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

THURSDAY, MAY 21, 2015

House of Representatives,

Subcommittee on Oversight and Investigations

Committee on Energy and Commerce

Washington, D.C.

The Subcommittee met, pursuant to call, at 10:20 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; Chris Knauer, Democratic Oversight Staff Director; Una Lee, Democratic Chief Oversight Counsel; Elizabeth Letter, Democratic Professional Staff Member; Adam Lowenstein, Democratic Policy Analyst; and Tim Robinson, Democratic Chief Counsel.

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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 states. Also, state efforts share many similar challenges. The National Governors Association said states made accurate--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:]

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Mr. {Murphy.} And I am purposefully cutting this short so we can keep this moving.

Ms. {DeGette.} Okay.

Mr. {Murphy.} Ms.--I recognize Ms. DeGette for 5 minutes.

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 that the states are doing--or 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 by the Colorado Consortium on Prescription Drug Abuse Preventions, 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 one 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 treatment--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 prepared statement of Ms. DeGette follows:]

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Mr. {Murphy.} Well, I agree, and--because I read the letter too. It is powerful.

Ms. {DeGette.} Yeah.

Mr. {Murphy.} Without--

[The information follows:]

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Ms. {DeGette.} Thank you. And thanks again for holding this hearing, and I will yield back.

Mr. {Murphy.} Yeah, 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 publically 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.

[The prepared statement of Mr. Bucshon follows:]

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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 on--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.

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[The prepared statement of Mrs. Brooks follows:]

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Mr. {Murphy.} Gentleman--

Mr. {Bucshon.} Yield back.

Mr. {Murphy.} --yields back? All right, I recognize Mr. Pallone for 5 minutes.

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 Medicare earlier this year, so I am interested to hear from all 3 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.

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

[The prepared statement of Mr. Pallone follows:]

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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 conduct opioid--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 Commissioner--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 stateliness is leaving a gap in how we tackle prescription drugs. To that end, I helped to cosponsor the Natural--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 to day. Dr. Stringer, I would love--and if you would be able to touch a little bit about your plans--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.

[The prepared statement of Mr. Kennedy follows:]

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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 XCIII, 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 bring--pull the microphone fairly close to you. Thank you.

Dr. Adams, you are recognized for 5 minutes.

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^TESTIMONY OF 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; LARRY WOLK, M.D., MSPH, 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, MISSOURI DEPARTMENT OF MENTAL HEALTH

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^TESTIMONY 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 Governor 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 co-infection 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 helplessness. 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. Fortunately, 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-resources 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:]

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Mr. {Murphy.} Thank you very much, Doctor.

And now, Dr. Bharel, you are recognized for 5 minutes.

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^TESTIMONY 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 2-1/2 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 hundreds of recommendations and e-mails. 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. Utilizing--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 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:]

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Mr. {Murphy.} Thank you very much.

Dr. Wolk, recognized for 5 minutes.

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^TESTIMONY 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 1/4 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 3-1/2 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, interuniversity 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 fortieth 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:]

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Mr. {Murphy.} Thank you, Dr. Wolk.

Mr. Stringer, you are recognized for 5 minutes.

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^TESTIMONY 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 one--if there is a theme running through our messages this morning, it is--and 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

792 treatment and recovery services, and we partner with
793 providers to ensure that services are high quality and
794 evidence-based. One tool for promoting quality is our
795 contracting authority; building in certain requirements that
796 providers must follow as a condition of receiving state
797 funds. We perform on-site certification reviews to assure
798 that providers are adhering to standards of care that are set
799 by the state. As an example, we use these tools to require
800 that all addiction treatment providers in Missouri who are,
801 again, contracted with the state make medication-assisted
802 treatment available, either directly or by referral. This
803 took time, resources, and education, and it is a work in
804 progress but it is the right step for Missouri. We have also
805 worked hard to leverage SAMHSA's Access To Recovery program,
806 or ATR, to build a statewide system of recovery services.
807 Prevention is critical. Our state has a strategic plan for
808 prevention, with a focus on prescription drug abuse. And we
809 have partnered with a group, just as an example, in a college
810 setting we have a group called Partners in Prevention, that
811 is a coalition of 21 college campuses located throughout
812 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 rehearsal--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:]

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

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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 would be hard--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 that--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--actually, with the flexibility that is already there.

Mr. {Murphy.} I asked that because we have had other witnesses say they would like to have--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 a an addition--an addiction medication physician, but fails to--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-- okay. 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 policymakers, 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 I--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, in your--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 higher-- 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.} --to work on behalf of the provider.

Ms. {DeGette.} Okay. 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.} It is--thank you, Representative DeGette. It is within the past 2 years.

Ms. {DeGette.} Okay, 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 us--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.} Yeah.

Mr. {Stringer.} --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, and building off what we have learned in the past. We had--a couple of years ago we had a hearing in another committee

with the Attorney Generals 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 stateliness 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. Is that something--Dr. Wolk, would you--I see you nodding on that, is that one of the things we should focus?

