

WHAT ARE THE STATE GOVERNMENTS DOING TO COMBAT THE OPIOID ABUSE EPIDEMIC?

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INVESTIGATIONS
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COMMERCE
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THURSDAY, MAY 21, 2015

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:19 a.m., in room 2322 of the Rayburn House Office Building, Hon. Tim Murphy (chairman of the subcommittee) presiding.

Members present: Representatives Murphy, McKinley, Burgess, Griffith, Bucshon, Flores, Brooks, Mullin, Hudson, Collins, Cramer, DeGette, Tonko, Clarke, Kennedy, Green, Welch, and Pallone (ex officio).

Staff present: Will Batson, Legislative Clerk; Andy Duberstein, Deputy Press Secretary; Brittany Havens, Oversight Associate, Oversight and Investigations; Charles Ingebretson, Chief Counsel, Oversight and Investigations; Chris Santini, Policy Coordinator, Oversight and Investigations; Alan Slobodin, Deputy Chief Counsel, Oversight; Sam Spector, Counsel, Oversight; Christine Brennan, Democratic Press Secretary; Jeff Carroll, Democratic Staff Director; Christopher Knauer, Democratic Oversight Staff Director; Una Lee, Democratic Chief Oversight Counsel; Elizabeth Letter, Democratic Professional Staff Member; Adam Lowenstein, Democratic Policy Analyst; and Timothy Robinson, Democratic Chief Counsel.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Good morning. Today we convene the fourth in a series of hearings examining prescription drugs and heroin addiction, the growing nightmare of one of America's biggest public health crises.

Since our opioid hearings earlier this month, approximately 2,400 Americans have died from drug overdoses, and most of them because of opioid abuse. The size of this problem and the need for a new paradigm of treatment cannot be understated, and the process of developing legislative solutions has already started. Ranking Member DeGette and I have identified 15 areas in need of reform. One of those is 42 C.F.R. Part 2, which governs confidentiality protections for all substance use treatment records, both behavioral and physical, generated at a substance abuse treatment facility. It is well intended, but out dated, and Part 2 compromises medical

care, increases the risk of dangerous and deadly adverse drug-to-drug interactions, and increases risk of relapse to addiction. My friend, Congressman Tonko from New York, and I have been working together to stop this medical records discrimination, and I thank him for his work.

At the State level, responses to the epidemic vary. States like Indiana are responding to outbreaks of HIV and hepatitis. States on the east coast are confronting the problem of heroin laced with fentanyl, another narcotic pain reliever 100 times as powerful as morphine. Some States, mostly in the South, are burdened with the highest prescribing rates of opioid pain relievers, rates that are tenfold the rates in some other States. Also, State efforts share many similar challenges. The National Governors Association said States need accurate and timely information at their fingertips concerning the incidence and scope of the problem in order to develop an effective response. States have no choice but to use incomplete and outdated data to identify areas on which to concentrate their efforts, given their limited resources. Some States operate Prescription Drug Monitoring Programs, but these systems may not be easy to use. In Massachusetts, I believe it takes doctors 11 steps to use the program, which makes it difficult to encourage a high degree of participation. State systems are not necessarily connected to the systems of neighboring States, enabling abusers to doctor-shop across borders since their actions are not tracked. Further, the data on these systems can sometimes be several weeks old, escalating the risk for errors from inaccurate data.

Overdose prevention remains a key aim of any meaningful State strategy, yet States have adopted different approaches to address it. Some provide liability protection for individuals who act in good faith to provide medical assistance to others in the event of an overdose, or expand access to the lifesaving drug naloxone, or use public education on the proper disposal of prescription drugs that are vulnerable to misuse.

States also differ on availability and financing of medication-assisted treatments. Opioid maintenance is a bridge for those with addiction disorders to cross over in the recovery process, and we support that. Full recovery is complete abstinence. Medication-assisted treatment is valuable, but it must be coupled with proven psychosocial therapies and other wraparound services to support the person traversing this difficult road and to help with long-term, sustained recovery.

Today we want to hear from the States about best-practice models, problems that they have encountered, and how States have addressed this problem. We also seek absolutely candid and honest input from each of our witnesses. Please tell us where there are problems, and please tell us where there are successes with any Federal programs or policies. We will hear from representatives of Indiana, Massachusetts, Missouri, and Colorado State Governments, a sampling of the 50-plus separate efforts being pursued by U.S. States and territories to counter opioid abuse. We are honored to have our witnesses join us this morning. We thank you for appearing today and look forward to hearing your testimony.

[The prepared statement of Mr. Murphy follows:]

PREPARED STATEMENT OF HON. TIM MURPHY

Today we convene the fourth in a series of hearings examining prescription drugs and heroin addiction; the growing nightmare of one of America's biggest public health crises. Since our opioid hearing earlier this month approximately 2,400 Americans have died from drug overdoses, most of them because of opioid use.

The size of this problem and the need for a new paradigm of treatment can't be understated. And, the process of developing legislative solutions has already started. Ranking Member DeGette and I have identified 15 areas in need of reform. One of those is 42 CFR Part 2, which governs confidentiality protections for all substance use treatment records, both behavioral and physical, generated at a substance abuse treatment facility. Well intended, but out dated, Part 2 compromises medical care, increases the risk of dangerous and deadly adverse drug-to-drug interactions, and increases risk of relapse to addiction. Congressman Tonko from New York and I have been working together to stop this medical records discrimination. I thank him for his work.

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Also, State efforts share many similar challenges. The National Governors Association said States need accurate and timely information at their fingertips concerning the incidence and scope of the problem in order to develop an effective response. States have no choice but to use incomplete and outdated data to identify areas on which to concentrate their efforts given their limited resources.

Some States operate Prescription Drug Monitoring Programs, but these systems may not be easy to use. In Massachusetts, it takes doctors 11 steps to use its program, which makes it difficult to encourage a high degree of participation. State systems are not necessarily connected to the systems of neighboring States, enabling abusers to doctor-shop across borders since their actions are not tracked. Further, the data on these systems can sometimes be several weeks old, escalating the risk for errors from inaccurate data.

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Opioid maintenance is a bridge for those with addiction disorders to cross over in the recovery process. Full recovery is complete abstinence. Medication assisted treatment must be coupled with proven psycho-social therapies and other wrap-around services to support the person traversing this difficult road and to help with long-term, sustained recovery.

Today we want to hear from the States about best-practice models, problems they have encountered, and how States have addressed these problems. We also seek absolutely candid and honest input and ideas about where there are problems and successes with any Federal policies.

We will hear from representatives of the Indiana, Massachusetts, Missouri, and Colorado State Governments, a sampling of the 50-plus separate efforts being pursued by U.S. States and territories to counter opioid abuse.

We are honored to have our witnesses join us this morning. We thank you for appearing today and look forward to hearing your testimony.

Mr. MURPHY. And I am purposefully cutting this short so we can keep this moving.

Ms. DEGETTE. OK.

Mr. MURPHY. I recognize Ms. DeGette for 5 minutes.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you very much, Mr. Chairman. I have been asking you to have a hearing so we can hear from the States, and I am glad that the States are here. I think it is important because much of the work in this area is happening in the States.

I am particularly glad that Dr. Wolk is here from my home State of Colorado. I am eager to hear about what is happening in Colorado, particularly the positive developments in reducing prescribing rates and illicit use of opioid painkillers. It is clear that if we wish to reduce the problem of opioid dependency in our communities, we also have to address the issue of overprescribing. Last year, the CDC released a report on the correlation between opioid prescribing rates and drug overdose rates. CDC Director Tom Frieden stated, "Overdose rates are higher when these drugs are prescribed more frequently. States and practices where prescribing rates are highest need to take a particularly hard look at ways to reduce the inappropriate prescription of these dangerous drugs."

Colorado has taken a number of important steps to address the opioid epidemic at its source. In September 2013, statewide leadership established the Colorado Consortium on Prescription Drug Abuse Prevention; its goal is to reduce the misuse of prescription drugs through physician training and education, public outreach, and safe disposal. The goal of the coalition is also to prevent 92,000 Coloradans from misusing opioids by 2016, and I am sure we can get a good progress report on that from Dr. Wolk. I know that Colorado has seen the rate of non-medical use of opioid painkillers fall already as a result of its work, and I am hoping we can hear about some of these best practices and lessons learned in this process.

I am also eager to hear about how the other States here today are working to monitor prescribing rates, and reduce the number of opioid painkiller prescriptions. Experts tell us that the State Prescription Drug Monitoring Programs, or PDMPs, are an integral part of the solution to overprescribing. PDMPs can facilitate better clinical decision-making by prescribers, reduced doctor-shopping, and help physicians refer individuals for addiction treatment. I am interested to hear about the efforts that the States are undertaking to make PDMPs a more effective tool. For example, again, in Colorado, we were able to double our PDMP utilization rate from 41 percent to 84 percent in just 1 year. Massachusetts also has high provider participation rates. I would like to know how we were able to achieve such great results in such a short time.

Finally, I am interested to know more about the innovative efforts that States are undertaking on the treatment side of the equation. For instance, Missouri has made medication-assisted treatment available through all its State behavioral health organizations. The State does not contract with organizations that do not provide MATs. This is an important step to ensure that patients have access to the full evidence-based care that they need. Colorado is also taking steps to improve treatment for substance abuse disorders by integrating behavioral and primary care services in the State Medicaid Program. This is an ambitious goal of integrating 80 percent of the primary care practices with behavioral health

services, including emergency departments, clinics, and private practices. I look forward to hearing more about this initiative and to similar efforts that are taking place in Massachusetts.

So the States before us have made some impressive efforts to address this public health concern, but I want to caution that a lot more work needs to be done. Even before the opioid epidemic began, our infrastructure for treating substance abuse disorders in this country was remarkably inadequate to deal with the prevalence of the disease of addiction. Given the history of neglect and underinvestment in substance abuse, it is no wonder that the opioid epidemic resulted in a public health crisis.

There is just one last thing I want to talk about, Mr. Chairman. We had a fellow show up just in the audience at our last hearing, Don Flattery, and Don came as a citizen because he lost his son, Kevin, to an opioid overdose last Labor Day, and when you hear about his son, Kevin, and when you hear about what this family went through, it is just heartbreaking. It is heartbreaking. I know all of our hearts go out to their family. They dedicated an immense amount of time and resources to getting the best treatment for Kevin, but they couldn't find access to the resources and quality treatment that they needed. I really want to thank Don for sharing his story with us, and for providing the committee with valuable insight into the problem. I am hoping we can hear from others like Don about the day-to-day challenges they face. Don wrote us a letter which talked about what has happened with his family, and I would ask unanimous consent to put that in the record, Mr. Chairman.

[The letter appears at the conclusion of the hearing.]

Mr. MURPHY. Well, I agree, because I read the letter, too. It is powerful.

Ms. DEGETTE. Yes. Thank you. And thanks again for holding this hearing, and I will yield back.

Mr. MURPHY. Yes, I just want to note too, I appreciate your request for doing this on a State level. I also want to acknowledge that I received a letter from you and Mr. Pallone on other suggestions for the committee. We do a lot of cooperative work together, and although that will never make the news that Members of Congress do work together on both sides of the aisle, I wanted to publicly acknowledge my gratitude for you on that.

Now, I don't know if there are any members on this side who want to make an opening statement, but I would like to give an opportunity to our colleagues from Indiana to introduce the witness from Indiana. Dr. Bucshon, are you going first or is Mrs. Brooks going first?

Dr. Bucshon, you are recognized first.

Mr. BUCSHON. Thank you, Mr. Chairman. Today, I have the pleasure of introducing Indiana State Health Commissioner, Dr. Jerome Adams. Through extensive work as a researcher, as well as a policy leader, Dr. Adams brings a vast breadth of knowledge and experience to both the current opioid abuse epidemic in our State and to the witness panel. As we continue to work to curb the opioid abuse epidemic occurring through the country, parts of Indiana have recently seen HIV outbreaks as a direct result from this epidemic, presenting Dr. Adams with a unique challenge and a unique

perspective on the current crisis. His expertise will undoubtedly be valuable to this committee.

Dr. Adams, thank you for appearing before us today, and I look forward to your testimony.

And I yield to Congresswoman Brooks from Indiana.

Mrs. BROOKS. Thank you, Dr. Bucshon.

I want to thank the chairman for holding, once again, this important hearing, and to hear from witnesses who are battling this in our States. I want to extend a special welcome to Dr. Jerome Adams, my friend and constituent. It is wonderful for you to be here. And, in fact, his first day on the job, we were in an emergency meeting in Indianapolis focused on Ebola. And so here we are fast-forward just a few months, and I believe with your background not only as a physician from my medical school, but an anesthesiologist at Ball Memorial Hospital, that you do have the right kind of experience and background to help lead the State Health Department at this time. And as of May 18, there have been 158 identified cases of HIV in Scott County, and that number has gone up from the time we last had a hearing, and we are asking the CDC about Scott County. And so we know that you and your team, many of whom are with you today, have done an amazing job of curbing the HIV epidemic and slowing its growth, and we look forward to hearing your testimony today.

Thank you for being here.

Mr. MURPHY. Gentleman—

Mr. BUCSHON. Yield back.

Mr. MURPHY [continuing]. Yields back? All right, I recognize Mr. Pallone for 5 minutes.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman. And I want to thank you and Ms. DeGette for the hearing, and for your due diligence in investigating the opioid abuse epidemic. I am glad the subcommittee is devoting significant attention to this issue because like all of the members here today, I am concerned about what is happening in my State.

A New Jersey State official recently reported that more than 6,000 people in New Jersey have died from overdoses since 2004. He also reported that more teens are dying from drug overdoses in New Jersey than car accidents. Today, we are hearing from State health officials about ongoing efforts within their agencies to combat this epidemic. And I know you all are dealing with many aspects of this issue, from reducing opiate prescribing rates, to increasing access to treatment to programs, and I look forward to hearing about the work you are doing, and I hope we can all learn from each other.

I also want to hear from all the witnesses today about how we as the Federal Government can help fight this epidemic. We heard earlier this month from a number of Federal agencies about their work, but I want to make sure we are supporting the States and their efforts to address the epidemic.

We have heard repeatedly throughout this series of hearings that significant barriers to treatment for substance use disorders still exist. For example, SAMHSA's 2013 National Survey on Drug Abuse and Health found that nearly 40 percent of individuals who make an effort to seek treatment were unable to get treatment due to lack of health coverage and the prohibitive cost of treatment. Another 8 percent reported that they had health coverage but it did not cover the cost of treatment. And with the passage of the Affordable Care Act, approximately 16.4 million Americans have gained health insurance coverage, and insurance companies are now required to provide treatment for substance abuse disorders and coverage, just as they would cover treatment for any other chronic disease. But we still need to understand where barriers to treatment remain, and we should work on making sure those who want to access treatment are able to do so.

I also want to hear from all of our witnesses today about how Medicaid expansion, or in Missouri's case of failure to expand Medicaid, has had an impact on treatment for substance abuse disorders. I know Massachusetts and Colorado both signed Medicaid expansions into law in 2013, and Indiana expanded Medicaid earlier this year, so I am interested to hear from all three of your States about how Medicaid expansion has improved access to behavioral health services, and I want to hear from Missouri how Medicaid expansion could help those seeking access to behavioral health services and what challenges you face by not expanding the program. So thanks again.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Mr. Chairman, thank you for holding today's hearing and for your due diligence in investigating the opioid abuse epidemic. I'm glad this subcommittee is devoting significant attention to this issue because like all of the Members here today, I am concerned about what is happening in my State.

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treatment for substance abuse disorders. I know Massachusetts and Colorado both signed Medicaid expansion into law in 2013, and Indiana expanded Medicaid earlier this year.

I'm interested to hear from all three of your States about how Medicaid expansion has improved access to behavioral health services. And I want to hear from Missouri how Medicaid expansion could help those seeking access to behavioral health services and what challenges you face by not expanding the program.

Thank you again for holding this hearing, and thank you to all our witnesses for sharing your insight today.

I yield my remaining time to Rep. Kennedy.

Mr. PALLONE. I would like now to yield the rest of my time to Representative Kennedy.

Mr. KENNEDY. Thank you. I would like to thank the ranking member. I would also like to thank the chairman of the committee for calling this extraordinary series of hearings. They have been, I think, extremely enlightening, and shining a light on an incredible epidemic our country is facing.

To the witnesses today, thank you so much for being here to discuss the States' efforts to combat opioid abuse. In my mind, we are here for one reason; to learn from you about what has worked on the ground in your States, and how we can try to support those efforts at a Federal level in any way possible.

Few in my home State have been spared the tragic consequences of the ongoing opioid epidemic. Last year, there were more than 1,000 deaths in our Commonwealth, spanning wealthy and low-income communities alike, areas rural and urban, faces young and old.

Dr. Bharel has been on the frontlines of this battle for long before she was appointed to the Public Health Commission earlier this year, but in her new role, she is focused on ensuring treatment options are available to all of our citizens, regardless of income. It is my honor to welcome her today to Washington, and I look forward to hearing your testimony.

One issue I hope to hear from all of you today is a little bit about one of the issues we have been wrestling with in Massachusetts, which is the rising cost of Narcan. At a time when our country needs every tool at its disposal in this fight, the price of lifesaving treatment continues to skyrocket. Last month in Needham, Massachusetts, the cost per dose rose to \$66.89, up from \$19.56 last June.

Now, Narcan is by no means an answer to this epidemic. It is a stopgap, not a solution, but it does save lives. It allows us to get individuals suffering from crippling addiction into treatment. It helps minimize the number of parents, brothers, sisters, and children with loved ones who are taken far too soon. So I would be interested to hear from our witnesses about any price spikes that you have seen at home, how those have impacted response efforts, and how the Federal Government can help ensure that no one's life is lost because a municipality simply can't afford a drug.

Another area that I would like to get some insight on is the effectiveness of Prescription Drug Monitoring Programs. I represent a district in Massachusetts that borders Rhode Island, and it has become clear to me that the lack of communication across State lines is leaving a gap in how we tackle prescription drugs. To that end, I helped to cosponsor the National All Schedules Prescription Electronic Reporting Act with Congressman Whitfield in an effort to

better support State PDMPs, particularly where interoperability is concerned. Drs. Adams, Bharel, Wolk, I hope you will expand a little bit more on the roles PDMPs have played in your States' efforts today. Dr. Stringer, I would love if you would be able to touch a little bit about your State's plans to develop a PDMP.

Tackling an epidemic of this scope requires partners across local, State, and Federal levels. To that end, we are all deeply grateful for your presence here today, and look forward to supporting you any way we can.

Thank you, and I yield back.

Mr. MURPHY. Gentleman yields back.

I would now like to introduce the witnesses on the panel for today's hearing. We have already heard about Dr. Jerome Adams, the Health Commissioner of the Indiana State Department of Health. Welcome. Dr. Monica Bharel, the Commissioner of the Massachusetts Department of Health. Dr. Larry Wolk, the Executive Director and Chief Medical Officer at the Colorado Department of Public Health and Environment. And Mr. Mark Stringer, the Director of the Division of Behavioral Health at the Missouri Department of Mental Health.

I would now like to swear in the witnesses.

You are all aware that the committee is holding an investigative hearing, and when doing so, has the practice of taking testimony under oath. Do any of you have any objections to testifying under oath? All the witnesses answered negative. The Chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do any of you desire to be advised by counsel today? All the witnesses indicate no. In that case, if you will all please rise and raise your right hand, I will swear you in.

[Witnesses sworn.]

Mr. MURPHY. You are now under oath and subject to the penalties set forth in Title XVIII, Section 1001 of the United States Code. You may now each give a 5-minute summary of your written statement, and please try to be under 5 minutes. You will need to press the button so the green light is on, and pull the microphone fairly close to you. Thank you.

Dr. Adams, you are recognized for 5 minutes.

STATEMENTS OF JEROME ADAMS, M.D., M.P.H., COMMISSIONER, INDIANA STATE DEPARTMENT OF HEALTH; MONICA BHAREL, M.D., M.P.H., COMMISSIONER, MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH; LARRY WOLK, M.D., M.S.P.H., EXECUTIVE DIRECTOR AND CHIEF MEDICAL OFFICER, COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT; AND MARK STRINGER, M.A., L.P.C., N.C.C., DIRECTOR, DIVISION OF BEHAVIORAL HEALTH, DEPARTMENT OF MENTAL HEALTH, MISSOURI

STATEMENT OF JEROME ADAMS

Dr. ADAMS. Thank you very much. My name is Jerome Adams. I am the Indiana State Health Commissioner, I am a physician anesthesiologist, and I am the brother of an addict. On behalf of Gov-

ernor Mike Pence and the people of Indiana, it is my honor to be here today.

In rural Scott County, we are dealing with the largest injection-drug-use-related HIV outbreak in decades, with what CDC Director Tom Frieden described as a higher incidence of HIV than any country in sub-Saharan Africa. In an area that had three total cases of HIV over the prior 4 years, we, as of today, have 160 positives, with 95 percent related to injection drug use, and Hepatitis C coinfection rate of 88 percent.

At the root of this outbreak is our country's prescription opioid crisis. The crisis is multifactorial, but I think it is helpful to separate it into three distinct problem and solution areas. Number one, we need to stop the flow of opioids into communities. Number two, we need to deal with the personal and public health consequences of communities with overflow of both opioids and people engaging in high-risk activities. And number three, we need to create an outlet for those seeking recovery from substance use disorder.

In terms of stopping the flow, in Indiana we witnessed a 10 percent decrease in prescriptions since we implemented new opioid prescribing rules in 2012, but we still have work to do. We need an aggressive education and prevention strategy starting in childhood. In addition to promoting the dangers of prescription drug misuse, we need better Prescription Drug Monitoring Programs with required reporting from the VA and Federal methadone treatment centers, higher thresholds for new FDA approvals of opioids, and safety and efficacy reviews of previously approved opioids based on recent data. Policies should further promote pharmacy and community opioid take-back programs, and require opioid manufacturers to facilitate these endeavors. And we should revisit both pain as the fifth vital sign, and the pain component of patient satisfaction as a consideration for physician and hospital reimbursement. Our focus needs to be on functionality and outcomes, and not simply on stopping pain with pills.

Regarding the consequences of opioid overflow, we have seen not just an HIV epidemic, but also regional epidemics of Hepatitis, overdose deaths, unsustainable levels of incarceration, and community hopelessness. Our comprehensive approach in Scott County includes increased HIV and Hepatitis testing, and immediate treatment referral, locally based harm reduction strategies, immunizations, healthcare coverage, job training, and an outreach campaign targeting drug users and those involved in the commercial sex trade.

On a State level, we have formed a Neonatal Abstinence Syndrome Committee, and recently made Naloxone available for first responders and friends or family members of those at risk. As Governor Pence said when he signed our Naloxone Bill, bills like this are about saving lives. Thanks to Governor Pence fighting hard to receive the only Federal waiver of its kind, and to Representative Pallone's point, we can further address the needs of those with substance use disorder, including healthcare coverage and access, the two are not equal, and job training via our Healthy Indiana Plan. If people don't have hope, they will increasingly turn to and stay on drugs; a painful lesson we have learned from Scott County. For-

tunately, over 225,000 Hoosiers have more hope now thanks to HIP 2.0.

Lastly, in terms of creating an outlet, we must provide options for those seeking recovery services. A national campaign could reduce the stigma of substance use disorder and HIV so people aren't ashamed to seek services, and could help reframe addiction from that of a moral failure to that of a medical disorder that requires a lifetime of attention. Lack of recovery reflects a lack of enlightenment on society's part, as much of it reflects a lack of earnestness on the sufferer's part.

Regarding recovery in Scott County, we have found a severe and unmet need for access to appropriate substance use disorder treatment, and we have accordingly worked to increase beds in outpatient services. When incarcerated, sufferers also should have access to mental health and addiction treatment, with linkages to these services upon release. Such programs exist in Indiana, but are often only found in the most well-resourced communities. And we must educate communities and the public about medication-assisted treatment as an important component of the recovery safety net. Recently enacted legislation in Indiana allows the establishment of additional methadone clinics in our State, and the criminal justice system at the county level is increasingly offering Vivitrol for inmates upon release, or as an option during drug court diversion programs.

Our situation in Indiana, in closing, may be unprecedented in many ways, but in many others, it illustrates problems faced throughout our country. There is much we do, but I am confident that we can succeed. If we focus on education, patient-centered care, and community and patient empowerment, I am confident we can successfully combat the scourge of opioid abuse.

Mr. Chairman, thank you for your time, and I look forward to the opportunity to answer your questions.

[The prepared statement of Dr. Adams follows:]

**TESTIMONY BEFORE THE UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS**

**Hearing on “What are the State Governments
Doing to Combat the Opioid Abuse Epidemic?”**

**Jerome Adams, MD, MPH
Commissioner, Indiana State Department of Health**

May 21, 2015

Summary of Testimony:

Scott County, Indiana is dealing with an unprecedented HIV outbreak related to intravenous drug use, with 158 confirmed cases and a Hepatitis-C co-infection rate of 88%. While focus is on the transmission of HIV, the underlying issue is one of rampant substance use disorder (SUD) in this and other communities across our country. As exemplified in Scott County, the problem of opioid abuse is multifactorial, and includes an inability to control flow of opioids into the communities, an increasing need to deal with the consequences of subsequent overflow (e.g. HIV and Hepatitis infections, overdose deaths, hopelessness and further lack of opportunity and resources in communities), and a lack of recovery options for those who are suffering from SUD. We must address each of the three areas if we hope to stem the tide of this epidemic.

Suggested policy options to mitigate the opioid epidemic include:

- 1) Educational initiatives for patients, prescribers, and payers regarding proper goals and means of pain management.
- 2) Standardization and optimization of prescription drug monitoring programs.
- 3) A review of “pain as the fifth vital sign” and its impact on opioid prescribing habits.
- 4) Assessment of patient satisfaction scores and how to assess functionality and outcomes vs. provision of opioids when determining hospital and provider reimbursement.
- 5) Assessment of policies related to approval of new opioids, and a review of previously approved opioid indications.
- 6) Promotion of opioid take back programs so that unused opioids are removed from society.
- 7) Promotion of best practices regarding HIV and hepatitis testing and treatment.

- 8) Comprehensive and patient centered care and support services for those with SUD, HIV, and Hepatitis infections.
- 9) Allowing for state led coverage options for vulnerable populations and low income populations, as we have done via our Healthy Indiana Plan 2.0.
- 10) Education and promotion regarding locally based harm reduction strategies to mitigate the public health consequences of risky behaviors in communities.
- 11) Increased availability of Naloxone for 1st responders and lay persons, as we have recently passed by our legislature.
- 12) Campaigns to reduce the stigma of SUD, and redefine as a chronic medical condition that people must be empowered to control, instead of a moral failure.
- 13) Increasing access to evidence based and comprehensive addiction and recovery treatment.
- 14) Educating the public and policy makers about the pros, cons, and goals of medication assisted treatment to assist recovery from SUD.

Full Testimony:

Chairman Murphy, Ranking Member DeGette, and members of the Committee, especially Representatives Brooks and Bucshon from the State of Indiana, thank you for the opportunity to testify today. My name is Jerome Adams, and I am the Indiana State Health Commissioner, as well as a practicing physician anesthesiologist at Eskenazi Hospital in Indianapolis, Indiana. On behalf of Governor Mike Pence and the people of Indiana, it is my honor to appear before you to discuss the important issue of combating the opioid abuse epidemic in our states and nation.

This year in Indiana we have faced the very real consequences of the opioid abuse epidemic in a way that has caught national attention. In Scott County, Indiana, we are dealing with what CDC Director Frieden has called the largest HIV outbreak related to injection drug use (IDU) in decades, with what he describes as a higher incidence of HIV than “any country in sub-Saharan Africa.” In a rural community that had 3 total cases of HIV in the previous 4 years, we as of May 19th have 158 positives, 95% related to IDU, and with a Hepatitis-C co-infection rate of 88%.

There is much we’ve learned during our response to this unprecedented HIV outbreak, but at its root is our country’s prescription opioid crisis. The problem of opioid misuse is multifactorial but it is helpful to separate the discussion into three different problem and solution areas:

- 1) Stopping the flow of opioids into communities,
- 2) dealing with the personal and public health consequences of overflow, or communities with

too many opioids and too many people engaging in high risk activities, and

3) creating an outlet for those seeking recovery from substance use disorder (SUD).

Residents of Scott County, from middle schoolers to senior citizens, tell us prescription opioids are all too easy to come by. Since 2012, Indiana has implemented new rules for physicians who prescribe opioids to treat chronic, non-terminal pain. We have witnessed a 10% decrease in opioid prescribing during that time, but we still have work to do. To stop the flow of opioids into communities, we need better education for the public, patients, and prescribers, more tools to access and use the robust data available in prescription drug monitoring programs (PDMPs) for provider education and public health surveillance, more disposal options for unused opioids, and reimbursement for true pain management versus simply paying for pills.

