Washington State Department of Health

Responding to the Opioid Epidemic

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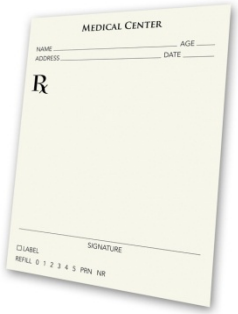
Nursing Care Quality Assurance Commission

September 7, 2017

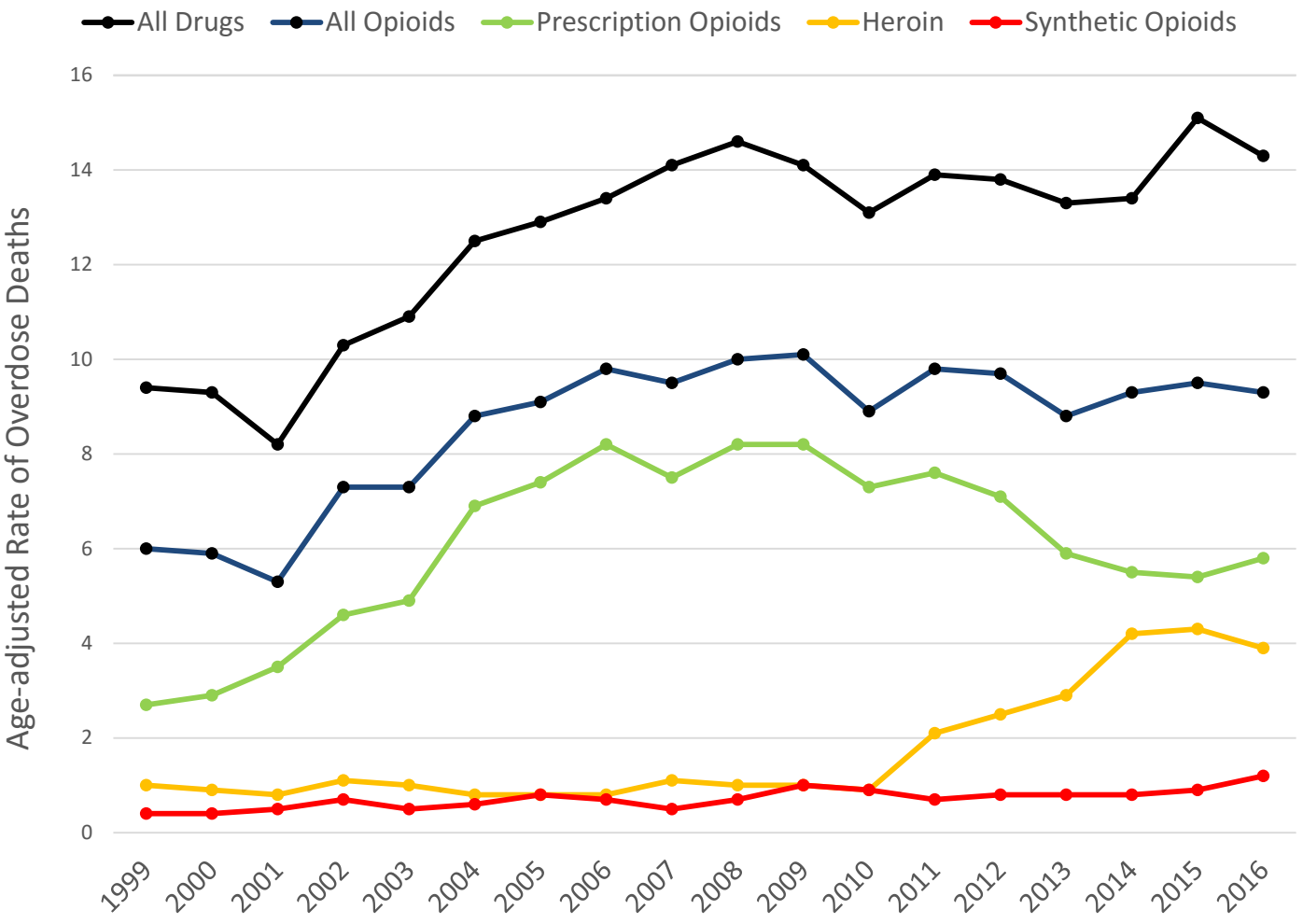
PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND HEALTHIER COMMUNITY



Overview

- Overview of the statewide opioid response
- House bill 1427
  - Improving opioid prescribing practices
  - Using data to improve prescribing practices
- Expanding access to treatment for opioid use disorder

Rates of Opioid-related Overdose Deaths by Type of Opioid, 1999–2016*



Source: DOH Death Certificates (*2016 data are preliminary)

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State Opioid Response Plan

Priority Goals

Goal 1: Prevent Opioid Misuse & Abuse	Goal 2: Treat Opioid Use Disorder	Goal 3: Prevent Deaths from Overdose	Goal 4: Use Data to Monitor and Evaluate
↓	↓	↓	↓
Improve Prescribing Practices	Expand Access to Treatment	Distribute naloxone to heroin users	Optimize and expand data sources

