Washington State Department of Health

Prescription Drug Overdose: Policy Approaches

November 9, 2015

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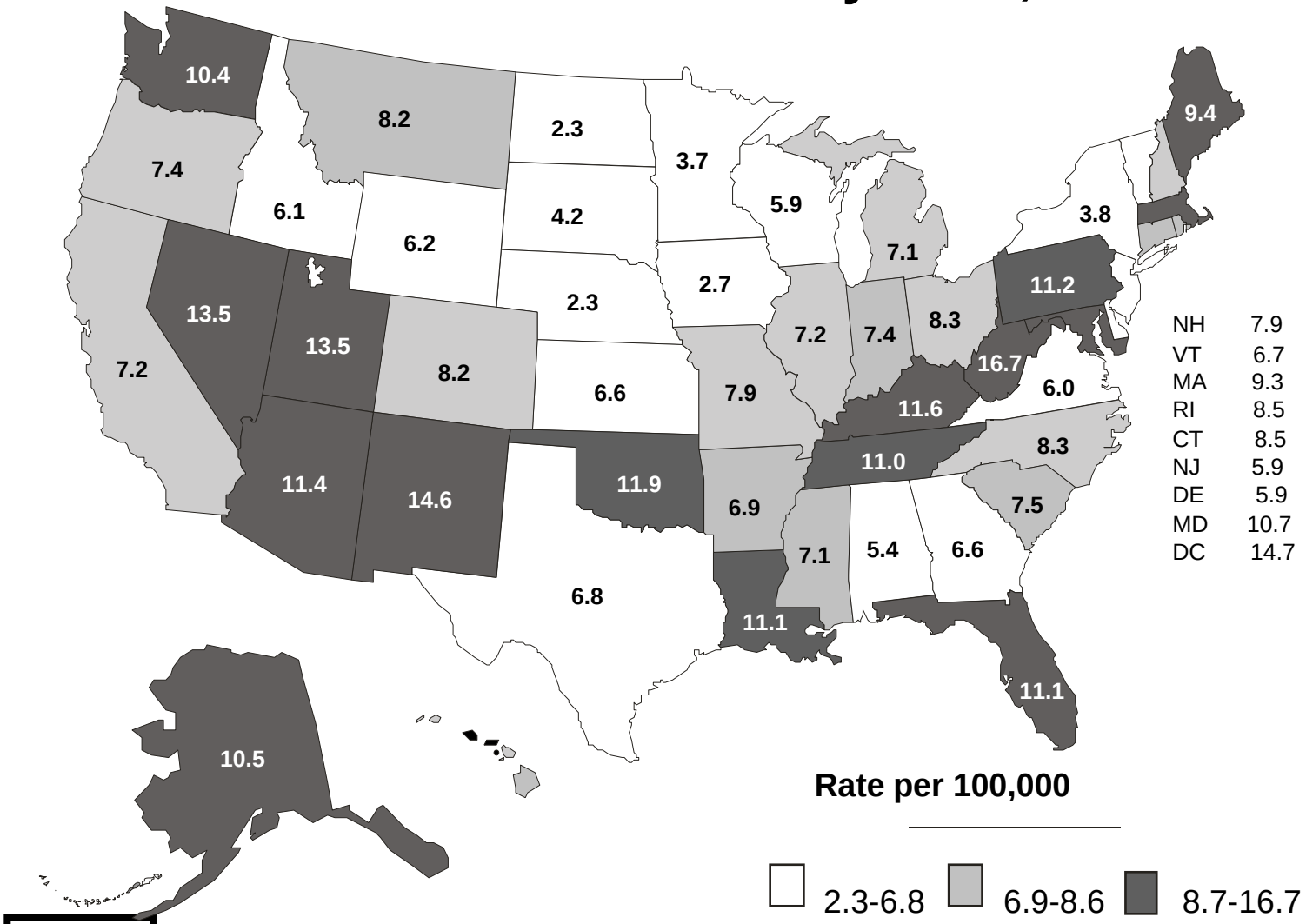
Washington State Department of Health

PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND HEALTHIER COMMUNITY

Outline

- Background information about WA
  - Cast of characters
  - How we got started, DOH role
- Policy interventions
- Impact on outcomes
- Where we are currently headed
- Group discussion: where are you headed?

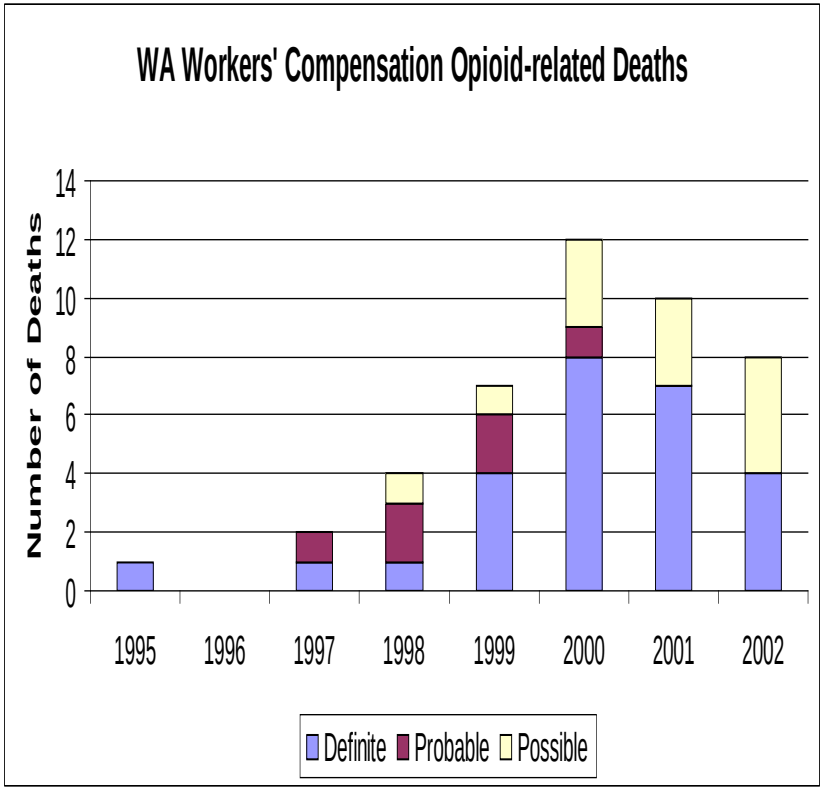
Unintentional and undetermined intent drug overdose death rates by state, 2004

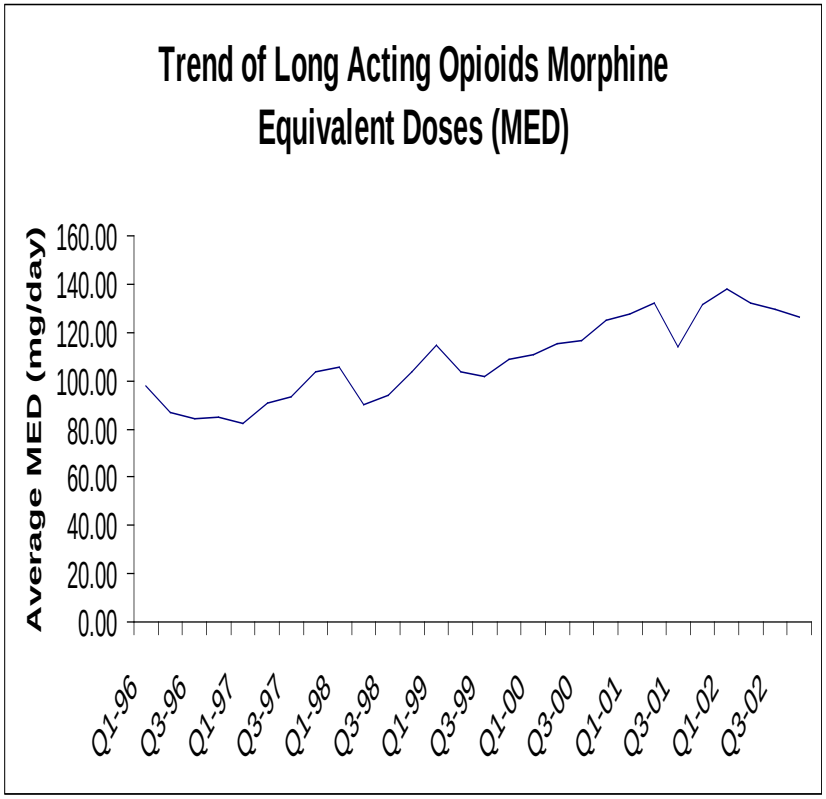


Cast of characters

- Workers' Compensation
- Medicaid
- University of Washington – Alcohol and Drug Abuse Institute

WA Workers' Compensation Experience





Franklin GM, Mai J, Wickizer T, Turner JA, Fulton-Kehoe D, Grant L. Opioid dosing trends and mortality in Washington State workers' compensation 1996-2002. Am J Ind Med 2005;48:91-99.

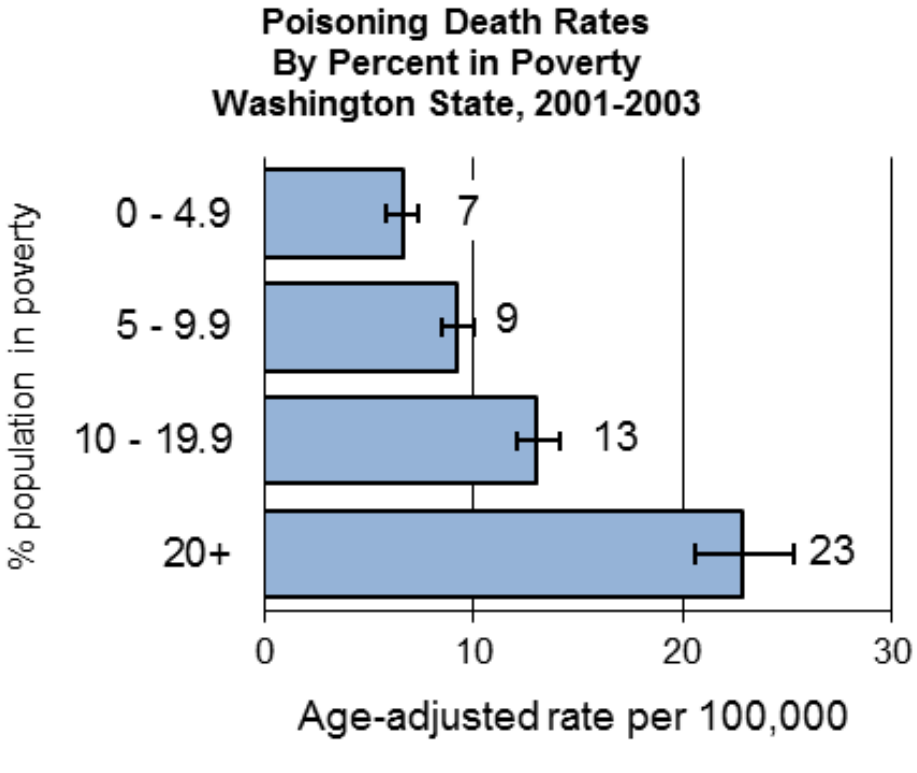
What's Causing the Deaths?
My Opinion

- Dramatically increasing avg daily doses not proven to be associated with improved outcomes, and are most likely related to increased tolerance
- Tolerance for euphoric effects likely precedes tolerance for respiratory depression

