FINAL BILL REPORT
SSB 5380

C 314 L 19
Synopsis as Enacted

Brief Description: Concerning opioid use disorder treatment, prevention, and related services.

Sponsors: Senate Committee on Health & Long Term Care (originally sponsored by Senators Cleveland, Rivers, Frockt, Walsh, Keiser, King, Randall, O'Ban, Conway, Darneille, Saldaña, Das, Dhingra, Hunt, Wilson, C. and Zeiger; by request of Office of the Governor).

Senate Committee on Health & Long Term Care
Senate Committee on Ways & Means
House Committee on Health Care & Wellness
House Committee on Appropriations

Background: Opioid Treatment Programs. Currently statute provides there is no fundamental right to medication-assisted treatment for opioid use disorder; treatment should only be used for participants who are deemed appropriate to need this level of intervention; alternative options, like abstinence, should be considered when developing a treatment plan; and if medications are prescribed, follow up must be included in the treatment plan in order to work towards the primary goal of abstinence.

Medications to Treat Opioid Use Disorder. Medications to treat opioid use disorder (OUD), also referred to as medication assisted treatment (MAT), is a form of treatment which uses medications approved by the Federal Drug Administration (FDA). Methadone, buprenorphine, and naltrexone are common medications used to treat OUD.

Opioid Overdose Reversal Medication. Medications can be administered to rapidly restore breathing to an individual experiencing an opioid overdose. Narcan, naloxone, and evzio are common opioid overdose reversal medications.

State Opioid Response Plan. Several state agency members of the Department of Health (DOH) Opioid Response Work Group developed a statewide plan for opioid response. On September 30, 2016, the Governor signed Executive Order 16-09—Addressing the Opioid Use Public Health Crisis—formally directing activities and state agencies to act in accordance with the Washington State Opioid Response Plan. In November 2016, state agency members revised the Washington State Opioid Response Plan to align with the executive order and activities directed by federal grants received in 2016. The work group meets quarterly and updates the plan annually.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Prescription Monitoring Program. All schedule II, III, IV, and V controlled substance prescriptions and dispensing is monitored by DOH through a prescription monitoring program (PMP). Information submitted for each prescription must include at least a patient identifier, the drug dispensed, the date of dispensing, the quantity dispensed, the prescriber, and the dispenser. With certain exceptions, prescription information submitted to DOH is confidential. The exceptions allow DOH to provide data in the PMP to:

- persons authorized to prescribe or dispense controlled substances;
- an individual who requests the individual's own records;
- health professional licensing, certification, or regulatory agencies;
- law enforcement officials who are engaged in bona fide specific investigations involving a designated person;
- authorized practitioners of the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) regarding Medicaid recipients;
- the director of the Department of Labor and Industries regarding workers' compensation claimants;
- the director of the Department of Corrections (DOC) regarding committed offenders;
- entities under court order;
- DOH personnel for the purposes of assessing and administering the program;
- drug testing laboratory personnel in order to determine what medications a patient may be taking;
- a health care facility or provider group of five or more, to provide medical or pharmaceutical care to the facility's patients; and public or private entities for statistical, research, or educational purposes after removing identifying information;
- local health officers of local health jurisdictions for the purposes of patient follow-up and care coordinating following a controlled substance overdose event; or
- the Coordinated Care Electronic Tracking Program, referred to as the seven best practices in emergency medicine.

Opioid Prescribing Rules. In 2017, the Legislature passed ESHB 1427 requiring 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 to adopt new rules for prescribing opioids by January 1, 2019. The rules establish prescribing and documentation guidelines for varying pain levels—acute, perioperative, subacute, and chronic—and require PMP checks, documentation justifying a prescription, one hour of opioid prescribing continuing education, and providing the patient with resources regarding risks of opioid use and how to safely dispose of the drugs. The rules do not apply to palliative care, in-patient hospital care, procedural medications and cancer related treatments.

Criminal Justice Treatment Account. The state funds substance use disorder treatment for certain offenders of the criminal justice system.

Summary: Opioid Use Disorder Treatment. The state declares that substance use disorders are medical conditions and should be treated in a manner similar to other medical conditions by using interventions that are supported by evidence. All individuals should be offered evidence-based treatments such as medications approved by the FDA for the treatment of OUD, behavioral counseling, and social supports. Providers must inform patients with OUD of options to access FDA approved medications for the treatment of OUD. OUD treatment

programs may order, possess, dispense, and administer opioid overdose reversal medication and medications approved by the FDA to treat OUD. Registered nurses and licensed practical nurses may dispense up to a 31-day supply of FDA approved medications to patients receiving OUD treatment. Medicaid and all state regulated plans must provide coverage without prior authorization for at least one FDA approved product for the treatment of opioid use disorder in the drug classes opioid agonists, opioid antagonists, and opioid partial agonists.

