



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

July 10, 2017

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing entitled “Combating the Opioid Crisis: Battles in the States”

The Subcommittee on Oversight and Investigations will hold a hearing on Wednesday, July 12, 2017, at 10:00 a.m. in 2123 Rayburn House Office Building, entitled “Combating the Opioid Crisis: Battles in the States.” The United States is experiencing an epidemic of opioid abuse and addiction, with drug overdose deaths increasing dramatically over the last two decades and becoming the leading cause of injury death in the U.S. In the early 21st century, overdose deaths primarily involved prescription opioids and then later, around 2005, heroin. Increasingly since 2013, the apparent next wave of the opioid epidemic includes fentanyl, a synthetic opioid 100 times more powerful than morphine.

This hearing will examine how a few states with particular challenges are battling the opioid crisis, what responses show evidence of effectiveness or great promise, where the federal government can assist with such responses, and any state policies that could help improve the federal response to this growing epidemic. This hearing follows up on a series of hearings that the Subcommittee has held over the past two Congresses. In particular, on May 21, 2015, the Subcommittee held a hearing entitled, “What Are the State Governments Doing to Combat the Opioid Abuse Epidemic?”

Pursuant to the 21st Century Cures Act enacted in December 2016, the Substance Abuse and Mental Health Services Administration (SAMHSA) is administering nearly one billion dollars in grants over the next two years to states and territories for substance abuse prevention programs, treatment, and training for health professionals. This hearing is also an opportunity for the Subcommittee to learn how some of these grants are being spent.

I. WITNESSES

- The Honorable Boyd K. Rutherford, Lt. Governor of Maryland;
- The Honorable Brian J. Moran, the Virginia Secretary of Public Safety and Homeland Security;
- The Honorable Rebecca Boss, Director, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals; and
- The Honorable John Tilley, Kentucky Secretary of the Justice and Public Safety Cabinet.

II. BACKGROUND

a. Committee activity on the opioid epidemic

113th and 114th Congresses. The Subcommittee held a series of hearings, beginning in April 2014 and continuing into early 2015, that examined the growing problem of prescription drug and heroin abuse nationwide and evaluated solutions to address the crisis. In the course of these hearings, the Subcommittee heard testimony from federal, state, and local levels, and developed a record demonstrating not only the various factors contributing to the opioid abuse epidemic, but also a number of possible solutions. Solutions presented at these Subcommittee hearings helped inform the Committee's legislative efforts ultimately enacted into law as part of the Comprehensive Addiction and Recovery Act (CARA), followed by authorized funding included in the 21st Century Cures Act.

115th Congress. Earlier this year the Committee began focusing on the synthetic opioid, fentanyl, which "has spawned a deadly drug crisis in the United States."¹ On February 23, 2017, the bipartisan leaders of the full Committee and the Subcommittee sent a letter to the Acting Director of the Office of National Drug Control Policy (ONDCP) seeking details about the fentanyl problem, actions taken, and any strategic plan to address the fentanyl threat.² On March 21, 2017, the Subcommittee held a hearing on "Fentanyl: The Next Wave of the Opioid Crisis." This hearing examined the unique threat that fentanyl has started to pose in communities across the country and what more we need to do at the federal, state, and local level to tackle fentanyl as part of the opioid epidemic.

On May 9, 2017, the Committee launched an investigation into the distribution of prescription opioids in West Virginia. The Committee sent letters to distributors as well as the Drug Enforcement Administration (DEA) inquiring about how so many prescription opioids have been distributed in such high quantities to such small communities, especially in a state that has the highest opioid overdose death rate in the nation.³ There needs to be a comprehensive approach to combat this growing epidemic that includes all components of the health care and law enforcement community.

¹ Press Release, U.S. Drug Enforcement Admin., *DEA Warning to Police and Public: Fentanyl Exposure Kills*, June 10, 2016, available at <https://www.dea.gov/divisions/hq/2016/hq061016.shtml>.

² Letter from Hon. Greg Walden, Chairman, H. Comm. on Energy & Commerce, Hon. Frank Pallone, Jr., Ranking Member, H. Comm. on Energy & Commerce, Hon. Tim Murphy, Chairman, Subcomm. on Oversight and Investigations, & Hon. Diana DeGette, Ranking Member, Subcomm. on Oversight and Investigations, to Mr. Kemp Chester, Acting Director, ONDCP, February 23, 2017, available at <https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/20170223ONDCP.pdf>.