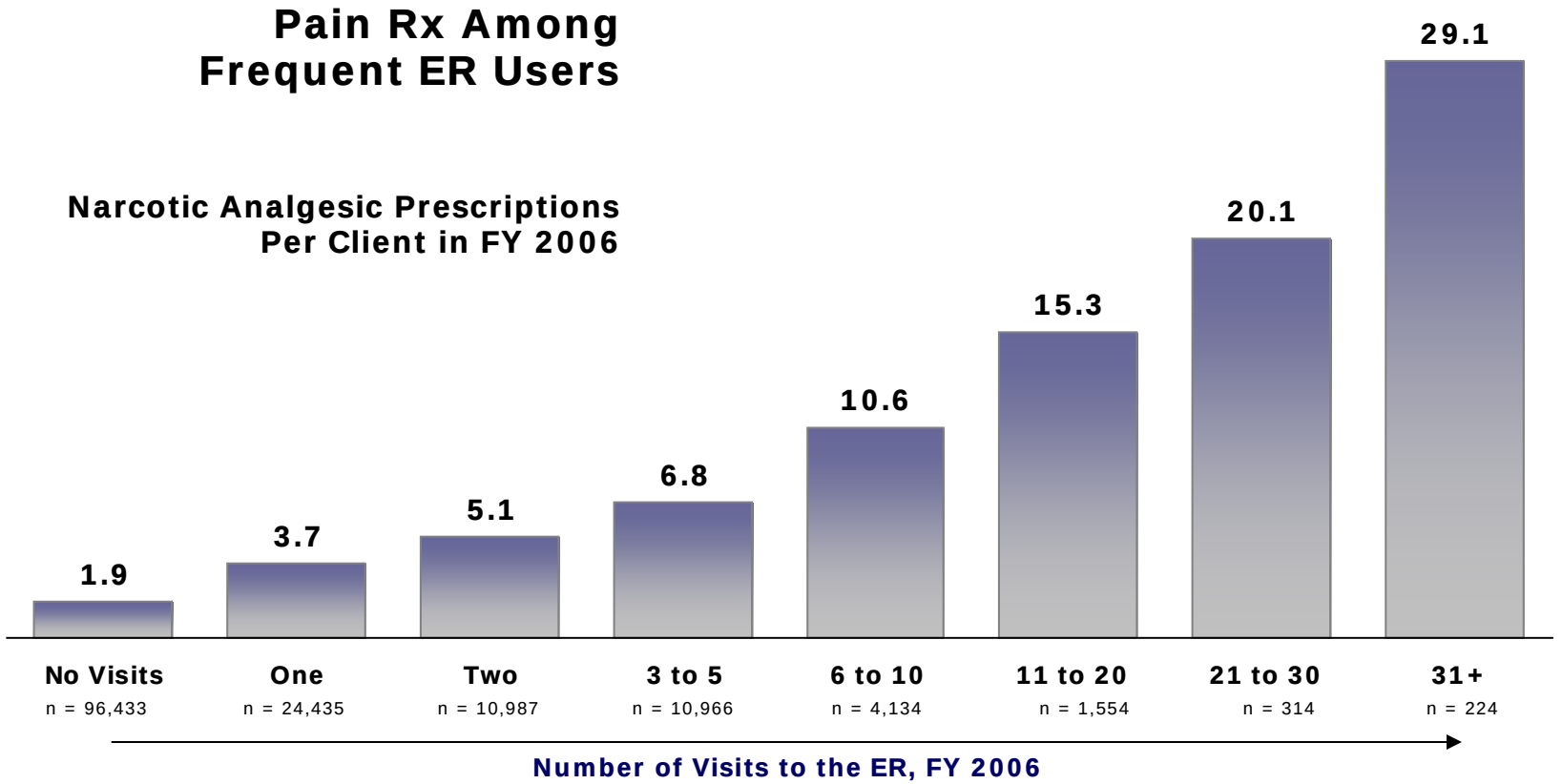
Interest at Medicaid

May 2005

- Identified “Top 320” Medicaid Clients who received highest volume of narcotics (non-cancer/non-hospice)
- **$7 million** in total annual health expenses ($900k narcotics & $3 million ER related)

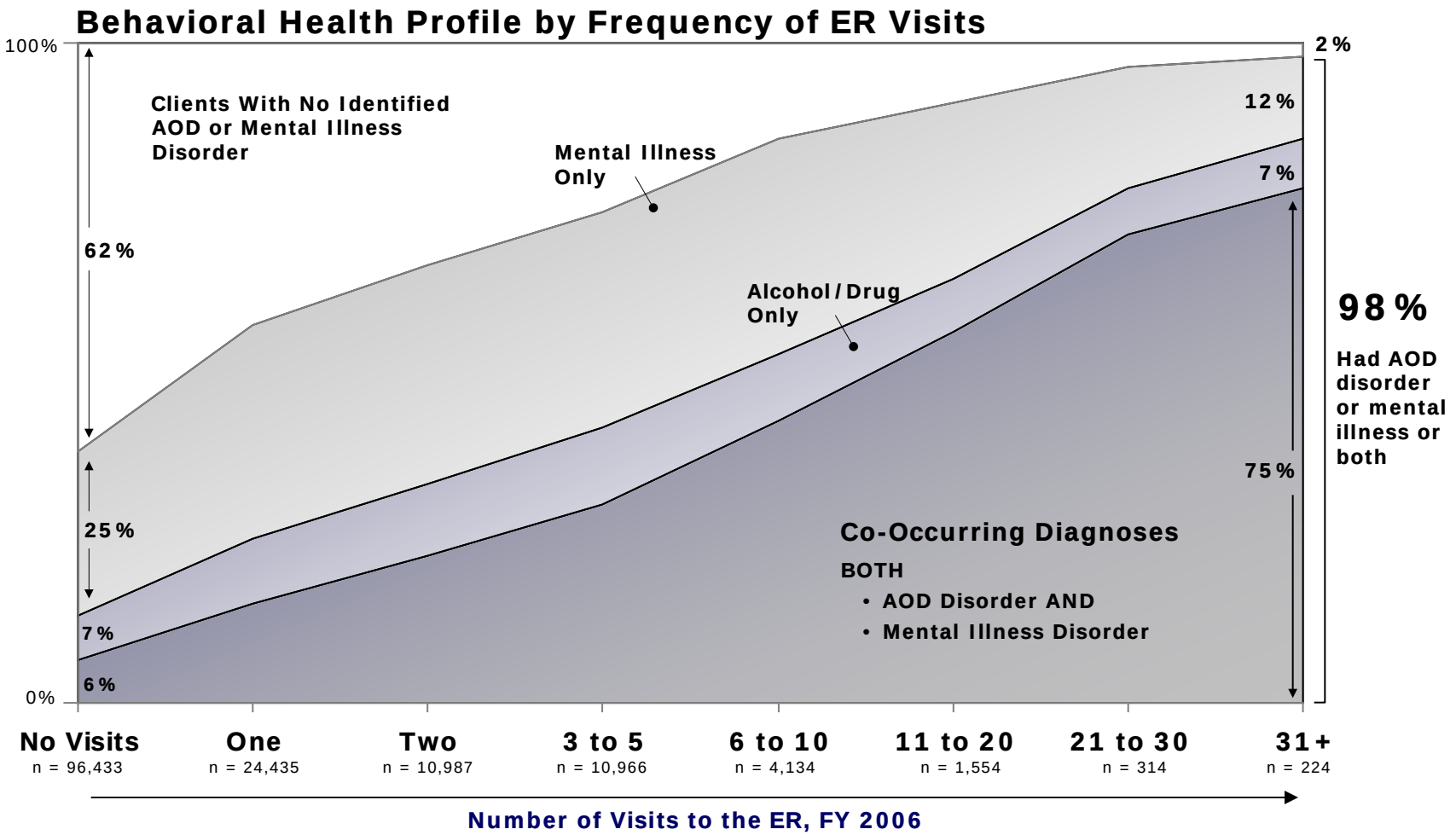


Average Number of Pain Prescriptions is Highest Among Those Most Frequently Visiting the ER



INCLUDES persons who are Medicaid-only aged, blind, disabled, presumptively disabled, or General Assistance-Unemployable in FY 2006.
SOURCE = DSHS RDA Client Outcome Database. TOTAL CLIENTS (FY 2006) = 149,050.

Frequent ER Use Signals Mental Illness, AOD Disorders



INCLUDES persons who are Medicaid-only aged, blind, disabled, presumptively disabled, or General Assistance-Unemployable in FY 2006.
SOURCE = DSHS RDA Client Outcome Database. TOTAL CLIENTS (FY 2006) = 149,050.

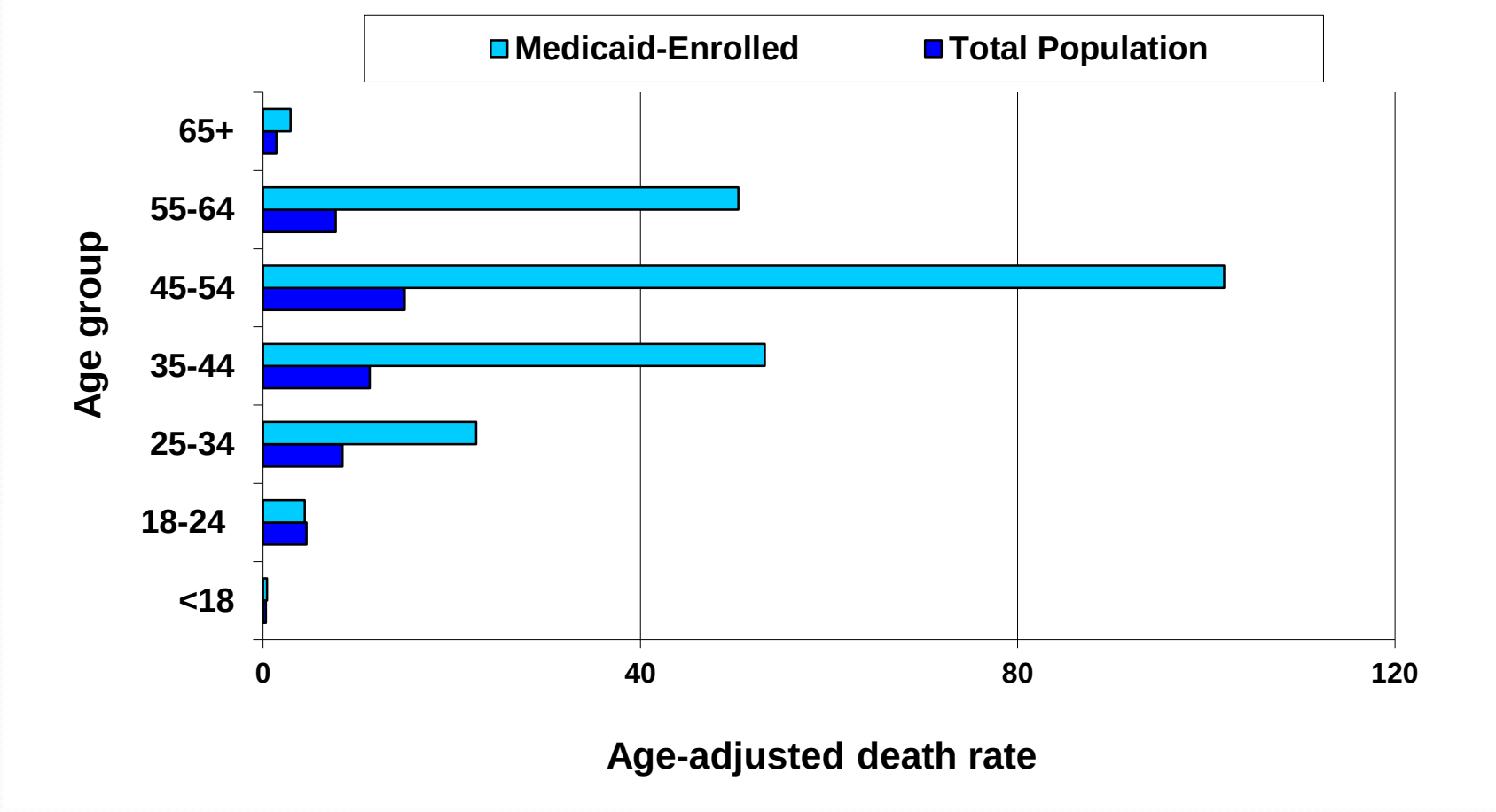
Key Findings on Opiates and ER Utilization

Aged, blind, or disabled medical assistance clients who are frequent ER visitors:

- Have high rates of mental illness and alcohol/drug disorders – frequently co-occurring
- Receive large volumes of prescription opiates
- Many receive MHD-funded mental health services
- Relatively few receive SA treatment services

Source: Washington State Department of Social & Health Services, Research Data and Analysis, November 2007

