Opioids: The worst man-made epidemic in modern medical history

- Over 200,000 deaths
- Many more hundreds of thousands of overdose admissions
- Millions addicted and/or dependent
  - Spillover effect to SSDI*
Evidence of effectiveness of chronic opioid therapy


responding to the EVIDENCE:

morphine equivalent dose RELATED RISK

- Risk of adverse ± overdose event increases at >50 mg MED/day
- Risk increases greatly at ≥100 MED/day

2007: WA State AMDG initially recommends 120 MED threshold dose
2009: CDC recommends: 120 mg/day MED
2012: CT work comp: 90 mg/day MED
2013: OH State medical Board: 80 mg/day MED
2013: Am College Occ. & Environ Med: 50 mg/day MED
2014: CA work comp: 80-120 mg/day MED
2016: CDC 50 mg/day MED yellow flag; 90 mg/day MED red flag

Courtesy G. Franklin 2014
Early opioids and disability in WA WC. Spine 2008; 33: 199-204

- Population-based, prospective cohort
- N=1843 workers with acute low back injury and at least 4 days lost time
- Baseline interview within 18 days (median)
- 14% on disability at one year
- Receipt of opioids for > 7 days, at least 2 Rxs, or > 150 mg MED doubled risk of 1 year disability, after adjustment for pain, function, injury severity

WA State leads on reversing the epidemic


- 2007-AMDG Guideline was first U.S. guideline with a dosing threshold (120 mg/day MED in 2007, updated 2010, substantial update 2015)
- 2010-1st report of clear association of high doses with overdoses (Dunn, Von Korff et al, Ann Int Med 2010; 152: 85-92)
- 2010 WA legislature-repeals old, permissive rules and establishes new standards-ESHB 2876-and DOH rules for all prescribers-MD, DO, ARNP, DPM, DDS)
- 2011-UW Telepain-Dr Tauben et al
### AMDG Mission Statement

The Agency Medical Directors' Group (AMDG) mission is to maximize the value, quality, safety, and delivery of state purchased health care.

### AMDG Goals

AMDG members collaborate across state agencies to accomplish the following goals:

1. Identify and assess ways to improve the quality of healthcare delivered to Washington citizens.
2. Assess the cost-effective purchase of health care services, and
3. Simplify the administrative burden for providers in Washington's health care financing and delivery systems.

"These goals support RCW 41.05.013 on coordinating state purchased health care programs and policies."

### AMDG Priorities

The AMDG’s medical directors and senior policy makers focus available resources on the following priority areas that provide immediate and long-term benefits for Washington's health care delivery system:

1. Protect public health: by advancing initiatives and programs that keep people safe and improve their health.
2. Purchase high value care: so public funds are used wisely for high quality care.
3. Implement evidence-based best practices: by using research to produce policies and guidelines on clinical topics that affect everyone.
4. Coordinate state health care coverage and purchasing: to make efficient use of resources.
5. Support and integrate healthcare reforms: that affect all Washington citizens.

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### Summary of 2015 Interagency Guideline on Prescribing Opioids for Pain


#### All pain phases

- Use non-opioid therapies, such as behavioral intervention, physical activity and non-opioid analgesics.
- Avoid opioids if the patient has significant respiratory depression, current substance use disorder, history of prior opioid overdose or a pattern of aberrant behaviors.
- Assess and document function and pain using a validated tool at each visit where opioids are prescribed.
- Don’t prescribe opioids with benzodiazepines, carisoprodol, or sedative-hypnotics.

<table>
<thead>
<tr>
<th>Acute phase (6–12 weeks)</th>
<th>Perioperative pain</th>
<th>Subacute phase (6–12 weeks)</th>
<th>Chronic phase (&gt;12 weeks)</th>
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<tbody>
<tr>
<td><em>Check the state’s Prescription Monitoring Program (PMP) before prescribing.</em></td>
<td><em>Evaluate thoroughly preoperatively: check the PMP and assess risk for over-sedation and difficult-to-control pain.</em></td>
<td><em>Don’t continue opioids without clinically meaningful improvement in function (CMIF) and pain.</em></td>
<td><em>Continue to prescribe opioids only if there is sustained CMIF and no serious adverse events, risk factors, or contraindications.</em></td>
</tr>
<tr>
<td><em>Don’t prescribe opioids for non-specific back pain, headaches, or fibromyalgia.</em></td>
<td><em>Discharge with acetaminophen, NSAIDs, or very limited supply (3–5 days) of short-acting opioids for some minor surgeries.</em></td>
<td><em>Screen for comorbid mental health conditions and risk for opioid misuse using validated tools.</em></td>
<td><em>Repeat PMP check and UDT at frequency determined by the patient’s risk category.</em></td>
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<tr>
<td><em>Prescribe the lowest necessary dose for the shortest duration.</em></td>
<td><em>For patients on chronic opioids, taper to preoperative doses or lower within 6 weeks following major surgery.</em></td>
<td><em>Recheck the PMP and administer a baseline urinalysis test (UDT) if you plan to prescribe opioids beyond 6 weeks.</em></td>
<td><em>Prescribe in 7-day multiples to avoid ending supply on a weekend.</em></td>
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<td><em>Opioid use beyond the acute phase is rarely indicated.</em></td>
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<td><em>Don’t exceed 120 mg/day of MDE without a pain management consultation.</em></td>
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Bree Collaborative Opioid Focus Areas

