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**Testimony of Jean Ross, RN
On Behalf of National Nurses United
Before the
House Oversight Committee
June 19, 2019**

Medical Experts: Inadequate Federal Approach to Opioid Treatment and the Need to Expand Care

Good morning and thank you, Chairman Cummings, Ranking Member Jordan, and members of the committee for holding this important hearing today. I have been a registered nurse for over 40 years, and I am President of National Nurses United (NNU), the largest union representing RNs in the United States. We represent over 155,000 members who work as bedside healthcare professionals in every state in the nation.

As registered nurses, NNU members see daily how the opioid and substance use epidemic has had tremendous impact on our patients and communities. Nurses not only provide care in response to overdose emergencies, but we witness how barriers to accessing much needed treatment and prevention services for substance use disorders has caused and exacerbated the opioid epidemic. We witness how poverty, income inequality, racism, and unethical profiteering by the pharmaceutical and health insurance industries all contribute to the inequitable responses to our current crisis. We are failing as a nation to ensure that our most vulnerable communities have the resources they need for substance use disorder treatment and prevention.

In my testimony today, I will make three main points. First, there is an abject lack of access to treatment, prevention, and harm reduction services for patients with opioid use disorder or patients at risk of opioid use disorder. Second, inequality and specifically health inequity is a main driver of the opioid epidemic, and, in order to comprehensively combat the opioid epidemic, we must address the broader problem of health inequity. Third, despite well-meaning steps forward, the national response to the opioid epidemic is inadequate and it must be sufficiently increased to ensure that people receive the substance use disorder treatment and prevention services they need.

I. Lack of Access to Treatment, Prevention, and Harm Reduction Services.

In many areas across the country, there are too few or no local providers who offer medication assisted treatment (MAT), withdrawal or detox services, inpatient or residential

treatment, or overdose treatment. Harm reduction services to prevent overdose, death, or disease transmission—like needle exchanges, drug testing kits, and safe injection sites—are also seldom available. Local facilities and providers have limited naloxone supply because of its high costs. In many places, early intervention and prevention services are nonexistent—people at risk for substance use are not provided the counseling or mental health services that they need. There are often no facilities that offer recovery and support services to help with the housing, job-related, child-care, or other services that people in recovery so desperately need. Registered Nurses from National Nurses United report that this lack of services exists in diverse communities in many parts of the nation, both urban and rural.

It is important to make clear that these services must all exist together—it is not enough just to ensure that patients have access to naloxone or other medically assisted treatment. Rather, communities need the resources to build all the infrastructure needed to comprehensively address this epidemic from community led prevention services and harm reduction services for substance users, to early-intervention services for people who have developed substance use disorder, to treatment services supplemented by recovery and support services.

A. Lack of Providers and Services.

Although the opioid epidemic impacts every segment of our nation, the crisis has grown exponentially in our most vulnerable communities where safety-net health services are underfunded, under-resourced, or simply non-existent.

I want to highlight one particular community here, where NNU members have lived and worked—Stark County, Ohio. Stark County has almost twice the rate of opioid overdose deaths than the U.S. overall.¹ From 2010 to 2015, the rate of unintentional drug overdose deaths in Ohio nearly doubled.² Nurses in Stark County report that, at times, the morgue in the county cannot handle the number of people dying of overdoses so they must resort to using refrigerated trailers to hold the bodies.³ And the problem has been getting worse with the increase of synthetic

¹ The Centers for Disease Control and Prevention reports that, in 2017, there were 39.2 opioid overdose deaths per 100,000 in Ohio. This is more than double the rate in the US overall, which is 14.9 deaths per 100,000. There were 27.3 opioid overdose deaths per 100,000 in Stark County. Daniulaityte, Raminta et al. Centers for Disease Control and Prevention. U.S. Department of Health and Human Services. “Overdose Deaths Related to Fentanyl and Its Analogs — Ohio, January–February 2017.” *MMWR Morbidity & Mortality Weekly Report* (Sept. 2017), Vol. 66:904-8, available at <http://dx.doi.org/10.15585/mmwr.mm6634a3External>.

