Quality Monitoring Program

Opioids: An Epidemic Crisis

TEXAS
Health and Human Services

References

1. CDC Guidance for Prescribing Opioids for Chronic Pain: **cdc.gov/drugoverdose/prescribing/guideline.html.**
2. Opioid Summary by State — Texas: **d14rmgtrwzf5a.cloudfront.net/sites/default/files/texas_2018.pdf**
3. "New AHRQ Reports Highlight Seniors' Struggle with Opioids": **ahrq.gov/news/newsroom/press-releases/seniors-struggles-with-opioids.html**
4. "Opioid-Related Inpatient Stays and Emergency Department Visits Among Patients Aged 65 and Older": **hcup-us.ahrq.gov/reports/statbriefs/sb244-Opioid-Inpatient-Stays-ED-Visits-Older-Adults.jsp**
5. The Screening Brief Intervention and Referral to Treatment: **samhsa.gov/sbirt/resources**
6. "HHS Awards Over $1 Billion to Combat the Opioid Crisis": **hhs.gov/about/news/2018/09/19/hhs-awards-over-1-billion-combat-opioid-crisis.html**
7. Strategy to Combat Opioid Abuse, Misuse, and Overdose: A Framework Based on Five Point Strategy: **hhs.gov/opioids/sites/default/files/2018-09/opioid-fivepoint-strategy-20180917-508compliant.pdf**
8. State Opioid Response Grants: **samhsa.gov/grants/grant-announcements/ti-18-015**
9. Get Connected Tool Kit: **store.samhsa.gov/system/files/sma03-3824.pdf**
10. "Pharmacists Can Help Right the Ship in the Opioid Crisis": **pharmacytoday.org/article/S1042-0991(17)31334-8/fulltext**
11. 2018 Annual Surveillance Report of Drug-Related Risks and Outcomes-United States Surveillance Special Report: **cdc.gov/drugoverdose/pdf/pubs/2018-cdc-drug-surveillance-report.pdf**

Scope of the Issue

In 2016, the United States had:

- An estimated 11.5 million adults misused prescription opioids.[1]
- An estimated 17,087 people died because of prescription opioid overdose.[11]

In 2016, Texas had:

- An estimated 1,375 opioid-related overdose deaths.[2]
- Since 2010, heroin-related deaths increased from 260 to 530.[2]
- Since 2010, deaths attributed to synthetic opioids (mainly fentanyl) increased from 156 to 250.[2]
- Opioid-related overdose deaths occur at a rate of 4.9 per 100,000 people in Texas as compared to 13.3 per 100,000 nationally.[2]

Older Adults — A Vulnerable Population

According to the statistical data from Agency for Healthcare Research and Quality, non-institutionalized older adults had significant increases in opioid-related complications between 2010 and 2015. In 2015, an estimated 125,000 hospitalizations were for an opioid-related diagnosis. Between 2015 and 2016, nearly 4 million seniors had received an average of four or more opioid prescriptions. During this same time period, an estimated 10 million seniors received at least one opioid prescription. [3]

Between 2010 and 2015, the number of opioid-related inpatient stays had increased by 54.4 percent in people 65 and older. In that population, the number of inpatient stays increased by 71.9 percent in those 65-74, 32.2 percent in those 75-84, and 42.6 percent in those 85 and older. During the same period, opioid-related emergency department visits by older adults almost doubled. Emergency department visits increased by 131.7 percent in people 65-74, 68.5 percent in those 75-84, and 52 percent in those 85 and older.[4]

Signs of substance abuse in older adults are often subtle, and often resemble those associated with aging, including fatigue, diminished cognitive capacities, and balance problems. However, barriers such

as lack of awareness from health care professionals and older adults and limited research might prevent older adults from receiving the screening and adequate treatment needed. The Screening Brief Intervention and Referral to Treatment, is an evidence-based tool useful in screening older adults for substance abuse.[5] This resource can be found at samhsa.gov/sbirt/resources.

