

LOCAL RESPONSES AND RESOURCES TO CURTAIL THE OPIOID EPIDEMIC

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTHCARE,
BENEFITS, AND ADMINISTRATIVE RULES
OF THE

COMMITTEE ON OVERSIGHT
AND GOVERNMENT REFORM
HOUSE OF REPRESENTATIVES

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LOCAL RESPONSES AND RESOURCES TO CURTAIL THE OPIOID EPIDEMIC

Wednesday, April 11, 2018

HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON HEALTHCARE, BENEFITS, AND
ADMINISTRATIVE RULES
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
Washington, D.C.

The subcommittee met, pursuant to call, at 10:05 a.m., in Room 2154, Rayburn Office Building, Hon. Jim Jordan, chairman of the subcommittee, presiding.

Present: Representatives Jordan, DesJarlais, Massie, DeSantis, Walker, Grothman, Palmer, Comer, Krishnamoorthi, Norton, and Kelly.

Mr. JORDAN. The committee will come to order. I would ask unanimous consent that members not part of the subcommittee can participate in today's hearing.

We want to thank you all for being here. Thank our witnesses. We will do a quick opening statement and we will introduce you. I will swear you in and get right to your important testimony. I am not even going to read my prepared remarks here. I am just going to say we all know how bad this crisis is.

In 2016, 64,000 Americans died from overdose from an opioid, and it has hit certain areas of our country, as evidenced by the people we have here today, in a dramatic way. The ranking member came to me a few months ago and said we need to have a hearing where we at least continue this conversation about what we can do to help improve this situation, and I said that is a great idea, let us get folks together and do just do that. So, I want to thank our witnesses for being here today.

I am going to turn it over to the ranking member for some opening comments. And then like I said, we will swear you in and hear your important testimony, and then get questions from members on the subcommittee and other members who have joined us for this important subject matter. So, with that I would recognize Mr. Krishnamoorthi for his opening remarks.

Mr. KRISHNAMOORTHI. Thank you very much, Chairman Jordan, for allowing us to have this hearing today on this very important topic. I really appreciate your cooperation and the cooperation of your staff. And thank you all for traveling from long distances to be here today, and thank you to people in the audience as well.

I asked for this hearing today because opioid addiction is a public health crisis that has devastated neighborhoods across Illinois and

communities in every State. Local communities are at the front line of this crisis, and Congress needs to listen to them.

Today we will hear from local experts who are addressing the horrific impact of opioid addiction and other substance use disorders in Ohio, West Virginia, and in one part of my district, namely DuPage County, Illinois. In Illinois, there are an estimated 180,000 people with an opioid use disorder. Every single day I feel the impact this crisis has on so many of my constituents in DuPage, Cook, and King Counties. In DuPage County alone, 126 patients died of heroin overdoses, and another 108 from fentanyl just in the last 3 years alone.

I applaud the \$3.2 billion in new funding for opioid treatment that Congress passed this year, but Chairman Jordan and I need to know is the Federal government doing enough about this disease. Is Congress supporting you in the most effective ways possible to address the opioid crisis? We need to know if you have the flexibility to respond to opioids because what works in one area is not necessarily what works in another.

We also need to know if you require more resources for prevention, treatment, and rehabilitation of those suffering from substance use disorders. We need to know if law enforcement is going after big drug cases and not just arresting addicts. We need to know if current law enforcement practices are preventing addicts from seeking treatment for fear of legal jeopardy.

The public health crisis of opioid addiction demands that we are committing sufficient resources and that we are spending efficiently and effectively. It is critical to increase the supply and use of the highly-effective opioid overdose reversal drug, naloxone, so that we can save the lives of those who overdose. We must ensure that first responders and others have sufficient supply to prevent overdose deaths in their communities.

I look forward to hearing today about evidence-based prevention efforts that have proven effective, including what we know about addressing the root causes of addiction, and that is something that is especially important to me. I want to know what is working in terms of preventing opioid addiction in the first instance.

I look forward to hearing about effective harm reduction strategies for addicts with children in their household in order to lessen the burden addiction put on families. Once addicts do come forward, there must be effective evidence-based treatments available to them, and they need to know where and how to find treatment. We know that various forms of medication-assisted treatment, or MAT, can effectively treat addiction, but current access to such treatment is woefully inadequate. Let me repeat that. Resources for that type of treatment is woefully inadequate today.

Recovering addicts should have the tools and support they need to both get clean and stay clean. I hear about this problem in Illinois nearly every day. Even when people can get treatment, can get into rehab, they and their families still have no support upon release. It is not enough for us to get them clean. We have to keep them clean. These people then struggle to maintain sobriety. I hope to hear today from our witnesses on ways to solve this problem.

Finally, Federal spending has to be held accountable. One of this committee's core missions, and I know Chairman Jordan agrees, is

to identify and root out government waste, make sure that we are not good money after bad. I look forward to hearing today how scientific evidence is being used to ensure that taxpayer dollars are being spent efficiently and effectively in local addiction response efforts.

I hope today's hearing will provide a constructive conversation about what local communities are doing and what the Federal government should be doing to address the opioid crisis and the disease of addiction, and I look forward to working with my colleagues on both sides of the aisle to address this public health crisis. Thank you so much.

Mr. JORDAN. I thank the gentleman for his opening comments. We will introduce our witnesses. Why do we not start with the ranking member? I will let him introduce one of our witnesses who is from back in his district.

Mr. KRISHNAMOORTHY. Thank you again, Chairman. Yes, I would like to introduce our distinguished witness, Ms. Karen Ayala. She is the executive director with the DuPage County Health Department in Illinois, and she is the lead staff at the DuPage Hope Task Force, which she will be talking about today. This addresses opioid prevention and education in my district.

Mr. JORDAN. Thank you. I now recognize the gentleman from, even though he is from Kentucky and going to introduce someone from Ohio, there is a relationship there. So, the gentleman from Kentucky, Mr. Massie, is recognize.

Mr. MASSIE. As the chairman well knows, there are some good people in Ohio.

Mr. JORDAN. Yeah.

Mr. MASSIE. But we are always on the lookout for the Buckeye Navy coming across the Ohio River there.

[Laughter.]

Mr. MASSIE. It is my honor to introduce the next witness. Thank you for allowing me to participate in this subcommittee. The next witness, Lisa Roberts, is a registered nurse from Portsmouth, Ohio. She has been working at their health department since 1989, and the City of Portsmouth, as the chairman knows, is located in Scioto County, Ohio.

Drug addiction does not recognize geographic boundaries, and the area of southern Ohio, eastern Kentucky, and western West Virginia, that tri-State area, has really been hit hard by opioid addiction. It has been the subject of some documentaries. But Lisa is at the forefront of fighting this. She helped form the Scioto County Drug Action Team Alliance, and she is currently administering the Drug Free Community Program in Scioto County, which is in its 6th year.

She oversaw Scioto County's first public health overdose prevention pilot program, and that has been a model for other communities in Ohio as I understand it. But the most remarkable thing about Ms. Roberts is my mother was her nursing instructor, and she survived by mother's class, and I know she has been taught well. My mother taught me, and so it is an honor to have her testify here today.

Mr. JORDAN. Thank you, Mr. Massie. Good to have you with us, Ms. Roberts. Ms. Haskins is the Jackson County Anti-Drug Coali-

tion representative from the great State of West Virginia. We are glad to have you here with us as well. And Mr. Siegle, who represents the Ohio HIDTA, High-Intensity Drug Trafficking Area Program, and we appreciate you being here also.

If you all would please stand up. We have to swear you in, and then we will get right to your testimony. Raise your right hand.

Do you solemnly swear or affirm the testimony you are about to give is the truth, the whole truth, and nothing but the truth, so help you God?

[Chorus of ayes.]

Mr. JORDAN. Let the record show that each witness answered in the affirmative, and there is a clock in front of you that you can see it is 5 minutes. If you can keep your remarks within that 5-minute timeframe, that is great. If you are a couple of seconds over, we are not going to hurt you or anything, and then we will just move right down the list. And then, like I said, we will get to questions.

Ms. Haskins, you can go first.

WITNESS STATEMENTS

STATEMENT OF AMY HASKINS

Ms. HASKINS. Good morning, Chairman Jordan, Ranking Member Krishnamoorthi, and esteemed members of the Subcommittee on Healthcare, Benefits, and Administrative Rules. My name is Amy Haskins, and I am the project director for the Jackson County Anti-Drug Coalition and also the administrator for the Jackson County Health Department located in West Virginia. It is on behalf of our coalition members and the Jackson County Board of Health that I want to thank you for the opportunity to testify today regarding the Drug Free Communities Program which is housed in the Office of National Drug Control Policy.

The Drug Free Communities Program is the only Federal prevention program that goes directly to communities to tackle the local drug issues. DFC provides training through the institute to enable communities to implement substance abuse prevention strategies. In our community, DFC provided us with the tools needed to build capacity to achieve significant reduction in opioid use and misuse despite the State of West Virginia having one of the highest use and misuse rates in the country. Not only did we reduce our prescription drug abuse among youth, but we reduced population-level rates of youth substance abuse across the board, not just prescription drugs.

Preventing or delaying substance abuse is the single most critical tool in stopping the pathway to addiction and overdose. Research shows that for each dollar invested in prevention, between \$2 and \$20 in treatment and other health costs can be saved. Substance abuse prevention has historically been under funded and underutilized in combating drug issues, including the current opioid epidemic.

DFC has allowed our coalition to leverage other funds to provide prevention education within the school systems. It has also enabled us to respond and to address local trends as they arise. DFC has enabled our coalition to work on environmental strategies that cre-

ate lasting population-level change and the ability to evaluate these changes through data collection. Specifically, we utilize the strategies of providing information, enhancing skills, providing support, enhancing access and reducing barriers, changes in physical design, and modifying or changing policies. Those environmental strategies are laid out in more detail in my written statement provided to you.

With the training and technical assistance provided through the Drug Free Communities Program and ONDCP, our coalition has been able to change the environment not only in our community, but throughout West Virginia. The destruction of medication from static collection sites is a tremendous issue across the United States. Our community determined what worked best for us and successfully advocated for similar changes across the State.

The individuality of each community is what makes ONDCP and DFC such a marvelous program. Our coalition has significant community-wide involvement from our school system to law enforcement, local business, media, youth-serving organizations, faith-based organizations, healthcare providers, civic organizations, parents, and more than a hundred youth to name just a few. We determine through data collection and assessment what the best plan is for our own communities. In fact, looking at the latest PRIDE survey data for Jackson County, 4.7 percent of our 12th graders report using prescription drugs in the last year, nearly 6 percent lower in use as compared to the national annual use as reported by the Monitoring the Future Survey. When looking at that same age group and the past 30-day use of prescription drugs, the national average is 4.9 percent as reported by the Monitoring the Future Survey, while only 1.8 percent of Jackson County 12th graders report using prescription drugs in the last 30 days.

Since receiving DFC funding, our coalition has been successful in reducing 30-day use among our high school students across the board. In fact, we have seen a 15 percent reduction in alcohol use, 13 percent reduction in tobacco use, 8 percent reduction in marijuana use, and nearly 6 percent in prescription drug abuse. The DFC Program is a great example of how a very small investment of \$125,000 per year of Federal funds can inspire a great deal of coordinated and steadfast effort at the community level.

Unfortunately, there is no one-size-fits-all solution to this opioid epidemic, but who best to determine what needs to be done to help a community than those who live, work, and raise their families there? I thank you for providing local communities like Jackson County, West Virginia the opportunity and the ability to do what is best to keep our children moving forward with positive change.

Thank you for the opportunity to testify before you today, and I am happy to answer any questions you may have.

[Prepared statement of Ms. Haskins follows:]

**Testimony of Amy RH Haskins, MA, Administrator
Before the Subcommittee on Healthcare, Benefits, and
Administrative Rules in the House Oversight and Government
Reform Committee**

Local Responses and Resources to Curtail the Opioid Epidemic

**Date: April 11, 2018
2154 Rayburn House Office Building**

Chairman Jordan, Ranking Member Krishnamoorthi and esteemed members of the Subcommittee on Healthcare, Benefits, and Administrative Rules, my name is Amy Haskins and I am the Project Director of the Jackson County Anti-Drug Coalition and the Administrator of the Jackson County Health Department in Jackson County, West Virginia.

Jackson County borders South East Ohio and is right on the Ohio River. We have Interstate 77 that runs vertically through the county, and Route 33 that is a direct line from Columbus, Ohio that brings travelers through to connect to Interstate 77.

Raised in southern Virginia by a public-school teacher and a social worker, growing up I have always had a strong desire to help those in need. Looking back at that time in my life, I realize that I have always advocated for those who believe their voice is not being heard or have had difficulty speaking up for themselves. I was taught from a very young age that we should all leave the world a better place than which we found it. Even today, this old adage is what I live by and how I choose to raise my own three children.

I became involved with substance abuse prevention after moving from Northern Virginia to Jackson County, West Virginia. I was hired as a Public Health Educator at the Jackson County Health Department to determine the needs of the

community and create programs to fill the gaps in services and resources. Looking at various data sets, it became quickly evident that Jackson County was experiencing an issue with addiction to pills, alcohol, and inhalants among the youth population. Over the last ten years I have been asked numerous times how I became so passionate about the issue of addiction. After seeing 16 families of young adults in our community face the death of their child, grandchild or significant other, and as a parent myself, it was absolutely heart breaking. I do not want one of my three children to become a statistic for the State of West Virginia, or the community of Jackson County. I do not want my children to have to deal with the loss of a friend to addiction. I do not want those families who have lost loved ones to feel as if their loss is in vain. The issue of addiction is an opportunity to learn from those we've lost and to try to save those struggling each day with addiction.

If we want to stem the tide of the opioid epidemic, we absolutely must focus on stopping the pipeline to addiction and preventing use before it starts. Not only is it necessary to preserve the lives of individuals who fall victim to addiction, but it saves our society between \$2 and \$20 in areas such as drug abuse treatment, overall health care and criminal justice system costs (Swisher, J.D., Scherer, J., and Yin, R.K. The Journal of Primary Prevention. "Cost-Benefit

Estimates in Prevention Research.” 25:2, October 2004), and allows us time to address the substantial shortfalls in our substance abuse treatment and recovery infrastructure.

The Drug-Free Communities (DFC) program, housed in the Office of National Drug Control Strategy (ONDCP) is the only federal prevention program that goes directly to communities to tackle their local drug issues. It promotes substance use prevention strategies and has helped communities, like mine, who needed the capacity to respond to and address local drug crises as they arise. It is because of this program that we have been able to achieve significant reductions in opioid use and misuse despite the state of West Virginia having one of the highest rates in the country.

The Jackson County Anti-Drug Coalition was created in 2006 following what the city thought was an isolated incident of a youth heroin overdose in a gas station bathroom. In the two years following, Jackson County saw 16 young adults between the ages of 15 and 26 experience fatal overdoses, in cars, and in front lawns of community residents. With the number of young adults losing their lives to overdoses, most of them from the same graduating class, the community could no longer ignore the problem. Open community meetings began to take place, along with candlelight vigils to remember those who lost their lives to substance

abuse. The Jackson County Health Department declared a public health crisis in December of 2008. As the public health educator, I volunteered to look for grant funding to help combat the issue and to provide education to the youth and public.

In researching grant opportunities, we began looking through various data points collected through the PRIDE Surveys administered by the Jackson County Schools. As I sifted through the data I noticed a trend and reached out to the West Virginia Office of Vital Statistics to determine the top five drugs at the time of death of the 16 fatal youth overdoses. From this data, we determined Methadone, Fentanyl, Hydrocodone, and Diazepam (Valium) were the drugs of choice in our community. For Jackson County this was unprecedented information and we immediately began to work on educating all ages about the dangers of these particular drugs. In 2009 we applied for and were awarded a Drug Free Communities Grant.

What makes the Drug-Free Communities program so unique is that the funding goes directly to local communities and offers maximum flexibility to respond to needs that are specific to that community. It is for this reason, that Drug-Free Communities recipients, like ourselves, are able to shift our attention to issues as they arise – whether it be the opioid epidemic, underage drinking,

tobacco, or notable spikes in the use of other illicit drugs. In short, the DFC program provides a successful long-term solution for tackling substance use and misuse in our country.

The DFC program is also a tremendous example of how a very small investment of federal funds can inspire a great deal of concerted, coordinated and steadfast efforts at the community level. Coalitions are provided up to \$125,000 and must provide a dollar-for-dollar match (cash or in-kind) for every dollar received. They must have significant community-wide involvement to reduce youth drug, alcohol and tobacco use through the involvement of twelve required sectors (e.g., schools, law enforcement, youths, parents, businesses, media, youth serving organizations, faith-based organizations, health care providers and civic and volunteer organizations, and other relevant community departments, sectors and participants) and are required to go through a yearlong academy coordinated by the National Community Anti-Drug Coalition Institute – a grant through Community Anti-Drug Coalitions of America (CACDA) that provides state of the art technical assistance and training for the DFC program. This training has been invaluable because gives our coalition access to all the best available tools and comprehensively plan, implement, and evaluate our efforts and outcomes over time. Because of the Community Anti-Drug Coalition Institute

our coalition is able to be maximize our success in developing and implementing comprehensive, strategic and targeted local strategies to achieve population level outcomes.

It is also because of the expertise of ONDCP that the DFC program has been so successful in achieving great outcomes. For all DFC recipients since the life of the program, prevalence of alcohol use declined by 27%, prevalence of tobacco use declined by 32%, prevalence of marijuana use declined by 14%, and prevalence of (illicit) prescription drug use declined by 11% from the first to the most recent data reports among middle school youth across all DFC coalitions ever funded.

Utilizing the PRIDE Survey, a survey available to schools across the country, our coalition was able to build effective substance abuse prevention strategies. Our coalition partners with the Jackson County Board of Education to implement this survey every other year in grades 6-12. Students with parental permission take the survey in paper form or online. Each year we have increased participation in this survey, starting with 764 students in 6-12 grades in 2007 to 1,975 students in grades 5-12 in 2017. The PRIDE Survey allows us to look at the Drug Free Communities program's four core measures: past 30 day usage; parental disapproval rates; peer disapproval rates; and perception of harm.

Our coalition utilized the data from the West Virginia Office of Vital Statistics as a means by which to increase our knowledge of fentanyl and methadone to make a difference in the community. Jackson County saw a problem with Fentanyl before it became a household name. In fact, many counties in rural West Virginia were still dealing with Hydrocodone and Oxycontin when Jackson County had moved on to Fentanyl and Methadone. Without this data it would have been difficult to identify proper strategies to assist our community in decreasing youth usage rates.

DFC and the yearlong academy teach coalitions to work on seven environmental change strategies to make sustainable change in the community. The strategies utilized by the Jackson County Anti-Drug Coalition around the prescription drug abuse issue were the following:

- **Providing Information:** The Coalition engaged in a multifaceted media campaign aimed at parents, youth, seniors, providers, businesses and the public. The coalition marketed an anonymous tip line for our local law enforcement agencies and engaged school aged youth in an Above the Influence Campaign. Members routinely provided information to the public around proper disposal; statistics gathered through the PRIDE Survey; talking to children at various developmental stages about substance abuse;

and offering community learning opportunities around drug trends, underage drinking, marijuana, tobacco, inhalants, and other substances.

The coalition partnered with local funeral homes to distribute information on proper disposal of a loved one's medications and needles. Members also educated parents of school aged children on the school's random drug testing policy, how it works, and how to enroll their children

- **Enhancing Skills:** Our coalition worked with local schools to provide presentations on addiction, how substances effect your body, as well as drug trends and their harmful effects. We also provided training on pill identification and diversion training for law enforcement officers. Medical staff were trained on the state prescription drug monitoring database and how best to utilize this tool in their primary care offices. Our coalition also provided presentations to the community on drug trends, proper disposal, and signs and symptoms of addiction. We worked with businesses to train management on identifying substance abuse among employees and in the work place. Our coalition and Sheriff's Department also trained law enforcement from across the state on best practices for the destruction of medications collected in permanent drop boxes and disposed of through regional incinerators.

- **Provide Support:** Our coalition provided support to the community by advertising the WV Rx Quitline number as an additional resource to treatment and mobilized the community with more than \$50,000 in cash, in kind to address local conditions surrounding prescription drug abuse. We developed disposal protocols for all three of our local law enforcement agencies and their permanent drop boxes. Our coalition also had a hand in developing the protocols for incinerating the medications collected on a state level. We also provided support by way of advocacy, education, and encouragement for local providers to utilize the WV Prescription Drug Monitoring Database.
- **Enhance Access/Reduce Barriers:** The Jackson County Anti-Drug Coalition has advocated tirelessly for local law enforcement agencies to have access to the WV State Prescription Drug Monitoring Database. Prior to the sharing of PDMPs, we also advocated at a state level to have access to other state monitoring systems. We are a border county to Ohio, and many of our residents were traveling across state lines to obtain prescriptions outside of West Virginia. We also had a large number of individuals that were utilizing the “Fleming Highway”, which is a direct flight from Huntington, West Virginia to Broward County, Florida for \$39 one way.

Flying down and back in the same day garnered hundreds and thousands of pills to sell. Our coalition also provided training for teachers, reviewing what supplies on their school supply list could be abused and teaching them to identify signs of abuse. The coalition has worked hard to integrate disposal information in to regular community communications. Jackson County has 3 static Take Back sites in the form of permanent drop boxes located at all three of our law enforcement agencies and regular take back disposal days.

- **Change in Physical Design:** The coalition, to protect local law enforcement, worked with the West Virginia Department of Environmental Protection, to purchase the first mobile incinerator in the state of West Virginia. The purpose; to burn household medications collected in static take back sites. The coalition then advocated on a state level for other communities to have access to mobile incinerators. To date there are now 9 incinerators across the state for this purpose, all modeled after our mobile incinerator.
- **Modify/Change Policies:** The Jackson County Anti-Drug Coalition has developed and implemented policies for static and point-in-time take back programs throughout the community, and these policies have been shared statewide with other communities. We have also created a local policy and

assisted in the development of statewide policy for mobile incineration use.

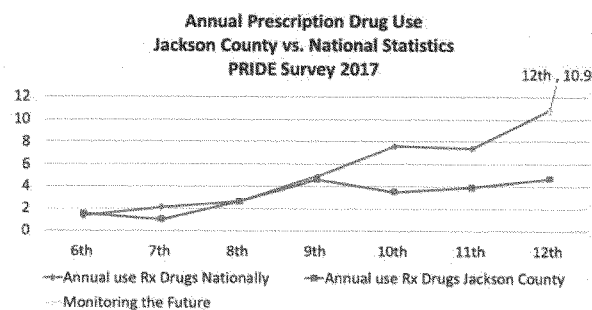
Our advocacy work on the state level assisted in the mandated use of the

WV Prescription Drug Monitoring Database by physicians. The coalition

also successfully worked on expanding the random drug testing policy at

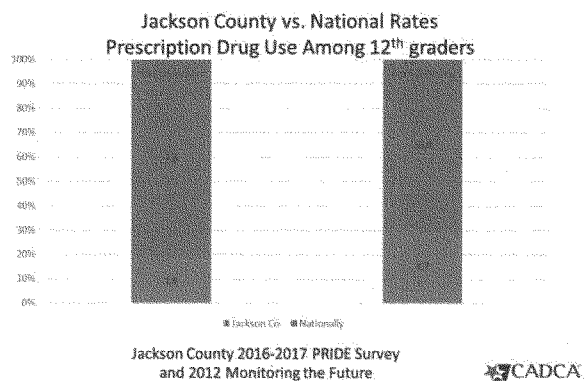
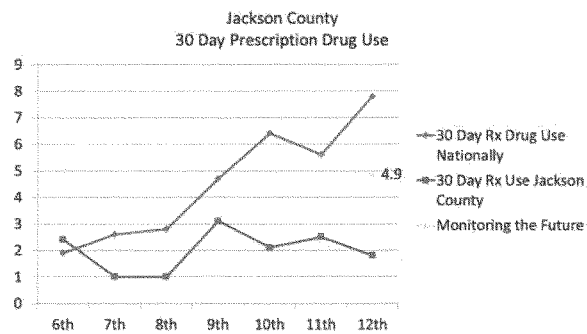
our middle and high schools to include specific prescription drug classes.

