HOUSE BILL REPORT
HB 2489

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to opioid use disorder treatment, prevention, and related services.

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

Sponsors: Representatives Cody, Rodne, Harris, Caldier, Macri, Robinson, Jinkins, Muri, Kagi, McBride, Wylie, Peterson, Slatter, Hayes, Sawyer, Pollet, Doglio, Kloba, Tharinger, Ormsby, Johnson and Kilduff; by request of Governor Inslee.

Brief History:
Committee Activity:
Health Care & Wellness: 1/19/18, 2/2/18 [DPS].

Brief Summary of Substitute Bill

- Requires the Department of Social and Health Services (DSHS), the Health Care Authority, and the Department of Health to partner on initiatives that promote a statewide approach in addressing opioid use disorder and modifies the protocols for using medication-assisted treatment for opioid use disorder.
- Permits the Secretary of Health to issue a standing order for opioid reversal medication.
- Establishes new requirements for how electronic health records integrate with the prescription monitoring program (PMP) and how PMP data can be used.
- Requires the DSHS, in conjunction with others, to develop strategies to support rapid response teams in communities identified as having a high number of fentanyl- or opioid-related overdoses and to create a program to connect certified peer counselors with individuals who have had a nonfatal overdose, within 24 hours of the overdose.
- Allows hospital emergency departments to dispense opioid overdose reversal medication when a patient is at risk of opioid overdose.
- Permits pharmacists to partially fill a prescription for a Schedule II controlled substance.
- Requires certain health care practitioners licensed to prescribed controlled substances to complete one hour of continuing education regarding best

---

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.

practices in opioid prescribing, register for the PMP, and sign an attestation that the practitioner has reviewed the rules for prescribing opioids adopted by the practitioner's appropriate disciplinary authority, in order to prescribe opioids.

- Requires practitioners who prescribe an opioid for the first time during the course of treatment for outpatient use to have an in-person discussion about the risks of opioids and pain management alternatives with the patient.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 16 members: Representatives Cody, Chair; Macri, Vice Chair; Schmick, Ranking Minority Member; Graves, Assistant Ranking Minority Member; Caldier, Clibborn, DeBolt, Harris, Jinkins, MacEwen, Maycumber, Riccelli, Robinson, Slatter, Stonier and Tharinger.

Staff: Kim Weidenaar (786-7120).

Background:

Opioid Treatment Programs.
The Community Mental Health Services Act provides that: (1) there is no fundamental right to medication-assisted treatment for opioid use disorder; (2) treatment should only be used for participants who are deemed appropriate to need this level of intervention; (3) alternative options, like abstinence, should be considered when developing a treatment plan; (4) that the main goal of opiate substitution treatment is total abstinence, but recognizes additional goals of reduced morbidity and restoration of the ability to lead a productive and fulfilling life; and (5) if medications are prescribed, follow up must be included in the treatment plan in order to work towards the primary goal of abstinence.

The hub and spoke model is a term used to describe a treatment network used to provide care for opioid use disorder. Hubs are regional centers serving a defined geographical area that support spokes. Hubs are responsible for ensuring that medication assisted treatments are available. Spokes are facilities that provide behavioral health treatment and primary health care to patients referred to them by the hub.

The Department of Social and Health Services (DSHS) certifies opiate substitution treatment programs.

Washington State Opioid Response Plan.
In 2016 several state agency members of the Department of Health's Opioid Response Workgroup developed a statewide working plan for opioid response. On September 30, 2016, Governor Jay Inslee signed Executive Order 16-09, Addressing the Opioid Use Public Health Crisis, formally directing activities and state agencies 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.

Prescription Monitoring Program.
The Department of Health (DOH) maintains a prescription monitoring program (PMP) to monitor the prescribing and dispensing of all Schedule II, III, IV, and V controlled substances. Each time one of these drugs is dispensed, the dispenser must electronically submit the following information to the PMP:

- a patient identifier;
- the drug dispensed;
- the dispensing date;
- the quantity dispensed;
- the prescriber; and
- the dispenser.