³ Letters from Hon. Greg Walden, Chairman, H. Comm. on Energy & Commerce, Hon. Frank Pallone, Jr., Ranking Member, H. Comm. on Energy & Commerce, Hon. Tim Murphy, Chairman, Subcomm. on Oversight and Investigations, & Hon. Diana DeGette, Ranking Member, Subcomm. on Oversight and Investigations, to Distributors and DEA, May 8, 2017, available at <https://energycommerce.house.gov/news-center/letters/letters-distributors-and-dea-regarding-alleged-pill-dumping-west-virginia>.

b. Scope of the opioid crisis

Drug overdose trends. Drug-poisoning (overdose) is now the leading cause of death from injury in the U.S., surpassing motor vehicle accidents, suicide, firearms, and homicide. More than 183,000 people have died from overdoses of prescription narcotics between 1999 and 2015, with more than 15,000 deaths in 2015 alone.⁴ Drug overdose deaths in 2016 most likely exceeded 59,000, the largest annual jump ever recorded in the U.S., according to preliminary data collected by the *New York Times*.⁵ Drug overdoses are now the leading cause of death among Americans under 50.⁶

Opioid-use disorders are surging. An analysis of millions of Americans' medical claims showed diagnoses of opioid-use disorder surged roughly 500 percent over the past seven years, according to a review by the Blue Cross Blue Shield Association.⁷ As the opioid crisis accelerates, one forecast projected that almost 500,000 Americans will die from opioids over the next decade.⁸

c. State policies and issues

While opioid abuse is a nationwide epidemic,⁹ state activities vary depending on circumstances in the particular state. For example, beginning in late 2013, there were sudden and large increases in the number of deaths involving fentanyl in a number of states throughout the country, with the increase seen particularly in states on the East Coast.¹⁰ Fentanyl is a narcotic pain reliever used to manage moderate to severe chronic pain.¹¹ The majority of

⁴ Centers for Disease Control and Prevention, Prescription Opioid Overdose Data, updated December 16, 2016, for 2015 alone, the estimate could be as high as 33,000 Americans dying of opioid overdoses, *available at* <https://www.cdc.gov/drugoverdose/data/overdose.html>.

⁵ Josh Katz, *Drug Deaths in America Are Rising Faster than Ever*, N.Y. TIMES, June 5, 2017, *available at* <https://www.nytimes.com/interactive/2017/06/05/upshot/opioid-epidemic-drug-overdose-deaths-are-rising-faster-than-ever.html>.

⁶ *Id.*

⁷ Anne Steele, *Opioid Addiction Climbs by 500%*, WALL ST. J., June 30, 2017, *available at* <https://www.wsj.com/articles/opioid-addiction-diagnoses-up-nearly-500-in-past-seven-years-study-shows-1498737603>.

⁸ Max Blau, STAT forecast: Opioids could kill nearly 500,000 Americans in the next decade, STAT News, June 27, 2017, *available at* <https://www.statnews.com/2017/06/27/opioid-deaths-forecast/>.

⁹ Drug poisoning is the leading cause of death from injury in 30 states, according to CDC in 2011. In addition, opioid analgesics were involved in more than 40 percent of drug poisoning deaths in 2008. According to a 2014 National Association of State Alcohol and Drug Abuse Directors (NASADAD) survey, roughly 40 states consistently say that prescription drug abuse is either “most” or “very” important (slide 17), with 34 states reporting that they have an active prescription drug task force, an increase from 29 reported in 2012. (slide 19). 35 States reported that their strategic plan explicitly addresses prescription drug abuse, and 12 of these states reported that their plan explicitly addresses heroin abuse. 37 states said that heroin abuse is either “most” or “very important” (slide 36), with 15 states reporting that they have an active task force for heroin abuse (slide 40). National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD), “State Substance Abuse Agencies, Prescription Drugs, and Heroin Abuse: Results from a NASADAD Member Inquiry,” 2014 update, *available at* <http://nasadad.org/wp-content/uploads/2014/05/NASADAD-Prescription-Drug-and-Heroin-Abuse-Inquiry-Full-Report-Final.pdf>.

¹⁰ Maryland Department of Health and Mental Hygiene, “Deaths Related to Fentanyl-Laced Heroin and Other Illicit Drugs,” July 2014, *available at* https://health.maryland.gov/data/Documents/fentanyl%20brief_draft.pdf.

