

**TESTIMONY BEFORE THE UNITED STATES SENATE  
SELECT COMMITTEE ON AGING**

**Hearing on “Opioid Use Among Seniors – Issues and Emerging Trends”**

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*Summary of Testimony:*

Over the past year in Indiana, we have faced the very real consequences of the national opioid abuse epidemic, and we have taken many actions in our state to address this issue.

In Scott County, Indiana, we are still dealing with an unprecedented HIV outbreak related to injection drug use (IDU). In a rural community that had 3 total cases of HIV in the previous 4 years, we had 189 people who were HIV positive as of February 18, 2016. Ninety-five percent of those cases were related to IDU, and 91 percent of the people infected with HIV are co-infected with hepatitis C. The causes of and contributors to opioid misuse are multifactorial, and the consequences and possible remedies are numerous, but it is an undeniable fact that actions by and for our country’s aging population play an important role.

Older adults are inextricably – and often unknowingly -- linked to the increased availability of prescription opioids, which has led to 1 in 5 high schoolers reporting trying a prescription painkiller for nonmedical reasons. Youth report their number one source for these pills is a relative’s medicine cabinet, with many stating that pills are easier to obtain and to hide than alcohol. Many times, these medicine cabinets belong to grandparents or other older relatives who have surplus pills in part because of initiatives that were designed to help seniors manage their pain.

In 1996, the American Pain Society introduced the phrase “pain as the 5<sup>th</sup> vital sign.” Three years later, the Veterans Administration unveiled the concept of pain as the 5<sup>th</sup> vital sign as a national institutional initiative. This was done in an attempt to address untreated pain in our mostly senior VA population, but it has not improved the treatment of pain and has instead led to a nation of citizens who expect to live pain-free, and who further expect that prescription opioids are the way to achieve this goal. Although there is no evidence to support the routine use of opioids in the management of chronic pain, the rapid subjective evaluation of pain, coupled with increased knowledge about opioid availability, has led to a subsequent increase in

the number of opioid prescriptions that did little to solve the pain problem and instead resulted in an epidemic of opioid misuse, addiction and overdose deaths.

In addition to treating pain as the 5<sup>th</sup> vital sign, prescribing habits have been affected by surveys that tie pain management to patient satisfaction scores, which impact reimbursements. It is no surprise that prescribers feel pressure to satisfy a public that has been led to believe they have a right to opioids if their pain score is not zero. This has led to increased prescribing, and ultimately to an opioid epidemic that does not discriminate by age, race or location.

Indiana has taken numerous steps to address this problem. Our Governor, Mike Pence, established a task force on drug enforcement, treatment and prevention. This task force includes medical professionals, members of law enforcement and community members and has traveled throughout the state, hearing stories about what has led to the opioid epidemic, what the fallout has been, and what communities are doing to turn the tide. The task force has heard more than one story about a doctor who was prepared to prescribe more opioids to a senior, only to find out through our state prescription drug monitoring program that the patient had been to several other providers in the recent past seeking pain medications. It has heard from first responders who used naloxone, an overdose-reversal medication, to save the life of an elderly patient who accidentally overdosed on legitimately prescribed pain medications. These are the stories that guide our work.

The work of this task force has resulted in recommendations that include increasing access to naloxone among first responders and lay people; improving INSPECT, our state prescription drug monitoring program; developing guidelines for prescribing acute pain medications; increasing access to medication-assisted therapy; and holding more events to take back unused pain medications. Steps like these will ensure that pain medications are prescribed appropriately in Indiana and help prevent individuals from acquiring surplus medications that could be diverted, either for financial gain or to feed someone's addiction.

Drug overdoses are at an all-time high in Indiana and many other states, and seniors are not immune. We must be proactive and continue to take steps to change our prescribing rules, get naloxone in the hands of those who need it and examine the concept of pain as the 5<sup>th</sup> vital sign and the use of pain management to determine patient satisfaction scores, and subsequently provider reimbursements, if we are to stop this opioid epidemic and protect our nation's most vulnerable citizens. There is much to do, but we are making progress and must continue to do so to protect our seniors and all who have fallen victim to this opioid epidemic.