Prescribers are not required to query the PMP prior to prescribing a controlled substance. Generally, prescription information submitted to the DOH is confidential; however, 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;
- a health professional licensing, certification, or regulatory agency;
- an appropriate law enforcement or prosecutorial official;
- an authorized practitioner of the DSHS or the Health Care Authority regarding Medicaid recipients;
- the Director of the Department of Labor and Industries (or designee) regarding workers' compensation claimants;
- the Secretary of the Department of Corrections (DOC) (or designee) regarding offenders in the custody of the DOC;
- an entity under grand jury subpoena or court order;
- personnel of the DOH for administration of the PMP or the Uniform Controlled Substances Act;
- certain medical test sites licensed by the DOH;
- a health care facility or entity for the purpose of providing medical or pharmaceutical care to the patients of the facility or entity if the facility or entity is licensed by the DOH or operated by the federal government or federally recognized Indian tribe, and the facility or entity is a trading partner with the Health Information Exchange (HIE);
- a health care provider group of five or more providers for the purpose of providing medical or pharmaceutical care to the patients of the provider group if all of the providers in the group are licensed and the provider group is a trading partner with the HIE;
- the local health officer of a local health jurisdiction for the purposes of patient follow-up and care coordination following a controlled substance overdose event; and
- the coordinated care electronic tracking program, often referred to as the seven best practices in emergency medicine.

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.

Opioid Overdose Medication.

A health care practitioner may prescribe, dispense, distribute, and deliver an opioid overdose medication: (1) directly to a person at risk of experiencing an opioid-related overdose; or (2) by collaborative drug therapy agreement, standing order, or protocol to a first responder, family member, or other person in a position to assist a person at risk of experiencing an opioid-related overdose. The practitioner must inform the recipient that as soon as possible after administration, the person at risk of experiencing an overdose should be transported to a hospital or a first responder should be summoned.

Any person or entity may lawfully possess, store, deliver, distribute, or administer an opioid overdose medication pursuant to a practitioner's prescription or order. A pharmacist may dispense an opioid overdose medication pursuant to such a prescription and may administer an opioid overdose medication. The pharmacist must provide written instructions on the proper response to an opioid-related overdose, including instructions for seeking immediate medical attention.

The following individuals are not subject to civil or criminal liability or disciplinary action under the Uniform Disciplinary Act for their authorized actions related to opioid overdose medications or the outcomes of their authorized actions if they act in good faith and with reasonable care: practitioners who prescribe, dispense, distribute, or deliver an opioid overdose medication; pharmacists who dispense an opioid overdose medication; and persons who possess, store, distribute, or administer an opioid overdose medication.

Opioid Prescribing.
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.

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.

Emergency Medications at Hospital Pharmacies.
A hospital may allow prepackaged emergency medications for patients being discharged from the emergency department to be prescribed by practitioners with prescriptive authority and distributed by these practitioners and registered nurses when: (1) community pharmacies and outpatient hospital services are not available within 15 miles by road; or (2) in the judgment of a practitioner and consistent with hospital policies, the patient has no reasonable ability to reach a local community or outpatient pharmacy.

The director of the hospital pharmacy must develop policies and procedures regarding the types of emergency medications to be prepackaged and the criteria under which prepackaged emergency medications may be prescribed and distributed, in addition to other requirements.

Summary of Substitute Bill:

Opioid Treatment.
Agencies administering state purchased health care programs are required to implement provisions of the act and the Washington State Interagency Opioid Working Plan, and provide status updates as directed by the Joint Legislative Executive Committee on Health Care Oversight.

The stated purposes of the Community Mental Health Act are expanded to recognize medications approved by the Federal Food and Drug Administration as evidence based treatment of opioid use disorder. The main goals of treatment are identified as cessation of unprescribed opioid use in addition to the goals of reduced morbidity and restoration of the ability to lead a productive and fulfilling life.

The Department of Social and Health Services (DSHS) must promote the use of Medication Assisted Treatment (MAT) and other evidence based strategies, and must prioritize state resources for treatment and recovery services to entities that allow patients to maintain their use of medications for opioid use disorder while engaging in services or to start on medications for opioid use disorder while enrolled in services.