¹¹ *Id.*

fentanyl-related deaths do not result from overdoses of pharmaceutical fentanyl, but instead involved an illicit, powdered form of fentanyl that was mixed with, or substituted for, heroin or other illicit substances.¹² In response to this problem, for example, the state of Maryland took the following actions to reduce fentanyl-related overdoses throughout the state: sharing data with law enforcement, expanding access to naloxone (a medication designed to rapidly reverse an opioid overdose)¹³, and launching a public awareness campaign.¹⁴

Despite differences in circumstances, prevention plans, and strategies, the states have identified certain overarching challenges.¹⁵ The challenges have included: a lack of or incomplete data, stigma, the need for increased and interoperable PDMP (Prescription Drug Monitoring Program) utilization, overdose prevention, increasing access to MAT (medication-assisted treatment); and evidence and research on effectiveness of strategies.

Data Needs. Concerns have been raised about real-time data/measurement, data quality, and data utilization. As noted by the National Governors Association, to develop an effective response to prescription drug abuse, states need accurate and timely information about the incidence and scope of the problem. It can be 6 to 12 months before the medical examiner's information becomes available, long after an OTP [opioid treatment programs] has reported the death to the state.¹⁶ States have reported that CDC data is slow to be released and cannot capture real-time changes in drug use that are occurring.¹⁷ For example, a CDC expert told bipartisan Committee staff that time lags in reporting, for example, would mean that CDC would not have 2016 overdose death data until the end of 2017. Moreover, CDC noted they primarily rely on death certificates which sometimes only note a "drug overdose" and do not always list the specific drug(s).

Serious challenges exist concerning state data on the cause of death regarding drug overdose deaths. State death certificates often do not specify the type of drug related to drug overdose deaths.¹⁸ Lethality issues can be hard to separate when multiple drugs are involved, especially with benzodiazepines.¹⁹ Additionally, defining the cause of death in patients receiving MAT is inherently complex, since, regardless of the cause of death, these patients may have a high level of methadone in their blood. Medical examiners often do not know that the individual is receiving methadone treatment.²⁰ Further, many states do not conduct the full medical review

¹² *Id.*

¹³ National Institute on Drug Abuse, Opioid Overdose Reversal with Naloxone (Narcan, Evzio), September 2016, available at <https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio>.

¹⁴ *Id.*

¹⁵ The Substance Abuse and Mental Health Services Administration, Successful Strategies in Addressing Opioid Overdose Deaths, White Paper developed for the Center for Substance Abuse Treatment, March 2010, available at https://www.michigan.gov/documents/mdch/SAMHSA_Overdose_Report_345238_7.pdf.

¹⁶ *Id.* at 11.

¹⁷ National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD), "State Substance Abuse Agencies, Prescription Drugs, and Heroin Abuse: Results from a NASADAD Member Inquiry," slide 14, 2014 update, available at <http://nasadad.org/wp-content/uploads/2014/05/NASADAD-Prescription-Drug-and-Heroin-Abuse-Inquiry-Full-Report-Final.pdf>.

¹⁸ A CDC expert in a briefing with Committee Staff estimated that 25 percent of death certificates listing overdose as a cause did not specify the drug.

¹⁹ Successful strategies, *Supra* note 15 at 10.

²⁰ *Id.*

for determining the cause of death.²¹ For example, Colorado noted that from 2004 to 2013, 2.4 percent of Colorado death certificates had an unknown cause of death.²²

CDC believes information collected in Will County, Illinois that tracks “accidental overdoses” by date of death, cause of death, and personal demographics would be extremely helpful if it were collected on all death certificates of drug overdose deaths in the U.S.²³ This information is useful to public health, medical, and legal entities as it helps researchers, investigators, health care providers, and public health practitioners understand and identify drug use risks, appropriate clinical and behavioral care, and possible public health interventions.²⁴ CDC reported to the Subcommittee that there are multiple national and state efforts underway to address these issues that align with the effort in Will County.²⁵ Currently, CDC is partnering with the Association of State and Territorial Health Officials (ASTHO) on a project to improve drug specificity on death certificates.²⁶

In a response to a Question for the Record that was submitted following the 2015 Subcommittee hearing, one state government witness noted that it had become clear that her state’s ability to address the underlying health issues and social determinants that are driving this epidemic “is dependent on the state’s ability to successfully leverage data and measure results.”²⁷ This witness wrote that her state had more “than 300 different internal data sources that have been developed by individual programs using a variety of different formats for a variety of different purposes. They are managed by different staff, reside on different servers, and don’t talk to each other.”²⁸

