Washington State Department of Health

Update on the Pain Rules, the PMP, and Resources for Opioid Epidemic

WPSC 16th Annual NW Patient Safety Conference

PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND HEALTHIER COMMUNITY

Disclosures

- Blake Maresh, Chris Baumgartner and Mary Catlin have no financial relationships to disclose that propose a conflict of interest

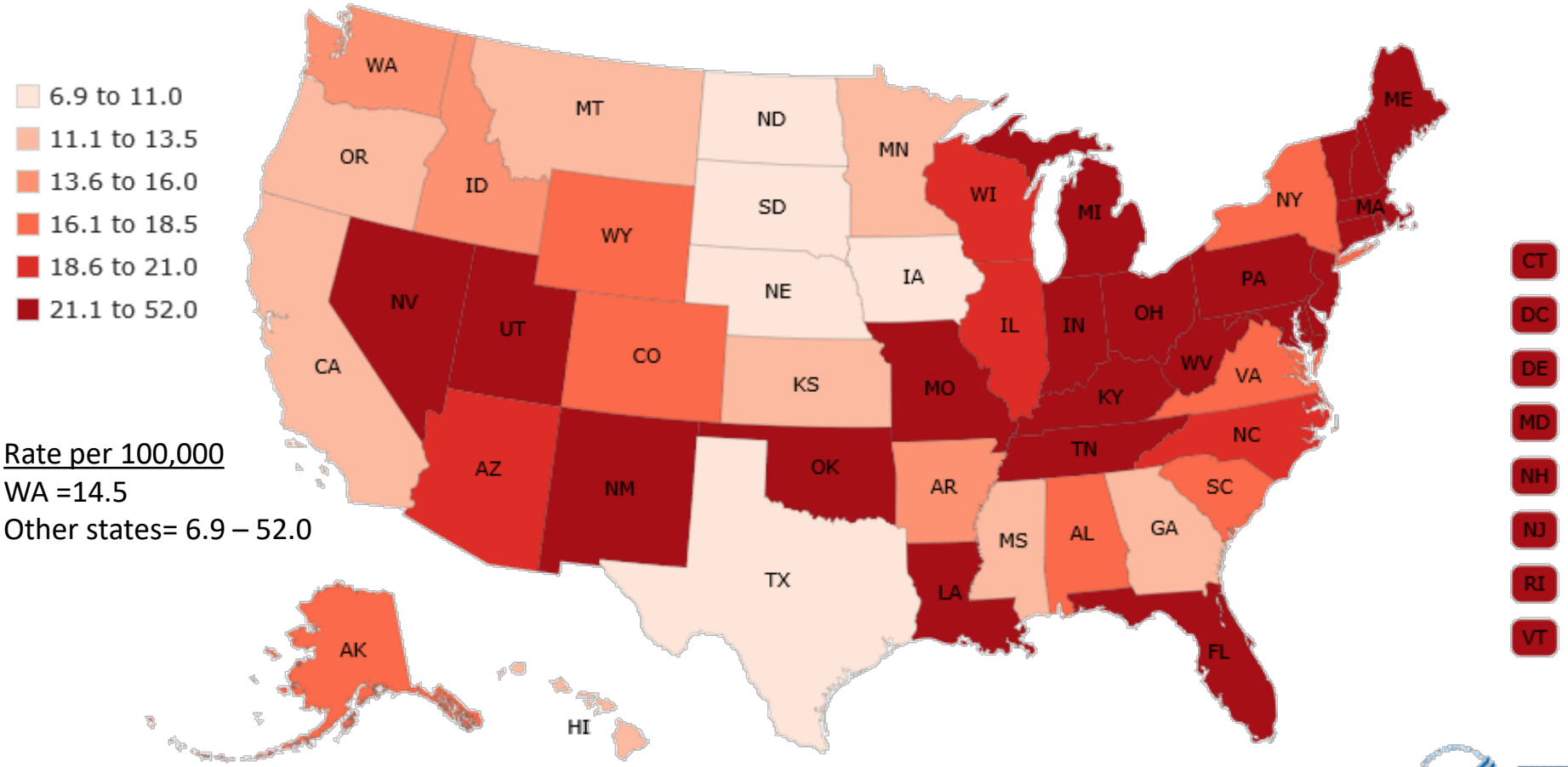
- There will be no unannounced mention of investigational or FDA off-label indications of drugs

Outline

- Overview of the Opioid Epidemic
- WA Prescribing Data
- Overview of House Bill 1427 and Prescription Monitoring Program (PMP) enhancements
- New Comprehensive Opioid Prescribing Rules
- PMP Overview
- Using Safety and Quality Assurance (QA) Professionals to measure compliance
- Questions and Answers

