Safely Prescribing Opioids in Practice
AAN Course C171-Opioids and Marijuana in Your Practice
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"To write prescriptions is easy, but to come to an understanding with people is hard."
-- Franz Kafka, “A Country Doctor”
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

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

By 2006, 10,000 patients in WA public programs were on >100 mg MED/day

How many chronic pain patients in your practice are on doses over 100 mg/day? How many are on combinations of opioids and benzodiazepines or sedative hypnotics?
**Limitations of Long-term (>3 Months) Opioid Therapy**

- Overall, the evidence for long-term analgesic efficacy is weak
- 100% of patients on opioids chronically develop dependence
- Discontinuation studies:
  - 60% of patients on opioids for 3 months will still be on opioids 5 years later (Martin et al)
  - 47% of patients on opioids for 30 days in the first year of use will be on opioids 3 years later (Express Scripts study)
- Jane Ballantyne—"a lost generation"


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**Evidence of Efficacy of COAT**

- Furlan et al 2011 systematic review (2011; Pain Res Manag 16: 337-351)
  - 62 RCTs
    - 51.6% adequately randomized
    - N=11,927 randomized, but only 7807 (65%) finished trials
    - 41/62 RCTs involved at least one author associated with pharmaceutical industry
    - All trials shorter term (<3 months)
    - Enriched enrollment trials overestimate benefit and underestimate adverse effects
    - Pain improvement moderate (30%) but function improvement small
  - Doses used in practice far in excess of those used in RCTs
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 – 4 studies
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

Incidence rate of Opioid Use Disorders after Initiation of Rx opioids*

<table>
<thead>
<tr>
<th>Incidence Rate</th>
<th>Adjusted OR (95% CI)</th>
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<tbody>
<tr>
<td>No opioids</td>
<td>0.004%</td>
</tr>
<tr>
<td>Acute, low dose</td>
<td>0.12%</td>
</tr>
<tr>
<td>med dose</td>
<td>0.12%</td>
</tr>
<tr>
<td>high dose</td>
<td>0.12%</td>
</tr>
<tr>
<td>Chronic, low dose</td>
<td>0.72%</td>
</tr>
<tr>
<td>med dose</td>
<td>1.28%</td>
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<tr>
<td>high dose</td>
<td>6.1%</td>
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Chronic—>/=90 days; low dose—1-36 mg; med dose—36-120 mg; high dose—>120 mg
**Enduring adaptation produced by established behaviors**

*Addiction criteria may be different for pain patients on chronic opioids*

For the illicit drug user:

- Procurement behaviors

For the pain patient – much more complex:

- Continuous opioid therapy may prevent opioid seeking
- Memory of pain, pain relief and possibly also euphoria
- Even if the opioid seeking appears as seeking pain relief, it becomes an adaptation that is difficult to reverse
- It is hard to distinguish between drug seeking and relief seeking

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
WHY NOT PRESCRIBE FOR CHRONIC LOW BACK PAIN?

- Alternative treatments, particularly programs that take a psycho-physical approach, have stronger evidence base\(^1\)
- Opioids generally are deactivating and not activating
- Reduced prescribing for non-specific back pain would significantly reduce overall prescribing and availability, and thus safety – public health benefit
- Eliminating prescribing for common indications that have failed would be a step towards identifying cases that do derive benefit

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**Washington Agency Medical Directors’ Opioid Dosing Guidelines**

- Developed with clinical academic pain experts in 2006-released online April 2007
- **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

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Guidance for Primary Care Providers on More Cautious 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
- Use PDMP initially and for monitoring

Morphine equivalent dose

Open-source Tools Added June 2010 Update of AMDG Opioid Dosing Guideline

- 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

Available as mobile app:
Yearly Trend of Scheduled Opioids

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**

Possible  Probable  Definite
Unintentional Prescription Opioid Overdose Deaths
Washington 1995-2012
-27% sustained decline-

* Tramadol only deaths included in 2009, but not in prior years.
Source: Washington State Department of Health, Death Certificates

New study-submitted—Garg et al, 2013
Reduce the Development of Preventable Disability

- Decrease the proportion of injured workers on Chronic opioids*

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<thead>
<tr>
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<th>Baseline: 2012</th>
<th>1Q 2013</th>
<th>2Q 2013</th>
<th>3Q 2013</th>
<th>4Q 2013</th>
<th>TARGET By 6/2015</th>
</tr>
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<tbody>
<tr>
<td>Percent of claims received with opioids 6-12 wks from injury</td>
<td>4.9%</td>
<td>4.6%</td>
<td>3.3%</td>
<td>1.4%</td>
<td>1.1%</td>
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*2013 opioid guideline for injured workers: http://1.usa.gov/1nYlarL
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 embedded in EMR and ready 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)

Emerging recommendations for prescribers
-Acute pain(0-6 weeks)-

- Avoid opioids for non-specific low back pain, headaches and fibromyalgia
- First use NSAIDS, acetominophen
- If using opioids, use only short acting opioids and only for a few days; check PDMP
- Use beyond a few weeks should be associated with clinically meaningful improvement in pain and function (at least 30%)
Emerging recommendations
-Subacute pain (6-12 weeks)-

- Decision to use opioids beyond this period should be a proactive decision including*:
  - Patient treatment agreement, including all potential harms
  - Screen for past and current substance use, and significant mental health disorders
  - Urine drug screen
  - Check PDMP

*Brief, publicly available tools can be found at: http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Opioids/Assess.aspx

Emerging recommendations
-Chronic pain (> 3 months)-

- Periodic monitoring with UDT, annual agreement, PDMP
- Do not use opioids chronically in patients with current substance use disorder (excluding nicotine), including cannabis use disorder (DSM-V); use extreme caution in patients with past opioid use disorder
- Do not exceed 120 mg/day MED (red flag); do not exceed 80 mg/day (yellow flag) with significant mental health disorder/other co-morbidities
- When to taper to zero:
  - Any overdose or severe adverse event
  - Patient/family request
  - Evidence of aberrant behavior
  - No meaningful improvement in function when treating routine pain conditions
Dosing policies since 2007

- 2007-WA AMDG-consultation at 120 mg/day MED
- 2009: CDC recommends 120 mg/day MED
- 2010: WA ESHB 2876-Directs DOH Boards and Commissions to establish dosing guidance and best practices
- 2012: CT workers comp-90 mg/day MED
- American College of Occupational and Environmental Medicine-50 mg/day MED
- 2014-CA medical board: physicians proceed cautiously (yellow flag warning) once the MED reaches 80 mg/day [http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf]
- 2014?-CO Dept of Regulatory agencies-120 mg/day MED [http://1.usa.gov/1DNpaxT]

Opioid Poisonings in WA Medicaid

- < 50% have chronic opioid use (> 90 days supply)
- 75% of opioid poisonings occurred in cases with prescribed doses < 120 mg MED
- About 45% have sedative-hypnotics in prior month
- 45% have another medication poisoning diagnosis on the same day
- 10-15% have an alcohol diagnosis on the same day
- Most cases have additional opioid prescriptions after poisoning-? Make overdose hospitalizations reportable to the WA DOH
- Over 60% of methadone poisonings occurred in cases that did not have a prescription for methadone in the prior year

Fulton-Kehoe et al. Draft
Concrete policy 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)
  - Eg, cognitive behavioral therapy has been found useful in systematic reviews of at least 8 different chronic pain conditions

THANK YOU!

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