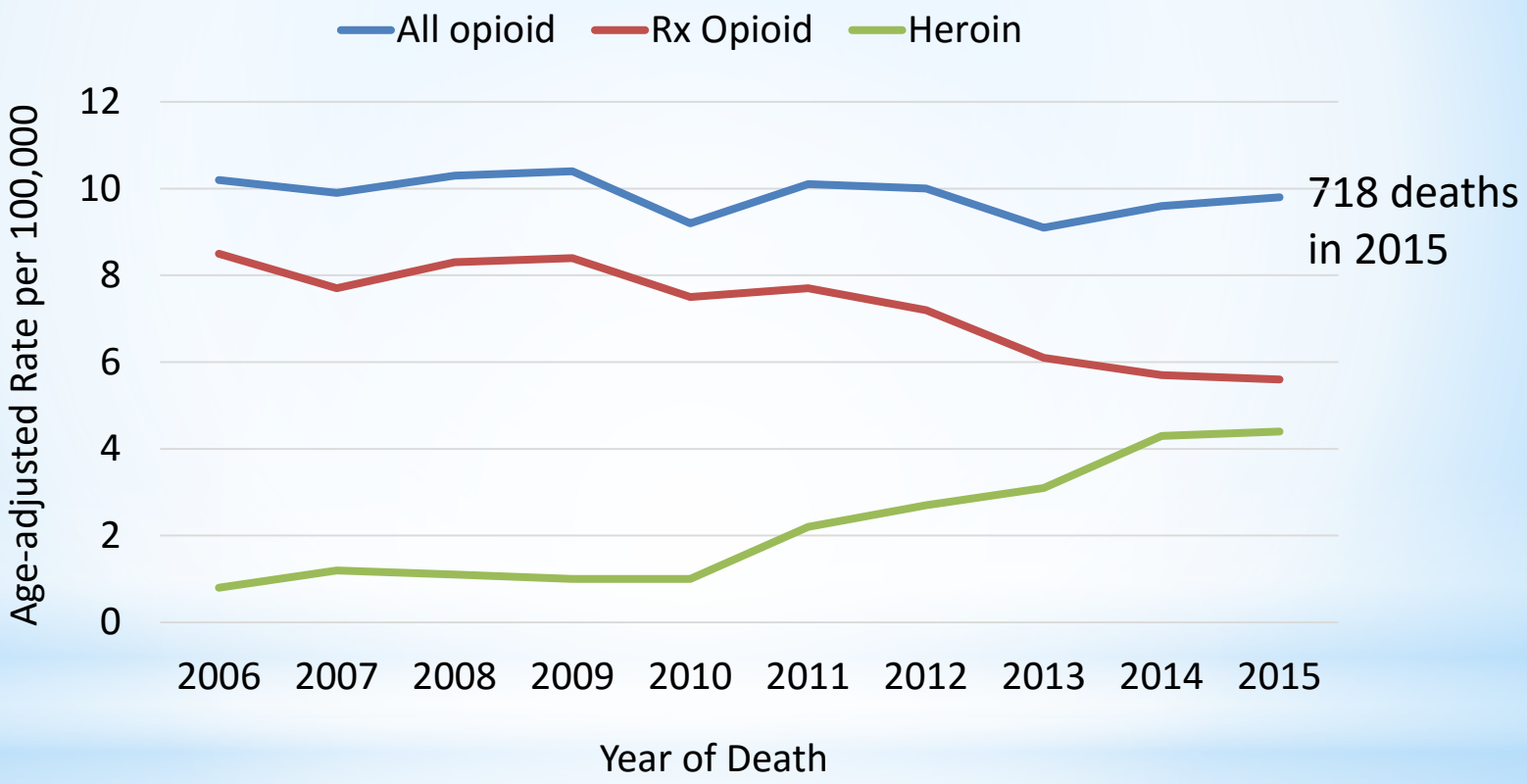
Reviewing Washington's Existing Pain Rules & Next Steps Under ESHB 1427

September 20, 2017

Washington Opioid Overdose Death Rates,* 2006–2015



Source: DOH Death Certificates

* Includes all intent of drug-related deaths with the additional ICD-10 codes of T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6

Note: Intentional self-poisonings account for ~9% of all opioid overdose deaths

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The days of freely prescribed painkillers are ending. Here's what's next.

