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116TH CONGRESS
2D SESSION

H. R. 5774

To direct the Secretary of Veterans Affairs to conduct a review on opioid overdose deaths among veterans, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 6, 2020

Mr. MURPHY of North Carolina (for himself and Mr. PETERSON) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To direct the Secretary of Veterans Affairs to conduct a review on opioid overdose deaths among veterans, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Veterans Heroin Overdose Prevention Examination Act'' or the ''Veterans HOPE Act''.

SEC. 2. FINDINGS; SENSE OF CONGRESS.

(a) FINDINGS.—Congress finds the following:

(1) New research shows that a dramatic rise in opioid overdose deaths among veterans in recent

years has happened increasingly among veterans dying from heroin and synthetic opioids.

(2) Furthermore, patients of the Veterans Health Administration of the Department of Veterans Affairs are seven more times likely to suffer from an opioid use disorder than commercially insured patients.

(3) Using records of the Veterans Health Administration linked to National Death Index data, the veterans' rate of overdose deaths from all opioids increased by 65 percent from 2010 to 2016, a rate change that includes adjustments for demographic changes in the veteran population over time.

(4) Furthermore, among all opioid overdose decedents, prescription opioid receipt within three months before death declined from 54 percent in 2010 to 26 percent in 2016, yet veteran overdoses resulting in death from heroin, synthetic opioids such as fentanyl, and nonprescription opioids still occurred.

(5) In fact, between 2010 and 2016, the veteran death rate from heroin or from taking multiple opioids almost quintupled and the death rate from synthetic opioids such as fentanyl increased by more than five-fold.

(6) Trends would suggest that, while the aggregate rise in opioid overdose deaths among veterans parallel those seen in the general population, the increase occurred mainly because of a rise in deaths from nonprescribed sources such as heroin, fentanyl, other powerful synthetic opioids, or multiple opioids in concurrent use.

(b) SENSE OF CONGRESS.—It is the sense of Congress that further veterans overdose prevention efforts and research should extend beyond patients actively receiving opioid prescriptions.

SEC. 3. REVIEW OF DEATHS OF VETERANS RELATING TO OPIOID USE.

(a) REVIEW.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Veterans Affairs shall complete a review of the deaths of all covered veterans who died from opioid overdoses during the five-year period preceding the date of the enactment for this Act.

(b) MATTERS INCLUDED.—The review under subsection (a) shall include the following:

(1) The total number of covered veterans who died from opioid overdoses during the five-year period preceding the date of the enactment of this Act.

(2) A summary of such veterans that includes the age, sex, and race, and ethnicity of each such veteran.

(3) A comprehensive list of the medications prescribed to, and found in the bodies of, such veterans at the time of death, specifically listing any medications that carry a black box warning, are off-label, or are psychotropic.

(4) A summary of medical diagnoses by physicians of the Department of Veterans Affairs that led to any prescribing of the medications referred to in paragraph (3).

(5) The number of instances in which such a veteran was concurrently on multiple medications prescribed by physicians of the Department.

(6) A summary of—

(A) the average period that elapsed between the last prescription opioid receipt and the date of the death of such a veteran; and

(B) the cause of death for each such veteran.

(7) The percentage of such veterans with combat experience or trauma (including military sexual trauma, traumatic brain injury, and post-traumatic stress).

(8) Identification of medical facilities of the Department with high prescription and drug abuse treatment rates for patients being treated at those facilities.

(9) A description of policies of the Department governing the prescribing of medications referred to in paragraph (3).

(10) A description of efforts by the Secretary to electronically track, collect, and properly dispose of prescription opioids that are either unused, past the prescription date, or not in the possession of the properly prescribed patient.

(11) A description of any patterns apparent to the Secretary based on the review.

(12) Recommendations for further action that would improve the safety and well-being of veterans and reduce opioid overdose rates for veterans, especially concerning research regarding such veterans who had not filed for a opioid prescription in the three months before death by overdose.

(c) PUBLIC AVAILABILITY.—Not later than 45 days after the completion of the review under subsection (a), the Secretary shall—

(1) submit to Congress a report on the results of the review;

(2) make such report publicly available; and

(3) provide to the Committees on Veterans' Affairs of the House of Representatives and the Senate a briefing on such review.

(d) DEFINITIONS.—In this section:

(1) The term ''black box warning'' means a warning displayed within a box in the prescribing information for drugs that have special problems, particularly ones that may lead to death or serious injury.

(2) The term ''covered veteran'' means any veteran who received hospital care or medical services furnished by the Department of Veterans Affairs during the five-year period preceding the death of the veteran.

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