Statement by Brad Bauer, Senior Vice President

Appriss Health

on

Combating the Opioid Crisis: Prevention and Public Health Solutions

before

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Summary of Key Points

Interstate Sharing of PDMP Data. The current state-based Prescription Drug Monitoring Program (PDMP) approach has made major progress over the last 10 years. In 2011, the National Association of Boards of Pharmacy created PMP InterConnect, with technical assistance from Appriss Health, to allow states to securely and efficiently share PDMP data. Today, 45 PDMPs share data across state borders through this highly effective and secure hub. For the remaining states, state-level policy issues, not technology, are the only barriers preventing them from joining PMP InterConnect and sharing PDMP data with other states.

Workflow Integration for PDMP Data. While the vast majority of states are sharing PDMP data, there is still a gap in usage of the PDMP by prescribers and pharmacists due to ease of use issues. To resolve this, PDMP data should be incorporated directly into the Electronic Health Record, Pharmacy Dispensation System, and Health Information Exchange to allow one click, near instantaneous access to PDMP information. Tremendous progress has been made in this area in the last two years, but much work remains. Today approximately 20% of prescribers have access to PDMP data and information in their EHRs, and additional funding is needed to increase that number.

PDMPs as Substance Use Disorder Platforms. Medication history is simply not enough to fight the evolving opioid crisis, including the rise of illicit substances. PDMPs should incorporate information and tools such as history of nonfatal overdose, patient risk analytics, treatment referral options, and the ability to coordinate amongst a care team. Multiple states have implemented these platforms in recognition that PDMPs need additional capabilities as the epidemic progresses and evolves.

PDMP Discussion Draft. The bill would authorize a number of activities the CDC is currently engaging in, including evidence-based prevention measures and enhanced surveillance of controlled substance overdoses. Grants would allow for more states to integrate data into workflow and explore innovative ways to elevate their PDMP to a substance use disorder platform, among other grant uses.

Chairman Burgess, Ranking Member Green, and Members of the Health Subcommittee, thank you for the opportunity to testify today on the role of Prescription Drug Monitoring Programs (or PDMPs) in combating the opioid crisis, as well as the PDMP discussion draft from Representative Griffith.

My name is Brad Bauer and I am Senior Vice President with Appriss Health and have responsibility for our state and federal PDMP solutions. We provide a common platform and software solution for 42 of the 52 established Prescription Drug Monitoring Programs (PDMPs) throughout the United States and U.S. Territories. The majority of those contracts were awarded through competitive bidding processes over a number of years.

State-based PDMPs continue to evolve and innovate in the face of our nation's opioid crisis. While each state faces unique challenges brought on by the crisis, tremendous progress has been made within a few critical areas, each of which have been identified by government and research organizations as important best practices to ensure effective and impactful PDMPs.

Interstate Data Sharing

The ability for states to share PDMP data in a secure and real time manner with other states provides prescribers and pharmacists with a more complete view of a patient's controlled substance prescription history. Effective and efficient interstate sharing of PDMP data enables a more accurate assessment and identification of a patient's risk towards prescription drug overdose events.

Interstate data sharing has come a long way over the past two to three years as more states have begun to share PDMP data with other states. Today, 45 PDMPs (44 states and the District of Columbia) are doing

exactly that by sharing over 18 million PDMP transactions per month across state borders through a highly effective and mature hub called PMP InterConnect. In 2011, the National Association of Boards of Pharmacy created PMP InterConnect, with technical assistance from Appriss Health, to allow states to securely and efficiently share PDMP data. Sharing through PMP InterConnect is available to all PDMPs at no cost. PMP InterConnect has established common and consistent data sharing standards that respect decades of state laws developed to support inter and intrastate data sharing. For the remaining states not currently participating, policy issues, not technology, are the only barriers and a number of the remaining states are looking to change that. Of the two largest states not currently sharing PDMP data, Florida recently passed HB 21 which will allow the state to join PMP InterConnect and share PDMP data, effective July 1, 2018. California has legislation pending (AB 1751) that would allow the state to participate in the existing PMP InterConnect data sharing hub by the end of 2018, if enacted.

Integration of PDMP Data and Analytics within Clinical Workflow

One of the most impactful developments for state PDMPs is integration of PDMP data and analytics within the clinical workflow for prescribers and pharmacists. State PDMPs have made tremendous strides on this front. In states with voluntary use of PDMPs, usage is typically up to 25%. Forty states now mandate provider use of PDMPs, but even with a mandate, use of PDMPs is typically 75-80%. The best way to increase provider usage of PDMPs is through integration that creates “one click” or in some cases “no click” access.

For the past two years, state PDMPs and Appriss Health have collaborated to create a common methodology to integrate PDMP data and analytics within a prescriber’s electronic health record (EHR) and a pharmacist’s pharmacy dispensation system. Within that two-year period, state PDMPs have gone from virtually no PDMP integrations to integrating over 288 million patient reports within workflow in

2017. Today, the majority of states are moving in the direction of active integrations of their data and analytics within clinical workflows. However, broader adoption has been slow due to the costs associated with integrations and the need for funding.

Integration of PDMP data and analytics in clinical workflow represents a major step forward in promoting efficient and consistent use of PDMPs by providers when making clinical decisions. For example, Ohio has seen a 1000% increase in usage of the PDMP as a result of their statewide PDMP integration project.

Many states recognize the positive impact of making PDMP data and analytics available within workflow and have made and continue to make tremendous progress. In-workflow PDMP integrations combined with interstate data sharing helps enable practitioners to identify potential misuse and abuse of opioid analgesics in a highly effective manner.

