Washington State Health Care Authority

HCA Opioid Prescribing Policy

Clinical Quality and Care Transformation
September 19, 2017

Washington State Health Care Authority

Housekeeping

- 40 minute presentation
- 20 minute Q&A session
- Use the questions function to submit questions to us
  - We will read and answer questions in the Q&A session
- All questions submitted to us will be answered
  - If they are not answered in the webinar, we will record the text and submit answers in a Q&A document after the webinar
  - The Q&A document can be sent to all registered attendees

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Agenda

- Introductions
- Background
- HCA opiate prescribing policy
- Additional strategies: collaboration, data and feedback
- Q&A

Introductions

- Dan Lessler, MD, MHA, Chief Medical Officer, HCA
- Charissa Fotinos, MD, MSC, Deputy Chief Medical Officer, HCA
- Emily Transue, MD, MHA, Associate Medical Director, HCA
- Donna Sullivan, PharmD, MS, Chief Pharmacy Officer, HCA
- Ryan Pistoresi, PharmD, MS, Assistant Chief Pharmacy Officer, HCA
- Nathan Schlicher, MD, JD, Secretary Treasurer, WSMA

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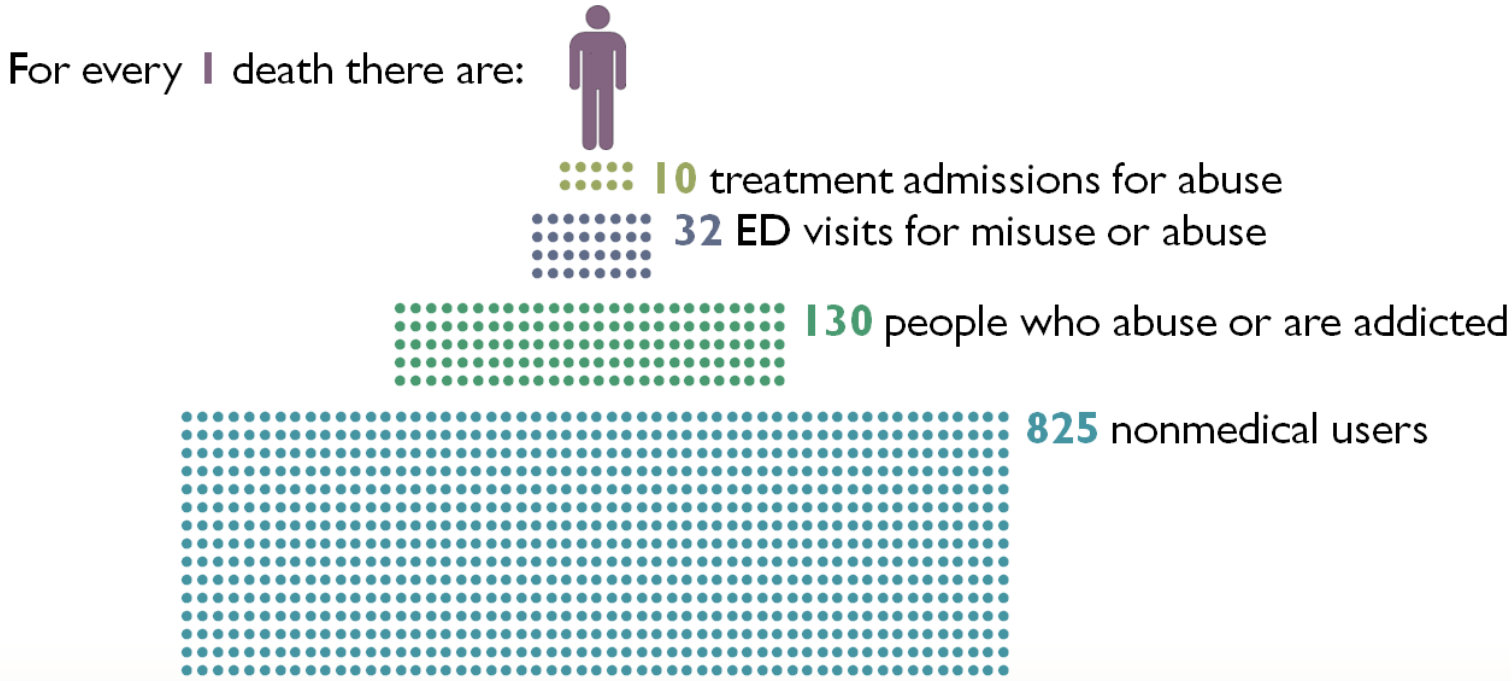
In 2013

