Prescribing for Pain: New Guidelines

Donna Poole, MSN, ARNP, PMHCNS-BC

Objectives for Learning Outcomes:

Following my presentation, participants will be able to :

1. Explain the rationale behind Washington State's creation and updating of rules related to the prescribing of opioids.

2. Prepare for changes to practice that will be required with the implementation of opioid prescribing requirements.

3. Identify available resources to aid the practitioner in implementing opioid prescribing requirements.

If handouts are not included in the session, they were not provided by the presenter.
The presenter may choose to provide handouts at the time of the presentation.

Washington State Department of Health

2018 Washington State Opioid Prescribing Requirements

for Advanced Registered Nurse Practitioners

Prescription Monitoring Program (PMP)

- ARNPs who prescribe opioids in Washington State are required to register with the PMP
- The ARNP is permitted to delegate performance of a required PMP query to an authorized healthcare designee
- PMP query must be completed at:
  - First opioid prescription
  - First opioid prescription refill or renewal
  - At each pain transition treatment phase (acute to subacute and subacute to chronic)
  - Periodic intervals for patient with chronic non-cancer pain

Opioid Prescription Schedule

Acute Pain 0 - 6 weeks	Subacute Pain 6 - 12 weeks	Chronic Pain 12+ weeks
Prior to prescribing opioids for non-operative and perioperative acute pain:	**Prior to prescribing opioids:**	**When treating chronic pain patients with opioids:**
Conduct and document a patient evaluation	Conduct and document a patient evaluation and PMP query	Conduct and document a patient evaluation and PMP query
Query the Prescription Monitoring Program (PMP) and document concerns	Consider risks and benefits for continued opioid use. Document a patient treatment plan	Complete a patient treatment plan with objectives
Document a patient treatment plan	Consider tapering, discontinuing, or transitioning patient to chronic pain treatment	Complete a written agreement for treatment
Provide patient notification on opioid risks, safe storage, and disposal	Document transition to chronic pain if planning to treat patient with opioids beyond 12 weeks in duration	Periodically review the treatment plan and query the PMP quarterly for high-risk, semiannually for moderate-risk, and annually for low-risk patients

Include the diagnosis or International Classification of Disease (ICD) code on all opioid prescriptions.

Exclusions

Rules do not apply to:

- Patients with cancer-related pain
- Palliative, hospice, or other end-of-life care
- Inpatient hospital patients
- Procedural pre-medications

Co-Prescribing

Opioids shall not be prescribed with the following medications without documentation in patient record, discussion of risks, and consultation with prescribers of other medications for patient care plan or consideration of tapering:

- Benzodiazepines
- Barbiturates
- Sedatives
- Carisoprodol
- Non-benzodiazepine hypnotics (Z drugs)

When co-prescribing opioids to a patient receiving medication assisted treatment (MAT):

- Consult the MAT prescriber or a pain specialist
- Do not discontinue MAT without documentation
- Do not deny necessary operative treatment due to MAT

Confirm or prescribe naloxone when:

- Opioids prescription is 50 MED or above
- Opioids prescribed to a high-risk patient
- As clinically indicated

Alternative Modalities

ARNPs are encouraged to consider treating pain with:

- Acetaminophen
- Acupuncture
- Chiropractic medicine
- Cognitive behavior therapy
- Nonsteroidal anti-inflammatory drugs
- Osteopathic manipulative treatment
- Physical therapy
- Massage therapy
- Sleep hygiene

Special Populations

Patients 25 Years and Under

Treat pain consistent with adults, but account for weight and adjust accordingly

Pregnant Patients

Weigh carefully the risks and benefits of opioid detoxification during pregnancy. Do not discontinue MAT without oversight by the MAT prescribing practitioner.

Patients 65 Years and Older

Consider change in tolerance, metabolism, and distinctive needs that occur with age

Consultation Requirements

- Consultation with a Pain Management Specialist is mandatory when prescribing over 120 MED.
- For information on consultation exemptions, please review WAC 246-840-487 and WAC 246-840-490 online at the Washington Administrative Code website.

