

# Reversing the Opioid Epidemic and Improving Outcomes for Pain Patients

Dental Conference

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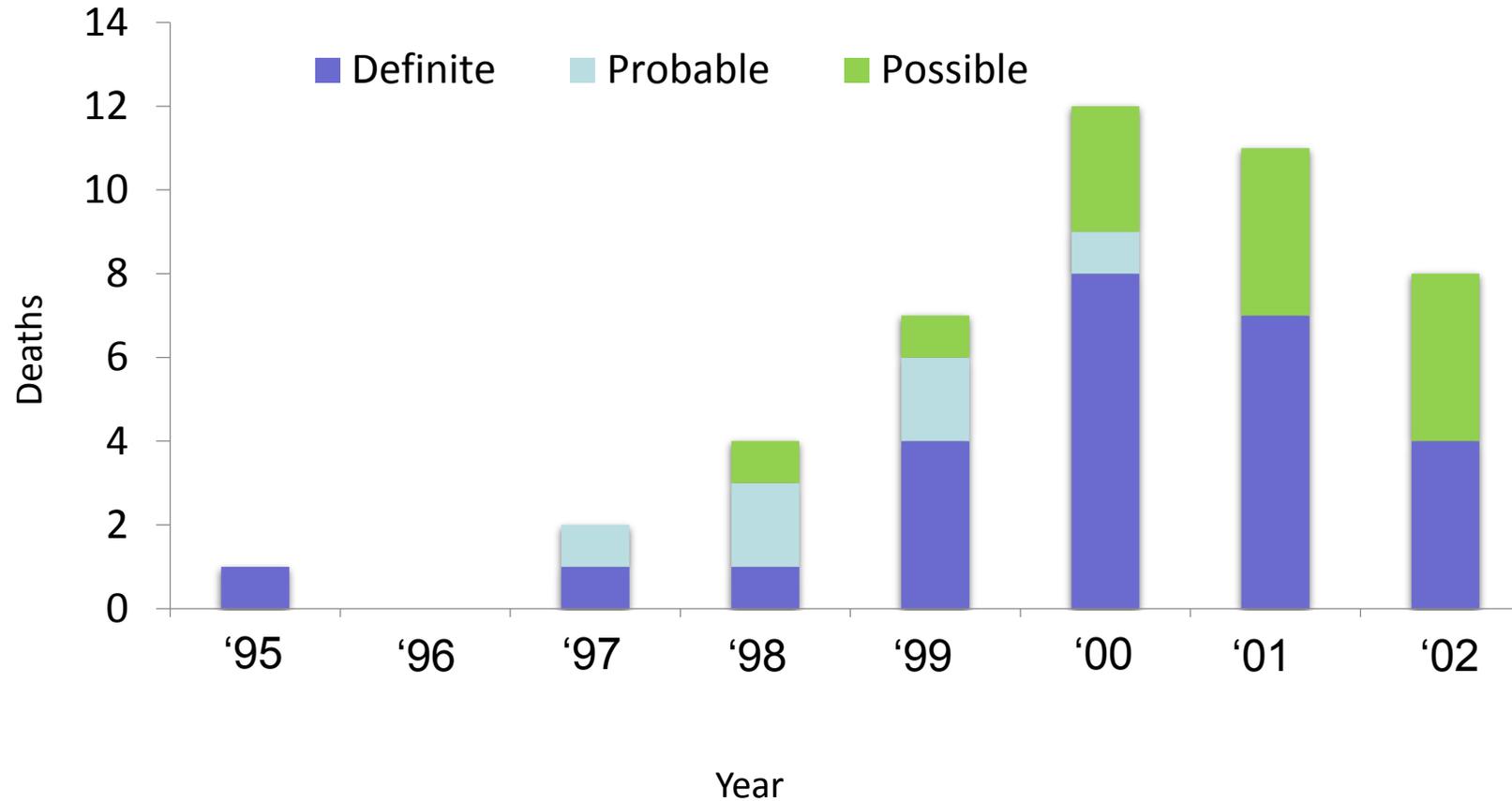
University of Washington

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# Opioid-Related Deaths

## Washington State Workers' Compensation 1992–2005



Source: Franklin 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)

# Rapidly increasing mortality in middle aged, lower educated whites

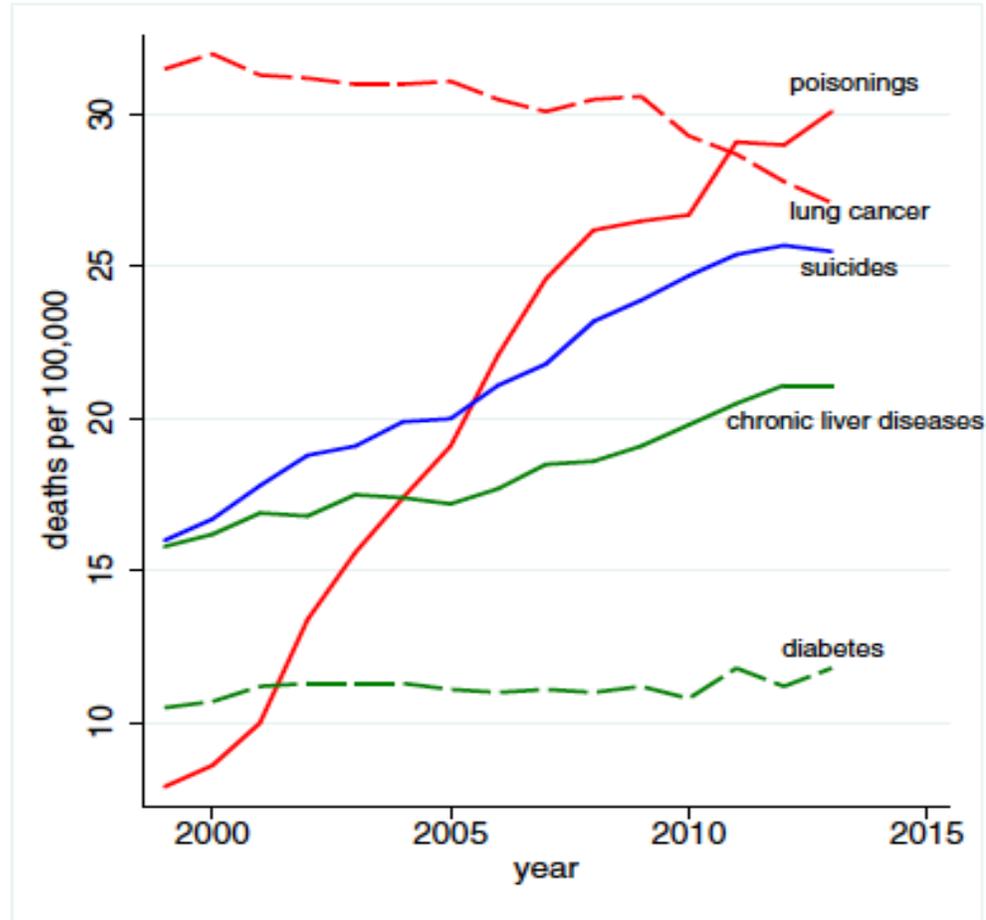


Fig. 2. Mortality by cause, white non-Hispanics ages 45-54.

