Reversing the opioid epidemic and delivering more effective pain care

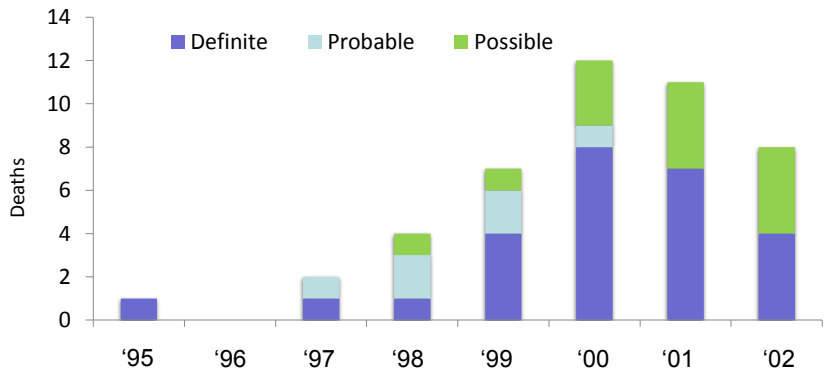
Aug 17, 2018 **NASHP**

Gary M. Franklin, MD, MPH, FAAN

Research Professor
Departments of Environmental Health, Neurology, and Health Services
University of Washington

Medical Director
Washington State Department of Labor and Industries

Opioid-Related Deaths, Washington State Workers' Compensation, 1992–2005



Franklin GM, et al, Am J Ind Med 2005;48:91-9

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
  - Degenhardt et al Lancet Psychiatry 2015; 2: 314-22; POINT prospective cohort: DSM-5 opioid use disorder: **29.4%**
- Spillover effect to to SSDI* and to heroin (40% new initiates started on Rx opioids)

*Franklin et al, Am J Ind Med 2015; 58: 245-51

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- **Has your state repealed the permissive "Intractable Pain Act" language from the late 1990s?**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:

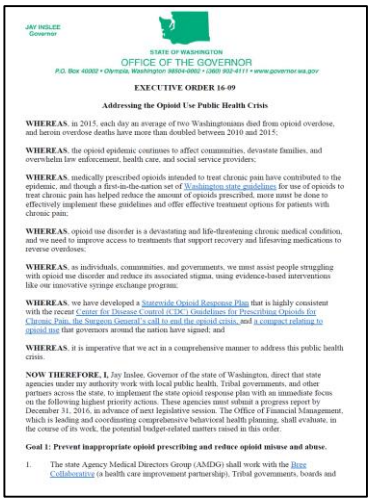
Preventing deaths from overdose

Treating opioid use disorder

Preventing opioid misuse & abuse

Using data to monitor and evaluate

Executive Order 16-09



JAY INSLEE
Governor

STATE OF WASHINGTON
OFFICE OF THE GOVERNOR
P.O. Box 40002 • Olympia, Washington 98504-0002 • (360) 902-4111 • www.governor.wa.gov

EXECUTIVE ORDER 16-09

Addressing the Opioid Use Public Health Crisis

WHEREAS, in 2015, each day an average of two Washingtonians died from opioid overdose, and heroin overdose deaths have more than doubled between 2010 and 2015;

WHEREAS, the opioid epidemic continues to affect communities, devastate families, and overwhelm law enforcement, health care, and social service providers;

WHEREAS, medically prescribed opioids intended to treat chronic pain have contributed to the epidemic, and though a first-in-the-nation set of Washington state guidelines for use of opioids to treat chronic pain has helped reduce the amount of opioids prescribed, more must be done to effectively implement these guidelines and offer effective treatment options for patients with chronic pain;

WHEREAS, opioid use disorder is a devastating and life-threatening chronic medical condition, and we need to improve access to treatments that support recovery and lifesaving medications to reverse overdoses;

WHEREAS, as individuals, communities, and governments, we must assist people struggling with opioid use disorder and reduce its associated stigma, using evidence-based interventions like our innovative syringe exchange programs;

WHEREAS, we have developed a Statewide Opioid Response Plan that is highly consistent with the recent Center for Disease Control (CDC) Guidelines for Prescribing Opioids for Chronic Pain, the Surgeon General's call to end the opioid crisis, and a compact relating to opioid use that governors around the nation have signed; and

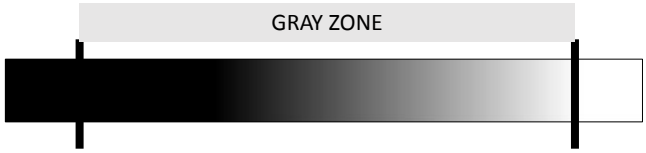
WHEREAS, it is imperative that we act in a comprehensive manner to address this public health crisis.

