Managing Pain During the Opioid Crisis

Testimony to Senate Committee on Health, Education, Labor, and Pensions (HELP)

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By:

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Good morning and thank you, Chairman Alexander, Ranking Member Murray, the distinguished members of the HELP Committee, and their staff for providing me with the opportunity today to discuss the management of pain during the opioid crisis. My name is Anuradha Rao-Patel, and I am a Lead Medical Director at Blue Cross and Blue Shield of North Carolina (Blue Cross NC). My background is in Physical Medicine and Rehabilitation and prior to joining Blue Cross NC four years ago, I was in private practice providing management and treatment for chronic pain and addiction. I continue to remain clinically active and see patients regularly in addition to my primary role at the health plan. I hope to provide a unique perspective to the Committee today based on my clinical training and practice as a board-certified physiatrist, my first hand management of chronic pain as well as addiction, as well as my perspective as a Medical Director at Blue Cross NC.

<u>Background-- Blue Cross Blue Shield Association and Blue Cross NC:</u>

Since 1929, Blue Cross Blue Shield (BCBS) companies have provided healthcare coverage to members in every ZIP code. Blue Cross Blue Shield offers a personalized approach to healthcare based on the needs of the communities where their members live and work. They work closely with hospitals and doctors in the communities they serve to provide quality, affordable health care.

We understand and answer to the needs of local communities, while providing nationwide health care coverage that opens doors for more than 106 million members in all 50 states, Washington, D.C., and Puerto Rico. Nationwide, more than 96 percent of hospitals and 95

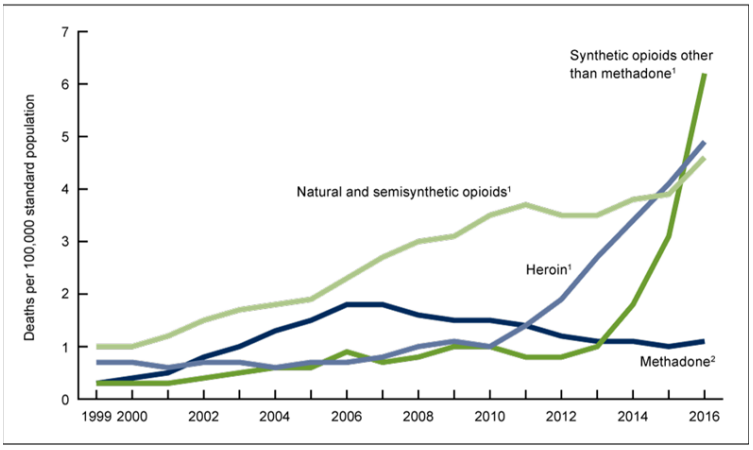
percent of doctors and specialists contract with Blue Cross Blue Shield companies — more than any other insurer.

At Blue Cross NC, we serve close to 4 million customers and are in every ZIP code of all 100 counties. The Blue Cross NC PPO network of health care providers includes 96% of medical doctors and 99% of all general acute-care hospitals. Blue Cross NC is accredited by the National Committee for Quality Assurance (NCQA), a not-for-profit organization dedicated to improving health care quality. NCQA is the most widely-recognized accreditation program in the United States. We have partnered with our provider network and continue to work collaboratively with other key state stakeholders including North Carolina Department of Health and Human Services (NCDHHS), North Carolina Medical Board (NCMB), North Carolina Medical Society (NCMS), and the North Carolina Attorney General's Office.

Scope of the Issue- Opioid Epidemic:

According to the Centers for Disease Control and Prevention (CDC), from 1999-2017 almost 400,000 people in the United States died from an overdose involving any opioid, including prescription and illicit opioids. They also estimate that the total "economic burden" of prescription opioid misuse alone in the United States is $78.5 billion per year, which includes the costs of health care, lost productivity, addiction treatment, and criminal justice involvement. The National Institute on Drug Abuse (NIDA) estimates that roughly 21 to 29 percent of patients prescribed opioids for chronic pain misuse them and between 8 and 12 percent develop an opioid use disorder. In North Carolina alone, Attorney General Josh Stein stated that in 2018 four people died every day from an overdose and that between 2017-2018, the number of fatal overdoses in North Carolina increased by 33% -- and that is even with efforts to reduce overdose deaths by distributing naloxone to reverse narcotic effects.

Figure 4. Age-adjusted drug overdose death rates, by opioid category: United States, 1999–2016



[1]Significant increasing trend from 1999 to 2016 with different rates of change over time, $p < 0.05$.
[2]Significant increasing trend from 1999 to 2006, then decreasing trend from 2006 to 2016, $p < 0.05$.
NOTES: Deaths are classified using the *International Classification of Diseases, Tenth Revision*. Drug-poisoning (overdose) deaths are identified using underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Drug overdose deaths involving selected drug categories are identified by specific multiple-cause-of-death codes: heroin, T40.1; natural and semisynthetic opioids, T40.2; methadone, T40.3; and synthetic opioids other than methadone, T40.4. Deaths involving more than one opioid category (e.g., a death involving both methadone and a natural or semisynthetic opioid) are counted in both categories. The percentage of drug overdose deaths that identified the specific drugs involved varied by year, with ranges of 75%–79% from 1999 to 2013, and 81%–85% from 2014 to 2016. Access data table for Figure 4 at: https://www.cdc.gov/nchs/data/databriefs/db294_table.pdf#4.
SOURCE: NCHS, National Vital Statistics System, Mortality.