# 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.” (WAC 246-919-830, 12/1999)
- Laws were based on weak science and good experience with cancer pain: Thus, **no ceiling on dose** and **axiom to use more opioid if tolerance develops**
- Pain as 5<sup>th</sup> vital sign campaign and JOINT COMMISSION/CMS satisfaction survey

# “Addiction Rare with Narcotics”

## ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

*To the Editor:* Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients<sup>1</sup> who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,<sup>2</sup> Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

JANE PORTER  
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1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind Y, Slone D. Comprehensive drug surveillance. *JAMA*. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. *J Clin Pharmacol*. 1978; 18:180-8.

# Opioids and Chronic, Noncancer Pain

- Retrospective case series chronic, non-cancer pain
- N=38; 19 Rx for at least 4 years
- 2/3 on <20 mg MED/day; 4 on >40 mg MED/day
- 24/38 acceptable pain relief
- No gain in social function or employment could be documented

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

**How many chronic pain patients in your practice are on doses over 100 mg/day?  
How many are on combinations of opioids and benzodiazepines or sedative  
hypnotics?**

# Effectiveness of Chronic Opioid Therapy

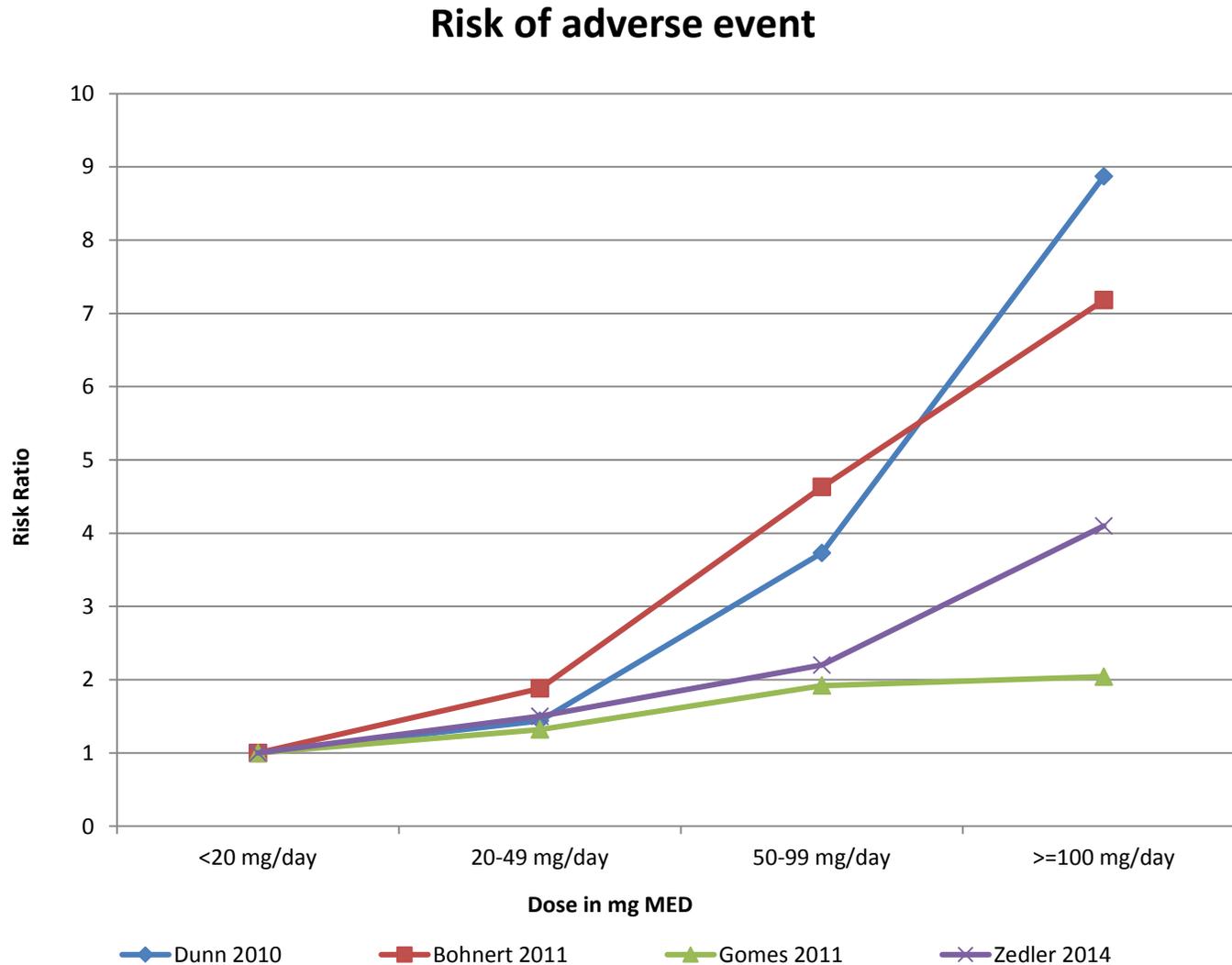
The Agency for Healthcare Research and Quality's (AHRQ) recent draft report, "The Effectiveness and Risks of Long-term Opioid Treatment of Chronic Pain," which focused on studies of effectiveness measured at >1 year of COAT use, found **insufficient data on long term effectiveness to reach any conclusion, and "evidence supports a dose-dependent risk for serious harms"**.

