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A PRACTICAL APPROACH FOR TREATING PAIN IN WEST VIRGINIA

The pendulum regarding prescribing Controlled substances has definitely changed in the past 5 years from prescribing whatever dose was necessary to get proper pain relief in 1997, to enacting laws in 2014 whereby doctors have decided not to prescribe for fear of DEA and state retribution.
The end result is still the same, we have patients who need the Controlled substances but are having a very hard time to find a prescriber and those who abuse still attempting to get their Opioid fix or divert their Rx for financial gain.

In the middle of this are the State and Federal Government trying to come up with political decisions for treating medical conditions.
While insurance companies have traditionally gotten involved in the treatment of most medical conditions, i.e. producing a preferred drug list, making brand drugs different tiers, both the federal and state governments have exerted their influence with how physicians utilize Opioids in their patient population suffering from acute as well as chronic non cancerous pain.

West Virginia state government has unilaterally gotten involved without requesting assistance from the medical community and instead moved forward on its own and created draconian laws that are being written for treating this group of patients.
I see this daily as for example, more and more surgeons are scared of writing Controlled substances post op and refer the patient to "chronic pain" management when all the patient needs is acute care Opioid management for 1-2 months while they recuperate. Controlled substances have become the "hot potato" that no one wants to hold or be accountable for. On the other hand, I see patients who were placed on Benzodiazepams (Xanax, Valium) for pain control by PCP's as well as 120 tabs of Percocet for months at a time which also makes no sense.
The heart of the problem appears to be education, both at the government level as well as the medical level.

At least in West Virginia, I can't blame most doctors for not Rx Opioids since they all feel that "Big Brother" is setting them up and they don't need the hassle of a DEA drug raid, a patient death, or being sued for allegedly making someone an addict.
This is not to say that I condone "pill mills" and clinics that do not follow guidelines by the AAPM, ASIPP, and other medical organizations that have taken the time to come up with rational treatment paradigms for treating patients who suffer from painful conditions. Rogue physician offices as well as pharmacy's need to know that if they do not follow guidelines and are selling Opioids, then they deserve to be prosecuted.

In West Virginia, we have the notoriety of having a subpopulation that has given the state a reputation for most methadone deaths, and now most Heroin deaths. Lumping this population into the true medical population which really needs treatment for their medical condition is not fair and in truth, discriminatory.
Nonetheless, legislators and politicians feel that best solution is enacting rules made to fit everyone. As physicians, we know that no two patients are the same.

Even with the 2 most recent bills to curb "pain clinics" and the "addiction" law, West Virginia continues to lead the way in overdose deaths. Adding Naloxone and trying to "fix" the problem with half ass attempts at demonizing doctors instead of making these addicted individuals as well as diverters responsible for their actions is the only way to face this problem head on. Somehow, politicians think that patients taking Opioids must be addicted or have a high chance of being addicted. This is not true especially if you allow the health care provider a chance at dealing with the individualized patient.

West Virginia as well as any other state in the Union has similar problems, which are essentially cultural issues that will only change if we as healthcare providers as well as legislators and government agencies work together to evoke a change. Demonizing, bullying, or emasculating healthcare professionals will not help to that end.

This is what I propose for West Virginia's legislature.

1) Repeal SB 437 and CSR 69CSR 8 which forces doctor's to become registered "pain clinics" if they Rx 51% Opioids in their offices. What this has done is essentially stopped most doctors from even writing simple Opioids for fear of retribution. As a result, legitimate patients can't rely on their own PCP and then are travelling 1-2 hours to get their opioid for better pain control. We get calls from clinic 2 hours away requesting that we treat their patients who need simple pain relief or long term pain control and every doctor in that area has decided against Rx opioids. Now, what do these legitimate patients do? Every year, I get a Controlled Substance license from West Virginia. That is all that should be needed by any physician who Rx Opioids. Why do we need to license an "Opioid Clinic" thru the same agency that licenses hospitals? It is burdensome and a waste of tax payer money. The West Virginia Controlled license(which cost $15/year) is something that only doctors who want to Rx Opioids should pay and have the Board of Pharmacy monitor.

2) The state of West Virginia has a very accurate Controlled Substance Statewide Opioid Monitoring system. The Board of Pharmacy from what I understand is responsible for

monitoring it. As a result, this is a very simple and useful device for overseeing the monthly dispensing of Opioids and Benzodiazepams in this state. All one has to do is look for trends of opioid dispensing and work with healthcare providers who may be outliers. This is all we need to do to see if healthcare providers are truly over prescribing, and if so, educate them 1st and then prosecute later if need be.

3) Unfortunately, good honest patients as well as well meaning healthcare providers are being demonized by the addicted population of individuals who are making the headlines.

4) Ensure that all Federal Government "methadone" clinics have to subscribe to the states Controlled substance monitoring system. Healthcare providers in West Virginia and in other states are not able to identify if their patient is or was enrolled in a SAMSHA program which severely handcuffs providers

5) Allow mid level providers, Nurse Practitioners and PA's to Rx Opioids and not fear retribution. Guidelines can be written so that these midlevel's can try low dose Opioids for 4-6 weeks then refer them out to Pain clinics if the patient is not responding. Midlevel's need to follow the same pain guidelines as their physician counterparts but not feel threatened for following them. The fact that I hear State Government officials' never wanting mid levels to prescribe Opioids makes no sense to me as to date, I have never read any quality report that states that midlevel's are directly responsible for our current Opioid crisis. Having them on board, with additional training by those of us who are trained in Interventional pain treatment would be a smarter way to go. The Heroin and Methadone deaths in West Virginia have occurred without Midlevel's having prescriptive authority. Nurse Practitioners as well as PA are a big asset in PCP offices for all sorts of medical conditions as they are known for spending more time with patients which is essential for "weeding out" pain patients who may have another agenda. It is well documented in the pain literature, that pain symptoms need to be addressed sooner rather than later.

6) Proper reimbursement for those brave individuals who treat psychological conditions. The majority of pain patients that I see are on Medicaid or SSI and have limited access to psych services. Worst is the fact that West Virginia Medicaid will only reimburse psych services if the person is an Psychiatrist, psychologist, or EDd. Pain literature specifies the importance of adjunct psychological intervention yet that is grossly missing for this population. Medicaid and SSI needs to fairly reimburse licensed counselors as they can make a big difference in this population. A happy patient gets motivated to stay happy.

7) The concept of the 3 legged stool, popularized by a Harvard cardiologist also needs to be addressed by or State Government. Patients who have painful conditions need to have 1) physical therapy, 2) psychological backup, 3) Interventional Pain Management.

This will cost the state money but from my vantage point in the foxhole, the current system of crisis management is and has not worked for years costing taxpayers even more money.

Call, write, and tell your legislator that you are sick of spending good money after bad and that we need a public debate of these issues not a totalitarian approach by bureaucrats (who are in office temporarily as oppose to healthcare providers who are here for the long haul) to look at how to better treat society with this current Opioid situation of diversion vs. proper delivery and let's do it right.

Sincerely

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