The Health Care Authority (HCA) is required to partner with DSHS, Department of Health (DOH), and Department of Corrections to develop a statewide approach to leverage Medicaid funding to treat opioid use disorder and emergency overdose treatment. Funding sources may include seeking a section 1115 demonstration waiver from the centers for Medicare and Medicaid services to fund opioid response treatment for persons eligible for Medicaid at or during the time of incarceration, and soliciting private funds, grants, or donations. By October 2018 the HCA must report to the Legislature their recommendations for covering nonpharmacologic treatment options for chronic, acute, and sub-acute pain that is not related to cancer.

The DSHS must replicate effective treatment approaches such as the opioid hub and spoke treatment networks to broaden outreach and patient navigation. The DSHS must collaborate with the DOH, the HCA, and Medicaid Managed Care Organizations to eliminate barriers and promote access to all effective medications known to address opioid use disorder at state-certified opioid treatment programs. The DSHS must work with DOH and HCA to: (1) reduce barriers and promote MAT in emergency departments and same day referrals; and (2) promote coordination between MAT prescribers, federally accredited opioid treatment programs and state-certified substance use disorder treatment agencies to increase patient choice in receiving medication and counseling, and address challenges presented for individuals needing treatment for multiple substance use disorders simultaneously.

State agencies are directed to review and promote positive outcomes from the accountable communities of health (ACH) funded opioid projects, and other collaborations set forth in the Washington interagency opioid working plan.

All approved opioid treatment programs that provide services to women who are pregnant must disseminate up-to-date information to all pregnant clients on what the effects of opioid use and opioid replacement therapy may have on their baby. The DSHS must adopt rules that require all opioid treatment programs to educate woman who become pregnant about the risks to both the mother and their fetus of not treating opioid use disorder.

The DSHS, in conjunction with others, must develop strategies to support rapid response teams in communities identified as having a high number of fentanyl- or opioid-related overdoses. The goals of the teams should include continued access to medication therapy for patients once the emergency is stabilized. The DSHS and the HCA must partner to create a program to connect certified peer counselors with individuals who have had a nonfatal overdose within 48 hours of the overdose.

The Secretary of Health (Secretary) is designated as the individual responsible for coordinating the state wide response to the opioid epidemic.

The title of the "Community Mental Health Services Act" is changed to the "Community Behavioral Health Services Act." References to "methadone" are replaced with "opioid replacement therapy," "opioid addiction" is replaced with "opioid use disorder," and "newborn addiction problems" is changed to "neonatal abstinence syndrome."

Opioid Overdose Reversal Medication.
By October 1, 2018, the DSHS must work with the DOH, the HCA, the ACHs, and stakeholders to develop a plan for the coordinated purchase and distribution of opioid overdose reversal medication across the state.

The Secretary or designee is permitted to issue a state wide standing order prescribing opioid overdose reversal medications 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. Pharmacists may dispense and administer opioid overdose reversal medication pursuant to a state wide standing order. When dispensing, a pharmacist must provide written instructions on the proper response to opioid-related overdose. The DOH must develop a training module for the use of opioid overdose reversal medications. The Secretary or designee are not subject to civil or criminal liability or professional disciplinary action for issuing the standing order.

Hospital emergency departments may dispense opioid overdose reversal medication, when, in the judgment of the practitioner and consistent with hospital policies and procedures, a patient is at risk of opioid overdose.

References to "opioid overdose medication" are changed to "opioid overdose reversal medication."

Prescription Monitoring Program and Other Data Systems.
Dispensers must submit the required information for each controlled substance prescription to the Prescription Monitoring Program (PMP) not later than one business day from the date of dispensing. All information submitted to the PMP is confidential and exempt from public inspection, and not subject to subpoena or discover in any civil action. These confidentiality

provisions continue whenever information from the PMP is provided to a person or entity requesting, accessing, or receiving information in the PMP. Licensed community behavioral health agencies are incorporated into the definition of health care facilities, which are provided access to the PMP for purposes of providing care to patients of the facility and for quality improvement purposes. The HCA Director or designee for members of the HCA self-funded or self-insured plans may access the PMP for quality improvement, patient safety, and care coordination.

