplishments%20website%20September%202019.pdf).
- ¹¹⁵ Code of the District of Columbia § 48–1103. Prohibited Acts. (2019), <https://code.dccouncil.us/dc/council/code/sections/48-1103.html>.
- ¹¹⁶ S. Rouhani et al., “Harm Reduction Measures Employed by People Using Opioids with Suspected Fentanyl Exposure in Boston, Baltimore, and Providence,” *Harm Reduction Journal* 16, no. 1 (2019): 39, <https://doi.org/10.1186/s12954-019-0311-9>.
- ¹¹⁷ Scholl et al., “Drug and Opioid-Involved Overdose Deaths.”
- ¹¹⁸ D.M. Tobin KE, Latkin CA, “Calling Emergency Medical Services During Drug Overdose: An Examination of Individual, Social and Setting Correlates,” *Addiction* 100, no. 3 (2005): 397-404, <https://doi.org/10.1111/j.1360-0443.2005.00975.x>.
- ¹¹⁹ A. Latimore and R. Bergstein, ““Caught with a Body” yet Protected by Law? Calling 911 for Opioid Overdose in the Context of the Good Samaritan Law,” *Int J Drug Policy* 50 (2017): 82-89, <https://doi.org/10.1016/j.drugpo.2017.09.010>.
- ¹²⁰ C. Davis, “Legal Interventions to Reduce Mortality: Naloxone Access and Overdose Good Samaritan Laws” (The Network for Public Health Law, 2018).
- ¹²¹ M. C. et al., “Opioid-Overdose Laws Association with Opioid Use and Overdose Mortality,” *Addictive Behaviors* 86 (2018): 90-95, <https://doi.org/10.1016/j.addbeh.2018.03.014>.; K.P. Banta-Green CJ, Coffin PO, Schoeppe JA., “Washington’s 911 Good Samaritan Drug Overdose Law - Initial Evaluation Results” (Alcohol & Drug Abuse Institute, University of Washington, 2011), <http://ada.uw.edu/pubs/infobriefs/ADAI-IB-2011-05.pdf>; H. Nguyen and B.R. Parker, “Assessing the Effectiveness of New York’s 911 Good Samaritan Law-Evidence from a Natural Experiment,” *International Journal on Drug Policy* 58 (2018): 149-56, <https://doi.org/10.1016/j.drugpo.2018.05.013>.
- ¹²² P. Jennifer J. Carroll, MPH; Traci C. Green, PhD, MSc; and Rita K. Noonan, PhD, “Evidence-Based Strategies for Preventing Opioid Overdose: What’s Working in the United States” (National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2018), <http://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf>.
- ¹²³ Ibid.
- ¹²⁴ “Good Samaritan Fatal Overdose Prevention Laws.” Drug Policy Alliance. Accessed September 16, 2019. <http://www.drugpolicy.org/issues/good-samaritan-fatal-overdose-prevention-laws>.
- ¹²⁵ Code of the District of Columbia § 7–403. Seeking Health Care for an Overdose Victim.
- ¹²⁶ Vermont Statutes, 18 V.S.A. § 4254, <https://legislature.vermont.gov/statutes/section/18/084/04254>.
- ¹²⁷ Substance Abuse and Mental Health Services Administration, “Preventing the Consequences of Opioid Overdose: Understanding 911 Good Samaritan Laws” (Center for the Application of Prevention Technologies, 2017).
- ¹²⁸ C.J. Banta-Green et al., “Police Officers’ and Paramedics’ Experiences with Overdose and Their Knowledge and Opinions of Washington State’s Drug Overdose-Naloxone-Good Samaritan Law,” *Journal of urban health : bulletin of the New York Academy of Medicine* 90, no. 6 (2013): 1102-11, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3853169/>.
- ¹²⁹ Latimore and Bergstein, ““Caught with a Body” yet Protected by Law? Calling 911 for Opioid Overdose in the Context of the Good Samaritan Law.”
- ¹³⁰ K.H. Jakubowski A, Huxley-Reicher Z, Siegler A, “Knowledge of the 911 Good Samaritan Law and 911-Calling Behavior of Overdose Witnesses.,” *Subst Abus* 39, no. 2 (2018): 233-38, <https://doi.org/10.1080/08897077.2017.1387213>.
- ¹³¹ Maryland Behavioral Health Administration, “Good Samaritan Law,” accessed Nov. 13, 2019, https://bha.health.maryland.gov/OVERDOSE_PREVENTION/Pages/Good-Samaritan-Law.aspx.