Patient Notification

- ARNPs must provide patient education on the risks, safe and secure storage, and proper disposal of opioids upon the initiation of treatment which is acute, and if it becomes subacute or chronic
- Patient notification handouts are available for download on the DOH website.

Continuing Education Requirement

- All ARNPs who prescribe opioids in Washington State must complete a one-time four hour continuing education on best practices in the prescribing of opioids.
- Continuing education hours count towards license renewal requirement and must be completed no later than the first full license renewal period beginning January 1, 2019.

360-236-4703 | nursing@doh.wa.gov
www.doh.wa.gov/Nursing

Resources

- 2018 Opioid Prescribing Rules
  www.doh.wa.gov/opioidprescribing.
- Department of Health resources on opioid prescribing best practices, treatment and support, data, and other related resources:
  www.doh.wa.gov/opioids
- To register with the Washington State Prescription Monitoring Program
  www.wapmp.org
- Opioid prescribing best practices
  www.cdc.gov
  www.agencymeddirectors.wa.gov

DOH 631-074 October 2018

JAY INSLEE
Governor

STATE OF WASHINGTON
OFFICE OF THE GOVERNOR
P.O. Box 40002 • Olympia, Washington 98504-0002 • (360) 902-4111 • www.governor.wa.gov

EXECUTIVE ORDER 16-09

Addressing the Opioid Use Public Health Crisis

WHEREAS, in 2015, each day an average of two Washingtonians died from opioid overdose, and heroin overdose deaths have more than doubled between 2010 and 2015;

WHEREAS, the opioid epidemic continues to affect communities, devastate families, and overwhelm law enforcement, health care, and social service providers;

WHEREAS, medically prescribed opioids intended to treat chronic pain have contributed to the epidemic, and though a first-in-the-nation set of Washington state guidelines for use of opioids to treat chronic pain has helped reduce the amount of opioids prescribed, more must be done to effectively implement these guidelines and offer effective treatment options for patients with chronic pain;

WHEREAS, opioid use disorder is a devastating and life-threatening chronic medical condition, and we need to improve access to treatments that support recovery and lifesaving medications to reverse overdoses;

WHEREAS, as individuals, communities, and governments, we must assist people struggling with opioid use disorder and reduce its associated stigma, using evidence-based interventions like our innovative syringe exchange program;

WHEREAS, we have developed a Statewide Opioid Response Plan that is highly consistent with the recent Center for Disease Control (CDC) Guidelines for Prescribing Opioids for Chronic Pain, the Surgeon General's call to end the opioid crisis, and a compact relating to opioid use that governors around the nation have signed; and

WHEREAS, it is imperative that we act in a comprehensive manner to address this public health crisis.

NOW THEREFORE, I, Jay Inslee, Governor of the state of Washington, direct that state agencies under my authority work with local public health, Tribal governments, and other partners across the state, to implement the state opioid response plan with an immediate focus on the following highest priority actions. These agencies must submit a progress report by December 31, 2016, in advance of next legislative session. The Office of Financial Management, which is leading and coordinating comprehensive behavioral health planning, shall evaluate, in the course of its work, the potential budget-related matters raised in this order.

Goal 1: Prevent inappropriate opioid prescribing and reduce opioid misuse and abuse.

1. The state Agency Medical Directors Group (AMDG) shall work with the Bree Collaborative (a health care improvement partnership), Tribal governments, boards and

commissions, professional associations, health care systems, insurers, teaching institutions, and others to consider amendments to the state pain guidelines and other training and policy materials, consistent with the 2015 AMDG and the 2016 CDC opioid guidelines, to reduce unnecessary prescribing for acute pain conditions for the general population, especially adolescents.

2. The Department of Health (DOH) and Department of Social and Health Services (DSHS), in partnership with my office and other agencies, including the Office of the Superintendent of Public Instruction, schools, and public and private partners, shall develop a communications strategy geared toward preventing opioid misuse in communities, particularly among youth, to raise awareness about the risks of opioid use and focus on reducing the stigma of opioid use disorder. This communication strategy shall promote safe home storage and appropriate prescription pain medication disposal to prevent misuse. Agencies shall also work with partners to consider and present options on how to best prevent misuse, including potential solutions like drug take-back programs.

