**July 23, 2024, House Energy and Commerce Health Subcommittee Questions for the Record Responses**

**Dr. Allison Arwady, National Center for Injury Prevention and Control**

**The Honorable Cathy McMorris Rodgers**

1. **What is your Center's annual budget?**

   The FY 2024 enacted funding level for the National Center for Injury Prevention and Control (NCIPC) is $761.4 million.

   a. **How much of this funding supports grants, cooperative agreements, or other external activities and partners, versus supporting internal CDC work and activities?**

   Broadly, approximately 80% of CDC's domestically focused funding is spent in extramural activities – these are resources that are used in our communities to help protect health at the local level. Variability among centers depends on intramural costs, particularly support for laboratories and other capabilities, which are resource intensive.

   For NCIPC, 85% of the funding is used to support extramural activities. CDC offers value-add by supporting grantees to most effectively utilize funding to implement evidence-based programs that work. Internal costs include the public health subject matter expertise, guidance development, technical assistance, and important coordination, implementation, and evaluation of evidence-based practices as essential components to the success of these programs.

   CDC continues to prioritize core public health capabilities of data, surveillance, lab, workforce, and domestic and global preparedness. These foundational components are necessary to protect health and improve lives; all of CDC's work and our support of jurisdictional partners – whether on influenza, cancer, injury prevention, or antimicrobial resistance – is strengthened when these core capabilities are strengthened.

2. **How many staff does your Center employ in total?**
   a. NCIPC employed 594 employees in FY24.

3. **How many of your staff could be immediately deployed in a crisis?**

   b. As a lesson learned from COVID, CDC created the CDCReady Responder program within CDC's Office of Readiness and Response (ORR), to enable our multidisciplinary workforce to train before a public health event and be ready to respond when and where needed. CDC staff with diverse expertise throughout the agency are enrolled in the program as responders with specific skill sets (e.g. epidemiology, data, communications) so they are ready to contribute to specific needs during a large response such as COVID 19, or to a new health threat that comes our way. So far, 2,750 staff from across the agency have enrolled in the CDCReady Responder program. The ability to surge staff and to respond faster than ever before represents a significant improvement over how CDC operated prior to COVID and is a key example of how CDC is breaking down silos,

effectively leveraging our public health workforce, and prioritizing readiness and response. In addition, in the President's Budget , CDC requested authority to waive some existing bureaucratic barriers to create additional flexibility to quickly assign or deploy people from across the agency to quickly respond to emerging public health challenges.

**The Honorable Brett Guthrie**

1. **For several grant cycles, the CDC has placed restrictive conditions on its Overdose Data to Action (OD2A) grants that require states to connect to RxCheck to be eligible for grant dollars from the CDC's Center for Injury Prevention. This is the opposite of ensuring state choice: states should be able to choose the technologies and partners they want for their prescription drug monitoring programs. We also need to be making sure states can stretch their finite dollars as far as they can go, not imposing burdensome requirements that do not pass a commonsense test. Why is CDC making it harder for our state partners—who are on the front lines of the opioid epidemic—to use CDC grant funding to support their prescription drug monitoring programs (PDMPs)?**

    a. **Why does the agency insist on imposing conditions, including in the form of technical requirements, that are making it harder for our states to stretch their limited PDMP resources as far as possible?**

    In its current Overdose Data to Action (OD2A) cooperative agreement, that began in 2023, CDC supports state health departments in using prescription drug monitoring program (PDMP) data to improve safer prescribing and to make PDMPs easier to use. States are free to choose their PDMP data-sharing hub, and CDC funding can be used for the option the state wants to use. States may spend up to 30% of prevention dollars on PDMP health IT activities if their PDMP meets qualified PDMP standards developed by Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS). These standards emphasize several components, such as open architecture, that are important in sharing allowable PDMP data across state lines and within EHRs. This is helpful to health systems in underserved areas, like rural areas, that may not be able to sustain integration efforts. States that do not have a PDMP that meets these standards may spend up to 20% of their prevention budget on PDMP activities. These PDMP strategies accompany other prevention strategies that are incredibly important in combating the current epidemic, which is driven by illegally manufactured fentanyl.

