Energy and Commerce Subcommittee on Health Hearing

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Good morning Chairman Burgess, Ranking Member Green, and Members of the Subcommittee. Thank you for the opportunity to share information about the efforts underway at the Centers for Disease Control and Prevention (CDC) to reverse the trajectory of our nation's opioid overdose epidemic. This epidemic is complex and requires a multi-sector, multi-pronged response. I am pleased to be here today to discuss the federal government's activities to curtail deaths stemming from opioid misuse, abuse, and overdose. In particular, I will focus on CDC's unique role in prevention, current programs, successes, and future endeavors.

Given the enormity of this national crisis, collaboration across agencies is essential. Each sector of government has a role to play—whether implementing prevention activities, providing treatment to individuals with opioid use disorder, identifying and disrupting the flow of illicit opioids into and across the country, or advancing research to increase our knowledge on strategies that hold promise. As the nation's public health and prevention agency, CDC is applying scientific expertise to understand the epidemic and use that information to create interventions to prevent further harms, including the spread of infectious disease and the impact of opioids on mothers and babies. CDC continues to be committed to the comprehensive priorities outlined in the HHS strategy and to saving the lives of those touched by this epidemic. CDC's work falls into five key strategies to address opioid overdose and other opioid-related harms: 1) conducting surveillance and research; 2) building state,

local, and tribal capacity; 3) supporting providers, health systems, and payers; 4) partnering with public safety; and 5) empowering consumers to make safe choices.

CDC tracks and analyzes data to improve our understanding of this epidemic. Since 1999, more than 632,000 Americans have died from drug overdoses. In 2016, the death toll continued to rise. Over 63,600 deaths resulted from drug overdoses.[1] More than 42,000 of those deaths involved opioids.[2] According to the most recent provisional data, there were 67,344 drug overdose deaths in the 12-month period ending August 2017. This is an increase of nearly 8,000 deaths attributed to drug overdose compared to the 12-month period ending August 2016. CDC's data indicate that these increases were primarily driven by synthetic opioids, including illicitly manufactured fentanyl (IMF). Given the evolving nature of this epidemic, it is essential that we continue to track and analyze data to target prevention efforts.

Data are crucial in driving public health action. Timely, high-quality data can help public health, public safety, and mental health experts better understand the problem, focus resources where they are needed most, and evaluate the success of prevention and response efforts. During the past few years, CDC has invested in strengthening the capacity of states to monitor the opioid overdose epidemic and target their prevention activities.

CDC currently provides funding and scientific support to 45 states and Washington, D.C. to equip states with the tools and technical expertise they need to implement a comprehensive prevention program within their communities. States utilize their funding to enhance Prescription Drug Monitoring

[1] https://www.cdc.gov/mmwr/volumes/67/wr/mm6709e1.htm
[2] https://www.cdc.gov/mmwr/volumes/67/wr/mm6709e1.htm

Programs (PDMPs) and leverage them as public health tools, improve health system and insurer practices for safer opioid prescribing, support community-level response and prevention activities, and evaluate policies that may impact the opioid epidemic (e.g., naloxone distribution and Good Samaritan laws). In addition, CDC funds 32 states and Washington, D.C. to improve the timeliness and comprehensiveness of fatal and non-fatal opioid-involved overdose reporting and to disseminate data to stakeholders.

PDMPs are state-run databases that collect patient-specific prescription information at the point of dispensing. While PDMPs vary from state to state in terms of their operation, components of PDMPs that optimize their utility include universal registration and use, real-time reporting, active management (ensuring there is proactive reporting of PDMP data), and interoperability with electronic health records (EHRs) and PDMPs in other states, particularly neighboring ones. PDMPs are among the most promising state-level interventions to improve opioid prescribing, inform clinical practice, and protect patients at heightened risk of opioid misuse, abuse, and overdose and can help providers identify patients who may be misusing prescription opioids or other prescription drugs. In addition, states can use PDMP data to determine "hot spots" or areas where there is a spike in opioid prescribing to target interventions, such as education for prescribers on best practices ("academic detailing").

