Reversing the opioid epidemic and delivering more effective pain care

Aug 17, 2018  NASHP

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Opioid-Related Deaths,


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The worst man-made epidemic in modern medical history

- Over 200,000 deaths
- Many more hundreds of thousands of overdose admissions
- Millions addicted and/or dependent
  - Spillover effect to SSDI* and to heroin (40% new initiates started on Rx opioids)


You will not be able to effectively alter epidemic if you don’t understand how the epidemic began

- 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-stated goal was to provide a safe “safe haven” for prescribing
  - WA law: “No disciplinary action will be taken against a practitioner based solely on the quantity and/or frequency of opioids prescribed.” (Washington Administrative Code 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
- Pain as 5th vital sign campaign and JOINT COMMISSION/CMS satisfaction survey
- Has your state repealed the permissive “Intractable Pain Act” language from the late 1990s?
Three strategic goals to reverse the opioid epidemic

1. **Prevent** the next cohort of our citizens from transitioning from acute/subacute opioids to chronic opioids
   - Dental, post-op opioids, sports injuries, adolescents

2. Systematically address and **treat** the millions of patients already on long term, often high dose opioids
   - Tapering, MAT if taper fails, Spoke and hub
   - But need much more rigorous screening methods

3. **Deliver** community based, multimodal care
   - Cognitive behavioral therapy, psychologically informed physical therapy
   - Goal is to improve patient self-efficacy

What Are We Working On:

- Preventing deaths from overdose
- Treating opioid use disorder
- Preventing opioid misuse & abuse
- Using data to monitor and evaluate

**Executive Order 16-09**

Executive Order 16-09,

**Goal:** Prevent inappropriate opioid prescribing and reduce opioid intake and abuse.

1. The state agency Led by a Primary Care Provider (PPCP) will work with the Governor's office to promote the following:
   - **Concerted efforts**: Health care workers must be trained to prescribe opioid medications.

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Most patients on chronic opioids are highly dependent or addicted = opioid use disorder

Evidence of effectiveness of chronic opioid therapy

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).
Krebs et al. SPACE randomized trial: JAMA 2018; 319: 872-82

- Pragmatic trial opioid vs non-opioid meds over 12 months
- Outcomes: pain-related function, pain intensity, and adverse effects
- N=240 with mod/severe chronic LBP or hip/knee osteoarthritis despite analgesic use in MSP VA clinics
- 234/240 (97.5%) completed trial
- Pain-related function no different at 12 months
- Pain intensity better in non-opioid group
- Adverse effects worse in opioid group

“Treatment with opioids was not superior to treatment with nonopioid medications for improving pain-related function over 12 months. Results do not support initiation of opioid therapy for moderate to severe chronic back pain or hip or knee osteoarthritis pain.”

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
Summary of 2015 Interagency Guideline on Prescribing Opioids for Pain

All pain phases
- Use non-opioid therapies, such as behavioral intervention, physical activity and non-opioid analgesics.
- Avoid opioids if the patient has significant respiratory depression, current substance use disorder, history of prior opioid overdose or a pattern of aberrant behaviors.
- Assess and document function and pain using a validated tool at each visit where opioids are prescribed.
- Don’t prescribe opioids with benzodiazepines, carisoprodol, or sedative-hypnotics.

Acute phase (0–6 weeks)
- Check the state’s Prescription Monitoring Program (PMP) before prescribing.
- Don’t prescribe opioids for non-specific back pain, headaches, or fibromyalgia.
- Prescribe the lowest necessary dose for the shortest duration.
- Opioid use beyond the acute phase is rarely indicated.

Perioperative pain
- Evaluate thoroughly preoperatively: check the PMP and assess risk for over-sedation and difficulty-control pain.
- Discharge with acetaminophen, NSAIDs, or very limited supply (2–3 days) of short-acting opioids for some minor surgeries.
- For patients on chronic opioids, taper to preoperative doses or taper within 6 weeks following major surgery.

Subacute phase (6–12 weeks)
- Don’t continue opioids without clinically meaningful improvement in function (CMIF) and pain.
- Screen for comorbid mental health conditions and risk for opioid misuse using validated tools.
- Recheck the PMP and administer a baseline urine drug test (UDT) if you plan to prescribe opioids beyond 6 weeks.

