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COMBATING THE OPIOID CRISIS: PREVENTION AND PUBLIC HEALTH SOLUTIONS

THURSDAY, MARCH 22, 2018

House of Representatives

Subcommittee on Health

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 9:00 a.m., in Room 2123 Rayburn House Office Building, Hon. Michael Burgess [chairman of the subcommittee] presiding.

Members present: Representatives Burgess, Guthrie, Upton, Shimkus, Latta, McMorris Rodgers, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Mullin, Hudson, Collins, Carter, Walden(ex officio), Green, Engel, Schakowsky, Matsui, Castor, Sarbanes, Lujan, Schrader, Kennedy, and Eshoo.

Also present: Representatives Walberg, Tonko, and Johnson.

Staff present: Mike Bloomquist, Staff Director; Adam

Buckalew, Professional Staff Member, Health; Daniel Butler, Staff Assistant; Karen Christian, General Counsel; Zachary Dareshori, Legislative Clerk, Health; Margaret Tucker Fogarty, Staff Assistant; Adam Fromm, Director of Outreach and Coalitions; Caleb Graff, Professional Staff Member, Health; Jay Gulshen, Legislative Associate, Health; Peter Kielty, Deputy General Counsel; Ed Kim, Policy Coordinator, Health; Mark Ratner, Policy Coordinator; Kristen Shatynski, Professional Staff Member, Health; Jennifer Sherman, Press Secretary; Danielle Steele, Counsel, Health; Austin Stonebraker, Press Assistant; Hamlin Wade, Special Advisor, External Affairs; Everett Winnick, Director of Information Technology; Jacquelyn Bolen, Minority Professional Staff; Jeff Carroll, Minority Staff Director; Waverly Gordon, Minority Health Counsel; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Tim Robinson, Minority Chief Counsel; Samantha Satchell, Minority Policy Analyst; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; Kimberlee Trzeciak, Minority Senior Health Policy Advisor; and C.J. Young, Minority Press Secretary.

Mr. Burgess. I ask all of our guests to please take their seats. The Subcommittee of Health will come to order. I want to welcome everyone to our second day of our hearing on Combating the Opioid Crisis through Prevention and Public Health Solutions. I want to thank our witnesses for taking time to testify before the subcommittee today. The good news for you is you don't have to listen to us, we spoke yesterday.

So we will hear from you this morning. Each witness will have the opportunity to give an opening statement that will be followed by questions from members. As I mentioned to some of you as we started, the brief housekeeping detail, we will have a vote on the floor probably around 10:30 to 10:40 and the committee will recess briefly when we have to go vote on the floor.

But today we are going to hear from Dr. Eric Strain, the Director for the Center for Substance Abuse Treatment and Research at Johns Hopkins University; Dr. Kenneth Martz, Special Projects Consultant, Gaudenzia; Mr. Brad Bauer, Senior Vice President of New Business Development and Customer Relationships; Dr. William Banner, Medical Director of the Oklahoma Center for Poison and Drug Information and the Board President of the American Association of Poison Control Centers; and, Dr. Michael Kilkenny, Physician Director, Cabell-Huntington Health Department of West Virginia. We appreciate all of you being here today. Dr. Strain, you are recognized for 5 minutes to summarize your opening statement, please.

STATEMENTS OF ERIC C. STRAIN, MD, DIRECTOR, CENTER FOR SUBSTANCE ABUSE TREATMENT AND RESEARCH, JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE; KENNETH J. MARTZ, PsyD MBA, SPECIAL PROJECTS CONSULTANT, GAUDENZIA, INC.; BRAD BAUER, SENIOR VICE PRESIDENT OF NEW BUSINESS DEVELOPMENT AND CUSTOMER RELATIONSHIP MANAGEMENT, APPRISS HEALTH; WILLIAM BANNER, MD, PhD, MEDICAL DIRECTOR, OKLAHOMA CENTER FOR POISON AND DRUG INFORMATION AND BOARD PRESIDENT, AMERICAN ASSOCIATION OF POISON CONTROL CENTERS; AND, MICHAEL E. KILKENNY, MD, MS, PHYSICIAN DIRECTOR, CABELL-HUNTINGTON HEALTH DEPARTMENT OF WEST VIRGINIA

STATEMENT OF ERIC STRAIN

Dr. Strain. Thank you. Thank you, Chairman Burgess, Ranking Member Green, and members of the subcommittee. Thank you for inviting me to participate in today's hearing and for devoting 2 full days to legislative solutions to address the opioid crisis and the scourge of addiction in our communities, a topic which has been the focus of my professional career.

My name is Eric Strain. I am a physician who practices as a psychiatrist and conducts substance abuse research, and I am the director for the Johns Hopkins Center for Substance Abuse Treatment and Research. I have seen the devastating impact of drug abuse and the current federal regulations that limit the use and disclosure of patients' substance abuse treatment records and I am pleased that this Congress is taking a proactive step to

update the law to be more in keeping with modern-day, multidisciplinary medical practice and the best patient care.

The Amendment in the Nature of a Substitute to H.R. 3545 as offered by Representative Mullin will enhance our ability to share vital health information in a timely manner. Though well intentioned at its enactment more than 40 years ago, 42 CFR Part 2 is outdated and, worse, it can result in harm to patients and impedes the relationship between providers and their patients. Full alignment of federal privacy rules with HIPAA for the purposes of treatment and healthcare operations will ensure that patients with substance use disorders receive accurate diagnoses, integrated and coordinated treatment, and patient-centered care.

Under 42 CFR Part 2, substance use disorder records must remain separate and segmented from any other medical record and cannot be shared with a patient's primary care provider or other specialist without the express written consent of the patient. Obtaining this consent can be a challenge under a variety of scenarios and the current segmentation of records runs counter to the idea of holistic and coordinated treatment of the patient. Not knowing a patient is in substance abuse treatment increases risks, for example, with medication interactions or in delivering care under an emergency situation.

It also can interfere with effective integrated care. Let me give you an example. The Johns Hopkins Center for Addiction and Pregnancy is a substance abuse treatment program that helps

pregnant women and their babies and includes substance use staff as well as OB-GYN, pediatrics, and psychiatry. This multidisciplinary program needs ready communication between providers. Full information is essential to support clinicians' efforts to care for the pregnant woman pre-term and then both patients, the mother and her child, postpartum. This example clearly demonstrates the varied teams of caregivers such as neonatologists, obstetricians, case managers, et cetera.

Our healthcare system does not put records for other medical conditions such as HIV and AIDS in a separate and protected system. We don't put a patient's social history behind a wall and tell other providers they can't have ready access to information about what may be sensitive topics. The various workarounds that are offered introduce more impediments in an already busy healthcare system and further contributes to the perception that substance use is different from all other medical care.

In my opinion, continuing to consider substance abuse disorder information distinct from other medical information actually perpetuates stigma. Concerns about inappropriate release of information are addressed in the Mullin amendment which includes vital antidiscriminatory language as well as protections against criminal prosecution.

Finally, I have reviewed Jessie's Law as well and I support any effort to promote dialogue that encourages coordination of care and the sharing of necessary information so long as it is

paired with the Mullin amendment. Jessie's Law relies on patient-volunteered information and it is my experience that through no fault of the patient, patient-volunteered information is sometimes inaccurate or incomplete, or places a large burden on the patient. Therefore, as I have already expressed, a system that relies on consents or patient-volunteered information is fundamentally flawed. Healthcare providers are on the front lines of treating opiate and other substance use disorders. We are uniquely positioned to help but we cannot do so without an unobstructed view of a patient's medical records. You have an opportunity to move us forward in these efforts and help those on the front lines of treating people who suffer from drug abuse.

I urge the committee to report out legislation amending 42 CFR Part 2 that allows the responsible sharing of patient records for the purposes of treatment and healthcare operations. Thank you and I would be pleased to answer any questions you may have.

[The prepared statement of Dr. Strain follows:]

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Mr. Burgess. Thank you, Dr. Strain.

Dr. Martz, you are recognized for 5 minutes, please.

STATEMENT OF KENNETH MARTZ

Mr. Martz. Good morning. Thank you so much, Chairman Burgess and Ranking Member Green, for this opportunity to come here and testify on this important issue. You know, this is an issue that is affecting 23 million Americans who are in recovery from substance use disorder and who have had their experience with treatment and are now working through the system in addition to those who are actively in substance use disorder.

I am Dr. Ken Martz. I am a licensed psychologist. I am working with Gaudenzia. I have been working in multiple states in private practice and in state government settings, in public settings as well as private, for 25 years. This has been my life's work and my passion and I love this work and I really appreciate this opportunity.

42 CFR's protections are critical to maintain, to ensure that people enter treatment for substance use disorder. This is something we know from SAMHSA, which has studied this extensively, and they find that the top reasons why people do not go to treatment continue to be fear of stigma. What will my employer think? What will my neighbors think? What harms will come of me if I disclose those secret harms and guilts and shames? The research finds that this fear of impacts is a primary reason.

You know, and the Congress recommended this as well, back in 1972, they stated that "The conferees wish to stress their

conviction that the strictest adherence to the provisions of this section is absolutely essential to the success of all drug abuse prevention programs." This was echoed by the Supreme Court as well, which affirmed "like the spousal and attorney client privileges, the psychotherapist patient privilege is rooted in the imperative need for confidence and trust."

Treatment by a physician for his physical ailments can often proceed successfully on the basis of physical examination and the results of diagnostic tests. Effective psychotherapy, by contrast, depends on the atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. For this reason, the mere possibility of disclosure may impede the development of the confidential relationship necessary for successful treatment. I urge you to remember the wisdom of these chambers.

Oddly, it is funny. We walk in here today and the news of the day is about hacking and data breaches and Cambridge Analytica with a new focus on there being death penalty for those who have a substance use history and have sold a drug. So if my child hands over some drugs to his girlfriend, she dies, he is now potentially at risk. We don't know what the laws will change in the future. This has a chilling effect on people being willing to attend treatment.

You know, the impacts on patients, you know, I know you know

you are hearing from many healthcare organizations that find this very inconvenient, but this is not about inconvenience. This is about patient care. This is about patient health and being able to access exactly what they need. If we want to discuss coordinated care the best way to do that is direct conversation with the patient and direct conversation therapist-to-therapist which is not impeded by 42 CFR protections. It actually gives the patient the respect of being involved in that process.

If you are going to share my information about my trauma and my trauma histories, please do me the respect of asking me and letting me know where it is going to go to before it gets shared to thousands of other people potentially having access. Now, put simply, some of the important protections included that once they are labeled it can affect clinical decision making for a lifetime. It cannot be amended and you cannot fix things like prison time or loss of employment. These are professionals we are talking about like teachers, physicians, government workers, who may avoid treatment for fear of harm, for fear of being disclosed, and therefore they may get worse because they didn't get the care that they needed because they have delayed. You know, the stigma is still alive long and strong.

Looking at some recent comments, one was said, overdose is nature's way of taking out the trash. Oh my gosh.

Overdose is nature's way of taking out the trash.

I have plenty of compassion for those who deserve it. I have

no compassion for those who made their own problems such as dopers, pedophiles, and murderers.

It is hard to even say these words. These are the levels of stigma that is out there today that our clients are facing on a daily basis and it is very difficult to identify and manage these harms that may arise. Eliminating these Part 2 protections will brand these individuals with like a scarlet letter so they when they walk in the door they can be identified immediately as having this problem, as having this history as well as the risks associated.

Stigma affects all of us in many different ways. Remember that making these changes is every time we make these changes, every time changes are made as a provider I need to learn about them, I need to train the field and, worse, tell the client that every day what they told me yesterday in private is no longer private today. You know, in all my years, I can't tell you how important this is. And if there was only one other thing that you could possibly do, and in addition to this I would be happy to answer other things, please get rid of that IMD exclusion. It is harming people and stopping care. Thank you.

[The prepared statement of Mr. Martz follows:]

**********INSERT**********

Mr. Burgess. Thank you, Dr. Martz.

Mr. Bauer, you are recognized for 5 minutes, please.

STATEMENT OF BRAD BAUER

Mr. Bauer. Thank you and good morning. Chairman Burgess, Ranking Member Green, and members of the Health Subcommittee, thank you for the opportunity to testify today on the role of Prescription Drug Monitoring Programs or PDMPs in combating the opioid crisis as well as the PDMP discussion draft from Representative Griffith and Ranking Member Pallone.

My name is Brad Bauer and I am senior vice president with Appriss Health and have responsibility for our state and federal PDMP solutions. We provide a common platform and software solution for 42 of the 52 established PDMPs throughout the United States and U.S. territories. State-based PDMPs continue to evolve and innovate in the face of our nation's opioid crisis. While each states faces unique challenges brought on by the crisis, tremendous progress has been made within a few critical areas each of which have been identified by government and research organizations as best practices to ensure effective and impactful PDMPs.

First, the ability for states to share PDMP data with other states provides prescribers and pharmacists with a more complete view of the patient's controlled substance history. In 2011, the National Association of Boards of Pharmacy created a PMP Interconnect with technical assistance from Appriss Health to allow states to securely and efficiently share data in real-time

at no cost to the states.

[Slide.]

Mr. Bauer. As you can see on the monitors, the numbers of states participating has grown rapidly to 45 PMPs today. For the remaining states not currently participating, policy issues not technology are the only barriers. Most recently, Florida passed legislation allowing the state to share their PDMP data with other PMP Interconnect states effective July 1st, 2018.

Second, and probably the most impactful developments for state PDMPs, has been integration of PDMP data and analytics within the electronic health record or pharmacy dispensation system to enable one-click or in some cases no-click access for prescribers and pharmacists. The majority of states are moving in the direction of active integrations of their data and analytics within clinical workflows with about 20 percent of providers currently having access to integrated PDMP reports.

However, broader adoption has been slow due to the need for funding to cover costs of integrations. Integration of PDMP data and analytics promotes efficient and consistent use of PDMPs by providers when making clinical decisions. For example, Ohio has seen a 1000 percent increase in usage of the PDMP as a result of their statewide PDMP integration effort.

States are also in the process of transforming their basic

PDMP systems into substance use disorder platforms that deploy the capabilities necessary to impact the epidemic and bend the overdose death curve down and not just drive down the number of controlled substances prescribed. States like Indiana, Oregon, Michigan, Delaware, Iowa, Ohio, and Virginia are just a few examples of states that have already taken steps to transform their PDMPs.

Examples of new developments in PDMP capabilities include inclusion of additional data sources such as history of nonfatal overdoses; drug court information and toxicology data; patient-at-risk scores to help a practitioner quickly assess the risk and engage the patient accordingly; the ability to refer patients to treatment, often referred to as a warm hand-off within the PDMP; and facilitation of care team communications.

All these capabilities and clinical tools are designed to help the practitioners identify prescription drug overdose sooner versus later, mitigate the chance of an illicit drug encounter, and engage with their patients and assure they have and receive the help they need. The PDMP discussion draft from Representative Griffith and Ranking Member Pallone would incentivize states to continue to improve their PDMPs through evidence-based prevention grants along with evaluating interventions to prevent overdoses and implementing new projects to respond to the evolving crisis in innovative ways.

As you have heard one of the panels yesterday, the Centers

for Disease Control is engaged in a number of these activities but the legislation authorized would help to improve on CDC's work. Second, the draft would establish grants for an enhanced surveillance of controlled substance overdoses which would authorize and provide funding for an existing CDC program to collect more comprehensive, timely, and quality data on overdoses.

We would recommend that this data be incorporated into the PDMPs. This discussion draft would allow states to continue their PDMP innovations to provide prescribers and pharmacists with a near instantaneous access to interstate PDMP information combined with the clinical tools to intervene in a meaningful way when a patient presents with a possible risk overdose misuse.

Thank you for your leadership on this critical issue facing so many communities and for the opportunity to address the committee today. I look forward to your questions.

[The prepared statement of Mr. Bauer follows:]

**********INSERT**********

Mr. Burgess. Thank you, Mr. Bauer.

Dr. Banner, you are recognized for 5 minutes.

STATEMENT OF WILLIAM BANNER

Dr. Banner. Chairman Burgess, Ranking Member Green, and members of the subcommittee thank you for the opportunity to testify in support of the reauthorization of the national poison center program entitled, Poison Center Network Enhancement Act of 2018. This legislation was first enacted into law in 2000 and has been reauthorized three times. The measure before the subcommittee today would reauthorize the poison center program through fiscal year 2024.

My name is Dr. Bill Banner and I currently serve as the president of the American Association of Poison Control Centers. I am also the medical director of the Oklahoma Center for Poison and Drug Information. For over 30 years, I have been privileged to care for critically ill children, currently practice in the pediatric intensive care unit at Baptist INTEGRIS Medical Center in Oklahoma City. I also happen to be downsizing to a home in Congressman Mullin's district.

The nation's 55 poison control centers operate 24/7/365 to cover all U.S. states and territories and receive three million calls annually including about 70,000 calls a year for exposures to opioids. Nearly one quarter of our calls come from emergency rooms and urgent care facilities. Calls are answered by highly trained medical professionals with 24-hour oversight from physicians who are board certified medical and clinical

toxicologists, many of whom are trained in addiction medicine. We handle calls related to over 430,000 products and substances and their related toxicities. Poison control centers are on the front lines of the opioid epidemic handling approximately a half million cases of opioid misuse and abuse since 2011. That is an average of 192 per day, every day. We assist first responders and hospital personnel.

[Slide.]

Dr. Banner. As you can see from the slide, the percent of opioid exposure calls from healthcare facilities to poison centers are on the rise and we believe this will continue in 2018. We deliver countless hours of education on topics like identifying emerging drugs of abuse and the safe storage and disposal of prescription opioids. Through national surveillance activities, poison centers have identified trends involving fentanyl and other opioid analogue penetration into communities which is then shared with federal, state, and local enforcement.

Centers also educate on the proper use of naloxone. With the rise of heroin mixed with the more potent fentanyl, the administration of naloxone has become far more complex and dangerous for emergency responders to administer. Centers also contribute to medical education on pain management, prescribing, and addiction treatment. Consultation with a poison control

center can also significantly decrease the patient's length of stay in a hospital and decrease hospital costs. In fact, poison control centers save more than $1.8 billion annually including $382 million in Medicaid and $307 in Medicare per year.

Poison center data can often be utilized to identify new and emerging drugs of abuse faster than virtually any other resource. For example, this past summer, the Georgia Poison Control Center, which serves Subcommittee Carter's district, was the first public health entity to detect and respond to a novel opioid outbreak. Yellow pills stamped with Percocet that in fact contained a mixture of two synthetic fentanyl analogues that could have remained undetected indefinitely and racked up untold fatalities but for the work of the Georgia center.

This unique capability exists at every poison center in the country. Centers are also a critical resource for emergency preparedness and response. For example, centers have served in response to Zika, Ebola, synthetic cannabinoids, e-cigarettes, H1N1, marijuana abuse and misuse, carbon monoxide, toxic exposures following national disasters, and even the social phenomenon, the so-called Tide Pod Challenge.

Additionally, each center has an educator working to increase public awareness on the dangers of poisoning and opioid misuse. In fact, this week is National Poison Prevention Week. Examples of education outreach surrounding the opioid crisis include presentations to parent groups regarding medicine

literacy and substance misuse prevention as well as participation in local community events.

In summary, poison control centers are a unique combination of clinical care, cost effectiveness, public health surveillance, and interaction with those on the front lines of the opioid crisis from first responders to law enforcement and everyone in between.

I want to thank Representatives Brooks, Engel, Barton, and DeGette for their continued support and bipartisan introduction of this critical legislation. It is a proven, highly efficient network most deserving of full congressional support and reauthorization. I am happy to answer any questions you may have. Thank you again for this opportunity.

