The 86th Texas Legislature's Policy Response to Opioids

Prepared by the Texas Orthopaedic Association

The United States is in the midst of an epidemic of substance misuse and abuse that applies to all types of drugs: both legal and illegal drugs. Certain parts of the country, such as the Northeast, have been hit much harder than other parts of the country.

The Texas Legislature has placed a spotlight on substance misuse and substance use disorder issues in the 2018 interim. At the conclusion of the interim, we expect several committees to address the following questions, which will then be addressed by the 2019 Legislature:

- What is the prevalence of substance misuse and substance use disorder in Texas?
- Have past legislative and regulatory measures by state policy makers resulted in decreases in substance abuse in Texas?
- What policy measures, if any, could be enacted in the future to address substance abuse?

High-Energy Injuries and Certain Surgeries Create Tremendous Pain

When policymakers make policy decisions related to opioids, care must be taken to limit unintended and undesirable consequences. Unfortunately, the current nationwide shortage of parenteral (intravenous) opioids can be traced to past responses to the opioid crisis.

With that said, TOA recognizes that opioids are part of our nation's overall drug misuse and abuse epidemic, and it is critical for orthopaedic surgeons to identify ways for physicians to be a part of the strategy to decrease opioid use, misuse, and abuse. Per the American Academy of Orthopaedic Surgeons (AAOS):

> *The AAOS believes that a comprehensive opioid program is necessary to decrease opioid use, misuse, and abuse in the United States. New, effective education programs for physicians, caregivers, and patients; improvements in physician monitoring of opioid prescription use; increased research funding for effective alternative pain management and coping strategies; and support for more effective opioid abuse treatment programs are needed.*

High-energy injuries, such as pelvic and femur fractures, and certain musculoskeletal surgeries, such as spine fusion for adolescent scoliosis, create tremendous pain that may require an opioid response. Therefore, it is critical for lawmakers to not enact policy measures that would have the unintended consequence of preventing patients who have suffered high-energy injuries or who are undergoing major surgeries from having access to adequate pain control mechanisms.

Texas orthopaedic surgeons have been at the forefront of addressing opioid use through educational efforts within the orthopaedic medical societies by focusing on non-opioid alternatives, when applicable. As evidenced by the following chart, opioid prescribing in Texas, which is already one of the lower rates in the nation, has been declining over the past few years.

TOA, AAOS, and Texas orthopaedic surgeons have implemented numerous initiatives to both reduce opioids and encourage better use of opioids. For example, David Ring, MD, PhD of Dell Medical School at the University of Texas at Austin has implemented the following protocols:

1. Use nonopioid alternatives as a first line of pain medication following orthopaedic procedures.
2. Prescribe the minimum necessary quantity of oral opioids for a limited period of time.
3. Avoid prescribing long-acting preparations of oral opioids for acute pain of injury or surgery.
4. Establish practice-wide strategies for prescribing opioid analgesics, to depersonalize discussions with patients and their caregivers about limiting the use of opioids.
5. Be mindful of requests for a greater amount or duration of opioids, as these may indicate opportunities to partner with other experts to address psychosocial stress using other approaches.
6. Before elective surgery, discuss and individualize pain management strategies for more effective pain relief, using as few opioid pills as possible.
7. Screen and address the potential for misuse and factors associated with greater pain intensity for a given nociception, including greater symptoms of depression or less effective coping strategies such as catastrophic thinking.
8. Call patients the day after their ambulatory surgery or hospital discharge to support and coach them in their recovery.
9. Avoid prescribing a large number of opioid pills for extended durations and minimize the potential for overuse by utilizing electronic prescribing to enable smaller prescriptions and to more closely monitor patients' opioid intake.

