

# Reducing Harm from Inappropriate Opioid Prescribing -WSIA Colloquium-

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# Two major policy streams nationally

- PREVENT the next cohort of our citizens receiving opioids inappropriately during acute/subacute pain
  - To achieve this we must also pay for alternatives to opioids for acute/subacute/chronic pain
- TREAT patients with severe dependence by 1) withdrawal, and/or 2) Medication-assisted treatment (eg buprenorphine)

# National Governor's Association Implementation Ideas

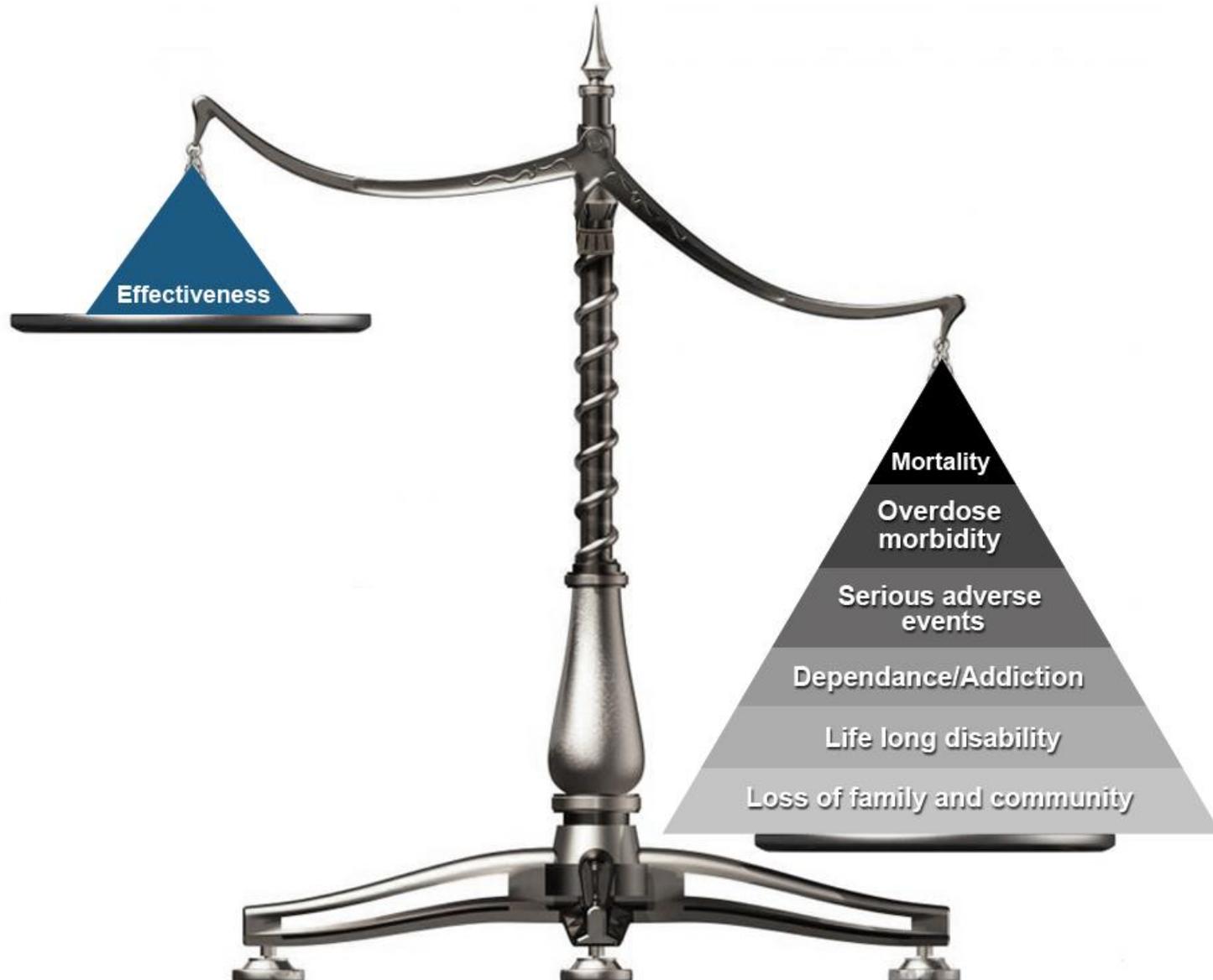
- Endorse/implement CDC guidelines, supplemented by other state guidelines that address gaps (eg, peri-op opioids, ED guidelines)
- Avert inappropriate acute prescribing
  - Focus on 3 days/10 tabs 5 mg hydrocodone for teens  $\leq 20$  (extractions, sports injuries)
  - EMR hard stops, pre-auth (eg, allow  $\leq 3$  days but need auth for more in acute injuries)
- Fund/develop regional capacity for MAT
  - Safety net clinics urgently need assistance
  - Add telehealth
- Reportability of overdose events
- Enhanced PDMP-mandatory use, facility sign-up, public agency use, interoperability with other states, VAHS, military
- Develop stepped care/collaborative care and **effective alternative Rx for pain**
- Develop set of metrics for both quality improvement at health plan/clinic level and “state of the state” progress

