National Safety Council Testimony on
Fighting Against a Growing Epidemic:
Opioid Misuse and Abuse Among Older Americans
United States Senate Special Committee on Aging
January 25, 2016
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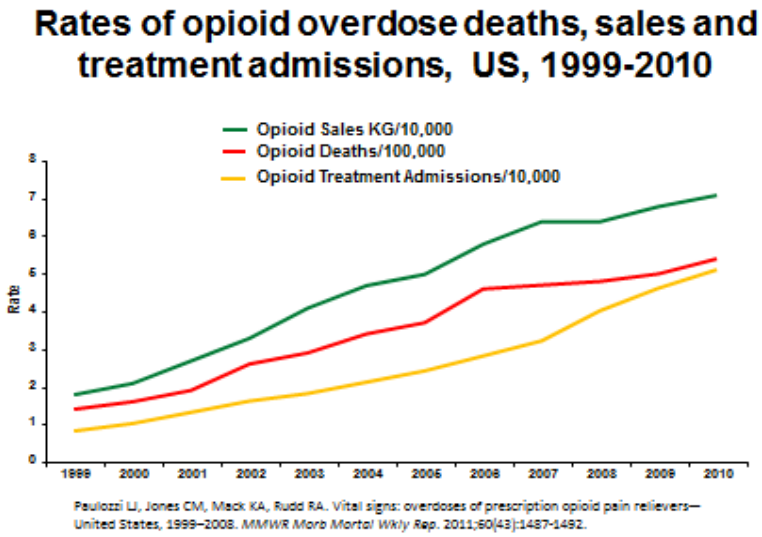
Senator Kaine, thank you for inviting the National Safety Council (NSC) to participate in this hearing today on Fighting Against a Growing Epidemic: Opioid Misuse and Abuse Among Older Americans.

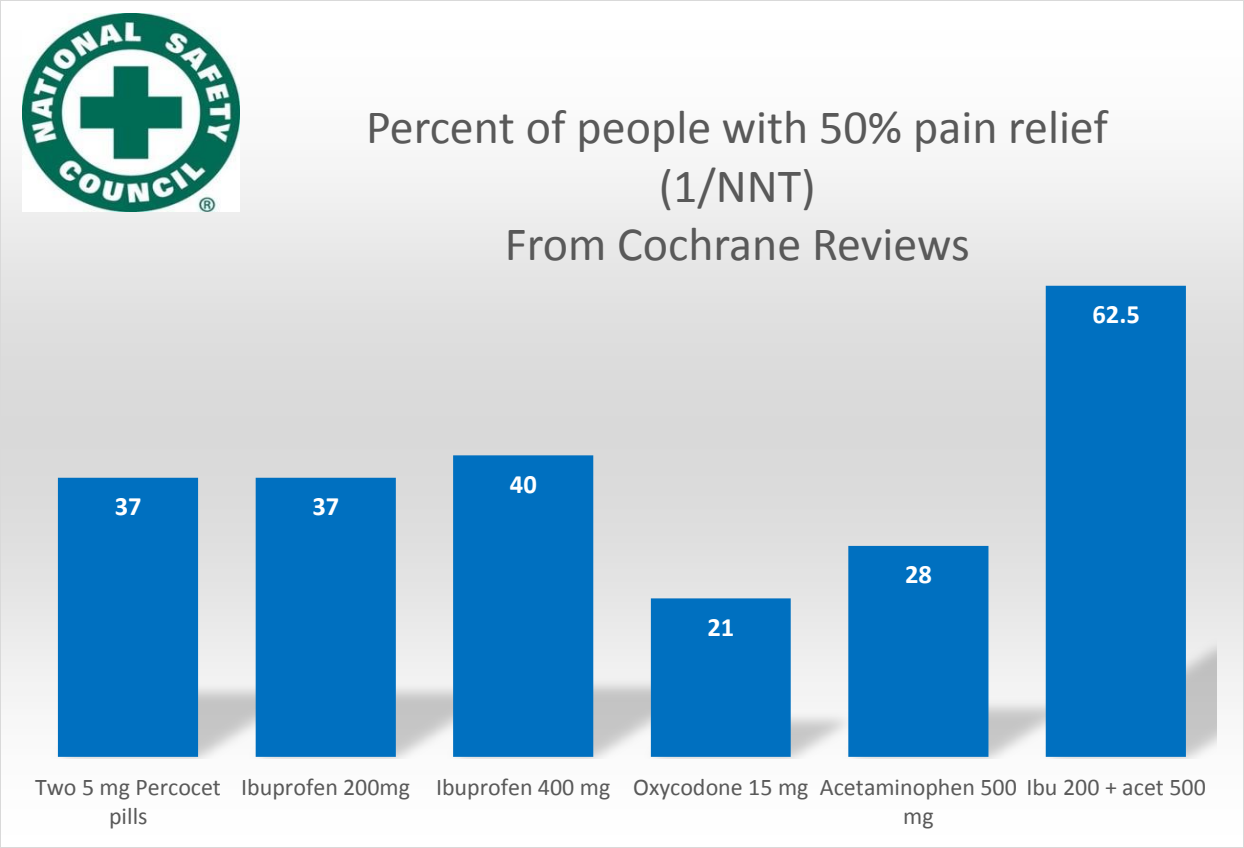
NSC is a 100-year-old Congressionally chartered nonprofit safety organization whose mission is to save lives by preventing injuries and deaths at work, in homes and communities and in transportation through leadership, research, education, and advocacy. NSC advances this mission by working with businesses, government agencies, elected officials and the public on the leading causes of preventable injuries and deaths, with a focus on distracted driving, teen driving, workplace safety, prescription drug overdoses and Safe Communities. Our more than 13,000 member companies represent nearly 8 million employees at more than 50,000 U.S. worksites, including 1,452 members in Virginia.

