

Reversing the opioid epidemic  
-Lessons from WA State-  
-Children, Families, Health, and Human Services  
Interim Committee-  
March 13, 2014

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# Change in National Norms for Use of Opioids for Chronic, Non-cancer Pain

- ❑ **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**



WAC-Washington Administrative Code

# “Intractable pain” guidance in Montana

- July, 2002-MT Boards of Medical Examiners, Nursing, and Pharmacy
  - “exaggerated fear of patient addiction and diversion..”
  - “Patient requests for more pain medication can often be interpreted as drug seeking behavior, when inadequately treated pain is actually the cause” (**Pseudoaddiction**)
  - “Studies have shown that the abuse potential of opioids is generally low in healthy volunteers who do not abuse drugs”
  - “The Boards...seek to ensure that no Montana resident will needlessly suffer due to under treated pain, and encourage both prescribers and pharmacists to do their part by responsibly prescribing and dispensing opioids”

# “Intractable pain” guidance in Montana

- March, 2009-Montana Board of Medical Examiners
  - “...opioid analgesics may be essential in the treatment of chronic pain...”
  - “tolerance and physical dependence are normal consequences of sustained use of opioid analgesics...”
  - “Physicians should not fear disciplinary action for ..prescribing...opioid analgesics”
  - “The Board will judge the validity of the physician’s treatment...based on documentation, rather than solely on the quantity and duration of medication administration”
  - Includes definition of Pseudoaddiction

# Limitations of Long-term (>3 Months) Opioid Therapy

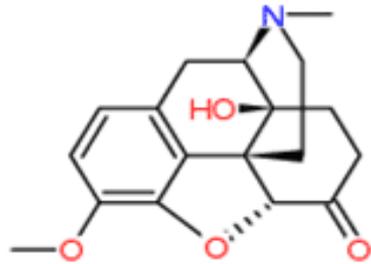
- ❑ Overall, the evidence for long-term analgesic efficacy is weak
- ❑ Putative mechanisms for failed opioid analgesia may be related to rampant tolerance
- ❑ The premise that tolerance can always be overcome by dose escalation is now questioned
- ❑ **100% of patients on opioids chronically develop dependence**
  - ❑ **More than 50% of patients on opioids for 3 months will still be on opioids 5 years later**

# Generalized View of Opioid Therapy for Chronic Pain

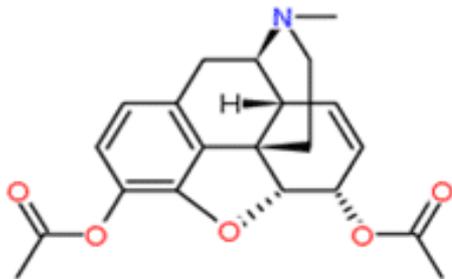
Scott Fishman, MD, UC Davis

- Data on Long Term Benefits
  - Weak to Inadequate
  - Short Duration
  - Low Dose
- Data on Risks
  - Clear and Convincing
  - Growing
  - Proportional with Dose
  - Special Populations at Additional Risk

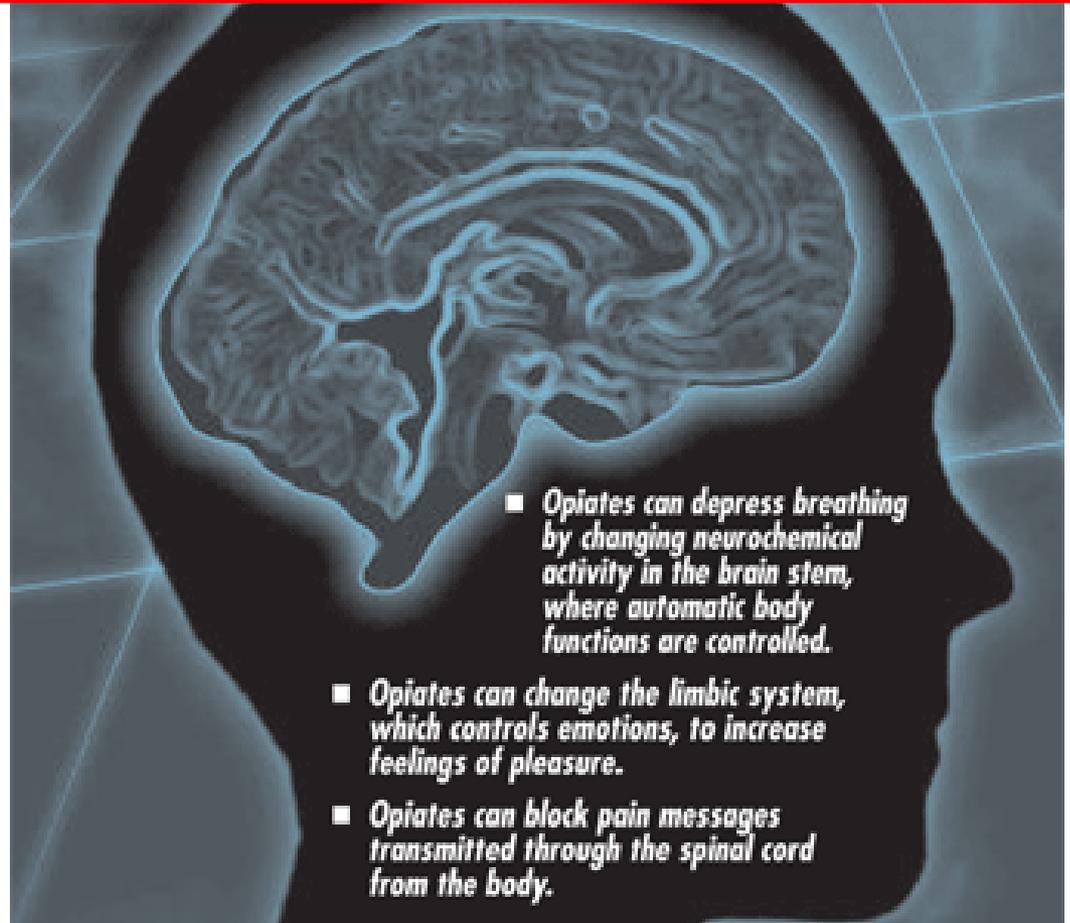
# Similarities Between Illicit & Prescription Drugs



OXYCONTIN (OXYCODONE)

