Statement of

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I. Introduction

Thank you, Mr. Chairman. My name is Mark Rosenberg, D.O., M.B.A., F.A.C.E.P., F.A.A.H.P.M., and I am the Chairman of Emergency Medicine at St. Joseph's University Medical Center in Paterson, New Jersey. In this role, I am responsible for overseeing the care of more than 170,000 adult and pediatric emergency visits annually – at the 4th busiest Emergency Department in the country. I currently serve on the Board of Directors of the American College of Emergency Physicians (ACEP).

On behalf of St. Joseph's University Medical Center, the 38,000 members of ACEP and the great state of New Jersey, I would like to thank the committee for this opportunity to provide testimony in support of HR 5197, The Alternatives to Opioids (ALTO) in the Emergency Department Act, and HR 5176, Preventing Overdoses While in Emergency Rooms (POWER) Act.

As you know, the United States faces a steadily growing crisis of opioid abuse and addiction that has reached epidemic proportions. According to data from Centers for Disease Control and Prevention, in 2016[1]:

- 11.5 million people misused prescription opioids;
- 2.1 million people had an opioid use disorder;
- 42,249 people died from opioid overdoses; and
- The total economic burden to the United States has been estimated to be well over $500 billion.

This opioid epidemic claims the lives of more than 116 Americans every day and more Americans have died each year during the past decade from drug overdoses than motor vehicle accidents.

Just last week, the CDC published new data[2] on this issue that showed a 30 percent increase in opioid overdose visits to Emergency Departments between July 2016 and September 2017. A further analysis of this data revealed opioid overdoses increased for all segments of the population and in all regions, which included:

- 30 percent increase for men; 24 percent increase for women;
- 31 percent increase for people ages 25-34;
- 36 percent increase for people ages 35-54;
- 32 percent increase for people ages 55 and over; and
- 30 percent average increase for most states with the highest average increase of 70 percent in the Midwestern region.

We could endlessly debate the factors that have contributed to the rise of this widespread and deadly epidemic in America, and how best to curb its growth. However, today I am here to discuss two innovative programs that emergency physicians have developed to help ameliorate this epidemic: The Alternatives to Opioids (ALTO) program and Emergency Department-initiated Medication Assisted Treatment (MAT).

II. ALTO

A study published in the New England Journal of Medicine in February 2017, found a wide variation in the prescribing habits of doctors working in the same emergency departments all across the country. In fact, some doctors were three times as likely to prescribe painkillers for patients with similar ailments as their colleagues. This is where the evidence-based protocols of ALTO come in to play.

ALTO was developed by my team at St. Joseph's University Medical Center in New Jersey in 2016 – to address the very issue of variation and over-prescribing. Our multidisciplinary acute pain management program not only helps treat painful conditions for emergency department patients without using opioids, but also helps other patients with drug dependency and addiction. We started this program with a very simple premise: the best way to avoid opioid misuse and addiction is to never start a patient on opioids. Instead of using opioids, which mask or cover up pain, ALTO protocols use an evidenced base approach to manage the pain. ALTO protocols use specific non-addicting drugs and therapies that target receptor sites and enzymes that mediate the pain therefore stopping the pain at the site of the problem. For example, a patient with back pain, instead of receiving an opioid and muscle relaxant, the patient is given a layering of targeted therapies that include non-addicting medications and a trigger point injection resulting in pain management and improved patient experience of care.

I am proud to say that after two years of implementation at St. Joseph's - the ALTO program has witnessed tremendous success. Six months before the program was launched, physicians at St. Joseph's Emergency Department wrote over 4,000 prescriptions for opioids. One year later, with

the use of ALTO protocols, that number decreased by 46 percent. Two years later, we've seen an 82 percent reduction in opioid prescriptions. These statistics reveal that (evidence-based) changes to clinical treatment and protocols can have a dramatic impact in the fight against opioid addiction and overdose. And, even more importantly, the ALTO program can save lives. This is why H.R 5197 and the $10 million per year for three years it provides can help expand access to this evidence-based program to other Emergency Departments across the country.

I would be happy to answer any questions you may have about our ALTO program - including the specific alternative therapies we use in ALTO pain management, the multidisciplinary approach behind the success of ALTO, or the increased interest of ALTO by physicians and Emergency Departments all across the country.

