Attachment—Additional Questions for the Record

Subcommittee on Health
Hearing on
"An Epidemic within a Pandemic: Understanding Substance Use and Misuse in America"
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The Honorable Frank Pallone, Jr. (D-NJ)

1. **One approach to address substance use disorder is to reduce excess or unnecessary prescriptions for narcotics and to increase access to medication that can treat substance use disorder and prevent overdose death. However, per SAMHSA's most recent report in 2019, 1.6 million people in the U.S. had Opioid Use Disorder yet only about 1 in 3 received evidence-based Medication Assisted Treatment from a certified treatment center. In addition, the rate of naloxone prescriptions has increased substantially, but prescribing rates for high-dose opioids still far exceed that of naloxone and naloxone dispensing varies substantially across the country. Dr. Wilson, as a physician, do you support additional training on safe opioid prescribing for health care professionals? If so, why do you believe that additional is necessary?**

We absolutely need additional training on safe opioid prescribing for health care professionals, but also, we need to broaden this type of training to better address the current opioid crisis. All health care professionals who prescribe opioids should receive training not only in how to safely prescribe and monitor opioids in individuals receiving them for pain, but also how to provide counseling and education in reducing overdose and misuse risks, and in how to identify and recognize those patients for whom opioid prescriptions have become problematic. Currently few health care professionals receive this kind of training as part of routine medical education. Current safe opioid prescribing lectures often solely focus on how to prescribe opioids for pain but fail to provide any information on how to manage suspected misuse or how to support and treat patients who have developed opioid use disorders. In response to suspected opioid misuse, many providers will then fail to recognize it or will recognize it and then abruptly discontinue or aggressively taper patients leading to severe withdrawal and increasing risk for illicit opioid use and potentially overdose. All providers able to prescribe opioids should receive mandatory training in a core curriculum recognizing how you prescribe and manage opioids safely for pain, and how you recognize, manage, and treat individuals who then develop side-effects to the medications, such as opioid use disorder.

2. **Dr. Wilson, legislation before the Subcommittee today would require a minimum level of training related to treatment and management of patients with opioid or substance use disorders. Do you believe this approach would help to support safe opioid prescribing?**

Education requirements around safe opioid prescribing must be broader than how to safely prescribe opioids for pain, but also must provide training on how best to identify and manage those patients with pain who have developed an opioid use disorder or other substance use disorder. Providers currently receive little to no training in identifying and treating patients with opioid use disorder as part of routine medical education. For all providers able to prescribe opioids, they should also receive training in how to identify and treat opioid misuse and how to offer treatment for those who go on to develop an opioid use disorder. I all too often will see patients abruptly terminated from a pain clinic where their doctor was prescribing opioids and stopped because of appropriate or inappropriate concern for misuse. Patients are left in severe withdrawal and often then turn to illicit opioids, increasing their risk for possibly fatal overdose. It is irresponsible to prescribe opioids without also knowing how to monitor for misuse and opioid use disorder and then how to safely transition patients to medications to treat opioid use disorder. Safe opioid prescribing also means knowing how to safely treat and manage opioid use disorder.

3. **Dr. Wilson, could you speak, as a provider in this field, to any consequences or barriers in an individual's recovery that might arise from the ID requirement set forth in H.R. 2355, the Opioid Prescription Verification Act of 2021?**

   I have repeatedly seen that ID requirements serve as a large and potentially unforeseen barrier to treatment engagement and retention for patients. For example, currently many methadone opioid treatment programs still require that patients present with an ID prior to connecting with the program. I see patients in the hospital who are eager to get plugged into substance use treatment and want to be on methadone, but who lack an ID. It is a tragedy when we as healthcare providers are ready and able to start patients on medication to treat their opioid use disorder, when patients are ready and willing to start, and when we cannot get them plugged into treatment because of ID requirements.

   Although not the intention of the Act, any addition regulation requiring that medications to treat opioid use disorder, such as buprenorphine or suboxone (as they are classified as opioids), would require an ID to be filled, would create an undue burden for vulnerable patients. The ID requirement would unintentionally serve as a barrier to treatment with potentially fatal consequences as stable patients would risk return to illicit use if unable to fill medications and patients eager to start treatment would be delayed. <u>Any delay or any interruption in receiving the life-saving medication to treat opioid use disorder could be fatal.</u>

Lacking an ID is a common experience for many of the patients for whom I provide care. These patients still provide their names and their date of birth to pharmacists when they pick up their medication. The medication is listed in our (PA) state PDMP under the individual patient's name. I can track their refills and see if they have filled any other opioids at other pharmacies. Adding an ID requirement would only serve as a barrier to my patients continuing or starting life-saving medication to treat their opioid use disorder without adding any additional clinical or regulatory benefits. An ID requirement would be a potentially tragic barrier interrupting and preventing care for an already vulnerable group of patients.

4. **Is it correct that vulnerable patients (such as the homeless) may be unable to continue their recovery medications and experience relapse and overdose if they are required to provide an ID to get their medications from the pharmacy?**

Patients with substance use disorders commonly struggle with having IDs (as they may be homeless, live lives with some chaos prior to connecting with treatment that may make it hard to keep an ID secure, and are at increased risk for victimization and theft causing their IDs to be taken). Replacing an ID is not an easy task: there is a financial burden to patients often with limited resources, patients often need other supporting documents, such as birth certificates they also lack, and even for patients who are able to start the process it can be a lengthy one. Any delay in care can be a deadly delay in care as patients risk return to use. A new pharmacy requirement would also threaten individuals who are already successfully receiving medications and engaged in treatment. The patients would experience acute opioid withdrawal and be at high risk for a relapse and possible overdose. Any new requirement stating patients would need to use an ID to pick up opioid medications to treat their opioid use disorder, such as to fill a buprenorphine or suboxone prescription, would lead to unnecessary deaths. ID requirements would create an undue burden for the most vulnerable patients.