Overview of the Opioid Epidemic

Age-adjusted Rates of Drug Overdose Deaths by State, US 2016

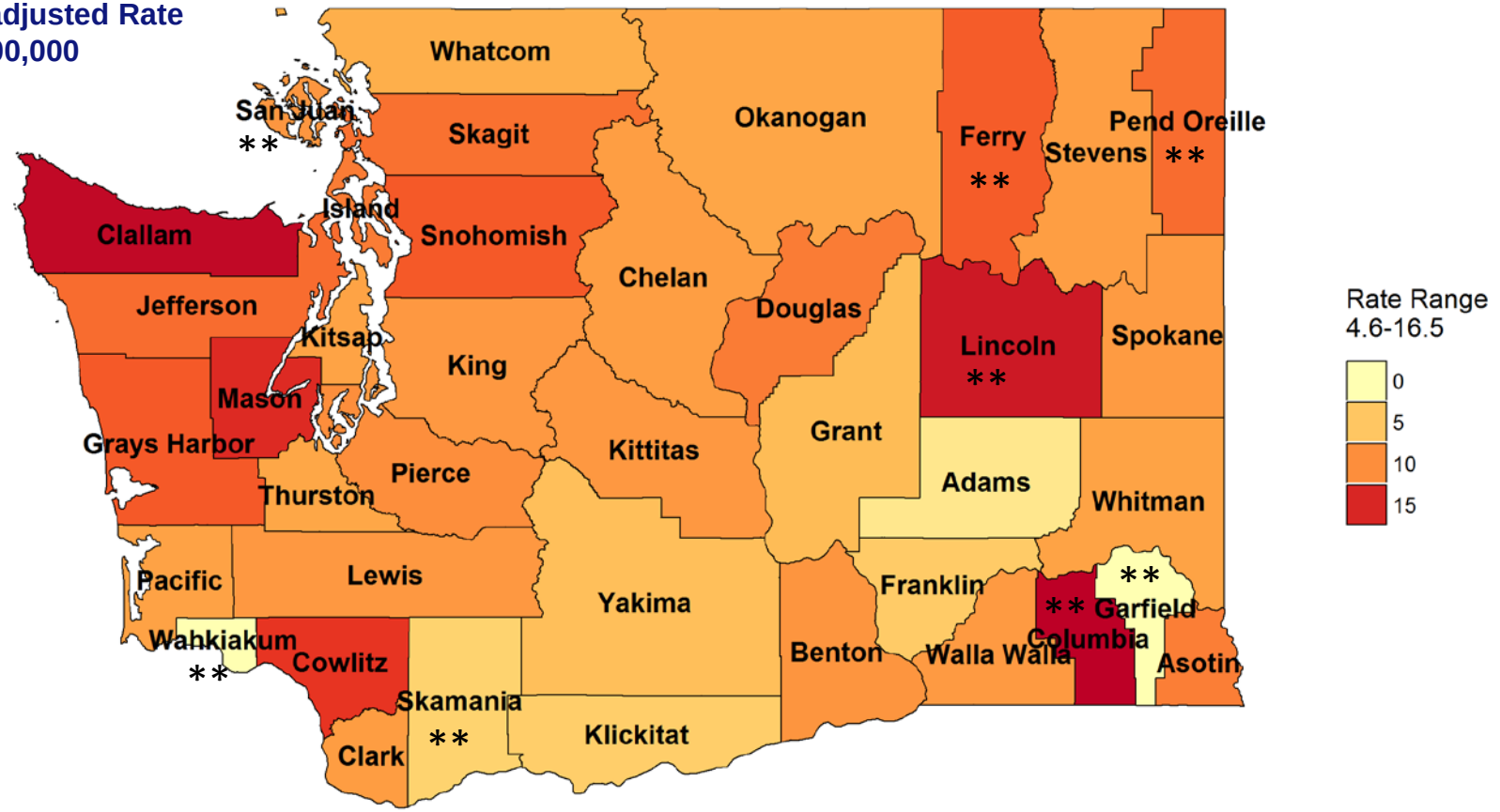


Rate per 100,000
WA =14.5
Other states= 6.9 – 52.0

Source: SOURCE: CDC/NCHS, National Vital Statistics System, Mortality.

Opioid Overdose Death Rates*
County of Residence, 2012–2016

WA Age-adjusted Rate
9.3 per 100,000

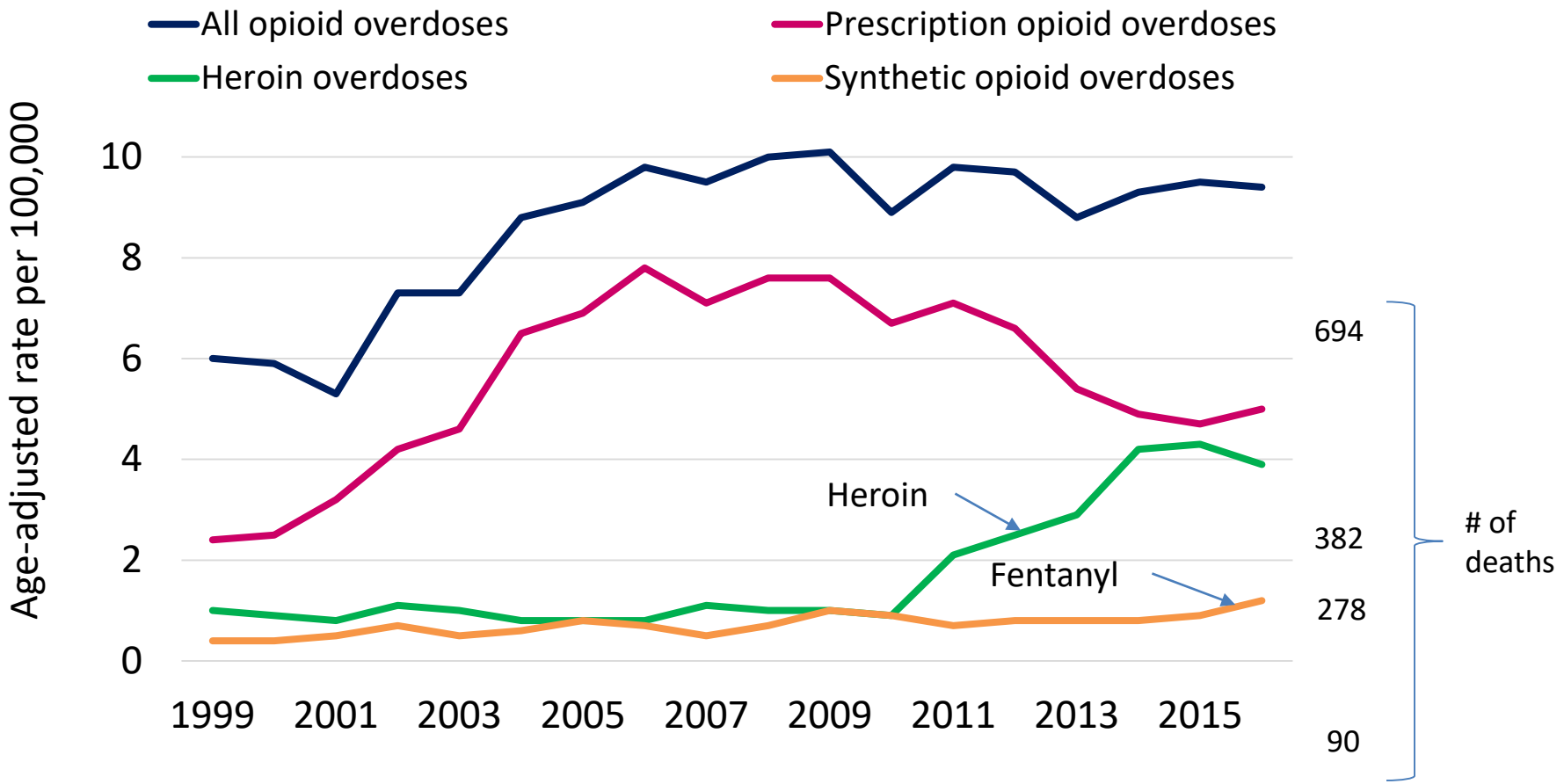


Source: DOH Death Certificates

* 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

** Rates are unstable due to a low number of deaths in that county.

Rate of opioid-related overdose deaths by type of opioid, WA 2000–2016



Source: DOH Death Certificates (Note: prescription opioid overdoses exclude synthetic opioid overdoses)

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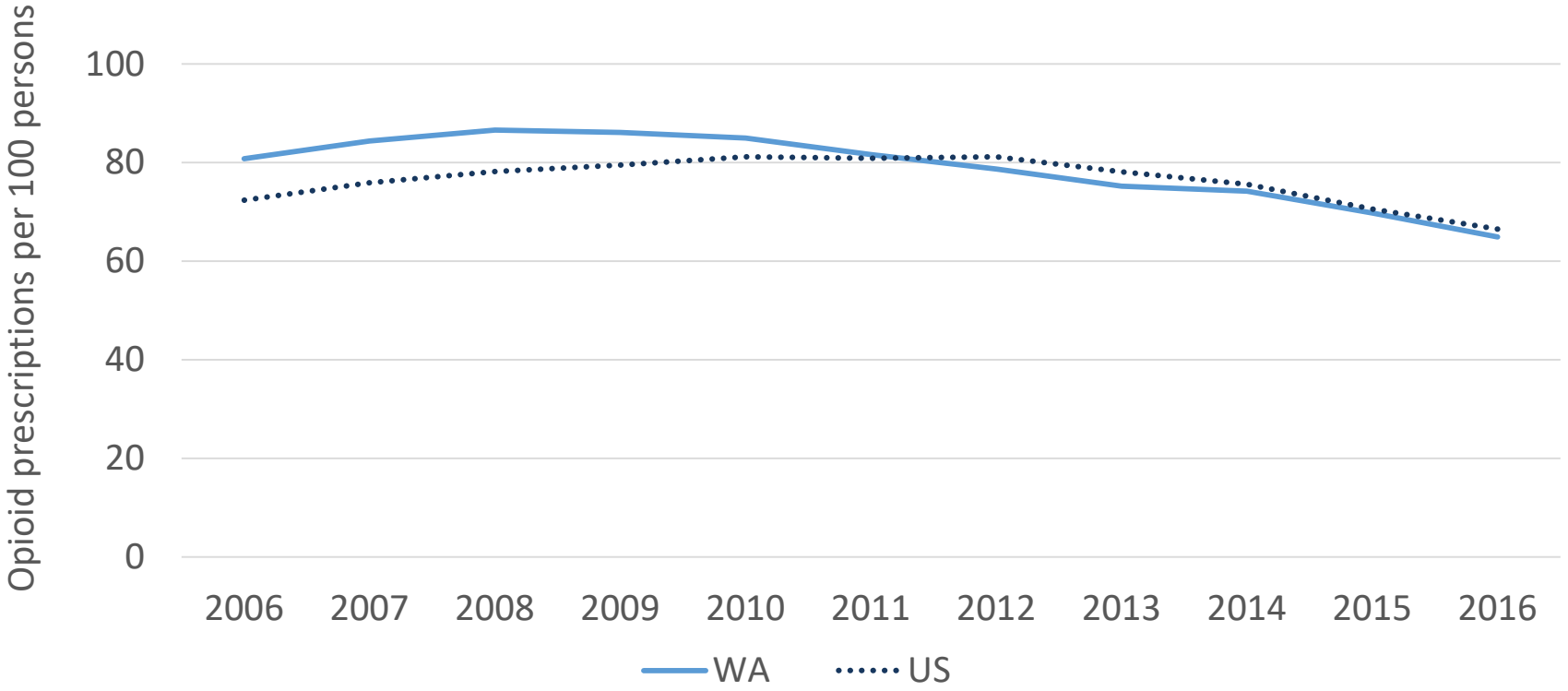
Opioid Prescribing Rates
Washington and US, 2006-2016



