



Washington's Opioid Guidelines

Educational pilot or *de facto* regulation?

Melissa Burke-Cain, AAG

- Washington's dosage guidelines: "who," "what", "why", and "how."
- Policy and legal challenges: inside and outside state government.
- 20:20 hindsight, missteps, next steps, and other bureaucratic clichés.

Washington's growing problem: the "why"

- More than 90% of Washington's poisoning deaths are drug overdoses; an increasing number are prescription opiate overdoses.
- From 1997-2004 sale of methadone as a painkiller increased 974%; oxycodone increased 580%.
- Poisoning mortality rate rose from 9/100,000 in 1996 to 14/100,000 in 2005; highest risk: males 45-54.

The guidelines: less than 120 MED/day: the “what”

- For primary care provider who prescribe opioids for adults when:
- Instituting or transitioning opioid treatment from acute to chronic non-cancer pain;
- Assessing and monitoring opioid treatment for chronic non-cancer pain; and
- Weaning opioids if an opioid trial fails to yield improvements in function and pain.

The guidelines: greater than 120 MED/day

Reduce, dose by 10%, objective assessment, pain and function, discontinue/continue.

Refer to pain management program.

Refer to addiction management program.

Only for chronic non-cancer pain not acute pain, cancer pain, surgery-related pain, or end-of-life or hospice care.

Intended for use by all providers who prescribe opioids for chronic, non-cancer pain.

The Agency Medical Director's Group: the “who” and “how”

- Ad hoc, self-branded, no specific legal authority.
- Workers' comp, Medicaid, state employee/retiree plans, corrections, veterans' affairs, State Health Officer (DOH).
- Website, CME, external marketing.
- Minimal stakeholder involvement.
- Jurisdiction questions.

Internal disputes: agency “sibling rivalry”

- Medical Commission adopted pain management rules (WAC 246-919-800) in 1999; policy guidelines in 1996.
- By statute the Secretary of DOH coordinates with the health professions regulatory boards to develop uniform guidelines re: opiate therapy. RCW 18.130.340. (Uniform Disciplinary Act).
- Assure effective medical treatment in accordance with recognized national standards and consistent with requirements of the public health and safety.
- DOH IVPP “Prescription Opiate Morbidity and Mortality Prevention Workgroup; stakeholders from private, public, academic, local and state public health, law enforcement.

Are the guidelines supportable on their merits?

- Potential state law conflict: unprofessional conduct, debarment, malpractice, 3rd-party payers.
- *De facto* rule.
- FSMB guidance.
- Not enough pain specialists for referral.
- “Many doctors assume that if the state of Washington suggests this level of care, then it is unacceptable to proceed otherwise.” (NY Times 6-17-07 quoting Scott Fishman MD).

External Disputes: *Janes v. State*

19 counts

- Filed by doctor under medical board investigation representing classes of physicians and chronic pain patients; Pain Relief Network funding.
- Age and disability discrimination (state; federal).
- Liberty interest; choice of provider or treatment.
- Collateral attack on medical board.
- state law conflict, unauthorized regulation of medical practice, tort claims.

An ounce of prevention...

- Connect dots of legal authority within the executive branch: executive order, express delegation of agency discretion, rulemaking or other administrative procedure, interagency MOU.
- Neutral square stakeholder work, transparency, ease bureaucratic inertia: lawyers' role?
- (with executive approval) work with legislative staff re: express direction, budget proviso, capture legislative debate or history.