



Physicians Caring for Texans

Select Committee on Opioids & Substance Abuse
Comments Submitted by Texas Medical Association
August 8, 2018

On behalf of the Texas Medical Association (TMA), which represents more than 51,000 physicians and medical students across Texas, thank you for the opportunity to provide written comments to the Select Committee on Opioids & Substance Abuse. TMA’s mission is to “Improve the health of all Texans.” Given the increase in substance use disorder (SUD) across Texas — and the challenges physicians and patients face trying to find effective, timely, and affordable treatment and management of SUD — we applaud the committee’s efforts to identify sound policy to prevent opioid and other substance use disorder while also ensuring that patients with such an addiction receive medically necessary and timely intervention and treatment.

Unfortunately, too many people still consider substance abuse to be a personal failure. But as physicians, we know it is indeed a chronic brain disorder that is marked by the compulsive use of a substance to the point it interferes with the person’s ability to function at home, work, or school. In recent years, opioid addiction has come to be the face of substance use. But opioid use disorder is just one type of SUD. The term “SUD” actually encompass a wide range of drugs, ranging from legally available stimulants, opioids, alcohol, and tobacco to street drugs like heroin. Further, people with mental health disorders are more likely than people without mental health disorders to experience a SUD.

At the same time, our members appreciate how complex the issue is and recognize that short- and long-term strategies to combat SUD effectively must involve collaboration among not only the medical, pharmacy and, social services communities but also law enforcement and criminal justice; primary and secondary school systems; and technology developers who can facilitate simple but effective prescription drug monitoring programs and greater use of telemedicine.

At prior hearings, TMA has provided testimony on a number of topics related to SUD including treatment of SUD in pregnant and postpartum women, opportunities to strengthen the Texas Prescription Monitoring Program (PMP), innovative use of telemedicine, SUD treatment in Medicaid managed care, and caring for patients with a SUD and a co-occurring mental health condition.

The following are TMA's recommendations for the committee to consider when drafting its report to the legislature.

➤ **Increase access to evidence-based community and crisis mental health and substance abuse services for high-risk populations, including pregnant and postpartum women and people with co-occurring mental health conditions.**

- **Provide funding to enhance coverage for substance use disorder screening and treatment for postpartum women.** Among pregnant women, substance abuse poses significant potential harm to mother and baby. According to the most recent data compiled by the Texas Maternal Mortality and Morbidity Task Force, drug overdoses are the leading cause of maternal death during and after pregnancy, with most deaths occurring after the 60-day postpartum period. In a majority of cases (77 percent), a combination of drugs were used, though legal and illegal opioids were detected in 58 percent of cases.

As the rate of opioid misuse among pregnant women has increased, so too has the incidence of neonatal abstinence syndrome (NAS), a condition in newborns caused by the sudden withdrawal of opioids taken by the mother. Between 2010 and 2014, rates of NAS in Texas increased by 51.3 percent. Newborns with NAS are more likely to have longer, medically complex initial hospitalizations. Texas Medicaid pays for 54 percent of all births in the state and is thus the primary payer of hospital charges associated with NAS, underscoring the state's critical interest in preventing and treating opioid use especially during pregnancy.

SUD treatment services are available to pregnant and postpartum women who are ineligible for Medicaid if they are indigent and meet the state's clinical requirements. This benefit is focused on pregnant women, "injecting women," pregnant and injecting women, or those referred by the Department of Family and Protective Services (DFPS). The narrow eligibility criteria mean women using noninjectable drugs, including alcohol and prescribed stimulants, or who haven't had a DFPS intervention may not get timely services — services that could prevent a DFPS referral later. The state should consider options to enhance coverage for SUD screening and treatment for pregnant and postpartum women.

- **Incorporate routine SUD screening into Medicaid, the Children's Health Insurance Program, Healthy Texas Women, and the Family Planning Program.** Medicaid provides for comprehensive SUD screening services known as "screening, brief intervention, referral, and treatment," but only physicians and providers who have undergone specialized training can bill for it.

Healthy Texas Women and the Family Planning Program are programs that low-income women rely on for preventive health care services postpartum when they are no longer eligible for Medicaid. The American College of Obstetricians and Gynecologists recommends universal screening during well-woman exams, yet SUD screening is not a benefit of either program.

