Opioids: A Public Health Emergency
-National Academy of Social Insurance-
Washington, DC
Feb 1, 2012

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"To write prescriptions is easy,
but to come to an understanding with
people is hard."
-- Franz Kafka, “A Country Doctor”

“We can’t solve problems by using the same kind of thinking we used when we created them”

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**
- **No dose ceiling+”pseudoaddiction” =Unfettered dose escalation**

WAC Washington Administrative Code

Pain champions, Pharma surrogates, and Astroturf organizations led the way

Older falsehoods

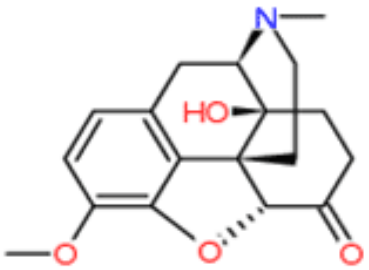
- Opioids not as addicting as we used to think (<1%)-"pseudoaddiction" coined
- No ceiling on dose-standard was to increase dose to address tolerance
- Pain as the fifth vital sign
- Patients should leave the ER in comfort-drove satisfaction scores

More recent falsehoods*

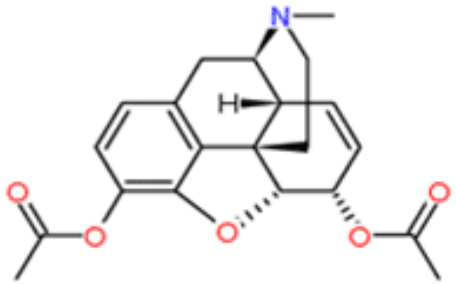
- Were it not for the heavy hand of law enforcement/gov't, we'd be fine
- It's all a methadone problem
- It's all abuse
- It's just a cluster of pill mills and a few others

*http://www.huffingtonpost.com/radley-balko/prescription-painkillers_b_1240722.html

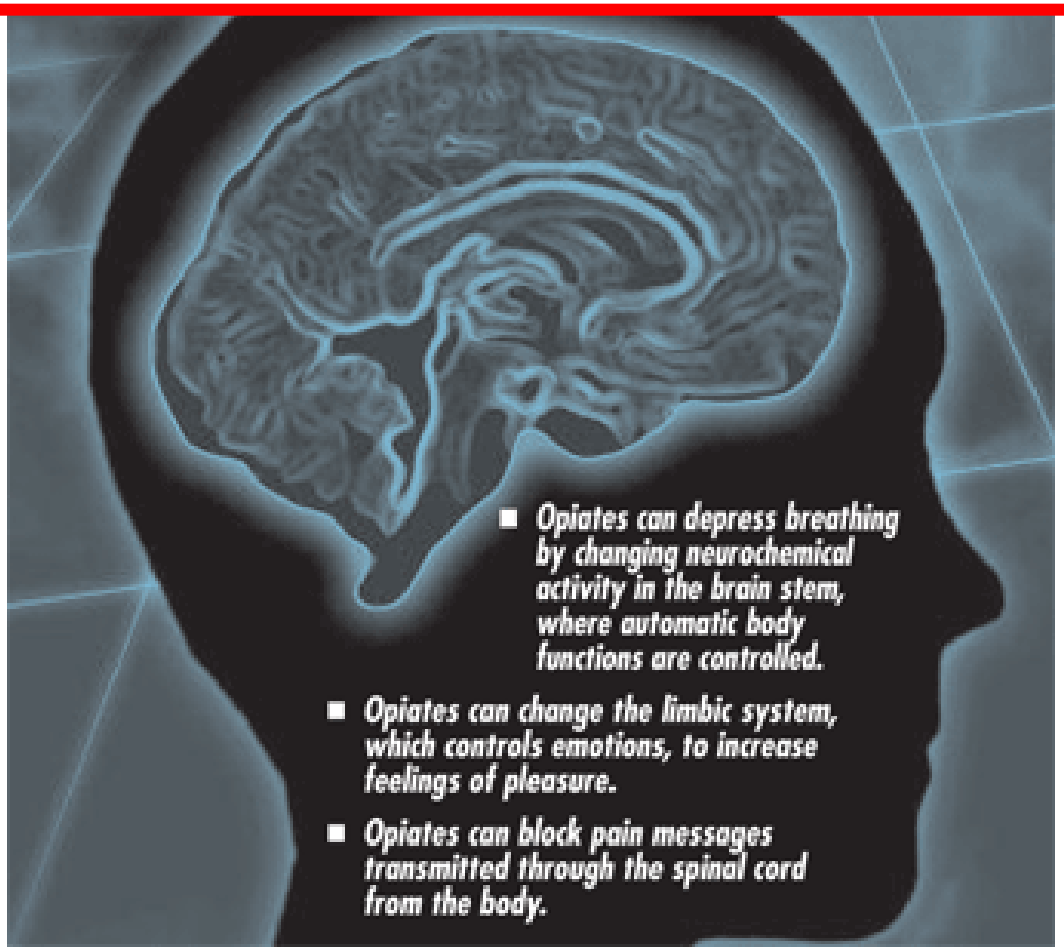
Similarities Between Illicit & Prescription Drugs



OXYCONTIN (OXYCODONE)



