

S. HRG. 114-853

**FIGHTING AGAINST A GROWING
EPIDEMIC: REDUCING THE MISUSE
AND ABUSE OF OPIOIDS IN AMERICA**

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BEFORE THE
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UNITED STATES SENATE
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TUESDAY, JANUARY 19, 2016

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 9:45 a.m., in 65101 Ballroom, Governor's Office Building, 200 Madison Street, Jefferson City, Missouri, Hon. Claire McCaskill, Ranking Member, presiding.
Present: Senator McCaskill.

**OPENING STATEMENT OF SENATOR
CLAIRE McCASKILL, RANKING MEMBER**

Senator McCASKILL. This hearing of the United States Senate Committee on Aging will come to order.

We will begin our hearing that is focused on the problem of opioid addiction in this country.

I am really happy to be here in Jefferson City. I spent a number of years here, working right down the street. I certainly sat through a lot of hearings during those years. This is the first time that we have had a field hearing of one of my Senate committees here in Jefferson City and I am very happy to be here.

I want to thank you all for coming out for this much needed hearing. I am proud to hold another Senate Aging Committee hearing in Missouri, this time in Jefferson City.

First, I want to thank my dear friend and Chairman of this Committee, Senator Collins. By the way, she is my dear friend and I think it is important to mention that because I think that there are a lot of people out in America that do not think any of us get along that are of different parties. That is not true. Susan is a Republican, I am a Democrat and we work closely together, and have throughout my time in the Senate, cosponsoring many pieces of legislation and now working closely together as the Chairman and Ranking Member on this particular committee. [dropped audio.] [continuing]. . . . program to prevent doctor shopping, control the. . . [inaudible] prescription drug abuse, and outline drug use and abuse trends to aid public health initiatives.

Tackling this complex issue requires a unified effort. I look forward to hearing from our panel of witnesses as they discuss their work to reverse this epidemic by reducing the misuse and abuse of opioids.

First, we have Dr. Bob Twillman. Dr. Twillman is the Executive Director for the American Academy of Pain Management. He is responsible for overseeing Federal and State pain policy developments and advocating for those supporting an integrated approach to managing pain. He also serves as the Chair of the Prescription Drug Monitoring Program Advisory Committee for the Kansas Board of Pharmacy.

Today, Dr. Twillman will testify on behalf of the Missouri Prescription Drug Monitoring Program NOW Coalition, a bipartisan organization composed of individuals, groups and associations that support a prescription drug monitoring program for Missouri.

Next is State Representative Holly Rehder. Representative Rehder is a Republican member of the Missouri House of Representatives, representing District 148, Scott and Frances County. She was elected to the State House in 2012. She has worked tirelessly to address Missouri's prescription drug abuse problem. She is committed to reducing the misuse and abuse of prescription drugs in Missouri.

She will discuss her efforts in the State House to pass legislation House Bill 130 that would establish a statewide prescription drug monitoring program in Missouri.

Dr. Paul Tatum is an Associate Professor at the University of Missouri—Columbia and the medical director for the Compassus Program. He practices in the area of family medicine, geriatrics and hospice and palliative medicine.

Dr. Tatum also serves on the American Academy of Hospice and Palliative Medicine Board of Directors. He helped write their guidelines for prescription drug monitoring programs.

Today Dr. Tatum will testify on behalf of the Missouri Hospital Association.

Dr. Maurice Redden is an Assistant Professor in the Department of Neurology and Psychiatry for the Division of Geriatric Psychiatry for the Saint Louis University School of Medicine. Dr. Redden specializes in psychiatric care for geriatric patients suffering from delirium, depression, dementia or other degenerative diseases, including Alzheimer's.

In that role, he works with older adults, specifically ages 65 and older, who are battling with illicit and licit substance abuse issues, and finally, Mr. Paul Walker is the Pharmacy Benefit Manager for Veterans Integrated Service Network 15 with the Veterans Health Administration. Mr. Walker will discuss the implement of the Department of Veterans Affairs Opioid Safety Initiative, which was developed to reduce the use of opioids among Americans veterans. OSI is a comprehensive effort to improve quality of life for veterans suffering from chronic pain. It emphasizes patient education, intensive monitoring with frequent feedback and complementary and alternative medicine practices.

Thank you all for joining us and we will begin with your testimony, Dr. Twillman.

**STATEMENT OF BOB TWILLMAN, PH.D.,
EXECUTIVE DIRECTOR, AMERICAN ACADEMY OF
PAIN MANAGEMENT, KANSAS MISSOURI**

Dr. TWILLMAN. Thank you. It is a pleasure to be here this morning.

Just by way of background. . . [inaudible] pain management.

The Academy is a organization in the country for pain management clinicians. Half of our 4,200 members are physicians while the others represent 30 distinct disciplines and all of them treat pain.

Since it was founded in 1988, the Academy has promoted a model of integrated pain management, recognizing phenomenon that is best addressed by a care team and a care plan that is multidisciplinary, multimodal and comprehensive in its approach to caring for each individual person in pain.

Today, in the United States, we find ourselves wrestling with two extraordinarily complex and stubborn public health crises. On the one hand, we have about 12.5 million Americans who report using prescription pain relievers non-medically each year, a costly and persistent problem that results in thousands of deaths.

On the other hand, we have chronic pain. By the Institute of Medicine in its 2011 report "Relieving Pain in America", it can affect more than 100 million American adults. Twenty-five million of those report suffering from daily pain and 10 million are disabled by their painful condition.

This problem costs our economy \$560 to \$630 billion per year, according to the IOM and brings with it a doubling of a risk of completing suicide.

The author H.L. Mencken said "For every complex problem, there is a solution that is neat, simple, and wrong." These are two complex problems, we may encounter twice as many separate solutions that are neat, simple and wrong, complex problems often produce negative unintended consequences.

In the case of these two problems. . . [inaudible] attempt to fix one problem makes the other problem worse.

Fortunately, there is. . . [inaudible].

I would like to talk very briefly about two of these. . . [inaudible].

Prescription drug monitoring programs, or PDMPs are state-run electronic data bases that collect, analyze and record information on controlled substance prescriptions dispenses to patients. This information is then accessible to prescribers and dispensers for use in the clinic, and to law enforcement and regulatory agencies investigating and adjudicating cases involving potentially inappropriate uses of these medications.

Forty-nine states, the District of Columbia, Guam, nine of 10 Canadian provinces, and one Canadian territory have PDMPs in operation or in development. The one place in this country that does not have a PDMP is Missouri. That is not because we have not tried to pass legislation to establish it.

PDMPs are useful in addressing both public safety and public health concerns. The public safety aspect involves feeding investigations involving controlled substances while deterring and detecting drug diversion activity. The most common form of this is

often called doctor shopping and pharmacy hopping where individuals obtain controlled substance prescriptions for multiple prescribers and fill them at multiple pharmacies so as to avoid detection.

PDMPs can be used to identify people's abuse and misbehavior so they can be investigated, evaluated, and treated appropriately.

From a public health standpoint, PDMPs enable clinicians to do two things: one to be reassured when prescribing for a new patient when the PDMP report says. . . [inaudible] appropriate behavior. Two, to detect behavior that may be indicative of substance abuse so that disorder can be diagnosed and treated appropriately, and three, to detect the presence of other prescriptions that, when combined with the new prescription, could produce a fatal overdose.

Missouri's failure to establish a PDMP undoubtedly contributes to increased rates of prescription drug abuse and overdose deaths and it undoubtedly makes it harder for clinicians to effectively treat pain and other conditions that require the use of controlled substances.

The second key solution, oddly enough, is treating chronic pain the right way. I believe that doing this not only improves the effectiveness of pain care received by each person with chronic pain, but it also reduces the risk of prescription drug abuse and all of the untoward consequences that result.

Every comprehensive guideline for treating chronic pain, the IOM's 2011 report, and the draft national pain strategy that grew out of it, all call for treatment that uses a comprehensive, integrated approach. This approach treats each person with pain as a unique individual and develops a pain care plan that is just as unique.

In addition to being individually tailored, these care plans use a variety of methods to treat pain, not just the procedures and the controlled and non-controlled medications that we commonly think of, but other types of care such as physical and occupational therapy, behavioral health interventions, chiropractic care, massage therapy, acupuncture, good nutrition and weight loss, exercise, and a whole host of other interventions.

We have lots of good research that says this approach is more effective and more cost effective. Importantly, it also reduces the need for opioid pain relievers, reducing exposure to them and thus, lessening the risk of developing substance abuse disorder.

Unfortunately, this type of care is not widely available and even less widely recommended by clinicians. Many of these non-pharmacologic treatments are poorly covered or not covered by third-party payers. For instance, Medicare limits the number of physical therapy and psychotherapy visits a patient can have. It covers chiropractic care, but only for certain diagnoses and only certain types of manipulations, and it does not cover acupuncture, biofeedback or massage therapy which the Department of Defense and the VA have endorsed as effective in treating chronic pain.

An additional barrier is a lack of education clinicians receive for these two health problems. The IOM report documents that the leading exposure to pain management for medical students is only 9 hours, while the Association of American Medical Colleges found

a median of only 5 hours on substance abuse with fully one-third of programs having no content at all.

Education on these two topics is necessary but not sufficient to change practice but it is necessary. Even if we are able to provide the comprehensive integrated care we need, an uneducated clinician is not likely to steer patients toward it.

Pain management clinicians and organizations want to be part of solving both of these public health crises. We are eager to propose solutions that address both effectively and we are eager to work with policymakers to craft policies that enable us to use those solutions. We think we have a good idea about what needs to be done, and now the challenge is making that possible.

Thank you.

Senator McCASKILL. Thank you, and before I turn to Representative Rehder, I would like to acknowledge the number of legislators that we have here this morning. If you are a member of the Missouri legislature, would you stand and introduce yourself briefly before we go to Representative Rehder's testimony?

Mr. LYNCH. Representative Steven Lynch. I represent the Fort Leonard Wood area.

Ms. LAVENDER. Representative Deb Lavender, District 90, Kirkwood, Missouri.

Mr. OTTO. Representative Bill Otto, the 70th House District in St. Louis County and St. Charles County.

Mr. KEAVENY. Senator Joey Keaveny. I am the Senator from the 4th District, St. Louis, Missouri.

Ms. MCNEIL. Margo McNeil. I am the State Representative from the 69th, which is part of the Florissant area, unincorporated, St. Louis County.

Ms. HUBRECHT. Tila Hubrecht, I am the Representative from Southeast Missouri District 151 and I also have a background in nursing.

