

**OPIOID ABUSE IN AMERICA: FACING THE
EPIDEMIC AND EXAMINING SOLUTIONS**

HEARING
OF THE
**COMMITTEE ON HEALTH, EDUCATION,
LABOR, AND PENSIONS**
UNITED STATES SENATE
ONE HUNDRED FOURTEENTH CONGRESS
FIRST SESSION
ON
EXAMINING OPIOID ABUSE IN AMERICA, FOCUSING ON FACING THE
EPIDEMIC AND EXAMINING SOLUTIONS

DECEMBER 8, 2015

Printed for the use of the Committee on Health, Education, Labor, and Pensions



Available via the World Wide Web: <http://www.gpo.gov/fdsys/>

U.S. GOVERNMENT PUBLISHING OFFICE

97-955 PDF

WASHINGTON : 2018

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
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TUESDAY, DECEMBER 8, 2015

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 10:02 a.m., in room SD-430, Dirksen Senate Office Building, Hon. Lamar Alexander, chairman of the committee, presiding.

Present: Senators Alexander, Collins, Scott, Hatch, Cassidy, Murray, Mikulski, Casey, Franken, Bennet, Whitehouse, Baldwin, Murphy, and Warren.

OPENING STATEMENT OF SENATOR ALEXANDER

The CHAIRMAN. The Senate Committee on Health, Education, Labor, and Pensions will please come to order. Senator Murray and I will each have an opening statement, and then we'll introduce our panel of witnesses.

We thank you for being here.

After our witness testimony, Senators will have 5 minutes of questions.

Today, we're meeting to discuss the growing epidemic in this country of opioid abuse and overdose. The term opioid includes prescription opioid painkillers, like hydrocodone and morphine, and also the illegal drug heroin.

Some people can become addicted to prescription opioid painkillers, and the illegal drug heroin is highly addictive, placing people at risk for overdose.

According to the National Institute on Drug Abuse, prescription opioid painkiller abuse may lead to heroin abuse. Dr. Tom Frieden, the director of the Center for Disease Control and Prevention, said the heroin epidemic is a one-two punch. First, a growing number of people are exposed to and become addicted to prescription opioid painkillers, which he said primes people for heroin addiction later. Then the second punch is, accessibility to heroin has increased.

The number of prescription opioid painkillers prescribed to patients in the United States has skyrocketed in the last 25 years, from 76 million in 1991 to nearly 207 million in 2013. Sadly, along with that trend, we've seen a staggering increase in overdose deaths in the United States due to prescription opioid painkillers, which have more than tripled over the last 15 years. Additionally, the number of heroin users has doubled since 2005 and reached

670,000 in 2012 and continues to trend upward, taking more than 8,200 lives in 2013 alone.

In September, Dr. Frieden came to Knoxville where we hosted a roundtable with local physicians, community leaders, and public health officials on ways to fight opioid abuse. He said then that opioid abuse is a growing epidemic that is gripping our country.

Tennessee ranks near the top of the list for prescription drug abuse, which includes opioids, with the third highest rate of abuse in the Nation. According to a 2011 survey, more than 69,000 people in our State were estimated to be addicted to prescription opioid painkillers, and more than 1,000 Tennesseans die each year as a result of drug overdose. The State is taking a number of actions to deal with it, including dealing with a practice called doctor shopping—those seeking prescription opioid painkillers going to multiple doctors.

At our September roundtable, Dr. Frieden announced that Tennessee was one of 16 States to receive funding through the CDC, \$3.4 million over 4 years, to help the State continue this fight. At the roundtable, we heard from Austin Maxwell, a father who lost his son to a prescription opioid painkiller overdose just days before that son had planned to head to college and walk on to practice with the school's football team.

I know I'm not alone in hearing about these challenges. Senator Collins has talked about this often. The truth is it affects all of our States. Senators Ayotte and Manchin have led a group of nine Senators in highlighting the damage of this epidemic.

Last month, the president signed into law the Protecting Our Infants Act of 2015, which came out of this committee. Senator McConnell, Senator Casey, a member of the committee, and Senator Ayotte all worked hard on that. There's a lot of interest in addressing this problem, as you can see by the number of Senators here today. I look forward to our conversation.

Here's an example of maybe one of the things we can look into. In our Knoxville roundtable, Representative Bill Dunn, a State representative, told me that the patient satisfaction survey from Medicare patients actually has the perverse effect of encouraging physicians to overprescribe prescription opioid painkillers, because reimbursements for hospitals are based to some extent on the score that patients give their doctors about how well they're satisfied with their treatment. I talked to Secretary Burwell about that. I was glad to see this direct response from the administration to a suggestion that came from our roundtable in Knoxville.

This is a complex problem that calls for action by all those who have a role in it. We know that recovery from opioid abuse can be a long and challenging road. We look forward to our witnesses today as they tell us about the challenges they face and suggest solutions that we can help with.

Senator Murray.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Thank you very much, Chairman Alexander.

To all of our witnesses, thank you for coming today to share your expertise.

The conversation that we're having today could not be more important, because the epidemic of opioid abuse is being felt across our country. According to the CDC, 44 people die each day in the United States from prescription painkillers. The Substance Abuse and Mental Health Services Administration estimated that in 1 month alone, 4.3 million people use prescription painkillers without a medical reason.

Opioid use is a serious problem in my home State of Washington as well. Compared to the early 2000s, University of Washington researchers found that drug deaths involving opioids have increased 31 percent. Publicly funded inpatient admissions for opioid-related treatment have increased 197 percent over the same time period.

Those statistics are deeply disturbing. What's worse is the suffering behind those numbers: millions of lives taken completely off track, mothers and fathers who worry about the late-night calls they might get or what it means if no call comes through, and communities across the country that have had to do without the contributions of those whom addiction seized.

As a parent and grandparent and a U.S. Senator, I believe the opioid epidemic is a challenge that cannot go unmet. I'm really glad that we have the opportunity today to hear from some experts, including someone who has lived through addiction, who are dedicated to tackling this.

There are a few key issues related to prevention and treatment that I am especially interested in. I believe we need to find ways to ensure that opioids are consistently prescribed for clinically appropriate reasons. We should make sure that patients in pain are able to get the help they need and that they are also being treated according to clinical best practices. That means taking a close look at prescriber guidelines.

My State of Washington was one of the first to develop prescribing guidelines for opioids and has a law in place to ensure that these guidelines are regularly updated. This is a valuable tool to help prevent unnecessary access and nonmedical use.

I'm also very interested in making sure that when doctors prescribe opioids, they have full information about whether their patient already has a prescription and how often they need refills. There is simply no reason a person struggling with addiction should be able to doctor shop and get multiple prescriptions. That's not only bad for those suffering from opioid abuse, but it also takes time away from true medical needs that doctors' offices and emergency rooms need to address. My home State has developed a system for tracking the use of prescription opioids to crack down on unnecessary prescriptions, and I'm looking forward to hearing from our witnesses about other best practices in this space.

In addition to taking action to keep people from becoming addicted in the first place, we also need to improve treatment and prevent overdose. One important way to do this is to expand access to naloxone, which acts to reverse the effects of an ongoing overdose. Policies that allow people without medical backgrounds to administer naloxone and that make sure this treatment is readily available in communities have been shown to save lives.

Dr. Wen, I know that is something that you have been focused on in your work, and I'm eager to hear more from you about that.

Access to medication-assisted therapy is another barrier to treatment. The most commonly used drug to treat addiction is buprenorphine, but providers with the training to prescribe it can only treat a certain number of patients. Earlier this fall, President Obama announced that the Administration aims to increase the number of prescribers in the United States from 30,000 to 60,000 over the next 3 years. That is an ambitious goal, but I believe it would go a long way to making sure that when people suffering from substance abuse disorders seek treatment, they can get it.

Tackling this epidemic is not going to be easy, and the steps I've laid out are a few of the many that we'll need to take in order to do so. I believe they would make a real difference for families and communities who are suffering right now. The bottom line is that every day that a child loses a parent or a parent loses a child to this crisis is a day too many.

I know that my colleagues on both sides of the aisle agree with that, and I'm looking forward to working together on ways to end this epidemic so that families and communities don't have to suffer from more losses. We have seen far too many already.

Thank you again to all of you for joining us, and I'll turn it back over to Chairman Alexander.

The CHAIRMAN. Thank you, Senator Murray.

Before I introduce the witnesses, Senator Murray and I need to go to the floor after we hear from the witnesses and ask our questions, because we need to speak, and we'll be voting on our bill to fix No Child Left Behind, which every member of this committee has had some role in. Senator Collins has agreed to chair the hearing at that point, and I wanted to call on her and see if she has a statement she would like to make at this point, and then we'll go to the witnesses.

STATEMENT OF SENATOR COLLINS

Senator COLLINS. Thank you very much, Mr. Chairman. I want to congratulate both you and Senator Murray on a truly outstanding accomplishment on education reform. I look forward to supporting your efforts on the floor today.

In many States, including Maine, the prescription drug abuse crisis has also become a heroin crisis, overwhelming our communities and families often with tragic consequences. Maine has been particularly hard hit by this epidemic. In 2014, there were 100 overdose deaths from heroin and other substances. That is up from only 16 in 2010.

In the first half of this year, 63 opioid overdose deaths have been reported. In the month of July alone, the city of Portland had 14 suspected heroin overdoses, including two deaths in 1 day. The number of people seeking treatment in Maine for opioid abuse has more than tripled in the past 4 years.

Perhaps most tragic is the impact on the most vulnerable in our society, the babies born to addicts. In Maine, in the last fiscal year, nearly 1,000 babies were born drug and/or alcohol addicted, a number which represents 8 percent of all births in our State.

Maine and New Hampshire have the dubious distinction of having the most prescriptions per person for long-acting and high-dose painkillers, according to the CDC. When those prescriptions lead to

addiction, the next stop is too often heroin. According to a study by the Maine Sunday Telegram, international drug cartels and the inner city drug gangs have targeted Maine as an emerging and lucrative market for heroin.

This epidemic is playing out in emergency rooms and county jails and on main streets in my State and throughout the country. Maine sheriffs tell me that their jails are overwhelmed by those struggling with addiction and that they cannot arrest their way out of this epidemic. They're not designed to take the place of treatment centers, yet sheriffs and police chiefs must train their officers to look for signs of withdrawal and to monitor mental health status.

I recently received from a constituent of mine a letter detailing his road to addiction, which began in high school as a result of football injuries for which he was given oxycodone. It was in college when the use of painkillers became a serious problem and later led him to use heroin. His letter goes on to describe his attempt to treat his depression with painkillers and, as he put it, years of chasing the feeling of being normal.

It's so important that our committee is examining this serious public health crisis, and I want to commend our leaders for doing so. Thank you.

The CHAIRMAN. Thank you, Senator Collins.

I'll ask Senator Mikulski to introduce our first witness and Senator Bennet to introduce our second.

Senator MIKULSKI. Thank you, Mr. Chairman, and also good luck and thanks to you today for moving the Every Child Succeeds Act, and we look forward to voting for it and passing it. Most of all, thank you for really working on a bipartisan basis to move this legislation.

We also want to thank you today for continuing this ongoing set of hearings on opioid abuse. In Maryland, it is, indeed, a public health epidemic and a public health emergency. Close to 600 people in Maryland died last year of an overdose. Fifty percent of those were in Baltimore City. In Baltimore City last year, we had 300 people die of a drug overdose. We also had 300 people shot, usually related to drug gangland type killings, some of whom were children who were caught up in street massacres that were shot while sitting on their own front steps.

Our Republican Governor says this is a public health emergency. No matter what county you go to in Maryland, this is, indeed, an epidemic.

We have one of our rising stars in Maryland, Dr. Leana Wen, who is the Health Commissioner in Baltimore City, to come and share her experiences and her solutions that are really showing results in our city. We're very proud of Dr. Wen. She is the head of the Baltimore City Health Commission. One thousand people work there, and it handles everything from maternity and child health to behavioral and drug addiction issues.

Since her appointment in 2015, Dr. Wen has led the implementation of citywide opiate overdose prevention and response plans, including innovative ideas like hot-spotting and street outreach teams that she's going to tell you about, how she trained police offi-

cers and lay people in terms of being able to respond to this crisis, and launching a significant public health education program.

She has done an outstanding job there, and during our recent uprising, she led the public health recovery efforts, ensuring that prescription medications, the legal drugs, were in the hands of the senior citizens, the diabetics, the others who needed it, and really helped lead. She was like a medical FEMA out there during these very difficult days.

She comes from this background: yes, a brilliant academic background, a Rhode scholar, a consultant to the World Health Organization, but her hands-on practice started as an emergency room doctor. Seeing what all comes into an emergency room, all of the trauma, the injury, and the human misery, led her into the field of public health and prevention.

You'll enjoy listening to her, and I think she will give us the kind of specific recommendations we need. I'm proud to introduce her to the committee as a Baltimore hometown girl.

The CHAIRMAN. Thank you, Senator Mikulski.
Senator Bennet.

STATEMENT OF SENATOR BENNET

Senator BENNET. Thank you, Mr. Chairman. I also would like to lend my congratulations to you and to Senator Murray for the reauthorization we're going to have today of the Elementary and Secondary School Act. It really was a remarkable accomplishment, and I think it has established a standard for bipartisan work in the Senate that I hope the rest of the committees will be able to live up to. So thank you for that.

Thanks also for giving me the opportunity to introduce Dr. Robert Valuck, who is here from the University of Colorado. At the University of Colorado, Dr. Valuck serves as a professor in the Department of Clinical Pharmacy. He holds additional employments at the Colorado School of Public Health and School of Medicine.

He's also currently the coordinator of the Colorado Consortium for Prescription Drug Abuse Prevention. The consortium was launched in 2013 to establish a coordinated statewide response to reduce the abuse and misuse of prescription drugs in our State. It is accomplishing that through improvements in education, public outreach, research, safe disposal, and treatment.

Dr. Valuck has been president of the Colorado Prescription Drug Abuse Task Force since 2009 and a member since 1998. He has authored several articles on the topic of opioid abuse and dependence. He received his bachelor's degree in pharmacy from the University of Colorado and his master's degree and a Ph.D. from the University of Illinois at Chicago.

Thank you, Dr. Valuck, for being here. We look forward to hearing your testimony.

The CHAIRMAN. Thank you, Senator Bennet.

Our third witness is Eric Spofford. He's the chief executive officer of Granite House, a sober living and halfway house in Derry, NH, they say, and New Freedom Academy, a substance abuse treatment center focusing on young men in Canterbury, NH. His perspective is unique. He not only helps serve individuals seeking help for addiction, but he's also a person in recovery.

We look forward to your testimony.

Dr. Wen, we'll start with you, if we may. We'd like to ask each of you to try to summarize your remarks in about 5 minutes, because we have a number of Senators here who would like to have a conversation with you about what you've said.

Dr. Wen.

STATEMENT OF LEANA WEN, M.D., BALTIMORE CITY HEALTH COMMISSIONER, BALTIMORE, MD

Dr. WEN. Chairman Alexander, Ranking Member Murray, and members of the committee, thank you for calling this important hearing. I'm here today, as Senator Mikulski said, as an ER doctor who has treated hundreds of patients who have overdosed on opioids. I'm also here as the Health Commissioner of Baltimore City, where I have declared the epidemic to be a public health emergency.

I wish to share the three pillars of Baltimore's innovative and science-based approach to this issue. Our first pillar is to prevent overdose deaths through widespread dissemination of the antidote, naloxone. I have used this medication, naloxone, hundreds of times, and I've seen how someone who is unresponsive and about to die will be walking and talking within seconds.

We have worked hard to break down the barriers to naloxone access so that everyone can save a life. This year alone, we have trained over 7,000 people, most of whom are lay people. As of October 1, I have the authority to write a blanket prescription for naloxone to all 620,000 residents in Baltimore City. This standing order is one of the single largest efforts in the country to achieve widespread naloxone distribution.

We also began training our police officers, as Senator Mikulski mentioned. Initially, there was some resistance from a few who did not see medical interventions as part of their job. However, in the first month of carrying naloxone, four officers have used naloxone to save the lives of our residents. I just conducted a training where officers were talking about how their duty is to save a life, which is a significant paradigm shift and one that we need across the country.

Naloxone, though, is necessary but not sufficient, because we know that addiction is a chronic brain disease, and we are just treading water unless we can ensure access to ongoing treatment. That's why our second pillar is that we work to increase access to on-demand treatment, which includes medication-assisted treatment with buprenorphine and methadone and long-term recovery support.

Nationwide, only 11 percent of patients with addiction get the treatment that they need. There is no physical ailment for which we would find that acceptable. Imagine if I'm saying that only 1 in 10 patients with cancer can get chemotherapy. Yet I tell my patients seeking addiction treatment that they must wait weeks or months. Some will come back to me sooner in the ER, maybe with a fatal overdose, because we failed to get them help at the time that they asked for it.

In Baltimore, we are working toward treatment on demand with a 24/7 phone line that provides immediate consultation with a so-

cial worker or addiction counselor; crisis services, where an outreach worker will visit the patient in their home; and information for families seeking resources. We have also secured \$3.6 million from our State legislature toward establishing a stabilization center, also known as a sobering center, which is the first step to our starting a 24/7 urgent care for addiction and for mental health.

In addition, we are training peer recovery specialists, people who have a history of addiction themselves, because they are the most credible messengers. Not only does it bring jobs to individuals who may otherwise have trouble finding employment, but our trainees tell me every day that they are dealing with their addiction and how thankful they are to serve our fellow residents.

These are the stories we must tell together so that we can educate on the true nature of substance addiction, that addiction is a disease and that recovery is possible. That's why our third pillar is that we provide education to reduce stigma and prevent addiction. These efforts are targeted to two populations. First is the public. We launched a public education campaign, DontDie.org, with bus and billboard ads and targeted outreach in churches and neighborhood groups.

Second is physicians. In 2014, there were 259 million opioid prescriptions in this country. That's enough for one bottle of opioids for every adult American. I have sent best practice letters to every doctor in Baltimore that address the risk of addiction and overdose and requires co-prescribing of naloxone with opioids.

Through our three pillars, Baltimore is emerging from being the heroin capital to the model of addiction recovery. There is much that we have done at the local level, but challenges remain. My written testimony provides four specific actions for Congress that include, first, ensuring equitable insurance coverage for addiction services; second, providing cities and States the opportunity to innovate with new models; third, monitoring and regulating the rapidly rising price of naloxone; fourth, pushing for a national stigma reduction campaign.

The epidemic of opioid addiction is affecting the entire country, and we're all in this together. I thank you for calling this important hearing and look forward to working together to save lives, help families, and reclaim communities, and I'm happy to answer any questions that you may have.

[The prepared statement of Dr. Wen follows:]

PREPARED STATEMENT OF LEANA WEN, M.D.

SUMMARY

As an emergency room (ER) doctor, I have witnessed firsthand the effects of substance addiction on individuals and families, including treating hundreds of patients who have overdosed on opioids. As the Health Commissioner of Baltimore City, I work every day with my dedicated staff at the Baltimore City Health Department (BCHD) and partners across our city to prevent overdose and stem the tide of addiction. Our efforts are changing the face of Baltimore from the "heroin capitol" to becoming the center of addiction recovery. We are glad to share our lessons with our counterparts around the country and with our national leaders. With dedicated partners in Congress who are using a public health approach to combat opioid addiction, we can fight the epidemic together, save lives and reclaim people and their families.

BALTIMORE CITY HEALTH DEPARTMENT'S "3-PILLARS" OF COMBATING OPIOID ADDICTION

1. *Prevent deaths from overdose and save lives.* I have declared opioid overdose a public health emergency and led the charge in one of the most aggressive opioid overdose prevention campaigns across the country. This involves a "Standing Order" approved by the Maryland State Legislature so that I can prescribe the effective antidote, naloxone, for the city's 620,000 residents. This year, we have trained 7,000+ people, including police officers. In the first month of carrying naloxone, four officers have used naloxone to save the lives of our citizens.

2. *Increasing access to on-demand treatment and long-term recovery support.* Stopping overdose is only the first step in addressing addiction. To treat people with substance addiction, we must ensure there is adequate access to on-demand treatment. Nationwide, only 11 percent of patients with addiction get the treatment they need. Baltimore City has taken several actions to ensure access to treatment, including a 24/7 crisis, information and referral phone line that, in its second month, already has nearly 1,000 calls every week for crisis services and referral to appointments; \$3.6M in fund to build a sobering center; hiring of community-based peer recovery specialists; and universal screening hospitals for addiction in our hospitals. We strive to establish a 24/7 "Urgent Care" for addiction and mental health disorders and for increased case management and diversion programs.

3. *Provide education to reduce stigma and prevent addiction.* In addition to treating patients, we must also change the dialog around substance use disorder. We are leading a citywide effort to educate the public and providers on the nature of addiction: that it is a disease, recovery is possible, and we all must play a role in preventing addiction and saving lives. We have launched two public education campaigns—"DontDie.org" and "Bmore in Control". We have brought together hospitals and ER leaders and have implemented citywide best practices for opioid prescribing.

ACTIONS FOR THE FEDERAL GOVERNMENT

1. Expand funding and availability of on-demand treatment service.
2. Provide cities and States with opportunity to innovate around addiction recovery.
3. Monitor and regulate the price and availability of naloxone.
4. Push for national stigma-reduction and opioid awareness campaign.

Chairman Alexander, Ranking Member Murray and members of the committee, thank you for inviting me to testify on the epidemic of opioid abuse that is sweeping across our country. Opioid abuse is an epidemic and a public health emergency—one that is claiming the lives, the livelihoods, and the souls of our citizens.

As an emergency room (ER) doctor, I have witnessed firsthand the effects of substance addiction on individuals and families, including treating hundreds of patients who have overdosed on opioids. My colleagues and I frequently felt frustrated by the limitations of clinical practice; by the time patients made their way to us, we had missed significant opportunities to intervene further upstream in that individual's life. This experience is what drove me to public health: a desire to tackle the epidemic of opioid abuse at a population level, and, in doing so, save individual lives while also redefining our societal approach to the treatment of addiction. Now, as the Health Commissioner of Baltimore City, I work every day with my dedicated staff at the Health Department and partners across our city, to prevent overdose and stem the tide of addiction.

THE OPIOID PROBLEM IN BALTIMORE

With approximately 19,000 active heroin users in Baltimore and far more who misuse and abuse prescription opioid medications, our city cannot be healthy without addressing opioid addiction and overdose. Last year in our city, 303 people died from drug and alcohol overdose, which is more than the number of people who died from homicide. Drug addiction impacts our entire community and ties into nearly every issue facing our city including crime, unemployment, poverty, and poor health. It claims lives every day and affects those closest to us—our neighbors, our friends, and our family.

To develop our framework to fight addiction and overdose in Baltimore, Mayor Stephanie Rawlings-Blake convened the Heroin Treatment and Prevention Task Force in October 2014. Understanding that health is not just about physical health, but also behavioral health, the Mayor made this one of her administration's top priorities. She charged the Task Force with developing bold and progressive rec-

ommendations that could be implemented to turn the tide against addiction in our city. These recommendations serve as our roadmap and call to action, led by the Baltimore City Health Department, in close collaboration with public and private partners across the city, including our major partner, Behavioral Health System Baltimore, a nonprofit that is the designated behavioral health authority of the city (of which I serve as chair of the board).