- **Reduce acute opioid use**
  - Focus on adolescents (e.g., after dental procedure, sports injury)-eg,presentation to DQAC on 7/15/2016
- **System Implementation**
  - Longer term goal: incent non-pharmacological alternatives to opioids
- **Improved use and interoperability of the WA Prescription Monitoring Program**
- **Enhance clinician education**
  - Diffuse AMDG guidelines (via WSMA, WSDA, CME)
  - Get desktop tools to clinicians
  - Work with UW to stabilize funding for tele-pain
  - Pilot reportability of overdose events
- **Convene metrics group to get to a small set of metrics useful at state, plan and provider levels**

**When to discontinue**
- At the patient’s request
- No CMF
- Risks outweigh benefits
- Severe adverse outcome or overdose event
- Substance use disorder identified (except tobacco)
- Aberrant behaviors exhibited
- To maintain compliance with DOH rules or consistency with AMDG guideline

**Considerations prior to taper**
- Help the patient understand that chronic pain is complex and opioids cannot eliminate pain.
- Consider an outpatient taper if the patient isn’t on high-dose opioids or doesn’t have comorbid substance use disorder or other active mental health disorder.
- Seek consultation if the patient failed previous taper or is at greater risk for failure due to high-dose opioids, concurrent benzodiazepine use, comorbid substance use disorder or other active mental health disorder.

**How to discontinue**
- Taper opioids first if patients are also on benzodiazepines.
- Unless safety considerations require a more rapid taper, start with 10% per week and adjust based on the patient’s response.
- Don’t reverse the taper; it can be slowed or paused while managing withdrawal symptoms.
- Watch for unmasked mental health disorders, especially in patients on prolonged or high-dose opioids.

**Recognizing and treating opioid use disorder**
- Assess for opioid use disorder and/or refer for a consultation if the patient exhibits aberrant behaviors.
- Help patients get medication-assisted treatment along with behavioral therapies.
- Prescribe naloxone (especially if you suspect heroin use) and educate patient’s contacts on how to use it.

**Special populations**
- Counsel women before and during pregnancy about maternal, fetal, and neonatal risks.
- For children and adolescents, avoid prescribing opioids for most chronic pain problems.
- In older adults, initiate opioids at 25-50% lower dose than for younger adults.
- For cancer survivors, rule out recurrence or secondary malignancy for any new or worsening pain.

Check out the resources at www.AgancyMedDirectors.wa.gov
- Free online CME
- Opioid Dose Calculator
- Videos from Primary Pain Care Conference
Washington Unintentional Prescription Opioid Deaths
1995 – 2015
44% sustained decline

Source: Washington State Department of Health

Unintentional Opioid Overdose Deaths
Washington 1995-2014

Source: Washington State Department of Health, Death Certificates
1. Prevent future dependence, addiction and overdose among our citizens

- Repeal permissive 1999 “model” pain language
- Adopt and operationalize the CDC guidelines via:
  - Setting new prescribing standards through state licensing boards
  - Leveraging public health care purchasing programs (e.g. Medicaid)
- Foster strong collaboration across public program at the highest level of state government and among leaders in the medical community
Second key to prevention: Protect our children and teenagers

- For patients ≤ 20 years, limit Rx’s to no more than 3 days (or 10 tabs) of short acting opioids for acute use
  - Dental extractions (56 million Vicodin 5 mg/year) and sports injuries at emergency department/urgent care
    - NSAIDS or Tylenol preferred
  - Could be implemented with system changes (eg, EMR “hard stops” or mandatory informed consent after 3 days)

2. Optimize capacity to effectively treat pain and addiction

- Deliver coordinated, stepped care services aimed at improving pain and addiction treatment
  - Opioid overdose case management
  - Cognitive behavioral therapy or graded exercise to improve patient’s functioning and ability to self manage their pain
  - Medication-assisted treatment (MAT) for patients with opioid use disorder
- Increase access to pain and addiction experts for primary care via telepain (mentor consultation service)
- Incorporate these alternative treatments for pain and care coordination into payer contracts (e.g. Medicaid)
3. Metrics to guide both “state-of-the-state” and provider quality efforts

• Use a common set of metrics
• Start with public programs
• Establish a process for public/private implementation (e.g. WA statutory, governor appointed “Bree Collaborative”)
• Use metrics to notify outlier prescribers

Timing of stepped care management to prevent transition to chronic pain

![Chart showing percentage of time loss claims with duration beyond given month.](chart.png)
Collaborative Care: Defined

- A type of integrated healthcare developed to treat common behavioral health conditions
  - Originally mental health conditions
  - Used now for pain & other conditions
- Team-based system of care
- Based on 5 core principles
  
  https://aims.uw.edu/collaborative-care

- Cochrane Review 2012: 79 trials and 24,308 patients
Principles of Effective Collaborative Care

- Patient-Centered Team Care / Collaborative
  - Team focused on patient’s goals

- Population-Based Care
  - No patients “falling through the cracks”
  - Specialists support care

- Measurement-Based Treatment to Target
  - Outcomes measured + stepped up care

- Evidence-Based Care
  - Psychosocial and pharmacological treatments

- Accountable
  - Reaching treatment targets

Emerging examples of stepped care management/collaborative care for pain

- VA Health System Stepped Care Model of Pain Management

- Vermont Spoke and Hub regional support for medication assisted treatment for opioid use disorder/severe dependence

- WA state Centers of Occupational Health and Education/Healthy Worker 2020
THANK YOU!

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