Good morning, Madam Chair Klick and esteemed members:

My name is Dr. C.M. Schade from Dallas, and I'm a board-certified physician with five decades of experience specializing in Pain Medicine. Thank you for the opportunity to testify today on behalf of the Texas Medical Association and its more than 56,000 members and the Texas Pain Society. TMA has been actively engaged in finding solutions to decrease opioid overdose deaths for over a decade. Research, which we've included in the submitted written testimony, shows the "opioid crisis" is no longer just about curtailing perceived over-prescribing of opioids. In fact, despite some of the strongest state and federal opioid regulations in recent history that have resulted in significant declines in opioid prescribing, unfortunately opioid deaths continue to rise because the increasing opioid deaths are no longer being driven by prescription opioids. Illicitly manufactured fentanyl, which I will refer to as IMF for short, has been identified as the main culprit.

IMF is a cheap, strong, and deadly drug. Fentanyl is up to 50 times more potent than heroin and 100 times more potent than morphine. IMF is colorless, odorless, and tasteless, so its users have almost no idea they are risking death when they take just one of these pills. This is why this crisis is particularly concerning for young Texans, who are more likely to swallow a pill than inject a drug. And just two milligrams of fentanyl — about the weight of a mosquito — is a fatal dose.

OK – that's the drug – now let's examine who is using IMF and TMA's 8 recommendations.

To address the IMF epidemic, let us review what has changed in the last 2 decades. The opioid prescribing pendulum went from OVER prescribing of prescription opioids that peaked in 2010 to the UNDER prescribing of prescription opioids in this decade. Thus, as the supply of prescription opioids is dramatically decreasing, this void has and is being filled with IMF which is much cheaper to produce than heroin. Conceptually, **there are 3 types of people** that take IMF: those who

choose to use it - oftentimes unaware of the risks, those who are desperate for pain relief, and those who are addicted.

In the first group, take for example, 22-year-old Cassandra Saldivar from Arlington last year, or 17-year-old Kevin McConville from Hays County as recently as last month --both dead after taking only one pill suspected to be laced with IMF. **This is terrible-so sad!** Cassandra thought she was taking a prescription painkiller. Kevin was taking something to help him sleep. The perception is that these drugs are safe, but they end up taking people's lives!

Next, the second group of people that take pills laced with IMF are those that are desperately in need pain relief but who struggle with stigma hanging over legitimate pain medicine prescribing or who cannot get adequate relief in the current system. Contrast them with these two examples of how it should be— fortunate patients who did not have to turn to illegal pills for pain relief. (Please note: I have changed their names and situations to protect their identity):

- Student Shandra had sickle cell disease, which is an inherited disease with no cure—you can only treat the symptoms. It is extremely painful. When the red blood cells deform or sickle, they cause blood clots, obstructing blood flow. The affected tissue is then starved of blood and dies, which is debilitating. When I first saw Shandra at the request of her primary care physician, her pain was out of control, and she was in an emergency room every time she had an attack. I was able to stabilize her with an at-home treatment combination of high-dose prescription fentanyl and antinausea medications, which are commonly prescribed for cancer patients. Thus, she could go to school and enjoy her family by taking her medications at home while avoiding costly and time-consuming treatments in an emergency room. She was stable in my practice for 15 years until she unfortunately died from the disease.

- Another patient, “Bowling Billy,” is in his thirties, is a semi-professional bowler, and has chronic pancreatitis. His uncontrolled pain sent him to an emergency room several times a month. There is no cure, you can only treat the symptoms. I was able to stabilize Billy on high-dose methadone and antinausea medications–with dosages typically used in methadone treatment clinics for opioid use disorder, but appropriate to control his pain. He now functions normally, has won bowling tournaments, rarely has to go to an emergency room, and is an active family man.

However, unfortunately, many patients dealing with both acute and chronic pain are not so fortunate and are at risk of an accidental overdose due to IMF because they cannot access pain medicine legitimately prescribed by a physician, due to serious restrictions on opioid prescribing. Many physicians choose not to prescribe any opioids amidst regulatory enforcement concerns. Or those who once did, have retired or have stopped prescribing all opioids, leaving their patients struggling to find a physician to continue prescribing their pain medications. Alarmingly, we’re seeing something else, too: Even physicians who are exempt from many opioid regulatory prescribing requirements--like surgeons and emergency physicians—feel forced to forgo prescribing opioid pain medication. Instead, they are referring their patients to other physicians for pain treatment because they’re concerned about opioid prescribing overregulation.