# Evidence of effectiveness of COAT

The Agency for Healthcare Research and Quality's (AHRQ) recent draft 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).

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

-Franklin; Neurology; Sept 2014-Position paper of the AAN-



## Risk/Benefit of Opioids for Chronic Non-Cancer Pain -Franklin; Neurology; Sept 2014; AAN Position paper-

Opioids should not be used routinely for the treatment of routine musculoskeletal conditions, headaches or fibromyalgia\*

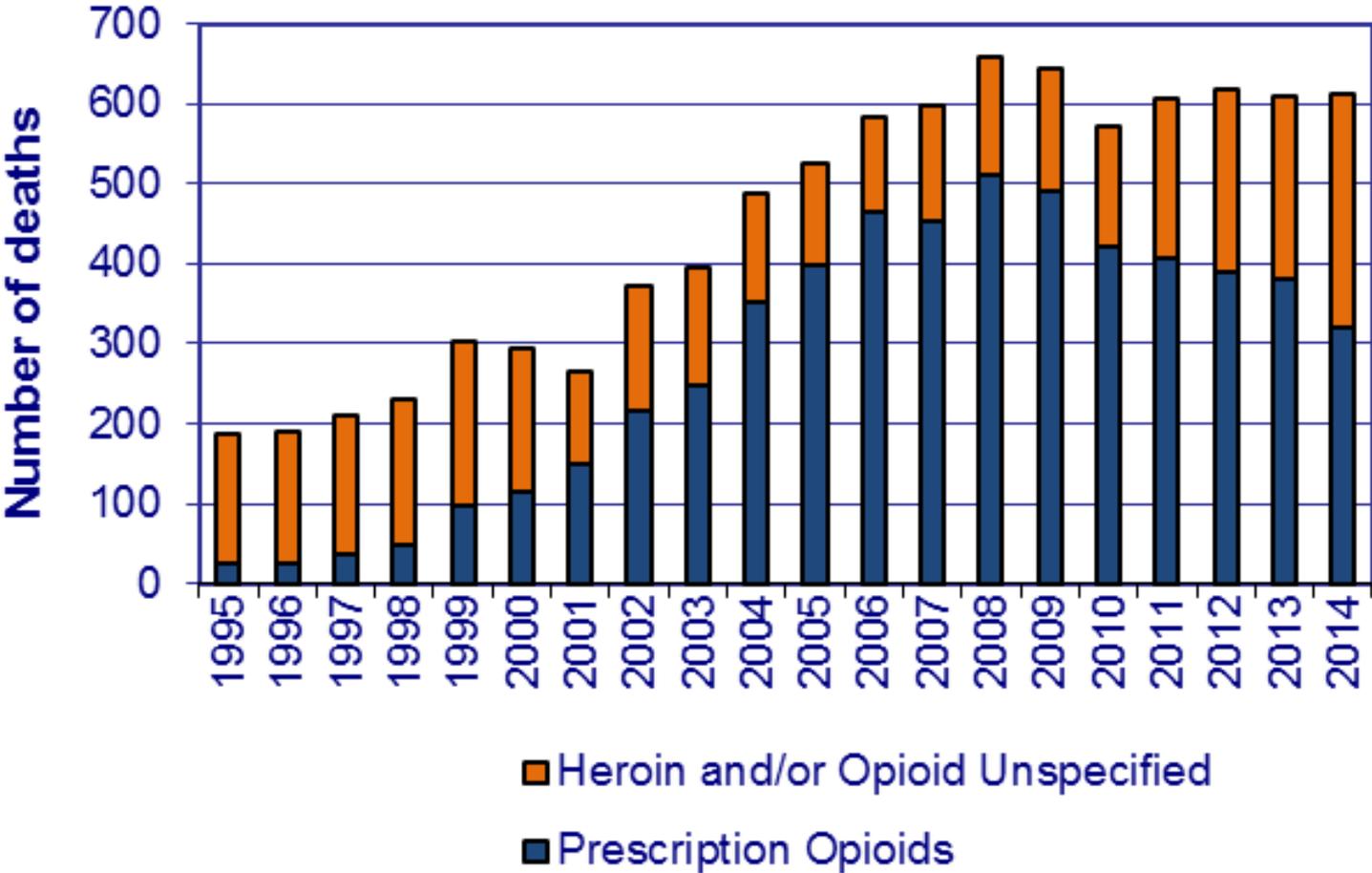
\*WA DLI opioid guidelines, 2013 <http://1.usa.gov/1nYlarL>

