



Bonnie Bizzell

Stephen Lovell

Foundation for Health Care Quality

Patient & Family Advisory Council

October 1, 2014

# **(RE)FOCUS on SAFETY**

**Incorporating the Patient's Perspective  
for Better Patient Safety**

# And Now!

## Something Completely Different

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70,000 - 440,000

1/3

2.8 30

177

10-40

60

1/2

3

# Goal & Agenda

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**We want to...**

*explore components needed for patient involvement  
in patient safety*

- **The Trifecta, I – Process: Patient-Centered Practice**
- **The Trifecta, II – Communication: Patient-Centered Service**
- **The Trifecta, Grand Finish – Trust: Patient-Centered Partnership**
- **Quick Detour: Patient- and Family- Centered Care**
- **So What? Applications and Implications**
- **Closing Remarks /Q&A**

# The Trifecta, I

## Process: Patient-Centered Practice

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*You never get a second chance to make a first impression.*

- Decided to have neck surgery
- Chose a well-respected surgeon
- Office staff experience
- Surgery outcome
- But, what if it had not gone as expected?

# The Trifecta, II

## Communication: Patient-Centered Service

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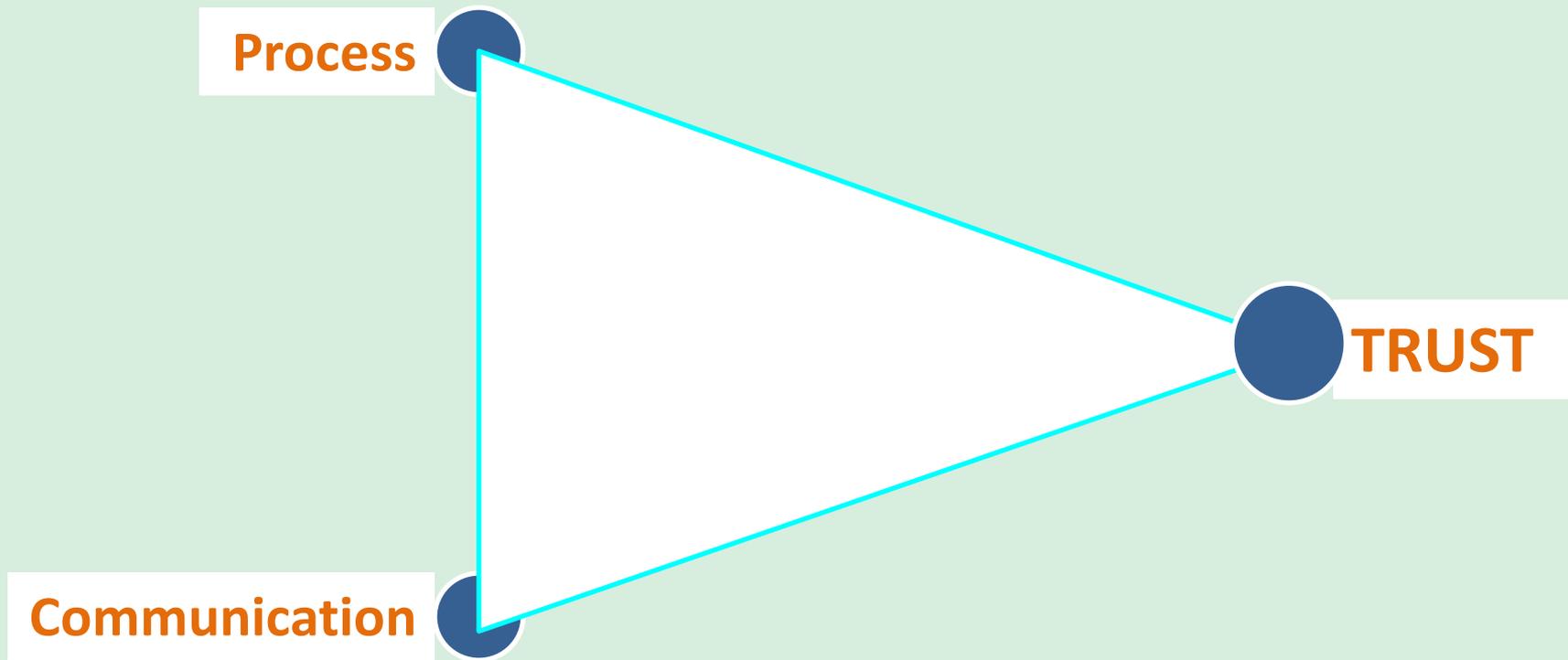
*If speaking is silver, then listening is gold.*



# The Trifecta, Grand Finish

## Trust: Patient-Centered Partnership

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# Quick Detour: Patient- and Family-Centered Care

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## *Driving forces for patient care*

- **System-Centered**

- The priorities of the system and those who work within it drive the delivery of health care.

- **Patient-Focused**

- The patient is the focus or unit of care. Interventions are done to and for him/her, instead of with the patient. The patient is not seen within the context of family or community.

# So What?

## Applications & Implications

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### *What Patients Want – Process: Patients Involved*

- **Patients need to prepare for appointments**
- **Ways patients can participate:**
  - Medical lists
  - Medical history
  - List of questions
- **Providers can set expectations for patients**
- **The provider community is helping**
- **Ask for advice**
  - PFAC and other councils

# So What?

## Applications & Implications

### What Patients Want – Communication: Patients Invited

The screenshot shows the Washington State Department of Health website. The header includes the logo and navigation links: Home, Newsroom, Publications, About Us. A search bar is present with a 'Go' button. Below the header is a main navigation menu with categories: You and Your Family, Community and Environment, Licenses, Permits and Certificates, Data and Statistical Reports, Emergencies, and For Public Health and Healthcare Providers. The current page is 'Medical Commission', indicated by the breadcrumb 'Home > Licenses, Permits and Certificates > Medical Commission'. A left sidebar contains a dropdown menu with options: Birth, Death, Marriage and Divorce; Facilities - New, Renew or Update; File Complaint About Provider or Facility; Medical Commission (selected); Medical Licensing; Practitioner Regulation; Medical Resources; Commission Information; Nursing Commission; Professions - New, Renew or Update; and Provider Credential Search. The main content area is titled 'Medical Commission' and features a banner image of healthcare professionals. Below the banner is a 'We Can Help You:' section with a list of links: File a Complaint, About Us (PDF) and Contact Us, Renew Your License or Verify Your License, Change Your Contact Information, View an MD or PA License, Medical Marijuana Information, and Public Records. To the right of the banner is a 'Join our ListServ' button and a list of links: Commission Newsletters, Legal Actions, Minutes and Agendas, and Rules. Below this is an 'Update!' banner for the Medical Commission Newsletter, with a link to the Current Newsletter (PDF). At the bottom of the page is a 'Current Topics' section with a list of links: Physician Assistant Rule Making, Practitioner Regulation, October Educational Conference, 2013-2014 Flu Season Provider Resources, Pain Management Resources, Office-Based Surgery Rules, and More on our Current Topics Page.

Washington State Department of Health

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Home > Licenses, Permits and Certificates > Medical Commission Print

**Medical Commission**

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Facilities - New, Renew or Update  
File Complaint About Provider or Facility  
**Medical Commission**  
Medical Licensing  
Practitioner Regulation  
Medical Resources  
Commission Information  
Nursing Commission  
Professions - New, Renew or Update  
Provider Credential Search

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- [Change Your Contact Information](#)
- [View an MD or PA License](#)
- [Medical Marijuana Information](#)
- [Public Records](#)

**Current Topics**

- [Physician Assistant Rule Making](#)
- [Practitioner Regulation](#)
- [October Educational Conference](#)
- [2013-2014 Flu Season Provider Resources](#)
- [Pain Management Resources](#)
- [Office-Based Surgery Rules](#)
- [More on our Current Topics Page](#)

# So What?

## Applications & Implications

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### *What Patients Want – Trust: Patients Included*

- **Communication and Resolution Program (CRP)**

- Managed by HealthPact (Foundation for Health Care Quality)

- Based on just culture approach

- Goals

- \* Ensure that patient/families harmed by healthcare have needs met

- \* Promote learning within and across providers/institutions to prevent reoccurrence

- Creates transparent and accountable system

- \*(Re)Builds trust

# So What?

## Applications & Implications

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- The best resolution is to have no issues (we all know this)
- However, there will always be unexpected outcomes
- How might a difficult situation turn out differently if there was trust in the relationship?
- The impact on the Commission could be significant

# And Now!

## Something Completely Different

---

**70,000 - 440,000**  
*deaths due to med. errors*

**1/3**

*trillion spent on healthcare*

**2.8 30**

*% of amount wasted*

**177**

*billion treading medication problems*

*hosp. patients harmed during stay*

*adults with chronic disease*

**1/2**

*% benefit from aspirin*

**60**  
*but no advice*

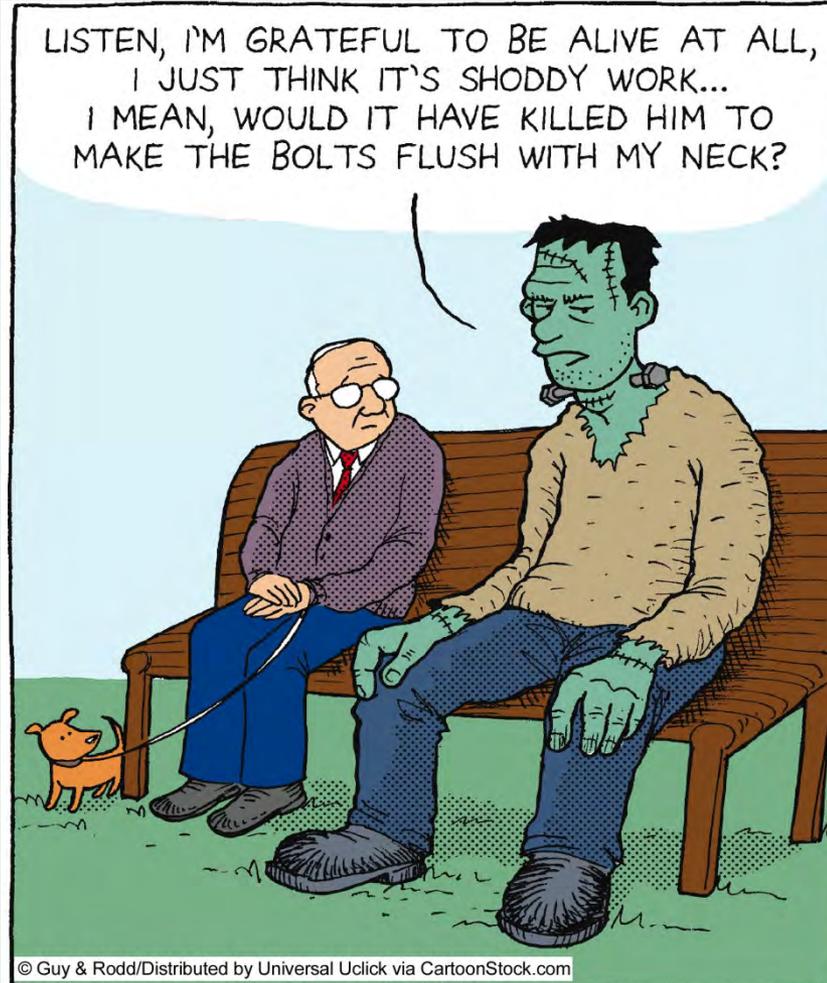
*wrong site surgeries/week*

**10-40**

*% invested in prevent*

**3**

# Few Closing Remarks



# Q&A

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**What do you want to know about patients and families in the system?**

*We will be here through lunch to address additional questions OR contact us for a consultation*

Bonnie Bizzell [bizzellb@gmail.com](mailto:bizzellb@gmail.com)

Steve Lovell [selovell01@gmail.com](mailto:selovell01@gmail.com)

<http://pfacqualityhealth.wix.com/pfac>

# References

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## Slides 2 & 12

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Classen, D. C., Resar, R., Griffin, F., Federico, F., Frankel, T., Kimmel, N., ... & James, B. C. (2011). 'Global trigger tool' shows that adverse events in hospitals may be ten times greater than previously measured. *Health Affairs*, 30(4), 581-589.

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## Slides 7 & 8

Adapted from: Schwab, B. MD. (2014, March 31). Recognizing patient- and family-centered care. *Moving Forward with Patient- and Family-Centered Care: Partnerships for Quality and Safety*. Lecture conducted from Institute for Family- and Patient-Centered Care, Burlingame, CA.



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Patient & Family Advisory Council

October 1, 2014

*Thank you!*

**(RE)FOCUS on SAFETY**

Incorporating the Patient's Perspective  
for Better Patient Safety

# Communication and Resolution Programs: Policy Goals and Legal Issues

William M. Sage, MD, JD  
The University of Texas at Austin

THE  
UNIVERSITY  
OF TEXAS  
SCHOOL OF LAW

# The Real Malpractice Problem

Little Connection Between the Malpractice System and the Health Care System!

# How Medical Liability Affects Cost/Access/Quality of Care

- Two-sided mismatch between negligence and litigation
  - Not only unjustified lawsuits, but also
  - Uncompensated injuries
  - High rates of avoidable error
- Poor process
  - Restricted information
  - Limited non-monetary remedies
  - Extreme delay
  - Lack of quality feedback to providers
- Misdirected focus on individual physicians rather than “systems”
  - Fear of harm to reputation
  - Financial stress over insurability
  - Defensive assurance: costly over-testing and overtreatment
  - Defensive avoidance: refusing “risky” (sick or litigious) patients

# Why Isn't Malpractice Policy Part of Health Policy?

- Doctors and Lawyers
  - Longstanding professional conflict
  - Unfinished battles for professional leaders
  - Paradox of public accountability in self-regulated profession (“holding experts accountable to non-experts”)
- Government Structure
  - Judicial rather than legislative issue
  - Tenuous connection to state regulatory oversight
  - Minimal federal presence (Medicare and Medicaid not engaged)
- Politics
  - Specialized lobbying on both sides
  - Poster child for/against general business “tort reform”
- Periodicity and bias
  - “Crises” of mid-1970s, mid-1980s, early 2000s
  - Defined by availability/affordability of physicians’ malpractice insurance

# Malpractice Crises May End, But Improvement Shouldn't

“All bleeding stops.”  
- Surgical adage

- Crises are definitional
  - Premiums may fall
  - Lawsuits may drop
- BUT
- Errors remain high
  - Compensation is poor
  - Process is miserable
  - Change is possible

# Guiding Principles for Malpractice Reform

- Think big: Do more than tinker with the legal system.
- Start small: Start with demonstration projects in the right places and with the right health care providers.
- Stay focused: Better health care is the goal, not more or fewer trial lawyers.

# Communication and Resolution Programs

- Tell patients what happened
- Try to put things right
- Improve safety for the future
- Empower and support caregivers

# What Do Patients Want?

- The truth
  - Did something happen?
- The facts
  - What was it?
- Emotional first aid
  - Empathy and compassion
  - Recognition and validation of emotions
  - Non-abandonment (a process, not an event)
- Accountability, including apology
- Future prevention
- Remediation

# What Does the Ideal CRP Event Look Like?

- Early event reporting by provider
- Careful analysis by institution-was unanticipated outcome caused by medical error? If so, how can recurrences be prevented?
- Prompt, compassionate disclosure to patient
- Fast, fair resolution for patient
- Learning at individual and institutional level

# Key Attributes of CRPs

1. Closer to the bedside
2. Farther from the courtroom
3. Based on teams and institutions

Therefore,

- Relevant to ongoing care
- Focused on system improvement
- More compassionate
- Less adversarial
- Less costly

# Established CRPs

- University of Michigan (Early settlement)
  - Claims half as likely, lawsuits 1/3 as likely
  - Time to resolution cut nearly in half
  - Reduced liability costs
- University of Illinois-Chicago (Seven Pillars)
  - Increase in patient safety event reporting from 1,500 to 7,500 per year
  - 50% reduction in new claims
  - Median time to resolution now 12 months compared with 55 months before program

# “The Need for Speed”

Delayed resolution means:

- Insufficient information for patients and families
- Lack of safety improvement; feedback after litigation is usually irrelevant
- High administrative cost
- Slow compensation
- Emotional pain/adversarial stress
- Actuarial unpredictability for liability insurers

# Legal Issues Can Intrude

CRPs convey an ethical and practical commitment from providers to patients, but can be constrained by:

- Litigation concerns
- Regulatory and economic complications

These can also be barriers to patient participation!

# Litigation Issues

- Damage caps
- Pre-suit notification laws
- Sovereign and charitable immunities
- Apology protection laws
- Legal representation of claimants

# Regulatory/Economic Issues

- State and federal reporting requirements
- Professional disciplinary response
- Medicare/private insurer subrogation or non-payment

# Example: Washington State CRP Certification Proposal

- Important exclusions: Gross provider negligence, provider impairment, boundary violations
- Certification process based at Foundation for Healthcare Quality
- MQAC retains all current authority.
- All mandatory reporting requirements remain in effect
  - Responsibility of institution, insurer
- Process is voluntary, open to all Washington physicians
- CRP Certification group will not perform independent investigations

# CRP Certification Review

- Case reviewed by multi-disciplinary group including patient advocate, risk/claims specialists, physician leaders, individual with regulatory experience.
  - Reviewers can not be affiliated with institution where event occurred
- Review addresses whether key elements of CRP were met
- Institutions/insurers can resolve CRP deficiencies and resubmit

# Hypothetical CRP Certification Request

- Provider uses bedside ultrasound, misses DVT
- Patient has PE, hospitalization, lost income
- Institution uses CRP: reporting by provider, communication with patient, prevention plans
  - Provider passes ultrasound course
  - New institutional policy developed
- Financial resolution of \$30K proactively provided to patient. Mandatory reporting to MQAC.

# Hypothetical (continued)

- Institution submits case for CRP Certification review.
- Review group determine all key elements of CRP present. Certification report provided back to institution/insurer.
- Institution/insurer send Certification Report to MQAC
- MQAC reviews report. Closes case as satisfactorily resolved without additional investigation.
- MQAC may conduct additional investigation before determining if closure is appropriate.



*"I'm afraid you've had a paradigm shift."*

# CRP Paradigm Shift

	Traditional Response	Open Accountability
Incident reporting by clinicians	Delayed, often absent	Immediate
Communication with patient, family	Deny/defend	Transparent, ongoing
Event analysis	Physician, nurse are root cause	Focus on Just Culture, system, human factors
Quality improvement	Provider training	Drive value through system solutions, disseminated learning
Financial resolution	Only if family prevails on a malpractice claim	Proactively address patient/family needs
Care for the caregivers	None	Offered immediately
Patient, family involvement	Little to none	Extensive and ongoing

# Washington State Medical Commission

## Educational Conference 2014

*With*

*Augustus A. White, III, MD, PhD*

*Harvard Medical School*

Wednesday, October 1, 2014

12:30 pm



**What  
Dr. Martin Luther King,  
Jr. Would Want Us To  
Know About Health  
Care Disparities**

**by  
Augustus A. White, III, MD, PhD**

**“Of all the forms of  
inequality, injustice in  
health is the most  
shocking and  
inhumane.”**

**-Dr. Martin Luther King, Jr.**

*Source:*

*King, ML Jr., National Convention of the Medical Committee for Human Rights,  
Chicago IL, March 25, 1966.*

# The Health Disparities List

- African Americans
- Appalachian poor
- Asian-Americans
- Elderly

*Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Smedley B, Stith A, Nelson A. Washington, DC: The National Academies Press; 2003.



