114TH CONGRESS
2D SESSION

H. R. 4641

IN THE SENATE OF THE UNITED STATES

MAY 12, 2016

Received; read twice and referred to the Committee on Health, Education, Labor, and Pensions

AN ACT

To provide for the establishment of an inter-agency task force to review, modify, and update best practices for pain management and prescribing pain medication, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. DEVELOPMENT OF BEST PRACTICES FOR THE USE OF PRESCRIPTION OPIOIDS.

(a) DEFINITIONS.—In this section—

(1) the term ''Secretary'' means the Secretary of Health and Human Services; and

(2) the term ''task force'' means the Pain Management Best Practices Inter-Agency Task Force convened under subsection (b).

(b) INTER-AGENCY TASK FORCE.—Not later than December 14, 2018, the Secretary, in cooperation with the Secretary of Veterans Affairs, the Secretary of Defense, and the Administrator of the Drug Enforcement Administration, shall convene a Pain Management Best Practices Inter-Agency Task Force to review, modify, and update, as appropriate, best practices for pain management (including chronic and acute pain) and prescribing pain medication.

(c) MEMBERSHIP.—The task force shall be comprised of—

(1) representatives of—

(A) the Department of Health and Human Services;

(B) the Department of Veterans Affairs;

(C) the Food and Drug Administration;

(D) the Department of Defense;

(E) the Drug Enforcement Administration;

(F) the Centers for Disease Control and Prevention;

(G) the Health Resources and Services Administration;

(H) the Indian Health Service;

(I) the National Academy of Medicine;

(J) the National Institutes of Health;

(K) the Office of National Drug Control Policy;

(L) the Substance Abuse and Mental Health Services Administration; and

(M) the Office of Women's Health;

(2) State medical boards;

(3) subject to subsection (e), physicians, dentists, and nonphysician prescribers;

(4) hospitals;

(5) subject to subsection (e), pharmacists and pharmacies;

(6) first responders;

(7) experts in the fields of pain research and addiction research;

(8) experts in the fields of adolescent and young adult addiction research;

(9) representatives of—

(A) pain management professional organizations;

(B) the mental health treatment community;

(C) the addiction treatment and recovery community;

(D) pain advocacy groups;

(E) veteran service organizations; and

(F) groups with expertise on overdose reversal;

(10) a person in recovery from addiction to medication for chronic pain;

(11) a person in recovery from addiction to medication for chronic pain, whose addiction began in adolescence or young adulthood;

(12) a person with chronic pain;

(13) an expert on active duty military, armed forces personnel, and veteran health and prescription opioid addiction;

(14) an expert in the field of minority health; and

(15) other stakeholders, as the Secretary determines appropriate.

(d) CONDITION ON PARTICIPATION ON TASK FORCE.—An individual representing a profession or entity

described in paragraph (3) or (5) of subsection (c) may not serve as a member of the task force unless such individual—

(1) is currently licensed in a State in which such individual is practicing (as defined by such State) such profession (or, in the case of an individual representing an entity, a State in which the entity is engaged in business); and

(2) is currently practicing (as defined by such State) such profession (or, in the case of an individual representing an entity, the entity is in operation).

(e) DUTIES.—The task force shall—

(1) not later than 180 days after the date on which the task force is convened under subsection (b), review, modify, and update, as appropriate, best practices for pain management (including chronic and acute pain) and prescribing pain medication, taking into consideration—

(A) existing pain management research;

(B) research on trends in areas and communities in which the prescription opioid abuse rate and fatality rate exceed the national average prescription opioid abuse rate and fatality rate;

(C) recommendations from relevant conferences and existing relevant evidence-based guidelines;

(D) ongoing efforts at the State and local levels and by medical professional organizations to develop improved pain management strategies, including consideration of differences within and between classes of opioids, the availability of opioids with abuse deterrent technology, and pharmacological, nonpharmacological, medical device alternatives to opioids to reduce opioid monotherapy in appropriate cases and the coordination of information collected from State prescription drug monitoring programs for the purpose of preventing the diversion of pain medication;