# Pain Relief Better with Non-opioids

- 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.”**

# Evidence on Opioid Dose-related Risk

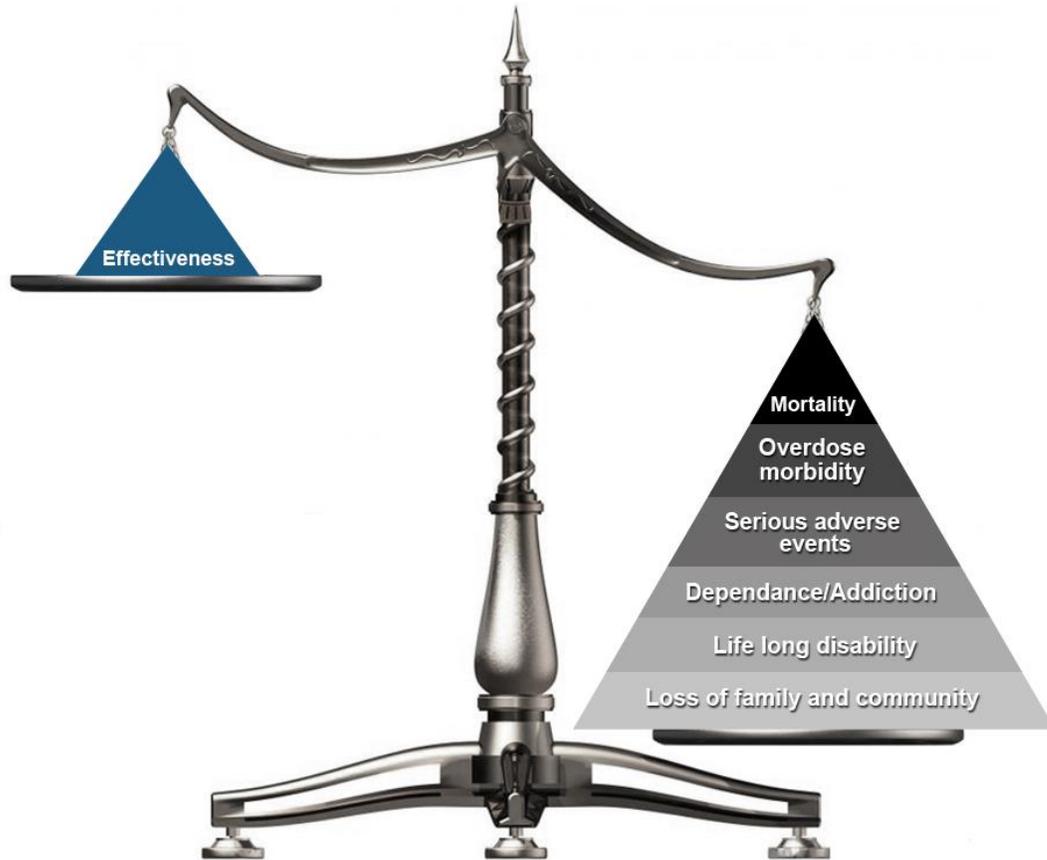


- Risk of adverse  $\pm$  overdose event increases at  $>50$  mg/d MED
- Risk increases greatly at  $\geq 100$  mg/d MED

# Early Opioids and Disability in Workers' Compensation

- 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/d MED doubled risk of 1 year disability, after adjustment for pain, function and injury severity

# Risk/Benefit of Opioids for Chronic Non-cancer Pain



- Opioids should not be used routinely for the treatment of musculoskeletal conditions, headaches or fibromyalgia\*
  - Tension type headaches: Bendtsen et al, EFNS guideline, Eur J Neurol 2010; 17: 1318-25;
  - Migraine: Buse et al, American Migraine Prevalence and Prevention Study, Headache 2012; 52: 18-36
  - Chronic LBP: Chaparro et al, Spine 2014; 39: 556-63
  - Fibromyalgia: Gaskell et al, Cochrane Review; 2014: CD010692

# Enduring Adaptation Produced by Established Behaviors

For the illicit drug user:

- Procurement behaviors

For the pain patient – much more complex

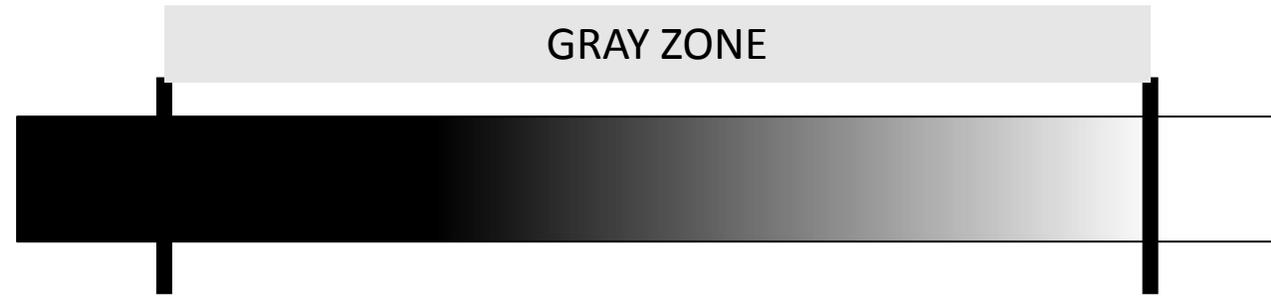
- Continuous opioid therapy may prevent opioid-seeking
- Memory of pain, pain relief, and also euphoria
- Even if the opioid-seeking appears as seeking pain relief, it becomes an adaptation that is difficult to reverse
- It is hard to distinguish between drug-seeking and relief-seeking

