Academy of Integrative Pain Management

Leaders in Multidisciplinary Care Since 1988

Oral Testimony on Senate Bill 165
Provided by Robert Twillman, Ph.D.
On Behalf of the
Academy of Integrative Pain Management
February 20, 2017

Madam Chairwoman and Members of the Committee:

My name is Bob Twillman, and I am the Executive Director of the Academy of Integrative Pain Management. The AIPM is the nation's largest organization for healthcare professionals who treat pain. Approximately half of our nearly 4000 members nationwide are MDs and DOs, while the remainder represent 30 additional professional disciplines. As suggested by its name, AIPM promotes an integrative model of pain management, in which all evidence-supported interventions are brought together to provide the best possible treatment for pain. Each individual person with chronic pain requires a unique treatment plan that is tailored to their specific circumstances. Put another way, there is no cookbook for treating chronic pain, and one size doesn't even fit most, much less all. Our mission is to teach professionals how to find a formula that works for each patient, and to advocate for policies that make it possible to carry out such a treatment plan.

I'm here today to testify in support of Senate Bill 165, an act that would expand access to both abuse-deterrent opioid analgesics and to emergency opioid antagonists. AIPM recognizes the challenges involved in addressing two major public health crises, namely, inadequate treatment for pain, and prescription drug abuse, and to that end, has been heavily involved in both national and state-level efforts to address both issues. The expanded access to two types of medications that would be provided by this bill is a vital component of a comprehensive approach to simultaneously addressing both public health crises and can save the lives of many Kansans.

While integrative pain management is inherently multimodal and multidisciplinary in nature, the fact remains that some portion of people with chronic pain require long-term treatment with opioid pain relievers.

When these medications are prescribed and monitored appropriately, most patients do well, and experience improvements in pain, function, and quality of life. There are instances, however, where medications are used inappropriately. The consequences of inappropriate use include a variety of adverse outcomes, including, potentially, death due to overdose. However, there are numerous steps that can be taken by policymakers to avoid those adverse outcomes, two of which are contemplated by SB 165: improved access to abuse-deterrent opioid analgesics and improved access to opioid antagonists such as naloxone.

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The path to opioid overdoses, in many cases, begins with the misuse of prescription pain relievers. Annually, according to the National Survey of Drug Use and Health, approximately 12.5 million Americans use prescription opioids in ways other than prescribed, or purely for the emotional effects derived from such misuse. In that same survey, more than 70% of people misusing prescription opioids report that, the last time they did so, they got the medications from friends or relatives—either being given them for free, or by stealing or buying them from those friends or relatives.

It's important to understand that, early in the course of prescription opioid abuse, the most common method used to engage in such abuse is by swallowing the medication intact. As substance abuse progresses and sometimes turns into a diagnosable substance use disorder, the most common method of ingestion becomes inhalation or injection. To achieve this, the prescription pills are crushed, melted or otherwise altered so that they can be either inhaled or injected. This can be especially dangerous behavior, because it is often high-dose tablets or capsules designed to deliver the drug over 12 hours after it is swallowed, that are manipulated in this manner. Thus, the abuser receives a full 12-hour dose over the span of approximately 30 minutes, driving blood levels so high that the individual can overdose and stop breathing.

When this form of prescription opioid abuse became common in the late 1990s and early 2000s, pharmaceutical manufacturers began working on ways to prevent their products from being altered in these ways. Over the years, a number of potential mechanisms to prevent such product alteration have been proposed. To date, there are nine distinct products approved by the federal Food and Drug Administration as having what they refer to as "abuse-deterrent" properties. These products fall into two classes: 1) products that, because of their makeup, are difficult to cut or crush, and which sometimes turn into a thick gel that can't be inhaled or injected; and 2) products that contain a second drug that blocks the effects of the opioid if the drug is inhaled or injected, but not if it is swallowed. This inability to alter the medications so that they can be inhaled or injected makes them far less desirable to those who would otherwise divert the medications for unlawful use.

