Washington State Health Care Authority

Washington State Department of Health

Monthly Tribal Meeting

July 3, 2018

Jessie Dean
Tribal Affairs Administrator
Office of Tribal Affairs

Tamara Fulwyler
Tribal Relations Director
Office of the Director

Agenda

9:00 AM	Welcome, Blessing, Introductions
9:10 AM	Local, State, and Federal Opioid Guidelines and Policies
9:30 AM	State-Tribal Workgroup on HCA Tribal Consolidated Contracting
9:40 AM	Updates on Various HCA Projects
10:00 AM	SAMHSA State Opioid Response/Tribal Opioid Response Grants • Planning for Tribal Roundtables and Consultation
10:40 AM	SAMHSA Block Grant • Planning for Tribal Roundtables and Consultation
10:55 AM	Break
11:00 AM	Interview panel for DOH Policy Director – Tribal representative
11:05 AM	Tribal Input on DOH Staff Training "Working with Tribal Gov's"
11:20 AM	DOH Healthy Youth Survey/Tribal Youth and Schools
11:30 AM	DOH Foundational Public Health Services
12:00 PM	Open Session and Closing

Washington State Health Care Authority

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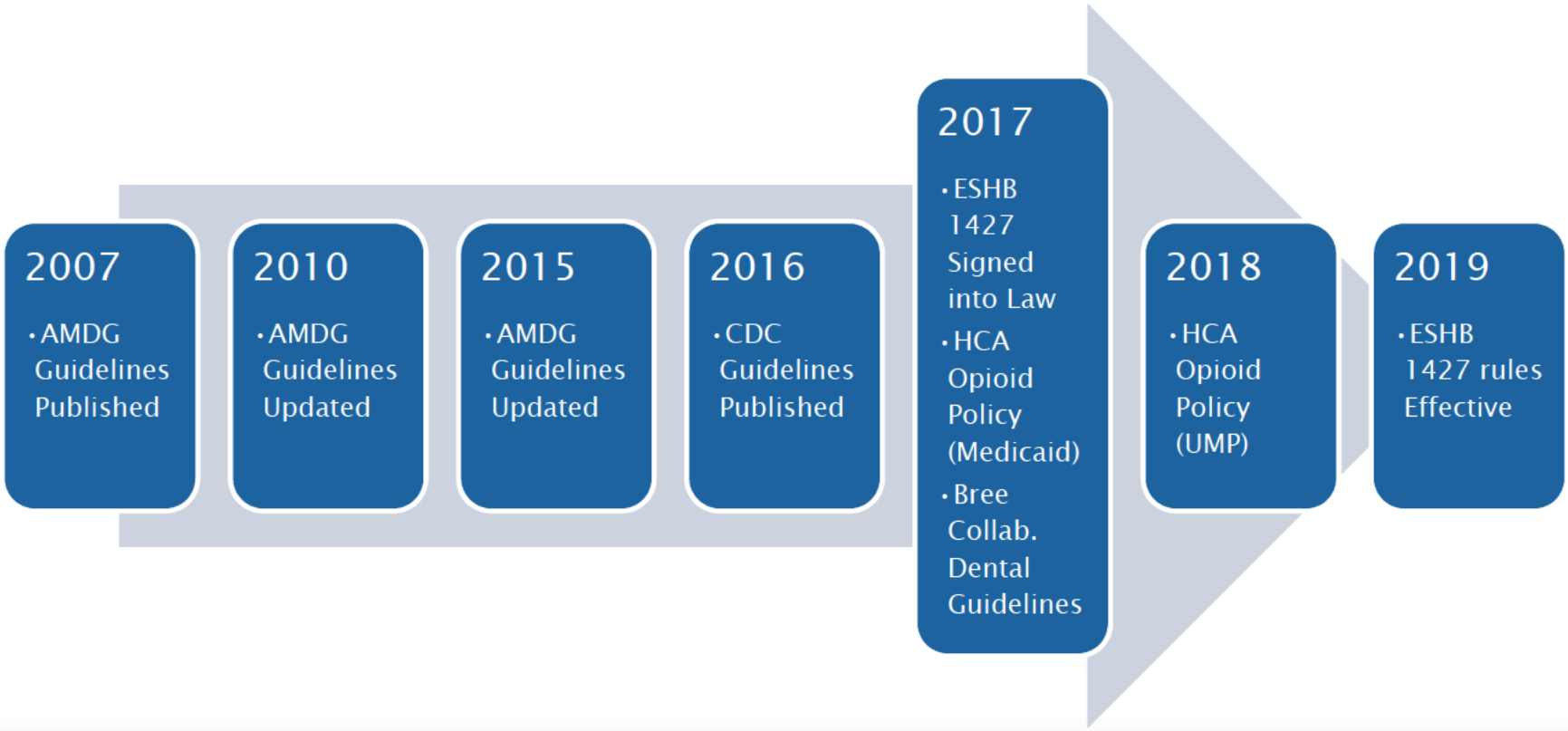
Local, State, and Federal Opioid Guidelines and Policies