43,982 Americans

DIED FROM DRUG POISONINGS

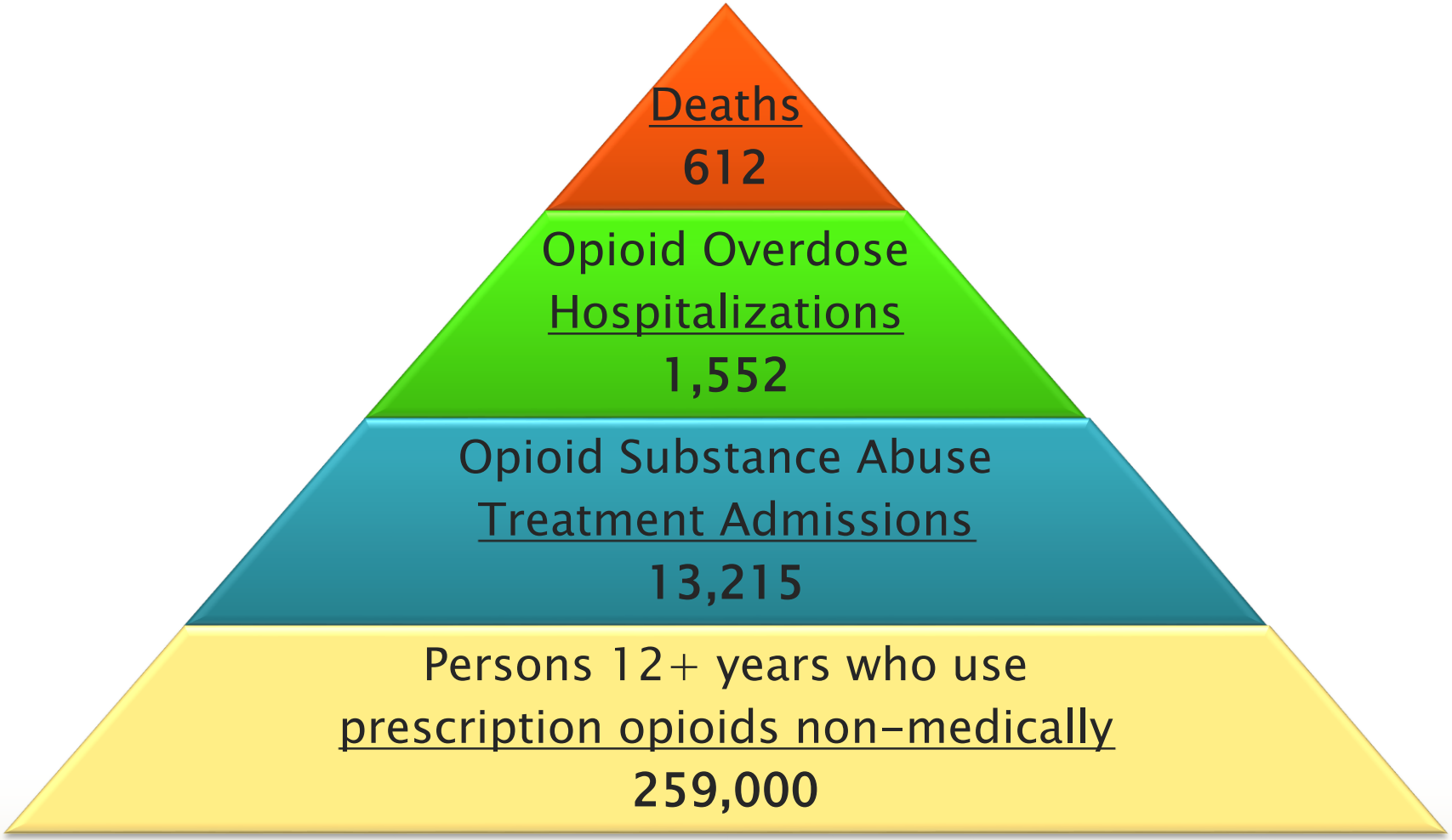
Nearly 16,235 deaths involved prescription opioids

In 2008



NCHS Data Fact Sheet, June 2015 http://www.cdc.gov/nchs/data/factsheets/factsheet_drug_poisoning.pdf
CDC. Policy Impact: Prescription Painkiller Overdoses. http://www.cdc.gov/homeandrecreationalsafety/rxbrief/ (Historical content - 2008 data) (accessed on 1/6/15).

Opioid-related Disease Burden in WA



1.Opioids involved in an unintentional overdose death listed as underlying cause of death. Washington State death certificate data, 2014.
2.Washington Hospital Discharge Data, Comprehensive Hospitalization Abstract Reporting System (CHARS) and Oregon State Hospital Discharge Data , 2014.
3.Treatment and Assessment Report Generation Tool, 2014
4.National Survey on Drug Use and Health, 2013-2014