The graphs below show information on usage rates with Jackson County youth as gathered through the PRIDE Survey in Spring 2017. In Jackson County, 4.7% of 12th graders report using prescription drugs in the last year, nearly 6% lower in use as compared to the national annual use of Prescription drugs as measured by PRIDE and the Monitoring the Future Survey.



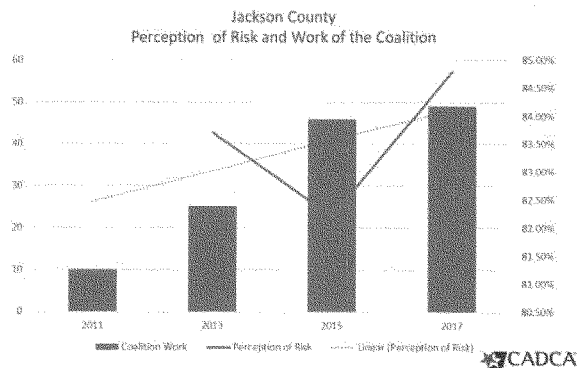
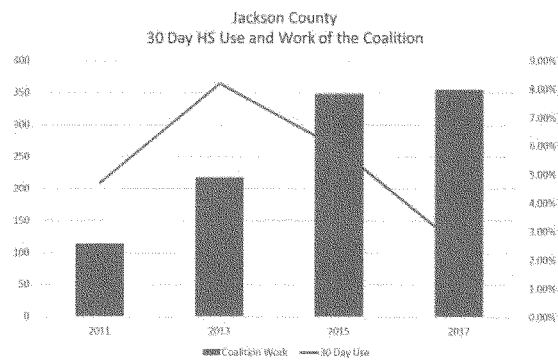
When looking at reported 30-day use of prescription drugs, again Jackson County is much lower than the national average. Jackson County 12th graders reporting 1.8% using, while nationally the rates at 4.9% when looking at

Monitoring the Future Survey information and nearly 7.8% when looking at national PRIDE Survey data.



The biggest challenge we were able to tackle was changing the conversation in the community around prescription drugs. Substance abuse issues were very discreet in this community of 29,000 where most everyone is related. We worked on changing the mindset of a large subset of the population, getting them to understand the addiction process, and what it means to be an enabler.

And while we are still working on the “Sharing Culture” of Appalachia within our community where we are willing to give our medication to someone else who cannot afford it, we are making strides in this. People now understand why they should not be sharing medications. As seen in the graph below, as the outputs increased for the coalition work, we began to see a decrease in youth usage rates.

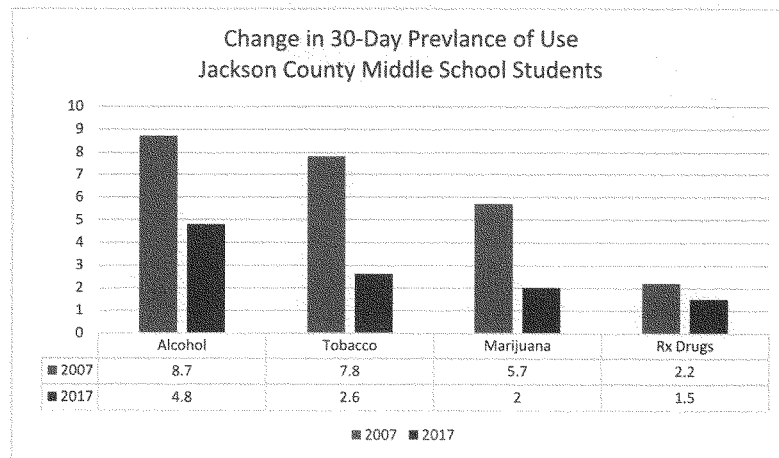


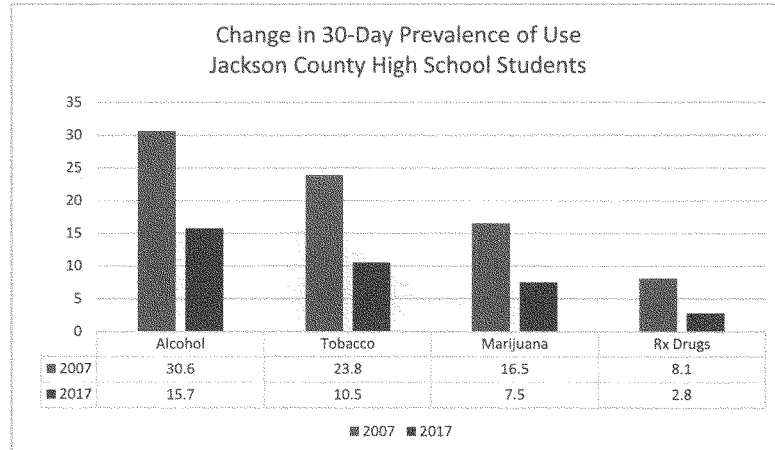
These types of outcomes were also seen when looking at the perception of risk among youth related to prescription drug abuse and the work of the coalition. As the coalition educated the community and provided trainings through the work of our Drug Free Communities Grant, we began to see an increased perception of risk among our youth.

The second biggest challenge was by far the issue of destruction of the medications collected in our community and the ability to provide a safe means by which to dispose of household medication. We no longer worry about law enforcement agencies hoarding medication for six months at a time waiting for a DEA takeback day for proper disposal. A team of law enforcement agents burn collected medications whenever the need arises, reducing the chances of diversion by law enforcement and the public.

ONDCP has exercised its policy level oversight on the program to ensure that it remains exclusively focused on reducing youth substance use and has managed the DFC program to be optimally effective and data driven by establishing one set of core metrics for the program. Every grantee must collect and submit outcomes to the national evaluators for the program, every two years, for at least 3 grades from 6th to 12th grade. ONDCP has also designed, managed and funded ICF to conduct the robust independent evaluation of the DFC program

mentioned above and has ensured that the focus of the DFC program has stayed true to the mission of substance use prevention for 12 to 17 year old's. Because of ONDCP, funding for the DFC program continues to go directly to communities and is used for implementing comprehensive strategies across an entire community, not just programs for a limited number of youth. With the independence of ONDCP and its single mission of reducing substance abuse among youth, they can ensure that funding is awarded to communities who are most likely to create outcomes of positive, lasting change. In looking at the graphs below, you can see the positive change the DFC program has created in Jackson County due to the ability of our community creating strategies we believe will create positive outcomes.





The DFC program has been instrumental in changing our community outcomes around substance abuse. The DFC program has been highly successful at not only turning around our community, but also changing norms, access, and availability, and reduced population level rates of youth substance use across the board. It has also helped to dramatically cut our overdose rate, and with a very small amount of federal support that resulted in community wide results, changing the trajectory of countless youth lives in Jackson County. Families in Jackson County, West Virginia thank you for the opportunities we have been provided through the DFC grant process to learn, assess, implement, and evaluate lasting positive change in our community.

I thank each of you on the committee for allowing me the opportunity to testify today on the importance of the Drug-Free Communities program and the need to reauthorize it in the Office of National Drug Control Policy along with the training and technical assistance provided to the program by the National Community Anti-Drug Coalition Institute. Thank you for providing local communities like mine the ability to do what is best to keep our children and future generations safe and always moving forward towards positive change.

Mr. JORDAN. Thank you, Ms. Haskins.
 Ms. Roberts, you are recognized for 5 minutes.

STATEMENT OF LISA ROBERTS

Ms. ROBERTS. Chairman Jordan, Ranking Member Krishnamoorthi, and esteemed members of the Subcommittee on Healthcare, Benefits, and Administrative Rules, my name is Lisa Roberts, and I am the coordinator for the Scioto County Drug Action Team in Scioto County, Ohio. I have been a public health nurse in Portsmouth, Ohio for 30 years. Portsmouth, located in Scioto County, is part of the Appalachian region that has been seriously impacted by prescription opioids since the mid-1990s.

In 2010, Scioto County has the highest prescription opioid distribution rate in Ohio and the highest fatal overdose rate in the State at more than double the State average. We also had the highest rate of infants born with neonatal abstinence syndrome and numerous other community problems related to opioid addiction. And like so many parents, my own child developed an opioid use disorder at a young age and has struggled mightily with this disease throughout adulthood. It has been a long and difficult struggle for my family.

In 2010, the county health authorities declared a public health emergency, and we formed a coalition. I have been the coalition coordinator since that time. In 2012, Scioto County was awarded both a Drug Free Communities Support Program and a High Intensity Drug Trafficking Area Program. These two programs work collectively to provide comprehensive supply and demand reduction strategies across our community landscape.

Thanks to the enhanced training, technical assistance, and programmatic support provided by the Office of National Drug Control Policy, I have been continuously professionally developed to guide this coalition's work. The combined efforts of these programs have resulted in numerous improved outcomes in our population.

The DFC Program has allowed us to regularly collect and measure youth substance use and behavioral data for the first time in our county's history. This information allowed our coalition to plan and implement locally-tailored and evidence-based strategies designed to reduce youth substance use. Since 2013, these biannual data sets have documented significant and sustained reductions in youth substance use, not only for prescription drugs, but for all 12 measured substances, including tobacco and alcohol.

I believe that these outcomes are a direct result of the DFC Program and the training provided by the required year-long Community Anti-Drug Coalition Institute, which teaches coalition leaders like myself the essential processes to guide a highly-effective coalition capable of achieving these types of successful outcomes. The Institute taught us how to use local data and to implement a combination of evidence-based strategies. These strategies are further detailed in my written statement that you have.

The opioid epidemic remains one of the biggest public health challenges of our time, but public health receives little funding to address it. The current structure of the DFC Program under the Office of National Drug Control Policy allowed my public health

agency to be eligible for this Federal support and to comprehensively address our local public health crisis.

In addition to improving youth substance use rates, we have also seen positive secondary outcomes. Our prescription opioid distribution rates are at the lowest point in a decade, and Scioto County no longer leads the State in fatal overdose. Less infants are being born opioid dependent, and our high school graduation rates are now above the State average. And because we have built a community interfere that supports treatment and recovery from addiction, more youth are living in stable homes and more adults are achieving recovery.

The Federal investment of \$125,000 annually provided by DFC has allowed our community to organize and work toward a better future for our residents and our children. It has also helped us to gain additional opioid fighting resources, and these will be sustained into the future through the institutionalization of programs and services. In short, this small Federal investment has seeded community recovery in Scioto County, Ohio.

America's drug problems are extremely complex, dynamic, and ever-evolving. ONDCP is uniquely positioned to have a clear and broad understanding of these issues and how they can best be addressed through policy. These complexities require that we support an agency that has expertise and influence so as to provide national leadership and oversight to these issues. I believe it is critical the DFC Program remain in ONDCP and that this successful model is not disrupted.

In closing, I want to thank the members of the committee for allowing me to testify on behalf of the critical importance of reauthorizing the Office of National Drug Control Policy and its vital programs. Because of them, we have been able to improve our community so that future generations of children and families can live safe, healthy, and drug free.

Thank you for allowing me to speak on this important topic, and I am happy to answer any questions that you may have.

[Prepared statement of Ms. Roberts follows:]

Testimony of Lisa Roberts, RN
Before the Subcommittee on Healthcare, Benefits, and
Administrative Rules in the House Oversight and Government
Reform Committee

Local Responses and Resources to Curtail the Opioid Epidemic

April 11, 2018
2154 Rayburn House Office Building

Chairman Jordan, Ranking Member Krishnamoorthi and esteemed members of the Subcommittee on Healthcare, Benefits, and Administrative Rules, my name is Lisa Roberts and I am the Coordinator for the Scioto County Drug Action Team Alliance in Scioto County, Ohio.

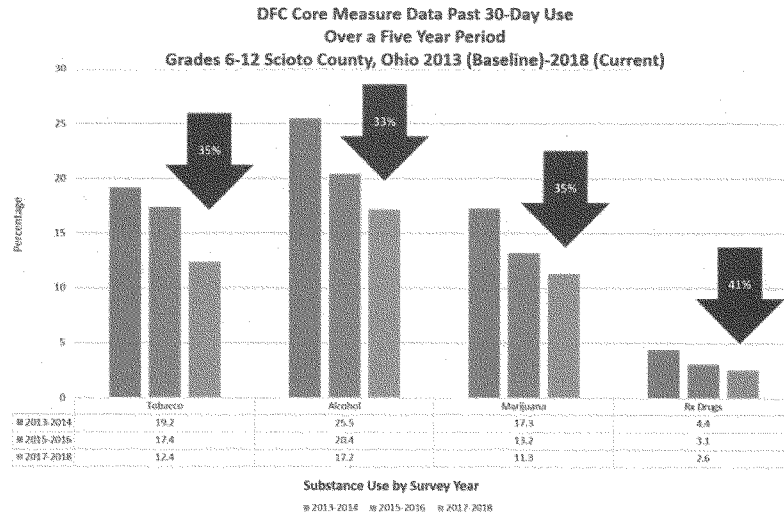
I have been a public health nurse in Portsmouth (Ohio) for 30 years, which is the county seat of Scioto County and borders Kentucky and West Virginia. It is a part of the Appalachian region that has been seriously impacted by prescription opioids since the mid-1990's. In 2010, my home county (Scioto) was identified by the state health department as having the highest prescription opioid distribution rate in Ohio with the equivalent of 123 opioid pain pills per citizen distributed in the county that year. In 2010, Scioto County also had a fatal overdose rate more than double the state average—the highest in Ohio. Scioto County was also identified as having the highest number of infants being born with Neonatal Abstinence Syndrome or opioid withdrawal at that time. Numerous other health and disease indicators showed the negative impact of prescription opioids on the citizens of Scioto County. And like so many parents, my own child developed an opioid use disorder at a young age following exposure and has struggled for many years to combat and manage this disease. It has been a long and difficult struggle for my family.

In January of 2010, the Scioto County Health Commissioner declared the opioid epidemic in the county a public health emergency and the local health departments formed a coalition to begin to address the opioid epidemic. I became the coalition coordinator for the Scioto County Drug Action Team Alliance (coalition) at that time, and I remain in that role today. With the enhanced training, technical assistance, and programmatic support provided by the Office of National Drug Control Policy (ONDCP) I have been prepared to help the coalition become an effective community change agent. This has led to significant reductions in youth substance use and improved outcomes in our population.

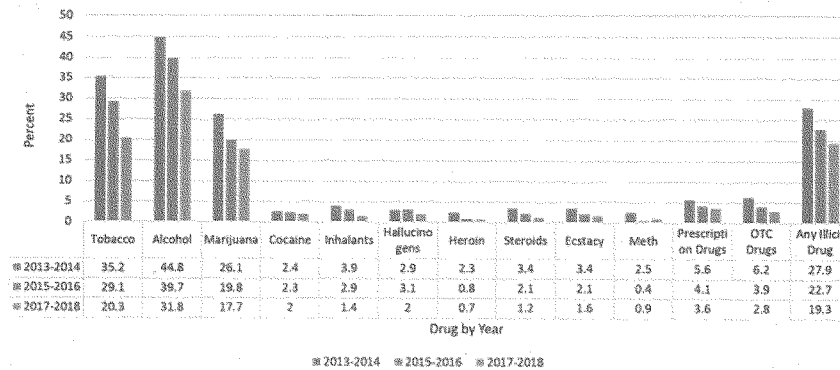
When the coalition first formed, the data that we had to work with primarily involved the adult population as there had been no efforts to survey or monitor adolescent substance use and risky behaviors in the county. There were no coordinated efforts to identify, prevent, or reduce substance use in the population at that time. The newly formed coalition recognized the need to invest in staff development and strategic planning in order to “get upstream” and prevent new initiates to substance use. In 2012, Scioto County was awarded both a Drug Free Communities (DFC) Support Program and a High Intensity Drug Trafficking Area (HIDTA) program from the ONDCP. These two programs have significantly improved the situation in Scioto County by providing comprehensive

supply and demand reduction strategies to be coordinated and implemented across the community landscape. Law enforcement involvement is required of DFC Coalitions through the mandate of specific Sector Leaders which ensures that essential partners are involved in reducing access and availability of substances throughout the community. Everyone benefits from these community partnerships.

ONDCP has managed the DFC program to be optimally effective and data-driven by establishing one set of core metrics that every grantee must collect and submit to national evaluators every two years. This invaluable national data is used to monitor youth substance use trends across the country and to inform national strategies. Beginning in 2013, the DFC grant allowed us to obtain baseline data for youth substance use in Scioto County for the very first time in history. This data allowed our coalition to plan and implement locally tailored and evidence-based strategies. We are required to collect this information bi-annually to monitor trends and to measure outcomes. Youth surveys have been collected over the 5-year period that DFC has made possible. This comprehensive statistical surveillance has demonstrated continuous and sustained reductions in Scioto County youth substance use in grades 6-12 across the spectrum of alcohol, drugs, and tobacco as illustrated in the following charts:



**Percentage of Scioto County youth in grades 7-12 who report using drugs
annually/ by specific drug
Source: DFC Semi-Annual PRIDE Surveys 2013-2018**



I believe that these outcomes are a direct result of the DFC program and the requirement that coalitions go through a year-long Academy conducted by the Community Anti-Drug Coalition Institute which teaches coalition leaders core competencies and essential processes to establish and maintain a highly effective coalition capable of successful outcomes. This Institute training allowed our coalition to increase our capacity to identify and respond to substance use and to collect and use data to design and implement effective strategies. The strategies that we used involved adapting the Seven Strategies for Community Level Change specifically based on our local conditions. These included:

1. Providing Information:

- Educated prescribers and conducted training with Physicians on Ohio's Opioid and Other Controlled Substance Prescribing Guidelines and use of the prescription monitoring program.
- Collaborated with local hospitals to change and implement policy improvements related to opioid prescribing.
- Developed and distributed Opioid and Other Controlled Substance Prescribing Guidelines for Urgent Cares and ED's pocket cards for patient chart holders as a resource and reminder for Physicians.

- Conducted community forums and Town Halls for the public and educated them about the opioid epidemic.

2. Enhancing Skills:

- Implemented a countywide adult and caregiver educational initiative called "Start Talking!" designed to inform parents about prescription and OTC abuse and facilitate conversations with youth about the dangers of prescription drug misuse.
- Implemented youth-led prevention initiatives in 8 school districts.
- Conducted an annual youth-led prevention training for youth and adult DFC Advisors and integrated opioid information into the event.
- Conducted Drug Free Workplace Training for local businesses.

3. Providing Support:

- Collaborated with the CDC Division of Adolescent and School Health on a pilot project for youth at-risk for substance use disorders which allows for targeted indicated prevention strategies with the county's most vulnerable youth.
- Established a treatment-friendly Supreme Court Certified Juvenile and Family Drug Court for families experiencing opioid-related problems that come into contact with the criminal justice system whose goal is to

prevent further penetration into the justice system if possible and reunify families through treatment and counseling.

- Piloted Ohio's first Community-Based Naloxone Education and Distribution Program that has since been replicated throughout Ohio resulting in thousands of lives saved. Scioto County residents have been trained as community responders and have reversed hundreds of potentially fatal overdoses using naloxone distributed by the coalition.
- Conducted a county-wide educational campaign on overdose prevention, recognition, and response, and identified local "hotspots" for overdoses through epidemiological data. Conducted targeted outreach to identified high-burden communities.
- Trained 11 local Fire Departments and local law enforcement in overdose response and continue to provide them with naloxone.
- Established easy naloxone access under a county protocol allowing for people to get naloxone without a prescription at local pharmacies.
- Hosted multiple DATA2000 waiver trainings for licensed prescribers to bolster community access to medications to treat opioid use disorder.

4. Changing Physical Design:

- Installed permanent Prescription Drug Drop Boxes at four locations throughout the county to compliment the coalition’s established semi-annual Drug Take Back Days.
- Converted 3 former “pill mills” to addiction treatment centers.
- Implemented a controlled substance lock box initiative through local hospice.
- Embedded a Code Enforcement Officer with local law enforcement to immediately secure and condemn drug houses. Established a Land Reutilization Program to repurpose confiscated nuisance properties.

5. Modifying/Changing Policies:

- Collaborated with Ohio policymakers to pass statewide legislation that led to strict regulation of pain management clinics and effectively shut down Scioto County’s pill mills.
- Collaborated with the County Commissioners on passage of a local Ordinance that allows for legal abatement of any current or future establishments deemed as a threat to public health and safety.
- Worked with the Ohio Board of Pharmacy and state legislature to change laws which lead to increased access and utilization of naloxone to reverse opioid overdose.

- Developed and implemented an Overdose Rapid Action Plan through the local Emergency Management Agency to respond to fentanyl-induced spikes in overdose.

6. Changing Consequences:

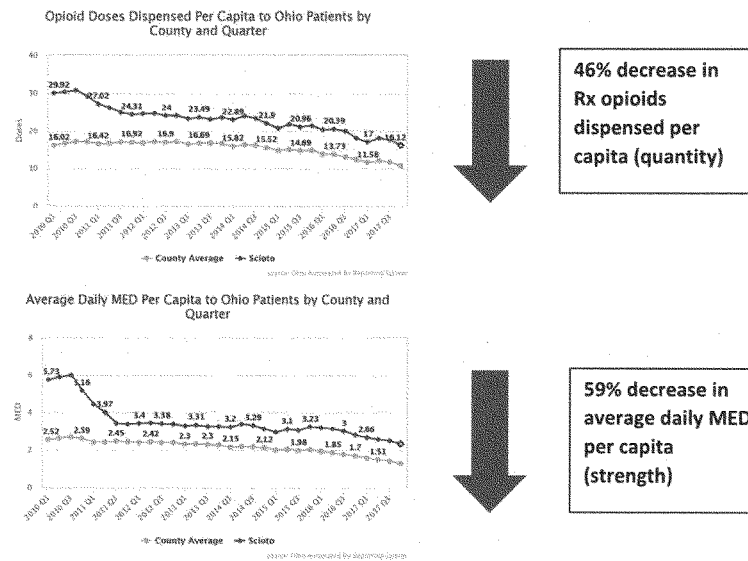
- Collaborated with local law enforcement and the Drug Enforcement Administration on stiffer penalties for criminal over prescribers which resulted in numerous convictions of pill mill operators.
- Worked with Ohio legislators to pass a Good Samaritan Law in 2016 which provides civil immunity to people who respond to or report an overdose while alleviating fear of arrest as a barrier to summoning emergency assistance for overdose victims.

