



127 Washington Avenue, East Building, 3rd Floor, North Haven, CT 06473  
Phone (203) 865-0587 Fax (203) 865-4997 www.csms.org

**Connecticut State Medical Society**  
**Testimony on**  
**House Bill 6856 An Act Concerning Substance Abuse And Opioid Overdose Prevention**  
**Presented to the Public Health Committee**  
**March 18, 2015**

Senator Gerratana, Representative Ritter and members of the Public Health Committee, on behalf of the physicians and physicians in training of the Connecticut State Medical Society (CSMS) thank you for the opportunity to provide this testimony to you today on **House Bill 6856 An Act Concerning Substance Abuse And Opioid Overdose Prevention**. This proposed legislation contains several sections with the intent of identifying opioid abuse and preventing opioid misuse and ultimately death from overdose. We provide the following comments on each section and offer concerns regarding the absence of language to increase resources for and access to substance abuse treatment services.

**Section 1** adds language to current statutes regarding Continuing Medical Education (CME), expressly adding one hour on “prescribing controlled substances and pain management” and further including it as an appropriate to meet the current statutory requirement for one hour of risk management. First, we must state that for many years now, CSMS has actively and aggressively sought to educate physicians about narcotic drugs, opioids, and other controlled substances. Additionally, CSMS has provided many American College of Continuing Medical Education (ACCME) accredited CME programs, not only with our own resources but through grants obtained at the local and national level, through both private and government entities. We are proud of our efforts, but recognize that much more needs to be done as more powerful medications are developed and addiction and abuse rises without adequate access to or coverage for substance abuse treatment.

Since the establishment in statute of CME requirements, CSMS has opposed the addition of new mandated individual requirements. This opposition in no way questions the importance of the issue at hand, but is focused on the ability of physicians and other health care professionals to obtain CME in topics pertinent to their specialty areas of patient care. Provided that physicians can make individual determinations as to the most appropriate form of risk management CME, which can include the prescribing of controlled substances and pain management, without adding an additional mandate, CSMS is ready to continue its successful efforts to provide nationally

accredited CME programs for our members and other health care providers who prescribe controlled substances.

**Section 5** contains language making several changes to the State's current Prescription Monitoring Program (PMP) currently operated by the Department of Consumer Protection (DCP). Much like with the CME program, CSMS has been actively involved throughout the history of the PMP. CSMS is proud of its efforts working in conjunction with DCP and members of the General Assembly to originally obtain a federal grant for the development of the PMP; CSMS physicians were part of the original PMP pilot program; ; and ultimately encouraged and supported the State's decision to maintain the program when the grant ended. CSMS has educated members of the PMP and promoted its use through various newsletters, web postings and other communications. In addition, CSMS was pleased to work with the General Assembly and DCP once again in 2013 to support the requirement that all prescribers register for its use when seeking or renewing their state license to prescribe.

Section 5 would (1) mandate usage of the PMP prior to writing any controlled substance prescription for a quantity greater than a seventy-two hour supply, (2) require physicians providing prolonged or continuous treatment to utilize the PMP once every ninety days, and (3) allow physicians to delegate required checking of the PMP to an authorized agent who is also a licensed health care professional. We raise certain concerns about this section and respectfully ask the Committee for the opportunity to work with members to develop the best possible language to increase appropriate use of the PMP without unduly burdening physicians or hampering their ability to provide timely, comprehensive, and high-quality care to their patients.

We believe that the inclusion of a seventy-two hour exemption is meant to address prescribing of controlled substance by emergency room physicians and possibly others who write prescriptions in an emergent or urgent situation to stabilize patients until they are able to obtain treatment from a primary care or treating physician. While we appreciate this exemption, situations can occur in which the seventy-two hour window may not be sufficient. We ask for the opportunity to work with the Committee and to address this concern. Connecticut's emergency room physicians and hospitals have been at the forefront of developing protocols for the prescribing of controlled substances. Attached to this testimony is a copy of *Connecticut Emergency Department Opioid Prescribing Guidelines*, developed by the Connecticut Society of Emergency Physicians and the Connecticut Hospital Association, and endorsed by those organizations as well as CSMS and the Department of Public Health (DPH).

We also appreciate the inclusion of language expanding the ability of physicians to delegate checking of the PMP to other licensed health care professions serving as their agents, as well as the exemption from checking the PMP with every script during the course of continuous or prolonged treatment. However, we must ask the Committee for the opportunity to partner on

developing language to appropriately increase use of the PMP. First, while the language allows the delegation of use of the PMP to other licensed health care professionals, its use can prove time-consuming. Whether it is the physician or another health professional serving as an agent, mandatory usage at the time of prescribing will pull busy professionals away from patient care. A one-size-fits-all mandate removes the physician's clinical judgment from the situation, and will give rise to situations in which checking the PMP is merely a formality, rather than improving patient care and safety. Conversely, some physicians provide prolonged and continuous treatment, in particular pain management specialists, and are high utilizers of the PMP. In situations which require long-term prescription use, these physicians have an established relationship with the patient, often developing "pain management contracts" and cautiously prescribe for these patients.