# The Health Disparities List

- Gays, Lesbians, Bisexuals, Transgendered (GLBT)
- Immigrants
- Latinos
- Native Americans

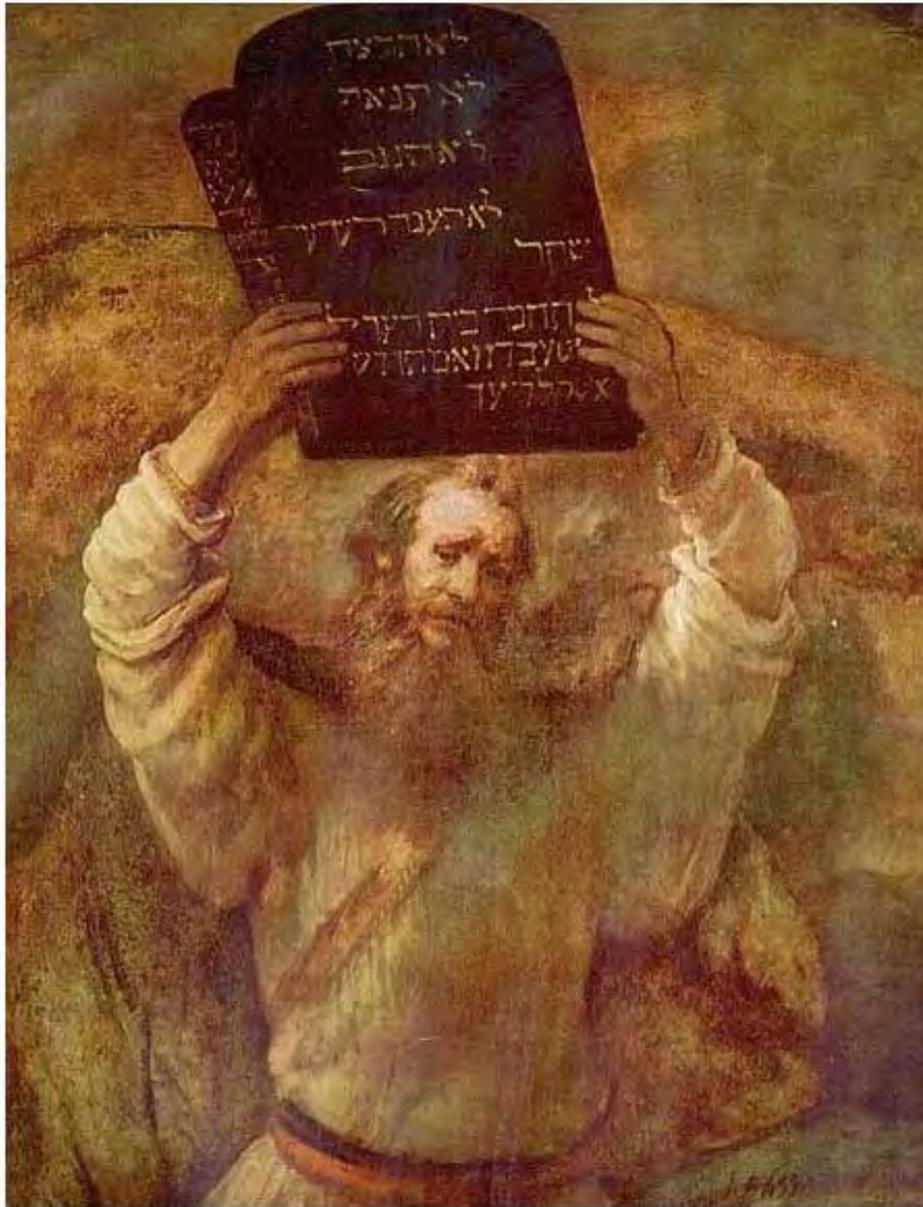
*Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Smedley B, Stith A, Nelson A. Washington, DC: The National Academies Press; 2003.



# The Health Disparities List

- Over weight people
- People living with disabilities
- Some religious groups
- Women
- Prisoners

*Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Smedley B, Stith A, Nelson A. Washington, DC: The National Academies Press; 2003.



Artist: Rembrandt (1659)

Source: Wikipedia

# Challenging the “-isms”

- Ageism
- Sexism
- Racism
- Classism
- Ableism
- Xenophobia
- Ethnocentrism
- Heterosexism



# African Americans

- Fewer kidney and liver transplants
- With diabetes, more amputations
- With prostate cancer, more castrations

# Among All Women vs. Men

- Fewer joint replacements
- Less medication following heart attack
- Women heart attack patients, more EMT time to the hospital

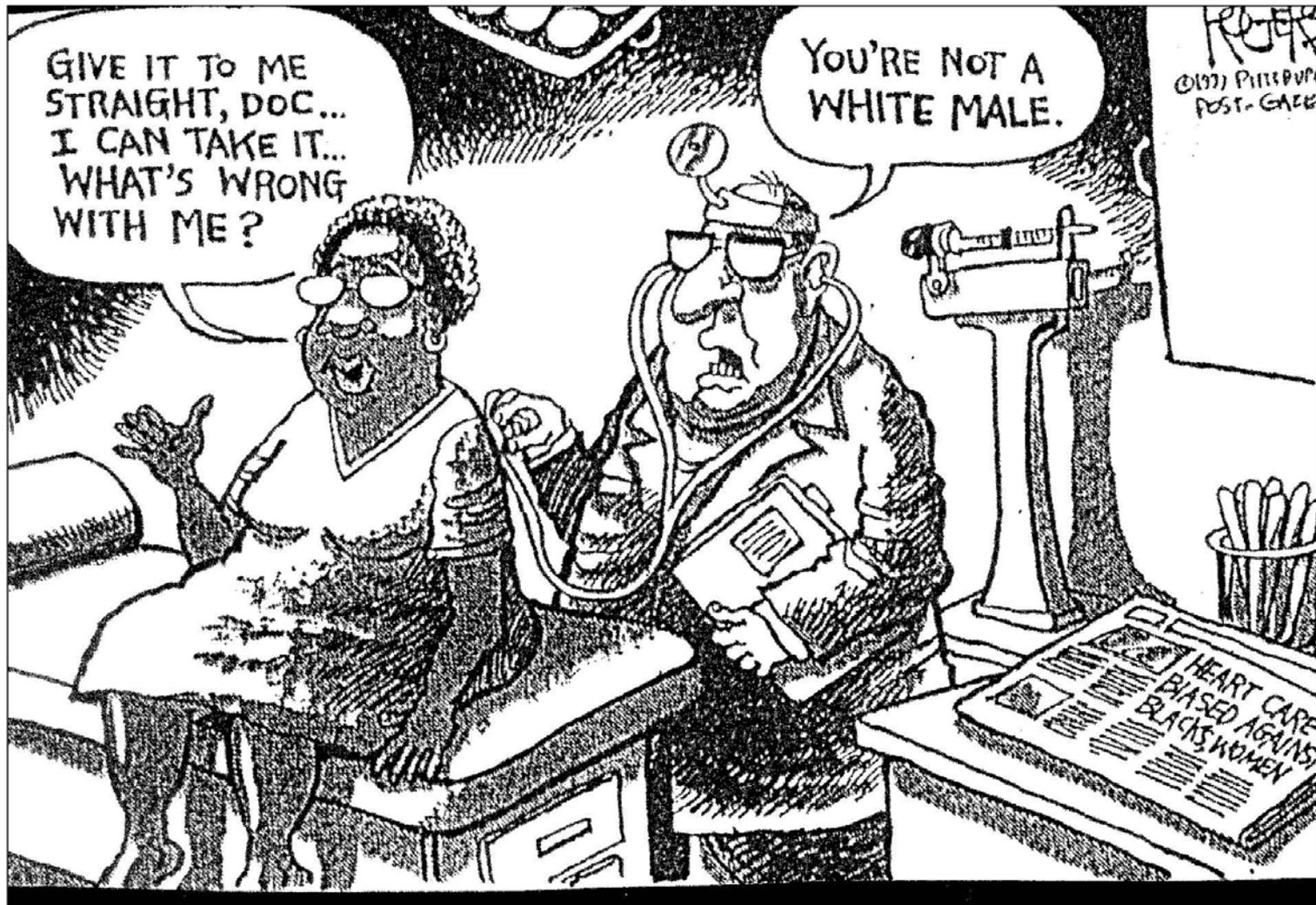
# For Hispanics

- Less pain medication for major fractures
- Less bypass surgery for heart disease
- Less basic recommended services, such as flu vaccines



*Pittsburgh Post-Gazette, 1999*

# Lesbian



*Pittsburgh Post-Gazette, 1999*

Lesbian

Over weight



*Pittsburgh Post-Gazette, 1999*

Lesbian

Over weight



*Pittsburgh Post-Gazette, 1999*

Disabled

Lesbian

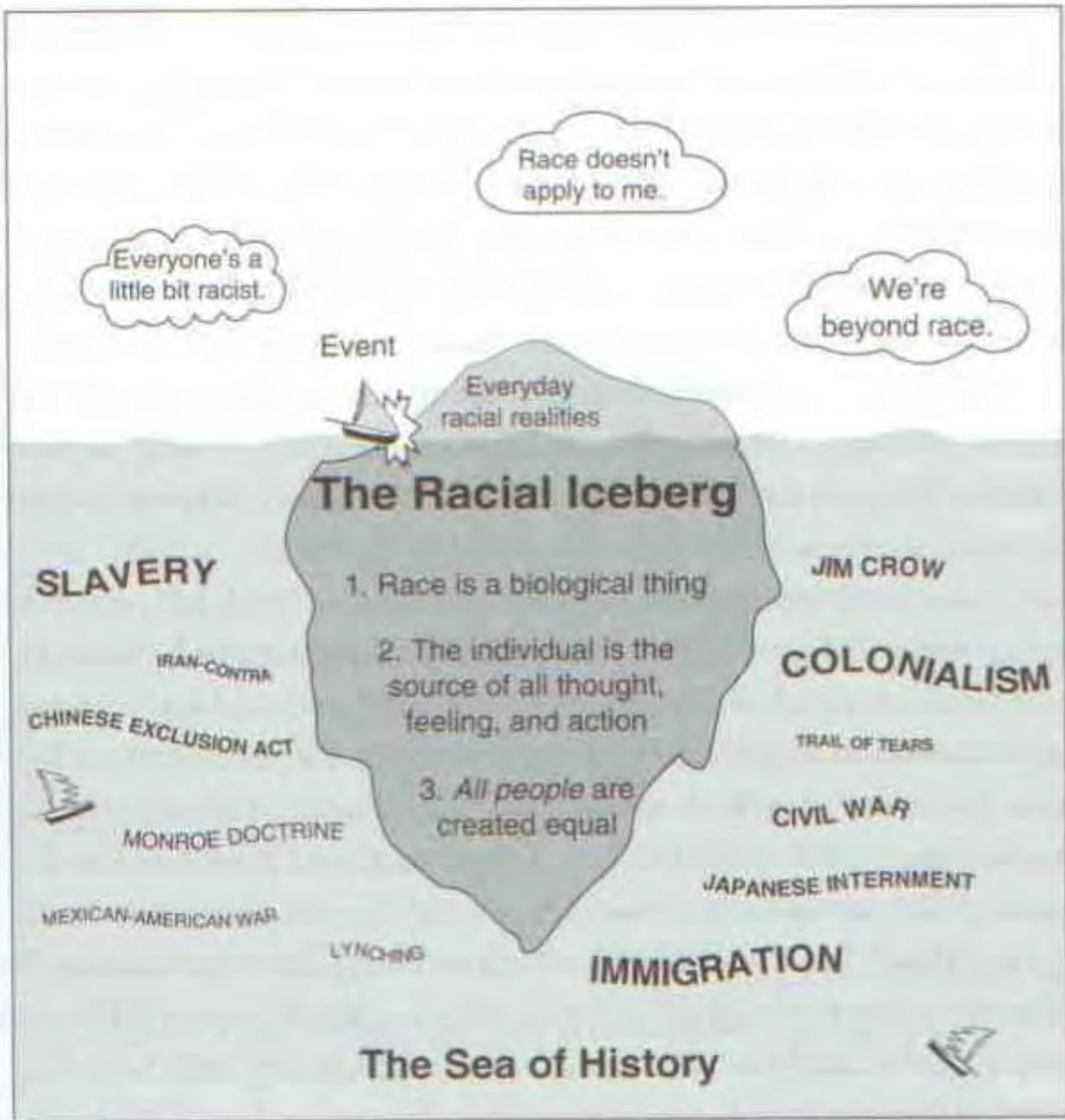
Over weight



*Pittsburgh Post-Gazette, 1999*

Disabled

Elderly



# Definition of Race

**Race** is a doing – a dynamic set of historically derived and institutionalized ideas and practices that...

*Doing Race*, Markus and Moya, 2010.

# Definition of Race

...sorts people into ethnic groups according to perceived physical and behavioral human characteristics that are often imagined to be negative, innate, and shared.

*Doing Race*, Markus and Moya, 2010.

# Definition of Race

...associates differential value, power, and privilege with these characteristics; establishes a hierarchy among the different groups; and confers opportunity accordingly.

*Doing Race*, Markus and Moya, 2010.

# “Doing Race”

Employment

Housing

Schooling

Medicine

# “Doing Race”

Justice

Sports

Media

- Stereotyping
- Unconscious Bias
- Conscious Bias



# Mahzarin Banaji

Implicit Association Test

<https://implicit.harvard.edu>

# Alex Green Study

“... physicians’ unconscious biases may contribute to racial/ethnic disparities in use of medical procedures ...”

- *Journal of General Internal Medicine* 22 (2007): 1231.

# The Economic Burden of Health Inequalities in the United States

by

Thomas A. LaVeist, PhD

Darrell J. Gaskin, PhD

Patrick Richard, PhD

September 2009

Source: Joint Center for Political and Economic Studies

<http://www.jointcenter.org>

# Disparate Care is more costly than Regular Care

2003 – 2006 Excess Costs of

30.6%

for

- African Americans
- Asians
- Hispanics

# Doctor Stressors

- Error prevention
- Malpractice: 10% of careers fighting claims
- Sleep deprivation
- Surgeons: 40% burnout, 30% depression, 15% alcohol abuse



# Doctor Stressors

Violence in health facilities are  
**FOUR TIMES** as common as in  
other private sector industries.

*- JAMA, Dec 2010*

# Doctor Stressors

AMA states impending  
“storm of regulations”  
will hurt physicians

# OH!

And by the way,  
You're a Racist.



# Getting to Equal: Strategies to Understand and Eliminate General and Orthopaedic Healthcare Disparities

by Daryll C. Dykes MD, PhD and  
Augustus A. White, III MD, PhD

*Clinical Orthopaedics and Related Research,*  
467: 2598-2605, 2009.

# Over 100 solutions

- Improve Health Literacy!!!
- Educate Caregivers
- Increase Diversity of Caregivers
- Educate Patients

# UC Davis Medical School

## Affirmative vs. Routine

*Graduation Rate*

94% vs. 97%

- Davidson and Lewis, JAMA, Oct 1997

# Affirmative vs. Routine

- Specialization rates
- Residency performance
- Honors received



Equal

- Davidson and Lewis, JAMA, Oct 1997

# Over 100 solutions

Expand Mandates like in  
New Jersey →

Must Have Culturally  
Competent Care Education to  
get or to renew license

# Over 100 solutions

## Verizon

Works to Eliminate  
Disparities in Health Care  
for its Workforce

Health Affairs (Millwood) 2005; 24: 21 – 423.

# Over 100 solutions

Thoroughly Address

ACGME Cultural

Competency

Requirements of Residents

# Over 100 solutions

Thoroughly Address **LCME**  
Directives 21 and 22 for  
Culturally Competent Care  
Education of **Medical Students**

# Over 100 solutions

## National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS)

March 2001

Source: U.S. Department of Health and Human Services, OPHS  
Office of Minority Health

<http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf>

# Over 100 solutions

“A-once-in-Human-History  
opportunity...”

Campaign to end health disparities by  
2035.

- Professor Lawrence Summers, et.al.

*Global Health 2035: a world converging within a generation.*

*The Lancet, 382 (9908), 1898-1955, 7 Dec 2013*

*Published online 3 Dec 2013*

# Over 100 solutions

A new report proposes doubling research and development spending, a heightened priority on family planning, and increased taxes on harmful substances such as tobacco, alcohol, and even sugar as part of an effort to eliminate health disparities between rich and poor nations.

- **Professor Lawrence Summers**

*Global Health 2035: a world converging within a generation.*

*The Lancet, 382 (9908), 1898-1955, 7 Dec 2013*

*Published online 3 Dec 2013*

# Over 100 solutions

Needed by 2020

45,000 Primary Care

46,000 Specialists

MUST “harvest” more  
minorities!

SOURCE: 12/30/13 article on The Pew Charitable Trusts website states that The Association of American Medical Colleges (AAMC) provided these estimates.

<http://www.pewstates.org/projects/stateline/headlines/are-there-enough-doctors-for-the-newly-insured-85899528912#>

# Over 100 solutions

Research shows that  
implicit biases are malleable

- Don't reinforce negative stereotypes
- Learn about people who contradict negative stereotypes

Howard J. Ross

Reinventing Diversity: Transforming Organizational  
Community to Strengthen People, Purpose and Performance.

Rowman & Littlefield Publishers, 2011.

# Over 100 solutions

November 2010 Google Scholar  
Article hits

Keywords:

Minority Health	1,140,000
Cultural Competence	552,000

Source:

Like RC. Educating clinicians about cultural competence and disparities in health and health care. *Journal of Continuing Education in the Health Professions* 2011; 31(3):196-206.

<http://www.ncbi.nlm.nih.gov/pubmed/21953661>

# Over 100 solutions

November 2010 Google Scholar  
Article hits

Keywords:

Health Care Disparities	438,000
Health Disparities	245,000

Source:

Like RC. Educating clinicians about cultural competence and disparities in health and health care. *Journal of Continuing Education in the Health Professions* 2011; 31(3):196-206.

<http://www.ncbi.nlm.nih.gov/pubmed/21953661>

**JUST DO IT.**



Source:

<https://plus.google.com/+nike/videos>

# Culturally Competent Care Pedagogy: What Works?

by Daryll C. Dykes MD, PhD and  
Augustus A. White, III MD, PhD

*Clinical Orthopaedics and Related Research,*  
469: 1813-1816, 2011.