Mr. BASYE. I am Chuck Basye, Representative from District 47, central Missouri including Boone, Howard, Randolph and Cooper.

Senator McCASKILL. I really appreciate you all being here—oh, I am sorry. I did not see you, sweetie.

Ms. MIMS. That is okay, I am from the best part of Missouri, South Kansas City. I am Bonnaye Mims, Representative from District 27 and I have a background in forensics.

Senator McCASKILL. Good to see you, sorry I missed you.

Anybody else?

[No response.]

Representative Rehder.

**STATEMENT OF HON. HOLLY REHDER, MISSOURI
HOUSE OF REPRESENTATIVES DISTRICT 148,
SIKESTON, MISSOURI**

Ms. REHDER. Thank you so much, Senator McCaskill, for having me here today and for your interest in this very important topic.

You have requested that I testify to the critical need for a PDMP, our efforts here in Missouri, my personal story related to this, and my commitment to reducing the misuse and abuse of prescription drugs in Missouri.

As you know, and we have already touched, Missouri is the only State that does not have this important program in place.

PDMPs have proven successful in curtailing drug diversion, increasing patient care and overdose rates. Since Kentucky's PDMP took effect in 2012, they have seen a decrease in doctor shopping by 52 percent. A California survey of physicians showed 74 percent had changed their prescribing practices to patients as a result of using their PDMP's patient activity reports. Since Florida implemented their PDMP, deaths related to oxycodone overdoses has dropped 41 percent.

With Missouri surrounded by eight states, we are not only harming their own population. My district is the majority of Scott and Mississippi counties down in the boot heel. My Charleston pharmacies are oftentimes the first stop for doctor shoppers coming from Illinois and Kentucky. My district is also only an hour from Arkansas, all states that have PDMPs in place.

My pharmacists, physicians, law enforcement, churches and social services department see the result of Missouri's inaction on a daily basis.

Our efforts to pass a PDMP in Missouri, I have been in office since 2013, fighting for this legislation. Representative Engler carried it even before my arrival while he was a Senator. Privacy concerns has caused threats in the Senate for a filibuster. Last year, 2015, the Senate did pass out a Senate compromise bill but once the fiscal note was completed, it had a \$6 million a year price tag and those in the trenches, our pharmacists, physicians and law enforcement, said it was not a workable program, so we were back to square one.

This year I filed House Bill 1892, the Narcotics Control Act. We changed the name due to many fear that prescription drug monitoring includes all of their medications and it does not. It is mainly those narcotics that are misused and abused, Schedule II through IV.

My personal story that is related to the need for this. I was raised on welfare in the drug culture, as many call it "the wrong side of the tracks." My mother had to deal with mental illness. One of my stepfather's was a dealer. My sister married a dealer at 16 and was a mainline addict. My cousin died at 39 from many years of drug abuse.

Right after I turned 15 we were in a terrible car accident and I was needed to help take care of my mother and younger sister. I dropped out of school, got married and pregnant soon after. At 15 I looked at my life. I was a pregnant high school dropout destined to raise my children in the same cycle of poverty and dependency, around the same type of people who harm others and children because of their drug abuse.

I went to work, working multiple jobs in whatever I could get hired to do. At 18 I took my GED and then took college classes when I could. It took my 17 years to finish my degree because I did it full time and raising a family.

My children have been raised in the same church, where we have attended for 27 years now. Through their lives, I have served as youth leader, Sunday school teacher, making sure they understand that God is the only reason their lives are different than many in our family.

My children were raised in a middle class home with two parents working and participating in their school activities, church activities and their lives in general. They came home to home-cooked meals at night and parents who knew where they were at all times.

At 17 my daughter worked in a local restaurant while attending high school and was an honor roll student. She was accepted to SLU, a very bright, positive, normal teenager raised in a two parent middle class home with many goals and dreams to become a pediatric physical therapist and live a successful life.

She cut her thumb opening a bag of okra at work and was sent to the ER to get it stitched up. There, they gave her a prescription of opiates for the pain. Once she ran out of that prescription she started buying them from co-workers. They were easy to get and seemed harmless since they were a prescription, and she loved the euphoric feeling.

That was 13 years ago. We have had 13 years of ups and downs, rehabs, prison, and my grandson born with opiates in his system. You see, the pills become too expensive because your body adjusts to them and you need more and more to stay at that euphoric level. Where heroin and meth might be the boogeyman to a teenager who has not experienced drugs, once they are hooked and cannot afford the pills, that is where they turn. Their mind is no longer afraid, and their body simply needs the opiate.

My daughter became a mainline user as well, meth, bath salts, whatever, to feel her need. My grandson, who I have guardianship of now, was pulled out of a meth lab at only 1 year old. He slept within a few feet of the shake and bake operation.

I tell you this story of both of our lives to show that drug addiction is no respecter of persons. It crosses all socioeconomic statuses. When you go into a high school and ask the kids what do you want to be when you grow up, their answers are a doctor, a lawyer, a nurse, a business owner. None say I want to be an addict. Yet, addiction is the growing epidemic of our time.

My commitment to reducing the misuse and abuse of opiates. I realize that PDMP is not the silver bullet. It is one major tool in our toolbox and I will continue to fight until we see it come to fruition. I am also working with the Recovery Network of Missouri to start a bipartisan recovery caucus.

Our goals are these: to enhance recovery outcomes in Missouri; to identify a Missouri solution to fund recovery support and services; to educate legislators on the needs and gaps in recovery services.

I met with several legislators from different states in D.C. last month. Their states all had active PDMPs and were on a phase two, per se, of their recovery efforts, working to identify addiction early, to put people back on the path to a health life, and curtail the state's costs by putting money into recovery efforts on the front side, versus the penal system which we know has a residual effect through social services and mental health departments.

In closing, we must change the face of addiction. That is why I am here.

Senator McCASKILL. Thank you very much for your brave. . . [inaudible].

I think we all—this is such a big problem that I doubt there is anyone in this room that does not have a story they can tell, a heartbreaking story, about someone that they love. That is how serious this problem is and we certainly respect your ability to tell yours. I congratulate you on your fight.

Dr. Redden.

**STATEMENT OF WILLIAM MAURICE REDDEN, M.D.,
ASSISTANT PROFESSOR, DEPARTMENT OF NEUROLOGY
AND PSYCHIATRY, DIVISION OF GERIATRIC PSYCHIATRY,
SAINT LOUIS UNIVERSITY SCHOOL OF MEDICINE,
ST. LOUIS, MISSOURI**

Dr. REDDEN. Good morning, Senator McCaskill, and thank you for allowing me to speak about the rising epidemic of illicit and licit substance use and misuse among older adults.

As previously stated, I am a geriatric psychiatrist at Saint Louis University School of Medicine.

This issue is of particular concern to me both as a clinician and researcher because of my interest in overall mental health and ways to improve cognitive function in late life. One way to do this is to address any potential risk factors that can be removed or modified, including substance use and misuse.

Historically, substance abuse has been considered a problem affecting younger adults that was thought to decrease as one ages. In my experience as a clinician, I have begun to encounter patient abuse of both illicit and licit drugs more often. The main illicit substances include marijuana, cocaine and heroin. However, an often overlooked problem of prescription, non-prescription and over-the-counter misuse of drugs is also on the rise.

The pattern of use can appear in early onset and late-onset users. The former describes individuals with a long history that persists as they age, while the latter includes individuals who develop a new habit in late life. Some of the risks factors that lead to new onset or continued use in the elderly include social isolation, financial difficulties, and poor support systems. In most instances, there may be mental health conditions that have not been properly diagnosed and/or treated.

When older adults use illicit and licit substances, even in small amounts, the negative effects can be magnified. In addition, one-third of elderly patients take, on average, five prescription medications daily. This increases the risk of drug interactions, which can complicate medical problems. This all leads to increased emergency department visits, as well as prolonged hospital stays.

For the sake of time, I would like to focus more on the rise of opioid use, which include both heroin and prescription opioids. One of the driving forces in this rise has already been mentioned, which includes the increased prevalence of chronic pain. Prescription opioid medications have been the most prevalent treatment options. When these options are not available, older adults have resorted to using someone else's prescription, buying medications off the street or straightforwardly using heroin. They have also been known to doctor shop in order to acquire more medications than actually needed.

The overuse and misuse of opioids is of particular concern to those in the mental health field because it can lead to suicide by

self-poisoning. The same factors that lead to drug abuse, which include social isolation and mental health illness, also are risk factors for suicide, and now with the increased distribution of prescription opioids, this vulnerable group has lethal means to carry out the intent.

Screening of the elderly, however, is very difficult as most available screening tools have been designed for younger patients. Recently, the DSM-V has been updated and the diagnostic criterion is called substance use disorder instead of abuse and dependency. However, relying solely on this diagnosis and criterion may exclude elderly patients.

One of the key features of substance use disorder is tolerance. Due to the age-associated physiologic changes that increase the effects of even small amounts that may be more pronounced in the elderly, making the diagnosis of substance use disorder extremely difficult.

The first step in recognizing elder drug abuse as a problem is to consider it a possibility. As clinicians, we are often pressed for time, but there are screening tools, such as CAGE-AID, which is alcohol and illicit drugs, are designed to help began the discussion.

Once elderly patients have been identified as having a substance use disorder, treatment interventions need to be tailored to meet the needs of this unique group. As such, medications that are typically used in younger patients may not be suitable for older adults. Therefore, risk versus benefit analysis needs to be made before seeking such options.

There is still some debate on whether elderly patients should participate in inpatient-treatment programs that are specifically geared for younger people. However, sometimes integrated programs may also be beneficial. In choosing appropriate programs, other factors should be considered, such as comorbid medical and psychiatric conditions that need to be addressed during treatment.

Another tool that every other State has enacted, that has already been mentioned, is prescription drug monitoring program. These programs vary across settings, but the main purpose is to detect and reduce diversion, abuse and misuse of schedule II prescription medications, such as opioids. Hopefully in the future, this will include all prescription medications that have high abuse potential such as benzodiazepines.

Prescription drug monitoring programs have shown to reduced over-prescription and doctor shopping by patients. They have also helped identify any suspected fraudulent prescribing or illegal activities of the dispensing of controlled substances, so therefore, in conclusion, substance abuse in the elderly is a growing problem and includes both illicit and licit substances. The identification of substance use is difficult, but first has to be acknowledged as a real possibility. Then, an assessment that is respectful and non-stigmatizing can be approached.