The DOH may publish or provide data to public or private entities after removing information that could be used directly or indirectly to identify individual patients, requestors, dispensers, prescribers, and persons who received prescriptions from dispensers. Indirect patient identifiers may be provided for research approved by the State Institutional Review Board and by agreement through a data-sharing agreement.

By December 1, 2018, all federally certified electronic health record (EHR) system vendors must ensure that their system can fully integrate with the PMP. Health care providers must demonstrate that the EHR is able to integrate by January 1, 2019. If the EHR is not able to comply by December 1, 2018, then the health care provider must demonstrate that the EHR is able to integrate by January 1, 2020. The vendors may not charge an ongoing fee or a fee based on the number of transactions or providers using such integration, and the total costs of connection must not impose an unreasonable burden on the provider utilizing the EHR.

By July 1, 2019, the DOH must establish a statewide electronic emergency medical services data system and adopt rules requiring every licensed ambulance and aid service report and furnish patient encounter data to the electronic emergency medical services data system. The system must be used to improve availability and delivery of emergency medical services, and must include data on fatal and nonfatal overdoses and drug poisoning.

Opioid Prescribing.
Pharmacists are permitted to partially fill a prescription for a Schedule II controlled substance, if requested by the patient or prescribing practitioner and the total quantity dispensed in all partial fillings does not exceed the quantity prescribed.

Beginning January 1, 2019, in order to prescribe opioids, licensed physicians, physician assistants, osteopathic physicians, osteopathic physician assistants, dentists, podiatric physicians, and advanced registered nurse practitioners must:

- complete a one time, 1 hour of continuing education regarding best practices in the prescribing of opioids; and
- following licensure or at the time of renewal:
    - register for the PMP or provide proof of registration; and
    - sign an attestation that the practitioner has reviewed the rules for prescribing opioids adopted by the practitioner's disciplinary authority.

Opioid Warnings.
Practitioners prescribing an opioid for the first time during the course of treatment for outpatient use must have an in-person discussion about the risks of opioids and pain management alternatives with the patient. The practitioner may designate an individual with a health care provider credential to have the in-person discussion with the patient. If the

patient is under eighteen or lack legal competence, the discussion must include the patient's parent, guardian, or the person designated under the informed consent statute RCW 7.70.065. A violation of this requirement constitutes unprofessional conduct under the Uniform Disciplinary Act. The DOH must create a statement that warns individuals of the risks of opioid use and abuse and provides information about the safe disposal of opioids, which practitioners must hand out during the in-person discussion . The practitioner must document the discussion in the patient's health care record.

The bill contains contingency sections for sections 2 through 5, in the event that House Bill 1388 or Senate Bill 5259 is enacted and changes the authority of behavioral health from the DSHS to the HCA.

Substitute Bill Compared to Original Bill:

The substitute bill:

- requires the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) to create a program to connect certified peer counselors with individuals who have had a nonfatal overdose within the past 48 hours;
- requires dispensers to submit information about controlled substances prescriptions to the prescription monitoring program (PMP) within one business day of dispensing, codifying what is required in rule;
- authorizes pharmacists to partially fill prescriptions at the request of the patient or prescriber, so long as the total amount dispensed does not exceed the amount prescribed;
- requires health care practitioners prescribing an opioid for the first time for outpatient use to discuss with the patient the risks of opioids and pain management alternatives;
- requires the Department of Health to create a warning statement of the risks of opioids and information about the safe disposal of opioids;
- requires seven types of health care practitioners licensed to prescribe controlled substances to complete one hour of Continuing Education on best practices for opioid prescribing, to register for the PMP following licensure or renewal or provide proof of registration, and sign an attestation that the provider has reviewed the prescribing rules, in order to prescribe opioids;
- states that the Secretary of Health shall be responsible for coordinating the statewide response to the opioid epidemic;
- allows emergency departments to directly distribute opioid overdose reversal medication to a patient at risk of opioid overdose; and
- retains all sections of the underlying bill, but makes several changes including:
    - removing access to the PMP for commercial health carriers;
    - expanding the scope of the nonpharmacologic treatment recommendations for chronic pain to also include acute and sub-acute pain; and
    - adding contingency sections for sections 2 through 5, in the event that House Bill 1388 or Senate Bill 5259 is enacted and changes the authority of behavioral health from the DSHS to the HCA.

