Wright, Kevin (Finance)

From: Esten, Anna (Whitehouse)
Sent: Thursday, February 15, 2018 3:58 PM
To: opioids,
Subject: FW: Comments for Senate Finance Committee on Opioid Epidemic

Below please find responses to the Chairman and Ranking Member's letter requesting feedback on ways to address the opioid epidemic from Dr. Jeff Ainley, Dr. Judy Nudelman, and Dr. Ellen Gurney, physicians from Providence Community Health Centers in Rhode Island.

Thank you,
Anna

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From: Andrew Saal <ASaal@Providencechc.org>
Sent: Sunday, February 11, 2018 6:13 PM
To: Abiade, Rele (Whitehouse)
Cc: Merrill R. Thomas
Subject: Comments for Senate Finance Committee on Opioid Epidemic

As requested, below are a collection of comments from several of our physicians and staff on the opioid epidemic.
I suspect several of our clinicians may have emailed your directly or commented via other means.
If your staff has any questions, please feel free to reach out to me directly. My contact information is below.

Thank you for this opportunity to share.

Andrew

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Our community needs to have comprehensive pain management clinics. This will allow a pharmacist or pharmacists help in managing pain meds with prescribers. They can work together as a team and manage the patient with the proper meds and dosage. Integrated substance abuse treatment requires more than a Suboxone clinic.

Opioids have also led to the large scale heroin epidemic which is tragically affecting the middle age and thus destroying families and affecting their children.

Jeff Ainley, OD
Optometrist

Our community needs a true pain management clinic that doesn't just do epidural injections. A comprehensive treatment program incorporates behavioral health, complementary therapies, effective physical therapy and the use of non-opiate pain relievers.

The state medical board knows which docs are prescribing the most opiates via the prescription monitoring database - but they aren't able to enforce the state rules because those same docs would do just enough to skirt the regulations. They began to use pain agreements and have their staff log into the database on occasion just to "check the box." I'm not convinced that they actually did anything with the information that their staff saw. Conversely when two docs did lose their licenses abruptly, their patients were left with no one to taper them off opiates.

Overall, the PMP database is not user friendly in its current incarnation. It's hard to navigate and hard to see the big picture when a person's data is one the screen.

Medicaid patients with real chronic pain have few options for Physical therapy, ortho, and rheumatology. But even when they do have insurance, care is still fragmented and too few of the specialists communicate with the primary care docs.

One of my patients with minor knee pain went to knee surgery with no one informing me—I would have advised against it for meniscus “tear” that was not bothering him. Now he’s 30 with a probably unnecessary surgery and a set up for knee arthritis in a few years. If CurrentCare (Rhode Island’s health information exchange) actually worked better, I would know when my patients are being treated by multiple providers.

Judy Nudelman, MD
Family Medicine

From the perspective of a pediatrician who does not prescribe many controlled medications, but happens to be living with chronic pain:

Short term management of acute pain in the hospital setting should be effective and not withheld. Having experienced both adequate and zero pain control, I can say that the *anticipation* of poorly controlled pain is probably a big risk factor for future overuse of narcotics on an outpatient basis in some individuals. The goal should be excellent pain control and rapid tapering of narcotics while an inpatient, and not using them on an outpatient basis for any significant time period - and instead use of alternative non-narcotic medications.

We need adequate access to initial appropriate medications and diagnostic tests without jumping through insurance authorizations hoops. Pain is not a diagnosis; it’s the symptom and the diagnosis should be explored. The underlying diagnosis should be the focus of appropriate treatment (cancer being the exception in pain control). Those treatment plans need to include adequate access to physical therapy, acupuncture, occupational therapy, hypnosis, and home care support

Patients appearing to be “at risk” for use of chronic opiates should be assessed for anxiety, depression, undiagnosed PTSD, trauma history and OCD. Any of these could be at the root of the perception of chronic pain. Behavioral health counselors in primary care and specialty care should have payment parity and unrestricted access without arbitrary Medicare restrictions on visits.

Ellen Gurney, MD
Pediatrician