Source: Centers for Disease Control and Prevention, from QuintilesIMS Transactional Data Warehouse; includes prescriptions paid by commercial insurance, Medicare, Medicaid and cash payment, and excludes mail order prescriptions.

WA Prescribing Data

Washington Tracking Network (State) –

https://fortress.wa.gov/doh/wtn/WTNPortal/

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Bree Metrics List

1. Patients with any opioid prescription
2. Patients with chronic opioid prescriptions
   - 60 or more days in the quarter
3. Patients with high dose chronic opioid prescriptions
   - 50 MME/day, 90 MME/day, 120 MME/day
4. Patients with concurrent opioid and sedatives
5. Patients with new opioid prescriptions (days supply)
   - 0-3, 4-7, 8-13, 14-59
6. Patients with new chronic opioid prescriptions
7. Future Metric: Track buprenorphine use

Opioid Prescriptions and Drug Overdoses County Data

https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/OpioidPrescriptionsandDrugOverdosesCountyData

Opioid Awareness	Patients with any Opioid Prescription	Patients with Chronic Opioid Prescriptions	Patients with High Dose Opioid Prescriptions	Patients with Concurrent Opioid and Sedative Prescriptions	Patients with New Opioid Prescriptions (Days of Supply)	Patients with New Chronic Opioid Prescriptions

Opioid Prescriptions and Drug Overdoses

County Data

- WA State is experiencing an opioid misuse and overdose crisis involving prescription opioids, heroin, and other illegal manufactured synthetic opioids (like fentanyl).
- Approximately 700 individuals die each year from an opioid overdose in WA State.
- Data presented here can be used to monitor prescription opioid use and opioid-related mortality and to raise awareness of the opioid epidemic in WA State.

PATIENTS WITH ANY OPIOID PRESCRIPTION

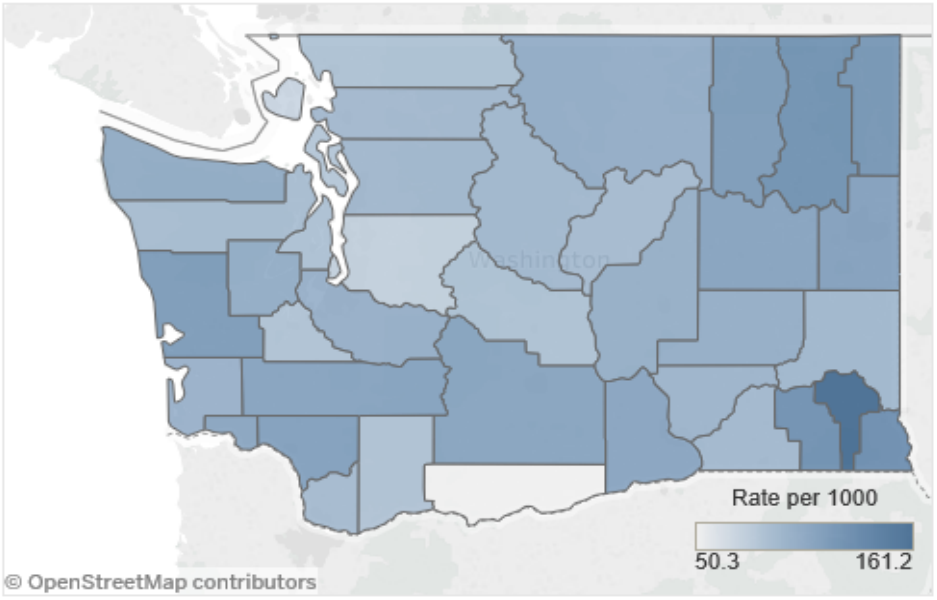
Proportion of the population with at least one opioid prescription submitted to the Prescription Monitoring Program in a calendar quarter.