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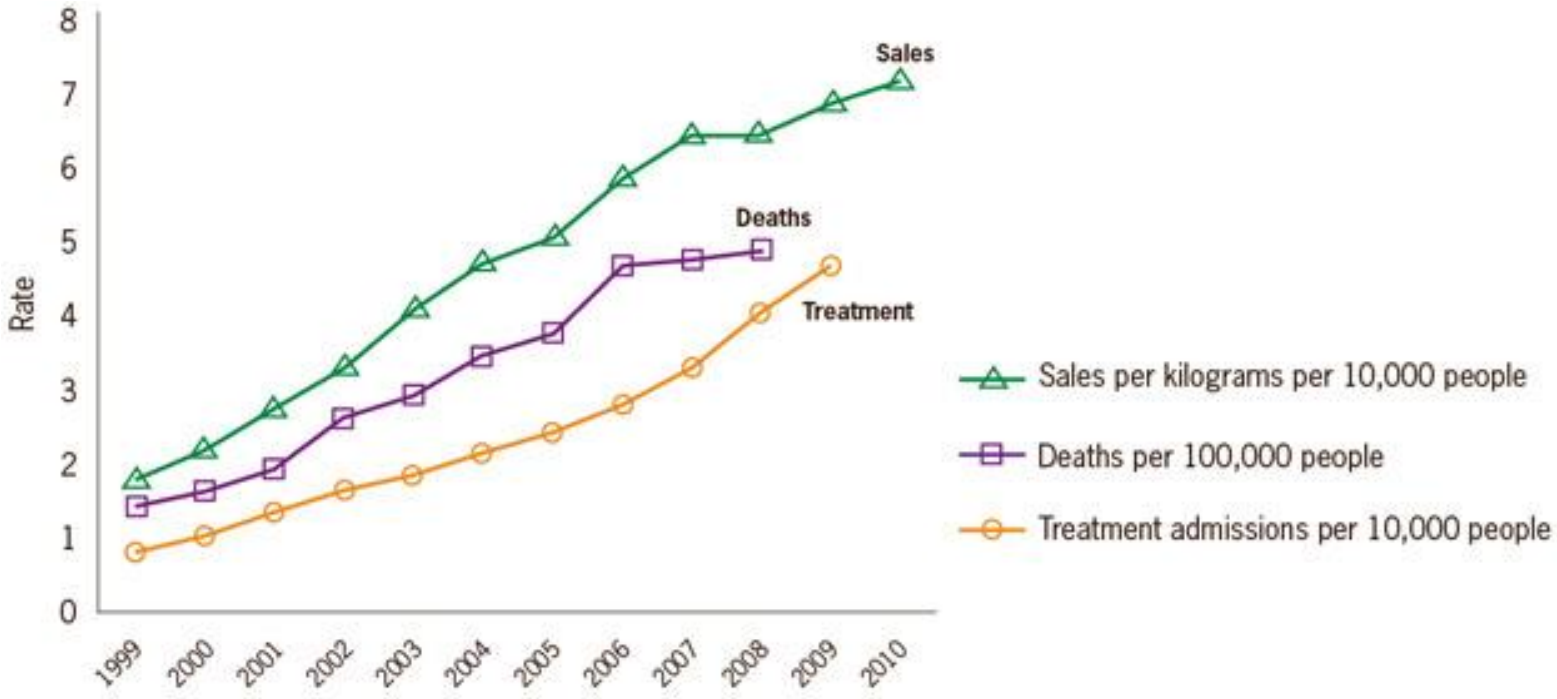
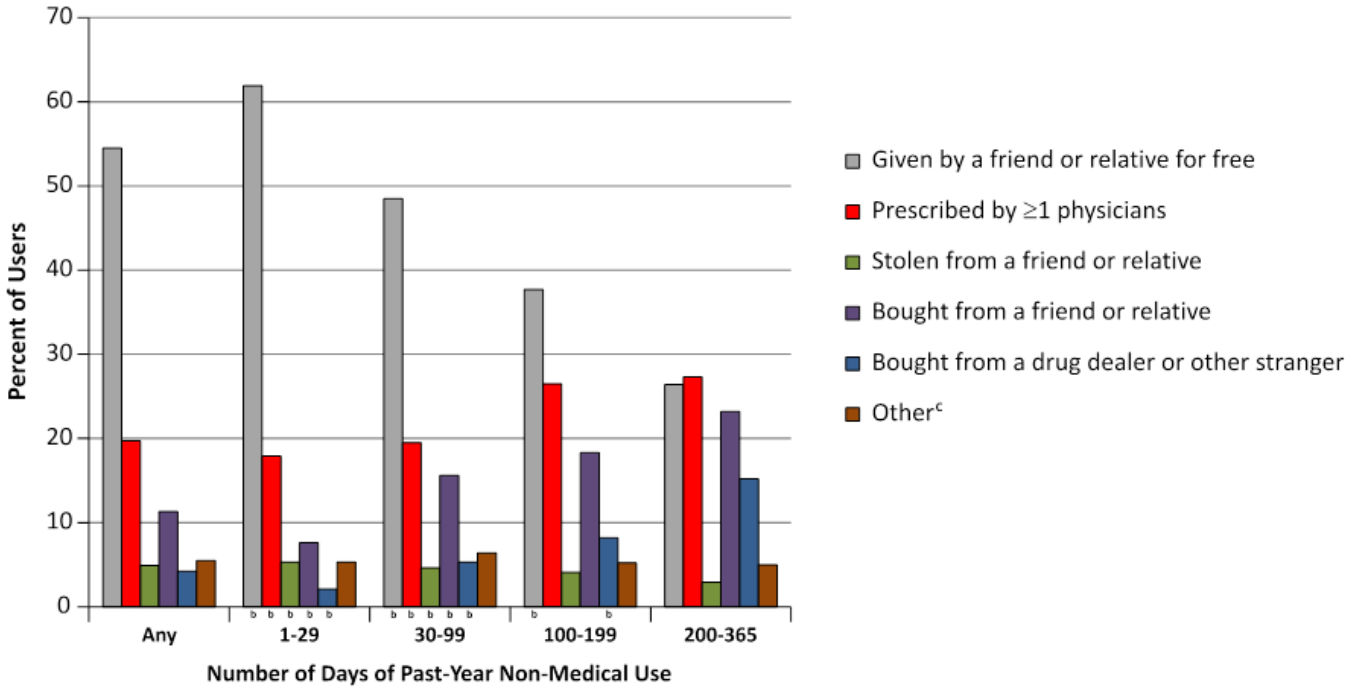
Prescription Painkiller Sales, Deaths and Substance Abuse Treatment Admissions: 1999-2010



Sources: National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders Systems of the DEA, 1999-2010; Treatment Episode Data Set, 1999-2009.