Blue Cross Blue Shield Findings:

Blue Cross Blue Shield Association (BCBSA), in collaboration with Blue Health Intelligence (BHI), examined opioid prescription rates, opioid use patterns and opioid use disorder among commercially insured Blue Cross Blue Shield (BCBS) members (excluding members diagnosed with cancer or who were undergoing palliative or hospice care). In 2017, BCBSA released a report, *The Health of America* report, illustrating the impact of opioid use and opioid use disorder on the health of Americans.

While progress has been made, there were approximately 241,900 BCBS members diagnosed with opioid use disorder in 2017.

Specific Findings

- Nationally, the total number of opioid medications filled by commercially insured BCBS members has declined by 29 percent since 2013, with significant variation among states. Thirty-four states had higher reductions, with Massachusetts leading at 51 percent.
- In 2017, 67 percent of BCBS members filled their first opioid prescription within the CDC-recommended guidelines for both dose and duration. Some states did significantly better than the average, led by Rhode Island at 80 percent, Mississippi at 74 percent and Vermont and Massachusetts at 73 percent.
- When examining total opioid prescriptions for BCBS members in 2017, not just the first prescription, 45 percent of members filled prescriptions within the CDC-recommended dose and duration guidelines, up from 39 percent in 2013.
- In 2016, opioid use disorder claims stabilized, with 6.2 in 1,000 BCBS members diagnosed. The rate dipped slightly to 5.9 in 1,000 members in 2017.

Why Opioids have the Potential for Abuse:

In order to understand why opioid medications have the potential for abuse, one needs to understand what an opioid is and how these medications are metabolized in the human body. Opioids are a class of drugs naturally found in the opium poppy plant. Some prescription opioids are extracted from the plant directly, while others are manufactured in laboratories using the same chemical structure. Opioid medications exert their analgesic effects predominantly by binding to mu-opioid receptors. These receptors are densely concentrated in brain regions that regulate pain perception (periaqueductal gray, thalamus, cingulate cortex, and insula), including pain-induced emotional responses (amygdala), and in brain reward regions (ventral tegmental area and nucleus accumbens) that underlie the perception of pleasure and well-being. Mu-opioid receptors are also located in other regions such as the gastrointestinal tract which explain other side effects of opioids such as constipation and in the brainstem which results in the respiratory depression associated with opioid-overdose incidents

and death. Opioid medications vary with respect to their affinity and selectivity for the mu-opioid receptor and there is also variability among the drugs with respect to their pharmacokinetics and bioavailability.

Chronic Pain:

Chronic pain generally is defined as pain lasting three or more months or beyond the time of normal tissue healing. According to the *Morbidity and Mortality Weekly Report* (MMWR) from the Centers for Disease Control and Prevention (CDC), approximately 50 million American adults — 20.4 percent of the U.S. adult population — have chronic pain, defined as pain most days or every day for at least the past six months. Age and sex do seem to make a difference, with a higher prevalence among older adults and women. For those with chronic pain, eight percent (19.6 million adults), report that the pain is bad enough to frequently limit their daily life or work activities. In addition, living with chronic pain can also lead to a variety of health issues, including anxiety and depression. All told, according to estimates cited by the CDC, the bill in the United States for chronic pain totals at least $560 billion a year in medical expenses, lost productivity and disability programs.

Use of Opioids to Manage Chronic Pain:

Opioids emerged into standard management for chronic pain management in the 1990s. There are many conditions for which opioids have been prescribed including arthritis, low back pain, fibromyalgia, musculoskeletal pain, and in dental issues. The recognition of the role of opioids in the management of acute and end-of-life pain, the inappropriate adoption of World Health Organization (WHO) analgesic ladder designed for use in cancer pain at the end of life, the utilization of pain scales (0-10 scale) to rate level of pain, the refractory nature of persistent pain, labeling pain as the fifth vital sign, and the influence of marketing by the pharmaceutical industry fueled an increase in the popularity of opioids as a treatment for chronic pain. Early studies seemed to provide sufficient evidence to support this approach. In 2013, however, it became evident that the rise in the prescribing of opioids was accompanied by a parallel rise in opioid-related harms, including addiction, overdose, and death. A reevaluation of the early clinical trials suggested that opioid use in clinical practice was neither as safe nor effective as previously believed.

