



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

May 19, 2015

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing on “What are the State Governments Doing to Combat the Opioid Abuse Epidemic?”

On Thursday, May 21, 2015, at 10:15 a.m. in 2322 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled, “What are the State Governments Doing to Combat the Opioid Abuse Epidemic?” The purpose of this hearing is to confer with a selection of state health officials regarding their ongoing efforts to combat the opioid abuse epidemic and explore how State and Federal policies can most effectively incentivize the development and broadened use of evidence-based practices and treatments in their communities.

I. WITNESSES

- Jerome Adams, M.D., M.P.H., Health Commissioner, Indiana State Department of Health
- Monica Bharel, M.D., M.P.H. Commissioner, Massachusetts Department of Public Health
- Mark Stringer, M.A., L.P.C., N.C.C., Director, Division of Behavioral Health, Missouri Department of Mental Health
- Larry Wolk, M.D., MSPH, Executive Director and Chief Medical Officer, Colorado Department of Public Health and Environment

II. BACKGROUND

This hearing follows up on the May 1, 2015, Subcommittee hearing on “What is the Federal Government Doing to Combat the Opioid Abuse Epidemic.” At that hearing, the Subcommittee questioned the relevant Federal agencies regarding their ongoing efforts to combat the opioid abuse epidemic and explored how Federal policies can most effectively incentivize the development and broadened use of evidence-based practices and treatments. Subcommittee members heard testimony from senior officials representing the full range of multi-disciplinary activities comprising the Federal response to this epidemic.

At the April 23, 2015, Subcommittee hearing on “Combating the Opioid Abuse Epidemic: Professional and Academic Perspectives,” the Subcommittee heard from a panel of

professional and academic witnesses that provided insights and findings, drawn from clinical practice and research—as well as constructive policy recommendations—from some of the nation’s foremost experts on opioid abuse. The Subcommittee also received testimony on treatment options currently available, as well as new and emerging evidence-based practices supporting individuals living with opioid abuse and addiction.

At the March 26, 2015, Subcommittee hearing on “Examining the Growing Problems of Prescription Drug and Heroin Abuse: State and Local Perspectives,” the Subcommittee heard from a panel of witnesses offering a “boots on the ground” perspective addressing the opioid abuse epidemic at the state and local levels, aiming to inform and improve the effectiveness of the Federal public health response to this nationwide problem.

Last year, on April 29, 2014, the Subcommittee held a hearing on “Examining the Growing Problems of Prescription Drug and Heroin Abuse.” At that hearing, the Subcommittee heard from a Federal panel of witnesses from the Office of National Drug Control Policy (ONDCP), the National Center for Injury Prevention and Control (CDC), the Office of Diversion Control (DEA), the National Institute on Drug Abuse (NIDA), and the Center for Substance Abuse Treatment at the Substance Abuse and Mental Health Services Administration (SAMHSA).

Origins and breadth of the problem

The trends related to prescription drug misuse and overdoses involving opioids are alarming. Drug overdose death rates have increased five-fold since 1980.¹ From 1999 to 2013, the rate for drug poisoning deaths involving opioid analgesics, or pain medications, nearly quadrupled.² By 2009, drug overdose deaths outnumbered deaths due to motor vehicle crashes for the first time. Abuse of opioid pain relievers claimed over 16,600 lives in 2010, resulting in over 400,000 emergency department visits in 2011, and cost health insurers an estimated \$72 billion annually in medical costs.³ Deaths related to heroin, an illicit opioid, also have increased sharply since 2010, including a 39 percent increase between 2012 and 2013.⁴ Mortality data show that there was a 6 percent increase in overall drug overdose deaths between 2012 and 2013 and approximately 37 percent of those deaths involved prescription opioids.⁵ The mortality rate from heroin overdose increased each year from 2010 to 2013.⁶ Deaths due to heroin overdoses increased by 39 percent from 2012 to 2013 alone and constituted as much as 19 percent of all

¹ M. Warner, et al, Drug poisoning deaths in the United States, 1980-2008, CDC National Center for Health Statistics data brief, no. 81 (CDC National Center for Health Statistics 2011).

² Centers for Disease Control and Prevention. QuickStats: Rates of Deaths from Drug Poisoning and Drug Poisoning Involving Opioid Analgesics – United States, 1999-2013. MMWR Weekly. Retrieved from: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6401a10.htm>.

³ CDC FY 2015 Budget Justification at 9.

⁴ Hedegaard H, Chen LH, Warner M.; National Center for Health Statistics (NCHS). Drug-poisoning deaths involving heroin: States, 2000-2013. NCHS data brief, no190. Retrieved from: <http://www.cdc.gov/nchs/data/databriefs/db190.pdf>.

