<u>**Answers to Questions for the Record**</u>

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Indiana State Health Commissioner
Hearing of the Subcommittee on Oversight and Investigations,
Committee on Energy and Commerce
"What are the State Governments Doing to Combat the Opioid Abuse Epidemic?"
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<u>The Honorable Michael C. Burgess</u>

QUESTION 1: 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. 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. This is a question that I had previously asked of the CDC, due to their state monitoring efforts. However, I would like to hear the state perspective. Do you think that national criteria and standardized content would be beneficial in fostering a more attractive state-based PDMP network for providers?

Interstate sharing of PDMP data is critical, and states should work together to ensure efficient and effective data standards. These standards will help keep patients safe by giving their care providers the information needed to make medically appropriate prescribing decisions.

In addition, most states have upgraded their data submission format to ASAP 4.2, but some states still use an older format. The newest submission format allows for more data to be collected, so states that use an older format do not have access to all available patient data. Also, shared data is especially important to prescribers near state borders. Patients should know that all care providers are aware of their medical history, in order to deter abuse.

QUESTION 2: Interoperable PDMPs would do much to decrease incidence of doctor shopping. What has been your experience with interstate accessibility of PDMPs? Are the current interstate data-sharing exchanges, such as the Prescription Monitoring Program Interconnect effective?

Indiana's PDMP, INSPECT, was the first PDMP to connect with bordering states, and it currently connects with 20 other states. The National Association of Boards of Pharmacy's PMPinterconnect hub (PMPi hub) is being utilized by almost every state that is engaged in sharing data. The PMPi hub has made use of PDMP data more accessible and more effective.

In the states utilizing the hub, it has greatly improved practitioner access to a complete and accurate controlled substance medication history on patients that travel, have moved, or who purposefully fill prescriptions in another state to avoid detection by their own state's PDMP.

One of the last hurdles is that PMPi hub data is not accessible to law enforcement, which should be able to use the data in fraud and drug diversion cases.

QUESTION 3: It is my understanding that obstacles to managing the opioid abuse epidemic vary widely from state to state, ranging from stigma associated with medication assisted treatments to lack of adequate data, which is sometimes associated with the need for interoperable PDMPs. Could each of you discuss what you recognize as being the biggest obstacle towards controlling the opioid epidemic in your state? Do you think that the federal response to the opioid epidemic has been sufficient?

The biggest obstacle to controlling the opioid epidemic is legal access to opioids.

Overprescribing by providers occurs for the following reasons, among others:

1. Training. Inadequate training about evidence-based management of pain and appropriate opioid prescribing
2. Co-Pays. Prescription co-pays prompt providers to prescribe "more than enough medication" for acute pain when a much shorter duration of treatment is effective for the vast majority of patients. For example, after an oral surgery, a provider may prescribe 30 tablets, when four is likely enough.
3. "Fifth Vital Sign." Providers are required to assess subjective pain as an objective vital sign and treat accordingly. For hospital-employed physicians, patient satisfaction scores are often tied to physician remuneration.
4. Time. Primary care providers have limited time available to adequately assess and manage pain and mental health status of patients. These patients are complicated and often require more lengthy visits.
5. Failure to check the PDMP. Providers should always check the PDMP before prescribing.
6. Patient Education. Patients expect physicians to completely relieve them of chronic pain, and complete elimination of pain is an unreasonable expectation. Effective treatment for the majority of chronic pain includes attention to the whole person.

The Honorable Tim Murphy

QUESTION 1: During the hearing you discussed the emergence of pain as the fifth vital sign as well as the impact of patient satisfaction surveys on the prescribing patterns in our country. Could you elaborate further on how this has contributed to the opioid abuse epidemic?

First, we should define vital signs. Vital signs (like blood pressure and pulse) are objective measures of physiologic processes necessary for life. Pain is a subjective measure, and it cannot always be eliminated.

Next, there is historical context. Beginning in 2001, the Joint Commission on Accreditation of Healthcare Organizations required hospitals to ask patients about their "pain level", but there is no evidence to support a known benefit to this practice. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS) survey questions have significant influence on payment to hospitals and providers.

If a patient rates their care as substandard, because the patient was not given the type or amount of opioid the patient requested, the provider and the hospital could see negative financial consequences. Because of the link between pain management, patient satisfaction, and reimbursement practices, an incentive exists for providers to make the patient happy, not necessarily to provide the best care.

QUESTION 2: What are the pros and cons of giving someone Naloxone? What type of educational component should be directly linked to the expansion of this overdose reversal drug?

Naloxone is a non-addictive, non-opioid antidote to opioid overdose, and it gives individuals a potential second chance at life. It is safe to use, with no effect on individuals who have not used opioids. Individuals surviving an overdose are often more receptive to substance abuse treatment options.

If someone is experiencing an overdose, there is no downside to administering naloxone.

When prescribed or distributed, providers should educate on the following: calling 911 immediately, staying with the overdose victim until help arrives, and administering a second dose of naloxone if the victim relapses before help arrives.

The Honorable David McKinley

QUESTION 1: You spoke in great detail about the measures you have taken in Indiana to combat this epidemic. Please share any ideas that you have that we would be able to apply to West Virginia and across the country.

I would suggest three best practices from Indiana.

1. We believe it is critical to encourage collaboration on this issue. The Prescription Drug Abuse Prevention Task Force was established in 2012 by the Indiana State Department of Health (ISDH) and the Office of the Attorney General. The Task Force is made up of state agencies, local partners, coalitions, law enforcement, healthcare providers, and others. The mission is to prevent opioid overprescribing, misuse, overdose, and death, enhance access to addiction treatment, and define the burden of opioid use.
2. The Indiana Medical Licensing Board adopted rules for the prescribing of opioids for chronic pain, and the Task Force published a complementary prescriber toolkit.
3. Indiana's "pill mill" law regulates the facility owner by requiring the owner have a controlled substance registration (CSR). This allows law enforcement to quickly intervene in the case of a bad actor by suspending or revoking the registration, thereby shutting down the facility and preventing the owner from practicing.

QUESTION 2: The rate of deaths from drug overdose in America is anywhere from seven to ten times higher than it is in Europe. What are they doing right and what are we doing wrong that there is such a drastic difference in our overdose death rates?

I do not have expertise in the European healthcare system, so I would defer to other providers for a complete answer to this question.