NOW THEREFORE, I, Jay Inslee, Governor of the state of Washington, direct that state agencies under my authority work with local public health, Tribal governments, and other partners across the state, to implement the state opioid response plan with an immediate focus on the following highest priority actions. These agencies must submit a progress report by December 31, 2016, in advance of next legislative session. The Office of Financial Management, which is leading and coordinating comprehensive behavioral health planning, shall evaluate, in the course of its work, the potential budget-related matters raised in this order.

Goal 1: Prevent inappropriate opioid prescribing and reduce opioid misuse and abuse.

1. The state Agency Medical Directors Group (AMDG) shall work with the Bree Collaborative (a health care improvement partnership), Tribal governments, boards and

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



ADDICTED

Meets DSM criteria for addiction

NOT ADDICTED

- No lost prescriptions
- No ER visits
- No early prescriptions
- No requests for dose escalation
- No UDT aberrancies
- No doctor shopping (PMP)

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

AMDG agency medical directors' group

A collaboration of state agencies, working together to improve health care quality for Washington State citizens.

See full guideline at
www.AgencyMedDirectors.wa.gov



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 difficult-to-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 lower 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.

over

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 unmasked 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 naloxone (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.

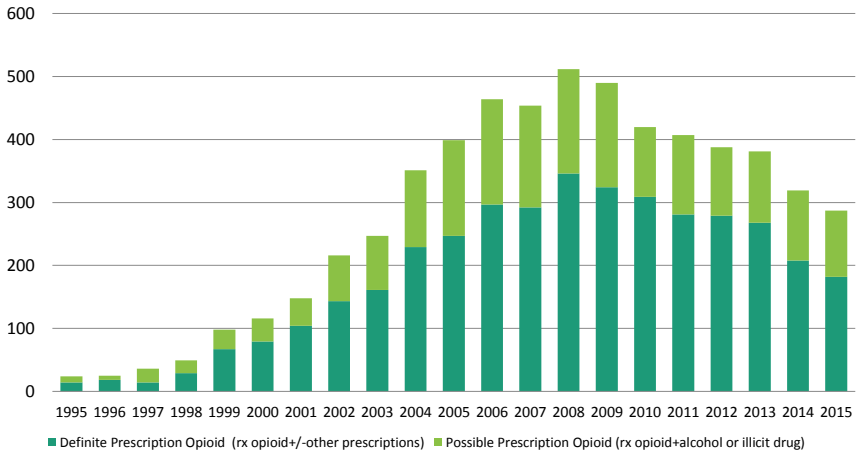


Check out the resources at
www.AgencyMedDirectors.wa.gov

- Free online CME
- Opioid Dose Calculator
- Videos from Primary Pain Care Conference

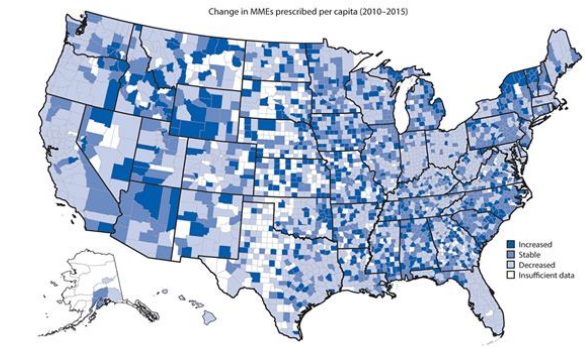
Washington Unintentional Prescription Opioid Deaths
1995 – 2015