Chronic phase (>12 weeks)
- Continue to prescribe opioids only if there is sustained CMIF and no serious adverse events, risk factors, or contraindications.
- Repeat PMP check and UDT at frequency determined by the patient’s risk category.
- Prescribe in 7-day multiples to avoid ending supply on a weekend.
- Don’t exceed 120 mg/day MED without a pain management consultation.

When to discontinue
- At the patient’s request
- No CMIF
- Risks outweigh benefits
- Severe adverse outcome or overdose event
- Substance use disorder identified (except tobacco)
- Aberrant behaviors exhibited
- To maintain compliance with DOH rules or consistency with AMDG guideline

Considerations prior to taper
- Help the patient understand that chronic pain is complex and opioids cannot eliminate pain.
- Consider an outpatient taper if the patient isn’t on high-dose opioids or doesn’t have comorbid substance use disorder or other active mental health disorder.
- Seek consultation if the patient failed previous taper or is at greater risk for failure due to high-dose opioids, concurrent benzodiazepine use, comorbid substance use disorder or other active mental health disorder.

How to discontinue
- Taper opioids first if patients are also on benzodiazepines.
- Unless safety considerations require a more rapid taper, start with 10% per week and adjust based on the patient’s response.
- Don’t reverse the taper; it can be slowed or paused while managing withdrawal symptoms.
- Watch for unmask mental health disorders, especially in patients on prolonged or high-dose opioids.

Recognizing and treating opioid use disorder
- Assess for opioid use disorder and/or refer for a consultation if the patient exhibits aberrant behaviors.
- Help patients get medication-assisted treatment along with behavioral therapies.
- Prescribe naltrexone (especially if you suspect heroin use) and educate patient’s contacts on how to use it.

Special populations
- Counsel women before and during pregnancy about maternal, fetal, and neonatal risks.
- For children and adolescents, avoid prescribing opioids for most chronic pain problems.
- In older adults, initiate opioids at 25–50% lower dose than for younger adults.
- For cancer survivors, rule out recurrence or secondary malignancy for any new or worsening pain.

Check out the resources at www.AgencyMedDirectors.wa.gov
- Free online CME
- Opioid Dose Calculator
- Videos from Primary Pain Care Conference
Washington Unintentional Prescription Opioid Deaths
1995 – 2015
44% sustained decline

Source: Washington State Department of Health

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Washington is among states that have reduced opioid prescribing:


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And overdose deaths:

NOTE: Percent change refers to the relative difference between the provisional number of reported deaths due to drug overdose occurring in the 12-month period ending in the month indicated compared with the 12-month period ending in the same month of the previous year. Provisional counts may not include all deaths that occurred during a given time period. Therefore, they should not be considered comparable to final data and are subject to change. Deaths are classified by the reporting jurisdiction in which the death occurred. Drug overdose deaths are identified using ICD-10 underlying cause of death codes X40-X44, X60-X64, Y85, and Y10–Y14.
Rate of patients with high-dose chronic opioid prescriptions (> 90 MME/day), 2012–2017

Source: Prescription Monitoring Program (https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization)

Rate of patients with concurrent opioid and sedative prescriptions, 2012–2017

Source: Prescription Monitoring Program (https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization)
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.**

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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 ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥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.
Continued Use by Initial Days of Therapy
MMWR March 17, 2017

Source: Shah et al. MMWR 2017 Mar 17;66(10):265-9

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

Source: IMS Vector ®One National, TPT 06-30-10 Opioids Rate 2009
Acute Opioid Prescribing by Specialty

Table 6: Number of pills by specialty, youth age 14–19: Means, medians, and selected quantiles of the number of tablets dispensed per prescription to children age 14–19 with acute opioid prescriptions between July 1 and December 31, 2015 (N = 33,835).