⁵ Centers for Disease Control and Prevention. Wide Ranging Online Data for Epidemiologic Research (CDC WONDER). Available at: <http://wonder.cdc.gov/>.

⁶ *Id.*

drug overdose deaths in 2013.⁷ A recent study of behavioral changes affecting U.S. population health since 1960 found that accidental drug overdoses, particularly those involving prescription opioid medications reduced life expectancy 0.26 years, even though overall life expectancy increased by 6.9 years during this period.⁸ Heroin and prescription opioid abuse also can result in other health consequences, such as neonatal abstinence syndrome, increased risk of transmission of HIV and Hepatitis C, and bone fractures in older adults due to falls.⁹ On average, heroin addicts lose about 18 years of life expectancy, and the mortality rate for injection users is roughly 2 percent per year.¹⁰

Although heroin use in the general population is low, the number of people beginning to use heroin has been steadily rising since 2007. According to NIDA, this may be due in part to a shift from the abuse of prescription pain relievers to heroin as a more potent, readily available, and cheaper alternative to prescription opioids.¹¹ In fact, nearly half of young people who inject heroin surveyed in three recent studies reported abusing prescription opioids before starting to use heroin.¹² Among those who began abusing opioids in the 2000s, 75 percent of individuals indicated they initiated their abuse with prescription opioids.¹³ Although the available literature indicates that abuse of prescription opioids is a risk factor for future heroin use, only a small fraction, roughly 4 percent of opioid abusers, transition to heroin use within five years of initiating opioid abuse.¹⁴

⁷ *Id.*

⁸ Susan T. Stewart and David M. Cutler, “The Contribution of Behavior Change and Public Health to Improved U.S. Population Health,” National Bureau of Economic Research, Working Paper 20631 (October 2014) <http://www.nber.org/papers/w20631>

⁹ Creanga AA, SabelJC, Ko JY, Wasserman CR, Shapiro-Medozza CK, Taylor P, Barfield W, et al. Maternal drug use and its effect on neonates: a population-based study in Washington State. *Obstet Gynecol.* 2012; 199(5):924-933.; Zibell JE, Hart-Mallory R, Barry J, Fan L, Flanigan C. Risk Factors for HCV infection among young adults in rural New York who inject prescription opioid analgesics. *Am J Public Health.* 2014 Nov;104(11):2226-32. Doi: 10.2105/AJPH.2014.302142. Epub 2014 Sep 11.; Mateu-Gelabert P1, Guarino H2, Jessel L2, Teper A2. Injection and sexual HIV/HCV risk behaviors associated with nonmedical use of prescription opioids among young adults in New York City. *J Subst Abuse Treat.* 2015 Jan;48(1):13-20. Doi: 10.1015/j.jsat.2014.07.002. Epub 2014 Jul 11.; Rolita L, Spegman A, Tang X, Cronstein BN. Greater number of narcotic analgesic prescriptions for osteoarthritis is associated with falls and fractures in elderly adults. *J Am Geriatr Soc.* 2013;61(3):335-340.; Miller M, Sturmer T, Azrael D, Levin R, Solomon DH. Opioid analgesics and the risk of fractures in older adults with arthritis. *J Am Geriatr Soc.* 2011;59(3):430-438.

¹⁰ B. Smyth, et al., Years of potential life lost among heroin addicts 33 years after treatment, 44 *Preventive Medicine* 369 (2007).

¹¹ Cicero TJ, Ellis MS, Surratt HL, Kurtz SP. The changing face of heroin use in the United States: a retrospective analysis of the past 50 years. *JAMA Psychiatry* 2014;71:821-6.

¹² NIDA Report Series, “Heroin,” NIH publication number 15-0165, 3 (November 2014, rev.). Some data have higher estimates. Data from SAMHSA shows that 81 percent of people who started using heroin from 2008 to 2010 had previously abused prescription drugs. Amy Pavuk, *Rx for Danger: Oxycodone crackdown drives addicts to other drugs*, Orlando Sentinel, July 28, 2012, http://articles.orlandosentinel.com/2012-07-28/health/os-oxycodone-drug-shift-dilaudid-20120728_1_oxycodone-prescription-drugs-dilaudid-pills.

¹³ Cicero TJ, Ellis MS, Surratt HL, Kurtz SP. The changing face of heroin use in the United States: a retrospective analysis of the past 50 years. *JAMA Psychiatry* 2014;71:821-6.

¹⁴ Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States. August 2013. Retrieved from: <http://www.samhsa.gov/data/2k13/DataReview/DR006/nonmedical-pain-reliever-use-2013.pdf>.

