ROSE BIGHAM, CO-CHAIR
WASHINGTON PATIENTS IN INTRACTABLE PAIN

Chronic Pain Patient Advocating for Other Chronic Pain Patients

WHO AM I

- Seattle-Area Native
- Former high-tech security and privacy specialist
  - 25 year veteran of Microsoft, Amazon prior to becoming disabled
- Former competitive athlete with commensurate sports injuries:
  - College scholarship athlete in volleyball
  - Competitive weight lifter
  - Softball
  - Hiking
  - Camping
  - Cross-country Skiing
  - Snow-Shoeing
  - Mountain biking
  - Horseback riding
  - White-water Rafting of many class IV rivers (Elwa, Green, Hoh, Methow, Nisqually, Sauk, Skagit, Skykomish, Tieton, Wenatchee, and the Thompson river in B.C.)
  - Kick-boxing
  - Competitive triathlete
- . … and then my physical and cognitive symptoms gradually progressed in severity until I had no choice but to give it all up.

QUICK MEDICAL HISTORY & PATH TO DX

- From high-powered career and aggressively athletic social life to increasingly limited work capacity and ADLs over time
- Eventual diagnosis of non-radiographic axial spondyloarthritis, Fibromyalgia, Crohn's disease
- Constant pain in lumbar and cervical spine as well as major joints severely limit productivity
  - Pain severity routinely increases temporarily into more severe pain (or 'flares') which are debilitating
  - Cognitive issues – concentration, memory – consistently impacted job performance
- After a long history of sports injuries, 3 modified Bankart surgeries of the left shoulder within 5 years (and one Restore™ porcine small intestine submucosa patch) as well as 4 other major surgeries and finally multiple incurable rheumatological diseases I stand before you today in progressive and incurable pain, but pain which is appropriately managed with prescription opioids. Like millions of other people in this country.

MY PATH TO SUCCESSFUL OPIOID THERAPY: PATIENT ENGAGEMENT

- I have been stable on a non-escalating dose of prescription opioids since 2005. The ability to somewhat manage my pain symptoms (through the careful, supervised application of prescription opioids) enabled me to continue working at the high-pressure career that I loved for 10 additional years. (I am never not in pain)
- First tried physical therapy, acupuncture, chiropractic, prescription NSAIDs, surgeries, CBT, mindfulness, talk therapy, osteopath – all with with minimal effect.
- No personal history of addiction or misuse (although one familial relative with addiction)
- Compliant with treatment plans and routine UDTs and pill counts
- Based on my experience and research as a chronic pain patient and advocate, I believe that my patient story represents many chronic pain patients in the country today: patients with confirmed clinical diagnosis/diagnoses; who are compliant with treatment, and with no history of misuse or diversion.

BUT FIRST: CLARIFYING OPIOID USE DISORDER DSM V OUD DIAGNOSTIC FEATURES

- "Opioid use disorder includes signs and symptoms that reflect compulsive, prolonged self-administration of opioid substances that are used for no legitimate medical purpose or, if another medical condition is present that requires opioid treatment, that are used in doses greatly in excess of the amount needed for that medical condition."
- "Individuals with opioid use disorder tend to develop such regular patterns of compulsive drug use that daily activities are planned around obtaining and administering opioids. Opioids are usually purchased on the illegal market but may also be obtained from physicians by falsifying or exaggerating general medical problems or by receiving simultaneous prescriptions from several physicians"

  - Page 542, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

- **Less than 1% of well-screened chronic pain patients become addicted to opioids.**
  - A Cochrane Review on long-term opioid management for chronic noncancer pain published in 2010 estimates opioid addiction rates of 0.27% *(Long-term opioid management for chronic noncancer pain - https://doi.org/10.1002/14651858.CD006605.pub2)*

ENGAGING YOUR PATIENT: WHO ARE THEY?

- For many chronic pain patients their ***pain is appropriately managed with a treatment plan which includes prescription opioids.***
- The medically-appropriate application of prescribed opioids to carefully-screened patients who are diagnosed with conditions which can cause intractable pain can restore basic functionality and some quality of life to patients who have exhausted all other treatment options.
- If a patient wishes to voluntarily taper their opioid medications to a lower dosage – or off of them entirely – then the provider should work with that patient to determine a safe, thoughtful tapering plan which temporarily includes existing prescription medication.
- If a patient has no medical need to taper their opioid prescription – no history of addiction issues, no unmanaged co-morbidities, no aberrant behavior and is compliant with care: consider continuing their stable, effective opioid therapy (SEOT). **If there is no medical need to taper and the patient has no desire – then WHY taper?**

A NOTE ABOUT WASHINGTON STATE

The Washington Medical Commission – which governs the majority of clinicians who prescribe opioids in WA state – have clearly said that there is ONE set of prescribing rules in Washington state, and those rules went into effect January 1, 2019 as the product of the ESHB 1427 task force.

In addition, the WMC has released a number of statements clarifying the state of pain management in the Evergreen state.

