FINAL BILL REPORT
ESHB 1427

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Synopsis as Enacted

Brief Description: Concerning opioid treatment programs.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Cody, Jinkins, Peterson and Pollet).

House Committee on Health Care & Wellness
Senate Committee on Health Care
Senate Committee on Ways & Means

Background:

Prescriptive Authority.
It is unlawful to possess, deliver, or dispense a legend drug except pursuant to a prescription issued by a health care provider who has prescriptive authority under Washington law. Providers with prescriptive authority include allopathic and osteopathic physicians and physician assistants, advanced registered nurse practitioners, dentists, naturopaths, optometrists, podiatric physicians, and veterinarians. Prescriptions must be for a legitimate medical purpose and within the provider's scope of practice.

In 2011 several disciplining authorities were required to adopt rules on chronic, noncancer pain management. Separately, the Agency Medical Directors' Group has adopted guidelines on prescribing opioids for pain.

Prescription Monitoring Program.
The Department of Health (DOH) maintains a Prescription Monitoring Program (PMP) to monitor the prescribing and dispensing of controlled substances and other drugs that demonstrate a potential for abuse. When one of these drugs is dispensed, the dispenser must electronically submit to the PMP a patient identifier, the drug dispensed, the dispensing date, the quantity dispensed, the prescriber, and the dispenser.

Data in the PMP may be accessed by:
- a person authorized to prescribe or dispense a controlled substance or legend drug for the purpose of providing medical or pharmaceutical care for his or her patients;
- a person requesting his or her own PMP information;

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- personnel of the DOH for administration of the PMP or the Uniform Controlled Substances Act, the Department of Social and Health Services (DSHS) or the Health Care Authority (HCA) regarding Medicaid recipients, the Department of Labor and Industries regarding workers' compensation claimants, and the Department of Corrections regarding offenders in the agency's custody;
- a health professional licensing, certification, or regulatory agency;
- an appropriate law enforcement or prosecutorial official;
- an entity under grand jury subpoena or court order;
- certain medical test sites licensed by the DOH; and
- a health care facility, entity, or provider group of five or more providers for the purpose of providing medical or pharmaceutical care to patients if: (1) the facility or entity is licensed by the DOH, or all the providers in the group are licensed; and (2) the facility, entity, or group is a trading partner with the Health Information Exchange.

A dispenser or practitioner acting in good faith is immune from civil, criminal, or administrative liability for requesting, receiving, or using information from the PMP.

Seven Best Practices in Emergency Medicine.
The 2012 Supplemental Operating Budget required the HCA to designate best practices and performance measures to reduce medically unnecessary emergency room visits for Medicaid clients. The practices are referred to as the Seven Best Practices in Emergency Medicine.

Opioid Treatment Programs.
The Community Mental Health Services Act makes several declarations related to opioid treatment including: the state declares the following:

- Opiate substitution treatment should be used only for participants who are deemed appropriate for this level of intervention and should not be the first treatment intervention.
- The state has the authority to control and carefully regulate the clinical uses of opiate substitution drugs in consultation with counties and cities.
- The primary goal of opiate substitution treatment is total abstinence from substance use.

The DSHS certifies opiate substitution treatment programs and is required to establish treatment and operating standards in consultation with treatment providers, counties, and cities. In making a decision on a program's application for certification, the DSHS must, among other things:

- certify only programs that will be sited in accordance with county or city land use ordinances. Counties and cities may require conditional or special use permits for siting programs;
- demonstrate a need in the community for opiate substitution treatment and not certify more program slots than justified by the need, up to a maximum of 350 participants unless authorized by the county;
- prioritize applicants that have the capability to provide services to assist participants in meeting statutory goals, including abstinence, obtaining mental health treatment, improving economic independence, and reducing adverse consequences associated with the illegal use of controlled substances; and

- hold at least one public hearing in the county and the area where the facility is proposed to be located.

Opiate substitution treatment programs must provide health education information to pregnant clients, including referral options for the addicted baby. To maintain certification, programs must submit an annual report to the DSHS and county legislative authority, including data necessary for outcome analysis. The DSHS must evaluate the data and take corrective action where necessary.

"Opiate substitution treatment" is defined as: (1) dispensing an opiate substitution drug approved by the Food and Drug Administration for the treatment of opiate addiction; and (2) providing a comprehensive range of medical and rehabilitative services.