3. The Health Care Authority (HCA) and Department of Labor and Industries (LNI), in collaboration with the Bree Collaborative, shall explore innovative methods and tools to deliver evidence-based alternatives and other promising practices, such as physical, occupational and cognitive behavioral therapy, to reduce overreliance on opioids while improving access to care and health outcomes with regard to the treatment of pain. HCA shall work with the University of Washington (UW) and other providers to utilize and make tele-mentoring prescriber education programs, such as UW TelePain, a fiscally sustainable telehealth service. These agencies will also establish support programs for providers, like an opioid prescribing consultation hotline.

4. To reduce the supply of illegal opioids, I have requested, and the Attorney General has agreed to partner with the Washington State Patrol and Washington Association of Prosecuting Attorneys, to convene local, state, and federal law enforcement agencies and community partners to develop and recommend strategies.

Goal 2: Treat individuals with opioid use disorder and link them to support services, including housing.

1. My office and HCA will work with health plans to support and implement behavioral health integration strategies in primary care, to include effective screening for opioid use disorder and increased management of medication-assisted and other needed treatments, like recovery support services. These strategies shall be implemented in a culturally appropriate and accessible manner, especially among historically marginalized communities such as American Indian and Alaska Native populations.

2. State agencies shall work with partner agencies and the health care community to expand availability of evidence-based medication-assisted treatment to:

    a. Identify policy gaps and barriers, in communities and the criminal justice system, that limit availability and utilization of medication-assisted treatment, including naloxone for overdose reversal.

b. Consider the spoke and hub, nurse care manager, and similar center of excellence models that closely align with Behavioral Health Organizations and Accountable Communities of Health systems so that regional differences can be addressed and treatments may be delivered on a regional and population basis.
c. Ensure availability of rapid, low-barrier access to treatment medications for people with opioid use disorder, especially pregnant women, intravenous drug users, and those who are homeless.
d. Work with the UW Alcohol and Drug Abuse Institute (UW/ADAI) to pilot and evaluate low barrier models that provide rapid access to and stabilization on buprenorphine.
e. Explore new and existing funding sources to increase capacity in syringe service and other evidence-based programs.

3. The Department of Corrections, in collaboration with DSHS and HCA, shall improve processes to identify offenders with opioid use disorder and develop evidence-based interventions to ensure offenders will receive timely and effective treatment in the community upon release, concentrating immediately in regions that have achieved behavioral health and physical health integration.

4. At my request, the Insurance Commissioner has agreed to work with state health care purchasing agencies, private insurers, and providers, to determine if access issues exist and explore and recommend solutions on how insurance payment mechanisms, formularies, and other administrative processes can ensure appropriate availability of medication-assisted services and evidence-based services for treatment of pain and overdoses. State health care purchasers shall assess whether current payment and coverage decisions support these treatments consistent with evidence-based practices and implement, as soon as feasible, value-based purchasing methods to improve results.

Goal 3: Intervene in opioid overdoses to prevent death.

1. DSHS and DOH will work with the UW/ADAI and other partners, including local public health officials, to educate heroin and/or prescription opioid users and those who may witness an overdose, on how to recognize and respond to an overdose. State and local data systems will be enhanced to document opioid overdose occurrence and response.

2. State agency health care purchasers shall ensure that covered individuals with opioid use disorder receive overdose education and access to naloxone.

3. Agency Medical Directors shall work with partners, including the CDC, to consider a centralized naloxone procurement process in order to reduce the cost of naloxone and increase its availability for first responders and families and friends of heroin users. Agency Medical Directors shall report recommended solutions when practicable.

Goal 4: Use data and information to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions.

1. DOH, the Agency Medical Directors Group, the Bree Collaborative, and UW shall collaborate with providers and other partners to develop statewide measures to monitor

prescribing practices and access to high quality and necessary pain care, focusing on metrics with a statewide and regional view. Using these measures, DOH will identify regional variations in prescribing practices and encourage health systems and insurers to use these measures to identify and intervene with health care providers who engage in unsafe prescribing practices.