III. ED-Initiated MAT

Another innovative program that has shown positive results in getting patients with opioid use disorders into treatment is Emergency Department (ED)-initiated Medication-Assisted Treatment (MAT). Beyond the high risk of overdose, patients with substance use disorders (SUDs) typically also have complicated health and social conditions and often seek care in the Emergency Department for treatment. This offers emergency physicians a unique opportunity to provide opioid misuse interventions and initiate referrals for continued treatment by appropriately trained pain management specialists, primary care providers, or addictions specialists, especially when confronted with a patient who has just experienced a non-fatal overdose.

Studies published in 2015[3] and 2017[4] showed that ED-initiated buprenorphine, versus simple referral for treatment or a brief intervention, is associated with increased engagement in addiction treatment, reduced use of illicit opioid use, and decreased use of inpatient addiction treatment services one and two months later. Data has shown that two months after their ED visit, 74 percent of patients who were given buprenorphine/naloxone (Bp/Nx) were engaged in addiction treatment, compared with 53 percent in the referral-only group, and 47 percent of those in the brief intervention with referral group.

One of the key elements of H.R. 5176, and frankly any successful ED-initiated MAT program, is the requirement that the health care site have agreements in place with a sufficient number of community providers to ensure a "warm hand-off" from the ED can be established. Initiating MAT in the ED can be the critical difference between a patient with a SUD following through on their addiction treatment or not, but just as important is ensuring sufficient access to and continuation of services in the outpatient setting.

This integrated, coordinated care model has shown great promise and H.R. 5176 is critical to validating that ED-initiated MAT can be not only efficacious, but cost-effective as well. This program can save lives. According to the 2015 study referenced previously, for those patients who were engaged in treatment at follow-up, only 11 percent who had initiated treatment with Bp/Nx in the ED were receiving inpatient care, while that number was 35-37 percent in the other groups.

Over the long-term, we need to also develop an appropriate, sustainable reimbursement structure that will foster and further enable the use of ED-initiated MAT. Such a structure should apply across private payers, Medicaid, and Medicare, given that all these populations can be affected by SUDs, as can any American.

IV. Conclusion

We appreciate what Congress has done so far to help address this opioid epidemic. The original Comprehensive and Addiction Recovery Act (CARA), 21st Century Cures Act, and the Excellence in Mental Health and Addiction Act included many useful programs to help with this national crisis and groups such as St Joseph's, ACEP, America's Essential Hospitals, and the New Jersey Hospital Association, were proud to offer our support for those bills. The financial commitment that lawmakers have made to fund these initiatives, especially the $6 billion that was recently included in the Bipartisan Budget Act of 2018, will be very helpful toward turning the tide against opioid misuse and we urge you and your colleagues to not only authorize HR 5197, The Alternatives to Opioids (ALTO) in the Emergency Department Act, and HR 5176, Preventing Overdoses While in Emergency Rooms (POWER) Act as part of CARA 2.0, but to seek full funding of these grant programs as well.

As you consider the various legislative proposals before your committee, I would like to encourage you to focus on evidence-based programs that promote adequate pain control, health care access, and allows for physician clinical judgment. For the patients I treat in the Emergency Department, there are circumstances when opioids are still the best clinical response to an acute emergency medical condition. Pediatric patients, the elderly, minorities and the cognitively

impaired are patients at high risk of inadequate pain management; and the emergency physician caring for the patient will need to ensure that an appropriate pain management plan in initiated.

It took many years to get to this crisis point and it will unfortunately likely take some time to resolve this epidemic, but we're on the right path. Provide us with the tools to help us administer the most appropriate care for our patients, based on their specific needs and circumstances, and we will provide a better future for them and society.

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[1] U.S. Department of Health and Human Services. The Opioid Epidemic by the Numbers. Available at: https://www.hhs.gov/opioids/about-the-epidemic/index.html.

[2] Centers for Disease Control and Prevention. National Center for Injury Prevention and Control. CDC Vital Signs. March 2018. Available at: https://www.cdc.gov/vitalsigns/opioid-overdoses/.

[3] D'Onofrio G, O'Connor PG, Pantalon MV, et. al. Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. *JAMA*. 2015;313(16):1636-44.

[4] D'Onofrio GD, Chawarski MC, O'Connor PG, et. al. Emergency department-initiated buprenorphine with opioid dependence with continuation in primary care: outcomes during and after intervention. *J Gen Intern Med*. 2017;32:660-666.