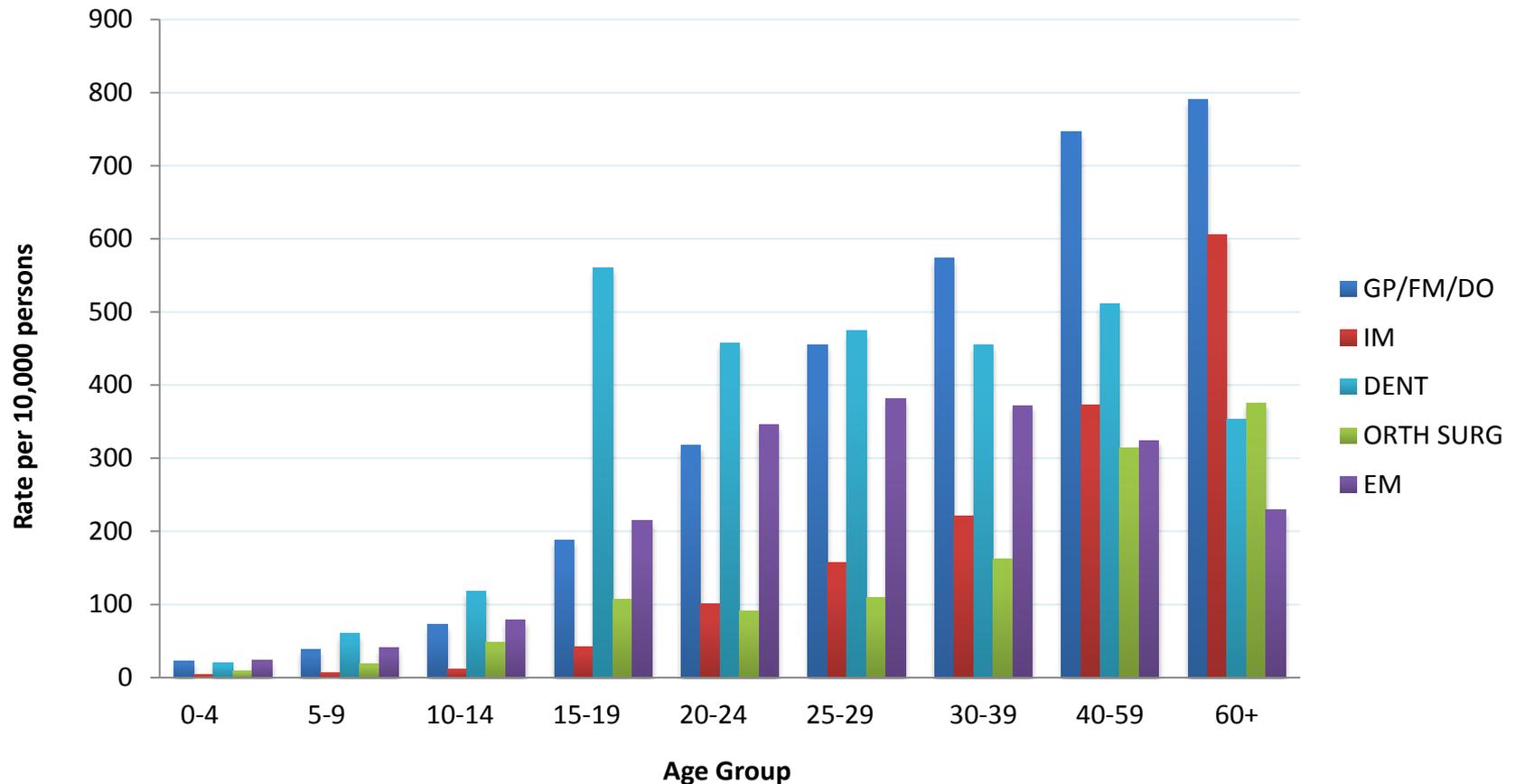


HEROIN



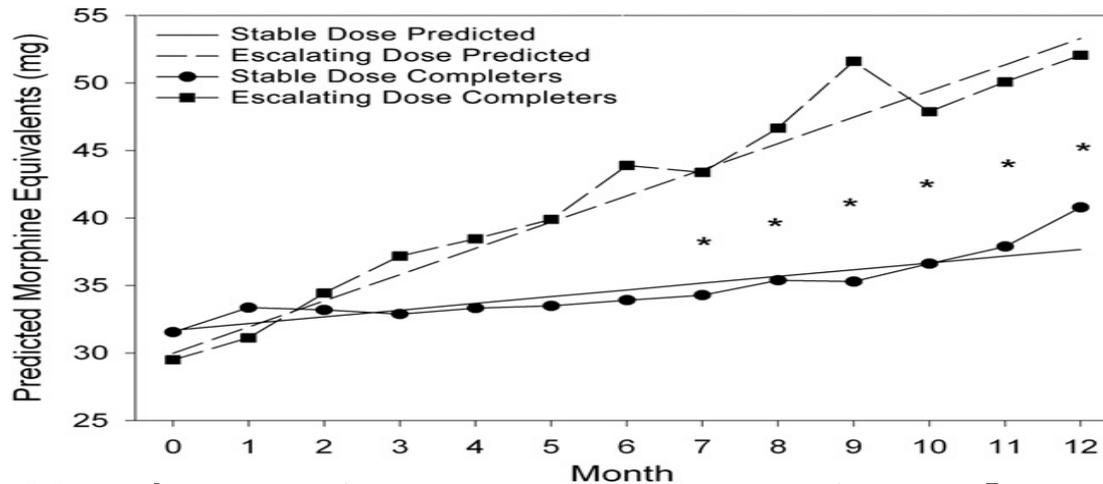
# Dentists and Emergency Medicine Physicians were the main prescribers for patients 5-29 years of age

5.5 million prescriptions were prescribed to children and teens (19 years and under) in 2009



# Dose escalation does not help improve pain and function

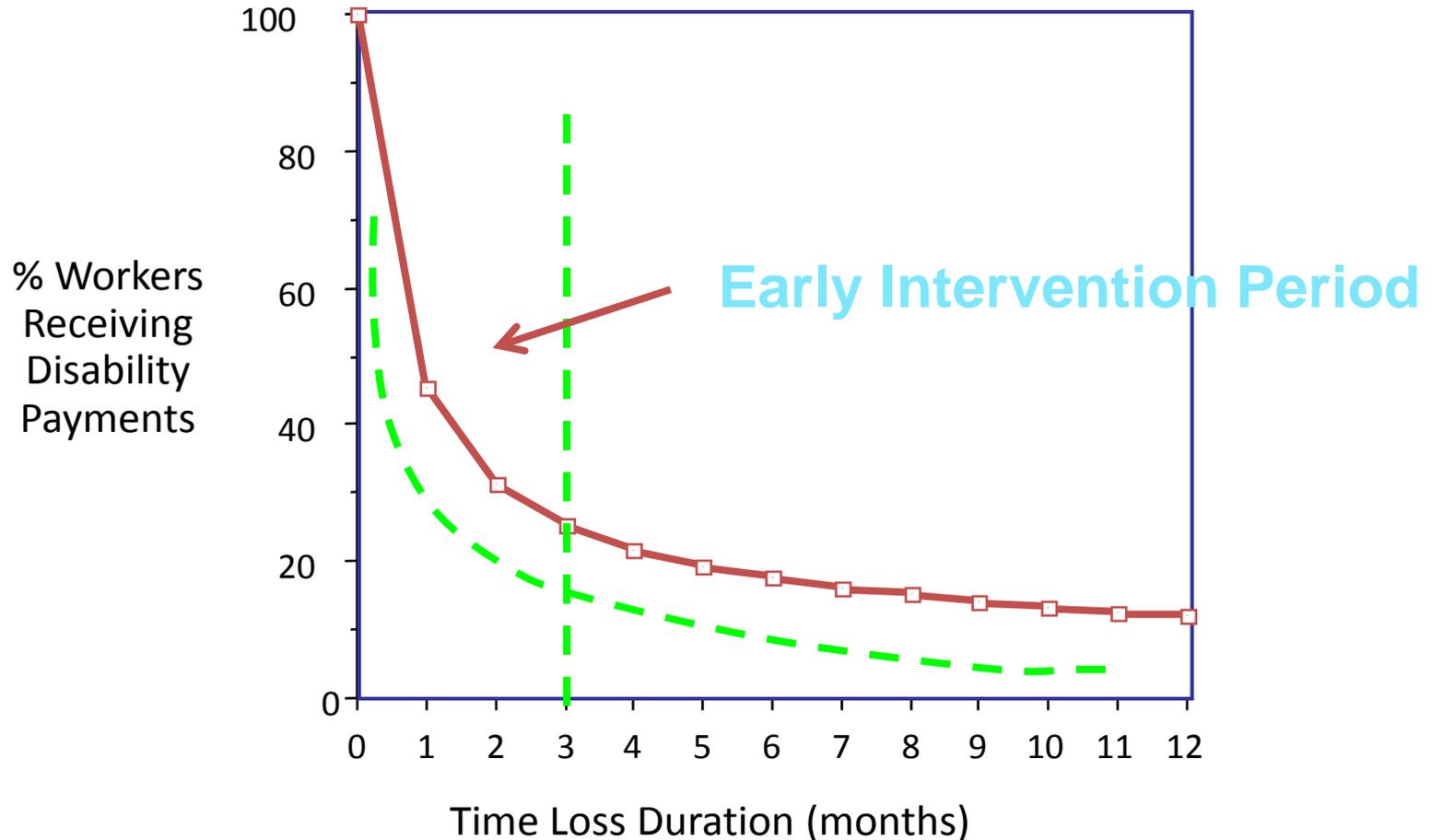
- RCT of “hold the line” vs escalating dose strategies
- N=135, parallel group pragmatic study