2. State agency health care purchasers, with assistance from DOH, shall identify persons at high risk for prescription opioid overdose and intervene when appropriate with outreach efforts to provide necessary medical care, including treatment of pain and/or opioid use disorder.

3. DOH shall collaborate with partners to explore policies and processes to enhance functionality and increase the use of the Prescription Drug Monitoring Program among health care providers.

4. DOH will work with HCA and LNI to explore methods to notify health care providers of opioid overdose events. These methods should include how the Emergency Department Information Exchange electronic health information system used by hospitals might use prescription drug monitoring program data to identify health care providers who recently prescribed opioids to an overdose victim and notify them of that overdose event.

This Executive Order shall take effect immediately.

Signed and sealed with the official seal of the state of Washington, on this 7th day of October 2016, at Olympia, Washington.

By:

/s/
Jay Inslee
Governor

BY THE GOVERNOR:

/s/
Secretary of State

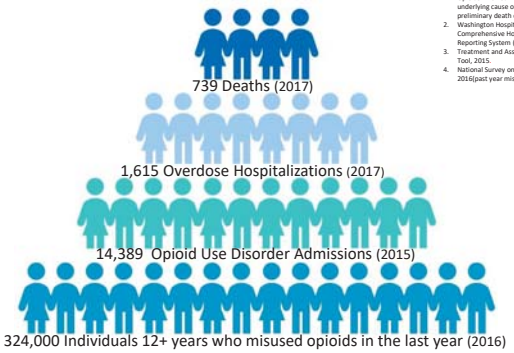
OVERVIEW AND IMPLEMENTATION OPIOID PRESCRIBING REQUIREMENTS FOR ADVANCED REGISTERED NURSE PRACTITIONERS

Nursing Care Quality Assurance Commission

Overview: Opioid Crisis in Washington State

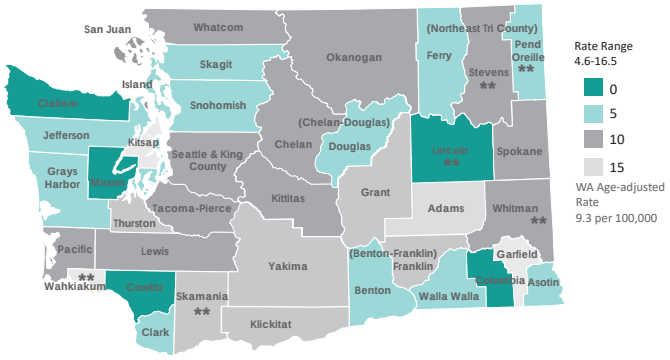
- On average, two Washingtonians die everyday due to an opioid-related overdose.
- Thousands of individuals in the state struggle with opioid use disorder.
- Public health crisis in Washington state and around the United States leading to:
  - Serious medical problems
  - Social problems
  - Financial problems

Washington State Opioid Related Disease Burden



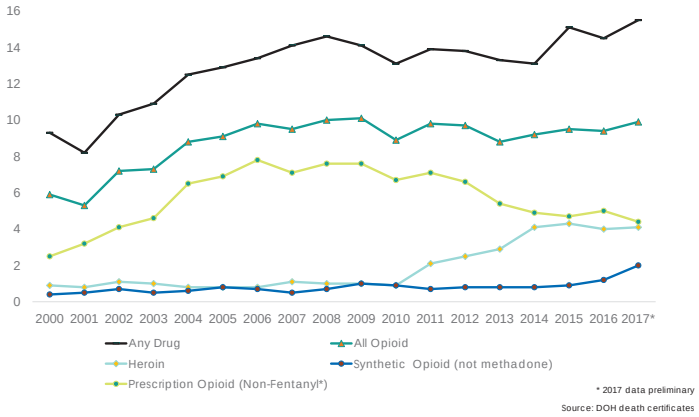
1. Opioids involved in an overdose death listed as underlying cause of death. Washington preliminary death certificate data, 2017.
2. Washington Hospital Discharge Data, Comprehensive Hospitalization Abstract Reporting System (CHARS), 2017.
3. Treatment and Assessment Report Generation Tool, 2015.
4. National Survey on Drug Use and Health, 2015-2016(past year misuse of pain relievers).