BALTIMORE'S RESPONSE TO ADDICTION AND OVERDOSE

Our work in Baltimore is built on three pillars:

- First, we have to prevent deaths from overdose and save the lives of people suffering from addiction.
- Second, we must increase access to quality and effective on-demand treatment and provide long-term recovery support.
- Third, we need to increase addiction education and awareness for the public and for providers, in order to reduce stigma and encourage prevention and treatment.

Our work in each of these areas is multifaceted because addressing a disease like addiction requires a comprehensive approach. We are glad to share these pillars with the committee and appreciate the greater national public health focus on this issue. The opioid epidemic is affecting every part of our country. We are all in this together, and Baltimore is happy to share our innovations and lessons learned.

1. Preventing deaths from overdose

In Baltimore, I have declared *opioid overdose a public health emergency* and led the charge in one of the most aggressive opioid overdose prevention campaigns across the country.

a. The most critical part of the opioid overdose prevention campaign is *expanding access to naloxone*—the lifesaving drug that reverses the effect of an opioid drug overdose. Naloxone is safe, easily administered, not addictive, and nearly 100 percent effective at reversing an overdose. In my clinical practice, I have administered naloxone to hundreds of patients and have seen how someone who is unresponsive and about to die will be walking and talking within seconds. Since 2003, we have been training drug users on using naloxone through our Staying Alive Program. Last year, we successfully advocated for change in State legislation so that *we can train not only individuals who use drugs, but also their family and friends, and anyone who wishes to learn how to save a life*. This is critical because someone who is overdosing will be unresponsive and friends and family members are most likely to save their life.

Our naloxone education efforts are extensive. This year, *we have trained over 7,000 people to use naloxone: in jails, public housing, bus shelters, street corners, and markets*. We were one of the first jurisdictions to *require naloxone training as part of court-mandated time in Drug Treatment Court*. We have *trained State and city legislators* so that they can not only save lives, but also serve as ambassadors and champions to their constituents. We use up-to-date epidemiological data to *target our training to "hotspots"*, taking naloxone directly into the most at-risk communities and putting it in the hands of those most in need. This was put into effect earlier this year, when we saw that 39 people died from overdose of the opioid Fentanyl between January and March of 2015. Fentanyl is many times stronger than heroin, and individuals using heroin were not aware that the heroin had been laced with Fentanyl. This data led us to target our messaging so that we could save the lives of those who were at immediate risk.

Already, our naloxone outreach and trainings are changing the way our frontline officials approach addiction treatment, with a focus on assessment and action. In addition to training paramedics, we have also started to *train police officers*. The initial trainings were met with resistance from the officers who were hesitant to apply medical interventions that some did not see as part of their job description. However, in the first month of carrying naloxone, four police officers used naloxone to save the lives of four citizens. Recently, I attended a training where I asked the officers what they would look for if they were called to the scene for an overdose. In the past, I would have received answers about looking for drug paraphernalia and other evidence. This time, officers answered that their job was to find out what drugs the person might have taken, to call 911 and administer naloxone, because their duty is to save a life. By no means is naloxone training the panacea for repairing police and community relations. However, it is one step in the right direction as we make clear that addiction is a disease and overdose can be deadly. We are changing the conversation so that all of our partners can join in encouraging prevention, education, and treatment.

b. As of October 1, 2015, I have the authority to write blanket prescriptions for naloxone for the roughly 620,000 residents in Baltimore City, under a “*Standing Order*” which was approved by the Maryland State Legislature. This is one of the single largest efforts in the country to achieve citywide naloxone distribution. A Standing Order means that someone can receive a short training (which can be done in less than 5 minutes) and immediately receive a prescription for naloxone, in my name, without having seen me personally as their doctor. We also successfully advocated for *Good Samaritan legislation*, which expanded protections for those who assist in the event of an overdose, and malpractice protection for doctors who prescribe naloxone. Finally, our State Medicaid program has agreed to set the *co-pay for naloxone at \$1*. While we still struggle with the pricing for naloxone, this has allowed us to provide prescriptions to patients and others at a greatly reduced cost. We have to get naloxone into the hands of everyone who can save a life—which we believe is each and every one of us.

Some people have the misconception that providing naloxone will only encourage a drug user by providing a safety net. This dangerous myth is not based on science but on stigma. Would we ever say to someone whose throat is closing from an allergic reaction, that they shouldn’t get epinephrine because it might encourage them to eat peanuts or shellfish? An Epi-Pen saves lives; so does naloxone, and it should be just as readily available. Our mantra is that we must save a life today in order for there to be a better tomorrow.

2. *Increasing access to on-demand treatment and long-term recovery support*

Stopping overdose is only the first step in addressing addiction. To treat people with substance addiction, we must ensure there is adequate access to on-demand treatment. Nationwide, only 11 percent of patients with addiction get the treatment they need. There is no physical ailment for which this would be acceptable—imagine if only 11 percent of cancer patients or 11 percent of patients with diabetes were being treated. If we do not increase access to quality treatment options we are merely treading water, waiting for the person who has overdosed to use drugs and overdose again.

a. In Baltimore, we have started a 24/7 “*crisis, information, and referral*” phone line that connects people in need to a variety of services including: immediate consultation with a social worker or addiction counselor; connection with outreach workers who provide emergency services and will visit people in crisis at homes; information about any question relating to mental health and substance addiction; and scheduling of treatment services and information. This line is not just for addiction but for mental health issues, since these issues in behavioral health are so closely related and there is a high degree of co-occurrence. Those who are seeking treatment for behavioral health should be able to easily access the services they need, at any time of day. This 24/7 line has been operational since October 2015; already, there are nearly 1,000 phone calls every week. It is being used not only by individuals seeking assistance, but by family members seeking resources and providers looking to connect their patients to treatment.

b. We have secured \$3.6 million in capital funds to build a “*stabilization center*”—also known as a sobering center—for those in need of temporary service related to intoxication. This is the first step in our efforts to start a 24/7 “Urgent Care” for addiction and mental health disorders—a comprehensive, community-based “ER” dedicated to patients presenting with substance abuse and mental health complaints. Just as a patient with a physical complaint can go into an ER any time of the day for treatment, a person suffering from addiction must be able to seek treatment on-demand. This center will enable patients to self-refer or be brought by families, police, or EMS—a “no wrong door” policy ensures that nobody would be turned away. The center would provide full capacity treatment in both intensive inpatient and low-intensity outpatient settings, and connect patients to case management and other necessary services such as housing and job training.

c. We are developing a *real-time treatment dashboard* to obtain data on the number of people with substance use disorders, near-fatal and fatal overdoses, and capacity for treatment. This will enable us to map the availability of our inpatient and outpatient treatment slots and ensure that treatment availability meets the demand. The dashboard will be connected to our 24/7 line that will immediately connect people to the level of treatment that they require—on demand, at the time that they need it.

d. We are expanding our capacity to treat overdose in the community by *hiring community-based peer recovery specialists*. These individuals will be recruited from the same neighborhoods as individuals with addiction, and will be trained as overdose interrupters who can administer overdose treatment and connect patients to treatment and other necessary services.

e. We have implemented the *Screening, Brief Intervention, and Referral to Treatment (SBIRT)* approach, which provides universal screening of patients presenting to ERs and primary care offices. Three of our hospitals are early pioneers in SBIRT; we are looking to expand it to all hospitals and clinics in the city to ensure delivery of early intervention and treatment services for those with or at risk for substance use disorders.

f. We are expanding and promoting *medication-assisted treatment*, which is an evidence-based and highly effective method to help people with opioid addiction recover. This combines behavioral therapy with medication, such as methadone or buprenorphine, along with other support. Taking medication for opioid addiction is like taking medication to control heart disease or diabetes. When prescribed properly, medication does not create a new addiction, but rather manages a patient's addiction so that they can successfully achieve recovery. Baltimore has been at the leading edge of innovation for incorporating medication-assisted treatment, including: *providing medications in structured clinical settings* through the Baltimore Buprenorphine Initiative. This year, we *expanded access to buprenorphine treatment by offering services in low-barrier settings*, such as recovery centers, emergency shelters, and mental health facilities. Providing access to buprenorphine services in these settings allows us to engage people who are more transient or unstably housed into much-needed treatment.

g. We are working to expand case management and diversion programs across the city so that those who need help get the medical treatment they need. In our city of 620,000, 73,000 people are arrested each year. The majority of these arrests are due to drug offenses. Of the individuals in our jails and prisons, 8 out of 10 use illegal substances and 4 out of 10 have a diagnosed mental illness. Addiction and mental illness are diseases, and we should be providing medical treatment rather than incarcerating those who have an affliction. Baltimore already has *highly effective diversion efforts such as Drug Treatment Courts and Mental Health Treatment Courts*. We are looking to implement a *Law Enforcement Assisted Diversion Program*, a pilot model that has been adopted by a select group of cities, which establishes criteria for police officers to identify eligible users and take them to an intake facility that connects them to necessary services such as drug treatment, peer supports, and housing—rather than to central booking for arrest.

Finally, we are increasing our capability for *case management services for every individual leaving jails and prisons*. These individuals are at a highly vulnerable State, and must be connected to medical treatment, psychiatric and substance abuse treatments if appropriate, housing and employment support, and more. Our outreach workers already target a subset of this population; we need to expand capacity to every one of these individuals. Additionally, as mentioned above, we are deploying community health workers in order to reach people where they are in the community as well as provide a credible messenger. In deploying this tactic, we are also excited to bring jobs and opportunities to vulnerable individuals and neighborhoods that otherwise have limited employment opportunities.

3. *Providing education to reduce stigma and prevent addiction*

In addition to treating patients, we must also change the dialog around substance use disorder. The Baltimore City Health Department is leading a citywide effort to educate the public and providers on the nature of substance addiction: that it is a disease, recovery is possible, and we all must play a role in preventing addiction and saving lives.

a. We have been at the forefront of changing public perception of addiction so those in need are not ashamed to seek treatment. We have *launched a public education campaign "DontDie.org"* to educate citizens that addiction is a chronic disease and to encourage individuals to seek treatment. This was launched with bus ads, billboard ads, a new website, and a targeted door-to-door outreach campaign in churches and with our neighborhood leaders.

We have also launched a concerted effort to *target prevention among our teens and youth entitled "BMore in Control."* We have established *permanent prescription drug drop boxes* at all nine of the city's police stations. This means that anyone can drop-off their unused, unwanted, or unnecessary prescription drugs—no questions asked. Drugs left in the home can end up in the wrong hands—spouses, elderly family members, or even our children. I have treated 2-year-olds who were dying from opioid overdose, again underscoring that all of us can be at risk and must play a role.

b. We are targeting our educational efforts to physicians and other prescribers of opioid medications. Nationwide, over-prescribing and inconsistent monitoring of opioid pain medications is a major contributing factor to the overdose epidemic. According to the Centers for Disease Control, there were 259 million prescriptions

written for opioids in 2014. That is enough for one opioid prescription for every adult American. Every day, people overdose or become addicted to their prescription opioids.

To address this, *I have sent “best practice” letters to every doctor in the city* and will also do so for all dentists and pharmacists. The letter addressed the importance of the Prescription Drug Monitoring Program and judicious prescribing of opioids, including not using narcotics as the first line medication for acute pain and emphasizing the risk of addiction and overdose with opioids. Importantly, this best practice *requires co-prescribing of naloxone* for any individual taking opioids or at risk for opioid overdose. Hospitals keep naloxone on hand if patients receive too much intravenous morphine or fentanyl. Patients must also receive a prescription for naloxone if they are to be discharged with opioid medications that can result in overdose.

These best practices were developed through convening ER doctors, hospital CEOs, and other medical professionals in the city. To reach practicing doctors, we have been presenting at Grand Rounds, medical society conferences, and are also about to launch *physician “detailing”*, where we will employ teams of public health outreach workers and people in recovery to visit doctors to talk about best practices for opioid prescribing. We are working with providers to ensure best practices will be used when prescribing opioids and that we all play our part—as providers, patients, and family members—to prevent addiction and overdose.

WORKING WITH THE FEDERAL GOVERNMENT

The Baltimore City Health Department, together with our partners across the city and State, has made significant progress in tackling the opioid epidemic. However, there are some areas where we face continued challenges. Though there is much that can be done on the city and State levels, the Federal Government plays a critical role in the campaign against addiction and overdose. We appreciate the opportunity to mention four specific areas that can be addressed.

1. *Expand funding and availability of on-demand addiction treatment service*

We must treat addiction as a disease and not a crime or a moral failing. In order to successfully treat the disease, we need to ensure there are sufficient high-quality treatment options available to those in need.

a. *Federal funding could expand treatment on-demand* including 24/7 dedicated centers for substance addiction and mental health and proven intervention models such as LEAD and expand case management services for vulnerable individuals. These programs will help to ensure that those in need have a path to recovery.

b. *Congress can push for equitable insurance coverage for addiction services.* Medicare pays for pain medications that can lead to addiction, yet many States do not cover medication-assisted treatment and other evidence-based interventions for addiction recovery. Congress can ensure that Medicaid, Medicare, and private payers cover on-demand treatment for acute care (such as sobering, urgent care, and residential services), as well as ongoing treatment and services like medication-assisted treatment and case management. *These rates should also be equivalent to mental health and physical health care rates* (which they are not currently, leading to a dearth of providers and inadequate care).

c. *Congress can remove barriers to prescribing Buprenorphine.* Buprenorphine is a medication-assisted treatment option with a much lower chance of overdose than methadone. Importantly, it can be administered by a primary care provider rather than in a designated drug-treatment clinic. This helps to increase the accurate perception that substance use disorder is a medical condition. Unfortunately, at the moment, only medical doctors can prescribe buprenorphine, and a doctor can only provide Buprenorphine to a maximum of 100 patients. This barrier does not exist for any other medication, and significantly limits the ability of patients to access a life-saving treatment option and leaves many patients with methadone as their only option for medication-assisted treatment. Methadone requires administration in a designated treatment clinic, which are often a point of contention within the communities in which they operate due to the stigma associated with drug addiction. We strongly support current efforts underway at the Department of Health and Human Services to revise the limits on buprenorphine prescription in a given year, and urge further support of broadened access to this proven treatment including by requesting Congress to consider broadening prescription authority of Buprenorphine to Nurse Practitioners and other providers.

2. *Provide Cities and States with the opportunity to innovate around addiction recovery*

There are many services not covered by Medicaid, Medicare, or other forms of insurance that are critical to addiction recovery. Congress can provide funding to local

jurisdictions and to States that can give grants and incentives to support innovative, evidence-based programs that do not simply focus on the medical component of addiction but the broader psychosocial components. These include:

a. *New care delivery models.* There is research on new treatment options such as starting buprenorphine from ERs, mobile buprenorphine induction, or telemedicine treatment that would be not eligible for existing reimbursement yet offer much promise. These are examples of delivery models that local and State agencies should have the option of providing grant funding for, with the option of being included in Medicaid formulary after sufficient time and evidence.

b. *Peer recovery specialists.* In Baltimore, we are aiming to provide a peer recovery specialist for every individual who presents for overdose or addiction-related condition to our ERs and other facilities. However, we are limited by the lack of funding for these individuals. There should be opportunities for expanded funding and reimbursement for services rendered by these trained community health workers; grant funding to local and State agencies can be one way to pursue this.

c. *Case management services.* Individuals leaving incarceration or inpatient stays are at very high risk; they must receive wrap-around services that connect them immediately to needed medical and psychiatric assistance. These case management services have inconsistent reimbursement; innovative programs including with telemedicine and use of peer recovery specialists should be encouraged.

d. *Community resources for recovery.* Recovery from addiction involves more than clinical treatment but also support and long-term care. Local and State agencies can also innovate with interventions such as *recovery housing and reentry support*; Federal funding can assist in these necessary steps.

e. *Prevention.* Grant support for tailored and targeted prevention support including public education and provider education must also be a critical component.

3. Congress can monitor and regulate the price and availability of naloxone

Naloxone is a generic medication that is part of the World Health Organization's list of essential medications. Over the last 2 years, the price of naloxone has dramatically increased. In Baltimore, the cost per dose of naloxone has quadrupled—meaning that we can only save a quarter of the lives we could have saved. This is particularly problematic for cities and counties that must purchase naloxone for use by paramedics, police officers, and other front-line workers. Manufacturers have claimed that this price increase is related to increased demand. However, it is unclear why the cost of a generic medication that is available for much lower costs in other countries will be suddenly so expensive. Congress can join efforts by Senator Sanders and Congressman Cummings to call for investigation into the reason for the price increase, which would otherwise prohibit us from saving lives at a time that we need to the most.

4. Congress can push for national stigma-reduction and opioid-awareness campaign

Many local jurisdictions like Baltimore have launched public education campaigns. There is much more education that must be done in order to encourage people with addiction into care and to disband stigmas that are leading many communities to avoid providing treatment altogether. Local jurisdictions are also limited by funding constraints. Congress can push for the launch of a national campaign to reduce stigma and to increase awareness of opioid addiction. This national campaign will provide the spotlight this critical issue requires.

CONCLUSION

While some of the challenges facing Baltimore may be unique, we join our counterparts around the country in addressing the epidemic of opioid addiction. According to the Centers for Disease Control, the number of people dying from overdose has quadrupled from 15 years ago. In many States, there are more people dying from overdose than from car accidents or suicide. Contrary to popular perception, the fastest growing demographic of people dying from prescription opioid overdose is white and middle-aged women.

There are some who say the opioid problem is too big and too complicated—that it cannot be solved. It is true that treating the opioid epidemic requires many approaches. However, this is an issue that requires our attention. According to the World Health Organization, treating opioid addiction saves society \$12 for every \$1 spent on treatment. Treatment also has impact in many other ways to communities by reducing excess healthcare utilization, increasing productivity and employment rates, and decreasing poverty and unnecessary cost to the criminal justice system. Not to mention that it is a moral imperative and a matter of life and death.

Baltimore has been fighting the heroin and opioid epidemic for decades and we continue to make progress with bold ideas and innovative strategies. Our efforts

around opioid addiction seek to change the face of Baltimore from the “heroin capitol” to becoming the center of addiction recovery. We are glad to share our lessons with our counterparts around the country and with our national leaders. With dedicated partners like you in Congress, we can fight the epidemic together, save lives and reclaim people and their families.

On behalf of the Baltimore City administration, I want to thank you for calling this important hearing. We look forward to working with you to stop the epidemic of opioid addiction in the United States.

The CHAIRMAN. Thank you, Dr. Wen.
Dr. Valuck.

STATEMENT OF ROBERT VALUCK, Ph.D., RPh, FNAP, PROFESSOR, DEPARTMENT OF CLINICAL PHARMACY, SKAGGS SCHOOL OF PHARMACY AND PHARMACEUTICAL SCIENCE, UNIVERSITY OF COLORADO, AURORA, CO

Mr. VALUCK. Thank you very much, Chairman Alexander, Ranking Member Murray, and members of the committee, for the opportunity to provide testimony to you today about our efforts to address the opioid epidemic in Colorado.

In 2012, we had the troubling distinction of ranking second, nationally, for self-reported, nonmedical use of prescription opioid painkillers. More than 255,000 Coloradans misused these drugs, and consequent deaths related to misuse nearly quadrupled in our State between 2000 and 2011. As the committee is well aware, these dramatic increases in the misuse and abuse of prescription drugs have been felt nationwide.

Since 2012, catalyzed by Governor Hickenlooper’s leadership as co-chair of the National Governors Association Policy Academy for Reducing Prescription Drug Abuse, we are currently implementing a unique, innovative, and coordinated approach to confront this public health crisis. Drawing upon stakeholder input, national best practices, and the success stories from other States, we have engaged and leveraged expertise of the healthcare community, educators, State and local law enforcement, public health, human services, community groups, and our legislative partners. In 2012, we set a goal of preventing 92,000 Coloradans from engaging in non-medical use of prescription painkillers by 2016 through the adoption of what we call the Colorado Plan to Reduce Prescription Drug Abuse.

The Colorado Plan currently focuses on eight key areas: improving surveillance of prescription drug abuse and misuse through better data systems; strengthening the Colorado Prescription Drug Monitoring Program; educating prescribers and other healthcare providers; increasing safe disposal options to prevent diversion and protect the environment; increasing public awareness; enhancing access and referral to evidence-based effective treatment; expanding access to the overdose reversal drug, naloxone; and, most recently, increasing the voice of those who are affected by the epidemic.

To implement the Colorado Plan and monitor and coordinate progress, State level leadership created the Colorado Consortium for Prescription Drug Abuse Prevention. The Consortium provides a statewide interagency framework designed to facilitate collaboration and implementation of the strategic plan by interested parties and agencies. The Consortium is comprised of eight work groups,

separated by the focus areas I just outlined, and now it has over 355 members actively participating in the effort statewide.

The Consortium is housed at the university, but draws on all of the universities and State agencies that we have in Colorado, in addition to all of our health profession associations, treatment providers, and other groups. The Consortium is a 501(c)(3) organization. It's not housed in any one State agency, but includes them all, and provides an independent statewide network designed not only to implement the strategic plan, but to survive beyond its short-time window to continue to address the epidemic over the long period of time that will be required to solve it.

Utilizing this innovative approach, Colorado has experienced a wide variety of successes and positive developments in each of its areas of focus. I detail those in my more substantial testimony, but they come in the form of legislation, collaboration, increased public awareness, community and affected family engagement, and the new creation of a statewide safe disposal program with permanent drop boxes in each of Colorado's counties.

With the Washington Agency Medical Directors' Group guidelines serving as a template for us, we developed joint prescribing guidelines through our medical, pharmacy, nursing, and dental boards to jointly develop a policy for prescribing and dispensing opioids in Colorado. We believe, to our knowledge, that's the only example of all of the regulatory boards in a single State gathering together to create a single joint policy.

We also have received strong bipartisan support from State agencies and offices. Our former attorney general, John Suthers, contributed a million dollars to the creation of a Take Meds Seriously public awareness campaign that we launched last spring. Most recently, we have increased access to naloxone through the cooperation of major pharmacies and pharmacy chains in Colorado, including the Kroger Corporation, Safeway-Albertsons, CVS, and a number of other independent pharmacies, such that by the first of next year, over 400 pharmacies in Colorado will have naloxone available through a similar standing order issued by our chief medical officer at the State level, Dr. Larry Wolk.

Finally, the Consortium has begun to be recognized as a national model for developing State-level approaches to addressing this problem. But despite some of the encouraging trends, we believe there are several ways that the Federal Government could help in the efforts for States to solve the opioid epidemic.

First, we believe Federal funding and agency support could be directed to the creation and support of additional State and regional level collaboratives to enable sharing of best practices and continued dialog among States and regions.