U.S. Health and Human Services Strategies to Combat the Epidemic

On the national level, HHS awarded over $1 billion to opioid-specific grants to fund the HHS 5-Point Opioid Strategy that was launched in 2017.[6] This strategy incorporates science as a foundation to combat opioid misuse and abuse in the United States.[7]

The ultimate purpose for the HHS 5-Point Opioid Strategy is to provide better services in research, treatment, pain management, prevention and recovery to decrease the opioid crisis plaguing the United States.

- **Point 1 Strategy:** Improve accessibility to programs to assist in prevention, treatment, recovery and pain management.
- **Point 2 Strategy:** Improve the reporting and collection of public health data to efficiently monitor trends and client outcomes with real-time data.
- **Point 3 Strategy:** Provide better pain management through evidence-based best practices to improve pain control and decrease the inappropriate use of opioid medications.
- **Point 4 Strategy:** Increase the availability and distribution of overdose-reversing medications with a focus on high-risk populations.
- **Point 5 Strategy:** Support research to provide understanding in addiction and overdose to help develop effective interventions to decrease opioid-related harm.

Substance Abuse Funding and Resources

The Substance Abuse and Mental Health Service Administration, an agency within HHS, promotes efforts to improve behavioral health. SAMHSA's mission is to combat mental illness and substance abuse that is plaguing our nation. SAMHSA works with other agencies to provide resources and funding.

The agency has granted $930 million to fund a State Opioid Response Grant. This grant will help states provide quicker access to medication-assisted treatment for the treatment of opioid-use disorder. States received a portion of this funding based upon a formula.[8] Texas was awarded $46,229,092.

SAMHSA has also provided a prevention kit called the Opioid Overdose Prevention Toolkit available at **store.samhsa.gov/system/files/sma18-4742.pdf**. This guide provides information for prescribers, first responders, patients and family members about opioid-use disorders.

SAMHSA also has a variety of resources and publications at **samhsa.gov**.

Mental Health in Older Adults

"Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."

— *World Health Organization, 2014*

Among the most common mental health disorders in older people are depression and anxiety. However, loneliness or fear might lead some older adults to substance abuse intentionally or unintentionally. Misconceptions concerning mental health issues and substance abuse in older people prevent this population from receiving treatment that is needed.

Recommendations include providing preventative strategies to curtail depression, anxiety and suicide in older people, screening for

these issues, and evidence-based interventions. The "Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities", "Treatment of Depression in Older Adults Evidence-Based Practice Kit," and "Get Connected Toolkit" are valuable resources that can be used in independent living, assisted-living facilities, nursing homes, as well as continuing care retirement communities to initiate assistance and training for staff and older people.

These resources are available:

Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities:
suicideinfo.ca/wp-content/uploads/2015/09/Promoting-Mental-Health-and-Preventing-Suicide_oa.pdf

Treatment of Depression in Older Adults Evidence-Based Practices KIT:
dmh.ms.gov/pdf/SAMHSA%20Toolkit.pdf

Get Connected Tool Kit:
store.samhsa.gov/system/files/sma03-3824.pdf

Clinical and Patient Education – Community Setting

Resources and strategies are available to people who live in community settings such as assisted living, retirement communities and independent living.

Connect with the Pharmacist

doi.org/10.1377/hlthaff.2018.1225

The pharmacist is the most easily accessible health care provider in the community and serves as the bridge between a patient seeking treatment and receiving it, and they can watch for red flags to spot addiction. Pharmacists can provide deliberate, watchful support and guidance by:

- Calling a doctor if they believe a medication amount is too high.
- Administering a long-acting monthly naltrexone injection for opioid dependence.

- Connecting a patient with a rehabilitation facility.
- Filling the gaps in patient knowledge and understanding of a medication's purpose and parameters for use.
- Monitoring for drug interactions, safe and appropriate use (*for example, watching for timely refill pickups*) and communicating to physicians and patients when needed.