Priority Actions

http://stopoverdose.org/section/wa-state-interagency-opioid-working-plan/

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Engrossed Substitute House Bill 1427

- Requires 5 boards/commissions to develop opioid prescribing rules by Jan 1, 2019 (MQAC, NQAC, DQAC, BOMS, PMB)
- Expands use of Prescription Monitoring Program data
  - Assessment of PMP data with morbidity/mortality data
  - Prescriber feedback reports / reports to provider groups
  - Overdose follow up by local health officers
  - Access by federal and tribal facilities
  - Overdose notification via the Emergency Department Information Exchange
  - Access by WSHA Coordinated Quality Improvement Program
- Modifies standards for certifying/siting Opioid Tx Programs

Source: http://lawfilesext.leg.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/House/1427-S.SL.pdf

Improving Prescribing Practices

Improving Opioid Prescribing

Goals:

- Decrease # of pills dispensed for acute pain
- Decrease # of patients transitioning from acute to chronic opioid use
- Reduce risk of overdose among those on chronic opioid therapy

Expanded Opioid Prescribing Rules

- Update existing opioid prescribing rule for chronic non-cancer pain
- Add new rules on the following potential topics:
  - Prescribing opioid for acute pain
  - Prescribing opioids in the sub-acute phase
  - Opioids for perioperative pain
  - Prescribing opioids in special population

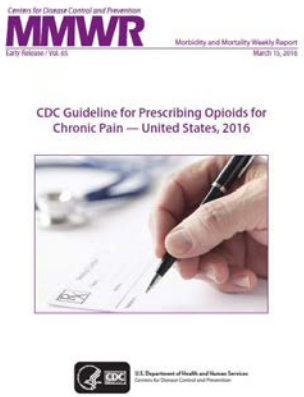
Opioid Prescribing Rule for Chronic Noncancer Pain, Effective Jan. 2012

- Healthcare provider shall:
  - Evaluate and document health history and PE (should include review of PMP data)
  - Discuss risks / benefits of treatment options
  - Document objectives to determine tx success
  - Use a written agreement (if patient high risk)
  - Periodically review course of treatment (should periodically review PMP data)

Source: WAC 246-919-850 - 246-919-863

Opioid Prescribing Rule for Chronic Noncancer Pain, Effective Jan. 2012

- Healthcare providers should:
  - Only use methadone if knowledgeable
  - Review PMP data when providing episodic care
- Healthcare providers are required to consult with a pain specialist if prescribing ≥120 MME/day (exceptions exist)



"Clinicians should use caution when prescribing opioids at any dosage…and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day (recommendation category: A, evidence type: 3)."

Source: WAC 246-919-850 - 246-919-863

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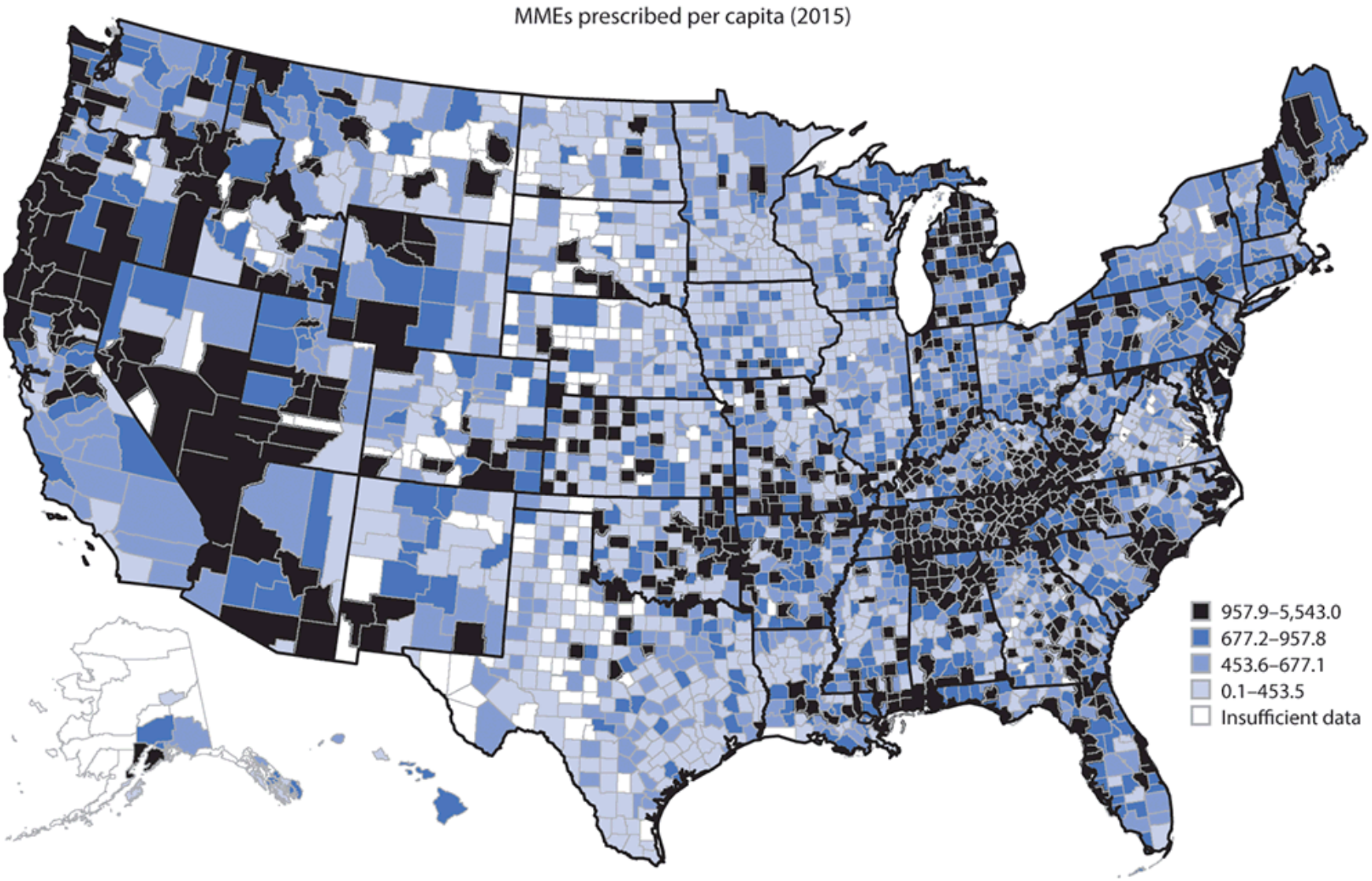
Guidance