There are a number of systematic reviews on use of opioid therapy for chronic pain. However, evidence on the benefits of long-term opioid therapy is still lacking. There appears to be no data that any one opioid is more effective than another and minimal evidence that opioids differ in their propensity to cause harm. An obvious limitation is the short duration of many clinical trials and the fact that most clinical trials were monitored and supervised closely and firm conclusions cannot be extrapolated into the long-term use in a clinical practice setting.

Evidence is also lacking regarding the relationship between or the progression from acute to chronic pain, although preoperative chronic pain is thought to be a risk factor. It has also been proposed that inadequate management of acute pain may increase an individual's risk for development of chronic pain.

Alternatives to Opioids to Manage Chronic Pain:

It is important to emphasize and understand that the term "pain management" has not been clearly defined and is generally lacking in research. Oftentimes, the term is used erroneously to denote solely pharmacologic tools, most commonly with the use of an opioid. However, pain management may involve the use of a number of tools—both pharmacologic and nonpharmacologic—to both relieve pain and improve function and quality of life. In my personal experience in clinical practice, patients more often than not equated a referral for pain management with an automatic prescription for a narcotic. Physicians fortunately are in a front-line role and have the unique opportunity to educate their patients on expectations and goals for management of their pain. As chronic pain represents a complex pathophysiologic condition that develops over time, its successful management often requires an equally complex and time-intensive approach. Therefore, combining multiple therapeutic modalities, nonpharmacologic and pharmacologic (non-opioid and opioid) and treating pain holistically by addressing the underlying cause as well as the immediate experience appears to be the best approach. In addition, redirection and emphasis on setting reasonable expectations and establishing mutually agreed-upon goals for the control of chronic pain, with an emphasis on communication and safety is paramount.

Role of the Payer in Management of Chronic Pain:

Blue Cross Blue Shield companies are strongly committed in doing our part to combat the epidemic of opioid use disorder while ensuring patients living in chronic pain have access to appropriate evidence based treatment. As evidence of this unified commitment, I have listed several examples below:

- We provide coverage for non-opioid pharmacological alternatives for pain management including nonsteroidal anti-inflammatory medications, antidepressants, anticonvulsants, topical analgesics, alpha 2 ($\alpha 2$) adrenoreceptor agonists, and others
- We provide coverage for non-pharmacological alternatives for pain management including physical therapy, occupational therapy, aquatic therapy, chiropractic care, trigger point injections, biofeedback, steroid joint injections, interventional pain therapies (facet blocks/medial branch blocks/epidural steroid injections and

spinal cord stimulators), TENS unit, intraarticular hyaluronan injections for knee osteoarthritis, Botox injections for migraine and spasticity and others

- We endorsed the CDC Guidelines for Prescribing Opioids for chronic pain and are working collaboratively with the prescriber community to implement these or similar guidelines
- We support access to Medication Assisted Treatment (MAT) including the associated counseling and behavioral therapy
- We support wide availability of naloxone
- We support enhanced operability of prescription drug monitoring programs (PDMPs) and encourage providers to access PDMP data before prescribing

Conclusion:

As chronic pain is a legitimate and debilitating medical issue, there are many opportunities for physicians to continue to manage pain effectively with or without the use of opioids. Physicians must incorporate "universal precautions" in the use of pain medicine for the treatment of chronic pain as excerpted from Gourlay, et al…2005 including the following:

1. Make a Diagnosis with Appropriate Differential

2. Psychological Assessment Including Risk of Addictive Disorders

3. Informed Consent

4. Treatment Agreement

5. Pre- and Post-Intervention Assessment of Pain Level and Function

6. Appropriate Trial of Opioid Therapy +/– Adjunctive Medication

7. Reassessment of Pain Score and Level of Function

8. Regularly Assess the "Four A's" of Pain Medicine: Analgesia, Activity, Adverse Effects, and Aberrant Behavior

9. Periodically Review Pain Diagnosis and Comorbid Conditions, Including Addictive Disorders

10. Documentation

The goal of long-term chronic pain management is to support the patient in improvement of their function and quality of life as much as possible despite their ongoing pain symptoms. Opioids are certainly an option to support select patients in managing symptoms, and should be prescribed with caution if they are effective in low doses and used intermittently as part of a broader pain management plan. In addition, patients must have realistic and honest expectations of pain management goals including an understanding that after an assessment of risk versus benefit in the use of opioids, that pain elimination may not be a possibility. Providers should continue self-education on appropriate and judicious prescribing and in participation in their state medical and licensing boards continuing medical education (CME) requirements. There must also be increased training in medical schools and residency programs on pain and addiction as well as increased research on pain. Finally physicians and payers must understand that there is no "one size fits all" approach to manage chronic pain and it must incorporate a holistic, multimodal, and thoughtful approach.

Thank you again for including me in this discussion. Blue Cross Blue Shield companies share your commitment in addressing America's opioid crisis and ensuring that those suffering with opioid use disorder and chronic pain get the care they need.

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