Distrustful

Suspicious

Anxious



Hostile

Frightened

# SEEING PATIENTS

UNCONSCIOUS BIAS IN HEALTH CARE

AUGUSTUS A. WHITE III, M.D.

with DAVID CHANOFF



# Suggestions for Caregivers

- Believe Biases Exist
- Believe Disparities can be diminished
- Review and Select from CLAS

<http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf>

# Suggestions for Caregivers

- Double F Criterion –  
Treat as Family or Friend
- Use “Teach Back” to help communications
- “Humanize” Our Patients

# Suggestions for Patients

- “Humanize” Your Doctor
- Build Bridge and Meet Doctor “Half Way”
- Not working? Do a Frank Check.

# Suggestions for Patients

- Study your Disease!!!

MayoClinic.com

Web MD

- Do a Teach Back with Your Doctor
- Take a Friend or Relative with You

# Summary

- Formidable national problem
- Moral ethical problem
- *We must improve!*

# Summary

- Unconscionable reality
- Shocking and inhumane
- The “11<sup>th</sup>” Commandment

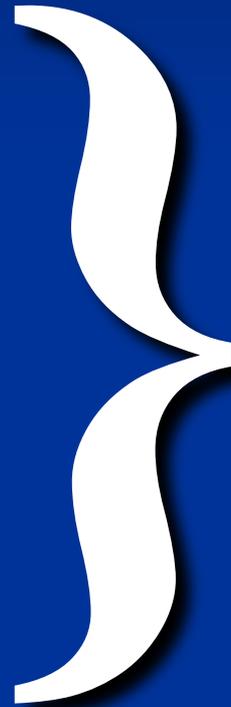
# Summary

Synergize

Solidify

Seize upon

Supplicate



Our common  
humanity



Rev. Dr. Martin Luther King, Jr. (Inspiration)

I believe Dr. King would want us to continue to strive to be a more humane society and for doctors, nurses, and others to strive to be humanitarian role models.

# SPHERE OF INFLUENCE

**Be Well!**

**Respectfully submitted.**

# Acknowledgements

- Dr. Mark Bernhardt
- Beth Israel Deaconess Medical Center,  
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- Blue Cross Blue Shield of Massachusetts
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(Richard J. Hindlian, Co-Trustee)
- J. Robert Gladden Orthopaedic Society
- Arthur and Barbara Higgins Charitable Foundation
  - The Macy Foundation
  - Massachusetts General Hospital,  
Department of Orthopaedic Surgery
  - McKesson Foundation
    - Macey Russell
  - Zimmer Holdings Inc.



# Building a Better Professional

Iconoclasts & Idiosyncrasies  
Dealing with Conflicts

Byron D. Joyner, MD, MPA

Vice Dean for GME and  
Designated Institutional Official

October 1, 2014

# Standardization in GME



# The GME Balance

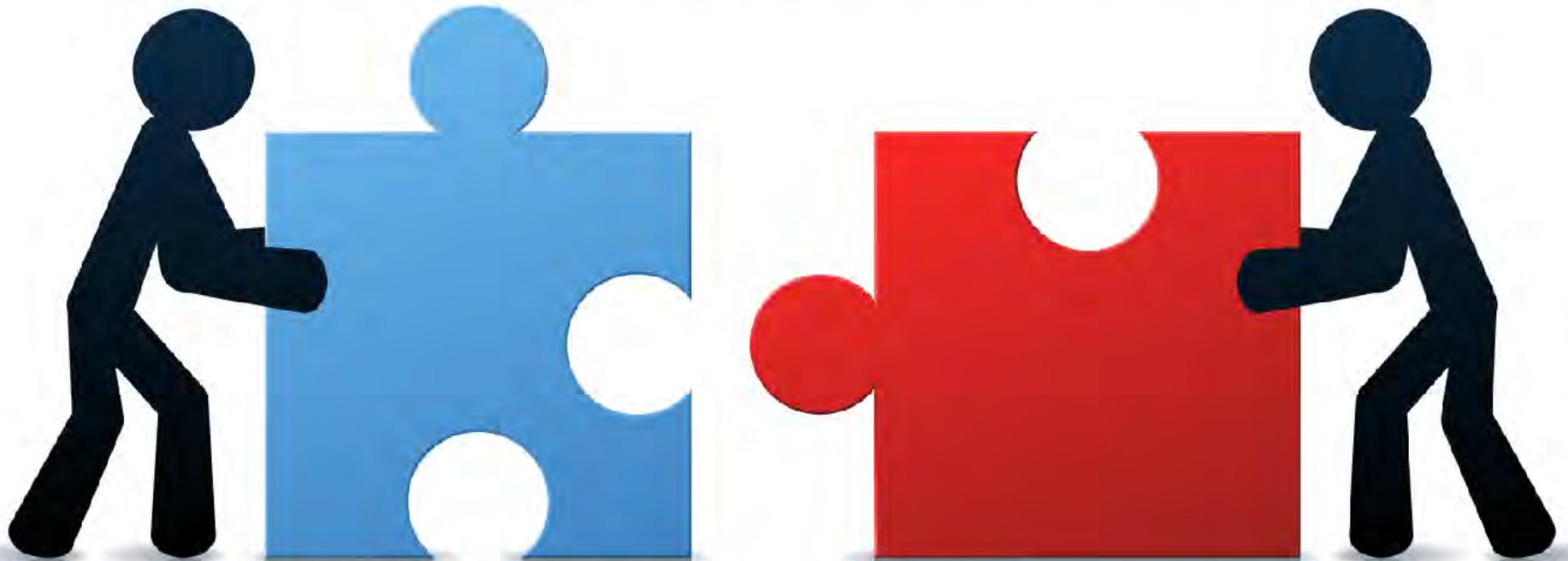
**Graduate Medical Education**

*Research*

*Education*

*Patient Care*

# Flexnerian Standards



"When a residency is set up with proper education standards, it is the most effective, economical and satisfactory method for obtaining this training."

Flexner Report, 1910

# Professional



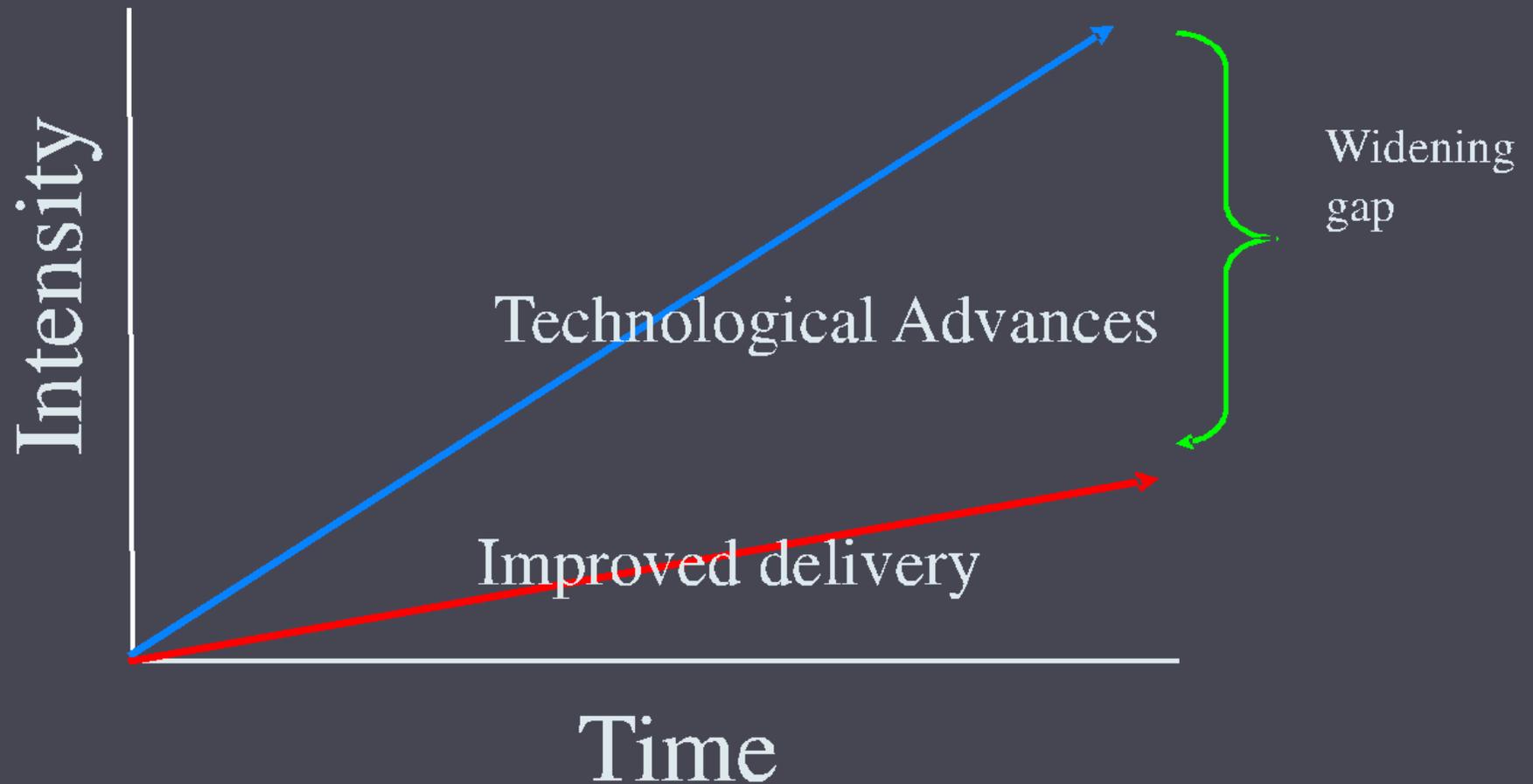
1. Esoteric knowledge and skills
2. Service and altruism
3. Financial reward is not a metric of success
4. Self-reflection → Self-regulation

Supreme Court Justice Louis Brandeis, 1912

1. Esoteric knowledge and skills
2. Service and altruism
3. Financial reward is not a metric of success
4. Self-reflection  Self-regulation

Supreme Court Justice Louis Brandeis, 1912

# Crossing the Quality Chasm



Institute of Medicine, 2001

nt



# ACGME Mission

*To improve healthcare by assessing  
and advancing the quality of  
resident physicians' education  
through accreditation*

# The Clinical Learning Environment



**ACGME**  
**Mission**

*To improve healthcare by assessing and advancing the quality of resident physicians' education through accreditation*



**Professionalism**

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

ACGME Outcomes Project, 2001





# Professionalism

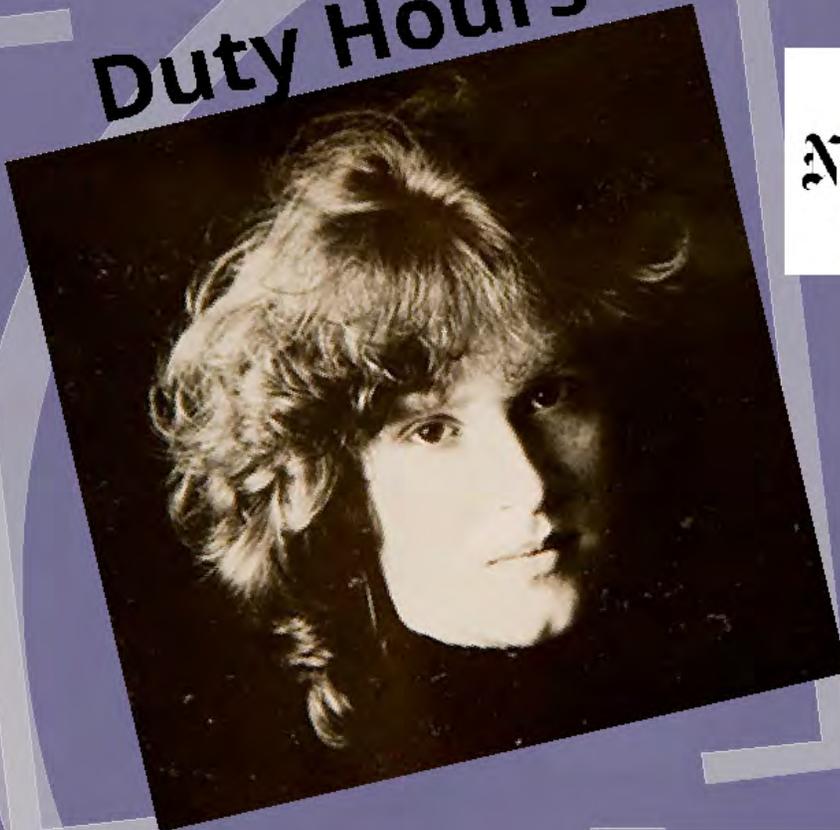
Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

ACGME Outcomes Project, 2001

# A Framework for Professionalism



# Duty Hours



The  
New York  
Times



The NEW ENGLAND  
JOURNAL of MEDICINE



NEW YORKER

## Fragmented Care

### Decreased

Relationships  
Training of all residents  
"ownership"

### Increased

Anxiety and stress  
Culture of shift work  
Culture of malpractice

# Fragmented Care

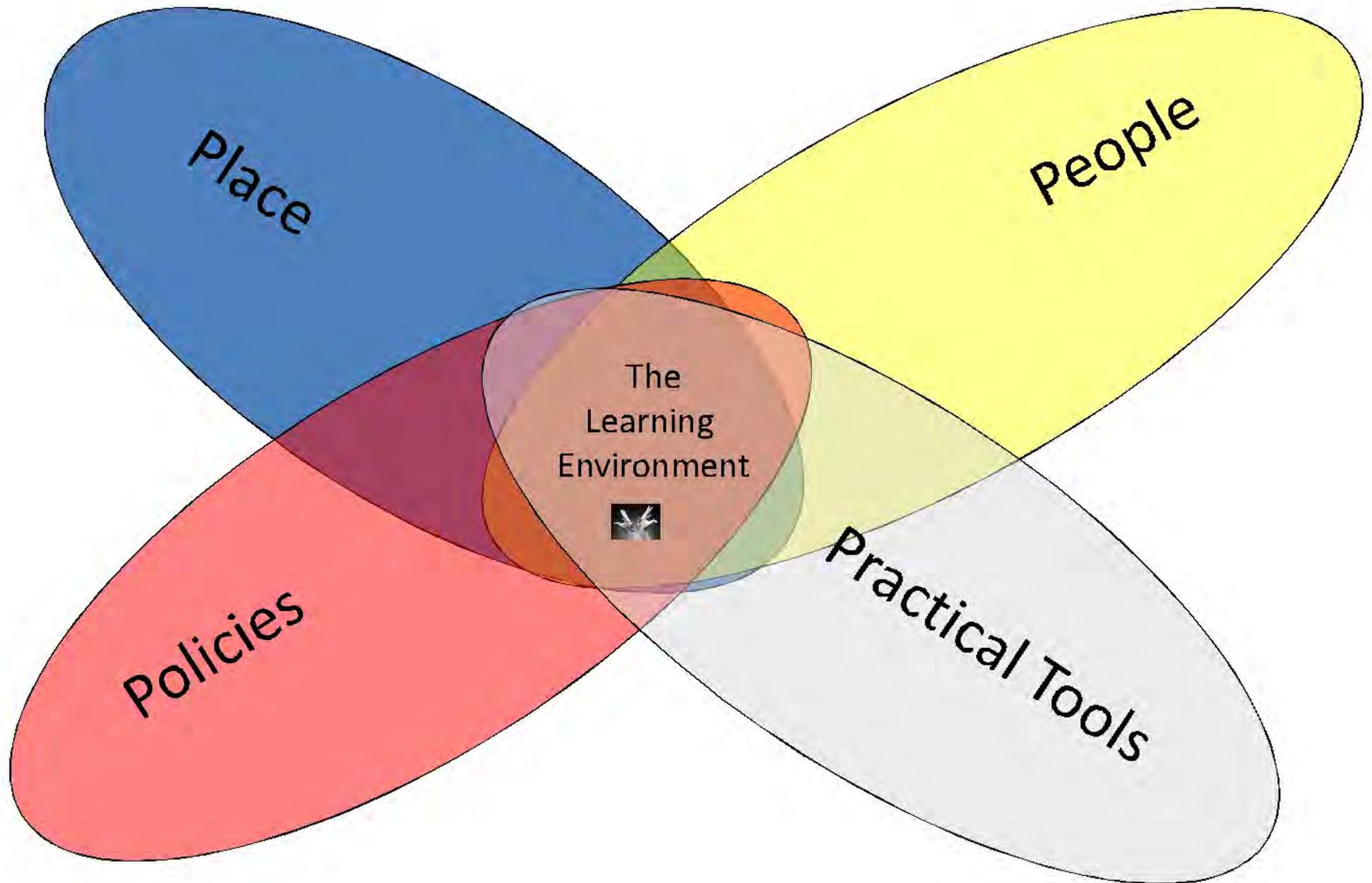
## *Decreased*

Relationships  
Training of all residents  
"Ownership"

