Testimony of
The UConn Health Opioid Task Force

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HB 7159 – An Act Addressing Opioid Use

Distinguished Members of the General Law Committee, thank you for allowing us, as Co-Chairs and representatives of the Opioid Task Force at UConn Health, to testify on HB 7159, An Act Addressing Opioid Use.

The Opioid Task Force at UConn Health is an interdisciplinary group of clinicians, educators and researchers at UConn Health collaborating (1) to develop policies pertaining to opioid prescriptions for chronic non-malignant pain, (2) to identify resources for alternative pain treatments, (3) to make recommendations for acute pain treatment protocols based on literature and evidence-based guidelines; and (4) to serve as an advisory council on issues pertaining to opioid use. Our membership includes doctors and other health care practitioners and experts practicing in primary care/internal medicine, orthopedic surgery, emergency medicine, pharmacy, psychiatry/addiction medicine, dentistry, hematology/oncology, poison control, neurology, and health care quality.

The members of the Opioid Task Force commend the Governor and this Committee for putting forth HB 7159. The goals of this legislation are laudable, and it is critical that we as providers and you as policy-makers continue to look at ways to address opioid misuse.

As clinicians, educators and researchers who work daily with the issue of opioid prescribing, and with developing and instituting best practices in this area, we would

like to work with the Governor and the Committee to help HB 7159 best achieve its goals.

Specifically, we have some concern that Sections 6 and 7 of the bill, as currently written, may not achieve their stated goals. We believe that there are changes that can be made that will be more effective and have more real impact.

Section 6 would require prescribers to specify a patient's diagnosis and ICD code on opioid prescriptions, with the intention of making providers think twice before prescribing opioids. However, we do not believe this additional work will be useful to either the patient or the provider, nor will it limit opioid prescribing. We respectfully submit that documenting the indication for use clearly in the patient's chart would be a more meaningful use of documentation. Additionally, if a patient plan is used by the prescriber, indication information could be written there.

Section 7 of the bill would require a medication agreement if an opioid is prescribed to a patient for longer than 12 weeks. This is a recommendation from the 2016 CDC guidelines, and in fact, UConn Health already does have a policy that requires a medication agreement for chronic opioid prescribing. However, there is not a lot of literature on medication agreements and whether or not they actually improve outcomes. We have concerns about putting such a requirement into state statute, since that will not allow the ease of change and modification as new literature emerges. Similar to our recommendation for Section 6, we believe that encouraging that this key information (treatment goals, risk of opioids, etc.) be incorporated into the progress note and/or patient plan would be a better requirement than mandating a medication agreement.

Our Opioid Task Force has some other recommendations to promote safe prescribing that we believe are achievable. For example, facilitating the use of the state's prescription drug monitoring program (PDMP) by ensuring single-click integration of the PDMP with prescribers' Electronic Medical Record systems (EMRs) would go a long way. Currently, most providers across the state need to leave the patient chart, open up the PDMP website, use a separate username and password to log on and then enter in the patient first and last name and their date of birth to access the report. Each of these steps are cumbersome and unnecessary, and discourages prescribers' use of the PDMP.

Last year, the legislature created a Medication Reconciliation and Polypharmacy Workgroup under the Health Information Technology Advisory Council, and this group has concluded that it is technically feasible to integrate a PDMP link directly into a state-wide Health Information Exchange (HIE) with a single click within the patient's chart, pulling up the patient's controlled substance prescription history. We believe that this functionality should be supported and expedited by the State as it develops its HIE.

Another recommendation of our Opioid Task Force where we believe legislation can make a real difference is in ensuring that all prescription controlled substances are reported to the PDMP. Currently methadone is not reported if it is being prescribed for Medication Assisted Treatment (MAT) of Opioid Use Disorder (OUD) or for detoxification from opioids. Historically, this was due to protect patients and reduce stigma for patients with opioid use disorders. However, we now have multiple options for treating OUD, including buprenorphine (suboxone), and those are reported to the PDMP. Additionally, methadone is reported if it is prescribed for chronic pain and dispensed through a pharmacy. Not having access to methadone prescription history puts patients at a high risk of overdose if prescribed an opioid in addition to their methadone, placing providers in a challenging position, particularly in an acute prescribing situation. Adding all methadone to the PDMP would provide the clinician with a more accurate morphine milligram equivalent (MME) and would enhance opioid prescribing safety. There are challenges to include methadone reporting in the PDMP, including the fact that Methadone for MAT and OUD is dispensed at a clinic and not a pharmacy. However, steps to include methadone in the PDMP should be considered for patient safety, particularly because other medications used for MAT are already reported.

In conclusion, we applaud the Governor and the Committee for raising HB 7159 and for its efforts to address the opioid crisis in Connecticut. As part of the State's only public academic medical center, we are ready and willing to talk with you further about our work and our recommendations and to assist you in any way.

We believe it is critical to get legislation like this right – to ensure that we achieve the goals of reducing abuse, but also to ensure that we do not create any unintended consequences. One of the unintended consequences of enhanced regulation and oversight of opioids has been the attrition of providers who are willing to prescribe these medications. Chronic pain affects hundreds of thousands of patients across the country. While we all agree that the current state of affairs is a true crisis and support the oversight of prescribing practices, we believe it is important to be careful to not unintentionally reduce healthcare access for an already stigmatized patient population. We respectfully submit that focusing on what really will impact long term outcomes, and being careful to avoid additional administrative burdens on prescribers that do not add value, should be primary goals of this and future legislation.

Thank you for your consideration and we are happy to answer any questions that the Committee may have.