INTEGRATING GUIDELINES INTO CLINICAL PRACTICE

WASHINGTON STATE’S
INTERAGENCY GUIDELINE ON
PRESCRIBING OPIOIDS FOR
PAIN

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No financial conflicts of interest.

• Grant support:
  • NIH Pain Consortium award: UW Center of Excellence in Pain Education
  • AHRQ: Team-Based Safe Opioid Prescribing in Primary Care
  • Mayday Fund: Tele-Coaching for Optimization of Pre- and Post-Operative Pain Management
Change in National Norms for Use of Opioids for Chronic, Non-cancer Pain

Washington State Law:
(WAC 246-919-830, 12/1999)

“No disciplinary action will be taken against a practitioner based solely on the quantity and/or frequency of opioids prescribed.”

WAC-Washington Administrative Code
The Allure of Opioids

1. They make patients happy, …at least initially.
2. They are very available in even the most remote sites.
3. Insurance covers them better than any other pain treatment.
4. The signed prescription closes the visit.
Correlation of Opioid Sales/Deaths/Abuse

Rates of prescription painkiller sales, deaths and substance abuse treatment admissions (1999-2010)

- Sales per kilograms per 10,000 people
- Deaths per 100,000 people
- Treatment admissions per 10,000 people

Past month **NON-MEDICAL** USE of types of psychotherapeutic drugs among persons aged 12 or older: 2002-2012

http://www.samhsa.gov
SOURCE where pain relievers were OBTAINED for most recent nonmedical use (age ≥12): 2011-2012

http://www.samhsa.gov
1. **Moral imperative**: ‘a professional responsibility and duty’ to care.

2. **Chronic pain**: can be a disease in itself.

3. **Value of comprehensive treatment**. Biopsychosocial problem needs comprehensive management.

4. **Need for interdisciplinary** assessment and treatment for the most severe/persistent pain problems.

5. **Importance of prevention**. $1^0$ & $2^0$ prevention through early intervention.

6. **Wider use of existing knowledge**. Mandate to improve education and training quality and access.

7. **The conundrum of opioids**.

8. **Roles for patients and clinicians**. Effectiveness depends ‘on the strength of the clinician-patient (and family) relationship working together.’

9. **Value of a public health and community-based approach**. Large numbers affected, disparities in occurrence and treatment, and prevention.
Overdose Deaths 2014

Overdose deaths in 2014 per 100,000

NIH Pain Consortium
Centers of Excellence in Pain Education

UW Medicine
PAIN MEDICINE
STATE-BY-STATE DRUG OVERDOSE-RELATED DEATHS


- Increased rates
- Decreased rates
- No change

Map showing states with increased drug overdose-related deaths, with a circle highlighting South Carolina.

SOURCE: U.S. Centers for Disease Control and Prevention's Web-based Injury Statistics Query

NIH Pain Consortium
Centers of Excellence in Pain Education

USA TODAY

UW Medicine
PAIN MEDICINE
Why is this so hard to FIX?

- Only 2% of chronic pain is managed by pain specialists
- 30% Primary Care visits involve chronic pain
  - Most opioids are prescribed by PCPs
  - 18-32% of opioid prescribed chronic pain patients in PCP practices meet addiction criteria
  - Just 6 minutes to evaluate amidst 7-item problem reviews and preventative health measures

AND:
- Insufficient training, tools, access to crucial physical and behavioral therapists
- Insufficient health and insurance systems support for multidisciplinary pain care
**Conclusion:** Evidence is insufficient to determine the effectiveness of long-term opioid therapy for improving chronic pain and function. Evidence supports a dose-dependent risk for serious harms.
PROCESS & TIMELINE of WA State Opioid Guidelines

2007: AMDG “Educational” guidelines:
   ✧ 120 mg MED (dose) threshold for consultation

2009: CDC recommends: 120 mg/day MED

2010: AMDG updated “Recommended” guidelines

2011: WA State Prescription Monitoring Program

2011: UW TelePain

2011: Relieving Pain in America: IOM Report

2011: “2876” WA State Legislation,

2015: Updated AMDG Guidelines

2016: CDC Guidelines:
   ✧ 50- ≤90 mg/day MED
Opioid Overdose Risk by Dose
“MEDs” (or “MMEs”)