7. Enhancing Access/Reducing Barriers:

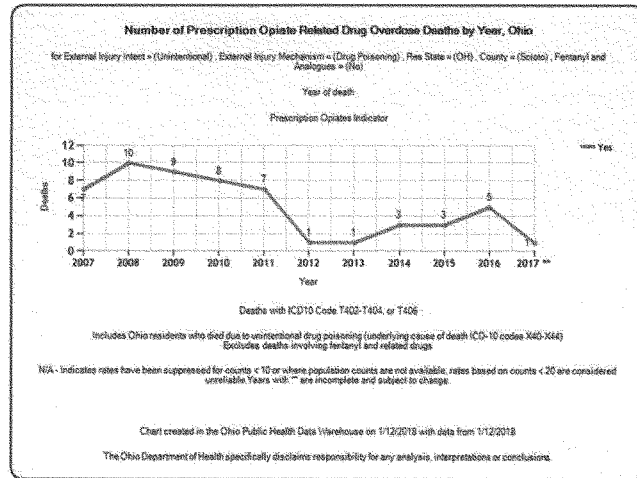
- Expanded access to treatment for opioid use disorder going from only one state-certified addiction treatment center in 2010 to 12 treatment centers in 2017, including 2 Detox Units and a Medical Stabilization Unit at the local hospital. We also established a local “hub” for treatment access called “Recovery Gateway” that case manages clients and streamlines immediate admission to an appropriate treatment program.

- Expanded the number of Physicians who are licensed to prescribe Buprenorphine which greatly enhanced access to Medication-Assisted Treatment for opioid use disorders.
- Established Overdose Response Teams at the local Emergency Department that serve as a conduit to immediate placement for addiction treatment when the client desires.

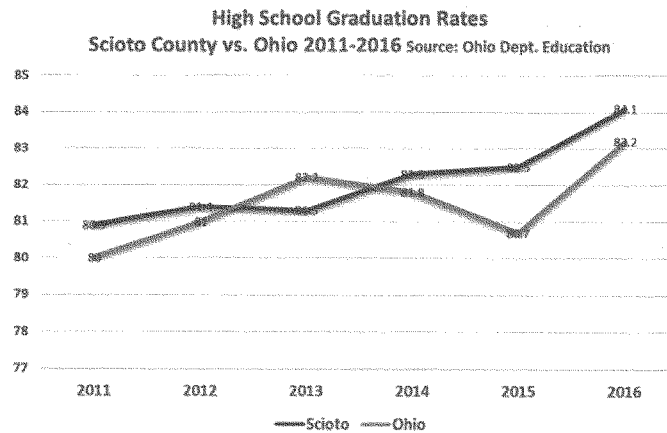
Secondary outcomes include significant reductions in opioid prescribing including both quantities and strengths of pills—which are now at the lowest point since they have been measured by the prescription monitoring program.



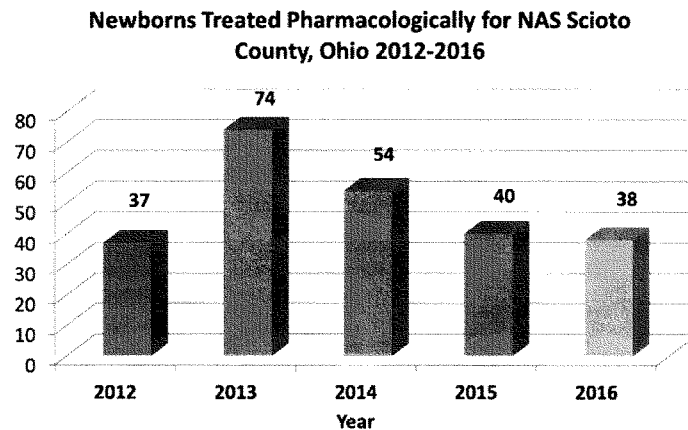
Prescription opioid-related overdose deaths have also declined in Scioto County.



Scioto County's high school graduation rates have improved and are now above the state average.



The number of newborns diagnosed with Neonatal Abstinence Syndrome and requiring pharmacological weaning at birth has steadily declined.



The DFC program has helped my community to address the opioid crisis and invest in long-term planning and strategies that are designed to offset future problems while addressing current problems. As the only federally funded drug prevention program that goes to local communities, it allowed my public health agency to apply for federal support to bolster our ability to address a local public health crisis. Because DFC coalitions must target the entire community and the program offers maximum flexibility based on local conditions, they develop and foster the kind of planning and cooperation in a community that leads to long-term community change and sustained improvements. The DFC program has also

helped us to build a community infrastructure that supports treatment and recovery from addiction, and treatment and recovery supports are accessible to our adult population — in fact, more youth are living in stable homes as a result. The DFC program has also allowed us to expand our local efforts to address adolescent Tobacco, Marijuana, Methamphetamine, and Alcohol use through collaborative interdiction with HIDTA as well as collaborations with local retailers and pharmacies. The DFC program allows us to conduct trainings and outreach with both youth and parents to provide education and support to prevent teen substance use.

DFC funding has allowed our community to come together to work toward a better future for our residents and our children. Through the coalition, members have worked collectively to align programs and services while coordinating efforts that avoid duplication and save money. We have also worked as a team to obtain additional resources to combat substance use and abuse across the lifespan. The DFC investment of \$125,000 annually must be matched by the grantee, but this investment has led to additional funding and resources for our community that we will sustain well into the future and allow us to institutionalize programs and services. The DFC program is the best example I have seen in my professional career of how a small investment of federal funds

can mobilize a great deal of concerted, coordinated, and effective efforts at the community level. The DFC program has also allowed Scioto County to assist other communities that are now dealing with the opioid epidemic. With the 2015 release of the award-winning book “Dreamland-the True Tale of America’s Opiate Epidemic” by author Sam Quinones, Portsmouth (Ohio) was cast into the national spotlight as a community that was working hard to overcome the opioid epidemic. Numerous coalition members, including myself, contributed to this best-selling publication that continues to spark a national conversation about the opioid crisis. Consequently, our DFC staff are frequently tapped to assist other communities as they attempt to navigate this burgeoning epidemic. The opioid epidemic continues to be one of the biggest public health challenges our country has ever face, but because of DFC and HIDTA, Scioto County is showing signs of improvement and has lived experience to share with other communities that are just beginning to address it.

Our coalition has been able to vastly expand services to at-risk youth by working with and within local schools and youth-serving organizations to identify at-risk youth and provide targeted services to these children and their families. The coalition has been able to gain additional assistance for at-risk youth through the implementation of comprehensive youth development programs that provide

supportive environments manned by coalition-trained adult leaders. Coalition-sponsored trainings allow for these adults and volunteers to acquire the necessary skills to deliver evidence-based prevention services to the youth they serve.

The coalition is comprised of the DFC-required 12 Sector Leaders and numerous volunteers. All Sector Leaders participate in the Strategic Prevention Framework and ensure successful planning and implementation of the Action Plan. The 12 Sector Leaders include 1.) Youth Sector; 2.) Parent Sector; 3.) Business Sector; 4.) Media Sector; 5.) Youth-Serving Organization Sector; 6.) Law Enforcement Sector; 7.) Religious or Fraternal Organization Sector; 8.) Civic or Volunteer Sector; 9.) Healthcare Professional Sector; 10.) State, Local, Tribal Governmental Agency with Expertise in Substance Abuse; 11.) Other Organization Involved in Reducing Substance Abuse; and 12.) School Sector. All these sectors ensure that the coalition is able to work across the various systems that have the ability to impact substance use and abuse in Scioto County and that the efforts take place within community settings.

In 2013, I and a fellow coalition member graduated from the year-long CADCA National Coalition Institute. The Institute is designed to increase the knowledge, capacity, and accountability of community anti-drug coalitions

throughout the United States and territories. This intensive training taught us how to think strategically to implement community-wide initiatives and to evaluate our outcomes. The products that we were required to produce before completion are designed to ensure that coalition leaders have a knowledge base that can translate into the desired community-level outcomes. The Institute also provides coalitions with ongoing training and technical assistance to immerse coalitions in best practices and essential processes to achieve these community-level outcomes. The Institute helped our coalition to use evaluation processes to measure outcomes and improve coalition performance. In addition, the Institute helped us to think about the future of the coalition beyond the funding period to ensure that its efforts are sustained into the future and that the coalition's work continues to impact future generations.

There remains much stigma associated with addiction and the coalition has been able to lead efforts to reduce stigma in Scioto County. Many people who are in recovery from a substance use disorder are stepping up through coalition-sponsored trainings to become Peer Recovery Coaches which enables them to become recovery-carriers to people who have a substance use disorder. They also frequently gain employment in the substance use prevention and treatment fields and promote positive and healthy behaviors in the population while becoming

productive members of society. The coalition has also been very instrumental in moving substance abuse prevention and treatment towards a more comprehensive public health approach while facilitating the implementation of evidence-based best practices in the prevention and treatment of substance use and addiction. In 2018, Scioto County's own Health Commissioner, a dedicated coalition member, became Board certified in Addiction Treatment and is actively recruiting fellow physicians to respond to the opioid crisis.

America's current drug problems are extremely complex and dynamic. The current opioid epidemic is a prime example of a situation where the problem did not start with a poor choice or a drug dealer—it started with a healthcare system and prescribers but has since evolved into a complex epidemic involving both licit and illicit drugs. ONDCP is uniquely positioned to have a clear and broad understanding of these complexities and how they evolve, and how they can best be addressed through policy and national leadership. This federal government leadership model is so important that many cities and states are already replicating it, with others seeking to establish and implement their own "offices of drug control policy" to better inform policy and laws. In Ohio, Attorney General Mike DeWine has devised a 12-point plan to curb the state's opioid epidemic. One component of this plan calls for the "establishment of a special position reporting

directly to the Governor with Cabinet-level authority, who works every day with the single-minded focus of fighting the opioid epidemic,” which he refers to as the “Drug Czar for Ohio”. The complexities and intricacies of our nation’s drug problems requires that we support an agency that possesses expertise and influence so as to provide leadership and oversight to these important issues. ONDCP has ensured that the focus of the DFC program has stayed true to its mission to prevent substance use in youth and has ensured that the funding for the program goes directly to communities in need. I believe it is critical that the DFC program remain in ONDCP so that this successful model is not disrupted.

In closing, I want to personally thank the all Members of the Committee for allowing me to testify on behalf of the critical importance of reauthorizing the DFC program and ONDCP. It is because of these programs that we have been able to piece by piece improve our community so that future generations of children and families can live safe, healthy and drug-free. Thank you again for the time to speak on this important topic – I am happy to answer any questions you might have.

Mr. JORDAN. Thank you, Mr. Roberts.
Mr. Siegle, you are now recognized.

STATEMENT OF DEREK SIEGLE

Mr. SIEGLE. Chairman Jordan, Ranking Member Krishnamoorthi, and distinguished members of the subcommittee, I am honored to appear before you today to testify and highlight the Ohio High Intensity Drug Trafficking Area Program, or HIDTA, and how the program assists localities in addressing the opioid problem.

Today fentanyl and fentanyl analogs account for approximately 58 percent of unintentional drug overdoses in Ohio. Opioids account for 86 percent of unintentional drug overdoses. Overdose deaths have risen 486 percent in the last 13 years from 904 in 2004 to an expected 5,300 in 2017. We are seeing a rise in the seizure of crystal methamphetamine and cocaine being trafficked in large quantities by Mexican organizations. Recently, 140 pounds of methamphetamine was seized near Akron, Ohio.

The foundation of the HIDTA strategy continues to be the co-location of law enforcement personnel in order to increase information and intelligence sharing, provide training, and incentivize participation in uniquely effective drug enforcement initiatives. These cooperative efforts support HIDTA's core mission of disrupting and dismantling drug trafficking organizations and money laundering organizations.

The Ohio HIDTA supports traditional drug task forces along with highway interdiction, package interdiction, bulk cash smuggling units, and fugitive apprehension teams. De-confliction services are a key contribution by the Ohio HIDTA for all our law enforcement partners. De-confliction prevents blue-on-blue incidents and duplication of efforts.

In 2017, the Ohio HIDTA de-conflicted 4,200 law enforcement operational events and 7,200 subject elements for more than 300 law enforcement agencies. The Ohio HIDTA participates in the ONDCP-sponsored Heroin Response Strategy, or HRS. The HRS is designed to enhance public health, public safety, and prevention collaboration supported by 10 HIDTAs across 22 states with the goal of reducing drug overdose deaths.

The Ohio HIDTA supports heroin-involved death investigation teams in our major metropolitan areas. These teams respond to overdose deaths and begin an investigation into the source of the drug. In July of 2016, the Ohio HIDTA began to train law enforcement officials throughout the State on an overdose incident form. Almost 10,000 overdose investigations have been entered from 42 of the 88 counties in Ohio, giving investigators the ability to instantly de-conflict information.

The Investigative Support Center spearheaded efforts to form overdose initiative groups within each of these counties. The purpose is to more efficiently link overdose data and enable intelligence support that otherwise might not have been available to them.

The Ohio HIDTA introduced the Overdose Detection Mapping Application Program, ODMAP, allowing first responders to report fatal and non-fatal overdoses and any administration of Narcan.

The incidents were plotted on a map allowing participating agencies to visualize overdoses in near real time.

The Ohio HIDTA participates in the Domestic Highway Enforcement Initiative promoting collaborative, intelligence-based, unbiased policing on the Nation's highways. Investigating Support Centers provide analytical help to participating and non-participating agencies, many of which do not have analytical support or record analysis capabilities. During 2017, the Ohio HIDTA provided in excess of 15,000 hours of free training to more than 1,400 students, many who would not be able to attend training without the HIDTA.

HIDTA has become more important as overdose deaths have doubled over the last decade while drug enforcement funding overall has declined. Because of the reputation that HIDTA has built for bringing individuals together and producing results, HIDTA components are often involved with prevention, treatment, and education initiatives. HIDTA executive boards are a key strength to the HIDTA program. Ohio HIDTA is managed locally by an executive board of 23 Federal, State, and local partners who each have an equal say in how their HIDTA prioritizes its efforts.

As a program, not an agency, HIDTA is viewed as a neutral partner whose goal is to help all levels of law enforcement reduce drug trafficking organizations and their effect in our communities. HIDTA is best served under ONDCP, who provides leadership from a neutral, unbiased, non-competing point of view. ONDCP possesses the expertise and authority to look at the drug problem holistically and set direction across the board.

Thank you for allowing me this opportunity to testify before you today. I look forward to answering your questions.

[Prepared statement of Mr. Siegle follows:]

WRITTEN STATEMENT OF

**Derek M. Siegle
Executive Director, Ohio High Intensity Drug Trafficking Area**

Subcommittee on Healthcare, Benefits, and Administrative Rules

**Committee on Oversight and Government Reform
United States House of Representatives**

**EXAMINATION OF THE OFFICE OF NATIONAL DRUG CONTROL POLICY AND ITS EFFORTS TO
COORDINATE DRUG POLICY ACROSS THE FEDERAL GOVERNMENT**

**April 11, 2018
Washington, DC**

Chairman Jordan, Ranking Member Krishnamoorthi, and distinguished members of the Subcommittee, I am honored to appear before you today to offer testimony highlighting the Ohio High Intensity Drug Trafficking Area Program (HIDTA) and how the HIDTA Program assists localities address the opioid problem and other drug crises.

The Ohio HIDTA was established in 1999 when six counties in Northern Ohio were designated as HIDTA counties. The Ohio HIDTA now covers 14 counties in Ohio and three counties in Northern Kentucky.

This growth is due to local towns, cities, and counties to take advantage of all possible resources to address the crippling drug threats that undermine the health of their communities.

Like the Ohio HIDTA, all 32 HIDTAs bring together federal, state, local, and tribal law enforcement resources to increase intelligence sharing and training, incentivize participation in uniquely effective drug enforcement initiatives.

These collaborative efforts support HIDTA's core mission of disrupting and dismantling Drug Trafficking Organizations (DTOs) and Money Laundering Organizations (MLOs). DTOs and MLOs are the bad guys responsible for bringing narcotics into our communities, feeding addictions, and profiting from the misery of individuals with substance abuse disorders, their families, and their communities.

I want to provide you with some background on the situation in Ohio which has been hard hit by the opioid crisis. The abuse of prescription opioids began to escalate in the early to mid-2000s. The prevalence of heroin became apparent in 2011 after the state was successful in

shutting down “pill mills” that were responsible for millions of illegitimate pills flooding the streets. In 2013, Ohio began to see a dramatic increase in fentanyl and related analogs.

Today, fentanyl and fentanyl analogs account for approximately 58 percent of the unintentional drug overdoses in Ohio. Overall, opioids account for 86 percent of unintentional drug overdoses. As this trend developed, other drug threats continued to wreak havoc on our communities. Cocaine, meth, and marijuana don’t take a hiatus while other dangerous and deadly narcotics come onto the scene. In fact, it’s often the same organizations and dealers who take advantage of the latest addictive poison to make a buck.

Overdose deaths have risen in Ohio from 904 in 2004 to 4,050 in 2016. That is a 348% rise in drug poisonings in just 12 years. Unfortunately, we estimate that once the numbers are compiled for 2017 the Ohio death count will exceed 5,000. Our neighbors in Northern Kentucky have seen similar increases. In 2011, St. Elizabeth Healthcare reported 252 fatal heroin overdoses. In 2016, that number was 1,584. The numbers are shocking. Yet over that time period, investment in key drug enforcement programs has remained stagnant or even decreased in some cases.

While the Ohio HIDTA together with our HIDTA colleagues nationwide have been working hard to address the threat, our law enforcement resources have frankly been overwhelmed. We applaud policy initiatives to increase availability of and access to much-needed treatment resources for substance use disorders. But we have not seen new resources pushed into effective prevention programs like the Drug Free Communities (DFC) program to prevent drug initiation. And we certainly have not pushed new resources into effective drug law enforcement programs like HIDTA or multi-jurisdictional drug task forces.

In fact, as addiction and deaths have spiraled upward, funding for drug enforcement initiatives has been stagnant or declined. Drug deaths have skyrocketed, yet there has been no commensurate response to increase enforcement of laws against illegal drug trafficking. If we are going to get real about reversing the trends and truly dealing with this threat, we have to properly resource drug law enforcement including HDTAs.

HIDTA is an integral part of the bigger drug enforcement picture that includes task forces, criminal intelligence analysis by police departments, sheriffs’ offices, state police and investigative agencies, fusion centers, the Regional Information Sharing Systems (RISS), and federal agencies.

The foundation of the HDTAs strategy continues to be the co-location of law enforcement personnel in order to foster enhanced information and resource sharing.

The HIDTA program breaks down traditional barriers between law enforcement agencies. It enables local, state and federal agencies to leverage and maximize resources and improve information and intelligence sharing.

The Ohio HIDTA supports traditional drug task forces along with highway interdiction, parcel interdiction, bulk cash smuggling units, and fugitive apprehension teams. Today we support over 40 task forces and law enforcement initiatives in Ohio and Northern Kentucky.

In addition, the Ohio HIDTA is a valued partner with treatment and prevention programs throughout the state.

Deconfliction services are a key contribution by the Ohio HIDTA for all of our local and regional law enforcement partners. In fact, the HIDTA Program has been instrumental in bringing deconfliction services to law enforcement nationwide over the past decade. Deconfliction prevents dangerous “blue on blue” incidents. It also ensures investigative efforts are coordinated across jurisdictional lines and resources are used effectively and efficiently. In 2017, the Ohio HIDTA deconflicted 4,269 law enforcement operational events and more than 72,000 case/subject/target elements for more than 300 law enforcement agencies.

In 2016, the Ohio HIDTA was added to the ONDCP- sponsored Heroin Response Strategy (HRS).

The HRS is an innovative platform designed to enhance public health, public safety, and prevention collaboration across 22 states, including 10 HIDTAs, with the goal of reducing drug overdose deaths.

The foundation of the HRS is a network of Public Health Analysts (PHAs) and Drug Intelligence Officers (DIOs). This network of professionals bridges public health and public safety efforts. The goal is to develop smarter responses to this increasingly widespread and complex issue.

PHAs enhance the timeliness, accuracy, and access to public health drug use indicators, especially drug overdose deaths. They analyze drug trends and develop reports and briefs that are shared with key local, regional, state, and federal public health and public safety agencies, as well as the larger HRS network.

DIOs help implement the Felony Arrest Notification Program which tracks drug felony arrests in Ohio of out-of-state residents and notifies the appropriate law enforcement agencies. They also track and analyze drug overdose incidents within the HIDTA region.

The Ohio HIDTA works closely with and provides funding to support Heroin Involved Death Investigation Teams (HIDITs) in most of our major cities and counties. HIDITs work closely with the county Medical Examiners and the prosecutors. When a heroin/fentanyl death is encountered by the Medical Examiner investigator or the responding emergency personnel, the HIDIT is immediately notified.

The HIDITs responds and begins an investigation into the source of the heroin/fentanyl.

Investigators focus on information gathering first as opposed to immediate arrest of witnesses and participants. They will further recover crucial evidence for immediate review by technicians.

The goal of the HIDITs is to work back to the supplier of the heroin/fentanyl with various investigative techniques that will support technical evidence and interview statements.

Beginning in July 2016, the Ohio HIDTA began to train law enforcement officials throughout the state on how to use the Case Explorer deconfliction system's "Overdose Incident Form."

This form gives investigators the ability to instantly deconflict names, phone numbers and addresses that come up during the course of their overdose investigations.

This information is deconflicted across not only other overdose data, but also ongoing case data from police departments, HIDTA task forces, Office of Criminal Justice Services task forces and numerous other partner agencies at the local, state and federal levels.

Overdose investigators routinely trace common suspect names and phone numbers across jurisdictional lines.

We have seen numerous cases where this capability helped illuminate previously unknown links between data from overdoses and subjects of ongoing task force investigations.

Since June 2016, almost 10,000 overdose investigations have been entered from 42 of the 88 counties in Ohio. My HIDTA continues to train additional counties, cities, and agencies.

The Ohio HIDTA Investigative Support Center (ISC) has also spearheaded efforts to form "Overdose Initiative" groups within each of these counties. The purpose of these shared groups is to more efficiently link overdose data from neighboring jurisdictions and enable intelligence support that otherwise be available to them.

Ohio HIDTA has also introduced the Overdose Detection Mapping Application Program (ODMAP) into our state.

The program uses a web service accessible through a smart phone or computer to allow first responders to report fatal and non-fatal overdose incidents. They can also report whether Narcan was administered and the number of dosages administered.

The location, date, and time of the incidents are transmitted to the Washington/Baltimore HIDTA secure map server and plotted on a map. The map allows participating agencies to visualize overdose incidents in and around their jurisdictions in near real-time.

ODMAP enables agencies to see where overdose spikes are occurring. The data can provide value to public health officials to identify areas that may be vulnerable to incidents in the near future and enable them to surge intervention and other resources into those areas.

The HIDTA Program - with the assistance of ONDCP developed the national Domestic Highway Enforcement (DHE) Initiative. The DHE promotes collaborative, intelligence-led, unbiased policing in coordinated and mutually supportive multi-jurisdictional law enforcement efforts on the nation's highways.

The DHE strategy both improves investigative efforts related to DTOs and has a significant impact on traffic safety, homeland security, and other crimes.

The Ohio State Highway Patrol (OSHP) administers the Ohio HIDTA's Ohio Highway Interdiction Initiative (OHII) as part of the DHE. The Colonel of the OSHP is also an Executive Board member of the Ohio HIDTA.

The interdiction of drugs on our highways is critical in combating the current opioid epidemic in Ohio and is often our first line of defense against the DTOs. Many large seizures occur on our highways. In 2017, the OHII seized more than 20 kilograms of fentanyl, 61 kilograms of heroin, 72 kilograms of cocaine, 66 kilograms of methamphetamine, and 2,898 kilograms of marijuana. Each dose of deadly narcotics that is interdicted on our highways is one less dose that could kill one of our citizens.