Opioid Overdose Death Rates* County of Residence, 2012-2016



Opioid Related Overdose Death Rates

Washington State 2000-2017*

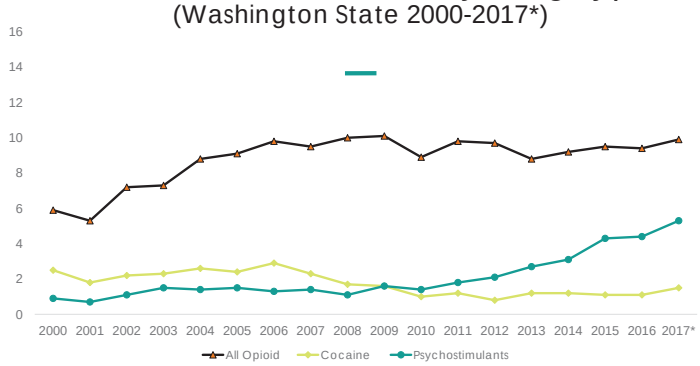


* 2017 data preliminary

Source: DOH death certificates

Overdose Death Rate by Drug Type

(Washington State 2000-2017*)



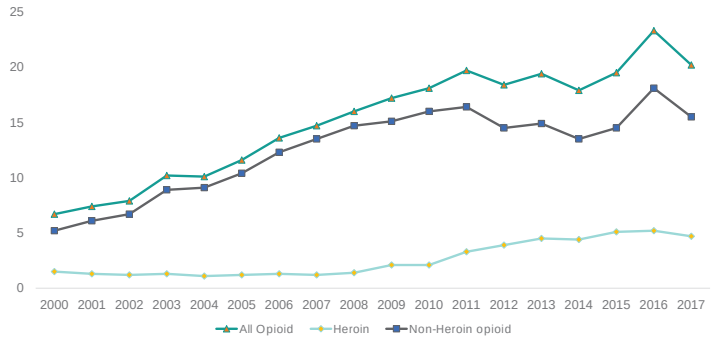
* 2017 data preliminary

Source: DOH death certificates

Data run: 26July2018

Overdose Hospitalization Rate by Drug Type

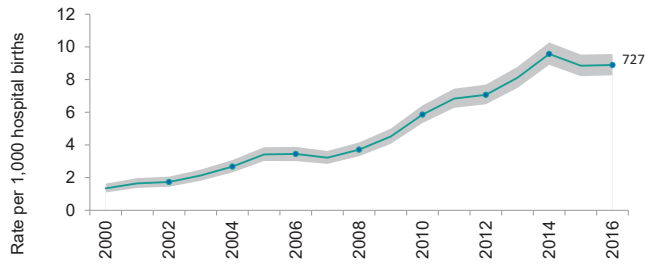
(Washington State 2000-2017)



Source: DOH Comprehensive Hospital Abstract Reporting System (CHARS)

Data run: 26July2018

Neonatal Abstince Syndrome (NAS) Hospital Discharge Data, WA, 2000-2016



Definition: 2000-Q32015 ICD9CM diagnosis code 779.5; Q42015-2016 ICD10CM diagnosis code P96.1

Source: DOH Comprehensive Hospital Abstract Reporting System (CHARS)

Data run: 26July2018

Governor Inslee's Executive Order 16-09

- Preventing deaths from overdose
- Treating opioid use disorder
- Preventing opioid misuse & abuse
- Using data to monitor and evaluate

State Response to Opioid Crisis

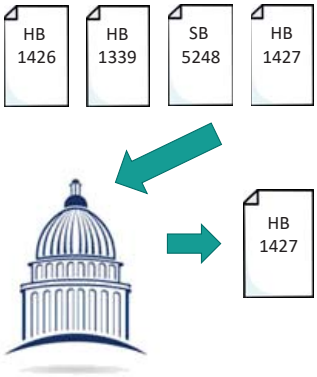
Priority Goals

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

Priority Actions

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

Legislative Process



ESHB 1427 Key components:

- Expands B/C prescribing rules--
  - Acute, subacute, peri-operative pain
  - Update chronic pain rules
- Authorizes Health Officer and other gov't access to PMP data.
- Authorizes facility/group access to PMP data.
- Authorizes hospital CQIPs to use PMP data.
- Authorizes prescriber feedback reports.