44% sustained decline



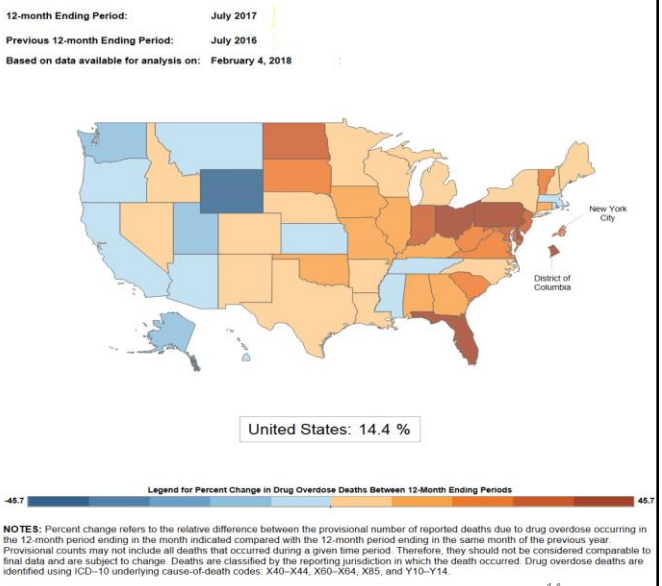
Source: Washington State Department of Health

Washington is among states that have reduced opioid prescribing:

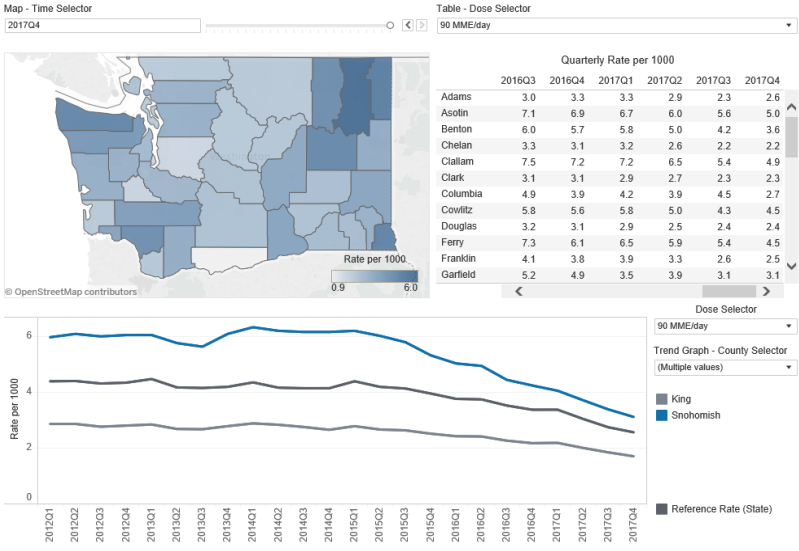


Guy GP Jr., Zhang K, Bohm MK, et al. Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:697–704. DOI: http://dx.doi.org/10.15585/mmwr.mm6626a4

And overdose deaths:

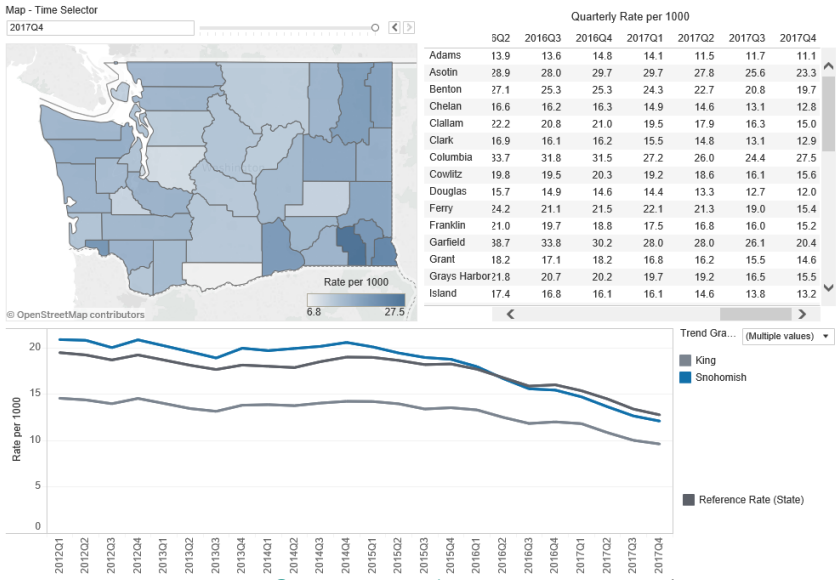


Rate of patients with high-dose chronic opioid prescriptions (≥ 90 MME/day), 2012–2017



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.