[The prepared statement of Dr. Banner follows:]

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Mr. Burgess. Thank you Dr. Banner.

The vote on the floor has been called. But, Dr. Kilkenny, let us hear from you and then we will recess until after votes. So you are recognized for 5 minutes.

STATEMENT OF MICHAEL KILKENNY

Dr. Kilkenny. Chairman Burgess, Ranking Member Green, and members of the subcommittee thank you for inviting me today to testify on behalf of local health departments across the country that are facing unprecedented threats in the form of opioid-related death and disease.

My name is Michael Kilkenny. I am the physician director of the Cabell-Huntington Health Department in Huntington, West Virginia. I am representing health departments today as a member of the National Association of County and City Health Officials, NACCHO. More than a hundred Americans die each day from overdose with a staggering economic toll impacting the workforce of this generation and threatening generations to come.

My state has nation leading rates of overdose death, Hepatitis B, Hepatitis C, and neonatal abstinence syndrome. My county along with 28 other counties in my state and 220 counties across the nation face the real threat of catastrophic HIV outbreaks. These challenges, however, create remarkable opportunities for us to save lives and prevent disease.

In 2015, Huntington leaders implemented a comprehensive opioid response plan that is changing those statistics at home. With help from CDC we started the first sanctioned harm reduction program in West Virginia. We trained and supplied all our law enforcement agencies with naloxone. Cabell County community

members and first responders reversed more than 2,500 overdoses last year, saving countless lives and a new Quick Response Team is linking overdose survivors to treatment. Without federal support we would not have been so successful.

Regarding infectious disease, the opportunity to prevent is now. In my county we have been able to decrease of new Hepatitis C cases by 60 percent, using harm reduction strategies and training from CDC. And CDC assistance in surveillance has allowed us to identify and implement specific strategic measures to prevent an HIV outbreak. The Eliminating Opioid-Related Infectious Diseases Act of 2018 authored by Representative Leonard Lance of this committee would provide an additional $40 million to CDC, money needed for Hepatitis C and HIV surveillance activities that help local health departments stop outbreaks before they occur, especially infections associated with injection drug use.

On behalf of NACCHO I would like to suggest the bill be expanded to include surveillance of Hepatitis B. Opioid overdose from prescription and illicit drugs require special surveillance and rapid intervention to address emerging drug threats.

Fentanyl, a particularly deadly opioid due to its potency, struck my city and other parts of our nation especially hard in 2016. It remains the drug most frequently found in overdose autopsies from my county. Any street drug product might contain fentanyl, and neither users, police officers nor public health

officers know if it is there or not. A bill to improve fentanyl testing and surveillance authored by Representative Ann Kuster addresses this threat with assistance to public health laboratories in detecting fentanyl and its many analogues.

NACCHO recommends that in addition to agencies named in this bill, CDC should be included in these efforts. I also support the pilot program authorized in this bill which would allow point-of-use testing that could save lives and modify drug use behavior. Local health departments like mine are working 24/7 to save lives and reduce the risk of opioid overdose and the risk of life-threatening infections.

In closing, I hope that Congress will make an increased investment in funding for CDC and other public health agencies engaged in this fight. We have seized our opportunity in Huntington and we are succeeding. NACCHO represents nearly 3,000 other local health departments, big and small, ready to fight this opioid epidemic and we need your ongoing help. Thank you.

[The prepared statement of Dr. Kilkenny follows:]

**********INSERT**********

Mr. Burgess. Thank you, Dr. Kilkenny.

Again the chair observes we do have a vote on the floor. So we are going to take a recess so members can go and be recorded on a procedural vote on the floor of the House and we will reconvene immediately after votes where we will start the member questions. So thank you all for your testimony. We stand in recess.

[Whereupon, at 10:30 a.m., the subcommittee recessed, to reconvene at 11:12 a.m., the same day.]

Mr. Burgess. I call the subcommittee back to order. Again I want to thank our witnesses for their testimony. We are going to move into the question portion of the hearing, but I do want to recognize the gentleman from Texas for his unanimous consent request.

Mr. Green. Thank you, Mr. Chairman. I request unanimous consent to enter into the record a statement from Representative Ann Kuster who actually sat through some of our hearing yesterday in support of her draft under consideration to improve fentanyl surveillance and testing as well as bills featured as part of the Bipartisan Heroin Task Force legislative agenda for 2018. I ask unanimous consent the statement will go in the record.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT**********

Mr. Burgess. And the chair will recognize himself for 5 minutes for questions.

Dr. Banner, in your testimony you referenced the difficulty of treating fentanyl with naloxone. Could you elaborate on that just a little bit?

Dr. Banner. That is a pharmacologic and toxicologic problem. As you, I am sure, recognize fentanyl's potency means that naloxone may at times be required to give increased doses to reverse it because it is binding to the mu receptors. And I know I am not talking to most of the people in the room, but --

Mr. Burgess. Just talk to me. It is okay.

Dr. Banner. The mu receptor affinities are so high --

Mr. Burgess. That is why I am sitting in this chair.

[Laughter.]

Dr. Banner. -- with that affinity it takes a lot of naloxone sometimes to reverse them. Plus, if they have, if they are chronically using fentanyl and they get their body burden increases then the apparent duration of action of fentanyl can exceed the duration of naloxone and you may have to give a repetitive dose. And the third issue is that there are pretty good case reports where reversing fentanyl produces such a surge in adrenalin that you actually can get noncardiogenic pulmonary edema, or a flooding of the lungs with fluid, and that of course can convert a life-threatening situation into a life-threatening situation. So, you know, we feel like that has upped the ante

quite a bit.

Heroin reverses pretty easily and it has, the duration of action of heroin itself is 7 to 8 minutes so it is a rapid high. If you get in trouble you reverse it and then the naloxone usually covers it. But drugs like methadone when they are involved or some of these fentanyl derivatives can really prolong the toxicity and therefore the need for repetitive doses and it makes it more complex.

Mr. Burgess. All right, thank you. The way you are in your testimony that administration of naloxone is far more complex and dangerous for emergency responders to administer, I misinterpreted it. I thought for some reason it would be dangerous to the ER doc, but you are saying it is dangerous to the patient --

Dr. Banner. Yes.

Mr. Burgess. -- during the administration episode. Very good. Thank you for clearing that up.

And, Dr. Kilkenny, let me just ask you. We started this week in another subcommittee, the Oversight and Investigation Subcommittee, with the acting administrator of the Drug Enforcement Administration and focusing more on sort of the enforcement side of this equation. And your state obviously came up for some discussion because of the delivery of pharmaceutical product to locations that seemed far in excess of the population that would be making itself available to that retail

establishment, and I am trying to say that as carefully as I can.

But then in your testimony you talked about in 2016 fentanyl sort of bumped up. Were you aware in your communities that this problem of the excess delivery was occurring? Was that something that was novel when it was discovered? Just kind of let us know what you saw on the ground as those years were unfolding.

Dr. Kilkenny. Because I live there and I have seen the pill mills operating and I knew when I was practicing how that worked, I was not surprised to know that there was an overabundance of supply to very small towns that were servicing certainly the vehicles parked in those parking lots had license plates from all over the country. So I was aware of that practice, but I wasn't aware of the staggering numbers until they came in later.

That distribution I think temporally occurred before the big switch to injection drug use that we saw using heroin. And there was always fentanyl around, but in 2016 something appeared to us to happen in the supply chain. And we saw --

Mr. Burgess. Let me just interrupt you. The supply chain of fentanyl is not coming through the supply chain, right?

Dr. Kilkenny. We are talking about the illicit supply chain.

Mr. Burgess. Illicit, okay.

Dr. Kilkenny. The illicit supply chain of fentanyl seemed to change really remarkably in the second half of 2016 and the entry of the fentanyl analogues really picked up then. That is

when we started seeing a massive increase in overdoses and overdose death.

Mr. Burgess. That seems to have been catalyzed by the initial excess distribution phenomenon that was happening in your neighborhoods.

Dr. Kilkenny. I certainly do not argue with that iatrogenic component that this started with prescription drugs.

Mr. Burgess. And I guess our frustration when we talked to the DEA on Monday was it seems like there was a blinking red light on the dashboard, why didn't anybody check the engine, you know what I mean? I always lived in fear of the DEA when I was in practice. I thought they knew everything about me, every prescription that I wrote, every patient that I treated. Then it turns out on Monday we hear that they really weren't paying that much attention and it was startling information to me.

Dr. Kilkenny. Apparently not, but I don't think we as physicians were as red-flagged as we should have been while we were prescribing under the pain as the fifth vital sign rule.

Mr. Burgess. Sure.

Let me recognize Mr. Green from Texas 5 minutes for questions. I have some additional questions that I may try to get to at the end. But, Mr. Green, you are recognized for 5 minutes.

Mr. Green. Thank you, Mr. Chairman, and I want to welcome our panel here today. I want to thank all our witnesses for

joining us.

We agree that the opioid epidemic is a multisided problem and will require a multipart solution. As part of the solution it is essential that we expand access to treatment. We must also identify strategies that encourage individuals with substance use disorders to seek and remain in treatment. I am concerned that the proposed proposal to roll back protections under code federal regulations titled 42 Part 2, commonly known as Part 2, would do the opposite.

Dr. Martz, in your testimony you state that if patients with substance use disorders are afraid their treatment records will be used against them they will not enter treatment. Could you explain the important role of confidentiality plays for individuals with substance use disorders in retaining and entering treatment and working towards recovery?

Do you want to turn on your mike?

Mr. Martz. Thank you. It plays a critical role. If you are working to decide whether or not I am going to enter treatment, whether or not I am going to deal with the issues that are most relevant in treatment that is a critical protection to have. We know that folks will not come to treatment if they are afraid of what the impacts will be. So, for example, I worked with parole and probation for quite some time and there would be some question of, you know, someone goes and they are having a holiday party, and they go and they show up and there is drinking there,

not a surprise. But then they start to have cravings.

So the work of treatment has to do with having a safe space to be able to discuss these issues clearly and directly without, rather, having to say oh no, I didn't have any problems and nothing was going on here, so that for fear that I would disclose it to somebody else. You know, it is a role like, more like a priest/penitent relationship than just other roles.

Mr. Green. Why are the heightened protections provided under Part 2 critical to creating the safe environment for treatment for individuals with substance use disorder that you describe in your testimony?

Mr. Martz. It is critical for the safety. One of the key elements in terms of treatment is that there is a therapeutic alliance and sometimes it takes weeks or months to build a relationship. I have had clients that were with me for 6 months before they suddenly say all right, now I am going to tell you the truth about what is really behind this, you know, so it takes time to build a relationship. It takes time to have that safety and anything that is going to damage that safety such as fear that this will be disclosed, it will impact that and prevent them from entering or staying in treatment or working on the critical elements within it.

Mr. Green. According to a letter submitted to the Committee from the Campaign to Protect Patient Privacy Rights, rolling back the Part 2 protections to the HIPAA standard will contribute to

the existing level of discrimination and harm to people living with substance use disorder and will only result in more people who need substance use disorder treatment being discouraged and afraid to seek the health care they need during the nation's worst opioid crisis.

Dr. Martz, will you discuss how rolling back Part 2 protections to HIPAA standard harms efforts to create a safe treatment environment and potentially leads individuals with substance use disorder in not to enter or remain in treatment?

Mr. Martz. Thank you. Many of our folks have dealt with trauma, for example, and so one of the things that is a really critical difference between HIPAA and 42 CFR is that with 42 CFR when I disclose to my clinician I know that it is private unless I sign and get information that it will be shared with somebody else. When I share with my clinician about the sexual trauma and assault that I faced previously that is a private conversation and before that gets shared with multiple other people without my knowledge, which is what the standard would be under HIPAA, that is a problem.

So when information comes back to me from some other clinician that gets the information from the clinical record rather than having that conversation with me directly when I am not ready to share it, it is a severe damage to the trust that is needed for a relationship for treatment.

Mr. Green. Thank you. I support strongly the efforts to

expand access to treatment, encourage individuals to seek and remain in treatment. I am concerned the proposed changes to 42 CFR Part 2 misses the mark.

And in my last few seconds, in my earlier life I did probate work and in Houston, Texas the probate judges are also the mental health judges. And I was honored, I think, when the judge decided he wanted to appoint me to be on the mental health docket for about 3 weeks, and this is before HIPAA. It was in the '80s and we still had that protection, though I don't know if it was under state law or federal law at that time that even the lawyers we had to destroy all our information.

And believe me it would have been really difficult to get people in treatment if they knew that would be available to potential employers and that. Now, if there is a danger we all have a responsibility to that whether you are a medical professional or what. But just that average letting people know someone is under care, it really bothers me.

Thank you, Mr. Chairman. I know I have run out of time.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from Kentucky, the vice chairman of the subcommittee, Mr. Guthrie, for 5 minutes.

Mr. Guthrie. Thank you, Mr. Chairman. I appreciate the opportunity to be here and all the witnesses being here. I am going to focus my questions to direct them to Mr. Bauer who is from back home. We have had several Kentucky witnesses over the

last yesterday and today and have been fantastic witnesses, but only says that we have a big issue in our state like surrounding states and then it is spreading. So that is why what we are doing here is so important to make sure that we move forward.

But I am going to focus on the Prescription Drug Monitoring Program. So when providers check their PDMPs or Prescription Drug Monitoring Program, what is, to Mr. Bauer, what is the evidence that this actually changes their prescribing or dispensing behavior resulting in improved patient outcomes and lives saved?

Mr. Bauer. I thank you, Vice Chairman, for the question. Today with the PDMP programs one most impactful issue with the program is integration of that information into workflow. And we are finding that that really helps to enable efficient access to the PDMPs, so the PDMPs are checking. There are 40 states that have mandated use laws in place today which mandate the checking of the PDMP in one way, shape, or form.

So we have seen the use of the PDMPs having an impact on the overall volume of opioids prescribed. We think that is in conjunction with policy at a state level as well. From an outcomes perspective there are current studies that are underway, one of which is Appriss Health has a study underway to understand the actual outcome of checking the PDP on opioid death, the death curve. So that study is not completed yet. We are about 3 to 4 months into that study.

Mr. Guthrie. Thank you. And also you mentioned that some states are turning the PDMP into a substance use disorder platform. Can you elaborate on what that means and how it would help someone who might be at risk of addiction or substance misuse?

Mr. Bauer. Sure. When PDPs were first formed many years ago they were more of a diversionary tool that was used to understand drug diversion. The programs have since morphed into more of a public safety tool.

So, today, information in the form of data, prescription data, is sent to the prescriber or pharmacist for review. States are now moving past that what they call the phone book of data trying to understand within that information what is the issue with this patient or what is the risk that this patient represents from an overdose perspective. And we are moving that into more of a substance use disorder platform to provide the clinicians, the prescribers, and pharmacists more clinical information so they engage with their patient while that patient is right there in front of them versus trying to read through a phone book of data in the 20 or 30 seconds that they have.

So, adding additional datasets such as nonfatal overdose, providing for referral of treatment while they are in their PDMP, a peer-to-peer communication, et cetera, are all clinical tools that are designed to truly engage that patient before they go to an illicit drug event.

Mr. Guthrie. Okay, thank you. And I have a final question

for you. PDMPs are not only critical to prescribers for identifying beneficiaries that are high users, but also in avoiding potentially dangerous drug interactions. It is my understanding that for the most part PDMPs are not allowed to have data or are prevented from having data on patients receiving methadone. On the other hand, buprenorphine prescribed in an office space setting is typically filled at a pharmacy which is then submitted to PDMPs. So why are methadone and buprenorphine treated unequally when it comes to PDMPs, and can we do anything to include this information but still protect patient privacy?

Mr. Bauer. Thank you for that question. What we find today from the PDMPs as far as collecting that data such as methadone or buprenorphine prescriptions, buprenorphine, for example, is a prescription that is actually prescribed and typically picked up at a retail pharmacy therefore reported to the PDMP. Methadone on the other hand is typically administered within a substance use, a clinic and therefore by law not reported to the PDMP.

So that is the difference as far as --

Mr. Guthrie. Well, could somebody get methadone at a methadone clinic and also have a prescription for buprenorphine, I mean, or are they interacted?

Mr. Bauer. They certainly, the short answer is it is possible.

Mr. Guthrie. So I mean, I guess just to the question because I am about out of time, can we address that with -- I know the

idea for the methadone is patient privacy. Can we address that?

Mr. Bauer. Yes. Obviously we want to take privacy into consideration from a PDMP perspective obtaining that methadone administration, administered methadone is critical to understanding the overall risk of that patient.

Mr. Guthrie. Okay, thank you. And I have 5 seconds, I yield them all back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentlelady from California, Ms. Matsui, 5 minutes for your questions, please.

Ms. Matsui. Thank you. Thank you, Mr. Chairman. And I want to thank the witnesses for being here today.

Dr. Martz, thank you for your testimony. I have been a champion of building greater education and awareness about HIPAA privacy regulations particularly as it applies to tricky mental health situations, because I recognize the necessary balance between patient privacy and access to information for purposes of quality treatment. I appreciated your nuanced understanding of the importance of confidentiality for patients suffering from a substance use disorder and the different ways a stigma plays into the situation.

I am also sympathetic to the caregivers and doctors who are trying to better serve patients and to stories of patients who are harmed because the provider didn't have the right information to make the right clinical decision. I am hopeful that working

together we can find the appropriate path forward on this issue. From your perspective, how well do you think patients know their rights under HIPAA and specifically under 42 CFR Part 2 and the recent SAMHSA update?

Mr. Martz. Thank you for the question. Patients are pretty widely available and it is usually one of the very questions that will be asked, who is going to get this information? And if even if they don't ask that up front, it is our responsibility as clinicians to immediately give them that information about what you are going to be sharing, what are the limits of confidentiality and what are the conditions under which is would be released or excluded.

One of the challenges with the multiple changes we have had in the last year now from SAMHSA is that every time it comes out of the change we have to identify the regulation, we have to update our forms, we have to retrain the field, and re-have that conversation with the client which is very damaging to the relationship that has been built.

Ms. Matsui. Right. So the familiarity amongst the doctors and caregivers need to be updated. So do you think it would be meaningful for HHS to conduct more education and awareness?

Mr. Martz. Absolutely, across the field not only treating clinicians but also physicians and other allied professionals that are interacting so that we better coordinate the care. Very often, the problems that are found from confidentiality are really

training issues rather than actual burdens.

Ms. Matsui. Sure. Well, do you think there is certain situations or circumstances under which sharing a patient's substance use records would be beneficial to their coordinated care? So, for example, in the case of accountable care organizations that are specifically targeting comprehensive services for those with multiple conditions such as substance use disorder co-occurring with something like diabetes or depression?

Mr. Martz. Yes. And it is very common to coordinate care and it is actually an expectation of myself and all the clinicians that I have worked with that we are to coordinate substance use, mental health, medical conditions. The difference is that there is a protected element for them to discuss the private areas and it is a clinical issue to engage them to have that trust to open the relationship and dialogue with the other clinicians to maintain that constant communication.

Ms. Matsui. Okay. Well, thank you.

Dr. Strain, thank you for your testimony. As I mentioned previously, I am committed to advancing coordinated patient care without sacrificing patient privacy, especially around a sensitive and stigmatized disease. Recently, SAMHSA released some regulations that broadened rules about re-disclosure and 42 CFR Part 2. Do you think that it has been helpful to providers; alternatively, did it go far enough?