History of Rules and Legislation

2011 Chronic Pain Rules

- ESHB 2876 passed legislation in 2010, directing the five prescribing boards and commissions in the state to adopt chronic non-cancer pain rules.
- Specifically excluded acute and palliative care.
- Rules adopted June 30, 2011.

2018 Opioid Prescribing Rules

- ESHB 1427 passed legislation in 2017, directed the same five boards and commissions to adopt opioid prescribing requirements.
- Must consider AMDG and CDC guidelines.
- Rules must be adopted by January 1, 2019, but early adoption requested by the Governor for late fall of 2018.

Rulemaking and Implementation of 1427

Joint Task Force

- Between Sept 2017 and Mar 2018, seven task force meetings were convened to develop draft rule language.
- Included two members of each board and commission.
- Interested stakeholders in attendance to provide testimony and input.

Draft Approval

- Draft language personalized to fit the needs of individual boards and commissions.
- Draft language approved by each individual board and commission.

Rule Adoption

- Nursing Commission adopted ARNP Opioid Prescribing Rules at August 10, 2018 hearing.
- Effective date for ARNP Opioid Prescribing Rules: Nov 1, 2018

New Opioid Prescribing Requirements Overview for ARNPs

Education and Outreach Resources

Online Resources and Toolkits: Healthcare Practitioners

- Profession Specific Overview Handouts
- Profession Specific Overview Videos
- Frequently Asked Questions

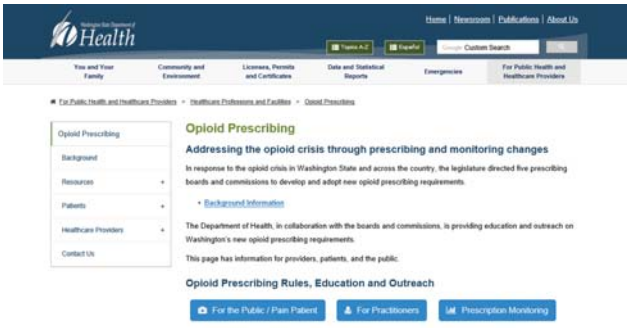
Patient Opioid Education Handouts

- Managing Acute (short-term) Pain
- Managing Surgical Pain
- Managing Chronic (long-term) Pain

www.doh.wa.gov/opioidprescribing

DOH Online Resources

www.doh.wa.gov/opioidprescribing



Rule Exclusions

The Opioid Prescribing Requirements do not apply to:

- Treatment of patients with cancer-related pain
- Provision of palliative, hospice, or other end-of-life care
- Treatment of inpatient hospital patients
- Procedural pre-medications

Continuing Education

ARNPs who prescribe opioids in Washington State must complete mandatory continuing education.

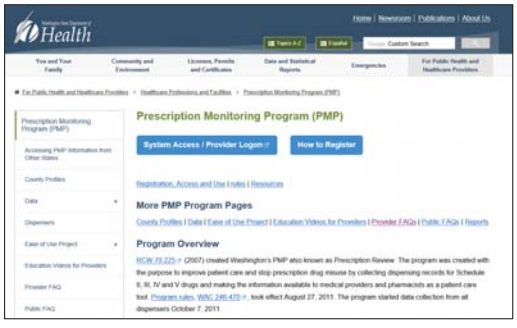
- One-time requirement
- Opioid prescribing best practices
- 4-hours for ARNPs
- Due after first full CE reporting cycle after January 1, 2019

Prescription Monitoring Program (PMP)

- The new opioid prescribing requirements incorporate increased mandatory use of the PMP to improve opioid prescribing best practices.
- Mandatory registration of the PMP to prescribe opioids

PMP Registration

If you are not registered with the PMP, please use www.doh.wa.gov/pmp to register.