CDC Opioid Guidelines-March 2016

- **Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation**

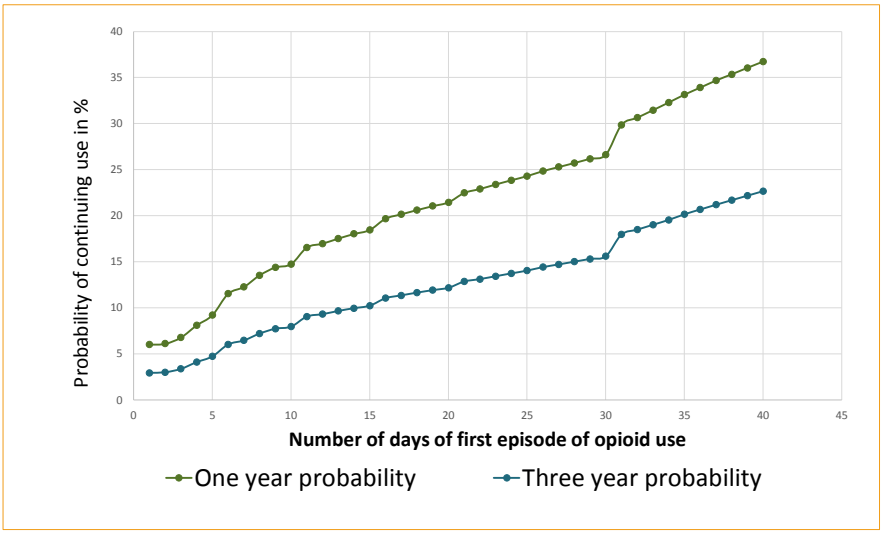
  4.When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

  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.

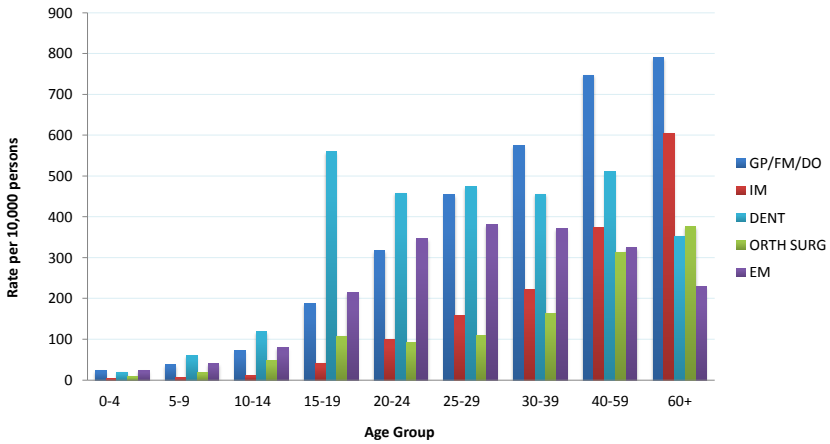
Continued Use by Initial Days of Therapy
MMWR March 17, 2017



