



Written Testimony of the Connecticut Orthopaedic Society

House Bill 6856 AN ACT CONCERNING SUBSTANCE ABUSE AND OPIOID OVERDOSE PREVENTION

Public Health Committee – March 18, 2015

Senator Gerratana, Representative Ritter and distinguished Members of the Public Health Committee, on behalf of the more than 250 orthopaedic surgeons of the Connecticut Orthopaedic Society, thank you for the opportunity to provide testimony regarding **HB 6856, AN ACT CONCERNING SUBSTANCE ABUSE AND OPIOID OVERDOSE PREVENTION**.

This bill is an important and timely response to the safe and appropriate use of narcotic pain medication prescribed by physicians. As orthopaedic surgeons, we prescribe controlled substances for legitimate medical purposes and unfortunately some of the opioid pain medications end up being abused as recreational drugs or sold as street drugs. This is known as “diversion” and is a high priority action item for the federal Drug Enforcement Agency. The proposal to implement a Prescription Drug Monitoring Program in our State, will enhance peer to peer communication to deter people who “doctor shop” in order to obtain multiple prescriptions of narcotics.

While there are no quick fixes to the national epidemic of opioid abuse, educating and training physicians that prescribe narcotics is a vital. Physicians should have access to the latest expert opinion and prescribing guidelines that maximizes patient safety and prevents diversion to the general public. The Connecticut Orthopaedic Society shares information from the American Academy of Orthopaedic Surgeons on an ongoing basis and we encourage our members to take advantage of the educational and training tools afforded by the AAOS. The information is thorough, extensive and readily available to the orthopaedic community throughout the year. In addition, the FDA has a program, “Extended-Release and Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy,” which is a voluntary program to educate physicians who prescribe these narcotic pain medications and provide them with tools that enable them to counsel patients and improve prescription safety.

Orthopaedic surgeons, in the vast majority of cases, prescribe narcotic pain medications for the sole purpose of short-term pain management in post -surgical patients and those suffering from acute musculoskeletal injuries, such as fractures. Many patients will only require narcotics for one or two weeks, while others, with extensive procedures and intense rehabilitation, may require several separate narcotic prescriptions as the need arises throughout their treatment protocol.

As an orthopedic surgeon practicing in Connecticut for now eleven years, I can recall just one patient in my practice that has received narcotic pain medication, prescribed by me, for longer than 8 weeks. While my experience may be unique, safe administration of pain medications can be accomplished without intrusive regulatory oversight. With that said, other providers may be more liberal in their prescribing patterns, and a balance clearly needs to be struck that does not penalize responsible prescribers but also protects patients and the broader community.

The language of the bill is unclear with respect to what constitutes “continuous or prolonged treatment”. For example, a patient who suffers an ankle fracture will be evaluated soon after injury, and will likely be given a prescription for opioid analgesics. The instructions will allow the patient to take more tablets in the beginning, when they are in more pain, and to taper off, as the acute pain subsides. The nature of the injury may be such that surgery must be delayed for 1-2 weeks. In this case, the patient will also receive a second prescription for post-operative pain management at the time of surgery. This would be another short course prescription with instructions to taper off the medication as the post operative pain subsides. Six weeks later, when the patient presents for physical therapy, the rehabilitation process can be quite painful, in which case, the patient would be given a third short-term narcotic prescription. In this case, since the narcotic treatment is not “continuous”, the current bill would require the physician to check the database on three separate occasions. The unintended consequence of the vague language could be that physicians check the database once at the initial visit, and give patients one large prescription to last the entire treatment period. It would be reasonable to clarify the requirement for a baseline check of a patient's narcotic use history at the initial visit, without a requirement to re-check the database for further episodic prescriptions within 90 days.

In order to manage patient flow, and ensure efficient care of our patients, we request that non-licensed office personnel who are bound by HIPAA compliance, to be granted access to the database and function as “authorized delegates” of the prescribing physician. This would greatly facilitate compliance with the law and would allow physicians to what they do best, care for patients.

The Society would also suggest adding more physician representatives to the important Connecticut Alcohol and Drug Policy Council proposed in the bill. Additional representation will certainly assist with ongoing efforts to enhance and improve this initiative. The most burdensome and costly aspect of this proposed legislation, the routine query of a state-run narcotics database, is being placed on the backs of providers. There appears to be little to no consideration of the impact on the clinical practice of medicine, and having additional providers on the Council may help to mitigate the administrative burden by providing insight into the areas of greatest clinical concern.

We stand ready to assist this Committee and the legislature with this important initiative and encourage legislators and government leadership to recognize that a good portion of the abuse occurs by those who use medications prescribed for someone else. Additional provisions should include public outreach, similar to the D.A.R.E program, and patient education on the proper storage and disposal of these medications in order to assist in the overall goal of curbing opioid abuse.

This is a complex issue, that in our opinion is not best solved through the legislative process. Any proposed and adopted regulatory efforts in this area needs to be the result of healthcare professionals, pharmacists, public health officials, law enforcement, patient advocates and others identifying the highest impact areas for action and developing an effective and efficient program to address those areas of real need. Models must exist in other states and jurisdictions that respect the legitimate concerns of all constituencies.

On behalf of the Connecticut Orthopaedic Society, thank you for the opportunity to provide feedback regarding this important bill.

Submitted by:

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