² *Id.*

³ Phillips, Kristine. “Drugs are killing so many people in Ohio that cold storage trailers are being used as morgues.” *Washington Post* (March 16, 2017), https://www.washingtonpost.com/news/to-your-health/wp/2017/03/16/drugs-are-killing-so-many-in-this-county-that-cold-storage-trailers-are-being-used-as-morgues/?utm_term=.15038afea879.

opioids. In 2017, 90% of unintentional overdose deaths in Ohio were due to fentanyl or other synthetic opioids, like carfentanil.⁴

It is no surprise that overdoses and substance use disorder has been rising in Stark County. There is an utter lack of health care services and providers to prevent or treat opioid substance use disorders. In recent years, the county has lost several mental health service providers and acute care facilities. The last general inpatient psychiatric unit in Stark County closed just last September.⁵

The lack of prevention and treatment services available in vulnerable communities such as Stark County means that people do not get treatment for underlying health conditions, and they often wait until they are overdosing to seek emergency care. Often, by the time our nurses see them, they are dying.

Similarly, NNU members in Florida's Tampa Bay Area report that their hospital regularly sees the same patients overdosing on drugs. The hospital treats the patient's immediate crisis, but there are no follow up or community-based services available for patients.

In California, NNU nurses report seeing more and more patients with complicated health needs due to the lack of mental health care in the community. These patients commonly self-medicate their mental health conditions with opioids and other drugs. When they end up at the hospital, they are often there for long periods of time and need complex care to treat their mental health conditions but nurses in an acute care setting are often unable to provide the ongoing treatment that these patients need.

Other barriers to access persist even if facilities and providers are available. Medication assisted treatment, harm reduction services, early intervention, and recovery services may not be covered by insurance. These services, even if you have insurance and even if providers are available in your area, are unaffordable for most. They are either cost prohibitive because of cost-sharing, people cannot afford to lose their job by seeking treatment, or people have no access to child care or transportation if they need to seek treatment.

B. Lack of Access to Naloxone and Medication Assisted Treatment.

⁴ Daniulaityte (2017) at 904.

⁵ Pritchard, Edd. "Aultman psychiatric unit closed." GateHouse Media Ohio (Sept. 12, 2018), available at <https://www.cantonrep.com/news/20180912/aultman-psychiatric-unit-closed>.

The importance of scaling up access to the opioid overdose antidote, naloxone, and medication assisted treatment, including buprenorphine, methadone, and naltrexone, cannot be overstated. Medical science has given us the treatments we need to address this disorder, and to prevent it from killing our patients, but high prices and lack of resources and education are preventing us from saving lives.

Tens of thousands of people die needlessly of overdose every single year, when naloxone could have prevented their deaths. Currently, the price of naloxone, which has risen in recent years, is cost-prohibitive for local and state governments. Further training and education of health professionals on how to effectively administer this lifesaving treatment is necessary to allow its use to be dramatically scaled up. Most states no longer require a prescription to purchase naloxone, but surveys have shown that many pharmacies aren't aware of that change.⁶ Broad education for pharmacies, health care providers, and communities about the ability to purchase naloxone without a prescription is needed.

Through the use of other medication assisted treatment including buprenorphine, methadone, naltrexone, and other medications, patients with substance use disorder have a lower risk for overdose and an improved chance for recovery. Given the benefits of medication assisted treatment, it's important to give patients the opportunity to use these treatment methods if appropriate.

C. Occupational Exposures Add to the Crisis.

Occupational exposures to opioids affect health care workers, first responders, emergency personnel, postal workers, customs agents, correctional workers, and many others. These exposures directly impact NNU members. For example, in hard hit areas like Stark County, patients are often brought to the hospital, unconscious and unresponsive, in private vehicles or dropped off outside the emergency department on the sidewalk. In 2017, when providing care to such a patient at a Stark County hospital, three nurses were exposed to opioids, lost consciousness, and had to be revived with multiple doses of naloxone. This kind of secondary exposure to opioids has received inadequate attention. It is critical that Congress require the National Institute for Occupational Safety and Health and other agencies to address hazardous occupational exposures to opioids.