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



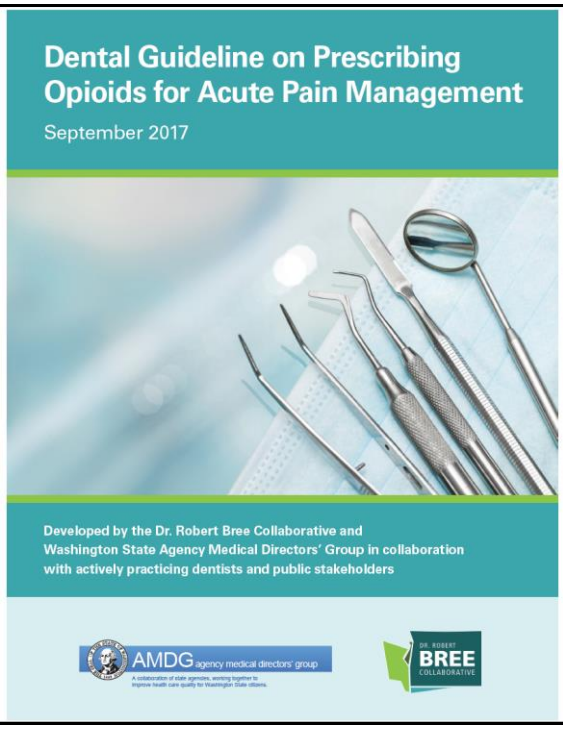
Source: IMS Vector ®One National, TPT 06-30-10 Opioids Rate 2009

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 ($N = 33{,}835$).

Provider specialty	N	mean	median	75th %tile	90th %tile	99th %tile
State Total	33,835	23.7	20.0	30.0	36.0	80.0
Dentist	13,345	22.3	20.0	30.0	30.0	40.0
Emergency Medicine	2,560	15.2	15.0	20.0	20.0	30.4
Family Medicine	1,295	20.6	20.0	25.0	30.0	60.9
Obstetrics & Gynecology	593	27.7	30.0	30.0	40.0	80.8
Oral & Maxillofacial Surgery	946	24.4	20.0	30.0	30.0	50.0
Orthopaedic Surgery	931	48.9	40.0	60.0	80.0	130.0
Otolaryngology	538	39.5	30.0	50.0	70.0	90.0
Pediatrics	475	18.9	16.0	24.0	30.0	60.0
Podiatrist	354	30.4	30.0	40.0	60.0	81.9
Student	385	22.7	20.0	20.0	40.0	90.0
Surgery	683	33.0	30.0	40.0	50.0	80.0
other	839	28.0	22.0	30.0	50.0	100.0
unknown	10,891	23.6	20.0	30.0	40.0	90.0

Source: DOH Prescription Monitoring Program Data



AMDG agency medical directors' group

A collaboration of state agencies, working together to improve health care quality for Washington State citizens

DR. ROBERT BREE COLLABORATIVE

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

The JAMA Network

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

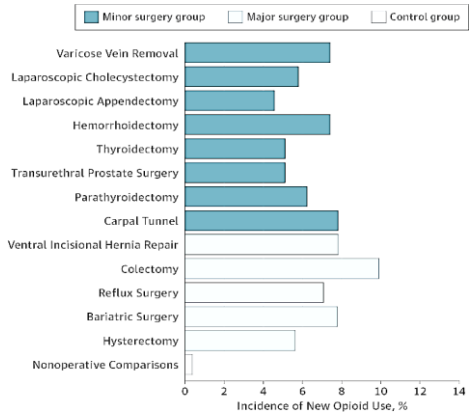


Figure Legend:

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%.

JAMA Surg. 2017;152(6):e170504. doi:10.1001/jamasurg.2017.0504

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

Type I – Expected rapid recovery	
Dental procedures such as extractions or simple oral surgery (e.g., graft, implant).	• Prescribe a nonsteroidal anti-inflammatory drug (NSAID) or combination of NSAID and acetaminophen for mild to moderate pain as first-line therapy. • 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. • For more specific guidance, see the Bree Collaborative Dental Guideline on Prescribing Opioids for Acute Pain Management.
Procedures such as laparoscopic appendectomy, inguinal hernia repair, carpal tunnel release, thyroidectomy, laparoscopic cholecystectomy, breast biopsy/lumpectomy, meniscectomy, lymph node biopsy, vaginal hysterectomy.	• Prescribe non-opioid analgesics (e.g., NSAIDs and/or acetaminophen) and non-pharmacologic therapies as first-line therapy. • 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.