Overprescribing of painkillers has been a significant driver of our present opioid and heroin epidemic. Since 1997, the number of Americans seeking treatment for addiction to painkillers has increased by 900 percent.¹⁵ The prevalence of opioid addiction started rising as long-term prescribing of opioids for chronic pain, a practice encouraged by opioid manufacturers, became more common.¹⁶ As a result, many states started to make extensive use of their prescription drug monitoring programs as a tool to monitor prescription sales of controlled substances.¹⁷

Paths to recovery

There is a wide consensus among experts that medical best practice demands a full menu of behavioral, pharmacological, and psychosocial treatments be made available to individuals with opioid addiction. This is especially critical, as the Center for Addiction and Substance Abuse at Columbia University, in a five-year study, found that only 1 in 10 people with alcohol or drug addiction other than nicotine receive any form of treatment, and of those, only 10 percent receive evidence-based treatment.¹⁸ Nearly 80 percent of opioid-addicted persons do not receive treatment for their addiction because of limited treatment capacity, financial obstacles, social stigma, and other barriers to care.¹⁹ Many counties lack substance abuse treatment facilities that accept Medicaid.²⁰ A 2007 SAMHSA analysis of workforce issues noted that more than 50 percent of U.S. counties in rural areas lack practicing psychiatrists, psychologists, or social workers.²¹

In particular, the data suggests that medication-assisted treatment (MAT) is effective in treating opioid addiction and reducing overdose deaths. As drug abuse changes the way the brain works, resulting in compulsive behavior focused on drug seeking and use, medications can be helpful in treating the symptoms of withdrawal during detoxification – which often prompt relapse – as well as become part of an ongoing treatment plan.²² Scientific research has established that MAT increases patient retention and decreases drug use, infectious disease transmission, and criminal activity.²³

At present, the Food and Drug Administration (FDA) has approved only three medications for the treatment of opioid dependence. Methadone, a Schedule II controlled

¹⁵ Science Daily, “Opioid and heroin crisis triggered by doctors overprescribing painkillers,” Brandeis University, February 4, 2015. <http://www.sciencedaily.com/releases/2015/02/150204125945.htm> .

¹⁶ *Id.*

¹⁷ Ileana Arias, et al., Prescription Drug Overdose: State Health Agencies Respond, Association of State and Territorial Health Officials, 2008, <http://www.astho.org/Programs/Prevention/Injury-and-Violence-Prevention/Materials/Prescription-Drug-Overdose/>.

¹⁸ <http://www.casacolumbia.org/addiction-research/reports/addiction-medicine>.

¹⁹ C.L. Arfken, et al, Expanding treatment capacity for opioid dependence with buprenorphine: National surveys of physicians, 39 *Journal of Substance Abuse Treatment* 96 (2010).

²⁰ SAMHSA Budget Justification FY2016 at 5.

²¹ *Id.*

²² NIDA Topics in Brief. Medication-Assisted Treatment for Opioid Addiction. April 2012. https://www.drugabuse.gov/sites/default/files/tib_mat_opioid.pdf.

²³ *Id.*

substance used as maintenance treatment for documented opioid addiction for over 40 years, may only be dispensed by clinics, certified by SAMHSA, and subject to both Federal and state regulation.²⁴ Buprenorphine, a Schedule III controlled substance – which may be offered, under certain circumstances, by methadone treatment clinics – is a more recently introduced synthetic opioid treatment medication approved as an outpatient physician-prescribed treatment for opioid addiction.²⁵ Naltrexone is a physician-prescribed clinician-administered injectable medication for the prevention of relapse of opioid dependence after detoxification, commonly known by the brand name Vivitrol.²⁶

Notably, the Department of Health and Human Services (HHS) includes expansion of MAT to reduce opioid use disorders and overdose among Secretary Burwell’s top three priority areas to combat opioid abuse, announced on March 26, 2015.²⁷ While MAT is a critical component of opioid addiction treatment, concerns have been raised that substance use disorders, as chronic conditions like diabetes or heart disease, demand a treatment model where long-term, sustained recovery – including extended engagement following formal periods of treatment – takes the place of what is too often the episodic, largely unsupervised prescription of medication followed by relapse to old habits.²⁸

With the aim of recovery in mind, long-term monitoring, both during and after episodes of MAT, is necessary to screen for the concurrent use of alcohol, illicit drugs, or the non-medical use of other prescription opioids that readily interfere with evidence-based treatments.²⁹ Dr. Robert DuPont, the first Director of NIDA, President of the Institute for Behavioral Health, and a witness at the April 23rd hearing has argued that widespread acceptance of “harm reduction” as the ultimate goal of MAT, has often undermined efforts to frame recovery, as opposed to relapse – or simply maintenance – as the expected outcome of addiction treatment.³⁰

At the March 26, 2015 hearing, the Subcommittee received testimony on the need for greater oversight of MAT and the need for standards on how these programs should be run. Professor Sarah Melton of East Tennessee University testified that “in Tennessee and southwest Virginia some buprenorphine programs have become pill mills where the physicians charge them high prices, they come in and get their medication, and they leave.” She also confirmed the “devastating” trend of medication-assisted programs providing methadone or buprenorphine in

²⁴ The American Society of Addiction Medicine. Advancing Access to Addiction Medications: Implications for Opioid Addiction Treatment. http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final.