Risk for Medicaid Clients
WA 2004-2007



Source: Washington State Department of Health, Death Certificates & Department of Social and Health Services

UW - ADAI

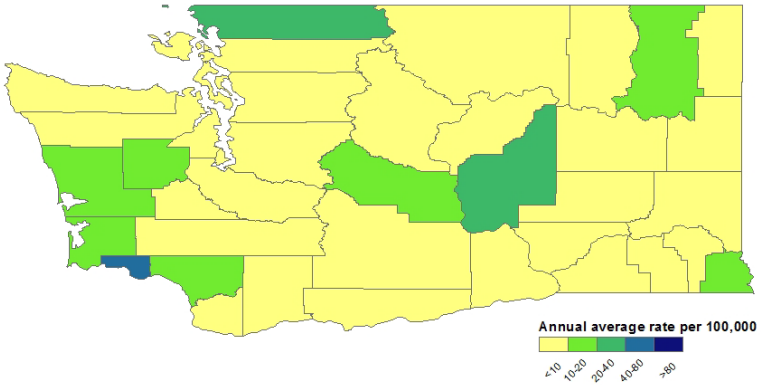
- Substance abuse perspective

In 2009…

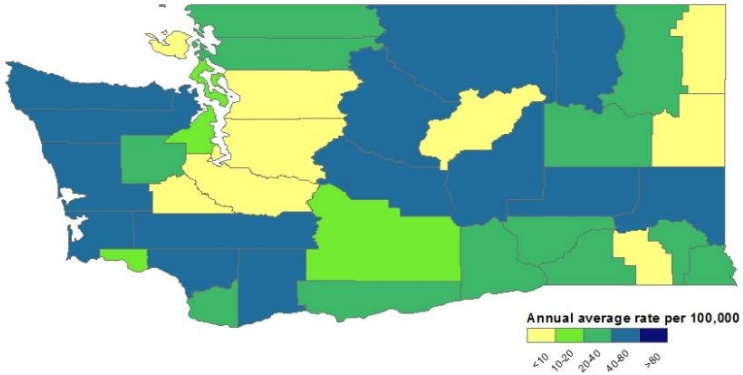
- Heroin & Rx opioids – talk about them together
- Addiction & chronic pain overlap
- Naloxone/Narcan as OD antidote
- Importance of OD prevention education

Trends in Police Evidence for Heroin and Rx-type opiates

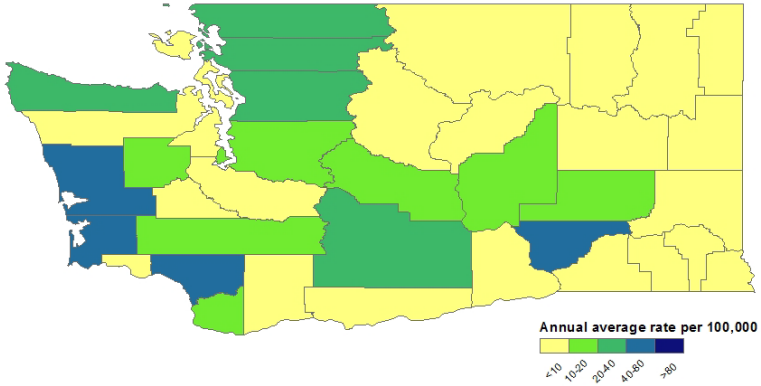
Rx-Type Opiates in Police Evidence
Annual Average 2001-2002



Rx-Type Opiates in Police Evidence
Annual Average 2011-2012



Heroin in Police Evidence
Annual Average 2001-2002



Heroin in Police Evidence
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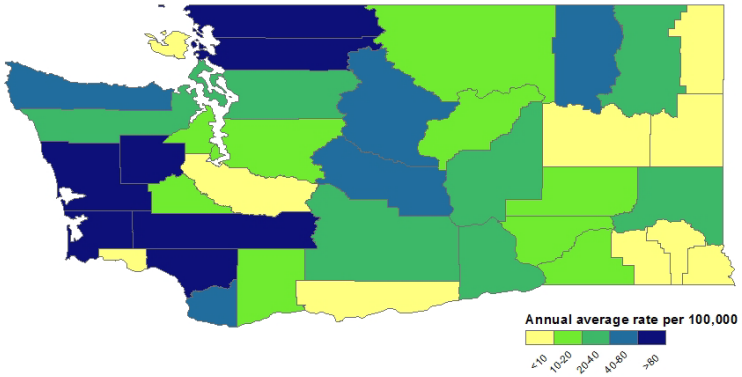
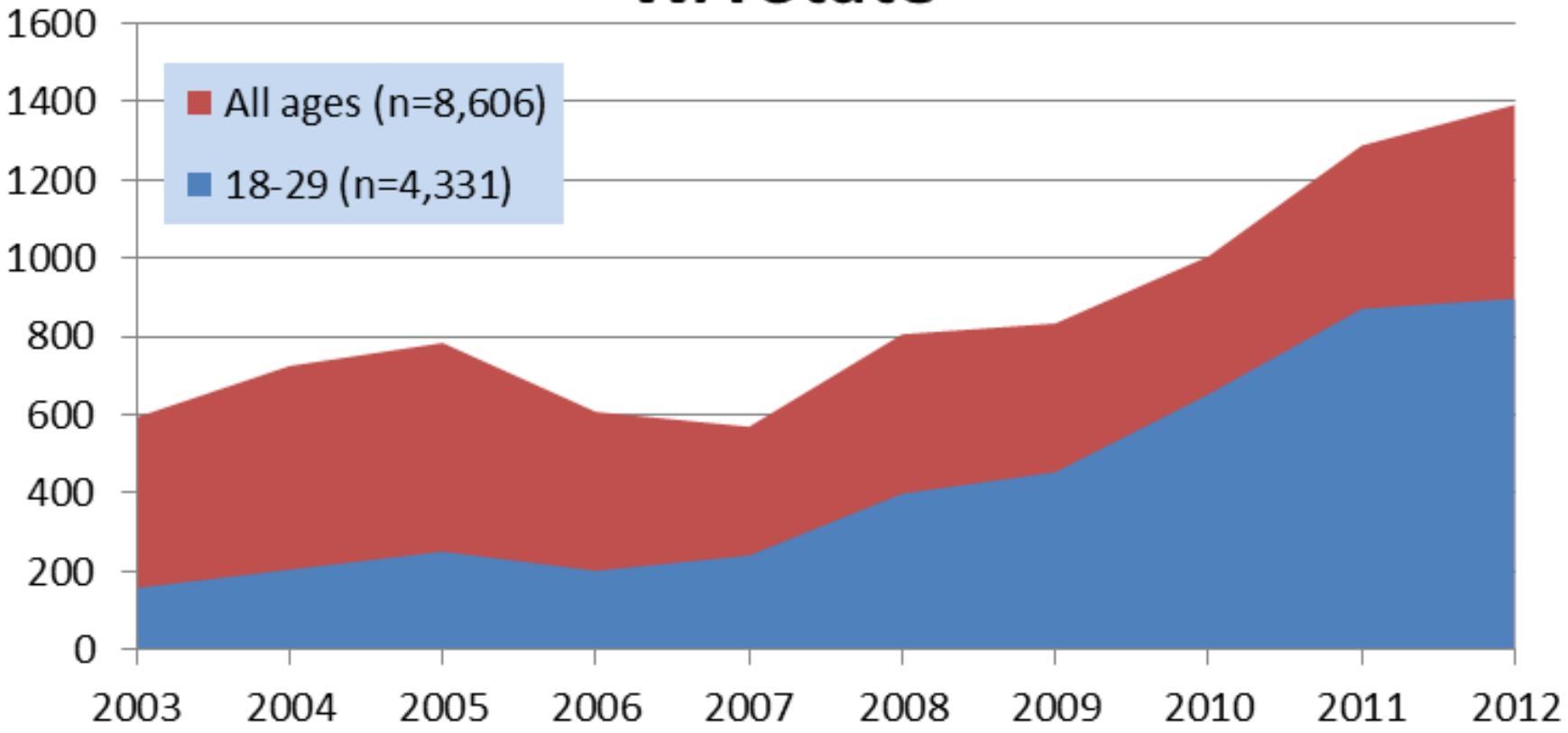


Data source: Washington State Patrol, Crime Lab, NFLIS data set
Data analysis and mapping: Caleb Banta-Green, University of Washington

UNIVERSITY of WASHINGTON
ADAI Alcohol & Drug Abuse Institute

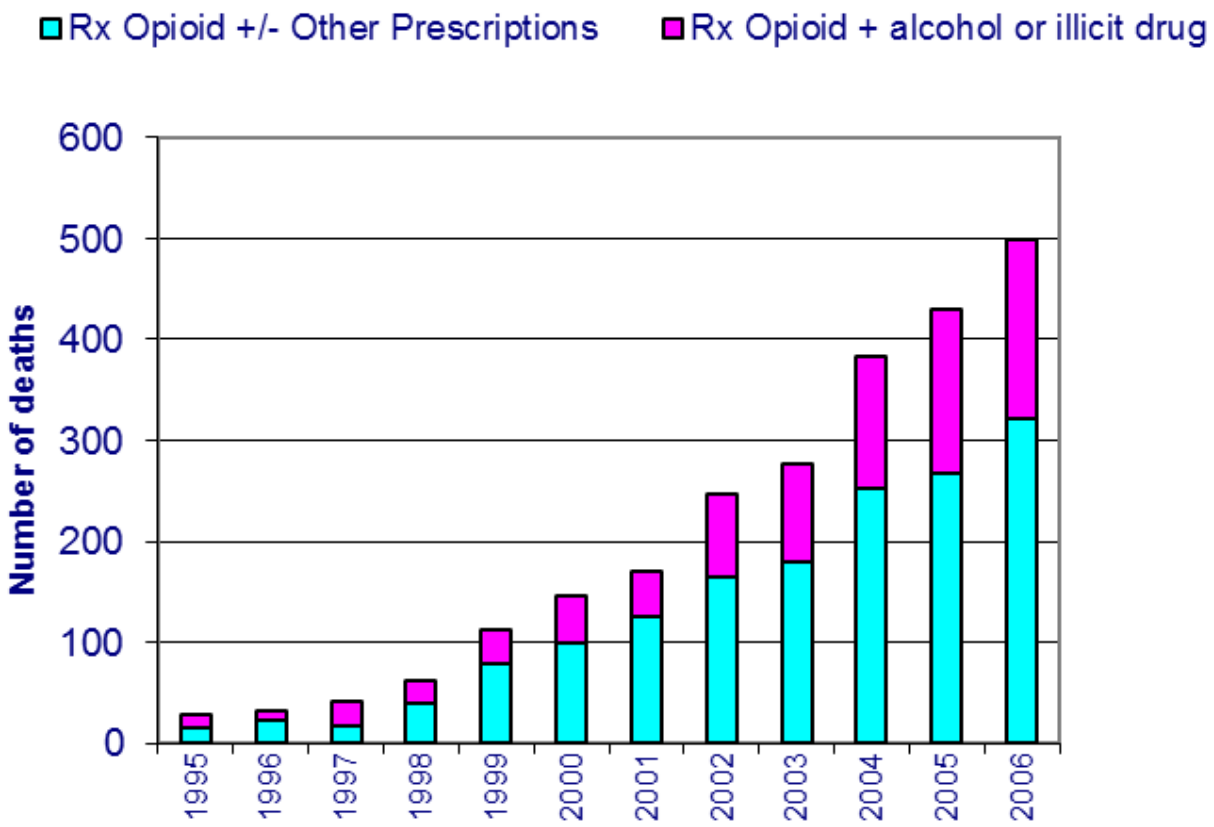
Heroin Treatment Admits, First Time
WA State



UNIVERSITY of WASHINGTON
ADAI Alcohol & Drug Abuse Institute

Department of Health's Role Begins with Surveillance

Prescription Opioid Involved Overdose Deaths Washington State, 1995-2006



DOH Leads an Interagency Opioid Workgroup

- Began in June 2008
- Broadened to include all opioids, including heroin, in 2014
- Focused on preventing and reducing unintentional opioid misuse, abuse & overdose
- Includes a diverse group of stakeholders

