Reversing the opioid epidemic in Washington State, and a path forward on treating pain

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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*
By the late 1990s, at least 20 states passed new laws, regulations, or policies moving from near prohibition of opioids to use without dosing guidance.

- WA law: “No disciplinary action will be taken against a practitioner based solely on the quantity and/or frequency of opioids prescribed.” (WAC 246-919-830, 12/1999)

- Laws were based on weak science and good experience with cancer pain: Thus, no ceiling on dose and axiom to use more opioid if tolerance develops.

- Pain as the 5th vital sign-HCAHPS pain satisfaction survey.
Evidence of effectiveness of chronic opioid therapy

WA State has led 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
- 2015-Expanded AMDG opioid guideline-highly consistent with CDC guideline
- 2017-Bree opioid metrics
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. Promote 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.
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
Rise in Heroin Deaths not due to Increasing Regulation-Compton et al, NEJM, 2016

- Rise started well before ANY regulation
- Occurring in all states, most of which have done no regs
- Main rise in heroin deaths in 18-30 year olds
- Main increase in prescription opioid deaths in 35-55 year age groups
NGA 1. Prevent future dependence, addiction and overdose among our citizens

- Repeal permissive 1999 “model” pain language
- Adopt and operationalize the CDC/AMDG guidelines via:
  - Setting new prescribing standards through state licensing boards
  - Leveraging public health care purchasing programs (e.g. Medicaid)
- Foster strong collaboration across public programs at the highest level of state government and among leaders in the medical community
Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.
Second key to prevention: Protect our children and teenagers

- For patients ≤ 24 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)
Continued Use by Initial Days of Therapy - B Martin, in preparation

The graph shows the probability of continued use in % over the number of days of the first episode of opioid use. The probability increases with the number of days. There are two lines representing one year and three year probabilities, both of which show a steady increase as the number of days increases.
DENTAL GUIDELINE ON PRESCRIBING OPIOIDS FOR PAIN

Developed by the Dr. Robert Bree Collaborative and Washington State Agency Medical Directors’ Group (AMDG)* in collaboration with Actively Practicing Dentists and Public Stakeholders

Written for Clinicians Who Care for Patients with Pain
July 2017

DRAFT
Preoperative Period

- Thorough evaluation including a patient interview with dental and medical history, PMP
- Unless contraindicated, prescribe non-opioid analgesics as the FIRST line of pain control in dental patients.
- Consider pre-surgical medication, such as an NSAID, one hour immediately prior to procedure, except where contraindicated.
- If use of an opioid is warranted, follow the CDC guidelines: “clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.”
  - For adolescents and young adults through 24 years old who are undergoing minor surgical procedures (e.g., third molar extractions), limit opioid prescriptions to 8-12 tablets.
- Avoid opioids at patient or parent request, patient is in recovery
- Educate patient and family on appropriate use and duration of opioids
NGA 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—e.g., increase regional capacity via Vermont spoke and hub method
- 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)
Improve systems/community capacity to treat pain/addiction

• Deliver coordinated, stepped care services aimed at improving pain and addiction treatment
  • Cognitive behavioral therapy or graded exercise to improve patient self-efficacy
  • Opioid overdose case management by ED to identify behavioral health needs, evaluate for MAT, notify providers involved and discuss recommendations (e.g. Vermont spoke and hub)
• Increase access to pain and addiction experts (e.g. WA telepain)
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
NGA 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
## Overview of WA Bree Metrics

### General prescribing
- Prevalence of opioid use: % with $\geq 1$ opioid Rx of all enrollees, by age

### Long-term prescribing
- Chronic opioid use: % with $\geq 60$ days supply of opioids in the quarter
- High dose use: % with doses $\geq 50$ and $\geq 90$ mg/day MED in chronic opioid users
- Concurrent use: % with $\geq 60$ days supply of sedatives among chronic opioid users

### Short-term prescribing
- Days supply of first Rx: % with $\leq 3$, 4-7, 8-13, and $\geq 14$ supply among new opioid patients
- Transition of chronic use: % new opioid patients transitioning to chronic use the next quarter

### Morbidity and Mortality
- Opioid overdose deaths: Rate of overdose deaths involving opioids
- Non-fatal overdoses: Rate of non-fatal overdoses
- Opioid use disorder: Rate of opioid use disorder among patients with $\geq 3$ quarters of use
Any opioid prescription

New users transitioning to chronic use

Chronic users with concurrent sedatives

Days supply of first prescription

Chronic opioid use

Percent high dose

Percent (%)

Days supply of first prescription

Percent (%)

≤3 days  >7 days ≥14 days

Percent (%)

Medicaid-WA KPWA-IGP KPWA-Network

Percent (%)

>50mg MED >90mg MED

Percent (%)

0 10 20 30 40 50
38% Increase since 2001
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
Claims With Opioid Prescriptions Within 6 to 12 Weeks of Injury

Percent claims with opioids within 6 to 12 weeks since injury

- Percent of claims with opioids
- Moving Average
- Baseline
- within 6 to 12 weeks since injury

received date

Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2

2013 2014 2015 2016

percent

0% 1% 2% 3% 4% 5%

data as of date: 7/3/2016
Owner: Research & Data Services
report run date: 8/5/2016
The Franklin-Mai Opioid Boomerang, 1991-2015 WA Workers Compensation

Projected Percent of Loss and Percent of Claims
Claims with Opioids Compared to All Claims

1991.25
1994.25
1997.25
2000.00
2002.25
2005.00
2007.25
2010.25
2012.25
2015.75

Projected Percent of Claims With Opioids by Accident Quarter
Rapidly increasing mortality in middle aged, lower educated whites
Case and Deaton, PNAS, 2015

Fig. 2. Mortality by cause, white non-Hispanics ages 45–54.
THANK YOU!

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