Targeted marketing by the pharmaceutical industry encouraged providers to use opioids more aggressively to treat chronic, non-terminal pain. The “Pain is the Fifth Vital Sign,” campaign, financially supported by the pharmaceutical industry, was adopted by the Joint Commission and led to requirements for subjective pain assessments during routine medical care. Although there is no evidence to support the routine use of opioids in the management of chronic pain, the rapid subjective evaluation of pain and subsequent increase in the number of opioid prescriptions did little to solve the pain problem and resulted in an epidemic of opioid misuse, addiction and overdose deaths. Pain management requires a holistic approach, with a focus on improving functionality and quality of life, and not absolute elimination of pain. In fact, many patients on chronic opioid therapy report no functional improvements and worse quality of life.

We should revisit both “pain as the 5th vital sign,” and the pain component of patient satisfaction as a consideration for physician and hospital reimbursement. Our goal should be to create best-practice models for integrated pain management practices where the focus is on functionality and outcomes, and not elimination of pain.

Accountability for this epidemic must be systemic and include parents and schools, the pharmaceutical industry, patients, prescribers, pharmacists, and payers. We need an aggressive prevention strategy beginning in childhood and adolescence to prevent diversion and the onset of SUD. In Scott County we met a 23 year-old in our HIV clinic who was first prescribed opioids in high school as a result of a knee injury. Less than 3 years later he was injecting opioids and he’s now HIV positive. These stories are all too common.

Policies to stop the flow of opioids could include: educational campaigns to promote the dangers of prescription drug diversion and misuse, required reporting from federal programs (e.g. Veterans Administration and Methadone treatment centers) to state PDMPs, and higher thresholds for new FDA approvals of opioids as well as reviews of previously approved opioid indications for safety and efficacy based on recent science. Policies should further promote pharmacy and community opioid take-back programs and require opioid manufacturers to facilitate these endeavors.

Regarding the consequences of opioid overflow there is rightly much attention on our HIV outbreak, but across the entire country we’ve also seen an epidemic of Hepatitis, overdose

deaths, unsustainable levels of incarceration, and community hopelessness, drug abuse, and worsening socioeconomic conditions.

Mitigating policies should create easy access to HIV and Hepatitis testing, with care coordinators on site for immediate referral to medical and SUD treatment. Comprehensive services should increase immunizations amongst vulnerable populations, promote adoption of locally based harm reduction strategies, and help people obtain healthcare coverage and jobs. There must be outreach and education regarding the dilemma of SUD leading to commercial sex work, and concerns of IDU disease transmission becoming sexual, and vice versa. We've had success doing all these things at our community outreach center in Scott County.

The Scott County Community Outreach Center has had 789 visitors, with 271 people being tested for HIV and 298 people receiving needed immunizations. 302 people have been enrolled in health care coverage through the Healthy Indiana Plan 2.0 and 38 people have received job referrals through the Indiana Department of Workforce Development.

We must also create easy access to life-saving Naloxone for 1st responders, and friends or family members of people on high dose opioid treatment or with SUD. We've recently passed legislation increasing Naloxone availability for this latter purpose in Indiana. As Governor Pence said when he signed our Naloxone legislation, bills like this "are about saving lives."

Policies must also address the needs of these vulnerable populations, including homelessness, hunger, unemployment, healthcare coverage and availability, reintegration after release from

jail, and educational and job opportunities. I'm happy to say that the Healthy Indiana Plan 2.0 which Governor Pence instituted earlier this year after obtaining a federal waiver provides many of these services. If people have no hope, they will increasingly turn to and stay on drugs, again a painful lesson from Scott County. Fortunately over 225,000 Hoosiers have more hope thanks to HIP 2.0.

Finally, we absolutely must provide increased options for people who are seeking addiction and recovery services. As part of this we must strive to reduce the stigma of SUD and HIV/AIDS so people are not ashamed or afraid to seek services when they are ready. A national education campaign would be helpful in reframing the discussion of addiction from moral failure to that of a medical disorder that will require a lifetime of attention.

In Scott County we've found a severe need for ready access to an SUD treatment safety net that includes a full array of culturally sensitive, integrated mental health and addiction treatment services. The criminal justice system in communities should also strive to provide evidence-based mental health and addiction treatment services to individuals who are incarcerated, and provide linkages to appropriate outpatient services and recovery coaching upon release. These programs do exist in Indiana, but because of the staffing requirements, are most often found in well-resourced counties. Finally, we must educate communities about medication assisted treatment (MAT) as an important component of the SUD recovery safety net. MAT has been shown in studies to double rates of opioid abstinence, lower HIV and Hepatitis-C infections, lower all cause mortality, particularly from overdose, and decrease criminality in communities.

There are currently 13 privately owned methadone treatment programs in Indiana and 74 cities with suboxone providers. Recently enacted legislation allows hospitals or community mental health centers to establish a total of 5 additional methadone clinics before 2018. In addition, the criminal justice system at the county level is increasingly offering Vivitrol as an option for inmates upon release or as an option during drug court diversion programs.

Our situation in Indiana may be unprecedented in many ways, but in many others, it illustrates problems faced by much of our country. There is much to do, but we can make progress. If we focus on education, patient centered care, and community and patient empowerment, I am confident we can successfully combat the problem of opioid abuse.

Mr. Chairman, thank you for the time and the opportunity, and I look forward to your questions.

Mr. MURPHY. Thank you very much, Doctor.
And now, Dr. Bharel, you are recognized for 5 minutes.

STATEMENT OF MONICA BHAREL

Dr. BHAREL. Thank you, Chairman Murphy, Ranking Member DeGette, and the members of the committee. Thank you for welcoming us here today, and for the opportunity to provide this testimony on this incredibly pressing issue today.

My name is Dr. Monica Bharel, and I am proud to have been appointed to serve the Commonwealth of Massachusetts and Governor Baker as its Commissioner of Public Health. I am honored to be here representing one of the Nation's oldest public health departments; one that traces its roots back to Commissioner Paul Revere, and one that has continually led the way in public health across the country. Yes, we can talk more about that later.

As a—

Mr. MURPHY. He alerted people with lanterns, I am aware of that. So—

Dr. BHAREL. He gave out information on cholera throughout the Commonwealth.

As a frontline physician and as a former Chief Medical Officer at Boston Healthcare for the Homeless Program, the largest of its kind in the Nation, I have seen firsthand the rising tide of an opioid epidemic that is overwhelming communities. We have watched our family and friends die on our streets, driven by a lethal cocktail of trauma and underlying behavioral health issues. This is not something we as a society should accept as the norm.

This epidemic will be far from easy to tackle, but this challenge is precisely what drew me here to work with you and our providers, our community leaders.

To that end, we are already hard at work in Massachusetts and throughout the Baker administration, redoubling our efforts to identify, triage, address, and treat the opioid epidemic.

First, to identify the problem. Like so many States across the Nation, Massachusetts is facing a growing epidemic of opioid addiction and overdose deaths. In 2013, there were 967 unintentional opioid deaths, compared to 371 motor-vehicle-related injury deaths. That is 2½ times as many people dying from opioid use as for motor-vehicle-related injuries. And behind those 967 deaths are over 2,000 hospital stays and more than 4,500 emergency room visits, and of course, unquantifiable human suffering. And in 2014, we have projected estimations of over 1,000 people dying of an opioid-related overdose. This is a 51 percent increase from 2012. We will fail in our efforts to address this crisis if we do not fully involve partners from all sectors. That includes law enforcement, public health, healthcare institutions, families, schools, and you, our elected officials.

Governor Baker prioritized the opioid epidemic early in his new administration. In February, Governor Baker appointed 18 individuals to serve on his Opioid Working Group. The group represents the many different perspectives that are important to this work, and was charged with developing tangible recommendations. The working group has held listening sessions across the Commonwealth, hearing from over 1,100 individuals, and receiving hun-

dreds of recommendations and emails. No matter which of the lens these individuals look at this epidemic, one thing is obvious, that opioids are impacting every city and town in the Commonwealth. People speak again and again about the wish to have early prevention and increased access to treatment.

Our success getting to the underlying health issues and social determinants that are driving this epidemic; trauma, and undiagnosed behavioral health issues are chief among those, will directly correlate with our ability to successfully leverage data and to measure results. This data will allow us over time to effectively target key populations and hotspot, if you will, to better understand the impact of our collective efforts, and how to use our limited resources better. Utilization of data to combat the opioid crisis has a long way to go. For example, currently in our Department of Public Health we have more than 300 different internal data systems that have developed by individual programs and use a variety of different formats. They are managed by different staff, and reside on different servers that don't talk to each other. However, this problem is not unique to Massachusetts, and across the country, public health needs to double down on data and on interoperable secure IT solutions, such as data warehousing, to create better linkages between our siloed data sets.

As a frontline clinician, I have experienced firsthand the real roadblocks to helping patients access care. In the area of access, particularly with regards to downstream post-detox care, individuals have had a lot of trouble with both residential and outpatient medication treatment service availability. In capacity, statewide bed capacity, the kinds of bed types available and how to access them are not well known. Services for mothers and fathers in recovery who are attempting to reclaim their lives, while trying to take care of their children, needs improvement. Individuals suffering from addiction need better access to childcare, stable housing, and employment opportunities, as well as access to timely treatment. We need more early interventions in schools, and perhaps most important, this issue of stigma.

What this hearing alone represents is an important step towards societal recovery. We need to talk about this disease. This is a chronic disease, and as a community and a nation, we will treat it and we will find pathways to recovery together by first speaking of it as a chronic disease. From the bedsides to the halls of bureaucracy, addressing this opioid crisis requires taking action across the spectrum of prevention, intervention, treatment, and recovery support. At DPH, we are proud of the progress we have made in areas such as access to Naloxone kits, with the cities of Quincy and Gloucester being some of the first communities in the Nation to arm themselves with Naloxone. Beyond saving lives, this measure has changed attitudes with police no longer arresting their way out of this epidemic, but looking towards solutions.

Mr. MURPHY. I will need you to wrap up, if you could.

Dr. BHAREL. Sure. And as a medical community, we know that 20 percent of pain relievers for nonmedical use are coming directly from clinicians, so we as clinicians must shift our expectations of practices that opioids are not the first line of defense. However, as our national data sets demonstrate, more than 80 percent of lethal

painkillers come from non-clinicians. And so, again, this highlights the element of truth of working across partnerships.

And I look forward to answering any further questions you have. Thank you.

[The prepared statement of Dr. Bharel follows:]

**Testimony of Commissioner Monica Bharel, MD, MPH
Massachusetts Department of Public Health**

Before the
**Committee on Energy and Commerce,
Subcommittee on Oversight and Investigations
United States House of Representatives**

May 21, 2015

Chairman Murphy, Ranking Member DeGette, and members of the Committee, thank you for your warm welcome and for the opportunity to provide testimony on this pressing issue today. My name is Dr. Monica Bharel, and I am proud to have been appointed to serve the Commonwealth of Massachusetts and Governor Baker as its Commissioner of Public Health. I am honored to be here representing one of the nation's oldest public health departments – one that traces its roots to Commissioner Paul Revere – and one that has continually led the way for public health across the country.

The mission of the Massachusetts Department of Public Health (DPH) is to prevent illness, injury, and premature death; to ensure access to high quality public health and health care services; and to promote wellness and health equity for *all* people in Massachusetts.

More specifically I believe that we as a state must ensure that vulnerable populations – and those with behavioral health issues chief among them – receive better, integrated, and de-stigmatized care throughout the continuum of life.

That mission is more critical than ever as we face the rising tide of an opioid epidemic that is overwhelming communities across our nation, in each and every one of your districts.

As a frontline physician and as the former Chief Medical Officer at Boston Health Care for the Homeless Program – the largest of its kind in the nation – I have seen first-hand what this disease can do to our communities. We are watching our friends and family members die on our streets, driven by a lethal cocktail of trauma and underlying behavioral health issues. That is not something we, as a society, should accept as a norm.

This epidemic will be far from easy to tackle, but this challenge is precisely what drew me to this job: to work with our providers, community members, and leaders – like yourselves – to find data-driven, and evidence-based solutions.

To that end, we are already hard at work throughout the Baker Administration, redoubling our efforts to identify, triage, address, and treat the opioid epidemic.

Identifying the Problem

First, to identify the problem. Like so many states across the nation, Massachusetts is facing a growing epidemic of opioid addiction and overdose deaths.

In 2013, there were 967 unintentional opioid deaths, compared to 371 motor vehicle-related injury deaths. Let me state that again: In 2013, more than 2.5 times as

many people died from opioid abuse than from motor vehicle related injuries. And those numbers barely touch the reality of this tragedy. Behind those 967 deaths were more than 2,000 hospital stays, more than 4,500 emergency department visits, and unquantifiable human suffering.¹

And in 2014, an estimated 1,008 people died of an opioid related overdose, or a 51% increase over the 668 deaths that occurred in 2012.²

Behind each case is a very human story. At a meeting with Governor Baker in February at Hope House in Roxbury, Massachusetts, I listened to the testimony of “Jimmy,” a person in recovery and a client of the facility. Jimmy told us about his progression from prescription opioids to heroin; about the life he had destroyed and rebuilt multiple times; about friends he had lost, and others he is now supporting through peer-support programs.

For me, Jimmy’s story highlighted an elemental truth – we will fail in our efforts to address this crisis if we do not fully involve partners from all sectors – law enforcement, public health, healthcare institutions, families, schools, and you, our elected leaders.

¹ <http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/county-level-pmp/burden-of-overdose-deaths.pdf>. Hospital Stays/ED Visits Data Source: MA Inpatient Discharge Database, MA Observation Database, and MA Emergency Department Discharge Database, Center for Health Information and Analysis (CHIA). Data are submitted by and reported by fiscal year (October 1, 2012 through September 30, 2013).

² <http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/county-level-pmp/data-brief-apr-2015-overdose-county.pdf>

Governor Baker prioritized the opioid epidemic early in his new administration. In February, Governor Baker appointed 18 individuals to serve on an Opioid Working Group chaired by his Health & Human Services Cabinet Secretary Marylou Sudders.³ The group represents the many different perspectives that are important to this work and was charged with developing tangible recommendations.

The working group held listening sessions across the Commonwealth hearing from more than 1,100 individuals, and received hundreds of recommendations and emails.⁴ We heard from parents of children who have died from addiction, friends and family members of individuals living with a substance use disorder, individuals who suffer from chronic pain, people currently coping with addiction, clinicians, advocates, teachers, judges, law enforcement officials, community leaders, and elected officials. No matter the lens you use to look at this epidemic - and that is what it is – it is obvious that opioids are impacting every city and town in the Commonwealth.

Our success getting to the underlying health issues and social determinants that are driving this epidemic – trauma and undiagnosed behavioral health issues chief among them – will directly correlate with our ability to successfully leverage data and measure results.

³ <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/governors-opioid-addiction-working-group-members.html>

⁴ <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/governors-opioid-addiction-working-group.html>

The Commonwealth is committed to making data – from overdose deaths to Prescription Drug Monitoring data – more available, more frequently. This data will better allow us over time to effectively target key populations and ‘hotspot’ to better understand the impacts of our collective efforts.

Attached with my submitted testimony today, please find several charts and data underscoring the extent of this crisis in Massachusetts.

Utilization of data to combat the opioid crisis along with all areas of public health throughout all state health departments have a long way to go before we can truly say we are fully leveraging data across program silos. For example, currently at DPH, we have more than 300 different internal data sources that have been developed by individual programs using a variety of different formats for a variety of different purposes. They are managed by different staff, reside on different servers and don’t talk to each other. The mechanisms put in place to secure information can be the barrier that allows our system to talk to each other.

This is not unique to Massachusetts, across the country, public health needs to double down on data, and on interoperable, secure IT solutions. I look forward to exploring ways we can better achieve that level of success by harnessing new technologies – such as data warehousing – that create better linkages between siloed data sets. Doing so will allow us to better “hotspot”, for highest areas of need for public health

interventions; and most importantly, whether the work we do actually makes the difference our missions commit us to.

Triaging the Roadblocks to Recovery

Across the Commonwealth, I have heard of and witnessed very real roadblocks to access and care. Insurance, particularly with regards to downstream, post-detox care for both residential and outpatient medication treatment services; statewide bed capacity, the kinds of bed types available and how to access them; services for mothers and fathers in recovery who are attempting to reclaim their lives while trying to take care of their children; the double digit increase in the costs of pharmaceuticals including Naloxone and other drugs; child care; stable housing and employment training; access to timely treatment information; early intervention services within our schools; education of not only our parents and community leaders of available resources and the early signs of addiction but children as well about the dangers of prescription drugs; and perhaps most prominently – stigma.

I have heard how the stigma associated with substance use disorder can drive a sufferer to find that one more hit, that one more pill, allowing them the brief relief and escape from the reality that is fraught with societal scorn. What this hearing alone represents is an important step towards societal recovery. We need to talk about this disease. This *is* a disease. And as a community and a nation, we will treat it and we will find pathways to recovery.

These and many other areas reflect needed conversations and reforms:

- We have to stop the “spin dry” cycle where individuals are admitted for short term detox and then are discharged without appropriate follow up services.
- We need to re-examine Massachusetts’ court ordered treatment provisions known as “Section 35” — courts and incarceration should not be the default substance use disorder treatment system.
- We need to improve access to treatment and we need to provide better, real-time, information to individuals with substance use disorders and their families.
- We need to work with physicians and other prescribers to decrease the number of opioid prescriptions in the Commonwealth while ensuring that individuals with chronic pain are protected.

Treating the Disease to Combat the Epidemic

From bedside to the halls of government, addressing the opioid crisis requires taking action across the spectrum of touch points: prevention, intervention, treatment, and recovery supports.

Prevention work should include a public awareness campaign to increase knowledge about the dangers of opioid use. Existing coalitions such as the Commonwealth’s statewide regional Opioid Addictions Prevention Coalitions and Learn to Cope peer networks can be crucial resources. Interventions should include expanding naloxone (or “Narcan”) availability to first responder, bystanders and other community members. Treatment should include a wide array of options depending on the individual

needs including inpatient and outpatient treatment, including equitable access and patient choice around medication assisted treatments – buprenorphine (i.e. Suboxone) and naltrexone (i.e. Vivitrol) and medical methadone. And we must expand our capacity to support patients once they are in recovery. These and other tools such as information and education are our chief defense in battling this disease.

And the road out of this heartbreaking situation will require active participation from many sectors of society – communities, schools, public safety, the addiction treatment and recovery community, and especially the medical community.

At DPH, we are proud of the progress that has been made to access to naloxone rescue kits in the past several years.⁵ The cities of Quincy and Gloucester represented some of the first communities in the nation to arm our first-responders with this powerful overdose reversal agent. Our efforts have resulted in over 5,000 reported overdose reversals. Narcan is becoming as familiar as EPI pens.

Beyond saving lives, this measure has changed attitudes. Police no longer see arresting their way out of this epidemic as a solution. Now, with each reversal, they see another opportunity to engage a person who is battling an addiction – a disease. We wouldn't leave a stroke patient on the roadside.

⁵ <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/intervention.html>

Today, I want to enlist your support in taking the next steps to increase access to and lower the cost of naloxone. Just as we would prescribe epinephrine for emergency response, we must identify, educate and prescribe naloxone rescue kits to at-risk patients, and while doing so, we need to ensure we are employing strategies to reduce and contain cost.

We must take greater advantage of the evidence-based treatments that we have at our disposal for opioid addiction. We need to improve access to all forms of Medication Assisted Treatment by integrating these treatments into our practices and making referrals as needed. This means looking at the way we pay for these medication to ensure true patient choice, ensuring whichever medication – like we treat diabetes and other chronic conditions – works best for that individual is provided with the full continuum of necessary wrap-around services.

As a medical community, we must do our part – all of us – and employ careful prescribing for acute pain, especially for young people. Clinicians must shift the expectations and practices so that opioids are not the first line of defense against pain, but are only introduced after other methods have failed. Our job as clinicians is to make people well and keep our patients safe. When more than 20% of pain relievers for nonmedical use are coming directly from clinicians, we – all clinicians alike – must shift our expectations and practice so that opioids are not the first line of defense against pain, but are only introduced after other methods have been considered.⁶

⁶ SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2011-2012

However, to be able to do this there must be adequate availability and insurance coverage for alternate therapies. There will also need to be a shift in public expectations of a “quick fix” for pain with pills received in the doctor’s office. And we will need to improve our educational outreach about the expectations around pain and the role of the doctor’s office. To underscore this need, just this past weekend, the Harvard School of Public Health released a poll that showed only 36% of Massachusetts adults prescribed pain killers reported being warned of the associated risks by their prescriber.⁷ This education starts in the classroom.

However, as our national data demonstrates, more than 80% of these lethal pain killers came from non-clinicians – in fact nearly 70% from family and friends.⁸ And so again, this story highlights an elemental truth: we will fail in our efforts to address this crisis if we do not fully involve *all* partners from all sectors – family and community of all ages and walks, law enforcement, public health, healthcare, schools, and you, our elected leaders.

Universal screening can help identify those patients whose use of alcohol and other drugs may lead to problems. Screening may also identify patients who are in recovery and this provides an opportunity to give ongoing recovery support. In addition, this is an opportunity to work with patients on addressing their health conditions without prescribing medications that might compromise their recovery.

⁷ <http://www.hsph.harvard.edu/news/press-releases/poll-many-americans-know-someone-who-has-abused-prescription-painkillers/>

⁸ SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2011-2012

DPH has also made progress with implementation of the needed improvements to the Prescription Drug Monitoring Program or “PMP.” We must all take advantage of this safety mechanism. However, it shouldn’t take 11 “clicks” – as it does in Massachusetts – to use this system; it must facilitate, not inhibit good clinical practice. In Massachusetts, I am working directly with the prescriber community to find ways to better streamline the end user experience to ensure increased utilization by prescribers. And in 2014, our state legislature mandated that all prescribers, including mid-level prescribers, must use the PMP.

Finally, with the Governor’s leadership, that conversation will include a focus on achieving greater behavioral health parity and increased support systems, including early interventions within our schools.

In closing, these and other examples reflect the approach of this Administration: work smarter, not harder, by focusing our shared efforts and resources on those most evidence-based and proven programs that truly impact the public’s health. And in doing so, show data to demonstrate which programs make the biggest difference.

Thank you for your hard work and dedication to this issue. I look forward to working together to build a stronger public health framework to tackle this epidemic head on.

Thank you.

Mr. MURPHY. Thank you very much.
 Dr. Wolk, recognized for 5 minutes.

STATEMENT OF LARRY WOLK

Dr. WOLK. Thank you, Chairman Murphy, Ranking Member DeGette, and members of the subcommittee for the opportunity to provide testimony to you today about our efforts to address the opioid epidemic in Colorado.

In 2012, we had the troubling distinction of ranking second nationally for self-reported, nonmedical use of prescription drugs. More than ¼ million Coloradans misused prescription drugs, and consequent deaths related to misuse nearly quadrupled between 2000 and 2011. Drug overdose remains the leading cause of injury death in Colorado, and almost 11 percent of Coloradans aged 18 to 25 still engage in nonmedical use of prescription drugs. In the last 5 years, the number of heroin users in Colorado has also doubled, and we are challenged with concerns that existing treatment capacity is not meeting a rising demand, as treatment admissions for heroin and prescription opioid abuse increased 128 percent between 2007 and 2014. However, recent data suggests that we are heading in a better direction. 2013 data released shows that our rate on nonmedical use has decreased from 6 percent to nearly 5 percent, which represents 39,000 fewer Coloradans who misused prescription drugs. Additionally, the Colorado youth use rate is decreasing and is now below the national average. Since 2012, catalyzed by Governor Hickenlooper's leadership as the co-chair of the NGA's Policy Academy for reducing prescription drug abuse, we are currently implementing a coordinated approach, setting as our goal to prevent 92,000 Coloradans from engaging in nonmedical use of prescription pain medications through the adoption of our Colorado plan to reduce prescription drug abuse. This commitment represents a reduction from 6 percent to 3 ½ percent of Coloradans who self-report nonmedical use of prescription drugs, focusing on seven key areas: improved surveillance of prescription drug misuse data; strengthening the Colorado PDMP; educating prescribers and providers; increasing safe disposal; increasing public awareness; enhancing access to evidence-based effective treatment; and expanding access to the overdose reversal drug, Naloxone.

To monitor and coordinate progress, State-level leadership created the Colorado Consortium for Prescription Drug Abuse Prevention. The consortium provides a statewide, interagency, inter-university framework designed to facilitate the collaboration and implementation of the strategic plan, and is comprised of seven work groups. For one, the Data and Research Work Group of the consortium has worked to map out all sources of data related to prescription drug use, misuse, and overdose in the State. Second, the PDMP Work Group has worked over the past 2 years to enhance our State's PDMP as an effective public health tool. As of July 2014, our PDMP utilization rate was 41 percent, and in April 2015, that rate more than doubled, reaching 85 percent. How did we accomplish this dramatic improvement? We recently implemented push notices to both prescribers and pharmacists when patients visit a certain number of prescribers and pharmacies to obtain a controlled substance. We require PDMP registration for

pharmacists and DEA-registered prescribers, but we allow prescribers and pharmacists to assign and register delegates in their office, because they are often busy, so that those delegates can check the PDMP. We have also enhanced the PDMP interface and moved to a daily upload of data so that it is constantly refreshed. The Provider Education Work Group focuses on issues related to improving the education and training of healthcare professionals through a jointly developed policy; a policy that has since been adopted by the dental, medical, nursing, pharmacy, optometry, and podiatry Boards in Colorado. It is the first joint policy of its type adopted by multiple regulatory Boards. As of October 2014, over 1,300 prescribers had completed the training developed from this policy, and 87 percent indicated that they intended to change their practice as a result. We were encouraged because the CDC morbidity and mortality report recently ranked Colorado 40th nationally for prescribing rates of opioids, fiftieth being the lowest rate of prescribing.

The Safe Disposal Work Group focuses on issues relating to safe storage and disposal of prescription medications, with the potential for misuse, abuse, or diversion, knowing that more than 70 percent of those who abuse obtain them from the unused supplies of family and friends. This work group developed guidelines and outreach efforts, and expanded the number of safe disposal sites throughout the State. By next year, we have plans to provide drop boxes in every county in the State.

Public Awareness Group has developed a new statewide advertising and public outreach campaign called Take Meds Seriously. Our consortium's Treatment Work Group has focused on identifying gaps in the need for medication-assisted treatment. And our Naloxone Work Group focuses on increasing awareness of and access to Naloxone, making clinical, organizational, and public policy recommendations to achieve this goal.

I thank you for the opportunity. I see that I am out of time, and thank you.

[The prepared statement of Dr. Wolk follows:]

Thank you Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee for the opportunity to provide testimony to you today about our efforts to address the opioid epidemic in Colorado. In 2012 (based on 2010-11 data), we had the troubling distinction of ranking 2nd nationally for self-reported, non-medical use of prescription drugs: more than 255,000 Coloradans misused prescription drugs, and consequent deaths related to misuse nearly quadrupled between 2000 and 2011. As the Subcommittee is well aware of, these dramatic increases in the misuse and abuse of prescription drugs have been felt nationwide. The expenses associated with prescription drug misuse are significant, and include costs attributed to lost productivity, criminal justice proceedings, treatment, and medical complications.

Since 2012, catalyzed by the Governor Hickenlooper's leadership as a Co-Chair of the National Governor's Association Policy Academy for Reducing Prescription Drug Abuse, we are currently implementing a coordinated approach to confront this public health crisis head on. Drawing upon stakeholder input, national best practice and the success stories from other states, we have engaged and leveraged expertise of the healthcare community, educators, state and local law enforcement, public health, human services, community groups, and our legislative partners. In 2012, we set a goal of preventing 92,000 Coloradans from engaging in non-medical use of prescription pain medications by 2016 through the adoption of the *Colorado Plan to Reduce Prescription Drug Abuse*. This commitment represents reduction from 6% to 3.5% of Coloradans who self-report non medical use of prescription drugs. Our plan is a coordinated, statewide strategy that simultaneously restricts access to prescription drugs for illicit use, while ensuring access for those who legitimately need them.

The *Colorado Plan to Reduce Prescription Drug Abuse* currently focuses on 7 key areas:

- improving surveillance of prescription drug misuse data;
- strengthening the Colorado Prescription Drug Monitoring Program;
- educating prescribers and providers;
- increasing safe disposal to prevent diversion and protect the environment;
- increasing public awareness;
- enhancing access to evidence-based, effective treatment; and
- expanding access to the overdose reversal drug Naloxone.

To monitor and coordinate progress, state level leadership created the Colorado Consortium for Prescription Drug Abuse Prevention (the Consortium). The Consortium provides a statewide, inter-agency/inter-university framework designed to facilitate the collaboration and implementation of the strategic plan by interested parties and agencies, and is comprised of 7 work groups, separated by the focus areas outlined above. The Consortium is housed in the University of Colorado (CU) Skaggs School of Pharmacy and Pharmaceutical Sciences at Anschutz Medical Campus (which houses the School of Pharmacy, the Colorado School of Public Health, Colorado State University, the University of Northern Colorado, the CU School of Medicine, and the CU College of Nursing). The Consortium provides a statewide network and serves as the strategic lead for the Colorado strategic plan with active participation from the Governor's Office and various state agencies and offices. The education, governmental, and

medical communities are well positioned to address many of Colorado's prescription drug abuse challenges, and the partnerships facilitated by the Consortium have been crucial in attaining optimum outcomes and increased federal funding.