Across the country HIDTAs are seeing a rise in the seizure of crystal methamphetamine, or "ice," that is being trafficked in large quantities by Mexican DTOs. The most recent instance was the seizure of 140 pounds of methamphetamine near Akron, Ohio.

Although down from 2014 (939 incidents), Ohio was third nationally in "Meth Clandestine Laboratory incidents" with 834 incidents in 2016, according to the Drug Enforcement Administration (DEA). By comparison, Ohio recorded 352 incidents in 2011.

Ohio HIDTA initiatives recorded an all-time high of 151.5 kilograms of methamphetamine and ice seizures in 2016. This number has increased markedly from 8.5 kilograms in 2012. While opioids continue to get the headlines, these other drugs clearly continue to harm our citizens. The people who profit from the misery they create are constantly innovating. It is our job to go after those people and stand between them and their next victims.

There are 32 HIDTAs nationwide. Each HIDTA operates in a region which may include several counties, and some cross state lines. Each HIDTA is managed locally by an Executive Board made up equally of federal and state/local partners who each have equal say in how their HIDTA prioritizes its efforts.

The Executive Boards are a key strength of the HIDTA Program. Although HIDTA funds are appropriated by Congress each year, it is the Executive Boards that provide our state and local members an equal voice in addressing specific threats in our communities and counties that make up the HIDTA Program.

The Executive Board has the ability on a local or regional basis to shift focus and resources in response to evolving threats. This this equal partnership is the basis of success of the HIDTA program. The Ohio HIDTA has 23 heads of local, state, federal law enforcement agencies on our Executive Board. These members are invested in the program because each of them has a significant voice in determining priorities.

The political or enforcement agenda of one agency may not match other agencies, and that is why the neutral ground of HIDTA is so important as a mechanism for facilitating drug enforcement collaboration.

HIDTA is a program, not an agency that is viewed as a neutral partner whose goal is to help all levels of law enforcement attack DTOs. It is this neutrality that has caused all levels of law enforcement to participate in the programs through deconfliction, sharing of information, and participation in HIDTA initiatives.

The ISCs provide analytical help to participating agencies and non-participating agencies. Many of the task forces that are part of HIDTA would not have analytical support and record analysis without the analysts assigned to the ISC.

Each HIDTA has a training program and provides free training to all law enforcement, not just those who participate or are funded by HIDTA. During 2017, the Ohio HIDTA provided 15,580 hours of training to 1,427 students. Many state, county and local agencies would not be able to train their officers if it were not for the training offered by HIDTA.

Because of the reputation that HIDTA has built for bringing individuals together and producing results, HIDTA components are often involved with prevention, treatment, and education initiatives. HIDTAs routinely partner with Drug Free Communities (DFCs) in their areas.

The Ohio HIDTA has helped bring Brain Power, the science-based K-12 substance abuse education curriculum developed by the National Institute on Drug Abuse to several local school districts.

HIDTA funding is rarely used to support prevention and treatment, but the information and knowledge that HIDTA can bring to the table is valuable. We all know it is going to take

enforcement, prevention, treatment, and education working together to successfully confront our opioid epidemic and our other drug threats.

The HIDTA Program embraces performance measurements and accountability. The efforts of each HIDTA are recorded in the Performance Management Process or PMP.

This program enables individual HDTAs, and the HIDTA program overall to account for accomplishments, including the number of DTOs/MLOs under investigation, the number of DTOs/MLOs that were disrupted and/or dismantled, the quantity and value of drugs removed from our communities, return on investment (ROI), clandestine labs disruptions, training assessment, case and event deconfliction, analytical support, and other areas of performance.

Each HIDTA produces an Annual Threat Assessment and a Strategic Plan to address its priority threats, as well as an Annual Report to highlight its accomplishments.

HDTAs undergo regular financial audits with their fiduciaries and performance audits. Both of these are coordinated through and overseen by ONDCP.

HIDTA provides a national ROI of approximately \$75.00 for every \$1.00 of HIDTA funding invested in 2017.

ONDCP provides policy direction and guidance to the HIDTA program. ONDCP provides leadership from a neutral, unbiased, noncompeting point of view. The office looks at the drug crisis from all aspects and utilizes the HIDTA program to provide complete data and perspectives from all levels of law enforcement.

HIDTA is best served under ONDCP. If HIDTA were to be placed under any federal enforcement agency there would be too many barriers for HIDTA to remain neutral, effective, and efficient. State and local law enforcement would likely eventually lose their voices and voting power.

Moving the HIDTA from ONDCP to a federal enforcement agency - as the administration has proposed in its FY 2019 budget - or another operational program would threaten critical relationships among state and local law enforcement and federal agencies.

To maintain the success of the HIDTA and the Drug Free Communities programs, it is imperative that ONDCP be re-authorized and properly funded to maintain proper staffing levels and oversight of the HIDTA and DFCs.

ONDCP is the only office in the federal government with the expertise and authority to look at the drug problem holistically and set direction action across the board. Addressing our national

drug problem is complicated and requires a well-resourced team of experts who focus solely on these issues full-time.

I have provided the Committee with several documents relating to HIDTA to include the 2017 Ohio HIDTA Summary and the 2017 HIDTA Program Effectiveness Summary.

Thank you for allowing me this opportunity to testify before you today. I look forward to answering your questions.

Mr. JORDAN. Thank you, Mr. Siegle.
 Ms. Ayala, you are recognized now for 5 minutes.

STATEMENT OF KAREN AYALA

Ms. AYALA. I am both grateful and humbled for the opportunity to speak before you today. My name is Karen Ayala, and I serve as the executive director of the DuPage County Health Department. DuPage County is the second-largest county in the State of Illinois. In this role, I have witnessed the heroin and prescription drug crisis unfold across our communities, and also instructed participation efforts to reduce the impact in our neighborhoods.

I am, oh, so proud of our nationally-recognized healthcare systems as well as the most recent recognition of DuPage County as the healthiest county in Illinois. However, we are now in the 5th year of our response to this opioid crisis, and with the framework that has recently been developed through the HOPE Task Force, which is included in my written documents, I realize that we lack the resources needed to fully and successfully address this public health epidemic.

I strongly believe as we are faced with responding to the complex needs of residents affected by this pervasive and impressive public health threat, we need additional resources. So, first, with the rise in direct consumer marketing of pharmaceutical companies, coupled with the efforts of the drug companies to market opioids as safe, effective treatments for chronic pain, our culture has developed an unprecedented reliance on these medications, while removing any perceived risk of harm or dependence.

With that realization, the first opportunity for action by our Federal partners is to review and to restrict the methods that pharmaceutical companies continue to use in order to increase the number of users of opioid medications. Until we are able to reduce the number of new users, we are waging a losing battle against this epidemic in our communities and across our country.

The next opportunity to support our local efforts is to expand the critical need for access to effective and evidence-based treatment. Integrating behavioral healthcare with primary healthcare ensures the best outcomes for individuals with multiple healthcare needs. This integrated care, however, requires unrestricted sharing of information between all members of the healthcare team. Currently, Federal law, specifically 42 CFR Part 2, prohibits access to substance use disorder treatment, which represents a significant barrier. This regulation prohibits information related to substance use disorder treatment to be shared across all members of an individual's healthcare team.

Earlier this year, the President's Opioid Commission identified this as an important component to address the crisis across our country. We and our DuPage County partners strongly support this recommendation and urge immediate action in this matter.

Expanding treatment to all individuals in need represents a strategic focus of our local efforts. With an increasing number of individuals ensnared in this chronic and lifelong illness, treatment, in fact, represents hope and the opportunity to succeed. Currently, estimates indicate that only 11 percent of individuals experiencing substance use disorders are actually able to engage in treatment.

Expanded publicly-funded treatment opportunities must be achieved in communities across our country. Although I recognize this is a bold goal, I believe the utilization of existing networks that Congress currently funds and established through the federally-qualified healthcare system, the community healthcare system, the rural health system, will assure this goal is achieved.

Funding for this critical expansion of treatment must be allocated to achieve the additional treatment capacity we need in local communities today. Public health systems must be equipped to address this crisis and prevent others in the long term. DuPage County has been successful through the development of the HOPE Task Force multifaceted and comprehensive response plan. I am confident that our efforts to develop systems preventing substance use disorders, while engaging individuals in treatment and recovery, may serve as a model for other communities attempting to address this goal as well. These efforts, however, must be supported with Federal assistance focused on developing new policies that reduce new opioid users coming into the system, easing of restrictions preventing the unrestricted flow of information across healthcare provider teams, as well as building the capacity through the expansion of treatment services from Federal intervention.

I look forward to continued partnership with you in these critical areas, and I wish to thank you once again for the opportunity to share.

[Prepared statement of Ms. Ayala follows:]



111 N. County Farm Rd., Wheaton, IL 60187

Written Testimony submitted to the House Committee on Oversight and Government Reform
Subcommittee on Healthcare, Benefits, and Administrative Rules
On behalf of the DuPage County Health Department
Prepared by Karen Ayala, MPH Executive Director

Thank you for allowing me this opportunity to provide a picture of the opioid crisis and how our local efforts to address this public health crisis have unfolded at the local level through public health efforts. My name is Karen Ayala and I serve as the Executive Director of the DuPage County Health Department. In that role, I've witnessed the crisis unfold as well as the efforts to reduce opioid deaths and substance use disorders.

Please understand some of the contextual backdrop of our experience—Illinois has some of the lowest rates of prescribers writing prescriptions for opioids, DuPage County has consistently received honors for the health outcomes that are the result of proper planning, community assessment, prioritization of funding and dedication to protecting the public health. In fact, DuPage County was recently named the healthiest county in Illinois by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

And yet, even though our response to this epidemic began over 5 years ago, we are not even close to seeing the peak of this crisis, let alone the successful conclusion of this epidemic. Like all epidemics, the opioid crisis has created a public health problem for DuPage, its neighboring 101 counties in Illinois, and every community in the United States. Opioid addiction and prescription drug abuse may be considered one of the biggest public health threats of this era.

Members of Congress, like any American citizen may question why Americans of all ages and demographic groups are struggling with addiction to illegal drugs and opioids. In a study published in the May 2016 issue of the *Journal of General Internal Medicine*, researchers at Boston University School of Medicine and Boston Medical Center concluded that the majority of patients misusing drugs and alcohol have chronic pain and many are using these substances to "self-medicate" their pain.¹ In fact, according to the National Safety Council, over 80% of individuals who identify themselves as being addicted to heroin, indicate their journey of addiction began with prescription medication.¹⁴

So, if chronic pain (real or perceived) is part of the answer to the question of why we have this struggle with addiction, there must be an understanding that self-medication may be one of the driving factors that has resulted in a massive substance use disorder epidemic that is claiming lives, overburdening our criminal justice system, adding to healthcare costs and reducing economic productivity.

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Pharmaceutical companies paid little or no attention to direct to consumer marketing until 1981 which led to federal regulations in 1985 that required “fair balance” and a brief summary that was designed to provide a safeguard against deceptive advertising.

However, it wasn’t until the 1990’s that the proliferation of television ads for pharmaceuticals began hitting the consumer directly, giving healthcare consumers the idea that there is a pharmaceutical solution to rid oneself of nearly any discomfort or malady. Further regulatory action in 1995 through 1999 attempted to provide further guidance and redefine rules and regulations.

The history of self-medication is intrinsically connected to pharmaceutical companies encouraging the long-term use of opioids for chronic non-cancer pain. In 1989, total direct to consumer advertising was estimated at \$12 million; it reached \$340 million in 1995, tripled to \$1.1 billion in 1998, and doubled again to \$2.2 billion by 1999.¹⁵

Specifically, between 1996 and 2002, Purdue Pharmaceuticals funded more than 20,000 pain-related educational programs through direct sponsorship or financial grants and launched a multifaceted campaign to encourage long-term use of Opioids for chronic non-cancer pain.² A key component of their program was unequivocal assurance that the risk of long term dependence and opportunity for misuse was not a concern for either patients or prescribers.

Further, in the mid 1990’s the American Pain Society introduced a campaign entitled “Pain is the Fifth Vital Sign” at the society’s annual meeting. This campaign encouraged health care professionals to assess pain with the “same zeal” as they do with vital signs and urged more aggressive use of opioids for chronic non-cancer pain.³

The Veterans’ Affairs health system, as well as the Joint Commission, which accredits hospitals and other health care organizations, followed suit and embraced the Pain is the Fifth Vital Sign campaign to increase the identification and treatment of pain. This led to efforts to tie funding incentives to providers’ treatment of pain, which although those incentives have been realigned, there is still further work to be done.

At the same time, professional health associations were cautioning against the imprudent prescription of opioids, the public and the medical community were being told that the risk of addiction and tolerance was low.

It is no wonder that the public demand for opioids, fueled by years of direct advertising, and the resulting prescriptions to meet those demands has produced staggering statistics that includes the fact that eighty percent (80%) of the global opioid supply is consumed in the United States although we represent only five (5%) of the world’s population.¹⁶

Years later, we have a public health crisis.

More than 64,000 Americans died from drug overdoses in 2016 alone, including illicit drugs and prescription opioids--nearly double in a decade.⁴ In comparison, automotive related fatalities stood at 40,000 deaths at the height of concern and when highway and transportation administrators began multiple interventions to address. Currently, every day 115 American's die from an opioid overdose. That fact, more than any other, indicates that we have a public health problem that must be solved with public health solutions.

Public health issues, by definition, are complex, cross-sectoral issues that must be addressed through a coordinated, diverse group of community representatives. In addition, public health issues require strategies to deal with prevention, early intervention, treatment and then recovery. DuPage County has been addressing this public health crisis through a comprehensive approach, including educating students, collecting unused medications, increasing Narcan use, partnering with hospitals for mental health services, and diversion programs.

The Heroin Opioid Prevention and Education (HOPE) Taskforce was formed, in DuPage, as the successor to the DuPage Coalition Against Heroin. HOPE Taskforce has three stated goals: (1) Professionally and comprehensively assess opioid use within DuPage County; (2) Recommend effective and actionable policies, initiatives, and programs; and (3) Measure success from desired program and initiative benchmarks and deliverables.

The HOPE Taskforce will leverage the success of other programs utilized in DuPage County, and across the country. The DuPage Narcan Program was the first countywide naloxone program in Illinois and has become the model for counties throughout the State of Illinois. The program was modeled after a similar response developed in Gloucester, Massachusetts. In the absence of external funding, the members of the DuPage County Board of Health redirected \$50,000 of their limited funds to supply the first year of product for police officers.

The program, administered by the health department, has reversed over 462 overdoses since January 2014. This model leveraged the existing relationships we had with law enforcement partners throughout the community that had been established to address other public health emergencies. As a result, we have trained over 3800 law enforcement officers to better understand the nature of opioids, the path of substance use disorders, and the administration of the antidote, itself.

Despite the relative success for the program, the DuPage County Coroner noted that there were 126 people who died of heroin overdoses between 2014 and 2017. Just as alarming, another 108 died from a combination of heroin and fentanyl or strictly through an overdose on fentanyl. This is a long-term concern that must have resources, commitment and focus over the course of the next generation.

Through the First Responder Comprehensive Addiction and Recovery Act federal grant, the DuPage Health Department has made naloxone more accessible to first responders. In addition, new state laws and available funding have allowed the health department to make naloxone more accessible to bystanders and family members of those at risk for overdosing. The DuPage Narcan Program currently has over 4,155 trained participants and 59 program sites.

Prevention has always been part of the effort to curb the use of opioids here in DuPage. The health department operates an RxBox program wherein residents drop off unused drugs to 17 police stations in the community, thereby taking dangerous unused opioids off the street and potentially out of the hands of those that may become addicted. Between 2009 and the most recent quarterly pick up, we have collected over 46 tons of unused medications in our program alone. The challenge with this program takes me back to my earlier comment regarding the self-medicating predisposition that our country has adopted. It also is a reminder that while the collection of the unused medication is a fairly straight forward and simple process, the challenges faced by communities is the safe disposal of these medications. Safe disposal of controlled substances is an expensive endeavor and while we have received funding through the Illinois Environmental Protection Agency to support this effort, those funds are extremely limited.

In other examples of a product creating a public health hazard, the manufacturer of that product is ultimately held responsible for the proper disposal and clean-up of the product. This appears to be one of the simplest ways that the pharmaceutical companies can assist in pushing back against this epidemic.

Despite developing education and prevention programs, there is a huge, growing gap of resources that exists in the effort to combat this public health crisis. This huge and growing gap of unmet need exists in the area of treatment for substance use disorders.

The DuPage County Health Department, which serves residents with behavioral health illnesses—primarily mental health disorders, has an added burden to reach and treat clients. Research demonstrates the alarming frequency of the co-occurrence of mental health and substance use disorders is well over 70%.

In fact, opioid use disorder has been linked to higher rates of depression, anxiety, and bipolar disorders.⁵ Left untreated, the individuals suffering from substance use disorders will often find themselves within the court justice system, making recovery difficult if not impossible.

For that very reason, public health practitioners have provided integrated care on issues that treats co-existing issues together. SAMHSA defines integrated care as the systematic coordination of general and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.⁶

Integrated care, however, requires the sharing of information between health professionals. Unfortunately, the complaint most often cited by treatment providers is that federal regulations prohibit the sharing of information about substance use disorders. Specifically, 42 CFR Part 2 prohibits the sharing of information without the written consent of the patient. The provision was at one time useful when everyone, including treatment providers stigmatized those that were addicted.

42 CFR part 2 was designed in an era when addiction treatment occurred exclusively in the old systems that failed to integrate addiction treatment into mainstream medicine. When a primary physician treats a patient's opioid use disorder with an addiction treatment medication within a primary care setting, the records of this care are protected by HIPAA but can be viewed by other practitioners within the health system treating that patient.

In that same example, however, with the same medication in an addiction treatment provider clinic, the information cannot be shared because of the rules in 42 CFR Part 2. The negative impact on care should be obvious since integrated care allows all the practitioners to understand the issues affecting the patient and is the gold standard of care. The obvious downside of the rule is that a physician can unknowingly prescribe opioids to a patient that has an opioid use disorder because the doctor was not provided with the full picture of the patient's treatment needs.

Earlier this year, the President's Commission on Combatting Drug Addiction and the Opioid Crisis also identified a need to update privacy laws, specifically citing 42 CFR Part 2, to ensure that information about substance use disorders are made available to all medical professionals treating and prescribing medication to patients.⁷

While 42 CFR Part 2 may have been well intentioned at one time, the passage of HIPAA has made the provision antiquated when it comes to treatment. The provision also perpetuates the stigma associated with the disease of addiction.

By treating addiction treatment as secretive, it perpetuates the old idea that opioid use disorder is a moral failure rather than a treatable disease. Public health practitioners, as well as all medical providers, would like to remove the stigma but the failure to treat this disease like any other stigmatizes the patient and makes treatment more difficult. It also creates an artificial barrier to much needed treatment resources that would be available through mainstream medical providers.

In the final analysis, identifying the problem is useless without also suggesting solutions. A comprehensive national system for treatment must be established. The President's Commission on Combatting Drug Addiction and the Opioid Crisis also recommended improving access to and the quality of drug addiction treatment.⁷

According to the CDC, expanding access to medication assisted treatment (MAT) is essential to an effective response to the dramatic increase in opioid-related problems.⁸ Research evidence indicates that MAT for clients with opioid use disorder, particularly outpatient methadone treatment (OMT), has the potential to save significantly more money than other forms of treatment.⁹ These cost saving impacts of MAT are attributable to a wide range of improvements in the health inequities that are commonly experienced by primary opioid clients, to include reduced rates of drug use, increased access to health care and other recovery support services, improved interpersonal relationships and living conditions, and decreased involvement in high-risk behaviors such as injection drug use. It has been observed that the regular, long-term involvement of opioid users in MAT plays a significant role in overall harm reduction practices.

Additionally, there is evidence of harm reduction benefits among both primary opioid clients who continue to use while in MAT, and those who prematurely discontinue treatment.¹⁰

In Illinois there are only 82 substance use disorder treatment centers.¹¹ Unfortunately, with 2.1 million individuals addicted to opioids nationally, the need far outweighs the treatment nationally and in Illinois.

The State of Illinois Department of Human Services released "The Opioid Crisis in Illinois" that reviewed the number of individuals afflicted and the need for treatment.

The Opioid Crisis in Illinois report noted that the CDC has concluded that for every opioid overdose death it can be estimated that there are 130 individuals who have some form of Opioid Use Disorder (OUD). If this estimation factor is applied to Illinois, it can be estimated that there are about 180,000 persons in our state with an OUD.

Using the same approach, the CDC also estimates that for every opioid overdose death there will be about 35 hospital emergency department (ED) visits. It is also worth noting that application of CDC's projection factor of 35 opioid-related ED visits for every opioid overdose death would yield over 48,000 expected opioid-related visits. This is substantially lower than the actual number of visits that were reported in 2015. This would seem to indicate the likelihood of substantial underreporting of these events.¹²

One possible solution is the use of the Federal Qualified Health Centers (FQHC) which number about 1367 Community Health Centers with 10,404 delivery sites across the United States. In Illinois, there are 45 Centers, with a total of 402 delivery sites. In Illinois alone, if there was an expansion of MAT and other outpatient substance use disorder treatments at only 82 of the 402 delivery sites, we would increase the capacity by 100%. If all FQHCs were equipped to provide these services, there would be 500% increase in capacity.¹³

FQHCs are safety net providers that include community health centers, migrant health centers, health care for the homeless health centers, public housing primary care centers, and health center program homes. FQHCs are paid based on the FQHC Prospective Payment System (PPS) for medically-necessary primary health services and qualified preventive health services furnished by an FQHC practitioner. Those services have, in some instances, included substance use disorder treatment.

Incentives for Medicaid reimbursement and to encourage providers to offer substance use disorder treatment should be part of any plan to combat the opioid crisis moving forward. Thank you for allowing me the opportunity to provide a local public health perspective to this problem.

Although DuPage County has been successful in leveraging federal grant support, at the local level we have been focused on responding to the urgent need and stemming the epidemic rather than calculating the comprehensive costs on our communities. I am very confident, however, that the costs of developing systems to support substance use disorder prevention, early intervention treatment, and recovery pale in comparison to the price of inaction and complacency.

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CHARTER

Taskforce Overview

The Taskforce is a joint operation of the DuPage County Board and the DuPage County Board of Health. The Taskforce will consist of members from across many sectors in our community, specializing in mental health, law enforcement, adjudication, substance abuse treatment, prevention, and education.

The Taskforce is responsible for advising DuPage County elected leaders on needed program development, supporting infrastructure, and policy recommendations to address DuPage County's opioid issues and may assist with other related issues as necessary. The Taskforce reports jointly to the County Board Chairman (through the Judicial Public Safety Committee) and the President of the DuPage County Board of Health. The HOPE Taskforce shall convene at least quarterly and more frequently, as needed. All meetings shall adhere to the Illinois Open Meetings Act.

Taskforce Goals

The HOPE Taskforce is an interagency-interdisciplinary advisory task force that will:

- (1) Professionally and comprehensively assess opioid use within DuPage County;
- (2) Recommend effective and actionable policies, initiatives, and programs; and
- (3) Measure success from desired program and initiative benchmarks and deliverables.

Membership

The HOPE Taskforce will be co-led by Board of Health Vice President Dr. Lanny Wilson and County Board Member Grant Eckhoff.

