BIPARTISAN POLICY CENTER

A Sustainable Solution to the Evolving Opioid Crisis: Revitalizing the Office of National Drug Control Policy

Written Testimony by BPC Chief Medical Advisor Anand K. Parekh, MD MPH

U.S. House Committee on Oversight and Government Reform

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Chairman Gowdy, Ranking Member Cummings and members of the committee, thank you for the opportunity to appear before the committee. I applaud the committee's efforts over the last year to identify ways to strengthen the White House Office of National Drug Control Policy (ONDCP) and enhance the federal response to the opioid epidemic.

My testimony today is based on my perspective both as a physician and a public servant. As a physician starting at Johns Hopkins Hospital 16 years ago, I treated many patients with substance abuse disorders, most commonly acute drug or alcohol intoxication.

I was also part of the medical establishment which in the late 1990s and early 2000s began to prescribe opioids, a new class of pain relieving medications at the time marketed to health care professionals as having no addictive properties. That claim as we now know is not and was never true.

Subsequently, as a public servant in the Office of the Secretary at the Department of Health and Human Services (HHS), I dealt with an array of substance abuse prevention and treatment policy issues. Specifically, as Deputy Assistant Secretary of Health (Science & Medicine), I witnessed firsthand the unique convening ability and leadership role that ONDCP plays in the development, implementation, and tracking of the National Drug Control Strategy.

I also recall the ability of ONDCP to convene timely briefings for executive branch agencies around emerging topics such as neonatal abstinence syndrome, a condition in which a baby experiences withdrawal symptoms after being exposed to substances such as opioids.

The need for an entity such as ONDCP to promote executive branch collaboration and coordination was so apparent that in 2010 HHS created a Behavioral Health Coordinating Council to provide a similar internal forum to address issues such as prescription drug abuse and marijuana.

Opioid Epidemic

Today, the opioid epidemic is one of the most significant public health challenges of our time. In 2016 alone, 2.1 million Americans had an opioid use disorder and 42,249 Americans died from overdosing on opioids, 116 every day. The epidemic touches all segments of the population – white and black; young and old; urban and rural; rich and poor; and, red states and blue states.

The crisis, 20 years in the making, will get worse before it gets better. Fortunately, there are evidence-based interventions and solutions that if scaled by the combined efforts of the public and private sectors can bend the curve of the epidemic.

Tackling a crisis of this scale will require aggressive action by both government and the private sector, active engagement by both public health and law enforcement, sufficient funding and targeted investment to scale what works, and additional research on opioid alternatives.

The Bipartisan Policy Center's Governors Council has previously recommended **four critical approaches: 1) curbing overprescribing; 2) curbing the illicit supply; 3) facilitating treatment and recovery; and, 4) educating America to reduce stigma and expand evidence-based harm reduction strategies.**[1]

With respect to overprescribing, education of all health care professionals on safer prescribing practices as documented in CDC's Guideline for Prescribing Opioids for Chronic Pain is essential to prevent opioid misuse and addiction. Tying renewal of a controlled substances license, obtained through the Drug Enforcement Administration (DEA), to a requirement for a course in proper prescribing and addiction is an idea whose time has come.

In addition, prescription drug monitoring programs need to be integrated with electronic medical records and made interoperable from state to state to maximize their utility.

While prescribing rates have dropped over the last several years, in 2016, 91.8 million (more than one-third of U.S. civilian, noninstitutionalized adults) used prescription opioids. As a physician I can tell you there is no reason, neither for acute pain nor chronic pain, that this many Americans should be prescribed or be using these drugs.

With respect to curbing the illicit supply, stemming the flow of illicit fentanyl from China and Mexico needs to be one of our top international diplomacy and foreign policy priorities. Domestically, more funding, cooperation and coordination is needed by federal agencies to interdict fentanyl and disrupt drug trafficking networks.

[1] Bipartisan Policy Center. "Former Governors Offer Recommendations to President Trump's Opioid Crisis Commission." July 2017. Available at: https://bipartisanpolicy.org/library/letter-to-the-presidents-commission-on-combating-drug-addiction-and-the-opioid-crisis/.

With respect to facilitating treatment and recovery, a significant and sustained investment of resources is needed to ensure that all treatment facilities offer medication-assisted treatment, public and private payers provide barrier-free coverage of these services, and health care professionals are trained in providing this care.

In comparison to prescribing opioids, we have made it far too difficult for health care professionals to prescribe medication-assisted treatment for opioid addiction. Whereas obtaining a DEA license to prescribe opioids requires only filling out a short form, obtaining a waiver to prescribe buprenorphine requires completion of an eight-hour training. In addition, there are arbitrary caps placed on the number of patients a health care professional can treat with buprenorphine. These barriers to treatment must be addressed.

Finally, with respect to educating Americans to reduce stigma, employing harm reduction strategies, including syringe exchange programs and increasing widespread availability of naloxone, would save lives, reduce rates of infectious diseases, and facilitate treatment and recovery.

Role of ONDCP

In order to comprehensively tackle the opioid epidemic, it is critical that states and communities have a federal partner that is itself coordinated. While this epidemic is a public health crisis, the federal response is one that demands not just HHS making it a priority but each and every executive branch department as well.

The federal response must include a comprehensive supply-side and demand-side strategy that is funded appropriately, promotes interdepartmental coordination and collaboration, and includes specific measureable goals and timelines. With this in mind, I am pleased to see this Committee's bipartisan discussion draft to codify provisions relating to ONDCP.