<table>
<thead>
<tr>
<th>Provider specialty</th>
<th>N</th>
<th>mean</th>
<th>median</th>
<th>75th %tile</th>
<th>90th %tile</th>
<th>99th %tile</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Total</td>
<td>33,835</td>
<td>23.7</td>
<td>20.0</td>
<td>30.0</td>
<td>36.0</td>
<td>80.0</td>
</tr>
<tr>
<td>Dentist</td>
<td>13,345</td>
<td>22.3</td>
<td>20.0</td>
<td>30.0</td>
<td>36.0</td>
<td>40.0</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>2,560</td>
<td>16.2</td>
<td>15.0</td>
<td>20.0</td>
<td>20.0</td>
<td>30.4</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>1,295</td>
<td>20.6</td>
<td>20.0</td>
<td>25.0</td>
<td>30.0</td>
<td>60.9</td>
</tr>
<tr>
<td>Obstetrics &amp; Gynecology</td>
<td>593</td>
<td>27.7</td>
<td>30.0</td>
<td>30.0</td>
<td>40.0</td>
<td>80.8</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Surgery</td>
<td>946</td>
<td>24.4</td>
<td>20.0</td>
<td>30.0</td>
<td>30.0</td>
<td>50.0</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>931</td>
<td>48.9</td>
<td>40.0</td>
<td>60.0</td>
<td>80.0</td>
<td>130.0</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>538</td>
<td>39.5</td>
<td>30.0</td>
<td>50.0</td>
<td>70.0</td>
<td>90.0</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>475</td>
<td>18.9</td>
<td>16.0</td>
<td>24.0</td>
<td>30.0</td>
<td>60.0</td>
</tr>
<tr>
<td>Podiatrist</td>
<td>354</td>
<td>30.4</td>
<td>30.0</td>
<td>40.0</td>
<td>60.0</td>
<td>81.9</td>
</tr>
<tr>
<td>Student</td>
<td>385</td>
<td>22.7</td>
<td>20.0</td>
<td>20.0</td>
<td>40.0</td>
<td>90.0</td>
</tr>
<tr>
<td>Surgery</td>
<td>683</td>
<td>33.0</td>
<td>30.0</td>
<td>40.0</td>
<td>60.0</td>
<td>80.0</td>
</tr>
<tr>
<td>other</td>
<td>839</td>
<td>28.0</td>
<td>22.0</td>
<td>30.0</td>
<td>50.0</td>
<td>100.0</td>
</tr>
<tr>
<td>unknown</td>
<td>10,891</td>
<td>23.6</td>
<td>20.0</td>
<td>30.0</td>
<td>40.0</td>
<td>90.0</td>
</tr>
</tbody>
</table>

Source: DOH Prescription Monitoring Program Data

Dental Guideline on Prescribing Opioids for Acute Pain Management

September 2017

Developed by the Dr. Robert Bree Collaborative and
Washington State Agency Medical Directors' Group in collaboration
with actively practicing dentists and public stakeholders

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Bree/AMDG Dental Guideline Recommendations

- Conduct a thorough history including dental and medical
- **Prescribe non-opioid analgesics as first line**
- Consider pre-surgical or pre-emptive medication
- **If an opioid is warranted, follow the CDC guideline (lowest effective dose of immediate-release opioids; ≤ 3 days will be sufficient)**
  - Limit to 8-12 tablets for adolescents and young adults through 24 years old
  - Avoid opioids when patient/parent requests no opioid prescription or patient is in recovery and at high risk of relapse for SUD
- Educate on appropriate use, duration and adverse effects of opioids and share information on disposal of leftover opioids
- Support patients with SUD who are undergoing dental procedure

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**New Persistent Opioid Use After Minor and Major Surgical Procedures in US Adults**

![Graph showing incidence of new persistent opioid use](image)

**Figure Legend:**

Incidence of New Persistent Opioid Use by Surgical Condition. The incidence of new persistent opioid use was similar between the 2 groups (minor surgery, 5.9% vs major surgery, 6.5%; odds ratio, 1.12; SE, 0.06; 95% CI, 1.01-1.24). By comparison, the incidence in the non-operative control group was only 0.4%.

Why Consider Post-op Pill/Duration Recs?

• The vast majority of pills prescribed post-op are left over and may be used for subsequent misuse or diversion

• Voepel-Lewis et al, JAMA Pediatrics 2015; 169: 497-8-leftover pills in kids via parent diaries
  • T&A 52 pills dispensed 44 pills left (day 4)
  • MSK 34 pills dispensed 30 pills left
  • Minor abd, GU,periph proc 31 pills dispensed 28 pills left

Why Consider Post-op Pill/Duration Recs?