Utilizing this coordinated, multidisciplinary approach, Colorado has experienced a wide variety of successes and positive developments in areas of focus:

Thorough and accurate data and research underpins the work that we do and informs the policy and regulatory decisions that we make. The Data and Research work group of the Consortium has worked to map out all sources of data related to prescription drug use, misuse and overdose in the state in order to monitor trends, educate the public and inform decision making by multiple stakeholders. The work group is also focused on identifying other efforts that successfully use crosswalks between diverse data sources and standardize data collection tools across state agencies.

The Prescription Drug Monitoring work group (PDMP) has worked over the past two years to enhance our state's PDMP as an effective public health tool. In 2014 we passed House Bill 1283, enhancing our state's PDMP. This bill included a variety of provisions, most notably: allowing the state to provide 'push notices' to both prescribers and pharmacists when patients visit a certain number of prescribers and pharmacies to obtain a controlled substance over a certain period of time; requiring mandatory PDMP registration for pharmacists and United States Drug Enforcement Administration (DEA) registered prescribers; allowing prescribers and pharmacists to assign and register delegates in their office to check the PDMP; allowing direct access to PDMP by the Colorado Department of Public Health and Environment; and providing permissive authority for federally owned and operated pharmacies to submit controlled substances data into the Colorado PDMP. Additionally, we have enhanced the PDMP interface and moved to a daily upload of data (it was twice monthly prior to October 2014). These improvements have demonstrated a powerful resonance throughout the Colorado prescriber and pharmacist community. As of July, 2014 our PDMP utilization rate was 41% and in April, 2015 that rate had more than doubled, reaching 85%.

The Provider Education work group focuses on issues relating to improving the education and training of health care professionals who prescribe, dispense, or otherwise provide care for those receiving prescription medications with the potential for misuse, abuse, or diversion. In the spring of 2014, a joint *Policy for Prescribing and Dispensing Opioids* was developed to address prescription drug abuse in the state and adopted by the dental, medical, nursing, pharmacy, optometry, and podiatry boards in Colorado. This is the first joint policy of its type adopted by multiple regulatory boards, and aims to provide guidance on best practices for pain management. Over the past year the Consortium has also developed online training and education for prescribers throughout the state. As of October 2014, 1,316 prescribers had completed the training, 87% of whom indicated they intended to change their practice as a result. The Provider and Prescriber Education Workgroup of the Consortium is currently expanding the curriculum to other professional health schools and postgraduate training programs. We were encouraged by these strategies when the CDC morbidity and mortality

report recently ranked Colorado 40th nationally for prescribing rates of opioids per 100,000 people (50th being the lowest rates of prescribing).

We know that more than 70% of those who abuse prescription drugs obtain them from the unused supplies of friends or family, highlighting the importance of supporting robust medication collection and disposal resources throughout the state. The Safe Disposal work group focuses on issues relating to safe storage and disposal of prescription medications with the potential for misuse, abuse or diversion. This work group has developed guidelines and outreach efforts and expanded the number of safe disposal sites throughout the state. For the past five years, the DEA operated "National Drug Takeback Days" each Spring and Fall, collecting significant quantities of medications at law enforcement sites (over 39 thousand pounds in Colorado in 2014). In light of the DEA discontinuing the takeback days and allowing specific entities to collect pharmaceutical controlled substances, we secured state funding to expand the existing collection and disposal program. Over the next year, we plan to provide drop boxes in every county to assure an ongoing, available mechanism for all citizens to safely dispose of unused/unwanted medications.

The Public Awareness work group of the Consortium focuses on raising awareness among Colorado citizens regarding the problem of prescription drug abuse. We recently launched a new statewide advertising and public outreach campaign - "Take Meds Seriously"- designed to educate consumers about the safe use, storage, and disposal of prescription drugs. Since our February launch, our new website - TakeMedsSeriously.org - has seen over 40,000 page views.

The Consortium's Treatment work group has focused on identifying gaps and needs in the provision of preventative, therapeutic, and rehabilitative substance use treatment programs and making clinical, organization, and public policy improvements to these systems. Primary areas of focus are: 1) lack of standardized, universal screening, brief intervention, referral, and treatment (SBIRT); 2) barriers to access and entry; and 3) critical treatment and clinical workforce shortages. We are working from a variety of vantage points to expand access to and availability of treatment resources, such as expanding statewide capacity to provide Medication Assisted Treatment (MAT) for opiate dependent patients by linking suboxone-licensed physicians with community-based substance treatment. We recently applied to the Substance Abuse and Mental Health Services Administration (SAMHSA) for a Targeted Capacity Expansion grant aimed at increasing the capacity to deliver MAT to treat opiate/opioid addiction.

The Naloxone work group focuses on increasing awareness of, and access to, the opioid overdose reversing drug Naloxone, and making clinical, organizational, and public policy recommendations to achieve this goal. This spring, we passed Senate Bill 15-053, which extends existing authority to prescribe or dispense opiate antagonists by permitting licensed prescribers and licensed dispensers to also prescribe or dispense a standing order directly to individuals, a friend or family member or an individual who may experience an opiate-related drug overdose, an employee or volunteer of a harm reduction organization or a first responder. This bill will help lead to more widespread distribution of life-saving opiate antagonists.

Despite encouraging trends, prescription drug abuse remains a serious health crisis as we work to expand upon and bolster work currently underway in Colorado. Drug overdose remains the leading cause of injury death in the U.S. and in Colorado, largely due to the misuse and abuse of prescription drug overdoses, and 10.72% Coloradans aged 18-25 still engage in non-medical use of prescription drugs. In the last 5 years the number of Heroin users in Colorado has also doubled, a rate increase that is suspected to have some correlation with our high rates of prescription drug misuse/abuse. We also have significant concerns that existing treatment capacity is not meeting a rising demand, as treatment admissions for heroin and prescription opioid abuse increased 128% between 2007 and 2014. Overdose death is a very real risk for people struggling with opiate addiction, and failure to provide vital treatment services means unnecessary, preventable deaths of our citizens.

Given some of the highlighted successes we've had and challenges we still face, recent data suggests that we are well on track to meet our 2016 goal. 2013 data released by the National Survey on Drug Use and Health shows that our rate on non-medical use has decreased from 6% to 5.08%, which represents 39,000 fewer Coloradans who misused prescription drugs during the survey time period (2012-2013). This drop represents a 15.33% reduction in our rate of prescription drug abuse, and our ranking in this category has positively dropped from 2nd to 12th nationally. Additionally, the Colorado youth use rate is decreasing and below the national average. In 2011, the percentage of students who had taken prescription drugs without a doctor's permission more than once during their lifetime was 19.6%. In 2013 that percentage had dropped to 13.6%. The national average for this measure in 2013 was 17.8%. While there is still much work to do in response to this public health crisis, we are emboldened by some of the progress seen in Colorado. We have confidence that the Consortium model will allow us to implement a multi-faceted, strategic approach that is responsive to changing trends and data, and the continued development of national best-practice. The *Colorado Plan to Reduce Prescription Drug Abuse* is a crucial part of our commitment to making Colorado the healthiest state in the nation. Better health is not just good for individuals and families; it has positive outcomes for our workforce, reduces the costs of government, and improves the quality of life in our communities.

Thank you, again, for the opportunity to provide testimony today. We would be happy to answer any questions related to the work we are doing in Colorado to prevent the misuse and abuse of prescription drugs.

Mr. MURPHY. Thank you, Dr. Wolk.
 Mr. Stringer, you are recognized for 5 minutes.

STATEMENT OF MARK STRINGER

Mr. STRINGER. Chairman Murphy, Ranking Member DeGette, and members of the subcommittee, my name is Mark Stringer and I am the Director of the Division of Behavioral Health in the Missouri Department of Mental Health. I also have the privilege of serving as President of the Board of the National Association of State Alcohol and Drug Abuse Directors, or NASADAD. It is truly an honor to offer remarks this morning about what Missouri is doing regarding the opioid problem in particular, and addiction in general.

If there is a theme running through our messages this morning, I believe one of the most important ones is that access to treatment and recovery services is essential to addressing this problem.

On this very day in Missouri, nearly 3,000 people are on waiting lists for substance use disorder treatment services. That equates to about 43,000 Missourians waiting for help during the course of a year. What is truly sad about this is that often a person seeks treatment after some kind of a life-altering event, a run-in with the law, a problem at work, some type of illness, an overdose. So every name on a waiting list is a potential tragedy for an individual, a family, and a community. In order to be successful, services must be accessible. They have to be individually tailored, evidence-based, and they must include recovery supports. One thing I know with certainty after 30 years in this field is that treatment cannot be effective and treatment cannot possibly work if you can't get access to it when you need it.

So I will give you some just quick information about my State of Missouri. We estimate that about 400,000 Missourians have substance use disorders. Last year, 43,000 actually received treatment services through the publicly funded system. With regard to opioids, Missouri saw 124 percent increase in treatment admissions related to prescription drugs from 2007 to 2012, and 125 percent increase in admissions related to heroin. We lose about 200 people to heroin deaths each year; most of them in eastern Missouri, including St. Louis.

Here are some steps we are taking to deal with the problem. We developed a statewide plan for coordinated treatment and recovery services, and we partner with providers to ensure that services are high quality and evidence-based. One tool for promoting quality is our contracting authority; building in certain requirements that providers must follow as a condition of receiving State funds. We perform on-site certification reviews to assure that providers are adhering to standards of care that are set by the State. As an example, we use these tools to require that all addiction treatment providers in Missouri who are, again, contracted with the State make medication-assisted treatment available, either directly or by referral. This took time, resources, and education, and it is a work in progress but it is the right step for Missouri. We have also worked hard to leverage SAMHSA's Access To Recovery program, or ATR, to build a statewide system of recovery services. Prevention is critical. Our State has a strategic plan for prevention, with

a focus on prescription drug abuse. And we have partnered with a group, just as an example, in a college setting we have a group called Partners in Prevention, that is a coalition of 21 college campuses located throughout Missouri, which is working specifically on prescription drug abuse among college students. This effort has made a difference. From 2013 to 2014, we have seen a 10 percent decrease in the misuse of prescription drugs among college students.

There are other initiatives in my written testimony, but I will now turn to a few recommendations. I recommend that all Federal initiatives specifically include involvement of State substance abuse agencies, like mine. Given their expertise and authority over the addiction prevention, treatment and recovery systems. And I particularly want to recognize the Director of the Office of National Drug Control Policy, Michael Botticelli, for his efforts to coordinate drug policy across Federal Government, and to keep States informed and engaged.

Second, I recommend strong support for the Substance Abuse Prevention and Treatment Block Grant, a vital part of the public safety net for treatment that also provides an average of 70 percent of State substance abuse agencies' funding for primary prevention.

Third, I support specific initiatives to increase the availability of all FDA-approved medications for substance use disorders, and I applaud the administration's proposed \$25 million for States to expand opioid treatment services where medication-assisted treatment is an allowable use of funding.

Fourth, I recommend specific resources to help States and localities purchase Naloxone. This would have an immediate lifesaving impact, and I appreciate the administration's proposal to provide \$12 million within SAMHSA for overdose reversal and prevention activities. I certainly support mandatory prescriber education and training on substance use disorders. And finally, I encourage Congress and the administration to continue to work with State-based groups heavily involved in this issue, including groups like the National Association of State Alcohol and Drug Abuse Directors, the Association of State and Territorial Health Officers, but also our parent group, the National Governors Association, which has provided critical leadership in this area.

Thank you for the opportunity to testify, and I look forward to answering questions.

[The prepared statement of Mr. Stringer follows:]

“What Are State Governments Doing to Combat the Opioid Abuse Epidemic?”

Testimony Submitted to the House Energy and Commerce Subcommittee on
Oversight and Investigations

The Honorable Tim Murphy, Chairman
The Honorable Diana DeGette, Ranking Member
2322 Rayburn House Office Building

Thursday, May 21, 2015

Submitted by Mark Stringer:
Director, Division of Behavioral Health, Department of Mental Health, Missouri

Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee, my name is Mark Stringer, and I serve as the Director of Missouri’s Division of Behavioral Health which is located within the larger Department of Mental Health. I also serve as the President of the National Association of State Alcohol and Drug Abuse Directors (NASADAD). Thank you for the opportunity to testify before the Subcommittee today to discuss actions states are taking to address the opioid issue.

Critical role of the state substance abuse agency: The state agency plays a critical role in overseeing and implementing the publicly funded prevention, treatment, and recovery service system. All state substance abuse agencies develop a comprehensive plan for service delivery and capture data describing the services provided.

An important focus of state directors across the country is the promotion of effective, high quality services. In Missouri, for example, we use our contracts as a mechanism to promote the use of evidence-based practices. In addition, we also utilize onsite “fidelity reviews” in order to assess the extent to which providers are employing best practices in the right way. We also engage in onsite certification surveys to ensure that providers are adhering to the standards of care set by the Division of Behavioral Health. These standards of care apply to a number of areas related to service delivery: from staffing requirements (number of staff, qualifications of staff, continuing education required of staff, etc.) to important rules governing the facilities that house service delivery.

State directors fulfill another important function: collecting and using data to improve service delivery. In Missouri, we collect data on a number of categories, including abstinence from the use of alcohol, abstinence from the use of drugs, the impact of services on housing, the impact of services on employment, and connectedness to community, among others. Our Division collects and then shares data with providers on a quarterly basis through reports. We believe this is a critical tool in order to assess performance and target areas of improvement. The Division tracks other measures such as the number of children returned under their parents’ custody and the number of patients receiving recovery services. A great deal of prevention data comes from the Missouri Student Survey, which provides data at the county and local levels, with a sample size of nearly 200,000 students.

State substance abuse agencies represent a key source of technical assistance to the workforce in each state. In Missouri, we partner with the Missouri Institute of Mental Health (MIMH) on a number of initiatives, including our Spring Institute that provides training to attendees in a variety of areas. My

Division works with MIMH to promote a catalogue of training resources, from videos to online training, which is very important in a state like Missouri with a number of rural areas.

Scope of the substance use disorder problem in Missouri: It is worth stepping back for a moment to examine the impact of all substance use disorders in the state first before focusing on the unique issues related to prescription drug abuse and heroin. Overall, it is estimated that 419,000 Missourians have a substance use disorder. Of these, 27,000 are between the ages of 12 and 17 years old.

We know that approximately 14,800 parolees and 35,800 probationers in my state need substance use disorder treatment (Missouri Department of Corrections, 2014). Close to 41,000 Missouri veterans have a substance use disorder (Missouri Department of Public Safety, 2014) and 4,100 pregnant women struggle with drug or alcohol use (Missouri Department of Health and Senior Services, 2014).

In FY 2014, about 43,200 Missourians received treatment for a substance use disorder through the publicly funded system. These are individuals who lack resources to pay for treatment. About one-half (52 percent) are referred through the criminal justice system. Alcohol is the most common substance problem presented at treatment admission (34 percent) followed by marijuana (21 percent), methamphetamine (17 percent), heroin (15 percent), and other drugs (13 percent). The state has been affected by methamphetamine use predominantly in the rural areas and heroin use in Eastern Missouri, including metropolitan St. Louis. Intravenous (IV) drug use is problematic statewide due to methamphetamine and heroin use.

Financial burden: In 2008, our state estimated that the impact of addiction on Missouri's state government was approximately \$1.3 billion each year while the societal costs averaged \$7 billion (Burden of Substance Abuse on Missouri, 2008). These costs are linked to premature death, hospital and emergency room visits, alcohol and drug related vehicle crashes, and more.

Benefits of prevention, treatment, and recovery: A primary message for this Committee is that services to prevent, treat, and maintain recovery from substance use disorders help millions across the country. These services are literally life saving for both individuals and families.

We know treatment services can also save dollars. For example, the average prison stay for an offender with a drug-related offense is 347 days at an average cost of \$57.42 per day – yielding an average cost per stay of \$19,925. The average length of engagement in community-based treatment is 84 days with an average cost of \$1,778. Intervention fees collected from offenders help pay a portion of the cost for community corrections and intervention services for offenders under community supervision.

Focus on prescription drug abuse and heroin: Approximately 235,000 Missourians misuse prescription drugs annually (SAMHSA, 2015). Of these, 41 percent or 97,000 are under the age of 25. Between 2007 and 2012, Missouri had a 124 percent increase in treatment admissions related to prescription drugs – climbing from about 1,300 in 2007 to 3,000 in 2012 (SAMHSA, 2014). Since then, prescription drug-related admissions have continued to trend upward to 3,200 in 2014. A higher portion of prescription drug-related admissions are for females compared to non-prescription drug-related admissions.

Missouri has seen an increase in heroin use in suburban and rural areas – particularly, surrounding the St. Louis area in Eastern Missouri. Between 2007 and 2012, Missouri had a 125 percent increase in treatment admissions related to heroin – increasing from 2,200 to about 5,000 (SAMHSA, 2014). Since then, heroin admissions have continued to climb to about 6,300 in 2014.

Annually, Missouri has over 200 heroin-related deaths. Most of these occur in Eastern Missouri. The overdose rate for heroin in Eastern Missouri is 11.34 deaths per 100,000 population – this is more than 3 times that for the state as whole (Missouri Department of Health and Senior Services, 2013). Missouri is seeing an increase in heroin use among: 1) females, 2) individuals of Caucasian race, and 3) young adults. The majority of IV drug use in Eastern Missouri is for heroin use (Missouri Department of Mental Health, 2012).

Actions moving forward in Missouri to address the opioid issue:

Treatment services, including the use of medication assisted treatment (MAT): Missouri introduced more recently approved medications for addiction treatment as part of a Robert Wood Johnson Advancing Recovery Grant in 2006. Research shows that pharmacologic interventions in conjunction with counseling are most successful. MAT, however, represented a change in the philosophy and culture of substance use treatment. The client's openness to taking medications correlates with the clinician's attitudes about MAT. Missouri found that client, clinician, and prescriber education was essential. The Department sponsored numerous training and educational opportunities for providers and referral sources about the benefits of MAT. The Department also provided one-on-one technical assistance to providers to support the integration of MAT into mainstream treatment. The FDA-approved medications are on the state's Medicaid formulary which has increased access; however, MAT continues to be restricted for the uninsured because of limited funding.

In Missouri, about 3,400 or one-third of consumers with an opioid use disorder receive MAT including methadone, buprenorphine, or naltrexone. Missouri's data show that higher retention in treatment is obtained with pharmacotherapy in combination with counseling. Missouri's clients who receive MAT tend to be more "difficult to treat" in terms of higher rates of unemployment, longer history of substance abuse, higher rates of psychiatric issues, and more recent substance use. However, these clients achieve comparable or better outcomes compared to those who receive counseling with no addiction medications. For example, 61 percent of clients receiving extended-release naltrexone have been abstinent for at least 30 days at discharge – compared to 54 percent who received counseling with no medications (Missouri Department of Mental Health, 2013).

Recovery services in Missouri: Missouri's work on recovery services is attributed in large part to SAMHSA's Access to Recovery (ATR) program. The state was just recently awarded its 4th ATR grant (\$13 million over 4 years, \$3.3 available in first year). The new round of grant funding will be used to support clinically appropriate treatment as well as recovery services. The grant will target veterans, including National Guard service members returning from Iraq and Afghanistan; offenders reentering the community from any of Missouri's Department of Corrections' institutions; treatment courts; and other disadvantaged populations as identified in local areas. The funding will support providers in the southwest, southeast, Kansas City, and west central areas of the state.

The funds from the ATR program from the previous three cycles helped our state move a number of recovery-related initiatives. We enhanced the array of available services by basing them on a recovery-oriented model and the patient's right to choose their path to recovery. We established a credentialing process for recovery support programs, increasing accountability and quality of services provided. The State also expanded the recovery workforce by establishing the Missouri Recovery Support Specialist (MRSS) and Missouri Recovery Support Specialist-Peer (MRSS-P) credentials in cooperation with the Missouri Substance Abuse Professional Credentialing Board. In addition, we created a process for offenders in reentry and under correctional supervision to apply to the DMH Exceptions Committee for

approval to be employed by a recovery support program. We also developed targeted training for faith- and community-based organizations, mentors, and peers in cooperation with the Missouri Substance Abuse Professional Credentialing Board. Finally, we developed an automated billing, documentation, and payment system.

The state collects outcome data on services supported by the ATR program. Data points include abstinence from alcohol use, abstinence from drug use, stable housing, employment, improved social connectedness, and elimination of criminal activity. From 2004-2013, ATR served 124,496 individuals and families with substance use disorders. Overall, 83 percent of consumers who received recovery support services (either alone or in combination with clinical treatment) were abstinent from alcohol and drugs after six months, and 95% of consumers had no new arrests after six months.

Prevention: In 2012, we began a strategic planning process for prevention, looking specifically at the non-medical use of prescription drugs. In 2011, 12% of young adults (aged 18-25) in Missouri reported that they were misusing prescription drugs. This compares to 6% for 12-17 year olds and 3% for adults older than 26. As a result, we decided to prioritize reducing the non-medical use of prescription drugs by 18-25 year olds.

Partners in Prevention (PIP) is a coalition of 21 college campuses across the state that works to promote health and safety for students. The coalition has specifically moved forward with a prescription drug abuse initiative in order to educate students on the dangers of prescription drug misuse and provide safe and healthy alternatives. Critical funding is provided by SAMHSA/CSAP's Partnerships for Success Grant along with support from the Missouri Department of Liquor Control, the Missouri Division of Highway Safety, and my division. One impressive aspect of the initiative is the array of stakeholders involved: campus prevention professionals, University administration officials, police and public safety officers, student volunteers, community business owners, and others.

In its first three years, PIP's prescription drug abuse prevention initiative noted several outcomes. From 2013 to 2014, PIP noted a 10 percent decrease in students' misuse of prescription drugs in the past year along with a 5 percent decrease in the amount of students misusing opioids, specifically pain medication, in the past year. Due to the project, the 21 participating campuses implemented take-back events, peer education presentations regarding the misuse of painkillers/opioids, and marketing campaigns regarding prescription drug misuse.

We have also partnered with the National Council on Alcoholism and Drug Abuse-St. Louis Area (NCADA) to launch a media campaign called "Curiosity and Heroin" in an effort to increase awareness about the dangers and realities of heroin in the St. Louis region. The campaign uses advertisements in movie theaters, newspapers, magazines, bus stops, and social media sites. The campaign also utilizes a website (www.curiosityandheroin.org) geared toward young people that provides statistics, information on the risks associated with prescription drug and heroin misuse, information on accessing treatment, and stories of recovery. One of the most poignant aspects of the website is a section composed of pictures and memorials to those who have died from a heroin overdose.

Recommendations for federal action:

Ensure that federal initiatives related to addiction work through state substance abuse agencies: State substance abuse agencies work with stakeholders to craft and implement a statewide system of care for substance use disorder treatment, prevention, and recovery. In so doing, state agencies employ a

number of tools to ensure public dollars are dedicated to effective programming. These tools include performance and outcome data reporting and management, contract monitoring, corrective action planning, onsite reviews, training, and technical assistance. States also redirect, redistribute, or eliminate support for programs that are not achieving results. In addition, state substance abuse agencies work to ensure that services are of the highest quality through state established standards of care. Federal policies that promote working through the state substance abuse agency ensure that initiatives are coordinated, effective, and efficient.

Maintain a strong commitment to the Substance Abuse Prevention and Treatment (SAPT) Block Grant – with strong commitment to primary prevention services: We recommend that Congress maintain robust support for the SAPT Block Grant, an effective and efficient program supporting prevention, treatment, and recovery services. In FY 2014, the SAPT Block Grant provided treatment services for 1.6 million Americans. During the same year, of patients discharged from treatment, 81.5 percent were abstinent from alcohol and 72.1 percent were abstinent from illicit drugs.

By statute, states must dedicate at least 20 percent of SAPT Block Grant funding for primary substance abuse prevention services. This prevention set-aside is by far the largest source of funding for each state agency's prevention budget, representing on average 70 percent of the primary prevention funding that states, U.S. territories, and the District of Columbia coordinate. In 33 states, the prevention set aside represents at least 50 to 99 percent of the substance abuse agency's budgets.

It is important to continue this work given the positive gains moving forward in a number of areas. For example, according to the Monitoring the Future (MTF) study funded by the National Institute on Drug Abuse (NIDA), from 2000 to 2014, past year alcohol use among high school seniors in America has declined by 18 percent; past year use of cocaine has declined by 48 percent; and since its peak in 2004, the country has seen a 36 percent decline in past year use of prescription opioids.

An important feature of the SAPT Block Grant is flexibility. Specifically, the program is designed to allow states to target resources according to regional and local circumstances instead of predetermined federal mandates. This is particularly important given the diversity of each state's population, geography, trends in terms of drugs of abuse, and financing structure.

We appreciate the difficult decisions Congress must face given the current fiscal climate. We believe it is equally important to note that trends in federal appropriations for the SAPT Block Grant have led to a gradual but marked erosion in the program's reach. Specifically, the SAPT Block Grant has sustained a 25 percent decrease in purchasing power since 2006 due to inflation. In order to restore this important program back to the purchasing power for 2006, Congress would have to provide an increase of \$450 million.

Federal resources for the purchase of naloxone: Naloxone is a prescription medication that is used to reverse the effects of an opioid overdose. It has long been the standard of care in emergency rooms and has been successfully administered by trained bystanders, including law enforcement, friends, or family members. According to data from the Centers for Disease Control and Prevention (CDC), in 2013 almost 17,000 Americans lost their lives to an opioid pain reliever overdose, and more than 8,000 to a heroin overdose. As of May 2015, 34 states and the District of Columbia passed laws that limit liability for prescribers and administrators of naloxone, and 26 states and DC passed Good Samaritan laws which provide limited immunity for individuals who call for help during an overdose. In 2014, Missouri enacted a law to enable first responders to be trained to carry and administer naloxone.

While states have taken the lead in efforts to increase access to this lifesaving medication, cost remains a significant barrier to its widespread use. Allocating funds for the purchase of naloxone is an incredibly important step that Congress could take to have an immediate, life-saving impact on the lives of families devastated by a loved one's opioid use disorder. I applaud the Administration for proposing a \$12 million grant within SAMHSA for overdose reversal and overdose prevention activities, and would encourage Congress to approve that funding and prioritize the purchase of naloxone.

Increasing access to treatment – specifically MAT services: There are currently three FDA-approved medications for the treatment of opioid dependence and relapse prevention. Scientific research has shown that these medications are an effective component of treatment and should be made available to all patients as part of a comprehensive treatment plan that includes counseling and behavioral interventions. Congress has already taken some steps to increase the use of MAT, appropriating \$12 million in the FY 2015 budget for states to expand access to opioid treatment services where MAT is an allowable use. SAMHSA has already released a Request for Application for this grant, and states have eagerly applied. The Administration has proposed doubling this funding to \$25 million in FY 2016. I encourage Congress to consider appropriating this additional funding given the serious challenges that states face in responding to this epidemic.

Mandatory prescriber education: Physicians receive little to no training about substance use disorders during medical school. As a result, it is reasonable to believe that this lack of understanding has likely contributed to the significant increases we've seen in prescriptions for opioid pain relievers during the last decade despite their significant risks. All providers who have been certified by the Drug Enforcement Agency (DEA) to prescribe controlled substances should be required to complete an educational course on substance use disorder prevention, intervention, and treatment. This small step could empower physicians to engage with their patients on substance use issues, and perhaps stem the tide of opioid misuse and overdose.

Assistance with improvements in linking substance use disorder services with primary care: We appreciate the proposal by SAMHSA to provide \$20 million in FY 2016 to fund the Primary Care and Addiction Services Integration (PCSAI) program. The program would award grants to help providers integrate substance use disorder treatment services with primary care. People with substance use disorders have a number of co-occurring physical illnesses such as hypertension, diabetes, and obesity. The goal of the program would be to improve the health of people with substance use disorders through coordinated primary care services in community substance abuse treatment settings.

Federal support of, and coordination with, state-based groups focused on opioid abuse - including the National Governors Association (NGA): Since 2012, NGA's Center for Best Practices has worked with 13 states to help them develop and implement comprehensive plans for reducing prescription drug abuse. States that participated in NGA's two policy academies have passed legislation, developed public awareness campaigns, launched cross-agency and regional initiatives, and established critical relationships with universities and the private sector. Governors John Hickenlooper (CO) and Robert Bentley (AL) co-chaired the 2012 policy academy, and Governors Brian Sandoval (NV) and Peter Shumlin (VT) co-chair the current effort, which is funded by the Centers for Disease Control and Prevention (CDC). We applaud NGA, led by Dr. Dan Crippen, for their leadership on this issue and look forward to our continued collaboration on this and other related efforts. In fact, the Executive Director of NASADAD has been working closely with NGA staff and will attend NGA's upcoming policy academy meeting in Burlington, Vermont.

We also wish to recognize the work of the Association of State and Territorial Health Officials (ASTHO) led by Dr. Paul Jarris. During the Presidency of Terry Cline (Oklahoma), the Association issued a call to action and promoted a coordinated approach to the opioid problem. ASTHO has been working with NGA and NASADAD on these issues, participating in the NGA policy academies, and leading its own set of meetings on the topic. The two Executive Directors of ASTHO and NASADAD have joined together to engage in joint presentations at meetings and conferences in order to ensure our efforts are coordinated.