-
- ¹³² N. Maghsoudi, "Training Law Enforcement to Identify Overdose and Use Naloxone," Harm Reduction Coalition, accessed Nov. 13, 2019, <https://harmreduction.org/overdose-prevention/training-law-enforcement-to-identify-overdose-and-use-naloxone>; North Carolina Harm Reduction Coalition, "Who Has NCHRC Trained," <http://www.nchrc.org/law-enforcement/who-has-nchrc-trained/>.
- ¹³³ C.D. Saucier et al., "An Initial Evaluation of Law Enforcement Overdose Training in Rhode Island," *Drug and Alcohol Dependence* 162 (2016): 211-18, <http://www.sciencedirect.com/science/article/pii/S037687161600154X>.
- ¹³⁴ Code of the District of Columbia § 7–403. Seeking Health Care for an Overdose Victim.
- ¹³⁵ Latimore and Bergstein, "'Caught with a Body' yet Protected by Law? Calling 911 for Opioid Overdose in the Context of the Good Samaritan Law."
- ¹³⁶ *Ibid.*
- ¹³⁷ Jennifer J. Carroll, "Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States."
- ¹³⁸ E. Wheeler et al., "Community-Based Opioid Overdose Prevention Programs Providing Naloxone—United States, 2010," *Morbidity and Mortality Weekly Report* 61, no. 6 (2012): 101-05, <https://www.cdc.gov/Mmwr/preview/mmwrhtml/mm6423a2.htm>; A.Y. Walley et al., "Opioid Overdose Rates and Implementation of Overdose Education and Nasal Naloxone Distribution in Massachusetts: Interrupted Time Series Analysis," *The BMJ* (2013): 346, <https://dx.doi.org/10.1136/bmj.f174>.
- ¹³⁹ Code of the District of Columbia § 7–404. Prescribing Authority of Opioid Antagonist for Overdose Victim and 3rd Parties; Substance Abuse and Opioid Overdose Prevention Amendment Act of 2016. D.C. Law 21-186 (2016). District of Columbia.
- ¹⁴⁰ C.R. Lewis, H.T. Vo, and M. Fishman, "Intranasal Naloxone and Related Strategies for Opioid Overdose Intervention by Nonmedical Personnel: A Review," *Substance Abuse and Rehabilitation* 8 (2017): 79-95, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4906694/>; M. Faul et al., "Disparity in Naloxone Administration by Emergency Medical Service Providers and the Burden of Drug Overdose in US Rural Communities," *American Journal of Public Health* 105, no. S3 (2015): e26-e32, <https://ajph.aphapublications.org/doi/10.2105/AJPH.2014.302520>.
- ¹⁴¹ C. Davis, Deputy Director & Staff Attorney, The Network for Public Health Law, telephone call to the Pew Charitable Trusts, Oct. 23, 2019.
- ¹⁴² National Institute on Drug Abuse, "Naloxone for Opioid Overdose: Life-Saving Science."
- ¹⁴³ M. Doe-Simkins et al., "Overdose Rescues by Trained and Untrained Participants and Change in Opioid Use among Substance-Using Participants in Overdose Education and Naloxone Distribution Programs: A Retrospective Cohort Study," *BMC Public Health* 14, no. 1 (2014): 297, <https://doi.org/10.1186/1471-2458-14-297>.
- ¹⁴⁴ *Ibid.*
- ¹⁴⁵ Opioid Learning Institute, "Opioid Overdose Prevention and Naloxone Education (Community)," DC Health, accessed Oct. 31, 2019, <https://opioidhealth.org/elearning/opioid-overdose-prevention-naloxone-education-2/>.
- ¹⁴⁶ National Drug Court Institute, "Naloxone Training for Treatment Court Professionals and Families," accessed Oct. 31, 2019, <https://www.ndci.org/resource/training/e-learning/naloxone-training/>. Harm Reduction Coalition, "Administer Naloxone". Accessed November 14, 2019. <https://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/responding-to-opioid-overdose/administer-naloxone/>.
- ¹⁴⁷ *Ibid.*
- ¹⁴⁸ Substance Abuse and Mental Health Services Administration, "Recovery and Recovery Support," accessed Nov. 11, 2019, <https://www.samhsa.gov/find-help/recovery>.
- ¹⁴⁹ E.L. Bassuk et al., "Peer-Delivered Recovery Support Services for Addictions in the United States: A Systematic Review," *Journal of Substance Abuse Treatment* 63 (2016): 1-9, <https://www.ncbi.nlm.nih.gov/pubmed/26882891>; Reif et al., "Peer Recovery Support for Individuals with Substance Use Disorders: Assessing the Evidence."
- ¹⁵⁰ District of Columbia Department of Behavioral Health, "Live.Long.DC. Accomplishments and Progress - September 2019."
- ¹⁵¹ District of Columbia Department of Health Care Finance, "District of Columbia Section 1115 Medicaid Behavioral Health Transformation Demonstration Program."
- ¹⁵² *Ibid.*

