Testimony before the Senate Special Committee on Aging

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Hearing on

"Fighting Against a Growing Epidemic: Opioid Misuse and Abuse Among Older Americans."

Statement of

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INTRODUCTION

Senator Kaine, thank you very much for this opportunity to examine the growing epidemic of prescription opioid misuse and abuse among older Americans. Prescription opioids are pain relievers such as Vicodin, Percocet, and Oxycontin that are legally prescribed but have a high risk of misuse and abuse, and can lead to life-threatening overdoses.

I am a family doctor and practice in Virginia Commonwealth University's Hayes E. Willis Health Center, which is located in an underserved community in the Southside of Richmond City. As a family doctor, I care for people across their life span: healthy children and young adults, complex adults with multiple, chronic conditions, and elderly patients.

I also serve as an Assistant Professor in the Department of Family Medicine and Population Health and the Associate Director of the Office of Health Innovation at Virginia Commonwealth University. I conduct research on the costs of untreated substance abuse and mental illness, and recently published a Policy Brief on the Opioid Crisis in Virginia. As the Director of the Integrated Care Initiative funded by Virginia's State Innovation Model design grant from the Center for Medicare and Medicaid Innovation, I brought together stakeholders to develop innovative models in integrated behavioral health and primary care. Our regional planning groups in Metro Richmond and Southwest Virginia designed models that integrate substance abuse screening and treatment into primary care with a focus on opioid abuse.

I have worked on these issues at the national and state levels. I served as a fellow at the Centers for Medicare and Medicaid Service, where I advised the Center for Medicaid and CHIP Services on delivery system reform and health care innovation including integrated behavioral health and primary care. I currently serve as a clinical advisor to Virginia's Medicaid agency on improving the Medicaid benefits and delivery system for individuals with substance abuse.

I am here today because of the many patients I see of all ages, races, and socioeconomic classes who have experienced the devastating effects of the opioid epidemic. I would like to share a patient story from my clinic that illustrates the potential long-term harm from taking opioids even when prescribed by a physician. One of my former colleagues started an older female patient on opioid pain relievers for her chronic back pain several years ago. This physician continued to increase the dose over time without adequately screening her patient for side effects. One evening, her patient fell down the stairs after taking the evening dose of her opioid, likely because of dizziness from the medication. The fall resulted in a severe foot injury that required surgery. The patient's foot never fully healed and she ended up in a wheelchair and requiring even higher doses of opioids for the chronic foot pain resulting from her fall.

Today, I will discuss how this patient's story is not unique but is part of the epidemic of prescription opioid misuse and abuse among older Americans and the general population. I will also explain the potential risks and harms or prescription opioids – including the fact that people, particularly the elderly, *can overdose even when they take opioids as prescribed*. I also will talk about three possible solutions to this epidemic. First, we need better provider education. Second, we need to increase the use of evidence-based guidelines among providers prescribing opioids. Third, we need to increase access to evidence-based addiction treatment.

THE PRESCRIPTION OPIOID EPIDEMIC

Prescription opioid pain relievers are the molecular cousins of heroin. Although they are perceived by the public as safer, many prescription opioids are just as addictive as heroin.[1] Prescription opioid abuse and misuse has become a public health crisis in our country because of the increasing prevalence and the rising mortality from overdoses. In 2014, opioid pain relievers

[1] Comer SD, Sullivan MA, Whittington RA, Vosburg SK, Kowalczyk WJ. 2008. Abuse liability of prescription opioids compared to heroin in morphine-maintained heroin abusers. *Neuropsychopharmacology* 33:1179–91

were involved in 18,893 deaths — far exceeding deaths from any other legal or illegal drug.[2] Each day, 52 people die from an overdose of prescription opioids in our country.

Health care providers wrote 259 million prescriptions for opioid pain relievers in 2012, enough for every American adult to have a bottle of pills.[3,4] Even though the amount of prescription pain relievers dispensed in the United States has quadrupled since 1999, there has been no overall change in the amount of pain reported by Americans.[5] As the prescriptions have risen, so has the number of people misusing these drugs. A total of 10.3 million Americans reported using prescription opioids non-medically in 2014.[6] This includes people who were using medications that were not prescribed for them or were taken because of the feeling or experience that they caused. This also includes teenagers and young adults who may have stolen a bottle of pain relievers from their parents or grandparents.

