Opioid Guideline Implementation Workgroup

Wednesday, December 5th, 2018 | 3:00 – 5:00pm

Agenda

- **Welcome and Introductions**
  - **Action Item:** Approve 10/10/2018 Minutes
- **Review Collaborative Care for Chronic Pain Recommendations**
  - Overlap with current work
- **Data from L&I and HCA**
- **Literature on Assessment Tools**
  - Identification
  - Assessment
- **Literature on Tapering**
- **Next Steps**
  - Conference planning
  - Workgroups
- **Public Comments and Closing**

Collaborative Care for Chronic Pain
Review of Recommendations

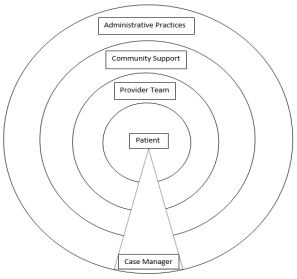
- Collaborative care is a reaction to siloed model of care centered around clinical or provider need not patient need
- Conceptually based on 2001 Chronic Care Model developed by Wagner and colleagues
- Other models used in this report include:
  - VA Multi-Model Review **four** system components
  - UW AIMS Center **five** principles
  - Learning from Effective Ambulatory Practice **six** building blocks
  - Bree Collaborative Behavioral Health Integration **eight** elements

Wagner E, Austin B, Davis C, Hindmarsh M, Schaefer J, Bonomi A. Improving Chronic Illness Care: Translating Evidence into Action. *Health Affairs* 20(6):64–78.. Available: http://dx.doi.org/doi:10.1377/hlthaff.20.6.64.
Wagner E. 1998. Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness? *Effective Clinical Practice* 1(August/September):2–4. Available: www.acponline.org/clinical_information/journals_publications/ecp/augsep98/cdm.pdf.
Peterson K, Anderson J, Bourne D, Mackey K, Helfand M. Evidence Brief: Effectiveness of Models Used to Deliver Multimodal Care for Chronic Musculoskeletal Pain. VA Evidence-based Synthesis Program Evidence Briefs [Internet]. Washington (DC): Department of Veterans Affairs (US); 2011-. VA Evidence-based Synthesis Program Reports.2017 Jan.
Advancing Integrated Mental Health Solutions. Principles of Collaborative Care. 2016. Accessed: November 2016. Available: https://aims.uw.edu/collaborative-care/principles-collaborative-care
Behavioral Health Integration Workgroup. (2017). Behavioral Health Integration Report and Recommendations. Weir, V, ed. Seattle, WA: Dr. Robert Bree Collaborative. Available: www.breecollaborative.org/topic-areas/behavioral-health/.
Parchman ML, Von Korff M, Baldwin L-M, et al. Primary Care Clinic Re-Design for Prescription Opioid Management. Journal of the American Board of Family Medicine : JABFM. 2017;30(1):44-51.

Collaborative Care for Chronic Pain
Members

- **Chair:** Leah Hole-Marshall, JD, General Counsel and Chief Strategist, Washington Health Benefit Exchange
- Ross Bethel, MD, Family Physician, Selah Family Medicine
- Mary Engrav, MD, Medical Director, Southwest WA, Molina Health Care
- Stu Freed, MD, Chief Medical Officer, Confluence Health
- Andrew Friedman, MD, Physiatrist, Virginia Mason Medical Center
- Lynn DeBar, PhD, MPH, Senior Investigator, Kaiser Permanente Washington Health Research Institute
- Mark Murphy, MD/Greg Rudolf, MD, President, Washington Society of Addiction Medicine
- Mary Kay O'Neill, MD, MBA, Partner, Mercer
- Jim Rivard, PT, DPT, MOMT, OCS, FAAOMPT, President, MTI Physical Therapy
- Kari A. Stephens, PhD, Assistant Professor - Psychiatry & Behavioral Sciences, University of Washington Medicine
- Mark Sullivan, MD, PhD, Professor, psychiatry; Adjunct professor, anesthesiology and pain medicine, University of Washington Medicine
- Nancy Tietje, Patient Advocate
- Emily Transue, MD, MHA, Associate Medical Director, Washington State Health Care Authority
- Michael Von Korff, ScD, Senior Investigator, Kaiser Permanente Washington Health Research Institute
- Arthur Watanabe, MD, President, Washington Society of Interventional Pain Physicians

