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Committee on Energy and Commerce

Subcommittee on Oversight and Investigations

"Combatting the Opioid Abuse Epidemic: Professional and Academic Perspectives"

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Thank you Chairman Murphy, ranking member DeGette, and members of the Committee for holding these hearings and for inviting me to speak. My name is Dr. Anna Lembke, and I am on the psychiatry faculty at the Stanford University School of Medicine, where I direct the Addiction Medicine Clinic, treat patients, teach, and conduct addiction research. I've spent over a decade treating patients dependent on, misusing, and addicted to opioids, many of whom became addicted through a doctor's prescription.

The main point I would like to make today is simple. We don't just have an opioid misuse epidemic, or an opioid overdose epidemic, we also have an opioid over-prescribing epidemic.

Doctors are a major pipeline of misused and diverted prescription opioids. Contrary to what is commonly believed, doctors who treat addiction are not the source of the problem. The methadone that accounts for 40% of single-drug opioid pain reliever deaths is almost entirely in the form of pills prescribed for the treatment of pain, rather than coming from methadone maintenance clinics that treat heroin-dependent patients[1]. We thus need to think broadly

about the problem of changing the behavior of all physicians and not just those who treat addicted patients.

I was pleased to see that education of providers was identified as one of three priority areas in the report issued last month by the Department of Health and Human Services, which called prescribers "the gatekeepers for preventing inappropriate access"[2]. But providing educational material on safe opioid prescribing, even if it's free and readily available, won't be enough.

To change doctor prescribing behavior, we need first to acknowledge the enormous incentives to prescribe opioids, and the disincentives to stop prescribing[3]. Many doctors are afraid that a patient will sue them or complain about them if they don't prescribe opioids, even when the doctor knows the opioid is harming the patient. Also, no insurer questions me when I prescribe Vicodin for pain, but if I want to prescribe Suboxone to help an addicted patient stop taking Vicodin, I typically have to spend hours fighting an insurance company to get the prescription approved. Despite the Mental Health Parity and Addiction Equity Act that Congress passed by a huge bipartisan margin in 2008, many insurers still resist reimbursing for addiction treatment.

The solution to this problem lies in giving doctors tangible incentives to prescribe more judiciously, such that neither pain nor addiction is undertreated.

Today I focus on three areas where I believe this Congress can make a positive difference.

1. **Require revision of health care quality measures**
2. **Incentivize use of Prescription Drug Monitoring Programs (PDMP's)**
3. **Scrutinize accreditation organizations and regulatory agencies**

First, require revision of health care quality measures

The Centers for Medicare and Medicaid Services and The Joint Commission exert enormous control over how doctors practice medicine. Their quality measures set the standard of care. In the 1990s, when they urged doctors to prioritize pain treatment, that's what we did. Prescriptions for opioids sky-rocketed, not always to the benefit of our patients.

CMS and The Joint Commission need to link quality measures to treatment outcomes for patients with addiction. This will incentivize hospitals and clinics to create an infrastructure to screen for and treat opioid addiction.

Quality measures should also limit excessive prescribing of multiple drugs to the same patient, especially of controlled medications. A younger person with no objective evidence of disease should not be on 10 different medications a day, yet I often see this, and the medications frequently include an assortment of stimulants, sedatives, and opioids. Also, far too many patients are on a prescription for benzodiazepines (i.e., tranquilizers) at the same time as opioids, which greatly increases their risk of overdose.

Finally, CMS and Joint Commission quality measures should *not* be linked to patients' satisfaction with opioid prescribing. Illness recovery, not patient satisfaction surveys, should be the arbiter of quality care. Doctors are not waiters and opioids are not items on a menu.

Second, incentivize use of Prescription Drug Monitoring Programs (PDMPs)

Prescription Drug Monitoring Programs allow doctors to see all the controlled medications prescribed to a patient, beyond just the ones they themselves are prescribing. When physicians make use of Prescription Drug Monitoring Programs, prescription drug misuse decreases[4]. PDMP's don't merely limit access to opioids when they should not be prescribed, they allow for patients who really need opioids to get them. The question is how to get more doctors to use PDMPs. By some reports, only 35% of prescribers use these databases[5].

Ways to incentivize doctors to use PDMP databases include making it a billable medical service, mandating education on use of PDMPs when physicians apply for DEA licensure, and amending privacy laws, such as 42CFR, so that health care providers can freely communicate with each other around issues related to prescription drug misuse.

Third, scrutinize accreditation organizations and regulatory agencies

The Joint Commission, the accreditation organization which sets standards for hospitals, was instrumental in socializing doctors to liberally prescribe opioids for pain. The Joint Commission's campaign on treating pain was funded in part by Purdue Pharma, whose main product is Oxycontin[6]. I don't think Congress should allow a major health care accreditation body like The Joint Commission to take money from the pharmaceutical industry.

In 2012, the Food and Drug Administration (FDA) wisely rescheduled hydrocodone products to Schedule II. But the very same week, the FDA approved the use of Zohydro, a longer acting opioid with high abuse potential similar to Oxycontin[7]. The FDA's own advisory

panel recommended not to approve Zohydro, yet it was approved anyway. Why? Do we really need one more high risk opioid medication on the market? It seems to me like trying to empty a bathtub with a thimble while filling it with a firehose.

Furthermore, the FDA should live up to its commitment to stop approving non abuse-deterrent formulations of opioids, which it did not do when it approved Zohydro. And doctors and patients need to understand that abuse deterrent formulations make it harder to crush and snort/inject an opioid, but don't prevent ingesting opioids orally at high doses, becoming physiologically dependent on and addicted to them, and overdosing on them.

To sum up, Congress can push back against the opioid epidemic by requiring revision of health care quality measures to reduce over-prescribing, incentivizing use of Prescription Drug Monitoring Programs (PDMPs), and scrutinizing accreditation organizations and regulatory agencies. All three approaches will save lives and improve the practice of medicine at the same time.

Thank you again for this opportunity to testify and for your leadership in addressing this public health epidemic.

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