AMDG
agency medical directors' group

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

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

WA State Nursing Commission-Sept 7, 2017

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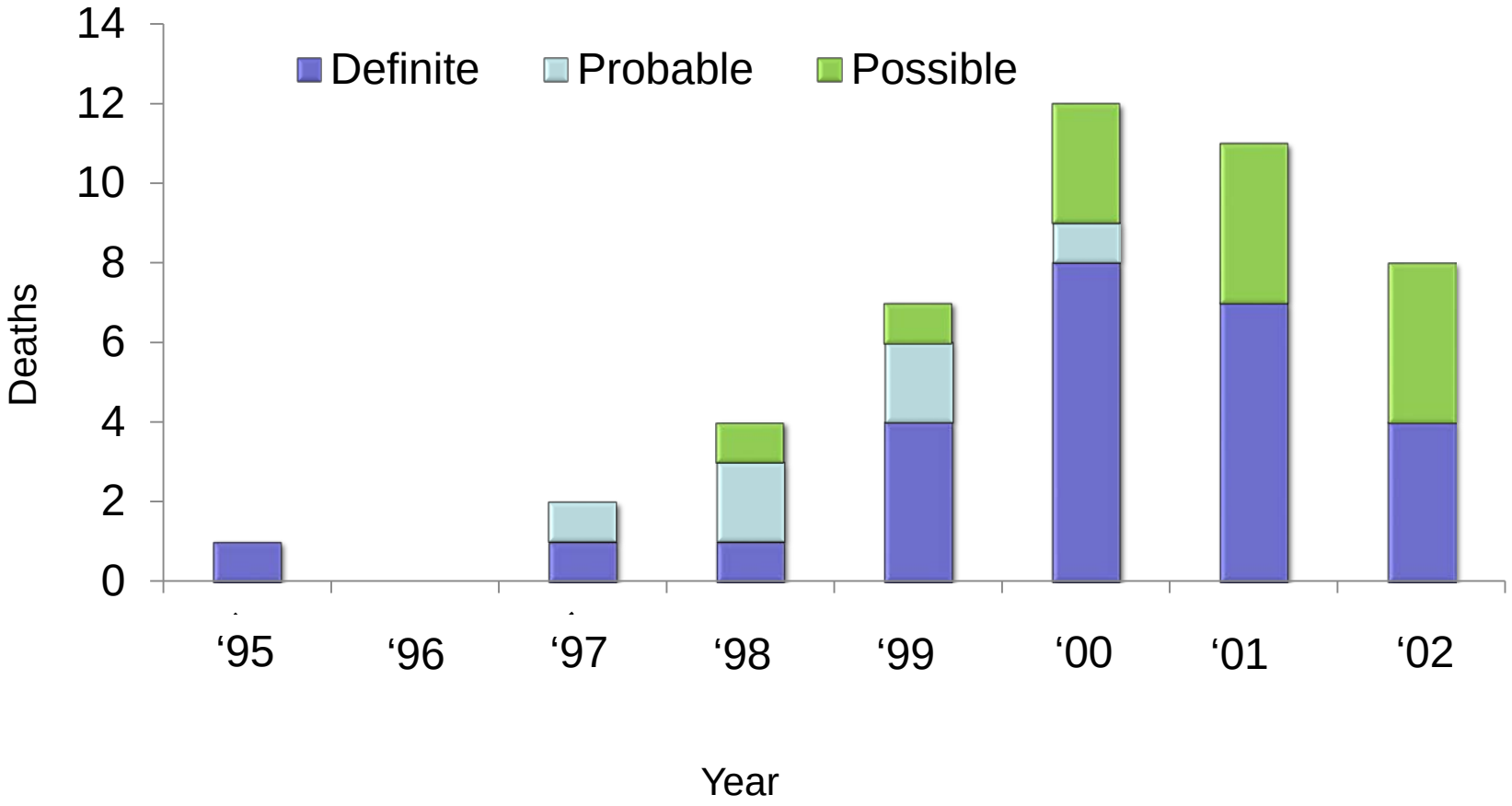
Opioid-Related Deaths, Washington State Workers' Compensation, 1992–2005



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

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

You will not be able to effectively alter epidemic if you don't understand how the epidemic began

- 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

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).

WA State has led on reversing the epidemic

- 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
- 2015-Expanded AMDG opioid guideline-highly consistent with CDC guideline
- 2017-Bree opioid metrics

Agency Medical Directors Group Website

AMDG agency medical directors' group

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

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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."