⁶ For example, a survey of Ohio pharmacies in 2018 conducted by *The Plain Dealer* in Ohio in 2018 found that a majority did not know that a prescription was not required to purchase naloxone in the state. Zeltner, Brie. "Life-saving overdose antidote Narcan should be available across northeast Ohio, but it's not." *The Plain Dealer* (April 29, 2018), available at <https://www.cleveland.com/healthfit/2018/04/life-saving-overdose-antidote.html>.

II. Economic, Racial, and Health Inequity Drive the Opioid Epidemic.

As we provide care to patients with opioid and substance use disorder, nurses see the devastation that economic, racial, and health inequality causes in their lives. The opioid epidemic does not exist in a vacuum—it is a symptom of the deeply unjust, systemic inequalities that exist in our nation.

Returning to Stark County, Ohio, we can see how health inequity has driven the opioid epidemic. Recent factory closures, other workplace closures, and poverty have contributed to high opioid use and overdose rates. Research literature has shown what we know as nurses to be true—that income inequality and lack of access to comprehensive health care contribute to the current opioid overdose crisis and substance use disorder. A one percent increase in unemployment is predicted to increase opioid fatalities by 3.5 percent and is predicted to increase opioid-related overdose emergency room visits by 7 percent.⁷ A recent piece in the *American Journal of Public Health* last year found that both economic and social distress—including poverty, lack of opportunity, and substandard living and working conditions—are factors in the opioid crisis. The authors observed that, “Over reliance on opioid medications is emblematic of a health care system that incentivizes quick, simplistic answers to complex physical and mental health needs. In an analogous way, simplistic measures to cut access to opioids offer illusory solutions to this multidimensional societal challenge.”⁸

Health inequity can drive people who have pain, whether physical or psychological, towards opioid use and substance use disorders. Often patients lack access to the kind of comprehensive health care services they need to manage their pain safely in addition to or in lieu of opioids, like surgery, rehabilitation, mental health services, or physical therapy. Some insurers won’t cover these services. As a result, some patients turn to self-medication through illicit opioids or opioid diversion. For others who have insurance, opioids may present the lowest cost-option available to manage pain. Importantly, for some patients, opioids may be an appropriate intervention for pain management when offered with other regular services that together ensure safety and effectiveness. However, financial barriers can prevent these patients from receiving the comprehensive care they need in addition to their opioid use, which may put them in danger of addiction and overdose.

⁷ Hollingsworth, Alex et al. “Macroeconomic Conditions and Opioid Abuse.” NBER Working Paper No. 23192. National Bureau of Economic Research (2017).

⁸ Dasgupta, Nabarun, Leo Beletsky, and Daniel Ciccarone. “Opioid Crisis” No Easy Fix to Its Social and Economic Determinants.” *Amer. J. Public Health* (2018). Vol. 108(2): 182-86, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5846593/>.

The opioid epidemic is a rapidly increasing concern in communities of color and, particularly, in African American communities. Opioid overdoses are increasing at faster rates for African Americans than other groups, more than doubling between 2011 and 2017.⁹ In 2017, Illinois, Iowa, Michigan, Minnesota, Missouri, Washington, West Virginia, Wisconsin, and the District of Columbia all had higher rates of opioid overdoses for African Americans than for white communities.¹⁰ The United States has extreme health and health care disparities among racial and ethnic populations that impact African American, Native American, and Latinx communities the hardest. These communities have disproportionately lower access to health care services, and, as a result, are at higher risk of unmanaged substance use disorder and overdose.

Long-standing inequities in access to healthcare in communities of color are reflected in how our nation is currently addressing the substance use epidemic in these communities. The way in which our country has thus far approached the substance use crisis serves to perpetuate and exacerbate health inequality. Rather than preventing overdose deaths in communities of color, decades of the “War on Drugs” has led to the incarceration of millions of African American, Native American, and Latinx people, while failing to address substance use disorders as a public health issue. It is critical that the federal government moves away from law enforcement and criminalization, and instead responds to all substance use disorders through public health interventions.