Ryan Pistoresi, PharmD, MS
Assistant Chief Pharmacy Officer
HCA Clinical Quality and Care Transformation

Overview

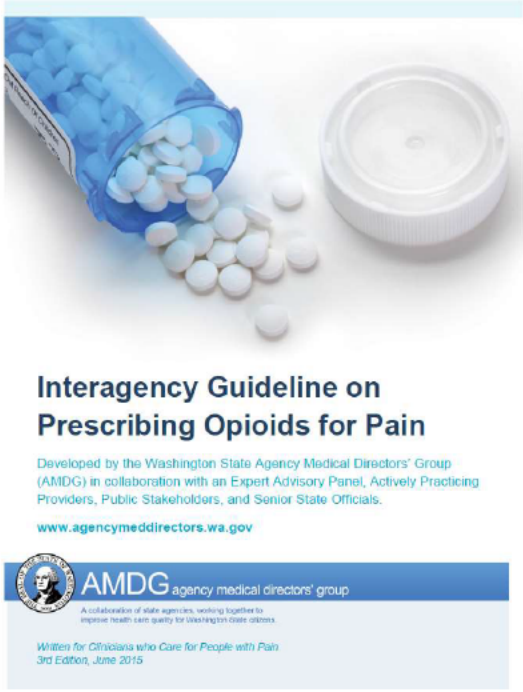
- **Agency Medical Directors' Group (AMDG) 2015 Guidelines**
  - Developed by state agency medical directors who collaborated with practicing clinicians
- **CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016**
  - National guideline published by Centers for Disease Control (CDC) in March 2016
- **Health Care Authority (HCA) Opioid Policy**
  - Agency clinical policy developed by HCA
  - Effective November 2017 for Medicaid and January 2018 for Uniform Medical Plan
- **Bree Collaborative Dental Prescribing Guideline, 2017**
  - Local private and public healthcare stakeholders working together on health care solutions
- **ESHB 1427 Opioid Rulemaking**
  - State opioid prescribing rules in Washington Administrative Code (WAC)
  - Undergoing review and approval, to be effective no later than January 2019

Timeline


2007
• AMDG Guidelines Published
2010
• AMDG Guidelines Updated
2015
• AMDG Guidelines Updated
2016
• CDC Guidelines Published
2017
• ESHB 1427 Signed into Law
• HCA Opioid Policy (Medicaid)
• Bree Collab. Dental Guidelines
2018
• HCA Opioid Policy (UMP)
2019
• ESHB 1427 rules Effective

AMDG Guidelines

- Committee of Medical Directors from Washington State agencies including:
  - Labor and Industries (L&I)
  - Health Care Authority (HCA)
  - Department of Health (DOH)
  - Department of Corrections (DOC)
- AMDG collaborated with actively practicing experts
- Originally published in 2007 as a guideline for primary care providers to treat chronic non-cancer pain
  - Updated in 2010 and 2015 to expand scope, tools, evidence, and audience based off feedback
  - Intended to supplement DOH rules on chronic non-cancer pain best practices (more on this for ESHB 1427 rulemaking)



AMDG Guidelines

- AMDG Guidelines were developed for primary care providers treating chronic non-cancer pain
  - Originally an educational pilot on opioid prescribing for providers
  - In 2009, providers were surveyed about the guideline. Responders found the guideline to be useful and providers asked for tools and additional, specialized information
- In 2010, the guidelines were updated to included tools to calculate MED[1], a threshold on MED, tools to screen for patient risk, information on special topics, and patient education materials
  - Adopted into rule (WAC) by Labor & Industries (LNI) as best practice for opioid prescribing
- In 2015, AMDG guidelines were expanded to cover all phases of opioid prescribing from acute to perioperative to special populations

1. Morphine Equivalent Dose (MED)

AMDG 2015 Guidelines

- AMDG 2015 recommendations include:
  - Using non-opioid analgesics as first-line therapy when treating pain in any phase. This will reduce the use of opioids or, if opioids are appropriate, reduce the overall dose.
  - When prescribing opioids for acute pain, use the lowest dose necessary for the shortest duration necessary (usually less than 14 days)
  - Avoid using opioids when evidence does not support their use, such as non-specific low back pain, headaches, and fibromyalgia
  - Seek pain consult prior to ≥120 MED or when identifying patients with high risk, such as substance use disorder, mental health disorders, concurrent use of other sedatives, or sensitive to opioid-related side effects (COPD, sleep apnea, advanced age, etc.)
  - Check PMP as frequently as needed according to patient risk – it requires checks more often if the patient is at high risk than if they are at low risk.

