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

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

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

May 21, 2015

Summary of Testimony:

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

Suggested policy options to mitigate the opioid epidemic include:

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

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

Full Testimony:

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

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

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

1) Stopping the flow of opioids into communities,

2) dealing with the personal and public health consequences of overflow, or communities with

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

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

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

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

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

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

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

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

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

Mitigating policies should create easy access to HIV and Hepatitis testing, with care coordinators on site for immediate referral to medical and SUD treatment. Comprehensive services should increase immunizations amongst vulnerable populations, promote adoption of locally based harm reduction strategies, and help people obtain healthcare coverage and jobs. There must be outreach and education regarding the dilemma of SUD leading to commercial sex work, and concerns of IDU disease transmission becoming sexual, and vice versa. We've had success doing all these things at our community outreach center in Scott County.
The Scott County Community Outreach Center has had 789 visitors, with 271 people being tested for HIV and 298 people receiving needed immunizations. 302 people have been enrolled in health care coverage through the Healthy Indiana Plan 2.0 and 38 people have received job referrals through the Indiana Department of Workforce Development.

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

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

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

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

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

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

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

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