Sources of Prescription Painkillers Among Past-Year Non-Medical Users[a]



[a] Obtained from the US National Survey on Drug Use and Health, 2008 through 2011.[5]
[b] Estimate is statistically significantly different from that for highest-frequency users (200-365 days) ($P < .05$).
[c] Includes written fake prescriptions and those opioids stolen from a physician's office, clinic, hospital, or pharmacy; purchases on the Internet; and obtained some other way.

SOURCE: Jones C, Paulozzi L, Mack K. Sources of prescription opioid pain relievers by frequency of past-year nonmedical use: United States, 2008–2011. JAMA Int Med 2014; 174(5):802-803.

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Opioid prescription use relationship to heroin use

The JAMA Network

From: **The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years**

JAMA Psychiatry. 2014;71(7):821-826. doi:10.1001/jamapsychiatry.2014.366

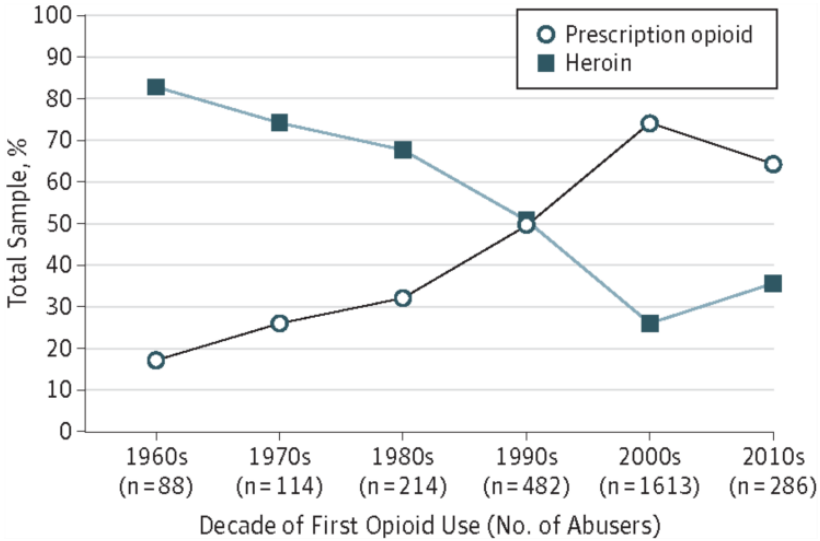

Figure Legend:

Percentage of the Total Heroin-Dependent Sample That Used Heroin or a Prescription Opioid as Their First Opioid of AbuseData are plotted as a function of the decade in which respondents initiated their opioid abuse.

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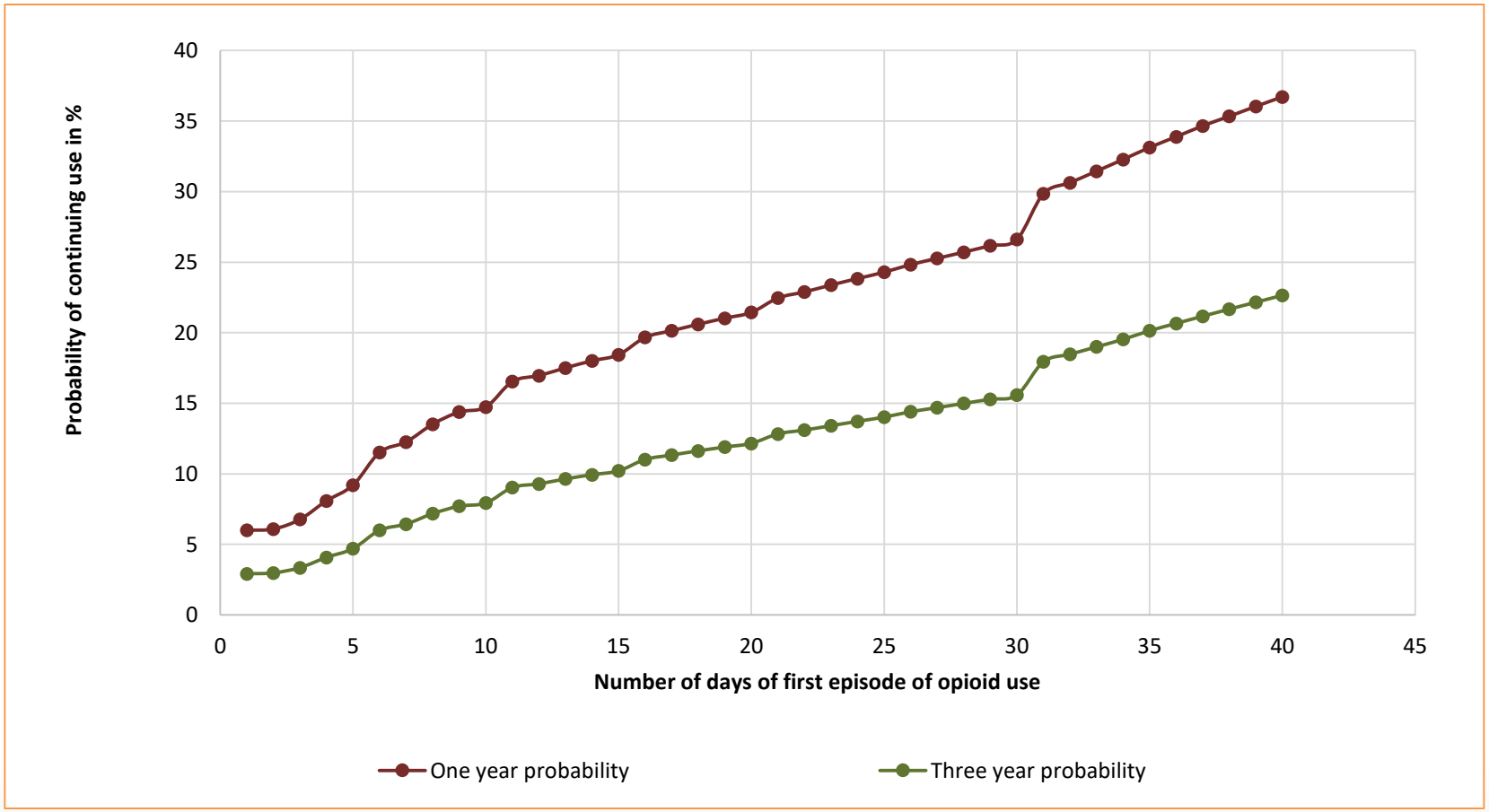
Acute Opioid Prescriptions: Continued Use by Initial Days of Therapy