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By Christine Vestal May 20, 2016

For more than a decade, doctors, dentists and nurse practitioners liberally prescribed opioid painkillers even as evidence mounted that people were

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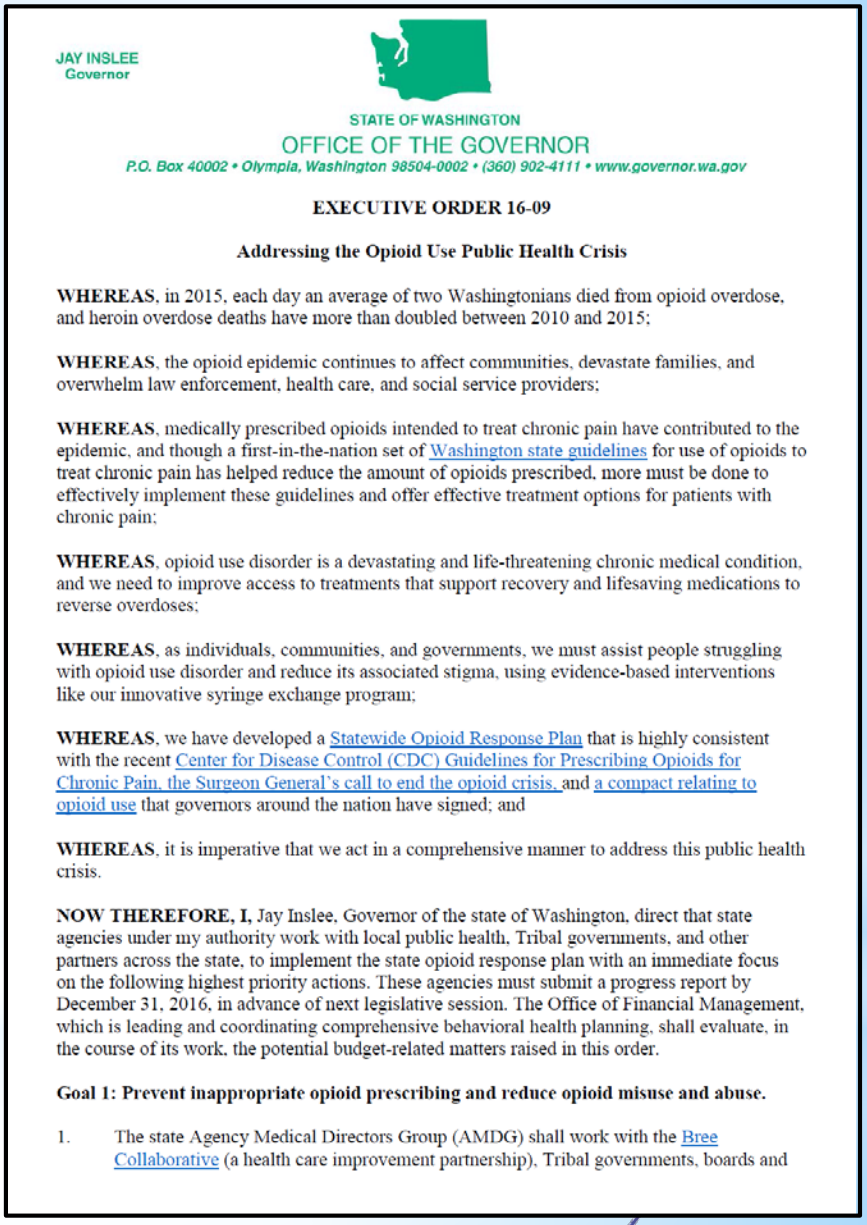
Executive Order

- Increasing heroin use and overdose rates identified as a critical public health imperative.
- Governor's EO 16-09 calls for:
  - Implementing safe prescribing practices
  - Exploring non-opioid alternatives to pain
  - Expanding access to medication-assisted treatment
  - Increasing use of PMP



JAY INSLEE
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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 program;

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

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Ideas that went forward

- Expand DOH access to be able to assess PMP data with morbidity and mortality data.
- Authority to send prescriber feedback reports.
- Local Health Officer access for overdose follow up.
- Allow facility access to Federal & Tribal agencies.
- Overdose notification via the Emergency Department Information Exchange (EDIE).
- Facility and group access to prescriber metrics.
- Hospital Association access to prescriber data.
- Revise immunity provisions to all end users.

