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Responses to Questions for the Record

House Energy and Commerce Subcommittee on
Oversight and Investigations

"What is the Federal Government Doing to Combat the Opioid Abuse Epidemic?"

May 1, 2015

I. Additional Questions for the Record

The Honorable Michael C. Burgess

1. **While technology has the potential to solve many problems in healthcare, we are hearing similar complaints about PDMPs as we do with EHRs. Some doctors suggest that PDMPs interrupt clinical workflow. The Health IT Policy Committee sought public comment on whether EHR certification could enable and support streamlined access to PDMPs. Because PDMPs are a critical tool for patient care and clinical decision making, ONC suggested in their September 2013 report to Congress that they would explore a PDMP requirement in certification of EHRs. Can anyone speak to further discussion regarding including PDMPs as a requirement for certification of EHRs?**

   Answer: I refer you to the response provided on behalf of the Department by Assistant Secretary Frank.

2. **Complaints regarding PDMPs suggest that these systems are not real time, not widely used, and are time consuming and burdensome. In 2005, Congress enacted NASPER, with strong support from health care providers and broad, bipartisan support. NASPER could explicitly address both of these programs. However, the program has not been funded since 2010 and faced similar lack of funding prior to 2010. NASPER would provide assistance to allow PDMPs to meet consistent national criteria and allow for interoperability between state PDMPs. Do you think that national criteria and standardized content would be beneficial in fostering a more attractive state-based PDMP network for providers?**

Answer: Prescription Drug Monitoring Programs (PDMPs) face the traditional struggle of creating a level of uniformity among states for national consistency and efficiency purposes while allowing individual states to address their unique policy direction and state laws. Encouraging states to implement identified best practices such as interstate data sharing and interoperability with health information technology (IT) may foster a more attractive PDMP network for providers thereby increasing PDMP utilization.

In an effort to streamline access to PDMP data so that it is available quickly and easily within the clinical workflow, the Office of the National Coordinator (ONC) Standards & Interoperability (S&I) Framework's PDMP/Health IT Integration Initiative was launched as part of the "Enhancing Access to PDMPs using Health IT" project (a joint effort between ONC, the Substance Abuse and Mental Health Services Administration (SAMHSA), The Centers for Disease Control and Prevention (CDC) and the Office of National Drug Control Policy (ONDCP)) to bring together the PDMP and health IT communities to evaluate data format standards for exchanging information between PDMP and provider health IT systems.[1]

With respect to content, most states already list in their PDMP statutes and regulations a set of data that is required for collection, with the PDMP Administrator having discretion to include additional data. From a healthcare perspective, we have heard from stakeholders that the key is identifying those pieces of information deemed important to clinical decision-making and ensuring that the data is provided to the health care professional end-user. The collection of a minimum set of data across states and more harmonized state policies could enable a more standardized technical solution.

a. What has been your experience with interstate accessibility of PDMPs? Are the current interstate data-sharing exchanges, such as Prescription Drug Monitoring Program Interconnect effective?

Answer: Since the beginning of the Administration, we made significant progress with respect to interstate data sharing. Current interstate data-sharing exchanges, such as National Association of Boards of Pharmacy's PMP InterConnect, enable the transfer of PDMP data across state lines to authorized users while adhering to the state's data-access rules. Twenty-nine states are currently sharing data though PMP InterConnect. PMP InterConnect allows participating PDMPs across the country to be linked, which can provide a more effective means of combating drug diversion and drug abuse nationwide. This data-sharing exchange enables a practitioner, pharmacist, or other authorized user to obtain multistate PDMP data, which gives the healthcare provider a fuller picture of a patient's controlled

[1] Additional information available at http://www.healthit.gov/PDMP.

substance prescription history. This information also helps providers to better identify patients with prescription drug abuse problems, especially if those patients are crossing state lines to obtain controlled substance prescriptions.

II. Member Requests for the Record

The Honorable David McKinley

1. **What one thing would you recommend that we could do to try to start reversing this epidemic and this problem?**

   Answer: We are pleased that this Subcommittee is interested in finding ways that the Congress can have a positive impact on tackling this important issue.