Second, we believe that the DEA National Take Back initiative, while extremely successful in each of its 11 iterations thus far, could be strengthened to better facilitate ongoing permanent mechanisms for drug collection and disposal.

Third, we have seen and applaud many of the efforts of Federal Government agencies and professional organizations to create continuing education programs and guidelines for safe and effective prescribing, dispensing, and use. We believe that what is needed

now are tools for providers to enable them to implement these educational materials.

The CHAIRMAN. Could you wrap up your testimony, Mr. Valuck? Thank you.

Mr. VALUCK. Thank you again for the opportunity to provide testimony to the committee today. We would be happy to answer any questions you may have related to the work we're doing in Colorado to prevent this problem.

Thank you.

[The prepared statement of Dr. Valuck follows:]

PREPARED STATEMENT OF ROBERT J. VALUCK, PH.D., RPH, FNAP

SUMMARY

Thank you Chairman Alexander, Ranking Member Murray, and members of the committee for the opportunity to provide testimony to you today about our efforts to address the opioid epidemic in Colorado. In 2012 (based on 2010–11 data), we had the troubling distinction of ranking 2d nationally for self-reported, non-medical use of prescription drugs: more than 255,000 Coloradans misused prescription medications, and consequent deaths related to misuse nearly quadrupled between 2000 and 2011. As the committee is well aware, these dramatic increases in the misuse and abuse of prescription drugs have been felt nationwide. The expenses associated with prescription drug misuse are significant, and include costs attributed to lost productivity, criminal justice proceedings, treatment, and medical complications.

Since 2012, catalyzed by Governor Hickenlooper's leadership as a co-chair of the National Governor's Association Policy Academy for Reducing Prescription Drug Abuse, we are currently implementing a unique, innovative, and coordinated approach to confront this public health crisis. Drawing upon stakeholder input, national best practices and the success stories from other States, we have engaged and leveraged expertise of the healthcare community, educators, State and local law enforcement, public health, human services, community groups, and our legislative partners. In 2012, we set a goal of preventing 92,000 Coloradans from engaging in non-medical use of prescription pain medications by 2016 through the adoption of the *Colorado Plan to Reduce Prescription Drug Abuse*. This commitment represents reduction from 6 percent to 3.5 percent of Coloradans who self-report non-medical use of prescription drugs. Our plan is a coordinated, statewide strategy that simultaneously restricts access to prescription drugs for illicit use, while ensuring access for those who legitimately need them.

The *Colorado Plan to Reduce Prescription Drug Abuse* currently focuses on eight key areas:

- improving surveillance of prescription drug misuse data;
- strengthening the Colorado Prescription Drug Monitoring Program;
- educating prescribers and providers;
- increasing safe disposal to prevent diversion and protect the environment;
- increasing public awareness;
- enhancing access and referral to evidence-based, effective treatment;
- expanding access to the overdose reversal drug Naloxone; and
- increasing the voice of those who are affected by the epidemic.

To implement the Colorado Plan and monitor and coordinate progress, State level leadership created the *Colorado Consortium for Prescription Drug Abuse Prevention* (the Consortium). The Consortium provides a statewide, inter-agency/inter-organization framework designed to facilitate collaboration and implementation of the strategic plan by interested parties and agencies, and is comprised of eight work groups, separated by the focus areas outlined above. The Consortium is housed at the University of Colorado (CU) Skaggs School of Pharmacy and Pharmaceutical Sciences at Anschutz Medical Campus (which houses the School of Pharmacy, the Colorado School of Public Health, Colorado State University, the University of Northern Colorado, the CU School of Medicine, and the CU College of Nursing). The Consortium, a 501c3 organization that is not housed in any one State agency but includes them all, provides an independent statewide network designed not only to implement the strategic plan, but to survive beyond its short time window to continue to address this epidemic over the long period of time that will be required to solve it. The education, governmental, and medical communities are well-positioned to address many of Colorado's prescription drug abuse challenges, and the partnerships facilitated by

the Consortium have been crucial in attaining optimum outcomes and increased Federal funding.

Utilizing this innovative, coordinated, multidisciplinary approach, Colorado has experienced a wide variety of successes and positive developments in each of its areas of focus. These successes have come in the form of legislation, collaboration, increased public awareness, community and affected family engagement, the creation of a statewide safe disposal program, and unprecedented interagency and professional association cooperation. Colorado's efforts have received strong bipartisan support from various key agencies, offices, and related task forces in the State. Our former Attorney General, Jon Suthers, contributed \$1 million to the work of the Consortium, primarily to launch the TakeMedsSeriously public awareness campaign. The Consortium has been named an official subcommittee of the legislatively mandated Substance Abuse Trend and Response Task Force, which addresses substance abuse more broadly, but now benefits from the collective expertise of the Consortium.

Further innovations in Colorado include our Department of Human Services, Office of Behavioral Health, including the Consortium in its next 5-year Substance Abuse Block Grant funding cycle, to serve as a coordinating hub for statewide prevention efforts aimed primarily at youth and young adults. Rise Above Colorado, the recipient of the statewide prevention grant for 2015–2020, is working to help extend the reach of the Consortium, the key messages it has developed, and bring them to these key target populations, where the problem of prescription drug misuse and abuse most often starts.

Finally, the Consortium has begun to be recognized as a national model for developing a State level, collaborative, coordinated, collective action approach to addressing this serious public health problem. Through the creation of a common agenda, shared measurement, mutually reinforcing activities, continuous communication, and a novel backbone infrastructure, we have worked to create a lean but effective vehicle for a collective approach to addressing prescription drug abuse in Colorado.

But despite encouraging trends, more needs to be done, and we continue to study the problem, engage and listen to all constituents to gather their ideas and input, scan the Nation for best practices, policies, and programs, and incorporate them into our own efforts. While we have made significant progress in Colorado, there is a clear place for Federal assistance in fighting this troubling epidemic. The current work by all Federal agencies and offices, from HHS (SAMHSA, CDC, FDA, HRSA, CMS), to DOJ, DEA, ONDCP, and OIT, among others has represented a very good start from a variety of perspectives, but we believe there are three specific ways in which you could help States address the opioid epidemic.

First, Federal funding and agency support should be directed to the creation and support of State and regional level collaboratives, similar to the Consortium model we have created in Colorado, but with room for tailoring to the needs of individual States and regions of the country. We know that working together is challenging but possible, and that each State and region has its own unique needs. Federal support could go a long way to creating viable, effective models to attack this problem at the appropriate levels, using local expertise and resources, where we believe the most success will obtain.

Second, we believe that the DEA National Takeback Initiative, while extremely successful in each of its 11 iterations over the past 6 years, should be strengthened to better facilitate prescription drug take back and destruction. The new regulations allowing pharmacies, clinics, and other organizations to become "reverse distributors" are laudable but we are concerned that sufficient economic incentives for these organizations to get into the reverse distribution business are lacking. Further, we suggest that the Federal Government assist in the creation of a national, permanent takeback network, whereby citizens may drop off their unused medications at any time, 365 days a year, and thus stem the tide of misuse where it starts, in the medicine cabinet.

Third, we have seen and applaud the many efforts of government agencies and professional organizations to create continuing education programs for prescribers and other providers, and to create best practice guidelines for safe and effective opioid prescribing, dispensing, and use. What is needed now are tools for providers, to enable them to implement the educational content and best practices into their routine, daily work. Information technology, software systems, connectivity, and mobile apps offer clinicians and patients the opportunity to make prescribing, dispensing, and using opioids safer, more effective, and with the ability to track outcomes and learn what works best and what doesn't. Funding for the development, testing, and implementation of clinical tools will help us move from "knowing what to do" to "knowing how to do it."

With additional help in these three areas, States will have substantially more resources, brainpower, and tools to address the opioid epidemic in their States and regions. We hope you will consider these suggestions, and work to develop policies and programs to support them.

In closing, while there is still much work to do in response to this public health crisis, we are emboldened by some of the progress seen in Colorado. We have confidence that the Consortium model will allow us to implement a multi-faceted, strategic approach that is responsive to changing trends and data, and the continued development of national best-practice. The *Colorado Plan to Reduce Prescription Drug Abuse* is a crucial part of our commitment to making Colorado the healthiest State in the Nation. Better health is not just good for individuals and families; it has positive outcomes for our workforce, reduces the costs of government, and improves the quality of life in our communities.

Thank you, again, for the opportunity to provide testimony today. We would be happy to answer any questions related to the work we are doing in Colorado to prevent the misuse and abuse of prescription drugs.

Thank you Chairman Alexander, Ranking Member Murray, and members of the committee for the opportunity to provide testimony to you today about our efforts to address the opioid epidemic in Colorado. In 2012 (based on 2010–11 data), we had the troubling distinction of ranking 2d nationally for self-reported, non-medical use of prescription drugs: more than 255,000 Coloradans misused prescription medications, and consequent deaths related to misuse nearly quadrupled between 2000 and 2011. As the committee is well aware, these dramatic increases in the misuse and abuse of prescription drugs have been felt nationwide. The expenses associated with prescription drug misuse are significant, and include costs attributed to lost productivity, criminal justice proceedings, treatment, and medical complications.

Since 2012, catalyzed by Governor Hickenlooper's leadership as a co-chair of the National Governor's Association Policy Academy for Reducing Prescription Drug Abuse, we are currently implementing a unique, innovative, and coordinated approach to confront this public health crisis. Drawing upon stakeholder input, national best practices and the success stories from other States, we have engaged and leveraged expertise of the healthcare community, educators, State and local law enforcement, public health, human services, community groups, and our legislative partners. In 2012, we set a goal of preventing 92,000 Coloradans from engaging in non-medical use of prescription pain medications by 2016 through the adoption of the *Colorado Plan to Reduce Prescription Drug Abuse*. This commitment represents reduction from 6 percent to 3.5 percent of Coloradans who self-report non-medical use of prescription drugs. Our plan is a coordinated, statewide strategy that simultaneously restricts access to prescription drugs for illicit use, while ensuring access for those who legitimately need them.

The *Colorado Plan to Reduce Prescription Drug Abuse* currently focuses on eight key areas:

- improving surveillance of prescription drug misuse data;
- strengthening the Colorado Prescription Drug Monitoring Program;
- educating prescribers and providers;
- increasing safe disposal to prevent diversion and protect the environment;
- increasing public awareness;
- enhancing access and referral to evidence-based, effective treatment;
- expanding access to the overdose reversal drug Naloxone; and
- increasing the voice of those who are affected by the epidemic.

To implement the Colorado Plan and monitor and coordinate progress, State level leadership created the *Colorado Consortium for Prescription Drug Abuse Prevention* (the Consortium). The Consortium provides a statewide, inter-agency/inter-organization framework designed to facilitate collaboration and implementation of the strategic plan by interested parties and agencies, and is comprised of eight work groups, separated by the focus areas outlined above. The Consortium is housed at the University of Colorado (CU) Skaggs School of Pharmacy and Pharmaceutical Sciences at Anschutz Medical Campus (which houses the School of Pharmacy, the Colorado School of Public Health, Colorado State University, the University of Northern Colorado, the CU School of Medicine, and the CU College of Nursing). The Consortium, a 501c3 organization that is not housed in any one State agency but includes them all, provides an independent statewide network designed not only to implement the strategic plan, but to survive beyond its short time window to continue to address this epidemic over the long period of time that will be required to solve it. The education, governmental, and medical communities are well-positioned to address many

of Colorado's prescription drug abuse challenges, and the partnerships facilitated by the Consortium have been crucial in attaining optimum outcomes and increased Federal funding.

Utilizing this innovative, coordinated, multidisciplinary approach, Colorado has experienced a wide variety of successes and positive developments in each of its areas of focus.

Thorough and accurate data and research underpins the work that we do and informs the policy and regulatory decisions that we make. The Data and Research work group of the Consortium has worked to map out all sources of data related to prescription drug use, misuse and overdose in the State in order to monitor trends, educate the public and inform decisionmaking by multiple stakeholders. The work group is also focused on identifying other efforts that successfully use crosswalks between diverse data sources and standardize data collection tools across State agencies. Under a new DOJ-BJA Harold Rogers grant, our Colorado Department of Public Health is working with the PDMP program and the Consortium to create better, more current, and linked data systems. This will enable us to better identify high risk populations and geographic areas, and to use this "hot spotting" approach to rapidly respond to any emerging public health concerns if or when they arise.

The Prescription Drug Monitoring work group (PDMP) has worked over the past 2 years to enhance our State's PDMP as an effective public health tool. In 2014 we passed House Bill 1283, enhancing our State's PDMP. This bill included a variety of provisions, most notably: allowing the State to provide "push notices" to both prescribers and pharmacists when patients visit a certain number of prescribers and pharmacies to obtain a controlled substance over a certain period of time; requiring mandatory PDMP registration for pharmacists and United States Drug Enforcement Administration (DEA) registered prescribers; allowing prescribers and pharmacists to assign and register delegates in their office to check the PDMP; allowing direct access to PDMP by the Colorado Department of Public Health and Environment; and providing permissive authority for federally owned and operated pharmacies to submit controlled substances data into the Colorado PDMP. Additionally, we have enhanced the PDMP interface and moved to a daily upload of data (it was twice monthly prior to October 2014). These improvements have demonstrated a powerful resonance throughout the Colorado prescriber and pharmacist community. As of July 2014 our PDMP utilization rate was 41 percent and by October 2015 that rate had more than doubled, reaching 85 percent.

The Provider Education work group focuses on issues relating to improving the education and training of health care professionals who prescribe, dispense, or otherwise provide care for those receiving prescription medications with the potential for misuse, abuse, or diversion. In the spring of 2014, a joint *Policy for Prescribing and Dispensing Opioids* was developed to address prescription drug abuse in the State and adopted by the dental, medical, nursing, pharmacy, optometry, and podiatry boards in Colorado. This is the first joint policy of its type adopted by multiple regulatory boards in a single State, and aims to provide guidance on best practices for pain management. Over the past year the Consortium has also developed online training and education for prescribers throughout the State.

As of October 2014, 1,316 prescribers had completed the training, 87 percent of whom indicated they intended to change their practice as a result. The Provider and Prescriber Education Workgroup of the Consortium is currently expanding the curriculum to other professional health schools and postgraduate training programs. We were encouraged by these strategies when the CDC morbidity and mortality report recently ranked Colorado 40th nationally for prescribing rates of opioids per 100,000 people (50th being the lowest rates of prescribing).

We know that more than 70 percent of those who abuse prescription drugs obtain them from the unused supplies of friends or family, highlighting the importance of supporting robust medication collection and disposal resources throughout the State. The Safe Disposal work group focuses on issues relating to safe storage and disposal of prescription medications with the potential for misuse, abuse or diversion. This work group has developed guidelines and outreach efforts and expanded the number of safe disposal sites throughout the State. For the past 5 years, the DEA has operated "National Drug Takeback Days" each Spring and Fall, collecting significant quantities of medications at law enforcement sites (over 39,000 pounds in Colorado in 2014 alone). In light of the uncertainty regarding future DEA takeback days, and responding to the new DEA rules allowing "reverse distribution" of pharmaceutical controlled substances, we secured State funding to expand the existing collection and disposal program. Over the next year, we plan to provide permanent drop boxes in every county to assure an ongoing, available mechanism for all citizens to safely dispose of unused/unwanted medications.

The Public Awareness work group of the Consortium focuses on raising awareness among Colorado citizens regarding the problem of prescription drug abuse. We recently launched a new statewide advertising and public outreach campaign—“Take Meds Seriously”—designed to educate consumers about the safe use, storage, and disposal of prescription drugs. Since our February 2015 launch, our new website—*TakeMedsSeriously.org*—has seen over 53,000 visits and 76,000 page views in less than 6 months; has had over 76 Million advertising impressions and over 62,000 click throughs; has received nearly \$100,000 in earned media coverage; and has increased awareness of the problem, as evidenced by 2 of 10 Coloradans reporting having heard or seen a campaign message, and 81 percent of those saying that they would talk to their children or family members about the dangers of prescription medicine abuse.

The Consortium’s Treatment work group has focused on identifying gaps and needs in the provision of preventative, therapeutic, and rehabilitative substance use treatment programs and making clinical, organization, and public policy improvements to these systems. Primary areas of focus are: (1) lack of standardized, universal screening, brief intervention, referral, and treatment (or SBIRT); (2) barriers to access and entry; and (3) critical treatment and clinical workforce shortages. We are working from a variety of vantage points to expand access to and availability of treatment resources, such as expanding statewide capacity to provide Medication Assisted Treatment (MAT) for opiate dependent patients by linking suboxone-licensed physicians with community-based substance treatment. We recently applied to the Substance Abuse and Mental Health Services Administration (SAMHSA) for a Targeted Capacity Expansion grant aimed at increasing the capacity to deliver MAT to treat opiate/opioid addiction.

The Naloxone work group focuses on increasing awareness of, and access to, the opioid overdose reversing drug Naloxone, and making clinical, organizational, and public policy recommendations to achieve this goal. This spring, we passed Senate bill 15-053, which extends existing authority to prescribe or dispense opiate antagonists by permitting licensed prescribers and licensed dispensers to also prescribe or dispense a standing order directly to individuals, a friend or family member or an individual who may experience an opiate-related drug overdose, an employee or volunteer of a harm reduction organization or a first responder. Shortly thereafter, our State’s Chief Public Health Officer, Dr. Larry Wolk, issued a standing order for all citizens of Colorado. In recent weeks, the Naloxone work group has worked closely with both small, independent pharmacies and major supermarket and chain pharmacies, to increase the number of locations who are dispensing Naloxone under the new standing orders. We are pleased to report that the Kroger Corporation, Safeway/Albertsons, and CVS have all signed on, and as of January 2016, Naloxone will be available in over 400 pharmacies across the State of Colorado, providing widespread distribution of life-saving opiate antagonists.

The new Affected Families and Friends work group, launched this Fall, focuses on giving those affected by the opioid epidemic a place to go, a place to learn, a place to share their stories and experiences with others, a network for providing media access and interviews, and a vehicle to give input to the consortium’s topic area work groups and the State legislature, regarding what patients and families experience, want, and need, as they live their lives under the impact of opioid misuse, abuse, and overdose. To our knowledge, no other State is currently engaging patients and families in this way, as part of their statewide efforts to address the epidemic.

It is also important to note that Colorado’s efforts have received strong bipartisan support, from various key agencies, offices, and related task forces in the State. Our former Attorney General, Jon Suthers, contributed \$1 Million to the work of the Consortium, primarily to launch the TakeMedsSeriously public awareness campaign. And the Consortium has been named an official subcommittee of the legislatively mandated Substance Abuse Trend and Response Task Force, which addresses substance abuse more broadly, but now benefits from the collective expertise of the Consortium.

Further innovations in Colorado include our Department of Human Services, Office of Behavioral Health, including the Consortium in its next 5-year Substance Abuse Block Grant funding cycle, to serve as a coordinating hub for statewide prevention efforts aimed primarily at youth and young adults. Rise Above Colorado, the recipient of the statewide prevention grant for 2015-20, is working to help extend the reach of the Consortium, the key messages it has developed, and bring them to these key target populations, where the problem of prescription drug misuse and abuse most often starts.

Finally, the Consortium has begun to be recognized as a national model for developing a State level, collaborative, coordinated, collective action approach to address-

ing this serious public health problem. Through the creation of a common agenda, shared measurement, mutually reinforcing activities, continuous communication, and a novel backbone infrastructure, we have worked to create a lean but effective vehicle for a collective approach to addressing prescription drug abuse in Colorado. Recent data suggests that we are well on track to meet our 2016 goal. 2013 data released by the National Survey on Drug Use and Health shows that our rate on non-medical use has decreased from 6 percent to 5.08 percent, which represents 39,000 fewer Coloradans who misused prescription drugs during the survey time period (2012–13). This drop represents a 15.33 percent reduction in our rate of prescription drug abuse, and our ranking in this category has positively dropped from 2d to 12th nationally. Additionally, the Colorado youth use rate is decreasing and below the national average. In 2011, the percentage of students who had taken prescription drugs without a doctor's permission more than once during their lifetime was 19.6 percent. In 2013 that percentage had dropped to 13.6 percent.

But despite encouraging trends, prescription drug abuse remains a serious health crisis as we work to expand upon and bolster work currently underway in Colorado. Drug overdose remains the leading cause of injury death in the United States and in Colorado, largely due to the misuse and abuse of prescription drug overdoses, and 10.72 percent Coloradans aged 18–25 still engage in non-medical use of prescription drugs. In the last 5 years the number of heroin users in Colorado has also doubled, a rate increase that is suspected to have some correlation with our high rates of prescription drug misuse/abuse. We also have significant concerns that existing treatment capacity is not meeting a rising demand, as treatment admissions for heroin and prescription opioid abuse increased 128 percent between 2007 and 2014. Overdose death is a very real risk for people struggling with opiate addiction, and failure to provide vital treatment services means unnecessary, preventable deaths of our citizens.

More needs to be done, and we continue to study the problem, engage and listen to all constituents to gather their ideas and input, scan the Nation for best practices, policies, and programs, and incorporate them into our own efforts. While we have made significant progress in Colorado, there is a clear place for Federal assistance in fighting this troubling epidemic. The current work by all Federal agencies and offices, from HHS (SAMHSA, CDC, FDA, HRSA, CMS), to DOJ, DEA, ONDCP, and OIT, among others has represented a very good start from a variety of perspectives, but we believe there are three specific ways in which you could help States address the opioid epidemic:

First, Federal funding and agency support should be directed to the creation and support of State and regional level collaboratives, similar to the Consortium model we have created in Colorado, but with room for tailoring to the needs of individual States and regions of the country. We know that working together is challenging but possible, and that each State and region has its own unique needs. Federal support could go a long way to creating viable, effective models to attack this problem at the appropriate levels, using local expertise and resources, where we believe the most success will obtain.

Second, we believe that the DEA National Takeback Initiative, while extremely successful in each of its 11 iterations over the past 6 years, should be strengthened to better facilitate prescription drug take back and destruction. The new regulations allowing pharmacies, clinics, and other organizations to become “reverse distributors” are laudable but we are concerned that sufficient economic incentives for these organizations to get into the reverse distribution business are lacking. Further, we suggest that the Federal Government assist in the creation of a national, permanent takeback network, whereby citizens may drop off their unused medications at any time, 365 days a year, and thus stem the tide of misuse where it starts, in the medicine cabinet.

Third, we have seen and applaud the many efforts of government agencies and professional organizations to create continuing education programs for prescribers and other providers, and to create best practice guidelines for safe and effective opioid prescribing, dispensing, and use. What is needed now are tools for providers, to enable them to implement the educational content and best practices into their routine, daily work. Information technology, software systems, connectivity, and mobile apps offer clinicians and patients the opportunity to make prescribing, dispensing, and using opioids safer, more effective, and with the ability to track outcomes and learn what works best and what doesn't. Funding for the development, testing, and implementation of clinical tools will help us move from “knowing what to do” to “knowing how to do it.”

With additional help in these three areas, States will have substantially more resources, brainpower, and tools to address the opioid epidemic in their States and

regions. We hope you will consider these suggestions, and work to develop policies and programs to support them.