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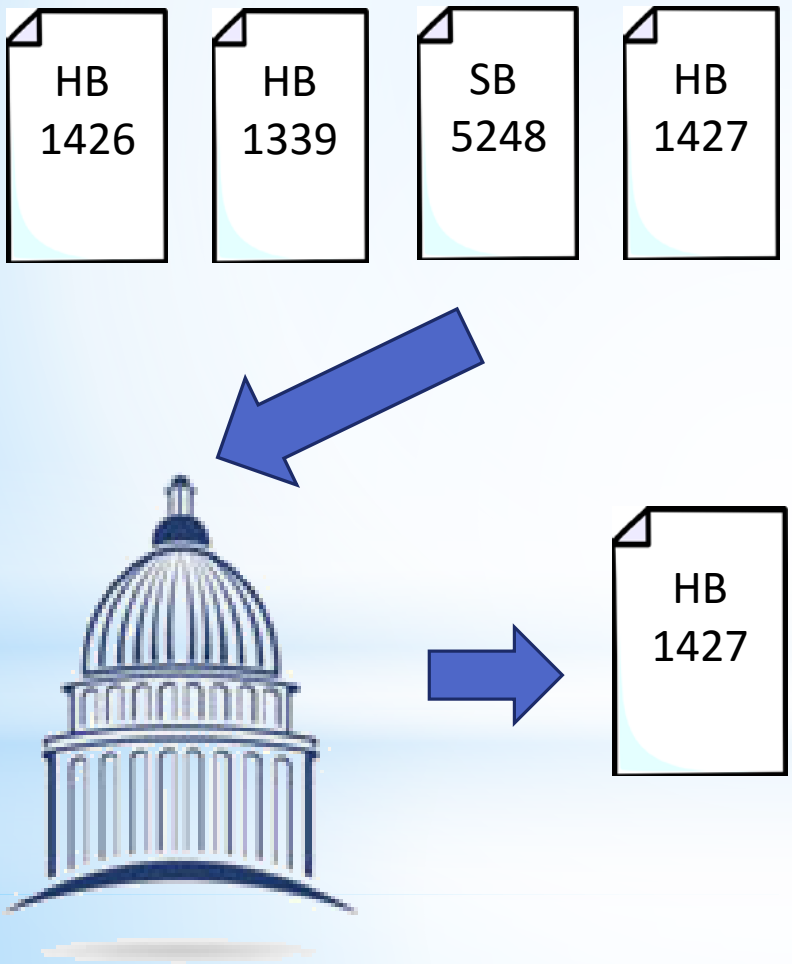
Legislative Process



ESHB 1427 Key components:

- Expands B/C prescribing rules--
  - Acute, subacute, perioperative pain
  - Update chronic pain rules
- Authorizes Health Officer and other gov't access to PMP data.
- Authorizes facility/group access to PMP data.
- Authorizes hospital CQIPs to use PMP data.
- Authorizes prescriber feedback reports.

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1427 Objectives – B/C Prescribing Rules

- Generate a boilerplate set of prescribing rules.
- Uniform recommendations on revising existing pain management rules.
- Each B/C will adopt rules under their own authority.
- Coordinated education and outreach campaigns.

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2011 – B/C Chronic Non-Cancer Pain Rules

- In 2010, ESHB 2876 directed:
  - Medical Quality Assurance Commission (MQAC)
  - Nursing Care Quality Assurance Commission (NCQAC)
  - Dental Quality Assurance Commission (DQAC)
  - Board of Osteopathic Medicine and Surgery (BOMS)
  - Podiatric Medical Board (PMB)

  to adopt chronic non-cancer pain rules by June 30, 2011.
- Rules included dosage limits for pain management consultation and any exceptions, education and training requirements, and other practice standards.
- Specifically excluded both acute and palliative care.
- Required consultation with Agency Medical Directors Group (AMDG), DOH, UW and professional associations.

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Highlights of Existing Pain Rules

- Defines terms like “acute pain”, “addiction”, “comorbidity”, “morphine equivalent dose”, and “multidisciplinary pain clinic”.
- Requires a comprehensive health history and physical examination.
- Sets requirements for treatment plans including physical and psychosocial function, additional diagnostics and alternative therapies needed.
- Establishes informed consent requirements.
- Prescriber-patient written agreements must be used, which describe drug testing requirements, process for releasing a patient for violations, and to whom (including authorities) a prescriber reports agreement violations.

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Highlights of Existing Pain Rules

- Stipulates how frequently, based on MED level, periodic patient reviews must occur, including patient compliance and function level.
- Long-acting opioids, including methadone, should only be prescribed by competent providers.
- Recommends that PMP or similar data be reviewed prior to prescribing for episodic care (e.g. ED or urgent care), and amount should be minimized to control pain temporarily.
- Requires consideration of referral for minor patients or those with a history of abuse.