Risk of Adverse OD Event

<table>
<thead>
<tr>
<th>Dose in mg MED</th>
<th>Risk Ratio</th>
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<tbody>
<tr>
<td>&lt;20 mg/day</td>
<td>1</td>
</tr>
<tr>
<td>20-49 mg/day</td>
<td>2-3</td>
</tr>
<tr>
<td>50-99 mg/day</td>
<td>4-5</td>
</tr>
<tr>
<td>&gt;=100 mg/day</td>
<td>6-9</td>
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Point of deflection
9-fold increased risk

Dunn 2010
Bohnert 2011
Gomes 2011
Zedler 2014
1. Specifies education and guideline use
2. Requires access to specialty care when pain/function not improved, or high risk dose (>120 MED)
3. Requires measuring > “pain intensity”
   ➢ Pain, Function, Mood, Risk
4. Requires tracking opioid Rx adherence

*Excluded: acute pain, surgical pain, palliative care, cancer pain
“BENDING THE CURVE” of the Opioid Epidemic

Source: Jennifer Sabel PhD Epidemiologist, WA State Department of Health, April 18, 2014

Prescription Opioid Involved Overdoses
Washington State

- Deaths
- Hospitalizations

Age-adjusted rate per 100,000


Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain:
An educational aid to improve care and safety with opioid therapy
2010 Update

NIH Pain Consortium
Centers of Excellence in Pain Education
CoEPE
Interagency Guideline on Prescribing Opioids for Pain

Developed by the Washington State Agency Medical Directors’ Group (AMDG) in collaboration with an Expert Advisory Panel, Actively Practicing Providers, Public Stakeholders, and Senior State Officials.

www.agencymeddirectors.wa.gov

Written for Clinicians who Care for People with Pain
Priorities

1. Clinical Preventative Services
2. Health Promotion and Wellness
3. Interagency Guidelines
4. Patient Safety
5. Pay for Quality

Participating State Agencies

- Department of Labor & Industries
- Health Care Authority
- Board of Health
- Health Officer
- Department of Veteran Affairs
- Office of Insurance Commissioner
- Department of Corrections

www.agencymeddirectors.wa.gov
<table>
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<tr>
<th>Guideline Advisors and Contributors</th>
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Statewide Representation
Each section:

- Definitions and Indications
- Clinical Recommendations
- Evidence
  - ‘Bree Collaborative’ endorsed
  - WA State Health Care Authority endorsed
## Comparison of 2010-2015 Guidelines

<table>
<thead>
<tr>
<th>2010 Guideline</th>
<th>2015 Guideline</th>
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<tbody>
<tr>
<td>120 mg MED Opioid Dosing Threshold proposed</td>
<td>Expanded discussion on dosing threshold</td>
</tr>
<tr>
<td>Recommended 120mg daily MED as a “yellow flag” dose as a strategy to prevent adverse events and overdose by advising providers to seek a consultation with a pain specialist.</td>
<td>Remains the same, plus adds guidance for safe prescribing at any dose, based on new studies showing significant risks occurring at lower doses.</td>
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**DOSING THRESHOLD not changed**
## Comparison of 2010-2015 Guidelines

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<td>Focus on Chronic Non-cancer Pain</td>
<td>Expanded focus</td>
</tr>
<tr>
<td>1. Initiating, transitioning, and maintaining patients</td>
<td>New &amp; Modified Sections</td>
</tr>
<tr>
<td>2. Optimizing treatment for patients on &gt; 120mg daily MED</td>
<td>1. Opioids in the Acute and Subacute Pain Phases</td>
</tr>
<tr>
<td></td>
<td>2. Opioids in the Perioperative Phase</td>
</tr>
<tr>
<td></td>
<td>3. Opioids in Chronic Non-cancer Pain (similar to previous guideline)</td>
</tr>
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**EXPANDED FOCUS**
<table>
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<th>Other New &amp; Modified Sections</th>
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<td>Clinically Meaningful Improvement in Function</td>
</tr>
<tr>
<td>Expanded &amp; modified tapering / discontinuing COAT</td>
</tr>
<tr>
<td>Non-opioid Options for Pain Management</td>
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<tr>
<td>Recognizing and treating substance use disorder</td>
</tr>
<tr>
<td>Opioid use during pregnancy, including neonatal abstinence syndrome</td>
</tr>
<tr>
<td>Opioid use in children and adolescents</td>
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<tr>
<td>Opioid use in older adults</td>
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<tr>
<td>Opioid use in cancer survivors</td>
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NEW SECTIONS
“Continuing to prescribe opioids in the absence of clinically meaningful improvement in function and pain, or after the development of a severe adverse outcome is not considered appropriate care.”