HEROIN

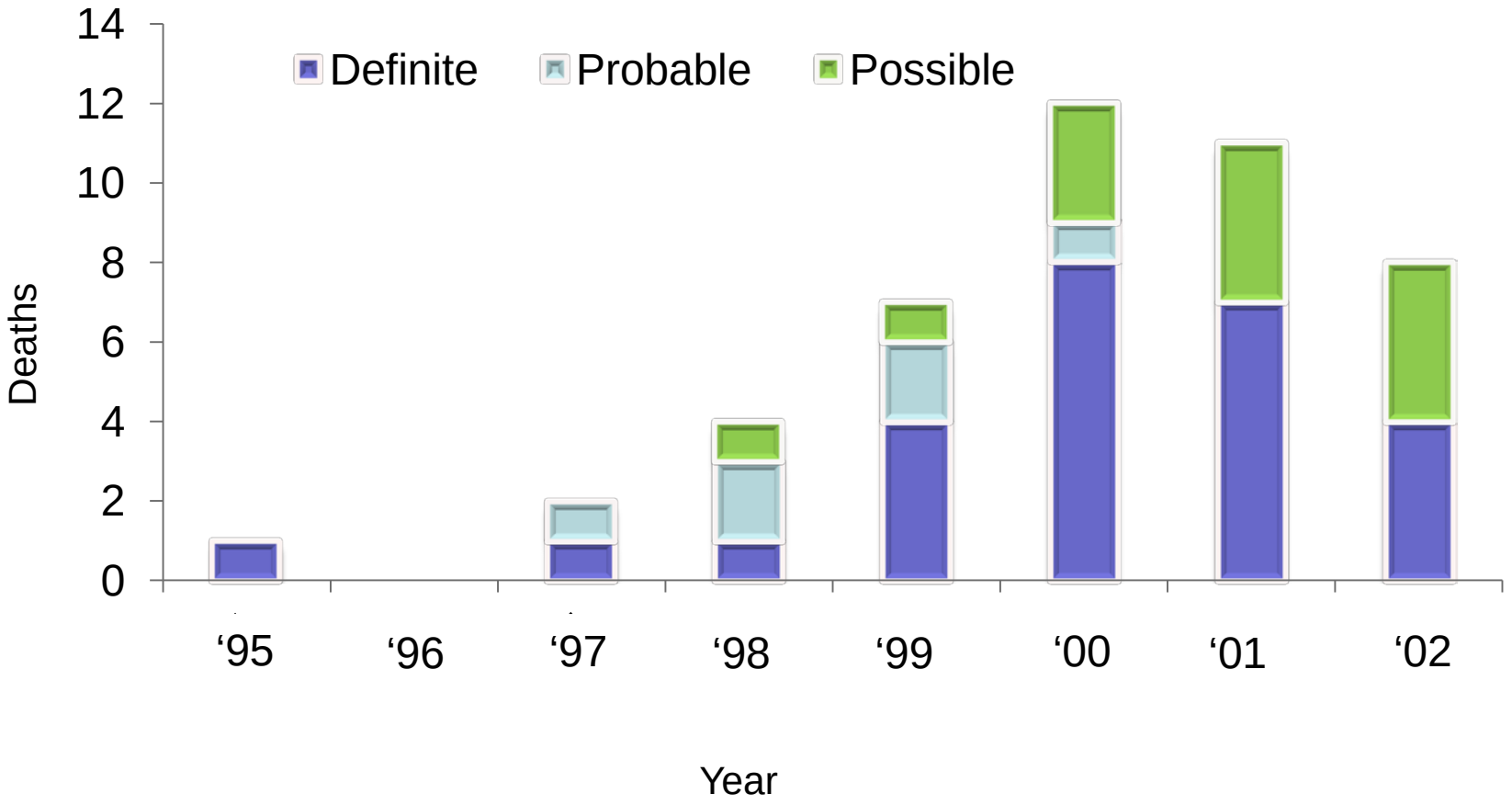


Portenoy and Foley Pain 1986; 25: 171-186

- Retrospective case series chronic, non-cancer pain
- N=38; 19 Rx for at least 4 years
- 2/3 < 20 mg MED/day; 4> 40 mg MED/day
- 24/38 acceptable pain relief
- No gain in social function or employment could be documented
- Concluded: “Opioid maintenance therapy can be a safe, salutary and more humane alternative…”

By 2006, over 10,000 WA citizens were taking over 120 mg/day MED

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



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

Washington Agency Medical Directors' Opioid Dosing Guidelines

- Developed with clinical pain experts in 2006
- Implemented April 1, 2007
- First guideline to emphasize dosing guidance
- Educational pilot, not new standard or rule
- National Guideline Clearinghouse
  - http://www.guideline.gov/content.aspx?id=23792&search=wa+opioids

AMDG agency medical directors' group

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**

AMDG agency medical directors' group

Guidance for Primary Care Providers on Safe and Effective Use of Opioids for Chronic Non-cancer Pain