CDC Guideline

- Published March 18, 2016 in Morbidity and Mortality Weekly Report (MMWR)
- Guideline is specific for prescribing opioids for chronic pain management
  - Does not cover acute pain, active cancer treatment, palliative care, or end-of-life care
- Audience intended for primary care clinicians
- 12 recommendations for 3 major categories:
  - When to initiate or continue opioids for chronic pain (3)
  - Opioid selection, dosage, duration, follow-up, and discontinuation (4)
  - Assessing risk and addressing harms of opioid use (5)

CDC Guideline

- **Recommendation 1:** Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain.
- **Recommendation 4:** Start with immediate-release opioids for chronic pain instead of extended-release/long-acting (ER/LA) opioids
- **Recommendation 5:** Prescribe the lowest effective dosage. Carefully assess dosages ≥50 MED[1]/day. Providers must justify their decision for ≥90 MED
- **Recommendation 6:** For acute pain, prescribe no greater quantity than needed for pain severe enough to require opioids.
  - "Three days or less will often be sufficient; more than 7 days will rarely be needed."
- **Recommendation 7:** Clinicians should evaluate within 1 to 4 weeks of initiating opioids and every 3 months thereafter or more frequently

1. Morphine Equivalent Dose (MED)

HCA Opioid Policy

- Effective November 1, 2017 for Medicaid; effective January 2, 2018 for Uniform Medical Plan (UMP)
- Derived primarily from CDC Guideline and Agency Medical Directors' Group (AMDG) 2015 Guidelines
  - Received input from Washington Pharmacy & Therapeutics (P&T) Committee, Washington State Medical Association (WSMA), Washington State Hospital Association (WSHA), and individual providers
- Pharmacy system programming that performs checks on every opioid[2] prescription
  - Includes acute and chronic pain, active cancer treatment, and palliative or end-of-life care
  - Applies to all types of prescribers, including primary care, surgeons, specialists, and dentists

2. Opioid policy does not include buprenorphine, buprenorphine/naloxone, or methadone

HCA Opioid Policy

- Pill limits during acute phase (up to 42 days in 90 day period)
  - 18 pills for patients 20 and younger; 42 pills for patients 21 and older
  - Expedited authorization (EA) codes for active cancer treatment and hospice, palliative, or end-of-life care
- Requires provider attestation prior to chronic opioid use (after 42 days in 90 day period)
  - Provider attests they are following best practices, including (1) using non-pharmacological and non-opioid pharmacological therapies, (5) regularly evaluating patients for improvements in pain and function, and (8) checking the PDMP
- No MED limit

Dental Guideline on Prescribing Opioids for Acute Pain Management

- Bree Collaborative worked with state academic leaders, pain experts, and dentists to develop these best practices
- Intended for dentists and oral surgeons managing acute pain
- Recommendations are similar to AMDG and CDC guidelines but adapted for dentists
  - Focuses toward perioperative pain and adolescents

ESHB 1427 (Opioid Rulemaking)

- Chronic non-cancer pain management rules were adopted by Washington State Medical Commission in March 2011 to be effective January 2012.
  - Based off AMDG Guideline from 2010 that was limited to chronic non-cancer pain.
- ESHB 1427 (signed into law on May 16, 2017) requires the Washington Department of Health (DOH) to adopt new opioid prescribing rules by January 1, 2019.
  - Expanded to include 4 new boards/commissions: dental, nursing, osteopath, and podiatry
- Taskforce with representatives from 5 boards/commissions met from September 2017 to March 2018 to discuss proposed rules.
  - Expanded to include all phases of pain management and other special topics.
  - The rules were primarily derived from the 2015 AMDG guideline and CDC guideline.

ESHB 1427 (Opioid Rulemaking)

- Rules are being reviewed by each board and commission over the summer
  - Rules are substantially similar between all the boards and commissions
- Boards are preparing CR-102 rule proposal packages for filing with Code Reviser Office.
- More public meetings will occur over the summer in preparation for adopting final rule to be effective on January 1, 2019.
- For more information, please visit the ESHB 1427 Implementation page on the WA DOH website.