Goal: Patient at the heart of care



Developed by Nancy Tietje, workgroup member

- Centered on the patient
- Built on patient self-management in the context of biopsychosocial model
- Goals are improved function, increased quality of life, and greater patient autonomy rather than primary focus on pain relief
- Ideally, both acute and chronic pain will be managed and treated over time using a systems approach to allow patients to stay within primary care supported by the elements of collaborative care

Adapted from MultiCare's vision mantra

Five Focus Areas

1. Patient Identification and Population Management
   - *Persistent pain with life activity impacts*
   - *Preventing transition from acute to chronic*
   - *Registry, dashboard, metrics*
2. Care Team
   - *Defined roles, specialty access, patient point of contact, standard workflow*
3. Care Management
   - *Coordination, identifying resources, management of referrals and medication*
4. Evidence-Informed Care
   - *Trauma-informed care, pain management skills (e.g. relaxation), ddressing pain amplifiers (e.g., sleep problems), Integrative health practices (e.g., massage, acupuncture), Movement and body awareness strategies*
5. Supported Self-Management
   - *Identifying goals, pain education, Addressing anxiety and anger, shifting thoughts, focusing on abilities*

REVERSING THE PERSISTENT PAIN CYCLE

Data from L&I and HCA

Charissa Fotinos, MD
Deputy Chief Medical Officer
Washington State Health Care Authority

Jaymie Mai, PharmD
Pharmacy Manager
Washington State Department of Labor and Industries

OCCUPATIONAL HEALTH **BEST PRACTICES**

WORKING TOGETHER TO KEEP PEOPLE WORKING

Chronic Opioid Therapy in Workers' Compensation

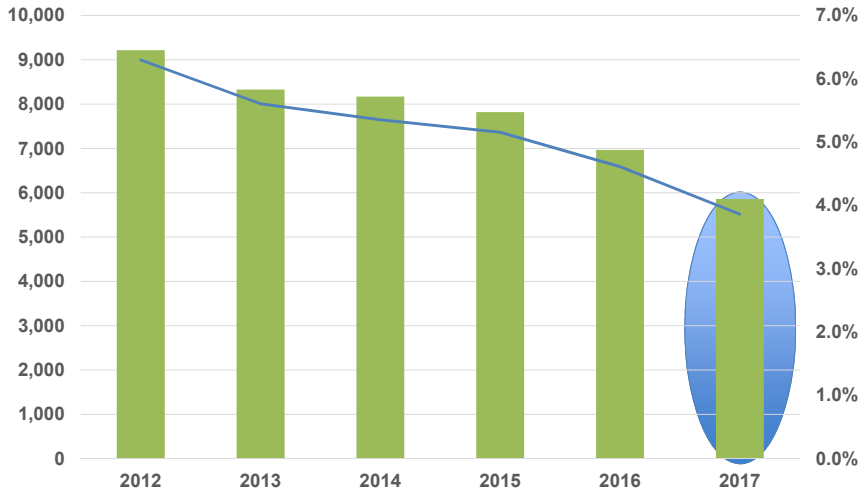
Bree Collaborative AMDG Implementation Workgroup
December 5, 2018

Washington State Department of Labor & Industries

Criteria for Data Pull

- Use PMP data for controlled substance prescription history from calendar year 2012 through 2017
- Limit to open state fund claims at the time prescription was filled
- Use Bree definitions for chronic opioid: ≥60 days (prescription days' supply) of opioid in at least 1 quarter in calendar year
- Claimants is the same as injured workers or patients
- Data is current as of 10/13/18

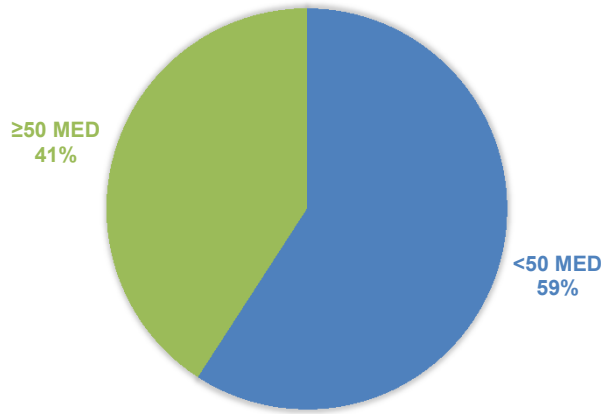
Claimants on Chronic Opioid ≥1 Quarter in CY