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

Slide 13

Source: Ballantyne et al. IASP: Pain clinical updates Dec 2013;21:1-7

# Most Patients on Chronic Opioids are Highly Dependent or Addicted



## 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)

# Open-source Tools Added to 2010 AMDG Opioid Dosing Guideline

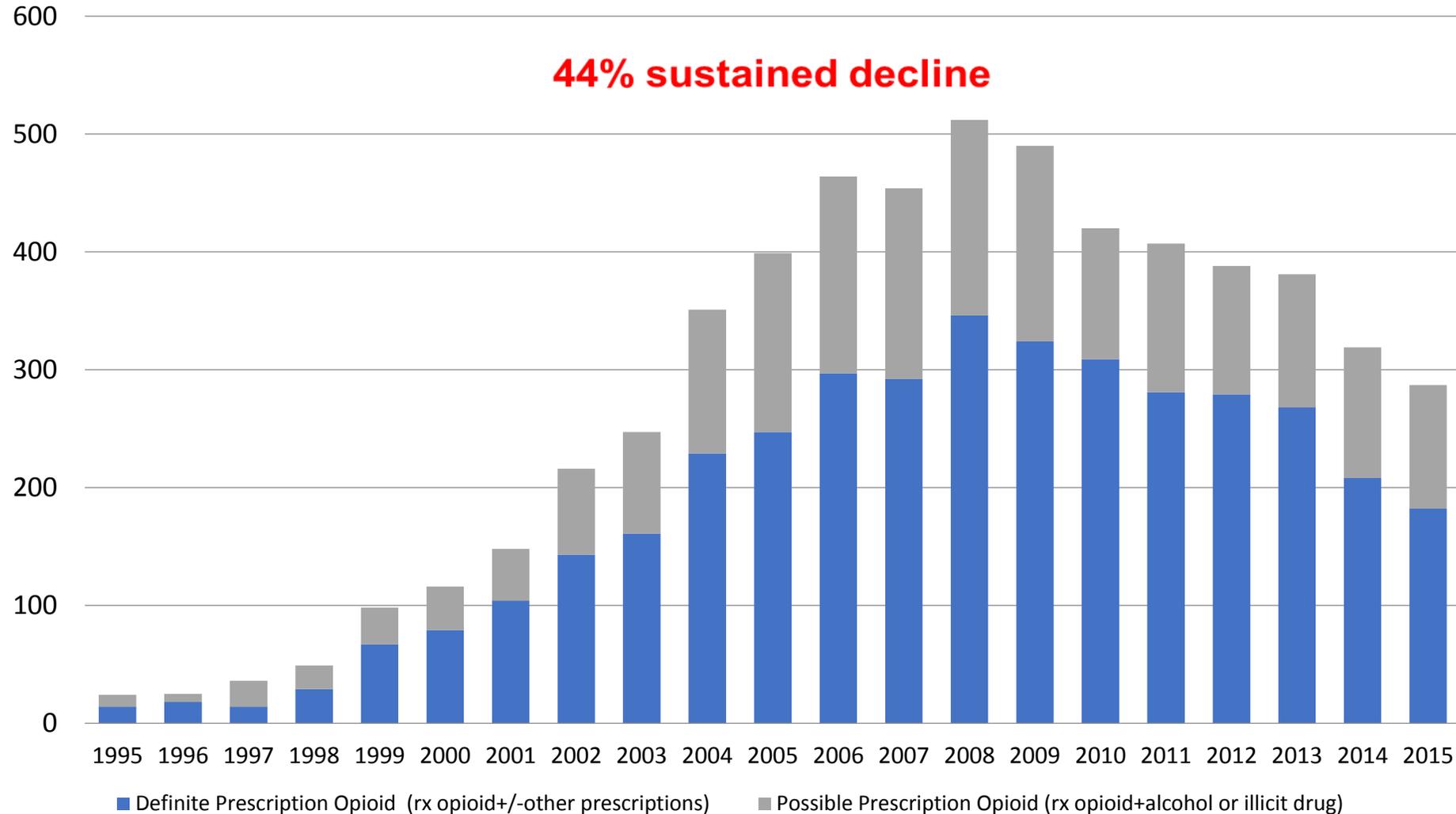
- Opioid Risk Tool: Screen for past and current substance abuse
- CAGE-AID screen for alcohol or drug abuse
- Patient Health Questionnaire-9 screen for depression
- 2-question tool for tracking pain and function
- Advice on urine drug testing

<b><u>OPIOID DOSE CALCULATOR</u></b>		
Opioid (oral or transdermal)	Mg per day	Morphine equivalents
codeine		0
fentanyl transdermal (in mcg/hr)		0
hydrocodone	20	20
hydromorphone		0
methadone		
up to 20mg per day		
21 to 40mg per day		
41 to 60mg per day	50	500
>60mg per day		0
morphine		0
oxycodone		0
oxymorphone		0
<b>TOTAL daily morphine equivalent dose (MED) =</b>		<b>520</b>

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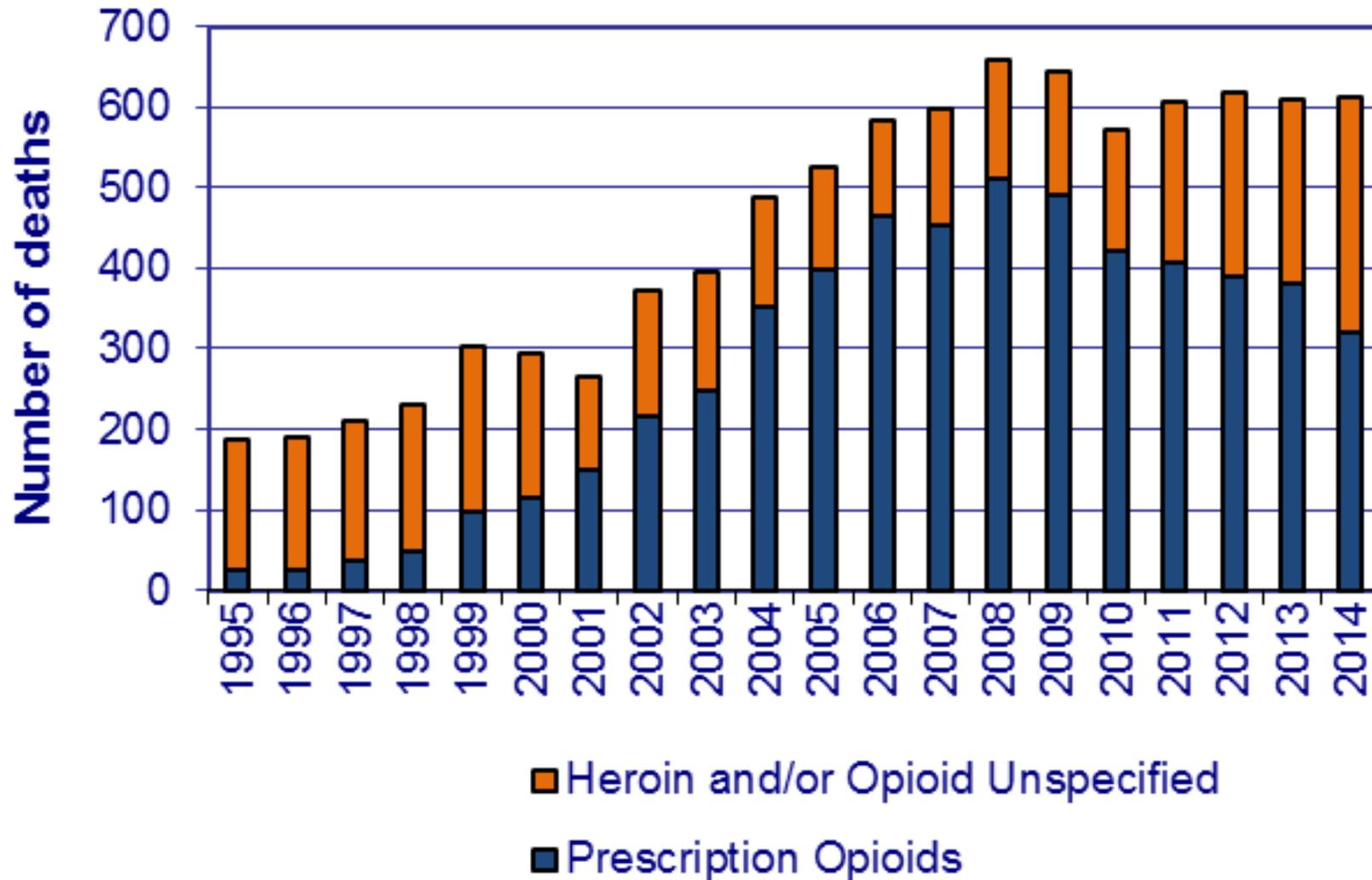
Available: <http://www.agencymeddirectors.wa.gov/opioiddosing.asp>