Unfortunately, opiate pain relievers can be harmful whether they are taken without a prescription or start with a prescription from a doctor. Many of these individuals started out with a legal prescription for a pain reliever given to them by a health care provider for acute or chronic pain. The provider may have given them too high a dose or too many pills or too many refills, causing them to become addicted and to take higher doses to obtain the same pain relief until they overdose. In fact, opioid overdoses appear to occur more frequently in people using opioids for medical reasons such as treating chronic pain. One study found that over 90% of the individuals who overdosed in a state had received a legitimate prescription for an opioid pain

[2] Centers for Disease Control and Prevention. CDC Multiple Cause of Death Mortality file. 2013. Available at: http://wonder.cdc.gov/mcd.html. (Accessed January 22, 2016).
[3] Centers for Disease Control and Prevention. Opioid Painkiller Prescribing. Available form: http://www.cdc.gov/vitalsigns/opioid-prescribing/index.html (Accessed January 26, 2016).
[4] Chang H, Daubresse M, Kruszewski S, et al. Prevalence and treatment of pain in emergency departments in the United States, 2000 – 2010. Amer J of Emergency Med 2014; 32(5): 421-31.
[5] Daubresse M, Chang H, Yu Y, Viswanathan S, et al. Ambulatory diagnosis and treatment of nonmalignant pain in the United States, 2000 – 2010. Medical Care 2013; 51(10): 870-878.
[6] Center for Behavioral Health Statistics and Quality. 2014 National Survey on Drug Use and Health: detailed tables. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

reliever from a health care provider.[7]

In Virginia, more people die from fatal drug overdoses than car accidents or homicides. Of the 785 drug overdose deaths related to opioids in Virginia in 2014, 70% involved prescription pain relievers and 30% involved heroin. The 546 overdose deaths involving prescription opioids is a 73% increase in prescription opioid-related overdose deaths since 2007.[8]

Our state and our country are experiencing a public health crisis driven by prescription opioids. Just as this epidemic is not limited to heroin, it is not limited to young people. Over the past decade, adults aged 55 to 64 and non-Hispanic whites had the greatest increase in the rates of overdose deaths related to opioids.[9]

EVIDENCE OF EFFECTIVENESS, POTENTIAL RISKS, AND HARMS

While there is evidence that prescription opioids are effective to treat chronic pain due to cancer, a number of recent studies have concluded that the overall effectiveness of chronic opioid treatment for chronic non-cancer pain is limited, the effect on improving function is very small, and the safety profile of opioids is poor. A number of potential harmful side effects are associated with opioid use including infertility, sleep breathing disorders, irregular heart rhythms, and opioid-induced hypersensitivity to pain. [10,11,12] Among the elderly, opioids have been shown to cause unsteadiness, confusion, and dizziness, leading to a greater risk of falls and

[7] Johnson EM, Lanier WA, Merrill RM, et al. 2013. Unintentional prescription opioid-related overdose deaths: description of decedents by next of kin or best contact, Utah, 2008–2009. *J. Gen. Intern. Med.* 28:522–29
[8] Virginia Department of Health (2015). Available from: http://www.vdh.virginia.gov/medExam/ForensicEpidemiology.htm. (Accessed January 22, 2016).
[9] Chen LH, Hedegaard, Warner M. Drug-Poisoning Deaths Involving Opioid Analgesics: United States, 1999-2011. National Center for Health Statistics Data Brief 166, Sept 2014. Available from: http://www.cdc.gov/nchs/data/databriefs/db166.htm (Accessed January 26, 2016).
[10] Furlan AD, Sandoval JA, Mailis-Gagnon A, Tunks E. Opioids for Chronic NonCancer Pain: A Meta-analysis of Effectiveness and Side Effects. CMAJ. 2006;174: 1589-1594.
[11] Ballantyne JC, Shin NS. Efficacy of Opioids for Chronic Pain: A Review of the Evidence. Clin J Pain. 2008; 24:469-478.
[12] Noble M, Treadwell JR, Tregear SJ, Coates VH, Wiffen PJ, Akafomo C, Schoelles KM. Long-term Opioid Management for Chronic NonCancer Pain. Cochrane Database Syst Rev. 2010;20: CD006605.

serious fractures.[13] These harmful side effects are associated with higher rates of health care utilization including ER visits and hospitalizations. There are also high rates of deaths from unintentional overdoses, especially at high doses of opioids, which generally occur due to respiratory depression and happen at home during sleep. Older Americans have the highest risk of these harmful side effects because they often have impaired kidney and liver function, which means that opioids stay in the body for much longer and that lower doses have stronger effects.