Definition for Risk Factors

- Concurrent: ≥60 days of overlapping opioid and sedative in a chronic opioid quarter
- High dose: ≥90 MED per day in a chronic opioid quarter. Total MED per day = sum MED from all opioid prescriptions during the quarter divided by 90 days, includes
  - Overlapping prescriptions and
  - Extending prescriptions into the next quarter
- Multiple prescribers: >1 prescriber in a chronic opioid quarter
- Timeloss (TL): paid wage replacement during chronic opioid quarter

Claimants on Chronic Opioid by Dose - 2017



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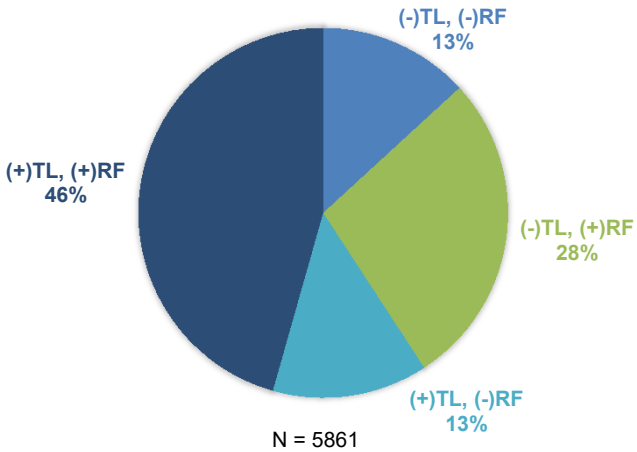
Claimants on Chronic Opioid by Timeloss and Risk Factors - 2017



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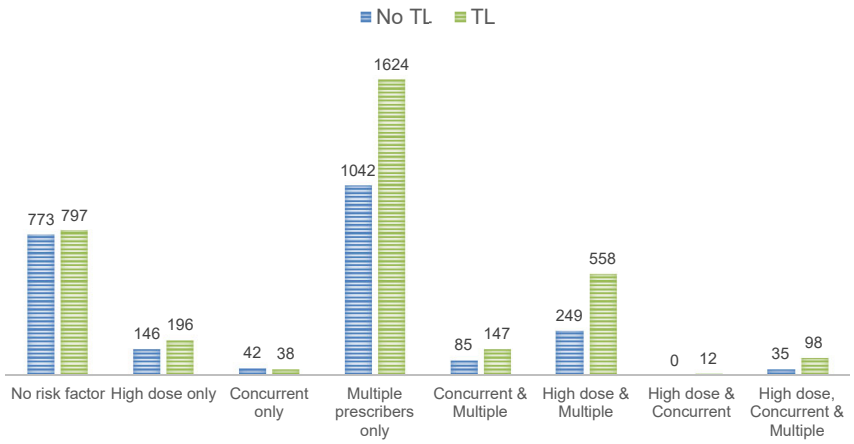
Claimants by Risk Factors - 2017



OCCUPATIONAL HEALTH **BEST PRACTICES**
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Washington State Department of Labor & Industries

Screening for Opioid-Related Problems among Persons Using Medically Prescribed Opioids Long-term

Michael Von Korff ScD
Senior Investigator
Kaiser Permanente Washington Health Research Institute

Spectrum of Problem Opioid Use Among Chronic Opioid Therapy Patients

1. Prescription opioid misuse (aka “aberrant behaviors”)
2. Illicit opioid use, illicit opioid use disorder
3. Prescription opioid diversion
4. Prescription opioid use disorder

Prevalence of Prescription Opioid Misuse Among COT Patients

“Aberrant Behaviors”

