Testimony for Senate Health on S.243
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It is clear we are facing an epidemic of use of illicit opioids. Clearly, some of the impetus for this crisis is due to irresponsible prescribing by physicians, nurse practitioners and physicians assistants. However, most practitioners are well aware of the potential for abuse and are careful prescribers of these powerful medications. Evidence shows the epidemic started in the mid 1990s with prescription opiates, one in particular- oxycontin. But now ,heroin has taken over as the preferred opiate. While in the past we can attribute much of the addiction crisis due to poor prescribing patterns by health care practitioners, today's crisis is more complicated than that.

1)Registering with VPMS
It is appropriate to require physicians, nurse practitioners and physicians assistants to register with VPMS.

Requiring practitioners who RX Schedule 2,3,4 register with VPMS is fine but to consider it professional misconduct if they fail to do so is inappropriate.

2) Increasing the frequency of queries of VPMS
The legislation requires that health care providers query the VPMS each time the provider issues a new or renewal prescription for an opioid Schedule II, III, or IV controlled substance to a patient

This is unrealistic given some of us prescribe on a weekly basis because we see them weekly. This is to monitor their care and to limit the number of doses a patient has at any one time at their disposal. We simply do not have time to query VPMS on every patient every week.

This measure begs the question -Is there data that we (practitioners)are doing worse that prompts this need for more VPMS queries?

Especially since the data now shows more overdose deaths from heroin than from prescription opioids. Are practitioners failing to register with VPMS. Are they failing to query VPMS?

In addition we must keep in mind –there are 2000 patients not in VPMS system who are on suboxone or MTD who are receiving treatment in the Hubs

Also, Vermont patients filling prescriptions in other states are not included in our VPMS. So our ability to police our patients is limited by these factors. What is the state doing to join efforts with other states?

3) Waste disposal of unused medications
This is very much needed in Vermont.

4) Expanding access to buprenorphine-
This measure is also a good idea but should include physicians with experience who may not be as board certified.

Federal restrictions allow physicians with a special license to prescribe to only 100 patients at any one time. This limits those physicians who have capacity to prescribe to more patients and assist physicians who are asking for more guidance in treating these complicated patients.

This measure would allow physicians with more expertise in addiction to assist physicians who are reluctant to take on more patients with opioid dependence . It would put the majority of the management of these patients in the hands of more experienced physicians who would then advise primary care physicians of appropriate dosing of patients. This is similar to what primary

care practitioners do now with patients with other chronic diseases when they refer these patients to specialists who recommend a certain prescription for the primary care provider to prescribe. This could offset the waiting lists in the hubs. It is essential that both practices be reimbursed for care management of the patient.

5) Telemedicine pilot-
One of the major problems in a rural state with an opiate crisis is that of geography. The hubs are not always accessible to patients without reliable transportation. I see patients who have lost everything. They are often living with relatives in rural locations with no transportation or means to get to facilities miles away on a daily or even weekly basis. However, there are often health care facilities in their towns that the patient can access. The pilot can involve hubs or other facilities with expertise , who have providers who can “see” the patients through telemedicine confer with a MAT team or case manager and therapist in that location and essentially give care where the patient is, rather than where the provider is. This makes sense and should be explored.

6) Pharmacists Pill count-
Once again, patients often have to travel great distances to get to their treatment centers . Part of this treatment is accountability, that is trusting a patient is taking their medication as prescribed and not diverting it. One way we ensure accountability are random pill counts. This is often difficult for patients to follow through on, and since there is usually a pharmacy in a reasonable distance to the patient’s home, having the pharmacy that dispensed the medication ,perform a random pill count, and report back to the treatment facility more sense. This also makes it more likely that it will be carried out.