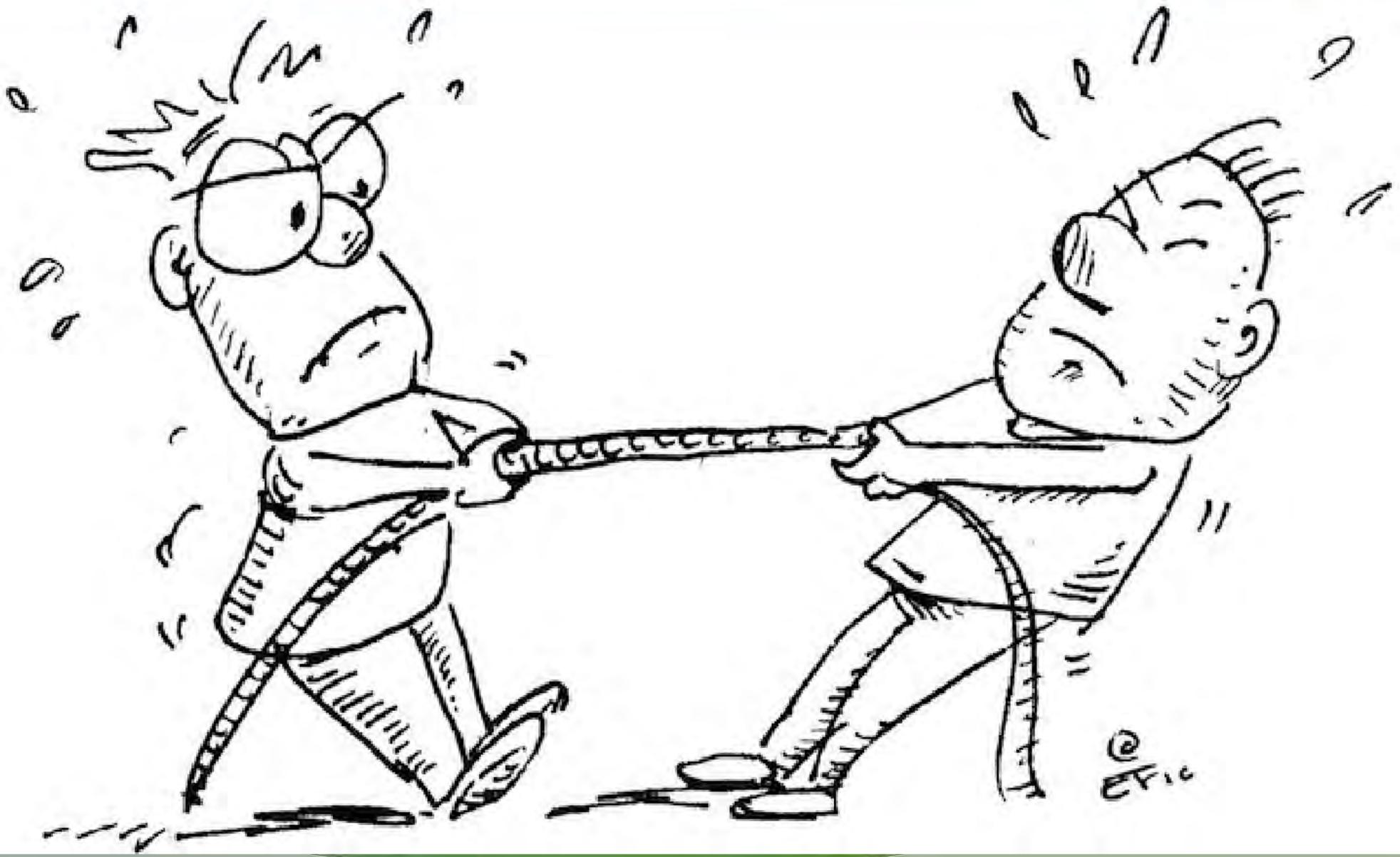
## *Increased*

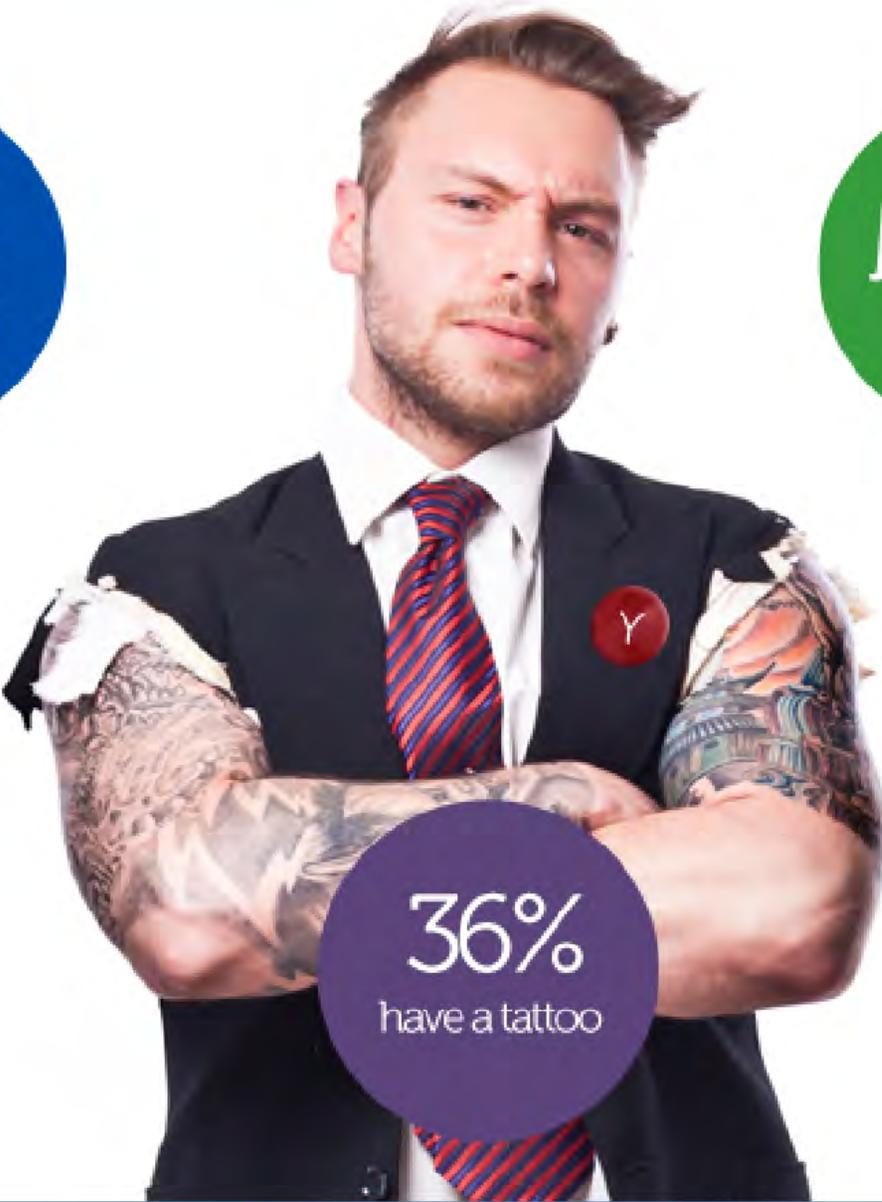
Anxiety and stress  
Culture of shift work  
Culture of conflict

# Clinical Learning Environment









75%  
of the 2025  
workforce

more  
MBAs  
than no  
degree

\$2bn  
US spending  
power

30%  
25-34s living  
with family

36%  
have a tattoo



*It is far harder to fathom the problem in its entirety than to criticize the specifics about the problem*

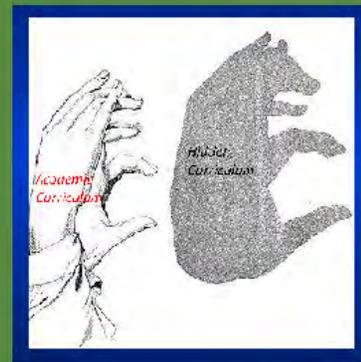
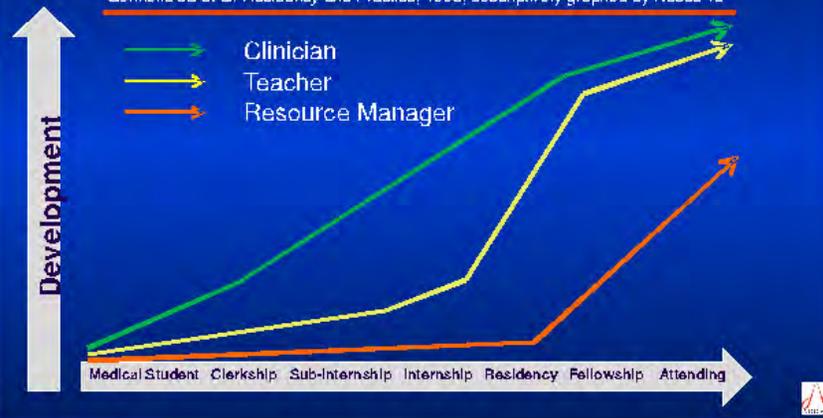


~Kenneth Ludmerer

# Adragogy

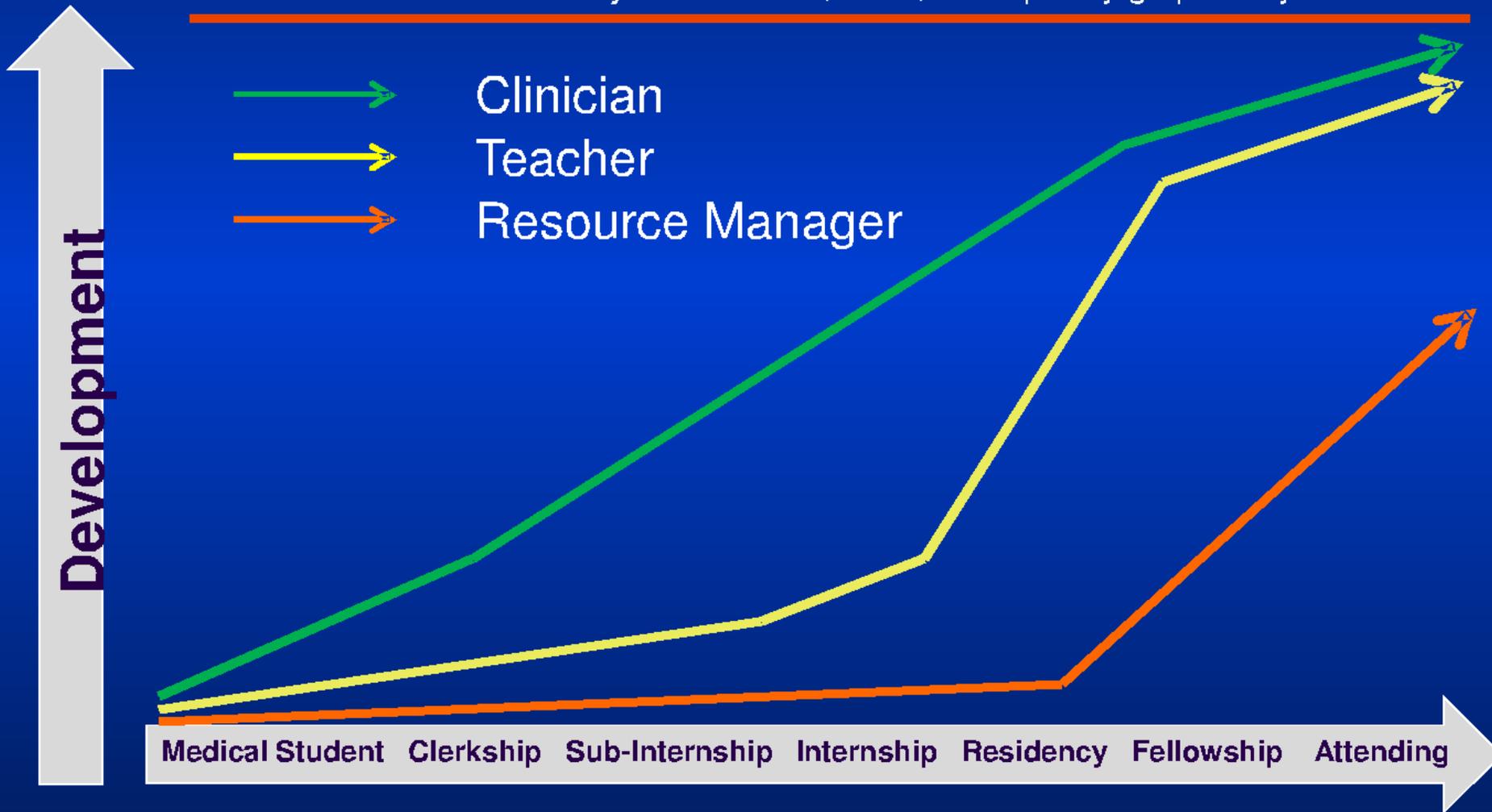
## Professional Development: The Three Roles of the Physician

Gonnella JS et al. *Residency and Practice*, 1998, descriptively graphed by Nasca TJ



# Professional Development: The Three Roles of the Physician

Gonnella JS *et al. Residency and Practice*, 1998, descriptively graphed by Nasca TJ





*S  
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*Academic  
Curriculum*



*Hidden  
Curriculum*

**CRISIS**

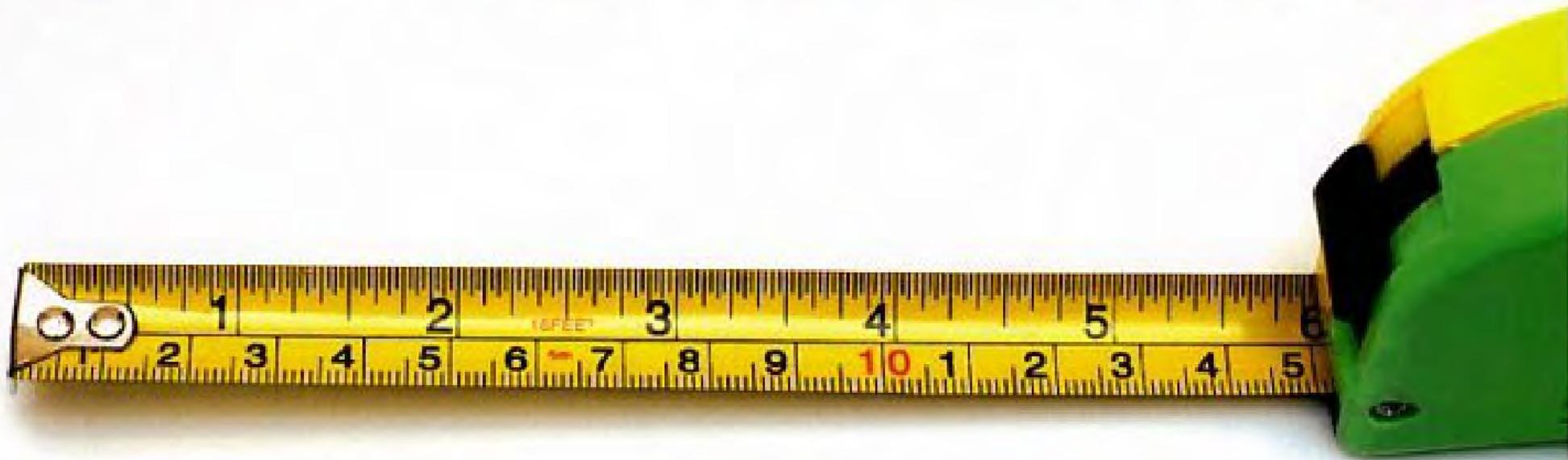
危

**Danger**

机

**Opportunity**

# SUCCESS



## **Challenges:**

- 1) Look, Listen and Learn**
- 2) Patient quality and safety**
- 3) Learner centeredness**
- 4) Einstellung Effect**



# Professionalism Appealing to the 6 Senses



Daniel Pink, A Whole New Mind: Moving from the Information Age to the Conceptual Age

Not just function but design





Not just argument but story







Not just focus but symphony

A close-up photograph of a glass flask containing a yellow liquid. The flask is partially filled, and the liquid level is visible. The background is white. Overlaid on the flask is the text "Not just accumulation but meaning" in a dark grey font. In the center of the flask, there is a yellow rectangular box containing the text "DATA INTO MEANING" in bold, black and white capital letters.

Not just accumulation but meaning

**DATA**  
**INTO**  
**MEAN**  
**ING**



Not just seriousness but fun

# How We Learn

## Experience

Standardization/  
Individualization

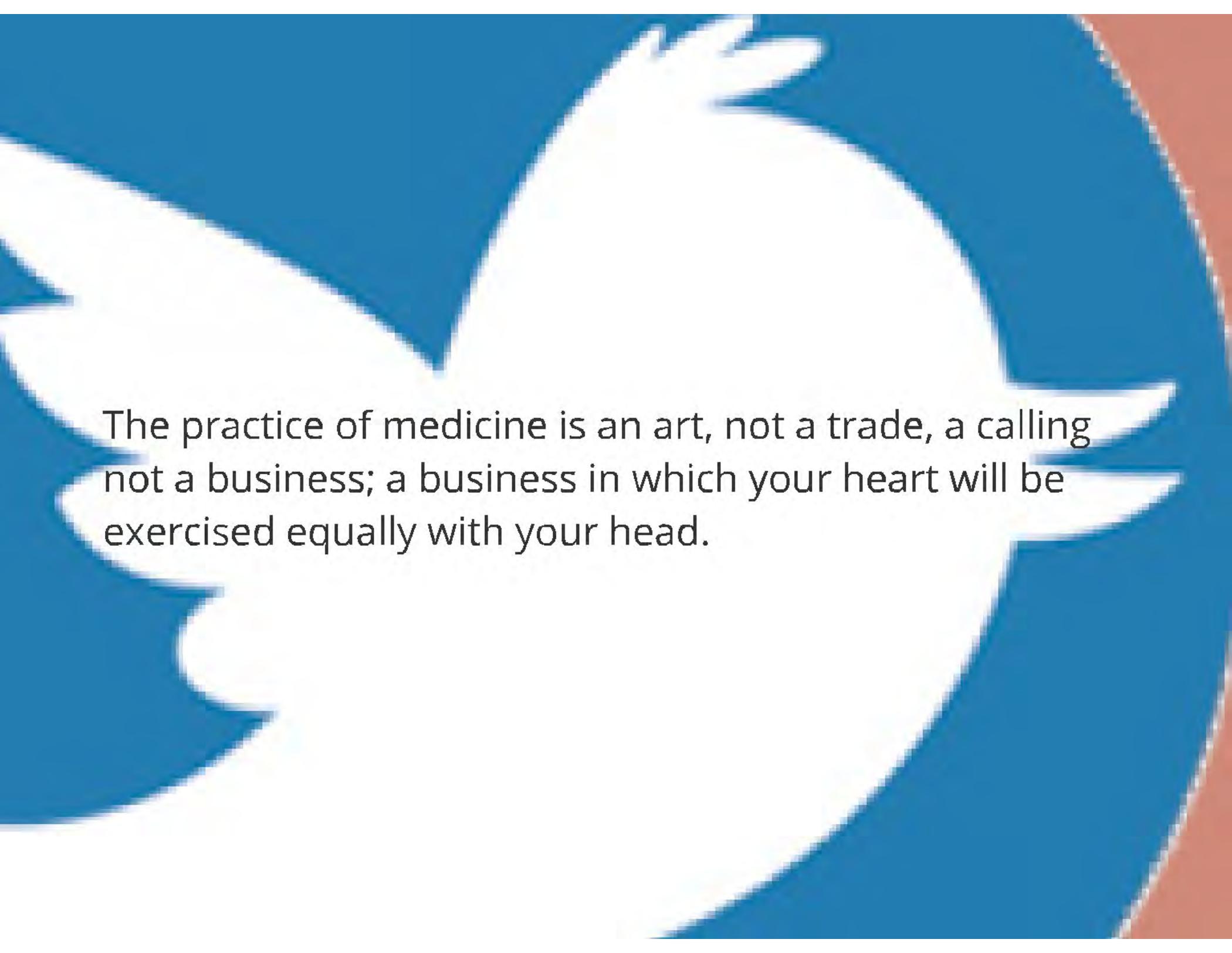
Self-Reflection

Learning by observing

Processing with others

A formal oil painting of Sir William Osler, a prominent British physician and medical reformer. He is depicted from the chest up, seated in a dark, high-backed chair. He has a serious expression and is looking slightly to the right of the viewer. He has a mustache and is wearing a dark, three-piece suit with a white shirt and a dark tie. The background is a dark, neutral color. The lighting is soft, highlighting his face and the texture of his clothing. The overall tone is professional and dignified.

SO, WHAT IF SIR WILLIAM OSLER  
HAD TWEETED?



The practice of medicine is an art, not a trade, a calling not a business; a business in which your heart will be exercised equally with your head.