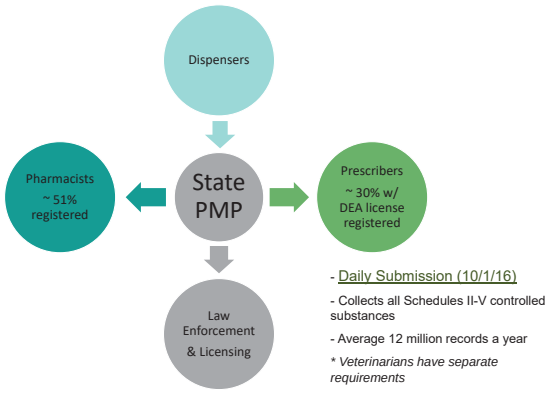
PMP Designee

An authorized healthcare designee is a current healthcare provider licensed with the Washington State Department of Health.

Examples:

- RNs
- LPNs
- Nursing Assistants
- Dental Assistants

PMP Data Collection and Access



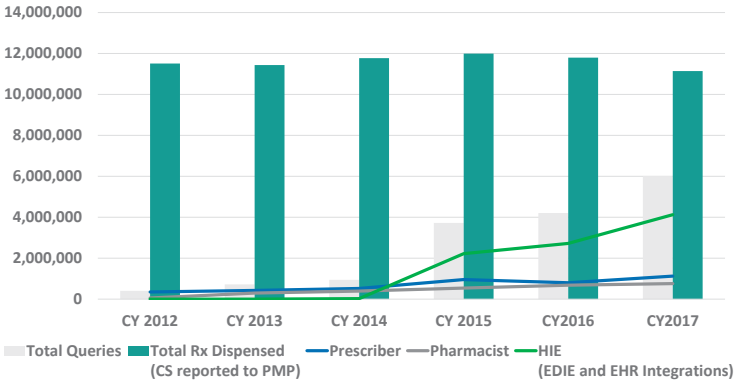
- Daily Submission (10/1/16)
- Collects all Schedules II-V controlled substances
- Average 12 million records a year

** Veterinarians have separate requirements*

PMP Use and Impact

	2012 Rx	2013 Rx	2014 Rx	2015 Rx	2016 Rx	2017 Rx
HYDROCODONE (all)	3,043,357	2,928,052	2,855,227	2,521,688	2,371,802	2,096,731
OXYCODONE (all)	1,816,171	1,827,750	1,889,380	1,952,720	1,937,349	1,819,159
DEXTRO/METH AMPHETAMINE (all)	466,702	323,013	579,927	626,923	701,795	777,311
TRAMADOL (all)	----	----	308,803	730,446	718,261	680,506
ZOLPIDEM TARTRATE	898,620	838,636	790,571	761,159	712,360	649,127
LORAZEPAM	632,757	634,566	643,922	640,505	623,551	589,411
ALPRAZOLAM	644,377	641,634	644,930	625,209	609,594	565,432
CLONAZEPAM	519,642	521,425	527,935	520,615	502,644	468,441
DEX / METHYL PHENIDATE (all)	397,021	410,821	422,664	420,891	443,262	487,343
MORPHINE (all) (not w/ Naltrexone)	327,191	330,399	336,190	362,408	351,167	329,280
Total Rx Dispensed (CS reported to PMP)	**11,509,488**	**11,434,877**	**11,771,216**	**11,992,986**	**11,798,943**	**11,141,708**

PMP Data and Utilization



Patient Notification, Secure Storage, and Disposal

Healthcare practitioners must educate patients on the risks, safe storage, and proper disposal of opioids.

Alternative Treatments for Pain

Healthcare practitioners should consider alternative treatments for pain rather than defaulting to the use of opioids whenever reasonable, evidence-based, clinically appropriate alternatives exist.