III. Broadening and Enhancing the Federal Government’s Response to the Opioid Epidemic.

In order to address the massive scale of the opioid and substance use epidemic, it is necessary to invest a significant amount of financial resources into a dramatic scale-up of treatment, prevention, and harm reduction services. The Comprehensive Addiction Resources Emergency Act of 2019 (CARE) provides a multi-pronged approach using treatment and prevention to slow and halt the opioid epidemic. Most importantly, this proposed legislation would appropriate \$100 billion over ten years to respond to this crisis. This is an adequate financial commitment that would allow our nation to sufficiently address the scale of this epidemic. As nurses, we know that this sum of money, and the ways in which it would be allocated, would save our patients lives.

⁹ See Kaiser Family Foundation analysis of Centers for Disease Control and Prevention (CDC), National Center for Health Statistics/ Kaiser Family Foundation. “Opioid Overdose Deaths by Race/Ethnicity, 2017.” (2019), available at <https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-raceethnicity/>.

¹⁰ *See id.*

The approaches prioritized in the CARE Act would drastically reduce overdoses, increase access to treatment for patients with substance use disorders, and provide the services necessary to help people manage their pain. Many of the other proposed policies in response to the opioid epidemic focus on restricting prescription and illicit opioid supply. These approaches are insufficient and serve only to blame individuals who need treatment for pain, which in some cases should include opioid treatment.

Let's be clear, corporate greed has been a major driving force in the crisis. Pharmaceutical companies have been pushing opioid sales to boost profits. In pursuing an aggressive physician marketing strategy to increase opioid prescribing, pharmaceutical companies lied about the risks of opioid dependency. Research demonstrates that these practices, in turn, have led to higher fatality rates—40 percent of opioid deaths are from prescription opioids.¹¹ Insurers also have been pushing opioids as a cheaper cost option than real comprehensive health care services that could prevent and more effectively manage pain. And employers pressure injured employees to keep working through the pain by using opioids rather than taking the time they need to recover. The CARE Act would reverse this trend by beginning to get patients access to the care that they need to treat and prevent substance use disorders and overdoses.

It's important to note, however, that as nurses, NNU believes that the most comprehensive intervention that the federal government could make to end the opioid crisis is to guarantee health care to every person living in our country. Only with a Medicare for All system, including the complete array of health care prevention, treatment, and harm reduction services for substance use disorder, will we be able to end the health inequities that pervade and fuel the opioid crisis.

Our nation should learn from the failures and successes of our response to past epidemics. Nearly 30 years ago, after years of failing to address the domestic HIV/AIDS epidemic, Congress enacted the Ryan White CARE Act which dramatically increased financial resources to local communities to invest in prevention, treatment, and health care services for people living with HIV/AIDS. The program was resoundingly successful in reducing HIV infection and mortality rates and should serve as a model for how to respond effectively to the opioid epidemic.

¹¹ Hadland, S., A. Rivera-Aguirre, B. Marshall, M. Cerdá, "Association of Pharmaceutical Industry Marketing of Opioid Products With Mortality From Opioid-Related Overdoses." *JAMA* (January 18, 2019), available at <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2720914>.

A. Dramatically Increasing Resources for the Response.

As a nation, we have no chance at containing the opioid and substance use epidemics we are experiencing without dramatically increasing funding to prevention, treatment, and harm reduction programs. As nurses, we know that putting funds into the hands of the communities impacted by this public health crisis—like the Ryan-White Care Act did for HIV/AIDS—is critical to ensure that substance use disorder treatment and prevention services are expediently scaled up and equitably supported throughout the country. These funds should be locally controlled by the affected communities, including meaningful involvement of recovery centers and, importantly, people who have substance use disorders. The CARE Act provides resources at the local level, which means quicker building of treatment and preventive services in a way that responds to local needs.

The funding provided by the CARE Act would match the scale of the epidemic currently facing our country. The legislation would provide \$4 billion per year to states, territories, and tribal governments to address substance use disorders, and an additional \$2.7 billion per year to the hardest hit counties and cities. It also includes dedicated money to expand access to naloxone, and \$1.7 billion per year for public health surveillance, biomedical treatment, and improved training for health professionals that treat substance use disorders.

B. Ensuring that Communities of Color and Marginalized Communities Are Supported.

The CARE Act would do a better job of distributing grant funds equitably to all affected communities, including communities of color, which have been overlooked by many in the national discourse. By allowing funds to be equitably distributed and locally controlled, the CARE Act takes an important and significant step towards remedying the racial health inequity so prevalent in how our country has addressed drug use in the past.