From: MMWR. 2017 Mar 17; 66(10):265-269

Opioid Pills Needed Post-Op*

- Surgery
  - Partial mastectomy (N=58)
  - Sentinel node bx (N=62)
  - Laparoscopic cholecystectomy (N=58)
  - Hernia repair (N=27)
  - Open inguinal hernia (N=18)
- Mean (SD) pills taken
  - 1.8 (3)
  - 1.9 (3)
  - 7.5 (8.3)
  - 9.7 (10.7)
  - 2.8 (7.7)

*From: Hill et al. Ann Surg 2017. Mar 6 doi:10.1097/SLA.0000000000002198

Governor's Executive Order

- In October 2016, Governor Inslee issued Executive Order 16-09.
  - Directed the state's agencies and resources to combat this crisis.
  - Efforts include preventing opioid use disorder as well as treating it
  - http://www.governor.wa.gov/sites/default/files/16-09OpioidPreventionE.pdf

WSMA/WSHA Input

- WSHA/WSMA Opioid Taskforce has developed multiple initiatives in collaboration with HCA
  - New Prescribing Guidelines
  - Feedback Reports
  - Renewed focus on MAT
- Collaborative effort modeled on prior ER for Emergencies collaboration

Medicaid Opioid Prescribing Policy

- Effective November 1, 2017
  - ***Note change in implementation date***
- Consistent policy across all 5 Medicaid managed care plans and fee-for-service

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Our Goals

- Reduce unnecessary exposure
- Reduce unused pills in community
- Ensure safe transitions and best practices when chronic use is needed
- Minimize administrative burden on providers
- Encourage adherence to guidelines while recognizing clinical need for exceptions

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Acute Use

- Only short-acting opioids will be approved for acute use unless an exemption is requested.
- Limits apply as follows (unless an exemption is requested):
  - Children (under 21) are limited to 18 doses (pill or liquid) (about a 3 day supply)
  - Adults (21 and over) are limited to 42 doses (pill or liquid) (about a 7 day supply)

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Transition to Chronic Use

- At 6 weeks (beyond 42 days of treatment in a 90 day period), you will need to sign and send in a form attesting that you are following best practices as outlined by CDC guideline for chronic opioid prescribing (https://www.cdc.gov/drugoverdose/prescribing/guideline.html)
- You do not need to send in documentation of these practices, but documentation should be in the chart if an audit is performed
- If some of the practices do not apply, simply document the reason in the chart
- You must sign the form; your staff cannot do this for you
- For the full detail on the attestation form, please read the opioid policy on the HCA website: https://www.hca.wa.gov/assets/billers-and-providers/opioid-policy.pdf

Examples from Attestation Form

- The patient has an on-going clinical need for chronic opioid use
- The patient is using or has tried and failed appropriate non-opioid medications, and/or non-pharmacologic therapies
- The patient has been screened for mental health disorders, substance use disorder, naloxone use
- The provider will conduct periodic urine drug screens
- The provider has checked the PDMP for any other opioid use and concurrent use of benzodiazepines and other sedatives
- The provider has discussed with the patient the realistic goals of pain management therapy
- The provider confirms that the patient understands the risks and benefits of chronic opioid use

- For the full detail on the attestation form, please read the opioid policy on the HCA website: https://www.hca.wa.gov/assets/billers-and-providers/opioid-policy.pdf

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Exemptions

- “Exempt” process: Provider types “exempt” on the script to override acute pill limits
- Grandfathering (more details below)
- Patients in hospice, end of life or palliative care, or being treated for active cancer pain (write this on the prescription)
- Patients who are new to a health plan within 120 days

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Grandfathered users

- Patients are to be grandfathered if there is a history of use of an opioid for ≥ 90 calendar days in the previous 120 days
  - Patients who meet this criterion are "grandfathered" under the policy, and can continue to receive opioid prescriptions without prior authorization
  - Includes patients who are new to a plan who get 90 days' fill in the first 120 days
- All other limits described elsewhere do not apply to grandfathered patients

Opioids affected by New Policy

- Codeine
- Fentanyl
- Hydrocodone
- Hydromorphone
- Meperidine
- Morphine
- Oxycodone
- Oxymorphone
- Tapentadol
- Tramadol

<u>Opioids not affected by this policy:</u>

- Buprenorphine
- Methadone

Case examples 1 and 2

You see a 17-year-old patient for extraction of an impacted wisdom tooth. You write for hydrocodone/APAP 5/500, ½-i PO Q4H PRN pain, #15. The patient has not received opioids in the last 90 days.