Education is critical in pain management. Pharmacists can explain to chronic pain patients that their pain is the disease at this point, and management strategies aim to set realistic goals and use a multimodal approach to maximize pain relief and coping strategies. The importance of maximizing the patient's functional status should be stressed in lieu of relying on a pain severity rating. Goals of therapy should also be SMART: specific, measurable, achievable, relevant and time-bound. To assess patients' functional status, pharmacists can consider using the PEG Pain Screening tool, a three-question validated measure that queries the patient's pain in the past week on a 0 to 10 scale, how much pain has interfered with their enjoyment of life, and how much pain has interfered with their general activity in the past week.[10]

Not all pain, particularly chronic pain, is opioid responsive. Non-pharmacologic interventions are frequently an important part of managing chronic pain. The pharmacist can play an important role in recognizing the need for physical therapy to manage chronic pain and in working with the health care team to adjust or taper the patient's opioid as physical therapy begins to provide benefit. Patients are often concerned about reducing their dose for pain relief, and pharmacists can provide reassurance.

Using the Centers for Disease Control and Prevention guide to opioid conversions or another validated tool, pharmacists can monitor a patient's total daily dose of opioid, the equivalence to 50 mg or 90 mg of oral morphine, and work with prescribers as appropriate. As health care providers, pharmacists and physicians must work together to help reduce the number of patients taking prescription opioids. Pharmacists and physicians can help control

the opioid epidemic by limiting the number of opioids prescribed, prescribing alternative options for acute and minor pain, carefully monitoring patients taking opioids, and making sure their patients are not going to multiple prescribers. Pharmacists can educate patients, families, other practitioners, and recommend non-pharmacologic integrative therapies. Cooperation and diligence from all levels of health care will be needed to address this epidemic.[10]

Safe Prescribing Practices:

The CDC has developed guidelines for the safe prescribing of opioid medications for chronic pain to adults in primary care settings. The guidelines include 12 recommendations in three categories:

- Determining when to initiate or continue opioids for chronic pain
- Considering opioid selection, dosage, duration, follow-up and discontinuation
- Assessing risk and addressing harms of opioid use

The guidelines recommend reassessing a patient's benefit and risk from opioid therapy when the total daily dose of opioid approaches the equivalent of 50 mg oral morphine. Doses in excess of 90 mg oral morphine should be avoided or used with great caution. Opioid care coordination alert, triggered by the prescriber who writes the prescription, helps identify potentially high risk patients whose cumulative morphine milligram equivalents reaches 90 mg or more per day across all opioid prescriptions who can benefit from closer monitoring and care coordination. This is not a prescribing limit. In reviewing the alert, the pharmacist can contact the prescriber to confirm medical need for the higher MME. Once a pharmacist consults with a prescriber on a patient's prescription for a plan year, the prescriber will not be contacted on every opioid prescription written for the same patient after that unless the plan implements further restrictions. Unfortunately, recent research has shown when practitioners were asked to calculate the equivalent dose of morphine for five different opioid regimens, they displayed substantial variability in their responses.

Prescribers must learn how to identify patients who might be at a high risk of opioid overdose before prescribing these medications. Also, prescribers must use their state's prescription drug monitoring program before prescribing opioids. The CDC has launched two new opioid trainings that support providers in safer prescribing of opioids for chronic pain. The modules are part of a series of interactive online trainings that feature recommendations from the CDC Guideline for Prescribing Opioids for Chronic Pain, clinical sce-narios, tools and resource libraries to enhance learning. The modules offer free continuing education.

Reference:

surgeongeneral.gov/priorities/opioid-overdose-prevention/naloxone-advisory.html

HHS issued guidance and recommended a set of indications for naloxone prescriptions at **hhs.gov/opioids/sites/default/files/2018-12/naloxone-coprescribing-guidance.pdf**

CDC Interactive Training Modules:
cdc.gov/drugoverdose/training/online-training.html

CDC Guideline Resources for Providers:
cdc.gov/drugoverdose/prescribing/resources.html

Safe Disposal Practices – Community Setting

How to Properly Dispose of Unused Medications

fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/ensuringsafeuseofmedicine/safedisposalofmedicines/ucm186187.htm

disposemymeds.org

areyouawellbeing.texashealth.org/properly-dispose-medication

Some police departments have full-time medication drop boxes so you can go by anytime to drop off unused or expired medicines.