- **Establish an opioid treatment agreement**
- **Screen for**
  - Prior or current substance abuse
  - Depression
- **Use random urine drug screening judiciously**
  - Shows patient is taking prescribed drugs
  - Identifies non-prescribed drugs
- **Do not use concomitant sedative-hypnotics**
- **Track pain and function to recognize tolerance**
- **Seek help if dose reaches 120 mg MED, and pain and function have not substantially improved**

http://www.agencymeddirectors.wa.gov/opioiddosing.asp

MED, Morphine equivalent dosec

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**

OPIOID DOSE CALCULATOR

Opioid (oral or transdermal)	Mg per day	Morphine equivalents
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
TOTAL daily morphine equivalent dose (MED) =		**520**

http://www.agencymeddirectors.wa.gov/opioiddosing.asp#DC

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

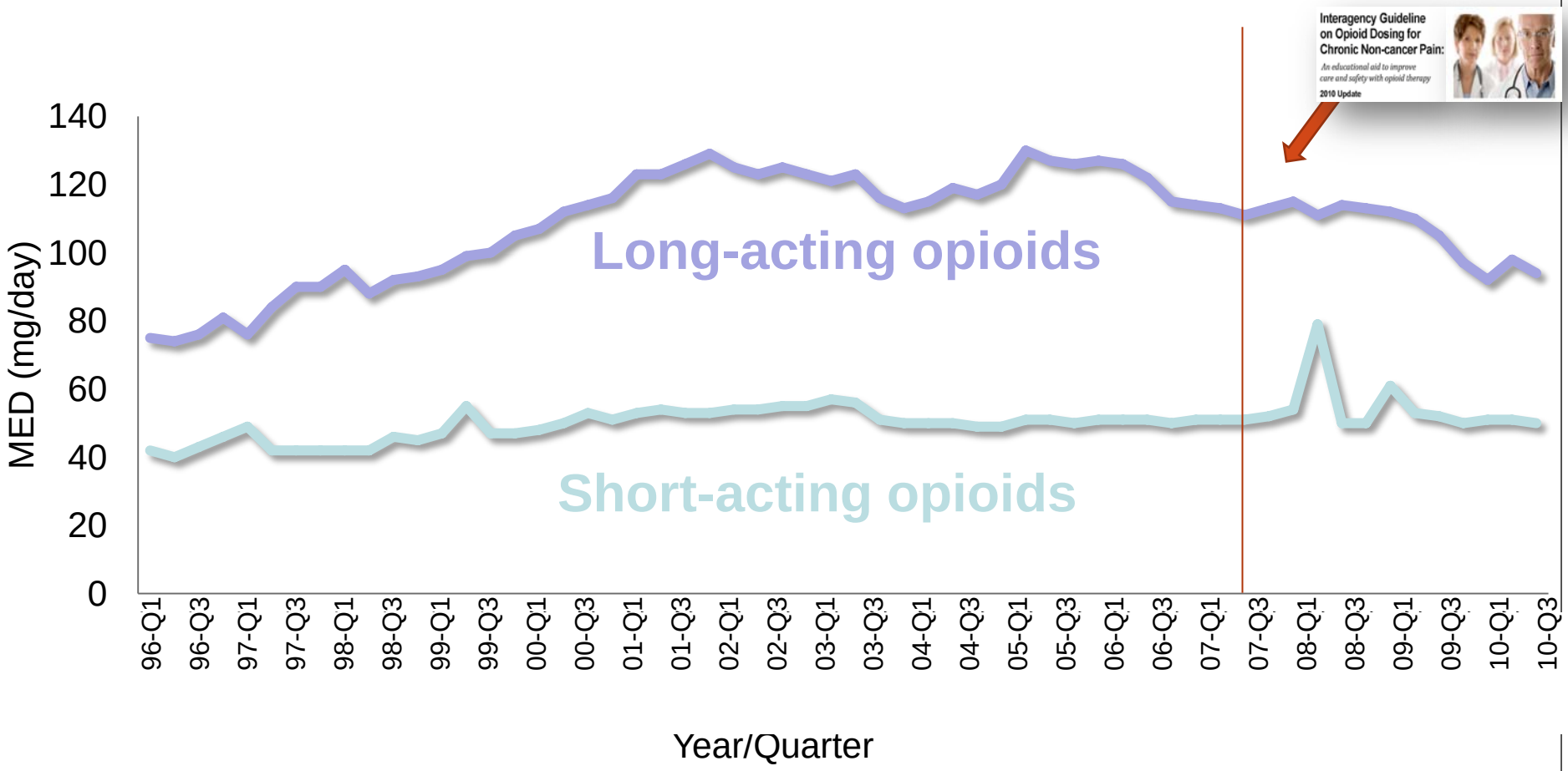
CDC recommendations-2009

- For practitioners, public payers, and insurers
- Seek help at 120 mg/day MED if pain and function not improving
- http://www.cdc.gov/HomeandRecreationalSafety/pdf/poision-issue-brief.pdf