I also recommend coordinating with other state-based groups that are working on this topic. For example, the National Alliance of State and Territorial AIDS Directors have been leaders on issues such as Hepatitis C and other matters related to intravenous drug use. The Safe States Alliance is another important group focused on injury and violence prevention. Close coordination between the federal government and state-based organizations does have an impact on our respective memberships on the ground level.

We commend Secretary Burwell for identifying the opioid issue as a top priority. We also appreciate her commitment to holding a 50-state meeting later in the year to continue this important dialogue regarding three broad categories: prescriber practices, access to MAT, and access to naloxone. NASADAD is pleased to join ASTHO as a co-sponsor of this important event.

Mr. MURPHY. I thank all the panelists.

I will now recognize myself for 5 minutes of questions.

Mr. Stringer, your office sits within Missouri's Department of Mental Health, and in the course of your work, have you found that Federal policies, including those affecting the ways in which certain treatment options are funded, have hampered any mechanism to treat individuals with co-occurring substance abuse and mental health disorders, and if so, what can be done, what do you suggest we do to correct that?

Mr. STRINGER. Mr. Chairman, I am not sure it is a policy issue. I am going to try to answer that yes or no. Yes. Yes, there are some things that get in the way of treating people with co-occurring disorders. Primarily has to do with funding screens, how funding comes to the States, what the limitations are, and how those funds are spent.

We have been successful in Missouri, I think, at braiding funds for people with co-occurring disorders, and so we treat some—so what we have done is really enhance our substance use disorder programs to include some mental health services. We have enhanced our community mental health services to include substance use disorder services. So we have been able to do that with the flexibility that is already there.

Mr. MURPHY. I asked that because we have had other witnesses say they would like to let the Federal Government merge some of those funds so they can treat both.

I would like to open this question up to all of you. I made some comments in my opening statement regarding the 42 C.F.R., and some concerns it has with interfering with doctors' ability to provide safe and effective treatment for patients. I don't know if any of you have reports from the State, but let me elaborate on this. A basic quality measure of good healthcare is medication reconciliation, as you are aware, which means assessing and documenting all the medications someone may be taking, which would include buprenorphine, Vivitrol, or all these other ones, but as a result of the 42 C.F.R. Part 2, a doctor's ability to complete these medication reconciliations is very compromised. As I said, Mr. Tonko and I are working on this, so a patient may be getting Suboxone from an addiction medication physician, but this person may fail to inform their family physician, who may recommend another thing, or you can have someone on Vivitrol and—doesn't tell a physician, and next thing you know, they get a pain medication, an opiate, and now you have someone who either has a risk of death, or you increase their risk for relapse. And I wonder if any of you can comment. Do you have any suggestions on this? Dr. Wolk, you are nodding your head. You have some comments on that?

Dr. WOLK. Thank you, Mr. Chair. Prior to assuming this role 2 years ago, I was the CEO for the State's Health Information Exchange, CORHIO. And you highlight a very big obstacle when it comes to exchanging and making available clinical information to all providers involved in a patient's care. If the health information exchange is going to work with regard to reducing duplication, improving quality, and reducing cost, the healthcare provider has to have access to all of the patient's information, whether it is physical, mental health, or substance abuse-related. So—

Mr. MURPHY. And we do have barriers that mental health therapy notes don't get into those things, which is—OK. That is a good point.

I want to follow up with one. Dr. Adams, I want to catch you before my time is out here. The diversion of buprenorphine for illicit nonmedical use is a significant problem, and that is just a part of the reason why the opioid epidemic is spreading. According to the Drug Enforcement Administration, buprenorphine is the third most seized prescription opiate by law enforcement. And so is the diversion of buprenorphine a significant problem in your State, and how are you handling that?

Dr. ADAMS. It is a significant problem in parts of our State, and that is why we need to have a larger conversation about medication-assisted treatment and what it can and cannot do. Vivitrol, for instance, is a wonderful drug for a very small subset of the population. Methadone, we need to separate the discussion between methadone for chronic pain versus methadone for substance abuse treatment in medication-assisted therapy. And so again, I would promote educational campaigns both for the public, for policy-makers, and for physicians, quite frankly, in terms of what can and can't be accomplished. And Suboxone is a great drug, again, for a certain subset of the population, when done right, but we have found when done wrong, diversion can occur, and that is a concern that has been brought up by particularly our correctional facilities where people say they can easily sneak it in to the correctional facilities.

Mr. MURPHY. I appreciate that. And my time is almost up, but this is the kind of thing we are going to want you to comment on. In addition, we made reference before to Don Flattery's letter to us, and he brings up an important point here that opiate pain relievers, or OPRs, can worsen chronic pain over time. And that is another area, it seems to me, as you are recommending we need to do much more in education—mandatory education of physicians and prescribers on that. So keep that thought in mind, we are going to want some input on that too.

I now recognize—

Dr. ADAMS. Mr. Chairman, one thing you can do concretely is you can have the VA and you can have Federal methadone programs report to Prescription Drug Monitoring Programs. You all can do that, and that will help get information out to the physicians.

Mr. MURPHY. Excellent, thank you. Thank you.

Ms. DeGette, 5 minutes.

Ms. DEGETTE. Well, thank you. This sort of follows up on your line of questioning, Mr. Chairman.

Dr. Wolk, I wanted to talk to you about the Prescription Drug Monitoring Program a little bit, and what we have done in Colorado, we passed a law in Colorado that now requires medical professionals who prescribe powerful controlled substances to sign up for an account. Is that right, Dr. Wolk?

Dr. WOLK. Thank you, Representative DeGette. That is correct.

Ms. DEGETTE. And since Colorado implemented that law, the use rate of the PDMP has doubled, going from about 40 to 85 percent in less than a year. Is that right?

Dr. WOLK. Thank you, Representative DeGette. That is also correct.

Ms. DEGETTE. And do you think that mandating the need to have an account with the PDMP is the key to Colorado's higher provider utilization rates? Is this something you think other States should consider?

Dr. WOLK. Thank you, Representative DeGette. I do. In addition to having the allowance for a delegate in the prescriber's office, because mandated participation—but then actual participation is enhanced by allowing that delegate to be assigned—

Ms. DEGETTE. Um-hum.

Dr. WOLK [continuing]. To work on behalf of the provider.

Ms. DEGETTE. OK. And I understand also that key medical Boards within the State came together, as we do in Colorado because that is the way we are, to create prescribing guidelines for opioid therapies. Can you talk about how this guidance is helping to guide Colorado doctors and dentists in their prescribing practices?

Dr. WOLK. Thank you, Representative DeGette. It is a policy that was developed, and then a training from that policy, and because of the universal endorsement or adoption by all of those different Boards of healthcare professionals that are in a position to prescribe, we really have seen a universal acceptance, high numbers of participation, and a very high number 87 percent, who said they would change their practice now as a result of that training.

Ms. DEGETTE. So when were all of these guidances, what year were they adopted?

Dr. WOLK. Thank you, Representative DeGette. It is within the past 2 years.

Ms. DEGETTE. OK, because you had some alarming statistics in your testimony about the way opioid use was going up in Colorado, and now we seem to be bringing it down. Do you think that these new guidelines have helped towards that goal?

Dr. WOLK. Thank you, Representative DeGette. I do think that they have, and we have some preliminary data coming in for 2014 that shows further stabilization, at least on the prescriptive opioids.

Ms. DEGETTE. And, Dr. Adams, I wanted to ask you, I understand that Indiana has adopted mandatory prescribing guidelines for opioid therapies. Can you talk to us about how the guidelines work, and what impact that they have had on this overprescribing problem?

Dr. ADAMS. Well, again, we have seen a 10 percent drop in prescribing since we have instituted our opioid prescribing rules. And I will tell you, I was on the State Medical Association Board of Trustees when these rules were coming through. Education is paramount any time you are trying to prescribe what doctors are and are not going to do.

As far as high points, we have an overall threshold in terms of if you go over 60 pills per month or 15 milligrams per day for over 3 consecutive months, you have to abide by these rules. There is a mandatory assessment which includes an H&P, and unfortunately we found people were prescribing pills without actually seeing patients or doing a full exam.

Ms. DEGETTE. Um-hum.

Dr. ADAMS. There are regular visits if you are prescribing, there is regular checking in with the Prescription Drug Monitoring Program, or our INSPECT program, upfront and then at regular intervals. There is drug testing, and docs have told us over and over and over again we need a way to prove whether or not they are taking the drugs or diverting the drugs. So drug testing is part of that. There is a daily threshold limit that if you go over 60 milligrams per day in the course of therapy, then you have to bring the patient back in for a face-to-face and consider referring them. And then there are contracts. And docs have told us those have been helpful too in terms of establishing the relationship, the expectations, and being able to fire a patient. The best man at my wedding got sued by someone who was using because they said he kicked them out of care and abandoned them. Contracts protect doctors moving forward in terms of being able to say I told you this, these will be the expectations, you violated them, and it empowers doctors to be able to participate. But we codified those into our rules and regulations, and it has been a tremendous success.

Ms. DEGETTE. Thank you. I just want to talk for one second about treatment because I have heard that there is a shortage of doctors who can administer this MAT treatment, particularly in rural areas. So I just wanted to ask you, Mr. Stringer, very quickly to talk about Missouri. I understand Missouri requires all State behavioral organizations to offer MAT treatment to all patients with opioid disorders. Has this helped improve access for the patients?

Mr. STRINGER. Thank you, ma'am. It absolutely has improved access to evidence-based care. I will tell you that this has not been easy for our providers to find physicians. We had one in southwest Missouri who has since become one of our leading providers in medication-assisted treatment, but in the early days had to go through the Yellow Pages physician by physician to try to find one who was willing, number one, to work with this population, because many are not—

Ms. DEGETTE. Yes.

Mr. STRINGER [continuing]. And then, secondly, who would work for the relatively low reimbursement rates that they could offer. So it was a real challenge, but absolutely, it has increased access to evidence-based treatment, but we still have these waiting lists.

Ms. DEGETTE. Thank you. Thank you, Mr. Chairman.

Mr. MURPHY. Thank you.

Mr. McKinley, recognized for 5 minutes.

Mr. MCKINLEY. Thank you, Mr. Chairman. Again, thank you for continuing this dialogue that we have now been doing for some time. We have had four or five hearings this year. Building off what we have learned in the past—a couple of years ago, we had a hearing in another committee where the Attorneys General had come in and talked about one of the things that they were suggesting on drug overdose and prescription—the pill mills, so to speak, whereas having a national registry in real time that was available to people across State lines as a way of capturing people that are trying to beat the system, is that something—I haven't heard any of you talk about the real-time entry data on that. Dr.

Wolk, would you—I see you nodding on that, is that one of the things we should focus on?

Dr. WOLK. Thanks, Representative McKinley. Yes, you know, we moved from periodic uploading to now daily uploading of the information, so it is real time with regard to our Colorado PDMP registry.

Mr. MCKINLEY. Yes, that is just in Colorado, but if they go across the State line, that is not available as well.

Dr. WOLK. Right. I think we would be happy to morph our State PDMP into a national PDMP so that—especially for neighboring States, I think this is a significant challenge.

Mr. MCKINLEY. Thank you.

Dr. Adams, your comment about overprescription—I would like to get some more—you started rattling off a lot of statistics and things that you do within Indiana to see how that works. I would like to see how we might be able to apply that in West Virginia as well and maybe across the country. So if that is not part of your testimony, if you have that separately, if you could send that, because we had this hearing just 3 weeks ago. We had seven panelists, and all of them said this is the number one priority, this is the number 1—and all of them were giving us different priorities. And I would like to think that Congress can walk and chew gum at the same time, but when we hear from professionals giving us all seven different directions, all seven agencies, so we asked them what is the number-one thing, and they talked about prescription.

Dr. ADAMS. Um-hum.

Mr. MCKINLEY. They said we are overprescribing. So in the last 3 weeks, I have talked to a number of doctors at roundtables in West Virginia, and they are concerned—they agree, they say, yes, we are making addicts with what we do, but we have to have a development of trust with our patients. And do you—I get nervous about the fact that we want Congress to try to medicate or try to control—try to practice medicine on pain. So they are saying it is trust. How have you been able to rectify that or reconcile that in Indiana about dealing with that problem?

Dr. ADAMS. Well, there is no doubt, and it is obvious from our outbreak, that we still have a lot of work to do. And I quickly want to touch on the point you brought up earlier. We could use a national registry for providers who divert on the job. That is the concern. Indiana was also the first State to have a Prescription Drug Monitoring Program talk across State lines. And it is still a problem. Scott County, Indiana, is just 20 minutes north of Louisville, but whether it is a national registry or just providing grants and funding to facilitate State PDMPs to adopt the best practices that talk across State lines, the consistent thing you heard all of us say is we need better communication, we need more real time information.

As far as the trust factor, again, it is an uphill climb, but we have worked closely with our State medical association, and we got buy-in from doctors in terms of participating and other prescribers. And I think an important point my counterpoint brought up from Massachusetts was that it is not just docs, a lot of these are delegated prescribers, and the way you get around that problem is you have integration with electronic medical records.

Mr. MCKINLEY. So the more that—if you could get me that information—

Dr. ADAMS. I would love to.

Mr. MCKINLEY. Then I want to open it up to all the panel. I am just curious, because you raised this issue last time, 3 weeks ago, and that was that the rate of deaths in America from drug overdose is anywhere from 7 to 10 times higher than it is in Europe. I raised that question, and I raise it again: What are they doing right, or what are we doing wrong? Why from 30,000 feet—what is the difference, why do we have such a problem in America compared to Europe?

Dr. ADAMS. Again, pain as the fifth vital sign, and overflow of opioids going into the system, a lack of education for providers, and understanding on the part of children in the States.

Mr. MCKINLEY. So they are doing a better job in Europe, the medical community is doing a better job in Europe?

Dr. ADAMS. I think they are. Less opioids available, in general, and I will yield to my counterpart from Massachusetts.

Mr. MCKINLEY. I am sorry, we are going to run out of time. So if you could get back to me, please, I would appreciate that. Thank you.

Mr. MURPHY. We will appreciate also the further elaboration on your point about when that becomes part of the hospital satisfaction survey, and then, of course, they get additional funding and that cycle, too.

Now recognize the ranking member, Mr. Pallone, for 5 minutes.

Mr. PALLONE. Thank you, Mr. Chairman.

I want to mention, even before the opioid epidemic began, our infrastructure for treating substance abuse disorders in this country was shamefully inadequate, including cuts to our healthcare system through sequestration. A combination of long-term neglect, social stigma, and underinvestment by both the State and Federal Governments has led to a system in which only 1 in 10 Americans with alcohol or drug addiction receive any form of treatment. And of those who receive treatment, only 10 percent received evidence-based care. You combine this neglected behavioral health system with an epidemic of opioid overprescribing and it is really not surprising that we are currently facing a public health crisis.

So questions. I would like to ask all the witnesses on the panel a question. Is our underinvestment in behavioral health services, including the effects of sequestration, hampering our response to the opioid epidemic? And let me combine that by saying, have you see the effects of sequestration affect what you are doing at the State level, and are you able to keep up with the increased demand for treatment with the current level of resources dedicated to the problem? I guess I will start with Dr. Adams and go down.

Dr. ADAMS. Thank you for putting me on the spot, Representative. One thing that I have always held as my own personal adage is spending more is not the same as spending wisely. And so we will all come to you all and say we want more money, but the fact is what we are concentrating on, and something you have heard continually, is that we need to do a better job of communicating with each other to make sure we are making the most efficient and effective use of the funds that we have available. We need to make

sure we are talking with communities, make sure we are talking with nonprofits, make sure that, through electronic medical records, we are getting the information that we need.

Policy is always a pie that gets split up. And so do we have enough money, again, I would always love more money, but what I would love most from you all is help in terms of making sure the right partners are at the table so that we can get the most out of what we are spending.

Mr. PALLONE. I mean—I appreciate what you are saying, but I am saying—my concern obviously is, first, sequestration, but even more so, you have more and more people that need treatment, and at best we are talking level funding. So, you know, if you could be a little more specific about the consequences of that, I would appreciate it. Not that I am taking away from what you said.

Dr. Bharel?

Dr. BHAREL. So I want to go back to this point about this chronic disease model. So if we look at how we treat other diseases within the medical spectrum, when we talk about diabetes, there are multiple places to enter based on the level of severity. So you come into the emergency room, you go to an ICU, you go to a hospital, you go to outpatient. When you are suffering with the disease of addiction, there are very few routes to enter the system. So when we talk about different funding sources, I would like our goal to be to look at it as a complete health system.

Getting back to this concept about Europe. If we think about health as a whole entity, and the public health starting at the community and going through the hospital system and out, we have to culturally think about not in our fast-paced thinking about pain being gone, but pain being relieved to a certain level, thinking culturally about pain not only being relieved with pills but other entities that are available as well, and then in addition to that, having PMP. Seventy-nine percent of our physicians in Massachusetts are on the PMP, but they say when we can't then use painkillers, what are other opportunities, so there are educational opportunities there as well.

Mr. PALLONE. All right. You guys don't want to—seem to want to talk about money.

VOICE. I do.

Mr. PALLONE. Let me add one more thing. Let me add one more thing. You know, SAMHSA, we understand that the SAMHSA Block Grant, or the Substance Abuse Prevention and Treatment Block Grant, you know, has actually been cut by 25 percent in the last 10 years. So, you know, maybe we want to talk about that if you don't want to talk about the other things. Go ahead.

Dr. WOLK. Thank you, Representative Pallone. I will be quick because I know you want to say something about that.

Absolutely, sequestration has had an impact. We cannot keep up with the demand, number one, so any additional resources that we can get through block grant money or however else we can do this would really be appreciated because even as a State ACA only goes so far with regard to coverages that folks can get adequate care. We received \$65 million from the Federal Government for our innovation model, as Representative DeGette alluded to, so that patients coming to their primary care doctor can get integrated phys-

ical and behavioral healthcare services, including substance abuse screening, treatment services as well, because we are so desperate to try and address this access issue and this lack of resource issue that maybe there is something there with regard to where they get their primary care.

Mr. PALLONE. Thank you.

Mr. STRINGER. Mr. Chairman, I know we are out of time. If I could—I would like to follow up in writing if I can. That is a great question. I very much appreciate that. I was at a women's prison in Missouri in Vandalia just Tuesday of this week, and I have some stories to tell from that experience.

Mr. MURPHY. We would appreciate that. Thank you very much. Now recognize Dr. Bucshon for 5 minutes.

Mr. BUCSHON. Thank you, Mr. Chairman.

And this has been very insightful, your testimony is very insightful.

Dr. Bharel, I was interested in one of the things you said that 20 percent of the medication that people are abusing have been prescribed for medical reasons, and one of the things we have been focusing on, of course, is, you know, I am an physician, I was a cardiovascular surgeon before, is prescribing, you know, monitoring prescribing habits, but if 80 percent is coming from somewhere else, where is it coming from? Seventy, 80 percent, whatever it is—I think you said 80 percent.

Dr. BHAREL. Yes, it is 80 percent of what is—70 percent is coming from family and friends.

Mr. BUCSHON. OK, that is what I figured, so it is not their particular medical use, but at the end of the day, it has been prescribed for a medical use for someone. OK, and that is where maybe, you know, drop boxes and other initially voluntary return policies potentially could be helpful because—last year, you probably know, there were enough prescriptions written that every person in the United States of America could have gotten a bottle of narcotic pain medicine. And Medicare Part D just came out and said recently that the number one prescribed medicine under Medicare Part D—and so this goes across ages, right—was Vicodin.

Dr. BHAREL. Um-hum.

Mr. BUCSHON. And so I am very interested in the prescribing programs and trying to monitor, you know, physician prescribing, and as part of that, education is, of course, important. And that is where it is not only for the people using it, but it is the people that are being trained to take care of patients as we speak in medical schools and other areas. So that is going to be very important.

Dr. Adams, in your testimony, you say an aggressive educational strategy beginning with childhood. Can you kind of expand a little bit on that, what your thoughts were on that?

Dr. ADAMS. Well, thank you for the opportunity. And for those of you who don't know, Congressman Bucshon married up, he married an anesthesiologist.

But as far as that—

Mr. BUCSHON. That is a true statement.

Dr. ADAMS. The aggressive education campaign—quick story, I was in Scott County just a few weeks ago meeting with a 23-year-old individual who had HIV, he was in our clinic. And I said how

did you get started, and he said, "I had an injury as a freshman in high school, a knee injury playing football. The doc prescribed me Vicodin. I kind of liked how it made me feel so I took all the Vicodin he gave me, took some more, ran out." He said it was easy to get in the community. "Got more Vicodin. Finally, that wasn't doing the job, switched to Oxycontin until that wasn't doing the job, then I started injecting." And then he switched over to heroin, and now he is a 23-year-old HIV addict.

We have to get to these people earlier. And when you talk about an aggressive strategy, it starts with recognition. We need an educational campaign to help students understand that this is a problem.

I used to sneak to my friend's house when I was in high school and have a beer. They sneak to their friend's house and pop a pill. And unfortunately, 1 out of 15 people who divert a pill will ultimately go onto heroin use. One out of 15 of my friends who popped a beer didn't go on to get HIV. So we need to increase the recognition of the problem. We need resilience in anti-bullying campaigns so that kids are OK saying no, I am not going to take a random pill out of that bowl. We need appropriate age level education, and I was meeting with people from the State just yesterday who showed us their data, and the interventions in each age group are different. What works for a fifth grader doesn't work for a sixth grader, doesn't work for an eighth grader. There has to be age-appropriate education and intervention. There has to be adult and peer outlets so, hey, if someone is doing something wrong, I know who to go to, I know who to tell. And then finally, to your point, we need take-back programs. Sixty-two percent of teenagers who use say they—number 1 reason they use is because it is easy to get the medication, it is from my parents' cabinet. It is right there. It is easier to get a pill than what it was for me to get a beer. And you can hide it and you can walk away with it. And so all that needs to be part of the campaign, and it needs to start in middle school and elementary school.

Mr. BUCSHON. I have one other question I want to ask about Naltrexone, because I have given that to patients in a hospital setting. And, Mr. Stringer, maybe you can comment on that, and I think not only the availability but the appropriate training for people, you know, for law enforcement people or EMTs about the fact that—like somebody pointed out, it is not a silver bullet here, there are also downsides to giving patients Narcan or Naltrexone. Can you comment on that, about what type of educational stuff is also—I mean—I think, were you one of the ones that were commenting on Naltrexone? Yes. Or maybe Dr. Bharel could answer that.

Mr. STRINGER. Maybe I can just—

Mr. BUCSHON. Yes.

Mr. STRINGER. I can start. And certainly, I will tell you, when I went to—

Mr. BUCSHON. And I am out of time, so can you—why don't we just do this—

Ms. DEGETTE. Let—

Mr. BUCSHON [continuing]. Why don't you just—

Ms. DEGETTE [continuing]. Dr. Bharel answer. She has been—

Mr. BUCSHON. Why don't we—

Mr. MURPHY. Why don't we let Dr. Bharel answer?

Mr. BUCSHON. That will be fine.

Dr. BHAREL. So as part of our Narcan Program, so we have handed out in Massachusetts since 2007 over 35,000 doses of Narcan, and part of that includes to your point about education. So the individuals who are handing out the Narcan to both bystanders and law enforcement, there is a training that goes along with it, and they are also trained on rescue breaths and the importance of it being short-acting and to call 911 at the same time. And we have recorded over 5,000 reversals—

Mr. BUCSHON. Yes—

Dr. BHAREL [continuing]. With that. So the educational component is directly linked when we hand out our—

Mr. BUCSHON. Yes, I think that is important because, in my opinion, if someone has to give someone Narcan, they should also be calling 911, and those people probably should be transported to a medical facility.

Thank you. I yield back.

Mr. MURPHY. We will want your other thoughts on it, too. We have all sorts of people saying that some people have a false sense of security thinking, oh, there is Narcan around, I can go ahead and take the risk.

Mr. Tonko, you are recognized for 5 minutes.

Mr. TONKO. Thank you, Mr. Chair.

Mr. Stringer, earlier on in the questioning about sequestration you had some comments that we didn't get to. Perhaps you could share those right now please.

Mr. STRINGER. Yes, thank you very much, Representative. In my written testimony, there is a two-page thing from NASADAD here that describes the block grant and the reduced purchasing power of the block grant over time. I will tell you just specifically that I think with regard to sequestration. We in the States have really counted on the Federal Block Grant to sort of be our—really it is our safety net. We have some States have the safety net funds, but the block grant has always been stable. It hasn't grown enough to keep pace with inflation, but it has been stable. What we saw with the sequestration was that our sense of stability was shaken because we were during tough economic times at the State level, and then our block grant funds were reduced temporarily.

Just this last Tuesday, I was visiting a women's program in Vandalia, Missouri, where we have a unique program going on right now where women offenders who leave that institution are started on medication-assisted treatment before they leave. So when they go home, they return to stable environments. Two of the women that I talked to had been on medications before they returned to prison. One was a young lady who was young, attractive, smart, had two children, was back in prison for her fourth DWI offense. Before coming to prison, she had been on medication-assisted treatment, but because of budget cuts at the State and Federal level, her medication-assisted treatment was stopped, and she returned to drinking very quickly after that, got her fourth DWI offense and then wound up back in prison.

So, you know, the stability of the block grant, and I hope future increases in the block grant, will really help to sure-up our safety net, and increase access and sustainability of treatment.

Mr. TONKO. I appreciate that. And for far too long our national infrastructure for treating substance use disorders has suffered from fragmentation, from neglect, and certain underinvestment. Only one in ten Americans with substance use disorders is able to access treatment, and of the few who receive treatment, few receive anything that approximates evidence-based care. Reimbursement is key to modernizing these services, and ensuring that Americans struggling with addiction receive timely, appropriate, and evidence-based care.

The Affordable Care Act, mental health parity efforts go a long way toward accomplishing this, but requiring insurers to provide coverage for substance abuse treatment, but much more work remains.

I know the States are experimenting with some innovative ideas. Dr. Wolk, can you provide us with an overview of Colorado's efforts to integrate behavioral health services into the primary care setting in the same Medicaid Program?

Dr. WOLK. Thank you, Representative Tonko. Yes, and it is actually not just for Medicaid, we have a goal that all payers in the State will evolve with payment reform models that will allow integrated behavioral and medical care to be provided at the site of primary care. Our goal over the course of the next 4 years is that 80 percent of all primary care practices in the State, whether they are federally qualified health centers, whether they are clinics, whether they are private practices, will all have some form of integrated behavioral healthcare as part of the primary care that is being provided as the patient's medical home.

Mr. TONKO. And are there any Federal policy changes that you would suggest required in order for us to provide—ensure integration is indeed successful?

Dr. WOLK. Thank you, Representative Tonko. There are along the lines, again, of really aligning the incentives to make sure that payers, for example, don't capitate or apportion behavioral health services and payment to a provider that is not part of this integrated model. It splits payment and, therefore, splits services. And so as a patient, you could come see your primary care provider, and that primary care provider would be prohibited from providing you mental health or substance abuse treatment services because the payer has allocated that money to a behavioral healthcare provider or substance abuse provider on a prepayment schedule, and that is where we could use some help with regard to reforming how those payments are made.

Mr. TONKO. Um-hum. And, Dr. Bharel, just quickly, what do you view as the main barrier to integration of behavioral health and physical health?

Dr. BHAREL. So I think the main barrier is stigma, and that stigma is—penetrates throughout our entire system. My time is up so I will stop there. If I can say one more thing is that in Massachusetts, we too are looking towards outcome-based, value-based care throughout our system which includes the real cornerstone being primary care and behavioral health integration at the office level.

We have multiple pilots going on including programs of prescribing Suboxone in our community health centers. Thank you.

Mr. TONKO. Thank you.

I yield back.

Mr. MURPHY. Thank you. Gentleman yields back.

It is interesting the way deal with stigma straight on, integration. Good.

Mr. Flores, you are recognized for 5 minutes.

Mr. FLORES. My questions have more to do with the education elements of that. The background for this is that I have three major educational institutions in my district—Baylor, Texas A&M University, and University of Texas—that are associated with medical schools. And so I would like to drill into going further upstream, and that is what can we do with the physician community and the expert community, professional community, to help them to be able to deal with this better?

So my first question is this, and this is for each of you. Should all physicians be required to complete a continuing medical education course on pain treatment, and if so, should they also be mandated to complete one on addiction? And I will just start with you, Mr. Adams.

Dr. ADAMS. Should all physicians? I would change that to say all prescribers—

Mr. FLORES. OK.

Dr. ADAMS [continuing]. Because it is not just physicians prescribing, and not all physicians prescribe opioids. But we have had tremendous success, again, in Indiana. Once we instituted the opioid prescribing rules, then that led to an educational campaign where we had the opportunity and created the passion for these docs, and they had to carve out the time these docs and other providers to learn about the proper ways to prescribe.

Mr. FLORES. OK. Dr. Bharel, your thoughts?

Dr. BHAREL. So we also have all physicians required to do pain management training, but to your point, I would say that most medical schools, PA schools, nurse practitioner schools, et cetera, other practitioners who prescribe, do not have acquired training on addiction or its variable in school.

Mr. FLORES. OK.

Dr. BHAREL. So going further upstream at a Federal level, these accreditation bodies could be looked at to require some of that training.

Mr. FLORES. OK. Dr. Wolk?