Dr. Strain. So I thank you for that question,

Representative. I think that we haven't gone far enough. I think that we need to provide a mechanism whereby information can be more seamlessly shared between providers who are not in a substance abuse treatment program and those who are in a substance abuse treatment program. I think that at the end of the day, I am interested in seeing us do better in terms of coordinating care across those two foci, and the current barriers make that difficult.

Ms. Matsui. Yes. So in your testimony you provided some very compelling examples particularly if a patient is incapacitated. For things like asking patients about history of substance use, what type of training do doctors currently receive about best practices?

Dr. Strain. So training by physicians is variable by medical school. There is not a national standard for training, a federal standard, but there is increasing amounts of training in medical schools and by, for physicians in terms of substance abuse and education and it is a critical part. It has become a critical part especially in the current climate.

Ms. Matsui. I can see that we need more, probably, continuing education about this. Generally, if a patient is incapacitated or unconscious your testimony implies there is no way for a doctor to know if a patient has a history of a substance use disorder. Is that absolutely true? For example, can a doctor make inquiries of next of kin?

Dr. Strain. I am sorry?

Ms. Matsui. Can the doctor make inquiries of next of kin?

Dr. Strain. Certainly the doctor can make inquiries of next of kin to attempt to determine that if they are available.

Mr. Guthrie. [Presiding.] Thanks. I know we are pushing up against votes for another round of votes --

Ms. Matsui. Okay, thank you.

Mr. Guthrie. Thank you. The gentlelady yields back. I now recognize the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. Griffith. Thank you very much, Mr. Chairman.

Over here, and I am going to continue, Dr. Strain.

Doctor, you were just talking about what the doctor can find out by asking the next of kin. And one of the issues that we dealt with, not opioid directly related but dealing with violent tendencies and violence that we were trying to deal with in CURES and in some other things, was trying to figure out how we keep privacy for individuals but at the same time have some family involvement where the family is actually involved in a person's life, because if they have a significant mental illness and maybe also a drug addiction on top of that it is sometimes very difficult for the family to get information because of the HIPAA laws.

So Dr. Martz raises good points, but how do we reach that balance where particularly if you are living in the home with parents or a sibling that they can have enough information to know

whether, A, they are in danger, or B, how they can be of most assistance to their beloved family member? Any ideas for us?

Dr. Strain. I think that -- thanks. It is a critical question, Representative Griffith. And it really comes down to, I think, the provider-patient relationship and that judgment that occurs in that relationship in terms of where do I -- I treat patients, and where do I go in terms of when I have information that I believe has reached a critical point where I need to bring in a family member and inform them that? And there can be instances where I may do that even if the patient is saying I don't want you to do that.

So obviously, for example, if there is issues of abuse of a child or a parent or things like that I may be compelled to do so, or if somebody is reporting that they are suicidal or homicidal. But at the end of the day, it does distill down to I think that relationship and the provider having determination of where do they need to go with the information that they are receiving. I think that trying to create a systematic answer to that may be challenging.

Mr. Griffith. Well, we found it to be a challenge but we are still working on it, because obviously with the number of violent situations we have had in our country, these tragedies that have occurred, we are trying to figure out what is both right for the patient and right for society as a whole.

Switching gears and continuing to talk about the opioid

tragedies that are afflicting us, Dr. Kilkenny, you work in Huntington and Cabell County. Do you find that, because we had in O&I we had an earlier hearing this week on pill dumping and particularly into a couple of towns in West Virginia, do you find that those drugs coming into the small towns outside of your community -- about 56 miles away was one of them, Kermit, and the reason I know that is because it is only about 53 miles from my district in western Virginia.

Do you find that that has a spillover with the patients that you are seeing that some of those folks are coming from those rural areas where all these drugs were dumped?

Dr. Kilkenny. I think the evidence in West Virginia indicates that the current injection drug use, the illicit trade was spawned by an overprescribing and then a more responsible set of prescribing.

Mr. Griffith. So it would be reasonable to conclude that your testimony would also affect my district, which is about an equal distance although it takes longer to get through the mountains to get to mine from Kermit or from the other towns, that the problems would be very similar. It would be reasonable to make that conclusion, would it not?

Dr. Kilkenny. I think that Virginia, West Virginia, Kentucky, Tennessee, any of the Appalachian districts in those states are going to be affected the same as we are.

Mr. Griffith. Yes. That is pretty much my district.

Mr. Bauer, thank you for being here as well and thank you for saying some nice things about our draft legislation on PDMPs. I was really pleased to see the graph that showed that just a few years ago there were only a couple of states, one of which was my state in Virginia in 2011, but that now we have more than 40 states and all of the states continuous to my district are now there, because at one point Martinsville had the highest per capita use of -- and there is a formula that you would know, the morphine --

Mr. Bauer. Equivalents.

Mr. Griffith. -- equivalents of anyplace in the country and North Carolina was not a part of it. So hopefully that will be of some help. Can you explain further what we need to do to get all the states on the same page so that we are able to compare apples to apples, because I understand in some of the PDMPs that there is a difference in the data. Can you give us a few seconds on that?

Mr. Bauer. Yes, I can. Thank you for that question. So today as you know there are 45 states that do share data securely and efficiently with each other. It is up to the states' purview as to what state they wish to share data with. Typically it is the surrounding states and then another concentric circle.

The states that are not sharing data today it is truly a policy issue. The example I mentioned in Florida, Florida just recently passed legislation that will enable them to share,

effective July 1st of 2018, California is the same way. So these are certainly policy issues that are involved in not being able to share data right now.

Mr. Griffith. And I am out of time so I have got to yield back, but I would love to know if we can get everybody on the same page. I appreciate it, thank you.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from New Jersey, the ranking member of the full committee, Mr. Pallone, 5 minutes for your questions, please.

Mr. Pallone. Thank you, Mr. Chairman. I have some questions of Dr. Martz. I would like to thank all the witnesses for joining us today. I stated in my opening statement yesterday that I was concerned that H.R. 3545, the Overdose Prevention and Patient Safety Act could dangerously erect a barrier to patients seeking and remaining in treatment and therefore harm our efforts to respond to the opioid crisis.

According to the Substance Abuse and Mental Health Services Administration, the disclosure of records of individuals' substance use disorders has the potential to lead to a host of negative consequences including loss of employment, loss of housing, loss of child custody, discrimination by medical professionals and insurers, arrests, prosecution, and even incarceration.

So, Dr. Martz, I am hoping you can help us better understand

these consequences. The first question, I understand from your testimony that you have worked in a number of states in a range of settings and served a diverse mix of patients. Based on that experience, can you provide some context on the issues facing individuals with substance use disorder that make Part 2 heightened confidentiality protections important?

Mr. Martz. Thank you. Thank you. I think, and in response to your question I may have to respond with a brief note from the last listening session of SAMHSA, some notes that were submitted regarding 42 CFR from the folks that are affected here.

"Dear Administrator Hyde, I have a criminal record and attending recovery. I don't want my history to become a burden. I realize individuals have discussed good medical care for me will be compromised if all medical professionals cannot see my treatment records, but available to ones who must see them. I don't want to risk losing my family or my job or my housing due to someone knowing or finding out I have been treated with addiction. I don't want my past to jeopardize my future because I am doing the right thing. I am writing to ask privacy protections for patient records be maintained. I do not wish for this to be a lifelong burden. My privacy records are very important. I am soon applying for a job and I fear I will never have the chance to better myself in society otherwise. Thank you so much for even considering. We know we are but little value to society, but even if we were to become trash men one day it

would be the best for us and for free men."

There are a stack of these letters coming from these individuals. I also worked in the Pathways to Pardons project in Pennsylvania where we worked with folks seeking clemency, and there were many folks who were seeking clemency because they couldn't get jobs, they couldn't become nurses, they couldn't become promoted. They had various challenges that they couldn't work with. So even many, many, many years later there is a lifelong stigma attached.

Mr. Pallone. All right. Now a recent study published in the Journal of Addiction Medicine found that a significant portion of the study population of ED physicians at Johns Hopkins had low regard for patients with substance abuse. For example, 54 percent of survey responders indicated that they agreed that they, quote, prefer not to work with patients with substance use who have pain, and 54 percent agreed that patients like that irritate me.

So, Doctor, is this unique to the physicians in the survey or do individuals with substance use disorders sometimes face stigma and discrimination from medical providers?

Mr. Martz. Absolutely. There is an old term for, in the profession in some areas what is called a GOMER, Get Out Of My ER. There is just such an absolute disdain. And even in recent weeks and months as I mentioned, there were a couple quotes just out there from recent providers some of which I mentioned before,

for example, "Jail, the best way to beat addiction."

"Why is this a problem? Opioids are eliminating the bad folks in our communities -- smiley face."

"If they would stop reviving them there would be less usage."

The level of stigma and vitriol out there is widespread and which is what we are trying to protect our folks from, because some of the discrimination will be overt but some will be covert and use other reasons to say you are just, you are fired and we are not going to use you, but rather than saying oh, it is because you have a history of this.

Mr. Pallone. And then my last question deals with the dramatic increase, the presence of substance use treatment records, you know, in electronic health records and health information exchanges a lot of these records will be increasingly vulnerable to cyber attacks and breaches. You know, one of my Republican colleagues noted in reference to our committee inquiry to the healthcare cybersecurity that as technology becomes increasingly integrated with all levels of health care, cyber threats pose a challenge to the entire sector.

You want to just explain the impact of such risk? I mean there was a recent Ponemon Institute survey that found that half of HIPAA organizations expose patient data at some point and improper disclosures on patients with substance use disorder. I know we are almost out of time so quickly if you could.

Mr. Martz. Absolutely. Cybersecurity has been a growing

threat. We know, for example, in February 2015, an Anthem Blue Cross Blue Shield organization had 37.5 million records stolen. Russell Branzell, president and CEO of College of Healthcare Information Management, has said that health care is ground zero for cyber attacks. According to the Department of Health and Human Services, while all industries face this growing threat, the size and scope of the attacks on the healthcare industry have accelerated rapidly in the past few years. This is valuable information that can be bought and sold. And so cyber attacks are a serious risk and have been growing rapidly.

Mr. Pallone. Thank you. Thank you, Mr. Chairman.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from Indiana, Dr. Bucshon, 5 minutes for your questions, please.

Mr. Bucshon. Thank you, Mr. Chairman. First of all, I mean I just want to respond a little bit to this study about ER doctors. I mean there are people who come to the ER legitimately drug seeking trying to get legal ways to get drugs. This has nothing to people who are drug addicted. They are treated just like everybody else. But if you have ever spent any time in an emergency room, and I have because I was a heart surgeon, there are legitimately large numbers of people trying to get legal prescriptions or legal narcotics through coming to the emergency room.

And it is honestly insulting for studies to try to show that

the ER physicians, you know, are in some way not treating patients in an ethical and moral way. It is just not right. And let me just also comment on what it is like to be a physician -- and my wife is an anesthesiologist by the way also -- and have patients with taking unknown medications or have an unknown medication history. This is a really serious problem. If you are as a surgeon you don't know if they are on opioids, benzodiazepines, and in many cases certain dietary supplements.

I have had myself, personally, two patients who almost bled to death after heart surgery because they were taking supplements for vascular health. And my wife tells me every day, she is still in practice, she still has patients that have unexplained difficulty in being anesthetized with narcotic or benzodiazepine-based anesthetic agents, and looking at the medical record there should be no reason for that and the reason is is because it is undisclosed.

So, look, there is a balance here and Dr. Martz makes some great points. But I just wanted to point that out that, you know, it is a difficult problem for medical providers and we need to find a balance.

Dr. Strain, I know there are concerns that if we amended the statute to allow substance use disorder treatment information to be disclosed it could be used in criminal proceedings, cause someone to lose their housing, employment, or even child custody. Does the amendment to H.R. 3545 include safeguards to prevent this

from happening?

Dr. Strain. Thank you, thank you for those comments and thank you for the question. Absolutely, my understanding is that there are safeguards within the Mullin amendment that does prevent those sorts of concerns.

Mr. Bucshon. Yes. And many people with substance abuse disorder also struggle with mental illness or have comorbid conditions such as diabetes or hypertension. How does 42 CFR Part 2 prevent quality care coordination?

Dr. Strain. So it is a great question. And the dilemma as you actually illustrated earlier is that the provider may be seeing a patient who is in substance abuse treatment and not know about that and then can't coordinate their care in terms of infectious illnesses or other medical problems that have arisen related to their substance abuse. And the patient may not be telling them about that or may not be fully disclosing, for example, what medications they are on through their substance abuse treatment program.

We want to be holistic about treating people. That is at the end of day that is what we should be striving to do and right now we are segmenting out this part.

Mr. Bucshon. Yes. I mean I also want to point out that, you know, again as a physician, family members may not know the medical history of their loved one and I think Congressman Griffith was talking about that. And we tried to, in a mental

health bill a year or 2 ago we tried to change HIPAA a little bit to allow parents who have adult children who have severe mental illness to have some minimal access and we couldn't get that done because of the privacy issues. In fact, in your state I think had a state senator whose son had an episode and tried to kill him and then subsequently killed himself and so the system failed both of them, really.

But if you look at, for example, the directed donor program, say you are going to have your hip or your knee done and you want family members to donate blood and put it in the blood bank for you, there is a pretty substantial instance of that blood being rejected by the blood bank because of a blood-borne problem, usually hepatitis history, and family members don't necessarily know that their family member has had that history and they don't want that disclosed and I understand that.

I think we should look back to what happened in the '80s and the '90s with HIV and the critical issue we had there with privacy. And we have worked through that I think and maybe this is where we are going with drug addiction also. We clearly don't want people discriminated against for any reason, but we also want to be able to have holistic medical care that includes knowledge of a patient's addiction history. I yield back.

Mr. Carter. [Presiding.] The gentleman yields. The chair recognizes the gentlelady from California, Representative Eshoo.

Ms. Eshoo. Thank you very much, Mr. Chairman, and thank you to all of the witnesses. It is good to have you here on a subject that is, well, it really is wrecking communities and wrecking people's lives and there is enormous loss of life surrounding this issue. Over the last at least month or 5 weeks, I have had five friends and my sister, so six individuals that have shared with me the following:

They had hip replacement surgery. And I am directing this to Dr. Strain. They were sent home with a bottle of 100 tablets of either Oxycontin or Percocet. Now a hundred tablets of either is, I think, over the top. I am not a physician but that is a lot of pills. Why is that the case? Why is so much being prescribed?

Dr. Strain. So --

Ms. Eshoo. I would think, excuse me, that if you are not an addict you may have a new hip, but by the time you are finished with your recovery you will be an addict. So can you -- is there a kickback on these drugs? Can you enlighten us as to why so much is being prescribed? And this is the second most common surgery in the country. Number one is cataract surgery, number two, hip surgery.

Dr. Strain. So certainly if we were having this conversation even 5 years ago I would have said the reason that there is large numbers of pain pills being prescribed is because the medical profession has had it drummed into its head that we

need to be more aggressive about treating pain. And that is something that goes back 15 years and 20 years.

Ms. Eshoo. Well, I think it is important to stay ahead of pain, but a hundred?

Dr. Strain. I agree. I think that that --

Ms. Eshoo. And these were all, they were different hospitals that they were discharged from.

Dr. Strain. The current CDC guidelines do not recommend doing that. The current thinking by other professional organizations is not to be prescribing those sorts of amounts of pain medications. I don't know the particulars of these situations, but it is alarming to hear. And I think that the medical profession hopefully is --

Ms. Eshoo. But what would you suggest? What would you prescribe?

Dr. Strain. Well, first of all --

Ms. Eshoo. I am not asking you what prescription you would and how many pills you would prescribe, I am speaking in terms of policy.

Dr. Strain. In terms of policy I would say that there should be a much lower of medicines prescribed whether it is oxycodone or whatever. I would follow things like the CDC guidelines for a week, reevaluating the patient, using non-opioid medications for the treatment of pain. I should parenthetically note I am not a pain treatment doctor. I am a psychiatrist by training.

But I think a lot of about this because of this issue and my recommendations would be along those lines. Did I answer your question?

Ms. Eshoo. Well, does CDC have guidelines now on this?

Dr. Strain. Yes.

Ms. Eshoo. They do.

Dr. Strain. Yes. They issued guidelines about a year ago.

Ms. Eshoo. It seems to me they are not being, they either don't know about it or that they are just not paying any attention to it.

Dr. Strain. Well, I think that --

Ms. Eshoo. Do you have any suggestions that have, excuse the expression, more teeth in it?

Dr. Strain. Well, I think that from a systems level what we could do, I think that we need to become, we need to continue to be aggressive in our education of all healthcare providers about this, but I don't --

Ms. Eshoo. We really have a crisis obviously on our hands, but it seems to me that in the system itself, professionally, we are creating a whole other wave of it.

Dr. Strain. I think though I like to hope that we are turning the corner on that and not doing that.

Ms. Eshoo. Well, I don't know if -- let me just switch gears because I don't have very much time left. I am an original cosponsor of Congressman Lance and Kennedy's bill which makes

investments in CDC's surveillance of injection drug related infections. What barriers currently exist to states implementing drug related infection surveillance systems today?

Dr. Strain. Are you asking me that question or --

Ms. Eshoo. Well, whomever wants to answer.

Dr. Strain. I think you were commenting on this bill.

Dr. Kilkenny. Thank you. I think I can speak to that. The barriers are probably mostly manpower. We need more people to do the adequate case tracking and we need more communication amongst the agencies to not the same level of communication that this end of the table is talking about, but communication in the public health sectors to basically identify the risk, the risky individuals, and case-track them and work that epidemic with the methods that we use. It is a labor-intensive method.

Ms. Eshoo. I am not so sure I understand the answer, but I know we are going to have the opportunity, Mr. Chairman, to submit questions to the witnesses and I will do that.

Mr. Carter. Sure. Thank you.

Ms. Eshoo. I will yield back. Thank you everyone.

Mr. Carter. The gentlelady yields. The chair recognizes the gentleman from Florida, Mr. Bilirakis.

Mr. Bilirakis. Thank you. Thank you, Mr. Chairman, I appreciate it. I thank the panel for their testimony.

Mr. Bauer, Florida law as of January 1st, 2018 requires that all controlled substances dispensed to an individual be reported

as soon as possible, but no later than the close of the next business day to afford its PDMP the electronic Florida online reporting of controlled substances evaluation. If the controlled substance is dispensed on a Saturday and the pharmacy is closed on Sundays it could result in a 48-hour latency. Does typical notification latency range from 2 hours to 7 days depending on the state?

Mr. Bauer. Thank you for that question. Today there are 43 states that require submission of controlled substance prescriptions no later than 24 hours. There is one state that is real time, Oklahoma, and there are, the remaining states are either on a 7-day to 8-day cycle.

Mr. Bilirakis. Okay, thank you. And yes, elaborate a little bit, you know, as far as how important that is.

Mr. Bauer. Absolutely. The timely submission of information is extremely important. The 43 states that do submit the information no later than 24 hours, there are typically multiple submissions that are made of the dispensation when it leaves the pharmacy. For example, when it comes into our system we append that information. We provide our logic as far as appending that to the right patient and make that information available within about 5 minutes' time. So it very much near real time that once that information is received by the PDMP, in the case of Florida that information is made readily available within about 5 minutes' time.

Mr. Bilirakis. Very good. I know it is critical. I understood that many states are able to share PDMP data across state lines. However, even if states are connected to an information hub, isn't it true that those states do not necessarily have across state line information for all other states connected to the hub? Is that true?