Policy Interventions

- Opioid Prescribing Guidelines & Provider Education
- Pain Management Rules
- Medicaid's efforts
- Emergency Department
- Good Samaritan - Naloxone access & OD prevention education
- PDMP - easier provider access & data visualization tool

1st AMDG Opioid Dosing Guideline

- Developed during 2006 by 15 clinical pain specialists in collaboration with the AMDG
- It was an **Educational Pilot**
- **Part I-** If patient has not had clear improvement in pain AND function at 120 mg MED, “take a deep breath”
- **Part II-** guidance for patients already on very high doses above 120 mg MED

AMDG Opioid Dosing Guideline Evaluation

- Trends 1996-2010 in workers compensation system
- Findings
  - Number of CSII and CSIII opioid rx declined
  - Mean MED declined 27% in 2002-2010
  - Proportion of claimants on opioids declined 37%
  - Proportion of claimants on 120+ MED declined 35%
  - Opioid-related deaths rose through 2009 and dropped sharply in 2010

AMDG Opioid Dosing Guideline
2010 Update

New tools:

- Tracking pain and function - Two item graded chronic pain scale
- Urine Drug Testing
- Specific opioid treatment agreement forms
- Screening tools recommended:
  - Opioid Risk Tool (ORT; 5 questions) screens for substance abuse hx
  - CAGE-AID (4 questions) screens for concomitant alcohol abuse
  - PHQ-9 (9 questions) screens for depression

Changes in prescribing after 2010 Washington State Opioid Prescribing Guidelines

- **Survey in 2011 of prescribers asked:**
  - "Has your opioid prescribing for chronic, noncancer pain changed in the past 3 years?"
  - Response rate ~8%
- **Responses:**
  - Now prescribes opioids to
    - More CNCP patients, 11%
    - Fewer CNCP patients, 44%
    - Stopped prescribing, 3%
  - Now prescribes
    - Higher doses more often, 6%
    - Higher doses less often, 47%

AMDG Opioid Dosing Guideline 2015

New and modified sections:

1. Recommendations for All Pain Phases
   - Clinically Meaningful Improvement in Function
   - Expanded discussion on dosing threshold
   - Non-opioid options for Pain Management
2. Opioids in the Acute & Subacute Phases
3. Opioids for Perioperative Pain

AMDG Opioid Dosing Guideline 2015

New and modified sections:

4. Reducing or Discontinuing Chronic Opioid Therapy
5. Recognition and Treatment of Opioid Use Disorder
6. New sections on opioid use in:
   - Pregnancy
   - Children & adolescents
   - Older adults
   - Cancer survivors

Provider Education Efforts: UW Tele-video Multidisciplinary Pain Consultation

- Since March 2011; weekly 1.5 hr sessions
- Expert panel: Primary care, Anesthesia, PM&R, Psychiatry, Addiction Medicine, Nursing, Pharmacy
- Web-based video-conferencing using existing Polycom infrastructure; or telephone
- Site visits and set-up assistance to every location

Pain Management Rules

Initial bill focus was mandatory provider education

Purpose:

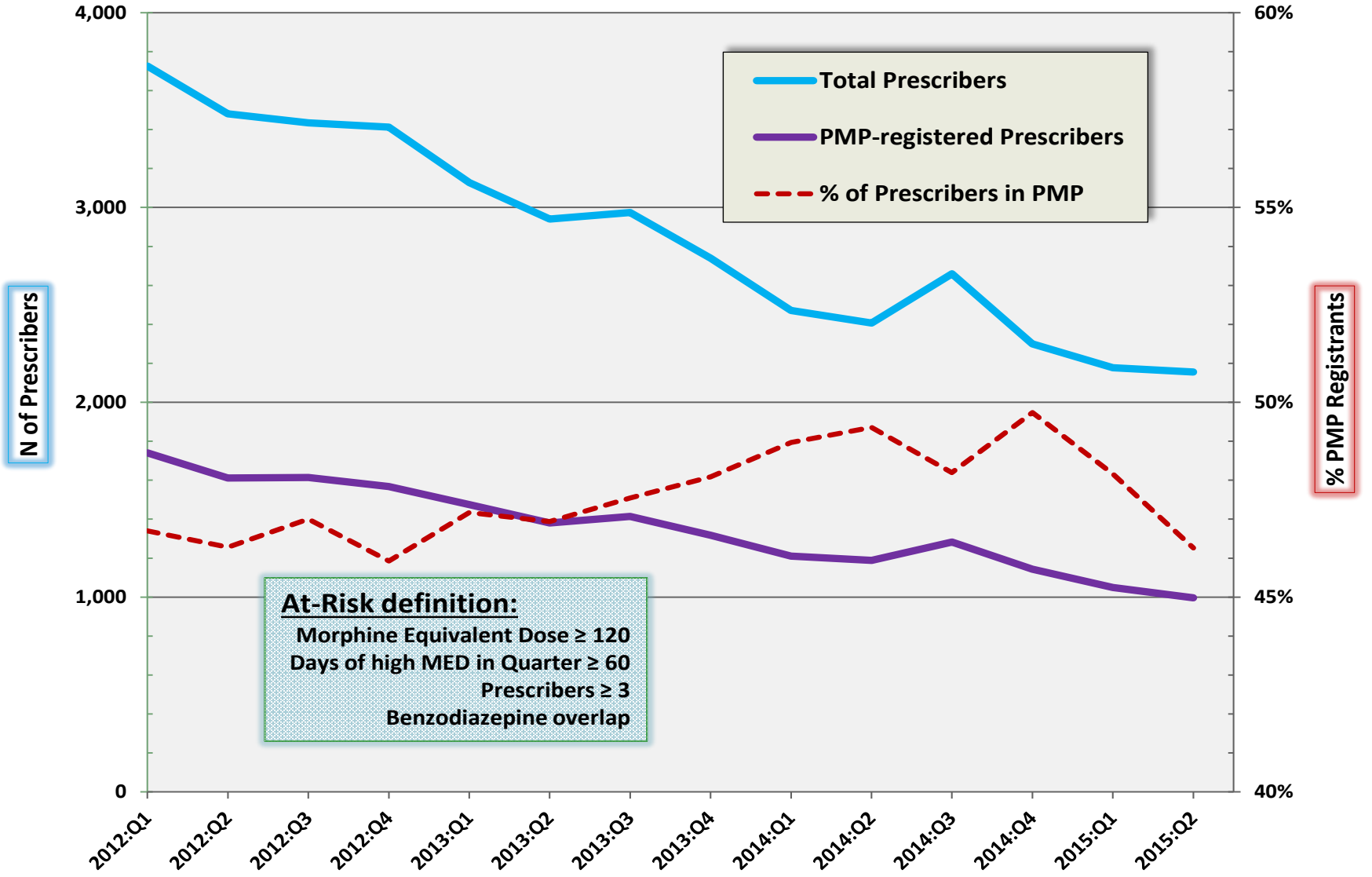
The 2010 Legislature passed ESHB 2876 in response to concerns about prescribing opioids for chronic non-cancer pain management:

- Opioid prescribing overall is on the rise
- Opioid related deaths and overdoses are on the rise
- High profile regulatory actions

Pain Management Rules:
Requirements

- “Dosing criteria” including a dosage threshold requiring pain management specialist consultation before it can be exceeded.
- Methods to increase consultation availability.
- Minimizing burden on practitioners and patients.
- Guidance on tracking clinical progress by using assessment tools focusing on pain interference, physical function, and overall risk for poor outcome.
- Guidance on tracking the use of opioids.

Total Number of Prescribers to At-Risk Recipients by Prescriber's PMP Registration Status (2012:Q1-2015:Q2)



Medicaid Efforts: Narcotic Prescription Programs

- **Background**
  - Identified “Top 320” Medicaid Clients who received highest volume of narcotics (non-cancer/non-hospice)
  - $7 million in total annual health expenses ($900k narcotics & $3 million ER related)
- **Intervention**
  - Narcotic Prior Auth – via a 12 month Rx review by the prescriber
  - Referral to the PRR “lock-in” program
- **Outcomes**
  - Significant reduction in narcotic scripts filled
  - A doubling of alcohol/drug treatment rates
  - Lower ER visits and overall medical costs

Medicaid Efforts: Patient Review and Coordination (PRC) Program

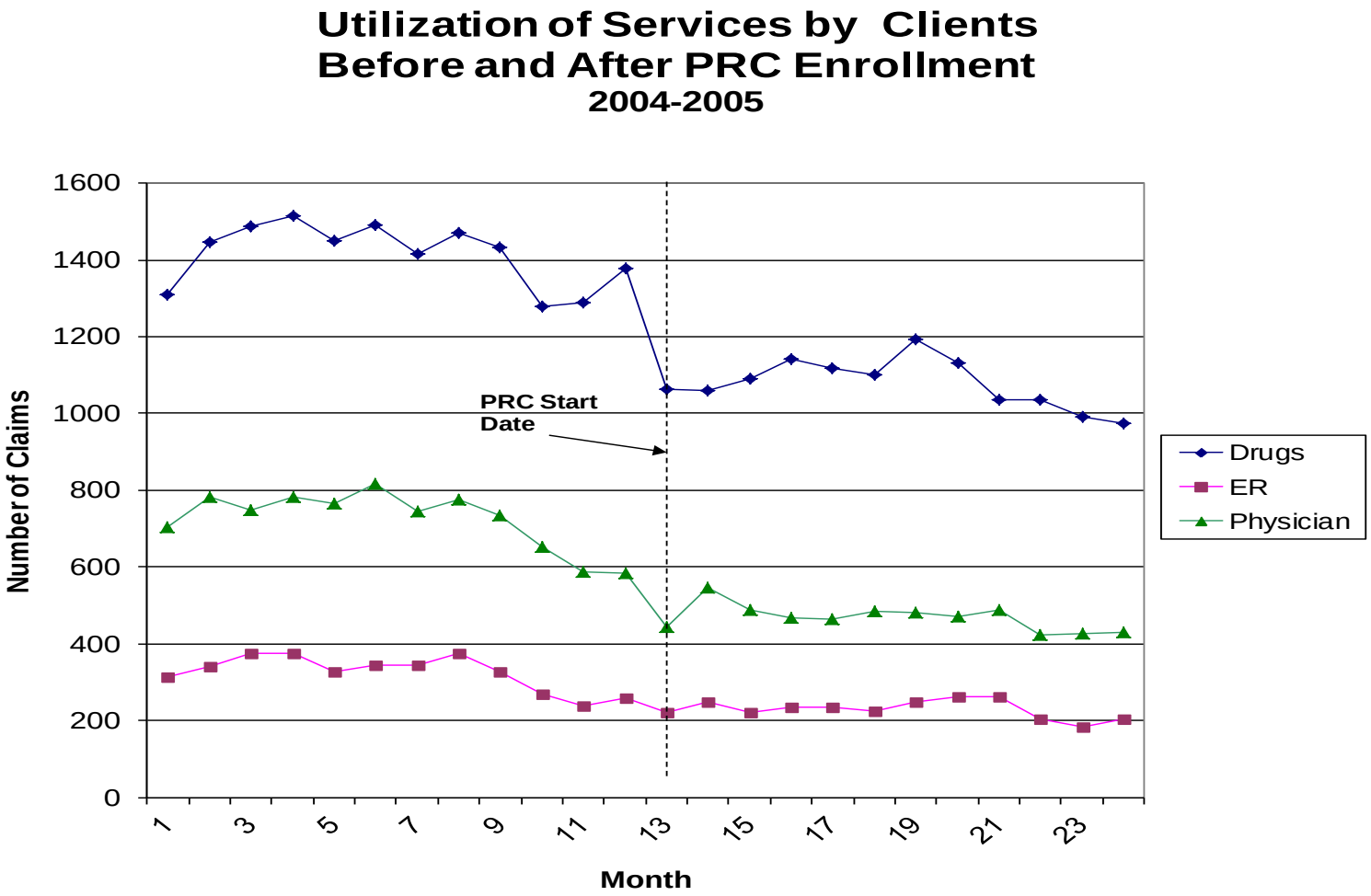
- Clients who inappropriately use or misuse health care services or who are considered “high risk”
- Client are restricted to specific providers for at least 24 months:
    - One primary care provider
    - One pharmacy
    - One narcotic prescriber
    - One hospital for non-emergent services (cannot restrict emergency services)

Outcome: reduction in utilization

33% decrease in emergency use

37% decrease in physician visits

24% decrease in number of prescriptions



Emergency Department Specific Activities

- Guidelines for Opioid Prescribing
  - Adopted and distributed by WA chapter of American College of Emergency Physicians http://washingtonacep.org/painmedication.htm
  - Accompanied by patient education poster http://here.doh.wa.gov/materials/prescribing-pain-medication
- Information Exchange
  - Shares patient information between EDs, focus frequent ED visitors

Prescribing Pain Medication in the Emergency Department

Our emergency department staff understand that pain relief is important when someone is hurt or needs emergency care. However, providing pain relief is often complex. Mistakes or misuse of pain medication can cause serious health problems and even death. Our emergency department will only provide pain relief options that are safe and appropriate.