Summary:

Opioid Prescribing.
By January 1, 2019, the following disciplining authorities must adopt rules establishing requirements for prescribing opioid drugs: the Medical Quality Assurance Commission, the Board of Osteopathic Medicine and Surgery, the Nursing Care Quality Assurance Commission, the Dental Quality Assurance Commission, and the Podiatric Medical Board. The rules may contain exemptions based on education, training, amount of opioids prescribed, patient panel, and practice environment. In developing the rules, the disciplining authorities must consider the Agency Medical Directors' Group and Centers for Disease Control guidelines and may consult with the Department of Health (DOH), the University of Washington, and professional associations.

Prescription Monitoring Program.
The DOH may provide data from the Prescription Monitoring Program (PMP) to:
- the Health Care Authority (HCA) regarding Medicaid clients for purposes of quality improvement, patient safety, and care coordination (but not contracting or value-based purchasing decisions);
- DOH personnel for the purpose of assessing prescribing practices and providing quality improvement feedback to providers;
- a provider group, health care facility, or health care entity (including those operated by the federal government or a federally recognized Indian tribe) for quality improvement purposes;
- a local health officer for patient follow-up and care coordination after a controlled substance overdose event; and
- the coordinated care electronic tracking program referred to as the Seven Best Practices in Emergency Medicine for purposes of providing: (1) PMP data to emergency department personnel when a patient registers in the emergency department; and (2) notice to providers, care coordination staff, and prescribers that the patient has experienced a controlled substance overdose event.

The DOH must determine the content and format of the notice to the coordinated care electronic tracking program in consultation with the Washington State Hospital Association (WSHA), the Washington State Medical Association (WSMA), and the HCA. The notice may be modified as necessary to reflect current needs and best practices.

At least quarterly and pursuant to a schedule determined by the DOH, the DOH must provide a facility, entity, or provider group with prescriber information if the facility, entity, or group: (1) uses the information only for internal quality improvement and prescriber quality improvement feedback purposes and not as the sole basis for a medical staff sanction or adverse employment action; and (2) provides the DOH with a standardized list of current prescribers. The specific information requirements must be determined by the DOH in consultation with the WSHA, the WSMA, and the HCA and may be modified as necessary to reflect current needs and best practices.

After entering into a data use agreement, the DOH may provide dispenser and prescriber data and data that include indirect patient identifiers to the WSHA for use solely in connection with its coordinated quality improvement program.

Persons authorized to receive PMP data who act in good faith are immune from civil, criminal, disciplinary, or administrative liability for acting under the PMP law.

Beginning November 15, 2017, the DOH must annually report to the Governor and the Legislature on the number of facilities, entities, and provider groups that have integrated their electronic health records with the PMP using the state Health Information Exchange.

Opioid Treatment Programs.
In making a decision on an application for certification of an opioid treatment program, the DSHS is not required to: demonstrate a need in the community for treatment; certify only the number of program slots justified by community need; or hold public meetings in the county and area where the facility is to be located. In addition, the requirements for the DSHS to establish evaluation criteria and for programs to submit an annual report are also removed.

Instead, the DSHS must: hold one public hearing in the community where the facility is to be located; consider whether an applicant has demonstrated the capability to provide appropriate services to assist participants in meeting the statutory goals of treatment for opioid use disorder; and prioritize certification of applicants who are able to measure their success in meeting such outcomes. Opioid treatment programs are subject to the same oversight as other substance use disorder treatment programs.

The 350-participant limit and authority for counties and cities to require special use permits for the siting of opioid treatment programs are removed. A county may impose a maximum capacity for an opioid treatment program of not less than 350 participants if necessary to address specific local conditions cited by the county.

Declarations in the Community Mental Health Services Act include the following:

- The state recognizes as evidence-based the medications approved by the Food and Drug Administration for the treatment of opioid use disorder.
- Providers must inform patients of all treatment options available. The provider and patient must consider alternative treatment options, like abstinence, when developing a treatment plan. If medications are prescribed, follow-up must be included to work toward the goal of abstinence.

- The main goal of treatment is abstinence, but the state recognizes additional goals of reduced morbidity and restoration of the ability to lead a productive and fulfilling life.
- A person who lawfully possesses or uses lawfully prescribed medication for the treatment of opioid use disorder must be treated the same in judicial and administrative proceedings as a person who lawfully possesses or uses other lawfully prescribed medications.

Opioid treatment programs include dispensing medication for the reversal of opioid overdose. Terminology is changed to "opioid treatment program," "medication assisted treatment," "opioid use disorder," and "substance-exposed babies" instead of "opiate substitution treatment programs," "methadone treatment," "opiate addiction," and "addicted babies."

Votes on Final Passage:

House	82	15	
Senate	46	3	(Senate amended)
House			(House refused to concur)
Senate	49	0	(Senate receded/amended)
House	88	8	(House concurred)

Effective: July 23, 2017
Contingent (Sections 14–17)