**Opening Statement**
**Senator Susan Collins**
**"Preventing and Treating Opioid Misuse Among Older Americans"**
**May 23, 2018**

Last year, the *Portland Press Herald* ran an in-depth series titled "*Lost*," which told the stories of Mainers who have been most affected by the opioid epidemic. The stories highlighted and exposed many, often unseen, facets of this crisis. It made clear that no one is immune from the devastating effects of addiction. Dr. Mary Dowd, who specializes in addiction treatment and sees hundreds of patients through her work at Catholic Charities Maine, told the newspaper, "I still think people have this idea in their head about who is caught up in this crisis. It could be anyone."

Many perceive the face of opioid addiction as young. Indeed, I met this very morning with a substantial group of young people from Maine called Young People in Recovery who were representing young adults from our state who are in recovery or are working with those who seek to be part of the recovery community. This epidemic, however, intersects just as much with older adults, something that I think has not received the focus that it deserves. According to the Inspector General, one in three Medicare Part D beneficiaries received an opioid prescription in 2016. The Center for Disease Control estimates that the number of people age 55 or older treated in emergency rooms for opioid overdoses increased by nearly a third from 2016 to 2017.

Treating pain effectively in an environment where abuse of prescription painkillers is rampant remains a concern for clinicians. Nearly half of older Americans suffer from chronic pain, and the incidence increases with age.

In addition to the risk of addiction, older adults taking opioids are also four to five times more likely to fall than those taking non-steroidal, anti-inflammatory drugs. Regrettably, health care providers sometimes miss substance abuse among older adults, as the symptoms can be similar to depression or dementia.

Alternatives to opioids are critical, yet those alternatives may also be more expensive and less convenient for patients. For example, physical therapy can benefit patients suffering from pain, support long-term recovery, and stave off the need for medication. Yet, patients who work may not have the flexibility to leave their jobs for regular physical therapy appointments. Repeated travel can also be a substantial hurdle for some patients, particularly during the winter or when a medical condition makes driving unsafe.

Challenges in treatment and recovery persist as well. Seniors in need of treatment may face serious obstacles to accessing care due to a shortage of geriatric health professionals as well as behavioral health care professionals. In rural areas, those obstacles may be worsened.

While there is no silver bullet to ending this epidemic, Congress and this Committee are fighting back on multiple fronts. Since our hearing on opioid use and abuse two years ago, we have made progress in how health care providers discuss pain with their hospitalized patients. At that hearing, I questioned whether hospital performance surveys could be contributing to the vast supply of prescription opioids in circulation by penalizing hospitals if physicians, in their best medical judgment, opted to limit opioid pain relievers to certain patients.

CMS concurred and since last January, surveys are now asking patients three questions that address *communication* about pain during their hospital stay, rather than pain management. For example, patients used to be asked, a question that I really thought was egregious, it was: "How often did the hospital staff do everything they could to help you with your pain?" Now, patients are being asked, "How often did hospital staff talk with you about how to treat your pain?" Big difference.

Since our hearing, Congress also passed the Comprehensive Addiction and Recovery Act, or CARA, as well as the 21st Century Cures Act, and the recent budget agreement contained $6 billion to address the opioid crisis. Last year, HHS issued more than $800 million in grants to support access to opioid-related treatment, prevention, and recovery, while making it easier for states to receive waivers to cover treatment through their Medicaid programs. I remain concerned, however, that, in some areas, it is taking far too long for those funds to reach local health care providers, treatment and recovery organizations, and groups and schools involved with prevention and education efforts.

I have authored two bills to further address this epidemic that have been included in the recent HELP Committee opioids package. The "Safe Disposal of Unused Medication Act" would authorize certain hospice employees to dispose of controlled substances in a patient's residence after the hospice patient dies. This would reduce the dangerous risk of diversion of unused painkillers.

Another bill, the "Opioid Peer Support Networks Act," would authorize grants to support the creation of peer support networks, and create a national technical assistance center to provide the resources and training to help them be successful. Through these networks, those battling addiction support one another on the road to long-term recovery. So, this bill addresses a gap in recovery care since, currently, an estimated 40 and 60 percent of recovering addicts relapse.

And just last week, FDA approved the first non-opioid treatment for the management of opioid withdrawal symptoms in adults. Greater innovation in this area as well as the development of more non-opioid painkillers is crucial, and I commend FDA Commissioner Gottlieb for his leadership.

While all of these steps represent progress, we must continue to re-examine this issue from every angle, as the opioid crisis continues to tighten its grip not only on older adults, but also on future generations.

I now look forward to hearing from our witnesses, but first, I turn to our Ranking Member, Senator Casey, for his opening statement.