- *Rx is under the #18 max for a patient under 21, so this is within limits*
- Patient receives #15 as written

You are seeing a 55-year-old patient recently discharged with a severe skin wound. You write a prescription for oxycodone 5mg i PO Q4H PRN pain, #40. The patient has not received opioids in the last 90 days.

- *Rx is under the #42 max for a patient 21 and older, so this is within limits*
- Patient receives #40 as written

Case example 3

You see a 15-year-old who was hit by a car while riding his bicycle and fractured his leg, casted in the ER. He also has extensive soft tissue injuries and a lot of pain. You write a prescription for oxycodone 5mg i PO Q4H PRN pain, #40, and type "Exempt" in the notes section since you believe this is a necessary amount for this patient.

- *Prescription is over the #18 max for a patient under 21, but is authorized under the "exempt" process*
- Patient receives #40 as written

Case example 4

You see a 12-year-old patient with a severe ankle sprain. You write for hydrocodone/APAP 5/325 mg, i PO Q4H PRN pain for #40 without an exemption. The patient has not received opioids previously.

- *Prescription is over the #18 max for a patient under 21, so this is over the limit*.
- Pharmacy dispenses #18 to the patient, and calls your office to notify you that only a partial fill was dispensed.
- If you feel #18 is adequate, no further action is needed.
- If you feel #40 is needed:
  - You can give a verbal "exempt" if you're available when the pharmacist calls.
  - You can notify the pharmacy and they can provide the additional pills. Alternately, you can write a second prescription for the additional pills.

Case example 5

You have a 55-year-old patient with chronic pelvic pain. She's had extensive workup without revealing a cause. She has an upcoming two-week family reunion, so you reluctantly prescribe #40 of hydrocodone/APAP 5/325 to "get her through" the event. She sees your partner three weeks later for follow up when you are out, reports that it worked great and she feels terrific, and gets a refill. She requests a third refill.

- *When a refill is requested beyond 6 weeks of therapy, prior authorization is required via an attestation form showing best practices are being followed for the transition from acute to chronic opioid use.*
- If you feel that chronic opioid use is the best option for this patient, you will need to document in the chart that best practices are being followed.

Case Example 6

You have inherited a 42-year-old patient with an unspecified connective tissue disorder from a colleague who retired. The patient has been taking slow-release oxycodone 80 mg BID plus hydromorphone 4 mg QID for 15 years, filling 115 days' supply in the last 120 days. You hope to taper the patient down gradually, but you feel that this will take time and you will need to build trust. You write to continue the current meds for now.

- *The patient is in the "chronic use" category, but is grandfathered under the policy and limits do not apply.*
- Patient receives meds as written; no PA/attestation is required.

Case Example 7

A 62-year-old woman presents to you with a 3-month history of progressive weight loss and RUQ pain. CT reveals widely metastatic pancreatic cancer. She is debating attempting aggressive treatment vs. hospice care. You prescribe oxycontin 10mg QHS and oxycodone 5 mg, #180, i-ii po q 2-4 hours as needed. You write "for cancer pain" on the sig.

- *Patient has a diagnosis of malignancy; limits including pill numbers and acute use of long-acting opiates do not apply. You do not need to type EXEMPT on the prescription.*
- Patient receives meds as written.

Issues not addressed by November 1st Implementation

- MED limits:
  - We are delaying the incorporation of dose limits in the policy in order to develop a process that addresses the needs of clinically complex and diverse populations
- Management of patients with opioid use disorder:
  - Efforts are underway statewide to support treatment availability, but this is outside the scope of this policy

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Using Data and Feedback to Improve Opioid Prescribing Practices

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Premise

- Providers respond to feedback to adjust behavior when confronted with valid evidence
- Provider led collaborative programs enhance buy-in and success