- **Provide funding to increase physician and provider education and awareness about what resources exist for community-based SUD treatment and mental health treatment.** Many physicians are unaware that Medicaid provides comprehensive SUD intervention, treatment, and recovery services for pregnant women or that indigent pregnant and postpartum women ineligible for Medicaid also may be eligible for services through the Health and Human Services Commission. Further, pregnant and postpartum women with a SUD also may experience maternal depression, which can greatly impact health outcomes of both mother and baby. Co-occurring disorders require proper diagnosis and treatment of both the SUD and the mental health condition. Integrated physical health and behavioral health services are a best practice for people with co-occurring conditions. Without knowing of treatment options, physicians may be reluctant to screen for SUD among their low-income pregnant and postpartum patients. Physicians should be educated on what community-based SUD and mental health treatments options exist to which they can refer patients.
- **Provide funding to ensure SUD treatment providers offer patients a comprehensive array of services, including medication-assisted therapy (MAT).** MAT is one of the most effective evidence-based treatments for SUD. MAT includes both medication and long-term counseling to provide a whole-patient approach to the treatment of substance dependencies. The different medications used in MAT have different effects such as taking away cravings; eliminating or decreasing the effectiveness of the certain opioids; decreasing withdrawal symptoms, relapse, overdose, and criminality; and preventing death.ⁱ Patients receiving medications as part of their treatment are 75 percent less likely to die due to SUD than those not receiving medications.ⁱⁱ MAT restores physiological function disrupted by drug use by improving social function and quality of life, and can reduce HIV viral transmission by reducing injecting behavior and improving opioid use disorder treatment outcomes.ⁱⁱⁱ

Three medications are commonly used to treat SUD:

1. [Methadone](#) (for opioid dependence) — clinic-based opioid agonist that does not block other narcotics during use while preventing withdrawal; daily liquid dispensed only in specialty regulated clinics
2. [Naltrexone](#) (for alcohol or opioid dependence) — office-based, nonaddictive opioid antagonist that blocks the effects of other narcotics; daily pill or monthly injection
3. [Buprenorphine](#) (for opioid dependence) — office-based opioid agonist/antagonist that blocks other narcotics while reducing withdrawal risk; daily dissolving tablet, cheek film, or six-month implant under the skin^{iv}

There are several misconceptions about MAT. One is that people who participate in MAT for substance use disorder just replace one addiction for another. Another is that long-term use of MAT might diminish a patient’s capacity to eventually achieve long-term abstinence from opioids and thus use of MAT should end as soon as possible. But research shows that opioid use disorder, like diabetes or heart disease, is a chronic disease; many patients will require ongoing treatments, including medication, to

successfully manage their addiction.^v MAT should be available, and paid for, for any SUD for which it is clinically indicated, including alcohol dependence.

- **Provide funding to ensure chemical dependency treatment facilities proactively connect women to preventive and primary health services available via Healthy Texas Women and the Family Planning Program, and vice versa,** including ensuring women receiving SUD treatment have timely access to long-acting reversible contraception — the most effective form of contraceptives — if they so choose. Research suggests women with opioid disorders have significantly higher rates of unintended pregnancies. Yet women who are able to plan their pregnancies are more likely to get early prenatal care, have healthier pregnancies, and reduce their risk of having babies born too early or too small.
- **Provide funding for increased availability of education about tobacco’s impacts on pregnancy and babies to decrease smoking among pregnant women and new moms.** Healthy Texas Women and the Family Planning Program benefits should be amended to include tobacco cessation medications. Smoking while pregnant is a risk factor for maternal mortality and morbidity.
- **Change Texas law to increase the age eligible to purchase tobacco products from 18 to 21.** About 95 percent of smokers start before age 21. In Texas, 13,700 kids become daily smokers every year. And one-third of them will die prematurely as a result. Raising the tobacco sale age to 21 is an effective strategy to fight tobacco use which is a gateway product for drug use. Tobacco costs Texas \$8.8 billion annually in health care bills, with the Medicaid costs totaling \$1.9 billion. Smoking-caused productivity losses in Texas exceed \$8.2 billion a year. And each Texas household has a state and federal tax burden of \$738 each year from smoking-caused government expenditures. Future addiction can be curtailed.
- **Provide funding to expand availability of neonatal abstinence syndrome programs (e.g., San Antonio Mommies Program).** NAS programs provide medication-assisted treatment for mothers with opioid addiction as well as support services to address opioid misuse. Once a baby is born, NAS programs provide mother and baby clinically recommended treatment to address addiction. Studies indicate babies born with NAS have an average hospital stay of 21 days but providing clinical interventions for their mothers can reduce the hospital stay by as much as half, saving Medicaid dollars. NAS programs also keep children and mothers together, reducing need for children to be taken into protective custody.
- **Provide funding to expand availability of the Nurse-Family Partnership.** This program matches low-income parents with trained nurses who conduct periodic home visits through the child’s second birthday and provide an array of educational and training services, such as teaching about nutrition, healthy parenting skills, and importance of routine preventive care for women and babies. Nurse-Family Partnership programs play a critical role in early identification of potential SUD or a SUD relapse and ensuring women get connected to treatment services quickly.