Acute Pain Overview (0-6 weeks)

The ANRP must comply with requirements by:

- Conducting and documenting a patient evaluation
- Querying the PMP and documenting concerns
- Documenting a patient treatment plan

Acute Pain Overview

- Provide patient notification on opioid risks, safe storage, and proper disposal.
- Seven-day supply for non-operative acute pain unless clinically documented in patient record.
- Fourteen-day supply for perioperative pain unless clinically documented in patient record.

Subacute Pain (6-12 Weeks)

- Pain lasting six to twelve weeks in duration.
- Fourteen-day opioid supply unless clinically documented in the patient record
- Document transition to chronic pain if planning to treat with opioids beyond twelve weeks

Subacute Pain: Patient Evaluation

The ARNP must comply with requirements by:

- Conducting a patient evaluation and documenting the patient record
- Querying the PMP and documenting concerns
- Educating patients on the risks and benefits for continued opioid use
- Considering tapering, discontinuation, or transitioning to chronic pain treatment

Chronic Pain Overview

The new chronic pain requirements provide minor updates to the 2011 pain management requirements.

Chronic Pain (12+ weeks)

The ARNP must comply with requirements by:

- Conducting and documenting a patient evaluation
- Completing a patient treatment plan
- Counseling the patient concerning the risks and benefits
- Completing a written agreement for treatment (???)
- Periodically reviewing the treatment plan and querying the PMP
  - **High-risk:** At least quarterly
  - **Moderate-risk:** At least semiannually
  - **Low-risk:** At least annually

Change in Treatment Plan

Consider tapering, changing treatment, discontinuing treatment, or referral for substance use disorder when:

- The patient requests
- Deterioration in function or pain
- The patient demonstrates non-compliance with the written agreement
- Other treatment methods are indicated
- Evidence of misuse, abuse, diversion, or substance use disorder
- Severe patient adverse event or **overdose**
- Unauthorized dose escalation by the patient
- Dose escalation with no improvement in pain, function, or quality of life

Co-Prescribing with Certain Medications

Opioids shall not be prescribed with the following medications without:

- Documentation in patient record
- Discussion of risks
- Consultation with prescribers of other medications
- Consideration of tapering

- Benzodiazepines
- Barbiturates
- Sedatives
- Carisoprodol
- Non-benzodiazepine hypnotics (Z drugs)

Co-Prescribing

When co-prescribing opioids to a patient receiving medication-assisted treatment (MAT):

- **Do** consult the MAT prescriber or a pain specialist
- **Do not** discontinue MAT without documentation of rational
- **Do not** deny necessary operative treatment due to MAT

Naloxone

Confirm or prescribe naloxone when:

- Opioids prescribed to a high-risk patient
- As clinically indicated
- Opioid prescription is 50 MED or above

Opioid Prescribing for Special Populations

Patients 25 Years and Under:
Treat pain consistent with adults, but account for weight and adjust accordingly.

Patient 65 Years and Older:
Consider change in tolerance, metabolism, and distinctive needs that occur with age.

Pregnant Patients:
Weigh carefully the risks and benefits of opioid detoxification during pregnancy.
Do not discontinue MAT without oversight by the MAT prescribing practitioner.

Consultation Requirements

Consultation with a pain management specialist continues to be mandatory when prescribing more than 120 MED

The purpose is to ensure patient care, when on higher doses of opioids, is carefully supervised.

Questions?

Prescription Monitoring Program

PMP
Doh.wa.gov/prescriptionmonitoring
360-236-4806
pmp@doh.wa.gov

Department Of Health

Department of Health
Doh.wa.gov/opioidprescribing
Opioidprescribing@doh.wa.gov

@WADeptHealth

Resources for Practitioners

2018 Opioid Prescribing Requirements
www.doh.wa.gov/opioidprescribing

Department of Health resources on opioid prescribing best practices, treatment and support, data, and other related resources:
www.doh.wa.gov/opioids

To register with the Washington State Prescription Monitoring Program:
www.wapmp.org

Opioid prescribing best practices
www.cdc.gov
www.agencymeddirectors.wa.gov

Washington State Legislature
www.leg.wa.gov


Washington State Department of
Health