## *Full Testimony:*

Chairman Collins, Ranking Member McCaskill, and distinguished members of the Committee, especially Senator Donnelly from the State of Indiana, thank you for the opportunity to testify today. My name is Jerome Adams, and I am the Indiana State Health Commissioner, as well as a practicing physician anesthesiologist at Eskenazi Hospital in Indianapolis, Indiana. On behalf of Governor Mike Pence and the people of Indiana, it is my honor to appear before you to discuss the effects of our nation's opioid epidemic on seniors.

Over the past year in Indiana, we have faced the very real consequences of the national opioid abuse epidemic, and we have taken many actions in our state to address this issue. In Scott County, Indiana, we are still dealing with an unprecedented HIV outbreak related to injection drug use (IDU). In a rural community that had 3 total cases of HIV in the previous 4 years, we had 189 positives as of February 18, 2016. Ninety-five percent of those cases were related to IDU, and 91 percent of the people who tested positive for HIV were co-infected with hepatitis C.

The true origin of this HIV outbreak is our country's prescription opioid crisis. The causes of and contributors to opioid misuse are multifactorial, and the consequences and possible remedies are numerous, but it is an undeniable fact that actions by and on behalf of our country's aging population play an important role.

To provide some context for a discussion about Indiana, it is worth noting that the Scott County HIV outbreak was not the beginning of a problem, but the culmination of an opioid epidemic that has been building for more than a decade.

- In 2014, Indiana was ranked 16<sup>th</sup> nationally for its overdose rate.<sup>1</sup>
- From 2003 to 2015, instances in which heroin was reported in overdose deaths in Indiana increased by a factor of 57.<sup>2</sup>
- Unintentional poisoning deaths in Indiana rose 500 percent from 1999 to 2009, and they have surpassed motor vehicle accidents as the leading cause of injury death in our state.<sup>3</sup>

These statistics are unfortunately representative of those in many other states. There are hundreds of places like Scott County across the country. If we don't address the root causes of this epidemic, namely the overflow of prescription opioids into communities and the lack of options for those battling substance use disorder, other places across the country will find themselves dealing with a situation like the one in Scott County. That is why our Governor, Mike Pence, ordered the formation of a task force on drug enforcement, treatment and prevention. This task force has traveled throughout the state, hearing stories about what has led to the opioid epidemic, what the fallout has been and what communities are doing to turn the tide.

I have been asked to talk to you about how seniors are a part of this epidemic. I will share with you my thoughts and lessons learned regarding the opioid epidemic, as well as our state's public health response, and point out where seniors are involved.

First and foremost, older adults are inextricably – and often unknowingly -- linked to the increased availability of prescription opioids, which has led to 1 in 5 high schoolers reporting trying a prescription painkiller for nonmedical reasons. Youth report their number one source for these pills is a relative's medicine cabinet, with many stating that pills are easier to obtain and to hide than alcohol. Many times, these medicine cabinets belong to grandparents or other older relatives.

So why do so many seniors have surplus pain pills? The reality is that doctors and other providers across the country are overprescribing, at least in part in response to initiatives that were designed to help seniors. In 1996, the American Pain Society introduced the phrase "pain as the 5<sup>th</sup> vital sign." Three years later, the Veterans Administration unveiled the concept of pain as the fifth vital sign as a national institutional initiative. This was done in a noble attempt to address untreated pain in our mostly senior VA population, but it has not improved the treatment of pain and has led to a nation of citizens who expect to live pain-free, and who further expect that prescription opioids are the way to achieve this goal. Although there is no evidence to support the routine use of opioids in the management of chronic pain, the rapid subjective evaluation of pain, coupled with increased knowledge about opioid availability, led to a subsequent increase in the number of opioid prescriptions that did little to solve the pain problem, and instead resulted in an epidemic of opioid misuse, addiction and overdose deaths. The aftermath unfortunately is that the United States currently constitutes 5 percent of the world's population but consumes more than 80 percent of the world's opioids. Further, prescribers and hospitals report feeling helpless to say no to demands, lest they face scrutiny from entities such as the Joint Commission and Centers for Medicare & Medicaid Services, who actively survey the healthcare industry regarding pain management.