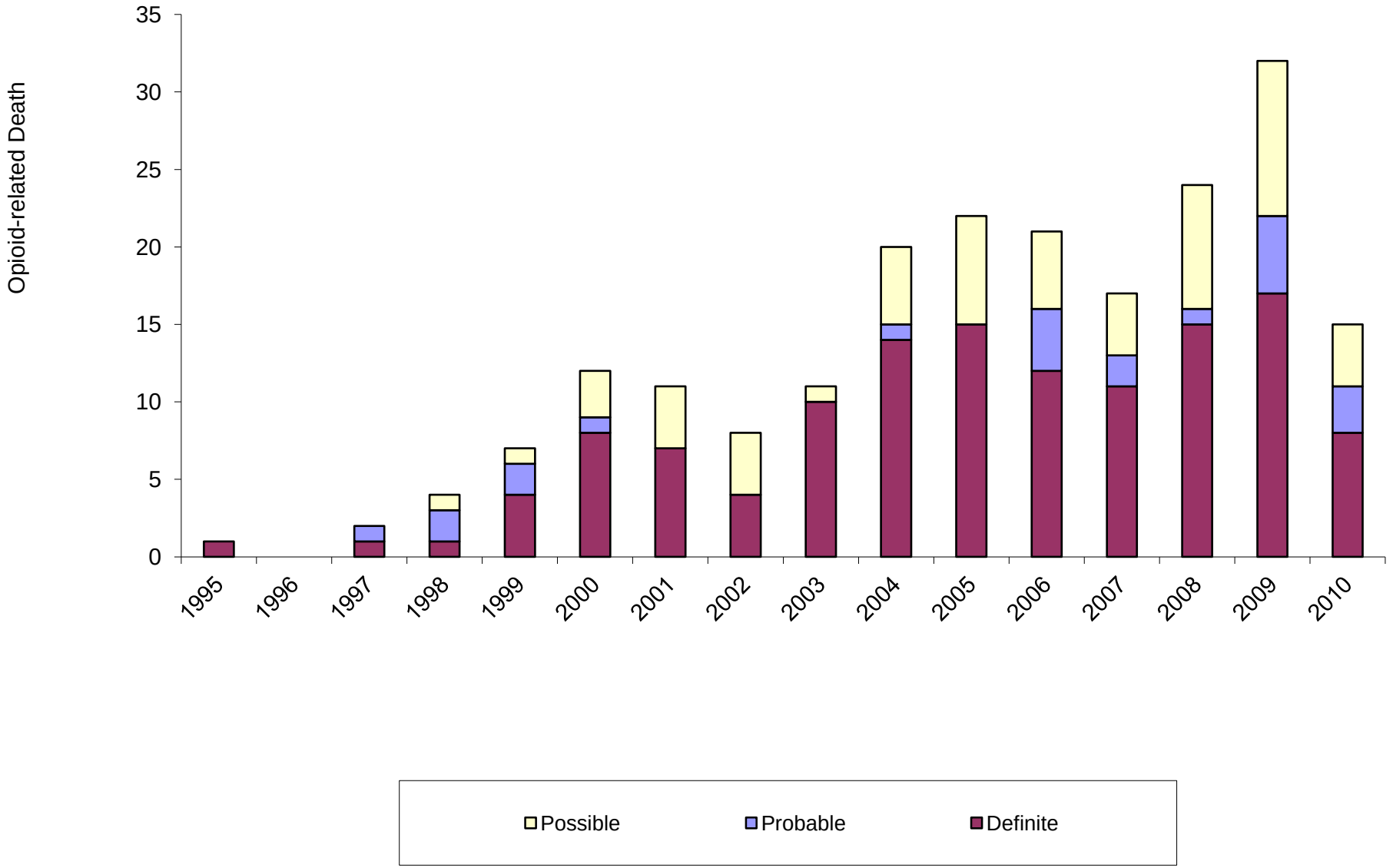
WA State Opioid Dosing Guideline contributes to reversal of opioid epidemic

Franklin GM, Mai J, Turner J, et al. Bending the prescription opioid dosing and mortality curves: impact of the Washington State Opioid Dosing Guideline. Am J Ind Med 2012; 55: 325-31