Policy Recommendations for the Texas Legislature

As referenced earlier, the interim committees are tasked with studying the prevalence of substance abuse and misuse in Texas and determining what, if any, policy responses should be put in place. When developing strategies to address this issue, it is important to recognize that we are dealing with two completely different populations, and each population requires a different strategy:

- Individuals who are currently addicted to legal and illegal drugs.
- How to deter the future abuse of and unnecessary use of prescription drugs.

The population that is currently addicted to legal and/or illegal drugs presents the greatest challenge. Ultimately, they will need rehabilitation efforts to wean them off of their addiction. In addition, they will need continuous follow-up throughout their lives to ensure that they do not return to the inappropriate use of drugs.

Some of the efforts to address the population that is currently facing an addiction include:

1. Recognizing that misuse disorders and addictions are a disease. These drugs change an individual's neurophysiology.
2. Society must decrease the stigma and other barriers to care.
3. Naloxone should be readily available to treat overdoses.
4. Medication-assisted treatment (e.g., Suboxone) should be widely available.
5. Finally, and perhaps most important, we must make available support programs that individuals are encouraged to utilize. This may potentially involve inpatient care that is followed by outpatient follow-up.

To prevent future addictions, it is critical for Texas physicians to continue following their current strategies, which have resulted in declining opioid prescription rates, as evidenced by the chart presented at the end. We encourage state lawmakers to partner with physicians to encourage and help medical professional organizations promote the safe and effective alleviation of pain and optimal opioid stewardship. Ultimately, it is up to the profession to continue to lead these efforts.

Creating the Nation's Model Prescription Monitoring Program

The Texas State Board of Pharmacy's prescription monitoring program (PMP) served as the centerpiece of the 2017 Texas Legislature's efforts to address opioid addiction through the practice of "doctor shopping." The 2017 Texas Legislature recognized that electronic health record (EHR) systems were not necessarily ready to connect to the PMP and delayed the mandate for physicians to check the PMP for certain drugs until September 1, 2019. Texas' PMP collects a patient's prescription drug history, which allows pharmacists and physicians to review a patient's prescription drug history. The ultimate goal of the Legislature's mandate is to stop the practice of "doctor shopping."

TOA highly supports a robust PMP in Texas and views it as an invaluable tool to help limit misuse and diversion. TOA would like to continue working with the 2019 Texas Legislature to create the nation's model PMP for other states to follow.

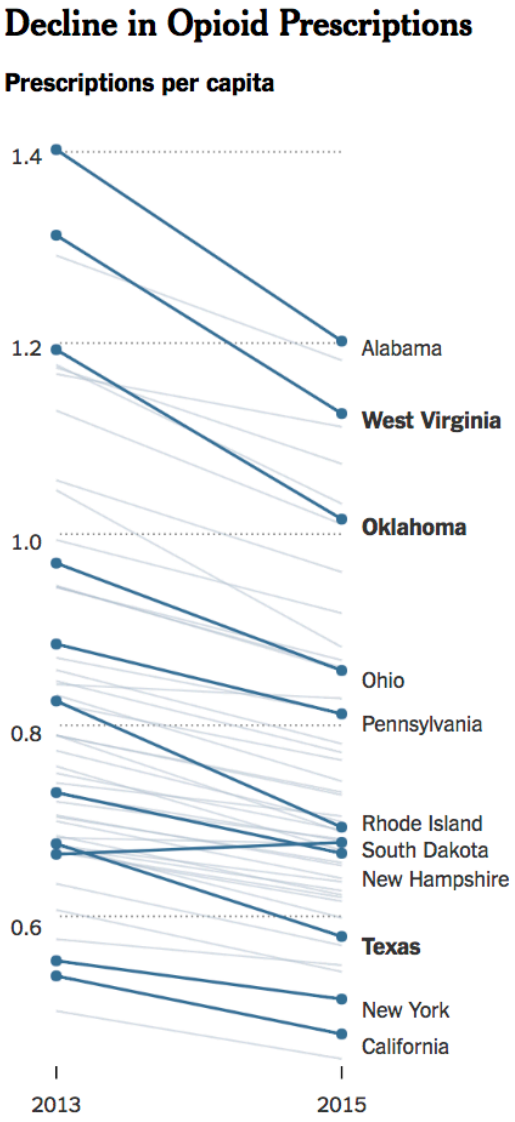
TOA believes that it is critical for the Texas Legislature to ensure that the following measures are in place before the 2019 mandate to check the PMP goes into effect:

> The ideal PMP should feature a seamless transition between the PMP and a physician's EHR program.