The third group are the people with opioid use disorder commonly called addiction. Addiction is a recognized medical disease that causes continued use of opioids despite harm. Unfortunately, there are many barriers and hurdles that addicts must overcome to get help which makes them more susceptible to taking counterfeit pills laced with IMF.

Realizing that there are these 3 groups, what does the TMA recommend?

It’s time to change course!

The laws of the previous decade are not addressing today’s problems. Instead, the current restrictions on valid prescribing practices to manage patients may be significantly contributing to the problem. TMA offers these eight recommendations: **The top 3 recommendations are:**

- **First, Establish a workgroup to revisit the current law on certification of pain management clinics and the inspection process for both pain and non-pain management clinics as required in Occupations Code Section 168**. The guardrails must be structured carefully to leave enough room to allow for proper prescribing practices so that people are not driven to seek illicit drugs for their pain.

- **Second, Implement Syringe Services Programs**. These are safe and effective strategies to tackle the substance misuse issue. They’re community-based prevention programs that can provide a range of services, including: linkage to substance use disorder treatment, access to and disposal of sterile syringes, vaccinations, linkage to care, and treatment for infectious diseases. Two failed bills last session proposed that several major Texas counties and their hospital districts establish pilot programs to curb substance misuse and prevent the spread of infectious diseases by allowing anonymous exchange of used needles and syringes for new ones. There is over 30 years of research demonstrating the effectiveness of these programs.

- **Third, Fund physicians’ use of the Prescription Monitoring Program**. Consider utilizing the Opioid Abatement Fund or licensing fee funds for the integration software that links the PMP to the physicians’ electronic health records and the pharmacy-prescribing software. Further, support the use of effective data mining software that compares pharmacy purchases to pharmacy PMP sales as a superior way to find illegal prescribing and dispensing practices. This is being done in four other states.

The remaining 5 recommendations are in my written testimony and to save time today and will just go over the highlights:

- **Next, Improve education and prevention programs**. We recommend a statewide effort to inform the public on IMF overdoses caused by counterfeit pills. This can include public service announcements and education in schools, from middle school through university-level programs, about the serious risks—including death—associated with taking counterfeit medications, IMF, or illegal drugs.

- **Fifth, Encourage equitable access to medication for opioid use disorder and fentanyl test strips.** [1] Please consider legislation that would make the opioid antidote naloxone available over the counter without a prescription. TMA policy recognizes this strategy, and the National Institute on Drug Abuse says it is a safe medication that only reverses overdoses in people with opioids in their system**.** We also recommend considering legalization of fentanyl test strips to help prevent fentanyl-related overdoses and deaths. Individuals may not realize they have a counterfeit pill with a lethal dose of IMF in it. Fentanyl test strips can help as an important line of defense against this deadly drug.

- **Sixth, Seek funding to support strategies to target IMF overdoses.** We recommend accessing the $4 billion available in the American Rescue Plan to expand access to vital mental health and substance use disorder services, including $30 million for harm reduction services like naloxone, Syringe Service Programs, and fentanyl test strips. We also recommend accessing the increased federal funding in the National Drug Control Budget for effective opioid substance use disorder prevention, treatment, harm reduction, and recovery.

- **Our Seventh recommendation is data collection.** We encourage the state to develop and implement systems to collect adequate, timely,

[1] TMA Policy No. 95.049 ("Encourage Equitable Access to Medication for Opioid Use Disorder").

and standardized data to identify at-risk populations and to fully understand polysubstance drug use and implement public health interventions that directly address removing structural and racial inequities.

- **Finally, Community collaboration.** Please consider how Texas might collaborate with the U.S. Department of Health and Human Services, community-based agencies, and schools to implement a comprehensive behavioral health strategy in response to the landmark Bipartisan Safer Communities Act, which was signed into law on June 23rd this year.

With these recommendations, this concludes my testimony. I'm happy to take questions and thank you again for your time.