


Is Your Organization Compliant?
The Washington PMP and Opioid Prescribing Rules

2018 Health Care
Compliance Association
Conference

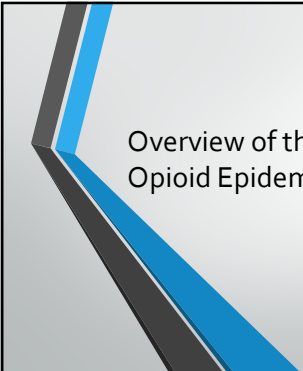
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Outline

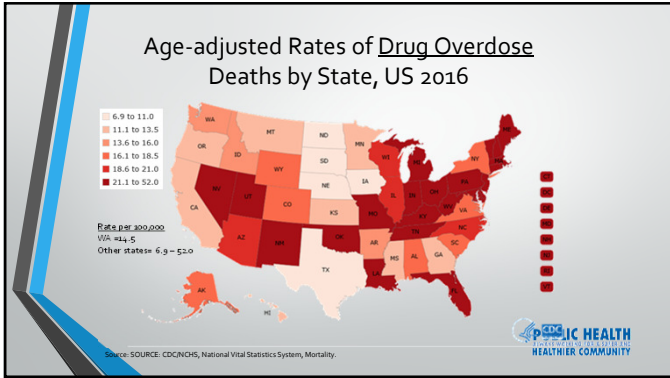
- Overview of the Opioid Epidemic
- Overview of House Bill 1427 and PMP enhancements
- New Comprehensive Opioid Prescribing Rules
- PMP Overview
- PMP Enhancements under HB 1427
- Q&A

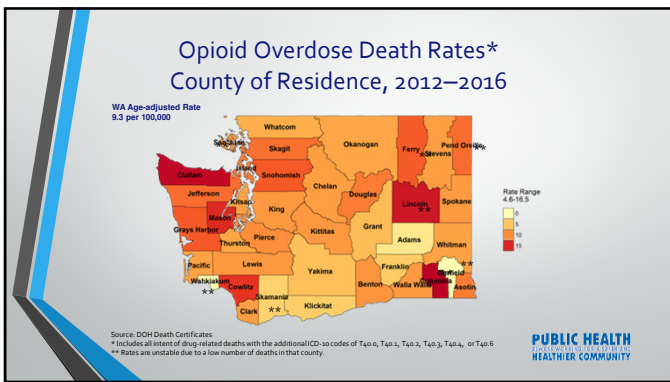
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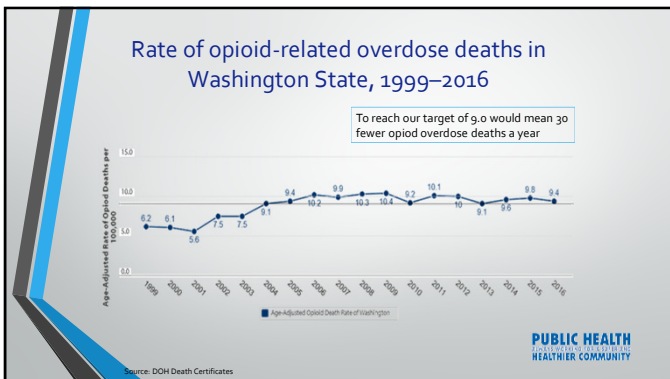