- No change in any primary pain or function outcome
- 27% discharged due to misuse/non-compliance

**\*Naliboff et al, 2011 (FEB); 12: 288-96**

# Preventing disability/chronic pain in workers' compensation

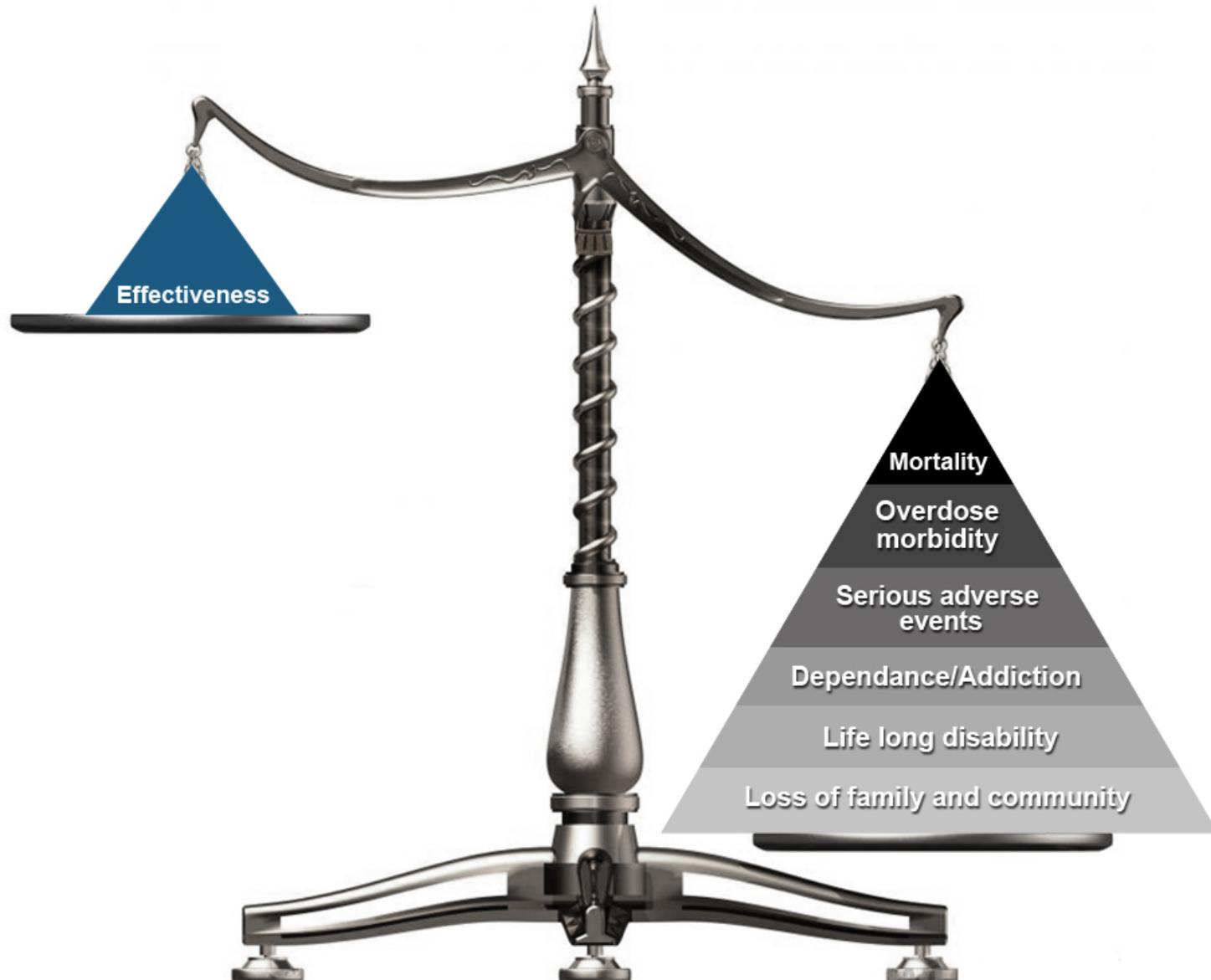


# Early opioids and disability in WA WC.

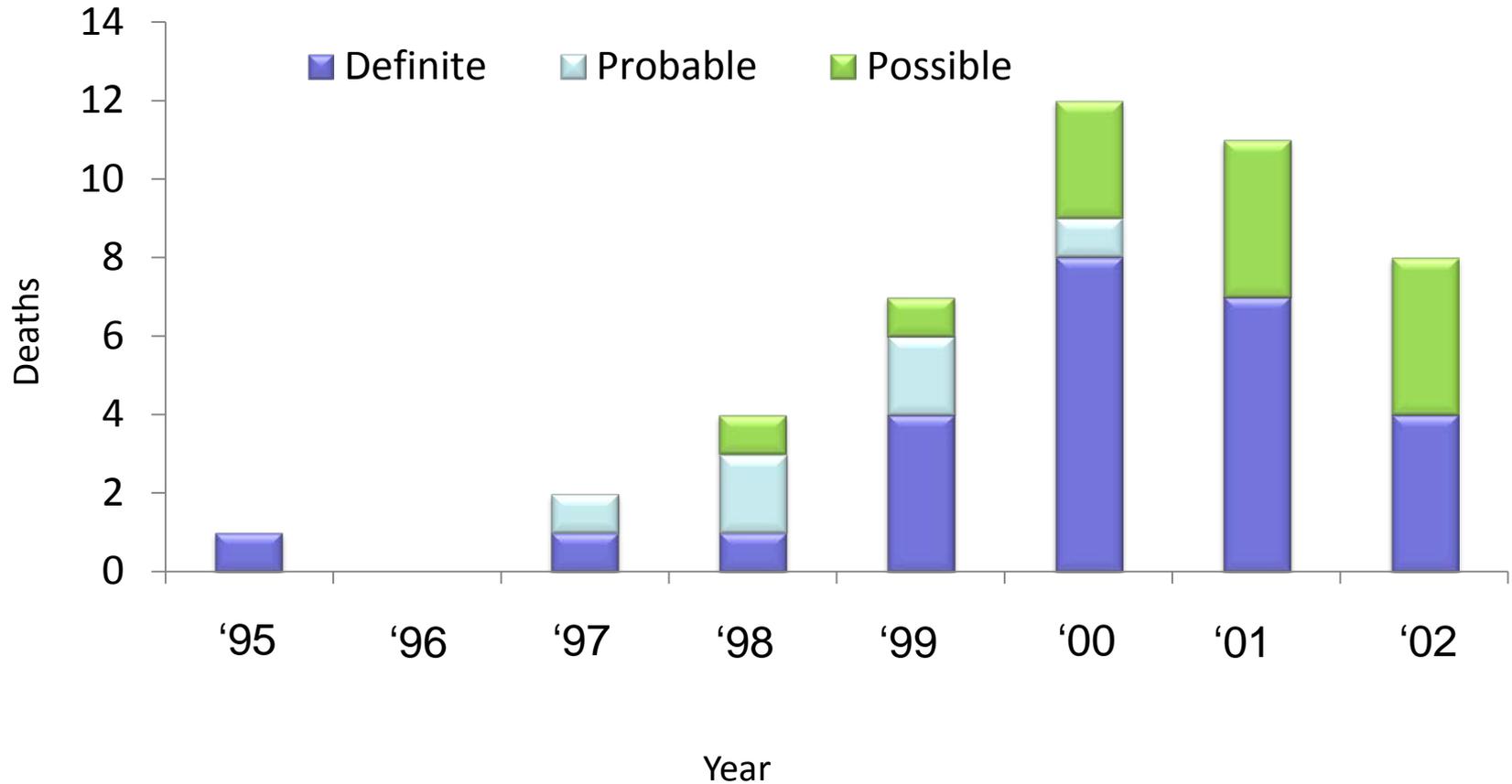
Spine 2008; 33: 199-204

- 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

# Risk/Benefit of Opioids for Chronic Non-Cancer Pain

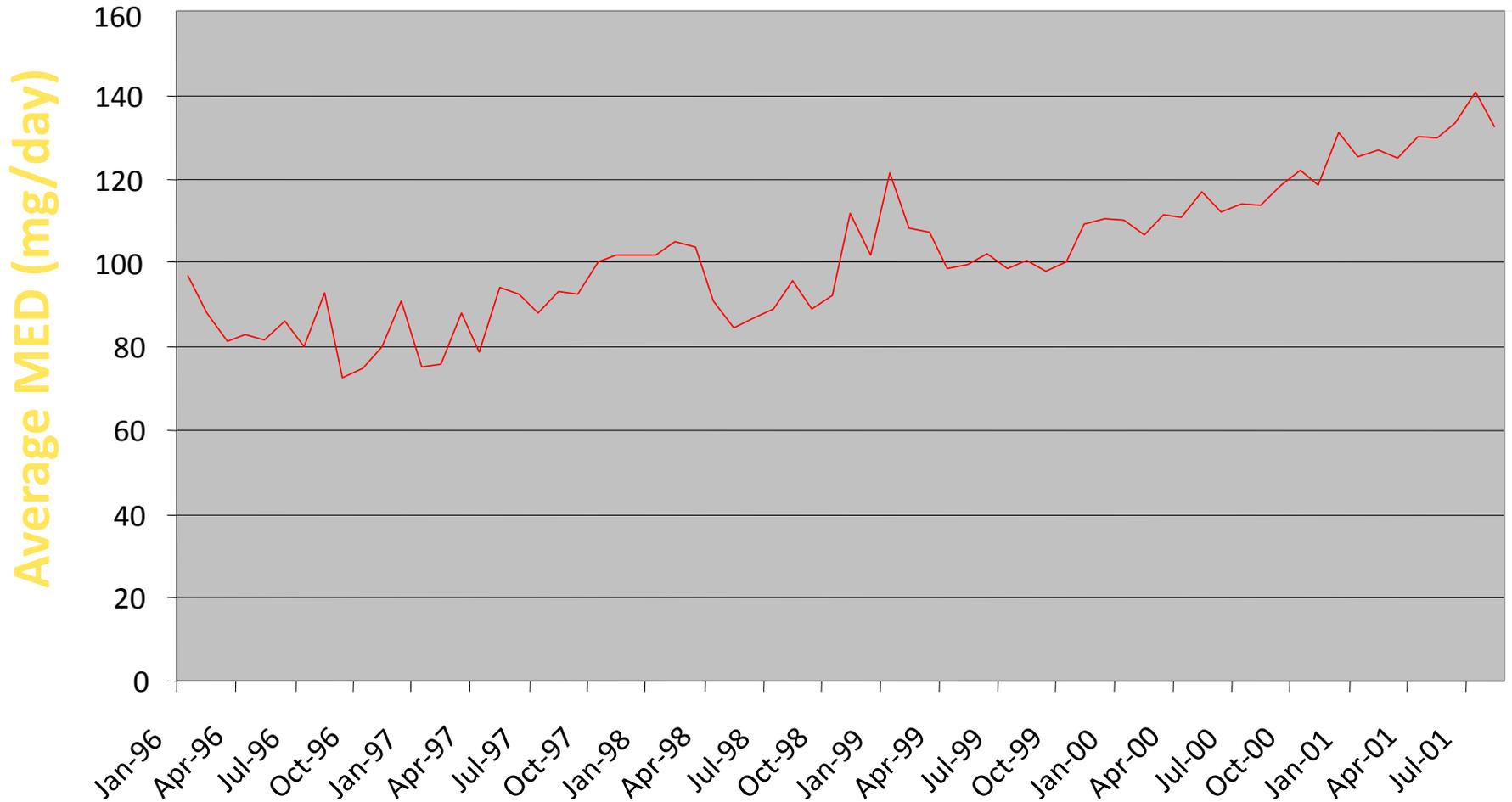


# Opioid-Related Deaths, Washington State Workers' Compensation, 1992–2005



Franklin GM, et al, Am J Ind Med 2005;48:91-9

# Trend of Long Acting Opiates Morphine Equivalent Dosages (MED)



# Washington Agency Medical Directors' Opioid Dosing Guidelines

- Part I – If patient has not had clear improvement in pain AND function at 120 mg MED (morphine equivalent dose) , “take a deep breath”
  - If needed, get one-time pain management consultation (certified in pain, neurology, or psychiatry)
- Part II – Guidance for patients already on very high doses >120 mg MED
- Placed online April, 2007, with 3 hrs free Continuing Medical Education credit available



# Open-source Tools Added to June 2010 Update of Opioid Dosing Guidelines

- ❑ Opioid Risk Tool: Screen for past and current substance abuse
- ❑ CAGE-AID screen for alcohol or drug abuse
- ❑ Patient Health Questionnaire-9 screen for depression
- ❑ 2-question tool for tracking pain and function
- ❑ Advice on urine drug testing

<b>OPIOID DOSE CALCULATOR</b>		
<b>Opioid (oral or transdermal)</b>	<b>Mg per day</b>	<b>Morphine equivalents</b>
codeine		0
fentanyl transdermal (in mcg/hr)		0
hydrocodone	20	20
hydromorphone		0
methadone		
up to 20mg per day		
21 to 40mg per day		
41 to 60mg per day	50	500
>60mg per day		0
morphine		0
oxycodone		0
oxymorphone		0
<b>TOTAL daily morphine equivalent dose (MED) =</b>		<b>520</b>

CAGE, “cut down” “annoyed” “guilty” “eye-opener”

