Testimony of

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Dear Members of the Senate Special Committee on Aging:

Maine is in the midst of an opiate epidemic that affects all ages and socioeconomic classes. In Maine, Emergency Medical Services opiate overdose numbers increased 4% in 2014 compared to 2013, and expected an 8% increase in 2015, to a total of 3202 incidents. The age distribution is with a majority 25 to 54 years of age, yet about 12% of patients are aged 55-64 years of age, and 12% are 65 years or older. Our Emergency Department at MaineGeneral has also seen an increase in number of patients and an older age distribution in those affected by this epidemic. On average, we see 4 opiate overdoses per year in the 65 or older age group, but in 2015, we saw 10. This is a growing subset of total overdoses for this age group which is consistently averaging 20 per year.

The treatment of those with chronic pain is a significant part of this epidemic. Pain as the fifth vital sign became an initiative in 1995, and coupled with the query on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) of how we do with pain has resulted in an exponential prescribing of opiates. The HCAHPS query is both publicly reported and part of value based purchasing. This compulsion to do well on rankings for pain queries, coupled with pain toolkits proposing that medications for pain can be used ubiquitously and safely has created an untenable conflict. The result is that we now give more opiates and have more opiate addiction, diversion, and overdoses. This is increasingly a problem for the elderly.

The plan now to help seniors who have chronic pain needs to be both bolstered and immediately endorsed. Pain is a complex phenomenon for which one modality will not be the single source solution. One of the key issues in this discussion is the current physician gap in primary care, psychiatry, and physiatry. These three medical specialties are key for work in this arena, with a national shortage of each, which is amplified for those working and recruiting to rural areas, such as Maine.

For those who are addicted, medication assisted treatment thru intensive outpatient programs for stabilization and then support of primary care providers to help keep patients at steady state is required. As well, the primary care providers (PCPs) must have immediate access to specialists who can help if the patient is failing their steady state regimen, akin to having cardiologists available for PCPs when a patient's cardiac issue is worsening. Such addiction specialists are typically physicians who train in psychiatry, physiatry, or primary care with extended specialty education. To make providers who can support medication assisted therapy more widely available, allowing PCPs to prescribe for 250 people instead of 100 people would be a significant step, within the purview of Health and Human Services. Additionally, allowing Advanced

Practice Registered Nurses and Physician Assistants to prescribe medication assisted treatment in the form of Suboxone would help meet this much needed access.

The medical specialty most apt and truly needed to assess and offer treatments for those with chronic pain is physiatry. This specialty has broad training and the number of physiatrists practicing in chronic pain is currently not enough nor distributed well geographically, especially in rural states. At MaineGeneral, our physiatry clinic services our primary and secondary service areas of Kennebec county and the immediate surrounding area, but also sees patients from far rural northern Maine in significant numbers. The modalities and assessments needed to correctly practice chronic pain are broad, as pain has potentially multiple causes. The etiology may be similar amongst patients, yet the therapy that helps most may need to be individualized. Opiates for non-terminal chronic pain, especially in the elderly, should not be first line treatment. Chronic use of opiates may produce dependence, mental status changes, sleepiness, impaired breathing, constipation, and death. When used as prescribed, under the direction of an appropriate medical team, impaired breathing and death may be mitigated, but not if diversion part of the equation. In the elderly, side effects are increasingly problematic, as adult routine dosing may elicit significant untoward side effects. It is sad that we have advertising in the public media on a new medication to help with opiate-induced constipation, yet no public messages on avoiding opiates in the first place. Medical assessment, trial of therapies, mental health evaluation, psychosocial determinants and functional assessment are all key determinants of how to address an individual's chronic pain. This multidisciplinary evaluation is not always readily available, nor potentially supported even if patients have medical insurance, whether it be government or private third party insurance. Additionally, wellness and self-care exhibited through exercise, diet, yoga, meditation, acupressure, acupuncture, and access to other alternative medical therapies also a key component of helping those with chronic pain. Since insurance does not typically cover most of these modalities, it is an out of pocket payment and potentially financially untenable for older Americans.

Most specifically, the complex issue of chronic pain has behavioral health as a foundational unmet need. Either initially or in the course of this chronic illness, many have mental health disease as a co-morbid condition. It is of paramount importance to have a multidisciplinary approach with a behavioral health specialist to identify and treat co-existing mental health disorders, such as depression. As with primary care and physiatry, we need more psychiatrists in the US, and especially in rural areas such as Maine. Lack of insurance payor support is a significant issue. Specifically, behavioral health access for community, outpatient, intensive outpatient, emergency department, and inpatient services for all patients is a key foundational element in addressing chronic pain and the opioid epidemic, and specifically for the elderly.

Ideally, when a patient presents to the medical system for chronic pain or opioid addiction, whether it be through their primary care physician, medical or surgical specialist, therapist, emergency department visit or through an interaction through law enforcement, the pathway for intervention and expert clinical support is readily available. If the system of care is robust and patients expertly managed, it would be theoretically feasible that diversion, overdose, and crime related to the opioid epidemic would be mitigated. This is unproven, as the studies to quantify

the amount of diversion and crime would be considered observational at best. But the elderly are clearly targets of diversion, and without the tools and access for more comprehensive chronic pain management, as well as all other components presented, we will continue to watch this issue have uncontrollable growth.

Thank you.

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