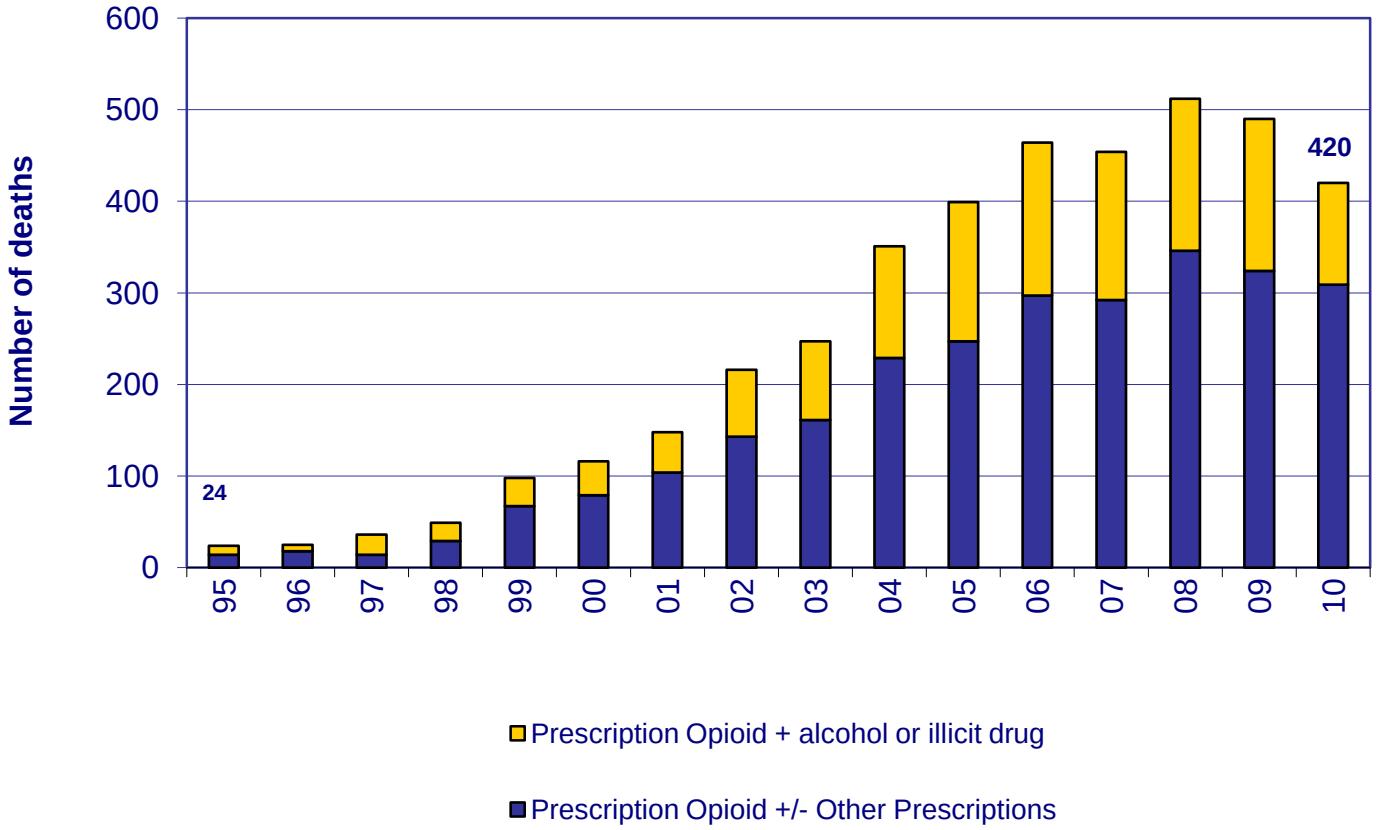
Average Daily Dosage for Opioids, Washington Workers' Compensation, 1996–2010