Time Selector

2016Q4

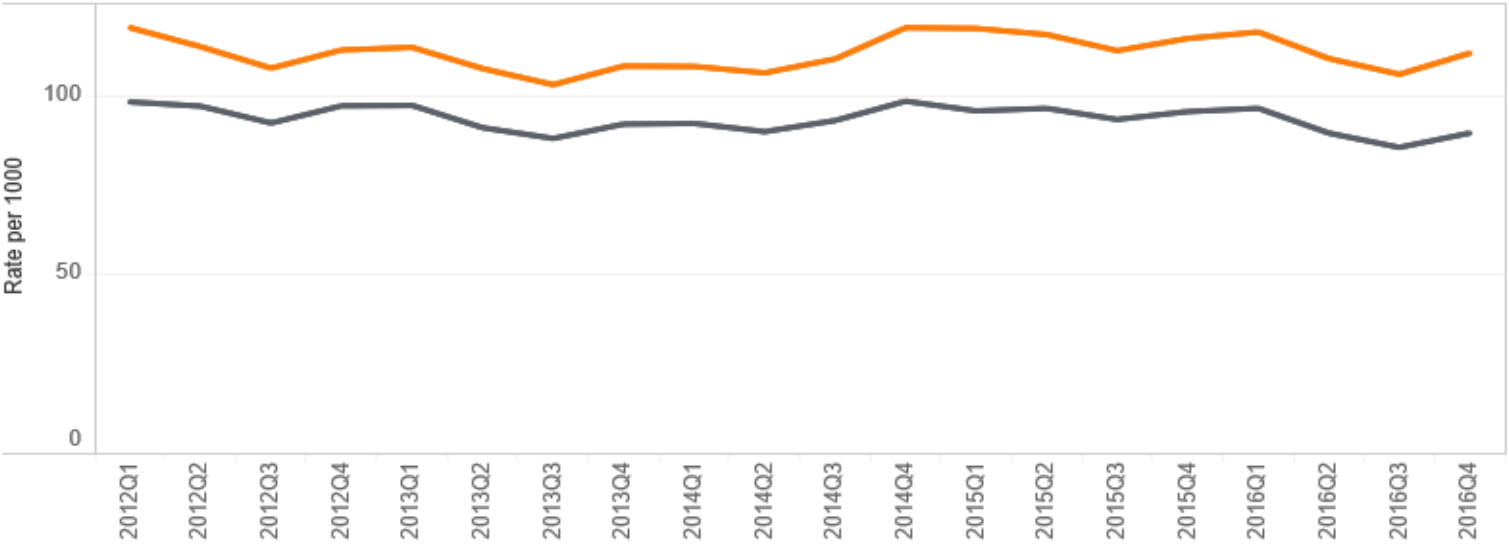
Age Group Selector

All ages



Age Groups

	0-9	10-17	18-24	25-34	35-44	45-54
Adams	5.3	16.7	45.2	83.9	74.4	151.7
Asotin	9.6	26.7	91.4	157.7	179.0	186.3
Benton	5.1	27.0	72.7	110.8	130.8	150.5
Chelan	10.4	31.6	56.7	92.0	101.7	129.9
Clallam	5.0	24.7	53.6	91.4	128.9	165.3
Clark	4.2	20.8	54.6	86.7	108.6	130.1
Columbia		19.3	82.4	134.8	183.0	200.5
Cowlitz	6.1	21.5	62.0	108.3	133.5	165.7
Douglas	8.7	29.9	66.6	83.5	101.6	120.0
Ferry		27.1	41.8	125.8	170.5	194.3
Franklin	5.2	22.6	62.2	87.3	100.5	126.1
Garfield		30.2	214.8	211.8	130.7	199.2
Grant	7.0	23.7	60.0	91.6	112.0	145.7



Age Group Selector

All ages

Trend Graph - County Selector

Spokane

Spokane

Reference Rate (State)

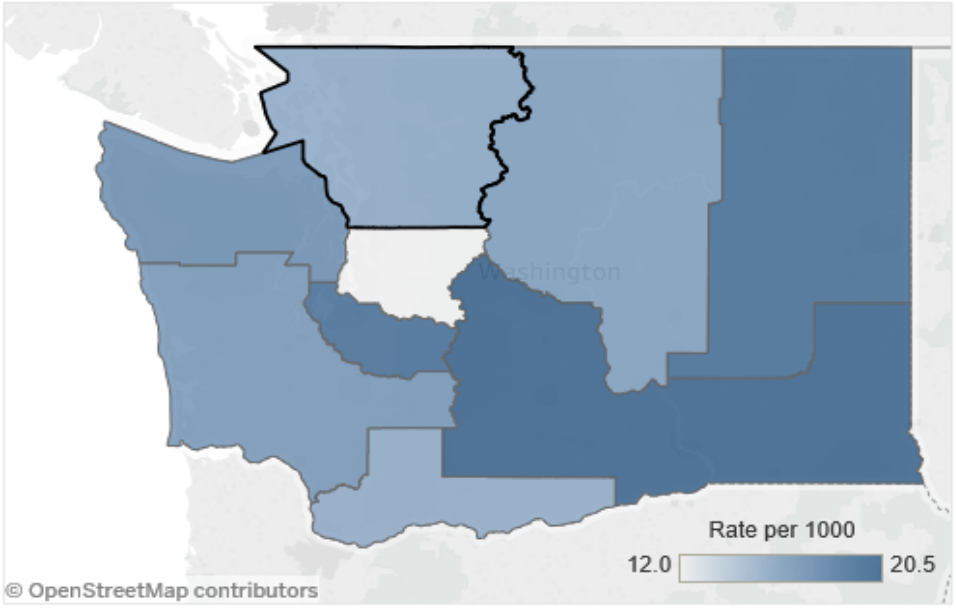
To view similiar dashboards at the Accountable Communities of Health (ACH) geographies, click on this link: ACH's Information

PATIENTS WITH CONCURRENT OPIOID AND SEDATIVE PRESCRIPTIONS

Age and sex-adjusted proportion of the population who receive one or more days of overlapping opioid and sedative prescriptions in a quarter according to the dates they were filled and the days' supply recorded in the PMP records. Days' supply, reported by the dispenser, refers to the estimated number of days the prescription will last. All authorized refills are included. ****

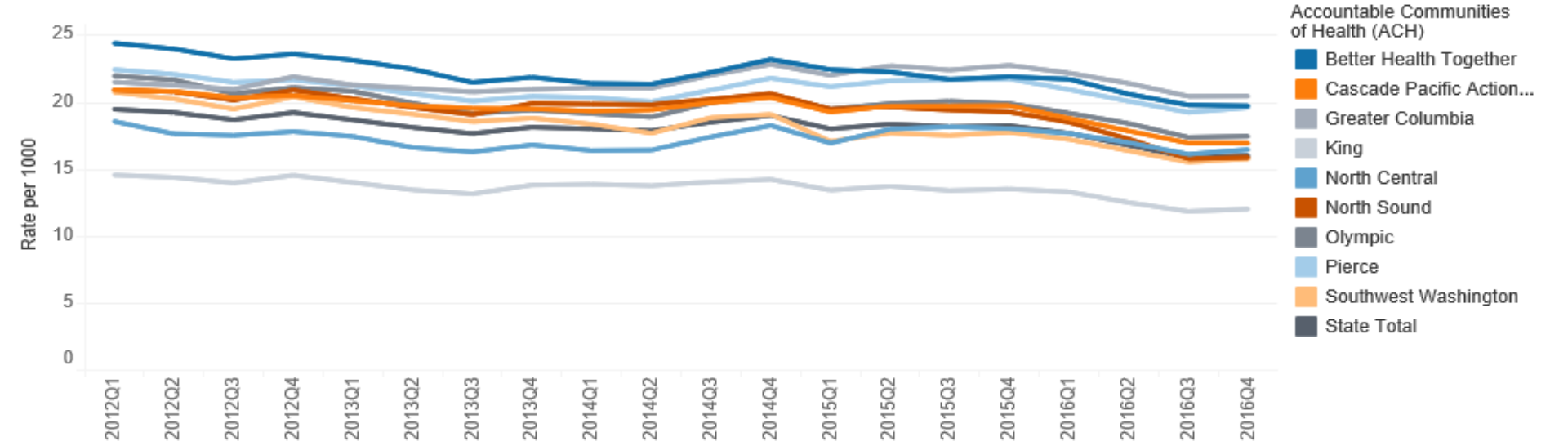
Map - Time Selector

2016Q4



Quarterly Rate per 1000

	2012Q1	2012Q2	2012Q4	2014Q4	2012Q3	201
Better Health Together	24.4	24.0	23.6	23.2	23.3	2
Cascade Pacific Action A..	20.9	20.8	20.5	20.4	20.4	2
Greater Columbia	21.5	21.3	21.9	22.9	21.0	2
King	14.6	14.4	14.6	14.3	14.0	1
North Central	18.6	17.7	17.8	18.3	17.6	1
North Sound	21.0	20.8	20.9	20.7	20.2	2
Olympic	22.0	21.7	21.1	20.6	20.7	2
Pierce	22.5	22.1	21.7	21.8	21.5	2
Southwest Washington	20.8	20.3	20.4	19.1	19.5	1
State Total	19.5	19.3	19.3	19.0	18.7	1