- Guidance that must be considered per ESHB 1427:
  - CDC Guidance for Prescribing Opioids for Chronic Pain (March 2016)
  - AMDG Interagency Guideline on Prescribing Opioids for Pain (June 2015)
- Other guidance to consider:
  - Bree Collaborative *DRAFT* Dental Guideline on Prescribing Opioids for Pain
  - *New* Medicaid Opioid Prescribing Policy

Using Data to Improve Prescribing Practices



Guy GP Jr., Zhang K, Bohm MK, et al. Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:697–704. DOI: http://dx.doi.org/10.15585/mmwr.mm6626a4

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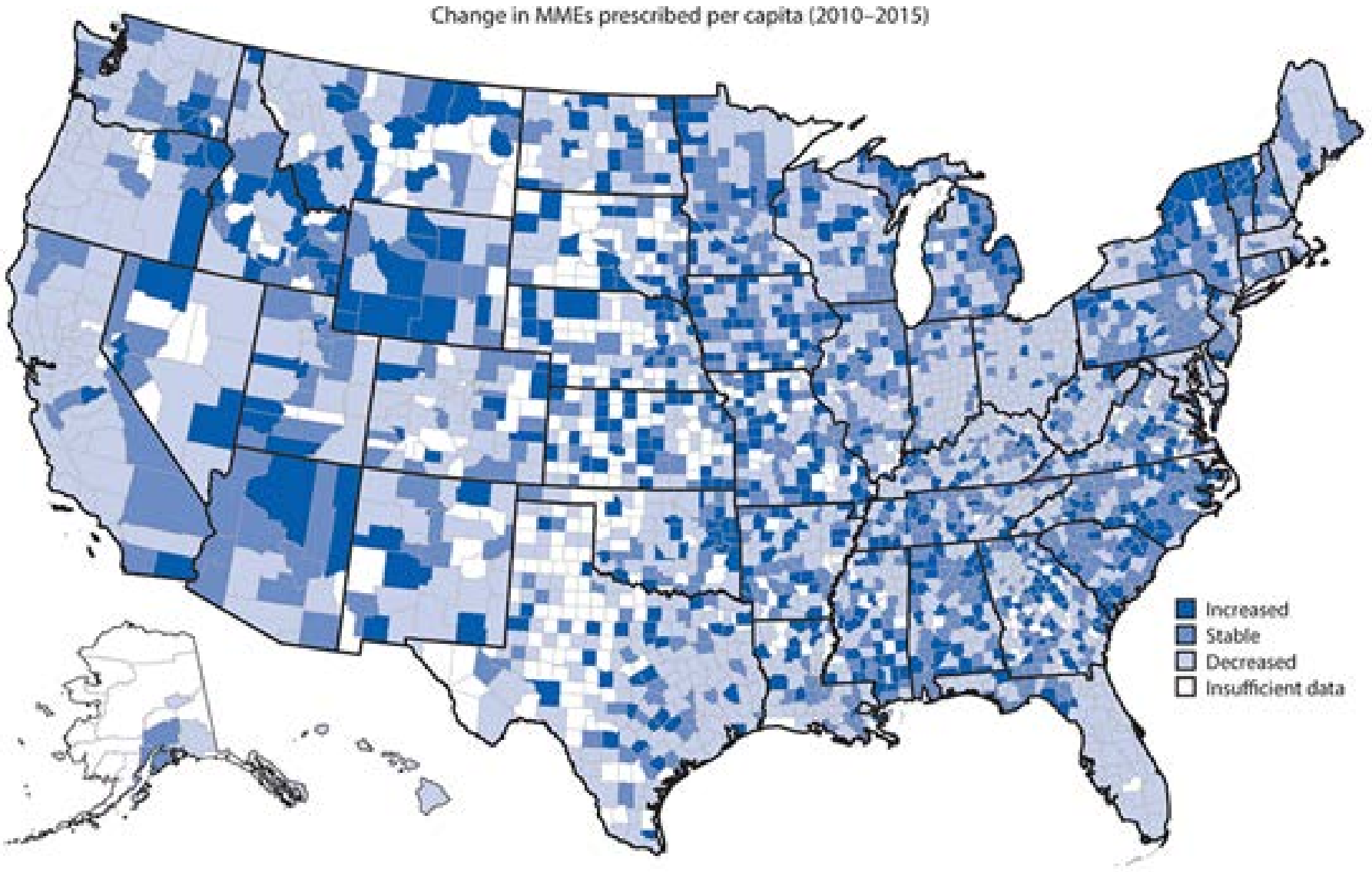

