Z-0420.1

HOUSE BILL 1331

State of Washington 66th Legislature 2019 Regular Session

By Representatives Cody, Caldier, Harris, Stonier, Peterson, Irwin, Macri, Mosbrucker, Jinkins, Kilduff, Appleton, Ryu, Davis, Robinson, Eslick, Lekanoff, Thai, Tharinger, Walen, Bergquist, Kloba, Leavitt, Ormsby, Pollet, and Wylie; by request of Office of the Governor

Read first time 01/18/19. Referred to Committee on Health Care & Wellness.

AN ACT Relating to opioid use disorder treatment, prevention, and related services; amending RCW 69.41.055, 69.41.095, 70.41.480, 70.168.090, 70.225.010, 70.225.040, 71.24.011, 71.24.560, 2.30.030, 71.24.585, 71.24.590, and 71.24.595; amending 2005 c 70 s 1 (uncodified); reenacting and amending RCW 69.50.312, 70.225.020, and 71.24.580; adding a new section to chapter 18.22 RCW; adding a new section to chapter 18.32 RCW; adding a new section to chapter 18.57 RCW; adding a new section to chapter 18.57A RCW; adding a new section to chapter 18.64 RCW; adding a new section to chapter 18.71 RCW; adding a new section to chapter 18.71A RCW; adding a new section to chapter 18.79 RCW; adding new sections to chapter 43.70 RCW; adding a new section to chapter 69.50 RCW; adding a new section to chapter 70.225 RCW; adding new sections to chapter 71.24 RCW; adding a new section to chapter 74.09 RCW; and creating a new section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** The legislature declares that opioid use disorder is a public health crisis. State agencies must increase access to evidence-based opioid use disorder treatment services, promote coordination of services within the substance use disorder treatment and recovery support system, strengthen partnerships between opioid use disorder treatment providers and their allied

community partners, expand the use of the Washington state prescription drug monitoring program, and support comprehensive school and community-based substance use prevention services.

This act leverages the direction provided by the Washington state interagency opioid working plan in order to address the opioid epidemic challenging communities throughout the state.

Agencies administering state purchased health care programs, as defined in RCW 41.05.011, shall coordinate activities to implement the provisions of this act and the Washington state interagency opioid working plan, explore opportunities to address the opioid epidemic, and provide status updates as directed by the joint legislative executive committee on health care oversight to promote legislative and executive coordination.

Sec. 2. 2005 c 70 s 1 (uncodified) is amended to read as follows:

The legislature finds that drug use among pregnant ((~~women~~)) individuals is a significant and growing concern statewide. ((~~The legislature further finds that methadone, although an effective alternative to other substance use treatments, can result in babies who are exposed to methadone while in uteri being born addicted and facing the painful effects of withdrawal.~~)) Evidence-informed group prenatal care reduces preterm birth for infants, and increases maternal social cohesion and support during pregnancy and postpartum, which is good for maternal mental health.

It is the intent of the legislature to notify all pregnant ((~~mothers~~)) individuals who are receiving ((~~methadone treatment~~)) medication for the treatment of opioid use disorder of the risks and benefits ((~~methadone~~)) such medication could have on their baby during pregnancy through birth and to inform them of the potential need for the newborn baby to be ((~~taken care of~~)) treated in a hospital setting or in a specialized supportive environment designed specifically to address ((~~newborn addiction problems~~)) and manage neonatal opioid or other drug withdrawal syndromes.

NEW SECTION. **Sec. 3.** A new section is added to chapter 18.22 RCW to read as follows:

By January 1, 2020, the board must adopt or amend its rules to require podiatric physicians who prescribe opioids to inform patients of their right to refuse an opioid prescription or order for any

reason. If a patient indicates a desire to not receive an opioid, the podiatric physician must document the patient's request and avoid prescribing or ordering opioids, unless the request is revoked by the patient.

NEW SECTION. **Sec. 4.** A new section is added to chapter 18.32 RCW to read as follows:

By January 1, 2020, the commission must adopt or amend its rules to require dentists who prescribe opioids to inform patients of their right to refuse an opioid prescription or order for any reason. If a patient indicates a desire to not receive an opioid, the dentist must document the patient's request and avoid prescribing or ordering opioids, unless the request is revoked by the patient.

NEW SECTION. **Sec. 5.** A new section is added to chapter 18.57 RCW to read as follows:

By January 1, 2020, the board must adopt or amend its rules to require osteopathic physicians who prescribe opioids to inform patients of their right to refuse an opioid prescription or order for any reason. If a patient indicates a desire to not receive an opioid, the osteopathic physician must document the patient's request and avoid prescribing or ordering opioids, unless the request is revoked by the patient.

NEW SECTION. **Sec. 6.** A new section is added to chapter 18.57A RCW to read as follows:

By January 1, 2020, the board must adopt or amend its rules to require osteopathic physicians' assistants who prescribe opioids to inform patients of their right to refuse an opioid prescription or order for any reason. If a patient indicates a desire to not receive an opioid, the osteopathic physician's assistant must document the patient's request and avoid prescribing or ordering opioids, unless the request is revoked by the patient.

NEW SECTION. **Sec. 7.** A new section is added to chapter 18.64 RCW to read as follows:

A pharmacist may partially fill a prescription for a schedule II controlled substance, if the partial fill is requested by the patient or the prescribing practitioner and the total quantity dispensed in all partial fillings does not exceed the quantity prescribed.

NEW SECTION. **Sec. 8.** A new section is added to chapter 18.71 RCW to read as follows:

By January 1, 2020, the commission must adopt or amend its rules to require physicians who prescribe opioids to inform patients of their right to refuse an opioid prescription or order for any reason. If a patient indicates a desire to not receive an opioid, the physician must document the patient's request and avoid prescribing or ordering opioids, unless the request is revoked by the patient.

NEW SECTION. **Sec. 9.** A new section is added to chapter 18.71A RCW to read as follows:

By January 1, 2020, the commission must adopt or amend its rules to require physician assistants who prescribe opioids to inform patients of their right to refuse an opioid prescription or order for any reason. If a patient indicates a desire to not receive an opioid, the physician assistant must document the patient's request and avoid prescribing or ordering opioids, unless the request is revoked by the patient.

NEW SECTION. **Sec. 10.** A new section is added to chapter 18.79 RCW to read as follows:

By January 1, 2020, the commission must adopt or amend its rules to require advanced registered nurse practitioners who prescribe opioids to inform patients of their right to refuse an opioid prescription or order for any reason. If a patient indicates a desire to not receive an opioid, the advanced registered nurse practitioner must document the patient's request and avoid prescribing or ordering opioids, unless the request is revoked by the patient.

NEW SECTION. **Sec. 11.** A new section is added to chapter 43.70 RCW to read as follows:

(1) The department must create a statement warning individuals about the risks of opioid use and abuse and provide information about safe disposal of opioids. The department must provide the warning on its web site.

(2) The department must review the science, data, and best practices around the use of opioids and their associated risks. As evidence and best practices evolve, the department must update its warning to reflect these changes.

(3) The department must update its patient education materials to reflect the patient's right to refuse an opioid prescription or order.

NEW SECTION. **Sec. 12.** A new section is added to chapter 43.70 RCW to read as follows:

The secretary shall be responsible for coordinating the statewide response to the opioid epidemic and executing the state opioid response plan, in partnership with the health care authority. The department and the health care authority must collaborate with each of the agencies and organizations identified in the state opioid response plan.

Sec. 13. RCW 69.41.055 and 2016 c 148 s 15 are each amended to read as follows:

(1) Information concerning an original prescription or information concerning a prescription refill for a legend drug may be electronically communicated between an authorized practitioner and a pharmacy of the patient's choice with no intervening person having access to the prescription drug order pursuant to the provisions of this chapter if the electronically communicated prescription information complies with the following:

(a) Electronically communicated prescription information must comply with all applicable statutes and rules regarding the form, content, recordkeeping, and processing of a prescription or order for a legend drug;

(b) ((~~The system used for transmitting electronically communicated prescription information and the system used for receiving electronically communicated prescription information must be approved by the commission. This subsection does not apply to currently used facsimile equipment transmitting an exact visual image of the prescription. The commission shall maintain and provide, upon request, a list of systems used for electronically communicating prescription information currently approved by the commission;~~

~~(c)~~)) An explicit opportunity for practitioners must be made to indicate their preference on whether or not a therapeutically equivalent generic drug or interchangeable biological product may be substituted. This section does not limit the ability of practitioners and pharmacists to permit substitution by default under a prior-consent authorization;

((~~(d)~~)) (c) Prescription drug orders are confidential health information, and may be released only to the patient or the patient's authorized representative, the prescriber or other authorized practitioner then caring for the patient, or other persons specifically authorized by law to receive such information;

((~~(e)~~)) (d) To maintain confidentiality of prescription records, the electronic system shall have adequate security and systems safeguards designed to prevent and detect unauthorized access, modification, or manipulation of these records((~~. The pharmacist in charge shall establish or verify the existence of policies and procedures which ensure the integrity and confidentiality of prescription information transmitted to the pharmacy by electronic means. All managers, employees, and agents of the pharmacy are required to read, sign, and comply with the established policies and procedures~~)); and

((~~(f)~~)) (e) The pharmacist shall exercise professional judgment regarding the accuracy, validity, and authenticity of the prescription drug order received by way of electronic transmission, consistent with federal and state laws and rules and guidelines of the commission.