Dr. WOLK. Thank you, Representative Flores. In Colorado, some of this training is tied to malpractice premium reduction, and so a way around us making a requirement is, you can save some money on your malpractice insurance if you take this training. And as we said, don't forget about the dentists, the nursing community, the optometrists, and the podiatrists because they are all prescribers, to the point that was made before.

Mr. FLORES. OK. Go ahead, Mr. Stringer.

Mr. STRINGER. And my answer to your question is unequivocally yes, there should be mandatory education.

Mr. FLORES. Right. So the next question would be, and this is again for all of you: Does your State think there is any merit to

linking mandatory physician education for PDMPs to DEA licensure as a way to promote physician use of PDMPs when prescribing a controlled substance? Dr. Adams?

Dr. ADAMS. I have been longwinded before so I will be very brief. Yes.

Mr. FLORES. OK. Dr. Bharel?

Dr. BHAREL. We already require, at the time of license renewal, for all physicians to sign onto PDMP—

Mr. FLORES. I see.

Dr. BHAREL [continuing]. And that is how we have increased—

Mr. FLORES. The question is yes on the merit?

Dr. BHAREL. Yes.

Mr. FLORES. OK, great. OK. Perfect.

Dr. WOLK. Yes, we already require.

Mr. FLORES. OK. Mr. Stringer?

Mr. STRINGER. Sadly, I can only speak theoretically or hypothetically since Missouri is the only State in the country that does not have a PDMP yet, although it came very close this session, but—

Mr. FLORES. OK.

Mr. STRINGER [continuing]. So I would say yes. Theoretically, yes.

Mr. FLORES. OK. Theoretically. I understand. Again, for each of you, and we have just a minute and 45 left. What are the opportunities to—or let me rephrase that. What are the opportunities to improve the education of physicians on the appropriate prescribing of prescription pain medication? Is it medical school, continuing education, all the above, or somewhere else?

Dr. ADAMS. It is both. I am an assistant professor at the medical school, and we don't get it in medical school, but then there are docs out there who are prescribing or want to prescribe who don't have that education. And I am sorry to keep bringing it back, but in many cases, the majority of people doing the prescribing of opioids are not physicians. So you can do all you want with docs, but if you aren't taking care of everyone who is prescribing opioids, you are not going to solve the problem.

Mr. FLORES. OK.

Dr. BHAREL. I would say all prescribers at all levels, but also to bring back to the point that we all have to be educated. So it is a cultural shift also to our expectations of pain relief.

Mr. FLORES. OK. Dr. Wolk?

Dr. WOLK. I believe it is ongoing, but again, think about tying it to their wallet and then their malpractice premiums.

Mr. FLORES. Uh-huh, OK. Mr. Stringer?

Mr. STRINGER. All the above.

Mr. FLORES. And the last question is this. And I have just a comment. Dr. Bharel, you said something about a cultural shift. Is this going to be hard to implement if we began pressing all of the prescribers to have continuing education, and then further upstream, to have the medical schools or the professional schools mandate this as part of their training? Do you see pushback in this?

Dr. BHAREL. It is mandated right now in Massachusetts, and I believe the prescribers really want to be part of the solution, so

they are looking to work together. So I think that will be the driving force. They are also fed up with the numbers and the statistics.

Mr. FLORES. Um-hum.

Dr. ADAMS. You will see pushback, but it is something that we have to do. And again, as Dr. Bharel mentioned, docs want it, but we need to facilitate them getting the education, and needing to carve out the time either via tying it to the wallet or tying it to certification.

Mr. FLORES. OK, thank you. I yield back the balance of my time.

Mr. MURPHY. Gentleman yields back.

Now recognize the gentlelady from New York, Ms. Clarke, for 5 minutes.

Ms. CLARKE. I thank you, Mr. Chairman, and I thank our ranking member. I also thank our witnesses for lending your expertise through your testimony here today.

I would like to ask about the impact of Medicaid expansion on increasing access to treatment for substance abuse disorders. According to the Centers for Medicare and Medicaid Services, an additional 11.7 million individuals were enrolled in Medicaid and CHIP programs since the initial marketplace enrollment began in October of 2013, however, 21 States have failed to adopt the Medicaid expansion, leaving large coverage gaps for adults whose incomes are too high to qualify for Medicaid, but too low to qualify for premium tax credits through the exchanges.

Let me start, Dr. Adams, by asking, has Medicaid expansion affected access to behavioral health services in the State of Indiana?

Dr. ADAMS. Well, the answer is yes, but I want to correct a term you used. In Indiana, we didn't expand Medicaid, we received a waiver to reform our Medicaid program via the Medicaid expansion funds. And I think that is a key here that we need to allow States to come up with—

Ms. CLARKE. No, I—

Dr. ADAMS [continuing]. The best possible policy.

Ms. CLARKE. That wasn't my point.

Dr. ADAMS. Yes.

Ms. CLARKE. It was just a question.

Dr. ADAMS. Yes, ma'am.

Ms. CLARKE. Has expansion impacted your ability to address the HIV outbreak in Scott County?

Dr. ADAMS. Expansion via the Healthy Indiana Plan has substantially increased our ability. We signed up over 300 people for health coverage as part of this outbreak into our Healthy Indiana Plan.

Ms. CLARKE. Well, I thank you for your illuminating response. I hope that other States recognize the impact that Medicaid expansion can have on their ability to diagnose and treat substance abuse disorders, and comorbidities such as mental illness, HIV, and Hepatitis C.

Mr. Stringer, I would like to turn to you. The current limit for nondisabled adults to qualify for Missouri's existing Medicaid program, MO HealthNet, is 18 percent of the poverty level, or \$2,118 a year. Missouri is a State that has not expanded Medicaid, resulting in a large coverage gap of adults whose incomes are between 18 and 100 percent of the Federal poverty level. Mr. Stringer, ap-

proximately 300,000 working adults would gain access to health coverage through Medicaid expansion, is that correct?

Mr. STRINGER. Yes, that is correct.

Ms. CLARKE. How would Medicaid expansion affect the population you serve in Missouri?

Mr. STRINGER. Well, ma'am, of those 300,000, we estimate that about 50,000 are people with some type of mental illness or substance use disorder that have no coverage at all right now.

Ms. CLARKE. Um-hum.

Mr. STRINGER. And so we are right now, for those that are in our system, we are paying for those with 100 percent general funds or block grant funds. If and when we expand Medicaid in Missouri, those people will receive Medicaid coverage, which does cover substance use disorder treatment in Missouri, and that would, therefore, free-up those funds to treat people who remain uninsured for whatever reasons, to provide other kinds of services to help people get back to work, things like that. So it would have a tremendous impact on Missouri.

Ms. CLARKE. Wonderful. I thank you for your perspectives.

And I yield back the balance of my time. Thank you.

Mr. MURPHY. Gentlelady yields back.

Now recognize Mrs. Brooks for 5 minutes.

Mrs. BROOKS. Thank you, Mr. Chairman.

Dr. Adams, you recently wrote an op-ed, and your quote was that building a model for prevention and response should this type of outbreak happen in other communities in the U.S. Can you talk to us a little bit, and kind of trying to bring it back a bit to the HIV outbreak in Scott County, can you explain for us what the model looks like? When you talk about the model, what model are you referring to?

Dr. ADAMS. Thank you for the opportunity. And the Governor and I sat down at the beginning of this and said we are going to make mistakes, but we want this to be a model moving forward. And one important part of that was a comprehensive program. The HIV spills over into the opioid epidemic, spills over into Hepatitis, et cetera. And at our community outreach center in Scott County, we wanted to make sure people were able to access a multitude of services that are constant barriers to them getting into the treatment that they need. At our community outreach center, we had over 789 visitors, 271 HIV tests, 302 people enrolled in the Healthy Indiana Plan, 87 mental health referrals, and 38 job referrals. And we also offer birth certificates and identification, which is a barrier for people signing up for insurance. And importantly, immunizations for Hepatitis A, Hepatitis B, and the Tdap. When you include the needle exchange into that, I would venture to say you won't find another place in our country that offers all those services under one small roof.

Now, what we need to do is look at that as a success, and in terms of responding to an epidemic in the future, other places should consider providing all those comprehensive services, but for the long-term, we need to make sure within communities we are not just providing one part, that we are providing the comprehensive services people need because, again, this is a vulnerable population. OK, here is health insurance. Well, I don't have an ID to

sign up for it. I can't prove I am a citizen. Well, here is access to HIV care. But I don't have transportation or it is not available. Well, there is an opportunity for you to get into a treatment center. But the people aren't here, they are not close by. So when I say a comprehensive response and a model response, it is including all those services and thinking about overcoming barriers for the people we are trying to reach.

Mrs. BROOKS. Thank you very much. And best of luck as you continue to lead the efforts on behalf of the State.

I want to shift very briefly in the time I have left to discussion about the criminal justice system. And in a previous hearing we talked about drug treatment courts, and obviously the State also has a tremendous responsibility for the corrections system, and the corrections systems are administered by the State. And so I would be interested in any of your comments with respect to what your States are doing with respect to opioid abuse in our corrections systems, and/or the coordination with the drug treatment courts. I know that is a big question, but yet I think that is a group of folks who are incarcerated or who are on their way to incarceration through drug treatment courts, and I am really curious what your thoughts have been in your States.

Dr. ADAMS. Briefly, in our district, we have had much success with Vivitrol and drug courts and diversion programs, and we have actually connected the prosecutors from Hamilton County, which is in our district, with the people from Scott County to share best practices. And I think that is going to be a critical, critical aspect moving forward to empowering people when they are, quite frankly, a captive audience.

Mrs. BROOKS. Thank you. Dr. Wolk or Mr. Stringer?

Mr. STRINGER. Well, I talked earlier about a project we have going on in Missouri within our Department of Corrections where people are started on medications before they leave prison. That is happening in several of our institutions right now, as well as the St. Louis City Jail, before people go into drug court. So we are starting people on medications before they leave incarceration. We also have a growing number of drug courts in Missouri, all of whom have embraced medication-assisted treatment. In fact, the drug court contracts in Missouri require that drug courts offer medication-assisted treatment for people for whom it is appropriate.

Mrs. BROOKS. Dr. Wolk, anything with respect to Colorado's approach?

Dr. WOLK. Thank you, Representative Brooks. It varies by where the population is most dense. So we have a very active program in the Denver metropolitan area. A variety of treatment options and transition programs from corrections back into the community as well. It is not as easy to take advantage of those in the more rural parts of our State.

Mrs. BROOKS. Thank you. Dr. Bharel?

Dr. BHAREL. And in Massachusetts, we have a strong support for drug courts, diversion programs, and starting medication-assisted therapy, and part of our working group includes law enforcement and multiple segments of the community. And in addition, we have several pilots going on where before release, individuals are con-

nected to community health centers so that their continuity of care can happen in both behavioral and medical illness.

Mrs. BROOKS. Thank you all for your work.

I yield back.

Mr. MURPHY. Mr. Green, you are recognized for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman.

I would like to focus question on the overprescribing of opioid pain relievers, and what States are doing to prevent the opioid addiction in the first place. CDC Director Tom Frieden quotes, "Overdose rates are higher where opioid painkillers are prescribed more frequently. States with practices where prescribing rates are highest need to take a particularly hard look at ways to reduce the inappropriate prescription of these dangerous drugs." As this quote says, the States where the rubber really meets the road in terms of prevention efforts and addressing the overprescribing of opioid.

Dr. Adams, I know Indiana has been hit hard by the opioid abuse epidemic. Can you tell us what the mandatory prescription guidelines that the Indiana Medical Licensing Board develops, and not just the Medical Licensing Board, if you could talk about all the practitioners: the nurses and dentists that have the same—hopefully their prescribing requirements are on all the specialties.

Dr. ADAMS. Thank you for the opportunity. And we passed those rules and the Medical Licensing Board passed them initially for physicians, and now the other Boards are adopting their own versions of the rules. But again, a critical part of that was the mandatory checking in and being a part of the INSPECT, the Prescription Drug Monitoring Program. A mandatory part was assessment and H&P and regular visits. You have to have a face-to-face and a relationship with a patient before you prescribe. A mandatory part of that is drug testing so we can know what you are taking, and if you are taking it appropriately. And as many people will take more, there are frequently people who are diverting.

Mr. GREEN. Um-hum.

Dr. ADAMS. And we found that problem in Scott County. Again, a lot of the prescriptions are to little old ladies who really do have chronic pain issues, but they can resell their pills for \$500, \$1,000, and quite frankly, put diapers on their grandchildren, versus properly use those opioids. So we need to be able to drug test people who we are giving opioids to, and we need to have contracts. Again, the docs have told me that they are scared to write, and then the docs that are writing are scared not to write because you can get sued either way. And so we need to be able to protect docs and their ability to do the right thing.

Mr. GREEN. OK. Do you believe efforts are making an impact on inappropriate prescribing of the opioid medications? I know you said the other specialties, but at least on the Medical Board that you may have some evidence on.

Dr. ADAMS. Well, exactly. We have seen drops of 10 percent in prescribing since we adopted the rules. We have a lot fewer pill mills, and that is really what was the impetus for this, but we have to do a better job with our Prescription Drug Monitoring Programs. Best practices need to be adopted, and the ability to communicate across State lines however we facilitate that, because we can't do anything if we don't know the numbers, and we can't do anything

if we know the numbers but we can't share the data with the appropriate prescribers.

Mr. GREEN. What should we be doing on the Federal level to support your efforts of implementing effective interventions to prevent opioid abuse?

Dr. ADAMS. Well, Senator Donnelly and Senator Ayotte have a bipartisan bill that they are promoting right now that has a lot of good ideas in it, and I would encourage you all to look at that rather than me spend time going through each of the points.

Mr. GREEN. Um-hum.

Dr. ADAMS. The Heroin and Prescription Opioid Abuse Prevention, Education, and Enforcement Act of 2015. I think it has a lot of the right ingredients in terms of taskforces and highlighting the areas that we need to concentrate on.

Mr. GREEN. OK. Dr. Wolk, can you tell us about some of the same in Colorado, the opioid prescribing guidelines developed by the State Boards, again, whether it is medicine, pharmacy, nursing, or dentistry?

Dr. WOLK. Thank you, Representative Green. Yes, it really just keeps coming back from the provider perspective to the two main points, or the two number one priorities; one is the mandatory participation in PDMP registration, and the second is some form of requiring or strongly encouraged training with widespread adoption across all the disciplines, because we have seen, like I said, 87 percent of those who participate in the training said that they would change their practice as a result of it.

Mr. GREEN. OK. I only have a few seconds. One of the issues is doctor-shopping, and is there anything technologically we can do to deal with that?

Dr. WOLK. Yes—

Mr. GREEN. And this would be for all of—

Dr. WOLK. Sure. We have had a lot of success with the use of our health information exchange and having broad participation by all of our hospital systems in the State of Colorado, and now well over 1,000 providers who have connected their electronic health records to each other so that when somebody comes into an office or an emergency room, it is relatively easy to now see who they have seen and what they have been prescribed or provided for.

Mr. GREEN. Mr. Chairman, in my last second, Dr. Bharel, you talked a lot about Federal qualified health centers and the community centers. In Massachusetts, do they have access to that same medical record across the lines of the different centers?

Dr. BHAREL. Yes, sir, there are many different integrated health records that we are looking at. And the PMP is really adding to this because it is system-wide, any prescription written within Massachusetts, or written out of Massachusetts for somebody residing in Massachusetts. What we really do need though is interoperability that is better between States and also between different EHRs, so we can then expand our view.

Mr. GREEN. OK, thank you. Thank you, Mr. Chairman.

Mr. MURPHY. Thank you.

Gentleman from Oklahoma, Mr. Mullin, is recognized for 5 minutes.

Mr. MULLIN. Thank you, Mr. Chairman, and thank you for being persistent on getting down to the roots of the problem. I mean this is obviously an epidemic, and I would say most of us know somebody that has abused prescription drugs at one time or the next. You know, recently I just went through a surgery on my elbow and got prescribed a big old pill of pain medicine, and I wouldn't even take one of them. Fortunately, I have had a lot of surgeries, or unfortunately, and I have built up some type of a pain tolerance, but it does become a habit. The pain is still there, it just masks it. And when you get used to it, it becomes a dependency. And what we are seeing is—in my opinion, it is severely being overprescribed. And, Dr. Bharel, you are aware of the severe rise in methadone prescriptions, I am assuming, right? The rise in it, how often it is being—

Dr. BHAREL. The rise in methadone, yes. Yes.

Mr. MULLIN. Right. Are you aware that methadone accounts for 30 percent of overdose deaths, while only—

Dr. BHAREL. Um-hum.

Mr. MULLIN [continuing]. Basically covering 2 percent of the prescriptions?

Dr. BHAREL. Yes.

Mr. MULLIN. Then I guess the question is why does Massachusetts leave it as a preferred list as a drug to be prescribed when CDC is saying it shouldn't be the first line, it should be considered just in a case-by-case situation, rather than being prescribed on a regular basis?

Dr. BHAREL. Thanks for your question. So methadone, you know, has become a part of the armamentarium of what can be used as pain relievers. In looking at our data within Massachusetts, and the data that we collect at the Department of Public Health, when we collect preferred drug of choice first and second, methadone is actually lower than the average in Massachusetts. It is less than 15 percent as the preferred drug of choice. But just like with all the other medications, there needs to be education around how to use methadone if it is going to be used for pain or not. So I agree with that point.

You brought up a point earlier about many people knowing somebody who has used or abused opioids, and I want to bring up a point. There was a recent study done through the Harvard School of Public Health—

Mr. MULLIN. Um-hum.

Dr. BHAREL [continuing]. Where they looked at the majority of us knows somebody who has struggled with addiction, and of those who have, 20 percent of us know somebody who has died from it. So it is really a profound problem, to your point. And one very interesting thing related to this question that you are asking is that 36 percent of individuals who were prescribed an opiate were not made aware or did not know about the addiction potential. So I think that needs to be part of the education.

Mr. MULLIN. And I agree with that, but then if we know that and it is so readily accessible, still yet I am concerned why Massachusetts and Indiana, Dr. Adams, would still leave it on your list of prescribed medications, I mean when CDC and American Academy of Pain Medicine both have said that methadone should not be con-

sidered a drug of first choice. But when it is listed, we all know that doctors refer to this constantly. In fact, that is where Medicaid and Medicare a lot of times gets the prescriptions or the drugs that they are able to prescribe from.

Dr. ADAMS. It is cheap.

Mr. MULLIN. Well, so—I know, but—so a person's life is cheap?

Dr. ADAMS. Well, no, a person's life is not cheap, and I appreciate that question. Again, as a person who has been trained in pain management, methadone is a great drug when used appropriately.

Dr. BHAREL. Um-hum.

Dr. ADAMS. So the problem is that the prescribers aren't educated and aren't using it appropriately. So you have a policy situation where you have a cheap drug that the doctors know can be used appropriately, but a real world situation where it is not being used appropriately.

Mr. MULLIN. Dr. Adams, I really appreciate your bluntness, but cheap shouldn't matter when we are talking about someone's life. We know it is being abused. History says it is being abused.

Dr. ADAMS. Um-hum.

Mr. MULLIN. So why is it still there?

Dr. ADAMS. Well, because, again, from a policy point of view, there are two different directions you can take this. You can either say take it off the formulary and what are we going to replace it with—

Mr. MULLIN. Education isn't working. We all get those little bottles with the little label on it, and then it even has a folded-up package. And I am sure everybody in this room has always read that folded-up package.

Dr. ADAMS. Um-hum.

Mr. MULLIN. And all of us know what the side-effects are and what the consequences are of everything that we have ever taken, and in fact, if you are one of those people, I am not—

Dr. ADAMS. And as a State health commissioner, I will tell you you are right, and again, I will be blunt and say you are right. There is a problem and we need to figure out the best way to address the problem, while still providing pain management options for the people who are out there.

Mr. MULLIN. So, Dr. Adams and Dr. Bharel, while we are figuring it out, do you still think it is a good idea to have it on your Web site as a preferred medication?

Dr. ADAMS. That is a great question, and again, the blunt answer is, that is a different division than my division. I have spoken with Dr. Werner about this problem, and docs feel passionately on both sides of the issue, but it is at the top of our radar in terms of making sure we are educating people and considering all options.

Mr. MULLIN. Dr. Bharel, you want to follow up on that?

Mr. MURPHY. Gentleman's time has expired. You can do it real quickly. We are about to have votes, so I want to move.

Dr. BHAREL. I think this issue is going to be a multipronged approach, and one of them is looking carefully at the medications we prescribe, and making sure that individuals are educated on how to best describe them. Thank you for your question.

Mr. MULLIN. Mr. Chairman, thank you.

Mr. MURPHY. Thank you.

I recognize now Dr. Burgess for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman. And I must say, every time I listen to the gentleman from Oklahoma, I learn something. And it is a hazard in relying on a medical education that is over 40 years old, but I remember the morning in medical school hearing the lecture on methadone, and it was repeated over and over again; methadone is for maintenance purposes only. I mean I will never forget the guy saying that. But is that no longer true; methadone now is being used for things other than maintenance? Dr. Adams.

Dr. ADAMS. In terms of maintenance for medication-assisted treatment, or you mean for chronic pain?

Mr. BURGESS. Well, for someone who has an opiate habituation.

Dr. ADAMS. Well, the answer is that there are a lot of prescribers out there who don't have the proper education to be prescribing the drugs that they are prescribing, and it is a problem. It is—

Mr. BURGESS. But again, 40-year-old wisdom, you have somebody who has a narcotics habit, they want to rehabilitate themselves, they want to get back to taking care of their family, back into society, they can be maintained on methadone and allowed to function because it didn't have the other effects that other opiates do, so they can get the high, but they solve the problem of the addiction, at least temporarily. But now methadone has uses beyond that?

Dr. ADAMS. Well, OK, so I am glad you brought that up. Again, there is a lot of misunderstanding about methadone. There is methadone as used for chronic pain, which the gentleman from Oklahoma was talking about, and then there is methadone for medication-assisted treatment, which is the person who has substance use disorder who is using it to continue functioning. And those are two very different uses of methadone, and confusion has led to a lot of policy decisions that I think are underinformed. It is important to know that methadone can be a substantial and important part of people's recovery if they are suffering from substance use disorder, but it is also important, to the point of the gentleman from Oklahoma, that we recognize and deal with the real problem of methadone being prescribed for chronic pain inappropriately, because it is killing people. I completely agree with you, and I thank you for bringing up that point, sir.

Mr. BURGESS. All right, I am going to switch gears because I had a couple of questions about Naloxone. And I have some other questions about NASPER, but then I will probably have to submit for written responses because of time. But we have had a number of these hearings, and I have expressed support for having compounds like Naloxone or Narcan available over the counter. I mean, let's be honest: People need it, they need it right now, they don't need to be going to get a prescription. So just this week the FDA announced a public meeting to discuss increasing the use of Naloxone. Now, Dr. Bharel, in Massachusetts, your State has been kind of an early adopter in this area. Can you share some of that experience with us?

Dr. BHAREL. Sure. So as I mentioned earlier, we have been using Narcan treatments since 2007. We first started by doing outreach to high-risk individuals who were using injection drugs as part of an, actually, HIV prevention, treatment education program, and

since then from there moved on to work with so-called bystanders, which are family and friends. And we use our existing community coalitions, such as our learn-to-cope, family-run coalitions throughout the State in order to have them provide Narcan. And this is done through standing medical orders, so it is still not an over-the-counter, it is through standing medical orders, as well as certain pharmacies participate in having it available through standing medical orders. And then finally, through the first responders program; both fire and police, in dozens of communities across Massachusetts have adopted the program as well.

Mr. BURGESS. And, Dr. Adams, can you share with us some of your experience in Indiana?

Dr. ADAMS. Well, we have had great success, some wonderful stories, but I want to second a point that Dr. Bharel made earlier that it is important not just to hand out Naloxone, but to provide education as part of that process. There is a big fear—and I think Representative Murphy brought this up earlier, Chairman Murphy—that if you are giving people this, they will then use it as an excuse to abuse. That has been proven not to be the case when you combine the passing out of Naloxone with education. So when you are considering policies moving forward, please don't forget the educational component because that is what saves lives, along with the Naloxone.

Mr. BURGESS. Yes, of course, that could be said about so many other things that we sometimes get involved in, but I appreciate your answers.

Mr. Chairman, I am going to yield back the time because I know votes are coming.

Mr. MURPHY. All right, I want to thank all of the members who were here for this, and this panel. This has been a fascinating process. We know what will come out of this. We will get our staffs together. You gave us a great set of recommendations today, thank you.

We do ask you to follow up on some of those other questions, and please feel free, if you have other thoughts that come from this, it is the kind of things you are thinking about on the plane ride back or when you get back to your colleagues. We want to see what we need to do in terms of drafting legislation, working with the administration on regulatory changes, working with associations on some of these issues. This is critically important. Too many people have died, even during the course of this hearing today. I know you all care deeply about this. We share that caring, and we want to see this change. So thank you very much.

So I want to thank all the witnesses and members again for being here, and remind members that they have 10 business days to submit their questions to record. And we ask that you respond promptly to that.

And with this, this committee hearing is adjourned.

[Whereupon, at 12:05 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]



U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

May 19, 2015

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing on "What are the State Governments Doing to Combat the Opioid Abuse Epidemic?"

On Thursday, May 21, 2015, at 10:15 a.m. in 2322 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled, "What are the State Governments Doing to Combat the Opioid Abuse Epidemic?" The purpose of this hearing is to confer with a selection of state health officials regarding their ongoing efforts to combat the opioid abuse epidemic and explore how State and Federal policies can most effectively incentivize the development and broadened use of evidence-based practices and treatments in their communities.

I. WITNESSES

- Jerome Adams, M.D., M.P.H., Health Commissioner, Indiana State Department of Health
- Monica Bharel, M.D., M.P.H. Commissioner, Massachusetts Department of Public Health
- Mark Stringer, M.A., L.P.C., N.C.C., Director, Division of Behavioral Health, Missouri Department of Mental Health
- Larry Wolk, M.D., MSPH, Executive Director and Chief Medical Officer, Colorado Department of Public Health and Environment

II. BACKGROUND

This hearing follows up on the May 1, 2015, Subcommittee hearing on "What is the Federal Government Doing to Combat the Opioid Abuse Epidemic." At that hearing, the Subcommittee questioned the relevant Federal agencies regarding their ongoing efforts to combat the opioid abuse epidemic and explored how Federal policies can most effectively incentivize the development and broadened use of evidence-based practices and treatments. Subcommittee members heard testimony from senior officials representing the full range of multi-disciplinary activities comprising the Federal response to this epidemic.

At the April 23, 2015, Subcommittee hearing on "Combatting the Opioid Abuse Epidemic: Professional and Academic Perspectives," the Subcommittee heard from a panel of

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professional and academic witnesses that provided insights and findings, drawn from clinical practice and research—as well as constructive policy recommendations—from some of the nation’s foremost experts on opioid abuse. The Subcommittee also received testimony on treatment options currently available, as well as new and emerging evidence-based practices supporting individuals living with opioid abuse and addiction.

At the March 26, 2015, Subcommittee hearing on “Examining the Growing Problems of Prescription Drug and Heroin Abuse: State and Local Perspectives,” the Subcommittee heard from a panel of witnesses offering a “boots on the ground” perspective addressing the opioid abuse epidemic at the state and local levels, aiming to inform and improve the effectiveness of the Federal public health response to this nationwide problem.

Last year, on April 29, 2014, the Subcommittee held a hearing on “Examining the Growing Problems of Prescription Drug and Heroin Abuse.” At that hearing, the Subcommittee heard from a Federal panel of witnesses from the Office of National Drug Control Policy (ONDCP), the National Center for Injury Prevention and Control (CDC), the Office of Diversion Control (DEA), the National Institute on Drug Abuse (NIDA), and the Center for Substance Abuse Treatment at the Substance Abuse and Mental Health Services Administration (SAMHSA).

Origins and breadth of the problem

The trends related to prescription drug misuse and overdoses involving opioids are alarming. Drug overdose death rates have increased five-fold since 1980.¹ From 1999 to 2013, the rate for drug poisoning deaths involving opioid analgesics, or pain medications, nearly quadrupled.² By 2009, drug overdose deaths outnumbered deaths due to motor vehicle crashes for the first time. Abuse of opioid pain relievers claimed over 16,600 lives in 2010, resulting in over 400,000 emergency department visits in 2011, and cost health insurers an estimated \$72 billion annually in medical costs.³ Deaths related to heroin, an illicit opioid, also have increased sharply since 2010, including a 39 percent increase between 2012 and 2013.⁴ Mortality data show that there was a 6 percent increase in overall drug overdose deaths between 2012 and 2013 and approximately 37 percent of those deaths involved prescription opioids.⁵ The mortality rate from heroin overdose increased each year from 2010 to 2013.⁶ Deaths due to heroin overdoses increased by 39 percent from 2012 to 2013 alone and constituted as much as 19 percent of all

¹ M. Warner, et al, Drug poisoning deaths in the United States, 1980-2008, CDC National Center for Health Statistics data brief, no. 81 (CDC National Center for Health Statistics 2011).

