***Testimony of Jeffrey Coben, MD, Director of the West Virginia University Injury Control Research Center before the Senate Finance Committee/Subcommittee on Health Care, on Thursday March 22, 2012 at 10:00 a.m.***

Chairman Rockefeller, Ranking Member Grassley, and distinguished Subcommittee members, thank you for inviting me to discuss this critically important public health issue. I would like to begin by providing you with some perspectives on the problem of prescription drug abuse from the viewpoint of a physician who has practiced emergency medicine in this country for nearly 25 years, and has spent the last 8 years working within West Virginia, a state that has been particularly hard hit by this growing problem.

As you know, emergency physicians are on the front lines of health care. We see, first-hand, the health and healthcare problems that are impacting our communities. The alarming increase in deaths, hospitalizations, and emergency department visits associated with drug overdoses over the past decade has been well documented. These statistics, which I will return to in a moment, tell an important story. But the numbers alone do not adequately describe the ravages of prescription drug misuse and abuse. I have seen the pain and torment of families who have suffered the loss of a family member; I've seen children removed from their homes; and I have seen shootings, stabbings, and suicide all as a direct consequence of prescription drug abuse.

As an emergency physician, I can also attest to the benefits of prescription opioid analgesics. The vast majority of patients we see in the emergency department are coming to us in pain, and when used appropriately, opioid analgesics can be some of our most effective treatments for painful conditions. Anyone here who has fractured a bone, suffered through a kidney stone, or undergone a painful surgical procedure can probably provide their own commentary on pain – and the relief they received from different medications. In fact, in many cases, providing adequate pain relief may be the best, only, or most important thing that we as healthcare providers can do for our patients. Fifteen years ago physicians in this country were being heavily criticized for not adequately addressing pain, and there were quality improvement initiatives designed to *increase* the use of opioid analgesics. Now, only a short time later, we are faced with a rising epidemic of prescription drug overdoses, fueled in part, by a dramatic increase in the prescribing and distribution of strong opioid painkillers.[1]

During the first decade in this century, we experienced a 128% increase in fatalities associated with poisonings and the majority of these were unintentional overdoses associated with prescription drugs.[2,3] In 2008, over 41,000 people died as a result of poisoning and nearly 90%

of these poisoning deaths are caused by drugs.[4] Prescription drugs abuse is the fastest growing drug problem in this country and prescription painkillers are involved in more than 40% of all drug poisoning deaths. There is no indication that this trend is leveling off.[5]

This is certainly a crisis that demands our attention. Balancing the appropriate and judicious use of prescription drugs with efforts to prevent their misuse and abuse is a complex and difficult challenge, and I applaud this Subcommittee's efforts to help address this challenge. While regulations and other approaches involving Medicare and Medicaid cannot solve this problem alone, they can certainly play an important role.

Although the prescription drug abuse problem can seem overwhelming, we should not lose sight of one of the most important public health success stories of our time. During that same first decade of this century in which we have noted the alarming rise in drug overdose deaths, there was a 25% reduction in injury fatalities due to motor vehicle crashes.[1] From the perspective of an injury control researcher, I would like to suggest that there are some important lessons we can learn from the strategies that have proven successful at reducing motor vehicle-related deaths.

Approximately 50 years ago, the United States was experiencing a dramatic escalation in deaths from motor vehicle trauma. We responded by developing a wide array of national, state, and local evidence-based interventions that are integrated, systematic, and sustained. We have improved the safety of our highways, demanded safer motor vehicles, and implemented public safety and education campaigns. These interventions combine engineering, education, economics, policy, legislation, regulations, enforcement, and enhanced trauma care systems.

As we now attempt to confront the problem of prescription drug abuse, a similar integrated strategy is needed. As with the motor vehicle trauma crisis of half a century ago, there are multiple factors contributing to the rise of prescription drug abuse. Addressing this problem will require a multi-factorial approach, and will require that we broaden and sustained our efforts over time.

Just as we have worked to change public attitudes towards seat belt use and drunk driving, we will need to address misinformed societal attitudes towards the recreational use of prescription opioids. The majority of teens responding to a national survey believed that using an opioid medication without a prescription did not pose a great health risk.[6]

We need to do a better job educating physicians and other healthcare providers about the safe and appropriate use of prescription analgesics and sedatives, including the broader use of recently developed expert pain management and opioid prescribing guidelines; and the best approach for screening, brief intervention, and referrals for patients with substance abuse problems. Within the last few years, new guidelines for prescribing opioid analgesics for chronic, non-cancer pain, have been developed by expert panels and disseminated, including the 2009 guidance jointly issued by the American Pain Society and the American Academy of Pain Medicine,[7] along with similar guidance issued by other expert panels in the U.S., Canada, and Great Britain.