The CARE Act also requires that people who are affected by the crisis, including people with substance use disorder and people in recovery from substance use disorder, are involved in the local planning councils which receive grant funds and decide how to allocate these funds. The local planning councils must also include representatives from a variety of community health providers and addiction and harm reduction organizations, members of Federally recognized Indian tribes, historically underserved groups and populations, individuals who were formerly incarcerated, labor unions, and the LGBTQ community (among many others). In doing so, the CARE Act is centered on the lived experience and expertise of all those who are affected in a community to ensure that funds are directed in an equitable way.

C. The CARE Act Begins to Investigate the Causes of Pain, Including Occupational Injury.

The role of work is a significant factor that is often left out of policy discussions on the opioid epidemic. Many jobs involve repetitive tasks and manual labor—so much so that nearly 20 years ago the Occupational Safety and Health Administration promulgated an ergonomics standard. Unfortunately, this standard was overturned by Congress a year later. Meanwhile, workers’ compensation coverage and wage replacement measures have been eroded in many states over the years. Many injured workers face significant economic pressure to return to work sooner, even before they have fully healed from their injuries, and so opt for opioids rather than risk losing their job or taking time off. This creates a need for ongoing pain management which, until recently, was almost exclusively opioids under workers’ compensation.¹² Additionally, many workers experience work-related pain that does not qualify as an injury under workers’ compensation. Workers seeking pain management in order to continue working draw the connection explicitly between working in manual labor occupations and increased risk for prescription opioid use disorder.¹³ Returning to the Stark County example, the three most common sectors for employment in the county are manufacturing, health care and social assistance, and retail trade.¹⁴ All three of these sectors are at high risk for occupational pain and injuries. The CARE Act directs the National Institute for Occupational Safety and Health to examine occupational risk factors for opioid use and provides funding to do so. This is a vital issue in responding to the opioid epidemic.

D. Important Steps Under the CARE Act.

The CARE Act takes important steps in addressing the opioid epidemic, which include:

- Providing much-needed funding for community services and local drug treatment, prevention, and harm reduction programs to support patients, which are necessary to effectively confront the opioid epidemic and to begin addressing health inequality.
- Providing consistent funding for treatment, prevention, and harm reduction programs over an extended period of time.

¹² Noguchi, Yuki. “Opioid Abuse Takes a Toll on Workers and Their Employers.” National Public Radio (Jan. 10, 2016), available at <https://www.npr.org/sections/health-shots/2016/01/20/462922517/opioid-abuse-takes-a-toll-on-workers-and-their-employers>

¹³ Rigg, K. and Mnnat S. “Urban vs. rural differences in prescription opioid misuse among adults in the United States: informing region specific drug policies and interventions.” *Int’l J. Drug Policy* (2015). Vol. 26(5): 484-91, available at <https://www.ncbi.nlm.nih.gov/pubmed/25458403>.

¹⁴ Data USA. “Stark County, Ohio.” Deloitte & Datawheel (2019). Accessed on June 17, 2019, available at <https://datausa.io/profile/geo/stark-county-oh/> (analyzing U.S. Census Bureau Data).

- Requiring that substance use disorder treatment includes improved access to mental health care in communities impacted by the opioid epidemic.
- Removing barriers to receiving medication assisted treatment and requiring that treatment programs include medication assisted treatment and mental health services.
- Requiring the federal government to negotiate naloxone prices, which will dramatically bring down its price.
- Taking important first steps in providing education and training for healthcare professionals on substance use disorders and treatment.

IV. Conclusion.

I wish to thank the Committee for inviting me to testify at this crucial hearing. On behalf of the 155,000 registered nurses that National Nurses United represents, I thank all of you for your commitment to addressing the opioid and substance use crisis. In order to effectively combat this horrible epidemic and save the lives of our patients, it is necessary for the members of this Committee, and the members of Congress in full, to commit to fully fund the response to the opioid crisis. We urge you to support and pass the Comprehensive Addiction Resources Emergency Act of 2019, and look forward to working with you to do so.