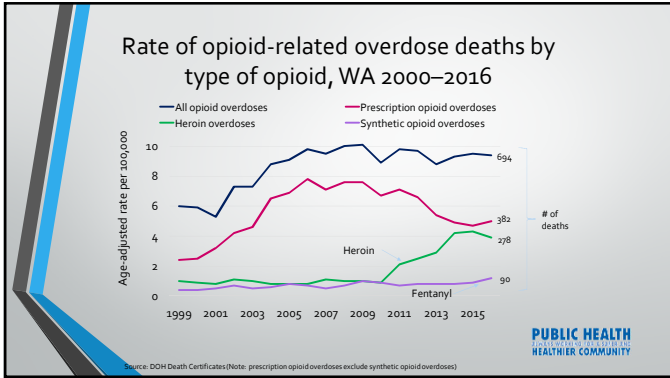
Overview of the
Opioid Epidemic

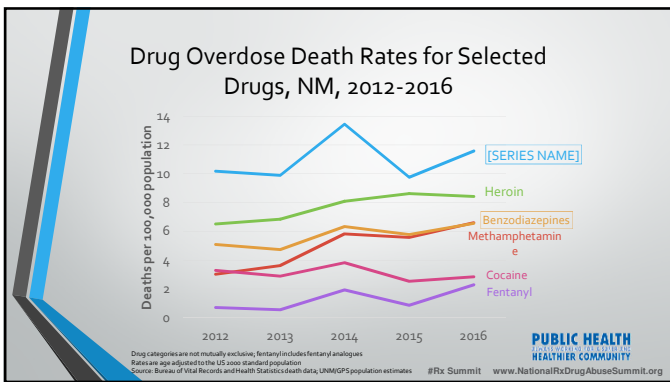
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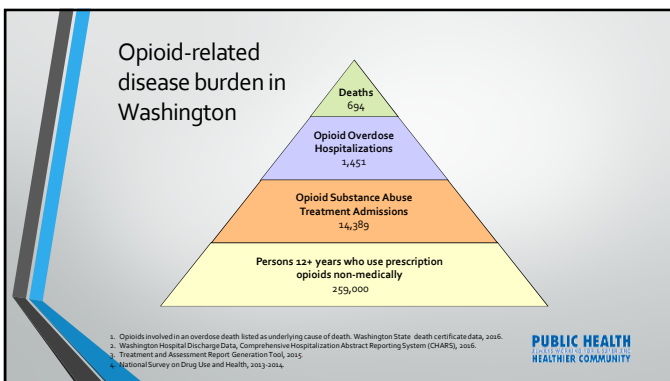













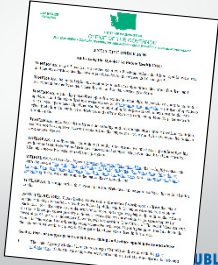

Overview of House Bill 1427



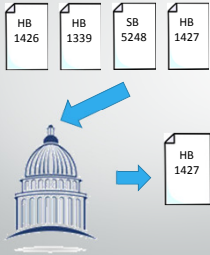
Executive Order 16-09

Key goals from the Order:

- Safer prescribing practices
- Expanding use of non-opioid alternatives
- Expanded access to medication-assisted treatment
- Increased use of the PMP





Legislative Process



ESHB 1427 Key components:

- Expands B/C prescribing rules--
 - Acute, subacute, peri-operative 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.



2011 – B/C Chronic Pain Rules

- In 2010, HB 2876 directed:
 - Dental Quality Assurance Commission (DQAC)
 - Medical Quality Assurance Commission (MQAC)
 - Nursing Care Quality Assurance Commission (NCQAC)
 - Board of Osteopathic Medicine and Surgery (BOMS)
 - Podiatric Medical Board (PMB)
- to adopt chronic non-cancer pain rules by June 30, 2011.
- Specifically excluded both acute and palliative care.

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2011 – B/C Chronic Pain Rules (cont.)

- Rules included dosage limits for pain management consultation and any exceptions, education and training requirements, and other practice standards.
- Required consultation with Agency Medical Directors Group (AMDG), DOH, UW and professional associations.

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New Comprehensive Opioid Prescribing Rules

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2017 – Expanded B/C Pain Rules

- Boards and Commissions 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.
- May consult with professional associations, DOH, and the UW.
- Must adopt rules by January 1, 2019.
- DOH convened a task force of representatives from each board/commission

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2017 Opioid Rules – Highlights

- Acute pain (0-6 weeks)
 - Patient evaluation and record; treatment plan.
 - 7 day prescribing limit without documentation in patient record.
- Perioperative pain
 - Treatment plan.
 - 14-day prescribing limit without documentation in patient record.

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2017 Opioid Rules – Highlights (cont.)

- Subacute pain (6-12 weeks)
 - Patient evaluation and record; treatment plan.
 - 14 day prescribing limit without documentation in patient record.
 - Additional screening, biological testing, and consultation requirements.
 - Consideration of pharmacologic or non-pharmacologic alternatives.
 - Acknowledgement that patient is transitioning to a period of increased risk for opioid addiction.

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2017 Opioid Rules – Highlights (cont.)

For chronic non-cancer pain (greater than 12 weeks), most requirements were unchanged.

- History, evaluation, and treatment plan.
- Written provider/patient agreement with periodic review.
- Consultation agreement remains when patient prescription exceeds 120 mg/day MED.
- Consultation exemptions for patients and prescribers.
- Education/experience requirements to be a pain management specialist.
- Tapering requirements. **NEW!**
- High-dose patients with new prescribers. **NEW!**

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2017 Opioid Rules – Highlights (cont.)