In closing, given some of the highlighted successes we've had and challenges we still face, recent data suggests that we are well on track to meet our 2016 goal. 2013 data released by the National Survey on Drug Use and Health shows that our rate on non-medical use has decreased from 6 percent to 5.08 percent, which represents 39,000 fewer Coloradans who misused prescription drugs during the survey time period (2012–13). This drop represents a 15.33 percent reduction in our rate of prescription drug abuse, and our ranking in this category has positively dropped from 2d to 12th nationally. Additionally, the Colorado youth use rate is decreasing and below the national average. In 2011, the percentage of students who had taken prescription drugs without a doctor's permission more than once during their lifetime was 19.6 percent. In 2013 that percentage had dropped to 13.6 percent. The national average for this measure in 2013 was 17.8 percent. While there is still much work to do in response to this public health crisis, we are emboldened by some of the progress seen in Colorado. We have confidence that the Consortium model will allow us to implement a multi-faceted, strategic approach that is responsive to changing trends and data, and the continued development of national best-practice. The *Colorado Plan to Reduce Prescription Drug Abuse* is a crucial part of our commitment to making Colorado the healthiest State in the Nation. Better health is not just good for individuals and families; it has positive outcomes for our workforce, reduces the costs of government, and improves the quality of life in our communities.

Thank you, again, for the opportunity to provide testimony today. We would be happy to answer any questions related to the work we are doing in Colorado to prevent the misuse and abuse of prescription drugs.

ATTACHMENTS

Note: Due to the high cost of printing, the attachments supplied by Mr. Robert Valuck, Ph.D. may be accessed at the following websites:

- Attachment 1—Colorado Plan to Reduce Prescription Drug Abuse at: www.cohealthinfo.com/wp-content/uploads/2014/08/Colorado-Plan-to-Reduce-Prescription-Drug-Abuse-Sep-2013.pdf.
- Attachment 2—Colorado Consortium for Prescription Drug Abuse Prevention Chart at: www.corxconsortium.org/wp-content/uploads/TakeMeds_About_Chart-2.png.
- Attachment 3—TakeMedsSeriously Wrap-Up Report at: https://coag.gov/sites/default/files/contentuploads/occe/Substance-Abuse_SA/SATF_presentations/11-0-15_tmswrap-up-report.pdf.
- Attachment 4—The Colorado Consortium for Prescription Drug Abuse Prevention, Public Awareness Work Group's 2015 Statewide Survey Report of Results at: <https://www.corxconsortium.org>.

The CHAIRMAN. Thank you very much.
Mr. Spofford.

STATEMENT OF ERIC SPOFFORD, CHIEF EXECUTIVE OFFICER, GRANITE HOUSE, DERRY, NH; NEW FREEDOM ACADEMY, CANTERBURY, NH

Mr. SPOFFORD. Good morning. It's an honor and privilege to be here. I'm the chief executive officer of two substance abuse treatment programs in New Hampshire and have a third opening up early next year. I'm also in long-term recovery from opiate and other drug addiction. I've been sober since December 7, 2006. I'd like to share some of my personal experience with the opiate epidemic.

In the late 1990s, a drug called Oxycontin was marketed as a non-addictive pain killer. This drug was an opiate, the same class of drug as heroin, with a similar potency. It had a time release

coating on it that was easily removed by moistening it and rubbing it off, making Oxycontin a highly abusable and addictive drug.

In 1999, I was a teenager and experimenting with drugs and alcohol. A friend that I grew up with since first grade came over with a 20 milligram pill. We crushed it, snorted it, and it was the most euphoric thing I had ever experienced and I fell in love instantly. The next day, all I wanted to do was more. I had no idea that my life had just changed forever.

What started as recreational use quickly turned into daily use and addiction. My tolerance for the drug became increasingly stronger. I dropped out of high school and shortly after graduated into using heroin, as most opiate addicts do. Before I knew it, it was too late.

Through 6 years of opiate addiction, I did and experienced many things I'm not proud of. I committed crimes to support my habit, got in legal trouble, was homeless, overdosed five times, and was a general burden on society. I attempted to achieve recovery many times before I finally did. On the morning of December 7, 9 years ago, I was done for good.

Since then, I've been in recovery, and I've been able to accomplish a lot. I'm a man of integrity today, a good friend, son, boyfriend, and father. I'm respected in my community, and recently I won the business of the year award from the chamber of commerce. At every opportunity possible, I'm of service, especially when it comes to combating the heroin epidemic.

In 2008, I started a program called the Granite House, a men's sober living home that quickly grew into a nationally recognized extended care program. Recently, I opened another residential inpatient facility, with another opening in early 2016. I also own several other businesses in the construction and real estate space. I've created close to 100 jobs in my home State of New Hampshire, and I have paid my fair share of taxes along the way.

I tell you all of this because 9 years ago, I was a man that appeared hopeless. I was a guy that was hard to like. I created a lot of problems everywhere I went because of my addiction, and because of the stigma associated with this disease, most people had given up on me.

Supporting addicts in their recovery process can have far greater benefit than just to them and their lives. We are some of the most intelligent and creative people that I have ever met and have the potential to do so much in this world, although it often doesn't appear so.

I have witnessed the opiate epidemic spiral out of control for a long time. The solution must be comprehensive with prevention and treatment. In the last several years, fentanyl has become widely available on the streets. It is a synthetic opiate that is 50 times more powerful than heroin and much cheaper. The dealers are cutting their heroin with it or selling it in the place of heroin for greater profits.

This has created an inconsistency of potency in the drugs that are on the streets and it is killing people. I've buried more people of drug overdoses in the last 2 years than I have in all the years before combined. On average, in New Hampshire, I know of two to four people that die a week.

Creating harder sentencing laws for the distribution and trafficking of fentanyl is incredibly important. This drug is a serial killer and so are the people selling it. They see the carnage it creates and keep selling it, despite how many people are dying.

Also important is the availability of naloxone, the lifesaving overdose reversal drug. The symptoms of the disease of addiction are ugly and make addicts hard people to like. The question we need to ask ourselves is do they deserve to die because of their disease? I overdosed five times and was revived with this drug. Without it, I would be dead and my life would have never had any meaning.

We must have better prevention systems in our schools. Young people experimenting with drugs is nothing new. What is new is that what is available to them is heroin, and it will change their lives forever and they don't even know it. We need to educate our children on the truth of opiates and the effects it will have on them and their peers.

Treatment availability is incredibly important. If we can support addicts from being in active addiction to getting into the recovery process, we will start to gain traction on this epidemic. Providing treatment for people with this disease is far less expensive than incarcerating them and so much more effective.

People do need to be held accountable for their actions. However, putting addicts in prison and expecting them to be different when they get out is of the same mentality as locking up a diabetic and expecting them to not have diabetes when released. The disease of addiction does not respond to punishment.

I sincerely appreciate your attention to this matter, and thank you for your time.

[The prepared statement of Mr. Spofford follows:]

PREPARED STATEMENT OF ERIC SPOFFORD

SUMMARY

- I. Opening comments
 - A. Introduction
 - B. Recovery background
- II. Active addiction
 - A. Prescription drug Oxycontin
 - B. Point of no return
 - C. Addiction behavior
 - D. Attempts at recovery, failure
- III. Personal recovery and afterwards
 - A. Complete turnaround
 - B. Accomplishment
 - C. Service
- IV. Recovery professional
 - A. The Granite House beginnings
 - B. New Freedom Academy
 - C. Green Mountain Treatment Center
 - D. Entrepreneurship
 - E. From hopeless to helpful
- V. The Epidemic
 - A. Fentanyl
 - B. Stricter laws
 - C. Naloxone (Narcan)
- VI. Prevention and treatment
 - A. Teach our children
 - B. Treatment availability
 - C. Treatment and accountability over jail—treat as a disease

VII. Closing

Good morning, my name is Eric Spofford and it is an honor and a privilege to be here. I am the chief executive officer of two substance abuse treatment programs in New Hampshire and have a third opening up early next year.

I'm also in long-term recovery from opiate and other drug addiction. I've been sober since December 7, 2006.

I'd like to share some of my personal experience with the opiate epidemic. In the late 1990s a drug called Oxycontin was marketed as a non-addictive pain killer. This drug was an opiate, the same class of drug as heroin with a similar potency. It had a time release coating on it that was easily removed by moistening it and rubbing it off, making Oxycontin a highly abusable and addictive drug.

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What started as recreational use quickly turned into daily use and addiction. My tolerance for the drug became increasingly stronger. I dropped out of high school and shortly after graduated into using heroin, as most opiate addicts do. Before I knew it, it was too late.

Through 6 years of opiate addiction I did and experienced many things I'm not proud of. I committed crime to support my habit, got in legal trouble, was homeless, overdosed five times, and was a burden on society.

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to educate our children on the truth of opiates and the effects it will have on them and their peers.

Treatment availability is incredibly important. If we can support addicts from being in active addiction to getting into the recovery process we will start to gain traction on this epidemic. Providing treatment for people with this disease is far less expensive than incarcerating them and so much more effective. People do need to be held accountable for their actions. However putting addicts in prison and expecting them to be different when they get out is of the same mentality as locking up a diabetic and expecting them to not have diabetes when released. The disease of addiction does not respond to punishment.

I sincerely appreciate your attention to this matter. Thank you for your time.

The CHAIRMAN. Thank you, Mr. Spofford, and thank you for your personal story.

Thanks to all three witnesses. We'll now begin a round of 5-minute questions each. I'll go first, and then Senator Murray.

Mr. Spofford, Dr. Wen talked about the medicine, naloxone, that's used when there's an emergency overdose, it sounds like. Take me through the process at the Granite House if, suddenly, you're introduced to someone who's in the midst of an overdose. Do you administer naloxone, or does someone do that? I believe you told me earlier that you gradually help people off their addiction within about a week. Is that right?

Mr. SPOFFORD. Sure. What you're referencing is the detox process. Understand that opiates, as a class of drugs, has a physical dependency and that folks go into withdrawal in the absence of them. A national standard is about a 5- to 7-day process of a taper, using a drug such as buprenorphine, to bring them back to sobriety.

Naloxone is not commonly used—it's actually never been used at the Granite House, my facility, because people aren't on drugs and alcohol there. In fact, they're achieving sobriety and are sober at that period of time. More often than not, we're seeing first responders administering naloxone. We're also seeing it being administered among the addicts.

The CHAIRMAN. Someone may have administered naloxone, and then they bring that person to you later. Is that right?

Mr. SPOFFORD. Correct, to come to treatment.

The CHAIRMAN. Some people say that a drug like methadone is needed for a long period of time for someone to get over an opiate addiction, and some people—and, obviously, you think it—you prescribe a different sort of treatment. Talk about that.

Mr. SPOFFORD. Methadone and buprenorphine, or the brand name, Suboxone, same thing, are replacement drugs, whereas they themselves are narcotics. If I took one right now, or anyone in this room did, you'd be high as a kite. You're still maintaining a physical addiction to opiates. It's just taking it from heroin and prescription medications bought illegally to a prescription under the oversight of a doctor.

I couldn't imagine what my life would look like if I woke up this morning and had to take a pill to not go into withdrawal before I came here to share with you. I believe in abstinence-based treatment. The treatment industry is very much split down the middle and polarized to two different types, medication-assisted recovery and abstinence-based. My facilities, my own personal program of recovery, and my industry peers believe that we can be free from all mind-altering substances, and we don't need a crutch such as buprenorphine or methadone to stay away from heroin.

The CHAIRMAN. Dr. Wen, what's your comment on that? Is it necessary to have a medicated recovery from an opiate addiction, or is it better not to?

Dr. WEN. First, I wish to say that Mr. Spofford's testimony was extremely touching and inspiring. From my standpoint, I have to use evidence and I have to use science, because I'm a doctor and a scientist. When we look at dozens, hundreds, of studies that have been done, they show that medication-assisted treatment works. Let me distinguish between the two, if I may.

The CHAIRMAN. When do you get to the end of medicated-assisted treatment? How long do you have that? Does that go on for the rest of your life?

Dr. WEN. Many patients are maintained on medications for the rest of their life, and I would equate that to high blood pressure or diabetes. I would never say to somebody with high blood pressure, "Why is it that you're still taking your Lisinopril? It's been 30 years," or say to somebody, "Why are you still taking your insulin? You've had diabetes for quite a long time."

We know that opioid addiction is a chronic disease of the brain, very similar to other physical ailments. Studies have shown that most individuals would benefit from chronic medication-assisted treatments, and that when somebody is stably maintained on methadone or buprenorphine, it does not cause them to "have a high," that these certainly can be misused in the same way that oxycodone or any other opioid could be misused, but that somebody could be stably maintained on these medications, and that they will look no different from you and me, they will not be prohibited from operating machinery or driving, and that this is the path to long-term recovery that is evidence-based.

The CHAIRMAN. Dr. Valuck, that's a difference of opinion. I suppose another difference of opinion, one which you referred to, is among physicians and their prescriptions for opiate addiction. Dr. Frieden, for example, the head of the Center for Disease Control, had a serious injury with a lot of pain, and he refused to take oxycodone because he sees it as a dangerous drug.

I know a great many other very well-respected doctors who regularly prescribe oxycodone after a serious back surgery or some other surgery to relieve pain, and it lasts for a few days. What did you do about that difference of opinion in Colorado?

Mr. VALUCK. Thank you, Senator Alexander. We have stressed in Colorado provider education and consensus building around evidence-based practice. Much as Dr. Wen noted, we do the same thing from upstream, from recommending from the very point of diagnosing pain to establishing treatment options to, ultimately, if there is pharmacological treatment of pain, that that might include opioids, but it might include other options that have also been shown to be effective for the treatment of acute or chronic pain.

We recommend, as much as the Institute of Medicine has recently recommended that the country do, that we view pain much more carefully, all the way from the initial diagnosis and understanding of what the cause of the pain is, what the various treatment options are for the pain, and then to use best available evidence to prescribe.

The CHAIRMAN. Do you recommend the substitutes for oxycodone or other such drugs that are less likely to be addictive?

Mr. VALUCK. We view this as a—that there should be options, again, for the provider and for the patient, given the circumstances, depending on the source of the pain, the type of the pain. I'm not a diagnostician, not being a physician.

As a pharmacist, understanding the pharmacology and therapeutics of treating pain, there are a variety of options that may range from nonsteroidal anti-inflammatory drugs to opioid painkillers to other medications that have pain relieving properties, like gabapentin or some other classes of drugs. There's a variety of options available, and we believe that physicians are best placed to make those decisions with their patients.

The CHAIRMAN. Thank you very much.

Senator Murray.

Senator MURRAY. Doctor Wen, you testified that part of Baltimore's response is ensuring adequate crisis response, and I'm very interested to hear more about the 24-hour phone line that you talked about to establish information and referrals. When SAMHSA Acting Administrator Enomoto testified before our committee in October, she noted that our healthcare system often lacks the resources to address the crisis situations. Those are critical times when patients and individuals with substance use disorders and their families seek help.

Talk to us a little bit about what benefits you have seen from establishing your 24-hour phone line and your stabilization center.

Dr. WEN. Thank you very much for the question. When I first came to Baltimore and we realized that this is a critical issue for us to work on, we looked at what were the existing resources, and we found five different phone lines. I called them. We did a secret shopper experience and tried all five lines. One only operated from 10 a.m. to 2 p.m. One was 9 a.m. to 5 p.m. One was for mental health only. One you had to know your own insurance.

We realized that if it was so confusing for me, for us as the healthcare providers, to figure this out, that it wasn't going to be working for our patients who are in need of immediate help. There was already a 24/7 crisis line for mental health emergencies, which is very closely related to addiction as well. We combined all of our resources into one phone line.

This phone line just started in October, so 2 months ago, and already we are up to nearly 1,000 calls a week. It's not only a resource for patients and families, but also for providers, because I can tell you, as an ER doctor, it is—you feel hopeless when you don't know what to do with your patients. When this patient is there looking for help, you're not going to be calling 20 different clinics, asking them for an appointment. It would be good to call a single line, and this line has been very effective so far.

I do think that the crisis services are critical. We also then need the next step, which is once we have the services available, how can we connect people into treatment immediately. That is the connection, that using peer recovery specialists would be the most helpful.

Senator MURRAY. Thank you.

Dr. Valuck, you talked about prescribing guidelines. We've done that in my home State of Washington. Can you talk a little bit about why that is an important tool in combating abuse?

Mr. VALUCK. Yes, thank you, Senator Murray. We believe that this is one of the cornerstones of addressing this problem, to first gather the best available, translate into actionable clinical guidance for practitioners, and then to disseminate those broadly and achieve consensus.

We have for years looked to Washington State and the University of Washington and the Agency Medical Directors' Group, who have been leaders in this for at least 15 or 20 years and continue to issue those revised guidelines. We view those as national exemplars for how to generate guidelines and what they contain.

That said, we don't think that any one set of guidelines is necessarily applicable to all situations. We took those, and within our State, modified those as we believed appropriate for our State, and all of our regulatory boards got on board together to issue these as joint guidance for Colorado.

Senator MURRAY. Thank you.

Mr. Spofford, thank you so much for coming and sharing your story. It was very powerful, and we all really appreciate it. Can you talk about what trends you are seeing on the ground?

Mr. SPOFFORD. Sure. The trends on the ground—they've done a very good job tightening up the availability of prescription pills up in my home State of New Hampshire, and Massachusetts is very close to us. It's created the opiate addicts mainly going to heroin. Whereas a lot of addicts were on Oxycontin and Percocet, they're now mostly on heroin.

As I spoke about, the latest trend over the last couple of years is the introduction of fentanyl. This drug is so much more potent than heroin and far cheaper. Whereas a good bulk, 10 grams, on the street of heroin is \$650, they're getting this fentanyl for \$150. They're selling bags of fentanyl that are 50 times more potent than a bag of heroin. It looks the same, smells the same, and they don't tell them the difference.

I just had a friend die on a public bathroom floor. When they tested the bag 3 months ago—when they tested the bag, he thought he was doing heroin. There wasn't any heroin in it. It was all fentanyl. In New Hampshire, we've had a spike in overdose deaths, and it's directly related to this fentanyl. That's really the biggest thing that's been going on.

Senator MURRAY. I really appreciate that. Thank you for sharing that.

I am going to join Senator Alexander on the floor as we debate our bill. Senator Whitehouse has agreed to take over my spot for me, and I appreciate it. I really appreciate all of you and all of our colleagues for focusing on this issue.

Mr. SPOFFORD. Thank you.

Senator MURRAY. Thank you.

The CHAIRMAN. Senator Collins will have the next set of questions, and she will chair the committee, and Senator Whitehouse will be the ranking member while Senator Murray and I go to the floor.

Senator Collins.

SENATOR COLLINS [presiding]. Thank you, Mr. Chairman. You know how much I love having the gavel in my hand.

[Laughter.]

As Dr. Wen mentioned, law enforcement officials throughout our country are often on the front lines of this epidemic. The sheriff of Penobscot County in Maine tells me that the intake room of his jail often resembles an emergency room, between the number of people who are drug addicted or who have untreated mental illness.

In western Maine, a police chief is spearheading a program called Project Save Me, and it's actually modeled after the Angel Program which was started in Gloucester, MA. The idea behind this program is to encourage addicts to come to the police department, turn in their drugs and their drug paraphernalia, and then get connected with a counselor who can get them on a treatment path. They won't be arrested, but instead they'll be paired with an individual who can help them begin facing their addiction. Other towns in Maine are also testing this model.

You each bring very different perspectives to this crisis, and I would be interested in hearing from each of you what more you think that we could do—at the Federal level, the State level, and the local level—to bring law enforcement and treatment options together. It's clear that you can't arrest your way out of this problem, and yet it's law enforcement that is having to deal with it in many cases.

I'd like to start with you, Mr. Spofford, and then just go down.

Mr. SPOFFORD. Sure. Any efforts to support similar programs as the one in Gloucester and in Maine are excellent. The treatment community and law enforcement have been a part of that—I know a lot of those folks—and have done a real good job on their own of trying to make this happen. Perhaps some official policy behind it, not just the good wishes of several police captains or chiefs, rather.

Another thing that is incredibly important is, believe it or not, as you probably know, the largest treatment center for substance abuse folks in the country is our Department of Corrections, with statistics of 85 percent of incarcerated people having substance use disorders. The money behind that—from a fiscal standpoint, an average of \$48,000 to \$52,000 a year to incarcerate them with almost very minimal and almost no rehabilitative services for these folks getting out.

You take an addict and you lock him up for 6 months, 1, 5, or 10 years, and when they get out, they will still be an addict. If they're not in a process of recovery, they will behave and act in the same ways that they always have. Implementing some sort of policy to bring treatment solutions into our jails and our prisons to prevent these people from coming back, and to getting out and being productive members of society and productive members of a recovery community is incredibly important.

Senator COLLINS. Thank you very much.

Dr. Valuck.

Mr. VALUCK. Thank you, Senator Collins. We in Colorado have been piloting various ways to engage law enforcement into the mix of solutions that we are crafting. One of the ways we're doing that is to expand take back of unused prescription drugs. We think this

is particularly important, given data that suggest between 70 percent and 73 percent of people who misuse prescription opioid painkillers start with a prescription drug they obtained from a friend or family member's medicine cabinet.

We view this as low-hanging fruit, that we must clear out unused opioids from the medicine cabinets of all citizens. Most people's fear is that they won't be able to get enough opioids so they'll save it, when, in fact, they may have the opposite problem. They might have too easy a time getting more. We think taking those drugs back and disposing of them properly is one of the major things that needs to happen.

Senator COLLINS. Thank you.

Dr. Wen.

Dr. WEN. Three concepts, Senator Collins, for working with law enforcement. The first is making sure that we have no round door policies for seeking care and increasing diversion programs, for example, pre-arrest diversion into treatment, rather than incarceration.

The second is if somebody is incarcerated, I completely agree that we need to be able to provide them with the care that they need. Yet in Maryland, just like across the country, if somebody is stably maintained on methadone or buprenorphine, we often are not able to keep them on these medications, which, again, we would never do for any disease. No medical society would condone stopping insulin, and no medical society condones stopping methadone or buprenorphine when somebody is already on those medications. Yet that often happens in our correctional system.

The third is that for people leaving our jails, these are people who are the most vulnerable. Many of them have lost their health insurance. They need help. They need case management to get them connected with medical treatment, psychiatric treatment, with addiction treatment, and also with housing. I'd say that those are the main things to work together with the law enforcement colleagues.

Senator COLLINS. Thank you very much.

Senator Mikulski.

STATEMENT OF SENATOR MIKULSKI

Senator MIKULSKI. Thank you, Senator Collins. Senator Collins, I have a full statement that I ask unanimous consent to go into the record.

Senator COLLINS. Without objection.

Senator MIKULSKI. Thank you.

[The prepared statement of Senator Mikulski follows:]

PREPARED STATEMENT OF SENATOR MIKULSKI

I wish we didn't have to be here today. I wish we didn't have a persistent and growing drug epidemic in this country—one that is ravaging our communities and killing our young people. But here we are. I commend Chairman Alexander and Ranking Member Murray for convening this important hearing.