Clinicians should be mindful of the roles of comorbid medical and psychiatric conditions when diagnosing and treating elderly patients who exhibit symptoms of substance use. The over-prescribing of opioids for the treatment of chronic pain can contribute to this problem; however, having deterrents in place such as a prescription drug monitoring programs and utilizing other methods to treat

chronic pain can help clinicians to combat this devastating problem.

Thank you for time and efforts in addressing this growing concern of me and my colleagues.

Senator McCASKILL. Thank you, Dr. Redden.

Mr. Walker.

**STATEMENT OF PAUL WALKER, PHARMACY BENEFIT
MANAGER, VETERANS INTEGRATED SERVICE NETWORK 15,
VETERANS HEALTH ADMINISTRATION, UNITED STATES
DEPARTMENT OF VETERANS AFFAIRS, WASHINGTON, D.C.**

Mr. WALKER. Good morning, Ranking Member McCaskill.

I appreciate the opportunity to discuss prescriptions and the safety initiative currently being implemented by the Department of Veterans Affairs.

The 2011 study by the Institute of Medicine established chronic pain as a serious health issue in America. Particularly, the study recognized that 60 percent of veterans returning from combat theaters in the Middle East and 50 percent of VHA-enrolled veterans suffered from a form of chronic pain.

Veterans suffer from multifaceted conditions, unlike counterparts in civilian hospitals. This involves battlefield injuries encompassing musculoskeletal and nerve systems. These impediments may be coupled with traumatic brain injuries. Traumatic brain injuries have lasting effects to overall brain structure and emotional health. This can independently increase the risk of substance abuse disorder.

It is well documented that uncontrolled pain, coupled with functional impairments, leads to a decreased quality of life. These conditions greatly increase the risk for overdose, substance use disorders, and consequently, suicide. The complexity of multiple conditions makes the accurate delivery of pain management challenging and intensifies risks of complications due to over-and underuse of opioid... [inaudible] therapies. In as much, veterans continue to call upon VA clinicians to alleviate their pain.

This country is now in the midst of an epidemic of misuse and overuse of opiate medication. The appropriate use of opioids is particularly important for VA due to the number of veterans who have musculoskeletal injuries and permanent nerve damage.

Shifting our prescribing practices has required a cultural change and changes to the modalities we use for pain management. This implemented approach is twofold. First, we immediately address the issue of inappropriate high dosage of opioid medications. Second, we develop an effective system of interdisciplinary pain management to provide safe and effective pain control.

To address the varied discretion in opioid prescribing, VA developed the Opioid Safety Initiative, or OSI. OSI was designed to make opioid prescribing visible throughout the VA. This platform includes key clinical indicators, such as the number of unique pharmacy patients dispensed opioids, unique patients on long-term opioids who receive urine drug screens, and the average morphine equivalent daily dose of opioids.

The system analyzes prescribing practices and provides feedback, ensuring opioid prescriptions are disbursed effectively and judi-

ciously. This system has demonstrated considerable promise in minimizing harm and promoting safe, yet effective, pain care.

After a brief pilot period, the VA implemented the OSI system nationwide in 2013. To monitor the impact, quarterly OSI trending data is circulated through VA medical centers, network offices, and the VA Central Office. Facilities with data outliers are required to submit action plans to VA Central Office. This monitoring is continued until data outliers have been resolved. The recent data results demonstrate the level of achievement obtained by utilizing this system.

VA facilities throughout the Missouri region, where 19 percent of chronic opioids are above the age of 70 years, we have reduced the number of veterans on opioid-based medications by 21 percent. The number of veterans on both an opioid and benzodiazepine medication has decreased by 47 percent. Last, we reduced the number of veterans on high dose opioids by 37 percent.

The OSI initiative has been augmented by deploying the Opioid Therapy Risk Report. This additional practice protects veterans using high dose opioid prescriptions or with risk factors placing them at risk for complicates. The report, used nationally, allows clinical staff to view narcotic and sedative dosage information and medical diagnoses. This all-inclusive data platform provides an efficient veteran-centric approach previously unavailable to primary care providers. VA continues to distribute training aids promoting the use of the system in daily practice.

Overall, we are proud of our advancements in promoting opioid safety, particularly in the State of Missouri. VA remains dedicated to providing the best care to veterans and continues to research innovative methods to continue this progression.

This concludes my testimony and I look forward to any questions you may have.

Senator McCASKILL. Thank you.

Dr. Tatum.

**STATEMENT OF PAUL E. TATUM, III, M.D.,
ASSOCIATE PROFESSOR, DEPARTMENT OF FAMILY
AND COMMUNITY MEDICINE, UNIVERSITY OF
MISSOURI-COLUMBIA, AND MEDICAL DIRECTOR,
COMPASSUS, COLUMBIA, MISSOURI**

Dr. TATUM. You know, before I begin, Representative Rehder, thank you for sharing your story. That was so powerful and brave. Thank you.

Senator McCaskill—

Senator McCASKILL. Would you pull your microphone a little bit closer.

Dr. TATUM. A bad combination of a geriatrician taking care of older adults who have hearing problems and a low talker. Is that adequate?

Senator McCASKILL. That is great.

Dr. TATUM. Thank you.

Senator McCaskill, thank you for so much for scheduling a public forum on opioid abuse among older adults. I find today's topic so important both from a national, public health standpoint, but also for me personally, as a physician, this impacts me day-to-day, but also my family's experience.

I have seen both the terrible toll of misuse of pain medicine, and I have also seen the tremendous relief they can bring when used appropriately to allow a person bed-ridden with cancer pain find the relief to spend their 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 of mine. As a physician who has had additional training in both geriatrics and palliative medicine, I am often asked to help doctors with difficult pain cases. I remember a patient with severe pain, as well as limited life expectancy. In the hospital, our teams' recommendations made a big difference. He left, he went home doing better. I was surprised to hear, in fact, later on he had died much earlier than we would have anticipated. I reviewed his meds and they seemed appropriately dosed. I was devastated to learn from autopsy that he had not one but multiple duplicative pain medications in his system provided by multiple 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 adults. The CDC has declared pain medicine misuse and the deaths associated with it an epidemic.

The common factors the CDC finds in deaths from opioid include: prescriptions at very high doses, and I am pleased to hear the VA's efforts to really impact that, prescriptions from multiple providers, and finally, a mixture of opioids with other medications. We have heard the impact you guys had on benzodiazepine sedatives, one of the major medicines.

In my experience, another factor this Committee in particular can help policymakers understand is the underappreciated fact of just how complicated opioid prescribing is for older patients. Physicians, despite their training in pain management, and we heard limited numbers of that from Dr. Twillman, have not been well trained in geriatric medicine and the necessary adjustments for patients as they age. Due to the physiologic changes associated with aging, a standard dose is too strong for older adults, and the body 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. I think your committee can really make a statement on that.

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

The good news is that physicians and organizations are working to make opioid prescribing safer. I would like to share with you the Missouri Hospital Association—I may refer to it as MHA's—re-

sponse. The Missouri Hospital Association noted between 2005 and 2014, hospitalization for opioid overuse has increased 137 percent in our State. At the University of Missouri we found that the impact of overdose is particularly serious for older adults. Unlike younger adults, the seniors admitted with an overdose had twice the need for intensive care unit admission. This has real impact.

The MHA had partnered 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, importantly, the Missouri Dental Association. They felt, in the coalition, that steps to reduce misuse and abuse in emergency room prescribing practices was a key initial step.

Based on national guidelines and evidence the coalition put together emergency department protocols which include that a comprehensive pain assessment plan is a key part of the emergency physician's work before prescribing. The diagnoses are made on evidence-based guideline. Especially important, non-narcotic treatment should be given for non-traumatic tooth pain. A huge impact on emergency rooms when people come in asking for pain med.

When possible, the emergency department should coordinate with the opioid prescriber when people come in asking for additional adjustments in meds, and that the emergency room prescribers should limit their prescriptions to 72 hours, then coordinate with the primary care physician, as well as other protocols, and importantly, the policy also asks for emergency departments to partner with other health officials to make naloxone available for dispense in pill form.

The good news is physicians are thinking about how to solve this on a national level. The AMA, 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. They have five: increasing physicians' registration and use of effective PDMPs, Prescription Drug Monitoring Programs; enhancing physicians' education on effective pharmaceutical prescribing; reducing the stigma of pain and promoting comprehensive assessment, not just pills; but also reducing the stigma of substance use and enhancing access to treatment of substance abuse, and then finally, the AMA again endorses access to naloxone in the community, but in closing, the other story that is so important is that of my father. My father died of a rare disease in a small town in East Texas. During his last days, as he writhed in pain, my mother was told, "I am sorry, we cannot give him morphine. That might kill him."

We have a public health crisis that demands response both to prevent unnecessary deaths to prevent them, but also a response to meet the true pain needs, which are often untreated or under-treated.

My colleague, Dr. Smith at UCSF and his colleagues, found 25 percent of older adults have significant pain in the last 2 years of life, rising to as much as 50 percent in the last year of life.

As we think about policies to reverse the opioid epidemic I think this Committee is especially positioned to help older adults. Speaking personally as a geriatrician, I think a key policy need is to improve geriatric medical education for all practitioners, and improve care coordination, in particular, between practitioners, other health care workers, hospitals, pharmacists and patients and their 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, or PCHETA, which actually create regional centers that improve care of the seriously ill and enhance end-of-life education, which is a gap in some of our physicians, but foremost this is about safety and real suffering. With your supportive actions for enhanced practitioner education in geriatrics and pain management, as well as systems which really help coordination, I think we can simultaneously reduce the prevalence of opioid addiction, reduce the harms from opioids, while ensuring that older adults who do have significant needs receive adequate and appropriate pain management and avoid unnecessary suffering.

Thank you for having us here today.

Senator McCASKILL. Thank you.

I think it is true that with older Americans, especially those who have diagnoses of a terminal illness, where the medical protocol acknowledges chronic pain associated with that, that is obviously not a problem, but let me just start with a global question to the doctors, the medical doctors, and to Dr. . . . [inaudible] on the panel. We are prescribing, by multiples, more narcotic pain medication in American today than we were 40 years ago. My multiples. Now, are we in that much more pain? I mean, you know, I do not understand what happened that all of a sudden America had so much more pain than we had 40 years ago.

I want to figure out, was this a solution looking for a problem and driven by the pharmaceutical injury and doctors that were not paying attention? Or did somehow, all of a sudden, America had more pain?

Dr. TWILLMAN. If I may, I think it is, as usual, not a simple answer to that question. Part of what happened—

Senator McCASKILL. I am afraid it is. Money.