Opioid Dosing - Quick Links

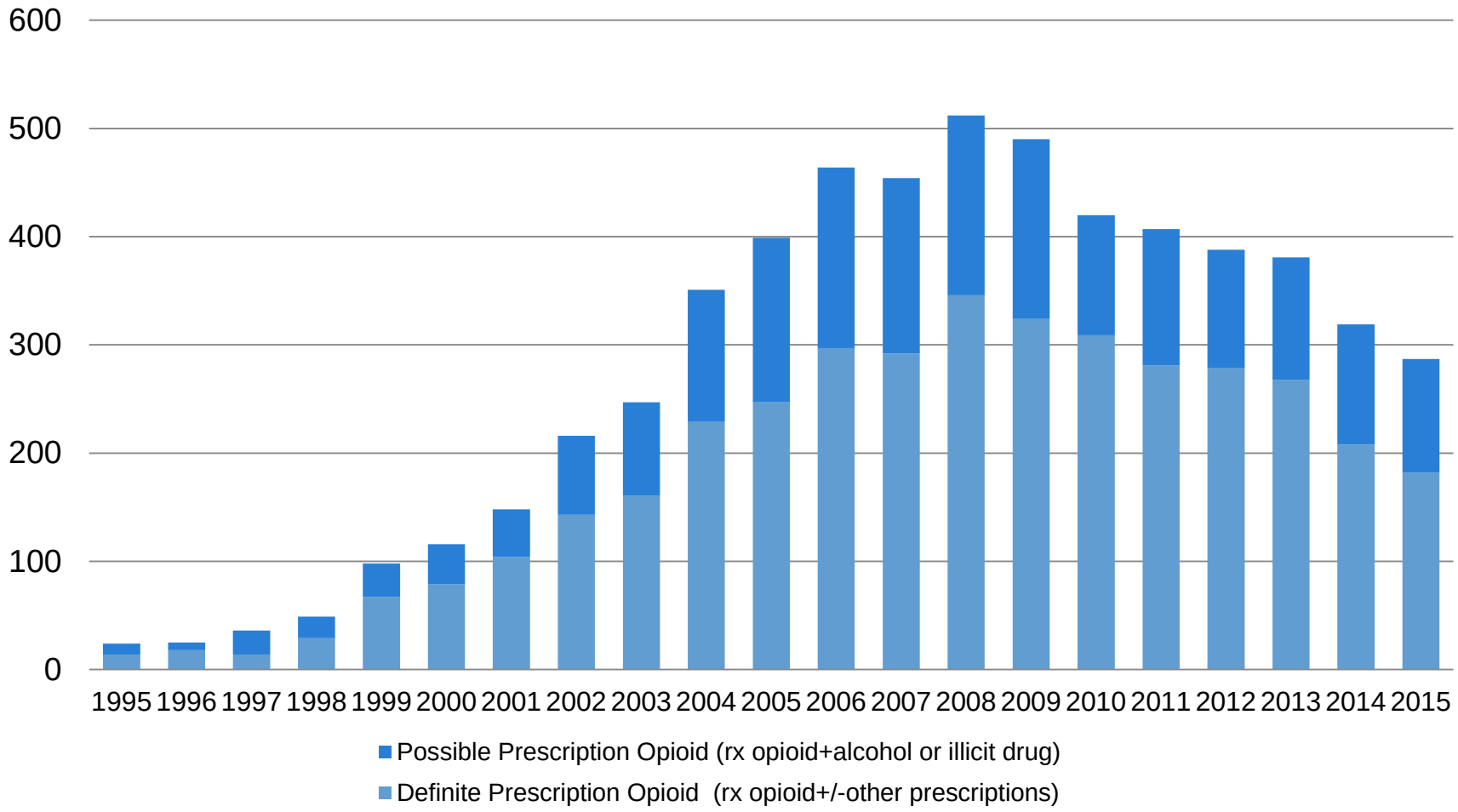
- **FREE** Online CME credits available for 2015 Interagency Guideline on Prescribing Opioids for Pain
- AMDG 2015 Interagency Guideline on Prescribing Opioids for Pain (1.75 MB PDF)
- Summary of AMDG Opioid Guideline (367 KB PDF)
- 2015 Primary Pain Care Conference
- Opioid Dose Calculator
- Assessment Tools
- Other Resources

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:

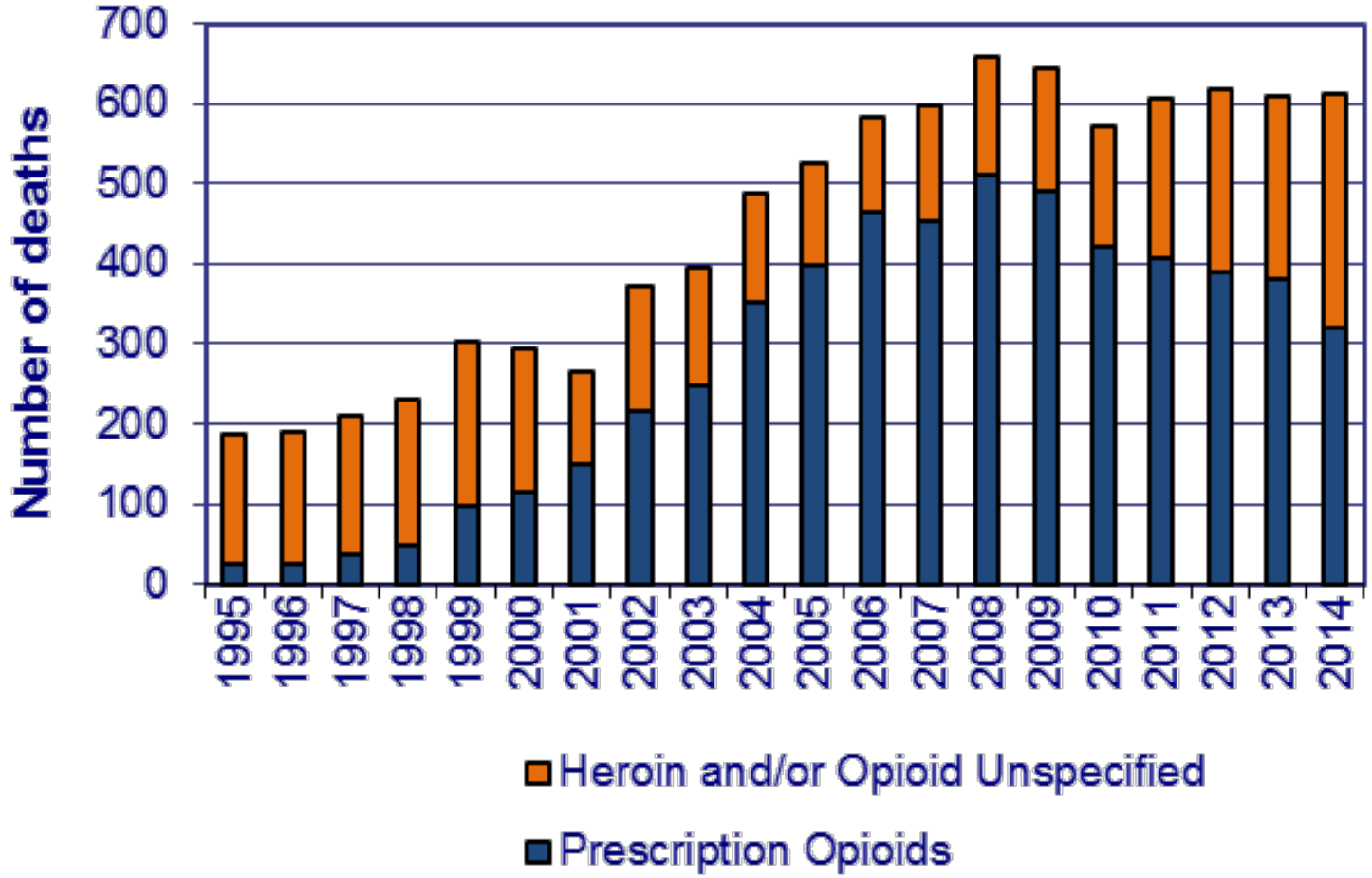
1. **Protect public health:** by advancing initiatives and programs that keep people safe and improve their health.
2. **Purchase high value care:** so public funds are used wisely for high quality care.
3. **Implement evidence-based best practices:** by using research to produce policies and guidelines 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