- Continuing Education—minimum 1 hour in first full CE cycle on opioid prescribing best practices.
- Alternative treatments—must consider pharmacologic and non-pharmacologic alternatives, rather than defaulting to opioids.
- Patient notification—discuss and document:
 - Risk of opioids
 - Safe and secure storage of opioid prescriptions.
 - Appropriate disposal of unused opioids.

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2017 Opioid Rules – Highlights (cont.)

- Co-prescribing:
 - With benzodiazepines or sedative hypnotics.
 - With buprenorphine, naltrexone, etc.
 - With naloxone.
- Special populations:
 - Patients under age of 25.
 - Pregnant women.
 - Aging populations.
 - Acute care for chronic pain patients.

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2017 Opioid Rules – Highlights (cont.)

- Required PMP checks are a “floor” and each board/commission may enact stricter standards.
- Required PMP registration if you prescribe opioids.
- Required use of PMP:
 - Second opioid refill for acute and perioperative care.
 - Between acute → subacute and subacute → chronic.
 - For all acute opioid and sedative hypnotic prescriptions where PMP data are integrated into the electronic health record.

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2017 Opioid Rules – Highlights (cont.)

- Required PMP check for patients on chronic opioids (continued):
 - At least quarterly for high-risk patients.
 - At least semiannually for moderate-risk patients.
 - At least annually for low-risk patients.
 - Any aberrant behavior.
 - During episodic acute or perioperative care.


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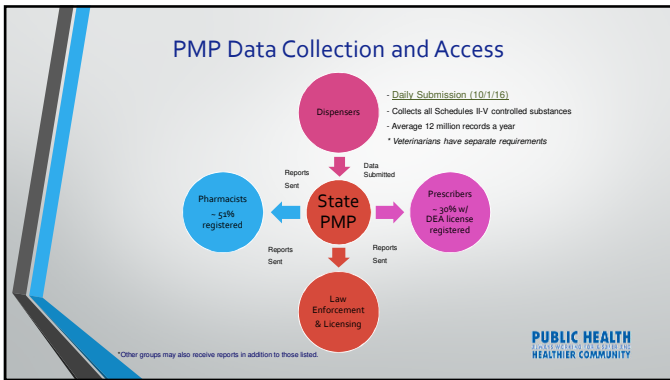
Next Steps

- May/June – boards/commissions will approve draft rules for public comment period.
- July – draft rules (CR-102) will be filed with Office of the Code Reviser; public comment period begins.
- August – boards/commissions will conduct formal rules hearings to consider comments/testimony.
- September – final rules (CR-103) adopted are filed with Office of the Code Reviser.
- October/November – final rules effective.
- September to December – education and outreach.