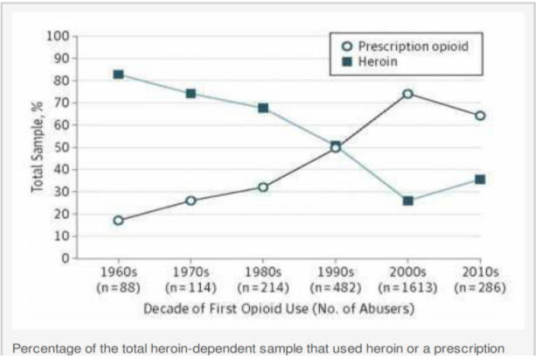
Fleming et al.(N=815), 2007

Requested early refills	47 %
Increased dose on own	39 %
Felt intoxicated from pain meds	35 %
Purposeful oversedation	26 %
Drank ETOH to relieve pain	20 %
Used opioids for purposes other than pain	18 %
Hoarded pain medications	12 %
Obtained opioids from other doctors	8 %

Grande et al. (N=233), 2016

Early refills	44 %
Not taking as prescribed	31 %
Angry behavior	21 %
Obtained opioids from ED	18 %
Lost or stolen opioids	18 %
Avoided urine drug test	13 %
Undisclosed prescribers	6 %

Prescription Opioid Use and Illicit Opioid Use



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. *Source: Cicero et al., 2014*

Prescription Opioid Use and Illicit Opioid Use

Less than 4 percent of persons abusing prescription opioids started using heroin within 5 years.

The most common pathway to heroin use is polydrug abuse.

While risk of transition from prescription opioids to heroin is low, the number of persons abusing prescription opioids at risk is large.

National Institute on Drug Abuse (NIDA)

Prescription Opioids and Heroin

Last Updated January 2018

https://www.drugabuse.gov

Prescription Opioid Use and Diversion

The prevalence of prescription opioid diversion among COT patients is unknown

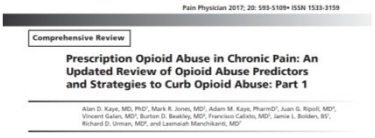
2007 NSDUH found that 57% of persons using prescription opioids non-medically obtained them from a friend or relative.

Common sources of prescription opioids on the street are:

Patients sharing or selling prescription opioids, doctor shoppers, pill brokers, and dealers working with these sources

Abusers view Rx opioids as:

Less stigmatizing
Less dangerous
Less subject to legal consequences than illicit drugs



Prescription Opioid Use Disorder: DSM5 Criteria

2-3 criteria = mild 4-5 criteria = moderate 6-7 criteria = severe

1. Taking the opioid in larger amounts and for longer than intended
2. Wanting to cut down or quit but not being able to do it
3. Spending a lot of time obtaining the opioid
4. Craving or a strong desire to use opioids
5. Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
7. Stopping or reducing important social, occupational, or recreational activities due to opioid use
8. Recurrent use of opioids in physically hazardous situations
9. Consistent use of opioids despite persistent/recurrent physical or psychological difficulties from using opioids
10. Tolerance: need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use *
11. Withdrawal: Withdrawal syndrome or substance used to avoid withdrawal *

* These criteria are not met for individuals taking opioids solely under appropriate medical supervision

Prevalence of Prescription Opioid Use Disorder and Opioid Use Disorder Among COT Patients

Boscarino et al. 2011 (N=705)	(Lifetime)	Total	35 %
Degenhardt et al. 2016 (N=1422)	(Lifetime)	Mild	12 %
		Moderate/severe	9 %
		Total	21 %
Von Korff et al. 2017 (N= 1442)	(Prior year)	Mild	17 %
		Moderate/severe	5 %
		Total	22%

Which Parts of the Spectrum of Opioid-Related Problems Among COT Patients Should Screening Detect?

Prescription opioid misuse /aberrant behaviors?

Illicit opioid use/illicit opioid use disorder?

Prescription opioid diversion?

Prescription opioid use disorder?

Screening for Problem Opioid Use/Aberrant Behaviors Among COT Patients with Various Screeners: Replication Validation Studies Only

Screener	Number of Items	N	Sensitivity	Specificity	Reference
COMM	17	226	71%	71%	Butler et al. (2010)
ORT	5	142	25%	83%	Jones et al. (2015)
SOAPP-R	24	302	79%	52%	Butler et al. (2009)
Count of medical record risk indicators	7	2752	60%	72%	Hylan et al. (2015)

Screening for Opioid-Related Treatment Agreement Violation Resulting in COT Discontinuation: Replication Validation Study

Screener	Number of Items	N	Sensitivity	Specificity	Reference
PDUQ	31	135	67%	60%	Compton et al. (2010)