<table>
<thead>
<tr>
<th>Pain intensity</th>
<th>Pain interference with:</th>
<th>General activity</th>
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<td>General activity</td>
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1. What number best describes your pain on average in the past week:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No pain</td>
<td>Pain as bad as you can imagine</td>
<td></td>
<td></td>
<td></td>
<td></td>
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2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

<table>
<thead>
<tr>
<th>0</th>
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<th>4</th>
<th>5</th>
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<th>10</th>
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<tr>
<td>Does not interfere</td>
<td>Completely interferes</td>
<td></td>
<td></td>
<td></td>
<td></td>
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3. What number best describes how, during the past week, pain has interfered with your general activity?

<table>
<thead>
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<th>4</th>
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PEG Tool

Krebs 2008
Pain: Acute Phase

- ≤ 6 weeks post episode of pain or surgery
- When alternative non-opioid options are ineffective or contraindicated.
- *Shortest duration and at the lowest necessary dose* (usually less than 14 days).
“Opioids in the Acute Pain Phase”

- Explore non-opioid alternatives
- Set reasonable expectations; educate risks & side effects.
- Provide patient education on safekeeping of opioids.
- Check the Prescription Monitoring Program (PMP)

**RE-EVALUATE THOSE WHO DO NOT FOLLOW THE NORMAL COURSE OF RECOVERY**

- Function & pain *with each follow-up*
  - Taper patient by 6 weeks if clinically meaningful improvement in function and pain has not occurred.
“Sub-Acute phase”
(6 - 12 weeks post episode of pain or surgery)

• Discontinuation of opioids unless:
  • Clinically meaningfully improvement in function,
    (pain interference with function level of \( \leq 4/10 \))

• Discontinuation of opioids if:
  • has led to a severe adverse outcome.

• Screen for depression, anxiety, (possibly PTSD), 
  opioid misuse risk using validated tools before 
  embarking onto COAT*.

  *COAT = Chronic Opioid Analgesic Therapy

• Avoid new prescriptions of 
  benzodiazepines/sedative-hypnotics.
Needs sustained **clinically meaningful improvement in function AND no serious adverse outcomes or contraindications.**

- Consultation when comorbid mental health disorder, family/personal history of substance use disorder, medical condition risk, or concurrent use of benzodiazepines.

- Routinely assess and document function, mood, pain, risk. **Consider pain expertise if dose ESCALATES ≥120 MED and/or RISKS**

- Know special **METHADONE** precautions
• **Assess** for opioid use disorder, **treat** or **refer** for a consultation with an addiction specialist if a patient demonstrates aberrant behaviors suggestive of substance use disorder.

**Patients diagnosed with opioid use disorder should receive a combination of medication-assisted treatment and behavioral therapies.**

• Consider prescribing **naloxone** as a preventive rescue medication for patients with opioid use disorder.
Tapering / Discontinuing Opioids

• Sequential tapers when on both chronic benzos and opioids.

Rate of taper based on safety

• Taper begins with a documented plan
  • Do not reverse taper

• May precipitate mental health disorders; be alert for need of expert help
Counseling preconception and during pregnancy

- Assess/educate re maternal, fetal, & neonatal risks

- Initiate short-acting opioids during pregnancy for severe pain and only when other medical treatments have failed.

- Assess pregnant women taking opioids for opioid use disorder. If present, refer for methadone or buprenorphine treatment for pregnant women.
Opioid Use in Children & Adolescents

• Avoid opioids for the vast majority of chronic non-cancer pain problems in children
  • Indicated for a small number of persistent painful conditions with clear pathophysiology

Limit total # pills dispensed & educate parents re storage/disposal

Adolescents should undergo similar screening for risk of substance use disorder that one would conduct with adults.
“Approximately 60% of Americans over age 65 have persistent pain, commonly from MSK disorders such as arthritis/degenerative spine conditions”

Go low and slow

• Careful medical and behavioral risk/benefit when selecting extended release or long-acting opioids

Anticipate side-effects
Opioid Use in Cancer Survivors

• **Make the diagnosis** for cause of pain
  - Recurrent cancer?
  - Residual chronic pain from effects of disease?
  - …or from treatments?

• When no longer treating active cancer, attempt to manage as “non-cancer” pain since many principals still apply:
  - functional goals, high value of multimodal and non-drug analgesia
  - similar opioid related risks…
Started by Legislature in 2011, funded by Health Care Authority:
“…to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State.”