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PMP Overview




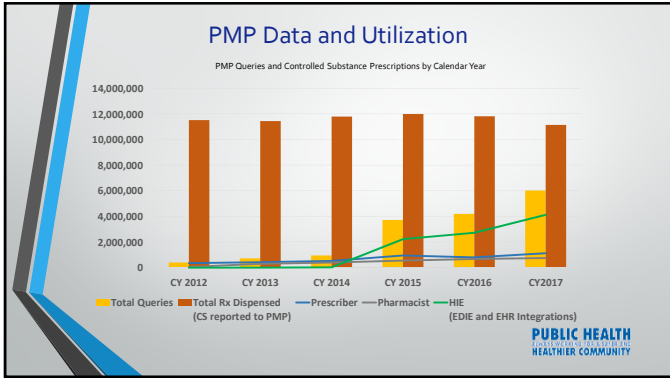


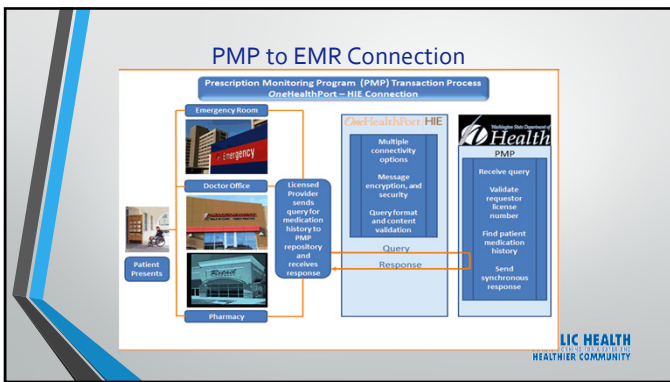
Prescriptions Dispensed 2012 – 2016

Generic Name	2012 Rx	2013 Rx	2014 Rx	2015 Rx	2016 Rx
HYDROCODONE (all)	3,043,357	2,928,052	2,855,227	2,521,688	2,371,802
OXYCODONE (all)	1,816,171	1,827,750	1,889,380	1,952,720	1,937,349
TRAMADOL HCL	---	---	308,803	730,446	718,261
ZOLPIDEM TARTRATE	898,620	838,636	790,571	761,159	712,360
DEXTRAMPHETAMINE/ AMPHETAMINE	466,702	323,013	579,927	626,923	701,795
LORAZEPAM	632,757	634,566	643,922	640,505	623,551
ALPRAZOLAM	644,377	641,634	644,930	625,209	609,594
CLONAZEPAM	519,642	521,425	527,935	520,615	502,644
METHYLPHENIDATE HCL	397,021	410,821	422,664	420,891	443,262
MORPHINE SULFATE	327,191	330,399	336,190	362,408	351,167
Total Rx Dispensed	11,509,488	11,434,877	11,771,216	11,992,986	11,798,943
CS reported to PMP	11,509,488	11,434,877	11,771,216	11,992,986	11,798,943

Update 03/16/2017









- ### PMP – HIE Status
- EDIE is currently sending requests for PMP data
 - 85 of 92 hospitals live
 - 5 Oregon ED's
 - 5 entities actively trading (CMT/EDIE, Valley Med, PTSO, UW, Kadlec)
 - 2 health systems actively testing with their EMRs (Kaiser and Providence)
 - 115 registrations of intent (meaningful use) to date representing 1,285 site locations
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PMP Enhancements
Under HB 1427




Assessing Overdose...

- Have linked PMP data to death data
 - Look at patterns most associated with deaths
- Would like to also look to do this with hospital overdose data
- Driven by recent high profile license revocations
 - [Seattle Pain Center cases](#)
 - Over 40 providers, estimated 12,000 patients
 - Possibly linked to 18 deaths



Local Health Officer Access

- County LHJ can make overdoses a notifiable condition
- When notified of overdose, the health officer checks PMP to find prescribers for overdose patient
- Three counties funded by CDC to follow up with living patients to refer to treatment with MAT.



Overdose Notification

- Emergency Department Information Exchange (EDIE) already receives:
 - Discharge information (overdose)
 - PMP information (prescribers)
- With this additional authority they can now send a notification to prescriber listed on the PMP report or to other PCPs they may have on record.

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SAMPLE Letters to Provider

RE: PATIENT'S FIRST AND LAST NAME, DOB, **FATAL OVERDOSE OF HEROIN**

Dear PROVIDER (LAST NAME AND DESIGNATED CREDENTIALS):

Your patient, **PATIENT'S FIRST AND LAST NAME**, died from an apparent opioid-related overdose at **HEALTHCARE FACILITY'S NAME**, an **IDENTIFIABLE**, Prescription Monitoring Program and Controlled Substance Reporting Program site, on **PATIENT'S DATE OF DEATH**. We are sorry to hear that your patient's death is a tragedy for you and your family.

We understand that the patient's death is difficult for both you personally to accept and process. We are providing you this information to support you in offering safe and effective care to patients.

Here are some important tips on managing pain and providing opioids:

- Consider providing patient education and resources regarding pain. See www.wa.gov/health.
- Follow opioid prescribing guidelines at www.wa.gov/health or www.wa.gov/health.
- If a patient needs opioids for acute pain, prescribe the lowest effective dose of immediate-release opioids for the shortest duration. Consider non-opioid analgesics with your patient. Patients rarely need more than one day's supply.
- Provide opioids for chronic pain only if benefits for both pain and function outweigh risks to the patient.
- Avoid all prescribing opioids, long-acting, or other addiction, including opioids with sedatives, benzodiazepines, or other sedatives. Combining opioids with sedatives, benzodiazepines, or other sedatives for the treatment of pain is a high-risk practice.
- Use the Prescription Monitoring Program database to verify if patients are receiving controlled substances from other providers. Register for the system at www.wa.gov/health.
- Participate in CME "Opioid Stewardship" or other continuing education opportunities or call the CME "Opioid Stewardship" at 1-800-533-XXXX to help in managing complex pain patients.
- Learn how to recognize opioid use disorder and offer evidence-based treatment. See the Recovery Program at www.wa.gov/health.
- Consider providing medication-assisted treatment (MAT) options to patients. See the related resources at www.wa.gov/health.