-
- ¹⁵³ Substance Abuse and Mental Health Services Administration, "Recovery and Recovery Support."
- ¹⁵⁴ District of Columbia Department of Behavioral Health, "Recovery Support Services," accessed Nov. 11, 2019, <https://dbh.dc.gov/service/recovery-support-services>.
- ¹⁵⁵ District of Columbia Department of Behavioral Health, "FY 18-19 Performance Oversight Questions" (2019), <https://dccouncil.us/wp-content/uploads/2019/04/dbh.pdf>.
- ¹⁵⁶ S.G. Sherman, Y. Cheng, and A.H. Kral, "Prevalence and Correlates of Opiate Overdose among Young Injection Drug Users in a Large U.S. City," *Drug and Alcohol Dependence* 88, no. 2-3 (2007): 182-87, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1950747/>.
- ¹⁵⁷ S.L. Linton et al., "The Longitudinal Association between Homelessness, Injection Drug Use, and Injection-Related Risk Behavior among Persons with a History of Injection Drug Use in Baltimore, Md," *Drug and Alcohol Dependence* 132, no. 3 (2013): 457-65, <https://www.ncbi.nlm.nih.gov/pubmed/23578590> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3926693/>.
- ¹⁵⁸ M.E. Larimer et al., "Health Care and Public Service Use and Costs before and after Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems," *JAMA* 301, no. 13 (2009): 1349-57, <https://doi.org/10.1001/jama.2009.414>; L.S. Sadowski et al., "Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations among Chronically Ill Homeless Adults: A Randomized Trial," *JAMA* 301, no. 17 (2009): 1771-78, <https://doi.org/10.1001/jama.2009.561>; D. Srebnik, T. Connor, and L. Sylla, "A Pilot Study of the Impact of Housing First-Supported Housing for Intensive Users of Medical Hospitalization and Sobering Services," *American Journal of Public Health* 103, no. 2 (2013): 316-21, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3558756/>; T.E. Martinez and M.R. Burt, "Impact of Permanent Supportive Housing on the Use of Acute Care Health Services by Homeless Adults," *Psychiatric Services* 57, no. 7 (2006): 992-99, <https://ps.psychiatryonline.org/doi/abs/10.1176/ps.2006.57.7.992>.
- ¹⁵⁹ A. Aidala et al., "Housing Status and HIV Risk Behaviors: Implications for Prevention and Policy," *AIDS and Behavior* 9, no. 3 (2005): 251-65, <https://doi.org/10.1007/s10461-005-9000-7>.
- ¹⁶⁰ District of Columbia Interagency Council on Homelessness, "Homeward DC: Strategic Plan 2015-2020" (2015), https://ich.dc.gov/sites/default/files/dc/sites/ich/page_content/attachments/ICH-StratPlan2.11%20web.pdf.
- ¹⁶¹ J.R. Woodhall-Melnik and J.R. Dunn, "A Systematic Review of Outcomes Associated with Participation in Housing First Programs," *Housing Studies* 31, no. 3 (2016): 287-304, <http://search.ebscohost.com/login.aspx?direct=true&db=buh&AN=114607406&site=ehost-live&authtype=sso&custid=s3229936>.
- ¹⁶² The Way Home, "Analysis of DC's Fiscal Year 2020 Budget" (2019), <https://drive.google.com/file/d/1qt2tQ5Dju7PUe8QvpEi8tF9YGSPhgW3G/view>.
- ¹⁶³ Ibid.
- ¹⁶⁴ S. Straw, Senior Community Investment Officer and Philanthropic Advisor, The Greater Washington Community Foundation, email to The Pew Charitable Trusts, Dec. 20, 2019.
- ¹⁶⁵ American Hospital Association, "Making the Case for Hospitals to Invest in Housing" (2019), https://www.aha.org/system/files/media/file/2019/05/AIHC_issue_brief_final.pdf.
- ¹⁶⁶ J. James, "Nonprofit Hospital's Community Benefit Requirements" (Health Affairs, 2016), <https://www.healthaffairs.org/doi/10.1377/hpb20160225.954803/full/>.
- ¹⁶⁷ M. Ayala and J. Trocchio, "Housing and Community Benefit: What Counts?," *Health Progress*, no. May-June (2018), <https://www.chausa.org/docs/default-source/health-progress/community-benefit-housing-and-community-benefit-what-counts.pdf?sfvrsn=0>.
- ¹⁶⁸ K. Reynolds et al., "Affordable Housing Investment: A Guide for Nonprofit Hospitals and Health Systems" (The Urban Institute, 2019), https://www.urban.org/sites/default/files/publication/100774/affordable_housing_investment_a_guide_for_non_profit_hospitals_and_health_systems_1.pdf.
- ¹⁶⁹ A. Ly and E. Latimer, "Housing First Impact on Costs and Associated Cost Offsets: A Review of the Literature," *The Canadian Journal of Psychiatry* 60, no. 11 (2015): 475-87, <https://doi.org/10.1177/070674371506001103>.