CDC Opioid Guidelines-March 2016

- **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.

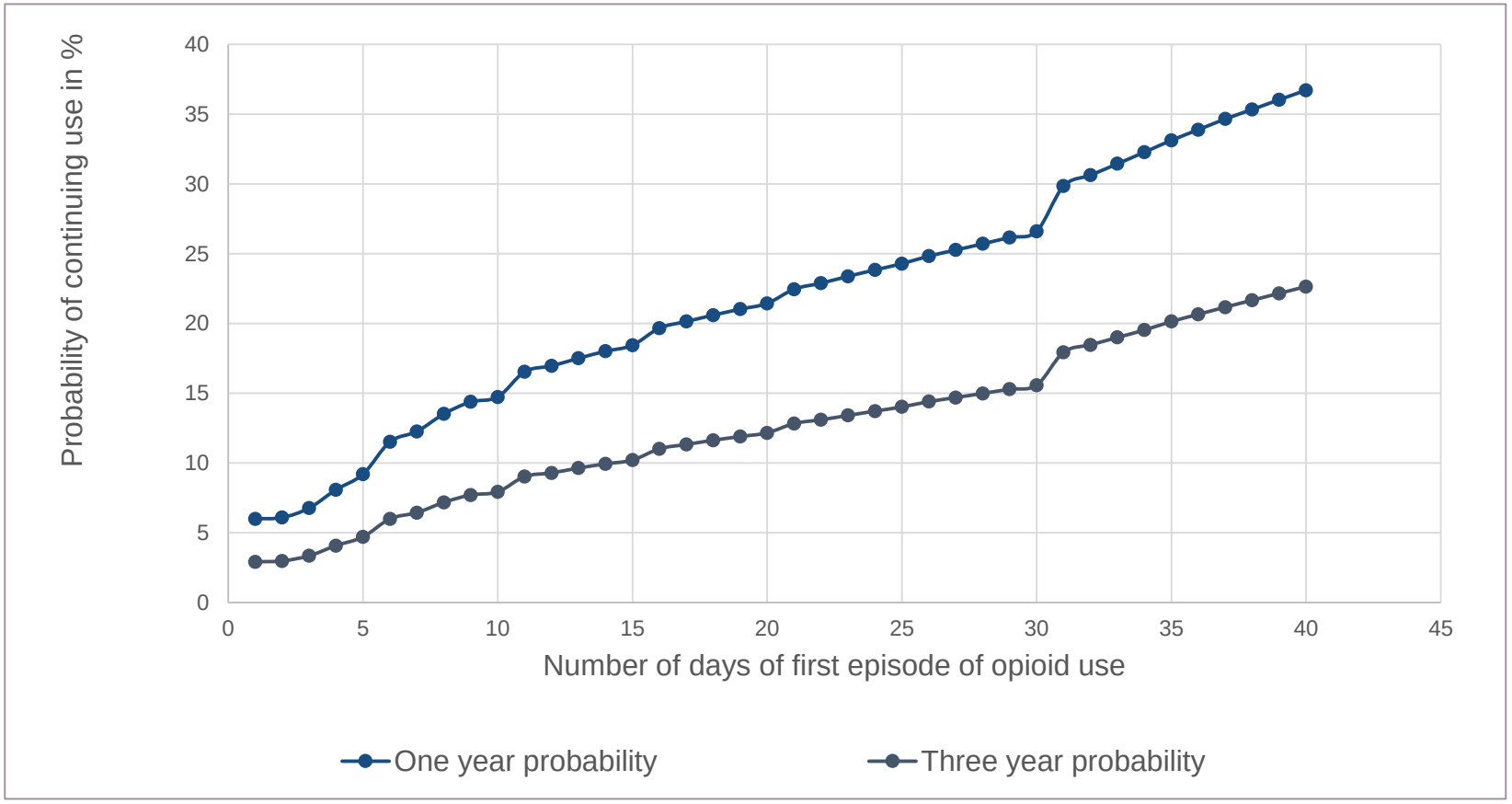
  6.Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. 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