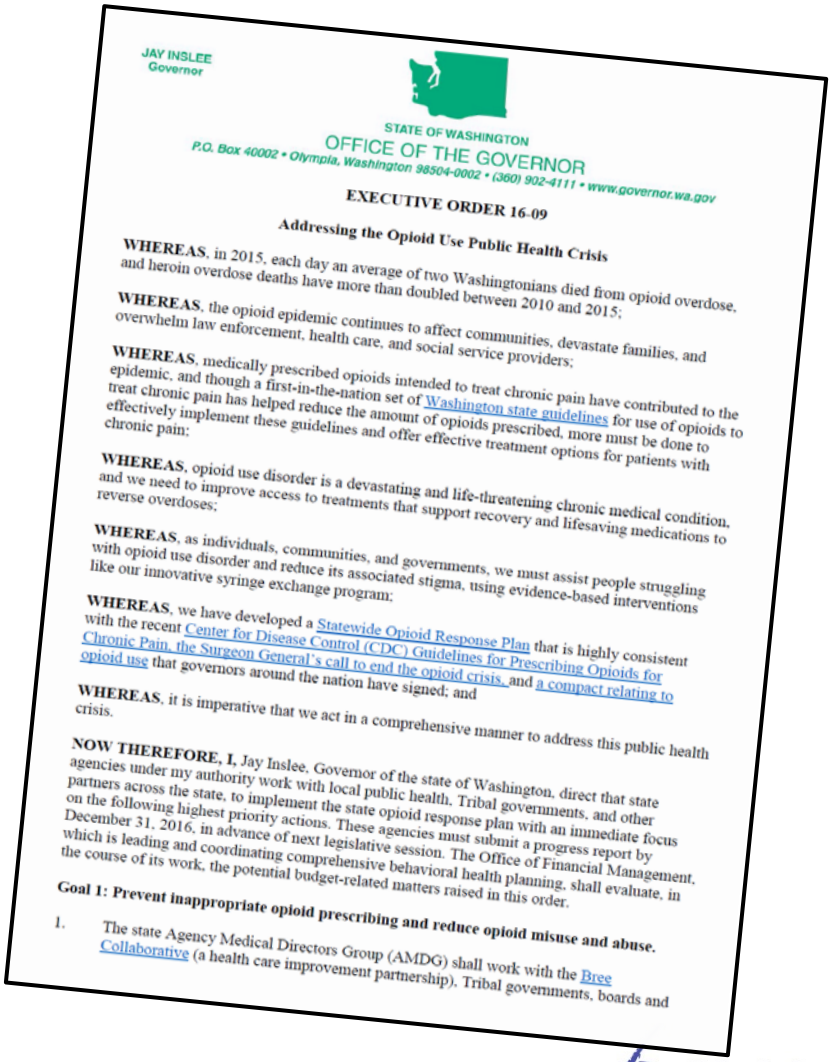
To view similiar dashboards at the county geography, click on this link: County Information

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



JAY INSLEE
Governor

STATE OF WASHINGTON
OFFICE OF THE GOVERNOR
P.O. Box 40002 • Olympia, Washington 98504-0002 • (360) 902-4111 • www.governor.wa.gov

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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New Comprehensive Opioid Prescribing Rules

Washington State Department of Health

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 Agency Medical Directors Group (AMDG) and Centers for Disease Control (CDC) guidelines.
- May consult with professional associations, DOH, and the University of Washington.
- Must adopt rules by January 1, 2019.

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.

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.

2017 Opioid Rules – Highlights

- 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 escalates over 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!

2017 Opioid Rules – Highlights

- 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.

2017 Opioid Rules – Highlights

- 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.

2017 Opioid Rules – Highlights

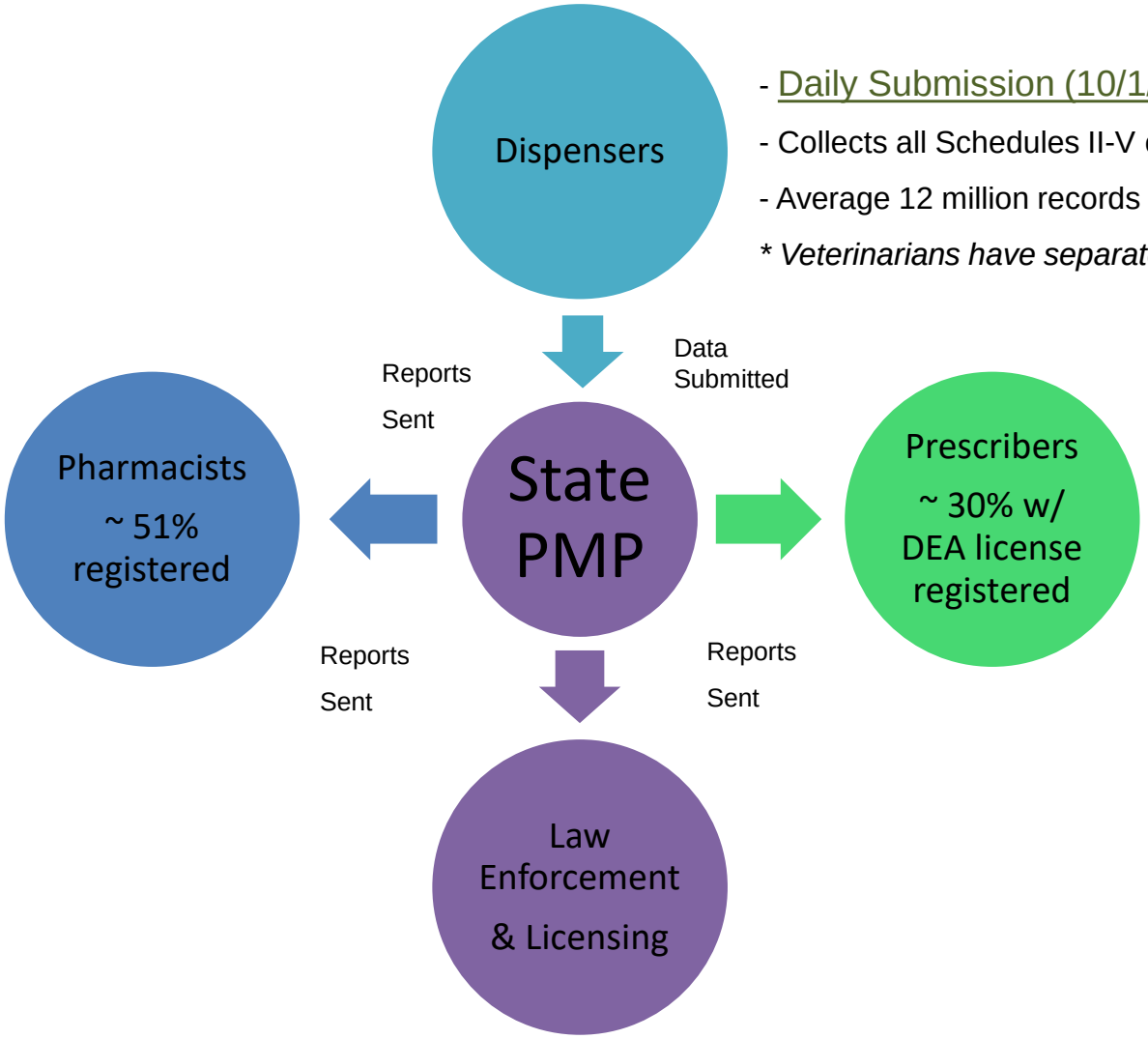
- Required PMP checks are a “floor” for safe practice. Individual boards/commissions may enact stricter standards.
- Required PMP registration if you prescribe opioids.
- Required use of PMP:
  - Second opioid refill for acute and perioperative care.
  - Between acute→subacute and subacute→chronic.
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

2017 Opioid Rules – Highlights

- 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.

PMP Overview

PMP Data Collection and Access



- Daily Submission (10/1/16)
- Collects all Schedules II-V controlled substances
- Average 12 million records a year

* *Veterinarians have separate requirements*

*Other groups may also receive reports in addition to those listed.

