Testimony of Lisa Wilkins

Acting Director, Virginia Change Addiction Now

Field Hearing: "Fighting Against a Growing Epidemic: Opioid Misuse and Abuse Among Older Americans"

Monday, January 25, 2016

10:30 am

United States Special

Committee on Aging

Thank you Senator Kaine [and other Senators by name] for including me in this important field hearing to discuss potential solutions to what the Centers for Disease Control has declared to be the worst opioid epidemic our country has ever faced – this public health crisis has arrived in every corner of the country, in Virginia, and sadly, with a vengeance throughout Northern Virginia and my home in the nearby Shenandoah Valley.

My name is Lisa Wilkins and I am a 20-year resident of Berryville, Virginia. I am speaking today as a concerned citizen and a dues-paying member of the sandwich generation, having been impacted both as a parent and a daughter. I have recently been named the Acting State Director for Virginia CAN (Change Addiction Now) – an advocacy organization dedicated to bringing the family voice to addiction and recovery in Virginia communities, assisting families seeking information about treatment and recovery, reducing stigma associated with addiction, and promoting Harm Reduction in public policy designed to stem the tide of substance use disorder.

I come to you today with several perspectives - all of which have had varying degrees of personal impact.

- I lost my 23 year old son to a heroin overdose in 2011.
- My surviving son self-medicated his grief with the misuse of prescription opioids, and subsequently heroin (he is now in recovery)
- I was primary caregiver to my disabled mother, who suffered from chronic pain for 13 years
- I have assisted in the caregiving of extended family members in end-stage cancer.
- I have received both short term and longer term opioid therapies for a number of medical issues.

I believe these perspectives illustrate the range of those in our society whose pathway to opioid addiction can be the result of non-medical use (abuse) as well as those who can become addicted through medically prescribed (overuse or misunderstanding) pain medications. Both pathways are implicated in today's explosive crisis.

In the case of my sons, the youngest was exposed to prescription opioids like many youth today, through their widespread availability among peers and schoolmates. Both sons were treated with prescription opioids after childhood injuries – the older after being mauled by a dog at age 11, and the younger after a motor vehicle accident at age 15.

In addition to youth affected by prescription opioid misuse, an often overlooked population at risk, are older patients. One such case involved my mother. She was exposed to prescribed opioids as a course of treatment for her chronic pain. Throughout my mother's care, her doctor and I had to consider a myriad of safety issues in treating her with opioids – from falls, to unintentional misuse through confusion, to kitchen fire potential. Those risks were evaluated against her comfort and quality of life - as well as the anticipated dosages and length of treatment. Very often alternative treatments were explored, and when higher dose opioid treatment was necessary, she was treated under 24-hour supervision by myself or admitted to a skilled nursing facility. The lesson I learned from my mother's pain treatment is that this type of doctor/patient/family medical decision making should be THE standard of care - not the exception. My mother and our family were extremely lucky. Others, who may not have had engaged family members or attentive physicians may have had far more tragic experiences.

With over 259 million opioid prescriptions written in the US as recently as 2012, these drugs are filling our communities, workplaces, schools and medicine cabinets – making them widely available for misuse. It is easy for our youth and elderly alike to misjudge the addictive nature of prescription opioids, not realizing they are family to their synthetic cousin, heroin, and often believe that using prescription opioids are "safe". One of the lessons here is that more widespread education and awareness aimed at both youth and the elderly is a critical part of any solution to address the current opioid crisis.

According to some studies, the age group with the fastest rate of overdose deaths due to prescription opioids is 55 to 64 years old. In addition, according to the National Association of

Medicaid Directors, Medicaid patients are two times more likely to be prescribed opioids and six times more likely to suffer fatal overdose deaths. These populations are often overlooked as medical practitioners, clinicians and policy makers pursue strategies to address the opioid addiction and mortality crisis. This must change.

I am pleased to learn that through your leadership, you have developed two specific legislative proposals which will have a dramatic impact in preventing further prescription opioid misuse and abuse, and potentially save the lives of those at risk of an overdose event.

The Co-prescribing Saves Lives Act is a commonsense measure to provide access to the overdose reversing and life-saving drug Naloxone. The availability of this drug to family members, especially to those involved in elder care, is a powerful mechanism to save lives.

There is no good reason to fail in co-prescribing Naloxone with opioid prescriptions.

Further, family/caregiver education and inclusion goes hand in hand with offering this life saving antidote - which can, but is unlikely to, be self-administered. The bill will ensure anyone at risk for experiencing or witnessing an opioid overdose will be thoroughly educated in both the signs & symptoms of an overdose, as well as the administration of Naloxone.

As further justification for co-prescribing Naloxone and the involvement and education of family members and caregivers, I would like to point out that Primary Care Providers rarely provide a heart patient with a prescription for Nitro without reviewing its use and administration with

family members. Likewise, diabetes care education also includes family members of the diabetic by the very nature of its risks and treatment. Opioid therapy should be no different.

I am also supportive of the Stopping Medication Abuse and Protecting Seniors Act which will authorize the use of patient review and restriction (PRR) programs in Medicare. The proposed Lock-in, or primary pharmacy use, just makes logical sense to ensure reduced risk of dangerous drug combinations and interactions, as well as providing a vehicle to identify potential drug seeking behaviors to facilitate early intervention. There may be a trade-off between the perceived privacy issue and the very high risks associated with opioid therapies. Additionally, while many seniors and their families shop multiple pharmacies as a method to contain the high cost of prescriptions, the risk of potentially overlooking one single adverse interaction can be fatal and cannot be taken lightly. Caregivers may need to help seniors manage the total cost of their prescriptions, rather than the cost of each individual medication.

I believe that these two bills will support a more integrated "team approach" to caring for our seniors. I am convinced that these bills are about protecting our most vulnerable citizens, while making sure that they receive the best medical care we can provide.

Finally, I would like to end with an endorsement of the development of opioid prescribing guidelines to better educate physicians in opioid therapies and risks. The two bills mentioned in parallel with prescribing guidelines set a stage where Primary Care Providers, their patients, and the patients' caregivers consider adding opioid therapy only where benefit outweighs risk and the patient fully understands and can weigh in on the risk/benefit analysis. This risk/benefit analysis

should be used in the development of treatment goals where the parties work together to set realistic expectations for pain management/relief based upon the nature of the chronic pain, with the primary drivers being function, patient safety and quality of life versus an illusion of pain free. Regular evaluation of the treatment plan, effectiveness, and any changes to the risks/benefit analysis can, and should, be conducted in a manner that does not place undue hardship on the patient in receiving treatment, obtaining refills, and filling prescriptions.

These two bills combined with additional prescribing guidelines will ensure family members and caregivers are given similar levels of patient education - including the signs and symptoms of overdose as well as other opioid-related harms. Family members should be included in the decision process, as their observations may not be consistent with patient perception.

Thank you for the opportunity to discuss this important public health issue today.