(2) The electronic or digital signature of the prescribing practitioner's agent on behalf of the prescribing practitioner for a resident in a long-term care facility or hospice program, pursuant to a valid order and authorization under RCW 18.64.550, constitutes a valid electronic communication of prescription information. Such an authorized signature and transmission by an agent in a long-term care facility or hospice program does not constitute an intervening person having access to the prescription drug order.

(3) The commission may adopt rules implementing this section.

Sec. 14. RCW 69.41.095 and 2015 c 205 s 2 are each amended to read as follows:

(1)(a) A practitioner may prescribe, dispense, distribute, and deliver an opioid overdose reversal medication: (i) Directly to a person at risk of experiencing an opioid-related overdose; or (ii) by prescription, collaborative drug therapy agreement, standing order, or protocol to a first responder, family member, or other person or entity in a position to assist a person at risk of experiencing an opioid-related overdose. Any such prescription, standing order, or

protocol ((~~order~~)) is issued for a legitimate medical purpose in the usual course of professional practice.

(b) At the time of prescribing, dispensing, distributing, or delivering the opioid overdose reversal medication, the practitioner shall inform the recipient that as soon as possible after administration of the opioid overdose reversal medication, the person at risk of experiencing an opioid-related overdose should be transported to a hospital or a first responder should be summoned.

(2) A pharmacist may dispense an opioid overdose reversal medication pursuant to a prescription, collaborative drug therapy agreement, standing order, or protocol issued in accordance with subsection (1)(a) of this section and may administer an opioid overdose reversal medication to a person at risk of experiencing an opioid-related overdose. At the time of dispensing an opioid overdose reversal medication, a pharmacist shall provide written instructions on the proper response to an opioid-related overdose, including instructions for seeking immediate medical attention. The instructions to seek immediate ((~~medication~~)) medical attention must be conspicuously displayed.

(3) Any person or entity may lawfully possess, store, deliver, distribute, or administer an opioid overdose reversal medication pursuant to a prescription ((~~or~~)), collaborative drug therapy agreement, standing order, or protocol issued by a practitioner in accordance with subsection (1) of this section.

(4) The following individuals, if acting in good faith and with reasonable care, are not subject to criminal or civil liability or disciplinary action under chapter 18.130 RCW for any actions authorized by this section or the outcomes of any actions authorized by this section:

(a) A practitioner who prescribes, dispenses, distributes, or delivers an opioid overdose reversal medication pursuant to subsection (1) of this section;

(b) A pharmacist who dispenses an opioid overdose reversal medication pursuant to subsection (2) or (5)(a) of this section;

(c) A person who possesses, stores, distributes, or administers an opioid overdose reversal medication pursuant to subsection (3) of this section.

(5) The secretary or the secretary's designee may issue a 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. The standing order may be limited to specific areas in the state or issued statewide.

(a) A pharmacist shall dispense an opioid overdose reversal medication pursuant to a standing order issued in accordance with this subsection, consistent with the pharmacist's responsibilities to dispense prescribed legend drugs, and may administer an opioid overdose reversal medication to a person at risk of experiencing an opioid-related overdose. At the time of dispensing an opioid overdose reversal medication, a pharmacist shall provide written instructions on the proper response to an opioid-related overdose, including instructions for seeking immediate medical attention. The instructions to seek immediate medical attention must be conspicuously displayed.

(b) Any person or entity may lawfully possess, store, deliver, distribute, or administer an opioid overdose reversal medication pursuant to a standing order issued in accordance with this subsection (5). The department, in coordination with the appropriate entity or entities, shall ensure availability of a training module that provides training regarding the identification of a person suffering from an opioid-related overdose and the use of opioid overdose reversal medications. The training must be available electronically and in a variety of media from the department.

(c) This subsection (5) does not create a private cause of action. Notwithstanding any other provision of law, neither the state nor the secretary nor the secretary's designee has any civil liability for issuing standing orders or for any other actions taken pursuant to this chapter or for the outcomes of issuing standing orders or any other actions taken pursuant to this chapter. Neither the secretary nor the secretary's designee is subject to any criminal liability or professional disciplinary action for issuing standing orders or for any other actions taken pursuant to this chapter.

(d) For purposes of this subsection (5), "standing order" means an order prescribing medication by the secretary or the secretary's designee. Such standing order can only be issued by a practitioner as defined in this chapter.

(6) The labeling requirements of RCW 69.41.050 and 18.64.246 do not apply to opioid overdose reversal medications dispensed, distributed, or delivered pursuant to a prescription, collaborative drug therapy agreement, standing order, or protocol issued in

accordance with this section. The individual or entity that dispenses, distributes, or delivers an opioid overdose reversal medication as authorized by this section shall ensure that directions for use are provided.

(7) For purposes of this section, the following terms have the following meanings unless the context clearly requires otherwise:

(a) "First responder" means: (i) A career or volunteer firefighter, law enforcement officer, paramedic as defined in RCW 18.71.200, or first responder or emergency medical technician as defined in RCW 18.73.030; and (ii) an entity that employs or supervises an individual listed in (a)(i) of this subsection, including a volunteer fire department.

(b) "Opioid overdose reversal medication" means any drug used to reverse an opioid overdose that binds to opioid receptors and blocks or inhibits the effects of opioids acting on those receptors. It does not include intentional administration via the intravenous route.

(c) "Opioid-related overdose" means a condition including, but not limited to, extreme physical illness, decreased level of consciousness, respiratory depression, coma, or death that: (i) Results from the consumption or use of an opioid or another substance with which an opioid was combined; or (ii) a lay person would reasonably believe to be an opioid-related overdose requiring medical assistance.

(d) "Practitioner" means a health care practitioner who is authorized under RCW 69.41.030 to prescribe legend drugs.

(e) "Standing order" or "protocol" means written or electronically recorded instructions, prepared by a prescriber, for distribution and administration of a drug by designated and trained staff or volunteers of an organization or entity, as well as other actions and interventions to be used upon the occurrence of clearly defined clinical events in order to improve patients' timely access to treatment.

Sec. 15. RCW 69.50.312 and 2013 c 276 s 4 and 2013 c 19 s 105 are each reenacted and amended to read as follows:

(1) Information concerning a prescription for a controlled substance included in Schedules II through V, or information concerning a refill authorization for a controlled substance included in Schedules III through V((~~,~~)), may be electronically communicated to a pharmacy of the patient's choice pursuant to the provisions of

this chapter if the electronically communicated prescription information complies with the following:

(a) Electronically communicated prescription information must comply with all applicable statutes and rules regarding the form, content, recordkeeping, and processing of a prescription for a legend drug;

(b) The system used for transmitting electronically communicated prescription information must ((~~be approved by the commission and in accordance~~)) comply with federal rules for electronically communicated prescriptions for controlled substance((~~[s]~~))s included in Schedules II through V, as set forth in Title 21 C.F.R. Parts 1300, 1304, 1306, and 1311((~~. This subsection does not apply to currently used facsimile equipment transmitting an exact visual image of the prescription. The commission shall maintain and provide, upon request, a list of systems used for electronically communicating prescription information currently approved by the commission~~));

(c) An explicit opportunity for practitioners must be made to indicate their preference on whether a therapeutically equivalent generic drug may be substituted;

(d) Prescription drug orders are confidential health information, and may be released only to the patient or the patient's authorized representative, the prescriber or other authorized practitioner then caring for the patient, or other persons specifically authorized by law to receive such information;

(e) To maintain confidentiality of prescription records, the electronic system shall have adequate security and systems safeguards designed to prevent and detect unauthorized access, modification, or manipulation of these records((~~. The pharmacist in charge shall establish or verify the existence of policies and procedures which ensure the integrity and confidentiality of prescription information transmitted to the pharmacy by electronic means. All managers, employees, and agents of the pharmacy are required to read, sign, and comply with the established policies and procedures~~)); and

(f) The pharmacist shall exercise professional judgment regarding the accuracy, validity, and authenticity of the prescription drug order received by way of electronic transmission, consistent with federal and state laws and rules and guidelines of the commission.