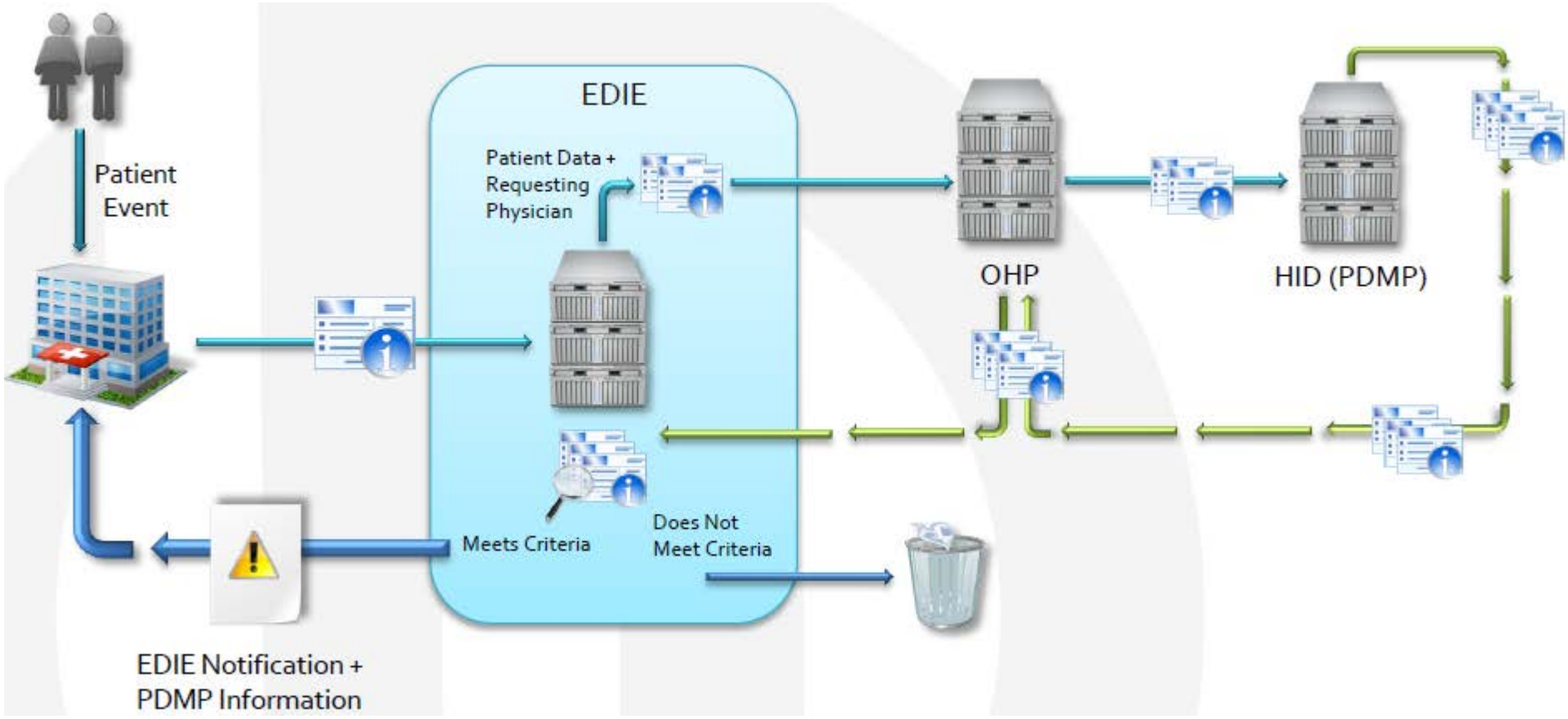
- Our main job is to look for and treat an emergency medical condition. We use our best judgment when treating pain, and follow all legal and ethical guidelines.
- We may ask you to show a photo ID (such as a driver's license) when you check into the emergency department or receive a prescription for pain medication.
- We may ask you about a history of pain medication misuse or substance abuse before prescribing any pain medication.
- We may only provide enough pain medication to last until you can contact your doctor. We will prescribe pain medication with a lower risk of addiction and overdose when possible.

- **For your safety, we do not:**
  - Give pain medication shots for sudden increases in chronic pain.
  - Refill stolen or lost prescriptions for medication.
  - Prescribe missed methadone doses.
  - Prescribe long-acting pain medication such as OxyContin, MS Contin, fentanyl patches, or methadone for chronic, non-cancer pain.
  - Prescribe pain medication if you already receive pain medication from another doctor or emergency department. An exception may be made after a urine drug test or contact with your doctor or clinic.

If you would like help, we can refer you to a drug treatment program.
Or you can call the Washington State Alcohol and Drug Help Line at **1-800-562-1240**.

Washington State Department of Health DOH 346-037 May 2011
PUBLIC HEALTH ALWAYS WORKING FOR A SAFER AND HEALTHIER WASHINGTON
ENA Emergency Nurses Association Washington State Council
Washington State Medical Association WSMA Physician Driven Patient Focused
Washington State Hospital Association
American College of Emergency Physicians Washington Chapter Advancing Emergency Care

Emergency Department Information Exchange (EDIE)



PMP Criteria for EDIE

PMP Specific Criteria:

- > 3 prescribers in 12 months
- > 4 CS within 12 months
- > 2 CS within last 40 days
- Any Rx for Methadone, Suboxone, Fentanyl Transdermal, LA Morphine, or LA Oxycodone in the last 6 months
- Any overlapping opioid and benzodiazepines Rx in last 6 months
- > 100 average MED/day in last 40 days

- **PMP is queried with every ED admission**
- **PMP report is provided anytime criteria are met**

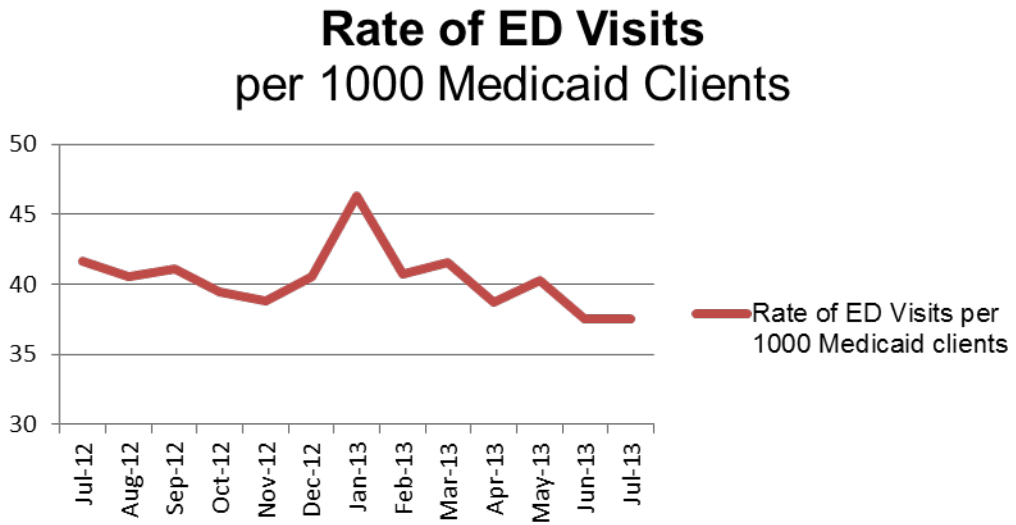
ED Information Exchange & PMP

- ED provider receives:
  - # of ED visits, dates of visits
  - Any treatment care plan info available “Do not provide controlled substances in the ED. Pt. has exhibited extensive drug seeking behavior”
  - All recent prescriptions available from PMP
  - Identified primary care provider

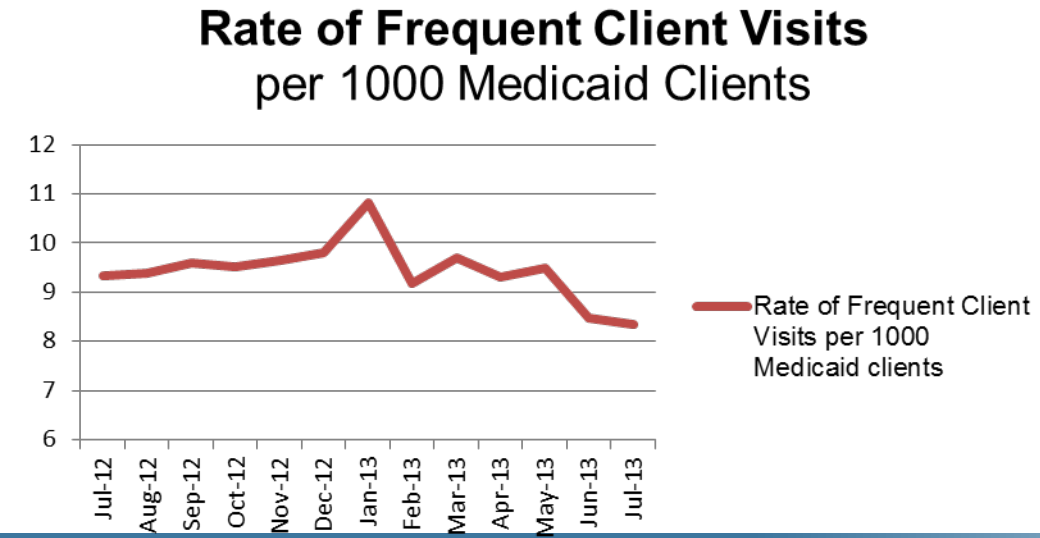
The Seven ED Best Practices

- Exchange patient information
- Patient education about use of ED
- Patient review & coordination (PRC) client information/identification
- PRC client care plans
- Adopt ED opioid prescribing guidelines
- Use prescription monitoring program
- Use of feedback information

WA Medicaid ED Visits - Post Seven Best Practices



Rate of ED visits declined by 9.9%



Rate of frequent clients* decreased by 10.7%

***5+ visits in 12 mos.**

Passage of the "911 Good Samaritan Overdose Law" took five years, keys to passage included:

- Framing the law as a public health issue, not primarily as a legal issue.
- The emergence of prescription medicines (e.g. opiate pain medicines) as the drugs involved in a majority of drug overdoses.
  - This increased the perceived public health risks of overdose and broadened the populations, demographically and geographically, that could be helped by legislative action.
- Keeping the scope of immunity narrow, just drug possession, was the only way to get support of law enforcement, prosecutors, and some legislators.

Implementation

- Information dissemination- *Good Samaritan*
  - Press conference June 2010
  - Earned media- Newspapers, Radio, Websites…
  - Radio PSA- not clear it was ever played
  - Presentations/meetings with health outreach workers
  - Written materials (examples…)
    - Information cards for heroin users
    - Opioid Rx Flier
  - www.stopoverdose.org

Information handed out by local public health & needle exchange

LIFE SAVING ALERT

Starting June 10, 2010

Under Washington's new "911 Good Samaritan" law, if you think someone's OVERDOSING, and you SEEK MEDICAL HELP for the victim, neither of you will be charged for POSSESSING OR USING DRUGS.