Programs aimed at providing a combination of expert prescription guidance to providers, coupled with tailored educational programs, have been implemented in states or locales, and some have shown promise. An interim evaluation of one such program in Washington State found that the fatal overdose toll had leveled off after prescription guidance and prescriber education.[8] A program in the State of Utah combining prescription guidance and education resulted in a 14% reduction in overdose deaths the year following implementation.[9]

Efforts to improve, standardize, and facilitate the more widespread use of Prescription Drug Monitoring Programs (PDMPs) are also needed. PDMPs offer the potential that prescribers will one day have real-time access to their patients' prescription histories from monitoring systems in each state that are linked with those in other states. Thus, patients who seek to acquire prescriptions for these dangerous controlled substances from multiple doctors and multiple pharmacies may be identified before additional prescriptions are written and dispensed. These "doctor-shopping" patients can then be referred for treatment where necessary, and curtailed (and prosecuted) if they are found to be diverting these drugs for profit. Through the efforts of the U.S. Department of Justice Harold Rogers Prescription Drug Monitoring Program, and the efforts of organizations such as The Alliance of States with Prescription Monitoring Programs[10] and the National Alliance for Model State Drug Laws[11], the number of PDMPs in the U.S. has rapidly increased during the 2000s. Currently, there are operational programs in 40 states and 1 territory, and laws that authorize the implementation of PDMPs in 9 other states.[10]

Despite the presence of these programs in a large majority of states, the ideal national network of linked prescription monitoring systems is not yet a reality. Current systems are not all comprehensive, capable of providing real-time reports, nor linked for data sharing.

There is also, of course, a critically important role for law enforcement and the DEA in detecting, and intervening to block, illegal efforts to obtain and distribute prescription painkillers, whether by fraud or theft.

Focusing now more specifically on public insurance programs, there are several strategies that need to be considered and evaluated. These include the expanded use of:

- real-time analysis of insurer claims data to identify potential cases of doctor shopping and other forms of abuse/misuse
- Drug Utilization Reviews, particularly those that can be implemented at the Point-of-Sale
- single provider/single pharmacist "lock-in" programs for individuals who have been identified as abusers or at high risk of abuse

Medicare and Medicaid have also had an important role in promoting the use of health information technology, including electronic health records and electronic prescribing. These systems have great potential for not only reducing fraudulent prescriptions, but also for helping to identify high-risk patients and potentially dangerous combinations of prescription drugs. Efforts to promote and incentivize the meaningful use of health information technology will be of continued benefit, and should be sustained.

Similarly, several state Medicaid programs have been at the forefront of efforts to promote the use of the Patient-Centered Medical Home Model of primary care. If done effectively, this medical home model also has the potential to help address the problem of prescription drug abuse by promoting better care coordination, the use of an expanded care team to better assess and detect substance abuse problems, and helping to promote integrated care with treatment resources within the community.

We must also recognize the important role for substance abuse treatment and, in most states, the real and critical shortage of treatment service availability. While shortages are apparent today in treatment facilities and resources, treatment needs may trend upward in the future. The Centers for Disease Control and Prevention (CDC) has estimated that for every overdose death caused by prescription opioids, there may be 461 nonmedical users.[1] SAMHSA reports that 2 million people used prescription painkillers non-medically for the first time in 2010,[6] which suggests that during 2012, another 62,000 people will become dependent upon these drugs. If the number of users continues to grow at a similar rate, the number of prescription-opioid-dependent people in the United States (estimated 210,000 in 2012) could reach half a million by

2017. Providing beneficiaries with coverage for substance abuse treatment is another important role for the state Medicaid programs. The programs should also try to ensure the quality and availability of services for their beneficiaries.

Finally, as an injury researcher, I would be remiss if I didn't mention the possibility of future interventions that are directed towards the "agent" of this problem—the prescription drugs themselves. Just as we have made our automobiles safer, we can find ways to make these medications safer. Drug manufacturers are working on new pharmaceutical preparations that formulate opiates in such a way as to prevent their misuse. An abuse–deterrant form of oxycodone, for example, comes as a gelatin capsule that does not release the drug when the attempt is made to grind it into a powder for snorting or when abusers attempt to extract liquid from the capsule for injecting.[12] Manufacturers are also creating formulations from combinations of drugs that retain opioids' analgesic properties while simultaneously blocking their euphoric and addictive effects. One such new drug, which is currently available for prescription only in the United Kingdom, combines prolonged release oral oxycodone, an opioid agonist, and naloxone, an opioid antagonist.[12] Similarly, there are new devices being developed that are focusing on the dispensing of limited quantities of medications held within tamper-proof dispensing units. These also may be of future benefit, particularly for dispensing long-acting opiates such as methadone. As these new drugs and products come to market in the United States, both Medicare part D and Medicaid programs will need to consider the potential benefits, costs, and cost-savings of adding them to their formularies.

My hope is that these comments will help us think creatively about new approaches, and work diligently together to solve this grave, and still escalating problem. I look forward to a robust discussion. Thank you.

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