AMDG
agency medical directors' group

A collaboration of state agencies, working together to improve health care quality for Washington State citizens

"Reinventing Pain Care: The Antidote to the Worst Man-Made Epidemic in Modern Medical History"

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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
  - Degenhardt et al Lancet Psychiatry 2015; 2: 314-22; POINT prospective cohort: DSM-5 opioid use disorder: **29.4%**
- Spillover effect to to SSDI*

*Franklin et al, Am J Ind Med 2015; 58: 245-51

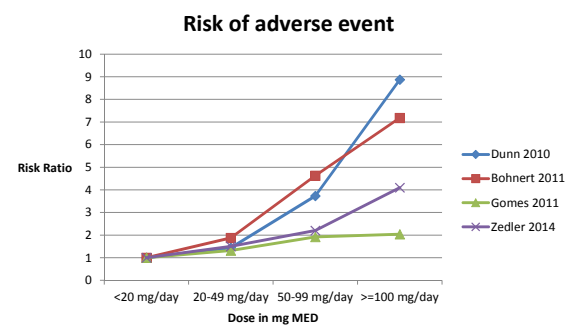
Evidence of effectiveness of chronic opioid therapy

The Agency for Healthcare Research and Quality's (AHRQ) recent report, "The Effectiveness and Risks of Long-term Opioid Treatment of Chronic Pain," which focused on studies of effectiveness measured at > 1 year of COAT use, found **insufficient data on long term effectiveness to reach any conclusion, and "evidence supports a dose-dependent risk for serious harms"**. (AHRQ 2014; Chou et al, Annals Int Med, 13 Jan 2015).

responding to the EVIDENCE:

4

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

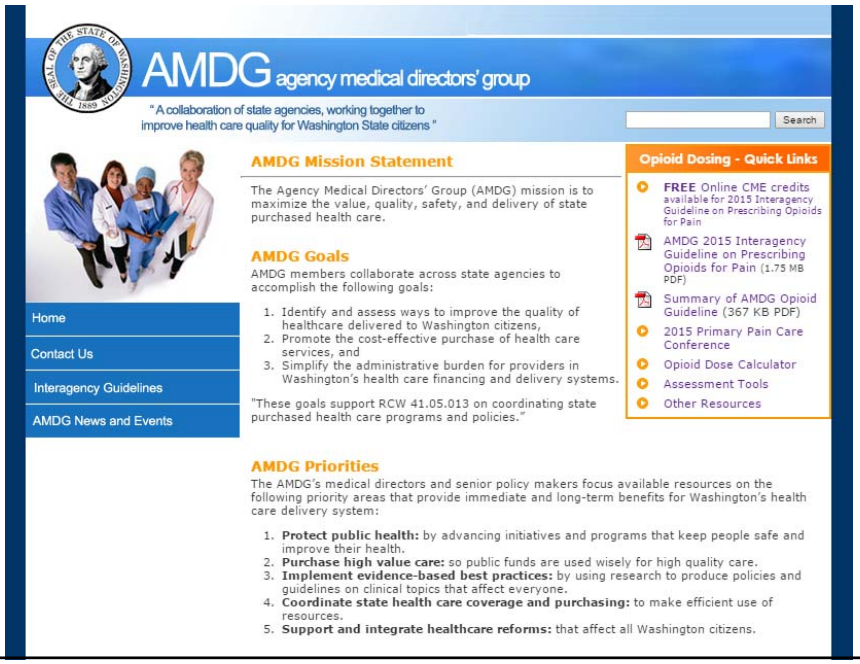
- Population-based, prospective cohort
- N=1843 workers with acute low back injury and at least 4 days lost time
- Baseline interview within 18 days(median)
- 14% on disability at one year
- Receipt of opioids for > 7 days, at least 2 Rxs, or > 150 mg MED doubled risk of 1 year disability, after adjustment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

WA State leads on reversing the epidemic

Collaboration key: Franklin et al Am J Public Health 2015: 105:463-9

- 2005-Reported first deaths-Franklin et al, Am J Ind Med 2005; 48:91-99
- 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

Agency Medical Directors Group Website



Slide 8

Summary of
2015 Interagency Guideline on Prescribing Opioids for Pain

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See full guideline at
www.AgencyMedDirectors.wa.gov

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.

Acute phase (0–6 weeks)

- Check the state's Prescription Monitoring Program (PMP) before prescribing.
- Don't prescribe opioids for non-specific back pain, headaches, or fibromyalgia.
- Prescribe the lowest necessary dose for the shortest duration.
- Opioid use beyond the acute phase is rarely indicated.

Perioperative pain

- Evaluate thoroughly preoperatively: check the PMP and assess risk for over-sedation and difficult-to-control pain.
- Discharge with acetaminophen, NSAIDs, or very limited supply (2–3 days) of short-acting opioids for some minor surgeries.
- For patients on chronic opioids, taper to preoperative doses or lower within 6 weeks following major surgery.

Subacute phase (6–12 weeks)

- Don't continue opioids without clinically meaningful improvement in function (CMIF) and pain.
- Screen for comorbid mental health conditions and risk for opioid misuse using validated tools.
- Recheck the PMP and administer a baseline urine drug test (UDT) if you plan to prescribe opioids beyond 6 weeks.