DRAFT

DENTAL GUIDELINE ON PRESCRIBING OPIOIDS FOR PAIN

Written for Clinicians Who Care for Patients with Pain
July 2017

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

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-eg, 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

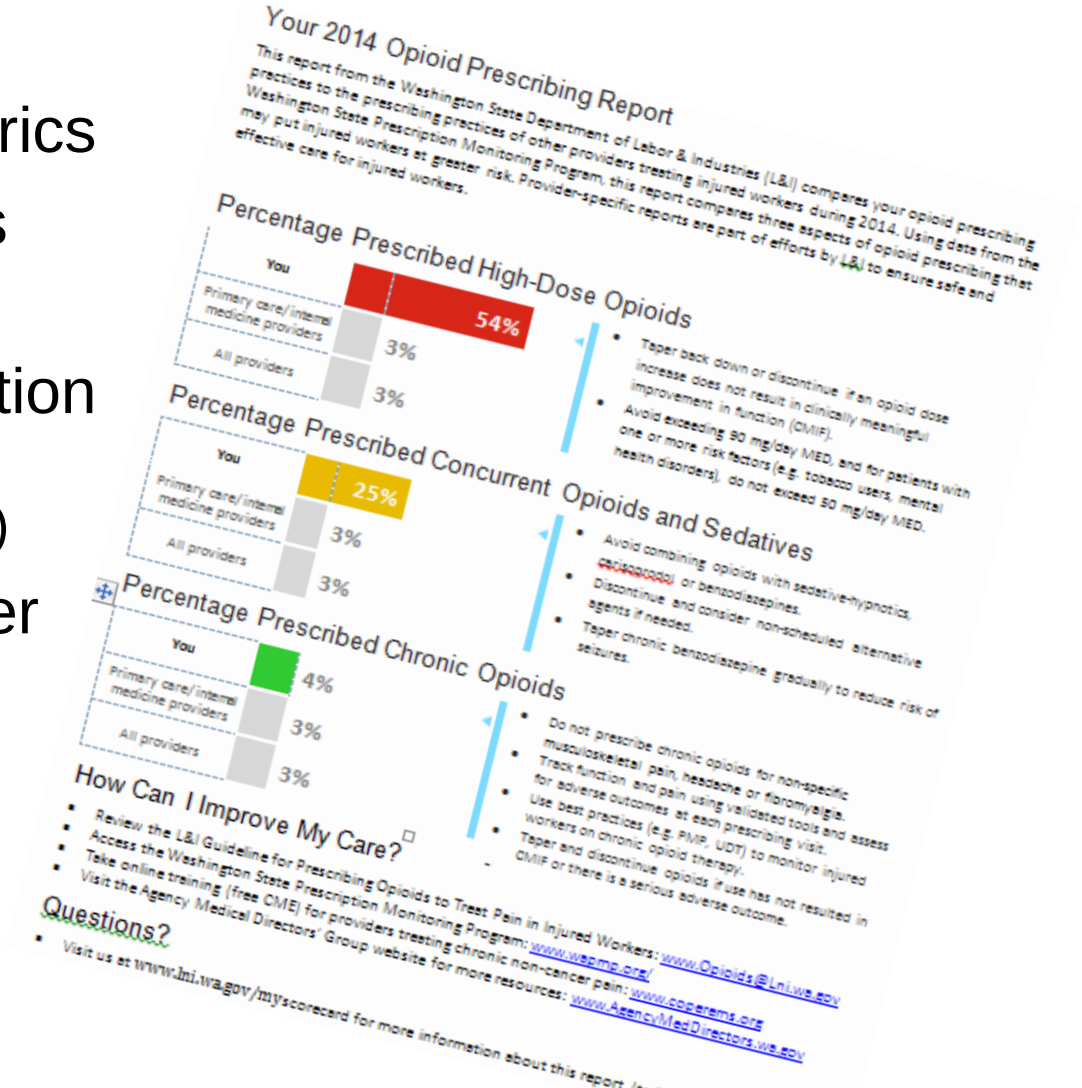
- Deliver coordinated, stepped care services aimed at improving pain and addiction treatment
  - Cognitive behavioral therapy or graded exercise to improve patient self-efficacy
  - Opioid overdose case management by ED to identify behavioral health needs, evaluate for MAT, notify providers involved 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
  - 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