Differences

- CDC, AMDG, Bree, and ESHB 1427 rules are intended for how providers care for patients and how to prescribe opioids.
  - Only ESHB 1427 rules are enforceable if not followed. ADMG, CDC, and Bree are not enforceable by state or federal agencies
  - HCA policy is intended for providers and pharmacies. Opioid policy is coded in pharmacy system and is always enforced on every prescription.
- CDC, AMDG, Bree, and ESHB 1427 rules include 'days supply' limits.
  - HCA policy places limits on amount of pills dispensed.
- CDC guideline is focused on chronic, non-cancer pain. AMDG, HCA policy, and ESHB 1427 rules apply to all phases of pain management.
  - Bree focuses on dental pain and is specific to dentists and oral surgeons

Summary

	AMDG (Jun 2015)	CDC (Mar 2016)	HCA (Nov 2017)	ESHB 1427 (Jan 2019)
Non-opioids	Use non-opioid analgesics	Preferred for chronic pain	Use first-line and as appropriate	Consider using when appropriate
Pill limits for acute	shortest duration (<14 days)	≤3 days; ≥7 days is rarely needed	#18 for <21; #42 for 21+	≤7 d. for acute; ≤14 d. periop /subacute
MED limits	Seek pain consult prior to ≥120 MED	Use caution ≥50; Justify use ≥90 MED	None	"High dose" is 90 MED or more per day
Check PMP	Check PMP according to patient risk	Periodically and every 3 months	At attestation (6 weeks)	Check at 2nd refill & at 6 & 12 weeks
Exclusions	None	Acute pain, active cancer, palliative, end-of-life care	None (EA for cancer, and others)	N/A

Questions?

More Information:

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

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Washington State Health Care Authority

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State-Tribal Workgroup on HCA Tribal Consolidated Contracting
+
Updates on Various HCA Projects

Jessie Dean
HCA Tribal Affairs Administrator
Office of Tribal Affairs

State-Tribal Workgroup on HCA Tribal Consolidated Contracting

During Tribal Consultation on April 30, HCA agreed to establish a state-tribal workgroup focused on developing:

1. The consolidated contracts between HCA and each tribe,
2. The processes for tribal staff to receive funds from HCA and submit reports to HCA under the tribal consolidated contracts, and
3. The protocols for technical assistance, collaboration, and issue resolution.

State-Tribal Workgroup on HCA Tribal Consolidated Contracting

On May 17, the leaders of HCA, DOH, and DSHS asked for appropriate tribal staff to participate in this workgroup, including potential accounting and fiscal staff who currently work with the DSHS tribal consolidated contract.

HCA committed to ensuring efficient use of staff time:

- Sending background materials at least one day before each workgroup meeting.
- Workgroup meetings no more than once every two weeks and no longer than one hour.

State-Tribal Workgroup on HCA Tribal Consolidated Contracting

We are looking to schedule the first meeting of the State-Tribal Workgroup on HCA Tribal Consolidated Contracting during the latter of half of August.

HCA Updates on Various Projects

- DBHR Merger into HCA and DOH
- DHAT SPA Request for Reconsideration
- Medicaid Transformation IHCP Specific Project Plans
- Tribal FQHC Medicaid State Plan Amendment
- MCO Payment of IHS Encounter Rate
- Dental Managed Care RFP
- Transition from Intergovernmental Transfer to Certified Public Expenditures for Tribal Match for SUD Services
- Governor's Indian Health Council
- New HCA Tribal Consultation Policy

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Behavioral Health and Recovery

Lucilla Mendoza
Tribal Behavioral Health Administrator
HCA Office of Tribal Affairs

SAMHSA Opioid Response Funding FoAs

- State Opioid Response - SOR
- Tribal Opioid Response – TOR

- Overall Purpose
  - Expand access to treatment and recovery support services as well as advance substance misuse prevention

General Information

	State Opioid Response	Tribal Opioid Response
Funding Amount	$ 21,260,403	Varies based on Tribe (see Excel Sheet) Total - $ 2,891,625
Application Due Date	August 13, 2018	August 20, 2018
Start Date and Length of Project Period	September 30, 2018 2 Years	September 30, 2018 2 Years

Required Activities

State Opioid Response

- Assess needs of tribes and include strategies to address needs
- Implement full spectrum of treatment and recovery support services
  - Hub and spoke
  - MAT for OUD plus psychosocial services
  - Specialty programs
  - Residential programs that include MAT
- Recovery support services
  - Peer supports
  - Recovery housing
  - Recovery coaches
- Prevention education services
- Ensure applicable practitioners associated with program obtain a DATA waiver
- Assistance to patients with tx costs
- Treatment transition for patients reentering communities from criminal justice settings
- Training and TA on EBP to healthcare providers who render OUD tx and recovery services