• 37.6 million commercially insured 2008-2016
• 1 million opioid naïve patients undergoing surgery
• Composite outcome dependence, abuse or overdose
• Total duration of opioid use was the strongest predictor of misuse, with each refill and additional week of opioid use associated with an adjusted increase in the rate of misuse of 44.0%
• Highest risk in 15-24 yr age group

Brat et al, BMJ 2018;360:j5790 http://dx.doi.org/10.1136/bmj.j5790
HB 1427 (2017) professional boards and commission rules underway – for implementing acute pain guidelines (chronic pain rules in place 2012)

- General provisions for prevention and treatment
- Use of alternative modalities for pain treatment
- Continuing education requirements for opioid prescribing
- Requirement for a treatment plan
- Requires patient notification
- Limits on number of prescriptions
- Requires Prescription Monitoring Program checks

Table 1: Evidence-Based Duration of Opioid Prescriptions on Discharge Following Surgery

<table>
<thead>
<tr>
<th>Type I – Expected rapid recovery</th>
<th>Type II – Moderate recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental procedures such as extractions or simple oral surgery (e.g., graft, implant).</td>
<td>Procedures such as laparoscopic appendectomy, inguinal hernia repair, carpal tunnel release, thyroidectomy, laparoscopic cholecystectomy, breast biopsy/lumpectomy, meniscectomy, lymph node biopsy, vaginal hysterectomy.</td>
</tr>
<tr>
<td>• Prescribe a nonsteroidal anti-inflammatory drug (NSAID) or combination of NSAID and acetaminophen for mild to moderate pain as first-line therapy.</td>
<td>• Prescribe non-opioid analgesics (e.g., NSAIDs and/or acetaminophen) and non-pharmacologic therapies as first-line therapy.</td>
</tr>
<tr>
<td>• If opioids are necessary, prescribe ≤3 days (e.g., 8 to 12 pills) of short-acting opioids in combination with an NSAID or acetaminophen for severe pain. Prescribe the lowest effective dose strength.</td>
<td>• If opioids are necessary, prescribe ≤3 days (e.g., 8 to 12 pills) of short-acting opioids in combination with an NSAID or acetaminophen for severe pain. Prescribe the lowest effective dose strength.</td>
</tr>
<tr>
<td>• For more specific guidance, see the Bree Collaborative Dental Guideline on Prescribing Opioids for Acute Pain Management.</td>
<td></td>
</tr>
</tbody>
</table>
**Table 1: Evidence-Based Duration of Opioid Prescriptions on Discharge Following Surgery**

<table>
<thead>
<tr>
<th>Type II – Expected medium term recovery</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedures such as anterior cruciate ligament (ACL) repair, rotator cuff repair, discectomy, laminectomy, open or laparoscopic colectomy, open incisional hernia repair, open small bowel resection or enterolysis, wide local excision, laparoscopic hysterectomy, simple mastectomy, cesarean section.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prescribe non-opioid analgesics (e.g., NSAIDs and/or acetaminophen) and non-pharmacologic therapies as first-line therapy.</td>
</tr>
<tr>
<td></td>
<td>Prescribe ≤7 days (e.g., up to 42 pills) of short-acting opioids for severe pain. Prescribe the lowest effective dose strength.</td>
</tr>
<tr>
<td></td>
<td>For those exceptional cases that warrant more than 7 days of opioid treatment, the surgeon should re-evaluate the patient before a third prescription and taper off opioids within 6 weeks after surgery.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Type III – Expected longer term recovery</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedures such as lumbar fusion, knee replacement, hip replacement, abdominal hysterectomy, axillary lymph node resection, modified radical mastectomy, ileostomy/colostomy creation or closure, thoracotomy.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prescribe non-opioid analgesics (e.g., NSAIDs and/or acetaminophen) and non-pharmacologic therapies as first-line therapy.</td>
</tr>
<tr>
<td></td>
<td>Prescribe ≤14 days of short-acting opioids for severe pain. Prescribe the lowest effective dose strength.</td>
</tr>
<tr>
<td></td>
<td>For those exceptional cases that warrant more than 14 days of opioid treatment, the surgeon should re-evaluate the patient before refilling opioids and taper off opioids within 6 weeks after surgery.</td>
</tr>
</tbody>
</table>

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Metrics to guide both “state-of-the-state” and provider quality efforts

- Use a common set of metrics
- Start with public programs
- Establish a process for public/private implementation (e.g. WA statutory, governor appointed “Bree Collaborative”)
- Use metrics to notify outlier prescribers