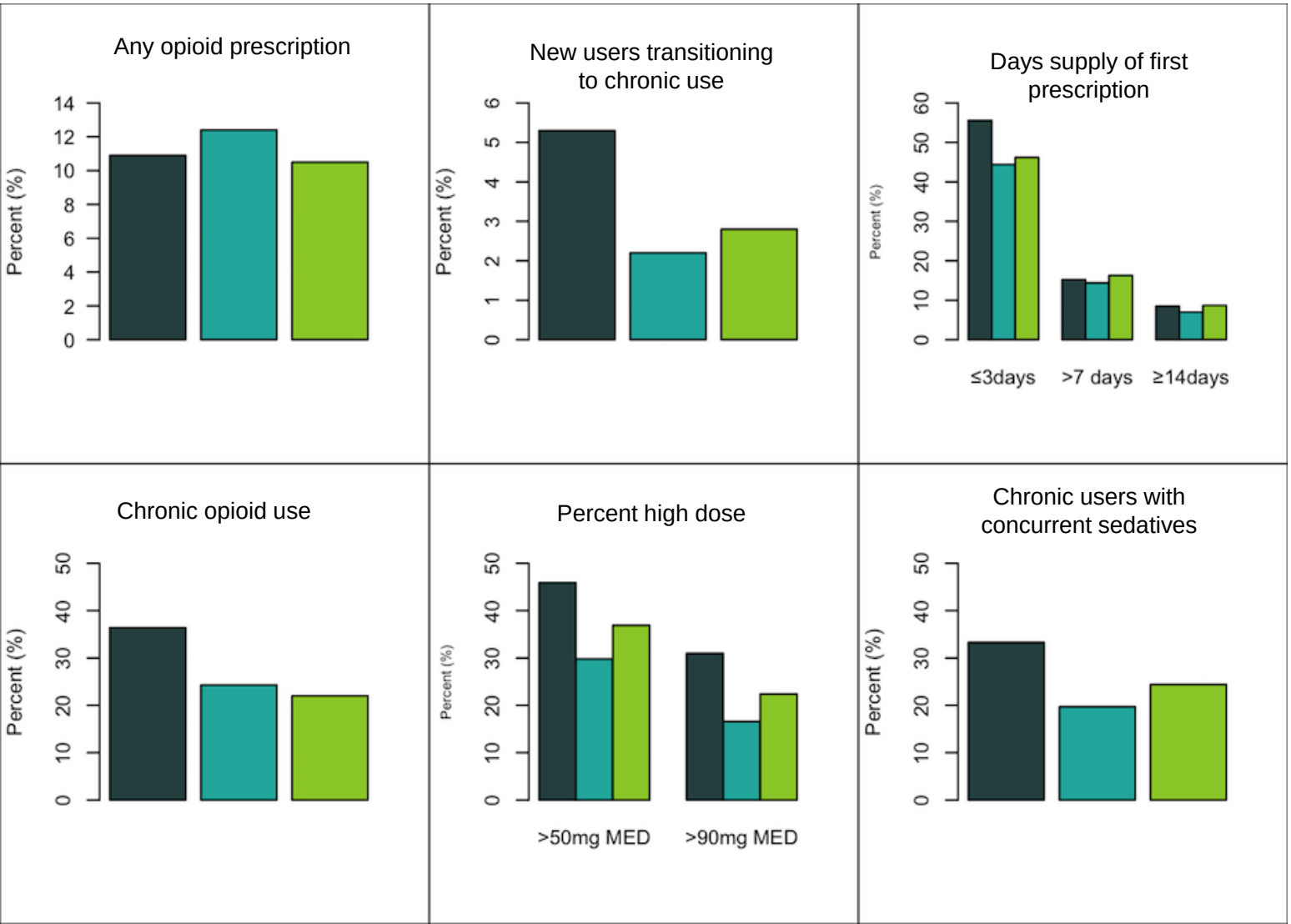
NGA 3. Metrics to guide both “state-of-the-state” and provider quality efforts