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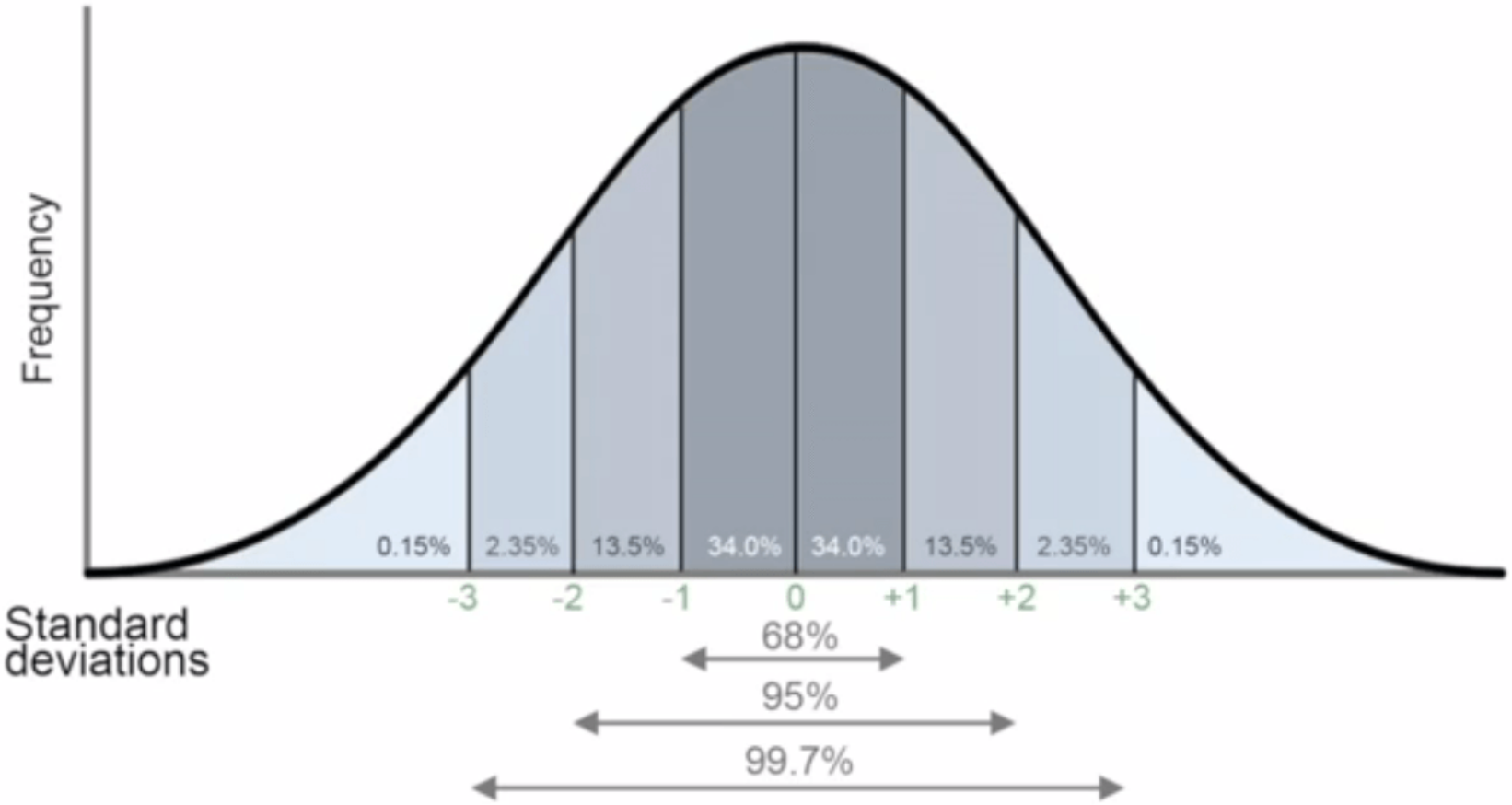

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ER for Emergencies: The Power of Collaboration

- Integrated response to financial and public health crisis
  - No additional regulation, only resources
  - Provider driven program to address a fractured health system (EDIE, PDMP, Care management)
- Results exceeded expectations:
  - Reduced Medicaid ED visits by 9.9%
  - Reduced high utilizers by 10.7%
  - Reduced opioid prescriptions by 24%
  - Saved $33.65 million in first year

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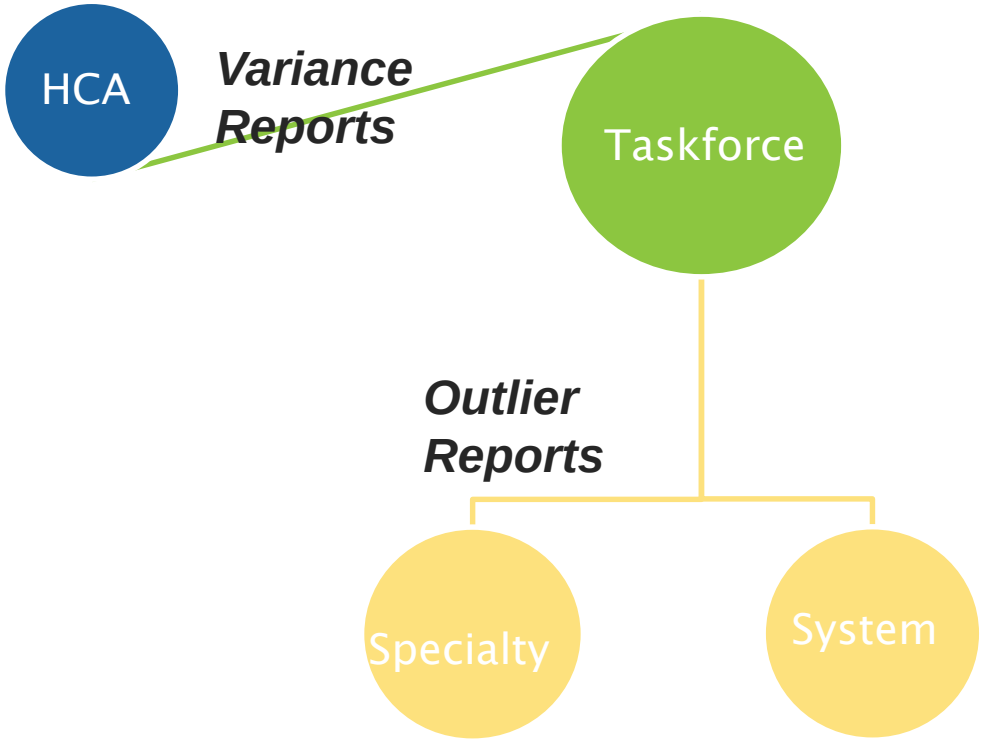
Feedback Program