Stigma. The stigma associated with seeking treatment was reported by states in 2014 as one of the top remaining challenges.²⁹ In addition to the underlying stigma against addiction, stigma and bias against MAT exists even after research has proved its value for treating opioid dependence. The stigma underlies a score of issues that states confront in developing their strategies. Such issues include: state moratoriums on establishing new opioid treatment programs (OTPs) despite large, unmet treatment needs for the opioid-dependent population, unwillingness of the criminal justice system to set up MAT in correctional facilities, and the requirement of some drug court judges that people must abandon the usage of MAT to participate in the program and of some family court judges who mandate that individuals must

²¹ *Id.*

²² Colorado Department of Public Health & Environment, Special Emphasis report: Drug Overdose Deaths, 1999-2013, October 2014, page 196-197, *available at* https://www.colorado.gov/pacific/sites/default/files/LPH_MCH_NA-Report-Appendix-only_2016-2020.pdf.

²³ Dr. Debra Houry, Director, National Center for Injury Prevention and Control, CDC, Responses to Questions for the Record, Subcomm. hearing on “Fentanyl: The Next Wave of the Opioid Crisis,” March 21, 2017, *available at* <http://docs.house.gov/meetings/IF/IF02/20170321/105739/HHRG-115-IF02-Wstate-HouryD-20170321-SD026.pdf>.

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.*

²⁷ Commissioner Monica Bharel, MD, MPH, Massachusetts Department of Public Health, Responses to Questions for the Record, “What are the State Governments Doing to Combat the Opioid Epidemic?”, Serial No. 114-46, 102, May 21, 2015, *available at* <http://docs.house.gov/meetings/IF/IF02/20150521/103501/HHRG-114-IF02-Wstate-BharelM-20150521-SD003.pdf>.

²⁸ *Id.*

²⁹ NASADAD, 2014 update, *Supra* note 9, at slide 34.

stop MAT before receiving custody of their children.³⁰ State initiatives to reduce the stigma of treatment for opioid use disorders are: increasing access to a full range of evidence-based therapies, facilitating access to recovery support services, and expanding access to effective therapies in the criminal justice system.³¹

Need for PDMP improvement. PDMPs are state-run electronic databases of prescriptions for controlled substances. PDMPs can provide a prescriber or pharmacist with information regarding a patient's prescription history, allowing prescribers to identify patients who are potentially abusing medications. With Missouri adopting a PDMP in April 2017, all 50 states, the District of Columbia, and Guam have legislation authorizing the creation and operation of a PDMP, and all but the District of Columbia program are operational.³² While there is evidence indicating the potential of PDMPs to identify high-risk patients and impact prescribing behaviors, the effectiveness of PDMPs is constrained by the lack of consistent utilization, timely data in some states, and limited interoperability with other PDMPs. Witnesses at the March 26, 2015, Subcommittee hearing also testified about their concerns over methadone clinics not being required to report methadone dispensing to PDMPs. One witness said it was "a very serious situation" because if these patients do not disclose their methadone treatment to their primary care providers and the providers do not know about it from accessing the PDMP, other opioids or benzodiazepines could be prescribed leading to an increased risk of an overdose death.³³ Another concern that was expressed at the hearing related to neonatal doctors not knowing about methadone treatment for pregnant women, which poses potential problems for the mother and the life of the fetus if the methadone is being increased while the mother and baby are receiving MAT to treat the addiction.³⁴

States have noted that it is critical to an effective statewide strategy for combatting opioid abuse to improve the effectiveness and use of PDMPs. While 50 states and the District of Columbia have legislation authorizing the creation and operation of a PDMP, they vary in their degree of use and overall effectiveness depending on who is registered to use them, whether data is current or real-time, whether there are limitations on authorized users, and whether processes

³⁰ Successful strategies, *Supra* note 15 at 9.

³¹ NASADAD 2014 update, *Supra* note 9, slide 48.

³² Summer Ballentine, *Missouri House Passes Prescription Drug Tracking Program*, ASSOC. PRESS, April 3, 2017, available at <https://www.usnews.com/news/best-states/missouri/articles/2017-04-03/missouri-house-passes-prescription-drug-tracking-program>. PDMP Training and Technical Assistance center, PDMP Frequently Asked Questions, available at <http://www.pdmpassist.org/content/prescription-drug-monitoring-frequently-asked-questions-faq>.