Using CDC funds, states are enhancing the utility of their PDMPs in various ways. For example, North Carolina has integrated prescribing data from its PDMP within the clinical workflow of existing health information systems across the state. In Washington, prescription review data from PDMPs are proactively sent to EHRs at emergency departments (EDs) and urgent care sites to inform clinical

decision making within those care venues. To enhance usage of PDMPs among providers, some states have taken steps to make access easier by integrating them into EHR systems, permitting physicians to delegate PDMP access to other health professionals in their office (e.g., physicians assistants and nurse practitioners), and streamlining processes for providers to register for PDMP access. Rhode Island has seen great success in streamlining provider registration by investing in PDMP outreach, education, and enforcement. The Rhode Island Department of Health conducted more than 40 continuing medical education (CME) and educational programs regarding responsible prescribing, PDMP registration, and PDMP use. As a result, PDMP registration in Rhode Island increased from 73 percent in January 2016 to 100 percent in September 2016

After the release of the CDC Guideline for Prescribing Opioids for Chronic Pain in March 2016, CDC began efforts to facilitate its integration in practice by updating clinical decision supports including alerts on morphine milligram equivalent thresholds within EHRs, setting lower defaults on prescribing amounts for the initiation of opioids for chronic pain management, and adding prompts for providers to check the PDMP for informed prescribing on behalf of their patients. Using CDC funds, New Jersey enhanced its PDMP so that it now automatically converts dosages of commonly prescribed opioids of differing potency—such as codeine and oxycodone—into morphine milligram equivalents allowing prescribers to compare the total potency of all opioid medications being used and thus identify individuals who may need closer monitoring, tapering, or other measures to reduce risks.

CDC supports states to improve data collection and the timeliness of reporting fatal and nonfatal opioid overdoses and associated risk factors in order to better inform the public health response within and across states. The program uses ED and emergency medical services (EMS) data, provided to CDC

regularly to track and analyze national patterns of morbidity data. At the state level, the system can detect sharp increases (i.e., potential outbreaks) or decreases (i.e., successful intervention efforts) in nonfatal overdoses which helps states target response and prevention resources to communities most in need or when potential outbreaks are detected.

To improve collection of data for fatal overdoses, funded states leverage CDC's National Violent Death Reporting System (NVDRS) platform to collect data on all unintentional or undetermined overdose deaths. The data includes valuable contextual information from death scene investigations, detailed information on toxicology, the route of administration, and other risk factors associated with a fatal overdose that help states target their interventions to decrease deaths.

CDC's support for enhanced data collection in states has provided a better understanding of the challenges states face in working toward more timely and comprehensive opioid overdose data. CDC identified capacity constraints within medical examiner and coroner offices as a hindrance to timely and quality data. To address this, with an increase in appropriations received in Fiscal Year 2017, CDC gave 32 states supplemental funding to support comprehensive toxicology testing through state medical examiner and coroner offices.

In a relatively short time, CDC-funded states have scaled up their data collection expertise to improve their understanding of the epidemic and enhance response and prevention efforts. For example, Ohio is leveraging more timely data to improve the rapidity of its public health response. When there is an anomalous spike in opioid overdoses detected through syndromic ED data, an alert is sent to the local public health department so that they can respond accordingly, increasing access to naloxone in

affected areas, working with community partners to increase linkage to treatment, and/or collaborating with law enforcement to detect and respond to changes in illicit drug supply. In Kentucky, public health officials are tracking naloxone administration reported to their EMS system and are using those data to detect anomalous spikes in opioid overdoses both at the state and local levels. In Wisconsin, public health officials are working to link ED and EMS data together to better understand non-fatal overdose trends. They are also linking their fatal overdose data with PDMP data to better understand instances where opioids were prescribed to decedents prior to their death. These data linkage initiatives have helped the state to better understand trends, determine areas within their state at particular risk, and identify and address pertinent risk factors to prevent further overdoses.