More Americans now die from drug overdoses than from car accidents. Prescription opioid painkillers like hydrocodone, oxycodone,

codeine, morphine and methadone are increasingly to blame for overdose deaths. Every day 46 Americans die from prescription opioid overdoses. That's two deaths an hour—17,000 annually. Heroin, an illegal opioid, is increasingly to blame. According to the American Society of Addiction Medicine, about 8,200 Americans die annually from heroin overdoses.

Last year in Maryland, we had 578 heroin-related deaths, more than 25 percent higher than the previous year and more than double the total in 2010. Last year in Baltimore City, 303 people died from drug and alcohol overdoses. That's more than the number of people who died from homicide. In Baltimore today, we have approximately 19,000 active heroin users and many more who are abusing prescription opioid medications.

This is a very real problem in every corner of my State. When I went around and met with Maryland's county executives, every single one of them talked to me about heroin and opioid abuse. It didn't matter if they were Republican or Democrat, from an urban or rural part of Maryland, or from southern Maryland or the eastern shore. This is a problem across Maryland and across the county.

That is why I have fought very hard as chairwoman and vice-chairwoman of the Senate Appropriations Committee to get funding in the Federal checkbook to help combat this epidemic. In the fiscal year 2015 Omnibus, I was able to get \$441 million for anti-heroin activities at the Department of Justice, the Department of Health and Human Services and at the White House.

The money we secured in the fiscal year 2015 Omnibus gave grants to States and local law enforcement to investigate and arrest those selling heroin and illegal prescription drugs and reduce drug trafficking. It provided funds to States for prescription drug monitoring programs so States can better monitor and track those offenders who are doctor shopping or otherwise abusing prescription drugs. It ensured States got the money they need to expand medication-assisted treatment and purchase Naloxone, which saves lives by rapidly reversing the effects of a heroin overdose.

I am continuing to fight alongside many people here today to ensure adequate funding for these programs in the fiscal year 2016 Omnibus.

This is a problem that demands immediate attention and a comprehensive response. It won't be solved just by the Federal Government or just by local governments. We must come together and devise a multi-pronged solution working with Federal, State and local governments, as well as allies in the public and private sector.

I look forward to hearing from the witnesses today. I want to hear from them about what's working and what isn't. I want to hear about what States and localities are doing—I know Baltimore City has a number of initiatives underway. I want to hear their ideas for how the Federal Government can be a better partner in these efforts.

I look forward to hearing from our witnesses. I know we all share the same goal. We simply have to stem this tide. We must do more and we must do better to reduce drug abuse, to help those struggling with addiction, to keep heroin out of the hands of our children and to stop those who are trafficking and selling these dan-

gerous drugs. We have to do better to train and equip those on the front lines—our doctors, our pharmacists, our first responders and our law enforcement personnel.

With that, it is my great pleasure to introduce Dr. Leana Wen, Baltimore City's Health Commissioner. Since January 2015, Dr. Wen has been responsible for heading up the Baltimore City Health Department, an agency dedicated to promoting health and improving well-being. In this role, she has led implementation of Baltimore City's opioid overdose and prevention and response plan, which includes street outreach teams to target individuals most at risk, training new police officers and lay people on Naloxone use and launching a new public education campaign.

She has not had an easy job. She directed the city's public health recovery efforts in the wake of Baltimore's civil unrest after the death of Freddie Gray. For that, the city and I are extremely grateful. Dr. Wen is a board-certified emergency physician and a Rhodes Scholar who has served as a consultant with both the World Health Organization and the Brookings Institute.

Baltimore City is lucky to have Dr. Wen, and I'm so pleased she's here today to inform the HELP Committee about the efforts underway in Baltimore City to combat this opioid and heroin epidemic.

Senator MIKULSKI. For our very distinguished panel, I have a question related to prevention. First, when we talk about treatment, whether it's the abstinence approach or a medically supported approach, That's to be determined by a clinician. In this country, choice often—we need choice on what works for that particular individual. We salute both methods. My question is this.

Dr. Wen, you talked about how to respond, the great hotlines, stabilization centers, and all this. How do we stop or prevent someone from getting on heroin or opiate addiction in the first place? Because these are all after the fact.

Dr. WEN. Thank you, Senator Mikulski. The first thing that we need to do for adults, in particular, is prescription opioid awareness and understanding that this is something that we can all do something about. I actually didn't know—my confession—when I'm trained in emergency medicine and when I first started practice as well, I'm not sure that I thought about what is the impact of what I'm doing. Somebody comes in with dental pain or back pain, and it was just natural that we prescribed Percocet or oxycodone or something else.

It wasn't until a patient of mine overdosed on medications that I prescribed him—

Senator MIKULSKI. Dr. Wen, I have 5 minutes, so what's the recommendation?

Dr. WEN. Thank you. I would say—

Senator MIKULSKI. I don't mean to interrupt your very compelling story, but—

Dr. WEN. Thank you. My recommendation for prevention is that we also focus on breaking the cycle as early as possible, specifically by providing mental health support and counseling and trauma support in our schools. We do crisis interventions relatively well in Baltimore and in other places. We at least have the services. We do not have screening for trauma, and we do not have support for every child and every parent who needs mental health help.

Senator MIKULSKI. I want to come back to the schools. You just said trauma in the schools and so on. Baltimore has been through a gritty time, but so has Chicago, and so have other communities. Are you saying that our children—are we talking about domestic violence? Are we talking about trauma in the community?

What the schools and the teachers and parents tell me is that for many of our children, it's like post-traumatic stress because of the violence around them. Is this what you're talking about?

Dr. WEN. Yes, it is. I spoke recently to a group of 8-year-olds, 10-year-olds, and every single one of them, without using the word, talked about the trauma that they experienced, not only trauma of seeing someone shot or killed in front of them, but also the trauma of being homeless, the trauma of being poor, the trauma of not knowing their parents, the trauma of having their caregivers being addicted to drugs. That is the trauma that we must recognize and treat, not only seeing people as the perpetrators of violence or something wrong with them, but rather how can we focus on preventing the trauma and then intervening early.

Senator MIKULSKI. Mr. Spofford, you went down a really rough road. What would your ideas be for prevention? Because you talk about young people as well and children.

Mr. SPOFFORD. My ideas are pretty simple and direct. The young people today don't understand the effects of heroin, and they don't understand the effects of prescription opioids. When they're 13, 14, and 15 years old, which is what we see when they're being introduced to this, they don't—they think so narrow-sighted, that, hey, it's a party, it's—my buddy brought this bag over. Let's try it. Let's get high.

What they don't know is—the information they don't have is in that decision, it's a game changer for the rest of their life, and that the addictive power of heroin, even at that age, is going to grab them the majority of the time and create a lifelong addiction.

Senator MIKULSKI. You were a young adventurous guy. How do you intervene without seeming schoolmarmish, nanny, whatever, to be able to get young people to pay attention and not feel it's just one more thing where we're lecturing them to be good, to which they then often rebel against?

Mr. SPOFFORD. What we do in my area is myself, for a long time, as well as graduates of our program and other young people that are in recovery, carry prevention efforts into our local schools. It's not a clinician with a master's degree and 20 years in the field. It's a 25-year-old that has been sober for a couple of years and has actually lived that and sharing their experience, and they have a little more cool appeal to them, and they'll listen to them a little easier.

Senator MIKULSKI. Cool appeal. Cool appeal is good, very good.

Mr. SPOFFORD. Yes.

Senator MIKULSKI. Thank you.

Madam Acting Chair, Dr. Wen's testimony—and it's also a part here—the mental health needs of children are really significant, and we need to start really paying attention to what we're doing about mental health in our schools. Thank you for the time.

Senator COLLINS. Senator Hatch.

STATEMENT OF SENATOR HATCH

Senator HATCH. Thank you, Madam Chairman.

I want to thank each of you for being here today. You've given a lot of information to us. In 2000, Senators Biden, Levin, and I authored the Drug Addiction Treatment Act, the DATA Act, which permitted physicians to apply for a license to prescribe buprenorphine as a treatment for opioid addiction up to 30 patients.

Then, in 2006, we co-authored the Office of National Drug Control Policy Reauthorization Act, which would extend the limit to 100 patients. In August 2015, I joined with Senator Markey and others in a bipartisan group of 11 other Senators in writing to HHS Secretary Burwell to call on the agency to use its full authority to raise that cap on the number of patients that a physician can treat with medication-assisted therapies, including buprenorphine. HHS has announced that they're considering that.

What would be your recommendation? Let's start with you first, Dr. Wen.

Dr. WEN. First of all, thank you, Senator Hatch, for your advocacy on this important issue. Buprenorphine along with methadone is first-line treatment, according to the World Health Organization and many of our other addiction societies. We absolutely—

Senator HATCH. I understand that. What would be your recommendation with regard to physicians?

Dr. WEN. There is no other medication for which there is a cap on how many prescriptions or how many patients—

Senator HATCH. You would take the cap off?

Dr. WEN. I'm sorry?

Senator HATCH. You would take the cap off?

Dr. WEN. I would take the cap off, and I would also encourage other prescribers, nurse practitioners and others, to be able to prescribe this medication.

Senator HATCH. Dr. Valuck.

Mr. VALUCK. Yes, Senator Hatch, we would also support removing the cap—anything we can do to increase access to all forms of treatment, including, but not limited to medication-assisted treatment.

Senator HATCH. We fully appreciated your testimony as a former user. What would your recommendation be?

Mr. SPOFFORD. I would not remove the cap.

Senator HATCH. That's good.

Dr. Wen, I understand that you have some contact with my home State of Utah. Your mother graduated from Utah State University. She's a proud graduate from there. We're really proud of you and your family and what you've been able to do. It's remarkable what a small world this really is.

As the author of DATA 2000 and subsequent legislation that shaped the structure under which physicians prescribe buprenorphine, I'm keenly interested in ensuring patients have access to the treatments they need to succeed in this battle against heroin and prescription drug addiction.

How have medication-assisted therapies, including buprenorphine, been integrated into your strategies for combating prescrip-

tion drug abuse in Baltimore? Also, have you seen any need for expanded access to buprenorphine?

Dr. WEN. Very much. Anecdotally, we have seen, Senator, individuals come all the way from the Eastern Shore or from other States asking our providers in Baltimore City to accept them. Of course, because of the cap, they are unable to. We know that the demand for buprenorphine treatment, in particular, far outstrips the supply that we currently have at the moment.

For us, it is very important that medication-assisted treatment is only one part of the treatment, as you mentioned, that psychotherapy has to be a part of it, along with community resources. That's the part that currently is not being reimbursed by Medicaid or by, really, any other forms of insurance, and so we depend on State and Federal grants to get recovery housing, to get peer recovery specialists, and others and case management. That's part of our strategy.

Senator HATCH. Those are good points. I was encouraged by Secretary Burwell's announcement that HHS will be taking steps to revise the regulations relating to the prescribing of buprenorphine and containing products.

However, some view the prescribing of medication-assisted treatment as simply adding more opioids into circulation. As access to treatment such as buprenorphine is appropriately increased, what efforts should be made to reduce the stigma associated with these therapies?

Dr. WEN. I would also hope that there is a national campaign that would be launched to put a spotlight on this issue, that addiction is a disease, that recovery is possible, and that we have to begin to seek treatment now. That treatment could include medication-assisted treatment, but, again, together with other community resources and psychosocial support that is needed.

Senator HATCH. What is your biggest hurdle with the State and local level to help people obtain treatment and comply with their treatment plans?

Dr. WEN. Compliance is not a problem in Baltimore City. Our compliance—our relapse rates for individuals who are on medication-assisted treatment is less than 10 percent. The main issue is getting access to treatment, that individuals have to wait weeks or months, and in that time, if they can't get access to treatment, they end up using drugs, because they're losing that high, they're addicted, and they have to have something to tie them over. It's getting access. That's the most important thing, not the retention in treatment.

Senator HATCH. Thank you. My time is up, but I want to thank all three of you for being here and highlighting these very, very serious problems.

Senator COLLINS. Thank you.
Senator Franken.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. Thank you, Madam Chair. What an important hearing.

Thank you all for your testimony, and we've seen a divergence in opinion on abstinence versus medication therapy. On another

area which is on mental health and especially in young people and kids and looking at trauma, I couldn't agree more, and that's why I'm very happy that in the new ESEA bill that we got mental health in the schools included.

This whole issue of providers, whether it be with alternate medication or with abstinence, this is a huge issue in terms of providers and mental health and addiction. Mr. Spofford talked about naloxone saving his life on a number of occasions, it sounds like. This was approved by the FDA first in 1971 as an injectable medication used primarily in hospitals to reverse drug overdoses. In the wake of the burgeoning opioid epidemic, demand for naloxone among first responders and other community members has soared. Unfortunately, so too has the cost.

Dr. Wen, in your testimony, you describe how the price of naloxone quadrupled. In Baltimore and Minnesota, naloxone kits which contain two doses cost about \$160 each. Healthcare providers and first responders are finding that they have to scale back their efforts or make crude calculations about who they will prioritize and equip with naloxone, and I don't think it should be this way.

In some prescription drug cases, like the famous Turing Pharmaceutical, we saw a 5,000 percent increase in the price of drugs. More and more, we're seeing corporations make profits on the backs of patients.

Dr. Wen, can you provide more information on how these price increases have affected your work to prevent overdose deaths?

Dr. WEN. Thank you, Senator Franken. The rising price of naloxone is significantly, hugely impacting our work. In the last year alone, the price of naloxone has nearly quadrupled in Baltimore, which is crazy. This is a generic medication that is on the list of the World Health Organization's list of essential medications. This is available by dimes in other countries, so why is it that as the demand has increased in our country, the price has increased so much?

For us, we have about 3,000, for example, police officers. We would love to be able to equip each of them with naloxone, but we're only able to pay for about 300, so we have to pick and choose which of our police officers will be getting this medication. Similarly, we have outreach workers who work in all types of places, who do home visiting, and we cannot equip them because we cannot afford it in the city.

I hope that this is something that the Federal Government can call for an oversight hearing to find out why is it that the price has increased. Also to not only—we have been encouraged to negotiate as each individual city and State, but perhaps it would be helpful to have the Federal Government negotiate on our behalf.

Senator FRANKEN. This is an issue we're seeing now about the price of drugs going up, of pharmaceuticals going up, and it's something we, as a Congress, have to address across the board. This is a drug that saves lives. It saved one of our witnesses life, who gave his moving testimony. If you have fewer officers who are able to carry it, someone like Mr. Spofford could have died.

These prices—anyone—what can the Federal Government do to prevent these outrageous drug price hikes? Does anyone have any specific ideas, or would you like to throw that back on us?

[No verbal response.]

That's the answer.

The opioid crisis has hit hardest among Minnesota's American Indian population. Even though American Indians represent only 2 percent of Minnesota's population, more than 28 percent of babies born addicted to opiates in Minnesota are Indian.

Melanie Benjamin, the chair of the Mille Lacs Band of the Ojibwe, called the opiate crisis the single greatest threat to her people, to their future, when she testified before the Indian Affairs Committee. At the same time, that opioid crisis is intensifying in Indian country. There are, again, few treatment programs that incorporate a cultural component.

Mr. Valuck, in your testimony, you describe how you've collaborated with Federal, State, and regional stakeholders to create tailored interventions to combat the opioid epidemic. I know there are a number of Indian tribes in Colorado. Have you engaged in collaborations with tribes, and how have you leveraged the input from native Americans or other underserved groups to develop effective culturally based interventions?

Mr. VALUCK. Thank you, Senator Franken. In Colorado, as an example, we have tried to identify local and regional issues and approaches. One example of that is in the south central part of Colorado, there's an area called the San Luis Valley. It's a six-county region that's bordered, entirely encircled, by large mountain ranges and requires several hours of driving to get outside of the San Luis Valley.

We've worked with leaders there to help assist in their development of prescribing guidelines, collaborations with schools and other community agencies, tapping into the resources of the Area Health Education Center, or AHEC system that exists around the—

Senator FRANKEN. This is tribal land?

Mr. VALUCK. This is not tribal land, but, again, it's an example of where we're trying to develop a local solution for this particular community that's largely a migrant, agricultural community in Colorado, to develop solutions that work in that specific area.

Senator FRANKEN. OK. I'm very sorry, Madam Chair, that I've gone well over my time. We'll get back—

Senator COLLINS. We do have a vote at 11:30, so I want to make sure everybody gets time. Thank you.

Senator FRANKEN. I apologize. Thank you for your indulgence.

Senator COLLINS. Thank you.

Senator Scott.

STATEMENT OF SENATOR SCOTT

Senator SCOTT. Thank you, Madam Chairwoman.

Thank you to the panelists for being here today.

Dr. Valuck, in South Carolina, we certainly are seeing what I consider an epidemic. I think it's from 2012 to 2014, we had about 8,000 patients who were treated in the emergency room about 10,000 times for opioid dependency. We had about 2,500 patients

who were treated 3,000 times in the ER for overdose. We've certainly seen a real campaign for the crackdown on over-prescribing.

The question I have is how do we, on the front end, prevent this rising challenge from occurring in the first place? Certainly, I know we look at how we treat addiction in the aftermath. My question really is are there key signs or things that we can do to help prevent it on the front end?

Mr. VALUCK. Thank you very much, Senator Scott. We believe that prevention hinges on doing education, both broadly—the general awareness of the public and the provider communities—but moving most of our educational efforts to those who are youth and young adult age, knowing where things start and what the consequences are that you point out.

We are advocating for increased SBIRT-like approaches—screening, brief intervention, and referral—in the school systems, and, last, focusing on—in our next wave of block grant money, focusing on positive youth development approaches in Colorado, shifting away from shaming and blaming kinds of approaches to positive youth development as alternatives to substance use, and we believe that's where the prevention activities will be best and most successful.

Senator SCOTT. Thank you. To the panel—and I'll start with Mr. Spofford—in South Carolina, we had about 516 people die in 2014 because of overdose. Around 2008, we only had about 250 folks die. We've seen an explosion in the deaths.

What can we do better, and what tools outside of treatment for addiction should we be looking for to address some of the challenges? My previous question to Dr. Valuck about how we on the front end eliminate this as the reality that we're seeing—how do we do that?

Mr. SPOFFORD. As it concerns the explosion and overdose deaths, fatalities, that your State has had, so has ours. I would assume that it's probably somewhat safe to say that that's directly related to the fentanyl. Increasing those sentencing laws for fentanyl and force—as sad as this may sound—forcing those drug dealers back into actually selling heroin and not something that's killing as many people is the first round.

Increasing the naloxone availability to prevent deaths—if you're talking solely on how to prevent people from dying from opioid addiction, fentanyl is killing people. Very rarely do you see anyone die from heroin and heroin alone. It's a combination of heroin and other drugs that has been what we've seen the most for overdose deaths in past years, and then recently with this upward spike of overdose is the fentanyl.

Senator SCOTT. Last question. There's a rule of nature in, of course, Colorado, New Hampshire, and South Carolina, so access to treatment is very difficult. Do you see bridges to take care of that problem or at least mitigate the concerns that we have in the rural areas of our States? Anyone on the panel?

Dr. WEN. Thank you very much, Senator Scott. Even though I don't practice or work in a rural area, we still have many challenges in our urban setting of not having enough access. That's why we are proponents for allowing cities and States that know

their own jurisdictions the best opportunities to innovate, including with telemedicine and telehealth.

There might be opportunities to work within ERs to do rapid buprenorphine induction within the ER setting. There might be other opportunities to work with peer recovery specialists and other models that may work best for those settings. We hope that those models will also be explored for potential funding and then Medicaid reimbursement.

Senator SCOTT. Any other comments?

Mr. SPOFFORD. Yes, to increase access to treatment. In my home State of New Hampshire, if you have Medicaid insurance, you're looking at a 4- to 8-week wait list to get a bed in a residential program. The reason for that is because of the day rate of the reimbursement for Medicaid. It's, quite frankly, unreasonable.

I ran a pro-forma for my own treatment center, and if I kept all of my beds filled with Medicaid reimbursements, it would cost me twice the amount of the income that would come through the door to be reimbursed. Maybe examining the reimbursement rates for the day rate of treatment would encourage treatment providers to open up more availability.

Senator SCOTT. Thank you.

Thank you, Madam Chairwoman.

Senator COLLINS. Thank you.

Senator Baldwin.

STATEMENT OF SENATOR BALDWIN

Senator BALDWIN. Thank you. I very much appreciate our Chairman and Ranking Member for holding this hearing and our Acting Chairman and Ranking Member for continuing it and our witnesses today.

Certainly, in the State of Wisconsin, we are experiencing the epidemic, both with regard to prescribed opioids and heroin. I wanted to just briefly mention that what has been particularly troubling to me in our State is the dangerous misuse of opioids in treating veterans at some of our VA facilities, including the VA hospital in Tomah, WI, where Marine veteran Jason Simcakoski passed away while in inpatient treatment of mixed drug toxicity.

His story and his family's willingness to turn tragedy into action inspired me to author the Jason Simcakoski Memorial Opioid Safety Act with Senator Capito of West Virginia to reduce the misuse of opioids and improve pain management training among practitioners who care for our Nation's veterans. We hope, in another committee, to see that measure advance forthwith.

I hope to get to several questions, so I ask for your answers to be as brief and specific as possible. With regard to access to opioids through prescriptions, you've talked a lot about databases and monitoring. You've talked a lot about improving the education and preparation of our prescribers.

I am interested in knowing the impact you think that the—what they call the fifth vital sign—that adding to the pulse, the blood pressure, respiration, and temperature, that there would be an assessment of every patient's pain level—what impact that had on our rising rates of prescriptions of opioids and this epidemic.

Dr. WEN. Senator Baldwin, unfortunately, that had a huge impact on physicians' understanding of pain and also patients' treatment of pain. Getting pain free is not necessarily the right outcome. If you fall down and you bruise your knee, you're going to have pain.

For us to say the goal is to take your pain to a 0 out of 10, what does that mean? Or also even if a patient comes in with 10 out of 10 pain, but they're texting on their phone—what does 10 out of 10 pain mean? It is important for us to discuss what our policy metrics should be that do take into account adequate treatment of pain but don't make that the single focus.

Senator BALDWIN. Any other comments on that question before I move on?

[No verbal response.]

I wanted to dig a little bit more deeply into things that I've been reading about use of methadone in treatment of addiction. As I understand the drug—and I am a lay person in terms of my reading—the sort of high or the euphoric effects of methadone wear off more quickly than the respiratory depressant impact of methadone, that that lasts longer and, therefore, that has some real implications in the medicine-assisted treatment of abuse.

We have actually—according to the CDC, methadone accounts for only 2 percent of prescription painkillers, but is responsible for a significantly higher number of overdose deaths. Where does that fit in with some of the other drugs that are being used in the treatment of addiction?