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Prescriber Feedback Reports

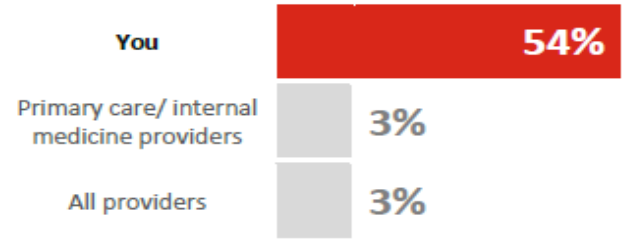
- New authority to send feedback reports to prescribers showing how their prescribing practices compare to best practice
- Plan to use newly collected NPI to create metric based reports with comparisons to like license and specialty
- Plan to make the reports available self-service in the PMP portal (if possible)
- Plan to send the reports out to providers

Bree Prescribing Metrics

- % of population prescribed opioids
- Distribution of days supply on first opioid prescription for new users
- % new opioid patients who transition to chronic opioids
- % of all opioid users prescribed chronic opioids
- % of chronic opioid users receiving high doses of opioids
- % of chronic opioid users prescribed concurrent sedatives

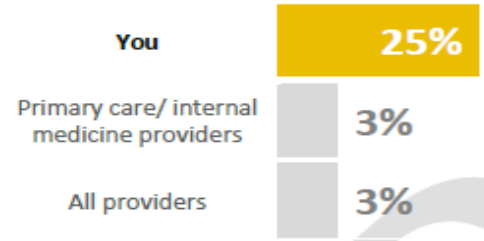
Department of Labor & Industry Report Cards

Percentage of Claims Prescribed High-dose Opioids



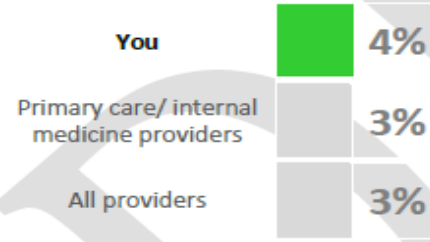
- Taper back down or discontinue if an opioid dose increase does not result in clinically meaningful improvement in function (CMIF).
- Avoid exceeding 90 mg/day MED, and for patients with one or more risk factors (e.g. tobacco users, mental health disorders), do not exceed 50 mg/day MED.

Percentage of Claims Prescribed Concurrent Opioids and Sedatives



- Avoid combining opioids with benzodiazepines, sedative-hypnotics, or carisoprodol.
- Taper off/discontinue above agents and consider non-scheduled alternatives if needed.

Percentage of Claims Prescribed Chronic Opioids



- Do not prescribe chronic opioids for non-specific pain.
- Track function and pain at each prescribing visit.
- Use validated assessment tools and best practices to monitor for adverse outcomes and compliance on treatment regimen (PMP, UDT).

