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**U.S. House Energy & Commerce Health Subcommittee**  
**Testimony Re: HR 3545**  
***The Overdose Prevention and Safety Act***  
May 8<sup>th</sup>, 2018

Chairman Burgess, Vice Chair Guthrie, Ranking Member Greene and members of the Energy and Commerce Subcommittee on Health, thank you for this opportunity to testify before you today regarding HR 3545, the Overdose Prevention and Safety Act.

As you know, our nation is in the midst of a public health crisis. Opiates are killing more and more people each year. In 2016, my home state of Ohio had the second highest opiate overdose death rate in the nation. According to the Centers for Disease Control and Prevention, 10,383 people have died from opiate overdoses since 2014.

One of the people who died of an opiate overdose in 2014 was my big brother, Brandon Johnathan McKee. He was 36. He was the father of three sons, ages 4, 11 and 16 at the time of his death.

Brandon's death was preventable. However, in part because of the antiquated provisions contained within 42 CFR Part 2, the medical professionals that prescribed him opiate based pain medications were not able to identify him as a high risk individual with a history of substance use disorders, substance use treatment, and countless relapses.

Brandon struggled with addiction for most of his adult life. When he was 17, he fell while attempting a trick on his skateboard and dislocated his shoulder. His ex-wife recalls him frequently saying that the opiate based pain medication he was given intravenously in the emergency department gave him the best sensation that he had ever experienced in his life. It seems as though that incident was the beginning of a long and ultimately unsuccessful battle with substance use and addiction.

Brandon was a talented salesman. By age 21, he was making a six figure salary as a sales manager at a car dealership in Mansfield, Ohio. However, despite his career success, his addictions constantly plagued him. Even after receiving two courses of residential substance use treatment, and ongoing outpatient treatment, his substance use led to several eventual job losses, multiple DUI's, family strife, and an eventual divorce.

After his divorce, Brandon moved into my mother's basement in Wooster, Ohio. He was 35 at the time. Although he was trying to get sober and going to meetings, he relapsed one night. He took his truck to the bar after taking some mixture of tranquilizers and alcohol. He drank until the tavern closed, and then tried to drive his truck home. That night, he passed out behind the wheel and crashed into a large post, shattering several vertebrae in his back.

After the accident he was taken to Wooster Community Hospital and was eventually transported to Cleveland Metro Hospital where he would have back surgery to repair his spine. Because of 42 CFR Part 2, his orthopedic surgeon had no way of knowing that Brandon had a serious opiate related substance use disorder. Brandon did not sign a waiver, nor would he ever sign such a waiver if he had a chance to get a long-term prescription for opiate pain killers. These medications made him feel perfect, and he couldn't resist such an opportunity.

After the surgery, his surgeon gave him a prescription for a high dose opiate-based pain medication, with multiple refills. Four months later, he fell down and broke the titanium screws in his back. This second accident required a second surgery. Due to 42 CFR Part 2, the surgeon was once again unable to see that Brandon was an addict with a long history of substance use disorder treatment. Unsurprisingly, this lack of care coordination led to yet another prescription for a high dose opiate-based pain medication with multiple refills.

After Brandon's pain medication prescriptions were used up, he turned to street heroin. However, until his fatal overdose, none of us knew that he was an intravenous drug user. He was going to work every day, selling cars and living in his own apartment.

Three days before he died, he called me. He finally admitted to me, and only me, that he was struggling with narcotics. He never told me he was addicted to heroin, he was too ashamed to say so. However, he said he'd been taking opiate based pain pills, and had been off of them for a week and a half.

He was crying. He told me he had made it through the "dope sickness" of withdraw, and would be attending an N.A. meeting that evening. Ironically, during our conversation, the battery in his phone was drained and his phone cut off before the conversation was finished. The last words he said to me was "I'm going to go to that meeting brother, I promise", and then the phone shut off.

Three days later, he died of a heroin overdose, alone in his apartment. He was found curled up in the fetal position. It was May 10<sup>th</sup>, 2014.

Mr. Chairman, as Brandon's tragic story demonstrates, 42 CFR Part 2 is a significant barrier to integrating physical and behavioral health. It is also a major patient safety issue. We at the National Alliance on Mental Illness (NAMI) feel strongly that this barrier to integration and source bad outcomes (for both physical and behavioral health) needs to be updated and brought into the 21<sup>st</sup> Century.

Individuals diagnosed with a mental health conditions are at much greater risk of abusing substances and falling into the grip of addiction. Additionally, we know that siloed treatment for mental illness and addiction is ineffective and leads to negative outcomes in both an individual's mental health and substance use condition. In many instances, it also creates an even greater risk that individuals will experience poorly managed co-morbid, chronic medical conditions. This is a major contributing factor to the high rates of early mortality for individuals living with mental illness. Numerous studies have found that life expectancy for adults with mental illness may be as much as 25 years less than the general population.

Integrating care across not only mental health and substance use care, but also with primary and specialty medical care, is effective at improving clinical outcomes. It also lowers overall costs across public programs, such as Medicare and Medicaid, and private programs like employer-provided health insurance. However, integration cannot be achieved without the sharing of treatment records among providers. 42 CFR Part 2 remains a significant barrier to the sharing of clinical data and the proper coordination of care. These burdensome consent requirements that are not aligned with HIPAA further

stigmatize mental illness and substance abuse as separate from the rest of the health care system. Parity is necessary across the health care system to ensure that behavioral health records are managed the same as all patient data. 2018 marks the 10<sup>th</sup> anniversary of this Committee passing the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act (MHPAEA). This was a huge victory for Americans living with mental illness and substance use disorders. At the same time, we will never achieve full parity until we live by the same rules and standards as the rest of health care. This is especially the case with the sharing of critical health information and the integration of care for the whole patient.

I would further emphasize that HR 3545 takes a very narrow targeted approach that simply aligns 42 CFR Part 2 with HIPAA for the purposes of sharing information for “treatment, payment and health care operations” or TPO. This legislation in no way places treatment records at risk of being shared outside of the context of health care TPO, that is to landlords, employers, law enforcement or civil litigation. In fact, the current draft strengthens existing penalties for inappropriate or illegal disclosure of behavioral health treatment records.

With bipartisan support, this Committee has embraced alternative payment models (APMs) and is moving our nation’s health care system toward paying for “value over volume.” As long as behavioral health records remain subject to separate rules that prevent the sharing of data for treatment, payment and health care operations, mental health and substance use will again be left behind the rest of the health care system. As you advance addiction treatment legislation this spring, I urge you to include the provisions that are in HR 3545 in any bill that is produced by the Committee. This is an important opportunity to improve coordination of care and produce better outcomes for people with mental health and substance use conditions.

Separate is never equal. It is time to align 42 CFR Part 2 with HIPAA and move us toward the goal of true health care integration.

The members of this subcommittee, along with their colleagues in the One Hundred Fifteenth United States Congress have an opportunity to prevent deaths like these. By passing HR 3545 and removing the antiquated barriers to care integration that exist today because of 42 CFR Part 2, physicians with high risk patients like Brandon can be fully informed so they can medically manage the hazards associated with prescribing opiate-based pain medications to people with a history of addiction treatment.

I urge you to make the common sense policy changes in HR 3545 by passing this legislation. The lives of your constituents may actually depend on it.

Thank you again for this opportunity to testify. I would be happy to answer any questions that the committee has at this time.