CDC recently released data using toxicological and death scene evidence from 10 funded states, allowing for a more robust characterization of opioid overdose deaths. Analysis found that fentanyl was involved in more than half of opioid overdose deaths and that more than half of deaths testing positive for fentanyl and fentanyl analogs also tested positive for cocaine, methamphetamine, or heroin. The findings also indicated that illicitly manufactured fentanyl and fentanyl analogs were a major driver of opioid overdose deaths in multiple states. Similarly, ED syndromic and hospital billing data on opioid-involved overdoses were analyzed and show that opioid overdose rates increased an average of 35 percent in 16 states reporting for the selected time period.

CDC has helped strengthen collaboration across sectors to jointly move forward on strategies; and employ programmatic enhancements to their PDMPs, insurance programs, and educational outreach efforts. In Fiscal Year 2019, CDC plans to release new funding announcements for states with a focus

on implementing the strategies that have demonstrated the most promise thus far. In addition, CDC hopes to expand support to all 50 states and Washington, D.C., increase timeliness of data sharing, and gain a truly national picture of the opioid crisis while assisting states with their ability to prevent opioid-related morbidity and mortality.

CDC is also taking the lead in preventing opioid-related harms such as the spread of infectious disease and the impact of opioids on mothers and babies. The recent threefold increase in hepatitis C and the 2015 HIV outbreak in Indiana underscore the urgency of the issue. New hepatitis C infections have increased more than 167 percent in recent years and states like Kentucky, Tennessee, Virginia, and West Virginia reported a 364 percent increase in new hepatitis C infections from 2006 to 2012 in persons under 30. Surveillance for viral hepatitis is limited. Infectious disease surveillance is essential to know the true scale of the epidemic and facilitate more effective state and local responses.

Collaboration at the community level between public health, public safety, healthcare, education, and faith-based stakeholders as well as coordination across multiple levels of the US health care system, and implementation of tailored community-based prevention services are needed to prevent infectious diseases, including HIV, attributed to injection drug use.

CDC also recognizes the serious impact that the opioid epidemic is having on mothers and babies. New data show that one baby is born with signs of neonatal abstinence syndrome (NAS) every 15 minutes in the United States – or nearly 100 infants per day. It is critical that we improve data collection in this

vulnerable population, and use this data to drive public health action to better protect mothers and babies. CDC is leveraging the infrastructure of existing birth defects surveillance systems to improve our ability to monitor the occurrence of NAS.

A comprehensive response to the opioid crisis requires a partnership across sectors. As such, CDC has been working closely with law enforcement agencies, such as the Drug Enforcement Administration (DEA), to determine risk factors for a fentanyl overdose and to implement prevention strategies. In addition, the Heroin Response Strategy (HRS), funded by the Office of National Drug Control Policy (ONDCP) and deployed in 10 High Intensity Drug Trafficking Areas (HIDTAs), links public health and public safety. The HRS covers 22 states, from Georgia to Maine. Under the governance of the HIDTA directors, CDC sharpens strategic directions, ensures proper coordination and training, and improves performance measurement. CDC also supports the training and technical assistance for the 22 public health analysts embedded in the program. As part of the HRS, CDC is launching 13 pilot projects to better understand what communities can do to prevent opioid overdose deaths. There is a shortage of evidence to guide public health-law enforcement integrated community response, and CDC's initiative is designed to build scientific evidence about what works.

CDC recognizes the successes that have been achieved, but also knows that there is much work to be done. Building the capabilities of public health laboratories to contribute to non-fatal overdose surveillance and resulting public health interventions is essential. There is a particular need to fill the gap of testing specimens for tracking morbidity through systematic, routine laboratory testing of drugs

and patient samples to obtain and disseminate public health information to public health officials and laboratories.

As this crisis continues to unfold, it is important that public health response is nimble and flexible to adapt to new threats. This fast-moving and complex epidemic will require sustained focus to sustain prevention and mitigate the consequences of opioid use disorder.

Thank you for the opportunity to testify on this important issue. I would be happy to answer any questions.