Tribal Opioid Response

- Comprehensive strategic plan
- Workforce development
- Effective prevention of OUD
- Treatment of OUD
  - Hub and spoke
  - MAT plus psychosocial services
  - Specialty programs
- Recovery support services
  - Peer supports
  - Recovery housing
  - Recovery coaches
- Assistance to patients with tx costs
- Treatment transition for patients reentering communities from criminal justice settings
- Assess the impact of grant

Additional Program Requirements

State Opioid Response	Tribal Opioid Response
• Coordinate activities to eliminate duplication of services • Collaborate and coordinate with Ryan White HIV/AIDS Program who are uninsured or underinsured. • Adopt tobacco-free facility/grounds and promote abstinence from tobacco products (except in regard to accepted tribal traditions and practices) • Utilize 3rd party and other revenue realized from provision of services to the extent possible • Address BH needs to service members, veterans, and their families	• Adopt tobacco-free facility/grounds and promote abstinence from tobacco products (except in regard to accepted tribal traditions and practices) • Utilize 3rd party and other revenue realized from provision of services to the extent possible • Address BH needs to service members, veterans, and their families

Required Deliverables

	State Opioid Response	Tribal Opioid Response

Reporting Requirements	• Government Performance and Results (GPRA) Modernization Act of 2010
	  ○ 4 data collection points
	• Project Performance Assessment
		• Government Performance and Results (GPRA) Modernization Act of 2010
		  ○ 4 data collection points
		• Annual Reports

EBP Requirements	• EBP for Px, Tx, Recovery Supports • All Grantees required to use MAT for patients with OUD	• EBP for Px, Tx, Recovery Supports • All Grantees required to use MAT for patients with OUD

Funding Limitations/Restrictions

	State Opioid Response	Tribal Opioid Response
Funding Limitations/ Restrictions	• No more than 5% for administrative/infrastructure • Up to 2% can be used for data collection and reporting • Only US FDA approved products • Cannot deny eligible patient to access programming due to MAT treatment • Standard Funding Restrictions	• No more than 10% for administrative/infrastructure • Up to 15% can be used for data collection and performance assessment and infrastructure development • Only US FDA approved products • Cannot deny eligible patient to access programming due to MAT treatment • Standard Funding Restrictions

Application Submission

- Registration of the eRA Commons Registration (takes up to 6 weeks) no exceptions
- Ten (10) page narrative
- Budget according to template
- Supporting documents including biographical sketches/position descriptions
- Data Collection Instruments/Additional Attachments

Next Steps

- Identify and plan for Tribal projects considering other funding resources
- Identify how to best leverage resources
- DTL, Roundtable and Consultation Planning
  - By August 1, 2018

SAMHSA Block Grant Renewal

- Substance Abuse and Mental Health Services Administration (SAMHSA), Substance Abuse Block Grant (SABG) renewal due September 1, 2018.
- DTL, Roundtable and Consultation Planning
  - By August 15, 2018

Questions?

Health Care Authority

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Department of Health

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DOH Tribal Relations Director

Department of Health

- Tribal representation on Interview panel for DOH Policy Director

- Tribal Input on DOH Staff Training: "Working with Tribal Governments"