Intentionality

Trial & Error

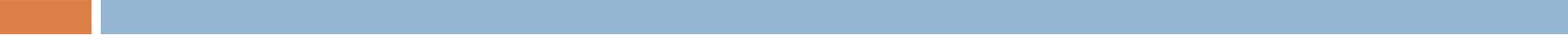
apoTHEOSIS

antiTHESIS

**Professionalism**

# Thank you





# **The Interstate Medical Licensure Compact**

*Medical Quality Assurance Commission  
Educational Conference*

*October 1, 2014*

# Disclosures

## Organizational Affiliations

- Federation of State Medical Boards (FSMB)
- Administrators in Medicine (AIM)
- Washington Department of Health (DOH)
  - Board of Osteopathic Medicine and Surgery

## Disclosure Statements

- The interstate compact does not reflect the views of, nor has it been endorsed by, the FSMB, AIM, or the Washington Department of Health.
- The interstate compact is not a formal work product of the FSMB, AIM, or the Washington Department of Health.
- The Board of Osteopathic Medicine and Surgery has formally endorsed the Compact and supports the Medical Commission's request legislation.
- The information and views expressed in this presentation are of the author only.

# Goals for Today

- Recap the historical, legal, and policy contexts that gave rise to the consideration and development of an interstate compact.
- Consider the potential implications of national licensure.
- Provide an overview of interstate compacts.
- Highlight the features and processes of the proposed Interstate Medical Licensure Compact.
- Share selected stakeholder and media interest in the Compact.
- Address questions and foster discussion.

# Historical Background

- “State”-based regulation of physicians actually dates to colonial times:
  - Virginia, 1639
  - Massachusetts, 1649
  - New York, 1665
- In US history, state regulation of physician licensing is largely uninterrupted, except for a brief period in the mid-1800s.
- However, the ACA, shifting demographics, technological advances, changes in physician specialty mix, consumer demands, and health care financing are changing expectations for how boards will regulate physicians.
- Large industry-based interest groups are lobbying for federal action on a national licensure system.
- Congress has passed or considered bills with the potential to erode state-based physician licensing.

# Legal/Constitutional Background

- Tenth Amendment to the US Constitution is generally the starting point for defense of state-based regulation of physicians.
- Important US Supreme Court Case law supports it:
  - *Dent v. West Virginia* (1889)
  - *Hawker v. New York* (1898)
- However, federalist approaches changed in the 20<sup>th</sup> century, creating greater opportunities for federal intervention into areas of traditional state regulation.
  - The “layer cake” vs. the “marble cake”
  - Conditional spending power

# Why NOT National Licensure?

- Important patient safety mission could be undermined:
  - Licensing funds are uncertain, but the same disciplinary mandate.
  - Public's practical ability to complain across state lines.
  - Could exacerbate the length and complexity of licensing, investigative and adjudicative activities
- Even “military” models, which Congress has looked to expand upon, dilute states’ jurisdiction.
- Ignores long history of successful regulation within the state domain.
- Ignores federalist principles embodied in the 10<sup>th</sup> Amendment to the US Constitution.

So is there a better option than federal intervention? I think so...

# Interstate Compacts – A Primer

- Like physician regulation, compacts also date to colonial times.
- Compacts are widely used, but not well understood, part of jurisprudence; the average state is a party to 25.
- They are explicitly authorized by the “Compact Clause” of the US Constitution (*Article 1, Section 10, Clause 3*).
- Compacts contain elements of both contract and statutory law; as a result, they supersede state laws, rules, courts, but are neither federal nor state.
- States pass legislation and governors sign; the legislation must be identical to be effective. Consequently, once enacted, they are very hard to amend.
- As a result, effective compacts are generally drafted broadly and grant rulemaking authority to administrative organizations to allow for adjustments over time.
- Allow states to collectively solve shared problems without federal intervention.

# Interstate Medical Licensure Compact

The interstate Medical Licensure Compact will:

- Set meaningful eligibility standards for physicians to participate.
- Create an Interstate Medical Licensure Commission to administer the Compact.
- Preserve revenues critical to state board operations.
- Clearly delineate the disciplinary protocols for medical and osteopathic boards in both “principal” and “compact” states.
- Require physicians to register their intent to practice in any and all states.
- Establish information systems for distribution of data between state boards.
- Be entirely voluntary, both for states and for physicians.
- Likely avert further federal encroachment on state authority for medical and osteopathic physician regulation.
- Promote multistate practice and telehealth in a manner responsive to patient safety.

# Physician Eligibility Requirements

- Physicians must meet the following requirements to participate in the compact:
  - Successfully pass each component of USMLE or COMLEX-USA within three (3) attempts.
  - Successfully complete a graduate medical education program.
  - Specialty certification or a time-unlimited certificate from American Board of Medical Specialties or American Osteopathic Association Bureau of Osteopathic Specialists.
  - No discipline on any state medical license.
  - No discipline related to controlled substances.
  - Not under investigation by any agency.
- Not all physicians will be eligible.

# Principal License

A principal license serves as the entry point for eligible physicians:

- Physician must obtain a full and unrestricted license from a member state.
- State of principal license cannot award a compact privilege without an underlying license.

What state can serve as state of principal license?

- State of physician's primary residence.
- State where 25 percent of medical practice occurs.
- Location of physician's employer.
- State designated for federal income taxes.

# Interstate Commission

- Interstate governmental organizations are commonplace among “modern” interstate compacts.
- The compact does not create a “superboard”.
  - Role is to oversee the administrative and policy elements of the compact.
  - No licensing or disciplinary role.
- Two representatives from each participating state (executive director or board member) participate in governance work of the Interstate Medical Licensure Commission.
- Does have rulemaking authority.

# Financial Considerations

- User fees are envisioned as the method for funding the Interstate Medical Licensure Commission.
- Analogous to how most medical and osteopathic boards operate today.
- Section 13 allows the Commission to collect an annual assessment from member states. While not been intended to be used, it is necessary:
  - States hold ultimate fiduciary responsibility for this government organization.
  - Tax implications for the Commission.
  - Qualified immunity implications for members serving on the Commission.
- Boards will continue to set fees for licensure and renewal for physicians licensed in their states as they do now.

# Investigative Functions

- Currently, states face challenges in effectively investigating complaints involving physicians beyond their borders.
- The compact would allow:
  - Boards to undertake joint investigations.
  - The timely sharing of investigative material.
  - Strengthened enforcement of administrative subpoenas across state lines for board investigations.
  - The information will be kept confidential, per Compact provisions.

# Registration and IT System

- An essential element of the Compact – member state boards have data on if a physician is, or is capable of, practicing in a given state.
- By requiring a full and unrestricted license to be issued, every state has a record of physicians who may practice there.
- More broadly, the Commission will serve as a clearinghouse for licensing data and disciplinary data:
  - States, in approving physicians to participate in the Compact, will notify the Commission, who will in turn notify other states.
  - States, including the principal state, will notify the Compact of licensure status, who will in turn notify other states.
  - The Commission will set out in rule disciplinary reporting requirements for boards, which will be accessible by member states.

# Sample Workflow – Licensing with a Compact



Dr. Doctor decides to apply to state of Emergency



Dr. Doctor first decides if he only wishes to practice in the state of Emergency, or if he wants to practice in multiple states.



If Dr. Doctor decides to seek only a standard state license (i.e., limited to practice in the state of Emergency), then he submits the normal application, documents and fee to the state board.



If Dr. Doctor decides wants to practice not only in his state of principal licensure but in other states within the Compact, he submits the normal application and documents for the principal state license, plus he submits a compact application with the principal state board. He submits only the check for the home state license to the state board.



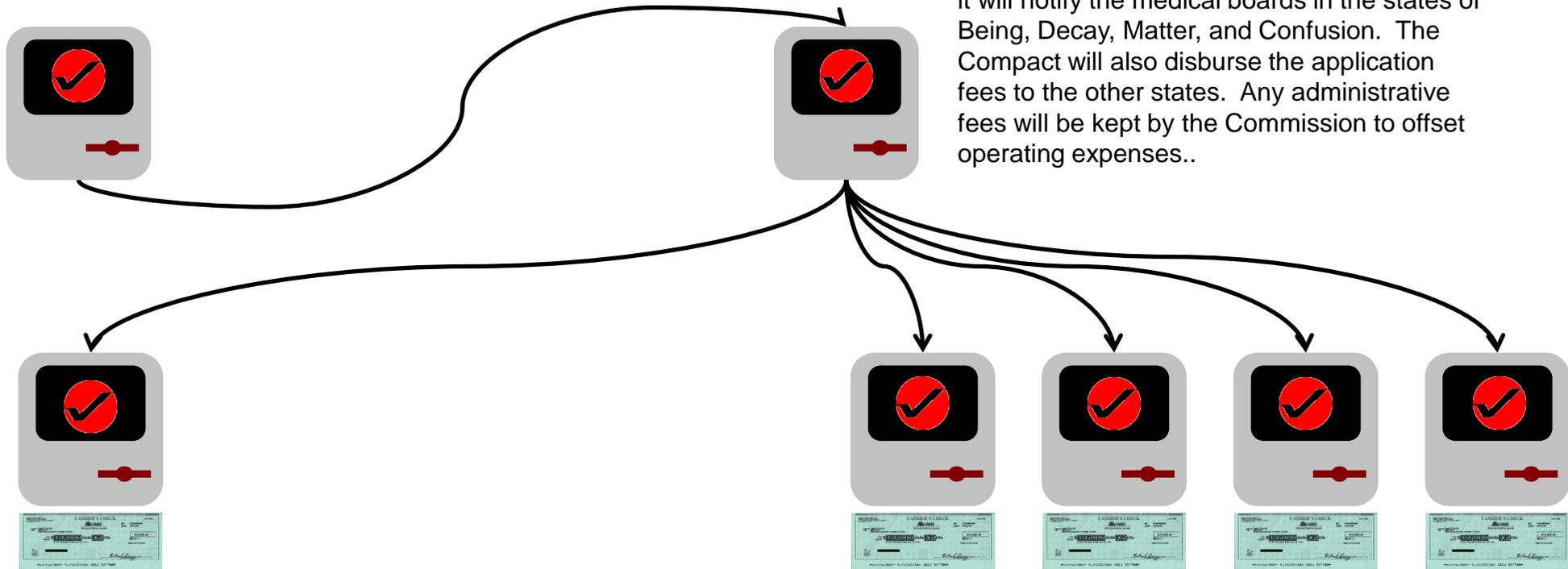
As part of his application, Dr. Doctor also submits to the Compact a registration form indicating he has applied to the state of Emergency, but also wants to practice in the states of Being, Decay, Matter, and Confusion and submits the appropriate fee(s).





Dr. Doctor's applications (both for principal state and the Compact authorization) are reviewed by the state of Emergency Medical Board. If he meets the qualifications for each, he may be an authorization for the compact. A compact authorization can only be held in conjunction with the principal state license. The principal state communicates that it has issued authorized Dr. Doctor for the Compact.

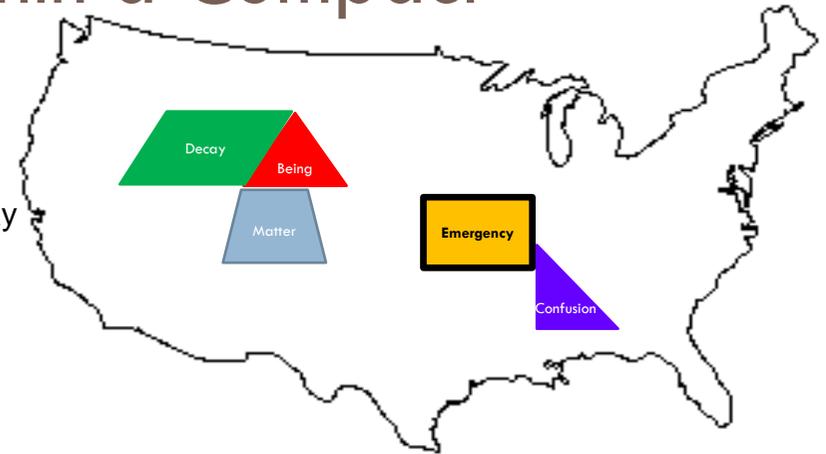
When the Compact is notified by the home state that the physician has been authorized, it will notify the medical boards in the states of Being, Decay, Matter, and Confusion. The Compact will also disburse the application fees to the other states. Any administrative fees will be kept by the Commission to offset operating expenses..



# Sample Workflow – Discipline within a Compact



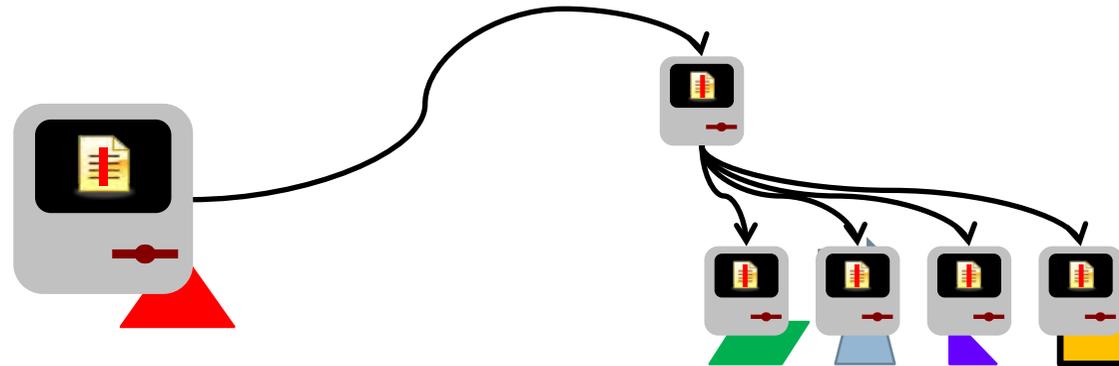
Dr. Doctor's home state is the State of Emergency. He applied for and received a compact privilege, and has licenses via the compact in the States of Being, Matter, Decay and Confusion.



Dr. Doctor commits a significant medical error while practicing in the State of Being, and the patient files a complaint with the State of Being Medical Board (BMB).

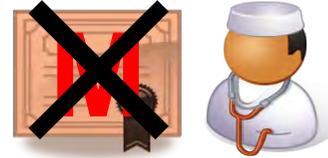


The BMB opens the complaint and refers it for investigation. The Board also notifies the Compact of the open investigation, which in turn provides notification to the other states where Dr. Doctor is licensed.



**IMPORTANT NOTE:** Regardless of any action(s) taken by any compact state against a licensee, he or she retains an underlying principal state license. While any state can act on a license issued via the compact, only the board in the state of principal licensure can act on the principal license.

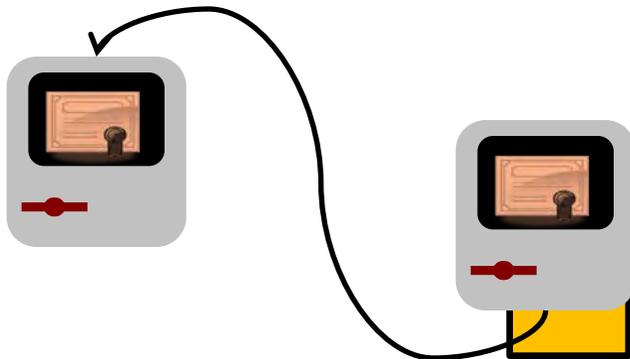
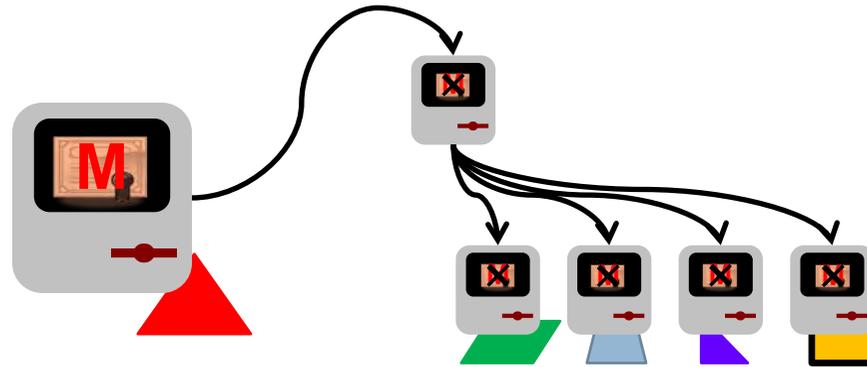
After investigation, the BMB decides to take action. Based upon the type of action taken, there are two possible outcomes for Dr. Doctor's multistate authorization.



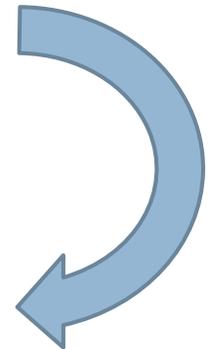
If the BMB takes an action that prevents Dr. Doctor's ability to practice (i.e., revocation, suspension, or surrender in lieu of discipline), then the action taken by the BMB affects Dr. Doctor's ENTIRE multistate authorization. In this case, he may only still practice in his state of principal license unless action is taken on that license by the EMB.



When the action is final, the BMB reports it to the Compact, which in turn communicates to all the other states where Dr. Doctor is licensed, including the state of principal licensure. The other "compact" states then rescind their licenses as well without further action.



The EMB must then decide whether to act upon Dr. Doctor's principal state license based on the action of the BMB. If it does, this action is also reported to the Compact for documentation.

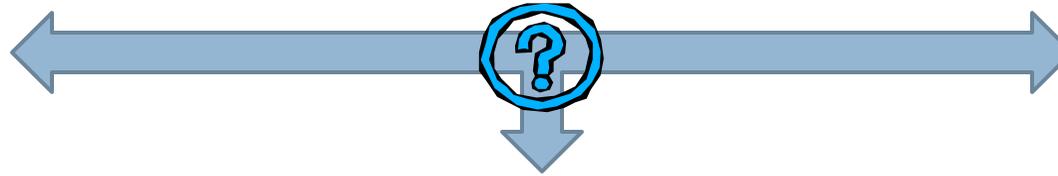




If the BMB takes a lesser action than revocation, suspension, or surrender in lieu of discipline, this information is also reported to the Compact to be reported to the other states where Dr. Doctor is licensed. For those “compact” states, they have three alternatives:



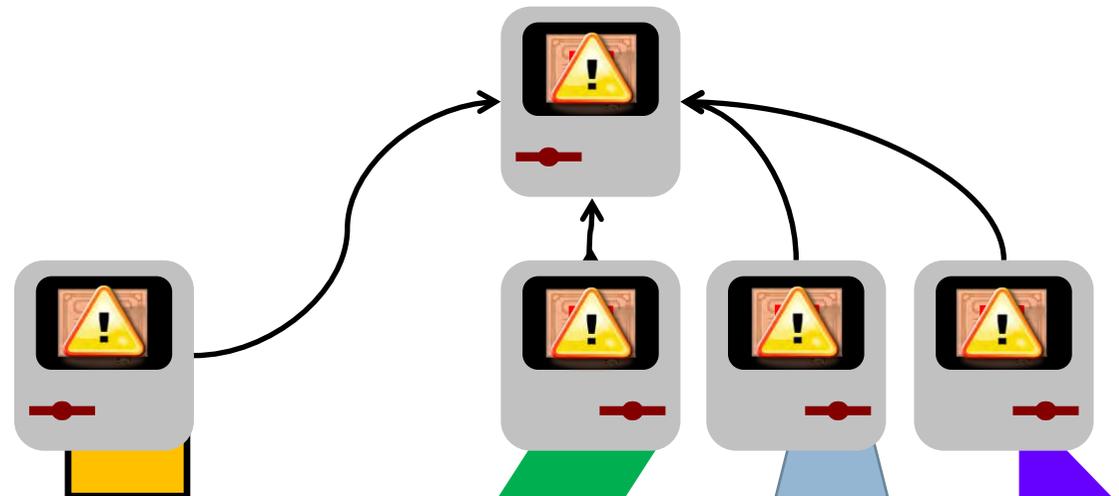
Concur: The other “compact” states can simply affirm the action of the BMB against Dr. Doctor.