The HOPE Taskforce consists of 17 members appointed as follows:

- DuPage County Board / Chairman Representative
- DuPage County State's Attorney Representative
- DuPage County Health Department / Board of Health Representative
- DuPage County Coroner Representative
- DuPage County Regional Office of Education Superintendent Representative
- DuPage County Sheriff Representative
- DuPage County Public Defender Representative
- DuPage County Chiefs of Police Association Representative
- DuPage County Drug Court Representative
- DuPage Mayor and Managers Representative
- IL Department of Alcoholism and Substance Abuse Licensed Treatment Provider Representative (2)
- DuPage County Hospital/ Healthcare System Representatives (2)
- DuPage County Fire Chiefs Representative
- National Safety Council Representative

Interested members of the community are invited to attend the HOPE Taskforce meetings, which will be open and announced on the DuPage County Board and DuPage County Health Department websites.



FRAMEWORK

1. Reduce Access to Drugs

- a. Expand RxBox and other drug take back programs
 - i. Provide education for patients on importance of disposing properly of medications and engaging hospice providers for the same
 - ii. Provide community education on importance of disposing medications properly
- b. Provide education or technical assistance to healthcare organizations on how to set-up take back programs
- c. Reduce supply of illicit drugs through law enforcement

2. Reduce Opioid Use and Misuse

- a. Reduce the number of opiates prescribed
- b. Increase use of Prescription Drug Monitoring Program (PDMP) by prescribers in DuPage County
- c. Educate consumers about identifying opioid medications and advocating for alternatives
- d. Increase use of non-opioid treatment options
- e. Promote consistent safe prescribing messages and policies used by healthcare providers and health systems
- f. Promote and provide safe prescriber training

3. Increase Overdose Response

- a. Make naloxone more accessible to first responders
- b. Make naloxone more accessible to bystanders and those most at-risk for overdose
- c. Communication campaign to increase awareness of 911 Good Samaritan Law and provision of treatment and harm reduction resources
- d. Expand overdose follow-up provided by hospitals, fire departments, police departments, and social workers

4. Integrated Mental Health & Substance Use Disorder Treatment and Recovery

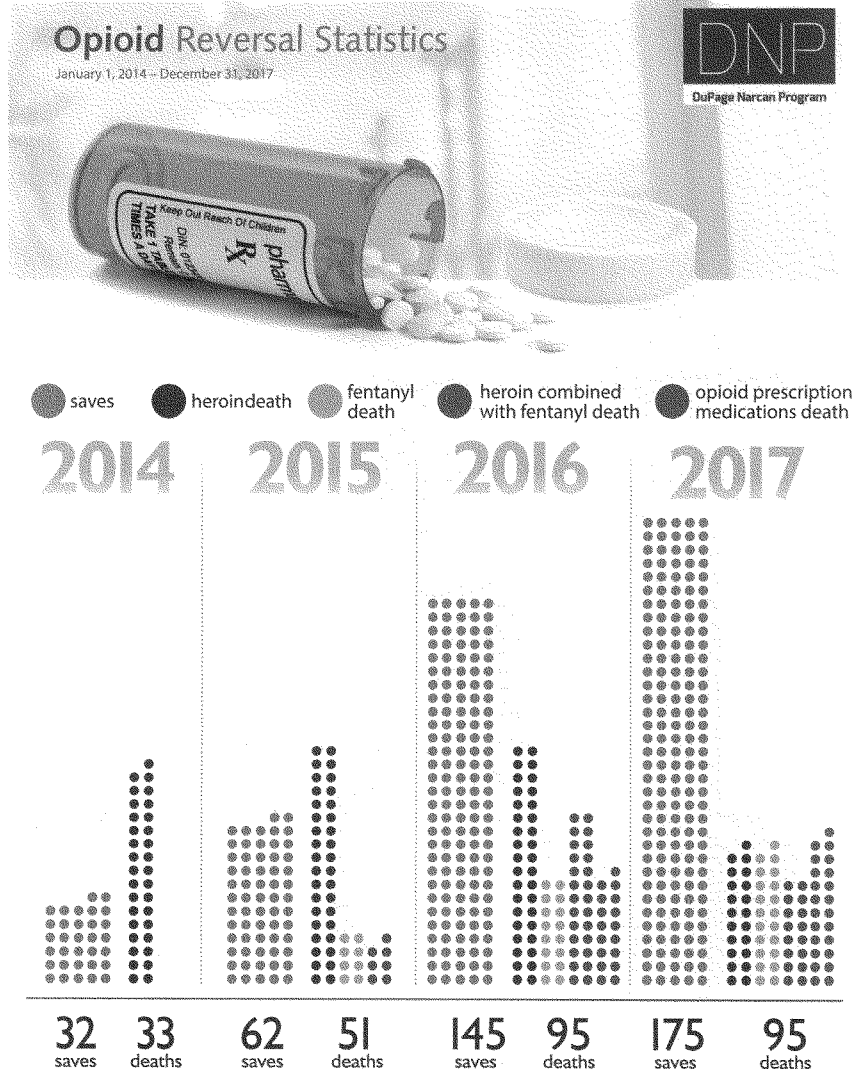
- a. Increase treatment community capacity
- b. Increase primary care and other healthcare provider referral to treatment
- c. Coordinate with criminal justice system partners to increase screening and referral to treatment
- d. Increase availability of Medication-Assisted Treatment
- e. Promote integration of mental health and substance use disorder treatment

5. Substance Use Prevention and Education

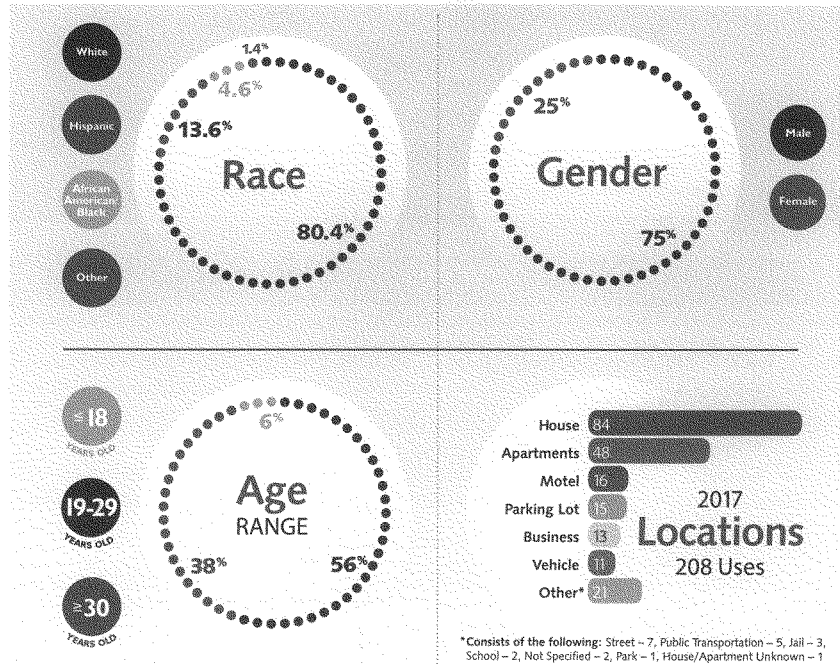
- a. Enhance and promote prevention efforts (i.e. evidence-based curriculum for youth and messaging for general population)
- b. Promote substance use disorder stigma reduction campaigns

Cross-cutting Goals of the Taskforce

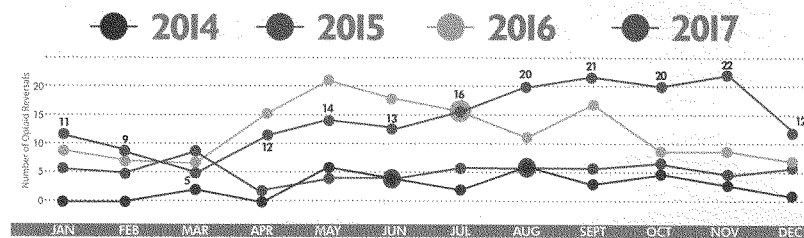
- Communication (i.e. media, social media, health promotion)
- Data collection (i.e. Illinois Youth Survey, DuPage Narcan Program, EMS, Morbidity and Mortality)
- Evaluation of efforts



Opioid Reversal Statistics January 1, 2014 – December 31, 2017



Opioid Reversal Statistics by Month



These statistics represent the opioid saves/reversals in the DNP and are not a comprehensive summary of naloxone activity in DuPage County.

Disposing Meds Safely

Bring your expired and unused medications to an RxBOX location that is convenient for you. The medications will then be incinerated in collaboration with the Illinois Environmental Protection Agency using state-of-the-art technology.

The medications will not be reused in any way.

Disposal Recommendations

- Bring household medication including over-the-counter, prescription medications, ointments and liquid medications that are expired or unused.
- Also drop off asthma inhalers.
- You can bring medications as they are in their original containers or, for spill-free disposal, place the pills or liquid medication bottles in a zipper top plastic bag.
- Cross off any personal information on the label to reduce concerns about personal identification information.



Items NOT Accepted

- Sharps, needles or EpiPens®
- Radioactive medicines
- Any other medical waste
- Household chemical waste; these items need to be disposed of using other methods.

Household hazardous waste (HHW) can be disposed of at the HHW facility in Naperville.

Sources

- CDC.gov
- Drugabuse.gov
- Drugfreeworld.org
- National Institute on Drug Abuse



**DUPAGE COUNTY
HEALTH DEPARTMENT**

Overseeing Drug Safety, Distribution



2/15/2018 Version 1.8

The Solution is Simple...

Reduce the amount of unused and expired medications in our households and dispose of them in a way that is the safest for our environment.



RxBOX Locations



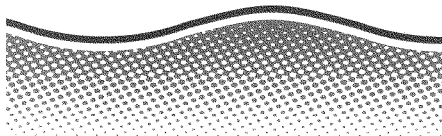
- Addison Police Department**
3 Friendship Plaza, Addison, IL 60101
- Bensenville Police Department**
345 E Green Street, Bensenville, IL 60106
- Bloomington Police Department**
201 S. Bloomington Road, Bloomington, IL 60108
- Burr Ridge Police Department**
7700 S. County Line Road, Burr Ridge, IL 60527
- Carol Stream Police Department**
505 E. North Avenue, Carol Stream, IL 60188
- Clarendon Hills Police Department**
448 Park Avenue, Clarendon Hills, IL 60514
- Darien Police Department**
1710 Plainfield Road, Darien, Illinois 60561
- DuPage County Sheriff**
501 N. County Farm Road, Wheaton, IL 60187
- Elmhurst Police Department**
125 E 1st Street, Elmhurst, IL 60126
- Glendale Heights Police Department**
300 Civic Plaza, Glendale Heights, IL 60139
- Glen Ellyn Police Department**
65 S Park Blvd, Glen Ellyn, IL 60137
- Hanover Park Police Department**
2011 W. Lake Street, Hanover Park, IL 60133
- Itasca Police Department**
540 W. Irving Park Rd., Itasca, 60143
- Lisle Police Department**
5040 Lincoln Avenue, Lisle, IL 60532
- Roselle Police Department**
103 S Prospect Street, Roselle, IL 60172
- Schaumburg Police Department**
1000 W. Schaumburg Road, Schaumburg, IL 60194
- Villa Park Police Department**
40 S Ardmore Avenue, Villa Park, IL 60181
- Wood Dale Police Department**
404 N. Wood Dale Road, Wood Dale, IL 60191

RxBOX

Disposing Meds Safely

The Problem:

Unused medication is a risk to families, the community and our environment.



 **DUPAGE COUNTY
HEALTH DEPARTMENT**
Everyone. Everywhere. Everyday.



The Solution is Simple...

The Problem

Nationally, regionally and even locally there has been growing concern about what we all do with the medicines that are left over in our cabinets. We take medication for so many reasons - for minor injuries, the occasional headache, back or muscle pain, to help relieve cold symptoms, for our high blood pressure or cholesterol. Over-the-counter medication, prescriptions, ointments and liquids...we often have medications that may be expired or no longer needed.

Unused Medications

- One-third of prescription and over-the-counter medicines go unused or expire.
- Unused medications left in the home increase accessibility, the number one contributing factor to all misuse and abuse of prescriptions and over-the-counter drugs.

Risks of Poisoning

- Accidental poisoning is the leading cause of unintentional injury death in the U.S. Nearly 9 out of 10 poisoning deaths are caused by drugs.
- Children, even when well-supervised, are exploratory and curious, they often have lots of opportunities to get into medicines in purses, cabinets and counter tops.

Teen Drug Abuse

- Prescription and over-the-counter drugs are the most commonly abused substances by Americans age 14 and older, after marijuana and alcohol.
- As many as 1 in every 4 teens in America say they have taken a prescription drug that was not prescribed for them.
- 90% of all teens who abused pharmaceutical drugs obtain their drugs from their home medicine cabinet or from a friend's medicine cabinet.
- A dangerous misconception teens have is that these drugs are safer to abuse than illegal drugs because they are prescribed by doctors.

Our Environment

- Whether they are put in the trash or in our water supplies, medications may pollute or have risks to our environment.
- Even though our drinking water is safe, low levels of pharmaceuticals have been recently found in drinking water of 24 U.S. cities.
- Studies are being done to help understand what impact these contaminants may have on our environment and our water supplies. In the mean time we know that we can reduce any potential risks by seeking out safe disposal methods.

Mr. JORDAN. Thank you, Ms. Ayala. I will now go to Dr. DesJarlais from Tennessee for the first round of questions.

Mr. DESJARLAIS. Thank you, Mr. Chairman. Thank you for being here to discuss this very important and relevant topic.

Mr. Siegle—I have a lot of questions for all of you, so if you can keep your answers short, that would be helpful—you testified that ONDCP's neutrality is an asset to the HIDTA Program. Can you elaborate on that for me?

Mr. SIEGLE. Yes, the participation and oversight and guidance given by the ONDCP versus a traditional law enforcement agency is actually a very good benefit. It is neutral. It does not make the State and locals feel alienated. It empowers the regional and local executive boards to make decisions in their area. And it, I think, has increased and continues the increase of the program because of the belief that they have a say in the program because it is not controlled by one agency. It is controlled and directed by the executive board.

Mr. DESJARLAIS. Okay. And how does the reauthorization of the ONDCP ensure the continued success of the HIDTA Program?

Mr. SIEGLE. It places the HIDTA Program under ONDCP and continue our operation under their coordination, and guidance, and funding.

Mr. DESJARLAIS. How important is ONDCP's national drug control strategy in shaping the focus of the HIDTA Program?

Mr. SIEGLE. It is very important, and it kind of goes both ways in that the drug problem started at the local or regional level, and all those combined feed in to the National Drug Strategy, which ONDCP puts together. And by having HIDTA and ONDCP together, they can reach out to the HDTAs across the country and have instant access to all the different drug information at the various, you know, regional areas and cities and levels of law enforcement across the country.

Mr. DESJARLAIS. Okay. Thank you. Ms. Haskins, the Drug-Free Communities Program provides Federal funding straight to the local level. How effective is ONDCP, a Federal policy shop, in administering a program geared towards local communities?

Ms. HASKINS. They are extremely effective. Something that is helpful with ONDCP being over the Drug-Free Communities Program is that ONDCP, their focus is substance use and abuse. So, there is nothing else that is kind of clouding their focus area. They provide us technical assistance whenever it is needed. They help us out if we have difficulty with our program officers or project officers through SAMHSA. They are there to help kind of connect us and help move that process forward.

Mr. DESJARLAIS. Okay. The DFC Program is required to collect and submit data about its coalitions every 2 years. How does this data collection share the effectiveness of your coalition?

Ms. HASKINS. We have to be able to prove that, the \$125,000 annually that we receive that we are seeing reduction in use. Without that data collection, we are unable to do that.

Mr. DESJARLAIS. Would it be helpful to collect the information on an annual basis?

Ms. HASKINS. There are some drug-free communities locations that do that. I think that in order to see long-term change, though, it is not going to be as effective to do it on an annual basis.

Mr. DESJARLAIS. What does ONDCP need to improve its data collection, or does it need to improve it in any way?

Ms. HASKINS. The reports that we have to provide, it is once every 6 months. They provide a submission of what we have turned into them so that we have an overarching idea of where we are moving from and where we are going to. At this point, I would not say that there would be anything that would need to be changed.

Mr. DESJARLAIS. Does your coalition work with the HIDTA Program?

Ms. HASKINS. We work with some of their officers in West Virginia. We particularly are not a HIDTA county, but all of the counties surrounding us are HIDTA counties.

Mr. DESJARLAIS. Okay. Ms. Roberts, as Congress appropriates increased funding to tackle the opioid crisis, the need for Federal-level coordination is imperative. How does ONDCP assist your local initiatives in preventing and reducing illicit drug use?

Ms. ROBERTS. ONDCP has helped us tremendously to address supply and demand at the local level. Sometimes evidence-based practices and best science does not get transmitted to the local-level area people so much. And so, by allowing us to be exposed to forums, conferences, the leadership, the reporting systems, we are able to find out what is kind of the cutting-edge types of things, science that is being researched at the Federal level. And we are able to take that to our local communities then and translate that into action at the local level.

Mr. DESJARLAIS. How does the reauthorization of ONDCP affect the HIDTA and DFC grant programs?

Ms. ROBERTS. Because they are both under the Office of National Drug Control Policy, these are their two main programs. Like Mr. Siegle said, it is very important that they be led by an agency that has very broad understanding. This is an extremely, extremely complex and evolving issue. And so, it is very important for an office to be able to look at law enforcement's concerns, public health's concerns, treatment concerns, and be able to kind of lead and develop policies that do not necessarily hurt another branch or another entity while developing a policy that helps another entity. So, it is just very important for them to be able to have a very broad picture, and to be able to translate that into information that communities like mine can use at the local level.

Mr. DESJARLAIS. Okay, thank you all for your responses. I yield back.

Mr. JORDAN. Thank you, Doctor. The gentleman from Illinois is recognized for 5 minutes.

Mr. KRISHNAMOORTHY. Thank you, Chairman, and thank you all for your really enlightening testimony. I wanted to first start out by saying representatives from three organizations, namely the Robert Crown Center for Health Education, the DuPage County Board, and the Gateway Foundation, have provided additional testimony for the record about local efforts to combat the opioid epidemic in Illinois. Mr. Chairman, I request unanimous consent that

this testimony be made part of the official record for today's hearing.

Mr. JORDAN. Without objection, so ordered.

Mr. KRISHNAMOORTHY. Thank you.

[The information follows:]

Mr. KRISHNAMOORTHY. I would like to start, I have several questions, so I ask everyone to please be brief. But, first, I would like to start with Ms. Ayala. Thank you again. We are honored to have you here today.

Ms. Ayala, how has the Federal grant landscape shaped the work you are able to do with the HOPE Task Force?

Ms. Ayala: So, it was not part of my comments provided earlier, but we have been a recipient of the Drug-Free Communities grant for the past 5 years. That, as other members providing testimony, has provided us with an opportunity to coalesce a group and really provide the framework in which we can develop a more expanded approach based in the local communities to meet our needs.

Primarily the efforts and the funding that we have received from the Federal level so far have been around the use naloxone, which we greatly appreciate, and it is very much needed within our community. However, one of the opportunities I think that grants such as the Drug-Free Communities and the HIDTA model provide is an opportunity for local communities to better define where their needs lie versus the categorical funding that has been historically provided to us.

Mr. KRISHNAMOORTHY. Got it. Thank you, Ms. Ayala. Ms. Haskins and Ms. Roberts, with the Drug-Free Communities grants that you have received, could you each just talk about a couple like tangible examples of how you use that money to reduce, you know, the addiction rates in each of your counties. I was especially interested in Ms. Haskins' testimony about the reductions pretty much across the board. Could you talk about this, the tangible application of the money?

Ms. HASKINS. Absolutely. The very first year that we began our coalition back in 2009, we had had 16 youth die in a matter of 2 years all pretty much from the same graduating class. So, that is pretty difficult for a community to put aside and not recognize that we have a prescription drug issue.

We were able to do a comprehensive public awareness campaign to help bring that forward and help kick off some conversation that otherwise was not being had in our community. We educated anybody from preschool all the way up to the elderly who participate in our senior centers, you know. We had pharmacy students that would come in and volunteer their time to go over medications with the elderly and let them know what were some of the medications that were being taken out of the home, you know, people watching mailboxes to take that medication out of mailboxes that had been sent through the Postal Service. So, our comprehensive public education strategy was probably the biggest thing that we have done.

That money has also helped us utilize, like I said, the destruction of prescription pills. We have three static takeback locations that we advertise constantly. We are a county of 29,000, and we usually get about 99 pounds of medication back per quarter. It is fiscally difficult to destroy that medication properly, so one of the things

that we were able to utilize, only \$2,000 of our Federal money was to build and purchase an incinerator for our community so that we can destroy these pills and it will not be a financial burden on our community. We then took that idea and we advocated that that needs to take place throughout the State of West Virginia, so, therefore, we now have regional incinerators throughout the State of West Virginia to help other small communities like our own.

You know, when you do public education, and you are going into the classroom, and you are teaching kids, you are teaching parents what to watch for for substance abuse, you are teaching teachers what substance abuse looks like so that they can understand, you know, when kids are high in the classroom. We have done law enforcement training to train them on diversion because when we started seeing pill issues in our county, law enforcement did not have a clue. They do not know if it is a blood pressure medication or an oxycodone, you know.

So, those types of trainings were very important, and our DFC funding enabled us to do all those of skill building opportunities. And that is how we ended up with a reduction across the board was all of our educational opportunities that we are able to provide.

Mr. KRISHNAMOORTHY. Thank you. Can Ms. Roberts answer briefly?

Mr. JORDAN. Sure.

Mr. KRISHNAMOORTHY. Ms. Roberts, can you please address the question?

Ms. ROBERTS. Yes, our DFC funding enabled us to do comprehensive strategies across the entire community. And one of the requirements of drug-free communities is that you have very broad sector representation. There are 12 sector members that are required to be part of the coalition.

When we first started our coalition in 2010, we were actually in incident command mode, which is a public health military type of strategy that is used for an emergency, which we had declared an emergency. But we needed to learn to be more strategic and long term and have outcomes that were going to last over a period of time after the urgency subsided.

So, sector leaders ended up being very important. One sector in particular is a healthcare provider. Our healthcare provider at the moment is our health commissioner who is also a Data 2000 waived physician, and just the coalition inspired him to become a Board-certified addictionologist.

And so, those strategies allowed us to have access to prescribers, the people that are actually writing prescriptions. And so, we were able to get into hospitals, and medical societies, and dental societies, and things like that, and tell them about the opioid crisis, which they were not aware of at the time in 2010. But also to change their prescribing habits, prescribing guidelines, to increase their access or utilization of the Prescription Monitoring Program.

And so, in my written testimony you can see that we are the lowest point since the Prescription Monitoring Program began in terms of opioid prescription being written. Thank you.

Mr. KRISHNAMOORTHY. Thank you.

Mr. JORDAN. If you could do just one thing and only one thing, what would it be? The single one thing you would do to deal with the problem? Ms. Haskins. I am just going to go down the line.

Ms. HASKINS. I would —

Mr. JORDAN. Single most important thing to address the problem in your community or communities across the country. What would it be? Only one thing.

Ms. HASKINS. I would have to put in place some type of parameters for the MATs that are in our area, for the Medication-Assisted Treatment programs that are in our area, for the adults. For youth, it would absolutely prevention, prevention, prevention.

Mr. JORDAN. Okay. That sounded like two things.

[Laughter.]

Mr. JORDAN. Ms. Roberts.

Ms. ROBERTS. Well, in terms of the overall, drugs are always a symptom of a bigger thing. And so, you know, Appalachia has been an area that has kind of been impoverished. And so, I think that overall anything that can improve the economy is going to be helpful in the long term.