² Centers for Disease Control and Prevention. QuickStats: Rates of Deaths from Drug Poisoning and Drug Poisoning Involving Opioid Analgesics – United States, 1999-2013. MMWR Weekly. Retrieved from: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6401a10.htm>.

³ CDC FY 2015 Budget Justification at 9.

⁴ Hedegaard H, Chen LH, Warner M.; National Center for Health Statistics (NCHS). Drug-poisoning deaths involving heroin: States, 2000-2013. NCHS data brief, no190. Retrieved from: <http://www.cdc.gov/nchs/data/databriefs/db190.pdf>.

⁵ Centers for Disease Control and Prevention. Wide Ranging Online Data for Epidemiologic Research (CDC WONDER). Available at: <http://wonder.cdc.gov/>.

⁶ *Id.*

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drug overdose deaths in 2013.⁷ A recent study of behavioral changes affecting U.S. population health since 1960 found that accidental drug overdoses, particularly those involving prescription opioid medications reduced life expectancy 0.26 years, even though overall life expectancy increased by 6.9 years during this period.⁸ Heroin and prescription opioid abuse also can result in other health consequences, such as neonatal abstinence syndrome, increased risk of transmission of HIV and Hepatitis C, and bone fractures in older adults due to falls.⁹ On average, heroin addicts lose about 18 years of life expectancy, and the mortality rate for injection users is roughly 2 percent per year.¹⁰

Although heroin use in the general population is low, the number of people beginning to use heroin has been steadily rising since 2007. According to NIDA, this may be due in part to a shift from the abuse of prescription pain relievers to heroin as a more potent, readily available, and cheaper alternative to prescription opioids.¹¹ In fact, nearly half of young people who inject heroin surveyed in three recent studies reported abusing prescription opioids before starting to use heroin.¹² Among those who began abusing opioids in the 2000s, 75 percent of individuals indicated they initiated their abuse with prescription opioids.¹³ Although the available literature indicates that abuse of prescription opioids is a risk factor for future heroin use, only a small fraction, roughly 4 percent of opioid abusers, transition to heroin use within five years of initiating opioid abuse.¹⁴

⁷ *Id.*

⁸ Susan T. Stewart and David M. Cutler, "The Contribution of Behavior Change and Public Health to Improved U.S. Population Health," National Bureau of Economic Research, Working Paper 20631 (October 2014) <http://www.nber.org/papers/w20631>

⁹ Creanga AA, SabelJC, Ko JY, Wasserman CR, Shapiro-Medozza CK, Taylor P, Barfield W, et al. Maternal drug use and its effect on neonates: a population-based study in Washington State. *Obstet Gynecol.* 2012; 119(5):924-933.; Zibell JE, Hart-Mallory R, Barry J, Fan L, Flanagan C. Risk Factors for HCV infection among young adults in rural New York who inject prescription opioid analgesics. *Am J Public Health.* 2014 Nov;104(11):2226-32. Doi: 10.2105/AJPH.2014.302142. Epub 2014 Sep 11.; Mateu-Gelabert P1, Guarino H2, Jessel L2, Teper A2. Injection and sexual HIV/HCV risk behaviors associated with nonmedical use of prescription opioids among young adults in New York City. *J Subst Abuse Treat.* 2015 Jan;48(1):13-20. Doi: 10.1015/j.jsat.2014.07.002. Epub 2014 Jul 11.; Rolita L, Spegman A, Tang X, Cronstein BN. Greater number of narcotic analgesic prescriptions for osteoarthritis is associated with falls and fractures in elderly adults. *J Am Geriatr Soc.* 2013;61(3):335-340.; Miller M, Sturmer T, Azrael D, Levin R, Solomon DH. Opioid analgesics and the risk of fractures in older adults with arthritis. *J Am Geriatr Soc.* 2011;59(3):430-438.

¹⁰ B. Smyth, et al., Years of potential life lost among heroin addicts 33 years after treatment, 44 *Preventive Medicine* 369 (2007).

¹¹ Cicero TJ, Ellis MS, Surratt HL, Kurtz SP. The changing face of heroin use in the United States: a retrospective analysis of the past 50 years. *JAMA Psychiatry* 2014;71:821-6.

¹² NIDA Report Series, "Heroin," NIH publication number 15-0165, 3 (November 2014, rev.). Some data have higher estimates. Data from SAMHSA shows that 81 percent of people who started using heroin from 2008 to 2010 had previously abused prescription drugs. Amy Pavuk, *Rx for Danger: Oxycodone crackdown drives addicts to other drugs*, Orlando Sentinel, July 28, 2012, http://articles.orlandosentinel.com/2012-07-28/health/os-oxycodone-drug-shift-dilaudid-20120728_1_oxycodone-prescription-drugs-dilaudid-pills.

¹³ Cicero TJ, Ellis MS, Surratt HL, Kurtz SP. The changing face of heroin use in the United States: a retrospective analysis of the past 50 years. *JAMA Psychiatry* 2014;71:821-6.

¹⁴ Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States. August 2013. Retrieved from: <http://www.samhsa.gov/data/2k13/DataReview/DR006/nonmedical-pain-reliever-use-2013.pdf>.

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Overprescribing of painkillers has been a significant driver of our present opioid and heroin epidemic. Since 1997, the number of Americans seeking treatment for addiction to painkillers has increased by 900 percent.¹⁵ The prevalence of opioid addiction started rising as long-term prescribing of opioids for chronic pain, a practice encouraged by opioid manufacturers, became more common.¹⁶ As a result, many states started to make extensive use of their prescription drug monitoring programs as a tool to monitor prescription sales of controlled substances.¹⁷

Paths to recovery

There is a wide consensus among experts that medical best practice demands a full menu of behavioral, pharmacological, and psychosocial treatments be made available to individuals with opioid addiction. This is especially critical, as the Center for Addiction and Substance Abuse at Columbia University, in a five-year study, found that only 1 in 10 people with alcohol or drug addiction other than nicotine receive any form of treatment, and of those, only 10 percent receive evidence-based treatment.¹⁸ Nearly 80 percent of opioid-addicted persons do not receive treatment for their addiction because of limited treatment capacity, financial obstacles, social stigma, and other barriers to care.¹⁹ Many counties lack substance abuse treatment facilities that accept Medicaid.²⁰ A 2007 SAMHSA analysis of workforce issues noted that more than 50 percent of U.S. counties in rural areas lack practicing psychiatrists, psychologists, or social workers.²¹

In particular, the data suggests that medication-assisted treatment (MAT) is effective in treating opioid addiction and reducing overdose deaths. As drug abuse changes the way the brain works, resulting in compulsive behavior focused on drug seeking and use, medications can be helpful in treating the symptoms of withdrawal during detoxification – which often prompt relapse – as well as become part of an ongoing treatment plan.²² Scientific research has established that MAT increases patient retention and decreases drug use, infectious disease transmission, and criminal activity.²³

At present, the Food and Drug Administration (FDA) has approved only three medications for the treatment of opioid dependence. Methadone, a Schedule II controlled

¹⁵ Science Daily, “Opioid and heroin crisis triggered by doctors overprescribing painkillers,” Brandeis University, February 4, 2015. <http://www.sciencedaily.com/releases/2015/02/150204125945.htm>.

¹⁶ *Id.*

¹⁷ Ileana Arias, et al., Prescription Drug Overdose: State Health Agencies Respond, Association of State and Territorial Health Officials, 2008, http://www.astho.org/Programs/Prevention/Injury-and-Violence-Prevention/_Materials/Prescription-Drug-Overdose/.

¹⁸ <http://www.casacolumbia.org/addiction-research/reports/addiction-medicine>.

¹⁹ C.L. Arfken, et al, Expanding treatment capacity for opioid dependence with buprenorphine: National surveys of physicians, 39 *Journal of Substance Abuse Treatment* 96 (2010).

²⁰ SAMHSA Budget Justification FY2016 at 5.

²¹ *Id.*

²² NIDA Topics in Brief. Medication-Assisted Treatment for Opioid Addiction. April 2012.

https://www.drugabuse.gov/sites/default/files/tib_mat_opioid.pdf.

²³ *Id.*

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substance used as maintenance treatment for documented opioid addiction for over 40 years, may only be dispensed by clinics, certified by SAMHSA, and subject to both Federal and state regulation.²⁴ Buprenorphine, a Schedule III controlled substance – which may be offered, under certain circumstances, by methadone treatment clinics – is a more recently introduced synthetic opioid treatment medication approved as an outpatient physician-prescribed treatment for opioid addiction.²⁵ Naltrexone is a physician-prescribed clinician-administered injectable medication for the prevention of relapse of opioid dependence after detoxification, commonly known by the brand name Vivitrol.²⁶

Notably, the Department of Health and Human Services (HHS) includes expansion of MAT to reduce opioid use disorders and overdose among Secretary Burwell's top three priority areas to combat opioid abuse, announced on March 26, 2015.²⁷ While MAT is a critical component of opioid addiction treatment, concerns have been raised that substance use disorders, as chronic conditions like diabetes or heart disease, demand a treatment model where long-term, sustained recovery – including extended engagement following formal periods of treatment – takes the place of what is too often the episodic, largely unsupervised prescription of medication followed by relapse to old habits.²⁸

With the aim of recovery in mind, long-term monitoring, both during and after episodes of MAT, is necessary to screen for the concurrent use of alcohol, illicit drugs, or the non-medical use of other prescription opioids that readily interfere with evidence-based treatments.²⁹ Dr. Robert DuPont, the first Director of NIDA, President of the Institute for Behavioral Health, and a witness at the April 23rd hearing has argued that widespread acceptance of “harm reduction” as the ultimate goal of MAT, has often undermined efforts to frame recovery, as opposed to relapse – or simply maintenance – as the expected outcome of addiction treatment.³⁰

At the March 26, 2015 hearing, the Subcommittee received testimony on the need for greater oversight of MAT and the need for standards on how these programs should be run. Professor Sarah Melton of East Tennessee University testified that “in Tennessee and southwest Virginia some buprenorphine programs have become pill mills where the physicians charge them high prices, they come in and get their medication, and they leave.” She also confirmed the “devastating” trend of medication-assisted programs providing methadone or buprenorphine in

²⁴ The American Society of Addiction Medicine. Advancing Access to Addiction Medications: Implications for Opioid Addiction Treatment. http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final.

²⁵ *Id.*

²⁶ *Id.*

²⁷ HHS Office of Assistant Secretary for Planning and Evaluation. Issue Brief, Opioid Abuse in the U.S. and HHS Actions to Address Opioid-Drug Related Overdoses and Deaths. March 26, 2015. http://aspe.hhs.gov/sp/reports/2015/OpioidInitiative/ib_OpioidInitiative.pdf.

²⁸ McGovern, John P. Institute for Behavior and Health, Inc. The New Paradigm for Recovery: Making Recovery – and not Relapse – the Expected Outcome of Addiction Treatment. March 2014. <http://ibhinc.org/pdfs/NewParadigmforRecoveryReportMarch2014.pdf>.

²⁹ *Id.*

³⁰ L. Merlo, M. Campbell, G. Skipper, C. Shea, and R. DuPont, “Recovery from Opioid Dependence: Lessons from the Treatment of Opioid-Dependent Physicians,” (Study supported by the Robert Wood Johnson Foundation, submitted for publication and currently under review) (2015).

cash transactions and being incentivized to become pill mills. She also testified that there is a “dearth of access to good treatment, and by ‘good treatment,’ I mean patients being seen frequently, getting urine drug screens at nearly every visit, if not every visit, requiring 12-step programs, group counseling, and not co-prescribing with other drugs of addiction such as benzodiazepines.”

Other issues

Use of methadone for pain. In addition to the overprescribing of prescription painkillers, public health risks have worsened by the increased prescribing of methadone for pain (as opposed to use in addiction treatment). The use of methadone as a treatment for pain has expanded in recent years. Although methadone can treat pain effectively, it carries outsized risks due to its unique pharmacologic properties, such as a long half-life, short analgesic window relative to respiratory-depressant effect, and potential for drug-drug interactions.³¹ While methadone from methadone clinics is in liquid form, which addicts drink on-site, methadone prescribed for pain is in pill form, making it easier to divert and misuse. In contrast to the regulation of methadone clinics, no special licensing or monitoring is required to prescribe methadone in pill form. Methadone accounts for two percent of opioid prescriptions for pain control, but is responsible for one-third of overdose deaths, according to a 2012 CDC Vital Signs report.³² Most state Medicaid programs encourage the prescribing of methadone as a first line treatment for pain, often due to its low cost, even though safer therapies are available.³³ Moreover, the FDA, the CDC, the American Academy of Pain Medicine, and the American Society of Interventional Pain Physicians have recommended that methadone not be used as a first-line therapy for chronic pain.³⁴

Prescription Drug Monitoring Programs. Prescription drug monitoring programs (PDMPs) are state-run electronic databases of prescriptions for controlled substances. PDMPs can provide a prescriber or pharmacist with information regarding a patient’s prescription history, allowing prescribers to identify patients who potentially are abusing medications. Currently, 49 states, the District of Columbia, and Guam have legislation authorizing the creation and operation of a PDMP, and all but the D.C. program are operational.³⁵ While there is evidence indicating the potential of PDMPs to identify high-risk patients and impact prescribing behaviors, the effectiveness of PDMPs is constrained by the lack of timely data in some states and limited interoperability with other PDMPs. Witnesses at the March 26, 2015, Subcommittee hearing also testified about their concerns over methadone clinics not being required to report methadone dispensing to PDMPs. One witness said it was “a very serious situation” because if these patients do not disclose their methadone treatment to their primary care providers and the

³¹ The Pew Charitable Trusts, “Prescription Drug Abuse Epidemic: Spotlight on Methadone,” August 2014.

³² <http://www.cdc.gov/vitalsigns/MethadoneOverdoses/>.

³³ The Pew Charitable Trusts’ Prescription Drug Abuse Project, Undated handout (provided to committee staff, March 20, 2015).

³⁴ American Society of Interventional Pain Physicians, Guidelines for Responsible Opioid Prescribing in Chronic Non-Cancer Pain: Part 2 – Guidance, 15 Pain Physician Journal S67 (2012), <http://www.painphysicianjournal.com/2012/july/2012;%2015:S67-116.pdf>.

³⁵ PDMP Training and Technical Assistance center, PDMP Frequently Asked Questions. <http://www.pdmpassist.org/content/prescription-drug-monitoring-frequently-asked-questions-faq>.

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providers do not know about it from accessing the PDMP, other opioids or benzodiazepines could be prescribed leading to death.³⁶ Another concern related to neonatal doctors not knowing about methadone treatment for pregnant women who are drug-addicted, which poses potential problems for the mother and the life of the fetus if the methadone is being increased while the mother and baby are receiving opioid medication to treat the addiction.³⁷

State Policies

While opioid abuse is a nationwide epidemic,³⁸ state activities will vary depending on circumstances in the particular state. For example, in late 2013, there were sudden and large increases in the number of deaths involving fentanyl in a number of states throughout the country, with the increase seen particularly in East Coast states.³⁹ Fentanyl is a narcotic pain reliever used to manage moderate to severe chronic pain.⁴⁰ The majority of the fentanyl-related deaths did not result from overdoses of pharmaceutical fentanyl, but instead involved an illicit, powdered form of fentanyl that was mixed with, or substituted for, heroin or other illicit substances.⁴¹ In response to this problem, for example, the state of Maryland took the following actions to reduce fentanyl-related overdoses throughout the state: sharing data with law enforcement; expanding access to naloxone, and launching a public awareness campaign.⁴²

The CDC has identified interstate variation in rates of prescribing of opioid pain relievers and other prescription drugs prone to abuse. For example, rates of opioid pain relievers prescribed were higher in the South, and Alabama, Tennessee, and West Virginia were the three highest-prescribing states, at two or more standard deviations above the mean.⁴³ The CDC notes that higher opioid pain reliever prescribing rates in the South are similar to the findings of higher

³⁶ Testimony of Fred Wells Brason II, Executive Director, Project Lazarus, Moravian Falls, North Carolina. (Unofficial hearing transcript, 40).

³⁷ See testimony of Stefan R. Maxwell, MD, Chair, West Virginia Perinatal Partnership, MEDNAX Medical Group, Director NICU, Charleston Area Medical Center, Charleston, West Virginia. (Unofficial hearing transcript, 90).

³⁸ Drug poisoning is the leading cause of death from injury in 30 states, according to CDC in 2011, with opioid analgesics involved in more than 40 percent of drug poisoning deaths in 2008. According to a 2014 NASADAD survey, roughly 40 States consistently say that prescription drug abuse is either “most” or “very” important (slide 17), with 34 States reporting that they have an active prescription drug task force, and increase from 29 reported in 2012. (slide 19). 35 States reported that their strategic plan explicitly addresses prescription drug abuse, and 12 States of these states reported that their plan explicitly addresses heroin abuse. 37 States said that heroin abuse is either “most” or “very important” (slide 36), with 15 States reporting that they have an active task force for heroin abuse (slide 40). National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD), “State Substance Abuse Agencies, Prescription Drugs, and Heroin Abuse: Results from a NASADAD Member Inquiry” (2014 update).

³⁹ Maryland Department of Health and Mental Hygiene, “Deaths Related to Fentanyl-Laced Heroin and Other Illicit Drugs,” July 2014.

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Id.*

⁴³ L. Paulozzi, et al, 63 CDC Morbidity and Mortality Weekly Report (MMWR), “Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines – United States, 2012,” 563 (July 4, 2014). <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a2.htm>

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prescribing rates for other drugs in the South, including antibiotics, stimulants in children, and medications that are high-risk for the elderly.⁴⁴

Despite differences in circumstances, prevention plans and strategies, the states have identified certain overarching challenges.⁴⁵ The challenges have included: stigma; data needs; need for PDMP improvement; overdose prevention; increasing access to MAT; and evidence and research on effectiveness of strategies.

Stigma. The stigma associated with seeking treatment was reported by states in 2014 as one of the top remaining challenges.⁴⁶ Stigma and bias against MAT exists even after research has proved its value for treating opioid dependence. The stigma underlies a score of issues that states confront in developing their strategies. Such issues include: state moratoriums on establishing new opioid treatment programs (OTPs) despite large, unmet treatment needs for the opioid-dependent population; unwillingness of the criminal justice system to set up MAT in jails and prisons; and the requirement of some drug court judges that people must leave methadone treatment or go off of suboxone to participate and of some family court judges that clients must stop methadone treatment before receiving custody of their children.⁴⁷ State initiatives to reduce the stigma of treatment for opioid use disorders are: increasing access to a full range of evidence-based therapies; facilitating access to recovery support services; and expanding access to effective therapies in the criminal justice system.⁴⁸

Data Needs. Concerns have been raised about real time data/measurement, data quality, and data utilization. As noted by the National Governors Association, to develop an effective response to prescription drug abuse, states need accurate and timely information about the incidence and scope of the problem. It can be 6 to 12 months before the medical examiner's information become available, long after an OTP has reported the death to the state.⁴⁹ States have reported that CDC data is slow to be released and cannot capture real-time changes in drug use that occur.⁵⁰ For example, a CDC expert told bipartisan committee staff that CDC would not have 2014 overdose death data until the end of 2015. Moreover, CDC noted they mostly rely on death certificates which sometimes only say "drug overdose" and do not always list the specific drug.

Serious problems exist concerning state data on the cause of death regarding overdose deaths. State death certificates often do not specify the type of drug related to overdose deaths.⁵¹

⁴⁴ *Id.*

⁴⁵ Successful Strategies in Addressing Opioid Overdose Deaths, White Paper developed for the Center for Substance Abuse Treatment (March 2010).

⁴⁶ NASADAD 2014 update, note 38 at slide 34.

⁴⁷ Successful strategies, note 45 at 8.

⁴⁸ NASADAD 2014 update, note 37 slide 48.

⁴⁹ Successful strategies, note 45 at 11.

⁵⁰ National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD), "State Substance Abuse Agencies, Prescription Drugs, and Heroin Abuse: Results from a NASADAD Member Inquiry" slide 14 (2014 update).

⁵¹ A CDC expert in a briefing with committee staff estimated that 25 percent of death certificates listing overdose as a cause did not specify the drug.

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Lethality issues can be hard to separate when multiple drugs are involved, especially with benzodiazepines.⁵² Defining the cause of death in MAT patients is inherently complex, since, regardless of the cause of death, these patients may have a high level of methadone in their blood. Medical examiners often do not know the person is in methadone treatment.⁵³ Many states do not conduct the full medical review for determining the cause of death.⁵⁴ For example, Colorado noted that from 2004 to 2013, 2.4 percent of Colorado death certificates had an unknown cause of death.⁵⁵

Even with the data limitations, states use available data sets to identify areas on which to concentrate their efforts and maximize limited resources. For example, in Massachusetts, the PDMP Center of Excellence at Brandeis University developed geospatial mapping of PDMP data, combined with data on prescription drug overdose emergency department visits and prescription drug overdose deaths, to identify concentrations in three suburban areas of the state.

Need for PDMP improvement. States have noted that it is critical to an effective statewide strategy for combatting opioid abuse to improve the effectiveness and use of PDMPs. While 49 states and the District of Columbia have legislation authorizing the creation and operation of a PDMP, they vary in their degree of use and overall effectiveness across depending on who is registered to use them, whether data is current or real-time, whether there are limitations on authorized users, and whether processes for accessing the databases integrate easily into clinical workflows.⁵⁶ Another major component of these PDMPs is their interoperability with other states, particularly neighboring states. The level of interoperability with other states varies greatly and currently lacks uniformity. This is a weakness among the programs because the lack of data sharing allows patients to doctor shop across state lines. Thus, a White House report issued in 2011 declared that “[a] major effort must be undertaken to improve the functioning of state PDMPs, especially regarding real-time data access by clinicians, and to increase the inter-state operability and communication.”⁵⁷ In addition, in many states, privacy concerns may limit the extent to which PDMP data can be used for law enforcement, public health, and research purposes.

States also vary with respect to their continuing medical education (CME) requirements for physicians. Some state licensing boards have established more robust CME requirements to improve prescribing practices among doctors in their state. California is an example of a state that has implemented stricter CME for prescribing while other states may have very little required CME of their doctors.

⁵² Successful strategies, note 45 at 10.

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ Colorado Department of Public Health & Environment, Special Emphasis report: Drug Overdose Deaths, 1999-2013, October 2014.

⁵⁶ National Governors Association (NGA), “Six Strategies for Reducing Prescription Drug Abuse,” Issue Brief (September 2012).

⁵⁷ Executive Office of the President of the United States, “Epidemic: Responding to America’s Prescription Drug Abuse Crisis,” 6 (2011).

CDC experts have found that a few states have been able to change prescribing patterns by increasing prescriber use of their PDMPs.⁵⁸ New York and Tennessee, for example, mandated prescriber use of the state PDMP in 2012.⁵⁹ They subsequently used their PDMPs to document declines of 75 percent and 36 percent, respectively, in their inappropriate use of multiple prescribers by patients.⁶⁰ Other actions taken by states affecting prescribers that CDC experts believe are promising interventions are: developing or adopting existing guidelines for prescribing opioid pain relievers that can establish local standards of care that might bring prescribing rates more in line with current best practices; state Medicaid programs managing pharmacy benefits to promote cautious, consistent use of opioids; and enacting law to address the most egregious prescribing excesses.⁶¹

It should be noted that methadone clinics are not covered by PDMPs; thus, physicians treating patients for pain cannot find out if the patient is on methadone, potentially dangerous if an opioid medication is prescribed.

Overdose prevention. State efforts to combat heroin abuse have varied from state to state. For example, several states have passed laws that generally provide immunity for victims and witnesses who act in good faith and seek medical assistance for an overdose; these laws are commonly referred to as “Good Samaritan Laws.”⁶² States have also taken different approaches to expanding access to naloxone, with some states permitting third party prescribing by family and friends of users at high-risk of overdose, and others providing a standing order for community organizations who distribute naloxone to those who meet certain criteria.⁶³ Liability protection for prescribers who administer naloxone, as well as the nature of naloxone distribution programs may differ from one state to the other.⁶⁴ In addition, many states have established task forces, or have initiated new law enforcement efforts to combat heroin and prescription opioids.⁶⁵

States efforts in this area have also targeted the proper disposal of prescription drugs. The majority of people who abuse or misuse prescription drugs get them from friends and family – many of those drugs are leftover medicines. These efforts have included public education on proper disposal and take-back activities, such as designating times and places where the public can safely dispose of unused prescription medication.⁶⁶

⁵⁸ L. Paulozzi, et al, 63 CDC Morbidity and Mortality Weekly Report (MMWR), “Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines – United States, 2012,” 563 (July 4, 2014). <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a2.htm>

⁵⁹ *Id.*

⁶⁰ *Id.*, citing Prescription Drug Monitoring Program Center of Excellence at Brandeis University. Mandating PDMP participation by medical providers: current status and experience in selected states.

⁶¹ *Id.* For example, Florida enacted pain clinic legislation in 2010 and prohibited dispensing by prescribers in 2011.

⁶² NGA, note 56.

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.*

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Increasing access to MAT. 49 states and D.C. have state opioid treatment programs (methadone maintenance). All 50 states and D.C. have physicians with waivers to prescribe buprenorphine. All three FDA-approved opioid treatment medications (methadone, buprenorphine, and naltrexone) are covered under the Medicaid Drug Rebate Program. The associated co-pays and authorization requirements vary from state to state. Twenty-six states reported last year that they have expanded or made plans to expand MAT during the past two years.⁶⁷ Although the opioid addiction field recognizes addiction as a chronic, relapsing disease, some substance abuse counselors and administrators have been reluctant to embrace new technologies for its treatment.⁶⁸ At the same time, most physicians and other health care professionals receive little or no training in the treatment of addiction.⁶⁹ As a result, adoption of MAT has been slow in some areas.⁷⁰

Evidence and research on effectiveness of strategies. Very little evidence-based research exists on the most cost-effective and efficacious strategies for states to use in reducing opioid overdoses. States are seeking guidance.⁷¹ Massachusetts, when developing its comprehensive state overdose prevention plan, turned to international sources to identify successful strategies.⁷² States have also been frustrated at not knowing the outcomes of their actions.⁷³ Potential outcomes include: (1) Did physicians change their opioid prescribing practices after receiving webinars and other training; (2) Why do so many physicians train to become registered providers of buprenorphine for addiction, and then not treat any patients; and (3) When informed by letter that a patient has shown up on the PDMP with multiple opioid prescriptions, does the prescribing doctor take action, and, if so, what action?⁷⁴ State representatives particularly requested studies that would look at overdose outcomes for opioid-dependent patients who receive drug-free treatment compared to those receiving MAT.⁷⁵

III. ISSUES

The following issues may be examined at the hearing:

- What state programs have been effective in combatting opioid abuse and why?
- What state programs have not been effective in combatting opioid abuse and why?
- Are state health programs combatting opioid abuse adequately coordinated with federal and other state government agencies?

⁶⁷ NASADAD 2014 update, note 38, slide 45.

⁶⁸ Statement of Mark G. Stringer, Director of Division of Behavioral Health, Missouri Department of Mental Health, available at <http://dmh.mo.gov/ada/provider/medicationassistedtreatment.html>.

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ Successful strategies, note 43, at 9.

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Id.* at 10.

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- Are state agencies collecting and evaluating the best data to determine the effectiveness of medication-assisted treatment programs?
- How can state and federal policies better support efforts to develop new and promising treatments for opioid addiction?
- What are the best practices for treating opioid addiction, and how can state and federal policies better incentivize these practices?

In addition, the following policy ideas or areas were mentioned at the April 23, 2015 Subcommittee hearing and could be raised for further exploration with the witnesses:

1. Changes to 42 CFR privacy regulations may be needed to update standards for integrating physical and behavioral medicine.
2. Addiction-treatment physicians should have all available tools “in their quiver” of treatment options, including the array of FDA-approved medications to treat opioid dependency.
3. Patients and sponsoring family members must be given more information regarding the probability of success for various treatment approaches. This will allow them to seek informed choices on which treatment approaches to consider.
4. Improve communication between pharmacies and physicians.
5. Define recovery – not in terms of today, but longer term – 5 years – so we see addiction as a chronic disease and see treatments as meeting chronic care.
6. Ensure physicians treating patients with pain have sufficient information and resources.
7. Make sure insurance parity is being enforced and that insurance companies are not arbitrarily discontinuing coverage for treatment at a certain time.
8. Increase the number of providers who are trained and experienced for mental illness, serious mental illness, and addiction.
9. Increase the number of in-patient beds for detoxification and in-depth treatment that meets the needs of patients.
10. Increase the number of physicians that can prescribe MAT in regions of the country where opioid abuse/dependency is high and where medical services are sparse.

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11. MAT alone or psychotherapy alone are rarely sufficient; make sure patient needs are met with all available treatment.
12. Ensuring drug courts allow treatment with MAT.
13. Combining the funding for mental health and substance abuse for dual diagnosis
14. Stop state Medicaid plan reimbursement policies from incentivizing the prescribing of methadone as first-line therapy for pain.
15. Making naloxone (narcan) available over-the-counter.

STAFF CONTACTS

If you have any questions regarding this hearing, please contact Alan Slobodin, Sam Spector, or Brittany Havens of the Committee staff at (202) 225-2927.