   The causes of the current opioid use disorder epidemic and related overdose deaths in the United States are complex and include an amalgam of medical, social, and economic factors. The consequences are also far reaching, affecting the health, social, and economic welfare of individuals with opioid addiction, as well as their families and the larger community.

   Unfortunately, the consensus among experts is that there is no single approach or initiative that will solve this complicated problem. Furthermore, no single organization or entity can address this problem alone; a coordinated, multifaceted response involving the Federal Government, state governments, public health officials, medical and other health partners, and community organizations is required.

   Addressing this crisis is a top priority for HHS and to do so, the Department has developed an aggressive, multi-pronged initiative that focuses on three priority areas, grounded in the best research and clinical science available, to combat opioid abuse. By leveraging the distinct strengths of the HHS agencies, HHS's three-part plan aims to:

   - Improve opioid prescribing practices to address the over-prescribing of opioids;
   - Expand the use of naloxone, used to treat opioid overdoses, to help reduce the number of deaths associated with opioid overdose; and
   - Expand the use of Medication-assisted Treatment (MAT), a comprehensive treatment model that combines the use of medication with counseling and behavioral therapies to treat substance use disorders.

   These priorities represent activities and interventions where evidence suggests that HHS has the greatest opportunity for measureable impact.

   As the nation's public health agency, CDC's core role in this epidemic is furthering the first part of the HHS initiative: Providing training and educational resources, including updated prescriber guidelines, to assist health professionals in making informed prescribing decisions and address the over-prescribing of opioids. Changes in the prescribing of opioid pain relievers contributed to and continue to drive the epidemic. Aligning safe and clinically appropriate prescribing to better reflect the risks and benefits of opioids would have a major impact by reducing opioid overprescribing, misuse, and overdose, ultimately protecting patients.

Improving opioid prescribing is complex as there are many different levers that affect this clinical practice. States, public and private payers, health systems, healthcare providers, and patients all play a role in improving opioid prescribing. CDC's aim is to advance this goal through several key programs and activities.

First, CDC is developing new opioid prescribing guidelines for chronic pain outside of the end-of-life setting. CDC is convening an expert group to inform the guideline development and plans to release the new guidelines in FY 2016. These guidelines will serve as a foundation to guide states, insurers, health systems, and providers on prescribing best practices. In addition to the development and release of the guidelines, broad dissemination and uptake among providers are crucial, and both are additional activities CDC is working to accomplish in FY 2016.

Second, CDC is supporting states through its *Prevention for States* program to provide direct support to advance promising strategies for improving prescribing and reducing overdose deaths. Building on lessons learned through its Prescription Drug Overdose: Boost for State Prevention program, which began in FY 2014 and funds five states, CDC launched *Prevention for States* in FY 2015 and anticipates funding approximately 16 states to conduct the following activities:

- Enhancing PDMPs (*i.e.*, real-time, proactive reporting) as a public health surveillance and clinical decision making tool;
- Implementing community-level and health system interventions such as patient review and restriction programs that limit high risk patients to one doctor and one pharmacy for their opioids;
- Evaluating prevention policies for effectiveness like those states passing pill mill or doctor shopping laws; and
- Advancing rapid response projects to afford states the flexibility and resources to respond to new and emerging problems.

If funded by the Congress at the level proposed in the FY 2016 President's Budget, CDC would be equipped to scale up its state-based program for a truly national response to the prescription drug overdose epidemic. CDC would fund all 50 states and Washington, D.C., to support the advancement of promising prevention on multiple fronts to improve prescribing practices nationwide, in support of and in alignment with the Department's initiative.

The opioid abuse epidemic is a critical issue for HHS, the Administration, and the Nation as a whole, and we know we cannot solve it alone. We look forward to continuing to partner with the Congress, the states, and other stakeholders to continue to make progress on this vital issue and prevent further morbidity and mortality from opioid related overdoses.