# Washington State Legislation on Opioid Treatment in 2010

## ESHB 2676

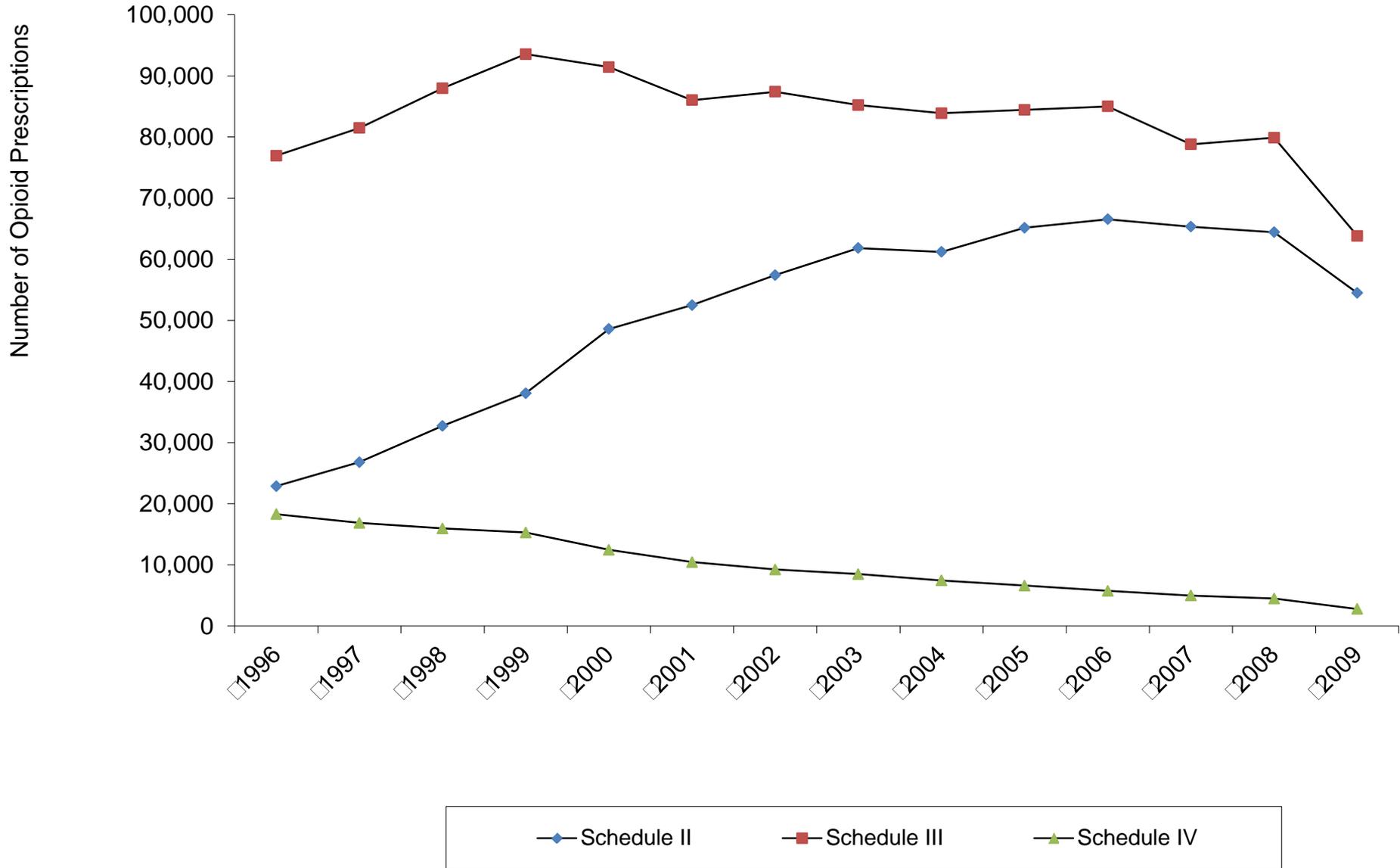
- ❑ Repealed current regulations; new regs implemented by 5 Boards & Commissions (MD, DO, DPM, DDS, ARNP)
- ❑ Provided specific dosing guidance and guidance on consultations, assessments, and tracking
- ❑ Signed into law by Governor Gregoire March 25, 2010



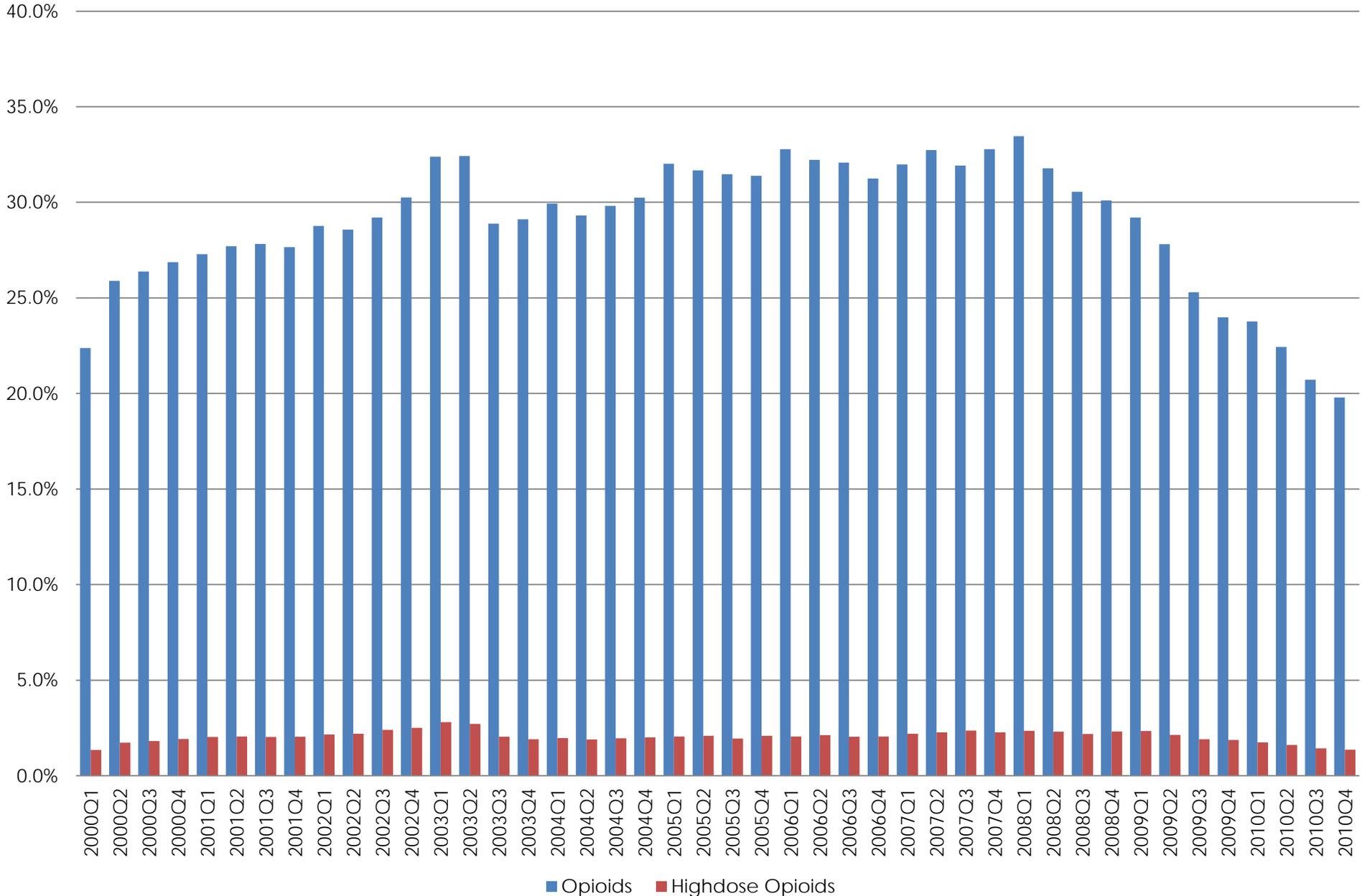
# Washington State Opioid Treatment Regulations

- **Emphasize tracking patients for improved pain AND function**
- **Emphasize widely agreed-upon best practices**
  - Screening for substance abuse and other comorbidities
  - Prudent use of urine drug screens
  - Opioid treatment agreement
  - Single pharmacy and single prescriber
- **Encourage use of Prescription Monitoring Program and Emergency Department Information Exchange, when available**
- **120 mg/day dosing threshold**