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

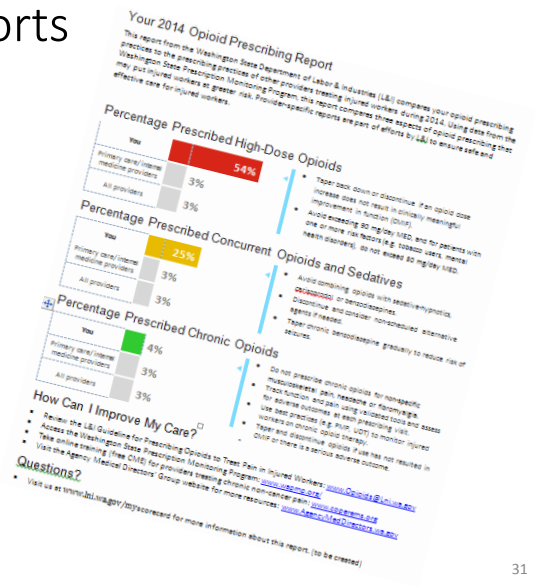
Type II – Expected medium term recovery	
Procedures such as anterior cruciate ligament (ACL) repair, rotator cuff repair, discectomy, laminectomy, open or laparoscopic colectomy, open incisional hernia repair, open small bowel resection or enterolysis, wide local excision, laparoscopic hysterectomy, simple mastectomy, cesarean section.	• Prescribe non-opioid analgesics (e.g., NSAIDs and/or acetaminophen) and non-pharmacologic therapies as first-line therapy. • Prescribe ≤7 days (e.g., up to 42 pills) of short-acting opioids for severe pain. Prescribe the lowest effective dose strength. • 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.

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

Type III – Expected longer term recovery	
Procedures such as lumbar fusion, knee replacement, hip replacement, abdominal hysterectomy, axillary lymph node resection, modified radical mastectomy, ileostomy/colostomy creation or closure, thoracotomy.	• Prescribe non-opioid analgesics (e.g., NSAIDs and/or acetaminophen) and non-pharmacologic therapies as first-line therapy. • Prescribe ≤14 days of short-acting opioids for severe pain. Prescribe the lowest effective dose strength. • 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.

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

General prescribing	
• Prevalence of opioid use	% with ≥1 opioid Rx of all enrollees, by age
Long-term prescribing	
• Chronic opioid use	% with ≥60 days supply of opioids in the quarter
• High dose use	% with doses ≥50 and ≥90 mg/day MED in chronic opioid users
• Concurrent use	% with ≥60 days supply of sedatives among chronic opioid users
Short-term prescribing	
• Days supply of first Rx	% with ≤3, 4-7, 8-13, and ≥14 supply among new opioid patients
• Transition of chronic use	% new opioid patients transitioning to chronic use the next quarter
Morbidity and Mortality	
• Opioid overdose deaths	Rate of overdose deaths involving opioids
• Non-fatal overdoses	Rate of non-fatal overdoses
• Opioid use disorder	Rate of opioid use disorder among patients with ≥3 quarters of use

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)
- Collaborative care conference June 2017: http://www.agencymeddirectors.wa.gov/collaborativecaresymposium.asp

Emerging examples of stepped care management/collaborative care for pain

- VA Health System Stepped Care Model of Pain Management
  - Dorflinger et al. A Partnered Approach to Opioid Management, Guideline Concordant Care and the Stepped Care Model of Pain Management. J Gen Int Med 2014; Suppl 4, 29: S870-6.
- 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
- >$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

- Cochrane Review 2012: 79 trials and 24,308 patients

Principles of Effective Collaborative Care



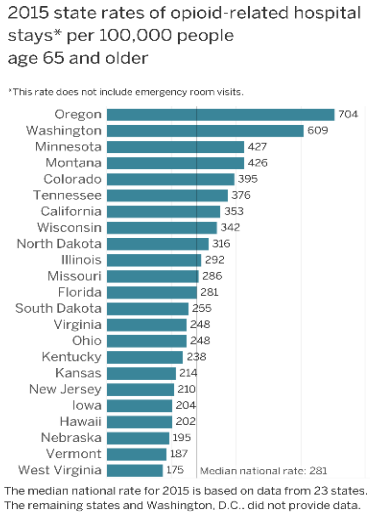
AMDG
agency medical directors' group

A collaboration of state agencies, working together to improve health care quality for Washington State citizens

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 ljl2@uw.edu

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