¹⁷⁰ J. Hobson, "To Reduce Chronic Homelessness, a Chicago Hospital Is Treating It as a Medical Condition," WBUR, accessed October 15, 2019, February 21, 2019, <https://www.wbur.org/hereandnow/2019/02/21/homelessness-as-medical-condition-chicago>.

¹⁷¹ G. Flaccus, "6 Portland Health Providers Give \$21.5m for Homeless Housing," *U.S. News & World Report*, Sept. 23, 2016, <https://www.usnews.com/news/news/articles/2016-09-23/6-portland-health-providers-give-215m-for-homeless-housing>.

¹⁷² State of New Jersey Housing and Mortgage Finance Agency, "Murphy Administration, St. Joseph's Health Announce First Affordable Rental Development under Agency's Hospital Housing Partnership Program," news release, July 10, 2019, <https://www.nj.gov/dca/hmfa/media/news/2019/approved/20190710.html>.

¹⁷³ J. Paradise and D.C. Ross, "Linking Medicaid and Supportive Housing: Opportunities and on-the-Ground Examples" (Kaiser Family Foundation, 2017), <https://www.kff.org/report-section/linking-medicaid-and-supportive-housing-issue-brief/>.

¹⁷⁴ District of Columbia Interagency Council on Homelessness, "Homeward DC."

¹⁷⁵ Paradise and Ross, "Linking Medicaid and Supportive Housing: Opportunities and on-the-Ground Examples."

¹⁷⁶ A. Clary and T. Kartika, "Braiding Funds to House Complex Medicaid Beneficiaries: Key Policy Lessons from Louisiana" (National Academy for State Health Policy, 2017), <https://nashp.org/wp-content/uploads/2017/05/Braiding-Funds-Louisiana.pdf>.

¹⁷⁷ Paradise and Ross, "Linking Medicaid and Supportive Housing: Opportunities and on-the-Ground Examples."

¹⁷⁸ *Ibid.*

¹⁷⁹ *Ibid.*