Designating opioids as an emerging threat will require ONDCP to produce a National Opioid Crisis Response Plan within 60 days. While the final report of the President's Commission on Combating Drug Addiction and the Opioid Crisis, in addition to several other evidence-based reports, specifies important strategies to deal with the epidemic, a detailed federal implementation and action plan with goals, measures, targets, and designations of responsible offices or officials has not been produced to date.

A response plan would also more clearly inform Congress about the appropriate federal funding levels necessary to address the epidemic over the next several years. While Congress has appropriated dollars targeting the epidemic through The 21st Century Cures Act and, more recently, the Bipartisan Budget Act of 2018, these amounts have not all been developed through a data-informed process.

I am pleased the Committee's discussion draft emphasizes that ONDCP ensure federal agencies and states adopt evidence-based standards for drug control policies, practices, and procedures. This is especially important to accelerate the adoption and integration of medication-assisted treatment within the health care delivery system.

More broadly, establishing in statute the importance of evidence-based standards is an example of good governance and consistent with the findings of the Commission on Evidence-Based Policymaking, jointly sponsored by Speaker Paul Ryan and Senator Patty Murray.[2]

The discussion draft's requirement of a national evidence-based media campaign within 60 days of the opioid epidemic being given an emerging threat designation is also promising. I recommend that ONDCP carefully consider the recommendations of the President's Commission to ensure that such a campaign is developed and implemented in a way that maximizes impact.

I also recommend that ONDCP consult with the Centers for Disease Control and Prevention which has a track record in implementing successful public health education and outreach campaigns, most recently with respect to the national *Tips From Former Smokers*® campaign.

My caution for the Committee in reauthorizing ONDCP is not to overcomplicate its organizational structure. There are currently multiple plans, strategies, dashboards, centers, and leadership offices envisioned. The structure should be simple enough to ensure results-oriented accountability and clear channels of communication with executive branch agencies.

The committee should also ensure that ONDCP remains a leadership and policy office first and foremost and refrains from taking on too many programmatic activities that might be best suited for implementation at the level of executive branch agencies.

Ultimately, ONDCP's role in combating the opioid epidemic will be judged on whether it can develop and implement an executive branch-wide action plan to support states and communities which leads to a reduction in overdose deaths and opioid addiction over the next several years. The expectations of the office should be high because the urgency of the crisis demands nothing less.

[2] The Bipartisan Policy Center's Evidence-Based Policymaking Initiative supports the implementation of the recommendations of the Commission on Evidence-Based Policymaking.

Committee on Oversight and Government Reform
Witness Disclosure Requirement — "Truth in Testimony"

Pursuant to House Rule XI, clause 2(g)(5) and Committee Rule 16(a), non-governmental witnesses are required to provide the Committee with the information requested below in advance of testifying before the Committee. You may attach additional sheets if you need more space.

Name:

1. Please list any entity you are representing in your testimony before the Committee and briefly describe your relationship with each entity.

Name of Entity	Your relationship with the entity
Bipartisan Policy Center	Chief Medical Advisor

2. Please list any federal grants or contracts (including subgrants or subcontracts) you or the entity or entities listed above have received since January 1, 2015, that are related to the subject of the hearing.

Recipient of the grant or contact (you or entity above)	Grant or Contract Name	Agency	Program	Source	Amount
NONE					

3. Please list any payments or contracts (including subcontracts) you or the entity or entities listed above have received since January 1, 2015 from a foreign government, that are related to the subject of the hearing.

Recipient of the grant or contact (you or entity above)	Grant or Contract Name	Agency	Program	Source	Amount
NONE					

I certify that the information above and attached is true and correct to the best of my knowledge.

Signature _____ Date: 5-15-18

Biography of Anand K. Parekh, MD MPH
Chief Medical Advisor
Bipartisan Policy Center

Dr. Anand Parekh is BPC's chief medical advisor providing clinical and public health expertise across the organization, particularly in the areas of aging, prevention, and global health. Prior to joining BPC, he completed a decade of service at the Department of Health and Human Services (HHS). As deputy assistant secretary for health from 2008 to 2015, he developed and implemented national initiatives focused on prevention, wellness, and care management. Briefly in 2007, he was delegated the authorities of the assistant secretary for health overseeing ten health program offices and the U.S. Public Health Service Commissioned Corps. Earlier in his HHS career, he played key roles in public health emergency preparedness efforts as special assistant to the science advisor to the secretary.

Parekh is a board-certified internal medicine physician, a fellow of the American College of Physicians, and an adjunct assistant professor of medicine at Johns Hopkins University, where he previously completed his residency training in the Osler Medical Program of the Department of Medicine. He provided volunteer clinical services for many years at the Holy Cross Hospital Health Center, a clinic for the uninsured in Silver Spring, MD.

Parekh is an adjunct professor of health management and policy at the University of Michigan School of Public Health. He currently serves on the dean's advisory board of the University of Michigan School of Public Health, the Presidential Scholars Foundation board of directors, and the board of directors of WaterAid America.

He has spoken widely and written extensively on a variety of health topics such as chronic care management, population health, value in health care, and the need for health and human services integration.

A native of Michigan, Parekh received a B.A. in political science, an M.D., and an M.P.H. in health management and policy from the University of Michigan. He was selected as a U.S. Presidential Scholar in 1994.