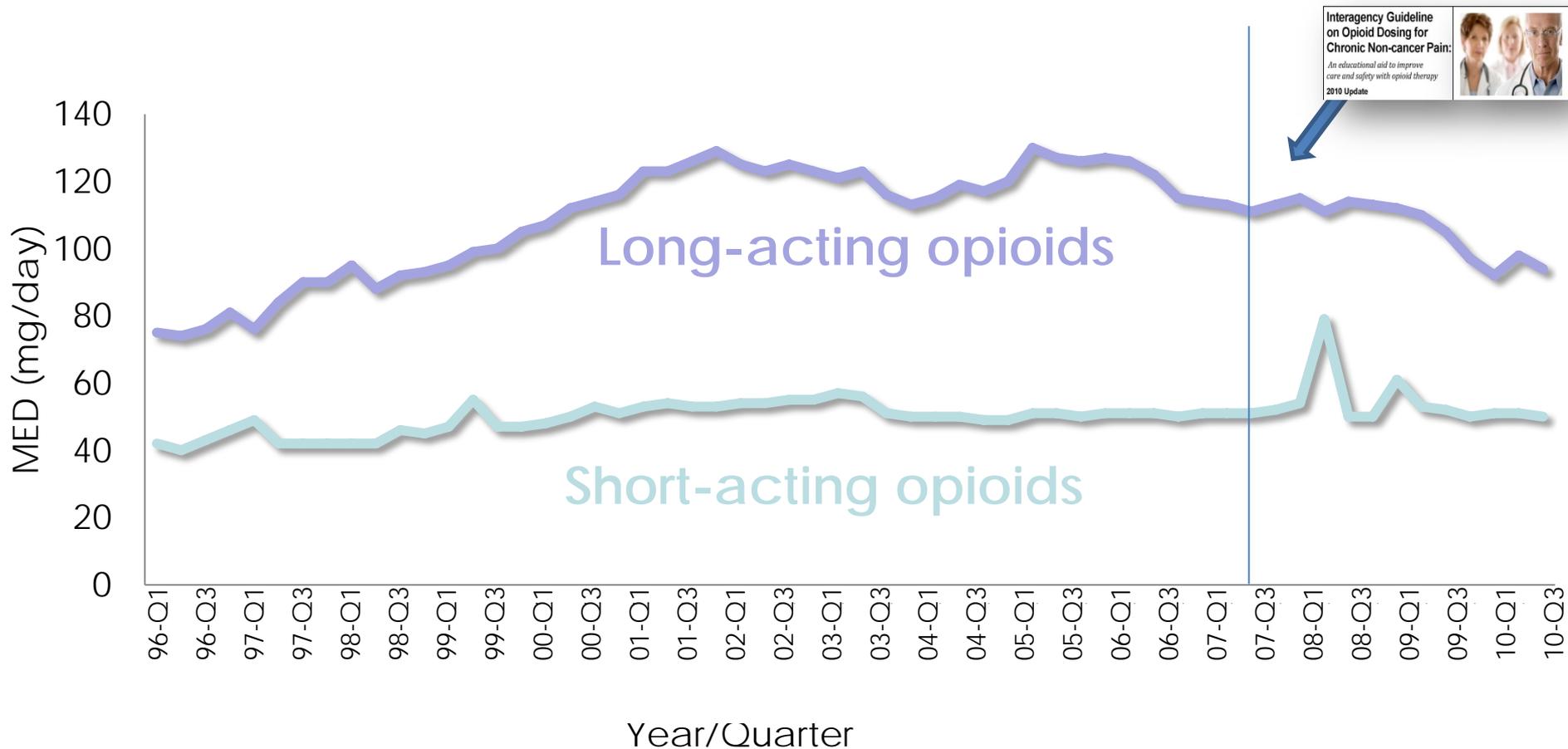
# Yearly Trend of Scheduled Opioids in WA workers' compensation (Franklin et al, Am J Ind Med 2012; 55: 325-31 )



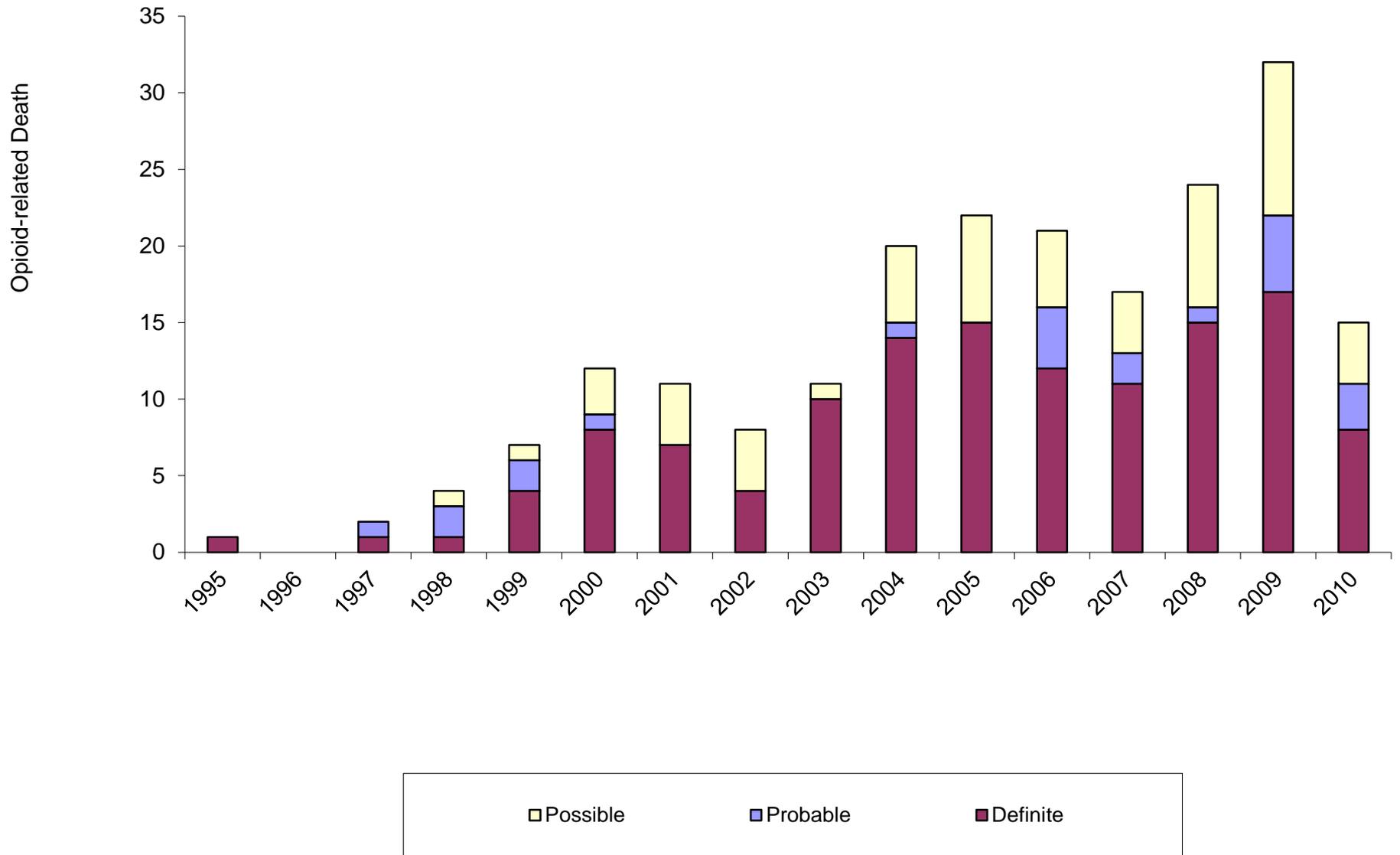
# Percent of Timeloss Claimants on Opioids 2000 - 2010