But I would have to say at the moment that this is not necessarily being treated like a public health emergency even though it has been declared. Whenever there is a public health emergency, there is typically a stabilization period where the crisis kind of gets contained. And having been through multiple addiction treatment facilities with my own child and experienced a gamut of things that did not work, my daughter thrives on medication-assisted treatment. But I cannot tell you how difficult that was for me to access for her.

So, I think that I would have to say I would like to see our regulations surrounding medication-assisted treatment be lessened, similar to what some of the other countries in Europe are doing. People can actually dose on a methadone at a local pharmacy on their way to work. I do not have any access to methadone in my community. The closest clinic is, like, a hundred-and-some miles away. And so, that would be my answer. Thank you.

Mr. JORDAN. Thank you. Mr. Siegle?

Mr. SIEGLE. Yes, if I could do one thing, it would be the continuance of HIDTA under ONDCP because, as I stated, it allows us to operate efficiently and effectively. And also interface and support the prevention and education and treatment sides more effectively. For instance, some of the items I mentioned, like ODMAPs, that is not just for law enforcement. We developed it for law enforcement, but it is open to hospitals, treatment people, other people, public health people to see where the overdoses are occurring.

Mr. JORDAN. Yep.

Mr. SIEGLE. And some of the HIDTAs are starting to use that information to forward out to the treatment people to say, hey, we have responded to this individual 5 times or 3 times. They have been Narcan'd X number of times. You may want to get out and talk to these people because they are going to be your next overdose victim. But I think that totality of strategy that ONDCP encompasses allows us as an enforcement program to partner and have greater access to the areas and provide assistance in those areas.

Mr. JORDAN. Ms. Ayala?

Ms. Ayala: My recommendation would be to integrate and expand access to substance use disorder treatment across the community with a particular focus on individuals who are uninsured or under insured using public funding for their care.

Mr. JORDAN. Do any of you believe that other social welfare, not other, but social welfare programs, government programs in our social welfare system I should say. There was a study by Senator Johnson's staff over on the Senate Oversight Committee, and there has been some research in this area, that the Medicaid expansion is actually in some ways maybe contributed to growing opioid use in certain communities. Do you think that is something that should be examined and may, in fact, be the case? Ms. Haskins?

Ms. HASKINS. I will not blame that for the reason that West Virginia has had an increase.

Mr. JORDAN. I am not saying cause and effect yet, but do you see a correlation and potentially cause and effect relationship between the Medicaid expansion and the opioid epidemic?

Ms. HASKINS. I believe it has made it easier for access, yes.

Mr. JORDAN. Yeah, that is what Senator Johnson's study indicates. Ms. Roberts?

Ms. ROBERTS. Ohio is one of the States that did expand Medicaid, and so I can probably speak on that a little bit. However, Ohio had a prescription opioid problem before Medicaid expansion. What Medicaid expansion —

Mr. JORDAN. If I could interrupt for a second. I am not saying it did not. I am asking do you as a professional in this area, do you think the Medicaid expansion exacerbated an already-existing problem?

Ms. ROBERTS. I think Medicaid expansion helped tremendously in terms of the problem because it allowed access. What I see at the community level is that it allowed access to addiction treatment for a lot of population that was not able to access it.

Mr. JORDAN. Do you think welfare reform would be a necessary part of actually addressing this overall problem? Reforming our welfare policies, incentivizing work, doing different things. You mentioned in your comments earlier, Ms. Roberts, that economic concerns you think led to this. So, do you think reforming our welfare system would help with this problem as well?

Ms. ROBERTS. I think that it would be worth taking a look at. But, you know, as far as where I am from, there really are not a lot of opportunities for people, and so, public assistance is necessary for those people. So, I was speaking more in terms of economic development and opportunities.

Mr. JORDAN. Ms. Haskins?

Ms. HASKINS. I would say, I mean, I would agree with that, yes. I think part of what would need to happen, though, is with the Medicaid expansion, they would need to be able to go across State lines to access treatment.

Mr. JORDAN. I am pushing my limit on time, so I am going to recognize Ms. Kelly for her 5 minutes of questioning.

Ms. KELLY. Thank you, Mr. Chair, and thank you and the ranking member for having this hearing. And welcome to all the wit-

nesses. I have another question that I had planned to ask, which I still will, but maybe I missed this.

When you think about your places that you represent, or even if you think about nationally, how did this start? Like the majority of the people that have opioid addiction or died, how did it first begin?

Ms. Ayala: If I could jump in. Within our community and within our research, we work closely with the National Safety Council, and what their evaluation demonstrates is that 75 to 80 percent of the individuals who are currently addicted to heroin began their journey into this complex world through the use of opioids prescribed by their physicians.

Ms. KELLY. Thank you.

Ms. Ayala: Or doctors.

Ms. HASKINS. I would tend to agree with Ms. Ayala. I would also say that West Virginia had a very high heroin usage rate, and when that balloon started to get contracted on the heroin side, it is going to automatically flip over to the opioid side. You know, our particular issue in our community was fentanyl way before fentanyl was a household name. And that was coming from local prescribers.

Ms. KELLY. Thank you. Anybody else?

Ms. ROBERTS. I would like to chip in. I am from Portsmouth, Ohio, which we ended up with a lot of notoriety for being an area that saw the opioid crisis really early. We were making headlines back in 2002 in terms of OxyContin. And so, these products were marketed heavily in Appalachia, you know? That is why they ended up being called "hillbilly heroin." And so, I would say the pharmaceutical company marketing played a role in that, but also what we saw was that it became a form of currency, currency in an impoverished area where people did not have access to other forms of making money. So, I think these things were interrelated.

Ms. KELLY. I have to be careful. Both the ranking member and I are married to doctors, so I have to be careful.

[Laughter.]

Ms. KELLY. And my husband is an anesthesiologist. But that is what I thought, and when I went to a meeting with my hospital where I represent in Illinois, they actually started a program where they gave out the medicine to prevent the deaths. But that was something they talked about, more education for the prescribers, that that was needed, too. But anyway, again, I want to thank you.

I wanted to talk to you about access to the lifesaving drug, naloxone. As you know, it is a drug that reverses opioid overdoses and prevents death, and last week the Surgeon General issued the first advisory in 13 years calling for expanded access to it. He wrote that "Increasing availability and targeted distribution of naloxone is a critical component of our efforts to reduce opioid-related overdose deaths."

Ms. Roberts, I understand you are a registered nurse, and you obviously worked in the public health field for a long time. So, I would like to ask you is access to this critical for first responders and others working on the ground to save lives?

Ms. ROBERTS. Well, as someone who has worked extensively with the drug naloxone, I think I can say that it is absolutely imperative, especially at this time when we are having a national crisis. But naloxone is a prescription drug, and so, therefore, it is subject to all of the rules and regulations that surround a prescription drug. In some other countries it is not necessary. It is an over-the-counter drug, and so it is, you know, sold over the counter, it is very cheap, and all of that kind of stuff.

So, it is a little bit difficult to navigate the system sometimes because of the rules and regulations that control it as far as who can dispense it, who can, you know, prescribe it, and all of those things. So, in Ohio we have actually had to navigate that system for several years, and have managed to be able to get it to a point where we are able to have it available at certain pharmacies through a corporate protocol. There has to be a licensed prescriber in the loop someplace, which makes things a little bit difficult.

And so, we have been able to get it to where people can get it without a prescription by going to a certain pharmacy, and it is covered by insurance. However, as far as supplying it to law enforcement and fire departments and these sort of non-traditional first responders, the fact that the price does increase frequently, you know, really does kind of impede our, we kind of fly by the seat of our pants all the time in terms of coming up with the medication.

Ms. KELLY. Well, and mentioning that, several of my Democrats colleagues did write to President Trump in September of last year asking that he take action to lower the prices. And this morning actually, Ranking Member Cummings sent yet another letter to President Trump urging him to adopt his own commission's recommendation to negotiate lower prices, and ensure that this life-saving drug is available to all who need it.

I know my time is over, so thank you.

Mr. DESANTIS. [Presiding.] Thank you. The chair now recognizes the gentleman from Kentucky for 5 minutes.

Mr. COMER. Thank you, Mr. Chairman. Ms. Roberts and Ms. Haskins, I represent a very rural district in Kentucky that has been hit especially hard by the opioid epidemic. How have you seen the opioid epidemic uniquely affect rural communities?

Ms. HASKINS. Especially in our community, much like Ms. Roberts said, it is a form of income for a lot of people in a location where there are no other jobs. Luckily for us with DFC funding, we are able to do some prevention with the children of those families and parents who are using a lot and abusing and selling, helping them create goals, and figuring out that there are some other options in life other than utilizing prescription drugs or some other form of a substance.

In particular, we have many of our elementary schools in Jackson County that are seeing difficulties just now with students coming up through the school system. They cannot retain information. This is pretty much the first wave of children who are coming through the school system from opioid. You know, I mean, they are opioid-exposed babies, and they are having difficulty retaining information that is being taught. That is not the fault of the teacher. That is not the fault of the school system itself. And we do not

know how to deal with these children because they cannot get qualified for special ed. They are not learning disordered as far as what the school parameters are. So, we are having difficulties even with behavior in our school systems. That is probably one of the most recent happenings from how it has affected our community.

Mr. COMER. Right.

Ms. ROBERTS. In answer to your question, I have seen opioids affect our community in so many negative ways. And so, prescription opioids really just sort of landscape. In Appalachia, we had never really had a heroin problem. Heroin was a problem that was associated with big metropolitan areas. And so, heroin is now a problem in Appalachia, and because of that, you know, we are absolutely seeing children who are, you know, having to live in families where substance use is a problem.

However, the Drug-Free Communities grant has allowed as a coalition to address parental substance use because that has such a negative effect on children. One of our sector leaders is the juvenile court judge, and he actually has started a family drug court to help families that are struggling with opioid use disorder so that they can retain their children and keep the family intact.

Mr. COMER. Now, one of the things that Chairman Jordan mentioned with the expansion of Medicaid is that, the question he asked was did that make the opioid epidemic worse. And the source of most of the opioids in my rural county, according to my law enforcement, from people on Medicaid for which you mentioned, a source of income.

Ms. HASKINS. Absolutely.

Mr. COMER. And that is something that, you know, you think about it, that is being paid for by the tax dollars. That is not coming in from drug cartels. That is coming from citizens in the communities that are getting free prescription drugs and turn around and selling them, which is having devastating effects on a community that has already been devastated by the new economy. So, that is something that I think we need to look into.

And do you have any advice on how to prevent that, alternative sources of payment? I mean, I do not know. There are certainly over prescribing that is going on in rural communities.

Ms. HASKINS. You know, in our particular community, at this point I do not think it is an over prescribing issue. It truly is an access issue. We have a needle exchange program that we just started in our health department, and I can tell you that most of our individuals that come through our program are actually using Suboxone, and Subutex, and crystal meth, you know, so, again, access is an issue.

I think one of the main fixes would be to have some additional quality mental health counseling available because right now in West Virginia, that is seriously lacking, and I am sure it would be similar in Kentucky as well, because until you deal with the root of the problem, and, you know, most people will tell you that with substance use there is some underlying mental health issue that is not being dealt with, they are going to continue to use.

Mr. COMER. Thank you, Mr. Chairman. I yield back.

Mr. DESANTIS. The gentleman yields back. The chair now recognizes the gentlewoman from the District of Columbia.

Ms. NORTON. Thank you, Mr. Chairman. I particularly thank the witnesses who have testified, whose testimony has already clarified much for me.

I want to make sure I know what we are talking about. I think it was you, Ms. Ayala, who talked about how people on heroin transition to opioid addiction, one of you did. And I think it is useful that we are using what looks like a broad term to describe what we are talking about when we hear "substance abuse," sometimes is a term used. But I would like to know essentially what we are dealing with.

One of you indicated, or perhaps it was my colleague, that it was called "hillbilly heroin" in his rural area. Well, obviously it is not called that in mine. I represent the District of Columbia, and big cities are where you had heroin abuse. Now you have something else, and it looks like physicians and the medical community is implicated.

And so, I would like to know exactly what we are talking about. When we talk about an opioid crisis, most people will think that are prescribed or highjacked medicines. I do not think they understand the relationship to heroin. So, anything any of you could do to clarify that I think would be useful for this hearing.

Ms. ROBERTS. I would like to clarify that. Prescription opioids are commonly called "pain pills, "pain killers." They are manufactured by pharmaceutical companies, and they have some molecular structure that includes morphine.

Ms. NORTON. Well, I understand that there is a difference between —

Ms. ROBERTS. Yeah, okay.

Ms. NORTON. I am trying to find out how these substances, why you find some in some place, some in the others.

Ms. ROBERTS. Okay.

Ms. NORTON. Why there is a crossover. Even if you think that they are hillbilly heroin in some places, was there any heroin there before?

Ms. ROBERTS. No.

Ms. NORTON. I do not understand how this got started. I do not understand whether it is sectional, whether we need different approaches for different parts of the country since apparently they all transition between and across one another.

Ms. ROBERTS. Molecularly, heroin and prescription opioids are very similar, so you can kind of think of them as being interchangeable. When somebody becomes addicted or dependent to prescription opioids, then heroin will fill the same need. It is also cheaper. It comes from a different place, so —

Ms. NORTON. Heroin is cheaper?

Ms. ROBERTS. Absolutely.

Ms. NORTON. Initially opioid has to come from a physician, I guess, from a prescription, how does that get to be like heroin so they are simply passed all around the community?

Ms. ROBERTS. Well, prescription opioids come from a physician, and they have been used widely for the last 20 years due to some changes that took place with something called a pain scale. There was a belief that we under treating pain in the United States, and so you saw prescription opioids, especially, you know, some very po-

tent ones, come on the market and end up being very liberally prescribed. When I mentioned that —

Ms. NORTON. So, they are liberally prescribed. Now, all right, I get a prescription. I go around selling that prescription. Is that really the only way people are able to market this as a drug? They keep going back. Where do they keep getting prescriptions from?

Ms. ROBERTS. Well, they can find a prescriber that will give them the prescription, and so —

Ms. NORTON. So, it looks like Congress or somebody needs to do something.

Ms. Ayala. So, if I could just interject. The prescription drug monitoring programs that have been established on a State-by-State basis have been very successful in addressing the multiple attempts by an individual to go to multiple prescribers and game for additional prescriptions. However, the flip side of that is once that source is diminished, then that individual tends to turn to street heroin both because of the availability as well as the price. So, that happens on a system-wide basis, but it also happens on an individual basis.

Ms. NORTON. Yeah, that is important to understand how that occurs. They become addicted whether with heroin or opioids, and it does not matter, they are addicted. Now, Governor Christie of New Jersey headed the President's commission on combatting drug addiction. And I just want to read to you what he said to find out what in the world Congress needs to do, because this is a crisis that is getting worse. This does not always happen. I mean, there was an Ebola crisis. That was very different, but we got a hold of it. Swine flu, we got a hold of it. This thing is running away from us.

Governor Christie said, "One of the most important recommendations in this final report is getting Federal funding, support more quickly and effectively to State governments who are the front lines of fighting this addiction." Do you believe this is the key to quelling the addiction you find in your communities, and I would like to have answers from all of you, increased funding from the Federal government.

Ms. HASKINS. Absolutely, increased Drug-Free Communities funding because that is letting local communities deal with whatever trends are coming through their communities. It is not a one-size-fits-all answer unfortunately.

Ms. NORTON. Ms. Roberts?

Ms. ROBERTS. I would have to agree with Ms. Haskins. Drug-Free Communities is extremely important. It does allow you to be fluid and to shift your focus when necessary, and the opioid epidemic is a good example of when that has happened. We have prescription opioids, kind of deal with that, took care of that, now we have a heroin problem.

Many Federal grants are very restrictive, and they will say, well you can only deal with prescription opioids. So, what do you half-way through when a heroin problem comes? You are kind of stuck. And so, Drug-Free Communities is very important because they allow us to kind of shift gears midstream when we need to along with the HIDTA program, because supply reduction is extremely important now, too.

Mr. DESANTIS. The gentlewoman's time has expired. The chair now recognizes himself for 5 minutes.

Ms. ROBERTS, I wanted to follow up with you. Chairman Jordan asked you about the Medicaid expansion. There has been testimony before the Congress and some data suggesting that that has fueled the epidemic, and I think the argument is, you know, you are expanding to able-bodied adults. The program is not really good for long-term quality care and things like that, but it does provide access to the prescription drugs.

And so, the stats, I think, are 13 of the 15 States with the highest opioid overdose rates are Medicaid expansion States. I think your testimony was you think it has helped mitigate the problem, not exacerbate it. And so, what is your basis for saying that and have you seen data that would substantiate your view?

Ms. ROBERTS. Well, thank you for the question. So, they are saying that prescription opioids become more liberally prescribed in States that expand Medicaid because now people have more Medicaid and have a way to access them. Am I correct? Is that what is being said?

Mr. DESANTIS. And I think, you know, you access it with, I think, pretty much no cost to the patient.

Ms. ROBERTS. Yeah, and there could very well be some truth to that. But what I can say about Ohio is that Ohio did not expand Medicaid until probably 2014 or 2015. At that time, my county had the highest distribution rate in the State of Ohio, so we had plenty of opioids before Medicaid expansion. What I saw Medicaid expansion do for Ohio was allow many of the people that we were not able to help get access to addiction treatment. So, I think it is just probably going to be one of those double-edged swords.

Mr. DESANTIS. Right, because I think some of the graphs, I mean, since 2013, I mean, you have seen, it is noticeable the increase in the Medicaid expansion States. Let me ask you this. Is the bigger problem too many prescriptions and abuse of that right now, or is a bigger problem the street drugs?

Ms. ROBERTS. Well, that depends on where you live.

Mr. DESANTIS. What is your experience?

Ms. ROBERTS. Well, where I live right now the bigger problem, we have seen almost a hundred percent transition to heroin. And that happened relatively quickly when the prescription opioids less easy to access. We have seen the analog drug fentanyl products show up in heroin, and now they are showing up in other illicit drugs, such as cocaine and crack. And so, we are starting to see our entire drug supply become contaminated with these analog drugs that are highly lethal.

Mr. DESANTIS. Where is that coming from?

Ms. ROBERTS. Primarily it is coming from China. There have been many labs that have been —

Mr. DESANTIS. So, China sends it where?

Ms. ROBERTS. It is a very condensed product. It is very small, so it is very easy to send in the postal system. And so, it can be mailed to different parts of Canada, driven across the border. It can also be mailed to the United States.

Mr. DESANTIS. Well, I think that is true, and it is interesting, they will not use Federal Express or UPS for that because it will

be identified. The Post Office has had a tough time. We passed a bill recently to try to provide some tools to deal with that, and so it does come in the mail, but a lot of it, you know, comes in, you know, across the border. And I think that if you look at this crisis, it shot up around the same time where we have had a lot of problems at the border.

And I think that, you know, there are issues with what taxpayers have to shoulder when we do not have a secure border. There are issues with the rule of law that are very important. But this drug issue is a huge deal, and this garbage is coming into our country. And I think the prescription stuff, you know, obviously has been an issue, still is. But the prescriptions are going down now, and yet this stuff out there is just absolutely killer.

So, we have got to get a handle on this. And I am all for treatment, I am all for, you know, fighting it on the demand side, but you have got to fight it on the supply side as well. There is no way you could just let our country just be an open field for this stuff and not think that we are going to have some really negative consequences.

And with that, my time has expired, and I will recognize the gentleman from Wisconsin for 5 minutes.

Mr. GROTHMAN. Okay. We have a few questions here for the experts. We have heard how much the opioid crisis has gotten, and it has gotten much worse. And, of course, you know, we are spending billions of dollars between law enforcement or treatment, or whatever. Are there any examples around the country of States or large or small municipal areas in which there has been a precipitous drop in the number of deaths caused by opioids that we could say these people know what they are doing? Are there any examples of that around the country?

Ms. HASKINS. I think in Huntington, West Virginia, they would be a good example. The health department there started a harm reduction program. Their issue is mainly heroin. They have provided thousands and thousands of doses of naloxone, and they have seen those drop.

Mr. GROTHMAN. And how big is Huntington? How many people live in Huntington?

Ms. HASKINS. I would say probably about 70 or 80,000.

Mr. GROTHMAN. Okay, and do you know what —

Ms. HASKINS. That is a large metropolis in West Virginia.

Mr. GROTHMAN. Okay. Yeah, I know, I got a district like that, too. Okay. So, there was not even a reduction in the use of the opiates. It was really just they got the shot to a lot of these people in time, right?

Ms. HASKINS. Yes. But now, as far as reduction and use, I think you look at any Drug-Free Communities grantee program recipient, and you will see a reduction in usage rates in their areas.

Mr. GROTHMAN. Yeah, can you give me an example of a city that if I look up or call their county, there has been a drop of deaths, and it is attributed to a drop in usage?

Ms. HASKINS. Well, I mean, if you look at Jackson County, West Virginia, we have had a drop in overdose deaths among adults and specifically youth.

Mr. GROTHMAN. Okay. Next question I have in general, one of the tragic things about this opioid epidemic is it strikes very good families, however we describe “good families.” And it just must be shocking for parents who did everything right and have this happen. Nevertheless, I always do wonder about overall statistics on family background of people who wind up in this situation. Do we have any statistics on that?

Ms. HASKINS. On family backgrounds?

Mr. GROTHMAN. Correct.

Ms. HASKINS. No, but, I mean, science has proven that if you have addiction somewhere in your family tree, you are almost —

Mr. GROTHMAN. Right.

Ms. HASKINS.—you know, 50 percent more at risk to have an addiction.

Mr. GROTHMAN. Right, so we have no —

Ms. Ayala: If I could add.

Mr. GROTHMAN. Sure.

Ms. Ayala: Most of our information is anecdotal and is geographic and demographic dependent, meaning whatever the representation of the community, that is what we are seeing reflected in the overuse and death data. So, for DuPage County, Illinois, the vast majority of our overdose reversals occur to young white males between the ages of 19 and 29 years old. That also happens to be the largest demographic in our community. So, it is absolutely agnostic when it comes to —

Mr. GROTHMAN. Well, let me cut you off because I only have so much time. It is kind of meaningless if you say the largest demographic has the most deaths. That is kind of expected. What I am wondering is are there any studies out there given the sea of money we are throwing at this who can give us some statistics on family background or parental background and that sort of thing?

Ms. Ayala: By the time an individual gets to the point of being addicted, many times they do not enjoy the support of their family regardless of where they started.

Mr. GROTHMAN. Well, you are not answering my question.

Ms. Ayala: Okay, I am sorry.

Mr. GROTHMAN. I am sure that is true. Do we have any statistics?

Ms. Ayala: We do not.

Mr. GROTHMAN. Okay.

Ms. HASKINS. Not that I am aware of.

Mr. GROTHMAN. Do you think it would be a good idea to get statistics like that given the gravity of the problem? It would be. Okay. Next question. One of the benefits of your program is that you have flexibility to do different things in different counties, right? Can you give me a solid example of how you should one strategy in Huntington and a different strategy in another type of city, or any city?

You know, one of the reasons we are talking about this program being good is you can adapt locally.

Ms. HASKINS. Right.

Mr. GROTHMAN. Which presumably means it is not one-size-fits-all. So, I am looking to kind of give you a softball question in which you guys can tell me, you know, we did this in this city and it

worked, but it would not have worked in this city where we did something else.

Ms. HASKINS. Well, I can tell you, for example, Huntington, West Virginia, they began the harm reduction program. They offer naloxone classes once a week. They give out thousands and thousands of doses of naloxone and save lives every day with that. In our particular community an hour north of Huntington, naloxone would not help in our community with what is being utilized at this point because what is being utilized by our adults at this point is Suboxone, Subutex, and meth. Naloxone is not going to save your life if you are using one of those three things, so.