²⁵ *Id.*

²⁶ *Id.*

²⁷ HHS Office of Assistant Secretary for Planning and Evaluation. Issue Brief, Opioid Abuse in the U.S. and HHS Actions to Address Opioid-Drug Related Overdoses and Deaths. March 26, 2015. http://aspe.hhs.gov/sp/reports/2015/OpioidInitiative/ib_OpioidInitiative.pdf.

²⁸ McGovern, John P. Institute for Behavior and Health, Inc. The New Paradigm for Recovery: Making Recovery – and not Relapse – the Expected Outcome of Addiction Treatment. March 2014. <http://ibhinc.org/pdfs/NewParadigmforRecoveryReportMarch2014.pdf>.

²⁹ *Id.*

³⁰ L. Merlo, M. Campbell, G. Skipper, C. Shea, and R. DuPont, “Recovery from Opioid Dependence: Lessons from the Treatment of Opioid-Dependent Physicians,” (Study supported by the Robert Wood Johnson Foundation, submitted for publication and currently under review) (2015).

cash transactions and being incentivized to become pill mills. She also testified that there is a “dearth of access to good treatment, and by ‘good treatment,’ I mean patients being seen frequently, getting urine drug screens at nearly every visit, if not every visit, requiring 12-step programs, group counseling, and not co-prescribing with other drugs of addiction such as benzodiazepines.”

Other issues

Use of methadone for pain. In addition to the overprescribing of prescription painkillers, public health risks have worsened by the increased prescribing of methadone for pain (as opposed to use in addiction treatment). The use of methadone as a treatment for pain has expanded in recent years. Although methadone can treat pain effectively, it carries outsized risks due to its unique pharmacologic properties, such as a long half-life, short analgesic window relative to respiratory-depressant effect, and potential for drug-drug interactions.³¹ While methadone from methadone clinics is in liquid form, which addicts drink on-site, methadone prescribed for pain is in pill form, making it easier to divert and misuse. In contrast to the regulation of methadone clinics, no special licensing or monitoring is required to prescribe methadone in pill form. Methadone accounts for two percent of opioid prescriptions for pain control, but is responsible for one-third of overdose deaths, according to a 2012 CDC Vital Signs report.³² Most state Medicaid programs encourage the prescribing of methadone as a first line treatment for pain, often due to its low cost, even though safer therapies are available.³³ Moreover, the FDA, the CDC, the American Academy of Pain Medicine, and the American Society of Interventional Pain Physicians have recommended that methadone not be used as a first-line therapy for chronic pain.³⁴

Prescription Drug Monitoring Programs. Prescription drug monitoring programs (PDMPs) are state-run electronic databases of prescriptions for controlled substances. PDMPs can provide a prescriber or pharmacist with information regarding a patient’s prescription history, allowing prescribers to identify patients who potentially are abusing medications. Currently, 49 states, the District of Columbia, and Guam have legislation authorizing the creation and operation of a PDMP, and all but the D.C. program are operational.³⁵ While there is evidence indicating the potential of PDMPs to identify high-risk patients and impact prescribing behaviors, the effectiveness of PDMPs is constrained by the lack of timely data in some states and limited interoperability with other PDMPs. Witnesses at the March 26, 2015, Subcommittee hearing also testified about their concerns over methadone clinics not being required to report methadone dispensing to PDMPs. One witness said it was “a very serious situation” because if these patients do not disclose their methadone treatment to their primary care providers and the

³¹ The Pew Charitable Trust, “Prescription Drug Abuse Epidemic: Spotlight on Methadone,” August 2014.

³² <http://www.cdc.gov/vitalsigns/MethadoneOverdoses/>.

³³ The Pew Charitable Trusts’ Prescription Drug Abuse Project, Undated handout (provided to committee staff, March 20, 2015).

³⁴ American Society of Interventional Pain Physicians, Guidelines for Responsible Opioid Prescribing in Chronic Non-Cancer Pain: Part 2 – Guidance, 15 Pain Physician Journal S67 (2012), <http://www.painphysicianjournal.com/2012/july/2012;%2015;S67-116.pdf>.