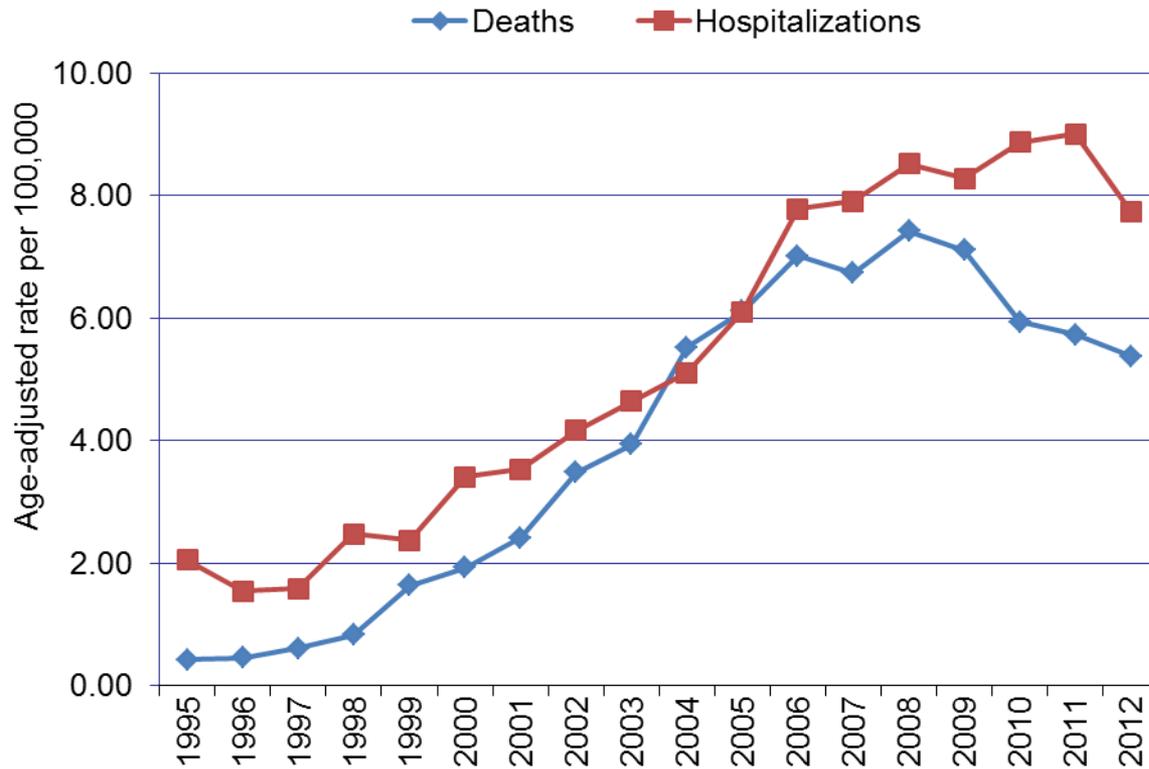
# Average Daily Dosage for Opioids, Washington Workers' Compensation, 1996-2010



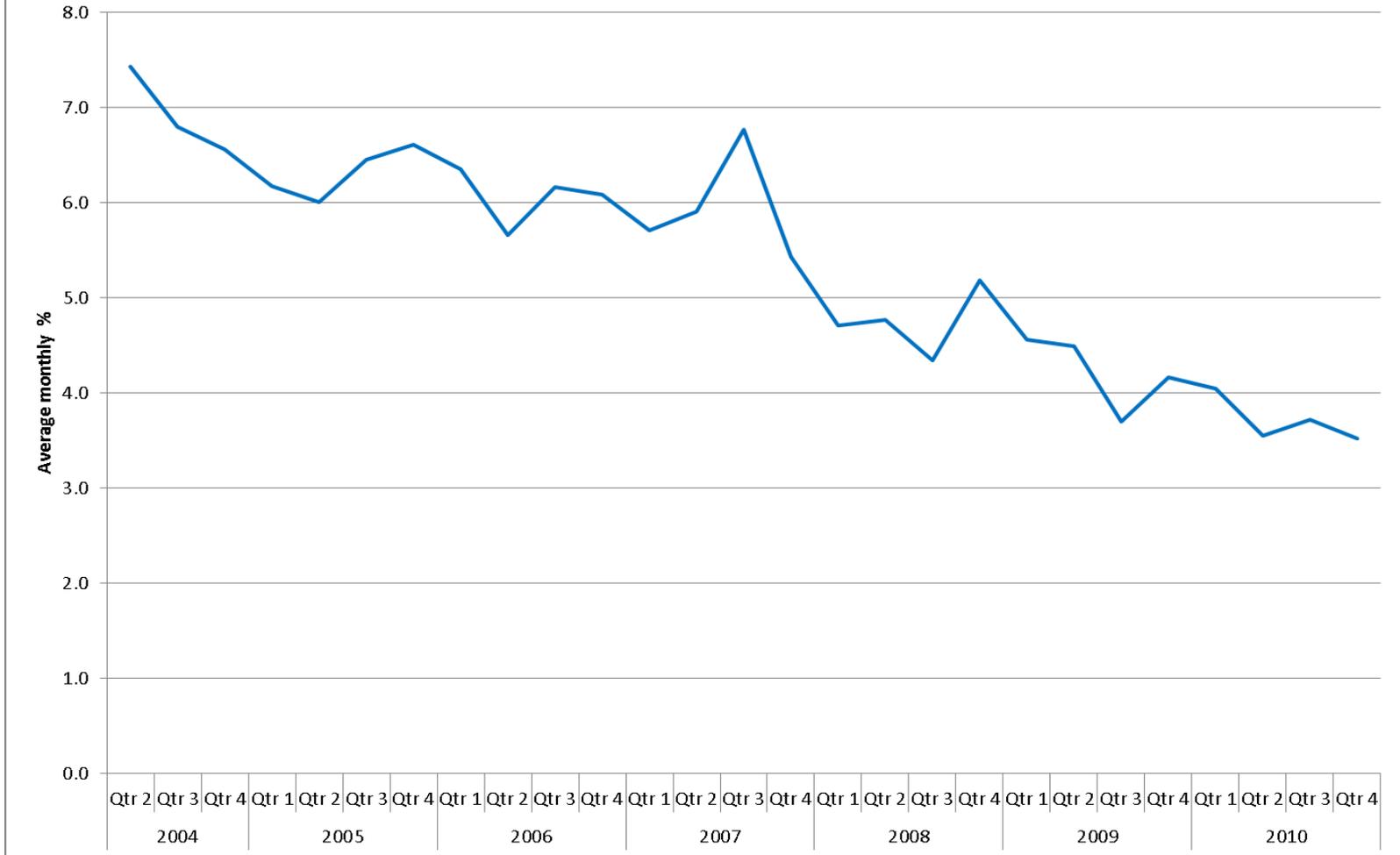
# WA Workers' Compensation Opioid-related Deaths 1995-2010