Mr. GROTHMAN. I guess are there differences by community other than just the type of drugs that are being used?

Ms. HASKINS. Absolutely, I mean, other than socioeconomic. I mean, the way that your communities are structured. We have wonderful relationships with our board of education, with our law enforcement, with our local city councils and mayors that come together for this issue, whereas Huntington may not have that type of partnership with their organizations and their movers and shakers.

Mr. SIEGLE. In Cleveland, Ohio, the medical examiner has been pretty active in putting out statistics and things that he sees. And it is kind of back to your question, but he has found that in the Cleveland, Ohio area, which is Cuyahoga County, which leads the State in overdose deaths, that what he has seen is primarily white males in their 30s and 40s. But there is a correlation between their education level, and most of them work in the trades.

And I think when you say they work in the trades, I think that is back to the pain pills that started because, you know, their back hurt or their something got hurt as they are working on one of the construction trades. So, there seems to be a push to educate and reach out to those trade unions to help educate their members.

Mr. GROTHMAN. When I said "background" —

Mr. PALMER. [Presiding.] The gentleman's time has expired.

Mr. GROTHMAN. Okay.

Mr. PALMER. I now recognize myself for questions. I want to point out, I want to ask Ms. Haskins, you talked about children with learning disabilities or other issues —

Ms. HASKINS. Yes, sir.

Mr. PALMER.—or children and parents who are addicted to opioids. Have you seen any disparity demographically between children of people who are enrolled in Medicaid versus children who are not enrolled? Is there a greater population of children with these issues who are from homes where the parents or parent are on Medicaid?

Ms. HASKINS. I would have to look at the school system for that, but just anecdotally from what we hear in our community and from my observation, a large number of the children that are in that situation are certainly parents who are either uninsured or on Medicaid. But having said that, we also have a lot of children who are being raised by grandparents whose parents are very financially well off, and able to provide whatever it is that they want, but because of their addiction, they are living with family members.

Mr. PALMER. I understand, but the point, and you verified and it is consistent with the data that I have seen. There was a CDC study in Washington State that showed persons on Medicaid are 5 to 7 times more likely to die an opioid-related death than someone not on Medicaid. It also said that the opioid prescription rate among Medicaid enrollees is at least twice the rate for persons on private insurance. So, you would naturally look at that data and conclude that some of the issues that you brought up about children having these learning disabilities would disproportionately come from households where they are on Medicaid, and I think that is a real issue with this.

Mr. Siegle, Ohio enrolled more than 700,000 adults in the expansion of Medicaid, and is now seeing unprecedented problems with opioid addiction. As a matter of fact, last year Ohio was on pace to have more opioid-related deaths than the entire United States did in 1990. That is one problem. I also want to know if you have also seen more trafficking of opioids that drew Medicaid enrollees.

Mr. SIEGLE. I do not know if I have any basis or statistics to support that one way or another. Most of the HIDTA funded counties in Ohio are centered in the major population areas. We only have one task force that operates down in Portsmouth in a rural area. And so, most of what I see coming from our interdiction efforts and enforcement efforts are in the larger metropolitan areas, and we are in 17 of the 88 counties, 14 of the 88 counties in Ohio. So, in those rural counties I really do not have a basis.

Mr. PALMER. Well, it would not be rural versus urban. It is more are people getting prescribed opioids and then selling them. There are a number of issues here that are related to this —

Mr. SIEGLE. We are—we are —

Mr. PALMER.—but we are seeing this across a number of programs where there is trafficking, whether it is a SNAP benefit card or opioids that someone got as a result of a Medicaid prescription.

Mr. SIEGLE. We are interdicting less pills and seizing less pills than before. Most of what we are getting now is the fentanyl, and it has actually overtaken heroin. So, if you want to make a correlation, I do not know if you can, between less pills and more people on Medicaid getting pills. But we are seeing and seizing less pills.

Mr. PALMER. Well, you mentioned fentanyl. It was recently reported that there were three people arrested who enough fentanyl to kill everybody in Toledo. In my district, there was a gentleman arrested who had 38,000 lethal doses of fentanyl that he bought on the dark web and paid for it with bitcoins. But, Ms. Roberts, you were talking about it is produced in China. I would also add that the North Koreans are doing this.

I was in a field hearing at Johns Hopkins Hospital with the former governor of New Jersey, Chris Christie, and I asked him if we had gone from a war on drugs to a drug with drugs, and that the 70,000 or so people who have died from overdoses, are they casualties of this war. But it is interesting to me that when you talk about how it gets into the country, it comes in the mail, but it is largely coming across the border. And you only mentioned the Canadian border, and perhaps that is because Ohio shares a border with Canada.

But I do think that this is the real issue of border security, and a lot of people lose sight of this, that we are in a war with drugs, and it is coming across the border. And the fentanyl issue I think is something that we are going to have to address outside of just drug policy because it is lethal. Any comment on that, Mr. Siegle, in your efforts?

Mr. SIEGLE. I would agree with you, it is coming across the border, and some of that is coming from China to Mexico and then up. And there is also a strong belief that the Mexican drug cartels are starting to produce their own fentanyl and transporting it up. But fentanyl, heroin, cocaine, all the major drugs are coming up from the south of border into Ohio and most of the HIDTAs. There is very little activity from other parts of the world. Some of the East Coast still see some from the Asia part of the world, but most of it is coming up through Mexico, at least in the Ohio HIDTA.

Mr. PALMER. One last issue here, Ms. Ayala. I raised this question in the field hearing as well about the fact that hospitals have quality surveys that they provide for their patients, and one of those was on pain management. And when you are tying the Federal government's reimbursement rate to the hospitals or to physicians based on the outcomes of these quality surveys and you include pain management, that creates an incentive to over prescribe. And I think we cannot address this whole issue of opioids without addressing that.

And it is my understanding, and I hope they are doing this, that beginning of the first of this year, they removed that as one of the criteria. Do you have any information about that? Any of you know anything about that? Have you seen any changes in that?

Ms. Ayala: That is my understanding as well from our own Senator Durbin's staff. That is our understanding. The issue, however, is still with patient satisfaction. It may not be directly tied to pain management, but if I went to the doctor with the expectation of getting an opioid prescription and I left without one, then my satisfaction in general is going to be decreased. So, I think that your point is right on, and we need to do additional kinds of analysis around those policies.

Mr. PALMER. I would like to thank the witnesses again for appearing before us today. Are there any other members? You wanted to ask? I recognize the gentleman from Illinois for one question?

Mr. KRISHNAMOORTHY. Two questions.

Mr. PALMER. Two questions.

Mr. KRISHNAMOORTHY. Thank you, Mr. Chair. Okay, two final questions. One is a very, like, tangible question based on what I have been hearing, which is I think each of you have kind of developed a program or strategy that was effective in combating the crisis. If there is one thing that you could share with the rest of the communities who are paying attention to this hearing or the others who are paying attention, what would it be? Like, what would be the most effective thing that you did in kind of dealing with the opioid crisis in your community?

Ms. HASKINS. I would say looking at data, analyzing and figuring out exactly what the root of the problem is.

Mr. KRISHNAMOORTHY. Okay, thank you. Ms. Roberts?

Ms. ROBERTS. I would say learning how to think strategically in long term, such as what is taught at the Community Anti-Drug Coalition Institute which we went to, which changed the way that we dealt with this all together. And the importance of data in being able to monitor, and, like Mr. Siegle said, live monitoring. You know, data that is a couple of years old is not real useful. So, I would say that Drug-Free Communities actually taught us how to do all of those things.

Mr. KRISHNAMOORTHY. Great. Mr. Siegle?

Mr. SIEGLE. I think the bringing of all the levels of law enforcement together, but also developing those systems that I talked about from ODMAPs to the intake form, and the sharing of information back out to all aspects of fighting this battle, the prevention, education, treatment, and enforcement. And I think the one area that we all tend to, I do not want to say "overlook," but I think is part of the prevention side is education. And, you know, what are going to do with future generations to look at the information we give them to process, and the training, and the educations in school to prevent this from happening down the road I think would be important.

Mr. KRISHNAMOORTHY. Got it. Ms. Ayala?

Ms. Ayala: I believe that it is two parts. So, the opportunity to discuss with our residents that issues of substance use disorder in the terms of public health and overall health of the community have probably been the most profoundly liberating aspects of our work. The other is to acknowledge that infrastructures for substance use disorder treatment is extremely limited.

Mr. KRISHNAMOORTHY. Well, that transitions to my last question, which is, you know, the 2018 omnibus package appropriated \$3.2 billion to address the opioid crisis. We are still trying to figure out exactly how that money is going to get spent. But at least in my understanding, I do not think it is going to be directed so much to DFC, Drug-Free Communities, or the HIDTA programs, more to certain treatment programs, which is also a huge unmet need as well. But, I mean, what is your kind of impression of the amount of money that was appropriated, and, you know, what are some of the unmet needs that we really need to address that maybe we are not addressing even in this package. Ms. Haskins and just down the row. Very briefly, please.

Ms. HASKINS. You will never be able to treat your way out of this problem regardless of how much money you throw at it. So, unless you continue to fund and at additional funding levels, unless you continue fund prevention —

Mr. KRISHNAMOORTHY. Right.

Ms. HASKINS.—you will never have enough money for treatment.

Mr. KRISHNAMOORTHY. Right, thank you. Ms. Roberts?

Ms. ROBERTS. I would have to agree with Ms. Haskins. It has been typical for a long time for most of the money to go towards these sort of downstream crisis problems and less money to go towards preventing them in the first place. And I think that is one of the reasons why we are seeing this crisis now.

Mr. KRISHNAMOORTHY. Thank you. Mr. Siegle?

Mr. SIEGLE. I would agree also, prevention. You know, also we cannot arrest our way out of it. We cannot treat our way out of it.

And I think we need to avoid getting those people at that level because we have lost them by that point.

Mr. KRISHNAMOORTHY. Thank you. Ms. Ayala?

Ms. Ayala: And although I absolutely agree and support everything that has been said, I also do not think we can ignore this large population that now find themselves ensnared in the chemical dependency. And so, I would say we have some obligation as a civil society to address their needs.

Mr. KRISHNAMOORTHY. Thank you. Thank you, Mr. Chair.

Mr. PALMER. I would just add I agree with all four of your responses on that, and just add this, and it is in regard to the Medicaid expansion. I think we cannot ignore this, that there has been a dramatic increase in addiction in the States that have expanded, and that we are better off, as each of you said, directing Federal funding on prevention. We cannot ignore the addiction issue either, that we have got to deal with it. But I think that we have also got to recognize that there is a problem, that we have created a problem with the expansion. And, you know, my previous career was with a think tank. Part of that was engineering, and one of the things that we fundamentally understood is you cannot solve a problem until you properly define it.

With that, again, I would like to thank the witnesses for appearing and for your testimony. The hearing record will remain open for 2 weeks for any member to submit a written opening statement or questions for the record.

[The information follows:]

Mr. PALMER. If there is no further business, without objection, the Subcommittee on Healthcare, Benefits, and Administrative Rules stands adjourned.

[Whereupon, at 11:37 a.m., the subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD



C O N G R E S S M A N
MARK WALKER

Oversight & Government Reform Hearing
Local Responses and Resources to Curtail the Opioid Epidemic

Wednesday, April 11, 2018

STATEMENT

Addiction has become a major problem in North Carolina in recent years. In 2014, deaths related to drug poisoning surpassed firearm and motor vehicle related deaths. According to a recent study, North Carolina holds 4 of 25 cities with the highest rate of opioid abuse in the country. Even with these staggering numbers, it is estimated that only about 10 percent of people who suffer from a substance abuse disorder receive any type of treatment.

In October, I hosted a two-day, seven-stop opioid crisis tour across North Carolina to better understand the full scope of the opioid epidemic and get a firsthand account of the realities, burdens, and struggles of opioid addiction in North Carolina. Throughout the tour, one fact was clear: more action is needed. We must remain committed to working with local law enforcement, first responders, and local government to stop the overwhelming hardship this is causing to the families of our community.

North Carolina is fortunate to have received \$31 million to address the opioid crisis through the 21st Century Cures Act. The state is focused on efforts to increase access to prevention, treatment and recovery supports, reducing unmet treatment need, and reducing opioid-related overdoses and deaths.



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House Committee on Oversight and Government Reform
Health Care, Benefits, and Administrative Rules Sub-Committee
c/o Ranking Member Raja Krishnamoorthi
515 Cannon House Office Building
Washington, DC 20515

April 9, 2018

Testimony on Local Responses and Resources to Curtail the Opioid Epidemic

Dear Chairman Jordan and Ranking Member Krishnamoorthi:

DuPage County was recently named the healthiest county in Illinois by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. It isn't the first time the study bestowed our county this distinction, as DuPage has consistently ranked in the top 10 counties in the survey. Despite its status as the "healthiest county" in the state, DuPage is not immune to one public health crisis impacting the other 101 counties in Illinois and virtually every community in the United States. The opioid epidemic has continued to be a devastating problem that requires well-researched solutions on multiple levels from entities both within and outside of government.

From a public health standpoint, the effects of opioid abuse are far-reaching. Opioid use disorder is defined as using a prescription opioid for non-medical reasons or using it for a time greater than prescribed. An estimated 2.4 million people in the United States abuse prescription painkillers, and almost half a million people suffer from heroin abuse.¹ By now, most Americans should be aware that there is a connection between prescription opioid use disorder and the use of heroin. However, while prescription opioid misuse is a risk factor for heroin use, only a small fraction of people who misuse pain relievers switch to heroin. According to a national survey, less than 4 percent of people who had misused prescription pain medicines started using heroin within five years.² Opioid use disorder has been linked to higher rates of depression, anxiety, and bipolar disorders.³ In addition to the fact that many of the addicted individuals will find themselves within the court system, the combination of mental illness, opioid use disorder and heroin addiction may make recovery more difficult.

¹ <https://www.drugabuse.gov/publications/research-reports/prescription-drugs/trends-in-prescription-drug-abuse/how-many-people-abuse-prescription-drugs>

² Muhuri PK, Gfroerer JC, Davies MC. *Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States*. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2013.

³ <https://www.ncbi.nlm.nih.gov/pubmed/21999943>



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Research suggests that simply using prescription opioids can put one at higher risk for depression. In one study at St. Louis University, researchers found that 10 percent of more than 100,000 patients prescribed opioids developed depression after using the medications for longer than one month. These patients were taking the medication for ailments such as back pain, headaches, arthritis, etc. and had not received a diagnosis of depression prior to treatment.⁴

Opioid addiction can lead to the feelings of hopelessness, despair and guilt often associated with depression, and researchers have estimated that 48 percent of people dependent on the drug will also experience depression. Heroin users are also at increased risk of suicide, with death by suicide among users reaching 35 percent.⁵

DuPage County's Response to the Opioid Epidemic

In 2011, the Pain Medicine Journal released a study showing the economic impact of the opioid crisis. The country has spent a staggering \$55 million a year in health and social costs related to prescription opioid use disorder and \$20 million a year in emergency department and inpatient care for opioid poisonings.⁶ Subsequent studies have agreed that the costs remain staggering. These costs are particularly hard-felt by counties like DuPage, where the growth in this epidemic's size and scope has far surpassed available funding mechanisms needed to respond appropriately. Despite the daunting health and financial impacts of this crisis, DuPage County responded quickly and effectively to address the spread of opioid addiction and treat those in need of help.

DuPage Narcan Program

In 2013, a coalition of DuPage County leaders, including County Board Chairman Dan Cronin, members of the County Board, Coroner Rich Jorgensen, State's Attorney Robert Berlin, Sheriff John Zaruba, Public Defender Jeff York, Regional Office of Education Superintendent Darlene Ruscitti, the DuPage County Health Department, and the Chiefs of Police Association formed the DuPage Narcan Program to administer Naloxone, an overdose reversal medicine commonly referred to as Narcan, in emergency situations in which individuals are found unresponsive due to an overdose. The DuPage Narcan Program was the first countywide program in Illinois and has become the model for counties throughout Illinois.

⁴ Ibid.

⁵ <http://www.annfammed.org/content/14/1/54>

⁶ <https://sunspirhealth.com>



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The Narcan program, administered by the Health Department, has saved 429 lives between 2013 and 2017. While patients primarily tended to be white males between the ages of 18 and 29, the program's results have found that no race or demographic group is immune to opioid addiction. Despite the relative success of the Narcan program, the DuPage County Coroner noted there were 126 people who died of heroin overdoses between 2014 and 2017. Just as alarming, another 108 died from a combination of heroin and fentanyl or strictly through an overdose on fentanyl. These figures made clear that Narcan alone wouldn't address the root of the opioid problem. It was clear DuPage needed to establish a coordinated, multi-stakeholder effort to combat opioid addiction.

The HOPE Taskforce

In recognition of this fact, Chairman Cronin formed the Heroin Opioid Prevention and Education (HOPE) Taskforce as the successor to the DuPage Coalition Against Heroin. HOPE comprises a broad group of local stakeholders, including the criminal justice system, the health system, substance abuse and treatment providers, and educators. The Taskforce has five primary goals: (1) Reduce access to drugs; (2) Reduce opioid use and misuse; (3) Increase overdose response; (4) Integrate mental health and substance use disorder treatment and recovery; and (5) Increase access to tools for substance use prevention and education.

Reducing access to drugs has been a principle of the HOPE Taskforce's efforts. The DuPage County Health Department has operated the RxBox program, which collects unused medication at 17 different sites in DuPage County. Since its inception in 2009, the program has collected more than 44 tons of unused medication that otherwise could have been misused. The county has been working with the goal to expand the RxBox program and other drug take back programs.

Disposing of unused opioids is one of many steps in the process of addressing the epidemic. At the forefront of the battle, as recognized by Congress and the President, is reducing the number of opioids being prescribed. Marketing campaigns designed to convince patients that opioids are necessary contributed to the increase of prescriptions, and built a market based on consumers demanding pain relief. Between 1997 and 2002, the number of opioids prescribed by doctors increased tenfold.⁷ DuPage County has been supportive of the Prescription Drug Monitoring Program and supports the increased use of the program by prescribers. At the same time, the county's efforts have recognized that the historic misuse of opioids can be traced back to 1996, when the American Pain Society introduced pain as the "fifth vital sign." In

⁷ Ibid.



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partnership with the medical community, the county's Health Department has hosted three prescriber education events to reduce the number of opioid prescriptions.

The DuPage County Health Department, which treats behavioral health illnesses, faces an added burden due to the connection of opioids and mental illness. DuPage County law enforcement, including the Sheriff's Office and the State's Attorney, have experienced a sharp increase in costs associated with opioid use disorder and mental illness. The cost of incarcerating a prisoner in Illinois is more than \$38,000 a year. That cost, along with lost economic productivity, healthcare costs, and police enforcement costs, can be greatly reduced through a focus on treating addiction as a health issue as opposed to imprisonment. Addressing this epidemic as a public health crisis is more likely to enable rehabilitated opioid patients to attain a healthier and more productive life in the future.

The county has also attempted to coordinate primary care, emergency care, and other healthcare providers with patient referrals to treatment facilities. Some of those efforts have proven to be difficult due to privacy laws such as HIPAA and the inability to share information about individuals saved by Narcan or treated at the emergency room for an opioid overdose, even to their own family members. Additionally, first responders are often prevented from transporting overdose victims to any location other than a hospital emergency room. If first responders were able to transport patients directly to substance abuse treatment facilities, it may help improve patients' likelihood of seeking long-term treatment for their addiction.

Workforce Development

Often lost in the discussion about the opioid epidemic is the toll it takes on the private sector from a macroeconomic perspective. Opioid addiction already has an immediate impact on employers' bottom lines. The National Safety Council reported that healthcare costs for employees who misuse or abuse prescription drugs are three times higher than an average employee. The annual cost of untreated substance use disorders ranges from \$2,600 per employee in agriculture to more than \$13,000 per employee in information and communications.⁸

The opioid epidemic is also on track to have long-term human capital implications for the American workforce. According to the Centers for Disease Control and Prevention (CDC), drug overdoses now account for more deaths than car accidents and suicides. Nearly 66 percent of those drug overdose deaths involve an opioid, and most victims were in the between the ages of 25 and 44.⁹ While further study is needed, rising

⁸ <http://www.nsc.org/learn/NSC-Initiatives/Pages/prescription-painkillers-for-employers.aspx>

⁹ <https://www.cdc.gov/nchs/data/databriefs/db294.pdf>



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overdose rates in this age demographic – not to mention the continued negative impacts addiction has on patients' own professional development – suggest that the opioid epidemic could eventually be large enough to contribute to labor shortages in communities across the country.

To help address the epidemic's human capital impacts, workforce development programs can be linked directly to treatment and recovery. With a federal commitment to retraining the victims of this epidemic, there could be many economic opportunities for rehabilitated patients and their employers. Beyond the work of the HOPE Taskforce, DuPage County has worked in partnership with the community to develop workforce training programs. The DuPage County Workforce Development Division is funded through the federal Workforce Innovation and Opportunity Act, which provides an extensive range of services such as job training programs, career counseling, and job search workshops to find gainful employment. The federal grant allows an organization to pay for individuals to attend local training programs to obtain a professional certification or skills needed for certain jobs. Employers are eligible for workforce training grants, free job training and assistance for workers being laid off.

The DuPage Workforce Division is currently working with the county's Health Department to develop a pilot program using federal dollars to assist people in drug court who are addicted to opioids or heroin. The goal of this pilot program is to help victims of the epidemic regain their ability maintain gainful employment, increase the productivity of their employer, eliminate the residual costs on society, and work towards eliminating the negative stigma associated with those suffering from addiction. Increased workforce training designed to assist victims of the epidemic can help patients reenter the workforce during their prime years of productivity.

Discussions are underway regarding how best to braid together multiple federal funding streams to support a program that will provide foundational manufacturing skills and workplace readiness training, while also preparing participants for placement in paid internships. The Workforce Development Division is also building a relationship with Serenity House, which runs a series of seven recovery homes throughout DuPage County. They plan to provide workshops to participants in the earlier phases of recovery, and, ultimately hope to provide vocational training and job placement assistance to those who are further along.

Next Steps

The policies and programs highlighted above are excellent steps toward stopping the epidemic that is robbing so many of a productive future. While the heroin and opioid epidemic has failed to spare any area of the country, each county must have flexibility to address the problems affecting its citizens. Certainly, common trends such as the



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lack of mental health services and treatment along with the need for an increase in substance abuse treatment must be recognized.

DuPage County has been proactive in recognizing that the opioid epidemic is a challenge that must be addressed across all levels of government. The County's HOPE Taskforce has recognized the need to increase the treatment capacity in the community and the DuPage County Health Board has adopted a resolution calling for the support of treatment within the community. The county has also spearheaded programs designed to assist patients' re-acclimation into the workforce and daily life. However, the lack of federal or state funding for such programs and the lack of insurance available for many victims, has caused treatment to lag behind initiatives such as the DuPage Narcan Program, which provides immediate, if only temporary, results. We would respectfully encourage your Committee to seek ways to fund health, treatment, and workforce development programs like the ones outlined in this letter to enhance and bolster prevention and education initiatives that can help end the opioid epidemic in this country.