APPENDIX – SAMPLE OF STATE RESOURCES

California: <http://www.scpr.org/news/2015/03/20/50478/county-and-private-hospital-er-s-join-forces-to-co/>

Colorado: Colorado Plan to Reduce Prescription Drug Abuse,

<http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheadname1=Content-Disposition&blobheadname2=Content-Type&blobheadvalue1=inline;+filename%3D%22Colorado+Plan+to+Reduce+Prescription+Drug+Abuse.pdf%22&blobheadvalue2=application/pdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251904827503&ssbinary=true>

Florida: [http://myfloridalegal.com/webfiles.nsf/WF/RMAS-94LJPF/\\$file/Statewide_Task_Force_on_Prescription_Drug_Abuse_and_Newborns_Final_Report.pdf](http://myfloridalegal.com/webfiles.nsf/WF/RMAS-94LJPF/$file/Statewide_Task_Force_on_Prescription_Drug_Abuse_and_Newborns_Final_Report.pdf)

Illinois: <https://www.isms.org/opioidplan/>

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Indiana: Bitter Pill, Indiana Prescription Drug Prevention Task Force, 2012:
<http://www.in.gov/bitterpill/about.html>

Kentucky: <http://atforum.com/2011/11/kentucky-heads-up-interstate-prescription-drug-task-force/> http://www.florence-ky.gov/sites/default/files/florence/2013_10_Boone_Co_Heroin_Task_Force_Fact_sheet.pdf

Maryland: <http://governor.maryland.gov/ltgovernor/home/heroin-and-opioid-emergency-task-force/>

- Montgomery County: <http://www.montcopa.org/overdosereport>

Massachusetts: <http://www.mass.gov/eohhs/docs/dph/substance-abuse/opioid/report-of-the-opioid-task-force-6-10-14.pdf>

Minnesota: <http://www.mnmed.org/About-the-MMA/MMA-Committees-amp-Task-Forces/Prescription-Opioid-Task-Force>

Missouri: Not Even Once (Adolescent Anti-Heroin Campaign), <http://not-even-once.com/>
Strategic Plan for Prevention,
<http://dmh.mo.gov/docs/ada/Progs/Prevention/StrategicPlanforPrevention2010.pdf>

New Jersey: <http://www.alcoholismdrugabuseweekly.com/m-article-detail/nj-task-force-urges-focus-on-opioid-addiction-in-young-people.aspx>

New York: <http://www.nysenate.gov/joint-senate-task-force-heroin-and-opioid-addiction-legislative-report>

Ohio: <http://www.healthy.ohio.gov/vipp/drug/~media/1F1DD52D1CA24ADBB98551AD588114EC.ashx>

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Oklahoma: Take As Prescribed project website, TakeAsPrescribed.org

Oregon: http://www.researchgate.net/profile/Dennis_Mccarty/publication/264426160_Oregons_Strategy_to_Confront_Prescription_Opioid_Misuse_A_Case_Study/links/53e8f14c0cf28f342f3e540e.pdf

Pennsylvania: https://www.portal.state.pa.us/portal/server.pt/document/1437808/governor_corbett_-_heroin_and_other_opioids_workgroup_pdf
<http://www.pamedsoc.org/MainMenuCategories/Laws-Politics/News-from-Harrisburg/Opioid-prescription-guidelines.html>

Texas: Behavioral Health Strategic Plan, <http://www.dshs.state.tx.us/mhsa/sap-strategic-plan/>

Vermont: Vermont Department of Health Strategic Plan,
<http://healthvermont.gov/adap/documents/ADAPStrategicPlan2012-2017.pdf>

Vermont Prescription Drug Abuse Workshop Final Report Workgroup Recommendations,
http://healthvermont.gov/adap/documents/Rx_workgroup_final_recommendations_122011.pdf

Virginia: <https://governor.virginia.gov/newsroom/newsarticle?articleId=6596>

Washington: <http://washingtonacep.org/Postings/edopiodabuseguidelinesfinal.pdf>

West Virginia: Comprehensive Substance Abuse Strategic Action Plan,
<http://www.dhhr.wv.gov/bhf/Sections/programs/ProgramsPartnerships/AlcoholismandDrugAbuse/Documents/strategicactionplan-info.pdf>

May 21, 2015

The Honorable Tim Murphy
Chairman
Subcommittee on Oversight and Investigations
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
Subcommittee on Oversight and Investigations
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Murphy and Ranking Member DeGette:

I am contacting you to thank you for conducting the series of hearings on the epidemic of prescription drug and heroin addiction the country is facing. I know you have heard in prior hearings from public health professionals, local community leaders and, today, from the states about steps being taken to stem the tide of the CDC-declared and much under reported epidemic exploding in our country. Through this letter, I am adding my voice as a citizen and impacted family member to these deliberations. It is my sincere hope that this letter will become part of the subcommittee's report on this serious public health crisis.

My name is Don Flattery and I live in the Mt. Vernon area of Fairfax County, Virginia. I am a recently retired federal manager, I am a member of the Virginia Governor's Task Force on Prescription Drug and Heroin Abuse, and I am an active participant in the development of a strategic plan for community action on opioid and heroin use in Fairfax County. But I am not writing today in any of those roles. I am addressing the subcommittee in this letter solely as a grieving parent, someone who has lost his 26 year old and only son to an opioid overdose less than nine months ago.

It is critically important to me and to my wife that we do our part to ensure that discussions about this scourge are personalized. You have already heard the appalling statistics about the explosion of opioid prescriptions, addiction rates and overdose deaths. I am intimately familiar with them and will not repeat them here. But those discussions are often far too clinical. As you, federal officials, state officials and public health practitioners deliberate and consider solutions, it is far too easy to become detached. As you proceed, I implore you to recall the personal impacts – we are not just speaking about shocking, obtuse statistics – we are speaking about my son, your daughter and our neighbors. They are real people, with real lives, suffering from a disease and their losses are the face of the epidemic we must stop.

PERSONAL IMPACT

Allow me to share my son's story. On the Friday of last Labor Day weekend, my family suffered the loss of our son Kevin to an opioid drug overdose. He had been battling and was being treated for issues related to panic attacks, stress, depression and starting in 2013, after self medicating with the opioid prescription drug Oxycontin, was being treated for dependence and then addiction. He had returned home to Northern Virginia in the fall of 2013 to his family, seeking treatment and our support.

He was working hard, with our help, to beat what I consider to be not a crime, not a moral failing, but a serious illness – a disease this subcommittee has been informed affects brain chemistry and nerve function. We hoped and believed he was on a good path. Like many struggling with opioid addiction, he tried a variety of treatment options including in-patient, intensive out-patient, medically assisted therapy and abstinence only step programs. Days before he was to start a program that we felt had great promise for success, the medically assisted treatment drug, Vivitrol, he used again, and did not recover.

My son attended parochial schools, was an altar server in our church, played golf at a local country club, participated in youth sports including travel ice hockey and later varsity high school ice hockey. He was a good student and was a 2006 graduate of a local all-male Jesuit prep school in Washington, DC. He was also a 2010 graduate of the University of Virginia where he enjoyed student and fraternity life.

He was intelligent, creative and expressive and made films/videos in the UVa film community. He had talent and was chosen by his university as their student representative to the Toronto International Film festival and after graduation, worked in LA and NY in film and video production.

He came from a loving two-parent home and led the quintessential middle class life, enjoying all of life's and God's blessings. He did not surrender his adolescence, abandon friends, personal interests or turn his back on his school work. He was pursuing his career passion as a working adult when he developed his addiction. Kevin had a lot to live for.

The short bio description I just gave you is an example of how the scourge of the opioid addiction epidemic before us today has no stereotypical victim. It is affecting people of all walks of life, all income levels and all backgrounds. This epidemic and my son's addiction do not respect income, social status or intelligence. That's what epidemics do.

SOLUTIONS

Since my son's death, I have retired from federal service to dedicate myself to advocacy for those suffering from addiction and for those who have lost loved ones to this avoidable and treatable disease. In the nine months since his passing, I have learned a great deal about the disease of addiction, this current epidemic, its underlying causes and painfully for me and my wife, some evidence-based treatment opportunities that offer hope, but now, only for others.

From the perspective of an impacted parent, as a citizen and as an advocate, I would like to share my view of what is needed to stem the tide of the epidemic before us. I attended your May 1st hearing at which the co-chair, with notable exasperation, challenged the seven federal

agency witnesses to identify the single thing they would recommend to solve this problem. While most strategies I hear discussed focus on preventing addiction from taking place, keeping the afflicted alive and expanding access to the most effective treatment possible, I will start by offering my singular focus -- my answer to the co-chair's fundamental question.

We must ensure more cautious prescribing of opioid drugs in this country. You have seen the statistics regarding the absolute exponential explosion of prescriptions and the coincident fourfold increase in overdose deaths in the last two decades. The nexus between the two is immutable. Until we can "bend the curve" of the number of prescribed opioid pain relievers, we will continue to swim in place and all the federal, state and community resources we can bring to bear for education, prevention, and treatment will be for naught.

This subcommittee can and should hold the Food and Drug Administration accountable for their role in the change in the culture of opioid prescribing in the US. In the face of what the Centers for Disease Control have declared as the most significant prescription drug and heroin epidemic the nation has ever experienced, the FDA continues to inexplicably approve new, more potent opioid drugs, at unnecessarily high dosage rates, and in less than transparent manner.

There are two dozen opioid drugs on the market and I understand there are four more in process of approval. Despite protestations from some advocacy groups that there are over 100 million (or nearly one out of every three) Americans suffering from chronic long-term pain that require the use of opioid pain relievers, an examination of the treatment of pain in many western European nations will yield a number of effective alternatives to OPRs. Moreover, several leading medical experts believe that continued use of OPRs for the treatment of chronic pain actually worsen the underlying pain conditions. We must ask ourselves, how many opioid drugs do Americans need. You have heard the statistic that the US with 5% of the world's population consumes over 80% of all prescribed opioids. If this does not change, the high rates of opioid and heroin overdose deaths will become a uniquely American problem. In reality, it already has.

I implore the oversight subcommittee to challenge a number of policy and process changes implemented by the FDA in recent years that have significantly contributed to the 259 million opioid prescriptions written in the country last year that are driving addiction caused by both non-medical use and medically prescribed overuse.

Some of the processes that should be re-examined include "enriched enrollment" which allows expedited safety reviews of proposed new opioid drugs by excluding patients from clinical trials who might have low tolerance. This practice clearly underestimates risk of use. Such a process was used for the reintroduction of the highly addictive and still abusable (via injection) opioid, Opana, which has now been implicated in the explosion of HIV and Hepatitis C infections in the midwest. The enriched enrollment process has been used to approve every new opioid since 2006 and it must stop.

A second questionable practice of the FDA is the abuse of the review process conducted by their own drug advisory panels. Without re-litigating the questionable Zohydro approval process, the complete dismissal of advisory panel recommendations, particularly those with overwhelming positions must be corrected.

I believe the pressure on the FDA to expedite requests for new drug approval is overriding more compelling public safety interests. If any drugs deserve more thorough and considered review, it is a newly proposed Schedule II opioid narcotic and the process should take as long as necessary to ensure risks are fully examined before approval. Expedited review processes should not apply given the number of such drugs already available in the marketplace. Moreover, the FDA is ignoring their own review policy on when to convene an advisory panel, resulting in decisions without expert review. This is a practice ripe for the subcommittee to review.

Finally, the composition of advisory panels, with some permanent members and some industry-associated temporary members, must be reexamined. The role of advisory panels should be transparent and have no element of potential conflict of interest.

As citizens, we rely on the FDA as our last line of defense for assessing products before widespread availability in the marketplace. Public health considerations are undermined by the FDA's current practices. As a follow up to your May 1st hearing on the federal response to this crisis, please ask the FDA to justify, in writing, the policies and practices I have delineated.

I would also like to bring to the attention of the subcommittee my strongly held conviction about the use of medically assisted treatment borne out of my son's treatment experience. My son was confronted at some AA and NA meetings (he attended many different meetings given the wide variety of meetings, people and discussions) where he faced judgment and pressure about his use of buprenorphine. He was made to feel that he was not in recovery, not serious about his sobriety and substituting one addiction for another - all utterly false but damaging to him nonetheless. Under no circumstances should anyone with an already impaired sense of self esteem be faced with such judgment and stigma when they are trying to find a supportive environment.

Further, when my son applied to attend a well known abstinence-only residential treatment facility, he was told he would have to taper off his buprenorphine (done in one week's time). He was conflicted - we were conflicted - we didn't know better. While there, he was faced with a step program focus including lectures about discipline, self control and appealing to a higher power to cure his disease. Few, if any, other diseases are treated in this way.

Sixty-four days after leaving the abstinence-only residential facility and being "released to the wild" without his MAT support, my son succumbed to an overdose. It is a well documented fact among those practicing addiction medicine that the afflicted detoxed or removed from their MAT support are at their highest risk for a fatal overdose even with a dose that previously would barely make them high. When working with local parents seeking information from me about treatment, I strongly encourage them to avoid such abstinence-only facilities. By ignoring today's emerging consensus, abstinence-only adherents are unnecessarily contributing to the rate of opiate overdose deaths. This must change.

Earlier this year, an extensive expose by Jason Cherkis entitled "Dying to Be Free" published in the Huffington Post documented the significant damage caused by the imposition of a one-size-fits-all abstinence-only approach, useful in the past for treating alcohol addiction but with horrific success rates in addressing opioid addiction. Within weeks of the release of this article, ONDCP director Michael Botticelli changed federal policy to deny Drug Free

Community grants to states whose drug courts shamefully force their participants to taper of MAT medications. That is a powerful statement of support coming from our federal government and much welcome.

The American Society of Addiction Medicine, the National Association of State Alcohol and Drug Abuse Directors, ONDCP and SAMHSA all have embraced the use of MAT tied to individual therapeutic assessment and individual and group support mechanisms as the most effective form of treatment for opioid addiction. It is time for the standard of care for treatment of opioid addiction to be changed to reflect this consensus. This issue, with lives in the balance, is worthy of further subcommittee investigation. As a minimum, I hope the subcommittee fully endorses MAT treatment when its hearings are completed and findings produced.

CONCLUSION

Mr. Chairman and members of the subcommittee thank you again for addressing this vastly under addressed public health crisis. While many solutions must and will be addressed at the community and state levels, this subcommittee can ensure federal entities do their part to appropriately protect our loved ones and the public health. We deserve no less.

Sincerely,



Don Flattery

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Majority (202) 225-2927
Minority (202) 225-3641

June 10, 2015

Dr. Jerome M. Adams
Health Commissioner
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Dear Dr. Adams:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Thursday, May 21, 2015, to testify at the hearing entitled "What are the State Governments Doing to Combat the Opioid Abuse Epidemic?"

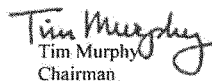
Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Wednesday, June 24, 2015. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Tim Murphy

Chairman
Subcommittee on Oversight and Investigations

cc: The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

Answers to Questions for the Record

Dr. Jerome Adams, M.D., M.P.H.

Indiana State Health Commissioner

Hearing of the Subcommittee on Oversight and Investigations,

Committee on Energy and Commerce

"What are the State Governments Doing to Combat the Opioid Abuse Epidemic?"

May 21, 2015

The Honorable Michael C. Burgess

QUESTION 1: Complaints regarding PDMPs suggest that these systems are not real time, not widely used, and are time consuming and burdensome. In 2005, Congress enacted NASPER, with strong support from health care providers and broad, bipartisan support. However, the program has not been funded since 2010 and faced similar lack of funding prior to 2010. NASPER would provide assistance to allow PDMPs to meet consistent national criteria and allow for interoperability between state PDMPs. This is a question that I had previously asked of the CDC, due to their state monitoring efforts. However, I would like to hear the state perspective. Do you think that national criteria and standardized content would be beneficial in fostering a more attractive state-based PDMP network for providers?

Interstate sharing of PDMP data is critical, and states should work together to ensure efficient and effective data standards. These standards will help keep patients safe by giving their care providers the information needed to make medically appropriate prescribing decisions.

In addition, most states have upgraded their data submission format to ASAP 4.2, but some states still use an older format. The newest submission format allows for more data to be collected, so states that use an older format do not have access to all available patient data. Also, shared data is especially important to prescribers near state borders. Patients should know that all care providers are aware of their medical history, in order to deter abuse.

QUESTION 2: Interoperable PDMPs would do much to decrease incidence of doctor shopping. What has been your experience with interstate accessibility of PDMPs? Are the current interstate data-sharing exchanges, such as the Prescription Monitoring Program Interconnect effective?

Indiana's PDMP, INSPECT, was the first PDMP to connect with bordering states, and it currently connects with 20 other states. The National Association of Boards of Pharmacy's PMPinterconnect hub (PMPi hub) is being utilized by almost every state that is engaged in sharing data. The PMPi hub has made use of PDMP data more accessible and more effective.

In the states utilizing the hub, it has greatly improved practitioner access to a complete and accurate controlled substance medication history on patients that travel, have moved, or who purposefully fill prescriptions in another state to avoid detection by their own state's PDMP.

One of the last hurdles is that PMPi hub data is not accessible to law enforcement, which should be able to use the data in fraud and drug diversion cases.

QUESTION 3: It is my understanding that obstacles to managing the opioid abuse epidemic vary widely from state to state, ranging from stigma associated with medication assisted treatments to lack of adequate data, which is sometimes associated with the need for interoperable PDMPs. Could each of you discuss what you recognize as being the biggest obstacle towards controlling the opioid epidemic in your state? Do you think that the federal response to the opioid epidemic has been sufficient?

The biggest obstacle to controlling the opioid epidemic is legal access to opioids.

Overprescribing by providers occurs for the following reasons, among others:

1. Training. Inadequate training about evidence-based management of pain and appropriate opioid prescribing
2. Co-Pays. Prescription co-pays prompt providers to prescribe "more than enough medication" for acute pain when a much shorter duration of treatment is effective for the vast majority of patients. For example, after an oral surgery, a provider may prescribe 30 tablets, when four is likely enough.
3. "Fifth Vital Sign." Providers are required to assess subjective pain as an objective vital sign and treat accordingly. For hospital-employed physicians, patient satisfaction scores are often tied to physician remuneration.
4. Time. Primary care providers have limited time available to adequately assess and manage pain and mental health status of patients. These patients are complicated and often require more lengthy visits.
5. Failure to check the PDMP. Providers should always check the PDMP before prescribing.
6. Patient Education. Patients expect physicians to completely relieve them of chronic pain, and complete elimination of pain is an unreasonable expectation. Effective treatment for the majority of chronic pain includes attention to the whole person.

The Honorable Tim Murphy

QUESTION 1: During the hearing you discussed the emergence of pain as the fifth vital sign as well as the impact of patient satisfaction surveys on the prescribing patterns in our country. Could you elaborate further on how this has contributed to the opioid abuse epidemic?

First, we should define vital signs. Vital signs (like blood pressure and pulse) are objective measures of physiologic processes necessary for life. Pain is a subjective measure, and it cannot always be eliminated.

Next, there is historical context. Beginning in 2001, the Joint Commission on Accreditation of Healthcare Organizations required hospitals to ask patients about their “pain level”, but there is no evidence to support a known benefit to this practice. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS) survey questions have significant influence on payment to hospitals and providers.

If a patient rates their care as substandard, because the patient was not given the type or amount of opioid the patient requested, the provider and the hospital could see negative financial consequences. Because of the link between pain management, patient satisfaction, and reimbursement practices, an incentive exists for providers to make the patient happy, not necessarily to provide the best care.

QUESTION 2: What are the pros and cons of giving someone Naloxone? What type of educational component should be directly linked to the expansion of this overdose reversal drug?

Naloxone is a non-addictive, non-opioid antidote to opioid overdose, and it gives individuals a potential second chance at life. It is safe to use, with no effect on individuals who have not used opioids. Individuals surviving an overdose are often more receptive to substance abuse treatment options.

If someone is experiencing an overdose, there is no downside to administering naloxone.

When prescribed or distributed, providers should educate on the following: calling 911 immediately, staying with the overdose victim until help arrives, and administering a second dose of naloxone if the victim relapses before help arrives.

The Honorable David McKinley

QUESTION 1: You spoke in great detail about the measures you have taken in Indiana to combat this epidemic. Please share any ideas that you have that we would be able to apply to West Virginia and across the country.

I would suggest three best practices from Indiana.

1. We believe it is critical to encourage collaboration on this issue. The Prescription Drug Abuse Prevention Task Force was established in 2012 by the Indiana State Department of Health (ISDH) and the Office of the Attorney General. The Task Force is made up of state agencies, local partners, coalitions, law enforcement, healthcare providers, and others. The mission is to prevent opioid overprescribing, misuse, overdose, and death, enhance access to addiction treatment, and define the burden of opioid use.
2. The Indiana Medical Licensing Board adopted rules for the prescribing of opioids for chronic pain, and the Task Force published a complementary prescriber toolkit.
3. Indiana's "pill mill" law regulates the facility owner by requiring the owner have a controlled substance registration (CSR). This allows law enforcement to quickly intervene in the case of a bad actor by suspending or revoking the registration, thereby shutting down the facility and preventing the owner from practicing.

QUESTION 2: The rate of deaths from drug overdose in America is anywhere from seven to ten times higher than it is in Europe. What are they doing right and what are we doing wrong that there is such a drastic difference in our overdose death rates?

I do not have expertise in the European healthcare system, so I would defer to other providers for a complete answer to this question.

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS
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June 10, 2015

Dr. Monica Bharel
Commissioner
Massachusetts Department of Public Health
250 Washington Street, 6th Floor
Boston, MA 02108

Dear Dr. Bharel:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Thursday, May 21, 2015, to testify at the hearing entitled "What are the State Governments Doing to Combat the Opioid Abuse Epidemic?"

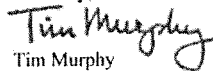
Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Wednesday, June 24, 2015. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

Commissioner Monica Bharel, MD, MPH
Massachusetts Department of Public Health

Responses to Questions for the Record:
"What are the State Governments Doing to Combat the Opioid Epidemic?"
Thursday, May 21, 2015

Committee on Energy and Commerce,
Subcommittee on Oversight and Investigations
United States House of Representatives

Attachment 1 – Additional Questions for the Record

The Honorable Michael C. Burgess

Q: Complaints regarding PDMPs suggest that these systems are not real time, not widely used, and are time consuming and burdensome. In 2005, Congress enacted NASPER, with strong support from health care providers and broad, bipartisan support. However, the program has not been funded since 2010 and faced similar lack of funding prior to 2010. NASPER would provide assistance to allow PDMPs to meet consistent national criteria and allow for interoperability between state PDMPs. This is a question that I had previously asked of the CDC, due to their state monitoring efforts. However, I would like to hear the state perspective. Do you think that national criteria and standardized content would be beneficial in fostering a more attractive state-based PDMP network for providers?

A: PDMPs represent an important safety mechanism that we must all take full advantage of and invest in. In 2009, Massachusetts expanded pharmacy reporting requirements and went "live" with the Massachusetts Online Prescription Drug Monitoring Program or "PMP." Four years later, Massachusetts conducted significant system upgrades, and began providing for automatic enrollment and local law enforcement training. In 2014, Massachusetts expanded mandated usage to all mid-level prescribers, including advanced practice nurses and physician assistants. I am proud that Massachusetts has made important progress with implementation of the state's PMP.

However, we still have critical work to do to improve the usability and overall effectiveness of this tool. For example, it should not take 11 "clicks" – as it does in Massachusetts – to use this system. To your point, a fully functioning PMP must facilitate, not inhibit good clinical practice. In Massachusetts, I am working directly with the prescriber community to find ways to better streamline the functionality of the PMP and incorporation into the clinical workflow in order to ensure increased utilization by prescribers. To this end, we in the Baker Administration are advocating for 24-hour pharmacy reporting requirements (now 7-days in Massachusetts), representing just one of several important changes that we believe will make critical improvements to functionality and effectiveness of this clinical tool.

With regard to national standards, while there are national reporting standards for PDMPs published by the American Society for Automation in Pharmacy, the quality of data received from pharmacies could be improved with guidelines for standardized reporting. Additionally, creating some appropriate level of federal standardization may assist state PDMPs in furthering interstate data sharing as different statutes, technologies, and funding streams from state to state make data compatibility difficult. However, federal standardization efforts should be approached with a careful eye towards encouraging state innovation, while also increasing abilities and incentivizing implementation towards greater interstate interoperability.

Finally, Massachusetts and the federal government must look to incentivize and create improved environments for critical linkages and integration of PMPs within electronic health records or “EHRs.”

Q: Interoperable PDMPs would do much to decrease incidence of doctor shopping. What has been your experience with the interstate accessibility of PDMPs? Are the current interstate data-sharing exchanges, such as the Prescription Monitoring Program Interconnect effective?

A: While interstate data exchange will soon be one of the primary technical enhancements for states to advance, Massachusetts is still working towards the ability to share data with states.

The goal of interstate data sharing is to allow prescribers and other healthcare providers greater access to patient record/data to be able to make an informed educated clinical decision on patient diagnosis and treatment. However, interstate data sharing capabilities have a long way to go before they will be truly useful to end users, the biggest concern being that it will be difficult to retain good, unique identifiers. Additionally, it is unclear whether the current systems across the country are robust enough to meet their intended objectives.

To this end, there are three (3) PMP Interstate Hubs that allow PMP data sharing between states: RxCheck, PMPInterconnect or “PMPi”, and RxSentry Hub. Massachusetts is currently on the RxCheck hub developed by the Bureau of Justice Assistance. This hub is currently maintained by the Integrated Justice Information Systems Institute (IJIS) on behalf of the RxCheck member states which governs the RxCheck Hub. Of those participating states, four (4) states are actively sharing data (OK, AL, ME, KY) through the Hub.

As you have stressed, interoperability between states will be a key component to improved functionality of PDMP systems nationally.

Q: It is my understanding that obstacles to managing the opioid epidemic vary widely from state to state, ranging from stigma associated with medication assisted treatments to lack of adequate data, which is sometimes associated with the need for interoperable PDMPs. Could each of you discuss what you recognize as being the biggest obstacle towards controlling the opioid epidemic in your state? Do you think that the deferral response to the opioid epidemic has been sufficient?

A: Across the Commonwealth, there are challenges in several areas that can present very real roadblocks – both in policy and availability of services – and that hinder access to timely and effective care: insurance coverage, particularly for downstream services, post-detox care (both residential and outpatient medication treatment services); statewide bed capacity, the types of beds available, and how to access them; services for mothers and fathers in recovery; the double digit increase in the costs of pharmaceuticals including Naloxone and other drugs; insufficient resources for child care, stable housing, and employment training; access to timely treatment information; early intervention services within our schools; education of our parents and community leaders of available resources and the early signs of addiction; and perhaps most prominently – stigma.

Addressing the opioid crisis requires taking action across the spectrum of touch points: prevention, intervention, treatment, and recovery supports. Each of these points is accompanied by unique obstacles – that as a state and a nation – we must develop solutions and strategies to overcome.

1. Prevention and Intervention:

Prevention work should include informational campaigns to increase public awareness of the dangers of opioid use. Existing coalitions such as Massachusetts' statewide regional Opioid Addictions Prevention Coalitions and Learn to Cope peer networks can be crucial resources.

In 2009, Massachusetts led the way, authorizing its first recovery high school. With the leadership of the Baker Administration, Massachusetts is poised to open its fifth recovery high school in Worcester, MA. While these efforts are critical to the state's recovery system, the question facing Massachusetts is how and when do we reach our children within the education system. Data clearly shows that early use of drugs increases a youth's chances of developing addiction. In addition, National Institute of Health data demonstrates that children as young as ten years old are having their first experiences with alcohol and drugs.

Investing in the prevention of youth's first use is critical to reducing opioid overdose deaths and rates of addiction. To this end, the Baker Administration is prioritizing support to our schools in order to implement substance use prevention curricula. While school districts should have the autonomy to choose the evidence-based curricula and grade levels most appropriate for their communities, these programs must be proven to reduce nonmedical opioid use. Finally, we must look at developing and targeting educational materials for school personnel, including our athletic coaching staff, and

parents about closely monitoring opioid use, as well as, signs and symptoms of drug and alcohol use.

Interventions should include expanding naloxone (or “Narcan”) availability to first responders, bystanders, and other community members. In Massachusetts, we are proud of the progress that has been made in the past several years to increase access to naloxone rescue kits. The cities of Quincy and Gloucester represent some of the first communities in the nation to arm our first-responders with this powerful overdose reversal agent. Since the start of these and other naloxone programs in 2009, our efforts have resulted in over 5,000 reported overdose reversals.

Beyond saving lives, this measure is starting to change attitudes. Police no longer see arresting as their only solution to this epidemic. Now, with each reversal, they see another opportunity to engage a person who is battling addiction – a disease.

We as a nation should support steps to increase access to, and lower the cost of, naloxone. Just as we would prescribe epinephrine for emergency response, we must identify, educate, and prescribe naloxone rescue kits to at-risk patients, and while doing so, we need to ensure we are employing strategies to reduce and contain cost.