(E) ongoing efforts at the Federal, State, and local levels to examine the potential benefits of electronic prescribing of opioids, including any public comments collected in the course of those efforts;

(F) the management of high-risk populations, other than populations who suffer pain, who—

(i) may use or be prescribed benzodiazepines, alcohol, and diverted opioids; or

(ii) receive opioids in the course of medical care;

(G) the distinct needs of adolescents and young adults with respect to pain management, pain medication, substance use disorder, and medication-assisted treatment;

(H) the 2016 Guideline for Prescribing Opioids for Chronic Pain issued by the Centers for Disease Control and Prevention;

(I) the practice of co-prescribing naloxone for both pain patients receiving chronic opioid therapy and patients being treated for opioid use disorders;

(J) research that has been, or is being, conducted or supported by the Federal Government on prevention of, treatment for, and recovery from substance use by and substance use disorders among adolescents and young adults relative to any unique circumstances (including social and biological circumstances) of adolescents and young adults that may make adolescent-specific and young adult-specific treatment

protocols necessary, including any effects that substance use and substance use disorders may have on brain development and the implications for treatment and recovery;

(K) Federal non-research programs and activities that address prevention of, treatment for, and recovery from substance use by and substance use disorders among adolescents and young adults, including an assessment of the effectiveness of such programs and activities in—

(i) preventing substance use by and substance use disorders among adolescents and young adults;

(ii) treating such adolescents and young adults in a way that accounts for any unique circumstances faced by adolescents and young adults; and

(iii) supporting long-term recovery among adolescents and young adults; and

(L) gaps that have been identified by Federal officials and experts in Federal efforts relating to prevention of, treatment for, and recovery from substance use by and substance use disorders among adolescents and young adults, including gaps in research, data collection, and

measures to evaluate the effectiveness of Federal efforts, and the reasons for such gaps;

(2) solicit and take into consideration public comment on the practices developed under paragraph (1), amending such best practices if appropriate;

(3) develop a strategy for disseminating information about the best practices developed under paragraphs (1) and (2) to prescribers, pharmacists, State medical boards, educational institutions that educate prescribers and pharmacists, and other parties, as the Secretary determines appropriate;

(4) review, modify, and update best practices for pain management and prescribing pain medication, specifically as it pertains to physician education and consumer education; and

(5) examine and identify—

(A) the extent of the need for the development of new pharmacological, nonpharmacological, and medical device alternatives to opioids;

(B) the current status of research efforts to develop such alternatives; and

(C) the pharmacological, nonpharmacological, and medical device alternatives to

opioids that are currently available that could be better utilized.

(f) CONSIDERATION OF STUDY RESULTS.—In reviewing, modifying, and updating, best practices for pain management and prescribing pain medication, the task force shall take into consideration existing private sector, State, and local government efforts related to pain management and prescribing pain medication.

(g) LIMITATION.—The task force shall not have rulemaking authority.

(h) REPORT.—Not later than 270 days after the date on which the task force is convened under subsection (b), the task force shall submit to Congress a report that includes—

(1) the strategy for disseminating best practices for pain management (including chronic and acute pain) and prescribing pain medication, as developed under subsection (e);

(2) the results of a feasibility study on linking the best practices described in paragraph (1) to receiving and renewing registrations under section 303(f) of the Controlled Substances Act (21 U.S.C. 823(f));

(3) recommendations for effectively applying the best practices described in paragraph (1) to im-

prove prescribing practices at medical facilities, including medical facilities of the Veterans Health Administration and Indian Health Service;

(4) the modified and updated best practices described in subsection (e)(4); and

(5) the results of the examination and identification conducted pursuant to subsection (e)(4), and recommendations regarding—

(A) the development of new pharmacological, nonpharmacological, and medical device alternatives to opioids; and

(B) the improved utilization of pharmacological, nonpharmacological, and medical device alternatives to opioids that are currently available.

Passed the House of Representatives May 11, 2016.

Attest: KAREN L. HAAS,

Clerk.