Appropriation: None.

Fiscal Note: Requested on January 9, 2018.

Effective Date of Substitute Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed, except for sections 2 through 5, relating to treatment for opioid use disorder and prevention of opioid-related overdose, which take effect if neither SHB 1388 nor SSB 5259 takes effect, and sections 10 through 13, relating to treatment for opioid use disorder and prevention of opioid-related overdose, which take effect if SHB 1388 or SSB 5259 takes effect.

Staff Summary of Public Testimony:

(In support) The opioid crisis is one of the greatest public health concerns of our time. The epidemic affects us all and no one should have to witness the horror of seeing a loved one overdose. Washington has done a lot to address the opioid epidemic, perhaps more than any other state. For example, unintended overdoses have been reduced by 44 percent, but there is still a lot more work to be done. This bill takes the next steps in terms of treatment, though many changes to the bill will be forthcoming and many more steps needed.

From a public health perspective this bill does a few main things. First, it expands access to naloxone through a statewide standing order. Secondly, it mandates that electronic health records (EHRs) connect their systems directly to the prescription monitoring program (PMP). This connection has already been completed in emergency departments and is a game changer. It incorporates vital data into the work flow of the visit, keeping the focus on the patient. This bill also requires data from emergency medical services on fatal and nonfatal overdoses be collected so that the whole picture of the epidemic can be seen.

The bill also makes a big shift in recognizing opioid use disorder (OUD) as the medical condition it is. It specifies that the goal for those with OUD is stabilization and a reduction in illicit drug use. Addiction is neither the individual addict nor the family's fault, and there is a lot of stigma around opioid use OUD. To help individuals with OUD we need to change the stigma and have treatment options available. Opioid use disorder is something that people struggle with for the rest of their lives, but there are medications that are effective. The individuals with OUD that do well are those who have a lot of support and are treated as though they have a chronic condition.

This bill supports the use of treatments that work for individuals and advances treatment programs like the hub and spoke model. It also focuses on removing barriers for those who seek treatment. However, the opioid treatment network is very fragile, many opioid treatment programs are teetering on closing. It is important to specifically mention and support opioid treatment programs in the bill.

In addition to treatment, the bill should consider prevention and in those considerations should take advantage of the proven community-based prevention program.

A big part of prevention is providing nonpharmacological treatments for pain. The bill includes a project to consider the evidence for nonpharmacological options for chronic pain, however acute and sub-acute pain should also be included. Eight other states consider nonpharmacologic options for their Medicaid patients.

There are concerns about the requirement for all federally certified EHRs to integrate with the state's PMP, particularly about the short timeline. Many hospitals and facilities have made significant investments in their EHR systems and there are significant costs to integrate as well as increased demands on staff. A mandate to integrate without the resources to do so could have an impact on particularly the small hospitals.

(Opposed) None.

(Other) A health impact review of the bill was conducted and found that there is strong evidence that increasing the distribution of naloxone and the use of medication-assisted treatment will decrease complications and the number of deaths from opioids. There is also evidence that the integration of the PMP will reduce doctor shopping and diversion.

Persons Testifying: (In support) Jason McGill, Office of the Governor; John Wiesman, Department of Health; Charissa Fotinos, Health Care Authority; Shannie Jenkins; Michael Hatchett, Washington Council for Behavioral Health; Michelle Karrer; Lori Grassi, Washington State Chiropractic Association; Seth Dawson, Washington Association for Substance Abuse Prevention; Molly Carney, Evergreen Treatment Services; Melissa Johnson, Physical Therapy Association of Washington; Curtis Eschels, Washington East Asian Medicine Association; and Christine Lohmeyer, Mason General Hospital.

(Other) Alexandra Montano, Washington State Board of Health.

Persons Signed In To Testify But Not Testifying: None.