Chronic phase (>12 weeks)

- Continue to prescribe opioids only if there is sustained CMIF and no serious adverse events, risk factors, or contraindications.
- Repeat PMP check and UDT at frequency determined by the patient's risk category.
- Prescribe in 7-day multiples to avoid ending supply on a weekend.
- Don't exceed 120 mg/day MED without a pain management consultation.

over

When to discontinue

- At the patient's request
- No CMIF
- 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

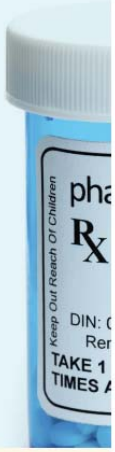
- Taper opioids first if patients are also on benzodiazepines.
- Unless safety considerations require a more rapid taper, start with 10% per week and adjust based on the patient's response.
- Don't reverse the taper; it can be slowed or paused while managing withdrawal symptoms.
- Watch for unmasked 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.AgencyMedDirectors.wa.gov

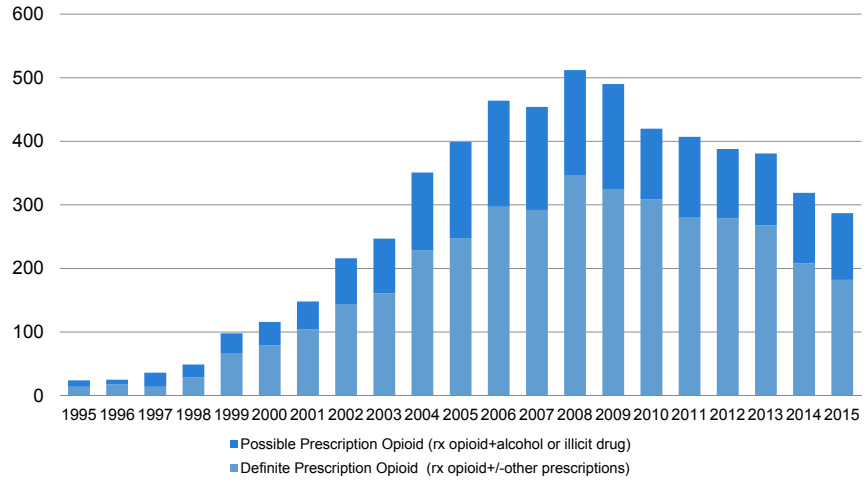
- Free online CME
- Opioid Dose Calculator
- Videos from Primary Pain Care Conference

Slide 10

Bree Collaborative Opioid Focus Areas

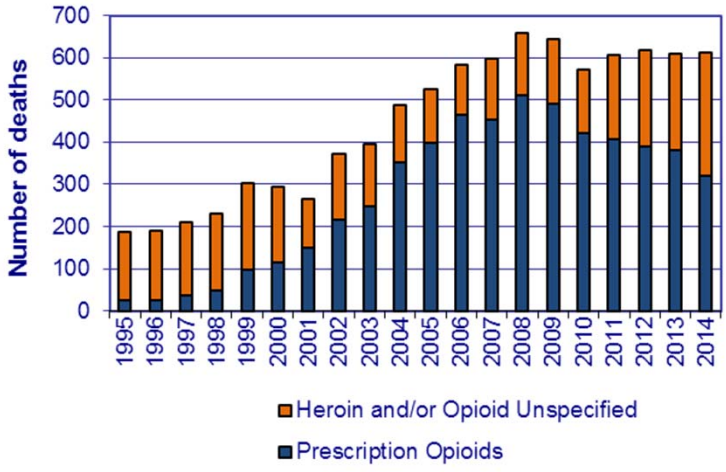
- **Reduce acute opioid use**
  - **Focus on adolescents (e.g., after dental procedure, sports injury)-eg,presentation to DQAC on 7/15/2016**
- System Implementation
  - Longer term goal: incent non-pharmacological alternatives to opioids
- Improved use and interoperability of the WA Prescription Monitoring 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

Washington Unintentional Prescription Opioid Deaths
1995 – 2015
44% sustained decline



Source: Washington State Department of Health

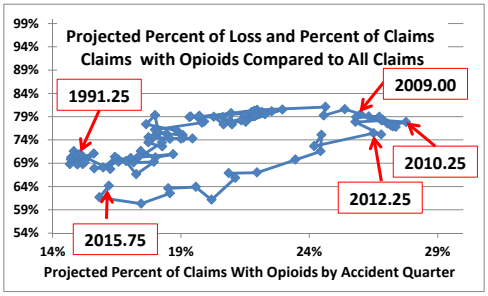
Unintentional Opioid Overdose Deaths Washington 1995-2014