(2) The commission may adopt rules implementing this section.

NEW SECTION. **Sec. 16.** A new section is added to chapter 69.50 RCW to read as follows:

(1) Any practitioner who writes the first prescription for an opioid during the course of treatment to any patient must, under professional rules, discuss the following with the patient:

(a) The risks of opioids, including risk of dependence and overdose;

(b) Pain management alternatives to opioids, including nonopioid pharmacological treatments, and nonpharmacological treatments available to the patient, at the discretion of the practitioner and based on the medical condition of the patient; and

(c) A written copy of the warning language provided by the department under section 11 of this act.

(2) If the patient is under eighteen years old or is not competent, the discussion required by subsection (1) of this section must include the patient's parent, guardian, or the person identified in RCW 7.70.065, unless otherwise provided by law.

(3) The practitioner shall document completion of the requirements in subsection (1) of this section in the patient's health care record.

(4) To fulfill the requirements of subsection (1) of this section, a practitioner may designate any individual who holds a credential issued by a disciplining authority under RCW 18.130.040 to conduct the discussion.

(5) Violation of this section constitutes unprofessional conduct under chapter 18.130 RCW.

(6) This section does not apply to:

(a) Opioid prescriptions issued for the treatment of pain associated with terminal cancer or other terminal diseases, or for palliative, hospice, or other end-of-life care of where the practitioner determines the health, well-being, or care of the patient would be compromised by the requirements of this section and documents such basis for the determination in the patient's health care record; or

(b) Administration of an opioid in an inpatient or outpatient treatment setting.

(7) This section does not apply to practitioners licensed under chapter 18.92 RCW.

(8) The department shall review this section by March 31, 2026, and report to the appropriate committees of the legislature on whether this section should be retained, repealed, or amended.

Sec. 17. RCW 70.41.480 and 2015 c 234 s 1 are each amended to read as follows:

(1) The legislature finds that high quality, safe, and compassionate health care services for patients of Washington state must be available at all times. The legislature further finds that there is a need for patients being released from hospital emergency departments to maintain access to emergency medications when community or hospital pharmacy services are not available, including medication for opioid overdose reversal and for the treatment for opioid use disorder as appropriate. It is the intent of the legislature to accomplish this objective by allowing practitioners with prescriptive authority to prescribe limited amounts of prepackaged emergency medications to patients being discharged from hospital emergency departments when access to community or outpatient hospital pharmacy services is not otherwise available.

(2) A hospital may allow a practitioner to prescribe prepackaged emergency medications and allow a practitioner or a registered nurse licensed under chapter 18.79 RCW to distribute prepackaged emergency medications to patients being discharged from a hospital emergency department in the following circumstances:

(a) During times when community or outpatient hospital pharmacy services are not available within fifteen miles by road ((~~or~~));

(b) When, in the judgment of the practitioner and consistent with hospital policies and procedures, a patient has no reasonable ability to reach the local community or outpatient pharmacy; or

(c) When, in the judgment of the practitioner and consistent with hospital policies and procedures, a patient is at risk of opioid overdose and the prepackaged emergency medication being distributed is an opioid overdose reversal medication.

(3) A hospital may only allow this practice if: The director of the hospital pharmacy, in collaboration with appropriate hospital medical staff, develops policies and procedures regarding the following:

(a) Development of a list, preapproved by the pharmacy director, of the types of emergency medications to be prepackaged and distributed;

(b) Assurances that emergency medications to be prepackaged pursuant to this section are prepared by a pharmacist or under the supervision of a pharmacist licensed under chapter 18.64 RCW;

(c) Development of specific criteria under which emergency prepackaged medications may be prescribed and distributed consistent with the limitations of this section;

(d) Assurances that any practitioner authorized to prescribe prepackaged emergency medication or any nurse authorized to distribute prepackaged emergency medication is trained on the types of medications available and the circumstances under which they may be distributed;

(e) Procedures to require practitioners intending to prescribe prepackaged emergency medications pursuant to this section to maintain a valid prescription either in writing or electronically in the patient's records prior to a medication being distributed to a patient;

(f) Establishment of a limit of no more than a forty-eight hour supply of emergency medication as the maximum to be dispensed to a patient, except when community or hospital pharmacy services will not be available within forty-eight hours. In no case may the policy allow a supply exceeding ninety-six hours be dispensed;

(g) Assurances that prepackaged emergency medications will be kept in a secure location in or near the emergency department in such a manner as to preclude the necessity for entry into the pharmacy; and

(h) Assurances that nurses or practitioners will distribute prepackaged emergency medications to patients only after a practitioner has counseled the patient on the medication.

((~~(3)~~)) (4) The delivery of a single dose of medication for immediate administration to the patient is not subject to the requirements of this section.

((~~(4)~~)) (5) Nothing in this section restricts the authority of a practitioner in a hospital emergency department to distribute opioid overdose reversal medication under RCW 69.41.095.

(6) For purposes of this section:

(a) "Emergency medication" means any medication commonly prescribed to emergency ((~~room~~)) department patients, including those drugs, substances or immediate precursors listed in schedules II through V of the uniform controlled substances act, chapter 69.50 RCW, as now or hereafter amended.

(b) "Distribute" means the delivery of a drug or device other than by administering or dispensing.

(c) "Practitioner" means any person duly authorized by law or rule in the state of Washington to prescribe drugs as defined in RCW 18.64.011((~~(24)~~)) (29).

(d) "Nurse" means a registered nurse as defined in RCW 18.79.020.

Sec. 18. RCW 70.168.090 and 2010 c 52 s 5 are each amended to read as follows:

(1)(a) By July 1991, the department shall establish a statewide data registry to collect and analyze data on the incidence, severity, and causes of trauma, including traumatic brain injury. The department shall collect additional data on traumatic brain injury should additional data requirements be enacted by the legislature. The registry shall be used to improve the availability and delivery of prehospital and hospital trauma care services. Specific data elements of the registry shall be defined by rule by the department. To the extent possible, the department shall coordinate data collection from hospitals for the trauma registry with the health care data system authorized in chapter 70.170 RCW. Every hospital, facility, or health care provider authorized to provide level I, II, III, IV, or V trauma care services, level I, II, or III pediatric trauma care services, level I, level I-pediatric, II, or III trauma-related rehabilitative services, and prehospital trauma-related services in the state shall furnish data to the registry. All other hospitals and prehospital providers shall furnish trauma data as required by the department by rule.

(b) The department may respond to requests for data and other information from the registry for special studies and analysis consistent with requirements for confidentiality of patient and quality assurance records. The department may require requestors to pay any or all of the reasonable costs associated with such requests that might be approved.

(2) The department must establish a statewide electronic emergency medical services data system and adopt rules requiring licensed ambulance and aid services to report and furnish patient encounter data to the electronic emergency medical services data system. The data system must be used to improve the availability and delivery of prehospital emergency medical services. The department must establish in rule the specific data elements of the data system

and secure transport methods for data. The data collected must include data on suspected drug overdoses for the purposes of including, but not limited to, identifying individuals to engage substance use disorder peer professionals to prevent further overdoses and to induct into treatment and provide other needed supports as may be available.

(3) In each emergency medical services and trauma care planning and service region, a regional emergency medical services and trauma care systems quality assurance program shall be established by those facilities authorized to provide levels I, II, and III trauma care services. The systems quality assurance program shall evaluate trauma care delivery, patient care outcomes, and compliance with the requirements of this chapter. The systems quality assurance program may also evaluate emergency cardiac and stroke care delivery. The emergency medical services medical program director and all other health care providers and facilities who provide trauma and emergency cardiac and stroke care services within the region shall be invited to participate in the regional emergency medical services and trauma care quality assurance program.

((~~(3)~~)) (4) Data elements related to the identification of individual patient's, provider's and facility's care outcomes shall be confidential, shall be exempt from RCW 42.56.030 through 42.56.570 and 42.17.350 through 42.17.450, and shall not be subject to discovery by subpoena or admissible as evidence.