The data clearly show the scope of the epidemic. Opioid overdose deaths, once rare in the United States, have resulted in more than 220,000 lives lost in the past 15 years (175,000 from painkillers and 45,000 from heroin). Drug overdoses have become the leading cause of accidental death, surpassing motor vehicle crashes, and every hour in the United States, five people die as a result of a drug overdose. As the graph below demonstrates, this increase in deaths and treatment admissions is directly correlated with a rapid increase in opioid sales.



Paulozzi LJ, Jones CM, Mack KA, Rudd RA. Vital signs: overdoses of prescription opioid pain relievers—United States, 1999–2008. *MMWR Morb Mortal Wkly Rep*. 2011;60(43):1487-1492.

However, opioids have never been proven to be effective for the treatment of long-term pain.[1] In fact, over-the-counter medications can be even more effective for most types of pain.



Opioid Pain Medications and Older Americans

In 2011, an important generational milestone was reached: "baby boomers" started turning 65. By 2030, nearly one in five U.S. residents will be age 65 or older.[2] As our nation ages, Americans age 65 and older are increasingly bearing the burden from the growth in the prescribing and use of opioid painkillers. In 2014, nearly 900 older Americans lost their lives to an overdose involving opioid pain medications.[3]

Evidence shows that older adults are as prone to addiction as others. The Drug Abuse Warning Network reports about 35,000 people over 65 years old reported to emergency rooms for opioid abuse in 2004. In 2011, that number had increased to approximately 94,000 people.[4]

While older adults comprise 13 percent of the population, they account for more than one-third of total outpatient spending on prescription medications in the United States,[5] including opioid pain

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[1] Chou R, Turner JA, Devine EB, et al. The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop. *Ann Intern Med*. 2015;162(4):276. doi:10.7326/M14-2559.
[2] U.S. Census Bureau. An Aging Nation: The Older Population in the United States. May 2014 Accessed at https://www.census.gov/prod/2014pubs/p25-1140.pdf
[3] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death. 2014
[4] Substance Abuse and Mental Health Services Administration. *Drug Abuse Warning Network, 2011: National Estimates of Drug-Related Emergency Department Visits*. Rockville, MD; 2013.

medications. According to Pew Charitable Trusts, 9 million Medicare Part D beneficiaries filled prescriptions for opioids to treat conditions not associated with cancer or hospice.[6] More than 1.7 million of these patients received a dose that put them at increased risk of overdose.[7] Nearly 225,000 received these high doses for more than 90 days.[8]

Aside from addiction and death, high dosages and long term use of opioids have additional adverse effects when used by older patients. For example, opioid patients can experience a negative cognitive impact for up to five hours after one dose, which can intensify existing cognitive decline.[9]

Compared with non-steroidal anti-inflammatory drugs (NSAIDs), like ibuprofen and aspirin, older adults on opioids are:

- Five times more likely to suffer a fracture.[10] Falls are the leading cause of unintentional death for adults 65 years of age and older.[11]
- More than twice as likely to have a heart attack.[12]
- 50 percent more likely to have kidney damage.[13]
- 50 percent more likely to die while taking the medication.[14]

Prolonged opioid use at any age should be preceded by the use of alternative pain treatments and a thorough discussion with a physician to understand the risks associated with opioid pain medications.