WA Workers' Compensation Opioid-related Deaths 1995-2010

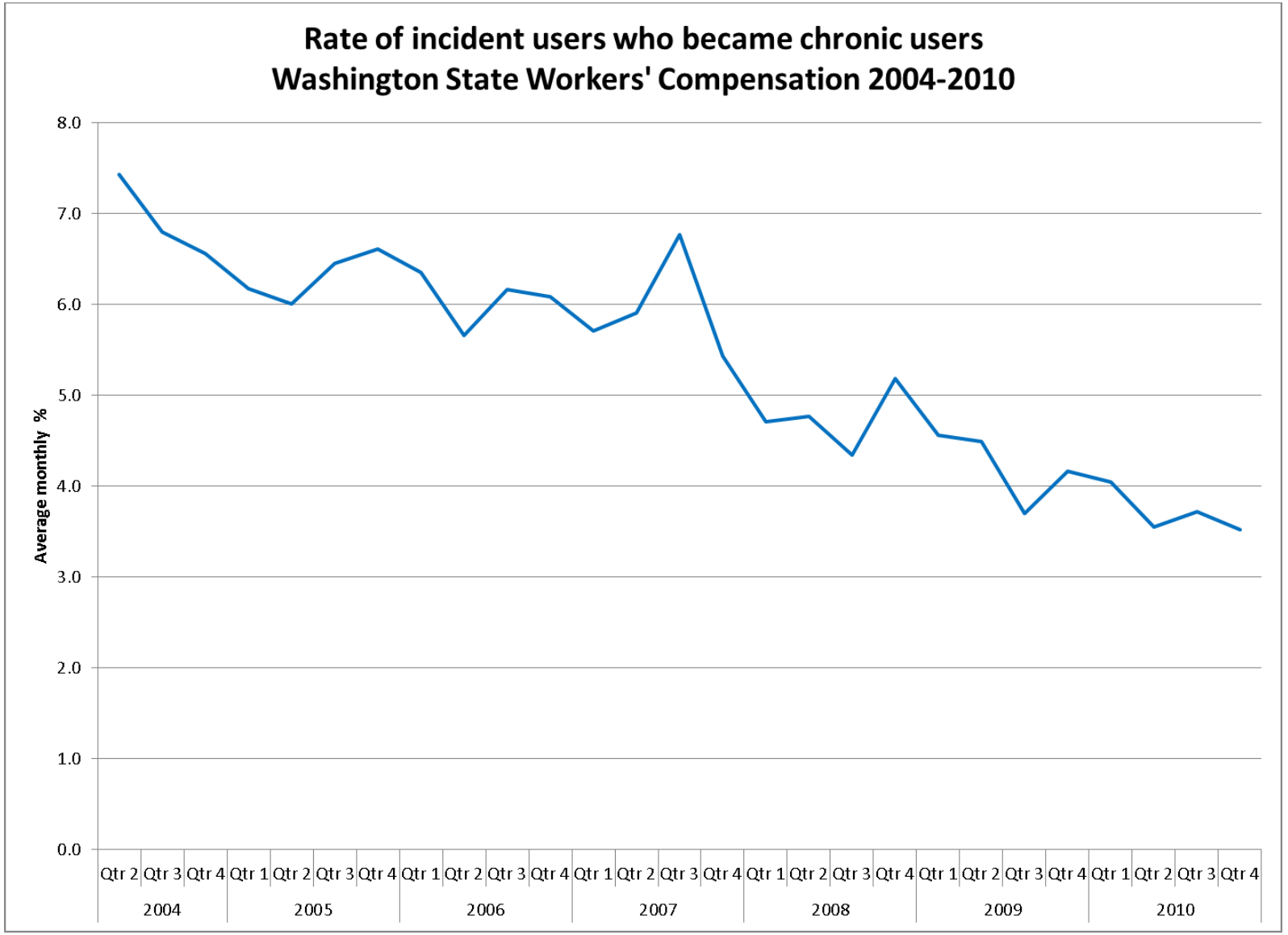


Unintentional Prescription Opioid Overdose Deaths
Washington 1995-2010



* Tramadol only deaths included in 2009, but not in prior years.

Source: Washington State Department of Health, Death Certificates


Rate of incident users who became chronic users
Washington State Workers' Compensation 2004-2010
Average monthly %
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Qtr 2 Qtr 3 Qtr 4 Qtr 1 Qtr 2 Qtr 3 Qtr 4 Qtr 1 Qtr 2 Qtr 3 Qtr 4 Qtr 1 Qtr 2 Qtr 3 Qtr 4 Qtr 1 Qtr 2 Qtr 3 Qtr 4 Qtr 1 Qtr 2 Qtr 3 Qtr 4 Qtr 1 Qtr 2 Qtr 3 Qtr 4
2004
2005
2006
2007
2008
2009
2010

Washington State Legislation: ESHB 2876, On Opioid Treatment. 2010

- Repeals current regulation; new regs by June 2011
- Provides specific dosing guidance and guidance on consultations, assessments, and tracking
- Signed into law by Governor Gregoire March 25, 2010

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.