Sincerely,



Dan Cronin
County Board Chairman
DuPage County



Grant Eckhoff
HOPE Taskforce Co-Chairman
DuPage Judicial & Public Safety Committee Chairman



Greg Hart
DuPage County Board
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Written Testimony submitted to the IL House Committee on Oversight and Government Reform
 On behalf of Gateway Foundation
Prepared by Jim Scarpace, LCPC, Executive Director

On behalf of Dr. Tom Britton, President and CEO, the entire Gateway Executive Management Team and its Board of Directors, I respectfully submit the following statement in response to the subject matter hearing being held on Wednesday, April 11, 2018 on the topic of "Local Responses and Resources to Curtail the Opioid Epidemic." As the largest non-profit provider of substance use disorder treatment in Illinois and the United States, Gateway is a leader in this field and has experienced many clients who struggle with this devastating and life threatening disorder. Opioid Use disorder has claimed countless lives and this epidemic will not go away without a strategic plan and focus on education, prevention and treatment. According to the CDC, "Since 2000, the rate of deaths from drug overdoses has increased 137 percent, including a 200 percent increase in the rate of overdose deaths involving opioids (opioid pain relievers and heroin)." More people die from drug overdoses, per the CDC, than in traffic accidents. Gateway is committed to providing medically and research informed treatment to battle this disease but to be successful it must be attacked from all fronts, which include education, prevention, and treatment.

Education and Prevention are key steps in understanding, preventing and treating this disease. The American Medical association identified Alcohol and Substance use disorder as a medical disease of the brain, not a moral failing; which can be treated. Yet Society's view of this illness continues to be clouded by judgement leading to shame and secrecy for those individuals who are struggling with this illness, creating Stigma and fear to come forward. The Stigma associated with addiction continues to be a barrier, thus "only allowing about 11% of individuals who need treatment to seek it out" (SAMHSA). We must change the way we talk about this illness, qualifying every statement to support the medical model of treatment. According to an article from the Huffington Post in 2015, the White House Office of National Drug control Policy stated and I quote "The negative words we use to describe drug addiction-"clean vs dirty", "patient vs. addict" can drive some individuals away from the very help they so desperately need." The Post article goes on to say "Research shows that the language we use to describe this disease can either perpetuate or overcome the stereotypes, prejudice and lack of empathy that keep people from getting treatment they need. In the article Michael Botticelli, the U.S. drug czar in 2015 went on to say and I quote "Scientific evidence demonstrates that this disease is caused by a variety of genetic and environmental factors, not moral weakness on the part of the individual. Our language should reflect that" (Huffington Post 2015). We have an obligation to educate our doctors, emergency rooms, schools and communities on what addiction is and what it isn't, removing labels such as addict and alcoholic from our lingo and replacing it with Alcohol and substance use disorder; thus describing individuals from the perspective of recovery and not labeling them by their illness. This is a disease they struggle with and can be overcome with proper treatment; not who they are. Opioid use disorder does not discriminate.

It doesn't matter who you are, what your occupation is, what the color of your skin is, or how much money or education you have. Everyone is susceptible based on genetic predisposition, exposure and family dynamic. We must make it our mission to educate our medical community and the public in order to use language that conveys the same dignity and respect offered to other patients with medical issues and illnesses. We must empower and engage families to reach out and connect their loved ones to treatment without fear of embarrassment or shame, allowing them access to current evidence based and medication assisted treatments that will save their lives and allow them to find recovery. Although this is a medical illness, the medical community including emergency room doctors and nurses as well as private practice physicians need to be educated on prevention and the high risk associated with prescription opiates as well as referring individuals properly to treatment who present in emergency rooms after or during an opiate overdose. According to a news report from NBC news in December of 2015 "a team at Stanford University reported that primary care physicians, not pain specialists, are by far the biggest prescribers of opioid drugs. They said sales of prescription opioids rose by 300 percent since 1999." Physicians must understand the risk associated with prescribing prescription Opiates to patients especially since we know that "80% of reported Heroin users started with use of prescription Opiate medication"(SAMHSA 2017) These prescriptions for those individuals who have a genetic predisposition to addiction will lead to continued increase in use, overdose and eventually death if not treated properly. Educating primary care physicians and dentists who prescribe opiates is mandatory, helping them understand there are effective non addictive forming alternatives to Opiate pain medications for clients who experience pain and need relief. In addition, emergency rooms must be prepared to treat individuals with Opioid use disorder properly instead of discharging them back to their community without support. The January 26, 2018 Health Affairs Blog states the following: "One in eight visits to the ED is related to a mental health or substance abuse issue, a number that has been increasing each year for the past decade. And yet, EDs remain poorly equipped to address these individuals' needs because of a variety of issues, including regulations, policies, training, culture, stigma, and the lack of integration and connectivity to other settings in the community." We know the importance of having the lifesaving drug Naloxone on hand for first responders, hospitals, schools, and community agencies. Last week according to the Chicago Tribune, "The Surgeon General, Dr. Jerome Adams issued his office's first national public health advisory in 13 years, discussing the importance of all Americans having access to this life saving antidote on hand to save lives"(Chicago Tribune, digital edition, 4/5/18). Yet, after someone is saved from an overdose and brought to an emergency room, many of these patients are released without proper support and referrals to help them get the treatment they need to achieve recovery. At a DuPage County Opiate Taskforce meeting, Congressman Krishnamoorthi heard from many fire and police first responders who described having to revive the same person multiple times, sometimes within the same day due to being released from a hospital emergency room and immediately overdosing again.

There is much evidence of the impact of the opioid crisis on opioid-related emergency department and hospital visits across the state. From 2009 to 2014, Illinois experienced a population rate of 269.1/100,000 of opiate-related inpatient hospital stays. This was the seventh highest rate among the 50 states. To help hospitals serve patients with Opioid Use

Disorder (OUD), Gateway Foundation has developed a program through funding from an Opioid STR grant, which allows us to dispatch licensed or certified clinicians who will provide screening, recovery coaching, and “warm hand-off” services to community-based treatment and Medication Assisted Treatment (MAT) partners for hospital patients who are indicated to have OUD.

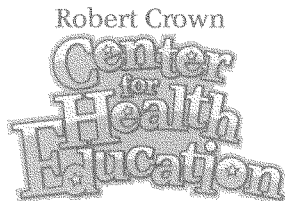
Gateway recruits and maintains a team of credentialed Engagement Specialists and Recovery Coaches and who will work with the medical teams at identified partnering Illinois hospitals. The team will work with patients who present to the Emergency Department with a medical issue related to OUD, and create a continuing care plan. These staff will work with the patients to provide education, perform a clinical assessment, create a continuing care plan, and make firm community referrals upon discharge from the hospital.

The goal for this initiative is for staff to coordinate a direct transfer or referral to treatment upon discharge from the hospital. For those who are not ready to take this step, the patient will be provided with education and information on how to access treatment services at a later time as needed. Patients will also be advised of risks related to delaying treatment, and the benefits of engaging supports. Recovery Coaches will follow up with patients on their resource referrals, or make subsequent attempts to engage patients who initially refuse assistance. These types of programs are crucial to engaging patients in the treatment process as soon as they are identified and more funding is needed to allow us to continue this type of initiative across the country. In addition, schools need to be educated on prevention strategies to decrease the risk of junior high and high school students experimenting with Opiate use which can lead to development of Opioid addiction at a young age. A report from the Centers for Disease Control and Prevention (CDC) found that between 1999 and 2015, Opiate related drug overdose death rates for 15- to 19-year-olds more than doubled. We must be willing to provide education on this epidemic in our schools, not in ways to scare teens into not using as some of our previous “DARE” programs were established to do, but instead to educate them on the disease of addiction from a medical and prevention framework. The Robert Crown Center for health education in Hinsdale, Illinois has an excellent curriculum on Heroin and substance use disorder intended to do this in a fun, interactive way for both junior high and high school teachers, students, and parents, yet very few schools in the state have utilized or are even aware of this curriculum. Funding should be provided to allow all schools access to this education in both health classes and in-services available to families and the community across the country.

The final and key component in the strategic plan to battle the Opioid epidemic is treatment. Gateway Foundation is located at multiple locations across the state of Illinois has the full continuum of care for adults and adolescents, male and females utilizing evidence based practices including Medication Assisted Treatment for Opioid use disorder. We know that the treatment process can provide support in helping individuals struggling with Opiate use disorder by providing education to patients as well as their families on the disease of addiction and its relationship to mental health and trauma disorders as well as unhealthy relationships. This also includes education from licensed doctors and nurses on medications such as Buprenorphine and Naltrexone that can help manage the cravings and withdrawals associated

with Opiate Use Disorder. Skills to achieve and sustain recovery as well as the ability to practice these skills are a substantial part of the treatment experience. Data shows that the sooner a person can access treatment and the longer they can stay in treatment, especially at the residential inpatient level of care for Opiate use disorder to help them gain some distance from the substance, get on the appropriate medications and develop skills to manage the psychological components associated with addiction can substantially improve their chances of sustained recovery. However, two significant events have occurred nationally and in Illinois over the past ten years directly impacting access to care for individuals with substance use disorders. Although we know based on the research that treatment can be effective in helping those with Opiate use disorder achieve recovery, treatment providers such as Gateway Foundation are experiencing barriers which are reducing access and length of stay for individuals who desperately need treatment for this disease. The first was the passage of parity legislation requiring insurers to maintain process, procedure and coverage for those with substance use issues that parallels that of those with medical issues. The second event was a reform of the health insurance system that included a requirement that all insurance plans include substance use treatment coverage. The second wave of health reform in Illinois included the expansion of Medicaid to indigent adults historically not covered by any form of insurance. While one would think that the passage of mental health parity laws almost a decade ago would have significantly improved access to services but unfortunately, that was not the case. In fact, many of the plans simply dropped substance use treatment as a covered benefit to avoid having to offer matching services. Health reform requiring coverage was a true game changer that dramatically expanded access and Gateway shifted its' business model to include commercially insured individuals but the insurers continue many activities that violate parity and present barriers to patients in desperate need for care. Expanding Medicaid on the other hand had benefits but also presented new barriers not historically experienced by indigent substance users. Namely, they were only accepted to Medicaid beds of which there were few. Demand has increased so dramatically that Gateway Foundation literally has 1,000 individuals on a waiting list for residential treatment. In the meantime, those individuals continue to drain resources from an already stressed healthcare system without even getting the services they need. In Gateway's 49 year history, never have we seen the demand so great and access to care so low. Programs throughout the state have closed due to financial distress and pleas for support have not been answered. In consideration of the level of public health crisis that addiction presents, all efforts and resources need to be applied. The most pressing issue to providing quality care to those in need is unfortunately related to funding that the current Medicaid Waiver put forth by the State of Illinois will not help. In FY17 Gateway provided \$8 million dollars of unpaid services to individuals in Illinois. Our financial deficit is driven by significantly outdated daily rates reimbursed for treatment to a population with increasingly complex medical and psychiatric needs. The rates were assigned at the time units were opened explaining the variance and the State hasn't made any significant adjustments to meet the actual cost of care. Gateway has been in an unsuccessful appeal process to the Department of Human Services for over a year seeking updates to this reimbursement system.

The second is an inability to pay for the medical and psychiatric care of patients under current funding mechanisms. The third and perhaps most important challenge is the inability to recruit and retain a younger workforce who will eventually replace the experienced team of professionals who will retire over the next ten years. Our recommendations are clear and we invite you as members of the Committee to invite our participation to find long term sustainable solutions. The system of care cannot sustain this situation any longer and providers like Gateway who are mission driven and non-profit providers can only do so by being creative and providing services to those with commercial insurance while reducing care to the uninsured population. Financial limitations and challenges of this type have three direct impacts on access to care. The first impact is our complete inability to open new residential treatment centers despite our opening projects and efforts to improve care. The first recommendation is to work closely and collaboratively with providers, The Kennedy Forum, The Department of Insurance and insurers to eliminate parity violations impacting commercially insured patients. The second is to work with DASA and DHS in collaboration with providers to implement a reimbursement model and rate structure that pays for the actual cost of care with opportunities to expand care to vulnerable populations in all areas of our state. The final recommendation is to recognize providers like Gateway that score the highest in benchmarked state measured indicators of treatment quality and engagement. Gateway as a team and organization remains committed to finding solutions for us to find funding to provide quality treatment for those battling Opiate use disorders. Thank you for your work and interest in improving the quality of care for individuals and the community. Gateway Foundation stands ready to be a partner in future legislation and initiatives to improve our ability to serve those who struggle with Opioid use disorder.



Statement of

Barb Thayer, Executive Director

The non-profit organization, Robert Crown Center for Health Education

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Hearing of the United States House of Representatives Committee on Oversight and Government Reform
Subcommittee on Health Care, Benefits, and Administrative Rules

"Local Responses and Resources to Curtail the Opioid Epidemic"

Wednesday, April 11, 2019 10:00 a.m.

2154 Rayburn House Office Building

To: House Committee on Oversight and Government Reform, Subcommittee on Healthcare, Benefits and Administrative Rules. Rep. Jim Jordan, Chairman and Ranking Member Rep. Raja Krishnamoorthi

I am submitting this written testimony to advocate for more targeted prevention education for youth in elementary, middle and high school. I am the Executive Director of the Robert Crown Center for Health Education, located in Hinsdale, Illinois, a suburb of Chicago. For nearly a decade, RCC has been working with researchers, health professionals, and local government agencies to deliver effective opioid prevention education to youth across metro Chicago. It is our belief that all middle and high school students in the United States need to learn the latest brain science and drug facts about the highly addictive nature of opioids, so they can make sound decisions before it is too late. I offer our experience partnering with Illinois schools, federal and local government and private funders to promote comprehensive opioid education, so you may understand some of the local actions and barriers for increasing opioid/heroin prevention education.

Robert Crown Center for Health Education is a non-profit organization that was founded in 1974. Each year we deliver health education to over 70,000 students. For the past seven years, our staff has been active with several local prevention coalitions and heroin task forces in northern Illinois, including the Prevention Leadership Team, a Drug Free Community grantee located in DuPage County. While strides have been made in Chicago to collaborate across sectors (education, health, public health, law enforcement, youth development, social services) and leverage resources, we see the need to dedicate more resources to improve prevention education for youth. I hope that this committee will prioritize school-based education programming for youth and support for increasing community awareness since these two prevention initiatives work in tandem to reduce the terrible statistics in the news.

Schools are a perfect place to reach youth and their parents, and the goal is to make it less likely for people to begin abusing prescription drugs such as Norco, Oxycontin and morphine and end up using heroin, fentanyl or worse. The Robert Crown Center health educators travel to schools across eleven Illinois counties to deliver our Science Behind Drugs programs every day. They teach students about the effects that alcohol and other drugs have on their bodies and introduce the concept of medication misuse in the fourth grade. They begin talking about medicine versus illicit street drugs with nine and ten-year olds because we know that many already see adults and older youth abusing medications (ADHD drugs are used as study drugs, people take opioids long after their back injury) and we want them to be well-prepared to handle any future instances where they may be tempted to use a painkiller off label. Teenagers are more vulnerable to substance use disorders, because their brains are still developing, and some areas of the brain are less mature including where they process feelings of reward and pain which are crucial drivers of drug use.¹ As children mature, they require more information and details regarding how drugs interact with the body and how to best avoid situations where they may be asked to use alcohol or substances. We incorporate more advanced science and age-appropriate discussions to help 6th-12th graders become more knowledgeable and resistant to using drugs.

In 2011, at the request of a local businessman who had a grandson who died because of heroin, we developed our first stand-alone heroin prevention program. At the time, many were dying of heroin overdoses in the Chicago suburbs, but area high schools were not yet educating teens about the pathway between prescription drug misuse and street heroin. We partnered with the Illinois Consortium on Drug Policy at Roosevelt University in Chicago to conduct primary research with young heroin users². Their interview and focus group findings revealed that young heroin users were unaware of many key facts about the drug back when they were still in high school, including:

- heroin can alter their developing brains.
- prescription pain medications are a pathway to heroin use.
- teens and young adults are at greater risk for using heroin during times of transition, stress, or when mental health issues, like depression, are present.
- heroin use can rapidly progress from experimentation to addiction to overdose.
- addiction can be mistaken for flu-like symptoms and discomfort that leads to increased use, loss of relationships, poor school and work performance and criminal behavior.
- repeated heroin use leads to an addiction that is extremely difficult to overcome and often results in death.

Our Science Behind Drugs (SBD) Curricular Resources were developed to assist diverse teachers to incorporate cross-cutting issues such as addiction science, neurological development and social-emotional skill building exercises, embedded in engaging age-appropriate lessons and activities. We incorporated current neurological research and successful prevention practices so that schools can enhance their classes with simple and customizable segments. We have worked closely with educators who want to target existing curricular areas allowing significant flexibility for content delivery throughout the school curriculum. All program materials are housed on our password-protected learning management system (LMS) with varied access based upon the individual school's need.

Our online teacher-led heroin curriculum has been used by middle and high school teachers to educate 36,765 students since 2012. This science-based program incorporates social-emotional learning concepts proven to increase resistance skills. The multi-session program addresses addiction science, the highly addictive nature of opioids, a self-assessment for heroin abuse risk and skills for starting conversations with peers, parents and trusted adults about heroin abuse. The intention of the program is to emphasize strong normative beliefs against opioids and substance abuse, to improve student knowledge of opioids and improve resistance skills and self-efficacy such that if students find themselves confronted with heroin, prescription pain pills and/or friends in need of substance abuse support they will know how to resist and seek support.

Over the past six years we received local and state government support as well as the backing of private individuals and foundations to create, deliver and evaluate our programs and we included improvements based on teacher and student feedback to our lesson plans and added additional interactive software for alcohol and marijuana. We have received funding from the state of Illinois Substance Abuse Prevention grant which utilizes the Substance Abuse and Mental Health Administration (SAMHSA) Treatment Block Grant funding. We also partner with county governments and private funders keen to provide high quality drug education in their schools. In 2016, we received funding from Chicago's High Intensity Drug Trafficking Area (HIDTA) to create an interactive brain software program and have delivered drug education programming to 13,000 4th- 8th graders across metro Chicago with HIDTA support. While it is wonderful to be able to offer free programming, it is not always enough to motivate school administrators to spend time on this topic. Addiction and mental health diagnoses are still stigmatized in some communities and school districts may be reluctant to be labeled as a "school with a drug problem" or as the "heroin school." Often it is a community tragedy or coordinated coalition that pushes schools to act. The community of Naperville in DuPage County lost several young people to heroin overdoses in a short period of time a few years ago and it galvanized the entire community to face the underlying issues directly. The schools in Naperville have been some of our best partners and we continue to work there today.

Mr. McBride, the principal of Nequa Valley High School, endorsed our curriculum in 2015 urging "every middle and high school...to take advantage of the opportunity to use the Robert Crown Center heroin curriculum. The program is extremely flexible and was easily integrated into our current curriculum." Our graphic novel stories are the most popular component as they engage the youth aged 12-18 and create a good starting point for reflection and group discussion on how these different drugs could affect someone like them. High school students from Naperville, Illinois gave powerful testimony on why they like the opioid graphic novel story:

- *the software was entertaining, it brought it down to a personal level.*
- *it was not just some guy coming in saying how you should not do drugs, it was kind of like a choose your own adventure book.*
- *It seemed like it was real life, it reminded me of how my friends are, how they talk.*
- *He did not set out to use heroin, he just went to the dentist and he ended up dead in a park*

Our middle and high school heroin education program is well-designed, and we have conducted multiple evaluations to determine students' learning gains. Our formative evaluation research found a 63% increase in those students who scored 80% or higher on heroin and opioid knowledge when comparing pre and post-test scores. Youth and parents surveyed were very pleased with the content and format and the majority wanted additional class time to discuss content and practice refusal skillsⁱⁱⁱ. (refer to our program [research evaluation and results page](#)). We have had some difficulty convincing school administrators to allocate sufficient classroom time to address the heroin and opioid prevention. In wealthy suburbs surrounding Chicago, there has been some resistance to adopting our heroin curriculum or to discuss prescription drugs and opioids with children in middle school out of a fear of a parent backlash. In other areas, we heard that there is simply not enough time to separate prescription pills, opiates and heroin from the other drugs that are more commonly used by teenagers. The wide-spread stigma about heroin, the assumption that prescription drugs and heroin affect older youth and the low awareness of the direct pathway from prescription pills to street heroin has impeded our ability to reach as many middle and high school youth as we would like. This is even though we have been working in concert with local coalitions and media to raise awareness in the general population and increase acceptance of drug prevention and parent-child conversations as key protective measures to ward off deadly addictions.

After implementing our complete heroin train-the-trainer model with dozens of schools in four Illinois counties, we surveyed the school personnel to see which parts of the program were most beneficial and which were least effective. Based on those findings, we modified our program and are currently marketing it as a more

flexible a la carte resource for teachers, so they can access the lessons they need and fill any gaps in their curriculum without the formality of getting school districts to approve an outside curriculum. These Heroin and Opioid Curricular Resources are housed in an online learning management system (LMS) along with Alcohol and Marijuana lesson plans and software stories so there is significant flexibility for content delivery throughout middle school or high school curriculum.

Our unique [web-based learning platform](#)¹ helps classroom teachers bring critical issues to life for students and they can use group discussion or individual assignments, so students can see what happens when opiates interact with the brain or how a simple visit to the dentist can end in a full-blown addiction. We have tried to adapt to what schools will allow or feel comfortable doing, but it is worth noting that many parent groups and schools across Chicagoland prefer to host a community panel or bring in an outside speaker during the day or evening than having more time dedicated to heroin and opioids during classroom teaching. While outside speakers and adult guests are powerful educational opportunities for adults, the shocking story from a former addict, or seeing grieving parents is not a substitute for the classroom learning with in-depth discussion, social emotional learning and opportunities to build skills necessary to face tough choices and stay safe in risky situations.

The Robert Crown Center for Health Education has been leading the fight to get more prevention education into elementary, middle and high schools so that youth can be armed with the facts and prepared to face the reality of brain science, understand the unique effect of opioids on the brain and recognize that heroin and opioid derivatives are in a class apart as highly addictive and deadly. One of our seasoned educators, Rose Tenuta, has been teaching drug prevention topics to youth since 1974 when she began as a high school science teacher. She has taught our heroin prevention program since 2008 and was involved in developing our curriculum, teaching faculty and parents about the opioid crisis and trained dozens of high school and middle school teachers in the use of our curriculum. Rose remarks that today's youth need this resource since many are "not aware of the extreme addiction potential of opioids" and that some "believe that if they snort or smoke heroin, they cannot overdose."

Many programs that address the opioid crisis begin once a person has already become addicted to opioid drugs. While this is essential, it is responding to a problem that has already developed. The Robert Crown Center for Health Education believes that prevention is a powerful way to allow children and adolescents to understand the consequences of drug experimentation **BEFORE** becoming addicted and thereby avoiding the need for treatment. In our prevention-oriented programs, students learn how their brains are more susceptible to addiction because they are still developing, and how drugs hijack their nervous system by mimicking their natural brain chemistry.

In 2018 with a raging opioid epidemic, it is not acceptable that so many adults are still misinformed, and that schools are not fully prepared to teach students the latest research in addiction science and the unique effects that opioids have on the human brain. It is essential that Congress focus resources to ensure that all young people are taught about opioids before high school graduation. I hope that you will invest in improved school-based drug prevention education as a key measure to stem the tide of this epidemic.

¹ <https://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/introduction>

² Understanding Suburban Heroin Use: Illinois Consortium on Drug Policy, Roosevelt University
https://www.robertcrown.org/files/Understanding_suburban_heroin_use.pdf

³ <https://www.robertcrown.org/programs/science-behind-drugs-curricular-resources/heroin-prevention-program-research-and-evaluation/>

⁴ <https://www.robertcrown.org/programs/science-behind-drugs-curricular-resources/>