Dr. WEN. I wish to distinguish between the use of methadone for pain and the use of methadone for medication-assisted treatment for opioid addiction. For pain, it is true that methadone has a high risk of overdose, and because of them—and also there are effects, the euphoric effects and so forth, that then lead to methadone being abused as a recreational drug.

On the other hand, individuals who are on long-term medication-assisted treatment, including with methadone or buprenorphine, are stably maintained, and so they do not experience the high. That said, individuals on buprenorphine have a much lower rate of overdose than individuals who are on methadone. This is the reason why we believe that buprenorphine access should be encouraged.

Senator BALDWIN. It would be interesting to see—I don't know if the CDC has a breakdown of what the initial prescription of methadone was for, whether for the medically assisted treatment or the pain.

I have one last question I want to get into the record for followup. I'm very interested in knowing about the shocking uptake in fentanyl abuse and where it's coming from. Is this being diverted from prescriptions? Is this something that people are bringing in illegally? What are the sources?

Mr. SPOFFORD. It's being brought in illegally and cooked in underground labs by Mexican cartels.

Senator WHITEHOUSE. A question for the record means you all have the opportunity to answer in writing.

Senator COLLINS. I should have explained that. Thank you.

Senator Cassidy.

STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. Thank you all. I have several questions. I'm a physician, so I'm going to take this—we want actionable items. We want to think about something that we leave from here and we can say, "Wow, this is something that maybe legislatively we can do."

Mr. Valuck, Congress in the past has appropriated lots of money for prescription drug monitoring programs, where every doc, theoretically, who writes a controlled substance, it goes into a database. The pharmacist can see—"Oh, my gosh. Is this person doctor shopping, getting prescriptions from everybody else?"

I've learned recently, though, that VA facilities do not automatically integrate into such databases, nor do necessarily neighboring States. To what degree are you all using in Colorado the PDMPs? What is their usefulness, and what can we do so that the VA in Denver, if it's ever built, can actually—the provider can seamlessly know whether or not the prescription that he or she is prescribing is for someone doctor shopping, et cetera?

Mr. VALUCK. Thank you very much, Senator Cassidy. Yes, we view PDMPs as a crucial tool in the fight against prescription drug abuse. The things we have achieved through just mandatory registration, where every provider and prescriber and pharmacist must have an account, has even within 1 year gone from 20 percent to 94 percent—

Senator CASSIDY. Do you mandate that every controlled substance prescribed and filled is put into the database?

Mr. VALUCK. Yes. Everything must be in the database, and—

Senator CASSIDY. If someone is in a neighboring State and not licensed in Colorado, can they access that PDMP?

Mr. VALUCK. There are two ways they can do that. One, they may apply for an account with our PDMP and be granted one through our Department of Regulatory Agencies. To the extent that States are now increasing their participation in the NABP Interconnect program, which is a sharing program, about 22 or 23 States are now sharing data and going through a single hub to be able to access this on a multistate basis. More and more States are joining because—

Senator CASSIDY. What about the Veterans Administration? Are they automatically in your system?

Mr. VALUCK. We passed enabling legislation, but as a State, we could not—obviously, we could not require that they report.

Senator CASSIDY. On a Federal level, if we, at a Federal level, had the VA granted access, provided those resources, that would be something tangible we could do to benefit those patients. Fair statement?

Mr. VALUCK. That would help, yes.

Senator CASSIDY. Mr. Spofford, I am struck. You've got frontline therapy of a guy that knows how people get drugs. These are controlled substances. A physician is writing the Rx. Tell me that process—and we have a short period of time. If I interrupt, I don't mean to be rude.

Mr. SPOFFORD. Prescription?

Senator CASSIDY. Correct.

Mr. SPOFFORD. Most recently, things have moved down to south Florida. They have pain pill mills. If you drive through from West Palm Beach to Miami, almost on every corner you'll see a pharmacy—

Senator CASSIDY. In Florida, they're getting the pills and they're bringing them all the way to New Hampshire?

Mr. SPOFFORD. There's crews of kids and drug dealers that take trips with fake MRIs and go down and doctor shop—20 doctors, 20 pharmacies, none of which are connected in southern Florida. They take the trip once a month and flood the streets of New England.

Senator CASSIDY. Going back to you, Mr. Valuck, if we have this PDMP, you should be able to do a frequency analysis and see which docs are prescribing, because I have to put my DEA number every time I write an Rx, a prescription. You should be able to use that database to say, "This doctor is prescribing in the third standard deviation. Let's investigate that doctor, in particular." Is that what is done in Colorado, or do you leave that up to DEA?

Mr. VALUCK. That, we leave up to DEA or complaints, or law enforcement can have access to the database, but only pursuant to a subpoena or a court order to do that. We have the concern that there may be physicians that are doing what you said and doing so in a way that would be considered inappropriate. There may be pain physicians who are treating a large number of patients.

Senator CASSIDY. I accept that, but when I write my prescription, they know whether I'm an oncologist, a pain doctor, or whether I just happen to be an FP, and they also know if I'm licensed in four States, and I'm rolling between them.

Mr. VALUCK. To some extent, but the specialty information is sketchy, and varies State by State.

Senator CASSIDY. I always think that if Google had this information, they'd be able to figure it out in about 3 minutes, and I'm probably being unfair to Google. It does seem as if this is something DEA should do. If we are going to—if all you've got to do is look on a controlled substance database and figure out who is writing two prescriptions a minute and whether or not they're a pain doctor or an oncologist or not, it seems like we should be able to do so.

I yield back. Thank you.

Senator COLLINS. Thank you.

Senator Warren.

STATEMENT OF SENATOR WARREN

Senator WARREN. Thank you, Madam Chair.

The opioid epidemic is a health crisis. In Massachusetts alone, there were more than 1,000 confirmed opioid-related overdose deaths in 2014. That is a 63 percent increase from just 2012. Fighting this epidemic will take smart, creative ideas like the efforts of Chief Campanello of the Gloucester Police Department. They have an Angel Initiative that ensures that anyone who enters the police station and asks for help with drug addiction receives it without getting arrested.

Dr. Wen, how does this type of initiative save both our justice system and our healthcare system money and at the same time save lives?

Dr. WEN. Thank you, Senator Warren. Chief Campanello actually just came to visit us in Baltimore yesterday—

Senator WARREN. Oh, good.

Dr. WEN [continuing]. And so we had a chance to learn about his approach. We know that addiction is a disease. We know that we're not going to be arresting our way out of it, that we also have to provide treatment. Providing this no round door, decreasing barriers into treatment, is critical. I very much applaud the initiatives in Massachusetts.

I wish to add, though, that there are two other components, which is that there must be enough treatment options so that when somebody comes to the police department or the ER or somewhere else for help that they must also be connected into treatment at that time, immediately, not wait 3 weeks or 4 months or something, but be connected immediately, and also that there are continued community support services that are also reimbursed, that we must be reimbursing our community health workers at the rate that they deserve, and also that we must have reentry services and housing and other support that is critical for individuals with addiction.

Senator WARREN. Good. Excellent points, but we've got a good entry point here with the Angel Program. This Gloucester program is a great example of local leaders understanding what it takes to treat substance use disorders on the ground. It takes hard, compassionate work by law enforcement, by medical professionals, and by members of the community.

The Federal Government also needs to help here. For example, the National Institute on Drug Abuse estimates that over 70 percent of adults who misuse prescription opioids get the medication from friends or relatives, meaning many patients receiving these prescriptions aren't using all of the medications that were prescribed for them. States like Massachusetts are considering policies that would allow opioid prescriptions to be dispensed by pharmacies a few days at a time—it's called a partial fill—so that patients don't receive more drugs than they will actually use.

Professor Valuck, how could the use of partial fill policies help to prevent opioid misuse and abuse?

Mr. VALUCK. Thank you very much, Senator Warren. We believe that all policies related to prescribing and dispensing of opioids should balance the desire and the need now to reduce abuse, misuse, and diversion, while at the same time not putting up barriers for people who have legitimate medical need for those drugs.

It becomes, in our view, an issue for the physician and the pharmacist to determine what is appropriate at the time for that patient to receive, and that it may not be something that, for any given patient, we can say what that optimal quantity might be.

Senator WARREN. What we're looking for here, obviously, is to have fewer loose drugs around. Current DEA regulations are silent on whether partial fills are allowed outside long-term care facilities or an acute pharmacy shortage. States that want to implement these policies don't know for sure if they're legal. I'll be sending a letter to the DEA with Senator Markey to request that the agency clarify these regulations.

It is important to reduce the amount of unused medication out there, and that means people also need to know how to dispose safely of their excess opioids. But here's a problem. The FDA, the EPA, and the DEA all have different recommendations on how to do this. While all the agencies highlight that the ideal plan is to take them to a police station or pharmacy for collection, there are varying recommendations about whether or not to throw them in the trash, the best way to do so, whether to flush them down the toilet, and so on.

Dr. Wen, can you clarify how people should dispose of their unused drugs?

Dr. WEN. Thank you, Senator Warren. The answer is do not flush it down the toilet, don't throw it in the trash can, but take it, ideally, to a permanent drop box. We just implemented in Baltimore City a couple of weeks ago, actually, nine permanent drop-off areas all at our police stations across the city. They are 24/7, no questions asked, which is critical because you do not want to be arrested while you're bringing these drugs back.

I also want to emphasize that this is not only important for prescription opioids, but also for any medications. I've seen 2-year-olds take their grandparents' high blood pressure medications or insulin and also overdose on those and die as well.

Senator WARREN. I thank you very much for that answer. Federal agencies need to coordinate—

Senator COLLINS. Senator Warren, I apologize for interrupting you, but the vote has started. You're over your time, and we still have two more people. My apologies.

Senator WARREN. That's quite all right.

Senator COLLINS. Let me say that the hearing record will remain open for 10 days, and if members have additional information or questions for the record, they can submit those.

Senator Casey.

STATEMENT OF SENATOR CASEY

Senator CASEY. Madam Chair, thank you. I'd ask consent to submit a full statement for the record.

Senator COLLINS. Without objection.

Senator CASEY. Thanks very much.

[The prepared statement of Senator Casey follows:]

PREPARED STATEMENT OF SENATOR CASEY

Thank you, Chairman Alexander and Ranking Member Murray, for holding a hearing today on this critical issue. Opioid abuse is a crisis that is engulfing families, public health professionals and law enforcement throughout the Nation. Right now, my own State is a national leader where we don't want to be—in the number of drug overdoses occurring each year. According to the Drug Enforcement Agency, Pennsylvania ranks ninth highest for drug overdose deaths in the Nation, at a rate of 18.9 per 100,000 people. According to the Centers for Disease Control and Prevention, more Pennsylvanians now die from drug overdoses than car accidents.

Prescription opioid and heroin abuse is not limited to certain kinds of communities, a fact that is illustrated both by reports in

the national media and hard data gathered by law enforcement agencies. An August 23 headline from the *Washington Post*, focusing on events in Washington County, PA, read “The Heroin Epidemic’s Toll: One County, 70 Minutes, Eight Overdoses.” The article describes how, in a period of just under 70 minutes, there were eight overdoses in a county of about 200,000 people. In 24 hours there were 16 overdoses. In 2 days, there were 25. Three people died. Meanwhile, a recent DEA report for Pennsylvania included a county-by-county summary of overdose deaths per 100,000 people. Although these statistics relate deaths from all drugs, heroin is a major contributor. What strikes me about this data is that the largest number of deaths are in Philadelphia, Susquehanna, Cambria, Fayette and Wayne counties. Although Philadelphia County is urban, the other four counties are mostly rural or made up of small towns. This is the nature of the problem, in Pennsylvania and throughout the country.

There is no simple solution or law that Congress can pass to fix this problem, but there are commonsense steps that we can take to identify and attack the roots of the opioid crisis in this country. I am a cosponsor of several pieces of legislation that would move us in the right direction. These include a bill called the TREAT Act, introduced by Senator Markey, that would expand the ability of physicians and nurse practitioners to prescribe buprenorphine, which is used to treat opioid addiction, as well as another of Senator Markey’s bills, the Treatment and Recovery Investment Act, which would increase funding for the Substance Abuse Prevention and Treatment Block Grant. I am also a cosponsor of legislation introduced by Senators Toomey and Brown that would prevent doctor and pharmacy shopping for at risk Medicare beneficiaries.

Congress has already taken one important step by passing the Protecting Our Infants Act, and I am grateful to this committee for moving quickly on the legislation. I am pleased that the Protecting Our Infants Act, which I introduced with Senate Majority Leader Mitch McConnell, was recently signed into law. This new law will address one of the tragic consequences of the opioid epidemic, the growing incidence of Neonatal Abstinence Syndrome, which occurs when infants are born in withdrawal from opioids taken by their mothers. The law requires the Department of Health and Human Services to develop a strategy to address research and program gaps on prenatal opioid use and Neonatal Abstinence Syndrome. However, although passage of this legislation promises to be a critical achievement for helping infants born in withdrawal, I am also aware of ongoing concerns around States’ implementation of Plans of Safe Care for these infants under the Child Abuse Prevention and Treatment Act. I hope that this committee will take steps to address these concerns as part of our larger strategy on opioid abuse.

Far too many of our local communities are struggling against the rising tide of prescription opioid and heroin abuse, and far too many families are being torn apart. I look forward to hearing from the witnesses on how we can combat opioid abuse in my own State and throughout the Nation.

Senator CASEY. Like a lot of States that we’ve highlighted today, Pennsylvania is not immune. In fact, unfortunately, the problem

has gotten as bad in Pennsylvania as probably anywhere in the country, most of it heroin. Maybe one headline would summarize it. This is a headline from the *Washington Post*, but it's about Washington, PA, the headline reading, "The Heroin Epidemic's Toll, One County, 70 Minutes, Eight Overdoses." Then it goes on to tell how many overdoses within a 24-hour period. Three of them were deaths.

Looking at a summary of various county data in Pennsylvania, what struck me about the number per 100,000 in terms of deaths—these are drug-related deaths—I realize a larger category—but most of them, in fact, the top five, I believe, are all heroin. It starts with Philadelphia, which fits a stereotype that it's a big city problem. The next four counties, Susquehanna, Cambria, Fayette, and Wayne are all small counties, substantially rural, and where it's not rural, it's mostly small town. This is the nature of it in a State like ours, and I know that's true across the country.

I'll start with Mr. Spofford. I want to ask you about young people and kind of your message to them. The first question is more technical, about insurance providers. I'm told that insurance providers often fail to reimburse stays at inpatient treatment facilities in a way that allows professionals to meet their standard of practice for treating their patients. Have you run into this issue of insurance coverage for that kind of treatment?

Mr. SPOFFORD. Almost every day.

Senator CASEY. That's something that we've got to address. Any recommendations you want to send to us or transmit to us, we'd appreciate that.

The second part—and only because we're—I'm going to go less than my time, probably, because of the vote. Young people—you went down a path that you described here today, and I can't even imagine how horrific it was. What do you say to young people? Or if you had a group of young people in front of you today who have started down that path, especially as it relates to the use of Oxycontin or something similar, what would you say to them?

Mr. SPOFFORD. If it was pre-use or no addiction was present, the education of what that path consists of and the addictive power of prescription opioids and heroin is incredibly important. For anyone who has started using, just conveying the message that hope is absolutely available and people do recover, we do get better, that sobriety and recovery is achievable.

Senator CASEY. If they've started on Oxycontin, where should they go? What should be their first step if they're listening to you?

Mr. SPOFFORD. Treatment.

Senator CASEY. Treatment?

Mr. SPOFFORD. Yes. By that time, it's gone too far. It's a bigger problem than most people realize, and they really need to be in treatment.

Senator CASEY. Thank you.

Dr. Valuck, I wanted to ask you—and, Dr. Wen, I might have to submit yours for the record. When you were developing best practices in connection with the provider education work group, were you able to determine, or did you attempt to determine this fundamental question, which overlays all of this, which is the question

about physicians, why some physicians are over-prescribing various opioids?

Mr. VALUCK. Thank you, Senator Casey. We, again, have tried to take an evidence-based approach and move to a discussion where we know we're downstream now, dealing with consequences, and trying to shift the discussion upstream to not only proper choices and what are the choices for prescribing, but how is pain better recognized and diagnosed and framed, as Dr. Wen duly noted. We're trying to move the discussion upstream into the decision-making about what the pain is, how pain can be treated in various ways, what the expectations would be, and to try to better manage expectations to deliver better care.

Senator CASEY. Thank you very much.

Senator COLLINS. Thank you very much.

Senator Whitehouse, I'm going to tell you that we have 3 minutes left in the vote, so if you don't mind, I'm going to thank our witnesses and allow you to ask your questions and close out the hearing without me.

Senator WHITEHOUSE. Subject to my questions, that's fine. I'm happy to close it out.

Senator COLLINS. Thank you. I appreciate that, never having missed a vote.

Senator WHITEHOUSE. Yes, you should not. Please go.

Senator COLLINS. Thank you to our witnesses.

Thank you, Senator.

STATEMENT OF SENATOR WHITEHOUSE

SENATOR WHITEHOUSE [presiding]. As I think everybody has said about their home States, Rhode Island is seeing this plague—239 deaths in 2014, which is more than homicides, more than suicides, more than car wrecks, indeed, more than all of those things combined. We're focused on this.

One of the areas where we could be helpful in this committee is to look at the problem of the coordination of prescription drug monitoring programs. Each State has one. They have very different funding sources. They have very different rules. Access to them is to very different groups. Prescribing practices are extremely helpful, but I also think some monitoring is important.

What would your suggestions be for getting some degree of commonality and some better coordination between different States' prescription drug monitoring programs? I say this as one of the 16 States that received the grant, and I hope that executive process will encourage better collaboration and coordination, but there's stuff we could do as well.

Dr. Wen, you first, then Dr. Valuck, then Mr. Spofford.

Dr. WEN. Thank you, Senator Whitehouse. I'd like to add my perspective as a practicing emergency physician, as well, one who has used our PDMP in different States, to talk about what the barriers might be. In theory, PDMP—all physicians support the idea. We would love to be able to look up the PDMP—

Senator WHITEHOUSE. Every State is different, and they don't talk to each other well.

Dr. WEN. That's right.

Senator WHITEHOUSE. How do we fix that problem?

Dr. WEN. I would, first of all, make each State's PDMP easy to use and have one place—ideally, one click would get us to one national database instead of having—I used to practice in DC Looking up Virginia and Maryland and DC was a lot, so having one national database. Ease of use is important.

The second thing is that most physicians are not doing bad things. We're not doing pill mills or other things. We actually don't know what our own prescription practice is. What we're beginning to do in Baltimore City is, looking at the high prescribers and sending them letters. Or if there are patients who have died who have received—

Senator WHITEHOUSE. Yes. I really want to focus on the question of coordination among the States, because that's really where we can be most useful.

Dr. Valuck.

Mr. VALUCK. Thank you, Senator Whitehouse. We support and would really love to see additional Federal support for interoperability and for physicians to be able to query, again, across multiple States. Some of the models that are happening now are collaborative and voluntary. We'd like to see some sort of way that when a physician queries or a pharmacist queries the database that they are getting an all 50-State query, whether that's a national database or a connected network of all 50.

Senator WHITEHOUSE. Should we be reviewing whether 42 CFR, Part 2, and its privacy provisions are an impediment to coordinated care?

Mr. VALUCK. To the 42 CFR, Part 2, question, that is a very difficult one. We absolutely want to protect patient privacy and the data, but we also want to—

Senator WHITEHOUSE. We also want to coordinate—

Mr. VALUCK [continuing]. Encourage coordinated care and being able to do that. We have found in Colorado that physicians and other providers don't well understand what is and isn't permissible under 42 CFR 2 and tend to take an approach of if there's a question, we'd rather not share and potentially risk anything. It may be hindering the cooperation that we want to have happen. Clarification about 42 CFR for physicians would be very helpful.

Senator WHITEHOUSE. Mr. Spofford, congratulations on your sobriety. I guess yesterday was your anniversary—so 9 years.

Mr. SPOFFORD. Thank you.

Senator WHITEHOUSE. It's amazing what you've accomplished in 9 years, because I doubt you were accomplishing a lot of this pre-sobriety, right?

Mr. SPOFFORD. That's right.

Senator WHITEHOUSE. Tell me a little bit—you run these facilities. You've got to be reimbursed. You touched on it briefly. We've tried in Congress to get mental health services, which include addiction services, treated more in parity with traditional physical health services. Do you feel you're getting paid and reimbursed in a way that is commensurate with people who are in other healthcare areas?

Mr. SPOFFORD. No, not at all. A standard of what's medically necessary for the treatment of substance abuse would be incredibly helpful. One definition that we adhere to—we see things like this.

We have, say, a 22-year-old heroin addict that's been an IV user for 3 or 4 years, and before he's able to receive inpatient treatment, the insurance company will say that he needs to fail at outpatient first. I've seen people die failing at outpatient. Continually arguing to get these——

Senator WHITEHOUSE. It's hard to imagine that taking place in a physical health setting, isn't it?

Mr. SPOFFORD. Yes, it's a little different. Then once we have them in the inpatient treatment, it's a day-in and day-out fight to get more days authorized.

The insurance company approves the initial authorization, and we get a person admitted into treatment. It then becomes this cat-and-mouse game of utilization review, fighting for more treatment, fighting for our patient to keep them engaged, with some case manager who has never even laid eyes on our patient trying to dictate their treatment and when they need to discharge and what's medically necessary for them over and above our clinician, our nursing staff, our docs, and things like that.

They'll cut treatment at 7 days. This kid's been on the street shooting heroin for 5 years. What are we going to do in 7 days?

Senator WHITEHOUSE. It's pretty much industry standard that 30 to 60 days is necessary, correct?

Mr. SPOFFORD. Should be.

Senator WHITEHOUSE. OK. Listen, time has run out. I'm the last person here. The vote is winding down. I've got to dash.

I really do thank you all for your testimony. I would ask, for the record, if you have the time and inclination, look at the Comprehensive Addiction and Recovery Act, which I have co-authored along with a great number of candidates. If you'd like to make any comments back about that bill, please take advantage of this opportunity to do so.

I know it's not in this committee. It's in the Judiciary Committee, and we are hoping to get a hearing on it early next year in the Judiciary Committee and be able to move forward. I'm sure your advice would be helpful.

Thank you all very much. The hearing record will remain open for 10 days. Members may submit additional information for the record within that time if they would like.

The committee is adjourned.

[Additional Material follows.]

ADDITIONAL MATERIAL

RESPONSE BY LEANA WEN, M.D. TO QUESTIONS OF SENATOR CASEY, SENATOR FRANKEN, SENATOR BENNET, SENATOR WHITEHOUSE AND SENATOR WARREN

SENATOR CASEY

Question 1. It sounds as though Baltimore is working hard to solve its opioid abuse epidemic, and I appreciate your efforts. As we are all aware, however, this epidemic, and the problems that are created by it, can easily cross local and State boundaries. What challenges has Baltimore faced when working with other local communities to stem the tide of opioid abuse? Are there common cross-jurisdictional hurdles that the Federal Government can help overcome?