Screening for Current Illicit Drug Use Disorder in Primary Care

Screener	Number of Items	N	Sensitivity	Specificity	Reference
Single item screener	1	286	100%	74%	Smith et al (2010)
DAST-10	10	286	100%	77%	Smith et al. (2010)

Single item: *"How many times in the past year have you used an illegal drug or used a prescription drug for non-medical reasons?"*

Screening for Prescription Opioid Use Disorder in Primary Care

No validated screeners

Screening for Prescription Opioid Use Disorder in Primary Care: Common DSM5 Indicators Among Cases

	Percent of Mild Cases (N=278)	Percent of Moderate/Severe Cases (N=73)
Wanted/tried to cut down more than once & was unable	88 %	93 %
Strong urge/desire to use opioids or preoccupied with use of opioids	45 %	67 %
Used more than intended or longer than planned	34 %	58 %
Gave up or cut down important activities due to opioids	24 %	74 %
Continued opioid use despite physical or emotional problems due to opioids	9 %	51 %

Von Korff et al. 2017

Conclusions and Implications

Screening tests for problem opioid use have moderate and variable sensitivity and specificity

Some support for asking simple, direct questions about illicit drug use

Long-term effectiveness of chronic opioid therapy is uncertain for most chronic pain patients, with notable risks of addiction and overdose

Since it is difficult to predict which patients will overdose or become addicted, and screening effectiveness in lowering risks is unknown, there is insufficient evidence to recommend routine screening as a means of lowering chronic opioid therapy risks

Discontinuing Long-Term Opioid Therapy

Mark Sullivan, MD, PhD
Psychiatry and Behavioral Sciences
Anesthesiology and Pain Medicine
Bioethics and Humanities
University of Washington

Who receives long-term high-dose opioid therapy?

- The vast majority of opioid therapy is short-term.
  (Noble 2010, Furlan 2006)
  - Most "ideal" candidates for opioid therapy discontinue before reaching 90 days
  - Three-fourths of patients started on ER/LA opioids will not fill a second prescription.
- Of patients prescribed opioids for chronic pain, those who go on to long-term therapy are a highly self-selected group
  (Morasco 2011, Seal 2012, Edlund 2013, Halbert 2016)
  - Depressed patients slightly more likely to be started on opioids, but twice as likely to progress to long-term use
  - PTSD patients more likely than other MH patients to get high-dose, long-term
  - SA and MH disorders much more common in long-term, high-dose users
  - Long-term opioid cohort progressively enriched with high-risk patients.
- 'Adverse selection':
  - combination of high risk patients with high risk med regimens
  - May link trends in use, abuse, and overdose

Who discontinues long-term opioid therapy?

- TROUP study of 'daily' COT recipients (Martin 2011)
  - Sample: used at least 90 days, no 32 day gap
  - Outcome: 6 months without any opioid Rx
  - In two diverse samples, 2/3 of patients remain on opioids years later
  - COT continuation predicted by: high daily dose (>120mg MED) and opioid misuse
- Nationwide VA study: >70% continue opioids (Vanderlip, 2014)
  - Continuation predicted by: high opioid dose, multiple opioids, multiple pain problems, tobacco use, but NOT other SA, MH disorders
- Other prospective studies show similar findings (Franklin 2009, Thielke 2014)

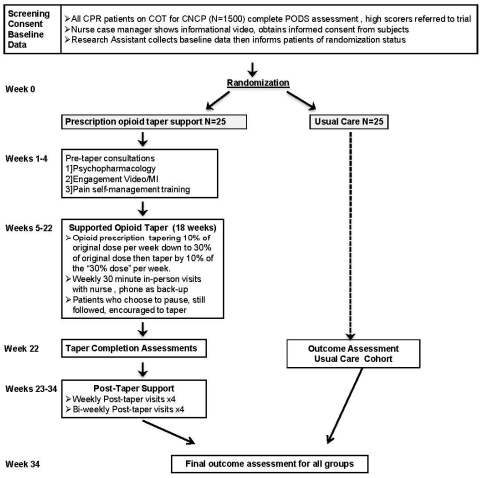
Long-term opioid therapy induces major depression

- Patients w opioid use > 30 days have incr. risk of new depression episode indep. of pain.
- Opioid use doubles risk of depression recurrence for patients with past episodes
- Long term opioid therapy interferes with depression treatment, increasing risk of treatment resistant depression by 50%
- [Scherrer et al, 2014, 2015, 2016, 2017]

Opioid taper: role of psychiatric symptoms

- Physical symptoms of opioid withdrawal:
  - Aches, rhinorrhea, gooseflesh, nausea, diarrhea
  - Usually absent in slow taper, easily treated
- Psych symptoms of opioid withdrawal:
  - Anxiety, depression, insomnia, craving, anhedonia
  - These may be significant despite slow taper, especially when psychiatric disorder preceded or followed opioid therapy

What can be done to support opioid discontinuation?