((~~(4)~~)) (5) Patient care quality assurance proceedings, records, and reports developed pursuant to this section are confidential, exempt from chapter 42.56 RCW, and are not subject to discovery by subpoena or admissible as evidence((~~.~~)) in any civil action, except, after in camera review, pursuant to a court order which provides for the protection of sensitive information of interested parties including the department: (a) In actions arising out of the department's designation of a hospital or health care facility pursuant to RCW 70.168.070; (b) in actions arising out of the department's revocation or suspension of designation status of a hospital or health care facility under RCW 70.168.070; (c) in actions arising out of the department's licensing or verification of an ambulance or aid service pursuant to RCW 18.73.030 or 70.168.080; (d) in actions arising out of the certification of a medical program director pursuant to RCW 18.71.212; or ((~~(c)~~)) (e) in actions arising out of the restriction or revocation of the clinical or staff

privileges of a health care provider as defined in RCW 7.70.020 (1) and (2), subject to any further restrictions on disclosure in RCW 4.24.250 that may apply. Information that identifies individual patients shall not be publicly disclosed without the patient's consent.

Sec. 19. RCW 70.225.010 and 2007 c 259 s 42 are each amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Controlled substance" has the meaning provided in RCW 69.50.101.

(2) "Department" means the department of health.

(3) "Patient" means the person or animal who is the ultimate user of a drug for whom a prescription is issued or for whom a drug is dispensed.

(4) "Dispenser" means a practitioner or pharmacy that delivers a Schedule II, III, IV, or V controlled substance to the ultimate user, but does not include:

(a) A practitioner or other authorized person who administers, as defined in RCW 69.41.010, a controlled substance; or

(b) A licensed wholesale distributor or manufacturer, as defined in chapter 18.64 RCW, of a controlled substance.

(5) "Prescriber" means any person authorized to order or prescribe legend drugs or schedule II, III, IV, or V controlled substances to the ultimate user.

(6) "Requestor" means any person or entity requesting, accessing, or receiving information from the prescription monitoring program under RCW 70.225.040 (3), (4), or (5).

Sec. 20. RCW 70.225.020 and 2013 c 36 s 2 and 2013 C 19 S 126 are each reenacted and amended to read as follows:

(1) The department shall establish and maintain a prescription monitoring program to monitor the prescribing and dispensing of all Schedules II, III, IV, and V controlled substances and any additional drugs identified by the pharmacy quality assurance commission as demonstrating a potential for abuse by all professionals licensed to prescribe or dispense such substances in this state. The program shall be designed to improve health care quality and effectiveness by reducing abuse of controlled substances, reducing duplicative

prescribing and overprescribing of controlled substances, and improving controlled substance prescribing practices with the intent of eventually establishing an electronic database available in real time to dispensers and prescribers of controlled substances. As much as possible, the department should establish a common database with other states. This program's management and operations shall be funded entirely from the funds in the account established under RCW 74.09.215. Nothing in this chapter prohibits voluntary contributions from private individuals and business entities as defined under Title 23, 23B, 24, or 25 RCW to assist in funding the prescription monitoring program.

(2) Except as provided in subsection (4) of this section, each dispenser shall submit to the department by electronic means information regarding each prescription dispensed for a drug included under subsection (1) of this section. Drug prescriptions for more than one day use should be reported. The information submitted for each prescription shall include, but not be limited to:

(a) Patient identifier;

(b) Drug dispensed;

(c) Date of dispensing;

(d) Quantity dispensed;

(e) Prescriber; and

(f) Dispenser.

(3) Each dispenser shall submit the information in accordance with transmission methods established by the department, not later than one business day from the date of dispensing or at the interval required by the department in rule, whichever is sooner.

(4) The data submission requirements of subsections (1) through (3) of this section do not apply to:

(a) Medications provided to patients receiving inpatient services provided at hospitals licensed under chapter 70.41 RCW; or patients of such hospitals receiving services at the clinics, day surgery areas, or other settings within the hospital's license where the medications are administered in single doses;

(b) Pharmacies operated by the department of corrections for the purpose of providing medications to offenders in department of corrections institutions who are receiving pharmaceutical services from a department of corrections pharmacy, except that the department of corrections must submit data related to each offender's current

prescriptions for controlled substances upon the offender's release from a department of corrections institution; or

(c) Veterinarians licensed under chapter 18.92 RCW. The department, in collaboration with the veterinary board of governors, shall establish alternative data reporting requirements for veterinarians that allow veterinarians to report:

(i) By either electronic or nonelectronic methods;

(ii) Only those data elements that are relevant to veterinary practices and necessary to accomplish the public protection goals of this chapter; and

(iii) No more frequently than once every three months and no less frequently than once every six months.

(5) The department shall continue to seek federal grants to support the activities described in chapter 259, Laws of 2007. The department may not require a practitioner or a pharmacist to pay a fee or tax specifically dedicated to the operation and management of the system.

NEW SECTION. **Sec. 21.** A new section is added to chapter 70.225 RCW to read as follows:

(1) In order to expand integration of prescription monitoring program data into certified electronic health record technologies, the department must collaborate with health professional and facility associations, vendors, and others to:

(a) Conduct an assessment of the current status of integration;

(b) Provide recommendations for improving integration among small and rural health care facilities, offices, and clinics;

(c) Establish a program to provide financial assistance to small and rural health care facilities and clinics with integration as funding is available, especially under federal programs;

(d) Conduct security assessments of other commonly used platforms for integrating prescription monitoring program data with certified electronic health records for possible use in Washington; and

(e) Assess improvements to the prescription monitoring program to establish a modality to identify patients that do not wish to receive opioid medications in a manner that allows an ordering or prescribing physician to be able to use the prescription monitoring program to identify patients who do not wish to receive opioids or patients that have had an opioid-related overdose.

(2) By July 1, 2020, a facility or entity identified in RCW 70.225.040 with ten or more providers that is not a critical access hospital as defined in RCW 74.60.010 that uses a federally certified electronic health records system must demonstrate that the facility's or entity's federally certified electronic health record is able to fully integrate data to and from the prescription monitoring program using a mechanism approved by the department under subsection (3) of this section.

(3) Electronic health record system vendors who are fully integrated with the prescription monitoring program in Washington state may not charge an ongoing fee or a fee based on the number of transactions or providers. Total costs of connection must not impose unreasonable costs on any facility, entity, office, or provider group using the electronic health record and must be consistent with current industry pricing structures. For the purposes of this subsection, "fully integrated" means that the electronic health records system must:

(a) Send information to the prescription monitoring program without physician intervention using one of the standard transmission and content standards supported by the state health information exchange for all controlled substances;

(b) Make current information from the prescription monitoring program available to a provider within the workflow of the electronic health records system; and

(c) Make information available in a way that is unlikely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information, in accordance with the information blocking provisions of the federal twenty-first century cures act, P.L. 114-255.

Sec. 22. RCW 70.225.040 and 2017 c 297 s 9 are each amended to read as follows:

(1) ((~~Prescription~~)) All information submitted to the ((~~department must be~~)) prescription monitoring program is confidential, ((~~in compliance with chapter 70.02 RCW and~~)) exempt from public inspection, copying, and disclosure under chapter 42.56 RCW, not subject to subpoena or discovery in any civil action, and protected under federal health care information privacy requirements ((~~and not subject to disclosure~~)), except as provided in subsections (3)((~~, (4), and (5)~~)) through (6) of this section. Such

confidentiality and exemption from disclosure continues whenever information from the prescription monitoring program is provided to a requestor under subsection (3), (4), (5), or (6) of this section except when used in proceedings specifically authorized in subsection (3), (4), or (5) of this section.

(2) The department must maintain procedures to ensure that the privacy and confidentiality of ((~~patients and patient~~)) all information collected, recorded, transmitted, and maintained including, but not limited to, the prescriber, requestor, dispenser, patient, and persons who received prescriptions from dispensers, is not disclosed to persons except as in subsections (3)((~~, (4), and (5)~~)) through (6) of this section.