# CDC Opioid Guidelines-March 2016

- **Determining When to Initiate or Continue Opioids for Chronic Pain**
  1. **Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain.** Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
  2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should **consider how therapy will be discontinued if benefits do not outweigh risks.** Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
  3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

# Unintentional Opioid Overdose Deaths Washington 1995-2014

40% sustained decline largest in the US



Source: Washington State Department of Health, Death Certificates

# Rise in Heroin Deaths not due to Increasing Regulation

- 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

From: **The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years**

JAMA Psychiatry. 2014;71(7):821-826. doi:10.1001/jamapsychiatry.2014.366

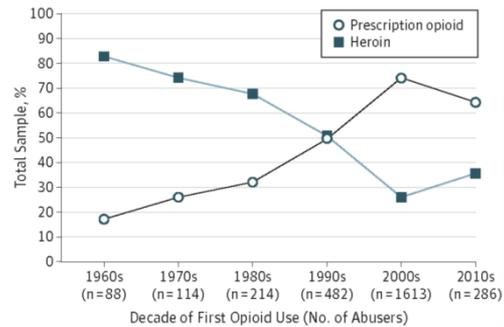


Figure Legend:

Percentage of the Total Heroin-Dependent Sample That Used Heroin or a Prescription Opioid as Their First Opioid of Abuse Data are plotted as a function of the decade in which respondents initiated their opioid abuse.

# 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.

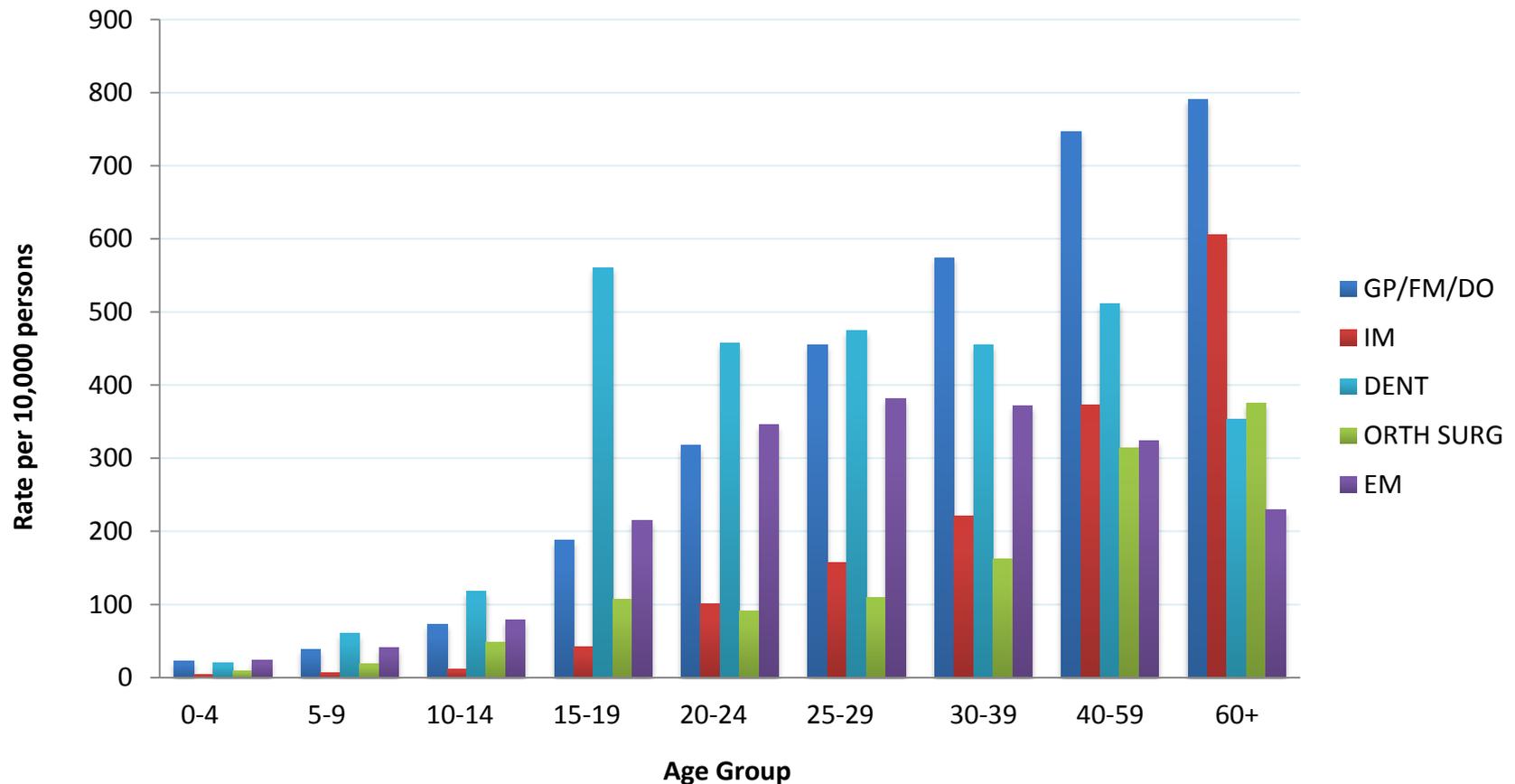
5. When opioids are started, clinicians should prescribe the lowest effective dosage. **Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to  $\geq 50$  morphine milligram equivalents (MME)/day,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