**WA Bree Opioid Metrics**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General prescribing</strong></td>
<td>% with ≥1 opioid Rx of all enrollees, by age</td>
</tr>
<tr>
<td><strong>Long-term prescribing</strong></td>
<td>% with ≥60 days supply of opioids in the quarter</td>
</tr>
<tr>
<td></td>
<td>% with doses ≥50 and ≥90 mg/day MED in chronic opioid users</td>
</tr>
<tr>
<td></td>
<td>% with ≥60 days supply of sedatives among chronic opioid users</td>
</tr>
<tr>
<td><strong>Short-term prescribing</strong></td>
<td>% with ≤3, 4-7, 8-13, and ≥14 supply among new opioid patients</td>
</tr>
<tr>
<td></td>
<td>% new opioid patients transitioning to chronic use the next quarter</td>
</tr>
<tr>
<td><strong>Morbidity and Mortality</strong></td>
<td>Rate of overdose deaths involving opioids</td>
</tr>
<tr>
<td></td>
<td>Rate of non-fatal overdoses</td>
</tr>
<tr>
<td></td>
<td>Rate of opioid use disorder among patients with ≥3 quarters of use</td>
</tr>
</tbody>
</table>
Improve Systems/Community Capacity To Treat Pain/Addiction

• Deliver **coordinated**, stepped care services aimed at improving pain and addiction treatment **at the population level**
  – Cognitive behavioral therapy and graded exercise to improve patient self-efficacy

• Develop **systematic method** to evaluate all patients on opioids for chronic pain to determine best treatment pathway-stay on opioids if proven effective, taper plan with multimodal care, MAT if addicted
  • Opioid overdose **reporting** and case management by ED to identify behavioral health needs, evaluate for MAT, notify providers involved and discuss recommendations (e.g. Vermont spoke and hub)


Emerging examples of stepped care management/collaborative care for pain

• VA Health System Stepped Care Model of Pain Management

• Vermont Spoke and Hub regional support for medication assisted treatment for opioid use disorder/severe dependence

• WA state Centers of Occupational Health and Education/Healthy Worker 2020.
Key Results from Centers for Occupational Health and Education Pilots

Wickizer et al, Medical Care; 2011: 49: 1105-11

One year follow up

▪ 20% reduction in likelihood of one year disability, 30% reduction for back injuries

▪ Among COHE participating doctors, high adopters of best practices had 57% fewer disability days than low adopters

Eight year follow-up: 26% reduction in permanent disability (SSDI offset, TPD, 5 yrs TL) among back sprains and other sprains (in press-Medical Care)

US Dept of Labor Demonstration projects

▪ President's FY2018 budget proposed that the Office of Disability Employment Policy (ODEP) at the U.S. Department of Labor (DOL) and the Social Security Administration (SSA) jointly conduct a demonstration testing the effects of implementing key features of these programs in other states and/or for a broader population beyond workers' compensation. [https://www.federalregister.gov/documents/2017/09/29/2017-20338/request-for-information-on-potential-stay-at-workreturn-to-work-demonstration-projects](https://www.federalregister.gov/documents/2017/09/29/2017-20338/request-for-information-on-potential-stay-at-workreturn-to-work-demonstration-projects)

▪ >$100 million for up to three projects

▪ In current Federal budget
Collaborative Care: Defined

- A type of **integrated healthcare** developed to treat common behavioral health conditions
  - Originally mental health conditions
  - Used now for pain & other conditions
- Team-based system of care
- Based on 5 core principles
  - [https://aims.uw.edu/collaborative-care](https://aims.uw.edu/collaborative-care)
- Cochrane Review 2012: 79 trials and 24,308 patients

Principles of Effective Collaborative Care

- **Accountable**: Reaching treatment targets
- **Patient-Centered Team Care / Collaborative**: Team focused on patient's goals
- **Population-Based Care**: No patients "falling through the cracks" (specialists)
- **Measurement-Based Treatment to Target**: Outcomes measured + stepped up care
- **Evidence-Based Care**: Psychosocial and pharmacologic treatments
Prescribing Opioids in Older Adults

- Goal – Reduce risk of falls
  - Follow same best practices for prescribing opioids (AMDG)
  - Prescribe immediate-release opioids at the lowest effective dose (AMDG)
    - Initiate opioid therapy at a 25% to 50% lower dose than that recommended for younger adults

Source: AHRC

THANK YOU!

For electronic copies of this presentation, please e-mail Laura Black lj12@uw.edu

For questions or feedback, please e-mail Gary Franklin meddir@u.washington.edu