Furthermore, long-term opioid use for chronic, non-cancer pain, is associated with minimal improvement in pain and function. In the context of the significant risks of harm including overdose and death, the overall risk/benefit balance is unfavorable for many current opioid users, especially older Americans. There are many other medications that are more effective than opioids in the treatment of chronic non-cancer pain and that have far fewer risks. For example, Tylenol can be used for many types of pain as long as the doses are within a safe limit, especially for the elderly. Medications including anti-depressants, anti-convulsants, and muscle relaxants are more effective than opioids in treating chronic non-cancer pain.

RECOMMENDATION #1: INCREASE PROVIDER EDUCATION

We can take several steps to address this public health crisis. First, health professional students and medical residents typically receive very limited education on treating chronic pain, including appropriate prescribing and dispensing of opioid pain relievers, and on identifying and treating substance use disorders. Inappropriate prescribing by providers and their failure to screen and identify patients at risk of addiction have played a large role in the abuse of prescription opioids and the development of addiction to these dangerous medications.

A recent report by the National Center on Addiction and Substance Abuse (CASA) found

[13] Schiller JS, Kramarow EA, Dey AN. Fall injury episodes among noninstitutionalized older adults: United States, 2001–2003. *Adv Data*. 2007;21: 1–16.

that most physicians fail to identify or diagnose substance use disorders or do not "know what to do with patients who present with treatable symptoms."[14] Addiction is linked to more than 70 diseases or conditions including HIV/AIDS, Hepatitis B and C, kidney failure, and liver cirrhosis, failure, and cancer and accounts for a third of inpatient hospital costs, according to CASA. However, addiction medicine is rarely taught in medical school or residency training.

Greater federal funding is required to expand graduate medical education (GME) opportunities for training in the identification, referral, and treatment of substance use disorders and to create interdisciplinary training among health care providers. In addition, federal and state agencies, state medical boards, and medical societies should fund and support pre-graduate and post-graduate training in pain management and opioid prescribing as well as in screening and treatment of substance use disorders.

Furthermore, states should be encouraged to create mandated annual continuing medical education (CME) requirements on appropriate opioid prescribing for physicians and other providers. Virginia does not have this requirement but proposed legislation under consideration by the General Assembly would require all physicians to obtain this education in order to renew their medical licenses. This proposed legislation came out of the Governor's Task Force on Prescription Drug and Heroin Addiction, a bipartisan task force that developed a number of recommendations that are currently being considered by Virginia's General Assembly.

RECOMMENDATION #2: IMPLEMENT PRESCRIBING GUIDELINES

Second, health care providers need prescribing guidelines with best practices that decrease the risks of addiction and overdose for their patients. I applaud Senator Kaine for his recent letter urging the Centers for Disease Control to release long-awaited opioid prescribing

[14] CASA Columbia. Addiction Medicine: Closing the Gap between Science and Practice. June 2012. Available at http://www.casacolumbia.org/addiction-research/reports/addiction-medicine. Accessed January 22, 2016.

guidelines. These common sense guidelines would encourage providers to recommend non-opioid therapies as the first choice for chronic, non-cancer pain; prescribe the lowest dose and the fewest number of pills that would effectively treat the patient's pain; and regularly evaluate the risks to the patient from the prescription opioids they are taking. As a practicing primary care physician, I strongly support these guidelines and believe that they should be released as soon as possible. A survey showed that 87% of physicians support the CDC's guidelines and would use these guidelines in practice.[15]

The Co-prescribing Saving Lives Act sponsored by Senator Kaine is also an important step in the right direction. By creating physician education and guidelines that encourage doctors to co-prescribe naloxone, an opioid antagonist that can reverse overdoses, when they prescribe opioids, this legislation would promote best practices and prevent opioid deaths.