Prescription Opioid Taper Study

R34DA033384

Theory behind POTS study design

- Many patients on long-term opioid therapy are ambivalent: "would love to stop if I could"
- Fear of pain and withdrawal symptoms is more important than actual pain and withdrawal symptoms
- Transition to chronic pain self-management has two phases:
  - Establishing importance (engagement)
  - Establishing confidence and skills (training)

POTS INTERVENTION

- Engagement
  - PODS, engagement video, MI
- Psychiatric/psychopharm consultation
  - Anticipate and treat pre-existing psych symptoms
  - Assess (PHQ9, GAD7, PC-PTSD) and Treat
- Skills training
  - adapted from pain CBT, delivered by PA
  - Pacing, relaxation training, flare management
  - Gradual taper: 10% per week, may be "paused"

PODS: prescription opioid difficulties scale

- PODS identifies problems attributed by patient to their opioid therapy in 2 domains:
- Psychosocial problems
- Opioid control concerns

- We use PODS answers to jump-start a discussion of the cons of opioid therapy from the patient's perspective

Engagement video

- Patients who have successfully tapered off prescription opioids describe their experience in two video segments
  - The end result: what is life like once you are off opioids?
    - pain level, emotions, "zombie"
  - The process: what are the challenges of going through opioid taper?
    - Pain, insomnia, anxiety, depression

SAMPLE POTS STUDY SUBJECT FLOW SHEET #1

Baseline opioid regimen:

Medication	Dose	Changes/date
Methadone	160	50mg 2/23
Dilaudid	32	Same
Total Baseline MED:	2048	1088

Other Medications:

Medication	Dose	Changes/date
Diazepam	10mg	NO Diazepam use this past week
Venlafaxine	375 mg	1/26
Tizanidine	12 mg	
Trimethobenzamide	900 mg	Not needed

Weekly Stats

Session Number	BL	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	we 24	we 28	we
Date	12/11	12/15	12/22	1/8	1/12	1/15	1/26	2/2	2/9	2/23	2/27	3/2	3/16	3/19						
phone (P), in-person (IP)	Ip	Ip	ip	IP	Ip	p	ip	ip	Ip	ip	P	Ip	ip	P						
Methadone	160	140	120	100	90	90	60	60	60	55	50	50	50	50						
Dilaudid	32	32	32	32	32	32	32	32	32	32	32	32	32	32						
Total MED	2048	1808	1568	1328	1208	1208	728	728	728	678	628	628	628	628						
PHQ	16	20	16	19	14	22		11	6	10	12	17	21	23						
GAD	16	18	14	18	14	20		11	3	10	9	11	18	18						
Pain Intensity	6	7	8	6	7	7		5	2	4	2	5	4	2						
Pain Interference	8	6	6	6	7	8		4	0	3	1	4	3	2						
Benzo dose	Y	y	y	y	y	y	y	N	n	N	n	N	N	N						
Alcohol use	n	n	n	n	n	n	n	n	n	n	n	n	n	n						

Baseline opioid regimen:
Long-acting Oxycontin 60mg BID
Short-acting Oxycodone 20mg QID

Other Medications:
Doxepin 150mg
Gabapentin 1800mg
Prazosin 4mg
Venlafaxine 150mg