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WA Prescriptions Dispensed 2012 – 2016

Rank by most recent year

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
DEXTROAMPHETAMINE/ 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 CS reported to PMP	**11,509,488**	**11,434,877**	**11,771,216**	**11,992,986**	**11,798,943**

Update 03/03/2017

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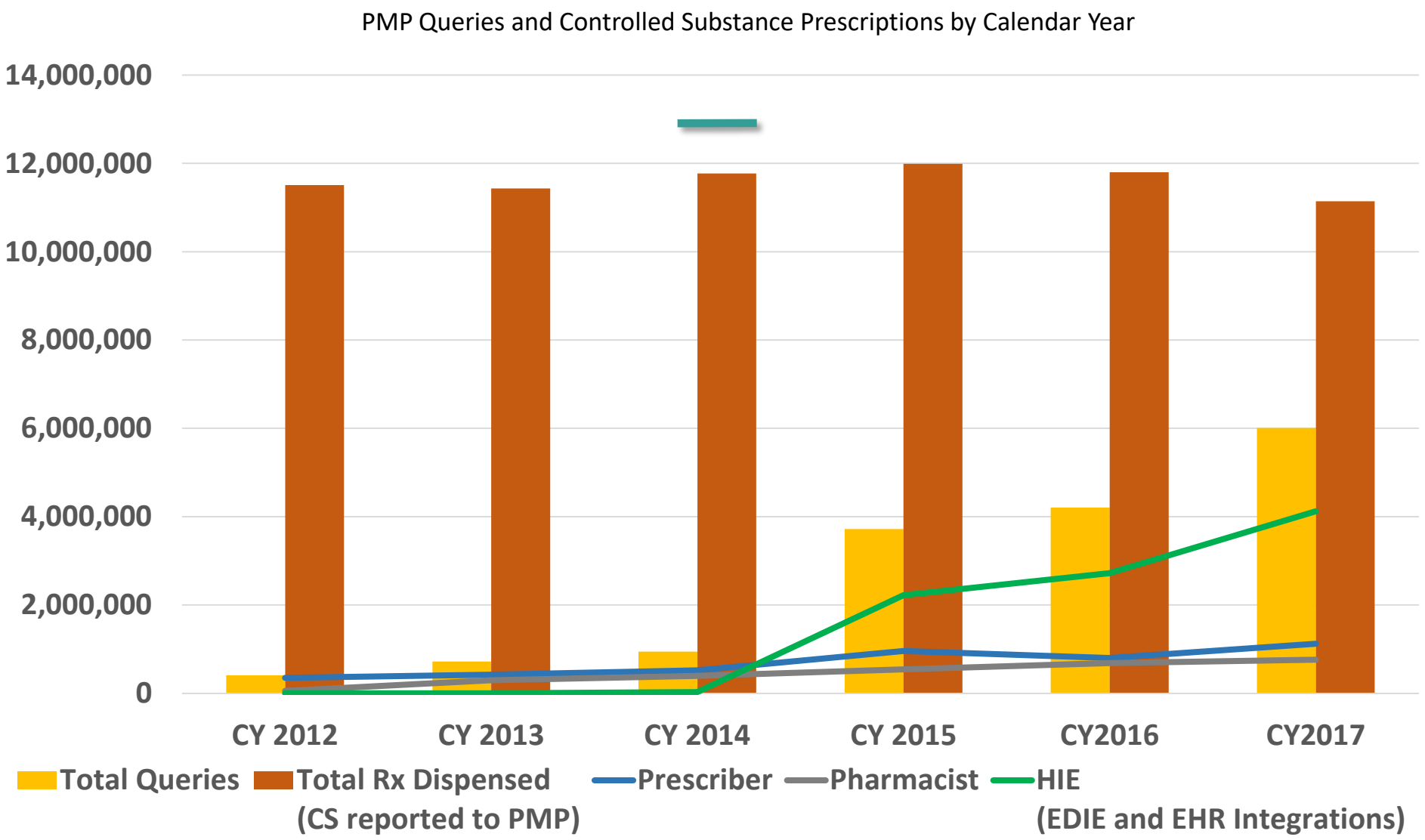
WA PMP Data and Utilization



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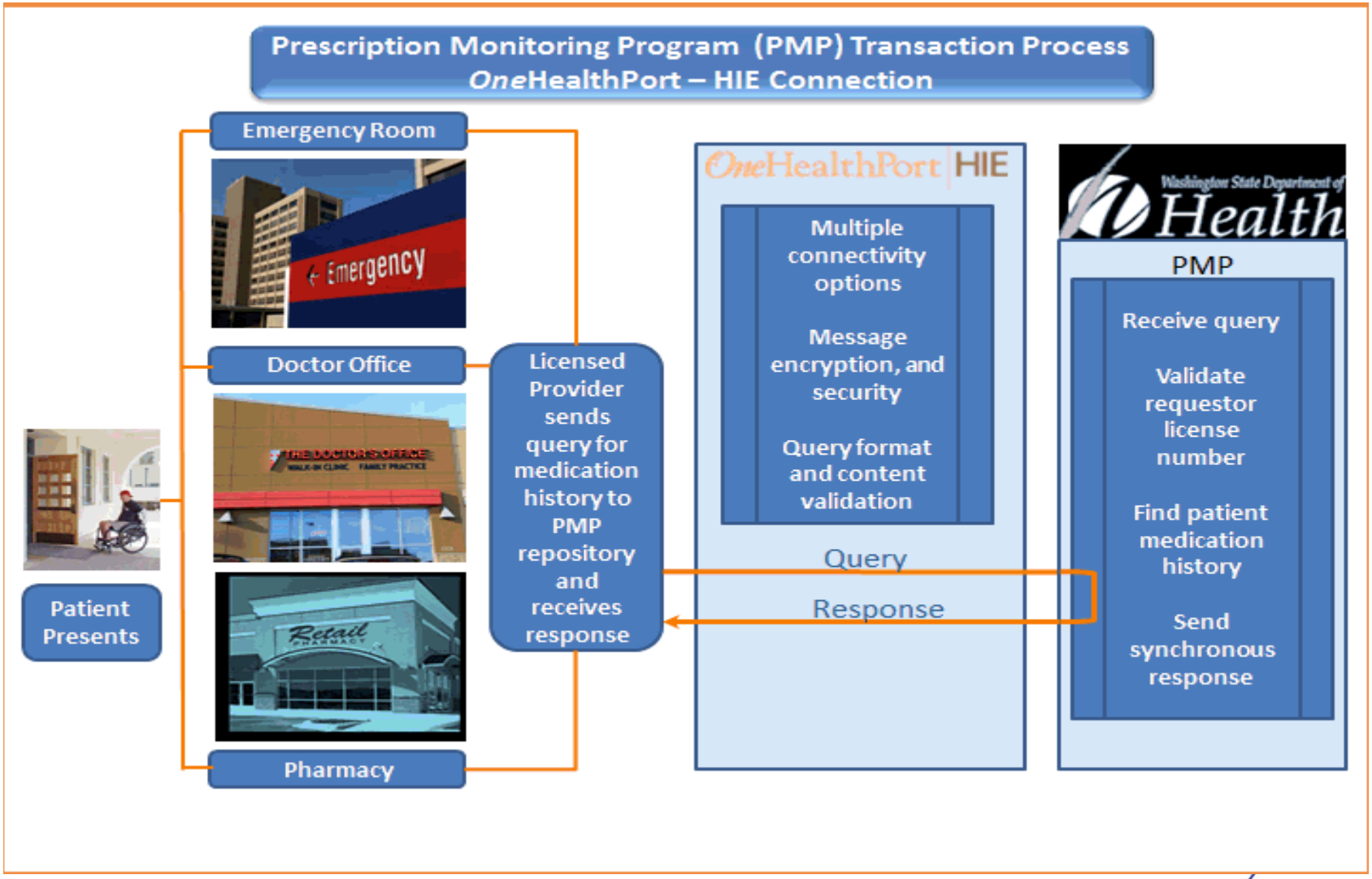
WA State - PMP to EMR Connection