Dr. TWILLMAN. Well actually, there is an element of that involved. One of the things, I talked about the sort of comprehensive care that we need to provide for people who have chronic pain that is not necessarily related to a terminal illness. If you go back 30 or 40 years in this country, we had a lot of programs that were set up that way. They were very—people would come in, they would be assessed by a number of providers with different perspectives, they would put together a comprehensive plan, and the data showed that that provided better pain management at a lower cost and got more people back to work than the traditional approach that we have now, which is prescribing medication after medication after medication.

The problem is insurance stopped paying for that, and so those programs went away. I think the numbers are something like they

went from 1,000 programs to 80 programs in the course of less than 10 years.

What happened is now physicians are reimbursed for having a very brief visit with a patient, for spending 15 minutes or less with every patient that is in the room with them, and the fastest way to get somebody out of the room is to write them a prescription and hand it to them like it is their ticket to get out of the room.

Unfortunately, what we have come to is a system that reinforces that kind of behavior and does not provide us the kind of reinforcement we need to give the care that we need to be giving.

Senator McCASKILL. Is that an accurate assessment, Dr. Redden and Dr. Tatum?

Dr. REDDEN. Yes, I would agree with that also. I do not prescribe a lot of opioids as a psychiatrist. I do mostly benzodiazepines, which are in the same category.

Fortunately for me, I am at an academic institute and my time slots are. . . [inaudible] so I have 25 minutes to fully assess a patient. I have colleagues who are chiropractors who get paid by the number of patients that they see versus the quality of medicine that they provide to the patient, so as he said, the easiest way to get people in and out is just to prescribe a medication without doing a full assessment.

Senator McCASKILL. I was never offered a narcotic pain medicine at the dentist 30 or 40 years ago, I am that old. I am older than dirt. I am now. What is up with that? Why would her daughter be given a narcotic pain medication for a cut on her hand? I mean, this is not chronic pain. This is episodic pain.

Dr. TATUM. I think if all you have is a hammer, everything looks like a nail, and I think that it is true that the patients who are on the older side, with multiple chronic diseases, as you go through severe arthritis where you no longer may be operable, opiates remain a potential tool, but there is a wonderful study just in the last few months in the Journal of the American Medical Association looking at back pain. It suggests if you compare standard regimens versus opioids, simple old-fashioned anti-inflammatories probably have better outcomes over time, and the problem is once you have started a prescription, it is—a subset are going to remain on it.

Senator McCASKILL. Of course, they are.

Dr. TATUM. I think the fact of—

Senator McCASKILL. It feels really good.

Dr. TATUM [continuing]. the matter is if you ask physicians and look at it from a physician education standpoint, as Dr. Twillman pointed out, they think that pain management, in some sense, has a short shrift in terms of the complexities and nuance. At the same time, culturally we have this move to pain as the fifth vital sign.

You know, to me, as you mentioned, chronic pain is cancer pain. There is pain at the end of life, which is one thing, and you treat that pain. A subset of chronic, non-malignant pain I think we need to think about is not what is your pain score? Certainly not a quality metric that might impact reimbursement if you did not get to a certain quality score. The real question is did we improve your function and your well-being?

A wonderful book by Eric Cassell, "The Nature of Suffering", describes in the beginning a person who has come in multiple times, seen multiple doctors again and again and again for pain, a back pain in particular, a younger person, and her suffering was, in part, what was this? The simple process that he recognized her pain was two levels above where everybody had shot an x-ray and found she had a compression fracture and a wedging down of the back vertebra from a trauma she had, and by naming it, what relief that brought to her.

I think Dr. Twillman has mentioned how complex systems, not just another pill, is the key. We need more than just the hammer.

Senator MCCASKILL. Why are not doctors offering a—by the way, I have some outpatient surgery coming up, and I will say for the first time a doctor said to me I will write you a pain medication if you want it, but most people find that Advil works just as well. That is the first time that has ever been said to me, but he still did not say by the way, that prescription, if you want it, it is addictive.

Why are doctors not telling patients that what they are prescribing for them is addictive? What is that not said? Nobody says that. Do you say, this is addictive when you prescribe opioids to patients?

Dr. REDDEN. I do when I prescribe benzodiazepines. I said I am not in the habit of prescribing opioids, but with benzodiazepines, I let—I also see younger patients—I let all my patients know that it is habit forming and that you can develop a physiological dependence where your body needs it, and a psychological dependence where you feel you need this, and often it starts with someone like you, getting a benzo or an opioid for short-term use and they like the feeling and they begin to seek it more and more, for whatever reason, and then they are on it for the rest of their lives. I see patients that take opioids when they are young and they come see me at 60 and 70 and they are wondering why they are not thinking right, why other mental health issues are going on, and no one has addressed that problem.

I do not know, I think it is lack of medication education, especially from medical school up into residency with focus on other things and they often do not want to make the patient feel bad either. If someone admits they have a problem, that may make them feel shameful or have that measure of stigma attached where they may not want to seek out help or treatment anymore.

I do not know why others—

Senator MCCASKILL. I certainly understand that in the psychiatric field. We have stigmatized mental illness in this country to the point that we are all suffering from it, but what about doctors that for—why are they not telling patients that these drugs are addictive?

Dr. TATUM. You know, I have a funny alternative take. I think you are right that that is a key issue.

The funny alternative, as a geriatrician when I think it is very appropriate for someone to have an opioid, if I do not address addiction with an 80-year-old, they are so afraid of it, they are never going to take a pill that might be very appropriate for them.

I think one of the real challenges is we do not have great tools that help screen for a person who is going to be a risk abuse. I think a PDMP is one part of that. I think the future, if I can think what NIA can accomplish with research in the future, would it not be amazing if, with personalized medicine, I could do a drug test before I prescribe an opiate? Would it not be amazing if with that blood test, number one, I can see the type of receptor that person has and know which ones are going to cause side effects to avoid versus which ones. . . [inaudible] even more importantly.

We are not anywhere near that. This is a dream. Would it not be amazing in personalized medicine if I could say this is the person who is going to be addicted? I think there is so much potential and research and, in particular, that is an exciting thing to think about in the future.

In the hear and now, I think it is a challenge, and the key thing that would help me in the short term in our local State, is a PDMP so I can recognize the person who has addiction issues up front. Partly, so I can refer them for treatment.

Senator MCCASKILL. By the way, the people who are addicted, it is always 10. I mean, they are trained to come in and say my pain is a 10, my pain is a 10 plus, my pain is a 10 plus. Now I do not know what asking somebody who is addicted what their pain is accomplishes.

Dr. TATUM. A Marine whose pain is a three is a problem.

Senator MCCASKILL. Right.

Representative, talk a little bit about your legislation. Why don't you take a stab—I would do it, but I would like to hear it from you instead—about this paranoia about people's privacy. That seems to be the problem.

Ms. REHDER. Yes, ma'am.

Senator MCCASKILL. To me it is an irrational paranoia, but why don't you address that so that we have it in the hearing record. You know, when 49 states have done it and one has not, my Missouri common sense tells me we are the problem, not the 49 other states, so why don't you help out with why this is not going to violate people's privacy as it relates to their health records.

Ms. REHDER. Yes, ma'am. Thank you.

I look at this as an extension of electronic medical records. This is something very less invasive than electronic medical records. It is housed with the State, and just as Missouri HealthLink has never had a breach, nor have any of the other PDMPs. California implemented theirs in the late 1930's.

I think, since there has not been a breach in all of these years, we already have a smaller PDMP working in the State that has never harmed anyone with our Missouri health plan, with our Medicaid, so to me, the privacy issue that continually gets brought up is just a red herring.

We have—PDMPs fall under HIPAA laws and so they are just as safe—your electronic medical records—they are just as safe. They are just an extension of that, and many people get their prescriptions filled at Walmart. Walmart has a national PDMP of their own. Walgreens, the same.

The small pharmacies are the ones that, you know, the single-owned pharmacies. They cannot look to see what you have gotten.

Walmart cannot look to see if you have gotten something from the pharmacy across town, and so that is the only element that we are trying to pick up, and so your doctor can look on the front end and say okay, what we actually need to be talking about is your addiction and address addiction on the front end, and so to me the privacy issue is just a red herring. That is something that has been thrown in here to say the sky is going to fall when it is not. It has not fallen and these have been in place in some form since the late 1930's.

Senator McCASKILL. Mr. Walker, I assume that our heroes and our brave and amazing men and women who have stepped across the line and said take me, we do have a PDMP for our veterans; correct? I mean, we know if veterans—with the veterans system, you can track the use of opioids?

Mr. WALKER. Yes, within our electronic health record we are able to track the use of opioids. We also have some——

Senator McCASKILL. Have any of the veterans complained to you about violating their privacy as it relates to that?

Mr. WALKER. No, and we also have the ability to have links to the Department of Defense, in terms of medications patients are on when. . . [inaudible]. We do have comprehensive medication information available through our electronic health record.

We also have our—recommend to our providers and our health care teams that they do access the State PDMPs. That is one of our universal precautions, in terms of our Opioid Safety Initiative, and so within our network we do have providers who access, and health care teams, access the information from the State of Kansas, the State of Illinois, and possibly from the State of Arkansas, and we also have, in the State of Missouri, the Missouri VA facilities that border those states and they actually do make some queries to those states to try to find out if the patients are taking any medications from other sources or other pharmacies outside of the VA.

That is considered to be an important part of our universal precaution, the process. . . [inaudible].

We also have, as part of our universal precaution, doing routine and periodic urine drug screens, and we also, for all of our patients that are on chronic opioids, and we have a definition of that, more than 90 days. They have to have a consent done, and within that consent, we talk about taking opioids responsibly, and that is really the starting point, to have that conversation with the patient or with their family, to start to talk about what are realistic expectations in terms of what medications can help you, what are other alternatives, and then that is kind of the starting point for a shared decisionmaking with our veterans in terms of deciding okay, what is going to happen with their pain management in terms of whether it is opioids or they are going to be referred to an interdisciplinary team for pain management to have access to other integrated health-type services, to help the veteran self-manage their pain in their lives and how they react to it, so those are all things that are readily available through the Department of Veterans Affairs.

Senator McCASKILL. You would be a good person to start with on this. The other flip side of this is when either the VA system or a doctor or an emergency room recognizes that someone is an

opioid addict and they sound the alarm and cut them off without appropriate care for withdrawal. Can you all address?

I was talking to Representative Lavender, she has a constituent where that happened to a woman where the doctor said we are cutting you off, that is it, without any kind of medical plan for the withdrawal. I assume that you all are aware that that can be as dangerous—that is where the heroin comes in if the plan is not one that is sound and that the patient buys into.

