Good morning. My name is Dr. Jeffrey Jacobs. I'd like to thank Chairman Kauffman and the members of the House Labor and Industry Committee for the invitation to speak today about opioid prescribing in Pennsylvania.

I have been a physician for over thirty years and have spent over 20 years as in Occupational Medicine providing medical support for worker health and safety, the last 12 in Pennsylvania.

I have been asked to describe the nature and the extent of the prescription drug abuse issues I have noticed in Pennsylvania’s Workers Compensation (WC) system and to comment on the best practices (including the creation of a drug formulary) that could be taken to reduce the amount of prescription drug abuse in the system.

Musculoskeletal pain, whether acute or chronic makes up the bulk of patient visits in the Workers Compensation system. For example, back pain is the most common physical condition for which patients visit their doctor. In any given year, between 12% and 14.0% of the United States’ adult population will visit their physician with complaints of back pain. (1)

It is estimated that 1 out of 5 patients with a non-cancer pain diagnosis is prescribed opioids in office-based settings with primary care providers accounting for about half of all opioid pain relievers dispensed. (2)

Additionally, as we see the opioid prescribing map from the Centers for Disease Control, Pennsylvania providers prescribe opioids at a moderately high rate, especially compared to NJ and NY. (3)
Comparative studies between select opioids and non-opioid medications (non-steroidal anti-inflammatory drugs, like Ibuprofen) have not found that the use of opioids is more effective in pain relief for acute or chronic musculoskeletal pain.

- There were four quality trials of acute pain patients treated with opioids compared with placebo, with a small overall magnitude of benefit, whereas the adverse effects profile was high. (4)

- Among trials for treatment of acute pain, ibuprofen was reportedly superior to codeine or acetaminophen for acute injuries including fractures. (4)

- Diflunisal was equivalent to codeine for sprains, strains, and mild to moderate LBP. Diflunisal was also superior to codeine/APAP for LBP. (4)

- Valdecoxib was better-tolerated and trended toward greater pain relief than tramadol for ankle sprains. Valdecoxib was equivalent to oxycodone as assessed by pain ratings, but trended toward less rescue medication use and had fewer adverse effects among patients with spine and extremity pain. (4)

- Ketorolac was equivalent for pain relief, but superior to meperidine regarding adverse effects for treating severe LBP. Ketorolac was also superior to codeine/acetaminophen for acute LBP treated in emergency departments. (4)

Adverse health risks associated with opioids include constipation, sexual dysfunction, sedation, insomnia, depression, reduced pain thresholds (Opioid-induced hyperalgesia) and tolerance requiring increases of the opioid dosage to achieve the same level of pain relief. Often, especially in those individuals with chronic pain, they are also prescribed additional medications to counteract the adverse reactions from taking the opioids. Some of these individuals have a poor quality of life, not just from their injury many years in the past, but also from multiple failed surgeries, the adverse effects of the medications and simply being deconditioned from lack of exercise and movement.
• Although 24% found a way to defeat the tamper-resistant properties of the abuse-deterrent formulation, 66% indicated a switch to another opioid, with 'heroin' the most common response. (9)

Most unfortunately, Pennsylvania has gone from 16 to 27 deaths per 100,000 people between 2010 and 2015 according to recent data from the CDC in December 2016. We currently have the 6th highest overdose rate in the US.

Age-adjusted rate of drug overdose deaths, by state — 2010 and 2015 (10)
3. Consult PDMP data, perform pill counts and obtain random urine drug testing to detect aberrant opioid drug-seeking behavior.

4. Use functional improvement as a guide to continue opioids.

5. Consider further testing (imaging studies or nerve conduction studies) or specialist referral should function and pain fail to improve with conservative treatment while on opioids. Suggest 2-3 week timeframe for primary care prescribing of opioids.

6. The maximum daily oral dose recommended based on risk of overdose/death is 50-mg morphine equivalent dose (MED). (4)

7. Acute or chronic opioid use is not recommended for patients who perform safety-sensitive jobs. [These jobs include operating motor vehicles, other modes of transportation, forklift driving, overhead crane operation, heavy equipment operation, sharps work (e.g., knives, box cutters, needles), work with injury risks (e.g., heights) and tasks involving high levels of cognitive function and judgment.] (5)

Recommendations for the Treatment of Chronic Musculoskeletal Pain (4)

An opioid trial, preceded by full informed consent and a trial agreement is recommended if other evidence-based approaches for functional restorative pain therapy have been implemented, with documented adherence, and with inadequate improvement in function.

Pain or pain scales alone are recommended as insufficient reasons.

Examples of functional gains to track include walking distance, numbers of repetitions of specific exercises, return to work, and return to modified duty.

Maintenance opioids are recommended for those achieving functional gains

Legislative Solutions
b. In New York

- 2012 Action: Required prescribers to check the state's PDMP before prescribing opioids.
- 2013 Result: Saw a 75% drop in patients' seeing multiple prescribers for the same drugs. (15)

c. In Pennsylvania

- Effective January 1, 2017, new legislative changes to the Pennsylvania Prescription Drug Monitoring Program (PA PDMP) took effect.
- Registration with the PA PDMP program is now required for all prescribers and dispensers licensed in the commonwealth.
- Prescribers must now query the PA PDMP each time a patient is prescribed an opioid drug product or benzodiazepine by the prescriber. (16)

2. Consider policy options relating to pain clinics to reduce prescribing practices that are risky to patients.

3. Promote and support the use of evidence-based guidelines for the evaluation and treatment of acute and chronic musculoskeletal pain. (4, 5, 7)


Research suggests that cognitive behavioral therapy utilizing these or similar tools can be effective in reducing opioid use, even in the context of chronic pain. A 3-week intensive behaviorally-based pain program on opioid use showed that, at 18-month follow-up, 123 patients not only used significantly less opioid medication (72% vs 24%), but also reported significantly lower pain levels (8.2/10 vs 4.2/10). (17)

Currently, CBT is the prevailing psychological treatment for individuals with chronic pain conditions such as low back pain, headaches, arthritis,
Conclusion

The points that I'd like to leave you with are that:

1. Opioids have a role in the treatment of pain, but they are not the first line medication in most situations.

2. Any decision to prescribe an opioid must take into account the risks and benefits to the individual.

3. The decision to prescribe or continue an opioid should be based on functional improvement.

4. There are tools available to the primary care provider that optimize the well-being of their patients with acute or chronic musculoskeletal pain.

5. All stakeholders have a share of the blame for the opioid epidemic and must be a part of the solution.

Citations


