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Senator McCaskill, other members and staff of the Senate's Special Committee on Aging, thank you so much for the opportunity to appear before you. I find today's topic so important both from a national, public health standpoint, but also for me personally both in my every day practice as a physician as well as in my family's experience.

I have seen both the terrible toll of misuse of pain medicine, as well as the tremendous relief they can bring when used appropriately to allow a person bed-ridden with cancer pain find the relief to spend her last few days holding up her grandchildren.

Two brief stories highlight the complexity and critical importance of the meeting today. First let me tell you about a patient from a number of years ago. As a physician who has had additional training in both geriatrics and palliative medicine, I am often asked to help doctors with very difficult pain cases. I remember a patient with severe pain and limited life expectancy related to multiple conditions. In hospital, our teams' recommendations made a big difference and he left for home doing better. I was surprised to hear from his physician that he died earlier than expected at home some time later.
A review of his medications seemed appropriately dosed. I was disheartened to discover that he had not one but multiple other pain medicines found in his system prescribed by several other doctors. We need better coordination of care systems for patients with pain.

I am so glad that we are before this committee today because opioid deaths are not just about younger people with addiction. The statistically significant rise in opioid deaths occurs in older adults over 65 as well as younger patients. The CDC has declared that pain medicine misuse and deaths has risen to the level of an "opioid epidemic." The common factors per the CDC that are associated with deaths from opioid include: prescriptions for opioids in very high doses, prescriptions from multiple providers (like my patient), and finally, mixture of opioids with other medications (notably alcohol and sedatives.)

In my experience, another factor this committee can help policy-makers understand is the underappreciated fact of just how complicated opioid prescribing is for older patients. Physicians despite their training in pain management have not been well trained in geriatric medicine and the necessary adjustments. Due to changes associated with aging, a standard dose is too strong for older adults, and the body often cannot process the drug as quickly. In short, a little medicine goes a long way. Failure to recognize the unique prescribing adjustments needed for our seniors is another key factor in opioid misadventures, which must be addressed with better geriatrics education.

The good news is we can work to reduce opioid deaths. Congress's Secure and Responsible Drug Disposal Act of 2010 allowing unused opioids to be disposed of at pharmacies will keep left-over medicine that was needed for grandmother's hip replacement from becoming the drug that starts a grandkid on the path to addiction. Thank you for this important legislation and we need to let more people know about it.

The good news is that physicians and organizations are working to make opioid prescribing safer.
I'd like to share with you the Missouri Hospital Association (MHA) response. MHA noted between 2005 and 2014, hospitalization for opioid over-use increased 137% in our state. At the University of Missouri we found that the

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impact of overdose is particularly harder for older adults, as seniors had twice the need for intensive care unit admission. The MHA in partnership with a coalition of the Missouri State Medical Association, the Missouri Association of Osteopathic Physicians and Surgeons, the Missouri Academy of Family Physicians, the Missouri College of Emergency Physicians and the Missouri Dental Association felt that focusing on steps to reduce misuse and abuse in emergency room prescribing practices was a key initial step. Based on national guidelines and evidence the coalition recommends the following as suggested emergency department protocols:

- A comprehensive pain assessment prior to determination of treatment plan; if the patient's pain prohibits a comprehensive assessment, then judicious use of opioids to alleviate pain is suggested.
- Diagnoses based on evidence-based guidelines and appropriate diagnostics whenever possible.
- Non-narcotic treatment of nontraumatic tooth pain.
- Treatment of patients with acute exacerbation of existing chronic pain should begin with an attempt to contact the primary opioid prescriber or primary care provider, if circumstances are conducive.
- Opioid analgesic prescriptions for symptoms including acute exacerbation of existing chronic pain management should be limited to no more than 72 hours, as clinically appropriate and assessing the feasibility of timely access for follow-up care.
- ED physicians and providers should not provide prescriptions for controlled substances that are claimed to be lost or destroyed.
- Unless otherwise clinically indicated, ED physicians and providers should not prescribe long-acting or controlled-release opioids.
- Consider prescribing abuse deterrent forms of opioids.
- Encourage policies that allow providers to prescribe and dispense naloxone to public health officials, law enforcement and family as an antidote for opioid overdoses.

The good news is physicians are thinking about how to solve this on a national level. The American Medical Association Task Force to Reduce Prescription Drug abuse states that ***'physicians have a professional obligation to reverse the nation's opioid epidemic.'*** As this committee thinks about policies to make prescribing safer, I personally would like ask that you focus on the AMA's recommended areas. They are excellent. The task force is focused on 5 areas:

- Increasing physicians' registration and use of effective Prescription Drug Monitoring Programs
- Enhancing physicians' education on effective, evidence-based prescribing
- Reducing the stigma of pain and promote comprehensive assessment and treatment
- Reducing the stigma of substance use disorder and enhance access to treatment
- Expanding access to naloxone in the community and through co-prescribing

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However in closing, the other story that's so important is my own father. My father died of a rare disease in small town East Texas. During his last days, as he writhed in pain, my mother was told, 'I'm sorry we can't give him morphine, as that might kill him.'

We have a public health crisis that demands both response to prevent unnecessary deaths but also demands a response to meet the true pain needs which are often untreated or undertreated. According to the research of Dr. Alex Smith of UCSF and colleagues, 25% of older adults have significant pain in the last 2 years of life, rising to as much as 50% of older adults in the last year of life.

As you actively think about policy to reverse the "opioid epidemic" I think this committee is especially positioned to help older adults. Speaking personally as a geriatrician, a key policy need is to improve both geriatric medicine education for all practitioners, but also to improve care coordination between physicians and other health care workers, hospitals, pharmacists and patients and families. Congress could expand Geriatric Academic Career Awards so we have the teachers needed to help providers understand the intricacies of prescribing to older adults. We could pass the Palliative Care and Hospice Education and Training Act to create regional centers that improve care of the seriously ill and enhance end-of-life education.

Foremost this is about safety and real suffering. Physicians need tools to identify at-risk patients who might not be appropriate for opioids in a way that is efficient, doesn't disrupt practice with information delivered in real time to the point of care where decisions must be made: at the bedside with a patient who may be suffering.

Thank You.

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