

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

A BILL

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

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Veterans Heroin Over-
5 dose Prevention Examination Act” or the “Veterans
6 HOPE Act”.

7 **SEC. 2. FINDINGS; SENSE OF CONGRESS.**

8 (a) FINDINGS.—Congress finds the following:

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

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

3 (2) Furthermore, patients of the Veterans
4 Health Administration of the Department of Vet-
5 erans Affairs are seven more times likely to suffer
6 from an opioid use disorder than commercially in-
7 sured patients.

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

14 (4) Furthermore, among all opioid overdose de-
15 cedents, prescription opioid receipt within three
16 months before death declined from 54 percent in
17 2010 to 26 percent in 2016, yet veteran overdoses
18 resulting in death from heroin, synthetic opioids
19 such as fentanyl, and nonprescription opioids still
20 occurred.

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

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

4 (3) A comprehensive list of the medications pre-
5 scribed to, and found in the bodies of, such veterans
6 at the time of death, specifically listing any medica-
7 tions that carry a black box warning, are off-label,
8 or are psychotropic.

9 (4) A summary of medical diagnoses by physi-
10 cians of the Department of Veterans Affairs that led
11 to any prescribing of the medications referred to in
12 paragraph (3).

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

16 (6) A summary of—

17 (A) the average period that elapsed be-
18 tween the last prescription opioid receipt and
19 the date of the death of such a veteran; and

20 (B) the cause of death for each such vet-
21 eran.

22 (7) The percentage of such veterans with com-
23 bat experience or trauma (including military sexual
24 trauma, traumatic brain injury, and post-traumatic
25 stress).

1 (8) Identification of medical facilities of the De-
2 partment with high prescription and drug abuse
3 treatment rates for patients being treated at those
4 facilities.

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

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

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

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

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

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

1 (2) make such report publicly available; and

2 (3) provide to the Committees on Veterans' Af-
3 fairs of the House of Representatives and the Senate
4 a briefing on such review.

5 (d) DEFINITIONS.—In this section:

6 (1) The term “black box warning” means a
7 warning displayed within a box in the prescribing in-
8 formation for drugs that have special problems, par-
9 ticularly ones that may lead to death or serious in-
10 jury.

11 (2) The term “covered veteran” means any vet-
12 eran who received hospital care or medical services
13 furnished by the Department of Veterans Affairs
14 during the five-year period preceding the death of
15 the veteran.

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