CALL 911!!!

For more information visit http://StopOverdose.org

THE 911 GOOD SAMARITAN LAW DOES NOT PROTECT YOU FROM:

1. Outstanding Warrants.
2. Probation or Parole Violations.
3. Drug Dealing (Example: If You Have Scales, Baggies, Lots of Cash Around)
4. Crimes Other Than Drug Possession (Including Weapons Possession, or If You're Driving Drunk or High).

YOUR LIFE IS VALUABLE!!! If you or a friend are overdosing and you seek medical assistance, you are protected from being charged with drug possession.

Washington's New 911 GOOD SAMARITAN LAW

Goes Into Effect on June 10th, 2010

Starting June 10th, 2010, **if you think you're witnessing a drug overdose and seek medical help,** you will receive immunity from criminal charges of drug possession. The overdose victim you're helping is protected, too. **Call 911.**

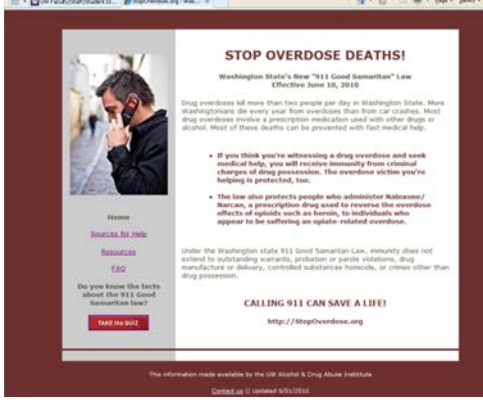
Drug overdoses kill more than two people per day in Washington. Most of these deaths can be prevented with fast medical help. **Calling 911 can save a life.**

For more information visit www.StopOverdose.org.

- Most drug overdoses involve a prescription medication used with other medications, drugs or alcohol. Death from these overdoses can be prevented with fast medical help. Call 911.
- The 911 Good Samaritan immunity does not extend to outstanding warrants, probation or parole violations, drug manufacture or delivery, controlled substances homicide, or other crimes besides drug possession.
- However, judges can give people who seek medical help for overdose victims shorter sentences even if the 911 Good Samaritan immunity doesn't apply to them. Call 911 to help save a life.

Alcohol and Drug Help Line: 1-800-562-1240

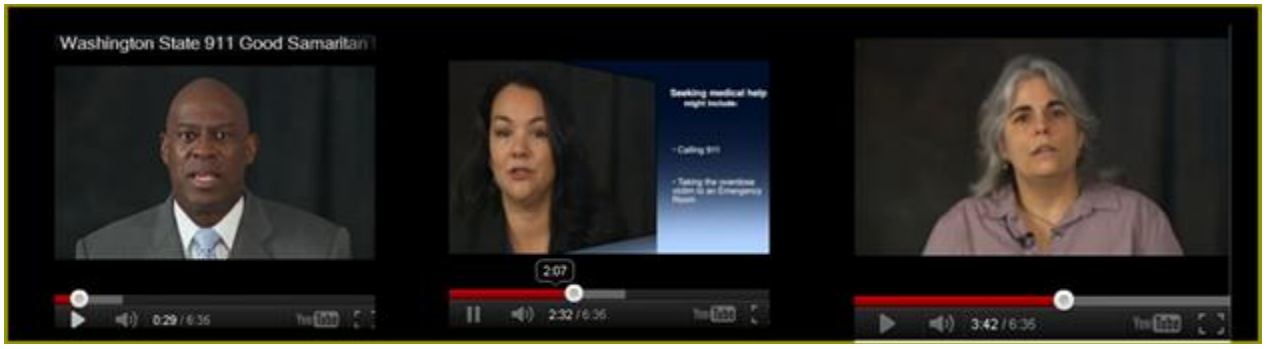
www.stopoverdose.org



- From June 2010 through October 2011 the website has had 3,273 visits from 2,601 unique visitors.
- In first year, most common traffic source was **typing in the website address** (37% of visitors), followed by Google searches (16%).
- After first year, **Google searches** have been the most common source (42%) followed by typing in the website address (20%).
- In first year, majority (67%) came from WA compared to after first year when minority (44%) came from WA.

Good Samaritan Law Evaluation

- Majority of police & paramedics had been to an opioid OD in last year
- Few officers (16%) & paramedics (7%) were aware of the law
- Identified need for training



Expanding Access to Naloxone

StopOverdose.org

Opioid overdoses can be prevented and reversed!

Home / Opioid OD Education

- Where to Get Naloxone / FAQ
- Sources for Help
- Law Enforcement
- Evaluation of WA Law
- Pharmacy/Prescribers
- Other Drugs and Overdose
- Resources
- News

Download & share!

Opioid Overdose Prevention Education

Learn how you can save a life:
WATCH a video, REVIEW the steps, then TAKE A QUIZ.

Prevent an Overdose, Save a Life

A community health worker expains overdose prevention and demonstrates how to administer

Patient Education re: Prescription Opioids

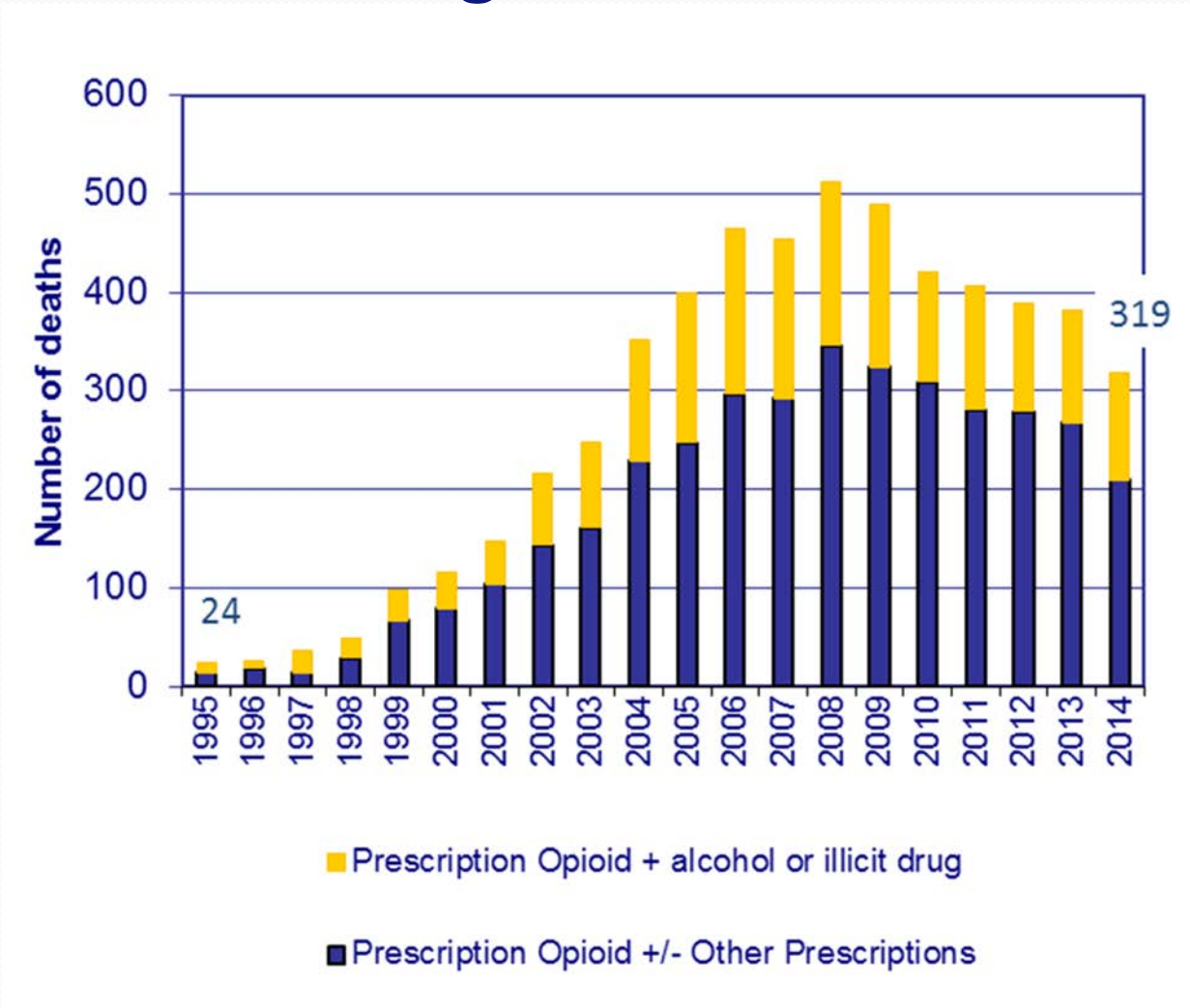
A doctor teaches patients, their families and friends, what to do in case of overdose from

Expanding Access to Naloxone

- Standing order law passed in 2015, allows pharmacists to prescribe directly under county health officer standing order or collaborative drug therapy agreement
- Training first responders
- Syringe exchange programs
- Working on emergency departments, jails
- A few pharmacies currently stock naloxone