³³ *Examining the Growing Problems of Prescription Drug and Heroin Abuse: State and Local Perspectives Before the H. Comm. on Energy & Commerce Subcomm. on Oversight and Investigations, 114th CONG*, Unofficial hearing transcript, 40, Testimony of Fred Wells Brason II, Executive Director, Project Lazarus, Moravian Falls, North Carolina, March 26, 2015, available at <http://docs.house.gov/meetings/IF/IF02/20150326/103254/HHRG-114-IF02-Transcript-20150326.pdf>.

³⁴ *Examining the Growing Problems of Prescription Drug and Heroin Abuse: State and Local Perspectives Before the H. Comm. on Energy & Commerce Subcomm. on Oversight and Investigations, 114th CONG*, Unofficial hearing transcript, 90, Testimony of Stefan R. Maxwell, MD, Chair, West Virginia Perinatal Partnership, MEDNAX Medical Group, Director NICU, Charleston Area Medical Center, Charleston, West Virginia, March 26, 2015, available at <http://docs.house.gov/meetings/IF/IF02/20150326/103254/HHRG-114-IF02-Transcript-20150326.pdf>.

for accessing the databases integrate easily into clinical workflows.³⁵ Another major component of these PDMPs is their interoperability with other states, particularly neighboring states. The level of interoperability with other states varies greatly and currently lacks uniformity. This is a weakness among the programs because the lack of data sharing allows patients to doctor shop across state lines. Thus, a White House report issued in 2011 declared that “[a] major effort must be undertaken to improve the functioning of state PDMPs, especially regarding real-time data access by clinicians, and to increase the inter-state operability and communication.”³⁶ In addition, in many states, privacy concerns may limit the extent to which PDMP data can be used for law enforcement, public health, and research purposes.

Some states are providing out-of-state access to their PDMPs. For example, prescribers in states bordering Maryland (Delaware, the District of Columbia, West Virginia, northern Virginia, and southern Pennsylvania) can have access to the Maryland PDMP. Maryland currently shares with limited states, but will continue adding new connections.³⁷ In addition, pharmacists employed outside of Maryland, but who possess a Maryland pharmacist’s license and dispense to Maryland residents are allowed to have access to the PDMP.³⁸

States also vary with respect to their continuing medical education (CME) requirements for physicians. Some state licensing boards have established more robust CME requirements to improve prescribing practices among doctors in their state. California is an example of a state that has implemented stricter CME for prescribing doctors while other states may have very little required CME of their doctors. With the release of the CDC guidelines for primary care providers prescribing opioids for chronic non-cancer pain, states are looking to these guidelines as an important tool for curbing overprescribing of opioids.³⁹

CDC experts have found that a few states have been able to change prescribing patterns by increasing prescriber use of their PDMPs.⁴⁰ New York and Tennessee, for example, mandated prescriber use of the state PDMP in 2012.⁴¹ They subsequently used their PDMPs to document declines of 75 percent and 36 percent, respectively, in their inappropriate use of multiple prescribers by patients.⁴² Other actions taken by states affecting prescribers that CDC experts believe are promising interventions are: developing or adopting existing guidelines for prescribing opioid pain relievers that can establish local standards of care that might bring

³⁵ National Governors Association (NGA), “Six Strategies for Reducing Prescription Drug Abuse,” Issue Brief, September 2012, *available at* <https://www.nga.org/cms/home/nga-center-for-best-practices/center-publications/page-hsps-publications/six-strategies-for-reducing-pres.html>.

³⁶ Executive Office of the President of the United States, “Epidemic: Responding to America’s Prescription Drug Abuse Crisis,” Page 6, 2011, *available at* https://www.ncjrs.gov/pdffiles1/ondcp/rx_abuse_plan.pdf.

³⁷ Maryland Department of Health and Mental Hygiene, PDMP FAQ, May 22, 2017, *available at* <https://www.crisphealth.org/wp-content/uploads/2017/05/PDMP-FAQ-v3.pdf>.

³⁸ *Id.*

³⁹ National Governors Association, Governors’ Priorities for Addressing the Nation’s Opioid Crisis, February 18, 2016, *available at* <https://www.nga.org/cms/home/special/col2-content/governors-priorities-opioid.html>.