# 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



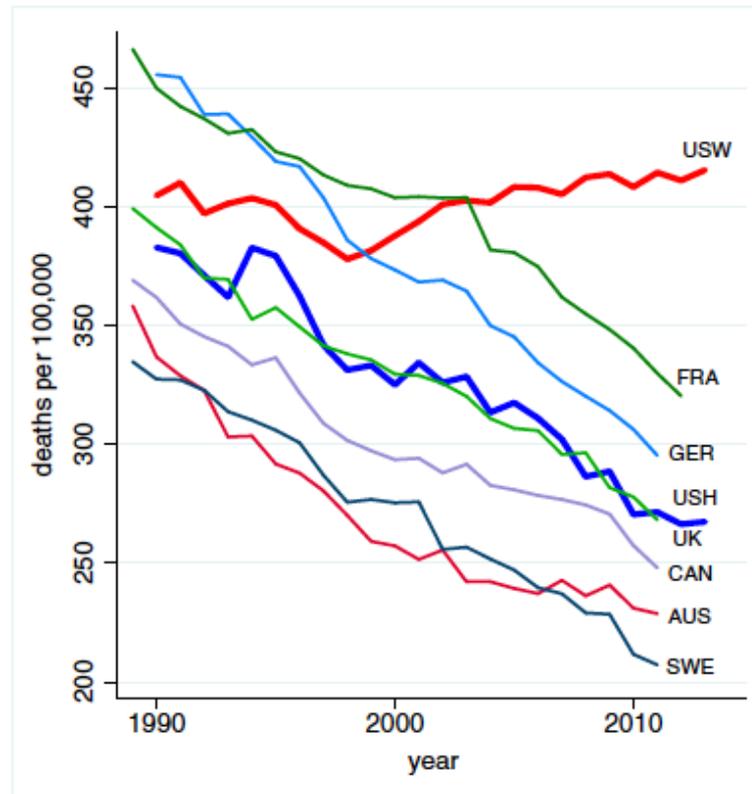
# Mieche et al, Pediatrics, Nov 2015: Prescription opioids in adolescence

## and future opioid misuse

- Prospective panel data from the Monitoring the Future Study
- N=6220 surveyed in 12<sup>th</sup> grade and followed up through age 23
- Legitimate opioid use before high school graduation is independently associated with a 33% increase in the risk of future opioid misuse after high school. This association is concentrated among individuals who have little to no history of drug use and, as well, strong disapproval of illegal drug use at baseline.

# Rapidly increasing mortality in middle aged, lower educated whites

Case and Deaton, PNAS, 2015



**Fig. 1.** All-cause mortality, ages 45–54 for US White non-Hispanics (USW), US Hispanics (USH), and six comparison countries: France (FRA), Germany (GER), the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE).