Retry: Each state board reserves its authority to take action. For example, the state of Confusion Medical Board could separately investigate, charge and take action against Dr. Doctor if it felt the BMB’s sanctions did not adequately protect the public.

No action: If a state board feels no further action is necessary against Dr. Doctor, no action need be taken.

As before, the EMB must decide whether to act upon Dr. Doctor’s underlying principal state license. If it does, this action is also reported to the Compact for documentation.



# Impact of Disciplinary Actions

## Action by State of Principal License—Effect on License(s) Granted Under Compact

Principal State Action	Major Action	Minor Action
Initial Action	Other licenses immediately placed on identical status without additional action by other member board(s).	Other member licensing board(s) may: 1) Deem factual findings to be <i>res judicata</i> and impose same or lesser sanctions; 2) Take separate action under its respective medical or osteopathic practice act; or 3) Take no action.
Reinstatement	Other license(s) remains encumbered pending action by the other member board(s).	

# Impact of Disciplinary Actions

## Action by Member State—Effect on Licenses in Other Member States

Member State Action	Major Action	Minor Action
Initial Action	Other licenses immediately suspended for 90 days automatically and without additional action necessary by other member board(s); however the other board(s) may lift or otherwise change the suspension prior to the completion of the 90 days	Other member licensing board(s) may: <ol style="list-style-type: none"><li>1) Deem factual findings to be <i>res judicata</i> and impose same or lesser sanctions;</li><li>2) Take separate action under its respective medical or osteopathic practice act; or</li><li>3) Take no action.</li></ol>
Reinstatement	Other license(s) remains encumbered pending action by the other member board(s).	

# State / Media / Stakeholder Interest

- TX, OK-MD, SD, and WA-MD & DO boards have formally expressed support, as has the MN Medical Association.
- CA, MN, NC, ND, NV, WI, WY boards have verbally expressed interest/support.
- Legislative interest in AR, AZ.
- American Medical Association is working on a support resolution for its House of Delegates.
- American Academy of Dermatology is close to issuing a letter of support.
- [16 US Senators issued a letter of support for the compact \(January 9, 2014\)](#)

# State / Media / Stakeholder Interest

- [New York Times \(June 29, 2014\)](#)
- [MedPage Today \(July 2, 2014\)](#)
- [DotMed Daily News \(July 7, 2014\)](#)
- [vRad Press Release \(July 8, 2014\)](#)
- [JAMA Viewpoint \(July 28, 2014\)](#)
- [The Interstate Medical Licensure Compact: Making the Business Case \(Journal of Medical Regulation, August 2014\)](#)

# State / Media / Stakeholder Interest

- [HealthLeaders Media \(August 7, 2014\)](#)
- [AMA Wire \(September 8, 2014\)](#)
- [HealthcareDIVE \(September 10, 2014\)](#)
- [Rapid City Journal \(September 14, 2004\)](#)
- [HealthLeaders Media \(September 17, 2014\)](#)

# What a Compact is NOT

A physician compact would not:

- Require state licensing boards to revise their practice acts.
- Create a pathway to national licensure – instead, it would likely forestall any further federal action.
- Clone the Nurse Licensure Compact, which is different in a number of respects.
- Alter the existing in-state functions or authority of medical and osteopathic boards.
- Increase fees for in-state licenses.

# Next Steps

- The final draft of the Interstate Medical Licensure Compact has just been released.
- State boards, legislatures, and stakeholders will review during the fall.
- Legislative action on the Compact will begin in January.
- Seven states are needed to activate the Compact.
- Once activated, Commissioners will be convened to begin administrative work, including:
  - By-laws
  - Rules
  - Election of officers
  - Staffing
  - Location of offices
  - IT/Financial systems Development
  - Forms



# Questions?

***Blake Maresh, MPA, CMBE***

*Executive Director*

*Washington Board of Osteopathic Medicine and Surgery*

*Washington Department of Health*

*360/236-4760 (W)*

*360/888-5080 (C)*

*[blake.maresh@doh.wa.gov](mailto:blake.maresh@doh.wa.gov)*

# Opioid Overdose Prevention and Response

## The roles of medical practitioners

Caleb J. Banta-Green PhD MPH MSW

Senior Research Scientist, Alcohol & Drug Abuse Institute

Affiliate Associate Professor, School of Public Health

University of Washington

# ADAI

About ADAI

Staff & Affiliates

Publications

ADAI Research Projects

Fetal Alcohol & Drug Unit

Parent-Child Assistance Program

NIDA-CTN Pacific NW Node

NW Confederation

ADAI Library

CTN Dissemination Library

Evidence-Based Practices

Instruments Database

WA State Data & Resources

Conferences & Training

Grants & Funding

Web Links

Treatment Help

Employment

Search web site



## Alcohol and Drug Abuse Institute

[University of Washington](#)

1107 NE 45th Street, Suite 120, Box 354805  
Seattle, WA 98105-4631 USA

phone: (206) 543-0937 | fax: (206) 543-5473

e-mail: [adai@u.washington.edu](mailto:adai@u.washington.edu)

The Alcohol and Drug Abuse Institute is a multidisciplinary research center at the University of Washington. Its mission is to support and facilitate research and research dissemination in the field of alcohol and drug abuse.

Last updated December 2, 2013 | <http://adai.washington.edu> | [Privacy policy](#) | [Terms of use](#)

## Current Highlights

More on our [ADAI News blog](#) o

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**ADAI**  
**Clearinghouse**

A Resource for  
Washington State

 **Marijuana**

Science-based information  
for the public



**WA State Data &  
Resources**

**Opioid Overdose**  
can be prevented  
and reversed!

[stopoverdose.org](http://stopoverdose.org)

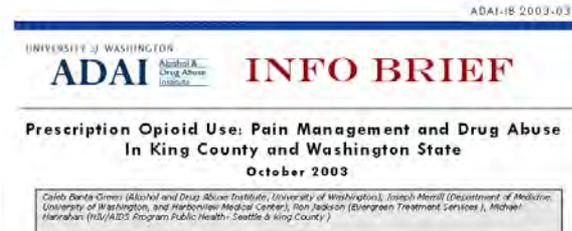
<http://www.adai.uw.edu/>

# ADAI-UW Opiate Work

EPIDEMIOLOGIC TRENDS IN DRUG ABUSE—Seattle-King County Area

## Recent Drug Abuse Trends in the Seattle-King County Area

*Caleb Banta-Green,<sup>1</sup> Susan Kingston,<sup>2</sup> Michael Hanrahan,<sup>3</sup> Geoff Miller,<sup>4</sup> T. Ron Jackson,<sup>5</sup> Ann Forbes,<sup>6</sup> Arnold F. Wrede,<sup>7</sup> Steve Freng,<sup>8</sup> Richard Harruff,<sup>9</sup> Greg Hewett,<sup>9</sup> Kris Nyrop,<sup>10</sup> Mark McBride<sup>11</sup>*



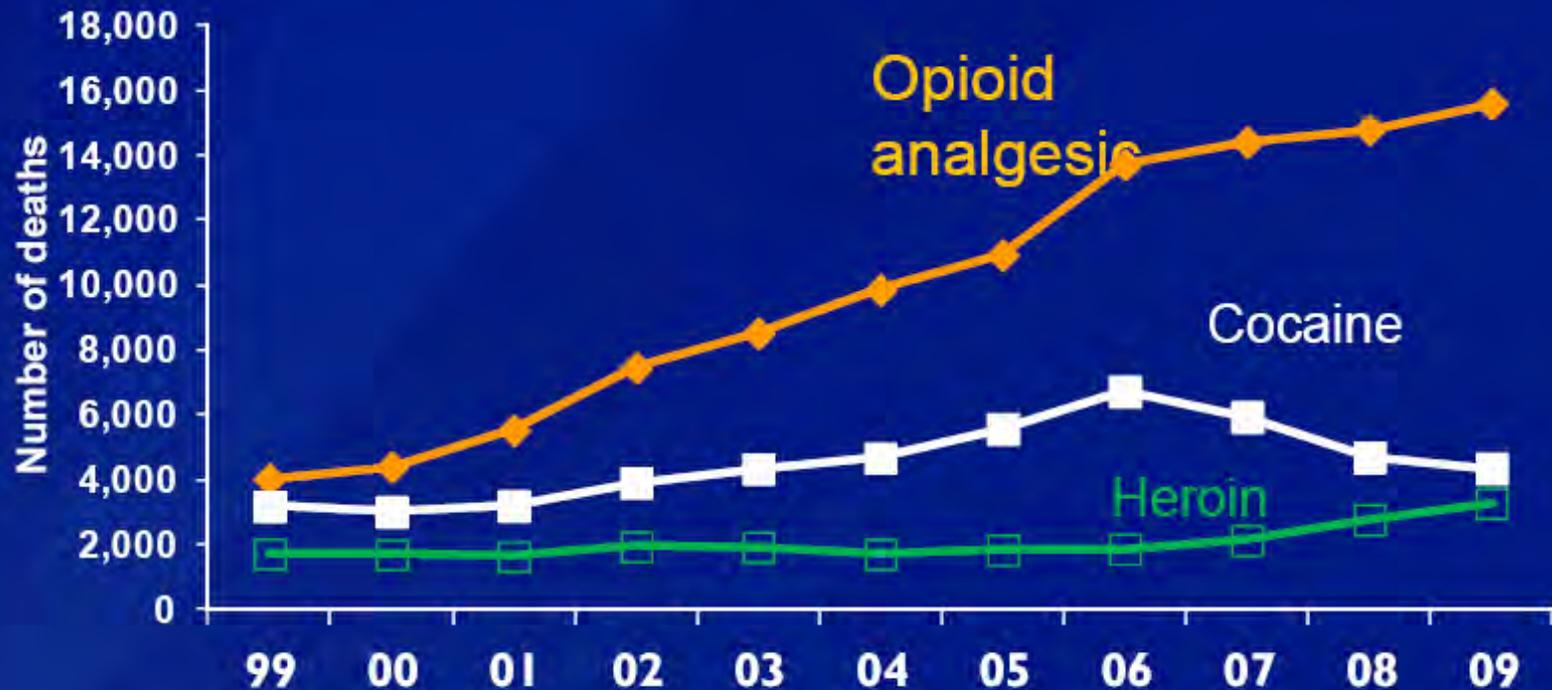
- HYS Rx opiate “to get high” question & analysis 2006
- DOH Opiate Workgroup since 2008
- Partnered with Public Health on syringe exchange survey analyses
- Group Health study of chronic pain patients and opiate use (NIH)
- Evaluated WA’s Overdose law, interviewing first responders
- PMP analyses (DOH)
- Study of overdose prevention with Rx and Heroin users in Harborview ER (NIH)
- O.D. training- Online & in person [www.stopoverdose.org](http://www.stopoverdose.org) (AGO)

# Outline

- Opiate drug trends in WA
- Prevention and Treatment of Opioid Abuse
- Overdose education and intervention
- Support for adding medical modelss

Opiate Overdoses in the U.S.  
Epidemiology, Prevention,  
Intervention and Policy

## Drug overdose deaths of all intents by major drug type, U.S., 1999-2009



Heroin substantially under-reported in deaths

Source: National Vital Statistics System. The reported 2009 numbers are underestimates. Some overdose deaths were not included in the total for 2009 because of delayed reporting of the final cause of death.

# Rx Opioids

- Prescribing appears to be leveling off for potent, long acting opioids in some states (ARCOS 2010)
- Mortality increasing nationally, declining in WA
- NSDUH indicate Rx non-medical “pain reliever” opioid use declined in 2011

# Heroin

- 18 to 24-year-olds admitted to treatment for heroin increased from 42,637 in 2000 to 67,059 in 2009 TEDS cited in [A]
- Epidemiologists in 15/21 US cities report increases in heroin, notably among young adults and outside of urban areas (NIDA CEWG June 2012)
- NSDUH data indicate the number of persons who were past year heroin users in 2011 (620,000) was higher than the number in 2007 (373,000).

A. Banta-Green, CJ 2012 Adolescent Abuse of Pharmaceutical Opioids Raises Questions About Prescribing and Prevention. Arch Pediatr Adolesc Med. 2012 May 7. [Epub ahead of print]

# Rx to Heroin

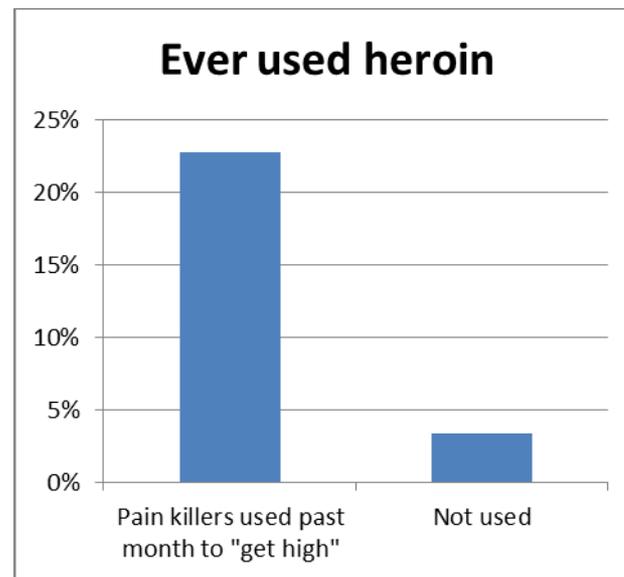
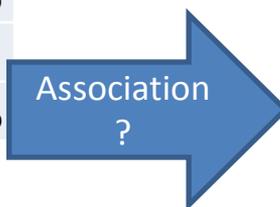
- A relationship between misuse of prescription-type opiates and subsequent heroin use is indicated by NSDUH data\* and published research\*\* particularly adolescents and young adults
- King County 39% reported being “hooked on rx-type opiates” before they began using heroin (2009)

\*C. Jones 2013 article

\*\* Peavy et al, 2012 and Lanckenau et al, 2012

# WA State, 12<sup>th</sup> Graders, 2012 Healthy Youth Survey

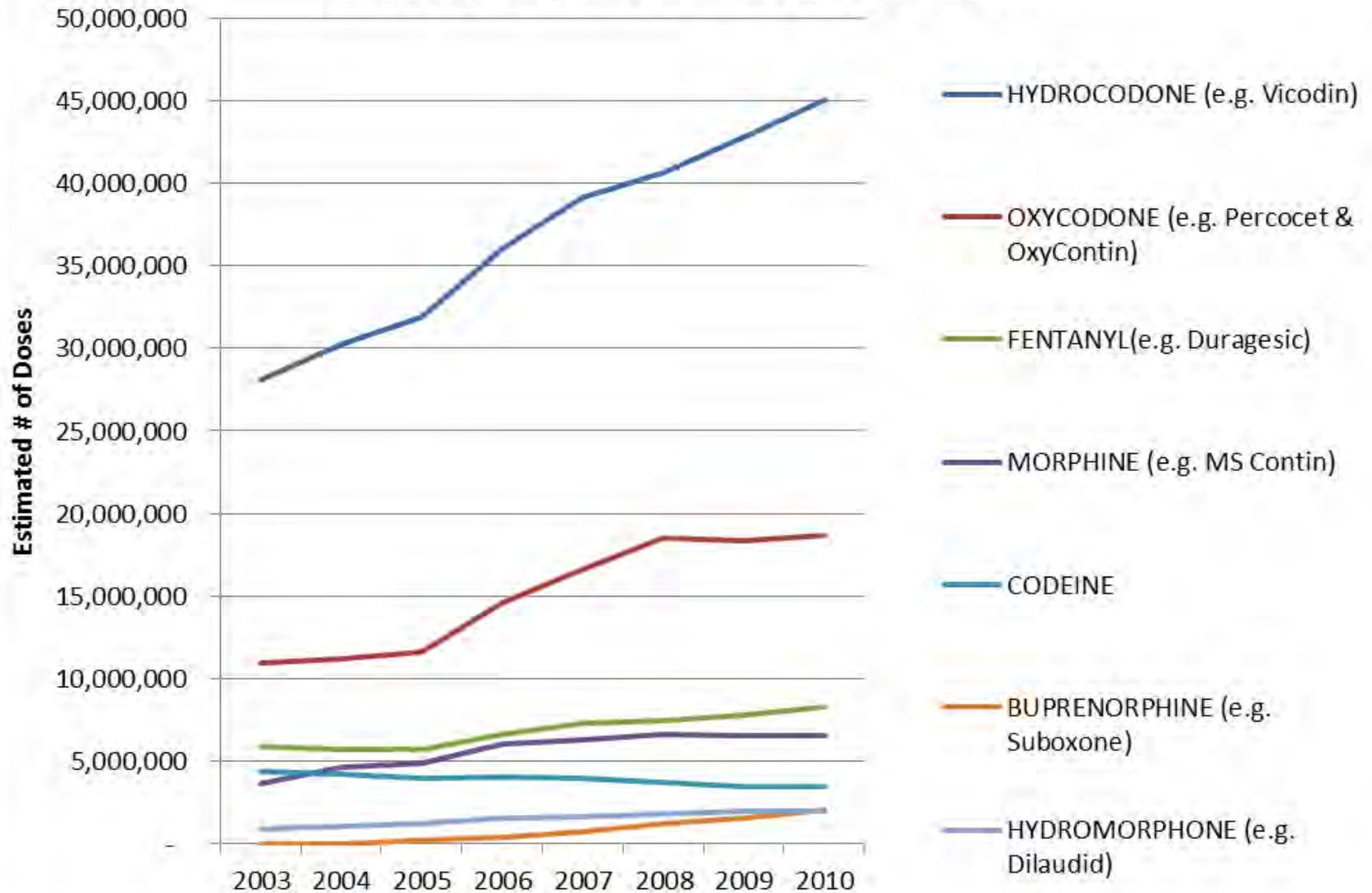
	Use Estimate	95% C.I.
Alcohol, past month	36.1%	± 2.3%
Marijuana, past month	26.7%	± 1.5%
Rx opiates, past month	7.5%	± 1.0%
Heroin, ever used	5.1%	± 1.3%