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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)
- 3 health systems actively testing with their EMRs (Kaiser, Providence, Multi-care)
- 115 registrations of intent (meaningful use) to date representing 1,285 site locations

Update
11/21/2017

PMP Enhancements under HB 1427

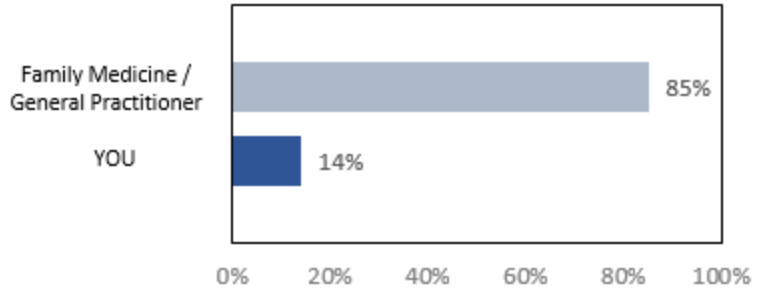
Washington State Department of Health

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
  - http://www.seattletimes.com/seattle-news/health/dea-state-crack-down-on-pain-doctor-over-opiate-prescriptions-citing-18-deaths/
  - Over 40 providers, estimated 12,000 patients
  - Possibly linked to 18 deaths

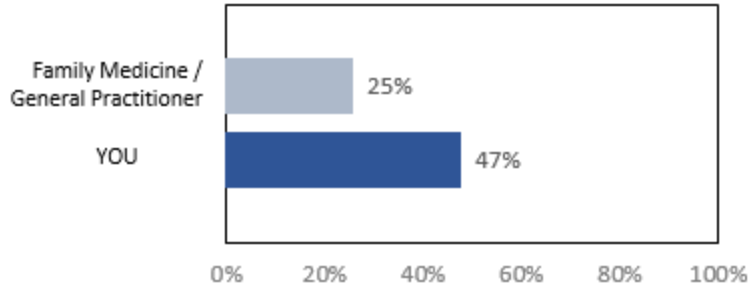
Prescriber Feedback Reports

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



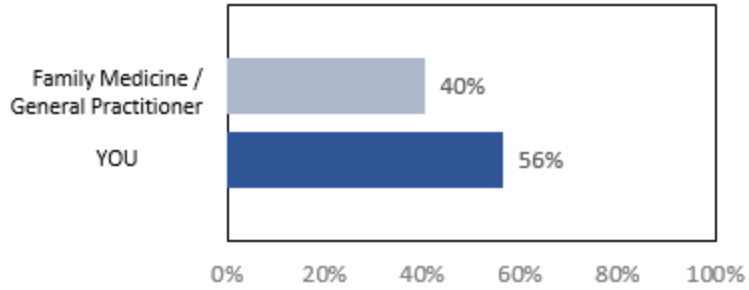
% PATIENTS WITH NEW >7 DAYS' SUPPLY OF OPIOIDS

Number of patients with a new opioid prescription with >7 days' supply (but less than 60) in the current quarter divided by the total number of patients with a new opioid prescription in the current quarter (and none in the previous quarter)



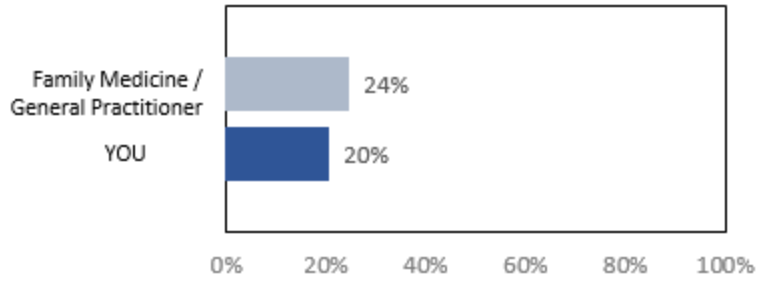
% PATIENTS WITH CHRONIC OPIOID PRESCRIPTIONS

Number of patients with ≥1 chronic (≥60 days' supply) opioid prescription in the current quarter divided by the total number of patients with an opioid prescription in the current quarter



% PATIENTS WITH HIGH-DOSE CHRONIC OPIOID PRESCRIPTIONS

Number of patients with a chronic (≥60 days' supply) opioid prescription of 90 morphine milligram equivalents (MME) per day or more averaged in the current quarter divided by the total number of patients with a chronic opioid prescription in the current quarter



% PATIENTS WITH CONCURRENT OPIOID AND SEDATIVE PRESCRIPTIONS

Number of patients who receive ≥1 day(s) of overlapping opioid and sedative prescriptions in the current quarter divided by the total number of patients with an opioid prescription in the current quarter

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Local Health Officer (H.O.) Access

- County LHJ can make overdoses a notifiable condition
- When notified of overdose, H.O. 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.

SAMPLE Letter to Provider

RE: (**PATIENT'S FIRST AND LAST NAME, DOB**), **FATAL OPIOID OVERDOSE**

Dear PROVIDER (**LAST NAME AND DESIGNATED CREDENTIALS**),

Your patient, (**PATIENT'S FIRST AND LAST NAME**), died from an apparent opioid-related overdose at (**HEALTHCARE FACILTY'S NAME**) on (**MONTH/DATE/YEAR**). Prescription Monitoring Program and Emergency Department Information Exchange data identified you as the patient's primary care provider, and/or as having prescribed a controlled substance to this patient, during the six months before the patient died. We do not know that your prescribing contributed to the death.

We understand that any patient's death is difficult for health care professionals 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 prescribing opioids:

- ✓ Consider providing overdose education and naloxone to patients on opioids. See www.stopoverdose.org
- ✓ Follow opioid prescribing guidelines at: http://www.agencymeddirectors.wa.gov/, http://www.coperems.org and https://www.cdc.gov/drugoverdose/prescribing/guideline.html
  - ✓ If a patient needs opioids for acute pain, prescribe the lowest effective dose of immediate-release opioids for the shortest duration. Discuss opioids' risks and benefits with your patient. Patients rarely need more than seven days' supply.
  - ✓ Prescribe opioids for chronic pain only if benefits for both pain and function outweigh risks to the patient.
  - ✓ Avoid co-prescribing opioids, benzodiazepines, or other sedatives. Combining opioids with sedatives, sleeping pills, or alcohol increases the risk of an overdose.
- ✓ Use the Prescription Monitoring Program database to verify if patients are receiving controlled substances from other prescribers. Register for the system at www.doh.wa.gov/pmp.
- ✓ Participate in UW TelePain (https://depts.washington.edu/anesth/care/pain/telepain/) or call the UW Medicine Pain Consult line (1-844-520-PAIN) for help in managing complex pain patients.
- ✓ Learn how to recognize opioid use disorder and offer evidence-based treatment. See the Recovery Helpline – https://www.warecoveryhelpline.org/
- ✓ Consider providing medication-assisted treatment for your patients. See the federal requirements at https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management

If you have any questions about the Prescription Monitoring Program, please contact the Washington State Department of Health at (360-236-XXXX or email).