- 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

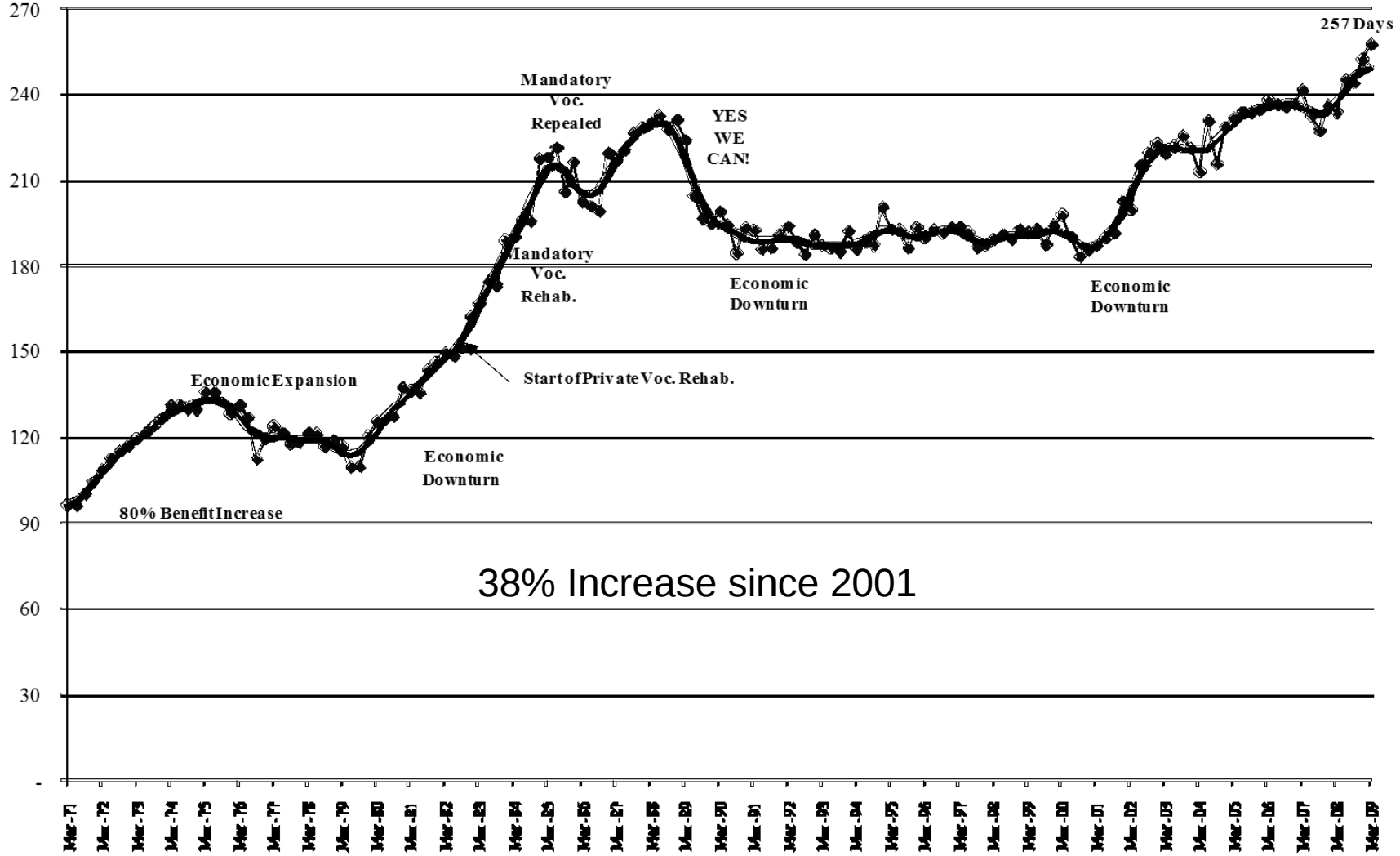


Overview of WA Bree Metrics

General prescribing	
• Prevalence of opioid use	% with ≥1 opioid Rx of all enrollees, by age
Long-term prescribing	
• Chronic opioid use	% with ≥60 days supply of opioids in the quarter
• High dose use	% with doses ≥50 and ≥90 mg/day MED in chronic opioid users
• Concurrent use	% with ≥60 days supply of sedatives among chronic opioid users
Short-term prescribing	
• Days supply of first Rx	% with ≤3, 4-7, 8-13, and ≥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 ≥3 quarters of use


Any opioid prescription
Percent (%)
0
2
4
6
8
10
12
14
New users transitioning to chronic use
Percent (%)
0
1
2
3
4
5
6
Days supply of first prescription
Percent (%)
0
10
20
30
40
50
60
≤3days
>7 days
≥14days
Chronic opioid use
Percent (%)
0
10
20
30
40
50
Percent high dose
Percent (%)
0
10
20
30
40
50
>50mg MED
>90mg MED
Chronic users with concurrent sedatives
Percent (%)
0
10
20
30
40
50
Medicaid-WA
KPWA-IGP
KPWA-Network

Average Timeloss Duration (Days)