Mr. Bauer. Yes. Today the 45 states that do participate in PMP Interconnect, for example, can share with all 45 states should they wish. It is up to the discretion of the actual state as to what states they wish to share information with. Again most states, in fact all states share data with at least their border states. Most draw another concentric circle and others look at different migration paths as far as the I-95 corridor or the I-65 corridor or the Northeast states as far as sharing information.

Mr. Bilirakis. Okay. I think I know the answer to this question but I am going to ask it. Can any state PDMP actually stop the fraudulent prescriptions from leaving the pharmacy if the patient obtained multiple prescriptions within the same day, potentially, across state lines?

Mr. Bauer. Yes. That is a great question. Built into today's PDMPs there are very efficient and effective ways where the states are actually proactively sending alerts based on various thresholds of the data both within their state and combined with multi-state data.

So, for example, understanding if a patient is traveling from

state to state to state accumulating prescriptions from multiple providers or multiple dispensers, that information can be made available via an alert is what we call based on specific thresholds that states set so those alerts are sent out proactively to the actual prescriber or pharmacist that is checking on that patient.

Mr. Bilirakis. What are we doing to call out those five states that aren't participating?

Mr. Bauer. Yes. That is a great question. Again it is more of a policy issue. California and Florida are addressing those issues as we speak. Florida will be online hopefully by July 1st, California later this year. The remaining states actually are in process, meaning the actual MOU, the memorandum of understanding that is required to share data among states is in review. The only states that are an exception to that are Nebraska and Hawaii. Those states have not yet engaged on the MOU process. But Washington State and Wyoming have.

Mr. Bilirakis. Very good, thank you. I yield back, Mr. Chairman, appreciate it.

Mr. Burgess. Will the gentleman yield to the chair for just a second?

Mr. Bilirakis. Yes, I will. Yes, I yield.

Mr. Burgess. I wanted to make the gentleman aware that in the appropriations bill that will be on the floor of the House, the NASPER language in the fiscal year 2018 omnibus bill, just to draw attention to the fact that it will promote these

Prescription Drug Monitoring Programs including implementation of activities described in the National All Schedules Prescription Electronic Reporting Act of 2005 that was this committee's product, and include, as amended, by the Comprehensive Addiction and Recovery Act of 2016 and this shall include efforts continuing to expand and enhance the utility of PDMPs in states and communities making them more interconnected real time and usable for public health surveillance and clinical decision making. The CDC shall use $10 million of the funds provided to conduct an opioid nationwide awareness and education campaign.

So that is a little bit different now we have actually got NASPER, which we have worked on in this committee as long as I have been on this subcommittee, is actually receiving funding in this appropriations bill should it pass in a little while.

So I now recognize the gentleman from New Mexico for 5 minutes for questions.

Mr. Lujan. Thank you, Mr. Chairman.

Mr. Martz, I would like to thank you for being here today, sir, all the witnesses who are with us today. My questions today will specifically be for Dr. Martz. Yesterday I was taken aback by the conversation about how providing individuals who continue to face stigma and discrimination with heightened Part 2 protections, which include the right to decide to whom to share their substance abuse treatment records, stigmatizes individuals

with substance use disorder. I was surprised to hear SAMHSA echo this accusation in the final rules modernizing Part 2 regulations. Those rules explicitly acknowledge the stigma and discrimination faced by individuals with substance use disorder.

All of America's antidiscrimination laws from Civil Rights Act to Americans with Disabilities Act to the Fair Housing Act provide heightened protections for populations like individuals with substance use disorder who face stigma and/or discrimination because of who they are. And, frankly, I am having a hard time understanding the argument that these protections stigmatize these individuals.

So, Dr. Martz, please describe the stigma and discrimination that individuals with opioid use disorder face.

Mr. Martz. Thank you. It is an excellent question and a critical area because and to the points earlier this is not limited to the ERs. This is stigma that goes across the way. One in four families has someone in the family now with substance use disorder, and so very often my experience of substance use disorder is cousin Joey who has been stealing from us. And so stigma runs deep and it is very different from the aspects of other medical conditions which are very unique to the substance use disorder which, for example, there is still crimes associated.

So you don't get thrown in jail for having depression. You don't have your kids taken away for your acne. You don't have a loss of your job because you have a heart attack. So, you know,

medical conditions are not all the same and so there are reasons why there may be some segregation even though there are ways to coordinate that care effectively. You know, these stigma issues are critical and to say, to suggest that the stigma is caused by these laws is a little bit of a misunderstanding.

I mean, for example, we don't have laws protecting antidiscrimination in the workforce because we are creating stigma in the workforce, we have laws protecting things like gender and race and ethnicity and religion because these things have been discriminated against in the past. And so even if we have come a long way as we have with HIV, we have not yet come that far with substance use disorder and so it still maintains a critical protection.

Hopefully some day in the future we will understand that these are brothers and mothers and sisters and children that we are talking about here and can move beyond that discrimination, but we are just not there yet. We need that protection desperately.

Mr. Lujan. So a yes or no question, is that stigma and discrimination the result of heightened protections provided by the Part 2 protections?

Mr. Martz. No.

Mr. Lujan. I was also taken aback by something in Dr. Strain's testimony. In his discussion of rolling back Part 2 for payment purposes he states that, quote, patients could retain the

ability to keep their substance use disorder treatment from their health plans by choosing to pay out-of-pocket for services which is a right guaranteed under HIPAA, close quote. To me this means that a person's ability to protect the privacy of their substance abuse treatment record would be based on their income, their ability to pay out-of-pocket for treatment. If you are rich you can keep it private.

Dr. Martz, is it appropriate to make a person's ability to keep their substance use information private based on a person's ability to pay cash for treatment?

Mr. Martz. Thank you. My gosh, that is such a fundamental civil right to be able to be private, have my own and disclose at my own pace when I am ready and when I am able. That shouldn't be something that is only available to the rich who can afford it. Many folks that we deal with are police officers and teachers and students and all walks of life so should have these opportunities should they choose to use that option.

Mr. Lujan. One thing that I was struck with as well is I learned that it was estimated that 20 million people in the U.S. have some form of substance use disorder. Currently, four million people are seeking treatment as has been reported, but the fear of not being provided confidentiality is one of the primary reasons people do not seek treatment. So, Mr. Chairman, I know that this is an important part of the conversation the legislative package that we have, and I certainly hope that

we take this into consideration as we try to make things better versus taking protections away from individuals. And I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. I am sure ICD-10 has not one but fifteen different codes. The chair now recognizes the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. Shimkus. Thank you, Mr. Chairman. And it is great to have you here. We have had 2 days of hearings and as I mentioned yesterday it is just not, I mean we are focused on opioids but there is a lot of other addictive drugs out there and challenges.

So I am going to be brief because I want to focus on what Gus Bilirakis was saying and to, really, Mr. Bauer on the Prescription Drug Monitoring Programs. One way we can shame the five states is to call them out, you know, and we can do it ourselves and we use the bully pulpit to say, you know, you guys need to start sharing information. We have got to stop the easy access especially across state lines or in other areas.

A good example, so I really live in the St. Louis metropolitan area, I am from Illinois. Illinois has one, Missouri does not. St. Louis County has one which really makes it very difficult to make sure we have the procedures in place to be able to access them when a state doesn't allow the states to have the memorandum of understanding and work through those processes.

We have seen these type of things when they can communicate

in the meth challenges. We have seen that be successful. We need your help in figuring out how to really force this national communication across state lines to address this. I am curious if you can expand on ways we can help ensure that these multiple systems are working together as opposed to creating new burdens and confusions.

Mr. Bauer. Sure, another excellent question around interoperability and states being able to share data among themselves. I think today with the current PMP Interconnect system, for example, that is facilitating about 18 million transactions a month with 45 states, again I stated earlier it is more a matter of policy and I think we are making some significant progress with the Florida coming on board and the remaining states are making, I think, measurable progress towards that.

So I think it is not out of the question that all remaining states that are not currently sharing data can share data. There is a very effective means to do that today with a single MOU in place to accommodate for different state laws and security concerns as well.

Mr. Shimkus. When someone has been prescribed legally and they go to the pharmacist, they should be able to get that dispensed but they shouldn't be able to go across the state lines and there should be a red flag saying, hey, it has already been filled. And that is what we need to work on and that would be

helpful.

Mr. Chairman, in lieu of time and other colleagues, I am going to yield back so you can give them a chance to ask.

Mr. Burgess. The chair appreciates the gentleman. The chair recognizes the gentlelady from Indiana for 5 minutes for your questions, please.

Mrs. Brooks. Thank you, Mr. Chairman. And thank you to our colleague from Illinois for yielding.

I want to ask you, Dr. Banner, I am the lead sponsor on H.R. 5329, a bipartisan bill to enhance our poison control centers in the country of which there are 55, I understand, across the country. But most people probably don't realize that the poison control centers field about three million calls, but more recently about 192 calls a day on average on the opioid misuse and abuse, and I really want to talk about the importance of not only the hotline but what the service that poison control centers provide.

How can poison control centers work with the educators, caregivers, people who call, children, others, what is poison control center's role? I think it is one of those you know the number and you rush there, and I have had to use it once or twice when my kids were young as well. I hate to admit it, but we all do at some point. And, but what is the role of the poison control centers with education?

Dr. Banner. We so very much appreciate your sponsorship and involvement in this. If we have a couple of hours I could really

explain this to you. We have a very multifaceted approach to education. Personally, I have emergency medicine residents rotating with me at all times in the poison center and in the ICU and we are educating them. I am teaching in the College of Pharmacy as part of my responsibilities at the poison center and I think the other 54 centers are similar. We are actively engaged in that level of education.

We also have each, the certification requirements for a center is to have an educator who is principally pointed at the public and, too, the National Poison Prevention Week is one of their big times, but they are engaging kids at the elementary and early-on levels about the dangers of things. And as we have evolved, they have incorporated more about substance abuse into those educational packages and teaching teachers, et cetera.

Did you have something else to add?

Mrs. Brooks. Well, I want to just, in your written testimony you actually mention that actually a quarter of calls to our poison control centers come from healthcare facilities. And so, and just your testimony now about rotating residents in and so forth, there is a significant need, is there not, to continue to increase the education of poison issues leading injury cause, by the CDC in this country, of death with our medical professionals?

Dr. Banner. This was a simple job back in the '90s. The explosion that has occurred with bath salt drugs, synthetic cannabinoids, synthetic opioids has just changed the landscape.

And I would agree with you, the reason we get about 25 percent of our calls from other healthcare professionals is because the level of training of the medical toxicologists and the people working in the poison centers is very, very unique.

And the other issue is Oklahoma has a lot of rural hospitals as do many of the poison centers, and my ability to reach out to a physician in a very rural hospital who has never seen this before, and I have, is very helpful. Plus, I am a critical care doctor. The vast majority of the doctors that are medical toxicologists are trained in emergency medicine or critical care and we are reaching out to rural areas with high level, intensive care, emergency medicine, and toxicology all at the same time and providing that and educating them at the same time.

Mrs. Brooks. In fact, in our bill we are directing HHS to implement call routing based on a caller's actual location because that is not necessarily how you receive that information now. Is that correct?

Dr. Banner. That is correct. When this was initially funded back in 2000 it was reasonable to have where your area code. And since then, area codes, now people are taking their phones, particularly the military they are moving all over the country. And one of the benefits of a regional poison center is I am speaking to a doctor that I know in that area and if I am suddenly faced with a caller who happens to have the Oklahoma area code and they are in California, I can't really say you need to go down to Dr.

Such-and-Such at this hospital, because I don't know them.

So the geo-routing, it sounds fairly simple. It is a little more technically complicated, but it is something we really need because we have got to, we have the regional resources to help people and it is where they are at right now, not where they used to live.

Mrs. Brooks. Thank you for your leadership in this area. And on behalf of citizens in Indiana and across the country and my colleague from Oklahoma, we really appreciate your advocacy for poison control centers.

Dr. Banner. Thank you.

Mrs. Brooks. I yield back.

Mr. Burgess. The chair thanks the gentlelady. The gentlelady yields back. The chair recognizes the gentleman from Texas for a unanimous consent request.

Mr. Green. Thank you, Mr. Chairman. I would like to ask unanimous consent to enter in the following letters from NAMA Recovery-the Campaign to Protect Patient Privacy Rights and the Pennsylvania Recovery Organizations Alliance, into the official record.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT**********

Mr. Burgess. The chair recognizes the gentleman from Oklahoma, 5 minutes for your questions, please.

Mr. Mullin. Thank you, Mr. Chairman.

Dr. Banner, good to see you here. We were taking little friendly wagers up here to see if you had your boots on or not. I said yes and you probably got your cowboy hat outside too. So I do appreciate the knowledge that you bring and thank you so much for coming up here. I know it is hard to leave our beautiful state especially where we live, right?

Dr. Banner. That is right.

Mr. Mullin. Dr. Martz, I want to dig in a little bit on some stuff that you have been saying. And I respect your opinion, but I have a problem with the fact that you are trying to push it off as facts. When we start talking about privacy -- I just want a yes or no here because you kept referring back to this -- is it legal for treatment to be shared with an employer right now? The answer to that is no, so is it legal? Yes or no.

Mr. Martz. There are conditions with which you can really make a release.

Mr. Mullin. Only if the individual has consent. Don't mix words with me, yes or no. Is it legal or no?

Mr. Martz. In that condition, no.

Mr. Mullin. Right. I am an employer. I have several hundred employees. It is completely illegal. Second -- I am also a landlord. Is it legal for treatment information to be

shared with a landlord? Yes or no.

Mr. Martz. No.

Mr. Mullin. No. It is absolutely not. Is it legal for information to be shared in a criminal case or a divorce hearing?

Mr. Martz. No.

Mr. Mullin. No. So what you are saying about privacy is completely irrelevant to what we are trying to do here. This is about patient. It is not about opinion or maybes. It already is illegal and under this legislation it stays illegal.

So when you are testifying with us, please be a little bit more factual on what you are saying instead of making a broad statement like that and drawing fears into people. We bring you here because you are considered an expert. Please be that expert. I know you have a wealth of knowledge up here, but you are misleading us and the panel when you don't put facts with it.

Second of all, you start talking about the stigma that is put in place and you referred back to SAMHSA several times. I sent out a letter to the assistant secretary asking for their information on our bill and what their thoughts were. Let me read you a quote that came out of it. This is my favorite letter that when they sent it back they said, "The practice of requiring substance use disorder information to be any more private than information regarding chronic illness such as cancer or heart disease may itself be stigmatizing." That is from SAMHSA. Pretty plain and simple there that they think, itself, it

shouldn't be treated any different.

Now let's talk about the fines, because you brought up fines about this. How many, underneath Part 2, how many penalties have been issued underneath Part 2 for violation of Part 2?

Mr. Martz. On federal or state level, because there will be sanctions against licenses on the local level.

Mr. Mullin. Federal.

Mr. Martz. Federal, not that I am aware of.

Mr. Mullin. Two. How many has been brought up underneath HIPAA?

Mr. Martz. That is outside of my scope.

Mr. Mullin. Let me just kind of put this out there, 173,426 since 2003. Now why is that?

Mr. Martz. There are --

Mr. Mullin. Because you talked about this in your opening testimony and I just want to make sure that we are factual here so you understand what we are talking about. A lot of people want to talk about privacy and about not providing or not separating or why Part 2 and HIPAA needs to be separated, but underneath Part 2 the penalty is $50 if that information is mishandled with the patient, $50. It is not worth the court's time to deal with it. It is only two cases. Underneath HIPAA it ranges between $150,000 per violation and a maximum of 1.5 million per year.

This is about patients. What we are trying to do here is treat the patient. But how can he treat the patient when the

doctor can't see all the medical information? How can he do it? And the reason why I am so passionate about it because it touches my family, we are currently dealing with it. I currently dealt with this situation yesterday over the phone because we have a family member that has a disorder of being addicted to drugs because it started with an elective surgery and now her life is completely ruined and she keeps going to doctors and they keep prescribing her stuff.

And they can't see her complete record and how many times she has been in treatment, so every time she goes in they start diagnosing, or prescribing her more pain medicine because she is in pain. Well, what is the difference between pain and a withdrawal? Because at some point you start coming off of it and you start having withdrawals and guess what, that is painful too and so we are talking about combining those two.

Are you following me on this? So what is wrong with my legislation that allows a patient to be treated completely? And don't tell me about the stigma because it is not about stigma. It is about treatment. It is about getting the patient back to who the person they were before.

Mr. Martz. Thank you for your passion and information. I fully agree with the points that you are making. I would add respectfully a couple of points in addition to that. In good clinical care and for the treatment of the use disorder, okay, for the --

Mr. Mullin. Make it short because I didn't know I was already over time.

Mr. Martz. Sorry. Thank you, that it is critical to have that patient be involved in that collaboration so that there can be the best collaborations. And even in --

Mr. Mullin. They are seeking more treatments because they are addicted to drugs.

Mr. Martz. Which will all be noted in the PDMP where they will all have access to that already, information.

Mr. Mullin. Which is important for the doctor to have the same information. That is why we are trying to see, or trying to compare the two and make sure that both of them are combined so the doctor can give the patient the treatment they need. That they need, they are professionals just like you are a professional. I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from Georgia, Mr. Carter, 5 minutes for your questions, please.

Mr. Carter. Thank you, Mr. Chairman, and thank all of you for being here. And this is a great panel and I appreciate your participation here.

Mr. Bauer, in 2009, as a member of the Georgia State Senate I sponsored the legislation creating the Prescription Drug Monitoring Program in the state of Georgia, so I am very interested in it. I appreciate you throughout your testimony clearing up

the fact that when states are sharing information they are not sharing it with all states, they are only sharing it with certain states. And initially that was a little confusing, so I hope my colleagues understand that just because you are sharing information you are not sharing it with all states. You are only sharing it with states that you choose to share it with and I just wanted to make sure we got that straight.

Mr. Guthrie asked you a question, Mr. Bauer, about who is mandated to see this information that is on the PDMPs and you answered him and said 40 states mandate. Mandate who to see it, pharmacists or doctors?

Mr. Bauer. Predominantly prescribers. So the 40 states that have a mandated use law or statute, typically that is a prescriber. In a handful of states it also includes the dispenser which would include the pharmacist.

Mr. Carter. I am not sure I agree with that but I will take your word on that. In fact, in the state of Georgia when we created it, it was the pharmacist who had to look at it. Starting July 1st, the doctors will have to look at it and I think in most cases it is for the pharmacists and not for the doctors. But anyway can we get, will you clarify that for me and follow up in my office on that?

Mr. Bauer. Yes, sir.

Mr. Carter. I appreciate that very much. Also I wanted to ask you, I have had a number of companies come into my office who

are showing me how they can incorporate the PDMPs with the electronic health records so that we are not disrupting workflow, and that is certainly something that is important and certainly something that we have experienced in the pharmacies when we are trying to incorporate the PDMPs with our workflow. It is a disruption and the more we can incorporate it into our workflow the better the program will work, and I am sure that is the case with physicians as well and I know it is the case with pharmacists.

Also I wanted to ask you, cash prescriptions, are they being included in your PDMPs?

Mr. Bauer. Yes, sir, all prescriptions, controlled substances, typically Schedules II through V, including cash, are required.

Mr. Carter. Okay. And let's talk about Schedule V prescriptions because sometimes that can cause a problem particularly with patients who are getting medications that are Schedule V and not necessarily medications of abuse. For instance, epilepsy patients may get some Schedule V prescriptions and sometimes this can cause a disruption in their therapy as well.

Have you experienced anything with that? Is that something that you are looking at to make sure that we don't disrupt that therapy?

Mr. Bauer. That is a great question. From a PDMP perspective that is not something that we weigh in on. That is typically a state policy decision that is made. Our

responsibility is to collect the information.

