**STATE OF MICHIGAN**
**HOUSE HEALTH POLICY COMMITTEE**
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**TESTIMONY: SUPPORT FOR SENATE BILLS 166-167**

Rebecca Cunningham, MD
Professor, Emergency Medicine
University of Michigan Medical School
Professor, Health Behavior Health Education
University of Michigan School of Public Health

Good morning and thank you, Chairman Vaupel, Vice-Chairman Tedder, Vice-Chairwoman Brinks, and members of the committee. I am Rebecca Cunningham, a Professor at the University of Michigan. I am addressing you as an emergency physician and public health professional in support of Senate Bills 166 and 167, legislation to strengthen Michigan's prescription drug monitoring program, the Michigan Automated Prescription System, known as MAPS. The views I express today are my own and do not represent those of any specific organization, center, or university with which I am currently affiliated.

Mr. Chairman, I applaud you for holding this hearing on the opioid epidemic, which causes more deaths in the State of Michigan than motor vehicle crash. Current trends show no sign of slowing down.

I'd like to share a story to illustrate my firsthand experience with this epidemic. As an emergency physician, I am often faced with a waiting room full of patients seeking relief from their pain. Recently, I met a woman I'll call Nancy, who had presented in the emergency room with excruciating pain in her leg. Although I did not recognize her personally, she looked as though she could be my friend or neighbor. When I was preparing to discharge her, she requested a prescription for a narcotic medication to treat her continued pain. While I had no suspicion, either from her appearance or demeanor that she was attempting to obtain a prescription for misuse, I performed a routine MAPS query on her, as I practice universal review of the MAPS system prior to writing ALL narcotic prescriptions.

To my surprise, I learned that Nancy had recently received a prescription for 30 tablets of oxycodone filled within the past 7 days, and that she had received over 20 prescriptions for narcotics from at least 4 prescribing physicians within the past 12 months. In short, she displayed classic signs of "doctor shopping" - the practice of obtaining narcotic prescriptions from multiple providers rather than one provider who could manage her pain adequately and ensure that she wouldn't develop a substance use problem. Our new MAPS system flagged this concern, making it easy to identify the potential problem. Based on this information, I was able to ensure that she left the emergency department, not with another prescription for Vicodin, but with a referral for substance use treatment.

Mr. Chairman, had I not checked the MAPS system, I would have had no indication that there was a problem, or that prescribing her yet another opioid medication could cause her harm or put her at risk for a subsequent overdose and possibly death. **When we as physicians choose only to check MAPS on patients we feel are high risk by medical history, exam, or physical appearance—we risk our own implicit bias driving our prescribing practices, and in doing so, put our patients and the community around our patients at greater risk**. The epidemic of opioid overdose in our communities does not discriminate by race or socioeconomic status. I have seen firsthand that this medical illness effects everyone - rich, poor, rural, urban, educated and uneducated, young adolescents and elderly adults. **Quite simply, physicians must check MAPS for ALL patients, as the use of objective data will inform safer prescribing practices.**

Michigan's new and updated MAPS system will only be effective if it is utilized universally by the physician and health provider community. Currently, only ~36% of providers are registered with MAPS – many physicians believe they can identify which patients may be at risk for abuse. While changing physician and provider behaviors is not easy, I strongly believe that mandating MAPS consultation is necessary to change prescribing behavior. **We must strive for universal use of MAPS by ALL providers prior to prescribing opioid medications.** Without the mandate, we as a broad group of providers will be too slow to change our practice patterns while our community members will continue to die in this epidemic. Mandatory use laws such as Senate Bill 166 will increase the speed of

providers adopting and utilizing this new system, ultimately helping to address patients like Nancy, as well as helping to address the broader opioid epidemic in Michigan.

Other states have seen significant progress after adopting similar registration and use mandates for prescribers. For example, after Tennessee enacted a mandate in April 2013, the number of patients meeting a threshold for "doctor shopping" declined 36% - and in New York, in the year following a similar mandate, the number of patients "doctor shopping" decreased by 74.8%. Kentucky experienced a 16% reduction in the number of opioid prescription fills, and an 18% reduction in morphine equivalent dosages dispensed following implementation of a robust prescription drug monitoring program.

As currently written, Senate Bill 166 would require licensed prescribers to obtain and review a prescription drug monitoring program – MAPS – report before prescribing a controlled substance to a patient. Data from multiple states suggest that the proposal would be strengthened with the following additions:

- A MAPS registration mandate (or automated enrollment) tied to Michigan physician and provider licensing;
- A provision allowing "delegate access" - allowing a busy provider to have a physician's assistant or other qualified staff query the MAPS system and bring them the report to ease workflow and aid efficiency;
- Integration of MAPS data into the electronic medical record (EMR). The two systems should be linked automatically so that prescribers are not required to separately log into MAPS. Although this may seem trivial, in the fast pace of health care today, these extra steps may mean the difference between a patient who leaves with a prescription for narcotics and one who does not. **Integration of the EMR and MAPS would substantially reduce the burden on providers, and facilitate use within the clinical setting. I strongly believe this integration is essential to achieve the widespread support of SB 166 and SB 167.**
- In addition, I urge you to support the work of MDHHS and other agencies to educate prescribers about MAPS and how to utilize its data. We must incorporate ongoing

feedback from providers who use MAPS daily to improve the ease of use within the clinical setting.

Regarding Senate Bill 167, which imposes penalties on providers for not checking the MAPS system, I believe the penalties included in the legislation are reasonable and necessary to move practice patterns to address this epidemic. Moreover, the penalties included in the bill are comparably stringent to those that have been effective in achieving results in other states. I believe that Michigan's physician community would be willing to support this legislation if they understand that the proposed penalties are comparable to those in other states - notably, the general disciplinary sanctions by the responsible licensing board.

In conclusion, urgent action is needed to reverse the current epidemic. Senate Bills 166 and 167 represent a common-sense step to addressing this public health problem, and they are supported by both the current data and experiences borne by other states. There is strong reason to believe, if implemented with provider education and imminent EMR integration, these bills will decrease unsafe prescribing that is contributing to an unacceptably high number of deaths from opiate overdose, without causing an undue burden on our health care system.

Thank you for the opportunity to provide testimony today.