November 16, 2017

Dear Chairman Turner:

Thank you for meeting with the representatives from the American College of Emergency Physicians (ACEP) on November 1 to discuss our mutual concern as to how the national opioid epidemic affects the health and readiness of members of the Armed Forces, both Active Duty service members and reservists. Despite some assertions, accurate awareness of the scope of this threat within the Department of Defense (DoD) is not readily known, especially to those best positioned and capable of mitigating this epidemic – individual providers and military treatment facilities (MTFs). Effective solutions used in the civilian sector are readily available but not utilized by the Defense Health Agency (DHA). As a result, we request your assistance in verifying opioid prescribing patterns for military personnel and directing DHA participation in state, regional, and national prescription drug monitoring programs (PDMPs) to help prevent opioid misuse by military personnel and ensure the safety and readiness of our troops.

Opioid misuse is not limited to civilians and the military is not exempt from the addictive nature of these drugs. Drug overdose is now the leading cause of death for Americans under age 50, which represents the age range of most Active Duty service members and reservists. This data point alone suggests a significant threat to an effective fighting force and this is compounded by the fact that Active Duty service members are prescribed opioid medications at a higher rate than the general population.

A 2010 study found that nearly one-third of Active Duty service members received at least one prescription for opioids, central nervous system depressants, or stimulants, with 26 percent having received at least one prescription for opioids. A 2014 study found that the prevalence of chronic pain and prescription opioid use rates by Service Members returning from Afghanistan were 44 percent and 15 percent, respectively, as compared to 26 percent and 4 percent in the civilian population. Furthermore, the impact of the health and well-being of Active Duty service members' dependents on their readiness should not be overlooked. This past year, 45 percent of outpatient and 76 percent of inpatient TRICARE visits occurred outside of MTFs. Unfortunately, health care providers at non-MTFs are not able to access or share care plans and records of opioid prescriptions, which could lead to unintentional overprescribing or "doctor shopping" (intentionally obtaining opioids from more than one physician or pharmacy).

The Department of Defense has taken several proactive steps to inhibit the diversion and misuse of prescribed medications. For instance, it has implemented programs to limit refills for Schedule III-V medications, restrict Schedule II medication to a 30-day prescription with no refills, improved pain management training for health care providers, expanded prescription drug take-back (DTB) programs, and developed the Controlled Drug Management Analysis and Reporting Tool (CD-MART) and Polypharmacy (Poly-MART) programs, among other things. These are laudable programs that have the intention of reducing access to unnecessary prescription medications. However, they are internal controls and do not account for the care received at non-MTFs. For this reason, ACEP believes this data needs to be shared across various platforms, including state PDMPs, for them to be truly effective.

The civilian sector has already made tremendous progress in reducing unnecessary opioid prescriptions through electronic information exchanges and PDMPs. In 2009, a Washington State emergency department (ED) opioid abuse workgroup started one of the first statewide PDMPs. From 2009-2012,

Washington State was one of two states that effected a sustained decline in the number of opioid prescriptions and related deaths. For Fiscal Year 2013, the Washington State Health Care Authority reported that, with the use of a PDMP, the rate of ED visits resulting in a scheduled drug prescription decreased by 24 percent. A 2016 study found that implementation, and weekly updating, of a state PDMP was linked to 1.55 fewer opioid-related overdose deaths per 100,000 population. PDMPs are now used by individual health care providers in 49 states and most Veteran Affairs (VA) facilities participate in their specific (but not adjacent) state PDMP.

Another tool that has been used effectively in the civilian sector to combat the opioid epidemic is collaborations by groups of providers to self-monitor opioid prescribing patterns for general, as well as high utilization, patients. A 2016 randomized controlled study demonstrated that a citywide care coordination program resulted in a 34 percent decrease in ED visits and a corresponding 80 percent decrease in the odds of receiving an opioid prescription. A 2017 study of an urban ED group that monitored provider prescribing patterns after the adoption of a prescription opioid policy resulted in a 40 percent decrease in the number of patients receiving an opioid prescription, and a 15 percent decrease in the number of pills per prescription. These decreases were sustained for over two years. However, these successes were only possible because of ready access and availability to records of opioid prescriptions.

Based on the limited data publicly available, ACEP encourages you to seek additional information from the Department of Defense to not only verify the data we have already cited, but to identify the overall cost to the DoD to combat and treat opioid misuse. Specifically, we would like to know:

- The number of TRICARE beneficiaries categorized by subset (Active Duty, reservist, dependent, retiree, etc.) who are treated in MTFs and non-MTFs,
- The number of TRICARE beneficiaries categorized by subset who receive any Schedule II-V medication, in particular any opioid, in MTFs and non-MTFs,
- The number of TRICARE beneficiaries categorized by subset who participate in the Prescription Monitoring Program, and
- How much the DoD spends annually to combat and treat the opioid epidemic.

We understand the DoD may have concerns about sharing information from its new electronic health record system, MHS Genesis, with PDMPs, and DoD has suggested several reasons for not allowing this interface.

- First, this feature is not a high priority. With the continued escalation of the opioid epidemic, increased vulnerability of Service Members, and the impact of opioid use on overall readiness, we would respectfully disagree.
- Second, as noted in the House report (114-537) accompanying the 2017 National Defense Authorization Act (H.R. 4909), DoD initiatives are suggested to be collectively countering opioid misuse in Service Members, citing, among others, monitoring by the DHA Pharmacy Operations Division and early detection of opioid misuse through random drug testing. However, lack of real-time participation in PDMPs hinders the integrity of the Prescription Monitoring Program (previously known as the Sole Provider Program) by non-MTFs. Furthermore, the reported decrease in the number of individuals testing positive for opioids is only applicable to those without an authorized prescription.

- Third, the DHA is developing its own centralized PDMP database and proposed that non-MTF providers could apply for access to the database. Requiring health care providers to search an additional database while actively providing care and the difficulty of non-MTF providers to easily identify DoD beneficiaries would undermine the ease and efficiency already afforded providers using state PDMPs.
- Finally, they cite data security of individual Service Members and that of a Federal system. The different parts of the DHA, including pharmacy and billing, already have the data regarding opioid prescriptions filled by DoD and non-MTF pharmacies. However, this data is not available to other parts of the DHA, including providers and MTFs. Furthermore, the Department of Veterans' Affairs, which is slated to adopt MHS Genesis in several years, already provides data to state PDMPs.

ACEP strongly believes these concerns do not provide a sufficient rationale for maintaining the separation of care plans and prescribing records between military and civilian health care providers that can help mitigate and prevent unnecessary opioid prescriptions for TRICARE beneficiaries. In addition, we are seeking similar information from the Department of Veterans' Affairs and the Indian Health Service as our overall objective is to reduce opioid misuse through the collaboration of all federal and civilian data sources.

Thank you for your time and consideration of our request. If you have any questions, or need any additional information, please contact ACEP's Congressional Affairs Director Brad Gruehn at bgruehn@acep.org or (202) 370-9297.