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.} Yeah, that is just in Colorado, but if they go across the Stateline, that is not available as well.

Dr. {Wolk.} Right. So I would support--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 back about the over-

prescription, maybe--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 that--how that--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 to--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, yeah, we are making addicts with our--what we do, but we have to have a development of trust with our

patients. And do you--I got nervous about the fact that, do 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 are you--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 need--we could use a national registry for providers who divert on the job. That is a--that is the concern. Indiana was also one of the first state--was 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, if you--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 seven to ten times higher than it is in Europe. And I was raised--I raised that question, and I raise it again, what are they doing right or what are we doing wrong? What--why is--why from 30,000 feet--what is the difference, why are--why do we have such a problem in American 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, that is what you are--they--the doctors are doing--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 the time for that. Thank you.

Mr. {Murphy.} I--and the--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 just--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 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 of 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 PNP. Seventy-nine percent of our physicians in Massachusetts

are on the PNP, 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 1, so any additional resources that we can get through block grant money or however else we can do this is--would really be appreciated because even as an ACA--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 physical 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. So--

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 are coming from--for medical reasons--that 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--you--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.} Okay, that is what I figured, and it is--so it is not their particular medical use, but at the end of the day, it has been prescribed for a medical use from--for someone. Okay, and that is where maybe, you know, drop boxes and other initially voluntary return policies potentially could be helpful because--yeah, there is--there are--last year, you probably know, there were more prescriptions--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 age--ages, right, was Vicodin.

Dr. {Bharel.} Um-hum.

Mr. {Bucshon.} And so the prescribe--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 that--about 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 in--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 how 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 okay 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 a--of the campaign, and it needs to start in middle school and elementary school.

Did you have a--

Mr. {Bucshon.} Can I--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 the--what type of educational stuff is also--I mean--I think were you one of the ones that were commenting on Naltrexone? Yeah. Or maybe Dr. Bharel could answer that.

Mr. {Stringer.} Maybe I can just--

Mr. {Bucshon.} Yeah.

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.} --why don't you just--

Ms. {DeGette.} --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.} Yeah--

Dr. {Bharel.} --with that. So the educational component is directly linked when we hand out our--

Mr. {Bucshon.} Yeah, I think that is important because in my opinion, if you--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 our--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.

I--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 out 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, that--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 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 reason for the--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 have--that are associated with physician hospitals--medical--excuse me, medical schools. And so I am--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 say--I would change that to say all prescribers--

Mr. {Flores.} Okay.

Dr. {Adams.} --because it is not just physicians prescribing, and not all physicians prescribe opioids. But we have had tremendous success, again, in Indiana. When--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.} Okay. 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.} Okay.

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.} Okay. 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.} Okay. Go ahead, Mr. Stringer.

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

Mr. {Flores.} Right. The--so the next question would be, and this is again for all of you, do you think your state--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.} Okay. 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.} --and that is how we have increased--

Mr. {Flores.} The question is yes on the merit?

Dr. {Bharel.} Yes.

Mr. {Flores.} Okay, great. Okay. Perfect.

Dr. {Wolk.} Yes, we already require.

Mr. {Flores.} Okay. Mr. Stringer?

Mr. {Stringer.} Sadly, I can only speak theoretically or hypothetically since Missouri is the only state in the country that has--does not have a PDMP yet, although it came very close this session, but--

Mr. {Flores.} Okay.

Mr. {Stringer.} --so I would say yes. Theoretically, yes.

Mr. {Flores.} Okay. 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.} Okay.

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.} Okay. 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, okay. Mr. Stringer?

Mr. {Stringer.} All the above.

Mr. {Flores.} And the last question is this. And I have just a comment for--is--you talked about--I think, Dr. Bharel, you said something about a cultural shift. Is this going to be hard to implement if we began pressing our--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 a--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, they--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.} Okay, 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 to--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 medical--Medicaid and CHIP programs since the initial marketplace enrollment began in October of 2013, however, 21 states have decided to--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.} --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 have--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. Approximately--Mr. Stringer, approximately 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, the--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, they will be--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 patients were able--or 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. Okay, 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 in--quite frankly, when they are 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 connected 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 by--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 and--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.} Okay. Do you believe efforts are making an impact in--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.} Okay. 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. Yeah, 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.} Okay. 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 all--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--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.} Okay, 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, an over--is it is severely being over--just prescribed. 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.} --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 a--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.

I wanted--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.} --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 the--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.} The--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 considered 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 are--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 the--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 men ail 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 a--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 is--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 is used for--has uses beyond that?

Dr. {Adams.} Well, okay, 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 they--and confusion has led to a lot of policy decisions that I think are under-informed. 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 Mass., but then I will probably have to submit for written responses because of time. But on the--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, you have been kind of--your state has been kind of an early adopter in this area. Do you--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 hare 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 to--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.} Yeah, 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. It has--this has been a fascinating process. We know that will come--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 12:06 p.m., the Subcommittee was adjourned.]