Mr. Carter. Okay. All right, one last question, you talked about methadone with I believe it was Representative Guthrie again. You said the methadone clinics were not required to report to the PDMPs?

Mr. Bauer. Any methadone administered in a clinic.

Mr. Carter. What about in pharmacies? I am required in Georgia to --

Mr. Bauer. If it is filled by a pharmacy that is reported to the PDMP.

Mr. Carter. If it is filled by a pharmacy, but if it is filled by a clinic it is not?

Mr. Bauer. Correct.

Mr. Carter. There we have it. You know, for awhile we didn't have the VA reporting and that was a problem, now hopefully they are online as well.

I want to go to you, Mr. Banner, because one thing that has concerned me and I just wanted to get your opinion on it was the use of naloxone and the dependency that it seems to be getting. I know we have had some situations where some of the ambulances have been carrying so much of it and actually had to administer so much that it is bankrupting, literally, some of their budgets and that they have had to stop and only carry a certain amount on that. Do you see that sometimes happening?

Dr. Banner. We definitely have areas where there are spikes

that are concentrated activities and that is concerning in and of itself. But yes, you know, there are lot of, for a lot of reasons there is a lot of shortages of a lot of drugs and that pushes prices up and that is a problem. I think it is going through a this-should-work-for-everything phase and we know it only works for the opiate receptor interaction drugs.

Mr. Carter. Right. But I think one of the problems too is that users are getting dependent on it knowing that oh, if I OD, they are going to come rescue me and I will be okay.

Dr. Banner. Yes. I think it does encourage people in some ways to push the envelope.

Mr. Carter. Exactly, exactly. Thank you. And also thank you, you mentioned something that throughout these hearings I have not heard anyone mention, synthetic marijuana. That has been a big problem in Georgia. Thank you for mentioning that because we want to continue that as well. And I know I am out of time and I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from New Jersey, Mr. Lance, 5 minutes for your questions, please.

Mr. Lance. Thank you very much, Mr. Chairman, and my thanks to the distinguished panel. We have been back and forth in several hearings today, several of the subcommittees and of course votes on the floor. I want you to know this is an incredibly important topic to the entire nation and you are among the great

experts on it.

Dr. Kilkenny, could you speak briefly about the opioid crisis and the rise of infectious disease rates and how the two issues are linked?

Dr. Kilkenny. Yes, sir. Blood-borne pathogens are spread by sharing blood and injection drug use. When people who are engaged in injection drug use are sharing syringes or other materials of injection they are often sharing blood. So there is a clear correlation between those blood-borne pathogens that would be Hepatitis B, Hepatitis C, and HIV, and injection drug use.

Mr. Lance. How have your efforts been successful in bringing together community partners in Huntington to address infectious diseases associated with the opiate epidemic?

Dr. Kilkenny. The city of Huntington has a remarkable history of working together against common threats. And with the opioid epidemic reaching a level that it impacts every family, we have no problem getting every entity aligned in a strategy against it. So we have brought in virtually every other entity in the community into the strategic plan.

Mr. Lance. Thank you. I have introduced legislation regarding the opiate issue and infectious diseases and my cosponsors are Congressman Kennedy on the other side of the dais. This is completely bipartisan and I hope that you as the experts might have the opportunity to review the legislation.

I think there is a growing awareness among the various avenues we have to pursue that there is a significant correlation between the opiate crisis and infectious disease rates. And we are in this battle together and I am sure we will overcome and conquer based upon our joint efforts both bipartisan and bicameral in nature here on Capitol Hill, but also with leading experts across the country including this distinguished panel.

Thank you, Mr. Chairman. I yield back the balance of my time.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair would recognize Mr. Walberg of Michigan, not a member of the subcommittee but my understanding is you want to waive on for questions. Is that correct?

Mr. Walberg. That is correct.

Mr. Burgess. The gentleman is recognized for 5 minutes for questions.

Mr. Walberg. I appreciate, Mr. Chairman, the opportunity to join the August subcommittee. I have a great interest in this and a personal interest and I appreciated hearing what I have been able to listen to today about the fuller subject that we are addressing. And of course there has to be compassion. There has to be a willingness of a patient to seek help, first and foremost, but there also has to be certainly a willingness of the medical profession and society in general to reach out and solve the problem as well.

Earlier this Congress, I introduced Jessie's Law with Congresswoman Debbie Dingell in an effort to try to find a solution to something that tragically took place in Michigan with Jessie Grubb, a resident who had been doing very well in beating her addiction and growing was involved in a sports accident injury in preparation for a marathon and had a surgery. Her family as well as Jessie herself notified the attending physician, the surgeon, of her problem with addiction, but it didn't reach the attention for some reason of the discharging physician and so she was sent home from the hospital with a prescription of oxycodone which she ultimately overdosed on the next day and lost her life.

So we want to find a solution to that. And, Dr. Strain, we are currently examining both Jessie's Law and H.R. 3545, the Overdose Prevention and Patient Safety Act. Can you elaborate on the major differences between the bills and, if so, why it would be helpful to have both?

Dr. Strain. First, I am sorry for that loss and for the family, for you and how you have had it impact you as well. It is a tragedy. I think both bills have value. I want to just be clear, I think that both have great value. I think that both illustrate the fact that as a physician I teach my residents and interns when in doubt get more data, and that is something that we are in a situation now where we may not know about how to get more data.

So I could, for example, have seen Jessie and not known about

her addiction history if she didn't tell me about that. I think that as I understand Jessie's bill, I think bringing together stakeholders who can look at how could something like this not happen in a medical record again is a worthwhile thing to do and to see if there is some way that that can be codified. I don't think it is enough. I think that we have a situation right now where we have got a whole treatment system, substance abuse programs that could be taking care of somebody and I may not know about that.

And it is artificial at this point if I could say, if I could take a moment to say it is artificial. I could know somebody has got a substance abuse treatment, substance abuse problem documented in the record, but it is only if they are in a particular program that I may not know about what is going on in that program.

So I have plenty of patients with substance abuse problems. I have asked them, they have told me. I have it documented in my records. Those records can be accessed by obstetricians, by orthopedic surgeons, by whoever. They can get access to that information in my record but they can't get access to the treatment records, which is artificial.

Mr. Walberg. So what will give that access? What are the additional things we need to do?

Dr. Strain. I think the Mullin amendment does that. I think the Mullin amendment, 3545, does that.

Mr. Walberg. It is mandatory and automatically shared with

any and all who need to know that?

Dr. Strain. Well, with the proper protections in place as they are required, yes, which Representative Mullin pointed out in his questions, I think.

Mr. Walberg. Okay. Thanks for the opportunity to ask those questions. I see my time is about expired. I will yield back.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from New York, Mr. Engel, 5 minutes for your questions, please. And the chair would observe that was the vote being called. So we will, after Mr. Engel we will recess and reconvene with the next panel.

But, Mr. Engel, you are recognized.

Mr. Engel. Thank you. Thank you, Mr. Chairman. This week, Congresswoman Brooks and I introduced the Poison Center Network Enhancement Act, a bill that will reauthorize the nation's poison center programs for an additional 5 years. Speedy access to poison centers through the national toll-free number, again 800-222-1222, is an essential resource for all Americans, especially parents who can take solace in the fact that there are 55 poison centers across the U.S. available 24 hours a day, 7 days a week, 365 days a year. These centers are a smart public health investment. They offer real time, lifesaving assistance while at the same time saving hundreds of millions in federal dollars by helping to avoid the unnecessary use of medical services and shortening the amount of time a person spends in the

hospital if hospitalization due to poisoning is necessary. Most of us already know about much of the work poison centers do thanks to a magnet on the refrigerator displaying the poison center phone number. But many may not know about the critical role poison centers are playing in the fight to end the opioid crisis.

Since 2011, our nation's poison centers have handled nearly 200 cases per day involving opioid misuse. Data from poison centers has helped detect trends in the epidemic and experts have helped educate Americans about the crisis in ways they could potentially save the lives of their loved ones. For example, the Upstate New York poison center used the New York State Fair to educate New Yorkers about proper use of naloxone, the overdose reversal drug. This bill would ensure that these important activities continue.

I was proud to co-author the last poison center reauthorization in 2014 and I am proud to be part of this legislation. I want to thank Congresswoman Brooks for working with me for this important bill as well as Congresswoman DeGette and Congressman Barton for being the original cosponsors.

Dr. Banner, let me ask you this in light of what I have said. Thank you for your being here and for sharing your expertise. This bill would authorize additional funding for the poison control center grant program. Would you talk about how this funding will help build capacity at poison centers and enhance their ability to respond to the opioid crisis?

Dr. Banner. I appreciate everything that you have done, Congressman, and you know on behalf of the poison centers I really appreciate you. We hope to continue this fight. We hope to expand our educational activities as we go forward. You know, we have a big state, so do you, and getting reaching out, particularly rural areas where education is critical, is difficult and expensive and so having extra funding and improving our funding base helps us in those outreach activities.

We are also actively seeking the first responders to get a hold of the poison control center as part of naloxone administration. As the good gentleman from Georgia pointed out, it could be misused or overused and we want to actively supervise and help in that program and our ability to continue that activity is very critical. So we see a lot of opportunities reaching out to minority communities where these are problems as well is an important issue for us. So we thank you.

Mr. Engel. Well, thank you, Dr. Banner. You mentioned in your testimony that poison centers have helped identify trends in the opioid epidemic. How do you think that this information in poison centers could help us as policymakers respond to the crisis more effectively?

Dr. Banner. Well, I think it already has in a lot of ways. You know, this is the kind of data when you see it, it may be coming from the CDC and we work closely with them. Every 8 minutes we upload from all 55 centers into a central database. Plus,

conversations, we have our listservs and there is a lot of human intelligence going on where we are identifying things very early.

The increasing Oxycontin, a lot of our recognition of those came from the NPDS database which is that contributory public health surveillance activity that we do. So we are constantly updating that database so that the FDA, the CDC, can be monitoring activities. We do that in real time for some acute events, but we also are looking over long terms. Every year we publish and people rely upon it heavily to look at trends in what drugs are becoming more prevalent and identifying new substances.

So I think you do rely upon us. You might not know it came from a poison center, but our data is there and it is I hope really helpful in guiding you to see where the future lies.

Mr. Engel. Well, thank you very much and thank you for your good work. And thank you, Mr. Chairman. I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from Virginia for a unanimous consent request.

Mr. Griffith. Mr. Chairman, I would request that we introduce into the record a letter from the president and CEO of Titan Pharmaceuticals, Inc., related to the therapeutics for select chronic diseases and related to opioids.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

2075 **********COMMITTEE INSERT**********

Mr. Burgess. And the chair wishes to thank this panel. You have been very informative. It has been a lively morning and that is what we wanted and so we appreciate your expertise and your sharing it with us. We are going to take a recess. This panel may be excused and we will reconvene 10 minutes after the vote series on the floor with our fourth and final panel. So the subcommittee stands in recess.

[Whereupon, at 12:44 p.m., the subcommittee recessed, to reconvene at 1:25 p.m., the same day.]

Mr. Burgess. We do want to thank all of our witnesses for being here this afternoon and taking the time to testify before the subcommittee. Each witness will have the opportunity to summarize their opening statement followed by rounds of questions from the members.

And this afternoon, for our fourth and final panel of this 2-day hearing, we are going to hear from Ms. Jessica Hulsey Nickel, Founder, President, and CEO, Addiction Policy Forum; Ms. Carlene Deal-Smith, Peer Support Specialist at Presbyterian Medical Services; Mr. Ryan Hampton, Recovery Advocate, Facing Addiction; Dr. Mark Rosenberg, Chairman of Emergency Medicine and Chief Innovation Officer, St. Joseph's Healthcare System, Board of Directors in the American College of Emergency Physicians; Ms. Stacy Bohlen, CEO of the National Indian Health Board; and Ms. Alexis Horan, Vice President of Government Relations, CleanSlate Centers.

Again thank you all for being with us today. Ms. Hulsey Nickel you are recognized for 5 minutes.

STATEMENTS OF JESSICA HULSEY NICKEL, FOUNDER, PRESIDENT AND CEO, ADDICTION POLICY FORUM; RYAN HAMPTON, RECOVERY ADVOCATE, FACING ADDICTION; CARLENE DEAL-SMITH, PEER SUPPORT SPECIALIST, PRESBYTERIAN MEDICAL SERVICES; MARK ROSENBERG, DO, MBA, FACEP, FAAHPM, CHAIRMAN OF EMERGENCY MEDICINE AND CHIEF INNOVATION OFFICER, ST. JOSEPH'S HEALTHCARE SYSTEM AND BOARD OF DIRECTORS, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS; STACY BOHLEN, CEO, NATIONAL INDIAN HEALTH BOARD; AND, ALEXIS HORAN, VICE PRESIDENT OF GOVERNMENT RELATIONS, CLEANSLATE CENTERS

STATEMENT OF JESSICA HULSEY NICKEL

Ms. Hulsey Nickel. Thank you so much, Chairman Burgess and Ranking Member Green.

[Disturbance in hearing room.]

Mr. Burgess. Ms. Hulsey Nickel, you are recognized for 5 minutes, please.

Ms. Hulsey Nickel. Thank you so much, Mr. Chairman, for your leadership on this important issue that is facing so many families and communities nationwide. My name is Jessica Hulsey Nickel and I am the president of the Addiction Policy Forum. I started the Addiction Policy Forum to bring patients, families, stakeholders across the country together to advocate for a comprehensive response to addiction including prevention, treatment, recovery

support, overdose reversal, criminal justice reform and law enforcement, and also bring a voice for families. We have one goal, to help create a world where fewer lives are lost to addiction and help exists for the millions of Americans who need it.

I am grateful to be with you today to discuss key legislation and how it will help address the addiction crisis. I know firsthand the devastating impact that substance use disorders has on families and communities. I lost both of my parents to addiction, and their substance use disorders meant for me and my little sister homelessness and foster care and being wards of the state until I was 10, and then being placed with our grandparents, and I lost both of my parents far, far too young.

Every day we lose 174 people to drug overdoses in our country. 174 -- that is like a plane crash every day. It is important to put real faces to the scope of this crisis and the real families and communities that are at the epicenter, so we wanted to share with you some of the stories from our families.

First up is Doug and Pam who lost their daughter Courtney when she was just 20 years old. He describes Courtney as a shining star. The room lit up when she walked in and everyone loved her. Doug writes, we were told that because it is not a matter of life or death there would be no coverage for treatment. On the advice of our local authorities we asked her to leave our home and canceled her insurance. By doing this she would be homeless and

then could be eligible to receive treatment. Courtney died alone, away from our home, and the day before she was scheduled to go into a treatment facility.

Lorraine describes her twin brother Larry as amazing, charming, funny, popular, and the most talented drummer you have ever heard. Larry died from a drug overdose leaving behind his 1-year-old son and Lorraine became a single parent overnight.

Jennifer lost her son Dylan when he was just 19 years old. She says to us, every day when I walk into my house I see Dylan's shoes sitting on the floor where he kicked them off and his jacket draped over the bannister where he left it. He will never have the chance to get married, to have kids, to travel, to do all the things that a 19 year old should have experiences.

And then Amy who runs our Massachusetts chapter, she lost her son Emmett when he was just 20 years old. In college studying computer science, Emmett had six overdoses reversed at his local hospital, but treatment was not initiated and the family was not notified. Each of these overdose was an opportunity to engage him in the help that he needed.

As a community of families, patients, and key stakeholders, we are so pleased to see the comprehensive approach that this committee is pursuing with the legislative proposals that are being considered. I would like to address three pieces of legislation in particular that will help us respond to this crisis.

First off, the Comprehensive Opioid Recovery Centers Act of 2018, we have an enormous treatment gap in this country. Of the 21 million people that need treatment for a substance use disorder, only about ten percent will receive it. Can you imagine if ten percent of Alzheimer's or ten percent of cancer or ten percent of diabetes patients received treatment?

Our current healthcare system has many systemic issues that continue to limit the effective and sustainable implementation of evidence-based practices to treat substance use disorders. For example, there is a lack of integration between general and specialty care. There is a lack of screening for substance use disorder in health care. There is inconsistency providing all three FDA-approved medications for opioid use disorder.

The Comprehensive Opioid Recovery Centers Act will help address these barriers through the development and promotion of integrated care models based on best practices which will build a pathway towards a comprehensive healthcare infrastructure that must be achieved to ensure that everyone suffering with a substance use disorder has access to quality treatment. This is a preventable and a treatable illness. The Addiction Policy Forum supports the quick enactment of CORC, the Comprehensive Opioid Recovery Centers Act which will help fill the need for coordinated, comprehensive care for patients. Many thanks, to Congressman Guthrie and Congressman Green, for their leadership on this bill.

I would also like to address the TEACH Act -- Treatment, Education, and Community Help Act to Combat Addiction. There is an alarming lack of substance use disorder education in medical school curriculums and among current physicians. According to the 2016 Surgeon General's report, only eight percent of U.S. medical schools have a separate required course on addiction and only a handful of medical schools have robust curriculum on the diagnosis and treatment of substance use disorders.

Often, healthcare providers do not feel prepared to deal with what is commonly perceived as a difficult patient population, and because of the lack of education for students and experienced practitioners patients can be denied access to a large portion of evidence-based treatment options. Physicians around the country also report not having enough training on the prescribing of pain medications and alternative treatments for chronic pain. This particular gap in physician education in the midst of a worsening opioid epidemic must be addressed.

The TEACH Act incentivizes the development of evidence-based education and curricula. The legislation would fund educational institutions be centers of excellence and substance use disorder education and require such institutions to collaborate with the stakeholders in their community who are really on the front lines of this crisis. We are supportive of the TEACH Act and I thank Congressman Bill Johnson and Paul Tonko for their work on this legislation.

And, finally, just very briefly, we are also very pleased to see the Preventing Overdoses While in Emergency Rooms, the POWER Act. This makes me think of Emmett and his mom, Amy, and how we can do a better job of equipping our emergency room physicians and all of our providers and emergency room departments to address nonfatal overdoses and to use this as an intervening moment. This is a high priority for the Addiction Policy Forum and we are in support of the POWER Act and grateful for this committee and your commitment to these issues.

And I just wanted to express on behalf of all of the families that your focus on this issue in such a comprehensive manner that includes all six of the key components -- prevention, treatment, recovery, support, overdose, reversal -- the focus means the world to us. We have millions of families that are struggling, some alone, some trying to come together and really fight for better responses. And so I am here to also transmit that heartfelt thank you for your leadership and focus on these issues.

So thank you so much for having me today.

[The prepared statement of Ms. Hulsey Nickel follows:]

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Mr. Burgess. We appreciate your testimony. Of course we also focused on enforcement during one of our first panels and as well as scientific discoveries to try to expand the universe of medications to treat pain.

Ms. Deal-Smith, you are recognized for 5 minutes, please.

STATEMENT OF CARLENE DEAL-SMITH

Ms. Deal-Smith. Good afternoon, ladies and gentlemen. My name is Carlene Deal-Smith. I am a Native American of the Navajo tribe from Farmington, New Mexico. I am employed with Presbyterian Medical Services Totah Behavioral Health Authority. I work with homeless individuals who have substance abuse problems.

Due to my own struggles with alcoholism I am able to assist with what they are struggling with. I understand the impact substance abuse has on their lives, understand them when they say nobody cares, the low self-esteem, and the unemployment they suffer with. The relatives, we call our clients relatives because that is how we relate to them, totah has a program that helps them get their life back.