Dr. TWILLMAN. I tell practitioners that I think that is malpractice to do that. There has been a big push to have patient agreements where patients who are on these medications sign agreements and say I will do certain things, and oftentimes those are written in such a way that if they violate the terms of that, the consequence is to stop all of their therapy. I think that is malpractice, because what has happened is you have just identified a new medical disorder, the disorder of addiction, and that needs appropriate treatment. Appropriate treatment is not cutting somebody off and kicking them out the door. Appropriate treatment is finding somebody who can treat that person appropriately for their disease of addiction.

Most often, the most effective treatments are some sort of medication-assisted treatments with methadone or buprenorphine products, and that is what needs to be done. People need to understand that that is the appropriate treatment for that disorder.

Senator McCASKILL. Do you believe that there is an increase in the prescriptions being given in more reasonable amounts for—this is really more ER than it is—or orthopedic surgeon, the—I remember when I finished having my knee replaced. Well, I had a whole bunch left over and I was not interested in them. I was wondering why they prescribed so many. I think the doctor gave me like 90 days or something for a knee replacement, or the dentist wanting to give a patient 30 days after a trip to the oral surgeon. Why not three pills? Why not four pills? Why is it typical that it is 30 or nothing, or sometimes even more than that? Is that something that has just been traditional in medicine, and prescribing just a handful of pills does not happen?

Dr. TATUM. I think this is a critical issue because I think of the young child who starts the pathway to addiction is often not that they received the prescription. It is that they got grandmother's prescription.

Senator McCASKILL. Right.

Dr. TATUM. I think that you learn the pharmacology—

Senator McCASKILL. That happened in my family, by the way.

Dr. TATUM [continuing] but the real world practice, frankly, is doctors learn from another doctor how to put the number on the pulls as they are writing the script the first time is not a good process, and I think as we start speaking more and more to the issue of opiate abuse, I think you are seeing efforts. You are starting to see efforts in Massachusetts on issue about the—cutting back on the number of prescribed—Missouri Hospital Association statement really speaks for emergency room physicians, in particular, limiting that to a 72 hour supply.

The danger, I think the danger in particular was in a South Carolina response, if you so limit the number and do not appro-

priately describe the physician you are talking to, they have the potential to make it very hard for a hospice physician who might take care of a very large rural area to be able to prescribe medication for that person where they may not be able to physically see them for a week or so because it is the nurse seeing them.

Senator McCASKILL. I see.

Dr. TATUM. I think the smart policy is education to help physicians limit the number down, limits particularly in the emergency room that are smart precautions. I think Texas had some good examples in their legislation about making smart exemptions for say palliative care patients and hospice patients.

Senator McCASKILL. Maybe the most important—I am sorry, did I interrupt you?

Dr. TWILLMAN. Sorry, Senator. I think there is a piece of research here that also would be very helpful to us and it would be easy to do and inexpensive to do.

My wife had arthroscopic knee surgery and was prescribed 80 Percocet tablets for that, and took 2.5.

What is happening is people are prescribing so that the patient never runs out of medication and needs a second prescription. They are estimating what that patient, whose need is at the 99th percentile, is. I think most of them do not know what the average patient uses because I think when people come back for post-op followup appointments they never ask the question, how much of that medication did you use?

Senator McCASKILL. Right.

Dr. TWILLMAN. It would be really simple for something like Medicare or Medicaid, where you have got the prescription records, to simply contact the patients afterwards and say how much did you use? If we found out that the average number used was five pills, maybe we would not be prescribing 80.

Senator McCASKILL. Yes. Well, that is a good idea for Medicare to take a look at. There is an awful lot of joint replacement going on in the Medicare population, a lot of hips, a lot of knees, a lot of shoulders. That would be a reasonable place for us to do the research about the average amount that is used.

Maybe the most important question I need to ask is for. . . [inaudible] this is the Committee on Aging, and I certainly know that there are lots of elderly out there that are addicted to opioids. What are the things I need to know? Obviously, if I could wave a magic wand and put a certain Senator locked in a closet, we could get this done in Missouri, but I am pretty sure that the law enforcement representatives that are here would have to arrest me for that, so that would get ugly and it probably would go viral.

I am not going to do that, and we know that is the obvious. That is the low-hanging fruit here, is for Missouri to join the rest of the country here in doing a basic, simple, common sense thing, but what are the things that we could be doing at the Federal level, both through the Medicaid and Medicare population, and through NIH, and through the ability to proscriptively change the Medicare program. Give me good ideas of what I can take back to Washington this afternoon and share with Senator Collins that perhaps we should take a closer look, a more detailed look, at a part of this

in a hearing in Washington where we could look at perhaps some legislation that might be helpful in this area.

Dr. TATUM. It is funny, in the Show Me State, the good thing is we have let 49 other states do this, so we will learn from their best practices. I think a Federal piece about absolute best practices on PDMPs would be very helpful, particularly as we build one here. Let us do it right because everybody else has done what is wrong.

The second piece, and looking at our State, if you look at hot spots about where the addiction issue is, the hot spots of opioid issues, really St. Louis and Kansas City are part of that. A Federal solution, with appropriate privacy safeguards, I think is the interoperability where one state's PDMP can talk to another's so that my patients—if I were in St. Louis or Kansas City—actually got their prescriptions also in Illinois at the same time.

I think a third key Federal response that comes to my mind is, again, the opportunity to really enhance geriatric education for this Committee, as mentioned.

Senator MCCASKILL. We have got a shortage of geriatric help in this country right now. John Morley is my husband's doctor and when I go to appointments I have to bring a lunch.

Dr. TATUM. Sadly, Dr. Morley is not shy.

Senator MCCASKILL. Dr. Morley will never let me out of the room until he explains to me the crisis facing America in terms of a lack of doctors ready to care for my generation, that geriatric medicine is not one of the big money glamorous specialties and we are sorely lacking geriatric professional medical help in this country.

What can we be doing, through the Medicare program, that would help with this problem of just having enough doctors that have enough time? Is it reimbursing the doctors more for their time with patients as it relates to preventative care?

Dr. REDDEN. Yes. We have a record system and within that we have measures to do certain screenings. I always get things, I do not do tobacco screenings, someone else can do it, but if we had screening measures of any substance abuse that would come across that would affect someone's pay or—we get paid through RVUs—if that would affect that some kind of way, many doctors. . . [inaudible] and start there.

Another thing I wanted to add is once you identify someone with substance use disorder, especially the elderly, the treatment options are very limited and treatment places to go for the elderly are very limited. Programs are always geared for younger adults, mainly with alcohol, and studies generally exclude elderly patients, 65 and up.

Senator MCCASKILL. Yes, that is really interesting. I had not thought about that. The treatment facilities are geared toward 18 to 35, not for 65 and older.

Dr. REDDEN. Who also may have some cognitive impairments. You have to tailor programs specifically geared toward the elderly, as well. That is something that can be done—

Senator MCCASKILL. Are there any elderly drug treatment programs in Missouri?

Dr. REDDEN. None that I know of, specifically in St. Louis. Everyone, especially my older patients who have problems, have to go with the younger people, the younger patients, and they also worry

about taking their medical medications and having those conditions addressed and most of the programs do not have doctors onsite on a daily basis, so they worry about that, as well.

Senator MCCASKILL. When you identify somebody who is addicted to opioids and they are, say, 72 years old, you have really no treatment options, especially if they have chronic conditions of other types?

Dr. REDDEN. Right, other than—

Senator MCCASKILL. Diabetics and heart disease.

Dr. REDDEN. Right. Usually detoxing is very hard also, to bring them to the hospital and God forbid, have some insurance cover that. If they understand that this is a chronic problem, nothing acute going on, then they are not reimbursed, as well, so oftentimes, the medical side may to get rid of them quicker. We have been facing that problem, as well. There is no sites, intense outpatient programs specifically for the elderly with substance abuse. . . [inaudible].

Senator MCCASKILL. Derron, we have got to—one of the things we need to—this is Derron Parks. Raise your hand. Derron is my Staff Director for the Committee on Aging.

We have got to get national statistics on drug treatment programs for the elderly, because there is not one in Missouri. I bet you there are a bunch of states where there are not any, because if there were one in Missouri, you would know about it; right?

Dr. REDDON. Correct.

Senator MCCASKILL. You know, it is funny, reimbursing—you know, this is a dangerous area to go down because I want to take this just because I like to explain this to folks.

The irony about the death panel controversy on the Affordable Care Act, that irony was so rich because all that was was reimbursing doctors for the time they spent with patients and their families explaining end of life decisions. We were going to pay doctors—right now, doctors are not reimbursed for the time they take to explain nutrition, hydration, those issues that occur at the end of life, and of course, when someone is there, usually they are not able to weigh in, so you have family members making very difficult decisions about continuing life support, whether it is hydration, nutrition or actually oxygen, without the benefit of having input from their loved one, and that is why we have these incredibly high costs near the end of life, because the loved ones do not want to make that decision for the person who is no longer capable of making it, so it just makes sense that if you can talk to your doctor about it when you are able to make those decisions, and then memorialize them so your family understands—I was lucky. My mother did that. She beat in our head a million times, if you put me on a breathing machine, I will haunt you until the end of time. If you put me on a feeding tube, I will haunt you until the end of time, so our decision was easy for my family, but reimbursing doctors for that time they spend with the elderly making those decisions, that is all it was. That is all it was, and we had to get rid of it because it became so controversial because the doctors were turning it into people who were telling people it was time to die. Of course, that is not what the doctors were doing, so it is another way we need to look at how we address some of the costs, so that

maybe we can have more money to, in fact, do drug treatment programs and reimburse doctors for other kinds of preventative care that they need to be administering to those folks between the ages of 65 and 80, 90. In my mind, 80 is the new 50, I am just saying. Since I am rapidly approaching the Medicare age myself.

Anything else that we need to be doing at the Federal level, besides what has been suggested so far. Yes, Dr. Tatum?

Dr. TATUM. Senator, first, thank you for your comments on the advance care planning importance.

I think of my father's physician who as uncomfortable caring for somebody at the end of life. There was a tremendous gap. I think we are really doing a much better job of educating physicians about this now. I think there is a tremendous gap from the average practitioners out in practice who has been there for 25 or 30 years who is not getting this.

The Palliative Care Hospice and Education and Training Act is one of the bills that has a neat aspect of it. It sets of regional training centers, so how do we actually get to that person who is out in practice now, not just the up and comers? That is a very nice way to address this important gap. I think it covers both pain as well as underlying care.