(3) The department may provide data in the prescription monitoring program to the following persons:

(a) Persons authorized to prescribe or dispense controlled substances or legend drugs, for the purpose of providing medical or pharmaceutical care for their patients;

(b) An individual who requests the individual's own prescription monitoring information;

(c) A health professional licensing, certification, or regulatory agency or entity in this or another jurisdiction. Consistent with current practice, the data provided may be used in legal proceedings concerning the license;

(d) Appropriate law enforcement or prosecutorial officials, including local, state, and federal officials and officials of federally recognized tribes, who are engaged in a bona fide specific investigation involving a designated person;

(e) ((~~Authorized practitioners of the department of social and health services and the health care authority regarding medicaid program recipients;~~

~~(f)~~)) The director or the director's designee within the health care authority regarding medicaid ((~~clients for the purposes of quality improvement, patient safety, and care coordination. The information may not be used for contracting or value-based purchasing decisions~~)) recipients and members of the health care authority self-funded or self-insured health plans;

((~~(g)~~)) (f) The director or director's designee within the department of labor and industries regarding workers' compensation claimants;

((~~(h)~~)) (g) The director or the director's designee within the department of corrections regarding offenders committed to the department of corrections;

((~~(i)~~)) (h) Other entities under grand jury subpoena or court order;

((~~(j)~~)) (i) Personnel of the department for purposes of:

(i) Assessing prescribing and treatment practices((~~, including controlled substances related to mortality and morbidity~~)) and morbidity and mortality related to use of controlled substances and developing and implementing initiatives to protect the public health including, but not limited to, initiatives to address opioid use disorder;

(ii) Providing quality improvement feedback to ((~~providers~~)) prescribers, including comparison of their respective data to aggregate data for ((~~providers~~)) prescribers with the same type of license and same specialty; and

(iii) Administration and enforcement of this chapter or chapter 69.50 RCW;

((~~(k)~~)) (j) Personnel of a test site that meet the standards under RCW 70.225.070 pursuant to an agreement between the test site and a person identified in (a) of this subsection to provide assistance in determining which medications are being used by an identified patient who is under the care of that person;

((~~(l)~~)) (k) A health care facility or entity for the purpose of providing medical or pharmaceutical care to the patients of the facility or entity, or for quality improvement purposes if:

(i) The facility or entity is licensed by the department or is licensed or certified under chapter 71.24, 71.34, or 71.05 RCW or is an entity deemed for purposes of chapter 71.24 RCW to meet state minimum standards as a result of accreditation by a recognized behavioral health accrediting body, or is operated by the federal government or a federally recognized Indian tribe; and

(ii) The facility or entity is a trading partner with the state's health information exchange;

((~~(m)~~)) (l) A health care provider group of five or more ((~~providers~~)) prescribers or dispensers for purposes of providing medical or pharmaceutical care to the patients of the provider group, or for quality improvement purposes if:

(i) All the ((~~providers~~)) prescribers or dispensers in the provider group are licensed by the department or the provider group

is operated by the federal government or a federally recognized Indian tribe; and

(ii) The provider group is a trading partner with the state's health information exchange;

((~~(n)~~)) (m) 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. For the purposes of this subsection "local health officer" has the same meaning as in RCW 70.05.010; and

((~~(o)~~)) (n) The coordinated care electronic tracking program developed in response to section 213, chapter 7, Laws of 2012 2nd sp. sess., commonly referred to as the seven best practices in emergency medicine, for the purposes of providing:

(i) Prescription monitoring program data to emergency department personnel when the patient registers in the emergency department; and

(ii) Notice to local health officers who have made opioid-related overdose a notifiable condition under RCW 70.05.070 as authorized by rules adopted under RCW 43.20.050, providers, appropriate care coordination staff, and prescribers listed in the patient's prescription monitoring program record that the patient has experienced a controlled substance overdose event. The department shall determine the content and format of the notice in consultation with the Washington state hospital association, Washington state medical association, and Washington state health care authority, and the notice may be modified as necessary to reflect current needs and best practices.

(4) The department shall, on at least a quarterly basis, and pursuant to a schedule determined by the department, provide a facility or entity identified under subsection (3)((~~(l)~~)) (k) of this section or a provider group identified under subsection (3)((~~(m)~~)) (l) of this section with facility or entity and individual prescriber information if the facility, entity, or provider group:

(a) Uses the information only for internal quality improvement and individual prescriber quality improvement feedback purposes and does not use the information as the sole basis for any medical staff sanction or adverse employment action; and

(b) Provides to the department a standardized list of current prescribers of the facility, entity, or provider group. The specific facility, entity, or provider group information provided pursuant to this subsection and the requirements under this subsection must be

determined by the department in consultation with the Washington state hospital association, Washington state medical association, and Washington state health care authority, and may be modified as necessary to reflect current needs and best practices.

(5)(a) The department may publish or provide data to public or private entities for statistical, research, or educational purposes 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 that has been approved by the Washington state institutional review board and by the department through a data-sharing agreement.

(b)(i) The department may provide dispenser and prescriber data and data that includes indirect patient identifiers to the Washington state hospital association for use solely in connection with its coordinated quality improvement program maintained under RCW 43.70.510 after entering into a data use agreement as specified in RCW 43.70.052(8) with the association. The department may provide dispenser and prescriber data and data that includes indirect patient identifiers to the Washington state medical association for use solely in connection with its coordinated quality improvement program maintained under RCW 43.70.510 after entering into a data use agreement with the association.

(ii) The department may provide data including direct and indirect patient identifiers to the department of social and health services office of research and data analysis for research that has been approved by the Washington state institutional review board and, with a data-sharing agreement approved by the department, for public health purposes to improve the prevention or treatment of substance use disorders.

(iii) The department may provide a prescriber feedback report to the largest health professional association representing each of the prescribing professions. The health professional associations must distribute the feedback report to prescribers engaged in the professions represented by the associations for quality improvement purposes, so long as the reports contain no direct or indirect patient identifiers that could be used to identify individual patients, dispensers, and persons who received prescriptions from dispensers, and the association enters into a written data-sharing agreement with the department. However, reports may include indirect

patient identifiers as agreed to by the department and the association in a written data-sharing agreement.

(c) For the purposes of this subsection((~~,~~)):

(i) "Indirect patient identifiers" means data that may include: Hospital or provider identifiers, a five-digit zip code, county, state, and country of resident; dates that include month and year; age in years; and race and ethnicity; but does not include the patient's first name; middle name; last name; social security number; control or medical record number; zip code plus four digits; dates that include day, month, and year; or admission and discharge date in combination; and

(ii) "Prescribing professions" include:

(A) Allopathic physicians;

(B) Osteopathic physicians;

(C) Podiatric physicians;

(D) Dentists; and

(E) Advanced registered nurse practitioners.

(6) The department may enter into agreements to exchange prescription monitoring program data with established prescription monitoring programs in other jurisdictions. Under these agreements, the department may share prescription monitoring system data containing direct and indirect patient identifiers with other jurisdictions through a clearinghouse or prescription monitoring program data exchange that meets federal health care information privacy requirements. Data the department receives from other jurisdictions must be retained, used, protected, and destroyed as provided by the agreements to the extent consistent with the laws in this state.

(7) Persons authorized in subsections (3)((~~, (4), and (5)~~)) through (6) of this section to receive data in the prescription monitoring program from the department, acting in good faith, are immune from any civil, criminal, disciplinary, or administrative liability that might otherwise be incurred or imposed for acting under this chapter.

Sec. 23. RCW 71.24.011 and 1982 c 204 s 1 are each amended to read as follows:

This chapter may be known and cited as the community ((~~mental~~)) behavioral health services act.

NEW SECTION. **Sec. 24.** A new section is added to chapter 71.24 RCW to read as follows:

(1) Recognizing that treatment strategies and modalities for the treatment of individuals with opioid use disorder and their newborns continue to evolve, and that improved health outcomes are seen when birth parents and their infants are allowed to room together, the authority must provide recommendations to the office of financial management by October 1, 2019, to better support the care of individuals who have recently delivered and their newborns.

(2) These recommendations must support:

(a) Successful transition from the early postpartum and newborn period for the birth parent and infant to the next level of care;

(b) Reducing the risk of parental infant separation; and

(c) Increasing the chance of uninterrupted recovery of the parent and foster the development of positive parenting practices.

(3) The authority's recommendations must include:

(a) How these interventions could be supported in hospitals, birthing centers, or other appropriate sites of care and descriptions as to current barriers in providing these interventions;

(b) Estimates of the costs needed to support this enhanced set of services; and

(c) Mechanisms for funding the services.

Sec. 25. RCW 71.24.560 and 2017 c 297 s 11 are each amended to read as follows:

(1) All approved opioid treatment programs that provide services to ((~~women~~)) individuals who are pregnant are required to disseminate up-to-date and accurate health education information to all their pregnant ((~~clients~~)) individuals concerning the ((~~possible addiction and health risks that their treatment may have on their baby~~)) effects opioid use and opioid use disorder medication may have on their baby, including the development of dependence and subsequent withdrawal. All pregnant ((~~clients~~)) individuals must also be advised of the risks to both themselves and their ((~~baby~~)) babies associated with ((~~not remaining on the~~)) discontinuing an opioid treatment program. The information must be provided to these ((~~clients~~)) individuals both verbally and in writing. The health education information provided to the pregnant ((~~clients~~)) individuals must include referral options for ((~~the substance-exposed baby~~)) a baby who has been exposed to opioids in utero.