# Washington Unintentional Prescription Opioid Deaths 1995 – 2015



Source: Washington State Department of Health

# Unintentional Opioid Overdose Deaths Washington 1995-2014



# 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 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.



## 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](http://www.AgencyMedDirectors.wa.gov)

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



# Clinically Meaningful Improvement

- Clinically meaningful improvement is improvement in pain and function of at least 30%
- **Assess and document function and pain using validated tools at each visit where opioids are prescribed**
- Recommend use of quick and free tools to track function and pain
  - PEG: Pain intensity, interference with Enjoyment of life, and interference with General activity
  - Graded Chronic Pain Scale: Pain intensity and pain interference

# Non-Pharmacologic Alternatives

- Do NOT pursue diagnostic tests unless risk factors or specific reasons are identified-no MR in first 6 weeks in absence of red flags
- Use interventions such as listening, providing reassurance, and involving the patient in care
- Recommend **graded exercise, cognitive behavioral therapy, mindfulness based stress reduction** (MBSR), various forms of meditation and yoga or spinal manipulation in patients with back pain
- Address sleep disturbances, BUT **the greatest risk lies in co-prescribing benzodiazepines and sedative/hypnotics with opioids, even at lower doses of opioids**
- Refer patient to a multidisciplinary rehabilitation program if s/he has significant, persistent functional impairment due to complex chronic pain

# Pharmacologic Alternatives

- Use NSAIDs for minor to moderate pain
- Consider antidepressants (TCAs/SNRIs) and anticonvulsants for neuropathic pain, other centralized pain syndromes, or fibromyalgia
- Avoid carisoprodol (SOMA) due to the risk of misuse and abuse. Do NOT prescribe muscle relaxants beyond a few weeks as they offer little long-term benefit
- Prescribe melatonin, TCAs, trazodone, or other non-controlled substances if the patient requires pharmacologic treatment for insomnia

# 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  $\geq 50$  morphine milligram equivalents (MME)/day, and should avoid increasing dosage to  $\geq 90$  MME/day or carefully justify a decision to titrate dosage to  $\geq 90$  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.

# CDC Opioid Guidelines - March 2016

- **Assessing Risk and Addressing Harms**

**8.** Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosage ( $\geq 50$  MME/day), or concurrent benzodiazepine use, are present.

**9.** Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him/her at high risk for overdose. Clinicians should review PDMP data when start opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

# CDC Opioid Guidelines - March 2016

- **Assessing Risk and Addressing Harms**

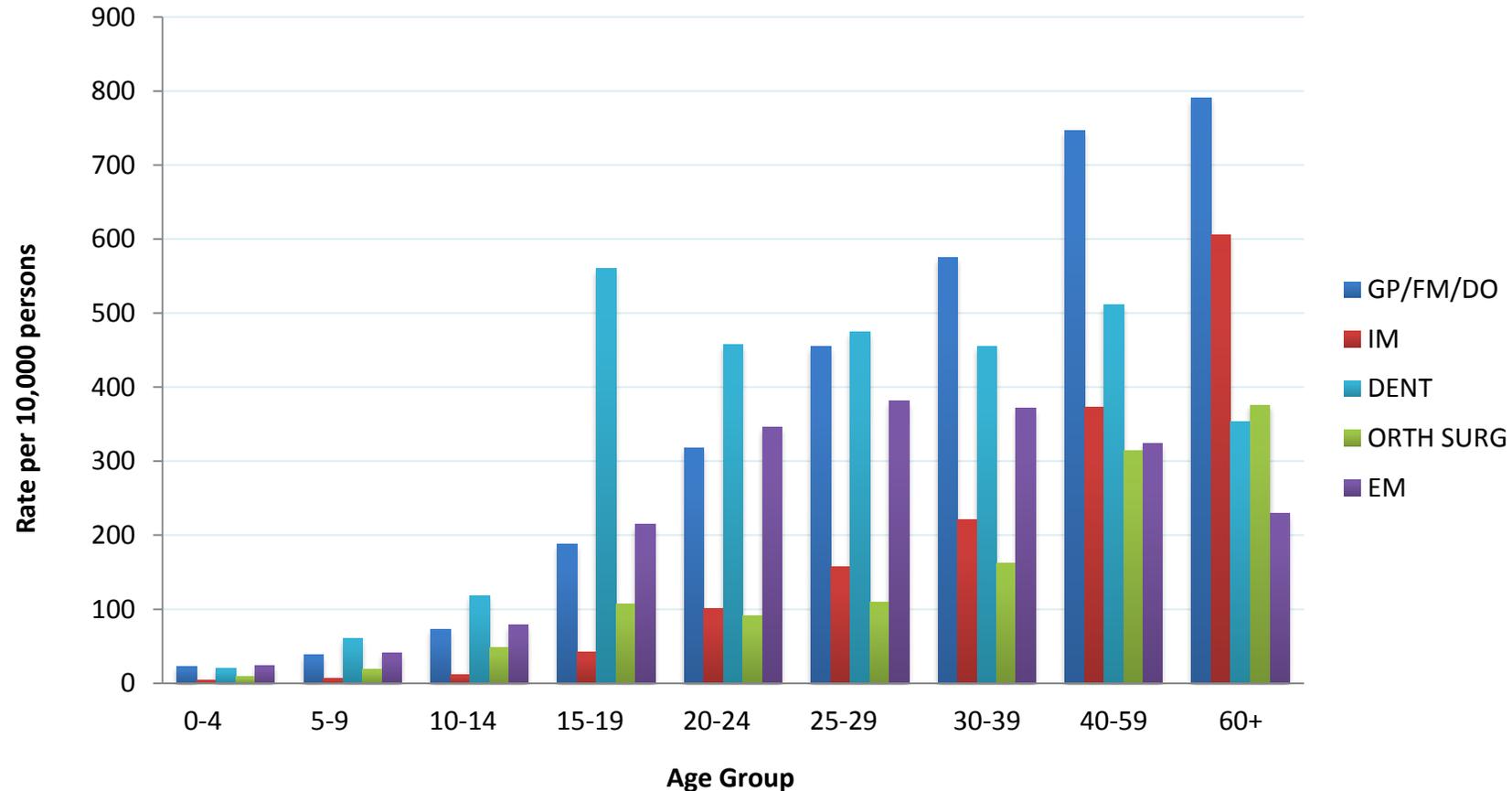
**10.** When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

**11.** Clinicians should **avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.**

**12.** Clinicians should **offer or arrange evidence-based treatment** (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) **for patients with opioid use disorder.**

# 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

# Why Consider Postoperative Pill or Duration Recommendations?

- The vast majority of pills prescribed post-op are left over and may be used for subsequent misuse or diversion
- Leftover pills in kids via parent diaries:

Surgical Procedures	# Pills Dispensed	# Pills Leftover (Actual on Day 4)
Tonsillectomy	52 pills	44 pills
Musculoskeletal	34 pills	30 pills
Minor abdominal, genitourinary tract, or peripheral procedures	31 pills	28 pills

# Education Decreases Opioid Prescribing After Surgeries

- Education to surgical residents, associate providers and attendings at Dartmouth-Hitchcock Medical Center
  - Use of non-opioid analgesics, reserve opioids for persistent pain
  - Prescribe the following number of opioid pills for partial mastectomy (PM) #5, sentinel lymph node biopsy (SLNB) #10, laparoscopic cholecystectomy (LC) #15, laparoscopic inguinal hernia repair (LIH) #15, open inguinal hernia repair (IH) #15
- Between June 2016 and September 2016, there were 246 surgeries

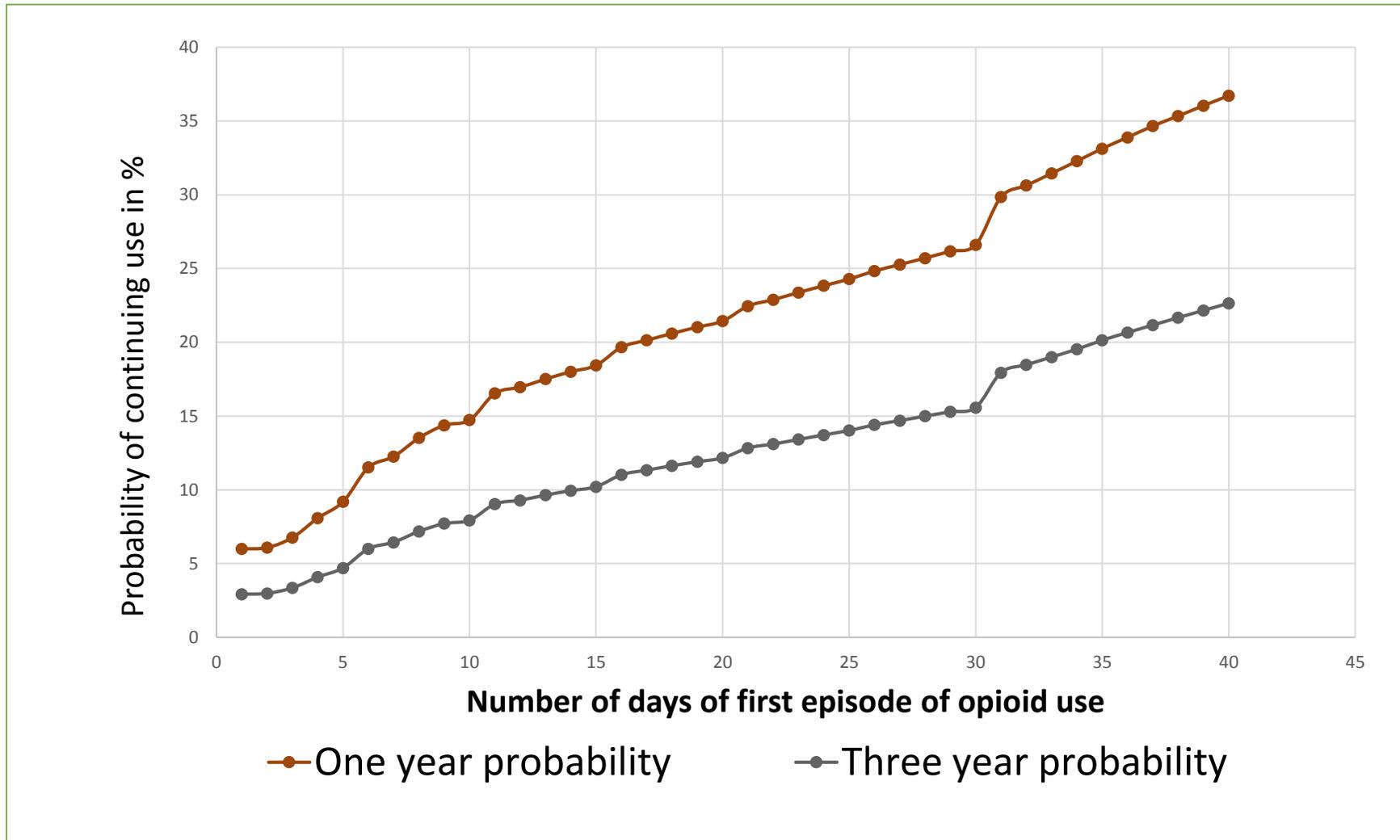
TABLE 2. Comparison of Opioid Prescriptions Pre versus Post Provider Education

Operation	Number of Cases		Mean Number of Opioid Pills Prescribed (SD)			Median Number of Opioid Pills Prescribed		Range	
	Pre	Post	Pre	Post	<i>P</i>	Pre	Post	Pre	Post
PM	175	58	19.8 (10.2)	5.1 (4.1)	0.0001	20	5	0–50	0–20
PM SLNB	112	62	23.7 (11.3)	9.6 (2.4)	0.0001	20	10	0–60	5–15
LC	240	58	35.2 (16.9)	19.4 (7.2)	0.0001	30	15	0–100	0–40
LIH	80	27	33.8 (9.0)	19.3 (7.3)	0.0001	30	15	15–70	0–30
IH	85	18	33.2 (15.7)	18.3 (8.7)	0.0003	30	15	15–120	0–40

TABLE 4. Opioid Pills Taken

Operation	PM	PM SLNB	LC	LIH	IH	Total
Patients	58	62	58	27	18	224
No. surveyed (%)	34 (58.6)	42 (67.7)	42 (72.4)	20 (74.0)	10 (38.9)	148 (66.0)
Pills prescribed (n)	162	398	823	390	140	1913
Pills taken (%)	59 (36.4)	75 (18.8)	307 (37.3)	187 (47.9)	28 (20.0)	656 (34.3)
Mean no. of pills taken (SD)	1.8 (3)	1.9 (3)	7.5 (8.3)	9.7 (10.7)	2.8 (7.7)	
Refills	0	0	0	1	0	1