Answer 1. Thank you for your recognition of our efforts here in Baltimore City. Our approach to the opioid abuse epidemic is evidence-based and comprehensive, and necessitates that we focus not only on what is achievable here in our city but also the multitude of local, State, and Federal-level factors that contribute to opioid use nationwide.

Naloxone accessibility and cost. One core challenge we face at the community level is naloxone accessibility, which varies even within a single city jurisdiction. Naloxone is a generic medication that is part of the World Health Organization's list of essential medications, but pharmacies vary in their stocking methods and sometimes do not fulfill prescriptions for this life-saving antidote. Additionally, the price of naloxone has dramatically increased over the past 2 years—in Baltimore alone, the cost per dose of naloxone has quadrupled—meaning that we can only save a quarter of the lives we could have saved.

This is particularly problematic for cities and counties that must purchase naloxone for use by paramedics, police officers, and other front-line workers. Manufacturers have claimed that this price increase is related to increased demand. However, it is unclear why the cost of a generic medication that is available for much lower costs in other countries will be suddenly so expensive. These challenges are not unique to Baltimore, and Congress can help overcome this obstacle by calling for investigation into the reason for the price increase. Additionally, the Federal Government should remove barriers that prohibit easy access to naloxone: for example, by making it available as an over the counter medication that is covered by both private and public insurance.

Access to treatment. Regardless of jurisdiction, we need to ensure that there are sufficient high-quality treatment options available to those suffering from opioid addiction. There are several ways that the Federal Government can impact access to treatment:

- Federal funding could expand treatment on-demand including 24/7 dedicated centers for substance addiction and mental health and proven intervention models such as LEAD and expand case management services for vulnerable individuals. These programs will help to ensure that those in need have a path to recovery.

- Congress can push for equitable insurance coverage for addiction services. Medicare pays for pain medications that can lead to addiction, yet many States do not cover medication-assisted treatment and other evidence-based interventions for addiction recovery. Congress can ensure that Medicaid, Medicare, and private payers cover on-demand treatment for acute care (such as sobering, urgent care, and residential services), as well as ongoing treatment and services like medication-assisted treatment and case management. These rates should also be equivalent to mental health and physical health care rates (which they are not currently, leading to a dearth of providers and inadequate care).

- Congress can remove barriers to prescribing Buprenorphine. Buprenorphine is a medication-assisted treatment option with a much lower chance of overdose than methadone. Importantly, it can be administered by a primary care provider rather than in a designated drug-treatment clinic. This helps to increase the accurate perception that substance use disorder is a medical condition. Unfortunately, at the moment, only medical doctors can prescribe buprenorphine, and a doctor can only provide Buprenorphine to a maximum of 100 patients. This barrier does not exist for any other medication, and significantly limits the ability of patients to access a life-saving treatment option and leaves many patients with methadone as their only option for medication-assisted treatment. Methadone requires administration in a designated treatment clinic, which are often a point of contention within the communities in which they operate due to the stigma associated with drug addiction. We strongly support current efforts underway at the Department of Health and Human Services to revise the limits on buprenorphine prescription in a given year, and urge further support of broadened access to this proven treatment including by request-

ing Congress to consider broadening prescription authority of Buprenorphine to Nurse Practitioners and other providers.

Crisis response. One of the biggest hurdles in the behavioral health system is the necessity of developing a full range of integrated crisis response services that divert people away from a criminal justice response and/or high cost inpatient services. The crisis response system serves as a major access point in the overall public behavioral health system. Because crises are defined by individuals and are also the point in time when individuals could be most willing to accept treatment for substance use disorder, having a 24/7 crisis response system is a critical component of “treatment on demand”. However, the majority of crisis response services are not reimbursable by Medicaid. Federal action to move toward reimbursement for this critical and cost saving component of a comprehensive behavioral health system would allow for more ready access to the treatment and peer support services that individuals need when they are in crisis.

Similarly, access to case management is essential for individuals facing substance abuse and behavioral health issues—particularly for those leaving incarceration or inpatient stays who are high risk and must receive wrap-around services that connect them immediately to needed medical and psychiatric assistance. These case management services have inconsistent reimbursement but there is significant medical literature linking those services to higher quality care and ultimately lowered cost. Many States have expanded their definitions of reimbursable, targeted care management to cover some aspects of these services, but the Federal Government could also explore reimbursement models via the Centers for Medicaid and Medicare.

Focus on Prevention and Stigma Reduction. Additionally, more funding for prevention services is critical to stopping the cycle of addiction. Treatment and service intervention for individuals with identified need are often seen as top funding priorities; however, investing in prevention services and tackling substance upstream is just as important. Many local jurisdictions like Baltimore have launched public education campaigns to this effect, but there is much more education that must be done in order to encourage people with addiction into care and to disband stigmas that are leading many communities to avoid providing treatment altogether. Local jurisdictions are limited by funding constraints, but the Federal Government can push for the launch of a national campaign to reduce stigma and to increase awareness of opioid addiction. This national campaign will provide the spotlight this critical issue requires.

Question 2. I am aware of the terrible toll that prescription opioid and heroin abuse can have on families, including children. When parents reach out to local governments for help with their opioid addiction, what extra actions need to be taken to ensure that their children do not fall through the cracks? Are there steps the Federal Government can take to assist in these efforts?

Answer 2. As mentioned above, access to comprehensive treatment services and supports are crucial for any individual impacted by opioid misuse. Essential actions include the following:

- *Case management support and parenting education.* As described above, wrap-around services for patients are essential—in the case of children and families, there must be protocols in place to ensure data-sharing and alignment between, for example, a case manager positioned within a behavioral health provider and case managers that have been assigned via the Department of Social Services or Child Protective Services. As with many government agencies, transparency between these entities is often limited. Federal incentives to ensure greater access to information, as well as grant funding to pilot innovative ways of partnering—similar to funding for diversion programs that bring together the criminal justice system and health system—are essential to ensuring this alignment.

- *Generational education and counseling.* Families facing addiction issues should receive ongoing education and support around the impact of addiction, early detection signs, and options for counseling and treatment. In Baltimore, our “Bmore in Control” program, as outlined above, is targeted at youth who may have experienced a parent or relative going through substance abuse and are looking for additional resources or simply a place to engage in dialog with others who have gone through similar experiences. Federal investment in increased counseling services for youth, as well as education and awareness programs like “Bmore in Control” can help break the all-too-frequent generational cycle of addiction by targeting specific interventions toward youth.

- *Foster Care Reform.* Finally, with increased opioid abuse leading to increased numbers of children ending up in the foster care system, it is imperative that we consider the overlap between the foster care system and substance abuse efforts.

Federal funding to improve the quality of foster care services and coordination nationwide are essential to ensuring that no child falls through the cracks.

SENATOR FRANKEN

Question 1a. According to SAMHSA only 10 percent of people who need treatment for substance abuse received it. The health parity act of 2008 and the ACA require mental health and substance abuse services to be covered to the same extent as physical health services. Yet, I have heard on numerous occasions that this is not the case. Furthermore, Medicaid currently prohibits the use of Federal funds for care provided to most patients in mental health and substance use disorder residential treatment facilities larger than 16 beds. This is known as the IMD exclusion.

Why are so few people who are suffering from substance abuse disorders able to access treatment services and what interventions would help improve treatment rates?

Answer 1a. The barriers to treatment are multi-pronged. In Baltimore City, we have identified the following hurdles—as well as proven solutions for addressing those hurdles, which the Federal Government can play a key role in supporting.

Naloxone accessibility and cost. One core challenge we face at the community level is naloxone accessibility, which varies even within a single city jurisdiction. Naloxone is a generic medication that is part of the World Health Organization's list of essential medications, but pharmacies vary in their stocking methods and sometimes do not fulfill prescriptions for this life-saving antidote. Additionally, the price of naloxone has dramatically increased over the past 2 years—in Baltimore alone, the cost per dose of naloxone has quadrupled—meaning that we can only save a quarter of the lives we could have saved.

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Question 1b. How has the Medicaid IMD exclusion affected a patient’s ability to access treatment for substance abuse?

Answer 1b. The IMD exclusion is a hurdle for individuals in need of services. Residential substance use facilities are currently prohibited from receiving Medicaid reimbursement because of this exclusion. Although States can apply for a waiver, the process is lengthy and does not enable us to address the urgent numbers of people who are currently dying from overdose. In addition, the IMD waiver limits the number of mental health residential crisis beds and residential detox beds that are available for individuals in crisis, which again is a critical access point in any successful behavioral health system. If the exclusion were eliminated, grant funding that is currently used to purchase these types of service could be used for other services that individuals are in great need of, such as supportive housing.

Question 1c. Do you feel that mental health and substance abuse parity is impacting patients’ access to care? If so, how would you recommend we further ensure that a patient’s mental health care is supported at rates equal to care for physical ailments?

Answer 1c. Yes, we believe that parity is a major issue impacting patients’ access to care. As discussed in previous answers, financial reimbursement for certain mental health services, including coverage of methadone treatment and behavioral health therapy, or services provided by all substance abuse treatment centers, regardless of whether they are residential or commercial, is key to ensuring that patients access the treatment that they need.

Question 2. Medicaid does not pay for any treatment, including substance abuse and other mental health treatments, for individuals in public institutions. This includes jails and juvenile detention, and even applies to people who are awaiting trial and still presumed to be innocent. However, individuals with private insurance who remain in jail until trial can receive benefits, as can Medicaid beneficiaries who post bond. Medicaid’s prohibition unfairly penalizes low-income individuals who cannot afford to post bond or pay for private coverage. This is especially problematic when it comes to mental illness and substance abuse because successful treatment requires continuity of care. When a person’s health insurance coverage is disrupted, so is their access to consistent medical care. This lack of continuity can lead to serious health consequences for the individual and for the community.

Baltimore has numerous programs underway to help individuals who suffer from mental illness connect to treatment after they encounter the criminal justice system. Do you have any programs to help ensure the continuation of medical care for Medicaid recipients as they await trial? What steps can the Federal Government take to minimize the disruptions in care for justice involved individuals?

Answer 2. The Baltimore City Health Department concurs that diversion and treatment opportunities for individuals who have contact with the criminal justice system is highly important. Here in Baltimore, we have piloted a law enforcement-

assisted diversion program in partnership with the Department of Justice and the Baltimore City police department, which establishes criteria for police officers to identify eligible users and take them to an intake facility that connects them to necessary services such as drug treatment, peer supports, and housing—rather than to central booking for arrest.

We also utilize highly effective diversion effort such as Drug Treatment Courts and Mental Health Treatment Courts, which ensure that individuals facing substance abuse and behavioral health challenges are able to access necessary services. At the other end of the criminal justice pipeline, we are increasing our capability for case management services for every individual leaving jails and prisons. These individuals are at a highly vulnerable state, and must be connected to medical treatment, psychiatric and substance abuse treatments if appropriate, housing and employment support, and more. Our outreach workers already target a subset of this population; we need to expand capacity to every one of these individuals. Additionally, as mentioned above, we are deploying community health workers in order to reach people where they are in the community as well as provide a credible messenger. In deploying this tactic, we are also excited to bring jobs and opportunities to vulnerable individuals and neighborhoods that otherwise have limited employment opportunities.

Question 3a. Current data has shown that the number of Medicaid-covered babies born in Minnesota with neonatal abstinence syndrome has more than doubled over the past 4 years. Dr. Wen, in your testimony you describe the importance of universal drug screenings for individuals presenting in emergency rooms and primary care offices. In Minnesota, HealthPartners is similarly screening all pregnant women for substance abuse. This practice is showing significant improvements in health outcomes.

What motivated providers in Baltimore to implement universal screening programs? How has it affected rates of opioid treatment across all populations?

Answer 3a. We have implemented the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach, which provides universal screening of patients presenting to ERs and primary care offices. Three of our hospitals are early pioneers in SBIRT; we are looking to expand it to all hospitals and clinics in the city to ensure delivery of early intervention and treatment services for those with or at risk for substance use disorders. Our hospital providers were motivated by the effectiveness of having a unified approach to screening patients for behavioral health and substance abuse issues, given the following benefits: (1) effective, evaluated process for assessing potential misuse and ensuring that patients can be matched with the appropriate treatment services; (2) ability to share data across clinical settings, given the standardized screening tool; (3) participation in a city-wide convening of emergency room departments and other hospital leaders.

While this is a relatively new intervention and we do not yet have quantitative data regarding the impact of this screening in Baltimore, studies have been conducted in several settings nationwide that demonstrate a range of 10–20 percent decrease in patients reporting opioid drug use 6 months after the intake is administered. These results also point to potential cost savings to the healthcare system: for example, a 2005 study found that the SBIRT process led to a \$3 reduction in healthcare costs for each \$1 spent on the intervention.

Question 3b. Dr. Wen, how would you design a national screening program aimed at reducing the rates of neonatal abstinence syndrome? What substances would you screen for and which locations within the continuum of care would you do this screening?

Answer 3b. The American Academy of Pediatrics and the American Pediatrics Association have developed standard recommendations regarding screening infants for neonatal abstinence. These screens should be administered at any point within the care continuum in which a pregnant mom with prior history of drug abuse comes into contact with the healthcare system. Maternal factors to be taken into account when developing screening protocols include:

- History of drug use/abuse (licit or illicit) within the past year—including amphetamines, barbiturates, benzodiazepines, cocaine, marijuana, and opiates;
- Past history of narcotic use;
- No prenatal care or infrequent prenatal care (<5 visits); and
- History of positive toxicology screens during prenatal care or during previous pregnancy.

Screening protocols should also include a best practice around informing the mother that she and/or the infant will be tested, and any testing for criminal issues

must require consent. Hospitals typically have standard legal standards in place for requests for release of any potentially incriminating information to legal authorities.

SENATOR BENNET

Question 1. How can we ensure that patients who need to be treated for addiction can receive care while preventing diversion for opioid drug abuse?

Answer 1. In Baltimore City, we have developed a comprehensive overdose strategy that is based on the philosophy that every interaction with a person with substance addiction must be treated as an entry point for intervention and treatment. These include:

- *Crisis Response:* In Baltimore, we have started a 24/7 “crisis, information, and referral” phone line that connects people in need to a variety of services including: immediate consultation with a social worker or addiction counselor; connection with outreach workers who provide emergency services and will visit people in crisis at homes; information about any question relating to mental health and substance addiction; and scheduling of treatment services and information. This line is not just for addiction but for mental health issues, since these issues in behavioral health are so closely related and there is a high degree of co-occurrence. Those who are seeking treatment for behavioral health should be able to easily access the services they need, at any time of day. This 24/7 line has been operational since October 2015; already, there are nearly 1,000 phone calls every week. It is being used not only by individuals seeking assistance, but by family members seeking resources and providers looking to connect their patients to treatment.

- *No Wrong Door:* We have secured \$3.6 million in capital funds to build a “stabilization center”—also known as a sobering center—for those in need of temporary service related to intoxication. This is the first step in our efforts to start a 24/7 “Urgent Care” for addiction and mental health disorders—a comprehensive, community-based “ER” dedicated to patients presenting with substance abuse and mental health complaints. Just as a patient with a physical complaint can go into an ER any time of the day for treatment, a person suffering from addiction must be able to seek treatment on-demand. This center will enable patients to self-refer or be brought by families, police, or EMS—a “no wrong door” policy ensures that nobody would be turned away. The center would provide full capacity treatment in both intensive inpatient and low-intensity outpatient settings, and connect patients to case management and other necessary services such as housing and job training.

- *Patient Tracking:* We are developing a real-time treatment dashboard to obtain data on the number of people with substance use disorders, near-fatal and fatal overdoses, and capacity for treatment. This will enable us to map the availability of our inpatient and outpatient treatment slots and ensure that treatment availability meets the demand. The dashboard will be connected to our 24/7 line that will immediately connect people to the level of treatment that they require—on demand, at the time that they need it.

- *Peer Recovery Specialists:* We are expanding our capacity to treat overdose in the community by hiring community-based peer recovery specialists. These individuals will be recruited from the same neighborhoods as individuals with addiction, and will be trained as overdose interrupters who can administer overdose treatment and connect patients to treatment and other necessary services.

- *SBIRT:* We have implemented the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach, which provides universal screening of patients presenting to ERs and primary care offices. Three of our hospitals are early pioneers in SBIRT; we are looking to expand it to all hospitals and clinics in the city to ensure delivery of early intervention and treatment services for those with or at risk for substance use disorders.

- *Case Management and Diversion:* We are working to expand case management and diversion programs across the city so that those who need help get the medical treatment they need. In our city of 620,000, 73,000 people are arrested each year. The majority of these arrests are due to drug offenses. Of the individuals in our jails and prisons, 8 out of 10 use illegal substances and 4 out of 10 have a diagnosed mental illness. Addiction and mental illness are diseases, and we should be providing medical treatment rather than incarcerating those who have an affliction. Baltimore already has highly effective diversion efforts such as Drug Treatment Courts and Mental Health Treatment Courts. We are looking to implement a Law Enforcement Assisted Diversion Program, a pilot model that has been adopted by a select group of cities, which establishes criteria for police officers to identify eligible users and take them to an intake facility that connects them to necessary services such as drug treatment, peer supports, and housing—rather than to central booking for arrest. Finally, we are increasing our capability for case management

services for every individual leaving jails and prisons. These individuals are at a highly vulnerable state, and must be connected to medical treatment, psychiatric and substance abuse treatments if appropriate, housing and employment support, and more. Our outreach workers already target a subset of this population; we need to expand capacity to every one of these individuals. Additionally, as mentioned above, we are deploying community health workers in order to reach people where they are in the community as well as provide a credible messenger. In deploying this tactic, we are also excited to bring jobs and opportunities to vulnerable individuals and neighborhoods that otherwise have limited employment opportunities.

Question 2. What suggestions would you have for strengthening Medication-Assisted Treatment? Is there a need to enhance psychosocial or behavioral components?

Answer 2. In Baltimore, we are expanding and promoting medication-assisted treatment, which is an evidence-based and highly effective method to help people with opioid addiction recover, through the use of best practices and standards throughout the city. This combines behavioral therapy with medication, such as methadone or buprenorphine, along with other support. Taking medication for opioid addiction is like taking medication to control heart disease or diabetes. When prescribed properly, medication does not create a new addiction, but rather manages a patient's addiction so that they can successfully achieve recovery.

Baltimore has been at the leading edge of innovation for incorporating medication-assisted treatment, including providing medications in structured clinical settings through the Baltimore Buprenorphine Initiative. This year, we expanded access to buprenorphine treatment by offering services in low-barrier settings, such as recovery centers, emergency shelters, and mental health facilities. Providing access to buprenorphine services in these settings allows us to engage people who are more transient or unstably housed into much-needed treatment. There is absolutely a need to combine Medication-Assisted Treatment with attention to psychosocial and behavioral needs. As described above, this is where funding for and implementation of case management services and other innovative models is crucial.

Question 3. You discussed removing the stigma associated with naloxone therapy to reverse an opioid drug overdose. Is there anything else we can do to remove the stigma associated with opioid abuse and increase access to care?

Answer 3. Yes. In addition to treating patients, we must also change the dialog around substance use disorder. The Baltimore City Health Department is leading a citywide effort to educate the public and providers on the nature of substance addiction: that it is a disease, recovery is possible, and we all must play a role in preventing addiction and saving lives. Our efforts include the following:

- *Community Education.* We have been at the forefront of changing public perception of addiction so those in need are not ashamed to seek treatment. We have launched a public education campaign "DontDie.org" to educate citizens that addiction is a chronic disease and to encourage individuals to seek treatment. This was launched with bus ads, billboard ads, a new website, and a targeted door-to-door outreach campaign in churches and with our neighborhood leaders. We have also launched a concerted effort to target prevention among our teens and youth entitled "BMore in Control." We have established permanent prescription drug drop boxes at all nine of the city's police stations. This means that anyone can drop-off their unused, unwanted, or unnecessary prescription drugs—no questions asked. Drugs left in the home can end up in the wrong hands—spouses, elderly family members, or even our children. I have treated 2-year olds who were dying from opioid overdose, again underscoring that all of us can be at risk and must play a role.

- *Clinician Education.* We are targeting our educational efforts to physicians and other prescribers of opioid medications. Nationwide, over-prescribing and inconsistent monitoring of opioid pain medications is a major contributing factor to the overdose epidemic. According to the Centers for Disease Control, there were 259 million prescriptions written for opioids in 2014. That is enough for one opioid prescription for every adult American.

Every day, people overdose or become addicted to their prescription opioids. To address this, I have sent "best practice" letters to every doctor in the city and will also do so for all dentists and pharmacists. The letter addressed the importance of the Prescription Drug Monitoring Program and judicious prescribing of opioids, including not using narcotics as the first line of medication for acute pain and emphasizing the risk of addiction and overdose with opioids. Importantly, this best practice requires co-prescribing of naloxone for any individual taking opioids or at risk for opioid overdose. Hospitals keep naloxone on hand if patients receive too much intravenous morphine or fentanyl. Patients must also receive a prescription for naloxone

if they are to be discharged with opioid medications that can result in overdose. These best practices were developed through convening ER doctors, hospital CEOs, and other medical professionals in the city. To reach practicing doctors, we have been presenting at Grand Rounds, medical society conferences, and are also about to launch physician “detailing”, where we will employ teams of public health outreach workers and people in recovery to visit doctors to talk about best practices for opioid prescribing. We are working with providers to ensure best seven practices will be used when prescribing opioids and that we all play our part—as providers, patients, and family members—to prevent addiction and overdose.

Question 4. Based on your experience in addressing the occurrence of opioid abuse and overdose in Baltimore, what hurdles need to be addressed on State and local levels?

Answer 4. Our approach to the opioid abuse epidemic in Baltimore City is evidence-based and comprehensive, and necessitates that we focus not only on what is achievable here in our city but also the multitude of local, State, and Federal-level factors that contribute to opioid use nationwide.

Naloxone accessibility and cost. One core challenge we face at the community level is naloxone accessibility, which varies even within a single city jurisdiction. Naloxone is a generic medication that is part of the World Health Organization’s list of essential medications, but pharmacies vary in their stocking methods and sometimes do not fulfill prescriptions for this life-saving antidote. Additionally, the price of naloxone has dramatically increased over the past 2 years—in Baltimore alone, the cost per dose of naloxone has quadrupled—meaning that we can only save a quarter of the lives we could have saved.

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Focus on Prevention. Additionally, more funding for prevention services is critical to stopping the cycle of addiction. Treatment and service intervention for individuals with identified need are often seen as top funding priorities; however, investing in prevention services and tackling substance upstream is just as important. Many local jurisdictions like Baltimore have launched public education campaigns to this effect, but there is much more education that must be done in order to encourage people with addiction into care and to disband stigmas that are leading many communities to avoid providing treatment altogether. Local jurisdictions are limited by funding constraints, but the Federal Government can push for the launch of a national campaign to reduce stigma and to increase awareness of opioid addiction. This national campaign will provide the spotlight this critical issue requires.