(2) The department shall adopt rules that require all opioid treatment programs to educate all pregnant ((~~women~~)) individuals in their program on the benefits and risks of medication-assisted treatment to ((~~their~~)) a developing fetus before they are ((~~provided~~)) prescribed these medications, as part of their treatment. The department shall also adopt rules requiring all opioid treatment programs to educate individuals who become pregnant about the risks to both the expecting parent and the fetus of not treating opioid use disorder. The department shall meet the requirements under this subsection within the appropriations provided for opioid treatment programs. The department, working with treatment providers and medical experts, shall develop and disseminate the educational materials to all certified opioid treatment programs.

(3) For pregnant individuals who participate in medicaid, the authority, through its managed care organizations, must ensure that pregnant individuals receive outreach related to opioid use disorder when identified as a person at risk.

Sec. 26. RCW 71.24.580 and 2018 c 205 s 2 and 2018 c 201 s 4044 are each reenacted and amended to read as follows:

(1) The criminal justice treatment account is created in the state treasury. Moneys in the account may be expended solely for: (a) Substance use disorder treatment and treatment support services for offenders with a substance use disorder that, if not treated, would result in addiction, against whom charges are filed by a prosecuting attorney in Washington state; (b) the provision of substance use disorder treatment services and treatment support services for nonviolent offenders within a drug court program; and (c) the administrative and overhead costs associated with the operation of a drug court. Amounts provided in this subsection must be used for treatment and recovery support services for criminally involved offenders and authorization of these services shall not be subject to determinations of medical necessity. During the 2017-2019 fiscal biennium, the legislature may direct the state treasurer to make transfers of moneys in the criminal justice treatment account to the state general fund. It is the intent of the legislature to continue in the 2019-2021 biennium the policy of transferring to the state general fund such amounts as reflect the excess fund balance of the account. Moneys in the account may be spent only after appropriation.

(2) For purposes of this section:

(a) "Treatment" means services that are critical to a participant's successful completion of his or her substance use disorder treatment program, including but not limited to the recovery support and other programmatic elements outlined in RCW 2.30.030 authorizing therapeutic courts; and

(b) "Treatment support" includes transportation to or from inpatient or outpatient treatment services when no viable alternative exists, and child care services that are necessary to ensure a participant's ability to attend outpatient treatment sessions.

(3) Revenues to the criminal justice treatment account consist of: (a) Funds transferred to the account pursuant to this section; and (b) any other revenues appropriated to or deposited in the account.

(4)(a) For the fiscal year beginning July 1, 2005, and each subsequent fiscal year, the state treasurer shall transfer eight million two hundred fifty thousand dollars from the general fund to the criminal justice treatment account, divided into four equal quarterly payments. For the fiscal year beginning July 1, 2006, and each subsequent fiscal year, the amount transferred shall be increased on an annual basis by the implicit price deflator as published by the federal bureau of labor statistics.

(b) In each odd-numbered year, the legislature shall appropriate the amount transferred to the criminal justice treatment account in (a) of this subsection to the department for the purposes of subsection (5) of this section.

(5) Moneys appropriated to the authority from the criminal justice treatment account shall be distributed as specified in this subsection. The authority may retain up to three percent of the amount appropriated under subsection (4)(b) of this section for its administrative costs.

(a) Seventy percent of amounts appropriated to the authority from the account shall be distributed to counties pursuant to the distribution formula adopted under this section. The authority, in consultation with the department of corrections, the Washington state association of counties, the Washington state association of drug court professionals, the superior court judges' association, the Washington association of prosecuting attorneys, representatives of the criminal defense bar, representatives of substance use disorder treatment providers, and any other person deemed by the authority to be necessary, shall establish a fair and reasonable methodology for

distribution to counties of moneys in the criminal justice treatment account. County or regional plans submitted for the expenditure of formula funds must be approved by the panel established in (b) of this subsection.

(b) Thirty percent of the amounts appropriated to the authority from the account shall be distributed as grants for purposes of treating offenders against whom charges are filed by a county prosecuting attorney. The authority shall appoint a panel of representatives from the Washington association of prosecuting attorneys, the Washington association of sheriffs and police chiefs, the superior court judges' association, the Washington state association of counties, the Washington defender's association or the Washington association of criminal defense lawyers, the department of corrections, the Washington state association of drug court professionals, and substance use disorder treatment providers. The panel shall review county or regional plans for funding under (a) of this subsection and grants approved under this subsection. The panel shall attempt to ensure that treatment as funded by the grants is available to offenders statewide.

(6) The county alcohol and drug coordinator, county prosecutor, county sheriff, county superior court, a substance abuse treatment provider appointed by the county legislative authority, a member of the criminal defense bar appointed by the county legislative authority, and, in counties with a drug court, a representative of the drug court shall jointly submit a plan, approved by the county legislative authority or authorities, to the panel established in subsection (5)(b) of this section, for disposition of all the funds provided from the criminal justice treatment account within that county. The funds shall be used solely to provide approved alcohol and substance abuse treatment pursuant to RCW 71.24.560 and treatment support services. No more than ten percent of the total moneys received under subsections (4) and (5) of this section by a county or group of counties participating in a regional agreement shall be spent for treatment support services.

(7) Counties are encouraged to consider regional agreements and submit regional plans for the efficient delivery of treatment under this section.

(8) Moneys allocated under this section shall be used to supplement, not supplant, other federal, state, and local funds used for substance abuse treatment.

(9) If a region or county uses criminal justice treatment account funds to support a therapeutic court, the therapeutic court must allow the use of medication-assisted treatment when deemed medically appropriate for a participant. All Washington state therapeutic courts must implement the national association of drug court professionals best practice standards to the extent that their jurisdiction has access to the necessary treatment and recovery support resources to enable implementation. If appropriate treatment and recovery support resources are not available, courts must contact the authority's designee for assistance with acquiring the resource. Each court must have all ten best practice standards implemented in their court by June 30, 2020. The authority must submit a report by December 1, 2020, to the legislature on the progress of the best practice implementation throughout all of the therapeutic courts in the state.

(10) Counties must meet the criteria established in RCW 2.30.030(3).

Sec. 27. RCW 2.30.030 and 2018 c 201 s 9002 are each amended to read as follows:

(1) Every trial and juvenile court in the state of Washington is authorized and encouraged to establish and operate therapeutic courts. Therapeutic courts, in conjunction with the government authority and subject matter experts specific to the focus of the therapeutic court, develop and process cases in ways that depart from traditional judicial processes to allow defendants or respondents the opportunity to obtain treatment services to address particular issues that may have contributed to the conduct that led to their arrest or involvement in the child welfare system in exchange for resolution of the case or charges. In criminal cases, the consent of the prosecutor is required.

(2) While a therapeutic court judge retains the discretion to decline to accept a case into the therapeutic court, and while a therapeutic court retains discretion to establish processes and determine eligibility for admission to the therapeutic court process unique to their community and jurisdiction, the effectiveness and credibility of any therapeutic court will be enhanced when the court implements evidence-based practices, research-based practices, emerging best practices, or promising practices that have been identified and accepted at the state and national levels. Promising

practices, emerging best practices, and/or research-based programs are authorized where determined by the court to be appropriate. As practices evolve, the trial court shall regularly assess the effectiveness of its program and the methods by which it implements and adopts new best practices.

(3) Except under special findings by the court, the following individuals are not eligible for participation in therapeutic courts:

(a) Individuals who are currently charged or who have been previously convicted of a serious violent offense or sex offense as defined in RCW 9.94A.030;

(b) Individuals who are currently charged with an offense alleging intentional discharge, threat to discharge, or attempt to discharge a firearm in furtherance of the offense;

(c) Individuals who are currently charged with or who have been previously convicted of vehicular homicide or an equivalent out-of-state offense; or

(d) Individuals who are currently charged with or who have been previously convicted of: An offense alleging substantial bodily harm or great bodily harm as defined in RCW 9A.04.110, or death of another person.

(4) Consistent with RCW 71.24.580(9), any jurisdiction ((~~establishing~~)) that has established or is establishing a therapeutic court ((~~shall endeavor to~~)) must incorporate the ((~~therapeutic court principles of best practices as~~)) national association of drug court professionals best practice standards to the extent that the jurisdiction has access to the necessary treatment and recovery support resources to enable implementation. If appropriate treatment and recovery support resources are not available, courts must contact a health care authority's designee for assistance with acquiring the resource. The national association of drug court professionals best practice standards are recognized by state and national therapeutic court organizations in structuring a particular program, which may include:

(a) Determining the population;

(b) Performing a clinical assessment;

(c) Developing the treatment plan;

(d) Monitoring the participant, including any appropriate testing;

(e) Forging agency, organization, and community partnerships;

(f) Taking a judicial leadership role;

(g) Developing case management strategies;

(h) Addressing transportation, housing, and subsistence issues;

(i) Evaluating the program;

(j) Ensuring a sustainable program.