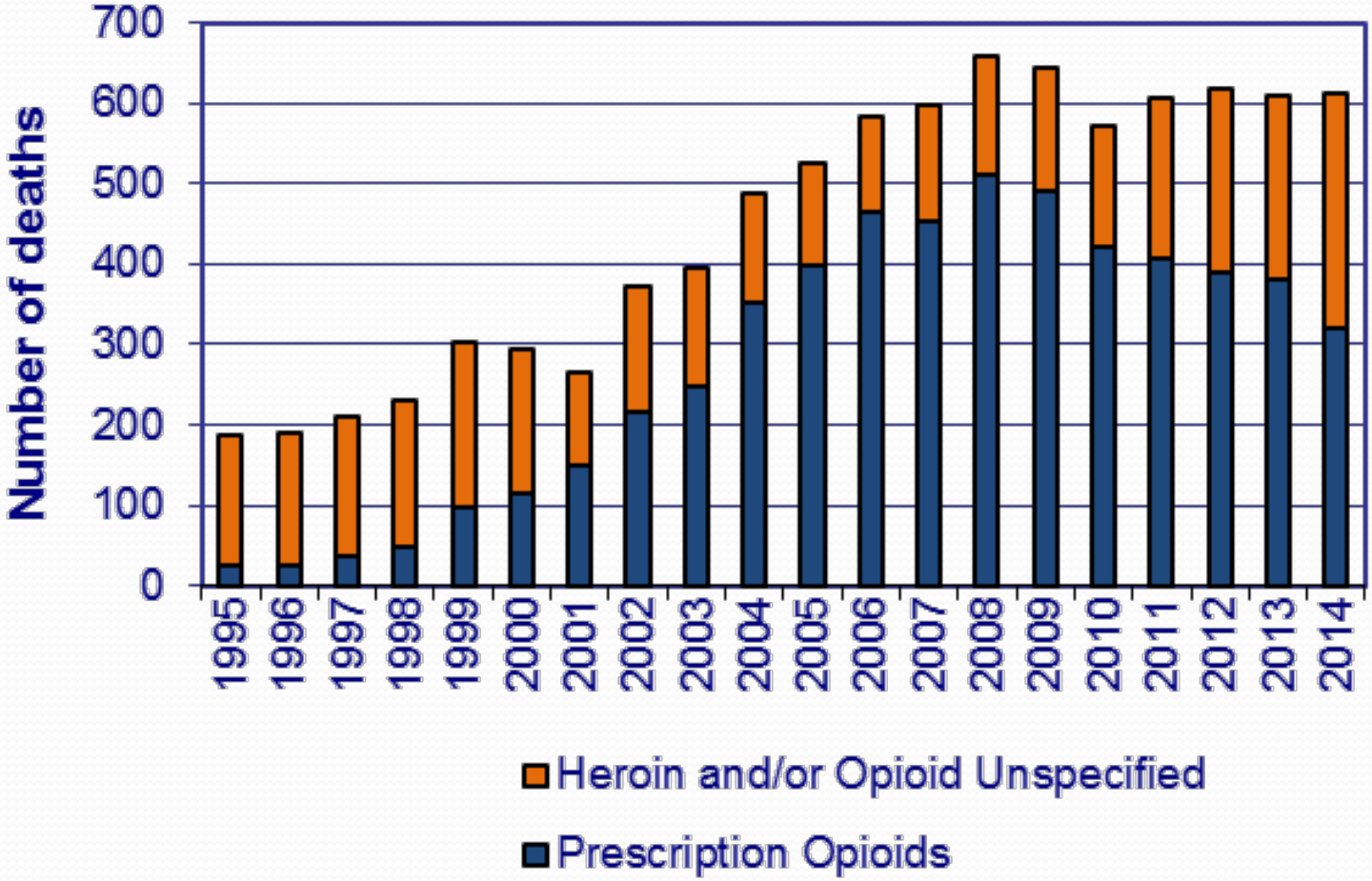
Impact of our collective efforts

Unintentional Prescription Opioid Overdose Deaths Washington 1995-2014



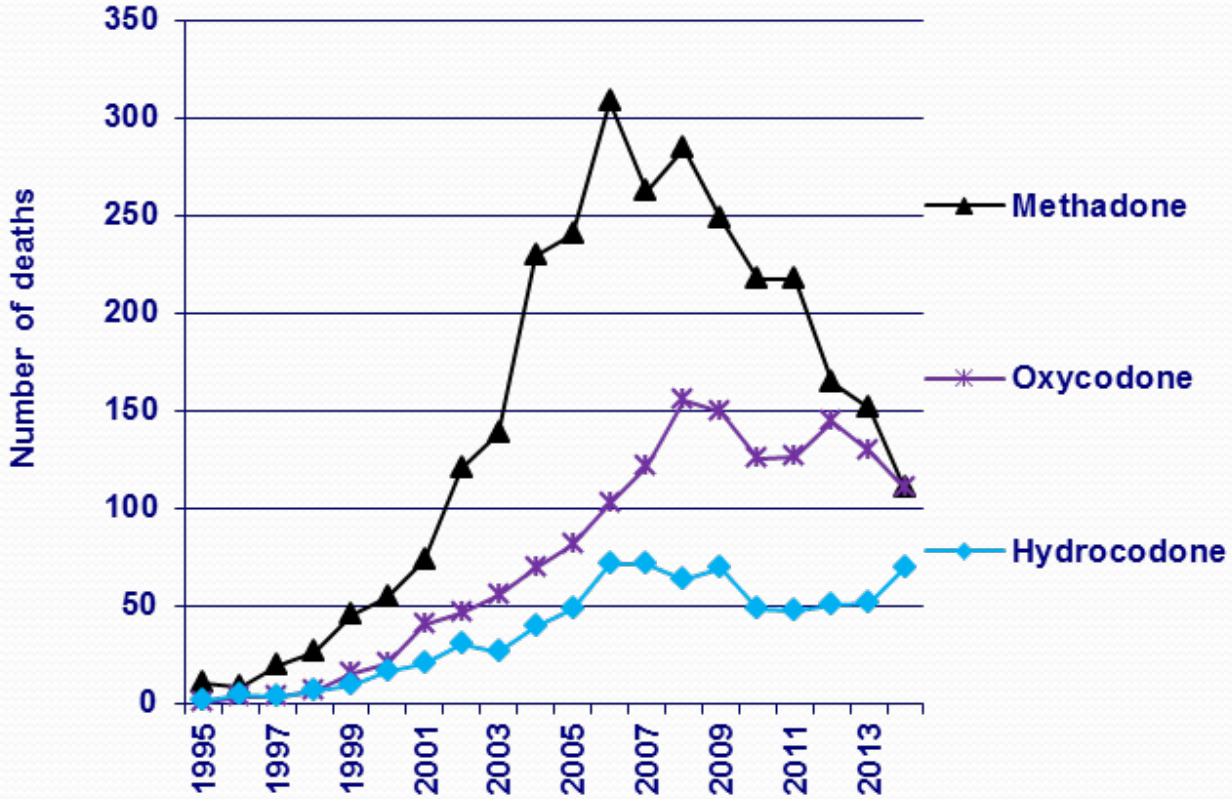
Source: Washington State Department of Health, Death Certificates

Unintentional Opioid Overdose Deaths Washington 1995-2014



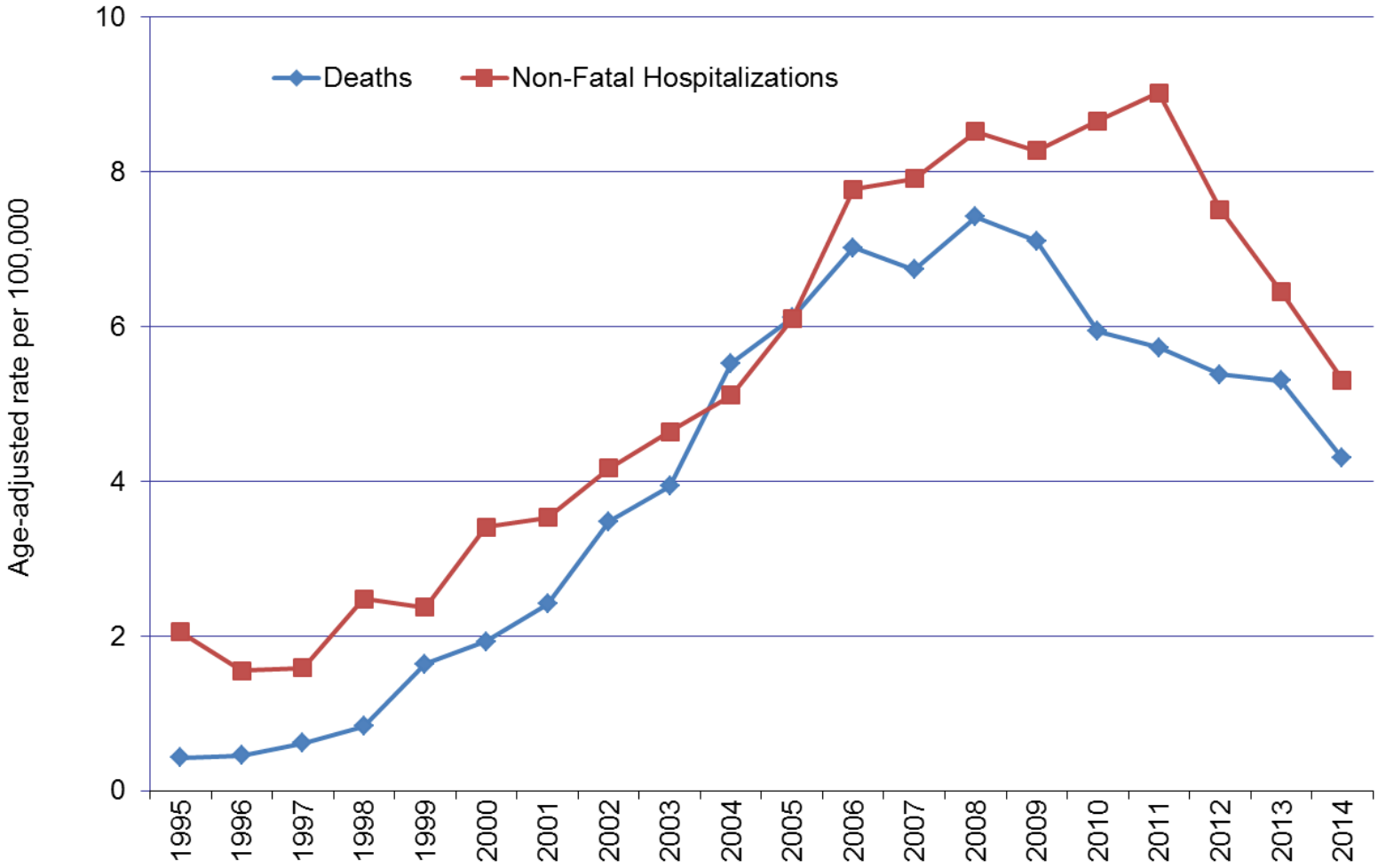
Source: Washington State Department of Health, Death Certificates