Virginia

Virginia recognized early the toll opioid pain medications were taking on its citizens. Leaders acted to address this problem with improvements to the state prescription drug monitoring program (PDMP). Virginia is a leader in its efforts to educate prescribers about responsible opioid prescribing and about the clinical benefits of using the state's PDMP. Virginia's PDMP will make it easier for medical providers to know when very high and potentially fatal opioid dosages are prescribed to patients with the rollout of a new report feature. State PDMP reports will alert prescribers of the total morphine equivalent dosage for any patient taking opioid pain medications. Sharing this information with medical providers will save lives. We applaud Virginia policy makers for taking these steps to save lives, but we know more can be done at the state and federal levels, including enacting laws like the ones NSC outlines below.

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[5] National Institute on Drug Abuse. Accessed at http://www.drugabuse.gov/publications/research-reports/prescription-drugs/trends-in-prescription-drug-abuse/older-adults

[6] http://www.pewtrusts.org/en/multimedia/data-visualizations/2015/risks-of-opioid-use-in-the-elderly-and-medicare-populations

[7] Ibid

[8] Ibid

[9] Cherrier MM, Amory JK, Ersek M, Risler L, Shen DD. Comparative cognitive and subjective side effects of immediate-release oxycodone in healthy middle-aged and older adults. *J Pain*. 2009;10(10):1038-1050. doi:10.1016/j.jpain.2009.03.017.

[10] Miller M, Stürmer T, Azrael D, Levin R, Solomon DH. Opioid analgesics and the risk of fractures in older adults with arthritis. *J Am Geriatr Soc*. 2011;59:430-438. doi:10.1111/j.1532-5415.2011.03318.x.

[11] National Safety Council , Injury Facts 2015 edition

[12] Solomon DH, Rassen J a, Glynn RJ, Lee J, Levin R, Schneeweiss S. The comparative safety of analgesics in older adults with arthritis. *Arch Intern Med*. 2010;170(22):1968-1976. doi:10.1001/archinternmed.2010.391.

[13] Ibid.

[14] Ibid.

Prescriber Education Requirements

The Controlled Substances Act of 1970 requires all prescribers to apply to the Drug Enforcement Administration (DEA) before they are able to issue prescriptions for opioids and other controlled substances. This application provides an opportunity to ensure that prescribers understand the effects of these drugs, options available to treat pain and the signs of addiction. Studies show doctors do not receive this information in other ways. Physicians receive fewer than 12 hours of education about pain management in medical school.[15] Another study found that 60 percent of physicians surveyed did not "receive training on identifying prescription drug abuse and addiction" in medical school.[16] NSC believes, however, that prescriber education is a necessary step in reducing dangerous prescribing and improving pain treatment.

Currently, if a physician is required to register with the DEA, he or she is only required to provide personal information, a state medical license, background check information and the registration fee. This registration occurs every three years. While there is scrutiny by the DEA of potential criminal activity, there is no requirement for showing even basic knowledge about prescribing these powerful and addictive drugs.

It is already the standard of care for doctors to either have ongoing continuing education or document proficiency in order to prescribe certain dangerous medications, perform certain procedures or operate in certain states.

- Hospital Privileges—Physicians and midlevel providers must document training and proficiency in certain areas of knowledge and procedures before the granting of hospital admitting privileges.
- Accutane—Physicians must have expertise in the treatment of acne and in the use of isotretinoin to prescribe Accutane®.[17]
- Buprenorphine—Physicians must take eight hours of training to become certified to prescribe buprenorphine (Suboxone®). Following certification, physicians are subject to periodic review of their records and practices by the DEA.
- Kentucky—Doctors are required to take 4.5 hours of activity related to KASPER (Kentucky All Schedule Prescription Electronic Reporting), pain management or addiction disorders. They must also read *Responsible Opioid Prescribing: a Clinician's Guide* and complete on online exam.
- New Mexico—Prescribers who are registered with the DEA must complete a five-hour CME about pain and addiction.

Requiring prescriber education about effective chronic and acute pain treatment, responsible prescribing that includes the use of state PDMPs and addiction identification is a common-sense way to target those doctors who are prescribing opioids. This additional information arms these physicians with information they need to impact their prescribing habits.

Centers for Disease Control and Prevention (CDC) Prescribing Guidelines

The CDC has drafted opioid prescribing guidelines for chronic pain, which we support and view as critical in protecting people from the adverse effects of these medications. NSC comments supporting these guidelines are included with this testimony. Evidence suggests that prescribing

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[15] Mezei, L., & Murinson, B. (2011). Pain Education in North American Medical Schools. *Journal of Pain*, 1199-1208.
[16] The National Center on Addiction and Substance Abuse. (2005). *Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the US.* New York: Columbia University.
[17] http://www.fda.gov/drugs/drugsafety/postmarketdrugsafetyinformationforpatientsandproviders/ucm094308.htm

guidelines can reduce opioid-related harms. For example, opioid overdose deaths declined in Washington State after the introduction of guidelines that called for more cautious prescribing. In November 2014, the Washington Department of Health reported a 29 percent decrease in prescription opioid-related fatalities since implementation of its Interagency Guidelines Opioid Dosing for Chronic Non-Cancer Pain.