## Prescription Opioid Involved Overdoses Washington State



### Rate of incident users who became chronic users Washington State Workers' Compensation 2004-2010



# New primary care survey in WA\*

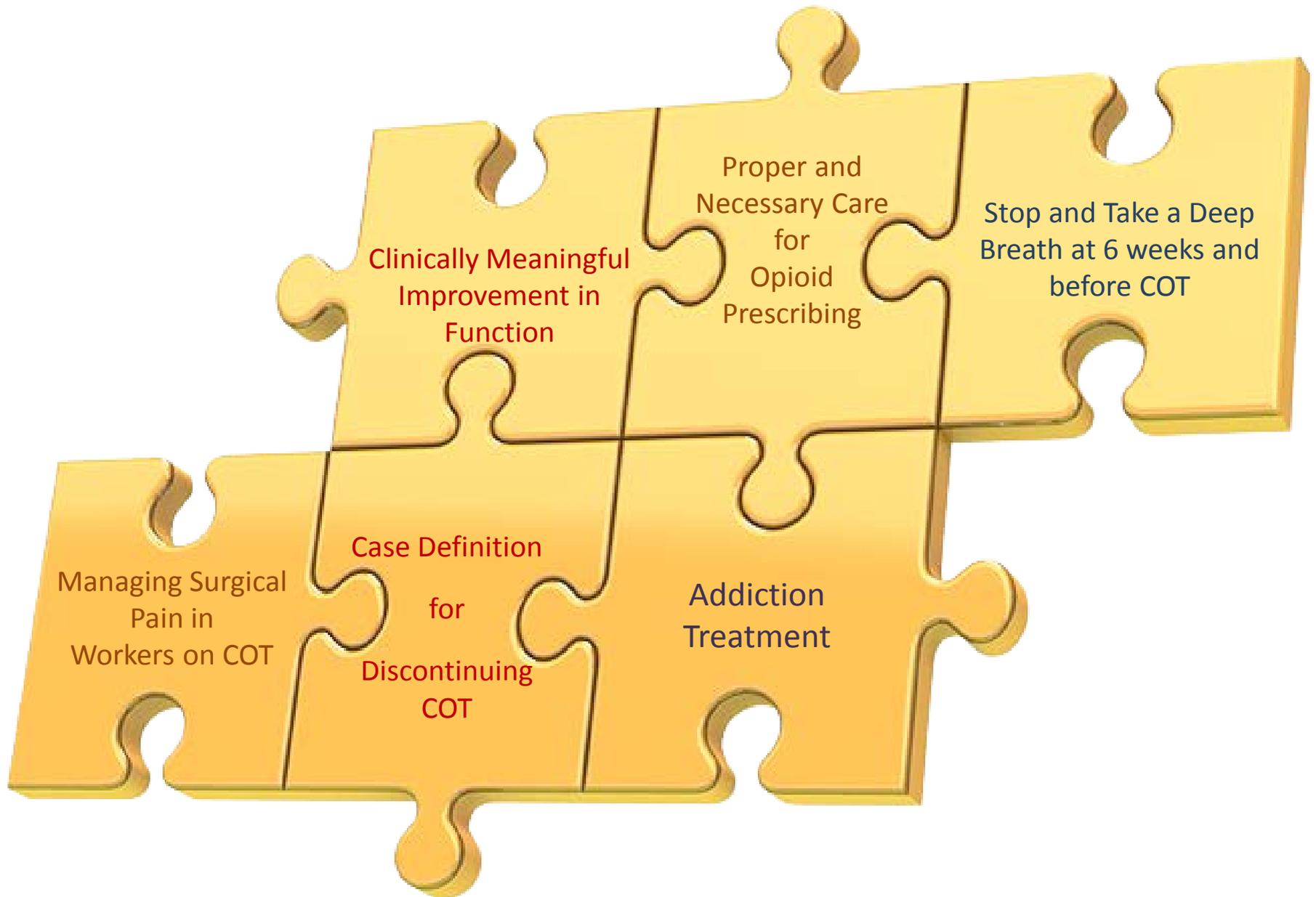
- Most providers (72%) reported concern about opioid overdose, addiction, dependence, or diversion. Only 25% indicated concern about regulatory scrutiny.
- Prescribing providers in WA reported ongoing concerns regarding opioid use for CNCP, but those affiliated with a health care organization with opioid prescribing guidelines and access to pain consultation were less likely to report being concerned about opioid-related problems or to have discontinued prescribing opioids.

\*Franklin et al, 2013, J Am Board Fam Med (in press)

# Jan, 2013 Workers' Compensation Opioid Guideline and Rules

- Addresses gaps in 2010 AMDG Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain
- This Supplement provides additional information and guidance for treating work-related injuries

DOH pain management rules, 2010 AMDG Guideline and this Supplement are reflective of the practice standard for prescribing opioids for a work-related injury or occupational disease.



# Opioid Use in Workers' Compensation

(continue)

- Measuring the Impact of Opioid Use
  - Beyond acute phase, effective use should result in clinically meaningful improvement in function (CMIF)
  - CMIF is an improvement in function of at least 30% compared to start of treatment or in response to a dose change
  - Evaluation of clinically meaningful improvement should occur at 3 critical phases (acute, subacute and during COT)

Continuing to prescribe opioids in the absence of CMIF or after the development of a severe adverse outcome is not proper and necessary care. In addition, the use of escalating doses to the point of developing opioid use disorder is not proper and

## Prescribing Opioids for a Work-related Injury or Occupational Disease

- Opioids in the Acute Phase (0-6 weeks after injury or surgery)
  - Use of opioids as initial treatment for back sprain or other strains is not supported, but if prescribed, should be limited to short-term

- Opioid use should result in improvements in pain and function of at least 30% or to pain interference of  $\leq 4$
- Providers should check PMP and administer screening tools per AMDG Guideline before prescribing opioids
- L&I will not pay for opioids beyond 6 weeks in absence of CMIF

## Prescribing Opioids for a Work-related Injury or Occupational Disease (continue)

- Opioids in the Subacute Phase (between 6 and 12 weeks)
    - Opioid use beyond the acute phase is rarely indicated if injury is a sprain or strain
    - Provider must perform the following best practices
      - Screen for opioid risk (ORT, SOAPP-R, DIRE or CAGE-AID)
      - Screen for depression to identify potential impact to treatment
      - Administer baseline urine drug test (UDT)
- Access PMP to ensure controlled substance history is consistent
  - Document clinically meaningful improvement in function and pain with acute use

# Additional Services

- L&I may authorize up to 6 months of addiction treatment when:
  - Worker has failed Step 1 and 2 AND
  - Opioid use disorder (DSM-V) is diagnosed and identified as barrier to recovery AND
  - Documentation of how treatment will improve work capacity and/or the ability to progress in vocational retraining AND
  - A time-limited treatment plan
- Treatment options for opioid use disorder
  - Medication assisted (e.g. buprenorphine, methadone or naltrexone)
  - Drug-free treatment
  - Residential treatment

# Concrete steps to take

- Collaboration among State agencies at the highest levels
- Reverse permissive laws
- Set dosing and best practice Guidelines/Rules opioid use for acute, subacute and chronic, non-cancer pain
- Establish metrics for tracking progress; Track deaths and overdose ED visits and hospitalizations; Track high MED and prescribers
- Implement an effective Prescription Monitoring Program;
- Encourage/incent use of best practices (web-based MED calculator, use of state PMPs)
- DO NOT pay for office dispensed opioids
- ID high prescribers and offer assistance (eg, (academic detailing, free CME,ECHO)
- **Incent community-based Rx alternatives (activity coaching and graded exercise early, opioid taper/multidisciplinary Rx later)**

# New state policies

## **Connecticut WC policy-7/1/2012**

The total daily dose of opioids should not be increased above 90mg oral MED/day (Morphine Equivalent Dose) unless the patient demonstrates measured improvement in function, pain or work capacity. Second opinion is recommended if contemplating raising the dose above 90 MED/day.

## **MaineCare (Medicaid)-4/1/2012**

Total 45 day maximum for non-cancer pain

## **New Mexico-Rule 16.10.14-2012**

A health care practitioner shall, before prescribing, ordering, administering or dispensing a controlled substance listed in schedule II, III or IV, obtain a patient PMP report for the preceding twelve (12) months

## **CA-several bills moving through-funding, mandatory use of CURES**

**OH-New state Medical Board guidelines with 80 mg/day MED “yellow flag” threshold-Oct, 2013; URL:**

**<http://www.med.ohio.gov/webhost/ooat.html>**

# What explains dramatic rise in working age disablement

- Bad medical care in workers' compensation
  - Opioids
  - Inappropriate spine surgery
  - Network example

**THANK YOU!**

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