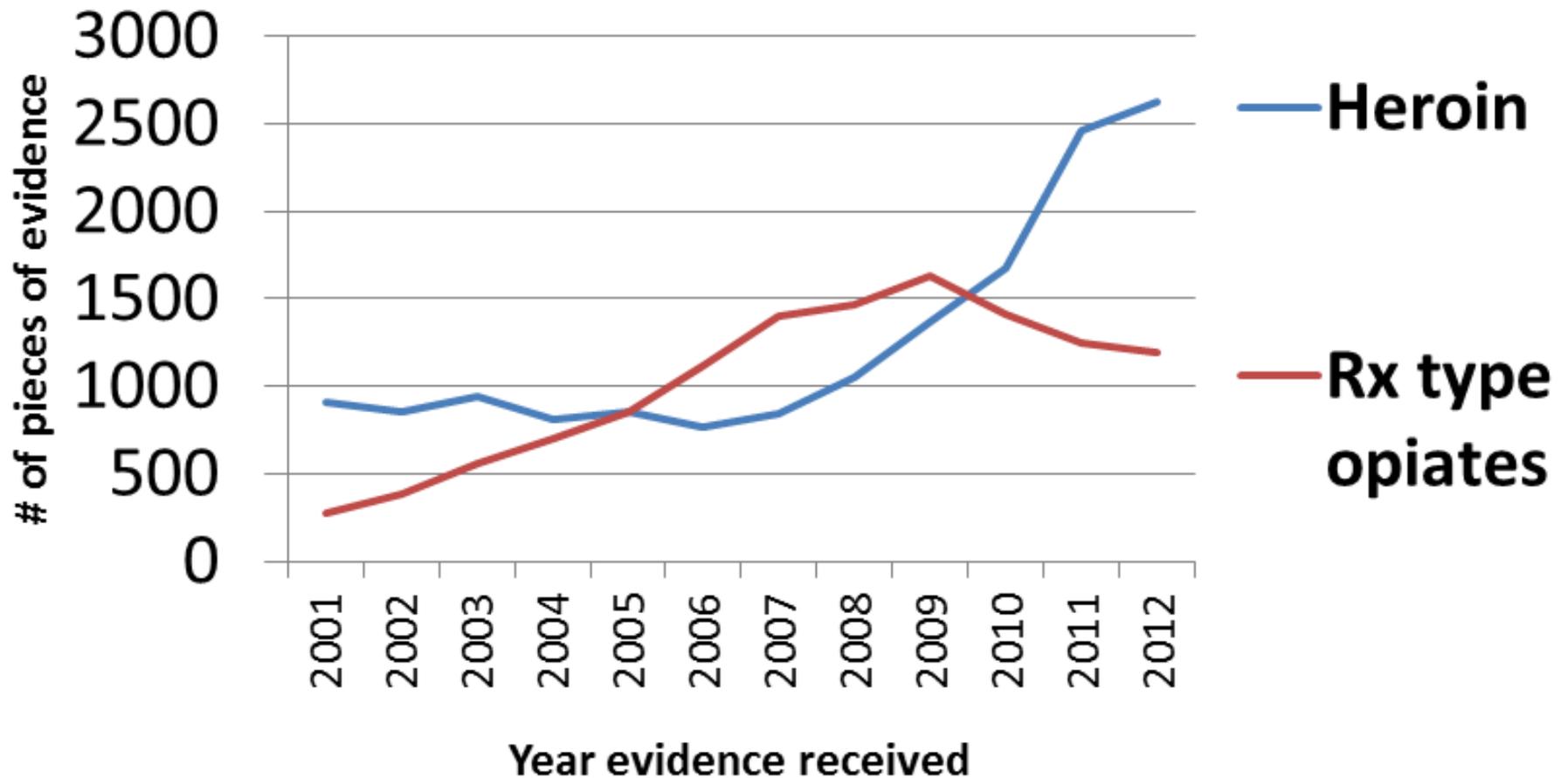
23% of recent users of Rx opiates to "get high" report ever using heroin, compared to 3% for those not recent using pain killers to get high

		Lifetime Heroin Use		
		No	Yes	Total
Current Use of Rx Opiates "to get high"	no days	96.6% ± 0.9% 2,703	<b>3.4%</b> ± 0.9% 94	100.0% 2,797
	any days	77.2% ± 5.8% 193	<b>22.8%</b> ± 5.8% 57	100.0% 250

## Selected Opioids Sold in WA State



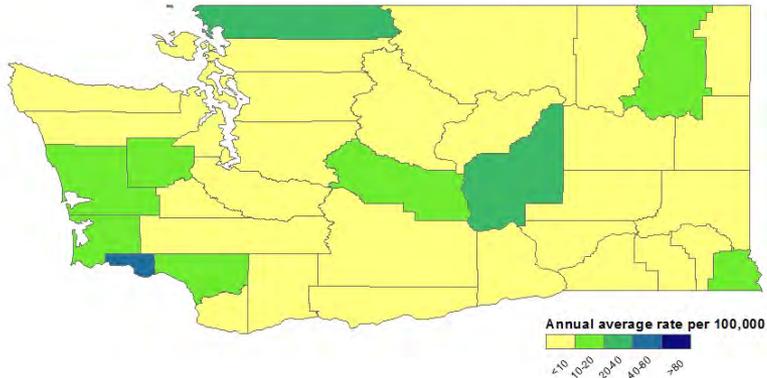
# WA State Local police evidence testing



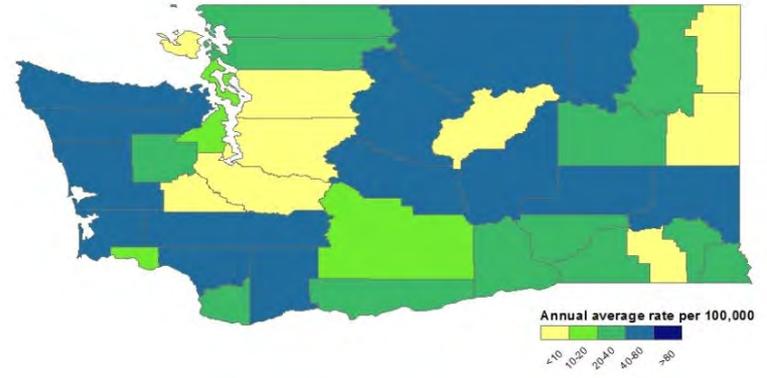
Data source: Washington State Patrol, Crime Lab, NFLIS data set  
Data analysis and mapping: Caleb Banta-Green, University of Washington

# Trends in Police Evidence for Heroin and Rx-type opiates

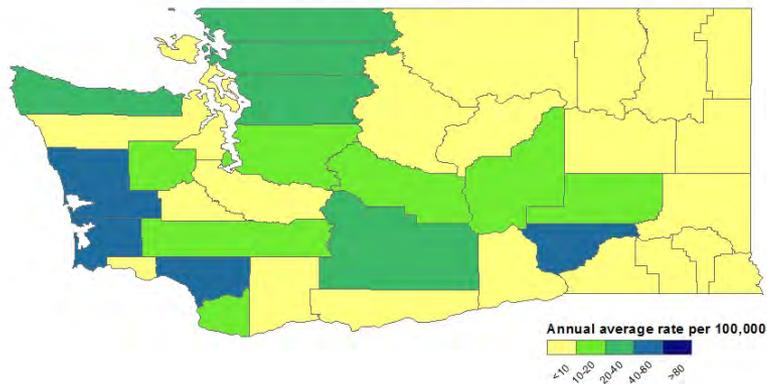
Rx-Type Opiates in Police Evidence  
Annual Average 2001-2002



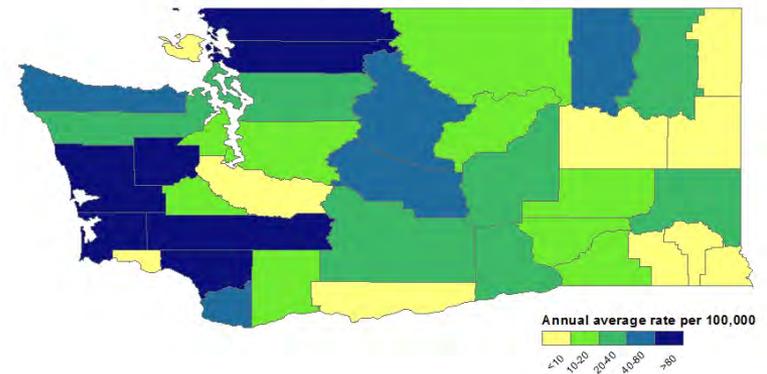
Rx-Type Opiates in Police Evidence  
Annual Average 2011-2012



Heroin in Police Evidence  
Annual Average 2001-2002

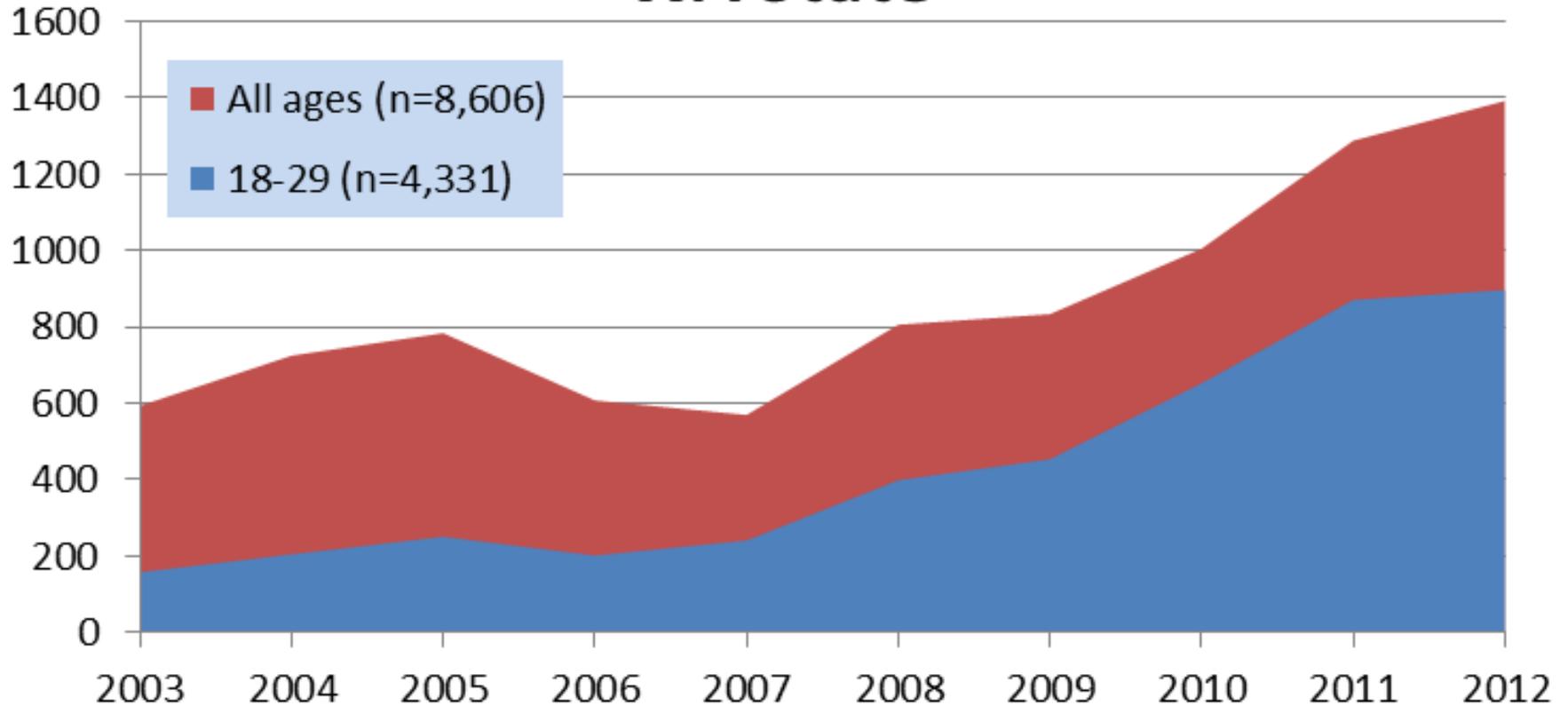


Heroin in Police Evidence  
Annual Average 2011-2012



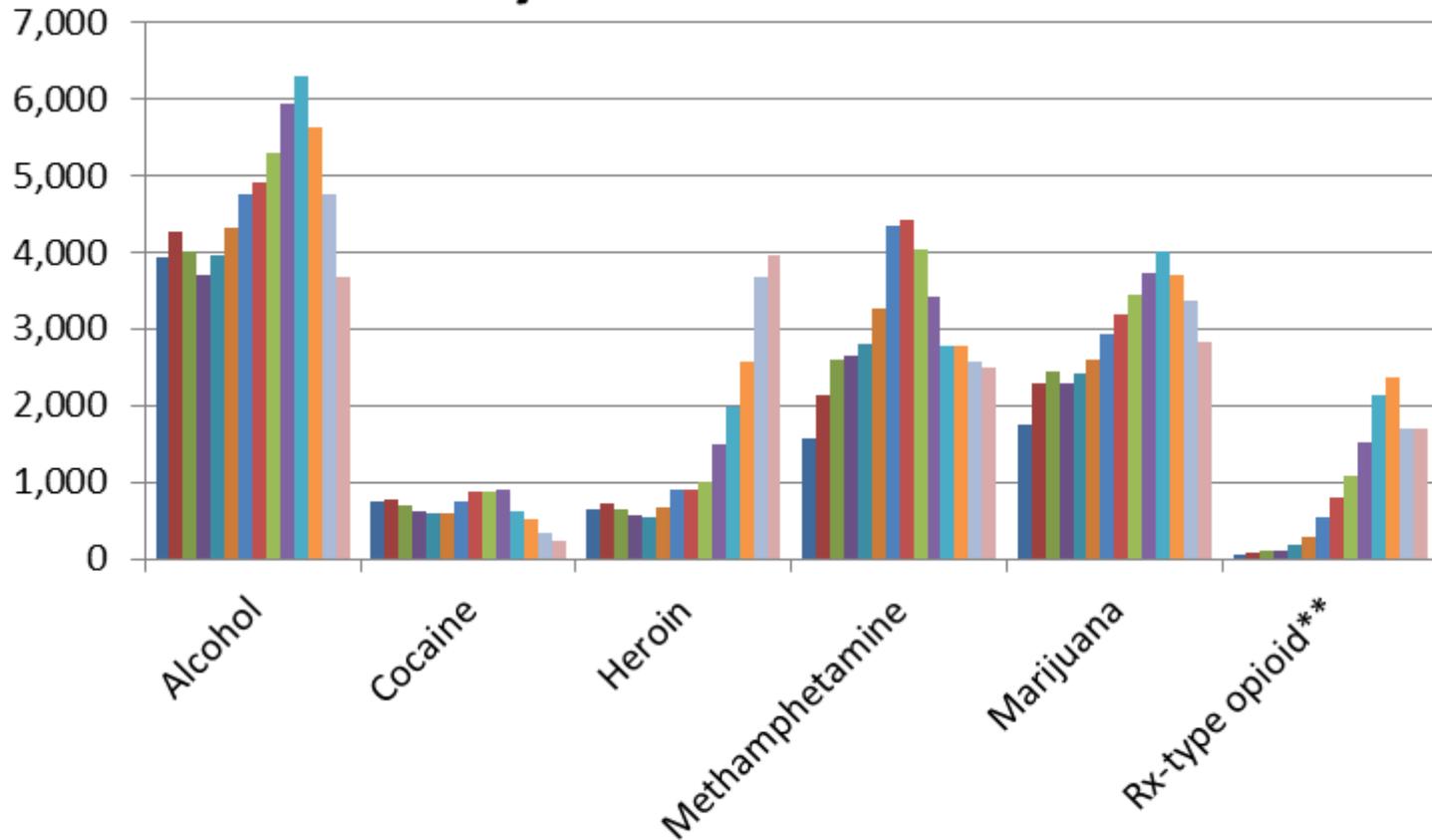
Data source: Washington State Patrol, Crime Lab, NFLIS data set  
Data analysis and mapping: Caleb Banta-Green, University of Washington

# Heroin Treatment Admits, First Time WA State



Two-thirds are injectors, remainder are smokers  
(who will likely transition to IDU)

# Treatment Admissions WA State 18-29 year olds 1999-2012

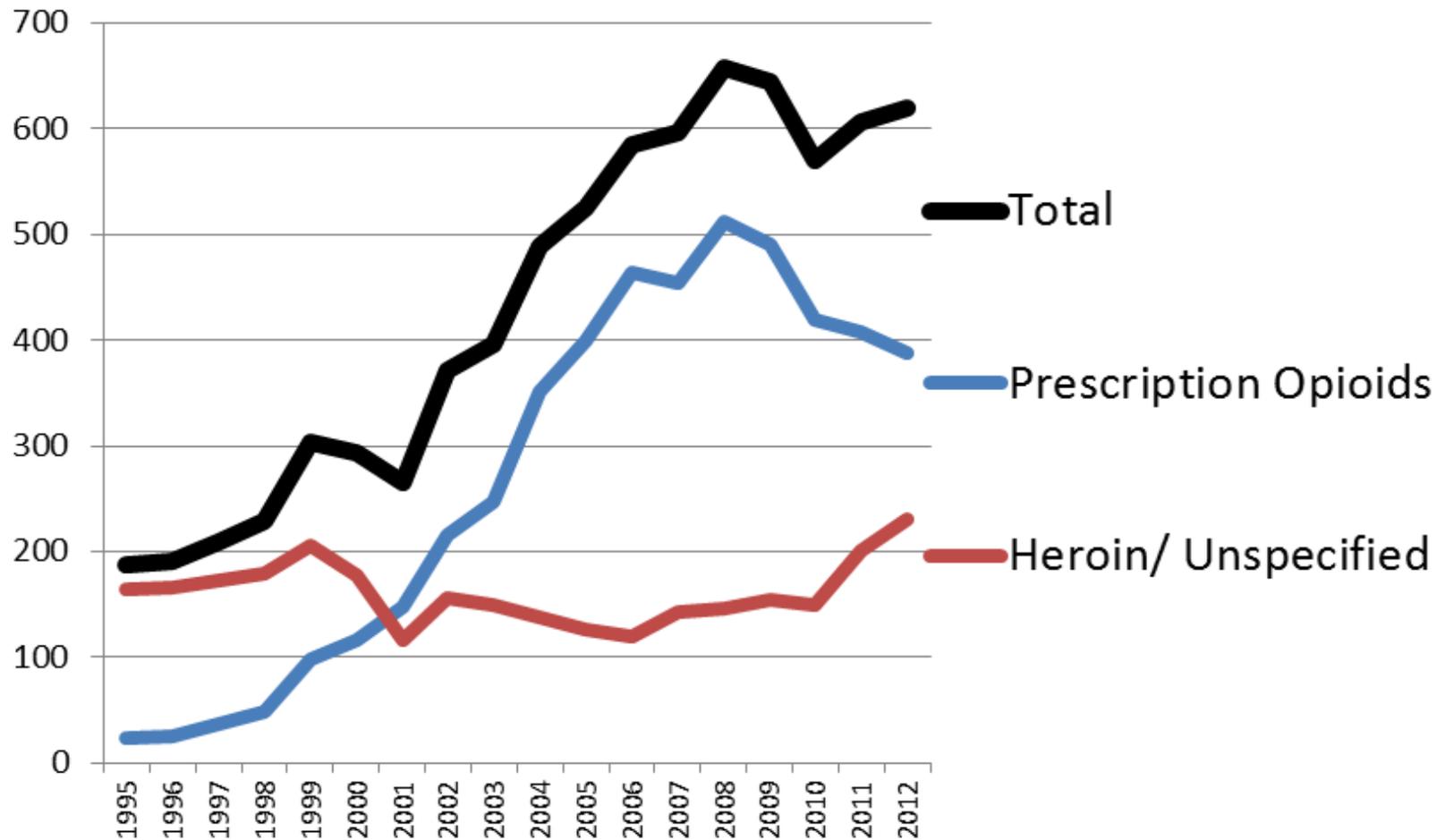


As every other substance declined,

- 512% Statewide among 18-29 year olds
- Heroin is the #1 drug in this age group
- Just public treatment, undercount overall