The second thought that comes to mind from a Federal standpoint, as we have been talking, is the AMA, I mentioned their task force to really address this, and I think would be a good partner. The AMA is very concerned about burnout of physicians. A key part of that is the electronic medical record not working well for them, and going out to the PDMP is a problem if it is not integrated very, very well. I think something like 35 percent of physicians actually registered with a PDMP if it is not mandatory in the State.

I think the Federal response that could be very helpful is actually push to make PDMPs integrate into electronic medical records. Give doctors the tools they need at the points of care that are easy to use and effective.

Senator MCCASKILL. Is that capability there now? In other words—

Dr. REDDEN. From the Missouri perspective?

Senator MCCASKILL. Obviously, not, but in other states? In Kansas—you work in Kansas, Dr. Twillman, is that software capability embedded, for example, in the Cerner products?

Dr. TWILLMAN. Well, we have two health information exchanges in Kansas, one of which is the LACIE exchange, which also covers parts of Northwest Missouri. We are actually fully integrated with the LACIE Health Information Exchange now.

Senator MCCASKILL. What is the LACIE?

Dr. TWILLMAN. Lewis and Clark Information Exchange, so health information exchanges basically link medical records across practices so that if you encounter a new patient, you can pull up their records that they have accumulated in other practices as well and see everything that is going on with the patient.

The problem right is for PDMPs, if you are in the medical records, you have to get out of that, go into a different place to get the PDMP report, hop back and forth. It is a challenge. The way we have set it up in LACIE is you open up a patient's record, you

have got all of the information there and it is a one button click to get the report from the Kansas PDMP, so it has been done. It is possible to do it. It is a matter of money, is really all that is keeping us from doing that.

Senator McCASKILL. Okay.

Dr. TATUM. I think if we are going to have PDMPs, they need to be useful and that is a powerful. . . [inaudible].

Senator McCASKILL. Derron? Okay.

Anything else? He is going to cut me off.

Dr. REDDON. There are legal ramifications if someone does have a red flag within these prescription drug monitoring programs, that should also include education to the public. I have a lot of patients that are worried about disclosing information that may get them into trouble from a legal standpoint. They do not know what the legal ramifications are going to be if they have been doctor shopping or abused the system, whether they would be prosecuted or not.

Senator McCASKILL. Well, I think, you know, I think most of the medical records and most of the information that is contained within the medical system is considered private unless it is subpoenaed and there would have to be probable cause to subpoena it that would come from somewhere other than the medical community, so I think patients can be reassured that what you tell your doctor is going to put you in jail, but if you are dealing heroin on the side, they may very well subpoena your doctor's records.

I think there is a little—but I think it is important to look at that, though, because you are right, we do not want to put up any barriers to people being honest about where they are and they need help. In the long run, we are much better off treating them than putting them in prison, which is what the drug courts have all been about and they have been great.

Senator McCASKILL. Well listen, I have learned a lot today. I think that I have got a good list of to-dos to go back to Washington with.

I want to thank all of you for your input and for your work. Thank you, Representative Rehder. I am going to cross my fingers and toes that you can figure out a way to get the Senator locked in a closet. I mean that metaphorically, not literally. Metaphorically only.

Thank you all for the work you do every day, and we will try very hard to see if we cannot help with this problem through the Medicare and Medicaid system in Washington to see if we cannot deal with this tragedy that is gripping our country right now.

Thank you very much.

[Whereupon, at 10:52 a.m., the Committee was adjourned.]

APPENDIX

Prepared Witness Statements



Our Vision: No Life Limited by Pain

**Testimony of Bob Twillman
Special Committee on Aging
United States Senate**

**Jefferson City, Missouri
January 19, 2016**

The United States finds itself beset by two major public health crises that often are perceived as being interrelated, namely prescription drug abuse and chronic pain. Many people perceive a sort of “zero-sum game”, in which efforts to resolve one of these two problems must, of necessity, worsen the other problem. Policymakers’ efforts to address these problems, to date, have skewed largely toward preventing prescription drug abuse, and have often resulted in policies that are perceived by people with pain and the clinicians who care for them as restricting access to some pain medications. Unfortunately, there is evidence to support this notion—in particular, Florida’s efforts to rein in “pill mills” have resulted in a dramatic decrease in overdose deaths related to prescription opioids, but they also have left many people with chronic pain unable to fill prescriptions for the opioid pain relievers that maximize their ability to function and their overall quality of life.

Prescription drug abuse and chronic pain share many similar characteristics. For instance:

- Both are highly prevalent
- Both are very costly, in economic and human terms
- Both highly stigmatized, and patients are blamed for having each condition
- Both involve tremendous suffering, both for patients and those who care about them
- Both are poorly understood by the medical profession, due to lack of content in training programs
- Both are under-resourced vis-à-vis treatment
- Both are very complex problems, with many moving parts
- Both are best treated with a multimodal, integrated, biopsychosocial approach

The writer H.L. Mencken is quoted as having said, “For every complex problem, there is a solution that is neat, simple, and wrong.” Our view is that many of the policy solutions developed to address these two problems have been those “neat, simple, and wrong” solutions. Trying to solve problems as complex as these with simple policy changes results, we believe, in the “zero-sum” game outlined above, and creates negative unintended consequences. We will succeed in addressing both of these

problems only when we are able to conceptualize and implement solutions that match the problems in terms of complexity.

Complex Solutions for Complex Problems

The American Academy of Pain Management is the premier organization for all clinicians who care for people with pain. The Academy's 4200+ members include approximately 2200 MDs and DOs, with the remaining 2000 members representing 30 distinct healthcare disciplines, all of which provide pain care. Since it was founded in 1988, the Academy has espoused a model of integrated pain care, in which professionals from multiple disciplines come together as a team to provide the best, most comprehensive, care possible for each individual person with pain. As an organization, the Academy fosters the formation of these teams and supports the professional growth of individual team members through education, credentialing, publications, and advocacy.

Our policy advocacy efforts have, for the past several years, focused heavily on two areas: Increasing access to multidisciplinary, multimodal, team-based pain care; and minimizing the risk of prescription drug abuse through the implementation of balanced policies that provide for the ongoing needs of people with pain. This agenda has provided us the opportunity to participate in a wide array of national, regional, and statewide groups, and has enabled us to weigh in on several hundred individual policy proposals. Two policy issues that have been among our most frequently encountered are prescription drug monitoring programs (PDMPs) and adequate education for clinicians about both substance abuse and chronic pain.

Prescription Drug Monitoring Programs

PDMPs are state-based electronic database programs that collect, analyze, and distribute information about controlled substance prescriptions dispensed to that state's citizens. The first of these programs was established by California in 1939, while the most recently-established program is in the District of Columbia, which began operating its program in 2015. At this time, 49 states, the District of Columbia, and Guam all operate PDMPs (see attached map). Additionally, seven Canadian provinces currently operate programs and two more have programs in development, while Yukon Territory is linked to the Alberta PDMP. The only exception in the United States is the state of Missouri, where efforts to establish a PDMP over the past half-dozen years have failed.

Public Safety Uses of PDMPs

Many people recognize the public safety utility of PDMPs in deterring, detecting, and intervening in drug diversion activities. This was the original purpose of PDMPs, and it remains the purpose that carries the most weight in policymaking. By analyzing records collected by the PDMP, it is possible to identify individuals who obtain prescriptions from multiple prescribers, fill them at multiple pharmacies, using multiple payment methods, all in order to accumulate large supplies of controlled substances that they can sell, while avoiding detection by insurance companies, prescribers, and dispensers. These individuals, often referred to as "doctor shoppers" are rare, but can be quite prolific. One study found that they represented 0.7% of opioid purchasers in one state, but those individuals accounted for 1.9% of all controlled substance prescriptions and 4% of all opioids dispensed by weight. The Academy's Executive Director, Bob Twillman, also serves as chair of the advisory committee for the

Kansas PDMP, known as K-TRACS. Two of the most egregious cases encountered in K-TRACS are the following:

- A person who, in one year's time, filled prescriptions for various controlled substances written by 86 unique prescribers, using 65 unique pharmacies to do so. It should be noted that this individual received prescriptions from physicians, physician assistants, nurse practitioners, and a sizeable number of dentists.
- A person who, over the course of two years (730 days), filled prescriptions totaling 4000 doses of zolpidem (Ambien®), a sleep medication. (The presumption of the advisory committee is that this individual was selling or trading the medication to people using methamphetamine, who frequently have problems sleeping.)

These two individuals also illustrate another important consideration for PDMPs. Data in any individual state's PDMP are collected from pharmacies in those states, and from mail-order pharmacies that ship medications into that state. Thus, a Kansas resident who has a prescription filled in Kansas will have a record in K-TRACS, but if that same resident fills the prescription in Missouri, it will not be in K-TRACS, even if the prescriber practices in Kansas. Thus, someone intent on avoiding detection through K-TRACS could simply fill all of his/her prescriptions in Missouri. The first individual above lived in Johnson County, Kansas, and thus could easily be filling prescriptions in Missouri; thus, we believe it is likely that she actually obtained even more medication than indicated here. The second individual above actually was a resident of Kansas City, Missouri, so we believe it's very likely that she obtained more than the indicated amount of medication.

To combat this problem (which is especially acute in Missouri, whose two largest cities border other states), states have begun entering into agreements to share data across state lines. This program, operated by the National Association of Boards of Pharmacy, is known as PMPInterConnect. As of this date, 30 states are participating; another five have completed Memoranda of Understanding and are waiting to come online, and three more are in the process of completing their Memoranda of Understanding (see attached map). Many of the non-participant states will need to revise their PDMP statutes to allow interstate data sharing. Periodically, policymakers have called for a national PDMP, presumably operated by the federal government, but we strongly believe that the current model, with participation by all states in PMPInterConnect, would be superior.

Public Health Uses of PDMPs

Often overlooked are the public health benefits of PDMPs. Clinically, information contained in PDMPs can be of tremendous value. This value falls out into three categories:

- Reassurance to prescribers: Often, especially when seeing a new patient with chronic pain, prescribers will be uncertain about whether or not prescribing a controlled substance is a good idea. Patients whose backgrounds are unknown to prescribers cause this uncertainty, because the prescriber has no data on which to base a prescribing decision. Using the PDMP, the prescriber can view the patient's history of controlled substance use, and can make a decision on the basis of that history. In most cases (we estimate ~85% of the time), the prescriber will be reassured by the patient's PDMP record, and will be less anxious about prescribing. This

benefits both the prescriber (who is less anxious) and the patient (who receives the medication he/she needs for pain).