The CDC guidelines, by definition, are not requirements and will not dictate medical decisions. For those physicians, however, who seek data on how to effectively treat chronic pain, these guidelines provide useful information and serve as a valuable tool that is greatly needed in the United States.

The guidelines appropriately:

- Incorporate the best evidence available at this time
- Encourage better information sharing between doctor and patient
- Discuss the dangers of long-acting and extended release opioid pain relievers
- Support co-prescribing of naloxone and other safety measures
- Encourage the use of prescription drug monitoring programs (PDMPs)
- Educate providers about dangerous opioid interactions with other medications

These guidelines will save lives, and we hope the CDC finalizes them for widespread use soon.

Medicare Drug Management Programs

Older adults covered by Medicare can benefit from drug management programs that allow insurers to identify misuse of controlled substances like opioid pain medications and better coordinate patient care.

The drug management programs, which are also known as patient review and restriction (PRR) or lock-in programs, can prevent opioid and prescription drug misuse by assigning patients who are at risk to pre-designated pharmacies and prescribers to obtain these drugs. Through this mechanism, PRRs allow insurers and providers to improve care coordination and prevent medication misuse and errors.

The effectiveness of PRRs has led to their adoption in the public and private sectors, with major insurers operating these programs in their Medicaid managed care and employer-based plans. In addition, 46 state Medicaid programs currently operate PRRs.[18] A CDC examination of state Medicaid PRR programs concluded that these programs have the potential to reduce opioid usage to safer levels and thus save lives and lower health care costs.[19]

Prescription Drug Monitoring Programs

State PDMP databases collect prescription information that, in turn, can be shared with medical providers and pharmacists to inform clinical decision-making. In the case of opioids, PDMPs allow physicians to ensure they are not prescribing dangerous drug combinations or an excessive dose of opioids for a patient.

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[18] Roberts AW and Skinner AC. Assessing the present state and potential of Medicaid controlled substance lock-in programs." *J Manag CarePharm*. 2014;20(5):439-46c.

[19] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control (2012). Patient review & restriction programs. Lessons learned from state Medicaid programs. Available at http://www.cdc.gov/homeandrecreationalsafety/pdf/PDO_patient_review_meetinga.
pdf_

NSC fully supports Federal funding to help states make PDMPs easier for clinicians to use and to allow data sharing between states. The required and timely use of PDMPs will better protect patients by reducing medication errors and allowing for safer prescribing of opioid painkillers.

Opioid Use Disorder Treatment

Finally, more can be done to reduce the harm caused by the overprescribing of opioid pain medications by increasing access to opioid use disorder treatment. Medication-assisted treatment – buprenorphine and methadone – can be effective, but this treatment in older adults can be complicated by co-existing illnesses and the use of other medications. Specialized programs should be considered for effective treatment.

Naloxone

Naloxone saves the lives of those who have overdosed on opioids or heroin. It stops the effects of opioids and can literally bring someone back to life. The National Safety Council strongly supports the availability of naloxone throughout the United States and believes this can be accomplished in a few different ways.

States can provide standing orders for naloxone so that anyone in that state can receive naloxone without a prescription. Further, Medicare, Medicaid and private sector insurers should include naloxone as a covered drug in their drug formularies with lowest possible co-pay. This allows people who are taking opioids to obtain naloxone at the same time they receive their opioid prescription. It also allows loved ones of those who may have an opioid or heroin addiction to obtain naloxone for those terrible moments when they may need it.

S. 2556, the Co-prescribing Saves Lives Act

NSC proudly supports Senator Kaine's legislation to require federal healthcare facilities to co-prescribe naloxone when prescribing opioids, which could save lives. We also support better training and education for medical professionals around addiction and pain treatment called for in the Senator's legislation. Through our work, we know the challenges communities face, including cost and training, when obtaining naloxone, and we are pleased to see grant funding for these purposes included in this legislation.

Drug Take Backs

The Council supports continuing the important DEA drug take back days. The next day is scheduled for April 30, 2016, and another one will occur in the fall. These events allow for the collection of opioids and other drugs to ensure these medications are not taken by those for whom they are not prescribed. NSC continues to support DEA drug take back days and encourages continued Congressional support. The most recent take back day in October 2015 removed 350 tons of unused drugs from American homes.[20]

The Council has outlined several initiatives we believe can save lives and prevent addiction for people at all age levels. We look forward to working with you to enact these initiatives.

[20] http://www.dea.gov/divisions/hq/2015/hq100115.shtml