

March 3, 2015

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PUBLIC HEARING: PUBLIC HEALTH COMMITTEE – MARCH 4, 2015

TESTIMONY SUBMITTED IN SUPPORT OF PROPOSED BILL No. 6279 – An Act Concerning Prescription Drug Monitoring, Continuing Education, and the Return of Unused Prescription Drugs

Senator Gerratana, Representative Ritter, and Members of the Public Health Committee,

As a primary care physician and medical educator at the Yale University School of Medicine, I am grateful for the opportunity to provide this testimony in SUPPORT of **Proposed Bill 6279: AAC Prescription Drug Monitoring, Continuing Education, and the Return of Unused Prescription Drugs**.

According to Connecticut's Department of Public Health statistics, Connecticut residents are more likely to die from an unintentional drug overdose, usually from a prescription opioid, than from a motor vehicle accident. Furthermore, national data indicate that nonmedical use of prescription drugs is the third most common category of drug abuse after marijuana and alcohol.¹ Studies also show that the most common source of abused opioids is friends and family and not from pharmacy theft or black market sales. Opioids are dangerous if not carefully prescribed, monitored, stored, and disposed of.

At the same time, chronic pain affects an estimated 100 million Americans at a cost of \$635 billion each year in medical expenses, lost wages, and reduced productivity.² Living with chronic pain can be disabling and despite their risks opioids remain an important part of the doctor's armamentarium against severe pain. Finding a balance between these risks and benefits is critical and should be the goal of any legislative effort. To this end, a number of interventions are necessary and many would be addressed by this bill.

First, doctors must be educated on how to assess pain and prescribe opioids safely. There are only 4 board certified pain specialists for every 100,000 people with chronic pain so most medical providers will *not* have specialist support and need to learn to prescribe safely on their own.³ Unfortunately, most physicians graduate medical school with little to no formal education on pain management and opioid safety. One study from 2011 found that only 5 of the nation's then 133 medical schools had any required education on this topic.⁴ Prescribing opioids is far too dangerous to do without proper training, so mandating some education on this topic is an essential first step.

Second, doctors must use the tools available to them to screen for evidence of opioid misuse, abuse, and diversion. The Connecticut Prescription Monitoring Program (CTPMP) is one such tool, but legislation requiring Connecticut physicians to register with the system has not yet been impactful since it has not been enforced. As of October, 2013 only about 9000 out of Connecticut's 26,000 prescribers actually registered with the program. Of those that have, far fewer actually use the system. Registration *and* use should be required and enforced.

Third, CTPMP has the ability to identify prescribers with unusual opioid prescribing patterns and regulators should use this data proactively. Representative Scanlon's proposal to leverage this data by having the Department of Public Health create an expert panel to review such cases and recommend further assessment and intervention as appropriate makes sense. The data alone can be deceptive; a palliative care specialist would be expected to prescribe more opioids than a psychiatrist. However, a panel of experts can review the specifics to better identify same-specialty outliers and recommend more informed requests for further analysis and intervention. CTPMP can be used to keep prescribers accountable and patients protected.

Finally, there must be an easy way for the public to safely discard their unused opioids. We need to keep opioids away from our children and those who would abuse them. We also need to keep them out of the water supply as the result of improper disposal. This will only be accomplished by making disposal as convenient as possible. There are medication drop boxes already available at some police stations for this purpose, but they are far too few and are not easily accessible. It makes sense to turn in unused pills at the same place they are dispensed – the patient's pharmacy. Pharmacies already have a mechanism to account for controlled medications and safely dispose of expired drugs, so this is a logical collection site.

I welcome the opportunity to work with the committee as it evaluates this and other similar legislative proposals.

A handwritten signature in blue ink, appearing to be a stylized 'R' followed by a long horizontal stroke.

References

1. SAMHSA. *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*. HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2014:
<http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.htm>. Accessed February 8, 2015.
2. Institute of Medicine (U.S.). Committee on Advancing Pain Research Care and Education. *Relieving pain in America a blueprint for transforming prevention, care, education, and research*. Washington, D.C.: National Academies Press; 2011:

http://www.nap.edu/openbook.php?record_id=13172http://www.nap.edu/openbook.php?record_id=13172#orgs.

3. Breuer B, Pappagallo M, Tai JY, Portenoy RK. U.S. board-certified pain physician practices: uniformity and census data of their locations. *J Pain*. 2007;8(3):244-250.
4. Roehr B. US needs new strategy to help 116 million patients in chronic pain. *BMJ*. 2011;343:d4206.