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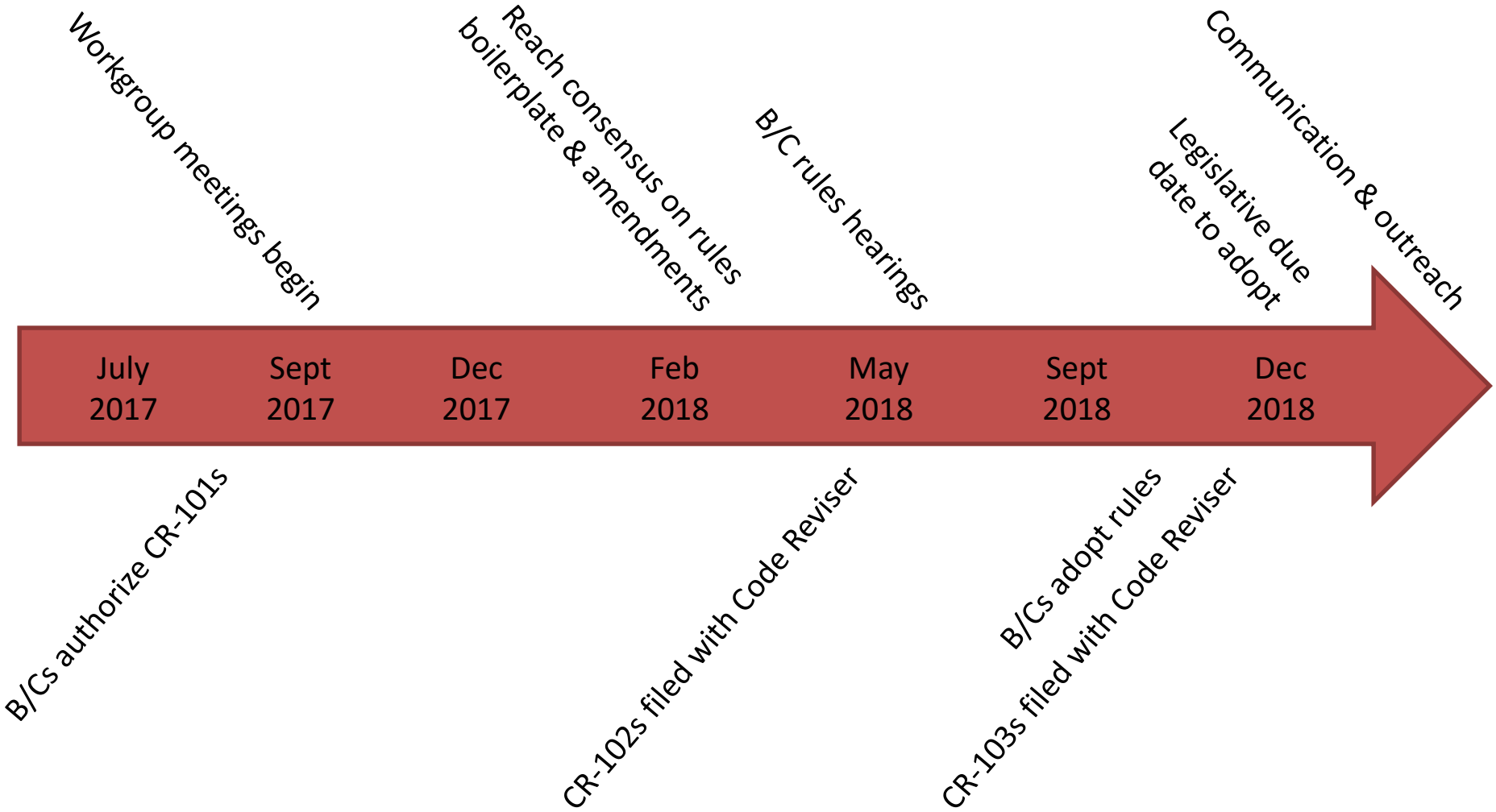
Opioid Prescribing after Non-fatal Overdose

- Study of commercially insured patients with non-fatal overdose between 2000–2012 (n=2848)
- After median follow-up of 299 days:
  - ✓ Opioids dispensed to 91% of patients after overdose
  - ✓ 7% of patients (n = 212) had repeated opioid overdose
- At 2 yrs, estimated cumulative incidence of repeat overdose:
  - ✓ 17% (95% CI, 14% to 20%) for patients receiving high dosages of opioids after the index overdose
  - ✓ 15% (CI, 10% to 21%) for those receiving moderate dosages
  - ✓ 9% (CI, 6% to 14%) for those receiving low dosages
  - ✓ 8% (CI, 6% to 11%) for those receiving no opioids

Source: LaRochelle, et al. Opioid prescribing after non-fatal overdose and association with repeated overdose: A Cohort Study. Ann Int Med 2016;164(1):1–9.

ESHB 1427 Implementation Process

PROPOSED 1427 Timeline – B/C Rules



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1427 Work Groups

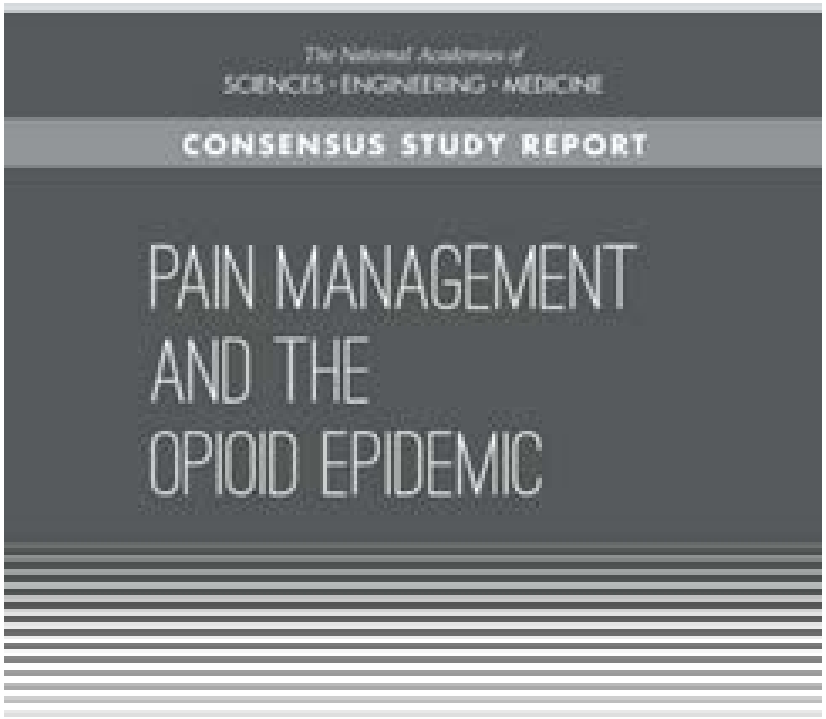
- Opioid Prescribing Task Force
  - Will develop a boilerplate set of prescribing rules that all Boards and Commissions support

