National Indian Health Board

May 4, 2018

The Honorable Michael C. Burgess
Chairman, Energy and Commerce Subcommittee on Health

c/o Zack Dareshori
Legislative Clerk, Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Burgess,

Thank you for submitting additional questions for the record related to my testimony on March 21, 2018 at the Health Subcommittee hearing entitled, "Combating the Opioid Crisis: Prevention and Public Health Solutions."

Please see attached my responses to the questions submitted for the record. Thank you for your continued leadership regarding America's opioid crisis and your particular attention to the needs of American Indians and Alaska Natives on this issue.

Please do not hesitate to contact me with any questions.

Yours in Health,

Stacy A. Bohlen
Chief Executive Officer
National Indian Health Board

Attachment — Additional Questions for the Record

The Honorable Michael C. Burgess, M.D.

Ms. Bohlen, as you have read from Chief Cook of the St. Regis Mohawk Tribe written testimony, there are concerns regarding the bill to enhance and improve state-run prescription drug monitoring programs.

- While I understand that integration with state-level PDMPs has been difficult, to what extent are the Indian Health Service and tribal physicians and pharmacies using PDMPs today?

Chairman Burgess,

Thank you for your question. Currently, the Indian Health Service (IHS) uses the Resource and Patient Management System (RPMS) as its single, combined electronic information system for both clinical and public health data. All Tribes must upload certain reports into RPMS, although some Tribes run their own health programs, and may use a different electronic health record (EHR) platform.

RPMS faces challenges to data interoperability with state Prescription Drug Monitoring Program (PDMPs) and other coordinated efforts, such as Electronic Clinical Quality measures (eCQMs). This is one reason why the Veterans Administration (VA) is moving away from its VistA program, which is very similar to RPMS, toward a more integrated platform where electronic health records can communicate with PDMPs. Congress has provided resourced for the VA to make this transition, but IHS will be unable to follow due to lack of funding.

In July, 2016, the IHS released a new rule mandating all IHS providers and dispensers of opioid medications to utilize their state PDMP database prior to issuing or dispensing a prescription for opioids. This policy mandate did not extend to providers and dispensers employed by a Tribe – meaning that those providers can elect to check their state PDMP system at their own discretion. Training staff on how to utilize new information technology (IT) systems such as PDMPs can require a significant amount of agency resources including funding and personnel time, and thus the National Indian Health Board would encourage Congress to continue its support for Health IT training within the Indian health system.

In FY 2017, Congress appropriated $1 million to the IHS to create a specific PDMP that would serve all IHS, Tribal, and Urban Indian facilities. To my knowledge, IHS has not created this yet, nor has the agency proposed a timeline for doing so. I would encourage you to use your oversight authority to ensure administrators at IHS prioritize this I/T/U PDMP given its potential to improve surveillance of prescription drug access and diversion.