It takes months, maybe sometimes years for them to achieve sobriety, and being their peer support you have to be consistent with being available to them. Each day is a new day. It doesn't matter if they had a bad day yesterday. Being a peer support you have to model being healthy by your own recovery. A hard day in sobriety can be achieved when you model you are taking care of yourself. Being healthy is the key to help the relatives that still suffer.

I come to you today to show my support for peer support programs. These programs offer more than just support, they

offer jobs and independence. Thank you.

[The prepared statement of Ms. Deal-Smith follows:]

**********INSERT**********

Mr. Burgess. The chair thanks the gentlelady for her testimony.

Mr. Hampton, you are recognized for 5 minutes, please.

STATEMENT OF RYAN HAMPTON

Mr. Hampton. Thank you, Mr. Chairman. Mr. Chairman, Ranking Member Green, and members of the committee, my name is Ryan Hampton. I would like to thank the committee for inviting me to speak on the Ensuring Access to Quality Sober Living Act on behalf of Facing Addiction with NCADD, which represents over 800 community organizations and 75 regional affiliates across the United States, a network now reaching over 35 million Americans.

As a person in sustained recovery and a member of the recovery community, it is an honor to speak about the impact that H.R. 4684 will have on Americans with substance use disorder. I spent a decade struggling with an addiction to heroin. Addiction is not the result of bad decisions, but rather a health condition that is exacerbated by drug use. I am one of millions of Americans affected by it.

Addiction affects people from all backgrounds, constituencies, races, classes, religions, and party affiliations. It does not discriminate. However, unlike other chronic illnesses like cancer and diabetes, we do have a solution. We are not struggling to find a cure. This issue is one that we can address together and prevent further loss of life. One of the ways we can do this is by supporting ethical guidelines for recovery housing.

The person you see sitting in front of you today is in

remission from the potentially fatal illness of addiction in spite of the broken system that we have in place. Long waiting lists, abstinence requirements for housing, unscrupulous operators, and unethical treatment practices all undermined my recovery. Some facilities discriminate against harm reduction measures and medication assisted treatment. That is a barrier to access and it kills.

I went through multiple treatment centers, detoxes, and sober living homes before I was finally able to sustain my recovery. Not everyone has been so lucky. I am here today because my friend Tyler died of a heroin overdose in a sober living home. Because there was no naloxone on site and because the home staff weren't trained to deal with overdoses, my friend lost his life.

Not having naloxone in a sober living home is like refusing to put lifeboats on an ocean liner. It doesn't mean that you are planning on a shipwreck. It means that in case of a disaster the passengers will make it safely to land. When I heard how Tyler had died I was outraged and I approached my congresswoman, Judy Chu. Thanks to her help, the support of Facing Addiction and the National Alliance of Recovery Residences, I stand before you today asking for bipartisan support of H.R. 4684 as a solution. I know it is not a silver bullet, but it will help get best practices in recovery housing implemented across the country.

Tyler's death was 100 percent preventable and H.R. 4684

addresses the changes we need in order to ensure that recovery homes are doing what they are supposed to do, saving lives and not endangering Americans. Recovery should never be about luck and it shouldn't be a guessing game for people who are in desperate need of help. H.R. 4684 is a step in the right direction that will for the first time allow SAMHSA to develop best practices that can be disseminated to states and help people and prevent more tragic overdoses like the one that killed my friend.

Quality, access, care, and choice are key parts of the existing NARR standards for recovery residences. Quality means defining the essential elements of a properly operated recovery residence. Access means providing a road map for developing the full spectrum of recovery housing to better match needs and a blueprint for housing providers to rise to the occasion. Care means evaluating the peer support components of a residences recovery environment. Choice means empowering informed recovery housing choices with regard to placement and resource allocation.

Everyone should have equal access to recovery support services. Not just prevention and treatment, but continuing care that includes peer support and housing. The 2016 Surgeon General's Report on Alcohol, Drugs, and Health, and the White House Commission on Opioids final report both recommend the use of peer recovery supports and recovery housing. Providing ethical and safe housing and support post clinical services is linked to higher rates of recovery. Without these measures

in place we will continue to lose people like Tyler. Millions of Americans who access treatment and continuing care ask for help in good faith. We must ensure that their safety net is strong, safe, and ready to catch them.

And, Mr. Chairman, on a personal note, to close I would like to say that not a single day goes by where I do not think about the friends that I have lost and the people that I have loved that are gone from this crisis, and I showed up to testify today for them, because of them, and in memory of them. Thank you.

[The prepared statement of Mr. Hampton follows:]

**********INSERT**********

Mr. Burgess. And the committee thanks you for your testimony.

Dr. Rosenberg, you are recognized for 5 minutes, please.

STATEMENT OF MARK ROSENBERG

Dr. Rosenberg. Thank you, Mr. Chairman. My name is Dr. Mark Rosenberg and I am the chairman of Emergency Medicine at St. Joseph's University.

Mr. Burgess. Dr. Rosenberg, may I just ask is your microphone light --

Dr. Rosenberg. I am sorry. My name is Dr. Mark Rosenberg and I am chairman of Emergency Medicine at St. Joseph's University Medical Center in Paterson, New Jersey. I serve on the board of directors of the American College of Emergency Physicians.

So on behalf of St. Joseph's University Medical Center and its 170,000 visits in the emergency department per year, the 38,000 members of the American College of Emergency Physicians, and the great state of New Jersey, I would like to thank the committee for this opportunity to provide testimony in support of two bills -- ALTO, the Alternative to Opioids in the Emergency Department Act, and POWER, Preventing Overdose While in the Emergency Room Act.

There are two cornerstones to ending the opioid epidemic, prevention and treatment, and they are represented by these two bills that I am supporting today. The prevention program is Alternative to Opioids, or ALTO, and the treatment program is MAT or the POWER Act, and both are necessary to stop the continued opioid misuse, abuse, and overdose.

Prevention, H.R. 5197 ALTO, was developed by my team at St. Joseph's University Medical Center in New Jersey in 2016 to address the variation in prescribing habits and to decrease the reliance on opioids by emergency physicians. We started the program with a very simple premise, the best way to avoid opioid misuse and addiction is to never start a patient on opioids. The ALTO program is evidence-based protocols using nonaddicting and therapies that target receptor sites and enzymes that mediate the pain. An example is a patient with back pain. Instead of giving them opioids I give them a layered treatment of therapies that include nonaddicting medication and trigger point injections resulting in better pain management and improved patient experience of care.

I am proud to say that after 2 years of implementation at St. Joseph's, the ALTO program has witnessed tremendous success. In the first year there was a 57 percent reduction of opioid use and by the end of the second year there was over an 80 percent reduction of opioid use. These statistics reveal that education, evidence-based clinical treatment protocols, can have a dramatic impact on the fight against opioid addiction and overdose. More importantly, ALTO program can save lives and already there are emergency physician acceptance across the country to use ALTO protocols.

Emergency Department-initiated MAT, or medical assisted treatment, represents the treatment arm of the equation. Let me

give you a moment to tell you about every single patient addicted or dependent on opioids or heroin fears going into withdrawal. Patient in withdrawal experiences a feeling of being sick with chills, sweats, GI symptoms, and agitations. These patients either have to do another dose of opioids to stop the withdrawal or they need medical assisted treatment to stop feeling sick and stop the withdrawal.

ED-initiated medical assisted treatment alone has shown positive results in getting patients with substance use disorders into addiction treatment. But MAT, plus a warm hand-off, yields the best opportunity for success in getting patients into addiction treatment as well as decreasing the need for inpatient addiction treatment services.

H.R. 5176 requires that healthcare sites have two essential ingredients that emergency physicians would like: Providers that are trained and licensed to provide MAT, and number two, agreements with community providers and facilities to continue services -- the warm hand-off.

We appreciate what Congress has done to help the opioid epidemic. The $6 billion included in the Bipartisan Budget Act of 2018 will be very helpful in turning the tide against opioid misuse. We urge you and your colleagues to not only authorize H.R. 5197 and H.R. 5176, but to support full funding of these programs as well. This is one of the biggest healthcare challenges of our generation. It took many years to get to this

crisis point and unfortunately it will take some time to resolve the epidemic.

But we are on the right track. Provide us with ALTO and MAT tools and funding and emergency physicians will be able to provide a better future for our patients as well as society. Thank you.

[The prepared statement of Dr. Rosenberg follows:]

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Mr. Burgess. Thank you, Dr. Rosenberg.

Ms. Bohlen, you are recognized for 5 minutes, please.

STATEMENT OF STACY BOHLEN

Ms. Bohlen. Thank you, Chairman. Chairman Burgess and Ranking Member Green, members of the subcommittee, on behalf of the National Indian Health Board and the 573 federally recognized tribal nations we serve, thank you for holding this important hearing. And in my native language I say, miigwech. I am Stacy Bohlen. I am the chief executive officer of the National Indian Health Board and an enrolled member of the Sault Ste. Marie Tribe of Chippewa Indians in Michigan.

The current opioid epidemic represents one of the most pressing public health crises affecting tribal communities. While this epidemic is impacting many communities throughout America, it has disproportionately impacted tribes and has further strained the limited public health and healthcare resources that are available to the tribes. American Indians and Alaskan natives had the highest rate of drug overdose deaths every year from 2008 through 2015. A 519 percent increase in drug overdose deaths from 1999 to 2015 is also one of our statistics.

These demonstrate the critical need for more comprehensive interventions in tribal communities to improve prevention and treatment measures. The epidemic is so bad that several tribes throughout the country have declared a state of emergency to tackle the crisis. Historical and intergenerational trauma including trauma across the life span, lack of funding at the

Indian Health Service, and a failure by states to include tribes in state level prevention and public health programs all contribute to this crisis.

In Minnesota, pregnant American Indian women were 8.7 times more likely to be diagnosed with maternal opioid dependency and American Indian infants were 7.4 times more likely to be born with neonatal abstinence syndrome, meaning that the repercussions of the trauma and this crisis are intergenerational.

But the lack of funding for the Indian health system overall is one of the greatest systemic contributors to this crisis. Deferral of needed care due to lack of funding, physician workforce shortages at IHS, has created greater dependence on opioids. Limited funding means denial of needed care nearly 80,000 times in 2016 alone. Instead of being referred for surgeries or simpler treatments, patients are offered and simply placed on prescription opioid medications to address their pain as they wait for treatment and sometimes they wait for years.

Policy solutions should focus on allowing tribes access to long-term, sustained resources improving data and disease surveillance, and traditional healing approaches. What would we like Congress to do? Well, number one, allow tribes access to the state targeted response to opioid epidemic grants. National Indian Health Board supports the provisions of H.R. 5140 that address this.

We also request that the legislation include a ten percent

set-aside for tribes. Direct funding of tribes reinforces the tribal sovereignty and the government-to-government relationship between the federal government and the tribes. It also will ensure that tribal communities are directing the programming so it can be most effective. Number two, establish tribally-specific funding streams such as behavioral health program for Indians modeled after the Special Diabetes Program for Indians. That is outlined in H.R. 3704, the Native Health Access Improvement Act. Number three, ensure parity between states and tribes in any opioid related legislation advanced by this Congress. This means specifically including tribes as eligible entities and requiring tribal consultation information, data sharing, and funding set-asides at the state level.

Number four, ensure that cultural and traditional healing practices are able to be utilized with federal resources that includes Medicaid funding. Tribal communities have been healing our own people for thousands of years and these practices are highly effective in the communities where they are used. And five, establish trauma-informed interventions in coordination with tribes to reduce the burden of substance use disorders including those involving opioids.

And we just learned that tribes received a $50 million set-aside in the fiscal year 2018 omnibus for the state opioid response grant and 5 million was set aside for tribal medication

assisted treatments. This is very important to us. We know that members of this committee were activists in getting this effort to happen and we say a big thank you, chi-miigwech, and this is an excellent start.

Health information technology and data also represents a serious challenge when it comes to the opioid crisis. I understand that my time is expired and I want to be respectful of the other witnesses, so the rest of my remarks appear in our written testimony. Thank you, Chairman.

[The prepared statement of Ms. Bohlen follows:]

**********INSERT**********

Mr. Burgess. Thank you for your testimony. Without objection, your full remarks will be made a part of the record.

Ms. Horan, you are recognized for 5 minutes.

STATEMENT OF ALEXIS HORAN

Ms. Horan. Thank you. Chairman Burgess, Ranking Member Green, and subcommittee members, my name is Alexis Horan, Vice President of Government Relations for CleanSlate Addiction Treatment Centers. CleanSlate is grateful for the opportunity to testify on H.R. 3692, the Addiction Treatment Access Improvement Act, and H.R. 5102, the Substance Use Disorder Workforce Loan Repayment Act, two bills that will expand access to high quality treatment and promote the growth of a stable, high quality, substance use disorder workforce capable of meeting the growing demand for evidence-based treatment for opioid use disorder.

CleanSlate is an office-based opioid treatment program. That means we help patients overcome their addictions using pharmacotherapies including buprenorphine and naltrexone, more commonly known as Suboxone and Vivitrol, in combination with supportive counseling and clinical and social care coordination services. Our treatment centers are physician practices staffed by a combination of physicians, nurse practitioners, physician assistants, care coordinators, and support staff each of whom play a critical role in delivering pharmacotherapy-based treatment for opioid and alcohol use disorders.

CleanSlate operates 41 centers across eight states, including Massachusetts, Indiana, Pennsylvania, Texas, Florida,

Arizona, Wisconsin, and Connecticut, with 8,000 patients currently under our active care. Since our inception in 2009, we have treated nearly 28,000 patients which we believe gives us a keen understanding of the role medical treatment for opioid addiction can play in ending the opioid epidemic.

We plan to open our first centers in Ohio and Kentucky this spring. Our decision to open a new center sets in motion an intensive recruiting, contracting, and community outreach effort. Sadly, there is no shortage of demand for our treatment services, but providing treatment to meet demand is increasingly difficult primarily due to the challenges we face in finding willing, experienced prescribers with sufficient buprenorphine waiver slots to support our program.

Fully 20 percent of CleanSlate prescribers are at or near their prescription limits. Despite our own internal workforce building efforts and the addition of advanced practice clinicians to the pool of eligible prescribers, we are not always able to fully meet the demand for treatment in the communities we serve. The Comprehensive Addiction and Recovery Act of 2016 took important steps toward helping close this treatment gap. However, demand for opioid use disorder treatment continues to grow while the workforce does not grow commensurately.

To give a sense of the dynamic we face, in 2017 CleanSlate hired and trained 85 providers for medication assisted treatment through our internal program, 58 of the 85 providers did not have

their prescribing waiver before they came to CleanSlate. Even with these additions we constantly face capacity challenges. H.R. 3692, the Addiction Treatment Access Improvement Act, and H.R. 5102, the Substance Use Disorder Workforce Loan Repayment Act, will meaningfully close key parts of the treatment gap that exist in our country and we appreciate that these measures are under active consideration by the committee today.

Broadening the pool of eligible prescribers and their capacity for highly qualified providers to treat larger panels of patients, simply stated, would enable CleanSlate clinicians and others around the country to treat more patients immediately. Allow me to share the experiences of some of our centers to illustrate this point.

Our Anderson, Indiana treatment center currently employs four prescribers who are authorized to prescribe MAT for a combined total of 190 patients. Still, we have 60 patients on a waiting list at Anderson. As a result, some patients are driving over an hour away to another CleanSlate program in Indianapolis to access treatment.

Alternately, our Scranton, Pennsylvania center has nine prescribers who currently treat 570 patients with 100 treatment slots still available. That may sound like a lot of capacity, but in January 85 new patients joined that center and in February 66 joined. At that rate, our capacity to treat more people could and likely will be filled by the end of April.

H.R. 3692, the Addiction Treatment Access Improvement Act, introduced by Representative Paul Tonko, addresses and alleviates these challenges by allowing a larger pool of advanced practice clinicians to prescribe MAT by making that prescriptive authority permanent instead of sunsetting the authority as it is under CARA, and by allowing highly credentialed prescribers or those working in qualified practice settings like CleanSlate to treat up to 100 patients at the outset instead of just 30 as is under current law.

As stated before, prescription limitations are not the only barrier to expanding access to treatment. There remains a dearth of providers who are willing to work in this field due in part to the complex medical, behavioral, and social needs of patients with opioid use disorder as well as the stigma associated with the patient population. These factors make provider recruiting a challenge.

Retaining a high quality, compassionate workforce is also a challenge. H.R. 5102, the Substance Use Disorder Workforce Loan Repayment Act, introduced by Representative Katherine Clark, authorizes a robust loan repayment program for a wide range of full-time substance use disorder professionals who provide treatment in underserved areas. Not only will this legislation incentivize newly minted providers to begin careers that involve treating substance use disorders, the bill will also help stabilize the workforce by meting out payments over 6 years which should counter attrition that is all too common in this field.

CleanSlate strongly supports these important bills and thanks Representatives Tonko and Clark for their thoughtful contributions toward addressing an opioid epidemic that affects us all. Together, H.R. 3692 and H.R. 5102 directly address barriers that preclude providers from adequately providing effective treatment for opioid and other addictions.

Thank you, Chairman Burgess, Ranking Member Green, and members of the subcommittee once again for the opportunity to speak in support of these bills and on behalf of my organization and the addiction treatment field at large. The hearings you are holding are tremendously important to increasing awareness and building support for the policy changes needed in our field and we look forward to assisting you in any way. Thank you.

[The prepared statement of Ms. Horan follows:]

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Mr. Burgess. And we thank you for your testimony. We thank all of you for your testimony this afternoon and thank you for bearing with us through what has been a pretty long day. At this time we will move into the question portion where members are each recognized for 5 minutes for a series of questions.

And if he is ready, I will yield to the gentleman from Virginia, Mr. Griffith, 5 minutes.

Dr. Bucshon, Mr. Griffith requests that I recognize you.

Mr. Bucshon. I would be happy to do that. Thanks, Mr. Chairman.

Since you were the last one to talk, I think maybe I will ask you a question. First, I have, it is a little opening kind of statement, then I will ask the other members of the panel.

So, doctors do not prescribe insulin to a diabetic without education, support or routine follow-up care. That said, prescribing buprenorphine without wraparound services, I would argue, is substandard care. I am fully supportive of doing everything we can to combat the opioid crisis ravaging the country. That includes expanding access to medication assisted treatment, Section 303 of CARA I helped author, for example. However, it is important that we do so in a thoughtful way.

I was a heart surgeon before, so I am a medical person. A health professional with no expertise in addiction medicine, for example, can now prescribe ultimately buprenorphine to 275 patients. That is about 14 patients per day. These patients are

seen just once per month. Do you think that a provider seeing 14 patients a day is consistently able to provide the comprehensive, therapeutic services that best fits the clinical needs of his or her patients?

Ms. Horan. Well, thank you for that question. To the training part, and I can only speak on behalf of CleanSlate and how we train and educate our physicians, our physicians do come from a wide range of backgrounds. Regardless of their background, however, they are all put through about a 4-week training program, internally with us, which includes a combination of didactic and onsite learning and training.

In terms of the wraparound services we provide as an organization, all of our clinicians are trained in supportive counseling. We staff care coordinators at most of our centers to make sure that the patient has at least access to, and not just access to in terms of here is a business card, good luck finding it in the community, but a warm connection to the referrals that we have made. That is part of the community outreach in terms of how we set up in a new community.

So our providers are, we believe, providing extensive supportive counseling and then relying on the expertise that is in the community to fill their primary care, dental care, OB-GYN care, additional behavioral healthcare needs.

Mr. Bucshon. So I guess if you hired someone new and they go through their training, would you think that they should be

able to see 14 patients a day, all month, right off the bat? Because I think that is in your testimony and based on the legislation is what you are implying that they should be able to go right to the full amount right off the bat.