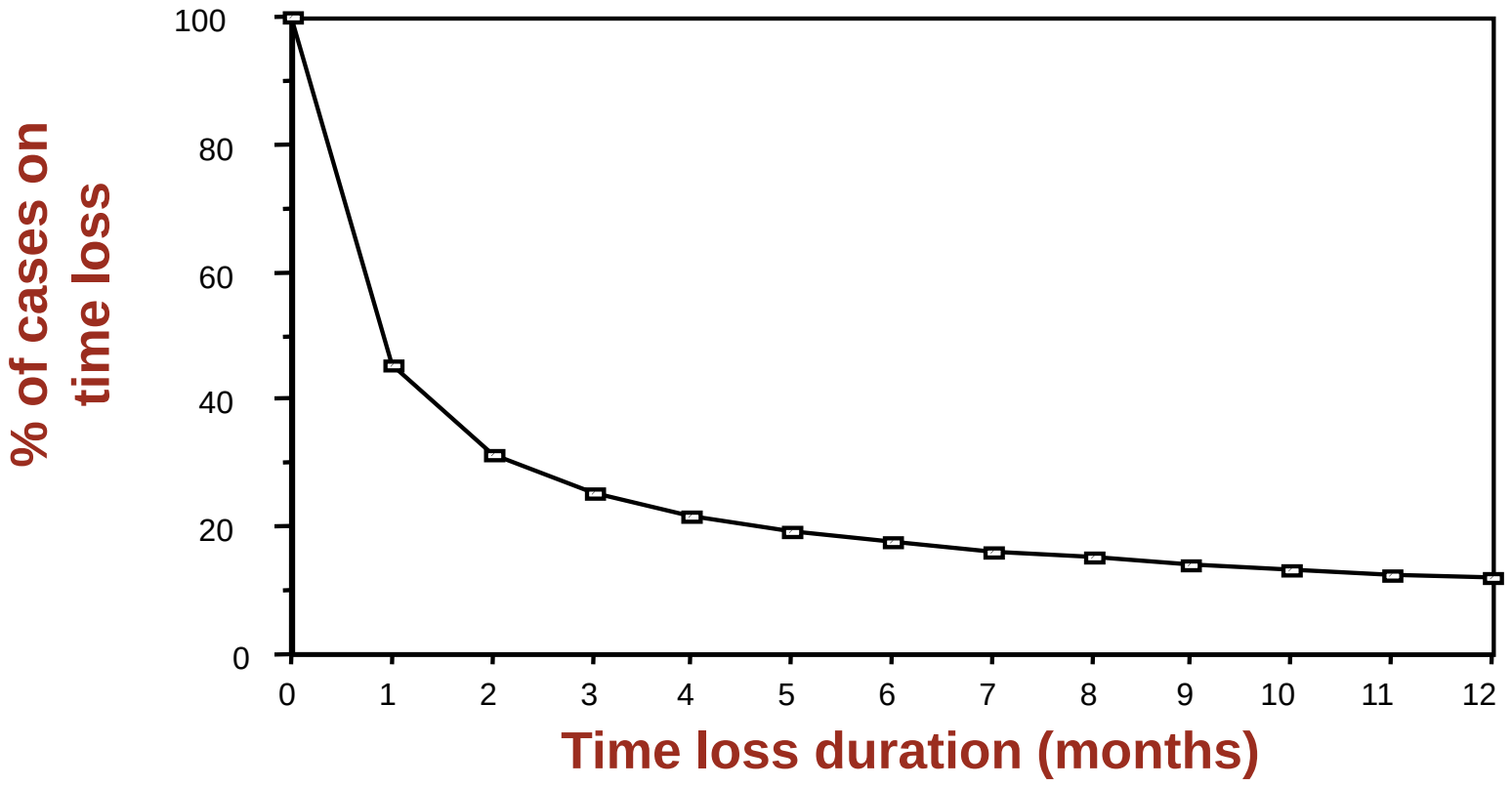
MaineCare (Medicaid)-4/1/2012

Total 45 day maximum for non-cancer pain

New Mexico-Rule 16.10.14-Proposed rules Aug, 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

Disability Prevention is the Key Health Policy Issue



Adapted from Cheadle et al. Am J Public Health 1994; 84:190–196.

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

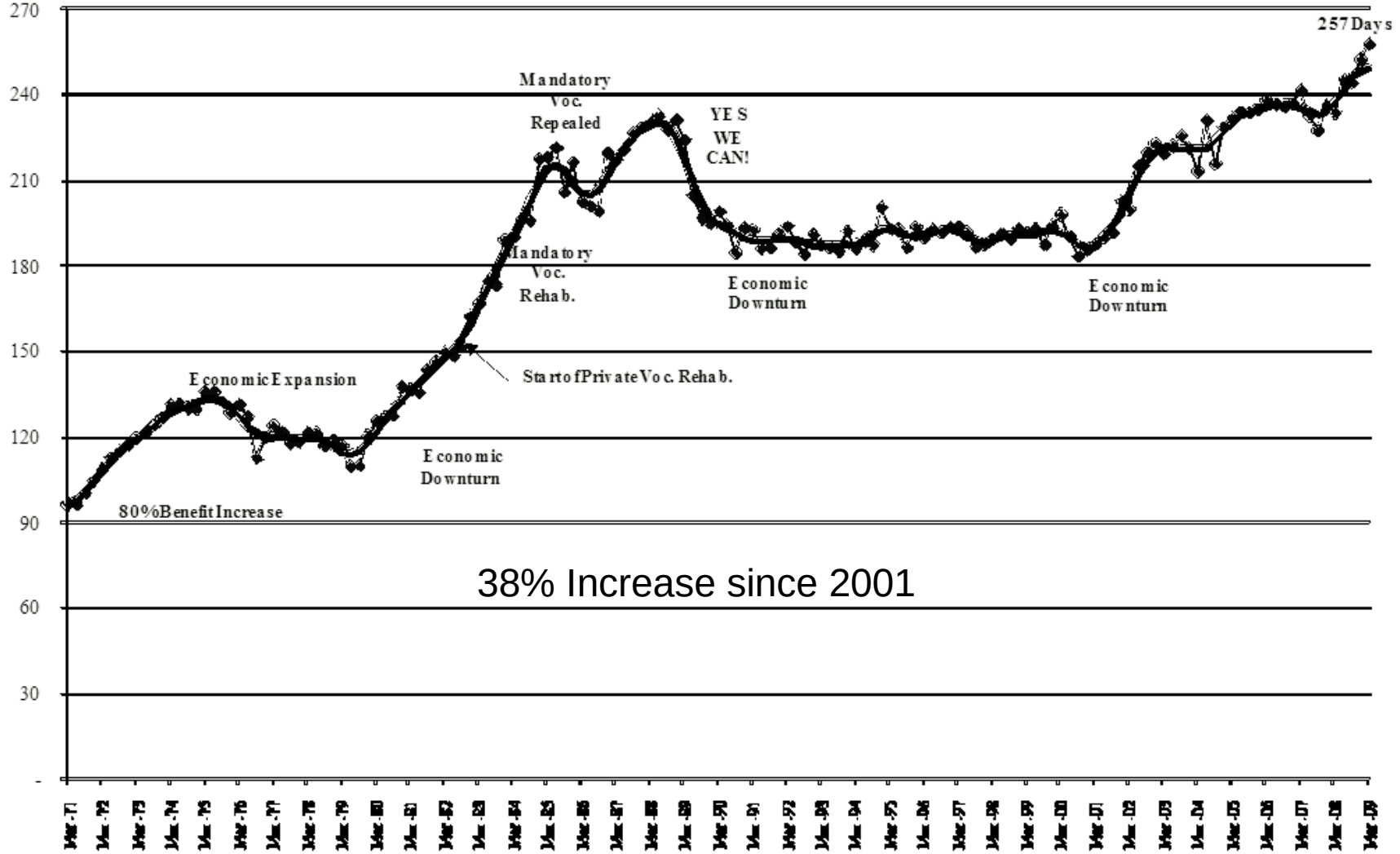
- Population-based, prospective cohort
- N=1843 workers with acute low back injury and at least 4 days lost time
- Baseline interview within 18 days(median)
- 14% on disability at one year
- Receipt of opioids for > 7 days, at least 2 Rxs, or > 150 mg MED doubled risk of 1 year disability, after adjustment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