22 Members appointed by the Governor:
- public and private health care purchasers, health plans, physicians, hospitals, and quality improvement organizations

Create evidence-based recommendations with community input and clinical experts: **Goal = Create Community Standard**

Washington State Health Care Authority
- funds the Bree Collaborative
- uses recommendations to guide health care for Medicaid and state employees

Current Bree Collaborative topic:
Guidelines for Prescribing Opioids for Pain
CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

12 Recommendations

3 Topic Areas

1. When to initiate or continue
2. Selection, dosage, duration, follow-up, and discontinuation
3. Assessing risk and addressing harms

Only discrepancy with AMDG: Threshold dose is lower
INSTITUTE OF MEDICINE 2011 calls for: “TRANSFORMATION” of Pain Care

1. Systems-oriented
2. Multidimensional assessment & treatment planning, and delivery
3. Interprofessional care teams
4. Patient-reported outcomes connected to the EMR
5. Innovative quality improvement activities
6. Evidence-based standards of practice
7. Patient involvement/self-management skills
8. Disease management models for care delivery

Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research, Institute of Medicine Report
KEY ELEMENTS

- Team approach with pain champion(s)
- Shared clinic policies and assessment tools
  - Consensus for a pain “standard of care”
  - Focus on functional gains
  - Address opioid safety and efficacy
- Emphasis on a multimodal treatment approach
- Address substance use disorders and have referral options with a defined referral process
- Patient self-management classes and support
- Longer visits
- After visit care with Case or Care managers
- Web-based program with Tele-mentoring and E-consults

Courtesy of Dr. Melissa Weimer, OHSU
UW TelePain
Multidisciplinary Pain Consultation

- Case based learning
- “TeleMentoring”
- Evidence-based guidance
- Interactive discussions
- CME & REMS education

Since 3/2011
Total attendees >7000
Avg/session: 35
Unique attendees >1100
# consultations: 425
# hours of didactic: >630
# hours of CME: 10,500
1. Highstreet Medical Center, Springfield, MA
2. Boston Medical Center’s TOPCARE, MA
3. Community Hospital of the Monterey Peninsula, CA
4. **Duke University Health System, NC**
5. Group Health (Seattle) Learning Health Systems, WA
6. Kaiser Permanente’s Southern California Medical Group
7. Lancaster General Health/Penn Medicine, PA
8. Medford Oregon’s Opioid Prescribing Group, OR
9. Oregon Health & Science University’s PROPEL clinic, OR
10. Priority Health (HMO), Lansing, MI
11. Rhode Island/Miriam Hospitals
12. Temple University Hospital Systems, PA
13. VA/DoD Health systems nationwide: Connecticut, Minneapolis, Indianapolis, Seattle/Puget Sound
14. University of Washington and its UW Neighborhood Clinics
An **URGENCY**

**Guideline Compliant Care**

- Epidemic in America
  - Influenza Pandemic (1918: 500,000)
  - HIV (1981-2005: 550,000)
  - Prescription Opioid ODs (1999-2014: 165,000, and counting)
- Families and communities are suffering from opioid-related accidental deaths and addictions

*Health care expenses can be reduced with multidisciplinary chronic pain care:*
  - Reduce direct costs 52%
  - Reduce disability costs 40%
Understand Safe & Effective Chronic Pain Treatments

1. For Clinicians
   - CDC Guidelines, & your state’s guidelines
   - UW’s “COPE REMS” www.coperems.org

2. For Patients and Families
   - YouTube: “Understand Pain”, “Brainman Stops His Opioids”
   - Stanford’s: Chronic Pain Self Management Program
   - U. Michigan’s: fibroguide.com
   - American Chronic Pain Association

3. For Policymakers and Payers
   - National Pain Strategy
   - IOM 2011 Report: Relieving Pain in America
The “National Pain Strategy”

A “Call to Action”:

...& as yet an unfunded mandate

- 5 Domains
- 2-4 Objectives, each
- & each lists:
  - Strategies
  - Deliverables
  - Stakeholders
  - Metrics
Transformation is a process, it doesn’t happen all at once

- **Start** with a *sense of urgency*
- **Identify** your team and its champions
- **Engage & communicate** goals within your group and throughout the larger organization
- **Prioritize** internal and external obstacles, and introduce steps that overcome initial barriers
- **Get** quick wins
- **Build** IT and other resources needed to support change
- Regularly **review** and **sustain** processes
Transformation of Pain Care

Uncoordinated Transitions

Over-medicated

Pre-authorizations

Stressed

Center
dose
many

patients

Disabled

care

Overwhelmed

Homeless

diagnosis

Overmed

medical

Unsafe

Insurance

Pain

Confused

Rx

High

UW Medicine
PAIN MEDICINE