Ms. Horan. I do. We do, because we believe that we have established programs that provide the administrative care coordination and clinical support necessary to enable that physician or that nurse practitioner or physician assistant to really attend to the patient's addiction treatment needs.

Mr. Bucshon. Because I think, you know, in CARA we were trying to expand the scope of who can do this with a 3-year, with a pilot, expanding the type of practitioner. But do you think we should really lock in this big of an increase in the number of patients, really, before we have seen a single piece of data from HHS as was part of CARA to see if these practices are successfully treating patients in adhering to the evidence-based guidelines and ensuring that buprenorphine or methadone or whatever, which is one of -- buprenorphine, which is one of the most diverted medications, is not being further diverted? Because the whole point was if we expanded this we wanted to get data to see if that was successful.

Ms. Horan. Right, right. Again I am going to speak on behalf of CleanSlate here and I will answer it in two parts. One, we feel like we have some data that shows that our treatment programs are successful. We worked with one of our payers to look

at our patient outcomes and we showed patients who had been in treatment with us for 6 months had shown, as compared to the treatment they had for 6 months prior, showed a 35 percent reduction in use of ERs, a 25 percent reduction in any in-hospital stay, and reduced their conversion to Hepatitis C by about 80 percent.

So we feel that at least again in our program, a program that really wraps not just the patients around with services, but the providers that work with them, the tools that they need to do their job well, we believe that MAT can be successful. We have worked now for almost a year with advanced practice clinicians, thanks in part to the CARA bill, and they are incredible additions to our team. There is no way we would be able to meet the demand for treatment in the communities without them and they work in collaboration with our physicians in almost every scope of practice.

Mr. Bucshon. Yes. I would just say this, and some of my personal views is sometimes the ends doesn't always justify the means. I mean I get that there is a lot of people out there on waiting lists, but as a healthcare provider I think we also want to be cautious. Your program is excellent, but there are others out there that probably are not.

And so when we try to put public policy in place we want to make sure, I do at least, is we think about the patient at the end of the day and across the country what is going to work. So

I would argue against immediately expanding, you know, to 275 without some sort of a ramp-up and that is my personal view. I yield back, Mr. Chairman.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from Texas, Mr. Green, 5 minutes for your questions, please.

Mr. Green. Thank you, Mr. Chairman. I want to thank all our panelists for joining us today, and I will start my questions with Ms. Nickel.

Ms. Nickel, you note in your testimony that I have been working with Congressman Guthrie, Lujan, and Bucshon to introduce the Comprehensive Opioid Recovery Centers Act. In your testimony you highlighted that of the 21 million Americans who need treatment for a substance use disorder like opioids, only ten percent receive such treatment.

This almost begs the question, why aren't more Americans in need receiving that treatment?

Ms. Hulsey Nickel. You know, our treatment system has a lot of gaps that we need to fill and there is lots of sort of silos and fragmentation. And I believe the CORC Act will help us to fill some of those gaps and make sure that for example, going to three different places to receive a medication if you have an opioid use disorder can be very difficult and we need to make sure we are streamlining how to have patient-centered care so the right medication is identified and given to that patient based on a

doctor's advice and not just who you happen to find near you or on a Google search or by calling someone off of a commercial.

We need to make sure that this is led by health care and have better provision of evidence-based service.

Mr. Green. What are the most common barriers to receiving that treatment?

Ms. Hulsey Nickel. I think we have some pair issues with sort of finding coverage and how do you pay for this. We have a lot of navigation problems that when this hits your family you usually are thinking about like how do I Google someplace and empty out my savings account, rather than how do I go find the right physician or a counselor to help me build a treatment plan for myself or for my loved one?

So I think the externalization from health care of removing this out of our healthcare system is one of the biggest barriers to making sure that we get the treatments to all the patients that need it.

Mr. Green. One of the unique requirements of our legislation is the need for treatment centers to have trained personnel responsible for outreach to the key community stakeholders such as institutions of higher education and the criminal justice system. Can you speak to the importance of this community integration as part of the treatment and recovery?

Ms. Hulsey Nickel. Absolutely. Addiction is an illness that begins mostly in adolescence or young adulthood. Ninety

percent of those that have a substance use disorder it began in those ages. So that component with higher education or even earlier, very important to make sure that you are initiating treatment and intervening early. Right now this is the only disease that we wait for it to worsen before we treat it. Can you imagine like waiting for an amputation before you would treat diabetes?

So when you have those community outreach functions out of your legislation and make sure that we are getting the help that we need into the places where you can intervene earlier and have better outcomes for that patient.

Mr. Green. Okay. Through your work with the Addiction Policy Forum do you have experience with treatment that have included outreach to these key community stakeholders? If so, can you share how community outreach has and has not improved the treatment outcomes?

Ms. Hulsey Nickel. I think any opportunity you have for community outreach is going to improve your outcomes and your access to care. We need to vastly expand that type of service and coordination. We need to go into younger ages and also figure out new ways to get into families and communities so that they know how to ask for help and where to go for evidence-based care.

High schools, through employers and through the workplace, through colleges, through our churches, it doesn't really matter how they sort of come in the door, but you need to make sure that

they find the right help so they don't get taken advantage of directed to nonevidence-based care that is going to have poor outcomes.

Mr. Green. In your work with your family members, people who unfortunately have lost their battle with addiction as a result of the opioid overdose, how common is it their loved ones completed treatment without being offered a range of treatment options and the necessary support services?

Ms. Hulsey Nickel. Unfortunately, of all of our families a very large majority could not find evidence-based care. They were denied care. They were offered very short periods of treatment, 14 days or 21 days, instead of the long-term wraparound care that they are needed. As I mentioned, trouble accessing medications to treat addiction, not providing MAT for someone who has an opioid use disorder, you are going to have a very, very difficult time having a positive outcome. So this is common in the stories we hear over and over again of not having that quality care.

Mr. Green. Okay. Well, Ms. Hulsey Nickel, thank you. Last month, the CDC published troubling new data showing that between July 2016 and September 2017 opioid overdoses visits to emergency room departments increased by 30 percent. In addition, opioid overdoses are increasing among men and women of all ages from all parts of the country. This data highlights the increasing severity of the opioid epidemic and the critical role

emergency departments must play in response to this.

And I will yield back what little time, I don't have any time left.

Mr. Burgess. No, you don't. The gentleman's time is expired. The chair recognizes the gentleman from Oklahoma, 5 minutes for your questions, please.

Mr. Mullin. Thank you, Mr. Chairman, and thank you once again for your continued effort on holding these hearings. It means a lot to me and so many other families. Thank you to the panel for being here too and sticking with us. It has been a long day and so I do appreciate it. Stacy, thank you for working with us on the IHS Task Force, coming in and talking to the staff, just Monday, and educating us and working with us trying to figure out how we can help better serve Indian country as a whole, and as you said in your testimony that it is disproportionate high of accidental overdoses inside of Indian country.

I represent the great state of Oklahoma. I am Cherokee myself and, you know, I have the highest Native American population of any district and so this hits home really tough. And, you know, part of what we are trying to do is make sure that it is not overlooked.

Tribes are unique because we are considered sovereign nations and so by getting funding to Indian country is vitally important because most health care for Native Americans are done within the IHS system. That was the federal government

obligation through the treaties to which they were signed. And I understand most people don't understand that but it is where I grew up my whole life. I am still living in Indian country. I still live at the same place I was raised and my family was raised. We are generational there.

I have got a question for you though. What are the benefits to direct funding the tribes throughout this program?

Ms. Bohlen. Thank you, Congressman.

Mr. Mullin. No, thank you.

Ms. Bohlen. Well, first of all, directly funding the tribes upholds the federal government trust responsibility and as you so eloquently expressed the promises that were made in the treaties to the tribes. The trust relationship that is established through the Constitution, federal law, and so forth, is a relationship between the federal government and the tribes.

When funding for programs is sent to the states with the hope or maybe even the intention that the state will share that funding with the tribes, there is no legal obligation and there is no accountability whatsoever on whether any of that money will reach the tribes and that is largely because the trust responsibility cannot be delegated to the states.

Mr. Mullin. Right.

Ms. Bohlen. It has to be honored at the federal level. So the benefits are tremendous. If I may, Special Diabetes Program for Indians, it is not a large investment from the government to

the tribes, but it is a public health program that is taking the best of Western medicine and the best of tribal traditional practices and implementing a preventive treatment program that is probably, after immunizations, the most successful public health program in the country. The tribes know how to do this.

Mr. Mullin. Right. And I want to elaborate just a second on what you said it is not their obligation. It is not the state's obligation. The treaty was made with the federal government and it is not a handout. It is payment from land that was taken from the tribes for years and years ago and that obligation and that payment still stays in place.

And for tribes to be able to ask the state for it, the state does look at it as it is not our obligation and which it is not, it is not any fault to the state. Oklahoma deals with this in a very unique way. I have 19 different tribes just in my district and we have a unique relationship with the states. But we do have to realize that through the grant programs they need to be available to the Indian country also.

So, one more question for you. Can you discuss the technical challenges that we have that is hampering Indian country with getting the data and the information that they need?

Ms. Bohlen. Yes, I can talk about that briefly. The health IT system in Indian country, it does not have great interoperability among the various electronic health records and so forth, that the tribes who are self-governance may choose to

use an application that is different from what the Indian Health Service uses which is the RPMS system. And RPMS system is very cumbersome in terms of trying to extract data and trying to make the picture that you actually want to make out of the disparate ways that data is collected.

There needs to be an investment in Indian country to advance electronic medical records. The agency, I believe, states it would require $3 billion over 10 years to bring that system into par with what the rest of America is experiencing.

Mr. Mullin. Thank you so much. My time is out. Thank you, Stacy, again for working with us. Thank you, Chairman. I yield back.

Mr. Burgess. The chair thanks the gentleman. The chair recognizes the gentleman from Maryland, Mr. Sarbanes, 5 minutes for your questions, please.

Mr. Sarbanes. Thank you very much, Mr. Chairman. I want to thank the panel for very compelling testimony. I wanted to focus particularly on H.R. 5102 which has been mentioned. This is a bill that I am very proud to be cosponsoring with Mr. Guthrie on this committee, but the prime sponsors are Katherine Clark of Massachusetts and Congressman Hal Rogers who have really taken the lead on this issue of trying to respond to shortages in the workforce. And it has been touched on by Ms. Horan, but I wanted to again kind of go over some of the statistics and information we have that call upon us to have an aggressive and,

I think, creative response to the provider shortage. We know that there are workforce shortages for all of the various substance use disorder healthcare professional categories across the United States. According to SAMHSA in 2012, in addition, the turnover rates in the addiction services workforce ranged from 18.5 percent to over 50 percent. And in a recent survey, nearly half of the clinical directors and agencies that specialize in providing a substance use disorder treatment acknowledge real difficulty in trying to fill these open positions and then keep them filled, dealing with the lack of qualified applicants on the one hand and the inability to keep folks in place on the other hand.

In Maryland, where we are certainly facing as every state in the country is a severe crisis in terms of substance use disorder and the effects of the opioid addiction epidemic, I have been hearing this as well. Recently I met with the head of Baltimore Medical System, which is one of our federally qualified health centers in Maryland, and she told me about her own difficulty in finding and keeping healthcare professionals that specialize in this arena.

So the bill that has been introduced by Congresswoman Clark and Congressman Rogers and is being cosponsored in this committee by Mr. Guthrie and myself, we create a pretty creative loan repayment program for substance use disorder treatment providers. Participants in this program could receive up to $250,000 in loan forgiveness if they agree to work as a substance use disorder

treatment professional in an area that is most in need of their services. So that could be a mental health professional shortage area or in a county or municipality that has overdose death rates above the national average. That would be one qualifying category. Participants can work in a wide range of facilities which is important. Community health centers, I alluded to that. Hospitals, recovery programs, correctional facilities, et cetera, wherever the need exists in a significant way. And it will be available to a broad range of direct care providers including physicians, registered nurses, social workers, other behavioral health providers.

So we are hoping that this will allow us to attract new providers into this very, very important field and it has received strong endorsements from the American Society of Addiction Medicine, the National Council for Behavioral Health, the Addiction Policy Forum, and so forth. So again I am very proud to be part of this.

I did want to ask you, Ms. Horan, just to speak, if you could, with a little more detail to what you have seen and gathered by way of data and otherwise about this shortage in these particular areas of practice and what it would mean to have this kind of an incentive program in place to address it.

Ms. Horan. Sure. Thank you for the opportunity. Again I am going to speak from CleanSlate's perspective on this because I think it is a slice of, I think, reality that might reflect what

other programs like ours are facing. Recruitment is an ongoing challenge. There are not a lot of highly trained physicians or advanced practice clinicians with a lot of addiction medicine background or addiction psychiatry background. Many of those that are out there are working in the field already. So we are always looking for, you know, new, compassionate, you know, committed talent to try and help us both grow our programs across the country, but just try and keep the programs that we have running.

You know, as you mentioned, turnover is very high for various reasons in the field. And turnover, while it might, you know, it might be a bear for us in terms of, you know the administrative side of it, the biggest problem is the danger to patient continuity of care. And so any effort, particularly this one, I think, will really help us bring, and probably newer, you know, younger talent to the field, I mean the folks that are really carrying the highest debt burden at this point and that is a good thing.

I think these are probably folks who are graduating within the last couple of years who may have had a little bit more of the addiction and pain education in medical school, we hope, but also who might not have some of the biases about addiction treatment that exist in other parts of the treatment. So certainly for us it is just another wonderful tool that we have in our toolbox to try and recruit the best, just so that we can provide our patients with the best care. Thank you.

Mr. Sarbanes. Well, thank you for your testimony. I yield back. And hopefully we will get this through and help will be on the way. Thank you. I yield back.

Mr. Burgess. The chair thanks the gentleman. The chair recognizes the gentleman from Georgia, 5 minutes for your questions, please.

Mr. Carter. Thank you, Mr. Chairman, and thank all of you for being here. You know, I have described the opioid epidemic in our country as being twofold. First of all, we have that part that is somewhat tangible that we can somewhat put our arms around, that is, how do you control these numerous prescriptions that are being written, limiting the number of prescriptions, limiting the pills, those things are somewhat tangible.

But then we talk about all those millions of people who are addicted now and how do you deal with that. That is a whole different subject, if you will, and a whole different situation. That is why I am so glad to see all of you here and I appreciate it very well, very much.

And, Dr. Rosenberg, I want to start with you, because as the only pharmacist currently serving in Congress I find it fascinating that -- I feel like there is a big void that exists right now in medicine. And I have preached this to the pharmaceutical manufacturers that, you know, we have opioids and once you get past opioids we really don't have anything else to prescribe.

I mean you have ibuprofen and tramadol and then you go to opioids and there is a big gap there. And I have been on the pharmaceutical manufacturers. We need to fill in that gap. And over my career I have witnessed miracles come out of research and development, but I still haven't seen them fill in that gap. That is why I am so interested in your program. And I want to tell you that until this hearing I was not familiar with it, but I commit to you that I am going to study it. I do think there is value in this. There are alternatives that can be used that we need to use as opposed to just putting people on the opioids.

I can remember practicing my pharmacy across from a dental clinic and they would always give them three prescriptions -- ibuprofen, the pain pill, and the antibiotic. And they would come in and say oh, I don't need the antibiotic, I just need the pain pill. Yeah, right. Well, we finally passed a self-imposed rule, you had to get the antibiotic if you are going to get the pain pill.

But, really, I am going to study more, so I want to acknowledge you. Now, I want to go to Ms. Nickel.

I found your testimony to be fascinating and I want you to know how much I appreciate what you are doing. I had the opportunity along with Chairman Burgess and Mr. Green to attend a conference a couple of weeks ago and we heard from a retired sheriff from West Virginia who told the story about a young man, a boy who was always late for school and who was in a family of

opioid addicts.

And instead of the police officer just simply turning him into juvenile detention he decided to mentor him and when he was mentoring him he had a birthday. And he asked him, he said, what do you want for your birthday? And he said I want a clock. And the policeman said why would an 8-year-old want a clock? And he said, because I don't want to be late. I want to be on time. He didn't even have a clock. And that is why I find your story so fascinating. I mean how do you break that cycle? What was different? What broke it for you? I mean how can we mentor people? We know particularly us in Congress that, you know, it is just cyclical and the generations it is hard to break those cycles like that.

Ms. Hulsey Nickel. Thank you. You know, when I get asked this question I sort of come back to it is all about science. We need to use evidence-based and science programs and interventions for kids that are impacted by this epidemic, kids like me, and we need to find them early and we need to give them the services right away.

And I love that you mentioned mentoring because that was one of the key components for me as well. The mental health department in our county assigned me a big sister when I was 11 years old and it was the first person I had ever met that had gone to college and was professional and a mentor and a real guide for me. But I also had mandated mental health. There was loving

family members that I was put with in kinship care, living with my grandma, my grandparents. And we know to identify children that are impacted. And there is trauma. There is adverse child events.

Mr. Carter. Right.

Ms. Hulsey Nickel. You are susceptible to lots of things. So we need to identify all these kids early and then get them the services that they need.

Mr. Carter. I am sure probably many of you read the book, Hillbilly Elegy, and, you know, J.D. Vance and that story, what a fascinating story. And it is just what you are saying, same scenario.

Mr. Hampton, I also found your testimony to be fascinating. Thank you for being here and thank you for what you are doing. I wanted to ask you, and I really want to ask all of you, what works? That is something I am struggling with because, you know, so many of my colleagues think all we have got to do is throw money at it and we know it has got to be more than that. What programs work?

Mr. Hampton. Thank you for that question, Congressman. It is a matter of throwing money at things, but I think it is a matter of throwing money at the right things, first of all.

Mr. Carter. Okay, fair enough.

Mr. Hampton. And, you know, so the Surgeon General's 2016 report, and then I will go into my own personal experience, said

that after year 1 people like myself we are considered in remission after year 1 of recovery. After 5 years we have an 85 percent chance at maintaining long-term recovery. So the question becomes why are we not supporting people beyond that in that first critical first year, but also up to those 5 years? For me --

Mr. Carter. Because this is a lifelong challenge.

Mr. Hampton. It is a lifelong challenge. For me, I had been through treatment multiple times, detox multiple times. I will say treatment works. Treatment saved my life. But my 18 friends who have died in the last 2 years all had been through treatment, all had been through detox. Where we, I believe the system is failing is we are not spending enough time and money on recovery and recovery support services and we are constantly, you know, we are bunching up treatment with recovery. Treatment is not recovery. Recovery happens when you leave treatment.

Mr. Carter. I am way over my time but I have to ask and I am going to ask, do programs with a spiritual component work better than others?

Mr. Hampton. Congressman, there are multiple pathways to recovery. You know, personally, me, I am a member of a 12-step fellowship and that is what works for me, but I have seen programs for all sorts of different people, faith-based, you know, folks who are agnostic. I mean it works and there are many different ways that people do this.

Mr. Carter. That is the big challenge for us that we find.

We want to fund the programs that work, but we -- it is just a struggle.

Mr. Hampton. I mean I will say, I will add to that you know, every year SAMHSA -- I went this year in September, they release all the numbers. We know, the federal government knows how many people are addicted to heroin, how many people are using cocaine, all the different drugs, the age groups, state by state data. There are 23 million people that are living in long-term recovery in the United States and I don't believe that the federal government has spent time studying us and how we achieved it. So maybe that would be a good first step.

Mr. Carter. Again I want to thank all of you for being here and I yield back, Mr. Chairman.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair would inquire of the gentleman of Oregon, do you wish to -- pass on questions.