RECOMMENDATION #3: INCREASE ACCESS TO EVIDENCE-BASED ADDICTION TREATMENT

Substance abuse is as common as diabetes in the adult population. In 2008, there were 24 million people with diabetes and 22 million people with substance abuse. Despite the prevalence of substance abuse, screening, early intervention, and treatment for addiction are much less available and accessible than screening and treatment for diabetes. Only about 1 in 10 people with addiction involving alcohol or drugs other than nicotine receive any form of treatment. Of those who do receive treatment, few receive evidence-based care. This is a tragedy because addiction is a disease with serious consequences including death, but effective treatment exists. The only way to end the opioid crisis is to provide treatment to Americans with addiction.

Medication assisted treatment (MAT) with suboxone or methadone is an evidence-based

[15] Business Wire, *Doctors Eager for CDC Guidelines on the Prescribing of Opioids*. 12 Jan. 2016. Available from: http://www.businesswire.com/news/home/20160112006450/en/Doctors-Eager-CDC-Guidelines-Prescribing-Opioids. (Accessed January 28, 2016).

treatment for opioid addiction. When prescribed with counseling and psychosocial support, MAT can help people with addiction recover and become functioning members of society. Over 4.5 million people need but are not receiving substance abuse treatment in the U.S., many with opioid addiction. However, only 3% of family physicians have obtained the federal waiver required to prescribe suboxone. The shortage of physicians trained in MAT has created long waiting lists in many rural and urban areas, requiring people to wait many months to receive life-saving treatment for their prescription opioid and heroin addiction.

Significant federal and state investment is required to train physicians to provide MAT and to support counselors in primary care and psychiatry practices who can provide the counseling alongside the suboxone that is required for evidence-based MAT. The recent grant by the Agency for Healthcare Research and Quality to provide $12 million to fund up to four research demonstration projects to support implementation of MAT for opioid addiction in rural primary care practices is a step in the right direction. Federal health agencies should engage in a coordinated effort to offer many more grant opportunities to primary care practices, communities, and states that are eager to provide the treatment needed to end the epidemic.

Congress could also make a difference by passing the Comprehensive Addiction and Recovery Act, which would designate up to $80 million to advancing substance abuse prevention and treatment in state and local communities across the country. Since every $1 invested in substance abuse treatment returns $7 in cost savings to the health care and criminal justice systems, this would be a wise use of taxpayer dollars with a significant return on investment.[16]

Despite the many benefits and cost savings, Virginia's Medicaid program, like Medicaid in many states, pays very poorly for substance abuse treatment. As a result providers do not

[16] Ettner, S.L., D. Huang, et al. (2006). Benefit-cost in the California treatment outcome project: does substance abuse treatment 'pay for itself'? *Health Services Research*, 41(1): 192-213.

provide treatment—it's not worth their time. Due to the lack of providers offering these services, Virginia's Medicaid program only spent $2 million on community-based substance abuse treatment in 2014, which is less than 1% of the nearly $1 billion spent by Medicaid on community-based mental health treatment.

To increase access to substance abuse treatment, Virginia's General Assembly is currently considering a proposed substance abuse treatment benefit that would reform the Medicaid program so that Virginians *currently eligible* for Medicaid would have recommended coverage and access to the full continuum of evidence-based substance treatment services. These services would include: inpatient detox, residential treatment, intensive outpatient treatment, outpatient services including Medication Assisted Treatment for opioid addiction, case management, care coordination, and peer recovery supports. These services have been proven to "cure" addiction. This benefit includes funding for provider recruitment, training, and education in MAT to support more physicians and practices in providing suboxone and counseling.

CONCLUSION

As a family doctor, I see the devastating consequences of opioid abuse daily. The steps that I've outlined today – increasing provider education, implementing evidence-based guidelines, and increasing access to evidence-based addiction treatment – are components of a comprehensive strategy that will need to engage health care providers, law enforcement, social service workers, parents, advocates, and policymakers. We have a tremendous amount of work to do to end this epidemic. I would like to thank Senator Kaine for the opportunity to testify and for his leadership in addressing a public health crisis that is impacting all Americans.