Source: Washington State Department of Health, Death Certificates

Washington State Department of Health

The Mercier-Franklin Opioid Boomerang, 1991-2015 WA Workers Compensation



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

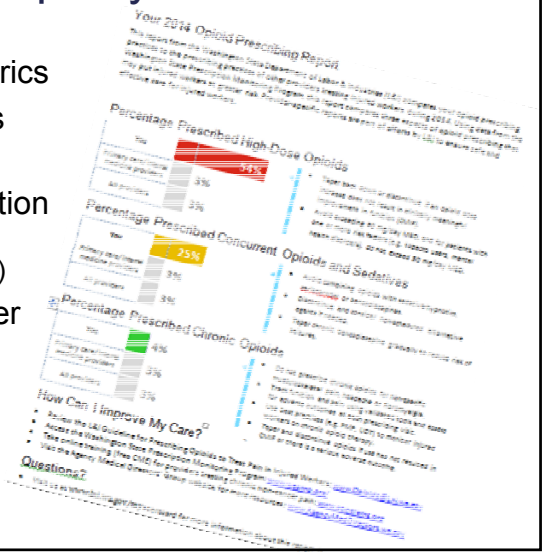
- For patients ≤ 20 years, limit Rx's to no more than 3 days (or 10 tabs) of short acting opioids for acute use
  - Dental extractions (56 million Vicodin 5 mg/year) and sports injuries at emergency department/urgent care
    - NSAIDS or Tylenol preferred
- Could be implemented with system changes (eg,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

2. Optimize capacity to effectively treat pain and addiction

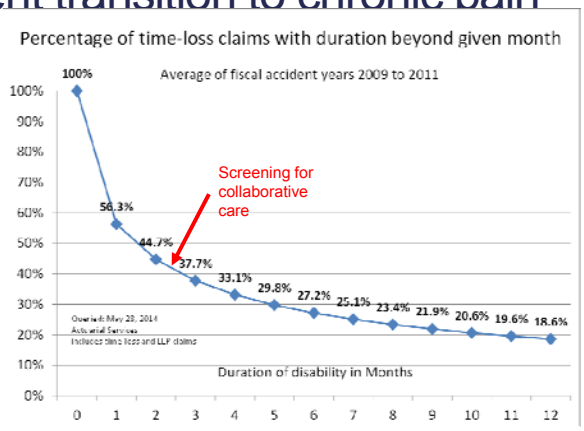
- Deliver coordinated, stepped care services aimed at improving pain and addiction treatment
  - Opioid overdose case management
  - Cognitive behavioral therapy or graded exercise to improve patient's functioning and ability to self manage their pain
  - Medication-assisted treatment (MAT) for patients 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

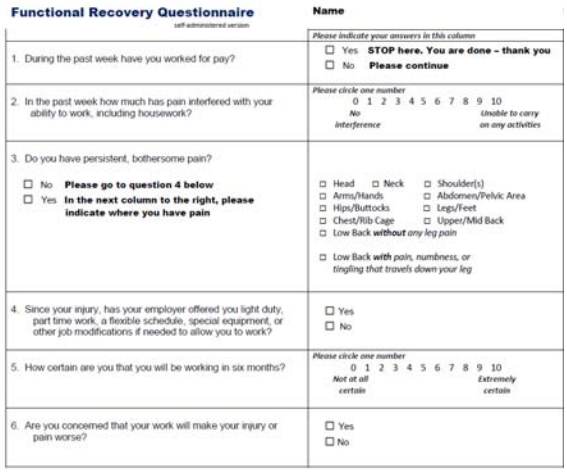


Timing of stepped care management to prevent transition to chronic pain



Screen → Assess → Intervene

FRQ



Functional Recovery Questionnaire

self-administered version

Name

	Please indicate your answers in this column
1. During the past week have you worked for pay?	☐ Yes **STOP here. You are done – thank you** ☐ No **Please continue**
2. In the past week how much has pain interfered with your ability to work, including housework?	*Please circle one number* 0 1 2 3 4 5 6 7 8 9 10 *No interference* — *Unable to carry on any activities*
3. Do you have persistent, bothersome pain? ☐ No **Please go to question 4 below** ☐ Yes **In the next column to the right, please indicate where you have pain**	☐ Head ☐ Neck ☐ Shoulder(s) ☐ Arms/Hands ☐ Abdomen/Pelvic Area ☐ Hips/Buttocks ☐ Legs/Feet ☐ Chest/Rib Cage ☐ Upper/Mid Back ☐ Low Back ***without*** *any leg pain* ☐ Low Back ***with*** *pain, numbness, or tingling that travels down your leg*
4. Since your injury, has your employer offered you light duty, part time work, a flexible schedule, special equipment, or other job modifications if needed to allow you to work?	☐ Yes ☐ No
5. How certain are you that you will be working in six months?	*Please circle one number* 0 1 2 3 4 5 6 7 8 9 10 *Not at all certain* — *Extremely certain*
6. Are you concerned that your work will make your injury or pain worse?	☐ Yes ☐ No

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

Emerging examples of stepped care management/collaborative care for pain

- VA Health System Stepped Care Model of Pain Management
  - Dorflinger et al. A Partnered Approach to Opioid Management, Guideline Concordant Care and the Stepped Care Model of Pain Management. J Gen Int Med 2014; Suppl 4, 29: S870-6.
- 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

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THANK YOU!

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