So the chair will recognize the gentleman from Virginia, 5 minutes for your questions, please.

Mr. Griffith. Thank you very much, Mr. Chairman. And I appreciate all of you being here. As I think one of the previous members said, it has been a long day for you all. We know that and we appreciate you being here.

Ms. Nickel, I am going to address most of my questioning to you. I represent 22 counties, mostly rural, and seven independent small cities. The biggest one is about 25,000. The

smallest of my cities is 3,500. We are all in an area that is underserved for drug abuse and mental health so we have problems there.

So it is, that is where I am coming from when ask these questions because we don't have enough treatment centers. In fact, in a huge number of my counties they just don't have anywhere to go. And I had some folks who are recovering and trying to do what they can, but there is no long-term treatment there. So that is where my questions are coming from and keep that in mind, if you would, with the answers to them.

So part of that is it is obviously important to build a pipeline of qualified healthcare providers that have been trained in substance use disorder treatment and pain management education, and as I understand it, the TEACH Act will help highlight curricula from centers of excellence and disseminate these best practices widely. What types of healthcare workers will the bill educate and how will the TEACH Act take into consideration the smaller institutions that are educating healthcare workers with limited resources, because if you are just doing the big ones you are not going to reach all of my counties.

Ms. Hulsey Nickel. Absolutely. Thank you so much for that, Congressman. The TEACH Act will help to make sure that we get the right curriculum and training to all different kinds of healthcare providers, from specialty physicians, emergency departments, primary care, pediatricians, nurse practitioners.

We need to sort of move this to a chronic disease model, chronic care, and make sure that we have qualified and trained healthcare providers in all different types of settings, hospitals, sort of, you know, in your regular doctor's office or your pediatrician's office so they can identify and assess and treat substance use disorders more early.

This is particularly important for rural communities where you are not going to find as much specialty treatment. Very long distances, we are doing work on the ground in a few places like Ohio in rural communities, very difficult to find medication assisted treatment, providers that can prescribe the medicines that you need to treat opioid use disorder that can do that long care follow up. And it also is true we need to have long-term care plans -- 12 months, 3 years, 5 years -- depending on the severity of that substance use disorders, and TEACH Act will give healthcare providers the tools that they need to assess, identify, and make sure we build those treatment plans.

Mr. Griffith. I appreciate that. Also, the Comprehensive Opioid Recovery Centers Act will identify some of the best centers in America providing care for addiction and recovery. And from what I understand, these centers deliver the full complement of addiction services. Congress will direct funding to support those centers and they in turn will provide documentation and data on their effectiveness, their models of care, and their collaboration with their communities.

Is the goal of the bill to scale up and spread so that there are more centers of excellence across the U.S. or is the goal to lift all boats with the rising tide so that any facility can improve even if they are not able to reach the centers of excellence level? And obviously when you don't have any you may need to start with something. Even if it doesn't meet the gold standard, we would like to have something that meets at least the silver standard.

But what do you think? Will the bill help with that?

Ms. Hulsey Nickel. I believe so. I think it could help actually with both. I think creating these centers of excellence so we can really advance what patient-centered care looks like, to take down these silos to have better coordinated care, and then the lessons learned from these centers to be applied throughout our healthcare systems and to all of the components that we need to treat this illness. So I think it will actually have both effects.

We have a lot of rural communities that are struggling with this illness and we need to have sort of more evidence and more new programs and protocols in place that we get to them quickly. And I believe that the Comprehensive Opioid Recovery Centers bill will help to do that.

Mr. Griffith. I appreciate that. And for those folks who came in to see me, I hope this helps them know that we are trying to find something and several of those folks as I said were in

recovery. Complement all, it is not easy.

I appreciate you, Mr. Hampton. But all those that we have had testify over the last couple of days, there have been a number of people that have had issues who are now in recovery and I compliment you all. And look, we have to realize there is a lot of talent out there that we are wasting if we don't use those people who are in recovery. And I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. Does the gentleman from Oregon seek recognition?

Mr. Schrader. Yes, just briefly, Mr. Chairman. I want to thank the panelists for coming and sharing their stories. That will help us craft hopefully a better solution at the end of the day. I am in a listening mode right now and appreciate it very much, but a colleague of mine I would like to yield to, the Ranking Member Mr. Green, for some salient questions, please.

Mr. Green. I want to thank my colleague for yielding to me.

I have got a question for you, Ms. Deal-Smith, but when I was practicing law and dealt with clients through the mental health process I saw so many times when people were -- it was a revolving door and a lot of things that we don't understand that this is a lifelong illness.

And I would see these patients, or clients of mine on a regular basis. I said, why weren't you, you left here, you had medication, you were doing fine. And a number of them said, well,

I felt so good I didn't think I needed my medication. And I said, do you have anybody in your household that has heart trouble? You know, I don't know if that is cured but you have to take the medication.

And so, but this is a lifelong illness in some cases and we need to recognize that. But sure, we would like a cure, but we would like a cure for cancer too, but we are still trying to manage it, so. But, Ms. Deal-Smith, how much of are you comfortable sharing, can you tell us about the background and history with substance use disorder?

Do you want to turn on your mike?

Ms. Deal-Smith. So my addiction started at an early age. I was 12 years old when I had my first alcohol and it progressed as the years went by and when I was like 28 years old I got into trouble with my addiction. I got a DWI and I had to go to residential treatment for 28 days. And in that treatment center I was given the tools to learn about my addiction and how to help myself get through hard times when they would be coming up and when I got out of treatment I had a director where I worked that helped me through the process because he was in recovery himself.

So I had a lot of support in my recovery and that is what I bring here is I am there for the people that are in recovery. I help them get along. I take them to the hospitals, the medication that are prescribed for them can they take this, can they not take it, so I talk to the therapists and the counselors,

the substance abuse counselors and we find a good, a better way to treat them.

And if it is an opioid that they are prescribed we have to say, okay, is this good for them? The person is in recovery, no, it is not good for them. Let's look for another alternative so we can assist with getting them through this hard time. So that is part of my job is to be there for the client when they need you most and that is in early recovery.

Mr. Green. I think it is -- congratulations. You were able to go from your history to be a peer support specialist. What do you think is the most important aspect of your job working with people in recovery, because if it works we would like to see how it works around the country, so.

Ms. Deal-Smith. It works because people like me who is in recovery are there to help them guide through the hardest time of their life to educate them and say, no you can't do this, yes you can do this. I will help you. I will do this. They meet me halfway and I meet them halfway. So I am able to be there for them when they need me the most.

I have people that are taking care of them at night and then they can call me when the clients, the relatives, need help, need assistance. I am there for them. I am there all the time.

Mr. Green. Thank you.

Thank you, Mr. Chairman. I yield back.

Mr. Burgess. The chair thanks the gentleman. The

gentleman yields back.

Mr. Tonko, you are not on the subcommittee, but do you wish to be recognized for questions?

Mr. Tonko. I do.

Mr. Burgess. You are recognized for 5 minutes.

Mr. Tonko. Thank you, Mr. Chair and Ranker Green. I thank you both for waiving me on to the subcommittee. I am grateful that the committee has decided to focus its attention on this life and death issue. It means a lot to the communities that I represent in the capital region to see Congress working together across the aisle to reduce the burden of this deadly opioid epidemic.

In particular, I am pleased that we are considering two bipartisan bills that I have had a hand in authoring, the Addiction Treatment Access Improvement Act and the TEACH to Combat Addiction Act. Combined, these bills would expand access to medication assisted treatments for opioid use disorders and help to prepare our next generation medical workforce to tackle the disease of addiction.

So, Ms. Horan, thank you for your testimony in support of the Addiction Treatment Access Improvement Act. In your written remarks you discuss the importance of including nurse practitioners and physician assistants as part of the addiction workforce. Can you go into a bit more detail about how NPs and PAs are integral to addiction care at CleanSlate and how

integrating other high skilled nursing professions might enhance CleanSlate's ability to provide high quality substance use treatment?

Ms. Horan. I would be happy to. Thank you for the question. I think, first and foremost, they help us meet the demand in the communities. You know, as we have mentioned before we have talked about workforce shortages, some of the limitations around, you know, prescriptive authority, even if you can and are willing to do it, and the nurse practitioners and physician's assistants have been willing, wonderful, warm additions to our team.

I would say more than that they work alongside in strong collaboration with our physicians to prescribe, rather to provide a whole host of, you know, clinical services from physical exams to the support of counseling to, you know, medication management. They are part of the backbone of our clinical program. In terms of adding additional, you know, highly trained, interested, invested prescribers, we welcome them all. I mean it is not easy to find, you know, folks who are this eager and this willing to work in the space and if they want to be part of the solution and join our team, you know, we more than welcome them.

Mr. Tonko. Thank you. And I would think struggling with that illness, when you have the moment of clarity, treatment on demand is essential.

Again, Ms. Horan, how do CleanSlate and other high quality treatment centers work to minimize the risk of diversion of

medication assisted treatment and how would the Addiction Treatment Access Improvement Act specifically encourage expanded treatment capacity in high quality settings like CleanSlate?

Ms. Horan. Again thank you for the question. So I am not sure I talked much about our treatment model aside from who staffs it. We are what we call a high touch model so the patients that come to our centers are seen with a high level of frequency. So the sicker you are, the more severe your illness is, the more frequently you will be seen. That would be about twice a week.

And then as you progress in your recovery, we are looking for markers of recovery, you know, a number of things that are telling us that you are getting better, you will be seen once a week. Even at your most stable you won't be seen less than once a month. So that is important for a number of reasons. One, it is a way to keep the patient and the provider accountable to the patient's goals. Two, it brings them into the office with enough frequency where and in each visit they are given urine drug screens and other things. So we are testing for not just the drugs of, you know, of misuse but to make sure that they are taking the medication properly.

We also do, I think, sort of more standard, you know diversion control tactics. We do random pill, or patient recalls where they have to come in and bring their films and then we count films. And I think those things all combined we feel pretty secure that our patients are using the medications as prescribed.

Should a patient for some reason be found to have diverted the medication for purposes other than why we prescribed it that would be a cold stop for us. That would be a reason why we would ask a patient to leave. Now having said that, you know, it is not in the interest of the patient or in the interest of the community to not make sure that that patient is somewhere else. Typically they will be referred up to methadone or somewhere else in the community. So I just want to make clear that they are not being, you know, exited to nothing. And there will be instances when they can rejoin depending on the circumstances but, generally speaking, diversion, we take a pretty hard stance on that.

Mr. Tonko. Thank you. In your testimony you described waiting lists to access treatment in your facility in Anderson, Indiana. Unfortunately this is not an isolated phenomena as I have spoken with individuals in my district who have had to wait a year or more for a treatment slot. When an individual who is struggling with addiction is faced with barriers to treatment like waiting lists, what does that do for their chances of recovery?

Ms. Horan. Well, first and foremost, I mean the data shows that you know, if access to MAT is a relapse prevention tool it also greatly increases, or reduces the chances that our patients will overdose. So when patients come to our centers, I mean we have talked about readiness for change. Readiness for change means we want to open the door and bring them in right away. To

have to turn a patient away means that we feel like we have put them at risk for relapse or for overdose. Moreover, it is just demeaning and demoralizing to finally be ready for change, to be ready to enter treatment, and to not be able to access it when you are ready for it. We will do everything we can to ensure that that patient even if they can't be seen in our center is at least seen in a treatment program within the community or within, as in the case of the Anderson patients can access the next closest CleanSlate Center. But I mean it is just, fundamentally it is a lost opportunity that really shouldn't exist.

Mr. Tonko. Thank you, Mr. Chair. I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. Does the gentleman from Texas have another request?

Mr. Green. Mr. Chairman, I have a unanimous consent request to place into the record a statement from Congressman Bill Pascrell in support of H.R. 5197, the Alternative to Opioids in the Emergency Department Act, and also a statement from Congresswoman Katherine Clark and Congressman Hal Rogers in support of H.R. 5102, the Substance Use Disorder Workforce Loan Repayment Act of 2018. I ask unanimous consent to place those in the record.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT**********

Mr. Burgess. The chair will recognize himself for 5 minutes for questions.

Dr. Rosenberg, I was intrigued by your testimony and your alternatives that you use in your emergency department. There is an ancillary bill that is not directly related to what you are doing, but it seems to me that it has some connection. Dr. Gottlieb, yesterday, when he, the commissioner of the Food and Drug Administration, was talking to us talked about the difficulty of developing new treatments for pain and that the datasets are sometimes vague and indecipherable. And you seem to be doing though some work with what you described as alternative pathways. Is that correct?

Dr. Rosenberg. That is correct.

Mr. Burgess. So the bill that actually it is only in draft form right now and it is one that is under development, but it is to encourage the Food and Drug Administration to develop draft guidance for alternative pain medicines and use and breakthrough designation along that development pathway. Again Dr. Gottlieb referenced how difficult that is in the research and regulatory environment, but you seem to have found a way to make that useful. Is that correct?

Dr. Rosenberg. That is correct, Mr. Chairman.

Mr. Burgess. What, if I may ask, if it is not proprietary, what is it? You reference enzymes in your testimony.

Dr. Rosenberg. The principles behind the ALTO protocol is

to really increase the number of tools in the physician's toolbox. As one of the congressmen suggested, there used to only be Tylenol, Motrin, and opioids, and if I wanted to guarantee the patient the best treatment we would give them opioids. Obviously that was a bad decision.

The principles between ALTO and the development of the ALTO protocols was really to search the world literature for existing protocols that existed without the use of opioids. Let me just give a quick example. Renal colic, if anybody had kidney stones, is a tremendously painful condition. But there have been treatment protocols and treatment successes in the literature using IV lidocaine that we used to use commonly for cardiac issues, now that works tremendously well for people with renal colic. It does two things. One, it relieves the pain. And we have to do more study on this, but it seems like it passes the kidney stone more quickly.

So the real secret behind ALTO is finding existing protocols, not going through an I or a B, not doing a lot of studies, at least that is how we created it by taking the protocols that are out there. We use medications like nitrous oxide and do nerve blocks and lidocaine and use patches, but it is a layering of different medications and protocols together to get the maximum benefit for the patient.

Mr. Burgess. Well, I thank you for that. It is very intriguing. Of course I am old enough to remember when we had

toradol and stadol as new medicines.

Dr. Rosenberg. Yes, indeed.

Mr. Burgess. We no longer have those in our toolbox.

Mr. Hampton, thank you for being here. Your testimony, very compelling. We have heard and learned something around sober homes or sober living homes and I assume you are from California --

Mr. Hampton. That is correct.

Mr. Burgess. -- since your representative is Representative Chu. Now there was recently some news from California about, I think, new regulations at a state level that they were applying to sober living homes. Do I recall that correctly?

Mr. Hampton. Actually, yes, Congressman. I have been working on that legislation also. Yes.

Mr. Burgess. And so I wasn't sure what it was, so I Googled it and then what impressed me was the vast number of sober living homes that are available. Sober living homes California, and there is a lot of stuff that comes up on the little iPad. And we have had some hearings in the Oversight Subcommittee and I will say this as delicately as I can, but apparently all sober living homes are not created equal. Is that fair to say?

Mr. Hampton. That is correct, yes.

Mr. Burgess. And I don't know whether it was you or someone else who referenced that how you get to treatment may vary and

it could be through an advertisement on the television. We have all seen the advertisements. I have wondered about the advertisements. Pretty hard for a patient to discern what is reasonable, what is not. They are in trouble, they know they need help, here is someone offering help.

So take us through that a little bit how, from a patient's perspective how do you navigate that?

Mr. Hampton. Currently, it is nearly impossible, I would say, to be able to find an ethical, stable home without having firsthand knowledge of the home or a referral from a trusted family or friend. As you know, there is a lot of claims-based marketing that is going on, false claims-based marketing that is going on with treatment centers and with sober homes.

Luckily for me, my story happens that I, I mean it is by sheer luck that I sit here today and that I found my way into a stable recovery residence. I had lived in Florida for some time also. That is where I am from. So I had been through multiple unscrupulous homes.

Families have a very hard time navigating the system. And I think that there is a solution to, you referenced California so the outcome of my friend Tyler dying was not just going to Congresswoman Chu and looking at the federal level, but it was going to our state senator as well and assembly members and drawing up legislation.

When we came up with SB-1228 there was no standard. There

was no federal standard. There were no best practices that the federal government was publishing saying here is what a recovery residence should look like. I believe that that is a solution. It would have helped us with crafting the California legislation and I do believe other states are looking for that as well and part of that should be a ban on claims-based marketing.

There is a lot of good places that people could find and we could draw them a road map, but unfortunately they don't have the types of budgets that some of these unscrupulous operators have because of the fraud they have committed and money that they have made off of the others' backs.

Mr. Burgess. Well, perhaps you will be good enough to share with the subcommittee some of the data that you have collected over time and that is a much longer conversation, but we may ask, if you would, to submit that in writing.

And I do recall during the previous Congress we worked on the CURES for the 21st Century bill and the mental health title in that and also the peer support that I think you described seemed at some times to be almost as effective as the medication assisted therapies. Is that a fair statement?

Mr. Hampton. Yes. I mean that is a fair statement. I think that again there is varying ways of recovery. I would say that peer support, in my opinion, medication assisted treatment does not work without the wraparound services as we have heard and the peer support. We need more MAT.

I am a supporter of MAT in other but going back to the housing issue, MAT is not welcome in, I would say, the super majority of sober homes in the United States. There is, you know, a huge disparity in terms of the services that someone on MAT can receive. So that is something that the states, I believe, need to deal with as well.

Mr. Burgess. Very well. Well, you have been a great panel. And seeing there are no further members wishing to ask questions, I again want to thank our witnesses for being here today. I do want to submit statements from the following for the record.

Regarding H.R. 5102: the American Medicine Foundation, the Addiction Policy Forum, the American Academy of Addiction Psychiatry, the American Association of Colleges of Osteopathic Medicine, American Nurses Association, American Osteopathic Association and the Massachusetts Osteopathic Society, the American Society of Addiction Medicine, Association for Behavioral Healthcare, the Coalition to Stop Opioid Overdose, the International Certification & Reciprocity Consortium, Legacy Community Health, National Board of Certified Counselors, the National Council for Behavioral Health, the United States Representatives Clark and Rogers.

Regarding the Mullin Amendment in the Nature of a Substitute to H.R. 3545, a Partnership to Amend Part 2: Confidentiality Coalition, Premier, America's Essential Hospitals, Congressman Patrick Kennedy, National Governors Association, President's

Commission on Combating Drug Addiction and the Opioid Crisis.

Articles from the following: The Journal of Accountable Care, American Journal on Addictions, New England Journal of Medicine, Journal of American Medicine, Ascension Michigan, Bloomberg Health Data Management.

And further statements from the following: The American Academy of Neurology, the American College of Obstetricians and Gynecologists, the American Society of Addiction Medicine, the Electronic Health Record Association, Keith Peradick, National Association of Chain Drugstores, National Coalition on Health Care, Ohio State University, United South & Eastern Tribes Sovereignty Protection Fund.

And I would also like to submit Congressman Patrick Kennedy's statement for the record. He was unable to join us yesterday due to weather, but had planned on it.

[The prepared statement of Mr. Kennedy follows:]

**********INSERT**********

Mr. Burgess. Pursuant to committee rules, I remind members they have 10 business days to submit additional questions for the record. I ask the witnesses to submit their responses within 10 business days upon receipt of the questions. Without objection, the subcommittee then stands adjourned.

[Whereupon, at 2:54 p.m., the subcommittee was adjourned.]