Opioid Use Disorder Treatment for Pregnant and Parenting Individuals. Opioid treatment programs that provide services to individuals who are pregnant must provide information about the effects opioid use and opioid use disorder medication may have on their baby. DOH must adopt rules requiring all opioid treatment programs to educate pregnant individuals about the risks to the parent and the fetus of not treating opioid use disorder. If a pregnant Medicaid client is identified at risk for opioid use disorder, HCA, through the managed care organizations, must provide outreach to the individual. HCA is required to provide recommendations to the Office of Financial Management by October 1, 2019, on how to better support individuals with OUD who have recently given birth, and newborns of individuals with OUD.

Opioid Prescribing. Pharmacists are permitted to partially fill a Schedule II controlled substance prescription. The partial fill must be requested by the patient or the prescribing practitioner, and the total quantity dispensed in all partial fillings must not exceed the quantity prescribed. By January 1, 2020, the boards and commissions for the various prescribers must adopt or amend their rules to require opioid prescribers to inform patients of their right to refuse opioid prescriptions. Electronic prescription systems are no longer required to be approved by the Pharmacy Commission. When prescribing an opioid for the first time during a patient's course of outpatient treatment, practitioners must have a discussion with the patient about the risks of opioids, and about pain management alternatives, and provide patients with a warning statement created by DOH. Practitioners must document the discussion in the patient's health record.

Prescriptions for controlled substances must be communicated electronically beginning January 1, 2021, unless one of the exceptions, including a waiver from DOH, is met. Additional requirements for electronic systems that communicate prescription information between prescribers and dispensers are established.

Prescription Monitoring Program. Beginning January 1, 2021, entities or facilities with ten or more prescribers must integrate their EHRs with the PMP, unless DOH grants a waiver or the entity or facility is a critical access hospital. Dispensers are required to submit the necessary prescription information to the PMP no later than one business day after the date the prescription is dispensed. DOH must collaborate with health professional and facility associations, vendors, and others to:

- assess the current status of EHR and PMP integration;
- provide recommendations for improving integration among small and rural health providers including exploring financial assistance options;
- comply with federal prescription drug monitoring program qualifications to facilitate eligibility for federal grants and establish a program to provide financial assistance with integration as funding is available;

- conduct security assessments of other commonly used platforms for integrating EHR and PMP;
- evaluate options to identify patients in the PMP who do not wish to receive opioids or patients who have had an opioid-related overdose; and
- include the result of the collaboration in DOH's annual PMP and EHR integration report to the Legislature.

PMP data may be provided to:

- a health professional licensing, certification, or regulatory agency or entity for use in legal proceedings regarding the license;
- the HCA director or designee for Medicaid recipients and member of HCA's self-funded and self-insured health plans;
- DOH personnel to assess the public health impacts of opioid use disorder and to identify possible interventions;
- a licensed, certified, or accredited behavioral health provider;
- public or private entities for statistical, research, or educational purposes after removing any unique identifiers;
- the Washington State Medical Association for uses solely in its coordinated quality improvement program;
- DSHS, L&I, and HCA for data analysis and research approved by the Washington State Institutional Review Board for public health purposes to improve the prevention or treatment of substance use disorders; and
- the largest health professional associations representing each of the prescribing professions for the purposes of quality improvement.

PMP data with direct and indirect patient identifiers may be provided for research that has been approved by the Washington State Institutional Review Board and by the department through a data-sharing agreement.

State Opioid Response Plan. The secretary of DOH is responsible for coordinating the statewide response plan and must work in partnership with HCA to execute the plan. State agencies shall promote positive outcomes associated with the accountable communities of health, local law enforcement, and human service collaborations to address OUD. In addition the work already underway by the State Opioid Response Plan, HCA and DOH are provided with additional directives.