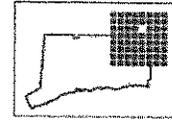
Section 6 allows pharmacists to dispense an opioid antagonist without the involvement of physicians. First, it must be stated that CSMS has been a vocal proponent of expanding the availability of opioid antagonists. Last session, we supported PA 14-61 expanding the civil and criminal protections for anyone administering an opioid antagonist in good faith. This has allowed our first responders, as well as family, friends and loved one of those suffering from addiction to carry and administer opioid antagonists. Second, we understand that language is included in HB 6856 to place training for pharmacists prior to dispensing an opioid antagonist. However, we must raise concerns with several points in Section 6.

The prescribing of medications -- regardless of category, safety, or even intent -- is a significant issue. Steps to provide such prescribing ability should be carefully crafted and implemented. Furthermore, when a trained professional, such as an addiction medicine physician, prescribes an opioid antagonist, the professional has an important opportunity to provide patient education about the disease, treatment options, and intervention possibilities. These opportunities should not be missed. Finally, no requirements exist in the language as drafted requiring counseling on addiction, understanding of available treatment options, or necessary information to be provided regarding the disease or treatment resources.

We offer our appreciation for the expansion of the Connecticut Alcohol and Drug Policy Council. However, CSMS has continually sought parity in coverage and available services to treat the disease of substance abuse. This bill contains a requirement for physicians regarding CME, mandated use of the PMP, and a potential expansion of the availability of opioid antagonists to be administered overdose situations. What is lacking, however, is any increase in resources for those suffering from opioid addiction, or opportunities to treat the underlying disease.

We stand ready to work with this Committee, the General Assembly, and the administration to fight a disease plaguing many of our citizens. We ask for the opportunity to be involved in the

process, and ask that we address the entire issue of addiction and opioid without placing a burden on those who seek to treat patients in need.



CT COLLEGE OF  
EMERGENCY PHYSICIANS

## Connecticut Emergency Department Opioid Prescribing Guidelines

Patient care goals may be optimized when one medical provider coordinates all prescribed opioids to treat a patient's chronic pain, to the extent possible. The following guidelines are an educational tool to assist emergency medical personnel (EMPs) in addressing the care needs of persons who come to the Emergency Department (ED), and who have a chronic pain condition that may involve the use of opioids.

### Specific Considerations for Emergency Departments:

The ED should coordinate the care of patients who frequently visit the ED, using an ED care coordination program, to the extent possible.

ED opioid prescriptions for acute injuries, such as fractures, should be in an amount that will last until the patient is reasonably able to receive follow-up care for the injury. In most cases, this should not exceed thirty (30) pills.

ED patients should be asked about a history of current substance abuse prior to prescribing opioids for acute pain. Opioids should be prescribed with great caution in the context of a substance abuse history.

EMPs generally should not order IV or IM opioids for acute exacerbations of chronic pain.

EMPs generally should not provide replacement prescriptions for controlled substances that were lost, destroyed, or stolen.

EMPs generally should not provide replacement doses for Methadone or Suboxone, but special consideration may be given in the event of natural disasters or other exigent circumstances.

EMPs generally should not prescribe long-acting opioids (e.g. Oxycontin, Fentanyl patches, methadone) for acute pain management.

EMPs should exercise caution when considering prescribing opioids for ED patients in situations in which the identity of the individual cannot be verified.

## **Specific Legal, Oversight, and Policy Considerations**

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires patients who present at the hospital seeking care to be screened for any emergency medical condition. This includes patients who present with reports of pain. If an emergency medical condition is present, EMTALA requires that the patient be stabilized prior to transfer or discharge. EMTALA allows an EMP to use his or her clinical judgment in treating pain, and does not expressly require the use of opioids.

The Joint Commission has various standards and guidelines relating to pain management. Where applicable, the standards that should be considered include: HR.01.04.01, EP 4; MS.03.01.03, EP 2; PC.01.02.01, EP 2; PC.01.02.07, EP 1-4; PC.02.03.01, EP10; PC.03.01.07, EP2; and RI.01.01.01, EP 8.

To the extent that these guidelines are expressly adopted by hospital policy, EMPs should be supported and should not be subject to adverse considerations when following these guidelines.

January 20, 2015

*Disclaimer: These guidelines are an educational tool. Clinicians should use clinical judgment in making treatment decisions and not base clinical decisions solely on this document. This document does not establish any standard of care. Deviation from it will occur when clinical situations dictate. No legal proceeding, including medical malpractice proceedings or disciplinary hearings, should reference a deviation from any part of this document as constituting a breach of professional conduct.*