

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.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

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

3 (a) DEFINITIONS.—In this section—

4 (1) the term “Secretary” means the Secretary
5 of Health and Human Services; and

6 (2) the term “task force” means the Pain Man-
7 agement Best Practices Inter-Agency Task Force
8 convened under subsection (b).

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

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

20 (1) representatives of—

21 (A) the Department of Health and Human
22 Services;

23 (B) the Department of Veterans Affairs;

24 (C) the Food and Drug Administration;

25 (D) the Department of Defense;

26 (E) the Drug Enforcement Administration;

1 (F) the Centers for Disease Control and
2 Prevention;

3 (G) the Health Resources and Services Ad-
4 ministration;

5 (H) the Indian Health Service;

6 (I) the National Academy of Medicine;

7 (J) the National Institutes of Health;

8 (K) the Office of National Drug Control
9 Policy;

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

12 (M) the Office of Women's Health;

13 (2) State medical boards;

14 (3) subject to subsection (e), physicians, den-
15 tists, and nonphysician prescribers;

16 (4) hospitals;

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

19 (6) first responders;

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

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

24 (9) representatives of—

1 (A) pain management professional organi-
2 zations;

3 (B) the mental health treatment commu-
4 nity;

5 (C) the addiction treatment and recovery
6 community;

7 (D) pain advocacy groups;

8 (E) veteran service organizations; and

9 (F) groups with expertise on overdose re-
10 versal;

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

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

16 (12) a person with chronic pain;

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

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

22 (15) other stakeholders, as the Secretary deter-
23 mines appropriate.

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

1 described in paragraph (3) or (5) of subsection (c) may
2 not serve as a member of the task force unless such indi-
3 vidual—

4 (1) is currently licensed in a State in which
5 such individual is practicing (as defined by such
6 State) such profession (or, in the case of an indi-
7 vidual representing an entity, a State in which the
8 entity is engaged in business); and

9 (2) is currently practicing (as defined by such
10 State) such profession (or, in the case of an indi-
11 vidual representing an entity, the entity is in oper-
12 ation).

13 (e) DUTIES.—The task force shall—

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

20 (A) existing pain management research;

21 (B) research on trends in areas and com-
22 munities in which the prescription opioid abuse
23 rate and fatality rate exceed the national aver-
24 age prescription opioid abuse rate and fatality
25 rate;

1 (C) recommendations from relevant con-
2 ferences and existing relevant evidence-based
3 guidelines;

4 (D) ongoing efforts at the State and local
5 levels and by medical professional organizations
6 to develop improved pain management strate-
7 gies, including consideration of differences with-
8 in and between classes of opioids, the avail-
9 ability of opioids with abuse deterrent tech-
10 nology, and pharmacological, nonpharma-
11 cological, medical device alternatives to opioids
12 to reduce opioid monotherapy in appropriate
13 cases and the coordination of information col-
14 lected from State prescription drug monitoring
15 programs for the purpose of preventing the di-
16 version of pain medication;

17 (E) ongoing efforts at the Federal, State,
18 and local levels to examine the potential bene-
19 fits of electronic prescribing of opioids, includ-
20 ing any public comments collected in the course
21 of those efforts;

22 (F) the management of high-risk popu-
23 lations, other than populations who suffer pain,
24 who—

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

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

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

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

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

17 (J) research that has been, or is being,
18 conducted or supported by the Federal Govern-
19 ment on prevention of, treatment for, and re-
20 covery from substance use by and substance use
21 disorders among adolescents and young adults
22 relative to any unique circumstances (including
23 social and biological circumstances) of adoles-
24 cents and young adults that may make adoles-
25 cent-specific and young adult-specific treatment

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

5 (K) Federal non-research programs and
6 activities that address prevention of, treatment
7 for, and recovery from substance use by and
8 substance use disorders among adolescents and
9 young adults, including an assessment of the ef-
10 fectiveness of such programs and activities in—

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

14 (ii) treating such adolescents and
15 young adults in a way that accounts for
16 any unique circumstances faced by adoles-
17 cents and young adults; and

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

20 (L) gaps that have been identified by Fed-
21 eral officials and experts in Federal efforts re-
22 lating to prevention of, treatment for, and re-
23 covery from substance use by and substance use
24 disorders among adolescents and young adults,
25 including gaps in research, data collection, and

1 measures to evaluate the effectiveness of Fed-
2 eral efforts, and the reasons for such gaps;

3 (2) solicit and take into consideration public
4 comment on the practices developed under para-
5 graph (1), amending such best practices if appro-
6 priate;

7 (3) develop a strategy for disseminating infor-
8 mation about the best practices developed under
9 paragraphs (1) and (2) to prescribers, pharmacists,
10 State medical boards, educational institutions that
11 educate prescribers and pharmacists, and other par-
12 ties, as the Secretary determines appropriate;

13 (4) review, modify, and update best practices
14 for pain management and prescribing pain medica-
15 tion, specifically as it pertains to physician education
16 and consumer education; and

17 (5) examine and identify—

18 (A) the extent of the need for the develop-
19 ment of new pharmacological, nonpharma-
20 cological, and medical device alternatives to
21 opioids;

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

24 (C) the pharmacological, nonpharma-
25 cological, and medical device alternatives to

1 opioids that are currently available that could
2 be better utilized.

3 (f) CONSIDERATION OF STUDY RESULTS.—In review-
4 ing, modifying, and updating, best practices for pain man-
5 agement and prescribing pain medication, the task force
6 shall take into consideration existing private sector, State,
7 and local government efforts related to pain management
8 and prescribing pain medication.

9 (g) LIMITATION.—The task force shall not have rule-
10 making authority.

11 (h) REPORT.—Not later than 270 days after the date
12 on which the task force is convened under subsection (b),
13 the task force shall submit to Congress a report that in-
14 cludes—

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

19 (2) the results of a feasibility study on linking
20 the best practices described in paragraph (1) to re-
21 ceiving and renewing registrations under section
22 303(f) of the Controlled Substances Act (21 U.S.C.
23 823(f));

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

1 prove prescribing practices at medical facilities, in-
2 cluding medical facilities of the Veterans Health Ad-
3 ministration and Indian Health Service;

4 (4) the modified and updated best practices de-
5 scribed in subsection (e)(4); and

6 (5) the results of the examination and identi-
7 fication conducted pursuant to subsection (e)(4),
8 and recommendations regarding—

9 (A) the development of new pharma-
10 cological, nonpharmacological, and medical de-
11 vice alternatives to opioids; and

12 (B) the improved utilization of pharma-
13 cological, nonpharmacological, and medical de-
14 vice alternatives to opioids that are currently
15 available.

Passed the House of Representatives May 11, 2016.

Attest:

KAREN L. HAAS,

Clerk.