- Prescription Monitoring Public Input Process
  - Will collect input from the public and stakeholders to shape how DOH will:
    - Establish an overdose notification message for providers;
    - Create standard prescribing metrics to be provided to facilities/ groups;
    - Develop rules for all PMP elements of HB 1427.

Get Involved!

- ESHB 1427 implementation
  - http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PainManagement/ESHB1427Implementation

- First stakeholder meeting is Sept 20 from 9–3pm at ESD 113, 6005 Tyee Dr. SW, Tumwater



Source: National Academies of Sciences, Engineering, and Medicine. 2017. Washington, DC: The National Academies Press. (http://www.nationalacademies.org/hmd/Reports/2017/pain-management-and-the-opioid-epidemic.aspx)

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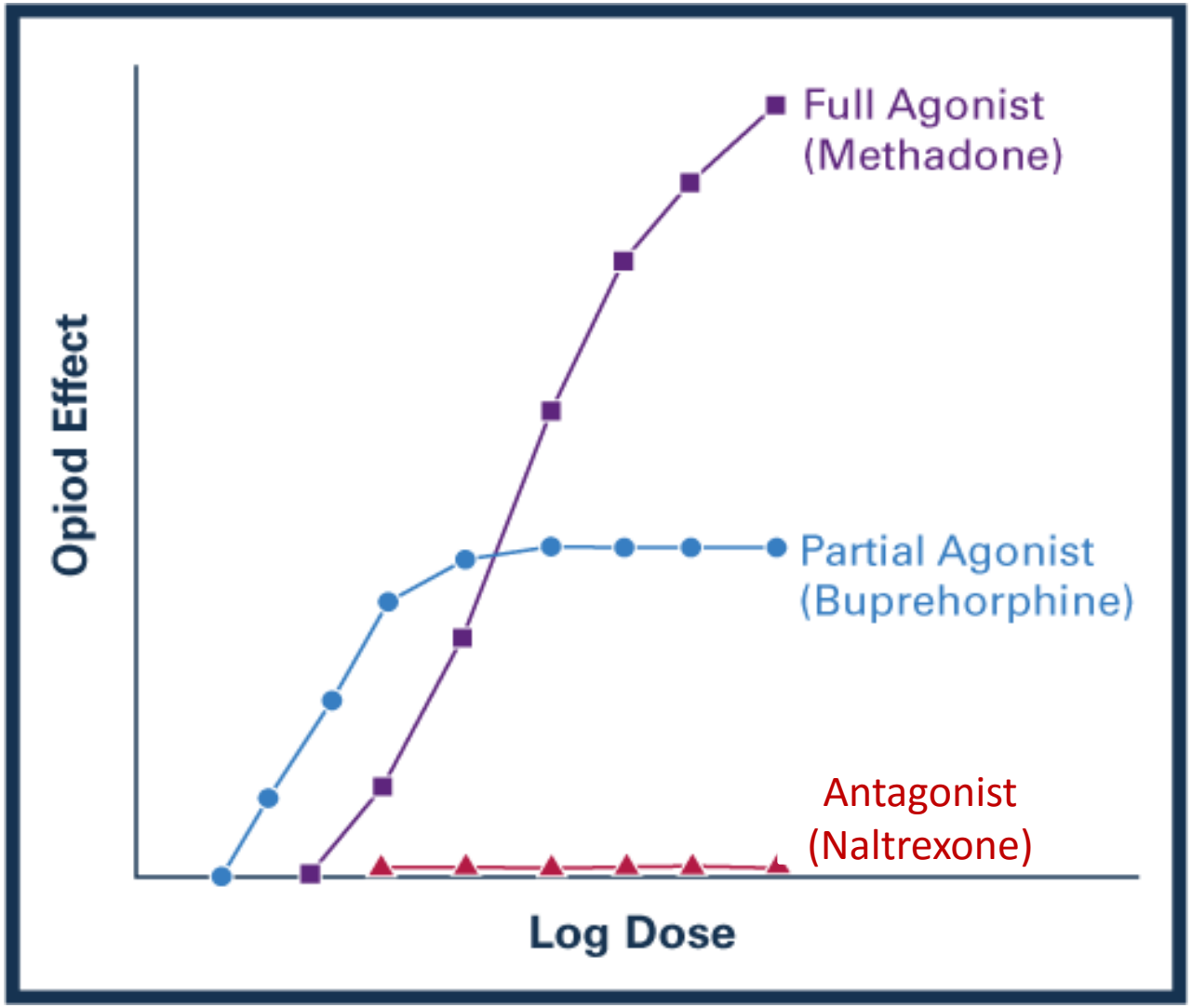
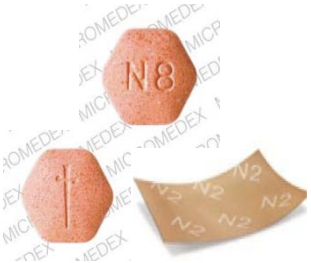
Treatment for Opioid Use Disorder