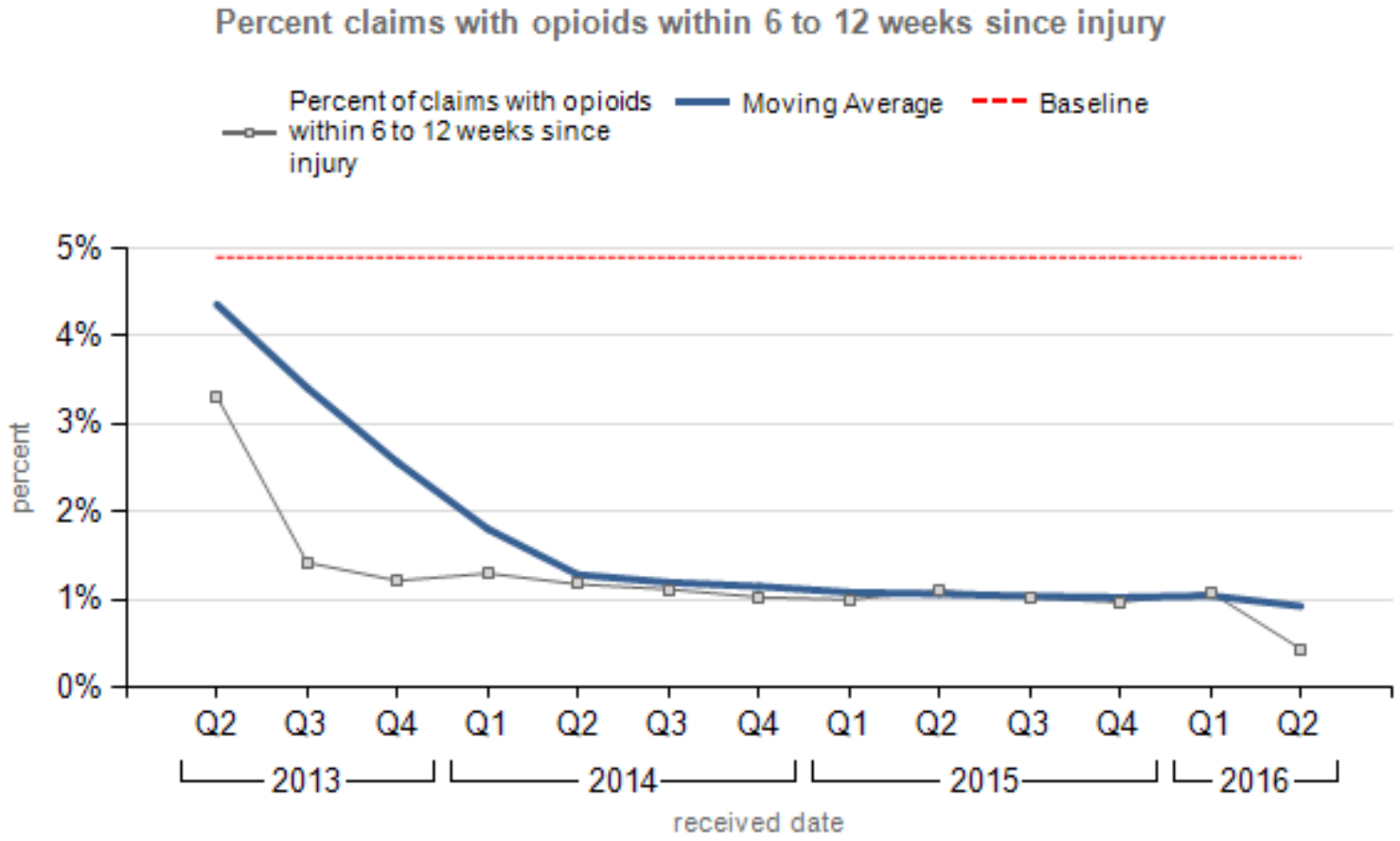


Early opioids and disability in WA WC. Spine 2008; 33: 199-204

- 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

Washington State Department of Labor & Industries

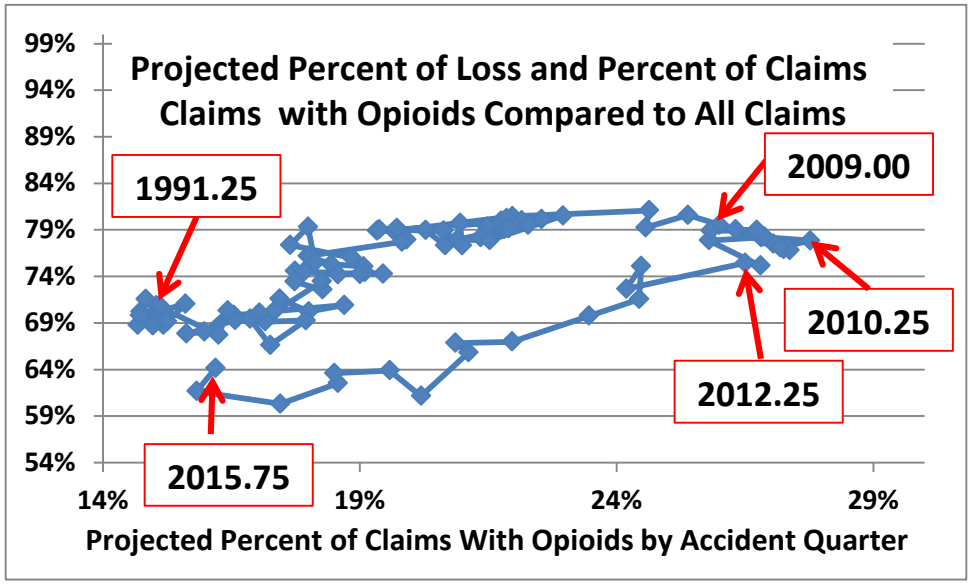


data as of date: 7/3/2016

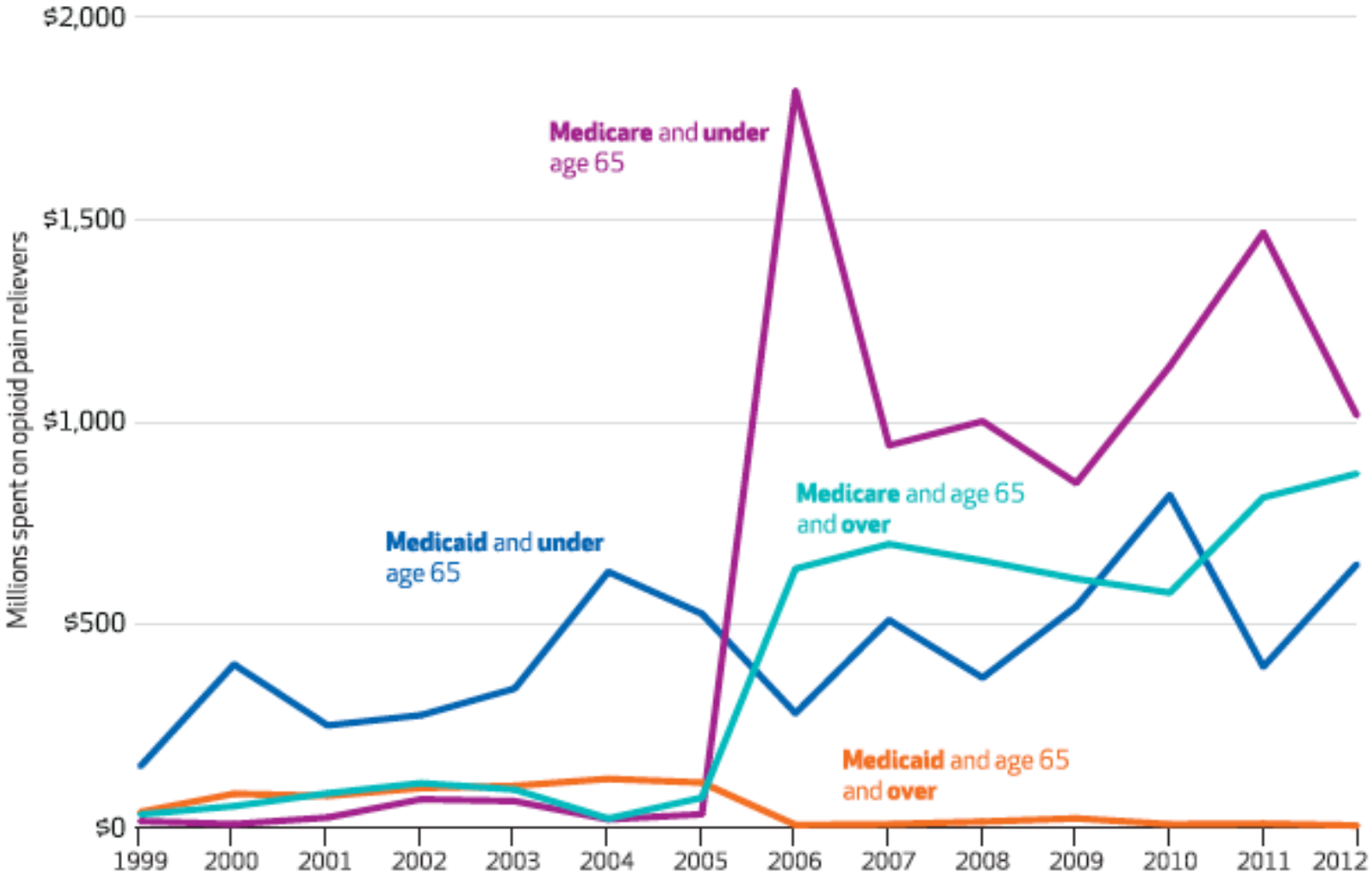
report run date: 8/5/2016

Owner: Research & Data Services

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



US expenditures for opioid pain relievers for enrollees in Medicare or Medicaid, by age group and year



SOURCE Authors' analysis. **NOTES** Expenditures were adjusted by the Medical Expenditure Panel Survey's pharmaceutical price index, which