# Continued Use by Initial Days of Therapy



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

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

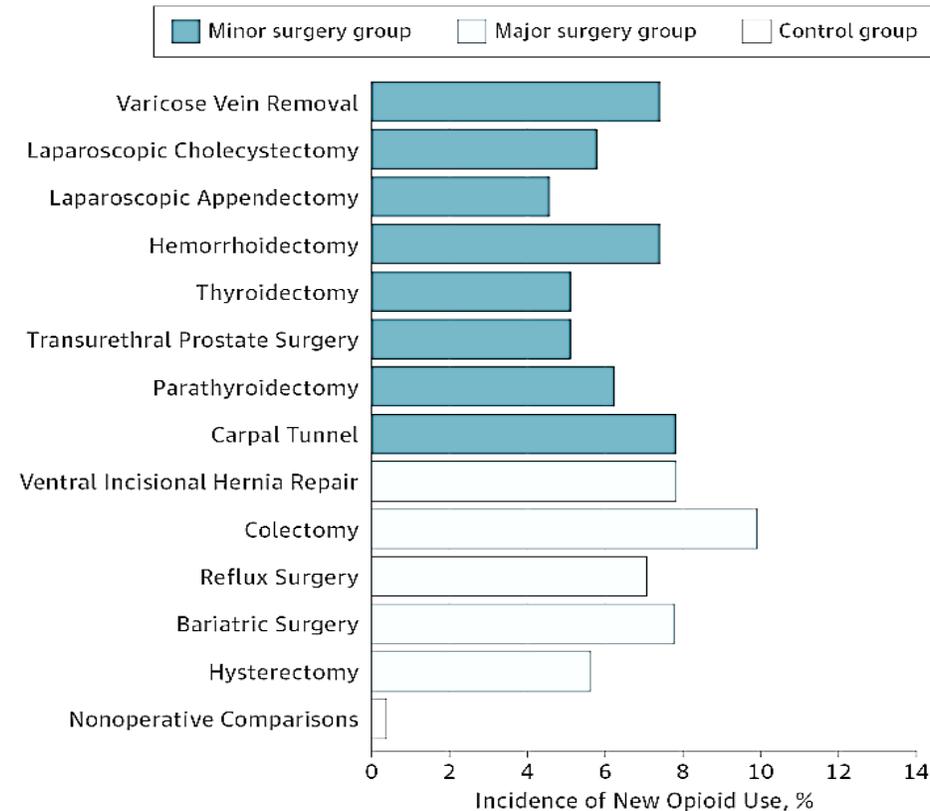


Figure Legend:

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%.

# Duration of Opioid Use is a Predictor of Misuse

- 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 year age group

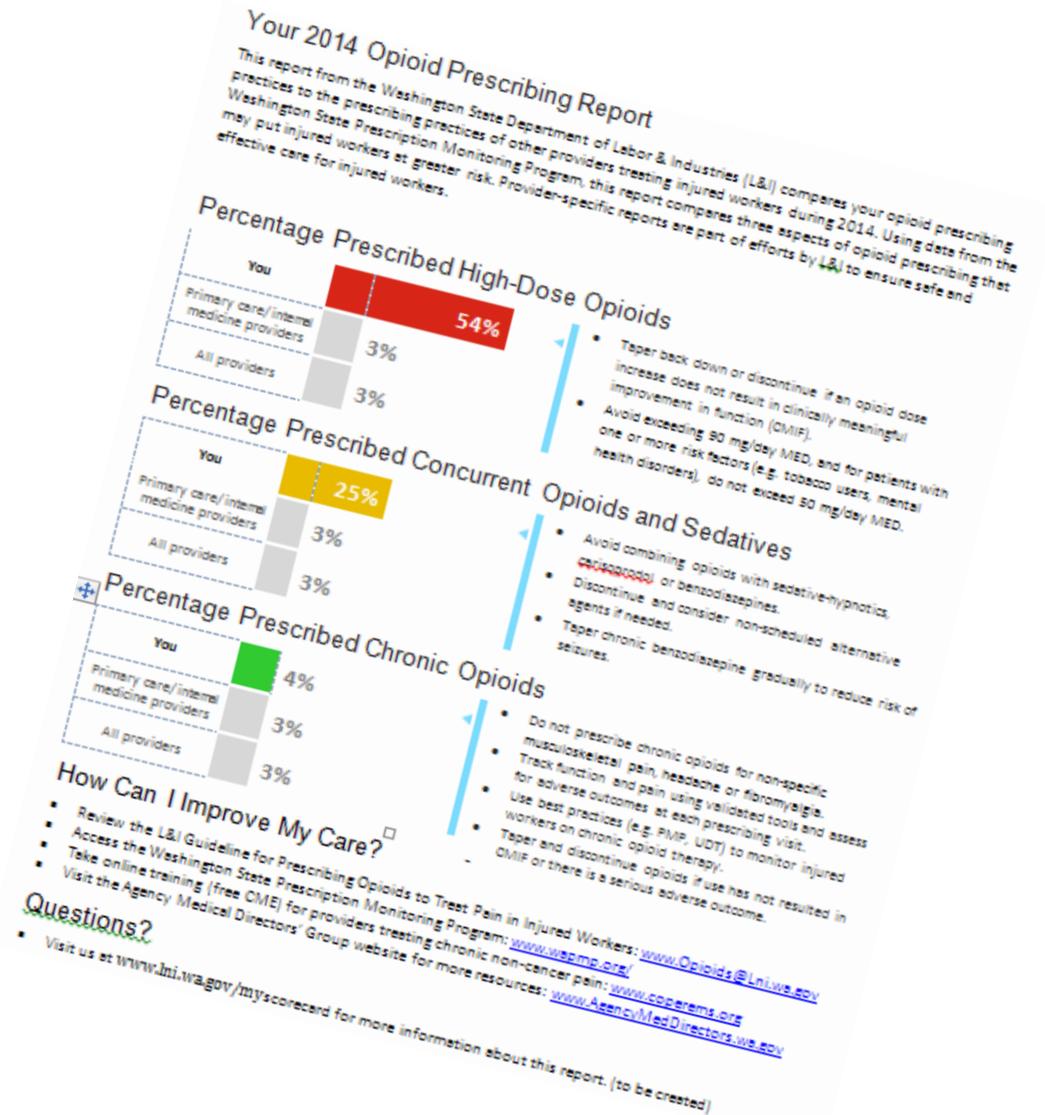
# DRAFT: Table 1. Duration of Opioid Treatment for Postoperative Discharge