Medications for Opioid Use Disorders





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Medications for Opioid Use Disorder

Methadone

- Delivered through approved clinics in larger cities which have many regulations stipulating counseling services and drug screen urinalyses

Buprenorphine (Suboxone®, Subutex®, Zubsolv®)

- Mainly delivered by physicians in office-based practice; also provided through OTPs

Vivitrol extended release naltrexone

- Delivered by physicians in office-based practice

Learn more at www.drugabuse.gov

Methadone vs. No Methadone

Comparison 1. Methadone maintenance treatment vs No methadone maintenance treatment

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Retention in treatment	7		Risk Ratio (M-H, Random, 95% CI)	Subtotals only
1.1 Old studies (pre 2000)	3	505	Risk Ratio (M-H, Random, 95% CI)	3.05 [1.75, 5.35]
1.2 New studies	4	750	Risk Ratio (M-H, Random, 95% CI)	4.44 [3.26, 6.04]
2 Morphine positive urine or hair analysis	6	1129	Risk Ratio (M-H, Random, 95% CI)	0.66 [0.58, 0.78]
3 Self reported heroin use	6		Risk Ratio (M-H, Random, 95% CI)	Subtotals only
4 Criminal activity	3	363	Risk Ratio (M-H, Random, 95% CI)	0.39 [0.12, 1.25]
5 Mortality	4	576	Risk Ratio (M-H, Random, 95% CI)	0.48 [0.10, 2.39]

Citation: Mattick RP, Breen C, Kimber J, Davoli M. Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *Cochrane Database of Systematic Reviews* 2009, Issue 3. Art. No.: CD002209. DOI: 10.1002/14651858.CD002209.pub2.