Additional information: www.waopiatereports.org

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Opioid Prescribing Resources

- WA State Prescription Monitoring Program (PMP)
  - http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PrescriptionMonitoringProgramPMP
- WA State Agency Medical Directors Guideline
  - http://www.agencymeddirectors.wa.gov/Files/FY16-288SummaryAMDGOpioidGuideline_FINAL.pdf
- CDC guideline
  - https://www.cdc.gov/drugoverdose/prescribing/guideline.html
- HCA additional information:
  - https://www.hca.wa.gov/billers-providers/programs-and-services/opioids

Opioid Prescribing Resources

- UW TelePain
  - A service for community-practice providers to increase knowledge and skills in chronic pain management
    - http://depts.washington.edu/anesth/care/pain/telepain
    - Questions: telepain@uw.edu
- UW Pain Hotline
  - "Real time" consultations for clinicians caring for patients with complex pain management regimens, particularly high dose opioids
  - 1-844-520-PAIN (7246) (Mon-Fri from 8:30 am – 4:30 pm)

Q&A

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Additional Questions

More Information:

https://www.hca.wa.gov/billers-providers/programs-and-services/opioids

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Addendum: additional case examples

Case example 8

You see an elderly woman who has fallen and has a non-surgical pelvic fracture with severe pain. The orthopedist indicates no intervention is appropriate, but pain is expected to last 3-4 months. You prescribe hydrocodone/APAP 5/325, ½-i q 4-6 hours PRN, #90, and type EXEMPT in the notes section of the prescription. The patient has not received opioids in the last 90 days.

- *Prescription is over the #42 max for a patient over 21, but is authorized under the "exempt" process.*
- Patient receives #90

Case example 8.1

One week later, your elderly patient with the nonsurgical pelvic fracture returns. She reports the hydrocodone/APAP works great for a few hours. However, she is waking up in the middle of the night with severe pain, and requests something that will last longer overnight. You prescribe slow-release oxycodone 5mg #30, i po QHS. You typically don't use long-acting preparations early in a treatment course but in this case you feel is it appropriate, so you write EXEMPT in the notes section of the prescription.

- *Long-acting opioids are not typically approved for acute use, but this prescription is authorized under the "exempt" process.*
- Patient receives slow-release oxycodone 5 mg #30 as written.

Case example 8.2

Your elderly patient with the pelvic fracture is improving slowly, but she continues to have pain at night that is unresponsive to APAP. Her first prescription goes through under the "EXEMPT" process, but the with the second prescription for slow-release oxycodone 5 mg #30, i PO QHS, you receive a call that she is going beyond 42 days of treatment, and a prior authorization is required for her to receive the full supply. You review the attestation form. You check the PDMP, and discover that her psychiatrist is prescribing 2 mg clonazepam QHS; you call them to discuss reducing the dose. You feel certain elements of the "best practices" are not applicable to her case (i.e., you do not feel urine drug testing is appropriate since she's very low risk), and you document why in her chart. You sign the attestation.

- *After 6 weeks/42 days of narcotic use, attestation is required that you are applying best practices for chronic narcotic use as appropriate.*
- You submit the signed attestation and patient receives slow-release oxycodone 5 mg #30.

Case example 9

You have a 60-year-old patient with recurrent back pain. You write a prescription for oxycodone 5mg i PO Q4H PRN pain, #40. The patient has previously received 40 days' supply of opioids in the previous 90 days. At the pharmacy, the prescription is processed and denies as needing prior authorization.

- *The current prescription pushes the patient beyond the 6 weeks in 90 days point, which defines chronic use. Attestation/PA is required to document that you are applying best practices for chronic narcotic use.*
- The pharmacist calls your office and informs you that an attestation must be completed prior to dispensing the full amount. If you are unavailable, the pharmacist can process the prescription for 2 days and dispense #12 to patient. Pharmacist notifies you that only a partial fill of a CII was dispensed to patient.

Case Example 10

You see a 38-year-old patient with recurrent severe low back pain. You write a prescription for oxycodone 5mg i PO Q4H PRN pain for #180 (30 day supply), and type “Exempt” in the notes section of the prescription. The patient received a 30-day supply of opioids in the previous 90 days, for a prior episode. At the pharmacy, the prescription is processed and the pharmacy enters in the code for the expedited authorization, but it is denied.

- The following can occur:
- Pharmacist calls and notifies you that an attestation must be completed prior to dispensing the full amount.
- The pharmacist can process claim for 12 days and dispense #72 to patient. Pharmacist calls your office to notify you that only a partial fill of a CII was dispensed to patient.