Where available, take expired or unwanted medications to pharmacy or public health-sponsored medication disposal sites. To find out when and where the next event will be, visit: **deadiversion.usdoj.gov/drug_disposal/index.html**

If a medication disposal program is not available in your area, the unwanted or expired medicines can be thrown away in the trash by following these steps:

- Delete all personal information on the prescription label of empty pill bottles or medicine packaging.
- Liquids should be poured over paper towels, cat litter or coffee grounds and tightly wrapped in sealable or watertight containers or bags.
- Solids (pills, capsules, tablets) should be placed into a sealable or water tight container or bag and add a small amount of water to at least partly dissolve them. You might want to add an undesirable substance like coffee grounds or cat litter so that they are less likely to be eaten.
- Place the container inside a package such as a box that doesn't show what's inside.
- Put the medication in the trash as close to pick up time as possible. Do not place in recycling bins.

Nursing Facility – Limiting Unnecessary Opioids

In nursing homes, the following guidelines might be useful to assist in the implementation of processes to eliminate unnecessary opioid use.

Facility Staff

- Implement policies and procedures to provide safe and effective dosing of opioids by ensuring staff competency in writing, interpreting and initiating of opioid medications. These policies should include ongoing education for nurses and prescribers to promote safe practices.

Prescribers

- Consider the benefits-to-risks ratio of opioid medications before prescribing this drug regimen. Non-opioid medications as well as non-drug therapies should be exhausted before initiating opioid medications.
- Consider the patient's characteristics such as age, end organ function, duration of pain, prior exposure to opioids, other simultaneous medical conditions, accompanying administration with other medications and the movement of the medication within the body.
- Consider special precautions in elderly and/or frail people.
- Use the lowest dose possible when initiating opioid therapy. Immediate-release preparations are preferred over long-acting preparations in the initial therapy for chronic pain. In acute pain, long-acting preparations are not recommended. The need to increase dosage should be minimum and slow with the goal of using the lowest effective dose.
- Set effective goals for pain relief and function for each person. Decisions should be made to determine if continuation of the opioid therapy is effective. If the medication is ineffective, then measures should be in place to ensure safe discontinuation of the medication. Follow-up is crucial in evaluating the risk of harm in each person. For acute pain, reevaluate for the effectiveness of the medication after three to seven days.
- Avoid therapeutic duplication of opioid medications of more than one type.
- Avoid prescribing opioid medications with other sedatives whenever possible. Concurrent use of these medications can increase the risk of central nervous depression. Benefits should outweigh risks in concurrent use of these agents.
- Review a person's drug history before initiating opioid drug therapy to determine if they're receiving opioid drug therapy from other sources. The prescriber should review the state prescription drug monitoring program before writing for opioid drugs and

during the course of the therapy. Urine drug testing should be used at least initially and yearly to determine the use of opioid prescription or illicit drug use.

Nurses — Assessing for Pain

- Complete a thorough assessment to include at least the pain intensity, pain characteristics, patterns of pain, response from other pain-relieving medications, allergies, and impact on function before determining the appropriate opioid to use.
- Implement and use valid pain assessment tools consistently with the patient. For instance, in people with cognitive impairment, use a valid, reliable tool tailored to that population.
- Assess and document completely a patient's response to an opioid dose after administration.
- Evaluate and reevaluate the patient periodically for possible risk factors for harm (for example, exercise or bowel regimens to prevent constipation, risk assessments for falls, and patient monitoring for cognitive impairment).

While the focus of these guidelines is to reduce opioid misuse, abuse of opioid medications might not necessarily be the issue at hand in certain populations. In some situations, pain is often undertreated because it is not as easily recognized in people with cognitive impairment. Other people at risk for under-treatment of pain include the older population, women, racial and minority groups, people with cancer and/or at the end of life. Pain alleviation, with or without opioids, is essential to appropriate care.

Nursing Facility Federal Regulations

The federal tags are federal requirements that nursing facilities must follow to be in compliance with regulations. Nursing facilities receive a deficiency for any f tags that are violated. The following f tags can be associated with pain management and could result in a facility being non-compliant in these areas if violated.