³⁵ PDMP Training and Technical Assistance center, PDMP Frequently Asked Questions. <http://www.pdmpassist.org/content/prescription-drug-monitoring-frequently-asked-questions-faq>.

providers do not know about it from accessing the PDMP, other opioids or benzodiazepines could be prescribed leading to death.³⁶ Another concern related to neonatal doctors not knowing about methadone treatment for pregnant women who are drug-addicted, which poses potential problems for the mother and the life of the fetus if the methadone is being increased while the mother and baby are receiving opioid medication to treat the addiction.³⁷

State Policies

While opioid abuse is a nationwide epidemic,³⁸ state activities will vary depending on circumstances in the particular state. For example, in late 2013, there were sudden and large increases in the number of deaths involving fentanyl in a number of states throughout the country, with the increase seen particularly in East Coast states.³⁹ Fentanyl is a narcotic pain reliever used to manage moderate to severe chronic pain.⁴⁰ The majority of the fentanyl-related deaths did not result from overdoses of pharmaceutical fentanyl, but instead involved an illicit, powdered form of fentanyl that was mixed with, or substituted for, heroin or other illicit substances.⁴¹ In response to this problem, for example, the state of Maryland took the following actions to reduce fentanyl-related overdoses throughout the state: sharing data with law enforcement; expanding access to naloxone, and launching a public awareness campaign.⁴²

The CDC has identified interstate variation in rates of prescribing of opioid pain relievers and other prescription drugs prone to abuse. For example, rates of opioid pain relievers prescribed were higher in the South, and Alabama, Tennessee, and West Virginia were the three highest-prescribing states, at two or more standard deviations above the mean.⁴³ The CDC notes that higher opioid pain reliever prescribing rates in the South are similar to the findings of higher

³⁶ Testimony of Fred Wells Brason II, Executive Director, Project Lazarus, Moravian Falls, North Carolina. (Unofficial hearing transcript, 40).

³⁷ See testimony of Stefan R. Maxwell, MD, Chair, West Virginia Perinatal Partnership, MEDNAX Medical Group, Director NICU, Charleston Area Medical Center, Charleston, West Virginia. (Unofficial hearing transcript, 90).

³⁸ Drug poisoning is the leading cause of death from injury in 30 states, according to CDC in 2011, with opioid analgesics involved in more than 40 percent of drug poisoning deaths in 2008. According to a 2014 NASADAD survey, roughly 40 States consistently say that prescription drug abuse is either “most” or “very” important (slide 17), with 34 States reporting that they have an active prescription drug task force, and increase from 29 reported in 2012. (slide 19). 35 States reported that their strategic plan explicitly addresses prescription drug abuse, and 12 States of these states reported that their plan explicitly addresses heroin abuse. 37 States said that heroin abuse is either “most” or “very important” (slide 36), with 15 States reporting that they have an active task force for heroin abuse (slide 40). National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD), “State Substance Abuse Agencies, Prescription Drugs, and Heroin Abuse: Results from a NASADAD Member Inquiry” (2014 update).

³⁹ Maryland Department of Health and Mental Hygiene, “Deaths Related to Fentanyl-Laced Heroin and Other Illicit Drugs,” July 2014.

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Id.*

⁴³ L. Paulozzi, et al, 63 CDC Morbidity and Mortality Weekly Report (MMWR), “Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines – United States, 2012,” 563 (July 4, 2014). <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a2.htm>

prescribing rates for other drugs in the South, including antibiotics, stimulants in children, and medications that are high-risk for the elderly.⁴⁴

Despite differences in circumstances, prevention plans and strategies, the states have identified certain overarching challenges.⁴⁵ The challenges have included: stigma; data needs; need for PDMP improvement; overdose prevention; increasing access to MAT; and evidence and research on effectiveness of strategies.

Stigma. The stigma associated with seeking treatment was reported by states in 2014 as one of the top remaining challenges.⁴⁶ Stigma and bias against MAT exists even after research has proved its value for treating opioid dependence. The stigma underlies a score of issues that states confront in developing their strategies. Such issues include: state moratoriums on establishing new opioid treatment programs (OTPs) despite large, unmet treatment needs for the opioid-dependent population; unwillingness of the criminal justice system to set up MAT in jails and prisons; and the requirement of some drug court judges that people must leave methadone treatment or go off of suboxone to participate and of some family court judges that clients must stop methadone treatment before receiving custody of their children.⁴⁷ State initiatives to reduce the stigma of treatment for opioid use disorders are: increasing access to a full range of evidence-based therapies; facilitating access to recovery support services; and expanding access to effective therapies in the criminal justice system.⁴⁸

Data Needs. Concerns have been raised about real time data/measurement, data quality, and data utilization. As noted by the National Governors Association, to develop an effective response to prescription drug abuse, states need accurate and timely information about the incidence and scope of the problem. It can be 6 to 12 months before the medical examiner's information become available, long after an OTP has reported the death to the state.⁴⁹ States have reported that CDC data is slow to be released and cannot capture real-time changes in drug use that occur.⁵⁰ For example, a CDC expert told bipartisan committee staff that CDC would not have 2014 overdose death data until the end of 2015. Moreover, CDC noted they mostly rely on death certificates which sometimes only say "drug overdose" and do not always list the specific drug.