WA Prescribing Rules Do Not Force Pain Patients Off Medication

WMC Interpretative Statements Provide Clarity and supported by CDC release

OLYMPIA, MAY 24, 2019 – New opioid prescribing rules, effective January 2019, do not mandate doctor's taper chronic pain patients. Pain lasting more than 12 weeks is considered chronic. Nor do they set pill limits. Some doctors and patients have been misinformed that the rules would cut off patients from their prescriptions. To be clear, the opioid prescribing rules for chronic pain patients in Washington have remained largely unchanged since 2012.

Adding to this worry, is misinterpretation of CDC guidelines released in 2016. Some providers have interpreted the CDC guidelines as law, despite CDC statements to the contrary, and changed or stopped prescribing opioids. Additionally, the CDC has recently made clear their concerns regarding forced tapering based on incorrect assumptions about their 2016 guidelines.

The Washington Medical Commission (WMC), the state agency that regulates and licenses MDs and who wrote the new rules, has done outreach to ensure confusion and concern is addressed. The outreach included more than thirty presentations to hospitals statewide, an informative booklet sent to all license holders, three Twitter town halls, a live webinar and multiple co-agency events.

But, the WMC went further by issuing interpretive statements for MDs and PAs on Opioid Prescribing and Monitoring and another directly for patients. Both of these statements address the issue of tapering opioids and refusal by practitioners to continue treatment.

The statements go so far as to say, "A practitioner who refuses to treat the condition (chronic pain) properly, including the appropriate utilization of opioids when opioids are clearly indicated, would be practicing below the standard of care." Practicing below the standard of care falls under WMC regulative authority and the Uniform Disciplinary Act.

Additionally, the statements clearly explain that tapering, "without consent of the patient or consideration of function or quality of life" is a violation of WMC prescribing rules.

"The 2019 Opioid Rules were created to address the opioid crisis in Washington that takes hundreds of lives annually. It was never our goal, nor is it permissible, to keep appropriate pain medications from people who need them, "said Micah Matthews, WMC Deputy Director. "Our interpretive statements should offer comfort and education to anyone who believes otherwise."

WMC INTERPRETIVE STATEMENT TO PROVIDERS

State of Washington
Washington Medical Commission

Interpretive Statement

Title:	Opioid Prescribing & Monitoring for Allopathic Physicians and Physician Assistants	INS2019-01
References:	RCW 18.71.800; RCW 18.71A.800; WAC 246-919-850 through WAC 246-919-985; WAC 246-918-800 through WAC 246-918-990	
Contact:	Washington Medical Commission	
Phone:	(360) 236-2750 E-mail: medical.commission@wmc.wa.gov	
Effective Date:		
Approved By:	Alden Roberts, MD, Chair (signature on file)	

WAC 246-919-950 clearly explains that tapering would be expected for chronic pain patients when:

- The patient requests tapering;
- The patient experiences an improvement in function or pain;
- The patient is noncompliant with the written agreement;
- Other treatment modalities are indicated;
- Evidence of misuse, abuse, substance use disorder, or diversion;
- The patient experiences a severe adverse event or overdose;
- Unauthorized escalation of doses;
- An authorized escalation of dose with no improvement in pain or function.

A patient on a stable, non-escalating dose with positive impact on function would be exempt from any need for additional consultation with a pain specialist regarding treatment. Additionally, there is no upper MED limit in Washington State or federal law. The Centers for Disease Control (CDC) has a 90 MED descriptor in their guidelines, which, while a valid indication for consultation, does not have the force of law in Washington. The Commission's opioid prescribing rules represent the only legal requirement and cite a 120 MED consultation threshold for allopathic physicians and physician assistants who are not considered pain management specialists under the rule. For those practitioners not considered pain management specialists treating patients over the 120 MED consultation threshold, there are several options to satisfy the exemption consultation requirement, including but not limited to:

- Receive a peer-to-peer consult with a pain management specialist;
- Participate in an electronic (audio/video) case consult such as the University of Washington (UW) Telepain or the Washington Health Care Authority (HCA) Opioid Hotline;
- Chart note documenting the attempt to get a consult but lack of success in attaining one;
- For a full list of options to satisfy the exemption consultation requirement, please see the rules.

TO SUM UP

- No local legislation today requires opioid tapering; no federal legislation requires opioid tapering
- Patients should not be tapered for non-medical reasons. Tapering considerations for chronic pain (according to WA's new prescribing rules): Physician shall consider tapering when:
  - The patient requests it;
  - The patient experiences a deterioration in function or pain;
  - The patient is non-compliant with the written agreement (pain contract);
  - Other treatment modalities are indicated;
  - There is evidences of misuse, abuse, substance use disorder, or diversion;
  - The patient experiences a severe adverse event or overdose; or
  - The patient is receiving an escalation in opioid dosage with no improvement in their pain or function.
- When a patient DOES require tapering of opioid doses, go low and slow - do NOT abandon the patient.
- **The objective is to appropriately manage the patient's pain while keeping them safe. That includes keeping the patient being safe from abandonment or non-medical/forcible tapering!**

RESOURCES

- Not Allowed to Be Compassionate – Human Rights Watch, December 2018
- FDA Voice of the Patient Chronic Pain Report – March 2019
- AMA Statement "How the CDC's opioid prescribing guidance went astray" – April 2019
- FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering – April 2019

QUESTIONS?

- Ask them here!

- Or contact me at rosebigham@hotmail.com