Disability generated in workers' compensation may be a public health problem of the highest order

- 1954-4% of men 25-54 unemployed
- 2010-20% of men 25-54 unemployed
- Federal (SSD) disability-8 million-will be bankrupt in 7 years
- Workers' compensation is likely contributing a large proportion of the permanently unemployed/disabled to State, Federal and private disability programs

David Leonhardt, Men, Unemployment, and disability, NYT, 4/8/2011

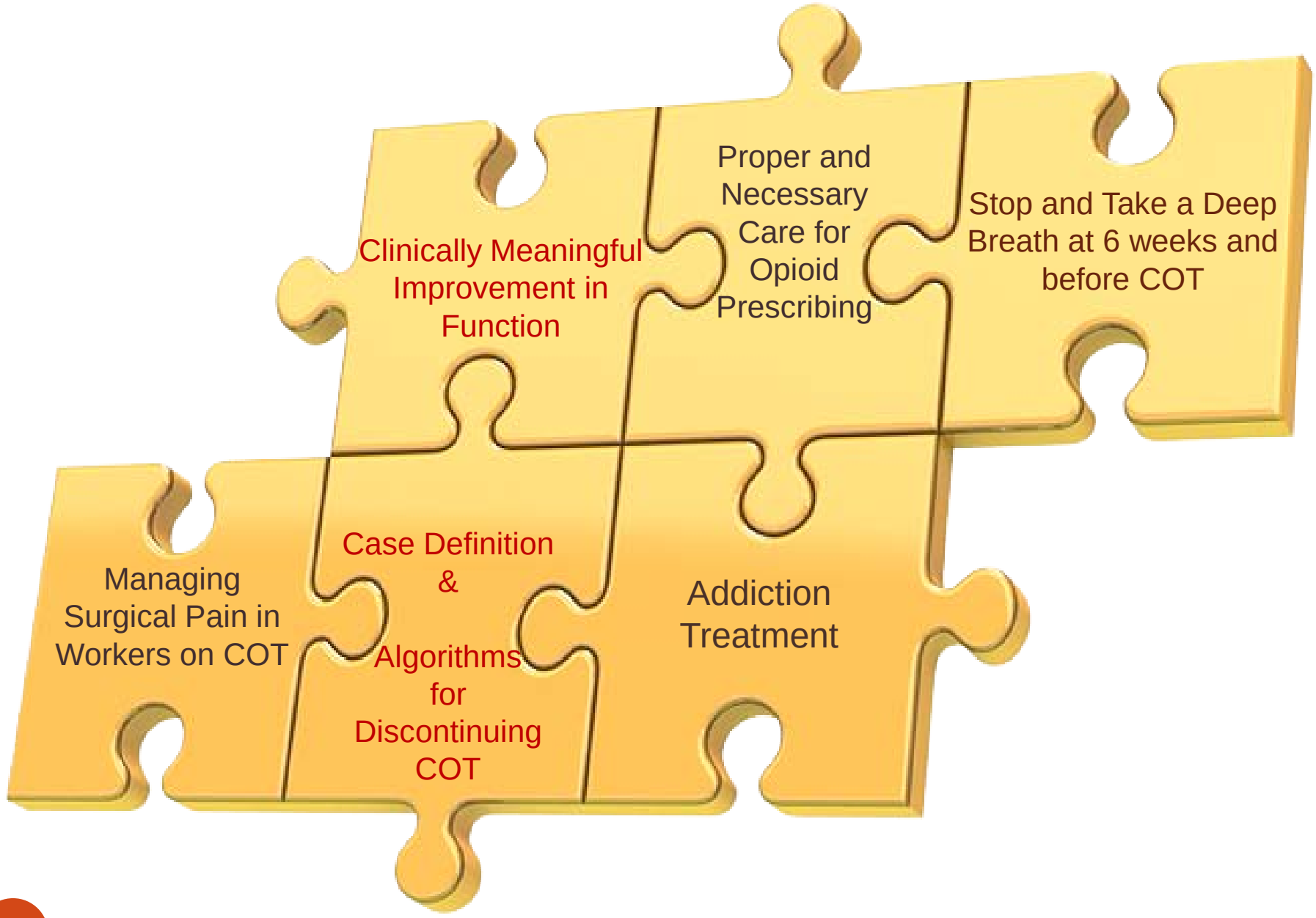
Average Timeloss Duration (Days)



38% Increase since 2001

Concrete steps to take

- Track high MED and prescribers
- Reverse permissive laws and set dosing standards for chronic, non-cancer pain
- Implement AMDG Opioid Dosing Guidelines (http://www.agencymeddirectors.wa.gov/opioiddosing.asp)
- Implement 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
- Incent community-based Rx alternatives (activity coaching and graded exercise early, opioid taper/multidisciplinary Rx later)
- Offer assistance (academic detailing, free CME,ECHO)


Clinically Meaningful Improvement in Function
Proper and Necessary Care for Opioid Prescribing
Stop and Take a Deep Breath at 6 weeks and before COT
Managing Surgical Pain in Workers on COT
Case Definition & Algorithms for Discontinuing COT
Addiction Treatment

Opioid Use in Workers' Compensation

- 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

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 necessary care.

THANK YOU!

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