    CDC has supported state health departments in advancing PDMPs since 2016 to increase their public health utility, whether using data to identify outlier prescribers and offering academic detailing on safe prescribing or by increasing clinical decision supports and embedding those into electronic health records.

    b. **Do you agree that we should be making it easier—not harder—for states to fight the ongoing opioid epidemic and this tragic public health crisis that continues to ravage our communities?**

    CDC continues to support overdose prevention, and utilization of PDMPs is an important tool in these efforts. Through its OD2A program, CDC helps states implement a menu of

public health activities that can save lives from overdose, including PDMP strategies as well as linking people to care and treatment and partnering with public safety.

2. **The HHS Office of the National Coordinator for Health IT recently proposed the Public Health Interoperability, or HTI-2 rule, which places significant new requirements on technologies critical to supporting prescription drug monitoring programs. Did CDC consider the adverse impact these new, costly, and burdensome, requirements will have on states and health care providers?**

   CDC defers to ONC.

   a. **Or how these burdens will adversely impact their substance use disorder focused work?**

      CDC defers to ONC.

   b. **Is this administration's measure of success the length of the red tape it imposes on states and health care providers?**

      CDC defers to ONC.

3. **The benefit that prescription drug monitoring programs (PDMPs) provide are realized when prescribers and pharmacists use them. Imposing burdensome standards for electronic prescribing will pose challenges when data is moving from one system and one standard to another over time. How will imposing burdensome new regulatory requirements support states and healthcare providers stay ahead of the basic challenges that we face in the fight against addiction and substance use disorders?**

   CDC defers to ONC.

4. **Will HHS commit to withdrawing the proposed rule?**
   CDC defers to ONC.

**<u>The Honorable Dianna Harshbarger</u>**

1. **Dr. Arwady, it is my understanding that currently, many drug screenings in emergency rooms only test for marijuana, cocaine, amphetamines, opiates, and phencyclidine (PCP)—but not fentanyl. Since fentanyl is a synthetic opioid, it does not show up on most rapid drug screenings. Many believe that adding fentanyl to routine drug screenings in emergency rooms could prevent many fentanyl-related deaths, which increased 97-fold in the United States from 1999-2021, according to HHS. It seems to me it would right up NCIPC's alley to conduct a study to determine how frequently emergency rooms are currently testing for fentanyl when patients come in for an overdose, as well as the associated costs and benefits or risks, and based on such a study, work with other offices within HHS to issue guidance to hospitals on implementing fentanyl testing in emergency rooms. Do you believe this is a worthwhile endeavor?**

   a. **And if so, will you work with patient advocates and other relevant stakeholders to engage HHS to take action on this to help save American lives? There is bipartisan legislation currently before Congress (H.R. 6600 and S. 3519) that would do just this.**

**But it should not take Congress passing a law requiring HHS take action on this important issue.**

- **Link: Overdose Prevention Strategy (hhs.gov)**

CDC appreciates the importance of this issue and agrees that many point-of-care tests can be valuable tools for emergency departments. CDC focuses on strategic and efficient testing methods to monitor and stay ahead of emerging threats. CDC's OD2A program provides funding to 90 health departments under two distinct OD2A programs to expand surveillance and prevention efforts.

While drug tests can provide useful information in some contexts, they should not be relied upon as the sole or primary diagnostic tool for fentanyl use or overdose in emergency department settings. For example, a test could show negative results simply based on the timing of when a urine test is taken in relation to the last time fentanyl was used by the individual. Adding fentanyl to standard drug tests could also increase costs for individual patients without necessarily changing their care or treatment as the clinical management of opioid overdose remains the same regardless of the specific opioid involved, including fentanyl. In cases of suspected fentanyl overdose, clinical presentation and response to the administration of naloxone are much more reliable than urine drug screen results and get clinicians and patients to the same decisions regarding care and next steps.

**The Honorable Mariannette Miller-Meeks, M.D.**

1. **The CDC does not have a mission or purpose defined in statute. If Congress were to go down the path of authorizing the CDC overall, we would also want to authorize each of your Centers and Offices. What would your mission be? Succinctly in 2-3 sentences, please.**

   CDC works 24/7 to protect America from health, safety and security threats, both foreign and in the U.S. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, human error or deliberate attack, CDC fights disease, improves health and saves lives, and supports communities and citizens to do the same. NCIPC protects health and saves lives by preventing and responding to injury and violence to keep individuals, families, and communities safe, health, and thriving.