Serious problems exist concerning state data on the cause of death regarding overdose deaths. State death certificates often do not specify the type of drug related to overdose deaths.⁵¹

⁴⁴ *Id.*

⁴⁵ Successful Strategies in Addressing Opioid Overdose Deaths, White Paper developed for the Center for Substance Abuse Treatment (March 2010).

⁴⁶ NASADAD 2014 update, note 38 at slide 34.

⁴⁷ Successful strategies, note 45 at 8.

⁴⁸ NASADAD 2014 update, note 37 slide 48.

⁴⁹ Successful strategies, note 45 at 11.

⁵⁰ National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD), "State Substance Abuse Agencies, Prescription Drugs, and Heroin Abuse: Results from a NASADAD Member Inquiry" slide 14 (2014 update).

⁵¹ A CDC expert in a briefing with committee staff estimated that 25 percent of death certificates listing overdose as a cause did not specify the drug.

Lethality issues can be hard to separate when multiple drugs are involved, especially with benzodiazepines.⁵² Defining the cause of death in MAT patients is inherently complex, since, regardless of the cause of death, these patients may have a high level of methadone in their blood. Medical examiners often do not know the person is in methadone treatment.⁵³ Many states do not conduct the full medical review for determining the cause of death.⁵⁴ For example, Colorado noted that from 2004 to 2013, 2.4 percent of Colorado death certificates had an unknown cause of death.⁵⁵

Even with the data limitations, states use available data sets to identify areas on which to concentrate their efforts and maximize limited resources. For example, in Massachusetts, the PDMP Center of Excellence at Brandeis University developed geospatial mapping of PDMP data, combined with data on prescription drug overdose emergency department visits and prescription drug overdose deaths, to identify concentrations in three suburban areas of the state.

Need for PDMP improvement. States have noted that it is critical to an effective statewide strategy for combatting opioid abuse to improve the effectiveness and use of PDMPs. While 49 states and the District of Columbia have legislation authorizing the creation and operation of a PDMP, they vary in their degree of use and overall effectiveness across depending on who is registered to use them, whether data is current or real-time, whether there are limitations on authorized users, and whether processes for accessing the databases integrate easily into clinical workflows.⁵⁶ Another major component of these PDMPs is their interoperability with other states, particularly neighboring states. The level of interoperability with other states varies greatly and currently lacks uniformity. This is a weakness among the programs because the lack of data sharing allows patients to doctor shop across state lines. Thus, a White House report issued in 2011 declared that “[a] major effort must be undertaken to improve the functioning of state PDMPs, especially regarding real-time data access by clinicians, and to increase the inter-state operability and communication.”⁵⁷ In addition, in many states, privacy concerns may limit the extent to which PDMP data can be used for law enforcement, public health, and research purposes.

States also vary with respect to their continuing medical education (CME) requirements for physicians. Some state licensing boards have established more robust CME requirements to improve prescribing practices among doctors in their state. California is an example of a state that has implemented stricter CME for prescribing while other states may have very little required CME of their doctors.

⁵² Successful strategies, note 45 at 10.

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ Colorado Department of Public Health & Environment, Special Emphasis report: Drug Overdose Deaths, 1999-2013, October 2014.

⁵⁶ National Governors Association (NGA), “Six Strategies for Reducing Prescription Drug Abuse,” Issue Brief (September 2012).

⁵⁷ Executive Office of the President of the United States, “Epidemic: Responding to America’s Prescription Drug Abuse Crisis,” 6 (2011).

CDC experts have found that a few states have been able to change prescribing patterns by increasing prescriber use of their PDMPs.⁵⁸ New York and Tennessee, for example, mandated prescriber use of the state PDMP in 2012.⁵⁹ They subsequently used their PDMPs to document declines of 75 percent and 36 percent, respectively, in their inappropriate use of multiple prescribers by patients.⁶⁰ Other actions taken by states affecting prescribers that CDC experts believe are promising interventions are: developing or adopting existing guidelines for prescribing opioid pain relievers that can establish local standards of care that might bring prescribing rates more in line with current best practices; state Medicaid programs managing pharmacy benefits to promote cautious, consistent use of opioids; and enacting law to address the most egregious prescribing excesses.⁶¹

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

Overdose prevention. State efforts to combat heroin abuse have varied from state to state. For example, several states have passed laws that generally provide immunity for victims and witnesses who act in good faith and seek medical assistance for an overdose; these laws are commonly referred to as “Good Samaritan Laws.”⁶² States have also taken different approaches to expanding access to naloxone, with some states permitting third party prescribing by family and friends of users at high-risk of overdose, and others providing a standing order for community organizations who distribute naloxone to those who meet certain criteria.⁶³ Liability protection for prescribers who administer naloxone, as well as the nature of naloxone distribution programs may differ from one state to the other.⁶⁴ In addition, many states have established task forces, or have initiated new law enforcement efforts to combat heroin and prescription opioids.⁶⁵