Trends for Specific Prescription Opioids Washington 1995-2014

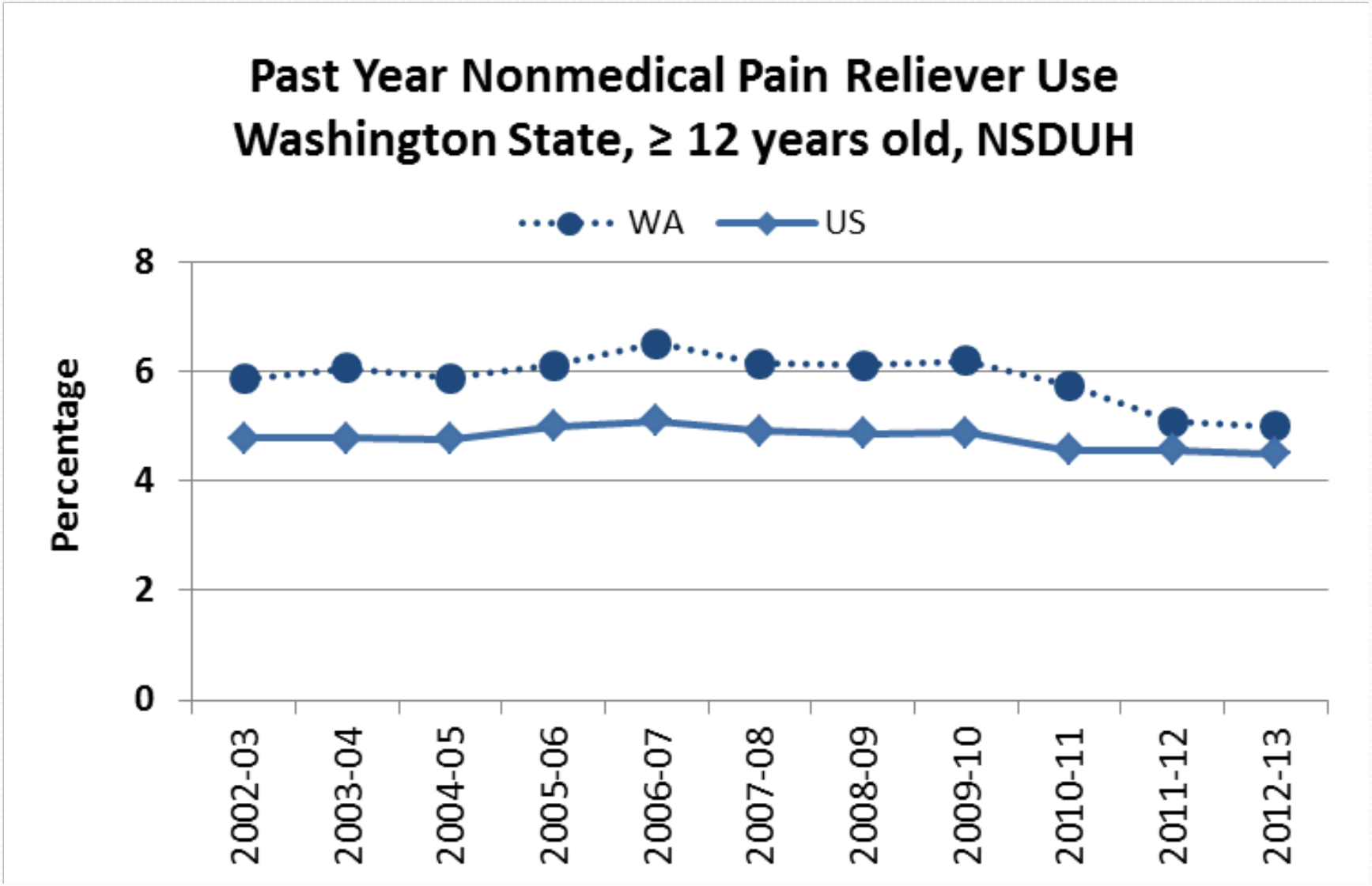


Source: Washington State Department of Health, Death Certificates

Unintentional Prescription Opioid Involved Overdoses
Washington State



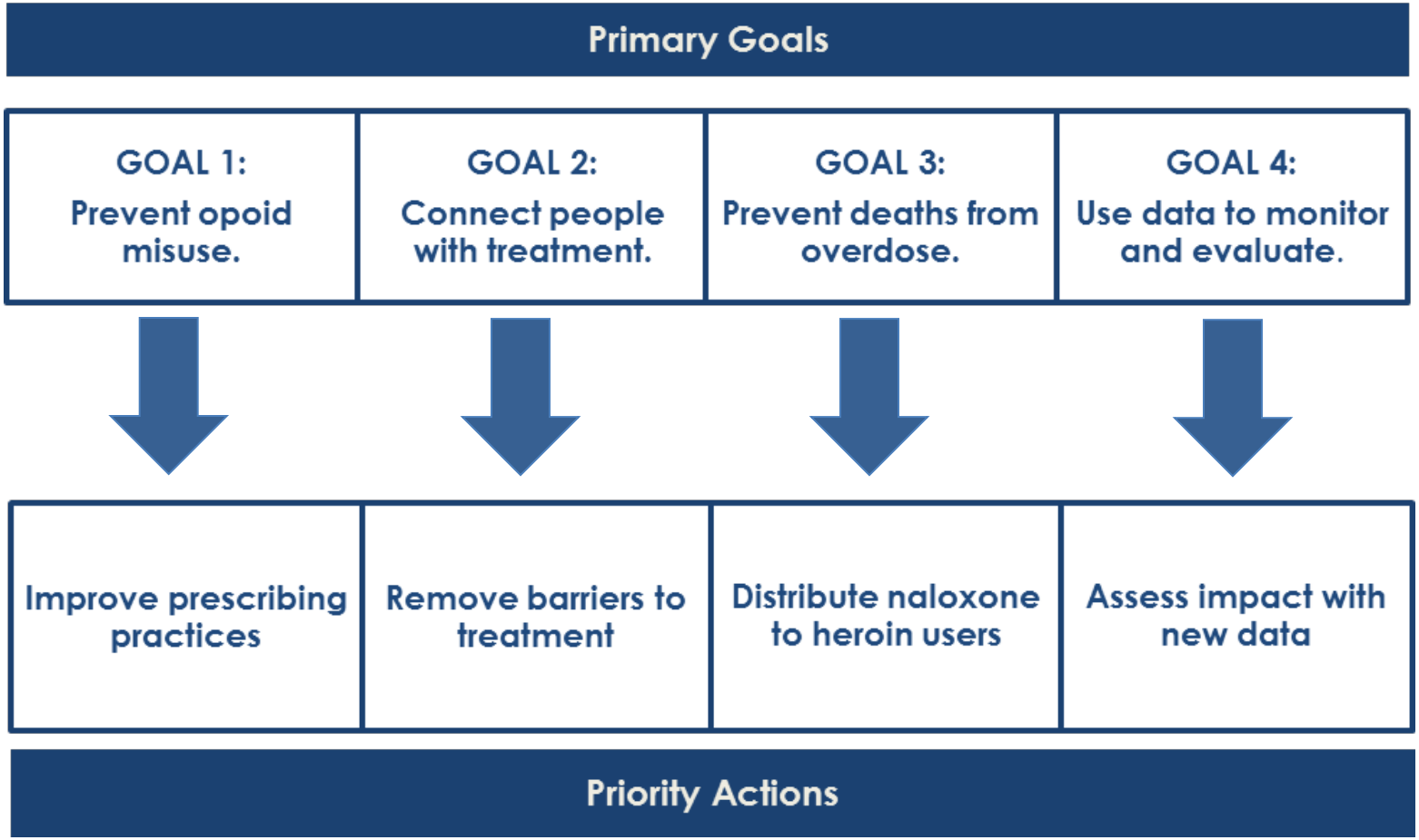
Sources: Washington State Department of Health, Death Certificates and Hospital Discharge Data



Sources: NSDUH

Next Steps

2015 Opioid Strategic Plan



PMP & Health Information Exchange

- Connecting to our state Health Information Exchange with the goal of providing access to PMP data through EHRs
- Have completed testing with Epic, and they will be building PMP data into next version of EHR.

PMP Data Visualization Tool

Plan

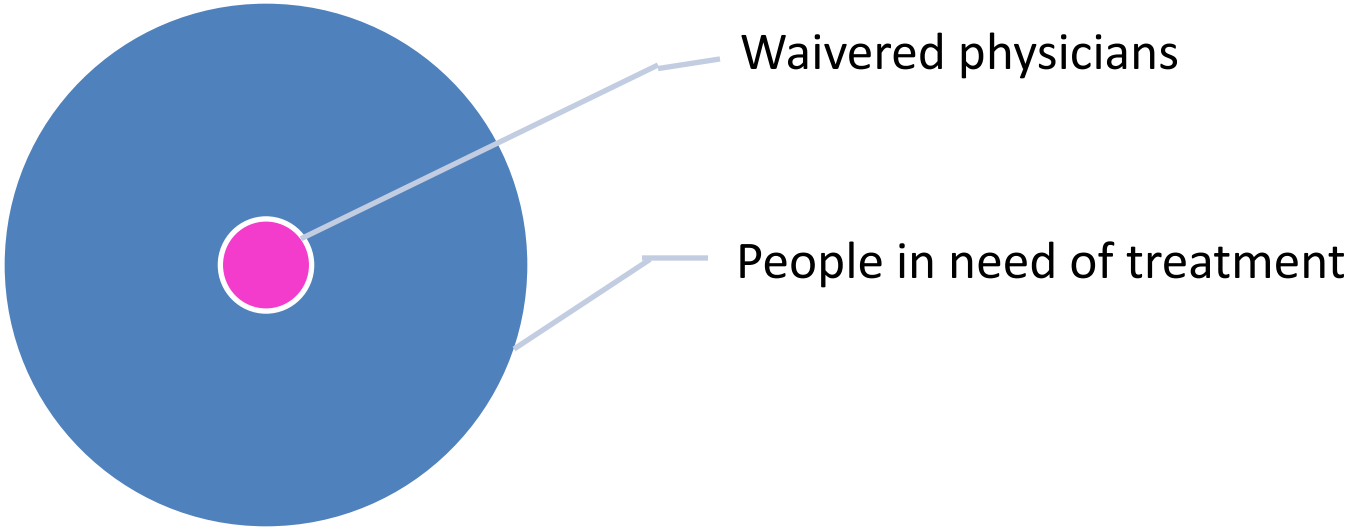
1. Integrate PMP with other datasets, construct composite indices across multiple sources.
2. Create web-based GIS mapping tool.

Potential indices

- Medication-Assisted Treatment Service Desert:
  High MAT need + Low MAT access
- PMP Desert:
  High Rx/prescriber/pharm overlap + Low PMP registration
- Overdose Prevention Area:
  High overdose or risky prescribing + Low OD prevention activity

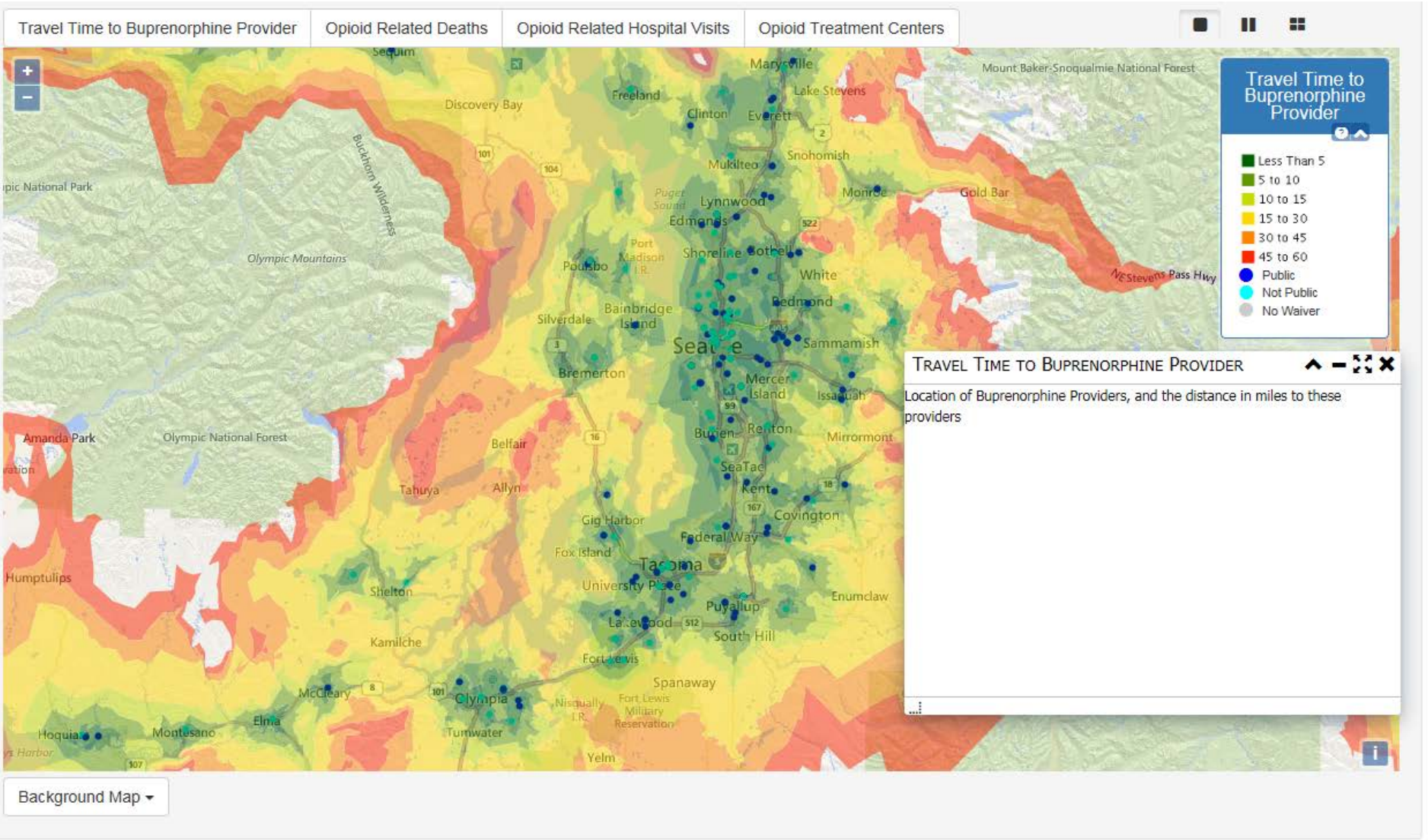
Example 1: Waivered Physicians

- Potential issue: Not enough waivered physicians (may particularly affect rural areas)



Note. 43% of US counties have no waivered physicians (Stein 2015)

Example Map


Travel Time to Buprenorphine Provider
Opioid Related Deaths
Opioid Related Hospital Visits
Opioid Treatment Centers
Travel Time to Buprenorphine Provider
Less Than 5
5 to 10
10 to 15
15 to 30
30 to 45
45 to 60
Public
Not Public
No Waiver
Travel Time to Buprenorphine Provider
Location of Buprenorphine Providers, and the distance in miles to these providers
Background Map
Mount Baker-Snoqualmie National Forest
Olympic Mountains
Olympic National Forest
Buckhorn Wilderness
Discovery Bay
Freeland
Clinton
Everett
Marysville
Lake Stevens
Snohomish
Mukilteo
Monroe
Gold Bar
Lynnwood
Edmonds
Shoreline
Bothell
White
Redmond
Sammamish
Issaquah
Bainbridge Island
Silverdale
Bremerton
Poulsbo
Port Madison I.R.
Mercer Island
Renton
Burien
SeaTac
Kent
Covington
Federal Way
Mirrormont
Enumclaw
Puyallup
South Hill
Tacoma
University Place
Fox Island
Gig Harbor
Belfair
Allyn
Tahuya
Shelton
Kamilche
Fort Lewis
Spanaway
Lakewood
Olympia
Tumwater
Nisqually I.R.
Fort Lewis Military Reservation
McCleary
Elma
Montesano
Hoquiam
Humptulips
Amanda Park
Yelm

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