(5) Upon a showing of indigence under RCW 10.101.010, fees may be reduced or waived.

(6) The health care authority shall furnish services to therapeutic courts addressing dependency matters where substance abuse or mental health are an issue unless the court contracts with providers outside of the health care authority.

(7) Any jurisdiction that has established more than one therapeutic court under this chapter may combine the functions of these courts into a single therapeutic court.

(8) Nothing in this section prohibits a district or municipal court from ordering treatment or other conditions of sentence or probation following a conviction, without the consent of either the prosecutor or defendant.

(9) No therapeutic or specialty court may be established specifically for the purpose of applying foreign law, including foreign criminal, civil, or religious law, that is otherwise not required by treaty.

(10) No therapeutic or specialty court established by court rule shall enforce a foreign law, if doing so would violate a right guaranteed by the Constitution of this state or of the United States.

Sec. 28. RCW 71.24.585 and 2017 c 297 s 12 are each amended to read as follows:

((~~The state of Washington declares that there is no fundamental right to medication-assisted treatment for opioid use disorder.~~)) (1)(a) The state of Washington ((~~further~~)) declares that ((~~while medications used in the treatment of opioid use disorder are addictive substances, that they nevertheless have several legal, important, and justified uses and that one of their appropriate and legal uses is, in conjunction with other required therapeutic procedures, in the treatment of persons with opioid use disorder. The state of Washington recognizes as evidence-based for the management of opioid use disorder the medications approved by the federal food and drug administration for the treatment of opioid use disorder. Medication-assisted treatment should only be used for participants who are deemed appropriate to need this level of intervention.~~

~~Providers must inform patients of all treatment options available. The provider and the patient shall consider alternative treatment options, like abstinence, when developing the treatment plan. If medications are prescribed, follow up must be included in the treatment plan in order to work towards the goal of abstinence.~~)) substance use disorders are medical conditions. Substance use disorders should be treated in a manner similar to other medical conditions by using interventions that are supported by evidence. There is a large body of evidence that medications approved by the federal food and drug administration for the treatment of opioid use disorder are highly effective for reducing deaths from opioid overdose and increasing medical outcomes in treatment. It is also recognized that many individuals have multiple substance use disorders, co-occurring behavioral health conditions, or histories of trauma. As such, all individuals experiencing opioid use disorder should be assessed for co-occurring disorders and history of trauma, and offered evidence-supported treatments to include behavioral counseling and social supports to address them. For behavioral health agencies, an effective plan of treatment for most persons with opioid use disorder integrates access to medications and psychosocial counseling and should be consistent with the American society of addiction medicine patient placement criteria. Through a strong collaborative care approach, involving the team of providers, the person with opioid use disorder must be provided with a well-coordinated plan of interventions based on evidence while preserving the patient voice in treatment. Providers must inform patients of all evidence-based treatment options available. Because some such medications are controlled substances in chapter 69.50 RCW, the state of Washington maintains the legal obligation and right to regulate the ((~~clinical~~)) uses of these medications in the treatment of opioid use disorder.

((~~Further,~~)) (b) Given the state of Washington recognizes substance use disorders as chronic medical conditions, the authority must work with other state agencies and stakeholders to develop value-based payment strategies to better support the ongoing care of persons with opioid and other substance use disorders.

(2) The authority must promote the use of medication therapies and other evidence-based strategies to address the opioid epidemic in Washington state. Additionally, by January 1, 2020, the authority must prioritize state resources for the provision of treatment and

recovery support services to inpatient and outpatient treatment settings that allow patients to start or maintain their use of medications for opioid use disorder while engaging in services.

(3) The state declares that the main goals of ((~~opiate substitution treatment is total abstinence from substance use for the individuals who participate in the treatment program, but recognizes the additional goals of reduced morbidity, and restoration of the ability to lead a productive and fulfilling life. The state recognizes that a small percentage of persons who participate in opioid treatment programs require treatment for an extended period of time. Opioid treatment programs shall provide a comprehensive transition program to eliminate substance use, including opioid use of program participants~~)) treatment for persons with opioid use disorder are the cessation of unprescribed opioid use, reduced morbidity, and restoration of the ability to lead a productive and fulfilling life.

(4) To achieve the goals in subsection (3) of this section, to promote public health and safety, and to promote the efficient and economic use of funding for the medicaid program under Title XIX of the social security act, the authority may seek, receive, and expend alternative sources of funding to support all aspects of the state's response to the opioid crisis.

(5) The authority must partner with the department of social and health services, the department of corrections, the department of health, the department of children, youth, and families, and any other agencies or entities the authority deems appropriate to develop a statewide approach to leveraging medicaid funding to treat opioid use disorder and provide emergency overdose treatment. Such alternative sources of funding may include, but are not limited to:

(a) Seeking a section 1115 demonstration waiver from the federal centers for medicare and medicaid services to fund opioid treatment medications for persons eligible for medicaid at or during the time of incarceration and juvenile detention facilities. The authority's application for any such waiver must comply with all applicable federal requirements for obtaining such waiver; and

(b) Soliciting and receiving private funds, grants, and donations from any willing person or entity.

(6)(a) The authority shall replicate effective approaches such as opioid hub and spoke treatment networks to broaden outreach and patient navigation with allied opioid use disorder community

partners, including but not limited to: Federally accredited opioid treatment programs, substance use disorder treatment facilities, jails, syringe exchange programs, community mental health centers, and primary care clinics.

(b) To carry out this subsection (6), the authority shall work with the department of health to promote coordination between medication-assisted treatment prescribers, federally accredited opioid treatment programs, substance use disorder treatment facilities, and state-certified substance use disorder treatment agencies to:

(i) Increase patient choice in receiving medication and counseling;

(ii) Strengthen relationships between opioid use disorder providers;

(iii) Acknowledge and address the challenges presented for individuals needing treatment for multiple substance use disorders simultaneously; and

(iv) Study and review effective methods to identify and reach out to individuals with opioid use disorder who are at high risk of overdose and not involved in traditional systems of care, such as homeless individuals using syringe service programs, and connect such individuals to appropriate treatment.

(c) Given the unique role opioid treatment programs serve in the continuum of care for persons with opioid use disorders, the authority must work with stakeholders to develop a set of recommendations to the governor and the legislature that:

(i) Propose, in addition to those required by federal law, a standard set of services needed to support the complex treatment needs of persons with opioid use disorder treated in opioid treatment programs;

(ii) Outline the components of and strategies needed to develop opioid treatment program centers of excellence that provide fully integrated care for persons with opioid use disorder; and

(iii) Estimate the costs needed to support these models and recommendations for funding strategies that must be included in the report.

(7) State agencies shall review and promote positive outcomes associated with the accountable communities of health funded opioid projects and local law enforcement and human services opioid

collaborations as set forth in the Washington state interagency opioid working plan.

(8) The authority must partner with the department and other state agencies to replicate effective approaches for linking individuals who have had a nonfatal overdose with treatment opportunities, with a goal to connect certified peer counselors with individuals who have had a nonfatal overdose.

(9) To achieve the goals of subsection (3) of this section, state agencies must work together to increase outreach and education about opioid overdoses to non-English-speaking communities by developing a plan to conduct outreach and education to non-English-speaking communities. The department must submit a report on the outreach and education plan with recommendations for implementation to the appropriate legislative committees by July 1, 2020.

NEW SECTION. **Sec. 29.** A new section is added to chapter 71.24 RCW to read as follows:

(1) Subject to funds appropriated by the legislature, the authority shall implement a pilot project for law enforcement assisted diversion which shall adhere to law enforcement assisted diversion core principles recognized by the law enforcement assisted diversion national support bureau, the efficacy of which have been demonstrated in peer-reviewed research studies.

(2) Under the pilot project, the authority must partner with the law enforcement assisted diversion national support bureau to award a contract, subject to appropriation, for two or more geographic areas in the state of Washington for law enforcement assisted diversion. Cities, counties, and tribes may compete for participation in a pilot project.

(3) The pilot projects must provide for comprehensive technical assistance from law enforcement assisted diversion implementation experts to develop and implement a law enforcement assisted diversion program in the pilot project's geographic areas in a way that ensures fidelity to the research-based law enforcement assisted diversion model.