States efforts in this area have also targeted the proper disposal of prescription drugs. The majority of people who abuse or misuse prescription drugs get them from friends and family – many of those drugs are leftover medicines. These efforts have included public education on proper disposal and take-back activities, such as designating times and places where the public can safely dispose of unused prescription medication.⁶⁶

⁵⁸ L. Paulozzi, et al, 63 CDC Morbidity and Mortality Weekly Report (MMWR), “Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines – United States, 2012,” 563 (July 4, 2014). <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a2.htm>

⁵⁹ *Id.*

⁶⁰ *Id.*, citing Prescription Drug Monitoring Program Center of Excellence at Brandeis University. Mandating PDMP participation by medical providers: current status and experience in selected states.

⁶¹ *Id.* For example, Florida enacted pain clinic legislation in 2010 and prohibited dispensing by prescribers in 2011.

⁶² NGA, note 56.

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.*

Increasing access to MAT. 49 states and D.C. have state opioid treatment programs (methadone maintenance). All 50 states and D.C. have physicians with waivers to prescribe buprenorphine. All three FDA-approved opioid treatment medications (methadone, buprenorphine, and naltrexone) are covered under the Medicaid Drug Rebate Program. The associated co-pays and authorization requirements vary from state to state. Twenty-six states reported last year that they have expanded or made plans to expand MAT during the past two years.⁶⁷ Although the opioid addiction field recognizes addiction as a chronic, relapsing disease, some substance abuse counselors and administrators have been reluctant to embrace new technologies for its treatment.⁶⁸ At the same time, most physicians and other health care professionals receive little or no training in the treatment of addiction.⁶⁹ As a result, adoption of MAT has been slow in some areas.⁷⁰

Evidence and research on effectiveness of strategies. Very little evidence-based research exists on the most cost-effective and efficacious strategies for states to use in reducing opioid overdoses. States are seeking guidance.⁷¹ Massachusetts, when developing its comprehensive state overdose prevention plan, turned to international sources to identify successful strategies.⁷² States have also been frustrated at not knowing the outcomes of their actions.⁷³ Potential outcomes include: (1) Did physicians change their opioid prescribing practices after receiving webinars and other training; (2) Why do so many physicians train to become registered providers of buprenorphine for addiction, and then not treat any patients; and (3) When informed by letter that a patient has shown up on the PDMP with multiple opioid prescriptions, does the prescribing doctor take action, and, if so, what action?⁷⁴ State representatives particularly requested studies that would look at overdose outcomes for opioid-dependent patients who receive drug-free treatment compared to those receiving MAT.⁷⁵

III. ISSUES

The following issues may be examined at the hearing:

- What state programs have been effective in combatting opioid abuse and why?
- What state programs have not been effective in combatting opioid abuse and why?
- Are state health programs combatting opioid abuse adequately coordinated with federal and other state government agencies?

⁶⁷ NASADAD 2014 update, note 38, slide 45.

⁶⁸ Statement of Mark G. Stringer, Director of Division of Behavioral Health, Missouri Department of Mental Health, available at <http://dmh.mo.gov/ada/provider/medicationassistedtreatment.html>.

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ Successful strategies, note 43, at 9.

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Id.* at 10.

- Are state agencies collecting and evaluating the best data to determine the effectiveness of medication-assisted treatment programs?
- How can state and federal policies better support efforts to develop new and promising treatments for opioid addiction?
- What are the best practices for treating opioid addiction, and how can state and federal policies better incentivize these practices?

In addition, the following policy ideas or areas were mentioned at the April 23, 2015 Subcommittee hearing and could be raised for further exploration with the witnesses:

1. Changes to 42 CFR privacy regulations may be needed to update standards for integrating physical and behavioral medicine.
2. Addiction-treatment physicians should have all available tools “in their quiver” of treatment options, including the array of FDA-approved medications to treat opioid dependency.
3. Patients and sponsoring family members must be given more information regarding the probability of success for various treatment approaches. This will allow them to seek informed choices on which treatment approaches to consider.
4. Improve communication between pharmacies and physicians.
5. Define recovery – not in terms of today, but longer term – 5 years – so we see addiction as a chronic disease and see treatments as meeting chronic care.
6. Ensure physicians treating patients with pain have sufficient information and resources.
7. Make sure insurance parity is being enforced and that insurance companies are not arbitrarily discontinuing coverage for treatment at a certain time.
8. Increase the number of providers who are trained and experienced for mental illness, serious mental illness, and addiction.
9. Increase the number of in-patient beds for detoxification and in-depth treatment that meets the needs of patients.
10. Increase the number of physicians that can prescribe MAT in regions of the country where opioid abuse/dependency is high and where medical services are sparse.