- **Pursue state matching funds to obtain federal grants available as a result of the 21st Century Cures Act.** Thanks to the 21st Century Cures Act, federal grant dollars are available for states to invest in programs that will expand availability of behavioral health services for key populations. The act requires states to provide matching funds to draw down federal funds. The Health and Human Services Commission has the opportunity to seek funding to support grants for the following:
 - State pediatric mental health access programs (child psychiatry access programs) to increase access to mental health and substance use services and increase the bandwidth and expertise of primary care physicians to care for children with mental health and substance use concerns;
 - Screening and treatment for pregnant and postpartum women with maternal depression;
 - Early childhood mental health promotion, intervention, and treatment programs; and
 - Initiation of a Project Echo program to expand availability of SUD treatment for Medicaid and indigent patients within physician offices and other ambulatory care settings.

➤ **Support technological enhancements to the Prescription Monitoring Program to improve patient care while minimizing physician overhead costs.**

Legislation passed in 2017 required the licensing boards for all prescribers to furnish information to the Board of Pharmacy so it can automatically register prescribers with the state Prescription Monitoring Program. Prescribers — physicians and others — still must complete their user profiles in the PMP, but the addition of information from licensing boards allows the Board of Pharmacy to push it out within the secure system of the PMP in an effort to identify instances of potential “doctor shopping.” In addition, each licensing board continues to have access to the data on prescribing. Another legislative provision from 2017 requires pharmacies to submit data to the PMP within one business day of dispensing.

To further improve the effectiveness of the PMP, TMA believes the next logical and most effective step will be to automatically link the PMP to physician electronic health record (EHR) systems and hospital patient record systems, particularly those used in emergency departments. This technology-driven solution would build on the efforts of 2017 and create a seamless and constant connection. As this would integrate the PMP data into the patient’s medical record, we believe it would be a cost-effective strategy to increase PDP utilization, minimize physician workflow interruptions, and improve patient care.

➤ **Oppose mandatory e-prescribing of controlled substances (EPCS).**

TMA supports EPCS and encourages physicians to use this technology. But the association opposes mandatory use of EPCS for a number of reasons — especially because existing market trends show a rapid adoption of EPCS, making a mandate unnecessary and counterproductive. A 2018 TMA survey of physicians found that 85 percent of physicians use an EHR system. Of these, nearly 9 out of 10 also electronically prescribe. Of these, 47 percent also electronically prescribe for controlled substances. This is a 17-percent increase

from TMA's 2016 survey findings. (It is important to note that not all physicians prescribe controlled substances, so the 47 percent who do is a significant number already using this technology). Of those who do use EPCS, 94 percent use their EHR to e-prescribe.

Physicians who are not using EPCS report it is not supported by their EHR (40 percent). Additionally, there is a significant increase in physicians who are not interested in using EPCS (11 percent), who find it cost-prohibitive to upgrade to EPCS (8 percent), or who say it interferes with their workflow (8 percent). Improving EHR support for EPCS and reducing cost to upgrade systems would result in greater physician use of EPCS.

Mandatory use of EPCS also could result in civil and criminal penalties for physicians. While proponents of mandatory EPCS promote the idea of waivers, we believe the waiver process will be seen as an additional level of paperwork and bureaucracy, and the failure to complete or renew a waiver would trigger both civil and criminal penalties.

There are no state standards or requirements specific for EHR interconnectivity with Texas programs such as EPCS. All Texas governmental health related systems should at a minimum become interoperable with all EHRs, meeting national standards as well.

To summarize: TMA data show the number of physicians who prescribe controlled substances electronically continues to increase rapidly, making a mandate unnecessary. A mandate would unnecessarily penalize small and rural practices, without ultimately making the PMP better. After all, prescriptions for controlled substances — whether written electronically or manually — all end up in the PMP database as they are filled.

➤ **Support public health approaches and other best practices to improve health outcomes of people with a SUD.**

TMA has assessed prevention methods and strategies shown to be effective in reducing substance misuse and overdoses as well as further harm to individuals and their communities. States and communities are investigating a variety of approaches to improve health outcomes associated with SUD.