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Highlights of Existing Pain Rules

- Sets mandatory consultation threshold at 120 MED and describes acceptable consultation formats.
- Exempts prescribers who comply with the rules and:
  1. are tapering, or
  2. in need of temporary acute care, or
  3. documents attempts to consult with a specialist, or
  4. The patient is stable on a nonescalating dose.
- Establishes exemption requirements for pain management consultation.
- Sets education, training, and practice standards for pain management consultants.

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2017 – Expanded B/C Pain Rules

- Same five B/Cs must adopt general opioid prescribing rules under HB 1427.
- Provides for possible exemptions based on education, training, prescribing level, patient panel, and practice environment.
- Must consider revised AMDG and CDC guidelines.
- Must consult with professional associations, DOH, and the UW.
- Must adopt rules by January 1, 2019.

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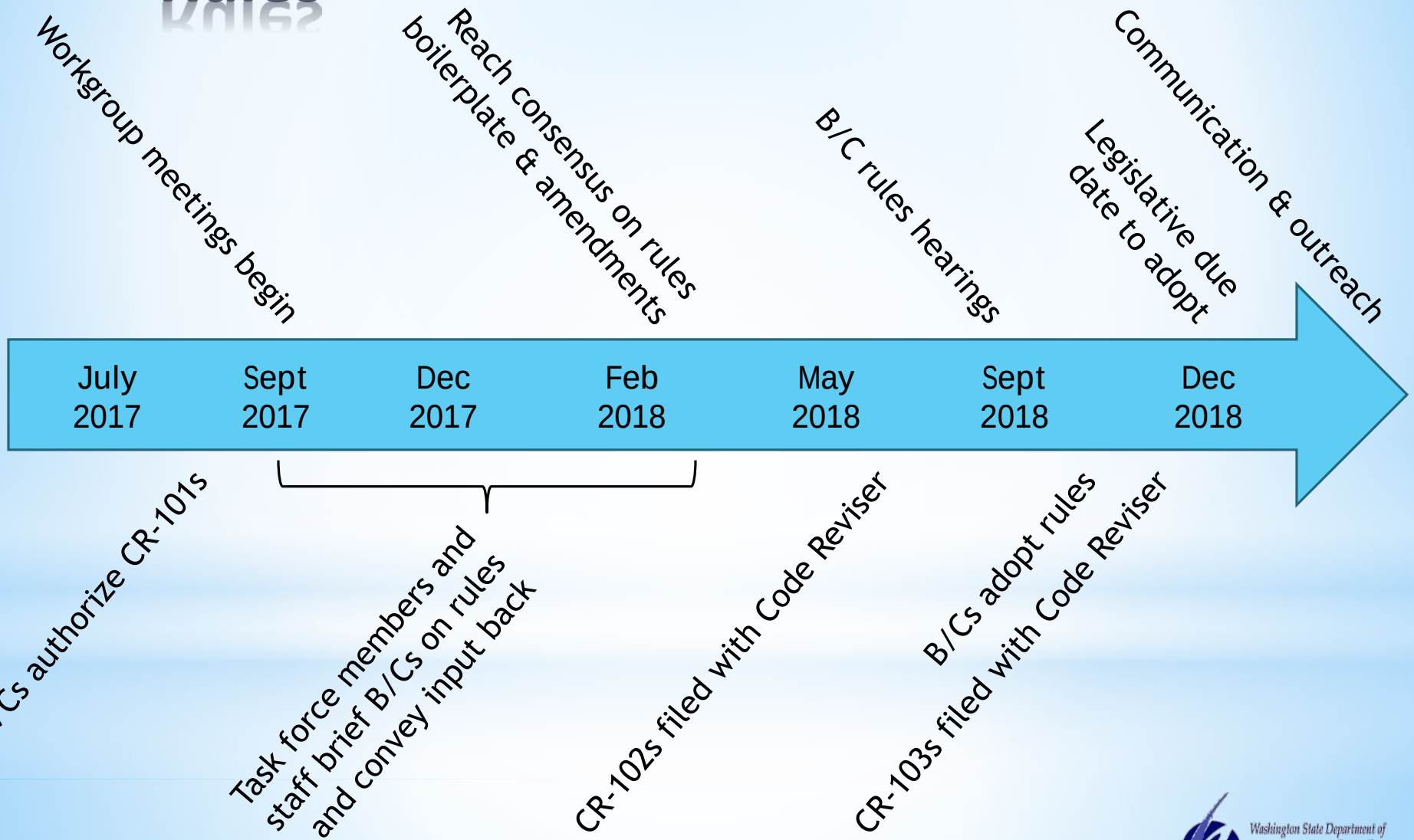
PROPOSED 1427 Timeline – B/C Rules



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Questions?

For more information, go to www.doh.wa.gov/opioidprescribing

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