Texas Hospital Association

# Texas Hospitals' Guidelines to Curb Opioid Use and Abuse

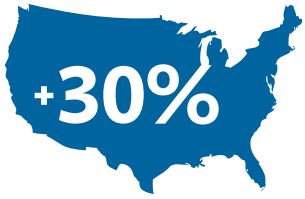
## THE OPIOID EPIDEMIC AND ITS EFFECT ON TEXAS

With more than 42,000 opioid-related deaths in the U.S. in 2016, drug overdoses are the leading cause of death for Americans younger than 50 years old. Almost 3,000 Texans died from drug overdoses in 2016. Opioids are to blame for the majority of these overdose deaths both nationally and in Texas. Relative to the rest of the nation, however, Texas' opioid abuse problem appears less severe, but insufficient and incomplete data reporting obscure the scope of the state's epidemic.

## Financial Consequences for Hospitals and State Economy

**OPIOID-RELATED COSTS IN EMERGENCY DEPARTMENTS**

JULY 2016-SEPT. 2017
**Total visits in 45 states**




**COSTS TO TREAT OPIOID OVERDOSES IN INTENSIVE CARE UNITS**

2009-2015
**Opioid overdose treatment in ICU**

**+60%**

2015
**Yielding a**

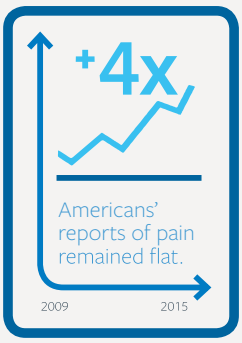
**+$93,000**
**cost per patient**

**The opioid crisis costs Texas $20 BILLION ANNUALLY (1.27 percent of GDP)**

NON-FATAL, PER CAPITA OPIOID COSTS ARE **$202** IN TEXAS
TOTAL COSTS, PER CAPITA – INCLUDING LOSS OF LIFE, ARE **$706**

## Source of the Problem

2009-2015
**U.S. Rx Opioid Sales**




2016
**The number of opioid PRESCRIPTIONS IS DECREASING,**

**BUT 60% OF TEXANS** received an opioid **prescription.**

**Almost 16.2 MILLION OPIOIDS prescriptions** were written in 2016.

References: Centers for Disease Control and Prevention, Texas Department of State Health Services, Castlight Health, The Council of Economic Advisers, American Enterprise Institute, Center for Healthcare Delivery Science, Beth Israel Deaconess Medical Center

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# Texas Hospitals' Role in Reducing Opioid Use and Abuse


Although **only a fraction of opioid prescriptions nationally are written for patients receiving care from hospital emergency departments, they account for approximately 45 percent of opioids diverted for non-medical use**, according to the American Academy of Emergency Medicine.

As anchors in Texas communities and public health advocates, Texas hospitals have taken a leadership role in educating lawmakers, the public and other health care professionals about the dangers of opioid use and abuse and strategies to avoid it.

In 2017, after extensive research and consultation with a number of clinical experts, **the Texas Hospital Association developed voluntary guidelines for use in Texas hospitals' emergency departments to advise ED prescribers of ways to minimize inappropriate use of opioids and ultimately reduce the number of opioid-related deaths in Texas.** THA recommends that **all** Texas hospitals adopt these guidelines. More than 20 other state hospital associations across the country also have developed similar opioid prescribing guidelines.

These guidelines are one element to help solve a problem with many causes and one that needs the engagement and support of all health care professionals, payers and policymakers.

## Voluntary ED Prescribing Guidelines to Reduce Opioid Misuse and Abuse

**1. Encourage hospitals to develop a process for identifying patients, including pregnant and post-partum women, at risk for developing a substance use disorder and for those with a substance use disorder.**

Studies show that **administering the Screening Brief Intervention and Referral to Treatment questionnaire is effective in reducing drug misuse and abuse**, helping to decrease individuals' illicit drug use, including opioids, by 70 percent.[1] With limited access to behavioral health treatment, Texas hospitals need referral sources in the community so that identified patients can get the services they need.

**2. Discourage ED providers, who are not the initial prescribers, primary care providers or pain specialists, from writing prescriptions for controlled substances that are lost, destroyed or stolen, or doses of methadone for patients in methadone treatment programs.**


This recommendation is intended to **guard against patients who are misusing controlled substances and possibly reporting their prescriptions as lost or stolen from obtaining more, medically unnecessary pills.** For individuals in methadone treatment programs specifically, all methadone treatment programs require patients to receive their dose daily and in person, supervised at the clinic.



[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2760304/

## 3. Emphasize use of short-acting opioids, if opioids are prescribed in the ED.

According to the U.S. Centers for Disease Control and Prevention, one possible factor contributing to **increasing mortality from long-acting opioids may be drug users overlapping doses in order to feel the effects of long-acting opioids more quickly.**[2] Researchers from the University of Toronto found similar results, with oxycodone-related mortality increasing by a factor of five and overall opioid-related mortality increasing by 41 percent as prescriptions for long-acting opioids increased by 850 percent between 1991 and 2007.[3]

## 4. Endorse adoption of a multi-modal non-opioid medication model for acute pain management treatment.

**The Joint Commission advises prescribers of pain medications to use both non-pharmacologic (physical therapy, acupuncture, etc.) and pharmacologic alternative therapies (non-opioid analgesics like acetaminophen, NSAIDs and muscle relaxants) to treat pain.** In its opioid prescribing guidelines, the CDC cited studies ranging in duration from two to six weeks that found non-pharmacologic and non-opioid pharmacologic treatments to be effective in managing chronic pain.

## 5. Recommend that when any opioid prescriptions for patients leaving the ED be written for the shortest duration possible, usually no more than five days, unless the diagnosing physician determines more are necessary.

Researchers at the University of Michigan Medical School found that **patients who received the maximum daily prescribed dose of opioids were at higher risk of opioid overdose death.**[4]

## 6. Recommend that, when opioids are prescribed, hospitals have a system in place to notify the patient's primary opioid prescriber or primary care provider of the ED visit and the medications prescribed.


Studies show that **concurrent opioid prescribing by multiple providers is associated with higher rates of hospital admission related to opioid use**.[5]

## 7. Encourage ED prescribers, or their designees, to consult the state's Prescription Monitoring Program (PMP AWARxE) before writing opioid prescriptions to check patients' prescribing history.

The PMP AWARxE is the online database that stores prescription data for all Schedule II, III, IV and V controlled substances dispensed by a pharmacy in Texas or to a Texas resident from a pharmacy located in another state. Through the database, practitioners can monitor patient prescribing history and orders for Schedule II Texas Official Prescription Forms. **THA's guidelines recommend consulting the PMP even though mandatory use of the system will not take effect until Sept. 1, 2019.** When New York required prescribers to check the state's PMP before prescribing opioids, the number of patients who obtained opioids from multiple prescribers decreased by 75 percent after a year. Tennessee saw a 36 percent decrease in "doctor shopping" after implementing the PMP requirement as well.

[2]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1586142/
[3]https://www.ncbi.nlm.nih.gov/pubmed/19969578
[4]https://jamanetwork.com/journals/jama/fullarticle/896182
[5]https://www.bmj.com/content/bmj/348/bmj.g1393.full.pdf

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