- Detection of substance abuse: In some cases (we estimate somewhere around 10-12% of the time), the prescriber will find information in the PDMP that suggests the patient may have a substance use disorder (SUD). In these cases, the PDMP information should lead the prescriber to conduct an evaluation for the presence of an SUD, and to treat the patient according to the results. For patients whose evaluations reveal an SUD, referral to substance abuse treatment is appropriate. Without PDMP information, those diagnoses may not have been made, and patients potentially would have had their SUD exacerbated by the prescriber's continued prescription of controlled substances.
- Patient safety: Patients sometimes fail to communicate all of their current prescriptions to their prescribers. In some cases, this is intentional, as the "patient" is attempting to obtain multiple prescriptions for purposes of abuse or diversion. In other cases, the omission is unintentional, resulting from poor memory or a failure to consider certain medications as being medically relevant. Older patients, in particular, are vulnerable to these circumstances, as they often take numerous medications and may not be able to remember all of them. Additionally, older patients who are experiencing memory difficulties may have trouble remembering all of their prescriptions. In these cases, a review of the patient's PDMP record can reveal controlled substances originating with other prescribers, which, when combined with a new prescription from another prescriber, could create a potentially fatal drug-drug interaction. In these cases, a simple review of PDMP data can be life-saving.

Clinicians who use PDMPs on a regular basis tell us that they don't know how they managed to practice without them. There is so much clinically relevant information contained in a PDMP record, with such significant potential to affect the patient's course of treatment and risk of overdose, that regular PDMP queries are strongly recommended.

In many ways, Missouri's lack of a PDMP not only impairs the ability of its public safety agencies to properly police drug diversion, but it also places citizens with chronic pain at greater risk of misuse, abuse, diversion, addiction, and overdose. Each year that goes by without a PDMP in place sees numerous people die of overdoses that a PDMP could have prevented. Each year that goes by without a PDMP in place sees numerous Missourians receive inadequate pain care because their prescribers do not have access to their complete controlled substance prescription history. And each year that goes by without a PDMP in place exposes numerous Missourians to harms associated with prescription drug abuse, addiction, and potential overdose, resulting from both proper and improper use of those prescription drugs. Further delay in passing a PDMP bill is unconscionable.

Clinician Education

Numerous studies have documented the inadequacy of pain management education for physicians. These studies are summarized in the 2011 report from the Institute of Medicine, *Relieving Pain in America*. This report states that, in four years of medical school, medical students receive a median of nine hours of education on pain management—despite pain being the reason for half or more of all physician office visits. Similar studies regarding education about substance abuse reveal that the median amount received by medical students is four hours. Both of these are grossly inadequate, and

go a long way toward explaining the problems clinicians have in diagnosing and treating these two conditions.

Clearly, there is a need to substantially upgrade the amount of education student clinicians receive, related to both of these conditions. This education needs to begin in primary training experiences (e.g., medical school, nursing school, pharmacy school, etc.), but the historical inadequacy of this education means that substantial improvement in continuing education of practicing clinicians is also needed.

Some states have begun mandating continuing education for clinicians in one or both of these topic areas. Unfortunately, the state mandates tend to be for one to three hours of continuing education for every license renewal cycle (usually every two years), and the content requirements are often quite vague. Expecting one or two hours of education every two years to produce a substantial improvement in clinical practice is unrealistic.

When we encounter policy proposals establishing mandated continuing education, we look for the following components: 1) the amount required is substantial—as much as five hours every renewal cycle; 2) the required components include both good pain management practices and the diagnosis and treatment of substance use disorders; and 3) the pain management education component must include more than just controlled substance prescribing practices.

This last component raises another important issue. There are a number of reasons why clinicians prescribe opioid pain relievers as frequently as they do, especially to older adults. First, for many years, experts at the American Geriatric Society have evaluated the research on the benefits and harms of a variety of pain medications, and have concluded repeatedly that opioid pain relievers may be safer and more effective for older adults than many non-controlled medications (e.g., NSAIDs, acetaminophen, anticonvulsants, muscle relaxants, etc.). Second, many clinicians are uneducated and inexperienced with respect to the use of non-pharmacological treatments for pain, such as chiropractic and osteopathic manipulation, acupuncture, massage therapy, biofeedback, yoga, etc. Third, even if clinicians know about the effectiveness of these non-pharmacological interventions, many patients effectively have no access to them. Chiropractic and osteopathic manipulation are covered to a limited extent by Medicare, while none of the others is covered at all. Consequently, if patients are to receive these treatments, they have to pay out of pocket, and many can't afford to do so. Legislative direction to, at the very least, study the economic impact of providing coverage for these non-pharmacological therapies, would be welcomed by many in the pain management community, including the Academy.

Clearly, any efforts the federal government can undertake to foster clinician education would be welcomed. Even the Risk Evaluation and Mitigation Strategy (REMS) currently in place for extended release/long-acting (ER/LA) opioids is tremendously under-subscribed, primarily because it is not required for clinicians to participate. There has been discussion about tying completion of this REMS program to renewal of the clinician's Drug Enforcement Administration (DEA) registration. Doing so would require passage of legislation, but this idea has not gained traction on Capitol Hill. Perhaps another mechanism that should be considered is making completion of the ER/LA REMS a condition of participation in Medicare. Doing so would not catch all of the prescribers who would be caught by making completion a requirement for DEA registration renewal, but it would capture most of the prescribers who treat older adults, and a substantial majority of prescribers treating patients of all ages.

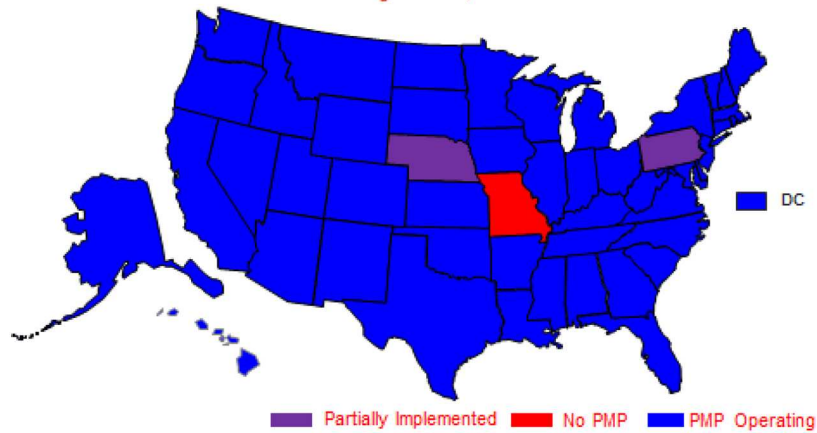
Additionally, any action the federal government can take to promote the following would, we believe, be important in improving pain care for all Americans, especially older Americans:

- Improved amount and quality of education about all forms of pain management, and about substance abuse, in:
 - primary training settings
 - practicum/internship/residency/fellowship programs
 - continuing education settings
- Policies that ensure an adequate workforce in other licensed and certified professions that deliver non-pharmacological pain care, including chiropractic, acupuncture, massage therapy, naturopathic medicine, mental health professions, and others
- Policies that ensure adequate reimbursement for non-pharmacological pain care, including, at a minimum, Medicare and Medicaid coverage of a wide range of chiropractic care, acupuncture, biofeedback, and massage therapy
- Increased research funding for clinical and translational research into all types of pain care, both pharmacological and non-pharmacological

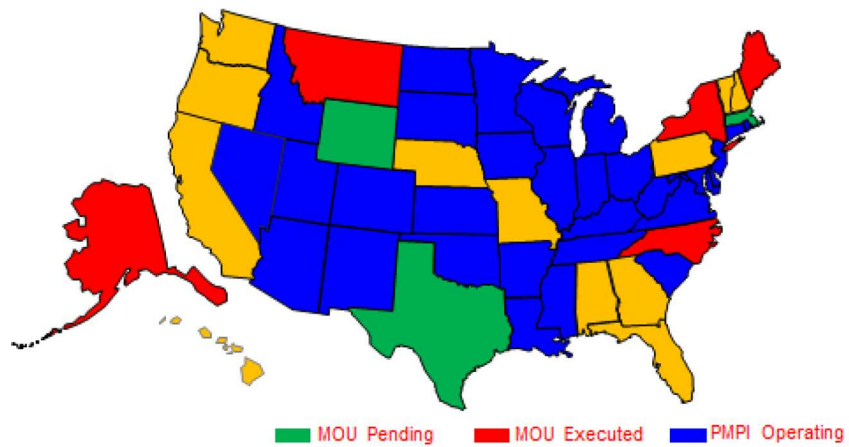
We view comprehensive, multimodal, multidisciplinary, integrated pain care to be one of those solutions that can solve both of the major public health crises identified at the beginning of this document, preventing a “zero-sum game”. By providing this type of pain care, we will produce improved pain control and improved functioning in multiple arenas, saving money and producing better outcomes when compared to the current “usual care”. We also will achieve this positive outcome while decreasing the use of opioid pain relievers, thus decreasing patients’ exposure to the potential harmful side effects associated with these important, but dangerous, medications.

The American Academy of Pain Management stands ready to assist the committee in any efforts it may pursue with respect to improving pain care and addressing prescription drug abuse. Our unique focus on integrated, team-based, comprehensive pain care makes us best suited to providing the kind of advice and support that will best enable policymakers to find solutions for the two major public health crises we face today.

State PMP Status January 19, 2016



PMP InterConnect Status January 19, 2016 (30 States)



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MISSOURI HOUSE OF REPRESENTATIVES

Senator Claire McCaskill
United States Senate
Special Committee on Aging
Washington, DC 20510-6400

Senator McCaskill and members of the Committee:

I thank you very much for having me today and for your interest in this very important topic. You have requested that I testify to the critical need for a PDMP, our efforts here in Missouri to have a PDMP, my personal story related to this and my commitment to reducing the misuse and abuse of prescription drugs in Missouri.

The Need for PDMP

As you know, Missouri is the only state that does not have a prescription drug-monitoring program. Abuse and misuse of narcotics, with the highest emphasis on opiates, has reached epidemic proportions. The Centers for Disease Control and Prevention (CDC) states that "since 1999, the amount of prescription painkillers prescribed and sold in the US has nearly quadrupled, yet there has not been an overall change in the amount of pain that Americans report." This is staggering.

PDMPs have proven successful in curtailing drug diversion, increasing patient care and overdose rates.