Evolution of the PDMP as a Substance Use Disorder Platform

Appriss Health also provides the nation's most comprehensive platform for early identification, prevention and management of substance use disorder (SUD), with a focus on opioid use disorder.

While interstate data sharing and integration of PDMP data and analytics within workflow are both considered industry best practices and have progressed significantly, there has also been recognition that, to maximize their impact on the crisis, PDMPs must be much more than medication history tools. Simply sharing or integrating raw data is not enough. Big data, analytics, and additional insights from non-PDMP data sets are needed to aid practitioners in identifying patient addiction and overdose risk. And clinical tools and resources must be readily available to aid practitioners in intervening to address that risk. The

CDC recently described the opioid epidemic as three waves and overprescribing represents just the first. The second and third waves represent heroin and fentanyl respectively, and PDMPs must evolve to identify and address those risks as well.

States are in the process of transforming their basic PDMP systems into substance use disorder (SUD) platforms that deploy the capabilities necessary to impact the epidemic and bend the overdose death curve, not just drive down the number of controlled substances prescribed. Indiana, Oregon, Michigan, Ohio, Virginia, Iowa and Delaware are just a few examples of states that have already taken steps to transform their PDMPs. Examples of such capabilities include:

Inclusion of Additional Data

PDMPs are increasingly mandating that additional data sources be included in the database, such as history of non-fatal overdoses, drug court information, and toxicology data. The combination of these data sets and PDMP data provide a robust patient risk model for the prescriber and pharmacist community.

Patient Risk Scores

Patient risk scores are designed to predict the likelihood of adverse events based on established thresholds and risk algorithms. For example, a risk score considers data points such as the number of active controlled substance prescriptions, therapy overlap, number of dispensers and dangerous drug combinations. Numeric scores can help a practitioner quickly assess risk and engage with their patients in ways not previously possible.

Treatment Referral

The ability to refer patients to treatment from within the PDMP platform can ensure that patients in need do not leave the Emergency Department or physician's office without an appointment for follow-up or treatment and clear instructions. PDMPs can play a vital role in helping practitioners identify available treatment options for the patient made available by the already massive investment in the treatment infrastructure. This is often referred to as a "warm handoff."

Care Team Communications

Facilitating effective communications and care coordination among practitioners and pharmacists is a common and unmet need in healthcare. Messaging among practitioners, the sharing of care plans and pain contracts, and the triggering of alerts can all ensure that practitioners are universally aware of a patient's SUD risk and can act in a coordinated fashion to address that risk.

PDMP Discussion Draft

As you can see, states are on the frontlines of using PDMPs in new and innovative ways as the opioid epidemic evolves, and federal policy and grant dollars should encourage this. To that end, the PDMP discussion draft from Rep. Griffith would be very beneficial for incentivizing these activities and enabling more states to take advantage of the latest developments in PDMPs. The Centers for Disease Control and Prevention (CDC) is already doing a number of the activities included in the draft, but the legislation would authorize and improve upon the CDC's work, along with providing funding.

First, the draft would create Evidence-Based Prevention Grants through the CDC. States would be able to use these grants for PDMP improvement activities such as:

- Improving registration of providers;
- Incorporating or improving the use of proactive alerts to flag potential misuse of controlled substances or inappropriate prescribing practices;
- Encouraging integration of PDMP data into Electronic Health Records and Pharmacy Dispensation Systems to improve ease of use and clinical decision making;
- Facilitating additional interstate sharing of PDMP data; and
- Using innovative PDMP capabilities to respond to the evolving crisis, such as incorporating additional data points (e.g., nonfatal overdose or drug court data), data analytics, and clinical tools (e.g., warm handoffs).

The Evidence-Based Prevention grants would also allow states to evaluate interventions to determine the best approaches to preventing overdoses and implementing new projects to respond to the evolving crisis in innovative ways.

Second, the draft would establish grants for Enhanced Surveillance of Controlled Substance Overdoses, which would authorize CDC's existing Enhanced Surveillance of Opioid Overdose Surveillance (ESOOS) program. ESOOS grants would allow states to increase the timeliness of reporting and collect more comprehensive and quality data, and then use the overdose surveillance data to help identify risk factors, among other purposes. We would also recommend that this data be incorporated into a state's PDMP, to the extent permitted by state law. Knowledge of a history of nonfatal overdose is critical information for a prescriber or pharmacist.

Lastly, I understand the Committee, Rep. Griffith and his staff are continuing to work on the discussion draft, including possible additions related to updating and reauthorizing the National All Schedules

Prescription Reporting Act (NASPER). We would support modernizing NASPER to reflect the progress states have made on PDMPs since the law was enacted in 2005. We would also recommend encouraging state PDMPs to provide a timely, consistent and comprehensive deidentified data extract for surveillance and research purposes to help identify important trends and allow for appropriate and more focused resources to combat the opioid epidemic.

We also appreciate and agree with the Committee's view of PDMPs first as a public health tool with law enforcement access in certain circumstances. As such, we view it as appropriate for primary federal involvement in and funding for PDMPs to come from public health-related agencies such as CDC, rather than the Department of Justice.

This discussion draft would allow states to continue to innovate through PDMPs to provide prescribers and pharmacists with near instantaneous access to interstate PDMP information via EHRs and pharmacy dispensation systems combined with the clinical tools to intervene in a meaningful way when a patient presents with a possible risk of opioid misuse.

Thank you for your leadership on this critical issue facing so many communities and for the opportunity to address the Committee today. I look forward to your questions.