We must employ careful prescribing practices for acute pain, especially for young people. According to SAMHSA, in 2011-2012 less than 5% of pain relievers used for nonmedical use were self-reported as coming from a drug dealer or online purchase. 21% were prescribed by one doctor, and more than 63% reported obtaining the pain relievers either free or through purchase from a friend or relative.¹ This means an overwhelming percentage of pain relievers come into the system of abuse from a legal prescription. Clinicians must shift their expectations and practices so that opioids are not the first line of defense against pain and are only introduced after other alternatives have been considered. In order to do this, alternate therapies must be available and covered by insurance. Public expectations must also shift away from a “quick fix” for pain, and we will need to improve our educational outreach about the expectations around pain and the role of the doctor’s office.

Simply put, prescribers need more education. To underscore this need, just this month, the Harvard School of Public Health released a poll that showed only 36% of Massachusetts adults prescribed pain killers reported being warned of the associated risks by their prescriber.² This education starts in the classroom. We in the Baker Administration will be looking to mandate pain management, safe prescribing training, and addiction training for all prescribers as a condition of licensure (physician assistants, nurses, physicians, dentists, oral surgeons, and veterinarians), while partnering with the medical and provider community to improve and increase educational offerings for prescribers and patients to promote safe prescribing.

¹ SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2011-2012

² <http://www.hsph.harvard.edu/news/press-releases/poll-many-americans-know-someone-who-has-abused-prescription-painkillers/>

To support this improved and expanded training, we need to be sure to arm our clinicians with tools. In Massachusetts, we have made progress with implementation of the needed improvements to the Prescription Drug Monitoring Program or “PMP.” We must all take advantage of this safety mechanism. However, it shouldn’t take 11 “clicks” – as it does in Massachusetts – to use this system; it must facilitate, not inhibit good clinical practice. To that end, I am working directly with the prescriber community to find ways to better streamline the end user experience to ensure increased utilization by prescribers. And in 2014, our state legislature mandated that all prescribers, including non-physician prescribers, must use the PMP.

2. Treatment:

Treatment should be tailored to an individual’s needs, and should include a wide array of options including inpatient and outpatient treatment, as well as equitable access and patient choice around medication assisted treatments – buprenorphine (i.e. Suboxone), naltrexone (i.e. Vivitrol), and medical methadone.

We must take greater advantage of the evidence-based treatments that we have at our disposal for opioid addiction. Access to all forms of Medication Assisted Treatment needs to improve by integrating these treatments into our practices, and making referrals as needed. Much like we treat diabetes and other chronic conditions, payment should ensure that treatment is tailored to the needs of the individual patient, and that it includes the full continuum of necessary wrap-around services.

3. Recovery

One of the greatest challenges facing our ability to address this epidemic is that, traditionally, it has been treated separately and differently from how we address other illnesses, too often, as a personal problem to be hidden away behind closed doors. Recovering from addiction requires a coordinated, community-wide range of support programs, resources, and tools.

To ensure that this support system is in place, to date, DPH has:

- Provided additional funding to increase the number of Recovery Support Centers statewide and to expand the hours during which these centers are open. Recovery Support Centers play a key role in providing community-based support to those in recovery from opioid addiction.
- Increased funding to peer-to-peer and parent-to-parent outreach efforts like Learn to Cope and the Massachusetts Organization for Addiction Recovery to support education, resources, peer support, and hope for parents and family members of people addicted to opioids and other drugs.

- Awarded funding for new Recovery High Schools, bringing the total number across the state to five. These high schools provide supportive environments to assist young people maintain their recovery while earning their high school diplomas.

4. *Data*

It has become clear that Massachusetts' ability to address the underlying health issues and social determinants that are driving this epidemic – trauma and undiagnosed behavioral health conditions chief among them – is dependent on the state's ability to successfully leverage data and measure results.

The Commonwealth is committed to making data – from overdose deaths to Prescription Drug Monitoring data – more available, more frequently, more timely. Over time, this data will better allow us to effectively 'hotspot' by targeting key populations in order to better understand the impacts of our collective efforts.

Utilization of data to combat our many public health challenges, including the opioid epidemic, has a long way to go – across all states – before we can truly say we are fully leveraging data across program silos. For example, currently at DPH, we have more than 300 different internal data sources that have been developed by individual programs using a variety of different formats for a variety of different purposes. They are managed by different staff, reside on different servers, and don't talk to each other.

This is not unique to Massachusetts. Across the country, public health needs to double down on data, and on interoperable, secure IT solutions. I look forward to exploring ways we can better achieve that level of success by harnessing new technologies – such as data warehousing – to create better linkages between siloed data sets. Doing so will allow us to better "hotspot" for highest areas of need for public health interventions; and most importantly, to measure whether our strategies and efforts are actually making the difference our missions commit us to.

Attachment 2 – Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable David McKinley

Q: You spoke in great detail about the measures you have taken in Massachusetts to combat this epidemic. Please share any ideas that you have that we would be able to apply to West Virginia and across the country.

A: As a frontline physician and as the former Chief Medical Officer at Boston Health Care for the Homeless Program – the largest of its kind in the nation – I have seen first-hand what this disease can do to our communities here in Massachusetts and across the country. We are watching our friends and family members die on our streets, driven by a lethal cocktail of trauma and underlying behavioral health conditions. This is a reality I am sure you too have witnessed in all too real of terms at home in your district as well.

This epidemic will be far from easy to tackle, but we will fail if we do not fully involve partners from all sectors – law enforcement, public health, healthcare institutions, families, schools, and you, our elected leaders.

To this end, I would encourage public awareness campaigns to increase knowledge about the dangers of opioid use and to break down the barriers built by stigma. Addiction is a chronic disease, and one that does not discriminate. All of us know a family, loved one, friend, or colleague who is suffering from this chronic disease.

Treatment capacity is an issue that is facing every state in the nation. Treatment should include a wide array of options depending on the individual's needs including inpatient and outpatient treatment, as well as equitable access and patient choice around medication assisted treatments – buprenorphine (i.e. Suboxone), naltrexone (i.e. Vivitrol), and medical methadone. We need to improve access to all forms of Medication Assisted Treatment by better integrating these treatments into our practices, and looking at the way we pay for these medications to ensure true patient choice.

Finally, existing coalitions such as the Commonwealth's many regional Opioid Abuse Prevention Collaboratives – as well as our District Attorneys, mayors, and health care systems that have developed task forces and localized capacity – offer important examples of frontline organizations which offer crucial resources and policy development at the community level. These collaboratives largely rely on federal funding from SAMHSA and maintaining these local, community-level organizations will be key to every state's ability to address this epidemic head on.

The Honorable Larry Bucshon

Q: What are the pros and cons of giving someone Naloxone? What type of educational component should be directly linked to the expansion of this overdose reversal drug?

A: Opioid overdoses have increased significantly in Massachusetts over the past ten years. Opioids include heroin and prescription drugs such as oxycodone (oxycontin), fentanyl, hydrocodone, and codeine. In response to this growing problem, Massachusetts has implemented a number of approaches to reduce the number of overdoses.

Interventions should include expanding naloxone (or “Narcan”) availability to first responders, bystanders, and other community members. In Massachusetts, we are proud of the progress that has been made to increase access to naloxone rescue kits in the past several years. The cities of Quincy and Gloucester represent some of the first communities in the nation to arm our first-responders with this powerful overdose reversal agent. Our efforts have resulted in over 5,000 reported overdose reversals.

Naloxone is an opioid antagonist that blocks the effects of opioids such as heroin, oxycodone, hydrocodone, fentanyl, and codeine. In response to the increasing number of opioid-related fatal overdoses in Massachusetts in the past decade, the Department of Public Health is sponsoring a pilot program that is distributing intra-nasal naloxone, along with opioid overdose prevention education, to opioid users and to trusted people in their lives such as family, friends, and staff of human services programs.

Emergency responders including paramedics and emergency room physicians have been using naloxone since the 1970's to revive people who are experiencing an opioid overdose. While naloxone is an important emergency lifesaving tool, it is important to remember that it is a temporary measure. The use of naloxone must be coupled with other interventions including medical evaluation, medication assisted treatment, counseling and other supports.

Beyond saving lives, this measure has changed attitudes. Police no longer see arresting their way out of this epidemic as a solution. Now, with each reversal, they see another opportunity to engage a person who is battling addiction – a disease.

We as a nation should support steps to increase access to, and lower the cost of, naloxone. Just as we would prescribe epinephrine for emergency response, we must identify, educate, and prescribe naloxone rescue kits to at-risk patients, and while doing so, we need to ensure we are employing strategies to reduce and contain cost.

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ONE HUNDRED FOURTEENTH CONGRESS
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COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Majority (202) 225-2927
Minority (202) 225-3641

June 10, 2015

Dr. Larry Wolk
Executive Director and Chief Medical Officer
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, CO 80246-1530

Dear Dr. Wolk:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Thursday, May 21, 2015, to testify at the hearing entitled "What are the State Governments Doing to Combat the Opioid Abuse Epidemic?"

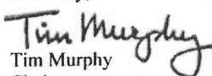
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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

Responses Submitted to the House Energy and Commerce Subcommittee on Oversight and Investigations, in follow-up to the Thursday, May 21 2015 hearing entitled “What are the State Governments Doing to Combat the Opioid Abuse Epidemic?”

The Honorable Tim Murphy, Chairman
The Honorable Diana DeGette, Ranking Member
2322 Rayburn House Office Building

Wednesday, June 24, 2015

Submitted by Dr. Larry Wolk:
Executive Director and Chief Medical Officer,
Department of Public Health and Environment, Colorado

The Honorable Michael C. Burgess

1. Complaints regarding PDMPs suggest that these systems are not real time, not widely used, are time consuming and burdensome. In 2005, Congress enacted NASPER, with strong support from health care providers and broad, bipartisan support. However, the program has not been funded since 2010 and faced similar lack of funding prior to 2010. NASPER would provide assistance to allow PDMPs to meet consistent national criteria and allow for interoperability between state PDMPs. This is a question that I had previously asked of the CDC, due to their state monitoring efforts. However, I would like to hear the state perspective. Do you think that national criteria and standardized content would be beneficial in fostering a more attractive state-based PDMP network for providers?

Colorado House Bill 14-1283- *Modifications to the Electronic Prescription Drug Monitoring Program*-amended Board of Pharmacy Rules, and with consolidated and cooperative efforts led by the Governor, we have made tremendous strides towards improving our PDMP from both an accessibility and technological standpoint. Our efforts have developed the Colorado PDMP to become more beneficial and usable to its prescribers and dispensers, and to align it with existing national criteria and standardized content. The recent modifications in Colorado include:

- Mandatory registration
- Allowing up to 3 delegates of a prescriber to access the PDMP on each prescriber's behalf
- Requiring pharmacies to upload dispensing data on a daily basis (versus the historically twice per month uploading requirement)
- Allowing federally owned and operated pharmacies to submit data into the PDMP
- Providing “push notices” to affected prescribers and pharmacies when patients visit a certain number of prescribers and pharmacies over a specific time to seek a controlled substance
- Enhancing the overall interface of the PDMP itself to allow for easier use.

With these changes, Colorado has targeted many of the existing national criteria and standardized content in place. This nationally accepted criteria has ultimately made the PDMP more usable for providers as illustrated by both higher utilization rates and fewer push notices being sent from month-to-month using the identical threshold for the generation of such push notices. The two elements of accepted criteria that Colorado may benefit from, but are cost-prohibitive, include real-time reporting and integration of PDMP data with decision support tools in the electronic health record and health information exchanges. This would add benefits such as a single sign-on (as opposed to having to access separate database to obtain different pieces of information). These elements are also criteria that most states have not yet achieved.

2. Interoperable PDMPs would do much to decrease incidence of doctor shopping. What has been your experience with interstate accessibility of PDMPs? Are the current interstate data-sharing exchanges, such as the Prescription Drug Monitoring Program Interconnect effective?

Colorado's PDMP is currently connected with the PDMPs in 28 other states including neighboring states (except Wyoming) by way of an interconnect program (PMP InterConnect) run by the National Association of Boards of Pharmacy. NABP anticipates that 70% of the state PDMPs will be either connected to or working toward a connection in 2015. Currently, 29 states are participating in PMP InterConnect, with Iowa being the latest state to go live in May 2015. Several other states have signed memorandums of understanding to participate in the program. While Colorado currently has no concrete data regarding the effectiveness of such an interconnection, it likely should be assumed that interconnection would ultimately support existing state work to decrease the incidence of doctor shopping and would ensure standardized criteria is utilized.

3. It is my understanding that obstacles to managing opioid abuse epidemic vary widely from state to state, ranging from the stigma associated with medication assisted treatments to lack of adequate data, which is sometimes associated with the need for interoperable PDMPs. Could each of you discuss what you recognize as being the biggest obstacle towards controlling the opioid epidemic in your state? Do you think that the federal response to the opioid epidemic has been sufficient.

As expressed in our testimony, 2010-11 data revealed that Colorado had the troubling distinction of ranking 2nd nationally for self-reported, non-medical use of prescription drugs. Since that time we have been encouraged by 2013 data released by the National Survey on Drug Use and Health, showing that our rate of non-medical use has decreased from 6% to 5.08%, which represents 39,000 fewer Coloradans who misused prescription drugs during the survey time period (2011-12). This recent data suggest that we are well on track to meet expressed goals. Despite encouraging trends, prescription drug abuse remains a serious health crisis as we work to expand upon and bolster work currently underway in Colorado. As a state, we have a variety of distinctive characteristics and challenges that continually inform the *Colorado Plan to Reduce Prescription Drug Abuse*, including our geographic diversity and state and local governance structures, increasing heroin usage rates, access to quality treatment resources, and general funding limitations.

Colorado faces unique challenges given our geographic and population-density diversity. Communities across Colorado- whether large or small, rural or urban, on the Eastern Plains or the Western Slope- face varying opportunities and obstacles. In some areas, access to appropriate resources is inadequate, and specific areas of the state are disproportionately impacted by the prescription drug abuse epidemic. Additionally, Colorado has a state-supervised and county-administered human services system. Under this system, county departments are the primary provider of direct services (primarily behavioral health services) to Coloradans. This system plays an integral role as we formulate policies and strategies directed at the state level to be responsive to community specific needs. It is vitally important that we work closely with our county partners and communities as our strategic plan develops and adapts to new data and emerging best practice.

In the last five years, the number of Heroin users in Colorado has doubled, a rate increase we suspect has some correlation with our high rates of prescription drug misuse and abuse. Although available literature suggest that the misuse and abuse of prescription drugs is a risk factor for future heroin use, currently available data doesn't appear to support that a crack down on the supply of opioid pain relievers is the driver of recent increases in heroin use. We look forward to working with our federal counterparts to continue to collect data and monitor the relationship between heroin and prescription opioids so we can provide the most appropriate prevention, early intervention, referral, treatment and recovery strategies.

We also have significant concerns that existing treatment capacity is not meeting a rising demand, as treatment for heroin and prescription opioid abuse increased 128% between 2007 and 2014. Our state has long supported evidence-based practices in treating substance use disorders, including opioid medication assisted therapy (MAT), but we are concerned that the capacity has not risen fast enough to keep up with the increasing demand. Overdose death is a very real risk for people struggling with opiate addiction, and failure to provide vital treatment services means unnecessary, preventable deaths of our citizens. We would urge our federal counterparts to continue to explore avenues to increase access to treatment resources, specifically MAT services. Additionally, we support maintaining a strong commitment to the Substance Abuse Prevention and Treatment (SAPT) Block Grant, an effective program supporting prevention, treatment, and recovery services.

While we applaud our federal counterparts in their leadership in prioritizing the prevention of prescription drug abuse, we can all agree that there is much work to be done. We look forward to continued partnership and collaboration.

The Honorable Tim Murphy

I. What are the pros and cons of giving someone Naloxone? What type of educational component should be directly linked to the expansion of this overdose reversal drug?

Fatal drug overdoses continue to be on the rise in Colorado, and the United States. Overdoses kill more people in the United States than car accidents. From 2000-2013, 8,802 Coloradans died from drug overdoses with opioids being a main factor in 2,875 of these deaths (Colorado Department of Public Health & Environment, 2014). While some of these deaths involve illegal drugs, many more involve prescription painkillers—drugs many of us have in our medicine cabinets. In most cases, these deaths are unintentional and could be prevented by the timely administration of Naloxone. This medication is used

in opioid overdoses to counteract life-threatening depression of the central nervous system and respiratory system, allowing an overdose victim to breathe normally. Naloxone is a nonscheduled (i.e., non-addictive), prescription medication, and only works if a person has opioids in their system; the medication has no effect if opioids are absent. As we work to expand access of Naloxone to laypersons in the community- where most overdoses are witnessed and can be immediately addressed- education and training is a critical component safe, effective use. For example, our educational efforts work to dispel any notion that administering Naloxone negates the importance of also contacting emergency medical services. Because this opioid antagonist is a temporary response that wears off in 20-90 minutes, additional medical intervention is most likely needed. Administering Naloxone could also highlight an underlying heart issue, or other medical condition, as the person is going into withdrawal.

Historically, only emergency department personnel and emergency medical services carried and administered this medication, and across the country access to opiate antagonists is often limited unnecessarily by laws that pre-date the overdose epidemic. To this end, Colorado has passed 3 statewide laws to reduce the harms associated with overdose. In 2012, Colorado passed the “Good Samaritan Law” (*SB 12-020*), to encourage witnesses to call for medical help during emergency overdose situations. The law provides limited legal protection from drug charges for those who call 911 for help. It also protects persons suffering an opiate overdose- rather than being arrested or prosecuted, they are referred to the proper treatment programs. In 2013, Colorado passed the “Third Party Naloxone Law” (*SB 13-014*), providing protection from criminal charges for medical professionals who prescribe Naloxone to third parties, and for non-medical people who witness an overdose and administer the drug. The law also protects healthcare professionals who administer Naloxone in an overdose emergency from charges. In 2015, Colorado passed “Standing Order” legislation (*SB 15-053*), extending existing authority to prescribe or dispense opiate antagonists by permitting licensed prescribers and licensed dispensers to also prescribe or dispense a standing order directly to individuals, a friend or family member or an individual who may experience an opiate-related drug overdose, an employee or volunteer of a harm reduction organization or a first responder. Licensed prescribers and licensed dispensers may prescribe or dispense permitted opiate-antagonist drugs in a good-faith effort.

In many cases, opioid antagonist medications can serve as our first line of defense in confronting this epidemic. Just this week, a local public health organization, the Harm Reduction Action Center, reported that Naloxone the organization has provided to the community has reversed 200 reported overdoses in the last three years. Recently, two police departments in Colorado started carrying Naloxone, with one reversal already reported. Denver Health and Hospital, Denver County's safety net hospital recently placed Naloxone on their formulary so any prescriber within their system can prescribe to their patients. With this policy change, anyone that comes in to their emergency department on an observation of an overdose, is discharged with a prescription for Naloxone that they can pick up on site. This type of resource is essential, especially for folks that do not identify as drug users and would not necessarily seek out such services.

Increasing awareness of and access to Naloxone through clinical, organizational, and public policy initiatives is critical component of our larger efforts to reduce prescription drug abuse throughout the state. Training interested providers, patients, and family members or friends on how to use and administer Naloxone is relatively easy; raising awareness of the need to have Naloxone readily available will require considerable effort.

The Honorable David McKinley

1. You spoke in great detail about the measures you have taken in Colorado to combat this epidemic. Please share any ideas that you have that we would be able to apply to West Virginia and across the country.

In addition to the specific areas of focus we articulated in our testimony, we would like to re-emphasize the importance of the Consortium for Prescription Drug Abuse Prevention (Consortium) model in our work to combat this epidemic. This cooperative, interagency/interuniversity framework is designed to facilitate the collaboration and implementation of the strategic plan by interested parties and agencies. The Consortium is housed in the University of Colorado (CU) Skaggs School of Pharmacy and Pharmaceutical Sciences at the Anschutz Medical Campus (which houses the School of Pharmacy, the Colorado School of Public Health, Colorado State University, the University of Northern Colorado, the CU School of Medicine, and the CU College of Nursing). The Consortium provides a statewide, inter-university/inter-agency network and serves as the strategic lead for the *Colorado Plan to Reduce Prescription Drug Abuse* with active participation from the Governor's Policy Office and relevant state agencies and engaged public and private partners. The educational, law-enforcement and medical communities are well positioned to address many of Colorado's key prescription drug abuse issues, and the partnerships facilitated by the Consortium are crucial in attaining optimum outcomes and increased federal funding to combat the growing problem. As the coordinating center, the Consortium houses each focus-area workgroup, co-chaired by an agency/community and university representative.

While the Consortium model specifically may not be the best fit for other states, we see enormous value in the establishment of a central entity that acts as a convener and medium for the varying disciplines and expertise areas so integral to executing a holistic, and multi-faceted response to this epidemic.

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
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June 10, 2015

Mr. Mark Stringer
Director
Division of Behavioral Health
Missouri Department of Mental Health
1706 E. Elm Street
Jefferson City, MO 65101

Dear Mr. Stringer:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Thursday, May 21, 2015, to testify at the hearing entitled "What are the State Governments Doing to Combat the Opioid Abuse Epidemic?"

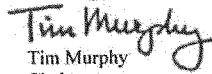
Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Wednesday, June 24, 2015. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

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June 23, 2015

Brittany Havens, Legislative Clerk
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Ms. Havens:

Thank you for the opportunity to provide testimony before the Subcommittee on Oversight and Investigations at their hearing, "What are the State Governments Doing to Combat the Opioid Abuse Epidemic?" Attached are my responses to the additional questions and member requests. Please let me know if I can be of further assistance.

Sincerely,



Mark Stringer, Director

Enclosure

Responses to Additional Questions for the Record

Honorable Michael C. Burgess:

Complaints regarding PDMPs suggest that these systems are not real time, not widely used, and are time consuming and burdensome. In 2005, Congress enacted NASPER, with strong support from health care providers and broad, bipartisan support. However, the program has not been funded since 2010 and faced similar lack of funding prior to 2010. NASPER would provide assistance to allow PDMPs to meet consistent national criteria and allow for interoperability between state PDMPs. This is a question that I had previously asked of the CDC, due to their state monitoring efforts. However, I would like to hear the state perspective. Do you think the national criteria and standardized content would be beneficial in fostering a more attractive state-based PDMP network for providers?

Since Missouri does not yet have one, I regret (truly) that I do not have the experience with PDMPs to give a helpful or meaningful response.

Interoperable PDMPs would do much to decrease incidence of doctor shopping. What has been your experience with interstate accessibility of PDMPs? Are the current interstate data-sharing exchanges, such as the Prescription Monitoring Program Interconnect effective?

Missouri does not currently have a PDMP. However, the most effective and efficient system would be one that would interconnect with other states, especially for Missouri since there are seven states that border us.

It is my understanding that obstacles to managing the opioid abuse epidemic vary widely from state to state, ranging from stigma associated with medication assisted treatments to lack of adequate data, which is sometimes associated with the need for interoperable PDMPs. Could each of you discuss what you recognize as being the biggest obstacle towards controlling the opioid epidemic in your state? Do you think that the federal response to the opioid epidemic has been sufficient?

Missouri could certainly benefit from a PDMP and increased access to treatment services and addiction medications. This problem warrants the need for increased prevention and intervention services.

Recommendations for federal action:

- Ensure that federal initiatives related to addiction work through state substance abuse agencies
- Maintain a strong commitment to the Substance Abuse Prevention and Treatment (SAPT) Block Grant – with equally strong commitment to primary prevention services
- Provide federal funding for the purchase of naloxone
- Increase access to treatment – specifically MAT services
- Mandate prescriber education
- Assist with improvements in linking substance use disorder services with primary care
- Support and coordinate with state-based groups focused on opioid abuse, including the National Governors Association (NGA)

Responses to Member Requests for the Record

The Honorable Tim Murphy:

What are the pros and cons of giving someone Naloxone? What type of educational component should be directly linked to the expansion of this overdose reversal drug?

The wide availability of naloxone could save lives by reversing overdoses from opioids if used correctly and with follow-up care and addiction treatment. Conversely, misuse of the product could result in deaths through lack of patient education and failure to receive additional medical services. I defer to health officials on recommendations for an educational component.

The Honorable David McKinley:

You spoke in great detail about the measures you have taken in Missouri to combat this epidemic. Please share any ideas that you have that we would be able to apply to West Virginia and across the country.

Treatment services, including the use of medication assisted treatment (MAT): Missouri introduced recently approved medications for addiction treatment as part of a Robert Wood Johnson Advancing Recovery Grant in 2006. Research shows that pharmacologic interventions in conjunction with psychosocial services (counseling, case management, etc.) are most successful. MAT represented a change in the philosophy and culture of substance use disorder treatment. A person's openness to taking medications correlates with the clinician's attitudes about MAT. Missouri found that client, clinician, and prescriber education were essential. The Department sponsored numerous training and educational opportunities for providers and referral sources about the benefits of MAT. The Department also provided technical assistance to providers to support the integration of MAT into mainstream treatment. The FDA-approved medications are on the state's Medicaid formulary, which has increased access; however, MAT continues to be restricted for the uninsured because of limited funding.

In Missouri, about 3,400 or one-third of consumers with an opioid use disorder receive MAT including methadone, buprenorphine, or naltrexone. Missouri's data show that higher retention in treatment is obtained with pharmacotherapy in combination with counseling. Missourians who receive MAT tend to be more difficult to treat in terms of higher rates of unemployment, longer history of substance use, higher rates of psychiatric disorders, and more recent substance use. However, these individuals achieve comparable or better outcomes compared to those who receive counseling with no addiction medications. For example, 61 percent of clients receiving extended-release naltrexone have been abstinent for at least 30 days at discharge, compared to 54 percent who received counseling with no medications (Missouri Department of Mental Health, 2013).

Recovery services in Missouri: Missouri's work on recovery services is attributed in large part to SAMHSA's Access to Recovery (ATR) program. The state was just recently awarded its 4th ATR grant (\$13 million over 4 years, \$3.3 available in first year). The new round of grant funding will be used to support clinically appropriate treatment as well as recovery services. The grant will target veterans, including National Guard service members returning from Iraq and Afghanistan; offenders reentering the community from prisons; treatment courts; and other disadvantaged populations as identified in local areas. The funding will support providers in the southwest, southeast, Kansas City, and west central areas of the state.

The funds from the ATR program from the previous three cycles helped our state move a number of recovery-related initiatives. We enhanced the array of available services by basing them on a recovery-oriented model and the patient's right to choose their path to recovery. We established a credentialing process for recovery support programs, increasing accountability and quality of services provided. The State also expanded the recovery workforce by establishing the Missouri Recovery Support Specialist (MRSS) and Missouri Recovery Support Specialist-Peer (MRSS-P) credentials in cooperation with the Missouri Substance Abuse Professional Credentialing Board. In addition, we created a process for offenders in reentry and under correctional supervision to apply to the DMH Exceptions Committee for approval to be employed by a recovery support program. We also developed targeted training for faith- and community-based organizations, mentors, and peers in cooperation with the Missouri Substance Abuse Professional Credentialing Board. Finally, we developed an automated billing, documentation, and payment system.

The state collects outcome data on services supported by the ATR program. Data points include abstinence from alcohol use, abstinence from drug use, stable housing, employment, improved social connectedness, and elimination of criminal activity. From 2004-2013, ATR served 124,496 individuals and families with substance use disorders. Overall, 83 percent of consumers who received recovery support services (either alone or in combination with clinical treatment) were abstinent from alcohol and drugs after six months, and 95% of consumers had no new arrests after six months.

Prevention: In 2012, we began a strategic planning process for prevention, looking specifically at the non-medical use of prescription drugs. In 2011, 12% of young adults (aged 18-25) in Missouri reported that they were misusing prescription drugs. This compares to 6% for 12-17 year olds and 3% for adults older than 26. As a result, we decided to prioritize reducing the non-medical use of prescription drugs by 18-25 year olds.

Partners in Prevention (PIP) is a coalition of 21 college campuses across the state that works to promote health and safety for students. The coalition has specifically moved forward with a prescription drug abuse initiative in order to educate students on the dangers of prescription drug misuse and provide safe and healthy alternatives. Critical funding is provided by SAMHSA/CSAP's Partnerships for Success Grant along with support from the Missouri Department of Liquor Control, the Missouri Division of Highway Safety, and my division. One impressive aspect of the initiative is the array of stakeholders involved: campus prevention professionals, University administration officials, police and public safety officers, student volunteers, community business owners, and others.

In its first three years, PIP's prescription drug abuse prevention initiative noted several outcomes. From 2013 to 2014, PIP noted a 10 percent decrease in students' misuse of prescription drugs in the past year along with a 5 percent decrease in the amount of students misusing opioids, specifically pain medication, in the past year. Due to the project, the 21 participating campuses implemented take-back events, peer education presentations regarding the misuse of painkillers/opioids, and marketing campaigns regarding prescription drug misuse.

We have also partnered with the National Council on Alcoholism and Drug Abuse-St. Louis Area (NCADA) to launch a media campaign called "Curiosity and Heroin" in an effort to increase awareness about the dangers and realities of heroin in the St. Louis region. The campaign uses advertisements in movie theaters, newspapers, magazines, bus stops, and social medial sites. The campaign also utilizes a website (www.curiosityandheroin.org) geared toward young people that provides statistics, information on the risks associated with prescription drug and heroin misuse, information on accessing treatment,

and stories of recovery. One of the most poignant aspects of the website is a section composed of pictures and memorials to those who have died from a heroin overdose.