If you have any questions about the Prescription Monitoring Program, please contact the Washington State Department of Health at 1-800-533-XXXX or email info@doh.wa.gov.

Dear PROVIDER (LAST NAME AND DESIGNATED CREDENTIALS):

Your patient, **PATIENT'S FIRST AND LAST NAME**, was diagnosed with your fatal opioid-related overdose at **HEALTHCARE FACILITY'S NAME**, an **IDENTIFIABLE**, Prescription Monitoring Program and Controlled Substance Reporting Program site, on **PATIENT'S DATE OF DEATH**. We are sorry to hear that your patient's death is a tragedy for you and your family.

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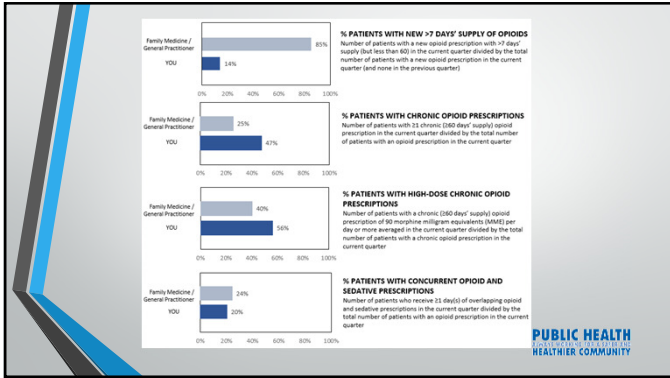
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Prescriber Feedback Reports

- DOH can send providers a report card about their prescribing practices
- Will use NPI to compare prescribing metrics of provider to those of like license type and specialty
- Plan to make the reports available self-service in the PMP portal
- Plan to send the reports out to select providers

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Facility/Group Prescribing Reports

- Allows chief medical officers to view prescribing metrics of those they supervise
- Use of quality improvement initiatives to drive adoption of prescribing guidelines
- Cannot be used for employment actions
- CMO must provide list of providers (with DEA #'s) to PMP for creation of metric reports
- Required by law to be sent quarterly

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Washington State Department of Health

Health Facility Name
CMO last name, first name
Reporting Period: MM/YYYY-MM/YYYY

Washington State Opioid Prescriber Feedback Report

Prescriber	Has WA PMP access	Prescriber's Specialty	Number of WA Prescribers In Practice	% NEW PATIENTS WITH >7 DAYS' SUPPLY OF OPIOIDS		% PATIENTS WITH CHRONIC OPIOID PRESCRIPTIONS		% PATIENTS WITH HIGH-DOSE CHRONIC OPIOID PRESCRIPTIONS		% PATIENTS WITH CONCURRENT OPIOID AND SEDATIVE PRESCRIPTIONS	
				Prescriber	Specialty	Prescriber	Specialty	Prescriber	Specialty	Prescriber	Specialty
YOU	yes	Internal medicine	25,699	55%	46%	30%	29%	13%	32%	27%	18%
Last name, first name	no	Psychiatry	19,022	14%	85%	47%	25%	58%	40%	20%	24%
Last name, first name	yes	Pediatrics	23,882	84%	61%	33%	80%	42%	21%	33%	45%
Last name, first name	no	Internal medicine	25,699	56%	48%	30%	29%	22%	32%	2%	18%
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Washington State Department of Health | Prescription Monitoring Program
www.doh.wa.gov/pmp | pscriptmon@dcsh.wa.gov

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Washington Hospital Association

- Coordinated Quality Improvement Program (CQIP)
 - Purpose: "to improve the quality of health care services by identifying and preventing health care malpractice"
 - Approved by DOH, confidential (no public disclosure)
- Receive a flat file of records (patients are de-identified)
- Allows the association's program to evaluate prescribing statewide for quality improvement opportunities

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Questions?

www.doh.wa.gov/opioidprescribing

Blake Maresh, MPA, CMBE
Executive Director
Office of Health Professions
Washington Department of Health
360/236-4760 (W)
blake.maresh@doh.wa.gov

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