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Before the Senate Finance Subcommittee on Health Care Field Hearing on Opiate Abuse in Southwestern Pennsylvania

Introduction

Chairman and Committee members, thank you for the invitation and opportunity to address you on this important issue that has contributed to the staggering increase in abuse, diversion, addiction and overdose deaths in our region and the country.

I am the Medical Director for the Allegheny Health Network Division of Pain Medicine, board certified in Anesthesiology and Pain Medicine by the American Board of Anesthesiology and American Board of Medical Specialties. My responsibilities include oversite of both employed and independent Pain Medicine physicians in the Allegheny Health Network, developing policy and procedures and direct patient care. During my career I have been invited to lecture on pain medicine at national, regional and local meetings.

In addition to my role as medical director, I am also the Program Director for the Multidisciplinary Pain Medicine Fellowship, Allegheny General Hospital/Western Pennsylvania Hospital Medical Education Consortium. The fellowship involves multiple medical disciplines, including Psychiatry, Neurology, Physical Medicine and Rehabilitation and Anesthesiology. Since starting the fellowship in 2000, I have trained 51 fellows and countless residents.

My medical career began at the Western Pennsylvania Hospital. After completing my fellowship, I started a pain medicine program to serve patients in the community, and assist my medical colleagues with their chronic pain patients. Around that time Purdue launched Oxycontin and a small but nationally influential group of physicians in positions of prominence were extolling the virtues and safety of opioids for chronic nonmalignant pain. Since that time I have observed a dramatic increase in opioid prescribing in Southwestern Pennsylvania by physicians, many of which were ill equipped and under trained to deal appropriately with chronic pain patients.

The Prescription Opioid Epidemic

One of the major contributors to the current opioid epidemic in the United States is the over prescribing of opioids for chronic pain. As a nation, we consume approximately 99% of the hydrocodone, 80% of the oxycodone and 58% of the methadone produced in the world (Institute of Addiction Medicine). This has contributed to a dramatic increase in opioid abuse, addiction and deaths due to overdose. In addition to the tragic personal toll, the direct and indirect economic cost associated with opioids places a significant burden on health care dollars (Birnbaum HG).

Multiple Drivers of the Epidemic

In the 1980's and 1990's, multiple factors contributed to a change in opioid prescribing for chronic nonmalignant pain. Based on scant and faulty medical data, the risk of addiction was touted as rare, end organ toxicity nonexistent and the incidence of tolerance low (Portenoy RK). Armed with this information, physicians became less reluctant to prescribe opioids, patient advocacy groups demanded better treatment for chronic pain, and pharmaceutical companies began reformulating opioids into extended release preparations (1996 Purdue launches Oxycontin). This brought about in a dramatic increase in analgesic prescribing for chronic nonmalignant pain that coincided with the rise in opioid related morbidity and mortality (Braden JB). Little has been done to effectively address and curtail the over prescribing of opioids.

Primary care physicians and Internal medicine physicians prescribe the majority of opioid medications in the United States, and most were not trained in addiction or pain management (Volkow ND). While most doctors prescribe opioids with good intent and to treat their patients' pain with compassion, once that treatment path is started, it is often times very difficult to reverse. This can lead to disgruntled patients and frustrated physicians. Physicians who have compensation or employment tied to patient satisfaction scores may feel pressure to prescribe opioids in response to patient pain complaints.

Nationally, there are major disparities in prescribing opioids for chronic pain (Paulozzi LJ). In some regions, including Southwestern Pennsylvania, this has resulted in "pill mills" for profit. They prey on those with the disease of addiction out of greed. This has been addressed by legislation and law enforcement. Ten states have enacted a pill mill law as of May 2013. There are also physicians who tacitly prescribe opioids to continue patients on a long path of procedures that financially benefit the physician with little long term benefit to the patient, in some circles known as "pills for pokes". This is a very small but difficult practice pattern to detect without close oversite.

While much attention has been focused on opioid abuse, addiction, and mortality, there is also the issue of unintentional opioid misuse and subsequent adverse events. This is an issue especially in the elderly population who are at increased risk of falls and fractures (Miller M), cognitive impairment and unintentional overdosing. These adverse events result in increased emergency room visits, hospital admissions and length of stay adding strain to the health care costs in the United States (Birnbaum HG).

To curb the prescription opioid epidemic, state medical boards and physician groups have developed and published guidelines on the use of opioids to treat chronic nonmalignant pain (Hughes MA). The Center for Disease Control and Prevention is currently drafting guidelines as well. Where treatment strategies do exist to aid providers, studies show that some providers do not follow them, even for high risk patients (Gupta A). When queried about inappropriate opioid prescribing in light of published guidelines, one group of physicians responded, "they are only guidelines". While opioid prescribing has slowed, it still remains at problematic levels. The CDC found that in 2012, United States physicians wrote 82.5 prescriptions for opioids for every 100 people.

A promising tool to combat prescription drug abuse are state Prescription Drug Monitoring Programs (PDMP). As of July 2013 there are 47 states with operational PDMPs, however they are significantly underutilized when not mandatory (PDMPs). To further address inappropriate opioid prescribing, Physicians for Responsible Opioid Prescribing (PROP) have petitioned for a mandatory limit on the amount and duration of opioids that can be prescribed to a patient with chronic nonmalignant pain. This has resulted in condemnation from patient advocacy groups, fearing absolute rules will leave many chronic pain patients without help.

Recommendations for Consideration

We cannot address the opioid epidemic by painting with a broad brush of absolutes, mandating dosing and time limits. There is a small subset of patients who will require large doses of opioids for extended periods of time and do well (Kalso E). They should not be denied this therapeutic option. However, this should be a treatment of last resort, when all other attempts to control chronic pain have failed. Most patients with chronic pain can be treated with satisfactory results using a multidisciplinary approach without the use of long term opioid therapy (Flor H).

To engage physicians in this endeavor we will require more than published guidelines that are either ignored or underutilized. Many physicians have opted out of the Risk Evaluation and Mitigation Strategy (REMS) for extended release and long acting (ER/LA) opioids as it is voluntary. Mandatory REMS coupled with obtaining a DEA number to prescribe opioids for chronic pain of longer three months might be one strategy. This should include short-acting opioids as well as they are widely

associated with abuse (MMWR). The REMS would require physicians to discuss with and educate the patient about potential risks, possible benefits, outline goals, and develop an exit strategy. This would not interfere with a physicians' ability to treat acute pain with opioids for a short period of time when appropriate.

Enacting pill mill laws in all states may be a promising modality to help curb abuse, diversion and overdose.

There needs to be in place in every state, and on the federal level, a prescription drug monitoring program, easily accessible and user friendly that is available to physicians and pharmacies. The use of this program should be mandatory before prescribing or dispensing controlled substances.

Referrals to multidisciplinary pain programs should be made in a timely fashion for patients on opioids for chronic pain for evaluation, treatment recommendations and if necessary, reasonable medication management and monitoring.

To curtail the prescription opioid epidemic, all stakeholders need to come together and act quickly to address this national health crisis

Thank you for your invitation and the opportunity to discuss this important issue.

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