The Hospital Consumer Assessment of Healthcare Providers and Systems, or HCAHPS, survey, a CMS initiative to address patient satisfaction, is a common reason prescribers cite when asked why they write prescriptions for opioids in spite of questions about their appropriateness in a given situation. Question 14 on the HCAHPS survey reads, "How often did the hospital staff do everything they could to help you with your pain?" With hospital executives focusing like never before on raising their HCAHPS scores, which are directly and increasingly linked to reimbursement, it is no surprise that prescribers feel pressure to satisfy a public that has been led to believe they have a right to opioids if their pain score is not zero. CMS recently held a webinar in which it stated that "HCAHPS does not encourage opioid prescriptions."

Unfortunately, while increased prescribing may not be the intent, providers are telling us the reality is a very different matter. Opioid overprescribing didn't start with HCAHPS, but prescribers continually tell me it is perceived as a barrier to changing habits.

As I said in prior testimony to the House Energy and Commerce Committee last year, we should revisit both the concept of "pain as the 5th vital sign" and the pain component of patient satisfaction as a consideration for physician and hospital reimbursement. Our goal should be to create best-practice models for integrated pain management practices in which the focus is on functionality and outcomes, not elimination of pain.

Encouraging usage of Prescription Drug Monitoring Programs (PDMPs) is another common theme that has come up as Governor Pence's task force has examined ways to stop the opioid epidemic in Indiana. The task force has heard more than one story about a doctor who was prepared to prescribe more opioids to a senior, only to find out through our state PDMP that the patient had recently been to several other providers seeking pain medications. Unfortunately, several state VA Hospital systems, including Indiana's, don't currently report controlled substance prescriptions to their state PDMP. This has led many experts to point to the VA as a major source of diverted prescription opioids in some communities, and led the CDC and others to point out surges in opioid dependence among veterans.

Based on feedback from Governor Pence's task force, we are working with the Indiana VA system to remedy this situation. In addition, the task force has made a number of additional recommendations, one of which is to ensure that all prescribers are utilizing our state's chronic pain prescribing guidelines, which were developed with input from experts in the management of chronic pain. The Governor has further asked his task force to work with stakeholders to develop acute pain prescribing guidelines. Prescribers tell us that the presence of guidelines, including standard checks of INSPECT, our state's prescription drug monitoring program, helps empower them to say no to patients who demand opioids for pain without fear of retribution or comparison to other providers who might otherwise issue prescriptions.

Beyond stopping overprescribing practices, more must be done to promote take-back of old and unused medications so that they aren't sitting in medicine cabinets waiting to be diverted. Indiana's Attorney General has also formed a task force, which has worked with pharmacies, police stations, and even local sports teams, to provide more venues and opportunities for safe disposal of narcotics.

Last but certainly not least in terms of diversion, an additional major driver is financial gain. Our State Department of Health has received many reports of seniors who are in nursing homes or in home health care who have had their pain medications taken by unscrupulous workers, leaving them helpless and with uncontrolled pain. We have even had reports of nursing homes and their medication carts being robbed at gunpoint. One of my employees reported that a man brought his elderly mother, who he said was deaf and mute, to a doctor's appointment to get a refill of her pain medication. The mother sat in a chair, unresponsive to questions

throughout the visit. Worried that the woman was being mistreated and used by her son to get opioids, the employee asked Adult Protective Services to follow up on the patient. APS visited the home and found an alert woman who could hear and speak and who denied any mistreatment. We may never know if that woman was coerced or complicit in the scheme to obtain an opioid prescription.

In poorer areas, diversion has occurred not only by associates of seniors but by the seniors themselves. In some instances, seniors with legitimately prescribed pain medications have decided to sell those pills for financial gain. Others might fake pain to obtain a prescription that has a street value of nearly twice the Social Security check, which is about \$1,300 a month. One provider described to us a patient who showed up regularly for appointments, never asked for refills before the end of the month and didn't appear in the prescription monitoring program as someone with multiple providers or multiple opioid prescriptions. According to the provider, this individual was "an ideal patient." But then the provider did a urine drug test and realized the patient had no evidence of the drug she had been prescribed. She wasn't taking the opioids she had been prescribed for years.