⁴⁰ L. Paulozzi, et al, 63 CDC Morbidity and Mortality Weekly Report (MMWR), “Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines – United States, 2012,” 563, July 4, 2014, *available at* <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a2.htm>.

⁴¹ *Id.*

⁴² *Id.*, citing Prescription Drug Monitoring Program Center of Excellence at Brandeis University. Mandating PDMP participation by medical providers: current status and experience in selected states.

prescribing rates more in line with current best practices, state Medicaid programs managing pharmacy benefits to promote cautious, consistent use of opioids, and enacting law to address the most egregious prescribing incidents.⁴³

The National Institute of Drug Abuse (NIDA) recently reported to the Subcommittee that in states with the most comprehensive initiatives to reduce opioid overprescribing, “the results have been encouraging.”⁴⁴ The state of Washington’s implementation of evidence-based dosing and best-practice guidelines, as well as enhanced funding for the state’s PDMP, helped reduce opioid deaths by 27 percent between 2008 and 2012.⁴⁵ In Florida, new restrictions were imposed on pain clinics, new policies were implemented requiring more consistent use of the state PDMP, and the DEA worked with state law enforcement to conduct widespread raids on pill mills, which resulted in a dramatic decrease in opioid prescribing and in overdose death between 2010 and 2012.⁴⁶ A recent analysis by the CDC found that while the rate of prescribing has decreased since 2010, the prescribing rate in 2015 is still three times as high as it was in 1999 and the amount of opioids prescribed in 2015 was enough for every American to be medicated around the clock for three weeks.⁴⁷

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

Overdose prevention. State efforts to combat heroin abuse have varied from state to state. For example, several states have passed laws that generally provide immunity for victims and witnesses who act in good faith and seek medical assistance for an overdose; these laws are commonly referred to as “Good Samaritan Laws.”⁴⁸ States have also taken different approaches to expanding access to naloxone, with some states permitting third party prescribing by family and friends of individuals who are at high-risk of overdose, and others providing a standing order for community organizations who distribute naloxone to those who meet certain criteria.⁴⁹ Liability protection for prescribers who administer naloxone, as well as the nature of naloxone distribution programs may differ from one state to the other.⁵⁰ In addition, many states have established task forces, or have initiated new law enforcement efforts to combat heroin and prescription opioids.⁵¹

⁴³ *Id.* For example, Florida enacted pain clinic legislation in 2010 and prohibited dispensing by prescribers in 2011.

⁴⁴ Dr. Wilson Compton, Deputy Director, NIDA, responses to Questions for the Record, “Fentanyl: The Next Wave of the Opioid Crisis,” March 21, 2017, *available at* <http://docs.house.gov/meetings/IF/IF02/20170321/105739/HHRG-115-IF02-Wstate-ComptonW-20170321-SD028.pdf>.

⁴⁵ *Id.* citing G. Franklin *et al*, A Comprehensive Approach to Address the Prescription Opioid Epidemic in Washington State: Milestones and Lessons Learned, 105 American Journal of Public Health 463 (2015).

⁴⁶ *Id.* citing H. Johnson *et al*, Decline in drug overdose death after state policy changes – Florida, 2010-2012, 63 MMWR 569 (2014).

⁴⁷ Centers for Disease Control and Prevention, Vital Signs, *Opioid Prescribing*, July 6, 2017, *available at* <https://www.cdc.gov/vitalsigns/opioids/index.html>.

⁴⁸ NGA, *Supra* note 35.

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

Naloxone is still a prescription in all 50 states and the District of Columbia, although states are taking steps to make naloxone available to their communities. Forty states and the District of Columbia have passed laws that in some way expand the availability of naloxone.⁵² This is a dramatic increase compared to the 17 states that had such laws in 2013.⁵³

States' efforts in this area have also targeted the proper disposal of prescription drugs. The majority of people who abuse or misuse prescription drugs get them from friends and family; many of those drugs are leftover because a patient did not take the full amount of pills prescribed to them. These efforts have included public education on proper disposal and take-back activities, such as designating times and places where the public can safely dispose of unused prescription medication.⁵⁴

The AnchorED program, developed in Rhode Island, matches overdose victims with peer recovery coaches to encourage treatment.⁵⁵ Michelle Harter, Manager of Operations for Anchor Recovery Community Centers, described how the program works:

When a person is brought to a hospital emergency department with an opioid overdose, a member of the hospital staff calls the AnchorED hotline, which is available 24 hours a day, 7 days a week. The hotline connects the caller with a peer recovery coach, who is then dispatched to the hospital. Prior to the patient's release from the hospital, the recovery coach meets with the patient to discuss available recovery supports and resources in the community. Coaches can also provide education on overdose prevention, including information on how to obtain Narcan or Naloxone, a medication used to reverse an opioid overdose, and may provide additional resources and support to family members with the patient's approval. Upon the patient's release from the hospital, AnchorED staff follow-up with the patient for the next 10 days, encouraging him or her to engage in recovery support services.⁵⁶

Increasing access to MAT. In 2015, 8.4 million people needed treatment for drug addiction, yet four out of five did not receive it.⁵⁷ Forty-nine states and the District of Columbia have opioid treatment programs. All 50 states and the District of Columbia have physicians with waivers to prescribe buprenorphine. All three FDA-approved opioid treatment medications (methadone, buprenorphine, and naltrexone) are covered under the Medicaid Drug Rebate Program. The associated co-pays and authorization requirements vary from state to state. Twenty-six states reported in 2014 that they have expanded or made plans to expand MAT in the

⁵² NASADAD, Overview of State Legislation to Increase Access to Treatment for Opioid Overdose, September 8, 2015, *available at* <http://nasadad.org/2015/09/overview-of-state-legislation-to-increase-access-to-treatment-for-opioid-overdose-3/>.

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ Addiction Policy Forum, AnchorED Rhode Island, February 2, 2017, *available at* <http://www.addictionpolicy.org/single-post/2017/02/02/AnchorED-Rhode-Island>.

⁵⁶ *Id.* quoting Michelle Harter, Manager of Operations, Anchor Recovery Community Centers.

⁵⁷ Statement of Richard Baum, Acting Director of the Office of National Drug Control Policy (ONDCP) cited in A. Knopf, Report from NASADAD – ONDCP to State Director: Increase Access to Treatment, June 2, 2017, *available at* <http://atforum.com/2017/06/report-nasadad-ondcp-state-directors-increase-access-treatment/>.

two years prior.⁵⁸ Although the opioid addiction field recognizes addiction as a chronic, relapsing disease, some substance abuse counselors and administrators have been reluctant to embrace new technologies for its treatment.⁵⁹ At the same time, most physicians and other health care professionals receive little or no training in the treatment of addiction.⁶⁰ As a result, adoption of MAT has been slow in some areas.⁶¹

Evidence and research on effectiveness of strategies. Very little evidence-based research exists on the most cost-effective and efficacious strategies for states to use in order to reduce opioid-related overdoses, however states are seeking guidance.⁶² Massachusetts, when developing its comprehensive state overdose prevention plan, turned to international sources to identify successful strategies.⁶³ States have also been frustrated from not knowing the outcomes of their actions.⁶⁴ Potential outcomes include: (1) Did physicians change their opioid prescribing practices after receiving webinars and other training; (2) Why do so many physicians train to become registered providers of buprenorphine for addiction, and then not treat any patients; and (3) When informed by letter that a patient has shown up on the PDMP with multiple opioid prescriptions, does the prescribing doctor take action, and, if so, what action?⁶⁵ State representatives particularly requested studies that would look at overdose outcomes for opioid-dependent patients who receive drug-free treatment compared to those receiving MAT.⁶⁶

III. ISSUES

The following issues may be examined at the hearing:

- What are the most critical data gaps facing state governments combating the opioid crisis?
- How can data collection and reporting in the states be improved for responding to the opioid epidemic?
- How could the federal response help bolster state PDMP programs?
- How can states improve surveillance of the fentanyl epidemic?
- What initiatives and programs are the states utilizing that have been successful?
- What barriers exist to enacting successful programs?

⁵⁸ NASADAD, 2014 update, *Supra* note 9, slide 45.

⁵⁹ Statement of Mark G. Stringer, Director of Division of Behavioral Health, Missouri Department of Mental Health, available at <http://dmh.mo.gov/ada/provider/medicationassistedtreatment.html>.

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² Successful strategies, *Supra* note 15, at 9.

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.* at 10.

- What additional burdens is the opioid crisis putting on society, the healthcare system, the criminal justice system, the emergency response system, and state budgets?

IV. STAFF CONTACTS

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