11. MAT alone or psychotherapy alone are rarely sufficient; make sure patient needs are met with all available treatment.
12. Ensuring drug courts allow treatment with MAT.
13. Combining the funding for mental health and substance abuse for dual diagnosis
14. Stop state Medicaid plan reimbursement policies from incentivizing the prescribing of methadone as first-line therapy for pain.
15. Making naloxone (narcan) available over-the-counter.

STAFF CONTACTS

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

APPENDIX – SAMPLE OF STATE RESOURCES

California: <http://www.scpd.org/news/2015/03/20/50478/county-and-private-hospital-er-s-join-forces-to-co/>

Colorado: Colorado Plan to Reduce Prescription Drug Abuse,

<http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheadname1=Content-Disposition&blobheadname2=Content-Type&blobheadvalue1=inline;+filename%3D%22Colorado+Plan+to+Reduce+Prescription+Drug+Abuse.pdf%22&blobheadvalue2=application/pdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251904827503&ssbinary=true>

Florida: [http://myfloridalegal.com/webfiles.nsf/WF/RMAS-94LJPF/\\$file/Statewide_Task_Force_on_Prescription_Drug_Abuse_and_Newborns_Final_Report.pdf](http://myfloridalegal.com/webfiles.nsf/WF/RMAS-94LJPF/$file/Statewide_Task_Force_on_Prescription_Drug_Abuse_and_Newborns_Final_Report.pdf)

Illinois: <https://www.isms.org/opioidplan/>

Indiana: Bitter Pill, Indiana Prescription Drug Prevention Task Force, 2012:

<http://www.in.gov/bitterpill/about.html>

Kentucky: <http://atforum.com/2011/11/kentucky-heads-up-interstate-prescription-drug-task-force/> http://www.florence-ky.gov/sites/default/files/florence/2013_10_Boone_Co_Heroin_Task_Force_Fact_sheet.pdf

Maryland: <http://governor.maryland.gov/ltgovernor/home/heroin-and-opioid-emergency-task-force/>

- Montgomery County: <http://www.montcopa.org/overdosereport>

Massachusetts: <http://www.mass.gov/eohhs/docs/dph/substance-abuse/opioid/report-of-the-opioid-task-force-6-10-14.pdf>

Minnesota: <http://www.mnmed.org/About-the-MMA/MMA-Committees-amp-Task-Forces/Prescription-Opioid-Task-Force>

Missouri: Not Even Once (Adolescent Anti-Heroin Campaign), <http://not-even-once.com/>

Strategic Plan for Prevention,

<http://dmh.mo.gov/docs/ada/Progs/Prevention/StrategicPlanforPrevention2010.pdf>

New Jersey: <http://www.alcoholismdrugabuseweekly.com/m-article-detail/nj-task-force-urges-focus-on-opioid-addiction-in-young-people.aspx>

New York: <http://www.nysenate.gov/joint-senate-task-force-heroin-and-opioid-addiction-legislative-report>

Ohio: <http://www.healthy.ohio.gov/vipp/drug/~//media/1F1DD52D1CA24ADBB98551AD588114EC.ashx>

Oklahoma: Take As Prescribed project website, TakeAsPrescribed.org

Oregon: http://www.researchgate.net/profile/Dennis_Mccarty/publication/264426160_Oregons_Strategy_to_Confront_Prescription_Opioid_Misuse_A_Case_Study/links/53e8f14c0cf28f342f3e540e.pdf

Pennsylvania: https://www.portal.state.pa.us/portal/server.pt/document/1437808/governor_corbett_-_heroin_and_other_opioids_workgroup_pdf
<http://www.pamedsoc.org/MainMenuCategories/Laws-Politics/News-from-Harrisburg/Opioid-prescription-guidelines.html>

Texas: Behavioral Health Strategic Plan, <http://www.dshs.state.tx.us/mhsa/sap-strategic-plan/>

Vermont: Vermont Department of Health Strategic Plan,
<http://healthvermont.gov/adap/documents/ADAPStrategicPlan2012-2017.pdf>

Vermont Prescription Drug Abuse Workshop Final Report Workgroup Recommendations,
http://healthvermont.gov/adap/documents/Rx_workgroup_final_recommendations_122011.pdf

Virginia: <https://governor.virginia.gov/newsroom/newsarticle?articleId=6596>

Washington: <http://washingtonacep.org/Postings/edopiodabuseguidelinesfinal.pdf>

West Virginia: Comprehensive Substance Abuse Strategic Action Plan,
<http://www.dhhr.wv.gov/bhf/Sections/programs/ProgramsPartnerships/AlcoholismandDrugAbuse/Documents/strategicactionplan-info.pdf>