Dear PROVIDER (**LAST NAME AND DESIGNATED CREDENTIALS**),

Your patient, (**PATIENT'S FIRST AND LAST NAME**), was diagnosed with a non-fatal opioid-related overdose at (**HEALTHCARE FACILTY'S NAME**) on (**MONTH/DATE/YEAR**). Prescription Monitoring Program and Emergency Department Information Exchange data identified you as the patient's primary care provider, and/or as having prescribed a controlled substance to this patient, during the six months before the overdose.

We understand that no health care professional wants any patient to experience an overdose. We are providing you this information to support you in offering safe and effective care to patients.

If you are providing ongoing care to this patient, we encourage you to immediately coordinate care with the patient's other providers, if necessary. We also encourage you to contact the patient to reassess the pain management plan, and to educate the patient about opioids' risks. Patients who experience an opioid-related overdose are at high risk of future overdose, either non-fatal or fatal.

Here are some other important tips on managing pain and prescribing opioids:

- ✓ Follow opioid prescribing guidelines at: http://www.agencymeddirectors.wa.gov/, http://www.coperems.org and https://www.cdc.gov/drugoverdose/prescribing/guideline.html
  - ✓ If a patient needs opioids for for acute pain, prescribe the lowest effective dose of immediate-release opioids for the shortest duration. Discuss opioids' risks and benefits with your patient. Patients rarely need more than seven days' supply.
  - ✓ Prescribe opioids for chronic pain only if benefits for both pain and function outweigh risks to the patient.
  - ✓ Avoid co-prescribing opioids, benzodiazepines, or other sedatives. Combining opioids with sedatives, sleeping pills or alcohol increases the risk of an overdose.
- ✓ Use the Prescription Monitoring Program database to verify if patients are receiving controlled substances from other prescribers. Register for the system at www.doh.wa.gov/pmp.
- ✓ Provide overdose education and naloxone to the patient. See www.stopoverdose.org
- ✓ Participate in UW TelePain (https://depts.washington.edu/anesth/care/pain/telepain/) or call the UW Medicine Pain Consult line (1-844-520-PAIN) for help in managing complex pain patients.
- ✓ Learn how to recognize opioid use disorder and offer evidence-based treatment. See the Recovery Helpline - https://www.warecoveryhelpline.org/
- ✓ Consider providing medication-assisted treatment for your patients. See the federal requirements at https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management

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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 provides list of providers (with DEA #’s) to PMP for creation of metric reports
- Required by law to be sent quarterly

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 Specialty	% 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 Average	Prescriber	Specialty Average	Prescriber	Specialty Average	Prescriber	Specialty Average
YOU	**yes**	**Internal medicine**	**25,699**	**55%**	**48%**	**30%**	**29%**	**13%**	**32%**	**27%**	**18%**
Last name, first name	no	Psychiatry	19,002	14%	85%	47%	25%	56%	40%	20%	24%
Last name, first name	yes	Pediatrics	15,682	84%	45%	55%	60%	43%	21%	32%	45%
Last name, first name	no	Internal medicine	25,699	56%	48%	10%	29%	22%	32%	2%	18%
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Washington State Department of Health | Prescription Monitoring Program
www.doh.wa.gov/pmp | prescriptionmonitoring@doh.wa.gov

PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND HEALTHIER COMMUNITY

Washington State Department of Health

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

How Safety and QA Professionals Can Contribute

Align Agency Safety Goals to include Mandatory and Important Safe Prescribing Goals

- 2018 Hospital National Patient Safety Goals (NPSG)
  - Use Medications Safely NPSG 03.06.01
  - Prevention Infection NPSG 07.03.01
  - Identify Patient Safety Risks NPSG 15.01.01 (Find out which patients are most likely to try to die by suicide.)
- 2018 Ambulatory Health Care National Patient Safety Goals:
  - Reconcile Medications

Using Medications Safely

- Safety professionals can set goals:

  -Have the organization or prescribers signed up to PMP, define who when and where will check PMP.

  -Communicate the law on PMP and monitor compliance.

  -Gather information on the quantify of opioids, benzodiazepines and other sedative hypnotics. (MED), and feed that back to specialty review boards. Use CQUIP data.

Using Medications Safely

NPSG 03.06.01 Maintain and communicate accurate patient medication information

- Pre-operative medication assessment:
  - Screen for opioid use disorder history
  - PMP
  - Identify if being treated with naltrexone, buprenorphine or methadone, or anticoagulants
  - Need to routinely ask all patients about their medical and non-medical use of pain meds and opioids.

Communication

- Anesthesiologists and provider treating OUD should have a common plan.
  - Consider alternatives (blocks, ketamine, duration how to manage buprenorphine, NTX-ER or methadone pre-surgery and during)
  - Close follow-up and support post op
  - Patient consents to discuss substance use treatment with hospital or ASC staff

Strategies to Address Medication Safety Goals

- To set post op orders by procedure: combine SSI infection review with rates of PMP check, prescribing of opioids (3, 5, 7, 14 , 30 or 30+).
- Do not give additional opioids without visit.
- Review or join Premier's work.

Medication Review

- Suggest that credentialing committee require that prescribers provide chair with any prescribing report cards they receive.

- As part of peer review have provider print up PMP self assessment that will be available in 2018. Share coded data amount peers to identify variations.

Eliminate standing orders for 30 day supplies

- Have patients bring back pills at post op visit and ask how many did they need?
- This give surgeons eye-opening data to develop their own duration of tx.
- Should generally be 3-7 days, not to exceed 14 days.

Central Line Blood Stream Infections

- Review sepsis, CLABSI
- Injecting drug use (1.8-3.3% of population ever.[1])
- To prevent relapse and CLABSI, screen for injecting drug use.
- Have an addiction medicine doc treat for OUD while inpatient; refer to OBOT or OTP upon release.
- Detox is not a treatment; detox and counseling has 50% higher death rate than tx with opioid agonists/antagonists.

1 Lansky A et al . Estimating the Number of Persons who Inject Drugs in the United states by Meta-Analysis…Plos One https://doi.org/10.1371/journal.pone.0097596

ED protocols: "No Tx and Street"

"Malpractice to give naloxone and discharge without offering MAT to patients with OUD ?"

- Safety goal:

  -Percent of OD and OUD patients who leave -ED with naloxone in hand

  -Percent of OD who present for at least one apt at clinic offering MAT

  -Percent of OD contacted in next 7 days.

Note: Surgeon General Advisory on Naloxone

First Do No Harm

Prescription Opioid Addiction and Overdoses are “the greatest iatrogenic epidemic in the history of American Medicine.”

With slight modifications of existing quality assurance and safety plans, hospitals and Ambulatory Surgery Centers can promote the safety of their patient and ensure that they are not actively contributing to create opioid misuse and overdose related deaths.

Von Korff MR, and G Franklin. Responding to America’s Iatrogenic Epidemic of Prescription Opioid Addiction and Overdose. Medical Care. Vol.54 (5). May 2016.

Questions?

www.doh.wa.gov/opioidprescribing

Chris Baumgartner

Drug Systems Director
Medical Marijuana Program
Prescription Monitoring Program
Washington Department of Health
360/236-4844 (W)
chris.baumgartner@doh.wa.gov

Mary Catlin, BSN, MPH, CIC

Institutional Nurse Consultant
Prescription Drug Overdose Prevention
Injury and Violence Protection
Washington Department of Health
206/616-1254 (W)
mary.catlin@doh.wa.gov

Blake Maresh, MPA, CMBE

Executive Director
Board of Osteopathic Medicine and Surgery
Podiatric Medical Board
Washington Department of Health
360/236-4760 (W)
blake.maresh@doh.wa.gov

Washington State Department of Health