- DOH Healthy Youth Survey/Tribal Youth and Schools

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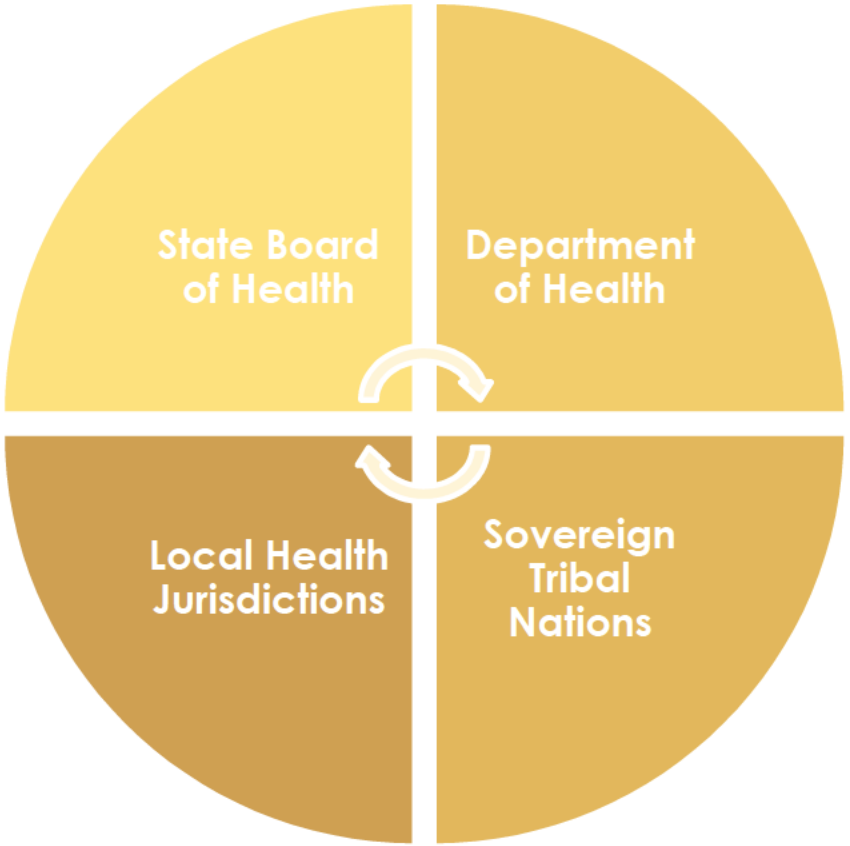
TRIBAL FOUNDATIONAL PUBLIC HEALTH SERVICES

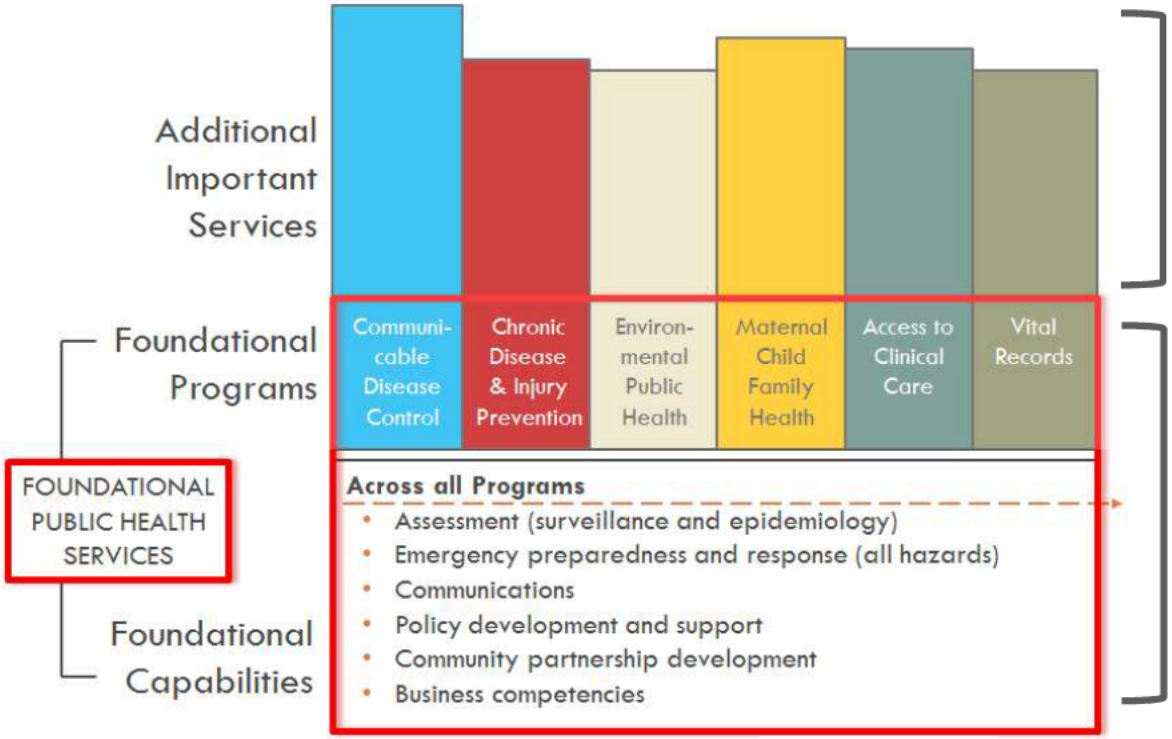
Tamara Fulwyler| July 3, 2018

Washington's Governmental Public Health System



What are Foundational Public Health Services?