- Since Kentucky's PDMP took effect in 2012, they have seen a decrease in "doctor shopping" by 52%. (*"Kentucky House Bill 1 Impact Evaluation", Univ. of Kentucky, March 2015*)
- A California survey of physicians showed 74% had changed their prescribing practices to a patient as a result of using PDMP Patient Activity Reports (PAR). 91% rated the "effectiveness of the PAR in maintaining the care and health of your patient" as good to excellent. (*Briefing on PDMP Effectiveness, dated Sept 2014, Center of Excellence, Brandeis University*)

- Florida saw a 24% decline in prescriptions for oxycodone and an 8% decline for methadone. Two drugs most implicated in prescription overdose and death. *(Briefing on PDMP Effectiveness, dated Sept 2014, Center of Excellence, Brandeis University)*

With Missouri surrounded by 8 states, we are not only harming our own population. My district is the majority of Scott and Mississippi Counties down in the bootheel. My Charleston pharmacies are often times the first stop for doctor shoppers coming from Illinois and Kentucky. My district is also only an hour from Arkansas. All are states with PDMPs. My pharmacists, physicians, law enforcement, churches and social services departments see the results of Missouri's inaction on a daily basis.

Efforts to Pass a PDMP in Missouri

I have been in office since 2013 fighting for this legislation. Representative Engler carried it even before my arrival while he was a Senator. Privacy concerns has caused threats in the Senate for a filibuster. Last year, 2015, the Senate did pass out a Senate compromise bill but once the fiscal note was complete it had a \$6 million dollar a year price tag and those in the trenches – our pharmacist, physicians and law enforcement – all said it was not a workable program. So we were back to square one.

This year I have filed HB 1892, the Narcotics Control Act. We have changed the name due to many fearing the previous title "Prescription Drug Monitoring Program" included all prescriptions – antibiotics, etc. We do have new leadership in the House and Senate this year, both very much in favor of Missouri passing a PDMP. I am hopeful.

Personal Story Related to the Need

I was raised on welfare, in the drug culture, as many call "the wrong side of the tracks". My mother had to deal with mental illness. One of my stepfathers was a dealer; my sister married a dealer at 16 and was a mainline addict. My cousin died at 39 from many years of drug abuse. Right after I turned 15 we were in a terrible car accident and I was needed to help take care of my mother and younger sister. I dropped out of school, got married and pregnant soon after. At 15 I looked at my life. I was a pregnant high school drop out destined to raise my child in the same cycle of poverty and dependency around the same type people who harm others and children because of their drug abuse.

I went to work. Working multiple jobs in whatever I could get hired to do. At 18 I took my GED and then took college classes when I could. It took me 17 years to finish my degree because I did it while working a full time job and raising a family. My children have been raised in the same church where we have attended for 27 years now. Through their lives I have served as Youth Leader and Sunday School teacher making sure they understand that God is the only reason that our lives are different from many in our family.

My children were raised in a middle class home with two parents working and participating in their school activities, church activities and their lives in general. They came home to cooked meals at night and had parents who knew where they were at all times.

At 17 my daughter worked in a local restaurant, attended High School and was an honor roll student. She was accepted at SLU. Very bright, positive, normal teenage girl raised in a two parent middle-class home with many goals and dreams to become a pediatric physical therapist and live a successful life.

She cut her thumb opening a bag of okra at work and was sent to the ER to get it stitched up. There they gave her a prescription of opiates for the pain. Once she ran out of that prescription she started buying them from co-workers. They were very easy to get, seemed harmless since they were prescription, and she loved the euphoric feeling.

That was 13 years ago. We have now had 13 years of ups and downs; rehabs, prison, and my grandson born with opiates in his system. You see the pills become too expensive because your body adjusts to them and you need more and more to stay at that euphoric level. Where heroine and meth might be the boogiemans to a teenager who hasn't experienced drugs, once they are hooked and can't afford the pills, that is where they turn. Their mind is no longer afraid, and their body simply needs the opiate.

My daughter became a mainline user as well. Meth, bath salts, whatever filled the need. My grandson, who I have guardianship of now, was pulled out of a meth lab at only 1 year old. He slept within a few feet of the shake and bake operation.

I tell you this story to show that drug addiction is no respecter of persons. It crosses all socioeconomic statuses. When you go into a high school and ask the kids "what do you want to be when you grow up?" The answers are "a doctor", "a lawyer", "a business owner". None say "I want to be an addict". Yet addiction is the growing epidemic of our time.

My Commitment to Reducing the Misuse and Abuse of Opioids

I realize that a PDMP is not a silver-bullet. It is one major tool for our toolbox and I will continue to fight until we see it come to fruition. I am also working with The Recovery Network of Missouri to start a bi-partisan Recovery Caucus.

Our goals are:

- To enhance recovery outcomes in Missouri
- Identify a Missouri solution to fund recovery support and services
- To educate legislators on the needs and gaps in recovery services

I met with several legislators from different states in DC last month. Their states all had active PDMPs and were on a phase two per se of recovery efforts working to identify addiction early to put people on a path back to a healthy life and curtail the state's costs by putting money into recovery efforts on the front side, verses the penal system which we know has a residual effect through social services and mental health departments.

Closing

We must change the face of addiction. That is why I am here.



WILLIAM MAURICE REDDEN, MD
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Dear members of the Senate Special Committee on Aging, my name is William Maurice Redden, MD and I am an Assistant Professor of Geriatric Psychiatry at Saint Louis University School of Medicine. Thank you for allowing me to speak about the rising epidemic of illicit and licit substance abuse/misuse among older adults. This is of particular interest to me as both a clinician and researcher because of my interest in ways to improve cognitive function in late life. One way to do this is to address any potential risk factors that can be removed or modified, including substance use and misuse.

Historically, substance abuse has been considered a problem affecting younger adults that was thought to decrease as one ages. In my experience as a clinician, I have encountered patient abuse of both illicit and licit drugs more often. My colleagues have also made this observation and there has been increased evidence in the literature of this growing problem. There is growing concern about the harmful effects of the substances, and how to treat this unique patient population. The main illicit substances include marijuana, cocaine and heroin; however, an often overlooked problem of prescription, non-prescription and over-the-counter misuse of drugs is also on the rise.

The pattern of use can appear in "early-onset" and "late-onset" users. The former describes individuals with a long history of use that persist as they age, while the latter includes individuals who develop a new habit in late life. Some risks factors that lead to new or continued use in the elderly includes social isolation, financial difficulties, and poor support systems. In most instances, there may be mental health conditions that have not been properly diagnosed and/or treated.

When older adults use illicit substances, even in small amounts, the negative effects can be magnified. This is in part due to a decreased metabolism and comorbid medical conditions that slow the processing of the drugs. In addition, one third of elderly patients take, on average, 5 prescription medications. This increases the risk of drug interactions, which can complicate medical problems. This all leads to increased emergency department visits as well as prolonged hospital stays.

Cocaine and marijuana can greatly affect an individual's health. The most dangerous consequences of using cocaine include increase risks of heart attack, stroke, and delirium. Marijuana use has been known to increase workload and demand on the heart as well as elevate blood pressure, and impair the immune system. The psychiatric manifestations include precipitating psychosis, leading to delirium and impairing both short-term and long-term memory.

I would like to focus more on the rise of opioid use, including both heroin and prescription opioids. One of the driving forces for this rise includes the increasing prevalence of chronic pain. Prescription opioid



medications have been the most prevalent treatment option. When access to these medications is not available, older adults have resorted to using someone else's prescription, buying medications off the streets or straightforwardly using heroin. They have also been known to "doctor shop" in order to acquire more medications than actually needed. The overuse and misuse of opioids is of particular concern to geriatric psychiatrists such as myself because it can lead to suicide by self-poisoning. The same factors that lead to drug abuse; social isolation, financial difficulties and mental health illness, also are risk factors for suicide. And now with the increased distribution of prescription opioids, this vulnerable group has lethal means to carry out the intent.

We know that substance abuse/misuse in the elderly is on the rise. The next question is how do we screen and identify those individuals at risk. Most of the available screening tools have been designed for younger patients. Recently, the DSM-V has updated our diagnostic criterion, and we now use the term substance use disorder (SUD) in place of abuse and dependency. However relying solely on the diagnosis of this disorder may exclude older adults who may not meet the criterion based on factors related to aging. For example, older adults may not develop tolerance, which is a hallmark of SUD, due to age-associated physiologic changes that increase the effects of substances. Thus makes diagnosing SUD in the elderly difficult, especially when the clinician already has limited time and some the symptoms of substance use may present as common illness that occurs during late life. Also as with younger adults, older adults may have difficulty recognizing their own substance use as being problematic.

The first step in recognizing that elderly drug abuse as a problem is to consider it a possibility. As clinicians, we are often pressed for time, but there are screening tools, such as CAGE-AID, that are designed to help begin the discussion. However once one chooses to approach this sensitive issue, it should be done in a gentle and respectful manner. Questions should be asked in a nonjudgmental manner, to help destigmatize substance use and any possible accompanying mental health conditions.

Once elderly patients have been identified as having a substance use disorder, treatment interventions needed be tailored to meet the needs of this unique group. As such, medications that are typically used in younger patients may not be suitable for older adults. This may be in part due to possible comorbid conditions that the elderly may have or to possible drug-drug interactions that could make treatment risks outweigh the benefits. In addition, the evidence is still lacking about the efficacy and safety of these medications for the older population. There is still some debate on whether elderly patients should participate in inpatient-treatment programs geared specifically for the elderly population or



should they be integrated with younger patients. In choosing the appropriate program, other factors should be considered, such as comorbid medical and psychiatric conditions that need to be addressed during treatment.

Another useful tool for clinicians that most other states have enacted is the use of prescription drug monitoring program (PDMP). These programs vary across settings, but the main purpose is to detect and reduce diversion, abuse and misuse of schedule II prescription medications, such as opioids. Hopefully in the future, all PDMPs will include other prescription medications that have high abuse potential such as benzodiazepines. PDMPs have shown to reduced over-prescription and doctor shopping by patients. They have also helped identify any suspected fraudulent prescribing or illegal activity related to the dispensing of controlled substances. However, one of the main concerns of such programs is a potential invasion of privacy. But information in PDMPs needs to be treated just as well, if not better, than any other medical record.

In conclusion, substance abuse in the elderly is a growing problem and includes illicit and licit substances. The identification of substance use is difficult, but first has to be acknowledged as real possibility. Then, an assessment that is respectful and non-stigmatizing can be approached. Clinicians should be mindful of the roles of comorbid medical and psychiatric conditions when diagnosing and treating elderly patients who exhibit symptoms of substance use. The over-prescribing of opioids for the treatment of chronic pain can contribute to this problem; however, having deterrents in place such as prescription drug monitoring programs and utilizing other methods to treat chronic pain can help clinicians combat this devastating problem.



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January 19, 2016

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.