- **Timely access to opioid antagonists** — TMA strongly supported Texas' passage of legislation in 2015 that expanded access to naloxone by allowing individuals to obtain this (or any future) opioid antagonist from a pharmacy without having a prescription. Many public and nonprofit agencies and organizations have trained their employees on the importance of naloxone in preventing an opioid overdose death. We encourage the legislature to promote increased public awareness of this important prevention measure, to encourage public health offices and other public entities to share information on naloxone access, and to offer this lifesaving resource in public facilities that have routine contact with the public.
- **Drug disposal and drug take back** — Physicians have long supported the safe disposal of medications provided to patients. Safe disposal reduces the patient's misuse of a drug, prevents diversion and misuse of a drug by another others in the household, and can reduce potential harm to our environment. While many unused medications can be safely

flushed or placed in a trash bin, some medications such as controlled substance drugs are not safe for disposal with these methods. Many pharmacy chains offer the public safe drug disposal options, but small communities with standalone pharmacies may be less likely to have that option. We encourage you to endorse the National Prescription Drug Take-Back events sponsored by law enforcement and the U.S. Drug Enforcement Administration held in the spring and fall. We also encourage you to promote greater public awareness of the importance of safe disposal of all drugs.

- **Syringe exchange** — In 2016, federal guidance was changed, allowing state and local public health officials to use federal funds for syringe exchange programs (SEPs)^{vi} that manage communicable disease outbreaks associated with injection drug use. Injection drug users can spread hepatitis and HIV, as they are likely to share tainted needles with others. Several states such as Indiana now allow public health officials to implement SEPs with community organizations such as those faith based when they confirm a disease outbreak. SEPs also provide comprehensive support services for injection drug users such as education and screening for other diseases (tuberculosis, other sexually transmitted diseases) and referral for treatment of their addiction. Texas public health officials should have the option to work with the faith-based and other non-profits to implement this evidence-based strategy to reduce the spread of serious, preventable infectious diseases in their communities. While there is no evidence that SEPs encourage continued drug use, there is evidence that comprehensive SEPs do encourage individuals to seek care.

Finally, while national data do not identify Texas as having a significant problem with drug overdoses compared with many other states, we do know that drug misuse is a continuing concern in our state. While Texas had a lower rate of overdose deaths than the national average in 2016, Texas saw *statistically significant increases* in overdose deaths from 2015 to 2016,^{vii} with 2,831 deaths in 2016. Only five other states had more overdose deaths than Texas. And in 2009, for the first time, the number of overdose deaths in Texas exceeded deaths from motor vehicle accidents.^{viii}

Like many other states, Texas relies on reports of poisonings submitted to poison control centers for monitoring drug use. This information is valuable in our surveillance of opioid overdoses, as having timely and accurate data on drug use can help guide the development of prevention and harm reduction efforts. But we also know that our state's death certificates may not accurately identify drug overdoses, and thus Texas' overdose death rates may be significantly underreported and underestimated. This may be in part because of Texas' requirements for medical certification of the cause of death. Most cities and counties do not have medical examiners who can conduct the testing needed to verify the cause of death; capacity and resources can vary by location. The ability to properly identify an overdose is essential to local health and emergency responders and families to ensure appropriate support and resources in a community.

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- ⁱ Substance Abuse and Mental Health Services Administration. (2016). *Medication and Counseling Treatment*. Retrieved from www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine
- ⁱⁱ Evidence-based Approaches to Treating Opioid Use Disorders (2018). Texas Department of Health and Human Services Grand Rounds.
- ⁱⁱⁱ Cheever LW et al. A model federal collaborative to increase patient access to buprenorphine treatment in HIV primary care. *JAIDS*. 2011;56 (Suppl 1):S3
- ^{iv} Substance Abuse and Mental Health Services Administration. (2016). *Buprenorphine Waiver*. Retrieved from www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/buprenorphine-waiver
- ^v Amato L, et al. Psychosocial combined with agonist maintenance treatments versus agonist maintenance treatments alone for treatment of opioid dependence. *Cochrane Database of Syst Rev* 2011, Issue 10. Art. No.: CD004147.
- ^{vi} Also known as needle exchange programs, needle-syringe programs, or syringe services programs.
- ^{vii} Hedegaard H, Warner M, Miniño AM. Drug overdose deaths in the United States, 1999–2016. *NCHS Data Brief*, no 294. Hyattsville, MD: National Center for Health Statistics. 2017/ CDC. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2016).
- ^{viii} U.S. CDC, Addressing Prescription Drug Abuse in the United States.