Associated Federal tags (f tags):

- **F652** Right to be Informed/Make Treatment Decisions
- **F653** Right to Participate in Planning Care
- **F755** Pharmacy Services/Procedures/Pharmacist/Records
- **F756** Drug Regimen Review, Report Irregular, Act On
- **F757** Drug Regimen Free From Unnecessary Drugs
- **F761** Label/Store Drugs & Biologicals
- **F636** Comprehensive Assessments & Timing
- **F636** Comprehensive Assessments After Significant Change
- **F638** Quarterly Assessments At Least Every 3 Months
- **F641** Accuracy of Assessments
- **F655** Baseline Care Plan
- **F656** Develop/Implement Comprehensive Care Plan
- **F697** Pain Management
- **F740** Behavioral Health Services

2019 Policy Updates

- Effective July 1, 2019, new and revised requirements related to pain assessment and management will be applicable to Joint Commission-accredited organizations including nursing care centers (*R3 Report Issue 21*), behavioral health (*R3 Report Issue 20*) and home health services (*R3 Report Issue 22*): **jointcommission.org/topics/?k=898&b**
- The Centers for Medicare & Medicaid Services published an opioids roadmap at **cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Opioid-epidemic-roadmap.pdf** detailing the three-pronged approach, focusing in on preventing new cases of opioid use disorder, treating patients who have opioid use disorders, and using data from across the country to target prevention and treatment activities.

- CMS issued a Provider Letter in February 2019: **cms.gov/About-CMS/Story-Page/Opioid-Provider-Letter-Feb-2019.pdf**
- CMS implemented new opioid policies with training materials, slide decks and tip sheets: **cms.gov/Medicare/Prescription-Drug-coverage/PrescriptionDrugCovContra/RxUtilization.html**
- CMS released a Medicare Learning Network Matters article, "A Prescriber's Guide to the New Medicare Part D Opioid Overutilization Policies for 2019": **cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18016.pdf.**
- The CMS overall strategy is described at **cms.gov/about-cms/story-page/reducing-opioid-misuse.html**

Additional Resources Available:

- The Office of the Attorney General and the Texas Health and Human Services system have partnered to launch "Dose of Reality," a public awareness campaign aimed at preventing prescription opioid misuse in Texas. The website features guidance and resources for individuals, health-care providers and businesses about managing pain properly, storing prescription painkillers safely, responding to an overdose and recognizing opioid misuse and use disorder. **doseofreality.texas.gov/**
- Texas Targeted Opioid Response promotes outreach and education for the public and professionals through training and community events, expands access to treatment, prevention and early intervention and provides long-term recovery supports for people with a history of, or who are at risk for developing, opioid-use disorders and overdose. This new opioid response initiative will also enhance re-entry, employment and housing for people affected by opioid use. **hhs.texas.gov/services/mental-health-substance-use/adult-substance-use/texas-targeted-opioid-response**

- First, Do No Harm: Marshaling Clinician Leadership to Counter the Opioid Epidemic:
  nam.edu/wp-content/uploads/2017/09/First-Do-No-Harm-Marshaling-Clinician-Leadership-to-Counter-the-Opioid-Epidemic.pdf
- Opioid Use, Abuse and Misuse Resource Center has multiple resources and tools, including patient and clinical information, as well as state and federal developments related to the opioid epidemic:
  pharmacist.com/opioid-use-abuse-and-misuse-resource-center
- Opioid Toolkit:
  aha.org/system/files/content/17/opioid-toolkit.pdf
- Opioid Overdose Prevention Toolkit:
  samhsa.gov/capt/tools-learning-resources/opioid-overdose-prevention-toolkit
- Best Practices to Prevent Loss of Drugs:
  ihs.gov/painmanagement/safestorage/
- HHS Adult Substance Use for community services:
  hhs.texas.gov/services/mental-health-substance-use/adult-substance-use
- Indian Health Services Initiatives:
  japha.org/article/S1544-3191(17)30005-5/pdf

  This article describes interventions implemented by pharmacists working in Indian Health Services locations throughout the United States. These interventions were designed to improve approaches to pain management, while ensuring responsible opioid prescribing.

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