A limited statewide set of core public health services that government is responsible for providing



Funded by grants, local , state & other targeted funds

Funded by federal grants, state funds & fees

Examples of FPHS and other Additional Important Services

- Foundational Public Health Services
  - Investigating communicable diseases, such as Tuberculosis and Hepatitis C
  - Promoting Immunizations
  - Protecting the public from radiation exposure

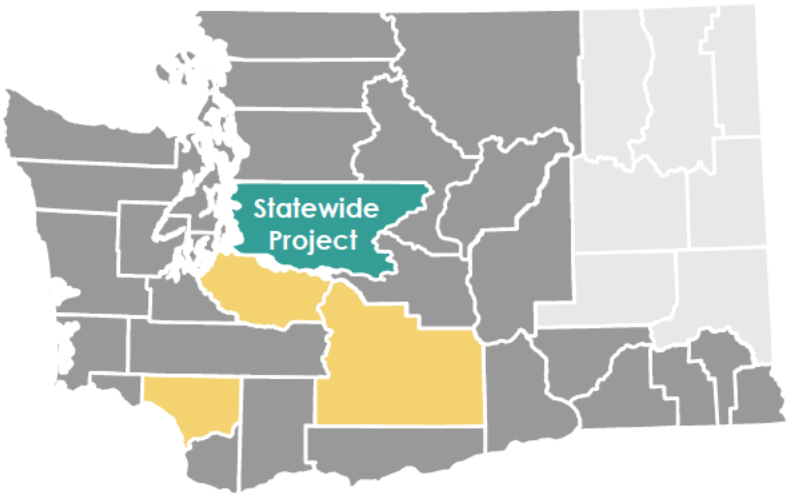
- Additional Important Services
  - Clinical services, such as family planning and immunizations
  - Women Infant Children (WIC) Nutrition Program
  - Substance abuse treatment

❖ May be provided by governmental public health and community partners

Work Underway

- One time FPHS initial investment of $12 million from the state legislature used to:
  - Strengthen communicable disease prevention and control across the state
  - Implement 3 service delivery demonstration projects
  - Continue transformation efforts
- One time investment of $3 million from the state legislature to strengthen communicable disease control in King County
- Statewide assessment of the public health system to identify:
  - Capacity
  - Expertise
  - Funding needed for full implementation of FPHS
- Tribal FPHS
  - Ongoing work with the American Indian Health Commission and Tribal nations to define FPHS from a tribal perspective