(4) The key elements of a law enforcement assisted diversion pilot project must include:

(a) Long-term case management for individuals with substance use disorders;

(b) Facilitation and coordination with community resources focusing on overdose prevention;

(c) Facilitation and coordination with community resources focused on the prevention of infectious disease transmission;

(d) Facilitation and coordination with community resources providing physical and behavioral health services;

(e) Facilitation and coordination with community resources providing medications for the treatment of substance use disorders;

(f) Facilitation and coordination with community resources focusing on housing, employment, and public assistance;

(g) Twenty-four hours per day and seven days per week response to law enforcement for arrest diversions; and

(h) Prosecutorial support for diversion services.

Sec. 30. RCW 71.24.590 and 2018 c 201 s 4045 are each amended to read as follows:

(1) When making a decision on an application for licensing or certification of a program, the department shall:

(a) Consult with the county legislative authorities in the area in which an applicant proposes to locate a program and the city legislative authority in any city in which an applicant proposes to locate a program;

(b) License or certify only programs that will be sited in accordance with the appropriate county or city land use ordinances. Counties and cities may require conditional use permits with reasonable conditions for the siting of programs. Pursuant to RCW 36.70A.200, no local comprehensive plan or development regulation may preclude the siting of essential public facilities;

(c) Not discriminate in its licensing or certification decision on the basis of the corporate structure of the applicant;

(d) Consider the size of the population in need of treatment in the area in which the program would be located and license or certify only applicants whose programs meet the necessary treatment needs of that population;

(e) Consider the availability of other certified opioid treatment programs near the area in which the applicant proposes to locate the program;

(f) Consider the transportation systems that would provide service to the program and whether the systems will provide

reasonable opportunities to access the program for persons in need of treatment;

(g) Consider whether the applicant has, or has demonstrated in the past, the capability to provide the appropriate services to assist the persons who utilize the program in meeting goals established by the legislature in RCW 71.24.585. The department shall prioritize licensing or certification to applicants who have demonstrated such capability and are able to measure their success in meeting such outcomes;

(h) Hold one public hearing in the community in which the facility is proposed to be located. The hearing shall be held at a time and location that are most likely to permit the largest number of interested persons to attend and present testimony. The department shall notify all appropriate media outlets of the time, date, and location of the hearing at least three weeks in advance of the hearing.

(2) A county may impose a maximum capacity for a program of not less than three hundred fifty participants if necessary to address specific local conditions cited by the county.

(3) A program applying for licensing or certification from the department and a program applying for a contract from a state agency that has been denied the licensing or certification or contract shall be provided with a written notice specifying the rationale and reasons for the denial.

(4) Opioid treatment programs may order, possess, dispense, and administer medications approved by the United States food and drug administration for the treatment of opioid use disorder, alcohol use disorder, tobacco use disorder, and reversal of opioid overdose. For an opioid treatment program to order, possess, and dispense any other legend drug, including controlled substances, the opioid treatment program must obtain additional licensure as required by the department, except for patient-owned medications.

(5) Opioid treatment programs may accept, possess, and administer patient-owned medications.

(6) Registered nurses and licensed practical nurses may dispense up to a thirty-one day supply of medications approved by the United States food and drug administration for the treatment of opioid use disorder to patients of the opioid treatment program, under an order or prescription and in compliance with 42 C.F.R. Sec. 8.12.

(7) For the purpose of this chapter, "opioid treatment program" means a program that:

(a) ((~~Dispensing a~~)) Engages in the treatment of opioid use disorder with medications approved by the ((~~federal~~)) United States food and drug administration for the treatment of opioid use disorder and ((~~dispensing medication for the~~)) reversal of opioid overdose; and

(b) ((~~Providing~~)) Provides a comprehensive range of medical and rehabilitative services.

Sec. 31. RCW 71.24.595 and 2018 c 201 s 4046 are each amended to read as follows:

(1) To achieve more medication options, the authority must work with the department and the authority's medicaid managed care organizations, to eliminate barriers and promote access to effective medications known to address opioid use disorders at state-certified opioid treatment programs. Medications include, but are not limited to: Methadone, buprenorphine, and naltrexone. The authority must encourage the distribution of naloxone to patients who are at risk of an opioid overdose.

(2) The department, in consultation with opioid treatment program service providers and counties and cities, shall establish statewide treatment standards for licensed or certified opioid treatment programs. The department shall enforce these treatment standards. The treatment standards shall include, but not be limited to, reasonable provisions for all appropriate and necessary medical procedures, counseling requirements, urinalysis, and other suitable tests as needed to ensure compliance with this chapter.

((~~(2)~~)) (3) The department, in consultation with opioid treatment programs and counties, shall establish statewide operating standards for certified opioid treatment programs. The department shall enforce these operating standards. The operating standards shall include, but not be limited to, reasonable provisions necessary to enable the department and counties to monitor certified or licensed opioid treatment programs for compliance with this chapter and the treatment standards authorized by this chapter and to minimize the impact of the opioid treatment programs upon the business and residential neighborhoods in which the program is located.

((~~(3)~~)) (4) The department shall analyze and evaluate the data submitted by each treatment program and take corrective action where

necessary to ensure compliance with the goals and standards enumerated under this chapter. Opioid treatment programs are subject to the oversight required for other substance use disorder treatment programs, as described in this chapter.

NEW SECTION. **Sec. 32.** A new section is added to chapter 71.24 RCW to read as follows:

By October 1, 2019, the authority must work with the department, the accountable communities of health, and community stakeholders to develop a plan for the coordinated purchasing and distribution of opioid overdose reversal medication across the state of Washington. The plan must be developed in consultation with the University of Washington's alcohol and drug abuse institute and community agencies participating in the federal demonstration grant titled Washington state project to prevent prescription drug or opioid overdose.

NEW SECTION. **Sec. 33.** A new section is added to chapter 71.24 RCW to read as follows:

(1) The department, in coordination with the authority, must develop 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 by the local emergency management system, hospital emergency department, local health jurisdiction, law enforcement agency, or surveillance data. The response team must provide technical assistance and other support to the local health jurisdiction, health care clinics, hospital emergency departments, substance use disorder treatment providers, and other community-based organizations, and are expected to increase the local capacity to provide medication-assisted treatment and overdose education.

(2) The department and the authority must reduce barriers and promote medication treatment therapies for opioid use disorder in emergency departments and same-day referrals to opioid treatment programs, substance use disorder treatment facilities, and community-based medication treatment prescribers for individuals experiencing an overdose.

NEW SECTION. **Sec. 34.** A new section is added to chapter 71.24 RCW to read as follows:

(1) By January 1, 2021, city and county jails in Washington must adopt requirements for addressing the behavioral health needs of

incarcerated individuals with an opioid use disorder, in accordance with chapter 70.48 RCW. These requirements must be adopted, as failure to treat opioid use disorder during incarceration has serious consequences, including an extremely high risk of overdose death after release, and high rates of crime and recidivism correlated with untreated opioid use disorder during incarceration. City and county jail requirements must include developing policies and practices that:

(a) Provide medication for the treatment of opioid use disorder to individuals in the custody of the facility, in any status, who were receiving medication for the treatment of opioid use disorder through a legally authorized medical program or by a valid prescription immediately before incarceration;

(b) Provide medication for the treatment of opioid use disorder to incarcerated individuals not less than thirty days before release when treatment is determined to be medically appropriate by a health care practitioner; and

(c) Make every possible effort to directly connect incarcerated individuals receiving medication for the treatment of opioid use disorder to an appropriate provider or treatment site in the geographic region in which the individual will reside before release. If a connection is not possible, the facility must document its efforts in the individual's record.

(2) Washington state recognizes that there are multiple initiatives in place for funding treatment under this section through multiple sources including medicaid funding and waivers, criminal justice treatment account funding, and decision packages. Jurisdictions are encouraged to look towards alternative funding streams to help bridge gaps in resources, while specifically working with local county and city governments to best coordinate already established funding sources for incarcerated individuals.

NEW SECTION. **Sec. 35.** A new section is added to chapter 74.09 RCW to read as follows:

(1) In order to support prevention of potential opioid use disorders, the authority must develop and recommend for coverage nonpharmacologic treatments for acute, subacute, and chronic noncancer pain and must report to the governor and the appropriate committees of the legislature, including any requests for funding

necessary to implement the recommendations under this section. The recommendations must contain the following elements:

(a) A list of which nonpharmacologic treatments will be covered;

(b) Recommendations as to the duration, amount, and type of treatment eligible for coverage;

(c) Guidance on the type of providers eligible to provide these treatments; and

(d) Recommendations regarding the need to add any provider types to the list of currently eligible medicaid provider types.

(2) The authority must ensure only treatments that are evidence-based for the treatment of the specific acute, subacute, and chronic pain conditions will be eligible for coverage recommendations.

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