Weekly Stats

Session Number	BL	1	2 &3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	24 week ohdp	28 week ohdp	36 week ohdp
Date	10/13	1/8	1/15	1/29	2/2	2/12	3/5	3/12	3/23	3/26	3/30	4/2	4/2	4/6	4/9	4/9	Pt no showed	4/23			
Phone (P) or in-person (IP)		IP	IP	ip	ip	Ip	ip	Ip	Ip	Ip	P	Ip	ip	P	Ip	ip		ip			
OxyContin	120	120	120	120	120	120	120	120	120	120	100	100	100	100	100			100			
Oxycodone	80	80	80	80	70	70	60	60	60	60	70	70	70	70	70			70			
Total MED	300	300	300	300	285	285	270	270	270	270	255	255	255	255	255			255			
PHQ		23	17	14	20	15	12	7	7	10	5		4	2	2			18			
GAD		15	15	21	16	16	19	21	8	14	3		4	5	1			20			
Pain Intensity		8	6	6	6	5	6	5	5	6	6		4	6	4			8			
Pain Interference		9	5	6	6	4	5	4	6	6	6		4	7	4			9			
Alcohol use	no	N	N	n	n	n	n	n	n	n	N		n	n	n						

Notes

- 2/26: She no showed to apt. on 2/26. No response. Daughter being treated for suicide attempt.
- 3/2: daughter now involuntary inpatient, pt feels she is in safe place and is feeling better. She did bring all her medications to visit and is on time. She has them very organized in a pill box each day. Did not want to reduce, as more pain associated with stressful situation, did not feel ready this week, but said she would like to reduce next week.
- 3/12 Still worried about her daughter who is inpatient. No change in dose.

Impressions from trial process…

- Opioid cessation similar to smoking cessation
  - Difficult in the short-term, less so in long-term
- Insomnia and anxiety emerge during taper
  - Sometimes depression, PTSD, borderline PD…
- Nortriptyline often useful, sometimes SNRIs
  - Don't add benzos, don't taper, stable dosing
- Use early taper to build skills, confidence
- Patients limit their opioid taper for many reasons, but rarely due to pain increase

Preliminary trial results

- 35/145 referred patients were randomized
  - Some ineligible, most declined as not ready, able
- 71% female, mean age 55, 83% white
- 11.5 years opioid tx, 55% HS or some college
- Baseline MED
  - 209mg MED Taper support
  - 244mg MED Usual care

RCT results: opioid dose, pain

- By 22 weeks, adjusted mean daily opioid dose was 43mg MED lower in support group (p=.09)
  - Dose reduction from baseline:
    - 46% in taper support, 18% in usual care
- BPI pain intensity (adj. mean diff = 0.7, p=.30)
  - Taper support 5.7 -> 4.7/10
  - Usual care 6.3 -> 5.8/10

RCT results: activities, self-efficacy

- BPI pain interference (adj. mean diff. -1.4, p=.05)
  - Taper support 6.0 -> 4.5
  - Usual care 6.6 -> 6.4
- Pain Self-efficacy (adj mean diff. 7.9, p=.02)
  - Taper support 30.6 -> 36.1
  - Usual care 31.9 -> 30.0
- PODS problems (adj. mean diff. -4.9, p=.02)
  - Taper support 12.7 -> 2.9
  - Usual care 12.0 -> 7.5

Patient reports of taper experience

- "I am no longer a zombie."
- "My husband is glad to have his wife back."
- "My pain is the same, but my head is so much clearer."
- "I was afraid my pain would go through the roof, but it hasn't."

RCT results

- Outcomes not different between groups:
  - PODS concerns
  - Opioid craving
  - Opioid misuse
  - Insomnia severity
  - Somatic symptoms (PHQ15)
  - Depression (PHQ9)
  - Anxiety (GAD7)

Lessons from trial

- Difficult to recruit into trial of "opioid taper"
  - Many interested, few willing to be randomized
  - May need to recruit for self-management support, later offering the option of supported taper
- Psychiatric symptoms are common
  - TCA useful because addresses pain, mood, sleep
  - Other patients needed SNRI started or adjusted
  - Prazosin useful for patients with PTSD

Lessons for clinical taper practice

- Pledge you will not abandon patient
- No rush, allow patient to pause taper
- Taper long-acting opioids first
- Discourage concurrent tapers
- Offer pain self-management skills support
- Anticipate pain "flare-ups"

Conclusions

- Opioids have diverse and important functions
  - Opioid use and taper affect many domains of experience and behavior
- Epidemiology of long-term opioid use suggests that opioids are treating various mental health and substance abuse problems
- It appears that opioid taper support can successfully facilitate opioid dose reduction without increasing pain intensity and may decrease pain interference