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Case and Deaton, PNAS, 2015

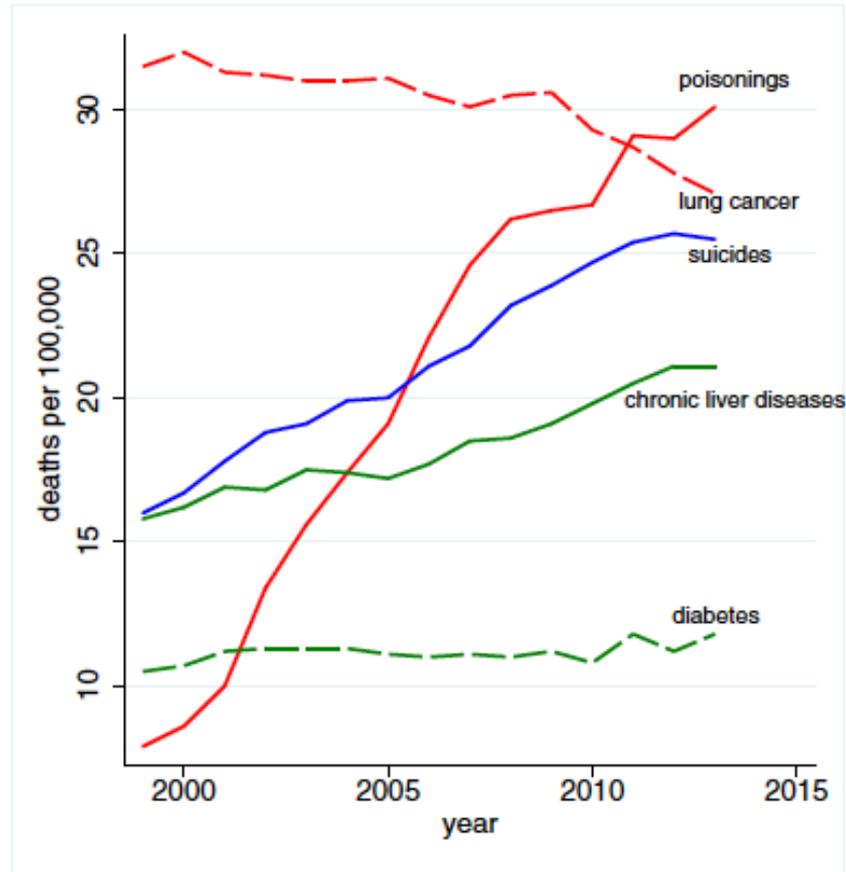
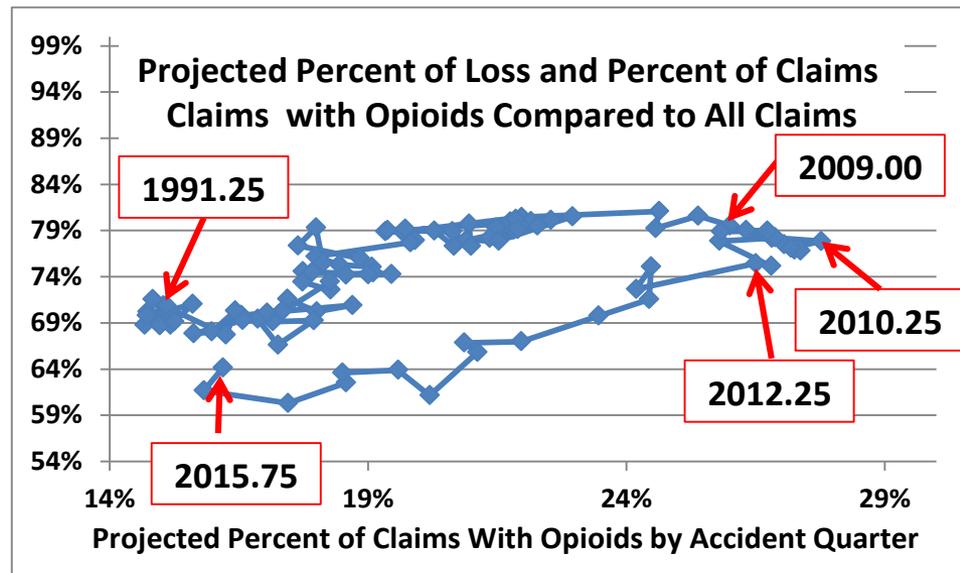


Fig. 2. Mortality by cause, white non-Hispanics ages 45-54.

# The Mercier-Franklin Opioid Boomerang, 1991-2015



**THANK YOU!**

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