used 2009 as the base year. Medicare spending for both elderly and nonelderly enrollees increased significantly ($p < 0.01$) from 2005 to 2006.

Zhou C, Florence CS, Dowell. Payments for Opioids Shifted Substantially To Public And Private Insurers While Consumer Spending Declined, 1999-2
Health Aff (Millwood). 2016 May 1;35(5):824-31. doi: 10.1377/hlthaff.2015.1103.

Rapidly increasing mortality in middle aged, lower educated whites

Case and Deaton, PNAS, 2015

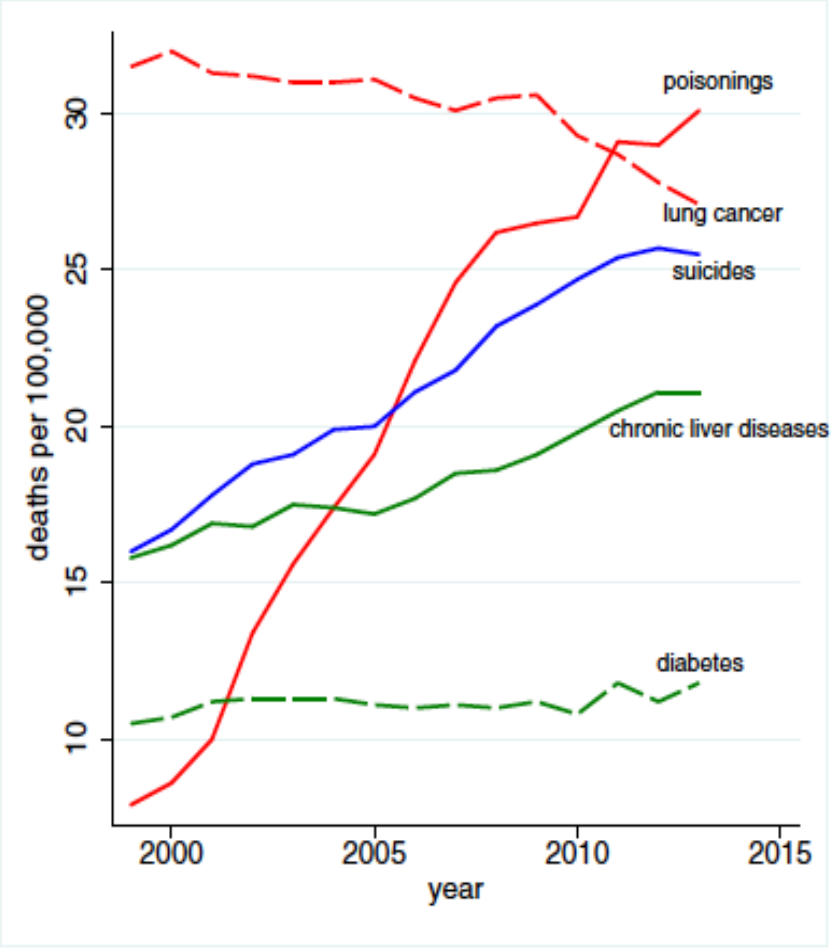


Fig. 2. Mortality by cause, white non-Hispanics ages 45–54.

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THANK YOU!

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