- Ensure that the majority of EHRs are able to work with Appriss Health's gateway that automatically connects an EHR to the PMP. Many physicians see dozens of patients a day, and if it takes several minutes to log into the PMP, that could take valuable time out of a physician's day. According to the Texas State Board of Pharmacy's data, a number of EHRs have already connected to the PMP or are in the process of doing so. It is critical for the Legislature to ensure that the majority of EHRs will connect to the PMP by September 1, 2019.
- Ensure that the financial burden is not placed on physicians. Several other states have dedicated appropriations to pay for the Appriss Health gateway license for each physician user. TOA encourages the Texas Legislature to dedicate funds to the licenses. In addition, TOA encourages the Legislature to serve as a "watchdog" to ensure that EHRs do not view the PMP mandate as a "revenue opportunity" by attempting to charge physicians for utilizing the PMP through the

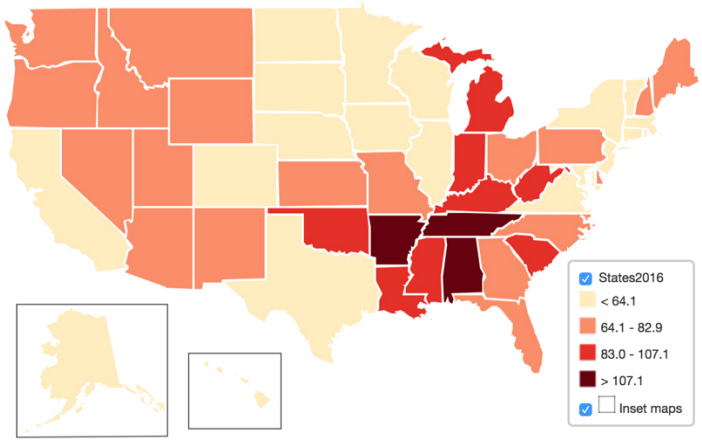
EHR. On a side note, TOA is aware of an EHR company that is, in good faith, actually paying for the Appriss Health license for each physician.

- Ensure that physicians are not penalized for PMP errors or malfunctions. TOA was pleased that lawmakers added language in the 2017 Legislature that protected physicians from PMP errors and malfunctions. TOA is aware of several instances in which it was not possible to find a patient in the PMP due to a human error. In addition, if the technology is not working, a patient should not be denied useful drugs as a result. Therefore, TOA encourages lawmakers to continue to ensure that physicians are protected from these instances.



The data measures dispensed opioids from more than 85 percent of all retail pharmacies in the nation and was produced by IMS Health. The chart was published in the May 20, 2016 edition of the New York Times. "Opioid Prescriptions Drop for First Time in Two Decades."

According to data from the Centers for Disease Control and Prevention (CDC), Texas had one of the lowest levels of retail opioid prescriptions dispensed per 100 persons in 2016:



By comparison, only eight states – California, South Dakota, North Dakota, Minnesota, Massachusetts, New Jersey, Connecticut, and New York – had lower rates than Texas. The following is a sample of several states from the CDC's list of 2016 prescribing rates:

- Texas – 57.6
- Oklahoma – 97.9
- Arkansas – 114.6
- Louisiana – 98.1
- Florida – 66.6
- California – 44.8
- Ohio – 75.3
- Illinois – 56.8
- Virginia – 63.4
- Washington – 64.9
- Pennsylvania – 69.5
- New York – 42.7