Type I	
Dental procedures such as third molar or wisdom tooth extraction, graft, implant	<ul style="list-style-type: none"> <li>Prescribe a nonsteroidal anti-inflammatory drug (NSAID) or combination of NSAID and acetaminophen for mild to moderate pain as first line therapy</li> <li>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</li> </ul>
Procedures such as hernia repair, laparoscopic appendectomy, carpal tunnel release, laparoscopic cholecystectomy, biopsy, meniscectomy	<ul style="list-style-type: none"> <li>Prescribe non-opioid analgesics (e.g., NSAIDs, acetaminophen) and non-pharmacologic therapies as first line therapy</li> <li>If opioids are necessary, prescribe ≤ 3 days (e.g., 8 to 12 pills) of short-acting opioids for severe pain</li> </ul>
Type II	
Procedures such as anterior cruciate ligament (ACL) repair, rotator cuff repair, discectomy, laminectomy	<ul style="list-style-type: none"> <li>Prescribe non-opioid analgesics (e.g., NSAIDs, acetaminophen) and non-pharmacologic therapies as first line therapy</li> <li>Prescribe ≤ 7 days (e.g., up to 42 pills) of short-acting opioids for severe pain.</li> <li>For those exceptional cases that warrant more than 7 days of opioid treatment, the surgeon should re-evaluate the patient before refilling opioids and taper off opioids within 6 weeks after surgery</li> </ul>
Type III	
Procedures such as lumbar fusion, knee replacement, hip replacement	<ul style="list-style-type: none"> <li>Prescribe non-opioid analgesics (e.g., NSAIDs, acetaminophen) and non-pharmacologic therapies as first line therapy</li> <li>Prescribe ≤14 days of short-acting opioids for severe pain.</li> <li>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</li> </ul>
Patients on Chronic Opioid Therapy	
Elective surgery in patients on chronic opioid therapy	<ul style="list-style-type: none"> <li>Follow the recommendations above for the appropriate surgery type</li> <li>Resume chronic regimen if patients are expected to continue postoperatively</li> </ul>

# Metrics to Guide “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. Bree Collaborative)
- Use metrics to notify outlier prescribers



# Bree Opioid Metrics



## *General prescribing*

- Prevalence of opioid use    % with  $\geq 1$  opioid Rx of all enrollees, by age

## *Long-term prescribing*

- Chronic opioid use        % with  $\geq 60$  days supply of opioids in the quarter
- High dose use              % with doses  $\geq 50$  and  $\geq 90$  mg/day MED in chronic opioid users
- Concurrent use            % with  $\geq 60$  days supply of sedatives among chronic opioid users

## *Short-term prescribing*

- Days supply of first Rx    % with  $\leq 3$ , 4-7, 8-13, and  $\geq 14$  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  $\geq 3$  quarters of use

# The State of US Health, 1990-2010: Burden of Diseases, Injuries, and Risk Factors

## Years lived with disability 2010

- Low back pain 3.18 million YLD
- Major depressive disorder 3.05 million YLD
- Other MSK disorders 2.6 million YLD
- Neck pain 2.13 million YLD
- Anxiety disorders 1.86 million YLD
- Diabetes (#8) 1.16 million YLD
- Alzheimers (#17) .83 million YLD
- Stroke (#23) .63 million YLD

# Improving Capacity to Treat Pain and Addiction

- Deliver coordinated, stepped care services aimed at improving pain **and** addiction treatment
  - Cognitive behavioral therapy or graded exercise to improve patient self-efficacy
  - Opioid overdose case management by ED to identify behavioral health needs, evaluate for MAT, notify providers involved and discuss recommendations (e.g. Vermont Spoke and Hub)
- Increase access to pain and addiction experts (e.g. WA TelePain)

# Emerging Examples of Stepped Care Management or 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 Intern Med 2014 Dec;29(Suppl 4):870-6
- 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

# WA Federally Funded “Hubs”

- Cascade Medical Advantage – Whatcom, Skagit, Snohomish, Island, San Juan
- Rainier Internal Medicine dba Northwest Integrated Health – Pierce County
- Peninsula Community Health – Jefferson, Clallam, Kitsap
- Valley Cities – King County
- Harborview Medical Center – King County
- Lifeline Connections – Clark, Skamania, Grays Harbor, Pacific

# State Opioid Response Plan

## Priority Goals

**Goal 1:  
Prevent Opioid  
Misuse & Abuse**



**Improve  
Prescribing  
Practices**

**Goal 2:  
Treat Opioid  
Use Disorder**



**Expand Access  
to Treatment**

**Goal 3:  
Prevent Deaths  
from Overdose**



**Distribute  
naloxone to  
heroin users**

**Goal 4:  
Use Data to  
Monitor and  
Evaluate**



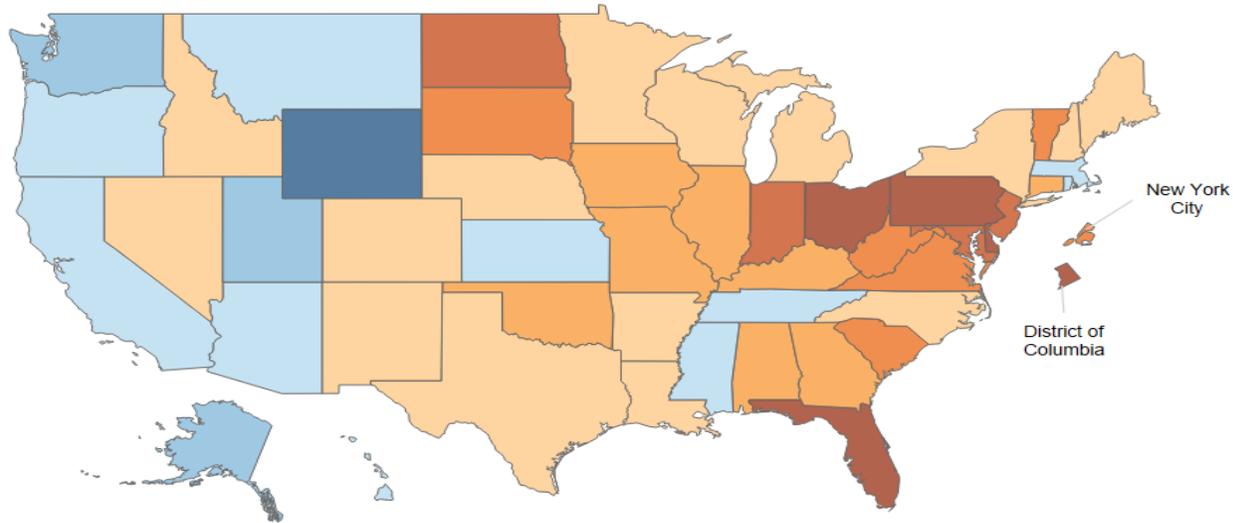
**Optimize and  
expand data  
sources**

## Priority Actions

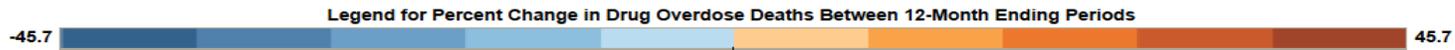
<http://stopoverdose.org/section/wa-state-interagency-opioid-working-plan/>

# Opioid Mortality 2016-2017

12-month Ending Period: July 2017  
Previous 12-month Ending Period: July 2016  
Based on data available for analysis on: February 4, 2018



United States: 14.4 %



**NOTES:** 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, X85, and Y10–Y14.

THANK YOU!

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