This tendency to unquestioningly prescribe to seniors presages another risk seniors face in this opioid epidemic, drug poisoning. Drug overdoses are at an all-time high in Indiana and many other states, and seniors are not immune. While a majority of our overdoses can be traced to illicit drug use, many seniors are overdosing simply because of the aforementioned legitimate overprescribing that is occurring. Seniors complaining of pain are especially likely to be co-prescribed a benzodiazepine for anxiety and an opioid for pain. Unfortunately, both of these medications are addictive, and when combined, the chances that a person will stop breathing increase significantly. Seniors are dying in their sleep because they've taken too much medication, or the wrong combinations of medications.

As I've mentioned, robust prescribing guidelines can help providers determine who legitimately needs and is taking their medications. Increased enforcement of drug dealers can disrupt distribution rings and discourage people who seek to take advantage of seniors and of our Medicare and VA systems. In Indiana, we are also working to increase access to and use of naloxone, a medication that can reverse the effects of an opioid overdose. Currently, one person dies every 25 minutes of an opioid overdose. Many of those deaths occur because of heroin, but our Governor's task force heard a story from a police officer who had initially been reluctant to carry naloxone in his police car because he thought it was enabling drug use. The first person he saved was an elderly woman who had accidentally overdosed on pain medications she was taking legitimately. This illustrates the very real risks that our national opioid epidemic pose to people of all ages, but especially our seniors, who are often more likely to have powerful opioids in their medicine cabinets.

As we attempt to get a handle on the opioid epidemic, we must make naloxone widely available so that no one dies unnecessarily. In Indiana, naloxone is available not only to emergency medical technicians and law enforcement officials, but also to laypeople who may find

themselves in the role of first responder. “Aaron’s Law” allows Hoosiers to obtain a prescription for naloxone if they believe someone they know is at risk of an opioid overdose. Prior to this law, only emergency workers were allowed to carry naloxone. Governor Pence has since directed that all state agencies promote awareness of Aaron’s Law and encourage people to learn about naloxone. Our State Department of Health has developed a website called OptIN.in.gov at which entities can register to dispense naloxone and citizens can find a place near them that dispenses it. Hundreds of sites have registered in our state, and more than 5,000 doses of naloxone have been administered in Indiana. That’s more than 5,000 lives saved.

As states see record numbers of seniors who are addicted to opioids, we need to examine what resources we have to help people of all ages recover from substance use disorder. Indiana plans to open a new mental health hospital, is in the early stages of exploring a medical section 1115 waiver to access additional federal funds for addiction and recovery wrap-around services, and is instituting a “gold card” program to make it easier for physicians to prescribe substance use disorder medications. We are consequently seeing an increased awareness of the benefits of medication assisted treatment, and increased uptake by communities, and even law enforcement officials.

In summary, I always suggest three general areas that communities and policy makers should focus on to address the opioid epidemic and prevent its sometimes tragic consequences. These areas are: increasing awareness of community risk factors, increasing opportunities to break the cycle of overprescribing and addiction, and forging non-traditional partnerships. States need to be aware of not only their consequences, such as overdose, hepatitis and HIV, and incarceration rates, but also of the root causes, particularly who is prescribing and who is getting opioids. Increased usage of prescription drug monitoring programs has a proven track record of reducing prescribing and diversion of opiates. State and federal policy makers must intervene by encouraging prescribing guidelines and taking a hard look at national and federally endorsed policies such as “pain as the fifth vital sign” and the currently worded HCAHPS survey questions on pain, which are causing more harm than good. They must increase opportunities for substance use disorder treatment by adding providers, venues, and medications. And finally, we should all encourage non-traditional partnerships and collaborative efforts, such as our multidisciplinary task force, to attack the scourge that is our nation’s opioid epidemic.

Our situation in Indiana may be unprecedented in many ways, but in many others, it illustrates problems faced by much of our country. There is much to do, but we can make progress, and we must make progress, to protect our seniors and all who have fallen victim to this opioid epidemic.

Madame Chair, thank you for the time and the opportunity, and I look forward to your questions.

1. WISQARS - Center for Disease Control
2. Indiana State Dept. of Health - Epidemiology Resource Center
3. WISQARS - Center for Disease Control
4. <http://www.qualityreportingcenter.com/inpatient/iqr/events/>