While these abuse-deterrent opioid products help prevent the most dangerous form of prescription drug abuse, they are not a panacea that will prevent all opioid overdoses. They are, however, one part of a comprehensive set of interventions that can help solve our national opioid abuse problem. For this reason, it is our belief that abuse deterrent opioids should be part of a multi-faceted approach to decreasing abuse. **Although ADOs do not prevent users from simply swallowing too much medication, they may help reduce the public health burden of prescription opioid abuse in Kansas by making it harder and less desirable to abuse opioid medications in the most dangerous ways.** People are prescribed ADOs, rather than non-ADOs, to treat their pain conditions for a variety of reasons: some want to prevent access to non-ADOs by the teenagers living in their home; some live with roommates or family members who have a history of drug abuse; and some have a history of substance use disorder themselves (not just prescription-related, but potentially including alcohol and illicit drug abuse). Whatever the reason, these persons, along with their health care providers, have decided that an ADO is an appropriate medication to simultaneously manage their health condition and to protect the public safety. **All persons, regardless of their unique medical condition or their financial standing, should have access to high quality, effective, and safe health care.**

It is vital that you act now to ensure appropriate access to ADOs. The Food and Drug Administration (FDA) wrote in a 2013 ADO-related guidance for drug makers that the "FDA considers the development of these products a high public health priority." Further, in February 2016 the FDA announced that they will now mandate that any new opioid go before an outside committee of experts, unless the product has abuse-deterrent properties. It is clear that the FDA has recognized the promise of these life-saving medications, but they will only live up to that promise if they are affordable to those who need them. This financial consideration is why legislation mandating that some of these products be covered by insurance is necessary.

In the second part of SB 165, provisions are made to improve access to drugs that counteract the dangerous effects of opioids. Many people with pain experience significant pain relief and improved functioning as a result of using opioid pain relievers. When used as prescribed by a competent provider, these medications are almost always safe. However, patients may develop transient medical conditions, such as respiratory infections, that make their usual doses unsafe and increase their risk of unintended overdose. Additionally, despite warnings to the contrary, patients occasionally may exercise poor judgment and consume alcohol or other substances that substantially increase overdose risk when combined with their prescription medications. **We do not believe that either of these circumstances should result in a patient's death, an outcome that can be prevented by the prompt administration of readily-available naloxone.**

Other individuals use licit and illicit opioids as part of a pattern of substance abuse. These people are at substantial risk of unintended fatal overdose as a result. In fact, according to the Centers for Disease Control and Prevention, "...from 2000 to 2014 nearly half a million Americans died from drug overdoses. Opioid overdose deaths, including both opioid pain relievers and heroin, hit record levels in 2014, with an alarming 14 percent increase in just one year." We believe that substance abuse should not be a fatal medical disorder, and we advocate for the availability of naloxone for these individuals, as well. **We know of no evidence that such a vital harm reduction strategy results in increased substance abuse, but we do know that such a strategy saves lives.**

This bill would direct the Board of Pharmacy to issue a statewide opioid antagonist protocol that establishes requirements for a licensed pharmacist to dispense naloxone, ensuring that this life-saving drug is able to be in the hands of patients, first responders, and concerned community members. Community-based access to naloxone is a vital way to save lives—according to the CDC, over 26,000 overdose rescues have been made using overdose reversal kits distributed by community groups (a figure that is ever-growing).

All individuals at risk of an opioid overdose, whether because of illicit drug use or through an unexpected reaction to a legitimately and appropriately taken medication, can benefit from passage of SB 165.

This bill is an important step in solving the current problem of unintended overdose deaths resulting from the use of opioid pain relievers and illicit opioid drugs. For this reason, the Academy of Integrative Pain Management enthusiastically supports this legislation, and urges this committee to move it on to the full Senate for consideration.