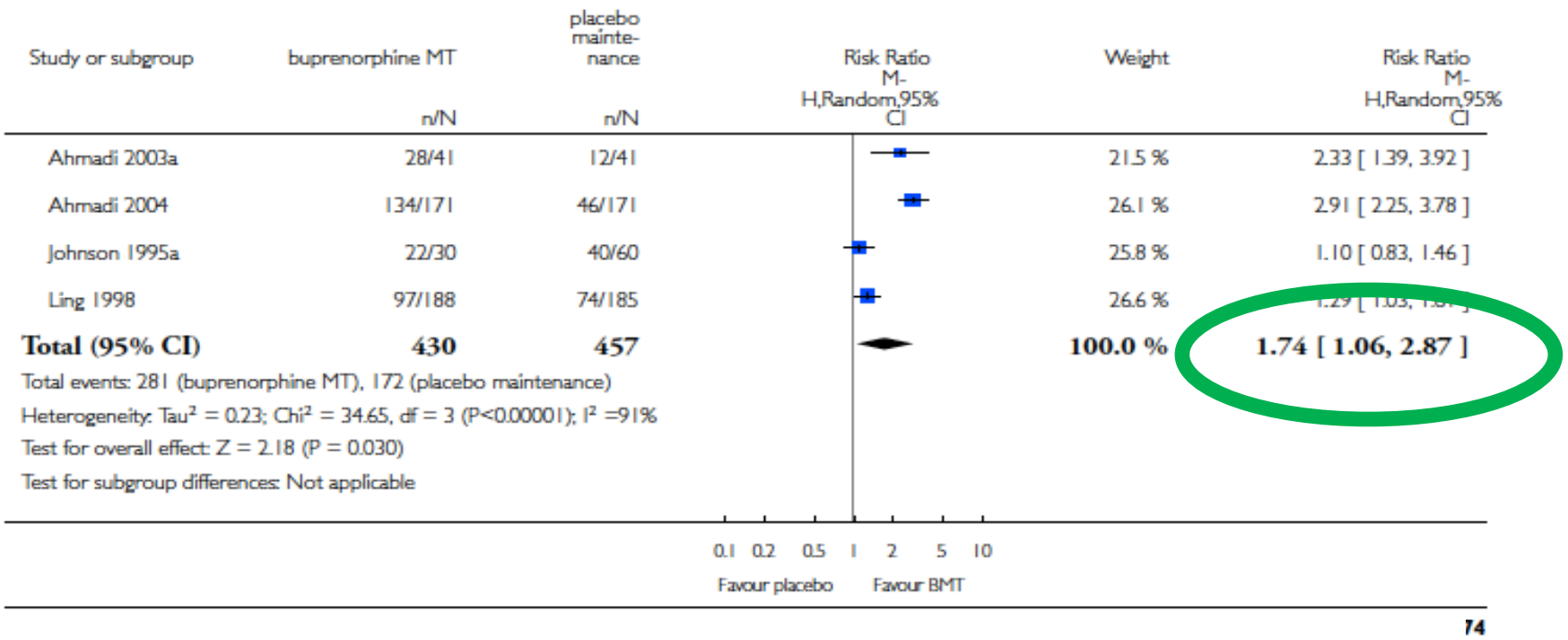
Buprenorphine vs. Placebo

Analysis 6.1. Comparison 6 Medium-dose buprenorphine versus placebo, Outcome 1 Retention in treatment.

Review: Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence

Comparison: 6 Medium-dose buprenorphine versus placebo

Outcome: 1 Retention in treatment



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Citation: Mattick RP, BreenC, Kimber J,DavoliM. Buprenorphinemaintenance versus placebo ormethadonemaintenance for opioid dependence. Cochrane Database of Systematic Reviews 2014, Issue 2. Art.No.: CD002207. DOI: 10.1002/14651858.CD002207.pub4.

Methadone or Buprenorphine Reduce Overdose Death Rate by 50%

ADDICTION

SSA SOCIETY FOR THE STUDY OF ADDICTION

RESEARCH REPORT

doi:10.1111/add.13193

Impact of treatment for opioid dependence on fatal drug-related poisoning: a national cohort study in England

Matthias Pierce[1,2], Sheila M. Bird[3], Matthew Hickman[4], John Marsden[5], Graham Dunn[2], Andrew Jones[2] & Tim Millar[1]

Institute of Brain Behaviour and Mental Health, Faculty of Medical and Human Sciences, University of Manchester, UK,[1] Institute of Population Health, Faculty of Medical and Human Sciences, University of Manchester, UK,[2] MRC Biostatistics Unit, Cambridge, UK,[3] School of Social and Community Medicine, University of Bristol, UK[4] and Addictions Department, Institute of Psychiatry, Psychology and Neuroscience, King's College London, UK[5]

ABSTRACT

Aims To compare the change in illicit opioid users' risk of fatal drug-related poisoning (DRP) associated with opioid agonist pharmacotherapy (OAP) and psychological support, and investigate the modifying effect of patient characteristics, criminal justice system (CJS) referral and treatment completion. **Design** National data linkage cohort study of the

Long-Acting Naltrexone

- Small RCT with criminal justice offenders (n=308) showed the naltrexone (Vivitrol) group had:
  - Higher rate of opioid-negative urine samples during 24 weeks of treatment but not at 78 weeks
  - Fewer overdoses during 78 weeks of follow-up

Source: Lee JD, Friedmann PD, Kinlock TW, et al. Extended-Release Naltrexone to Prevent Opioid Relapse in Criminal Justice Offenders. N Engl J Med 2016;374:1232-42.

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Need to Expand Treatment in WA

- 66% of drug injectors in Washington reported they would like help stopping or reducing their drug use
- An estimated 11,334 heroin injectors in WA State are interested in “getting help to stop or reduce” for drug use
- 14,330,534 clean syringes were distributed via the 21 syringe exchanges in WA State in 2015

Source: UW Alcohol and Drug Abuse Institute 2015 WA State Syringe Exchange Survey

Nurse Care Manager Model*

- Developed in Massachusetts to support FQHCs
- An RN or other Masters level clinician coordinates and manages the care
- Nurses manage ~100 patients
- Allows MDs to take on greater case loads
- Psychosocial services closely linked and provided on site or nearby

*Based on Alford DP et al. Arch Intern Med. 2011

Hub and Spoke Model

- Two levels of care: a bi-directional model
  - HUB regional center to induce and stabilize people on opioid use disorder treatment medications
  - SPOKE community-based providers who provide ongoing maintenance on treatment medications and other supportive services

- Creates more capacity in more types of places
- Provides community providers with
  - Partner specializing in opioid use disorder treatment
  - Stabilized patients

WA Federally Funded "Hubs"

- Cascade Medical Advantage – Whatcom, Skagit, Snohomish, Island, San Juan
- Rainier Internal Medicine dba Northwest Integrated Health – Pierce County
- Peninsula Community Health – Jefferson, Clallam, Kitsap
- Valley Cities – King County
- Harborview Medical Center – King County
- Lifeline Connections – Clark, Skamania, Grays Harbor, Pacific

New Models of Care

- Need to continue to improve intake processes for OTPs and office-based opioid treatment programs
- Need to consider new models of care to get tx to highest risk people at the right time and place
  - PH Seattle & King County Syringe Exchange
  - Emergency departments
  - Drug courts
  - In jails/prisons
- Treatment is long term overdose prevention!!

Questions?