Service Delivery Demonstration Projects



Statewide Tuberculosis Resource Center

Lead: Public Health Seattle and King County

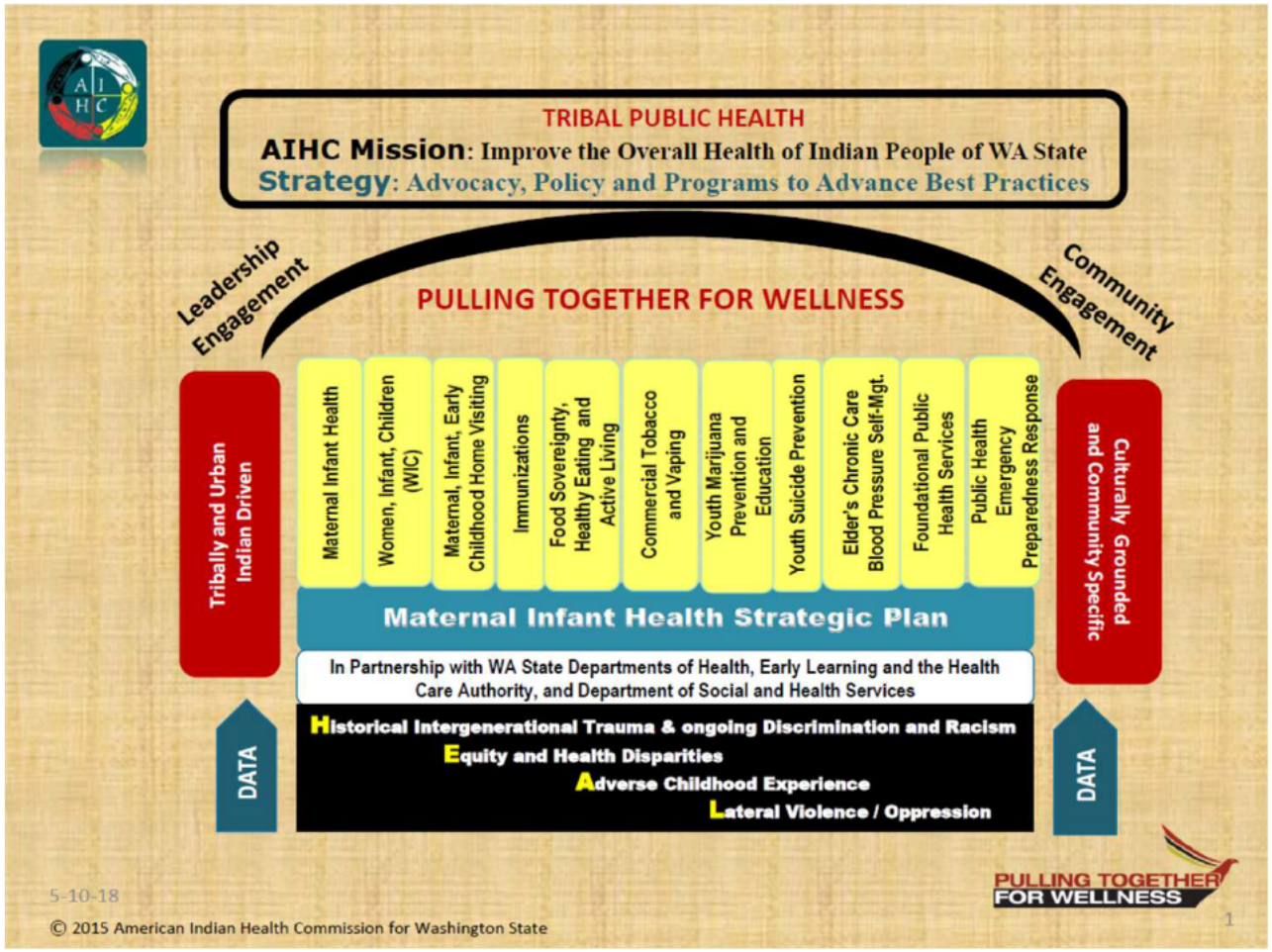
Timely Health Information for Providers

Lead: Tacoma-Pierce County Health Department

Shared Epidemiology Services

Lead: Spokane Regional Health District

Tribal Foundational Public Health Services



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KEY:

⊙ Tribal Services Profiles indicate many programs are provided in this assessment topic area

O Tribal Services Profiles indicate some programs are provided in this assessment topic area

■ No services available in this assessment topic area

TRIBE/URBAN INDIAN ORGANIZATION	CHRONIC DISEASE PREVENTION	ENVIRONMENTAL PUBLIC HEALTH	MATERNAL CHILD FAMILY HEALTH	EMERGENCY PREPAREDNESS & RESPONSE
Chehalis	⊙	⊙	⊙	⊙
Colville	O	O	⊙	⊙
Cowlitz	O	O	⊙	⊙
Hoh	O	O	⊙	⊙
Jamestown S'Klallam	⊙	O	⊙	⊙
Kalispel	O	⊙	⊙	⊙
Lower Elwha	⊙	⊙	⊙	O
Lummi	⊙	⊙	⊙	?
Makah	⊙	⊙	⊙	O
Muckleshoot	⊙	⊙	⊙	⊙
Nisqually	⊙	⊙	⊙	⊙
Nooksack	⊙	⊙	⊙	⊙
Port Gamble S'Klallam	⊙	⊙	⊙	⊙
Puyallup	⊙	⊙	⊙	⊙
Quileute	⊙	⊙	⊙	⊙
Quinault	O	⊙	⊙	⊙
Samish	O	O	?	?
Sauk-Suiattle	⊙	?	?	?
Shoalwater Bay	⊙	⊙	⊙	⊙
Skokomish	⊙	⊙	⊙	⊙
Snoqualmie	(no profile posted)			
Spokane				
Stillaguamish	⊙	?	?	?
Squaxin Island	⊙	⊙	⊙	⊙
Suquamish	⊙	⊙	⊙	⊙
Swinomish	⊙	?	?	⊙
Tulalip	⊙	⊙	⊙	⊙
Upper Skagit	⊙	⊙	⊙	?
Yakama	⊙	⊙	⊙	O
The NATIVE Project	(no profile posted)			
Seattle Indian Health Board & Urban Indian Health Institute[2]	⊙	?	⊙	?
Northwest Portland Area Indian Health Board & NW Tribal Epi Center[3]	⊙	O	?	O

2018-19Work Ahead

- Use the statewide assessment to cost out FPHS across the state
- Develop a governmental public health improvement and investment plan for the legislature – due November 30th
- Further engage tribal nations in FPHS

2019 Funding Request

- $500,000 for each tribal epi center
- $200,000 for partnership demonstration projects prioritizing strengthening communicable disease and environmental public health services across jurisdictions

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Open Session

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Closing