HCA is authorized to:

- work with other state agencies and stakeholders to develop value-based payment strategies for the ongoing care of persons with opioid and other substance use disorders;
- promote the use of MAT and other evidence-based strategies to address the opioid epidemic and by January 1, 2020, prioritize state resources be provided to treatment settings that allow patients to use MAT while engaging in services;
- seek, receive, and expend alternative sources of funding to support all aspects of the state's response to the opioid crisis;
- partner with DSHS, DOC, DOH, and Department of Children, Youth, and Families to develop a statewide approach to leveraging Medicaid funding to treat OUD and provide emergency overdose treatment;

- work with DOH to promote coordination between OUD treatment providers;
- work with stakeholders to develop a set of recommendations for the Governor and Legislature regarding a standard set of services needed to support individuals with OUD in treatment programs and identify what is needed to implement the recommendations;
- partner with DOH and other state agencies to replicate effective approaches for linking individuals who have a had a non-fatal overdose with treatment opportunities, including connecting them to certified peer counselors;
- implement a law enforcement assisted diversion program in two or more geographic areas of the state;
- work with DOH and managed care organizations to promote access to OUD medications at state-certified opioid treatment centers, and encourage the distribution of naloxone to patients who are at risk of an opioid overdose;
- recommend strategies to increase the number of waivered health care providers approved for prescribing buprenorphine, and to lower the cost of FDA approved products for the treatment of OUD;
- work with DOH, the accountable communities of health, and community stakeholders to develop a plan for coordinating purchasing and distributing opioid overdose reversal medication; and
- recommend coverage options for nonpharmacologic treatment options for acute, subacute, and chronic noncancer pain.

DOH is authorized to:

- display on its website a warning statement about the risks of opioids and information about the safe disposal of opioids;
- ensure training is available electronically and in a variety of media, identifying a person suffering from an opioid-related overdose and the use of opioid overdose reversal medication;
- establish an electronic emergency medical services data system for all licensed ambulance and aid services to report patient encounter data including data on suspected drug overdoses to engage individuals in treatment or other support services such as patient navigators, outreach workers, peer professionals, and other appropriate professionals;
- work with state agencies to develop a plan to increase outreach and education about opioid overdoses to non-English speaking communities and submit the plan to the appropriate legislative committees by July 1, 2020;
- coordinate with HCA on a strategy to rapidly deploy a response team to a local community identified as having a high number of fentanyl-related or other drug overdoses; and
- work with HCA to reduce barriers and promote the use of medication treatment therapies for OUD in emergency departments and same-day referrals to treatment programs.

Opioid Overdose Reversal Medication. The secretary of DOH, or designee, is authorized to issue a standing order for opioid reversal medication to any person at risk of experiencing an opioid related overdose or any person or entity in a position to assist a person at risk of experiencing an opioid-related overdose. Prescribers and dispensers are authorized to provide opioid overdose reversal medication pursuant to the standing order or a collaborative

drug therapy agreement to any person at risk of experiencing an opioid overdose or to any person in a position to assist a person at risk of experiencing an opioid overdose. When a pharmacist dispenses an opioid overdose reversal medication, the pharmacist must provide written instructions on the proper response to an opioid-related overdose which must include seeking medical attention.

Hospital emergency departments may provide prepackaged opioid overdose reversal medication when the practitioner determines the patient is at risk of an opioid overdose and it is authorized by the hospital's policies and procedures. The prepackaged medications are exempt from the Pharmacy Commission's labeling requirements.

Public high schools are permitted to obtain and store opioid overdose reversal medication. Beginning with the 2020-21 school year, public high schools in school districts with over 2000 students are required to obtain and store opioid overdose reversal medication, unless a district demonstrates a good faith effort to obtain the medication through a donation source, but is unable to do so. Public higher education institutions with a residence hall housing at least 100 students must develop a plan to maintain and administer opioid overdose reversal medication in residence halls. The Office of the Superintendent of Public Instruction in consultation with the Washington State School Directors' Association and DOH are directed to develop opioid related overdose guidelines, training requirements, and a grant program.

Criminal Justice. DOC is required to develop policies to prioritize services based on available grant funding and funds appropriated specifically for OUD. Any region or county that uses state criminal justice treatment account funds to support a therapeutic court must allow therapeutic court participants to use medications approved by the FDA for the treatment of OUD as medically appropriate. HCA may assist the courts with acquiring the medication. Plans submitted for criminal justice treatment account funds must include current evidence-based practices in SUD. To the extent funding is available, city and county jails must make reasonable efforts to directly connect incarcerated individuals receiving medication for the treatment of OUD to an appropriate provider or treatment site before release.

Votes on Final Passage:

Senate	47	0	
House	96	2	(House amended)
Senate			(Senate refused to concur/ asked House for conference)
Conference Committee			
House	97	0	
Senate	45	1	

Effective: July 28, 2019
January 1, 2021 (Section 16)