SENATOR WHITEHOUSE

Question 1a. Along with a bipartisan group of Senators including Senators Portman, Klobuchar, and Ayotte, I introduced a bill earlier this year called the Comprehensive Addiction and Recovery Act (S.524). The bill authorizes a series of grants to States and other eligible entities to promote an integrated approach—including prevention, treatment, law enforcement tools, and recovery support—to the substance abuse epidemic we are facing across the Nation. Among other things, the bill tries to increase screening for, and treatment of, co-occurring mental health and substance use disorders in the juvenile and criminal justice systems and elsewhere.

Do you support the objectives set forth in S.524? How would enactment of S.524 improve your organization’s ability to help address the opioid abuse epidemic?

Answer 1a. We strongly support the objectives set forth in S.524. This bill would provide funding for States to prepare a comprehensive plan for and implement an integrated opioid abuse response initiative. We fully support this proposal but encourage you to consider making this grant available to local jurisdictions as many local health departments represent the boots on the ground in the fight against addiction and overdose.

This bill would also support our efforts to train law enforcement personnel on naloxone by funding the creation of a formal opioid overdose prevention training program. As law enforcement personnel are often the first responders to a scene of an overdose, providing this training can save lives.

We suggest that this grant opportunity be expanded to include funding for the procurement of naloxone. Over the last 2 years, the price of naloxone has dramatically increased. In Baltimore, the cost per dose has quadrupled. While manufacturers claim that this price increase is related to increased demand, it is unclear why the cost of a generic medication, that is available for much lower costs in other countries, is suddenly so expensive. We also encourage Congress to call for an investigation into the reason for the price increase. Providing funding to supply law enforcement agencies with naloxone will help ensure our first responders are able to save lives.

We fully support the proposal to increase access to quality and effective on-demand treatment and provide long-term recovery support; but encourage that grants only be made available to evidence-based treatments that have proven to effectively treat drug addiction. In Baltimore, we are working to expand and promote evidence-based medication-assisted treatment. This combines behavioral therapy with medication, including methadone or buprenorphine, along with other support.

Finally, we fully support the proposal to fund diversion programs so that those who need help get the medical treatment they need. Addiction and mental illness are diseases, and we should be providing medical treatment rather than incarcerating those who have an affliction. This bill would promote more programs to help break the cycle of addiction rather than perpetuate the cycle through arrest and release policies.

Question 1b. What additional tools might you like to see at your disposal to address the overlap between substance abuse and mental health issues?

In addition to the funding opportunities recommended in S.524, we believe it is crucial for Federal funding to support cutting-edge, evidence-based approaches to combating substance abuse as well. Many of these services are not covered by Medicaid, Medicare, or other forms of insurance that are critical to addiction recovery, but Congress can provide funding to local jurisdictions and to States do not simply focus on the medical component of addiction but the broader psychosocial components. These include:

- *New care delivery models.* There is research on new treatment options such as starting buprenorphine from ERs, mobile buprenorphine induction, or telemedicine treatment that would be not eligible for existing reimbursement yet offer much promise. These are examples of delivery models that local and State agencies should have the option of providing grant funding for, with the option of being included in Medicaid formulary after sufficient time and evidence.

- *Peer recovery specialists.* In Baltimore, we are aiming to provide a peer recovery specialist for every individual who presents for an overdose or addiction-related condition to our ERs and other facilities. However, we are limited by the lack of funding for these individuals. There should be opportunities for expanded funding and reimbursement for services rendered by these trained community health workers; grant funding to local and State agencies can be one way to pursue this.

- *Case management services.* Individuals leaving incarceration or inpatient stays are at very high risk; they must receive wrap-around services that connect them immediately to needed medical and psychiatric assistance. These case management services have inconsistent reimbursement; innovative programs including with telemedicine and use of peer recovery specialists should be encouraged.

- *Community resources for recovery.* Recovery from addiction involves more than clinical treatment but also support and long-term care. Local and State agencies can also innovate with interventions such as recovery housing and reentry support; Federal funding can assist in these necessary steps.

SENATOR WARREN

Question 1a. Prescription Drug Monitoring Programs (PDMPs) hold tremendous power to help health care providers identify and treat patients who are addicted to or at risk of becoming addicted to opioids. However, PDMPs are only as good as the data stored in them. A 2013 Department of Health and Human Services report on “Prescription Drug Monitoring Program Interoperability and Standards,” found that PDMPs remain significantly underutilized in many States and recommended that the Federal Government take a leadership role in making them more useful to providers.

Many patients have similar names and birthdays, making it possible for patients’ PDMP records to become inappropriately merged or to be incomplete. To what extent are these patient record mismatches a barrier to the utility of PDMPs?

Answer 1a. While patient record mismatches can be a challenge, PDMP algorithms are built to be as conservative as possible due to the fact that many who suffer from opioid addiction are unable to provide standard contact information or other identifying information. As a result, PDMPs have been designed to prevent misidentification, and while this may result in duplicate records from time to time, it is a safe way to ensure that patients are not receiving inappropriate or wasteful amounts of prescription drugs.

We support the use of PDMPs and believe that it is essential to make them as user friendly and time-saving for clinicians as possible. One way to address the issue of patient record mismatches is to develop a unique identifier for each patient—this is standard practice for patient health records and could be similarly ap-

plied here. In Maryland, for example, we utilize CRISP, a statewide health information exchange that enables the development of patient records across institutions and provides physicians and their teams with insights into the care and prescriptions that a patient is receiving across multiple clinical settings. CRISP has driven significant efficiencies in identifying and unifying care plans for complex patients, and we believe that similar adoption of best practices could yield similar advantages for PDMP utilization as well.

Question 1b. How would the implementation of technical interoperability standards—including a standard system for matching the correct patient to the correct record—make it easier for PDMPs to integrate with electronic health record systems and increase the rate of PDMP utilization?

Answer 1b. The ability to uniquely identify an individual across systems is critical to improving health outcomes. The practice of public health touches on many aspects of an individual's life, many of the system interactions which people experience are not clinical (housing, food, etc). While patient matching and identification programs exist, they are focused on the clinical operations of isolated health systems. State health information exchanges improve this picture by extending the unique identification across a region, however the ability to combine this data with data sets outside of the clinical context remains one of the biggest challenges facing public health practitioners. PDMPs focus on the dispensing of drugs to an individual, however we know this is only a part of that individual's story. Being able to link this use with hospital admissions, needle exchange interactions, residential treatment programs, and other social programs is equally important.

Interoperability standards are the foundation for advancement across technology systems. This has played out for the Internet in general (with standards such as TCP/IP), and we are seeing a similar trend across clinical systems with the adoption of protocols such as HL7. While standards must be driven by groups of stakeholders within a sector, the government can play a critical role in convening these partners or providing the incentives to create such standards. Meaningful use has done more to advance interoperability of health data in a short-time than any effort previously. A similar incentive program should be developed for the interoperability of non-clinical systems. Such an initiative would bring stakeholders to the table for data exchange conversations which today are burdened with complex technical integrations, and facing legal challenges not well understood by the participants.

RESPONSE BY ROBERT VALUCK, PH.D., RPH, FNAP TO QUESTIONS OF SENATOR MURKOWSKI, SENATOR CASEY, SENATOR FRANKEN, SENATOR BENNET, SENATOR WHITEHOUSE AND SENATOR WARREN

Thank you Senators Murkowski, Casey, Franken, Bennet, Whitehouse and Warren for the opportunity to answer your additional, specific questions on this critically important issue for our Nation. My answers are provided below, and I remain available to you for further dialog or to provide additional information. I look forward to working together to find solutions to the epidemic of opioid abuse in America.

SENATOR MURKOWSKI

Question 1a. Dr. Valuck, Colorado is, similar to Alaska, though to a lesser extent, a rural State. Access to care is a huge problem in my State for every kind of patient, but it is especially bad for people searching for a treatment program. Anchorage, the largest city with a population of 300,000, only has 14 detox beds. Juneau, the second-largest city with a population of around 30,000, has none. So you can probably guess what access is like out in the more rural parts of Alaska, like Bethel or Nome.

What has Colorado done to specifically engage the rural parts of your State?

Answer 1a. We have worked extremely hard to engage the rural parts of Colorado in our efforts to address the opioid epidemic and its widespread effects. The Colorado Consortium for Prescription Drug Abuse, founded in 2013 to implement the Colorado Plan to Reduce Prescription Drug Abuse, includes over 300 members from across our State and serves as a backbone for collaboration, communication, and collective action. We have worked with coalitions in several rural areas of the State: the San Luis Valley (through a multi-county collaboration coordinated by the Area Health Education Center, or AHEC); northeast Colorado (through a collaboration coordinated by the North Colorado Health Alliance); and the Western slope (through a collaboration coordinated by Rocky Mountain Health Plans, the Mesa County Medical Society, and local providers). These coalitions have developed focused, regionally and culturally sensitive approaches to the problem, engaging community

leaders, health care providers, law enforcement, public health agencies, treatment providers, and patients and families to determine the most desirable and feasible approaches that can be implemented in their respective locations. The Consortium, and the major State agencies in Colorado (public health, behavioral health, regulatory, and law enforcement) are working to support these rural coalitions, share best practices, facilitate dialog, and connect local and regional efforts with statewide efforts to achieve maximum impact. Moving forward, a State block grant from SAMHSA (administered by the Office of Behavioral Health, in the Department of Human Services) is being used to extend the reach of the consortium and its key outreach and prevention messaging (on safe use, safe storage, and safe disposal) to youth and young adults, through a 5-year collaboration with Rise Above Colorado. The grant will allow seven high risk communities to develop and implement local, youth-directed prevention programs using a positive youth development approach. Our goal is to reach and involve all of Colorado, both urban, suburban and rural; at all levels (local, county, and regional), to coordinate and leverage our efforts.

Question 1b. Has Colorado leveraged Federal funds to provide detox or post-detox residential treatment for people dealing with addiction, or have you relied entirely on State funds?

Answer 1b. Colorado does use Federal, State and local funds to support community-based, clinically managed residential withdrawal management (detox) services. Both Medicaid funds, and the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment (SAPT) Block Grant support this type of care.

Colorado also supports residential treatment for substance use disorders using Federal SAMHSA SAPT Block Grant funds. Additionally, the State Medicaid program only includes residential treatment for substance use disorders for pregnant women. That treatment may continue up to 12 months postpartum, through a 1915B waiver. The postpartum services are only supported when the woman initiates treatment while pregnant.

It should be noted that for withdrawal management, many in opiate withdrawal may require a higher level of care than is typically available and that does not get direct Federal funding.

SENATOR CASEY

Question 1. What kind of economic incentives do you feel are necessary for pharmacies, clinics and other organizations to become reverse distributors?

Answer 1. At this time, there is no direct economic incentive for pharmacies, clinics, or other organizations to become reverse distributors. The costs of collection, storage, and ultimately disposal would be borne by these organizations, and such costs are substantial (and likely prohibitive, thus discouraging participation). Some form of economic model will be required to make reverse distribution a viable solution for safe disposal of opioids and other prescription drugs. Various models are being suggested and tested across the United States, ranging from requiring pharmaceutical manufacturers to fund disposal programs; to consideration of per-prescription fees for disposal of unused medications (akin to hazardous materials disposal fees for used tires, motor oil, and paint); to legislative (general fund) funding of disposal programs. The Colorado legislature has provided 1 year of funding for a statewide pilot disposal program, but the long term viability of the program or the funding is unknown and cannot be guaranteed. Federal solutions are also possible, ranging from ongoing funding for the DEA National Takeback Initiative; to creating, providing funding for, or coordinating a national collection program for reverse distributors. Moving forward, we are paying close attention to efforts across the country to determine which are viable, feasible, and sustainable and could be considered for implementation in Colorado.

SENATOR FRANKEN

Question 1a. According to SAMHSA only 10 percent of people who need treatment for substance abuse received it. The health parity act of 2008 and the ACA require mental health and substance abuse services to be covered to the same extent as physical health services. Yet, I have heard on numerous occasions that this is not the case. Furthermore, Medicaid currently prohibits the use of Federal funds for care provided to most patients in mental health and substance use disorder residential treatment facilities larger than 16 beds. This is known as the IMD exclusion.

Why are so few people who are suffering from substance abuse disorders able to access treatment services and what interventions would help improve treatment rates?

Answer 1a. The “treatment gap” that you mention is a terrible problem, resulting in countless Americans being unable to access treatment services, even when they are fully aware and ready and willing to enter treatment. Oftentimes, the long wait for treatment access leads to further abuse, overdose, and death. Barriers to treatment access are many: lack of available treatment facilities, programs, and providers; lack of insurance coverage for treatment; stigma and shame associated with seeking treatment; lack of awareness of available treatment options or methods for accessing treatment or obtaining referral to treatment; lack of parity in coverage for substance abuse services; and uneven distribution of services in many areas. Increases in all of these areas will be required to narrow the treatment gap and provide all Americans who need it, to have access to substance abuse treatment in their communities.

Question 1b. How has the Medicaid IMD exclusion affected a patient’s ability to access treatment for substance abuse?

Answer 1b. The Medicaid IMD exclusion is one example of coverage-related barriers to access to treatment for substance abuse. Such exclusions limit the availability of treatment options, and make it more difficult for Medicaid patients to obtain such services. This is particularly troubling, given the data that show Medicaid patients have a disproportionately high rate of opioid overdose compared with the general population.

Question 1c. Do you feel that mental health and substance abuse parity is impacting patients’ access to care? If so, how would you recommend we further ensure that a patient’s mental health care is supported at rates equal to care for physical ailments?

Answer 1c. Yes, I believe that mental health and substance abuse parity, or the lack thereof, is impacting patients’ access to care. I recommend and support any efforts to clearly define, require, and enforce the application of parity laws. Coverage must be adequate; must comprise physical health, mental health, and substance abuse services; and must be enforced to assure compliance with laws that mandate it.

SENATOR BENNET

Question 1. How can we ensure that patients who need to be treated for addiction can receive care while preventing diversion for opioid drug abuse?

Answer 1. We believe that the key to ensuring access to opioids for patients with legitimate medical need (for the treatment of either acute or chronic pain, or addiction) while preventing misuse, abuse, and diversion is a balanced approach focusing on several key areas simultaneously: public awareness, provider education, increased use of prescription drug monitoring programs, safe storage, safe disposal programs, improved treatment systems, increased access to naloxone, and improved data systems, all working in a coordinated, collaborative, and multidisciplinary manner. We stress and believe in education and in the creation of evidence-based guidelines and tools for providers and patients to safely use opioids when medically indicated and prescribed, giving providers the ability to best treat their patients.

Question 2. What suggestions would you have for strengthening Medication-Assisted Treatment? Is there a need to enhance psychosocial or behavioral components?

Answer 2. We support all efforts to expand access to Medication Assisted Treatment (MAT), including additional provider education and training on MAT; expansion of buprenorphine waiver limits; funding for additional treatment facilities, programs, and providers; improved mechanisms for referral to MAT treatment providers; and insurance reform to assure coverage of MAT for persons who need it. We believe that there is indeed a need to enhance the psychosocial and behavioral components of addiction treatment programs, and that physicians (particularly those specializing in addiction medicine) are best equipped to determine the most effective, safe, and evidence-based approach to addiction treatment for each of their patients, knowing that one approach is not likely to succeed for all patients.

Question 3. Dr. Valuck, in your testimony, you note that over a quarter of a million Coloradans have misused prescription drugs. Due to the good work in Colorado, you and others have been able to see a 20 percent reduction in this abuse. How can the Federal Government be a partner or get out of the way of the hard work that needs to be done?

Answer 3. We believe that the Federal Government can, and should, partner with States to help implement programs that meet the needs defined in each State

(which in some ways are similar, but in many ways are unique and require local or regional efforts to assure success). Agencies of the Federal Government should use their statutory authority and resources to address specific aspects of the opioid epidemic: FDA could move naloxone to “over the counter” status; DEA could continue to host National Takeback Initiatives or create an ongoing, permanent infrastructure for reverse distribution and ultimately safe destruction of unused opioids; CDC could assist with improving data systems and data sharing between PDMP programs, State health departments, and other agencies to help better understand, measure, and track the epidemic; HHS could increase efforts to expand access to MAT and increase the number of providers who are certified to provide MAT; and NIH could fund additional studies on everything from evidence-based treatments for addiction, to new classes of medications for treating pain, to evaluations of which prevention, intervention, or treatment strategies are most effective for reducing opioid overdose deaths. The Federal Government and its agencies should support and work with States to help them address this problem in a coordinated way.

Question 4. Dr. Valuck, you discussed the dramatic increase in heroin and prescription opioid abuse admissions, yet the lack of existing treatment options available. What should Congress think about when trying to reduce the rates of use of both heroin and prescription opioids?

Answer 4. We believe that efforts should be made to strike a balance—ensuring access to opioids for patients with legitimate medical need (for the treatment of either acute or chronic pain, or addiction) while preventing misuse, abuse, and diversion. Several key areas should be addressed simultaneously: public awareness, provider education, increased use of prescription drug monitoring programs, safe storage, safe disposal programs, improved treatment systems, increased access to naloxone, and improved data systems, all working in a coordinated, collaborative, and multidisciplinary manner. The opioid epidemic is a problem of massive scope, multifactorial causes, and staggering consequences. It requires us to address it in every way that we can, simultaneously, and will not be solved quickly or easily. The opioid epidemic is one of the defining public health crises of our generation.

Question 5. You described several aspects of Colorado’s plan to reduce prescription drug abuse including public awareness, patient engagement, strengthening the Prescription Drug Monitoring Program, and others. Are there certain components most important in achieving your goal of reducing non-medical use of prescription medications to 3.5 percent?

Answer 5. We believe that each of the components of our plan to reduce prescription drug abuse is critically important, and that the effort cannot succeed without continued emphasis on each and every one. The opioid epidemic has many causes, and many potential avenues for impact, and we believe that every available avenue should be pursued to address it. We are currently identifying both “key performance indicators” and “outcome indicators” to measure the scope and dimensions of the opioid epidemic, as well as the impact of our strategic planning (work group) domains on those indicators. Moving forward, we aim to determine which components of our approach work, how well they work, and how to most effectively address aspects of the epidemic in the coming years. We are moving to a clearly specified, data-driven approach with measurable goals and targets for our prevention work. The stakes are too high to move forward without measuring our efforts, to assure that we are as effective as we can be, given our limited resources.

Question 6. Based on your experience in Colorado in seeing the implementation of that Policy for Prescribing and Dispensing Opioids, do you have concerns that CDC guidelines on opioid prescribing for chronic care pain in adults treated in the primary care setting will inappropriately limit patients’ access to opioid medications?

Answer 6. We are very fortunate to have experienced the creation of a very collaborative, innovative Policy for Prescribing and Dispensing Opioids by our State’s health professions licensing boards. The policy is evidence-based, and was developed with the input of key stakeholders, to assure relevance to practitioners and patients in Colorado. The new (draft) CDC guidelines, while not yet finalized (at the time of this writing), may or may not serve to limit patients’ access to opioid medications for legitimate medical need; we are paying close attention to the CDC guideline development process and will review the final guidelines when they are released.

SENATOR WHITEHOUSE

Question 1a. Along with a bipartisan group of Senators including Senators Portman, Klobuchar, and Ayotte, I introduced a bill earlier this year called the Com-

prehensive Addiction and Recovery Act (S.524). The bill authorizes a series of grants to States and other eligible entities to promote an integrated approach—including prevention, treatment, law enforcement tools, and recovery support—to the substance abuse epidemic we are facing across the Nation. Among other things, the bill tries to increase screening for, and treatment of, co-occurring mental health and substance use disorders in the juvenile and criminal justice systems and elsewhere.

Do you support the objectives set forth in S. 524? How would enactment of S. 524 improve your organization's ability to help address the opioid abuse epidemic?

Answer 1a. Yes, we believe that enactment of S.524 would improve our ability to help address the opioid epidemic. Grant funding to States, to promote integrated approaches to the substance abuse epidemic, would be very useful to us. Such funding could help sustain our collaborative "Consortium model", which has proven to be an effective vehicle for organizing an effective network of systems and programs across Colorado. Further funding for prevention, screening and treatment of co-occurring mental health and substance use disorders in the juvenile and criminal justice systems would help stem the tide of addiction and reduce the number of persons who nonmedically use opioids, many of whom go on to become addicted and experience negative outcomes. Prevention of addiction is, and must be, the long term goal, and we support efforts to increase funding for integrated approaches to prevention.

Question 1b. What additional tools might you like to see at your disposal to address the overlap between substance abuse and mental health issues?

Answer 1b. We would like to see improved coverage (both in terms of scope and parity); improved access to treatment resources (additional facilities, programs, and providers); improved education of providers and patients; improved models of health care delivery that integrate mental health and substance abuse services with physical health services; and improved methods for screening, brief intervention, and referral to treatment, so that patients' specific condition(s) can be better identified, earlier, and referrals to appropriate services can be made, thus increasing the chances for successful treatment and lowering the chances for bad outcomes.

SENATOR WARREN

Question 1a. Prescription Drug Monitoring Programs (PDMPs) hold tremendous power to help health care providers identify and treat patients who are addicted to or at risk of becoming addicted to opioids. However, PDMPs are only as good as the data stored in them. A 2013 Department of Health and Human Services report on "Prescription Drug Monitoring Program Interoperability and Standards," found that PDMPs remain significantly underutilized in many States and recommended that the Federal Government take a leadership role in making them more useful to providers.

Many patients have similar names and birthdays, making it possible for patients' PDMP records to become inappropriately merged or to be incomplete. To what extent are these patient record mismatches a barrier to the utility of PDMPs?

Answer 1a. Patient record mismatches are one of several technical/system problems that reduce the utility of PDMPs. Some States (not Colorado) require patients to show a State-issued identification card (driver's license, State-issued ID card, etc.) with a unique identification number, thus reducing the likelihood of patient record mismatches (or the use of aliases or false or fabricated name or address information). Other technical/system problems include multiple system sign-ons (i.e., PDMP users must log in separately to multiple systems in the course of their work, which makes checking the PDMP more time consuming and difficult); complex navigation; multiple attestations, password changes, and verifications; and in some States, data that are not uploaded frequently enough by pharmacies (per State law) and result in "gaps" in PDMP information (coverage). Each of these problems are barriers to PDMP utility and use.

Question 1b. How would the implementation of technical interoperability standards—including a standard system for matching the correct patient to the correct record—make it easier for PDMPs to integrate with electronic health record systems and increase the rate of PDMP utilization?

Answer 1b. We believe that the implementation of technical interoperability standards would indeed make it easier for PDMPs to integrate with electronic health record systems and increase the rate of PDMP utilization. "Single sign on" systems, record linkage systems, clinical decision support systems, patient monitoring/tracking systems, etc., could all be more easily deployed if technical interoperability standards were implemented. PDMP data are extremely valuable, and any efforts to make the data more easily accessible, while maintaining strict data privacy and security protections, would increase PDMP utilization and in turn, reduce

the rate of doctor shopping and pharmacy shopping—one key dimension of the opioid epidemic.

[Whereupon, at 11:48 a.m., the hearing was adjourned.]