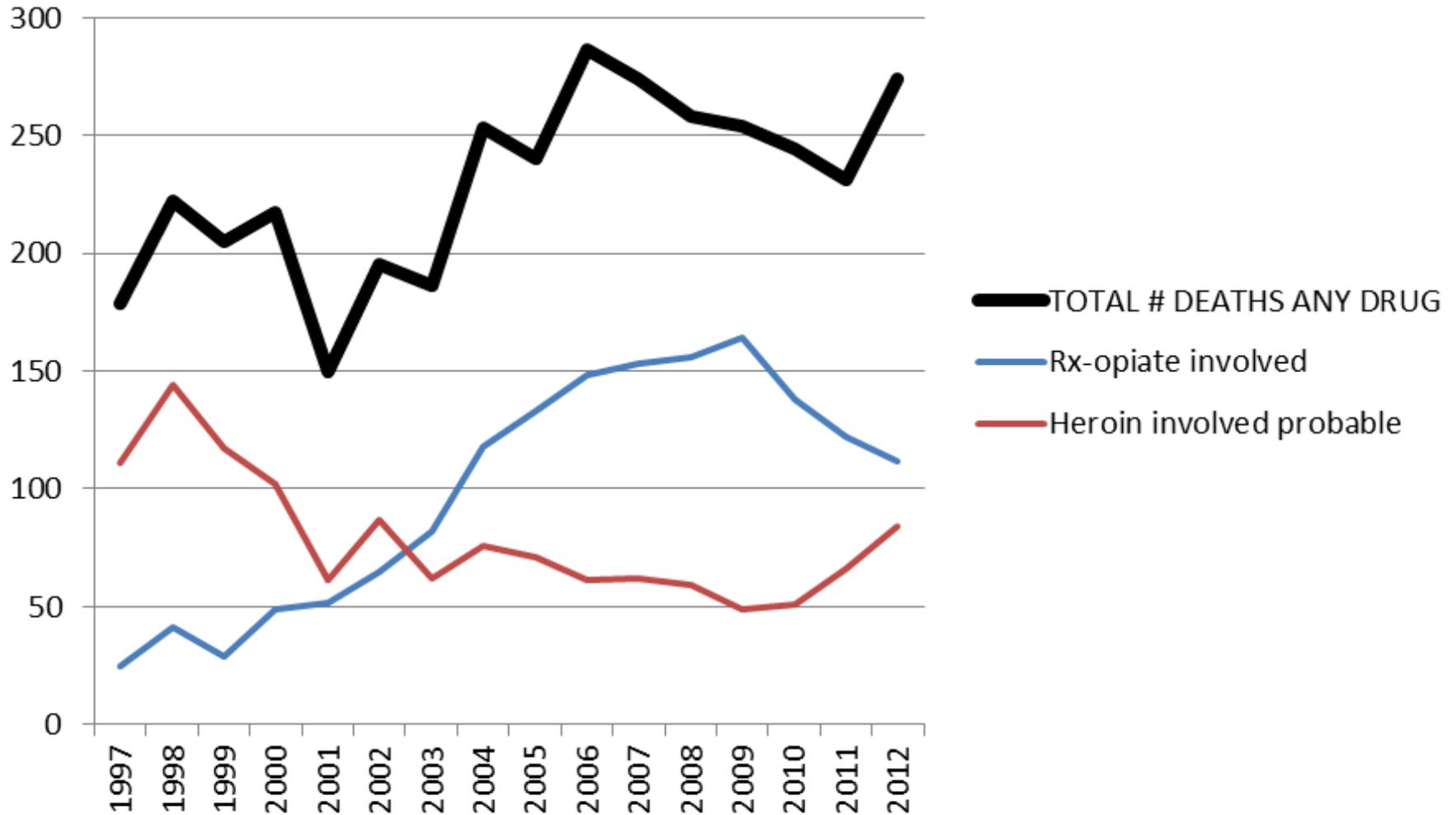
2,189 caseload for buprenorphine/Suboxone for 18-29 years olds (March 2012 per DOH PMP)

# Washington State Opioid Related Deaths, 1995-2012



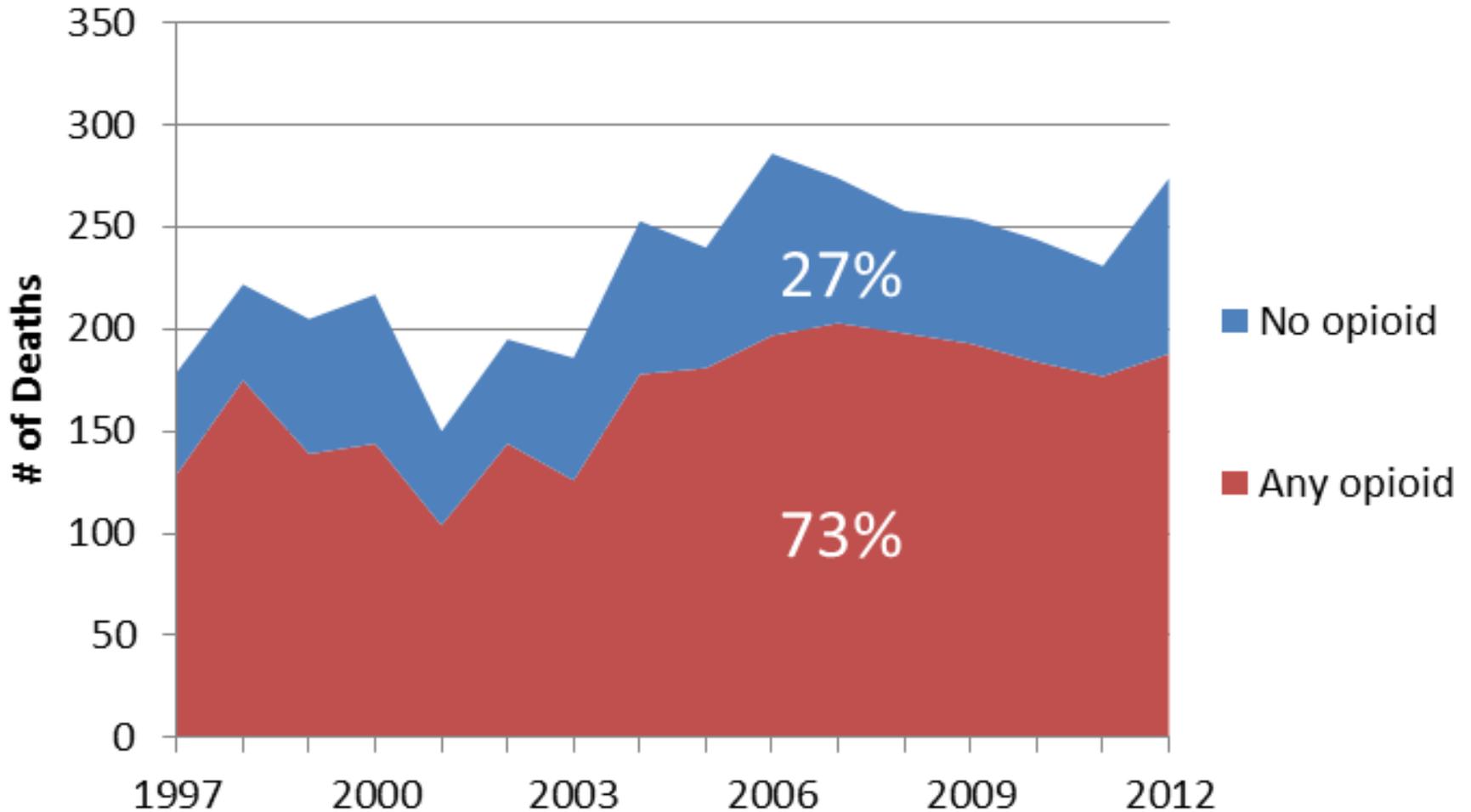
Center for Health Statistics, Washington State Department of Health, December 12, 2013.

# Drug Caused Deaths King County, WA



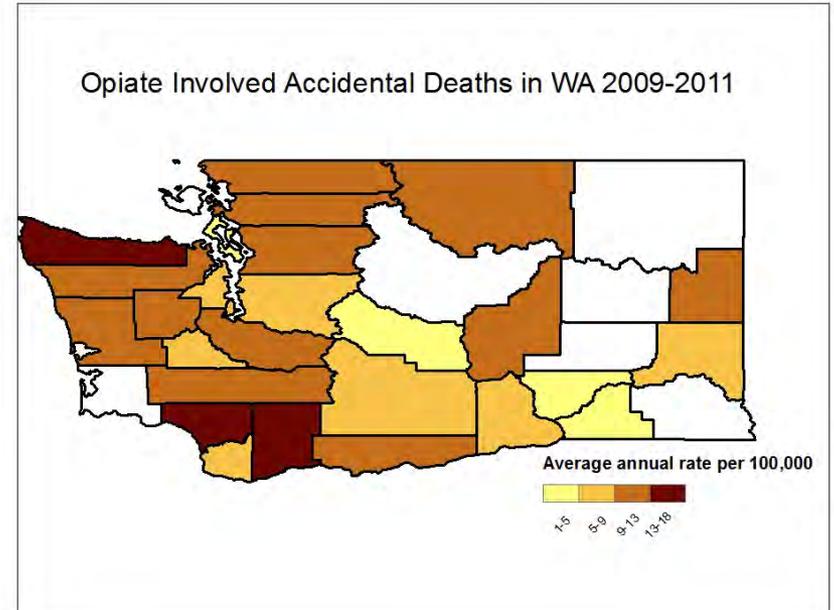
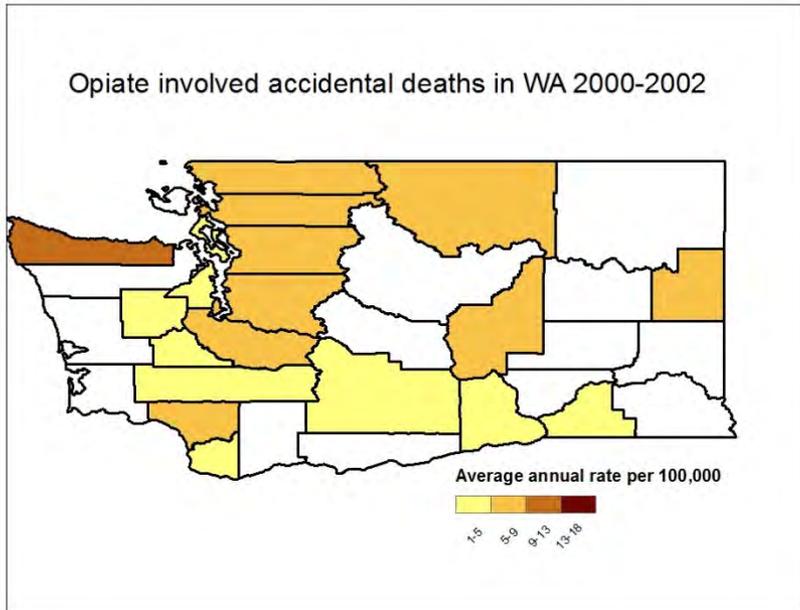
Source: PHSKC Medical Examiner's Office  
Data analysis Alcohol & Drug Abuse Institute, UW

# Drug Caused Deaths King County, WA



- All of these deaths were preventable
- Many of these overdoses could have been reversed before they became fatal

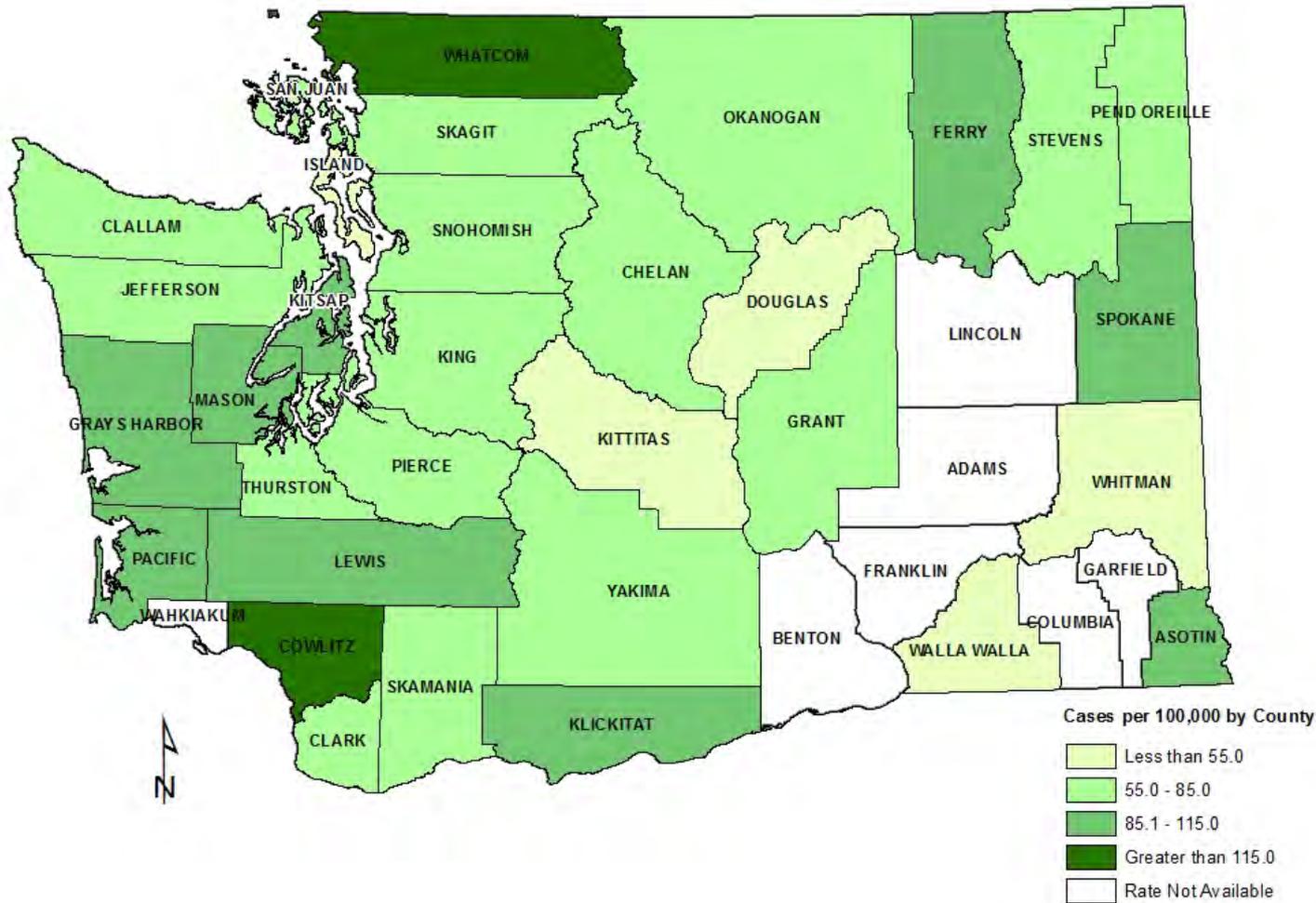
# Opiate involved death trend



- The average annual number of deaths from 2000-2002 was 310
- The average annual number of deaths from 2009-2011 was 607
- The majority of deaths involved prescription-type opiates

Note that rates for counties with counts less than 5 over the 3 year period are suppressed

# Chronic Hepatitis C Infection Diagnosis Rate per 100,000 by County Washington State 2009-2011



Data are substantially out of date due to diagnosis and reporting delays

Data source: WA Dept. of Health

# Conclusions

- Nationally young adult heroin treatment admits are up 57%
- Treatment data indicate a dramatic increase in heroin use among young adults 18-29 across Washington State.
  - **These data are a substantial, but unknown, understatement of heroin treatment utilization** (and need) given the exclusion of private/self pay treatment including buprenorphine maintenance treatment
- **These findings raise questions about the ability of local communities to meet the treatment needs of new heroin users, let alone the public health needs including *overdose* and *infectious disease* risks.**

# Preventing Inappropriate initiation of Rx opioids

- The past two years approximately one-third of people had at least one prescription for a controlled substance (e.g. **Vicodin, Valium, Ambien**)
- More than half of adults take a prescription medicine of any kind.
- Taking prescription medicines is now typical and normal, **talking about medication usage with family members purposefully and thoughtfully is not yet normal.**

# Access issues

- Most teens get Rx opiates from
  - Own Rx (33%)
  - A friend (28%)
  - Family gave (10%)
  - Took from a home (9%)
- Don't accept unneeded Rx's
- Dispose of unneeded medicines
- Lock up medications that are needed



<p><b>SAMA</b> SCIENCE AND MANAGEMENT of ADDICTIONS</p> <p><i>Working to eliminate the disease of substance addiction in youth by advancing research, education, and treatment.</i></p>	<p><b>Prescription Drug Abuse</b></p>  <p>When used appropriate necessary. Unfortunately to cause harm.</p> <p>Abuse of prescription d consequences to our fa misuse of medicines s in serious health risks i</p> <p>More than half of young people who misuse prescript — from us.</p>
---	---



# Addressing motivation issues

- Parents should reflect on their **own use** of alcohol/medication/drugs
- Consider what messages they are sending
- Determine if they are the messages they **want** to be sending
- Consider their youths' situation- e.g. trauma
- Be explicit about reasons for their use and expectations for youth
- This may be hard and involve the adult seeking help

# What are the treatments for opiate addiction?

- A variety of effective treatments are available including both behavioral/counseling and medications.
- Both help to restore a degree of normalcy to brain function and behavior, resulting in increased employment rates and lower risk of HIV and other diseases and criminal behavior.
- Although behavioral and medications can be extremely useful when utilized alone integrating both types of treatments is generally the most effective approach.

SOURCE: NIH NIDA

# Medication Assisted Treatment

## Buprenorphine/Suboxone

## Methadone

Saves lives

Is cost effective

Availability- geographic & financial varies greatly

“...mortality rates were 75 percent higher among those receiving drug-free treatment, and more than twice as high among those receiving no treatment, compared to those receiving buprenorphine...” or methadone

*Health Aff August 2011 vol. 30 no. 8 1425-1433*

## **Who prescribes buprenorphine for rural patients? The impact of specialty, location and practice type in Washington State.**

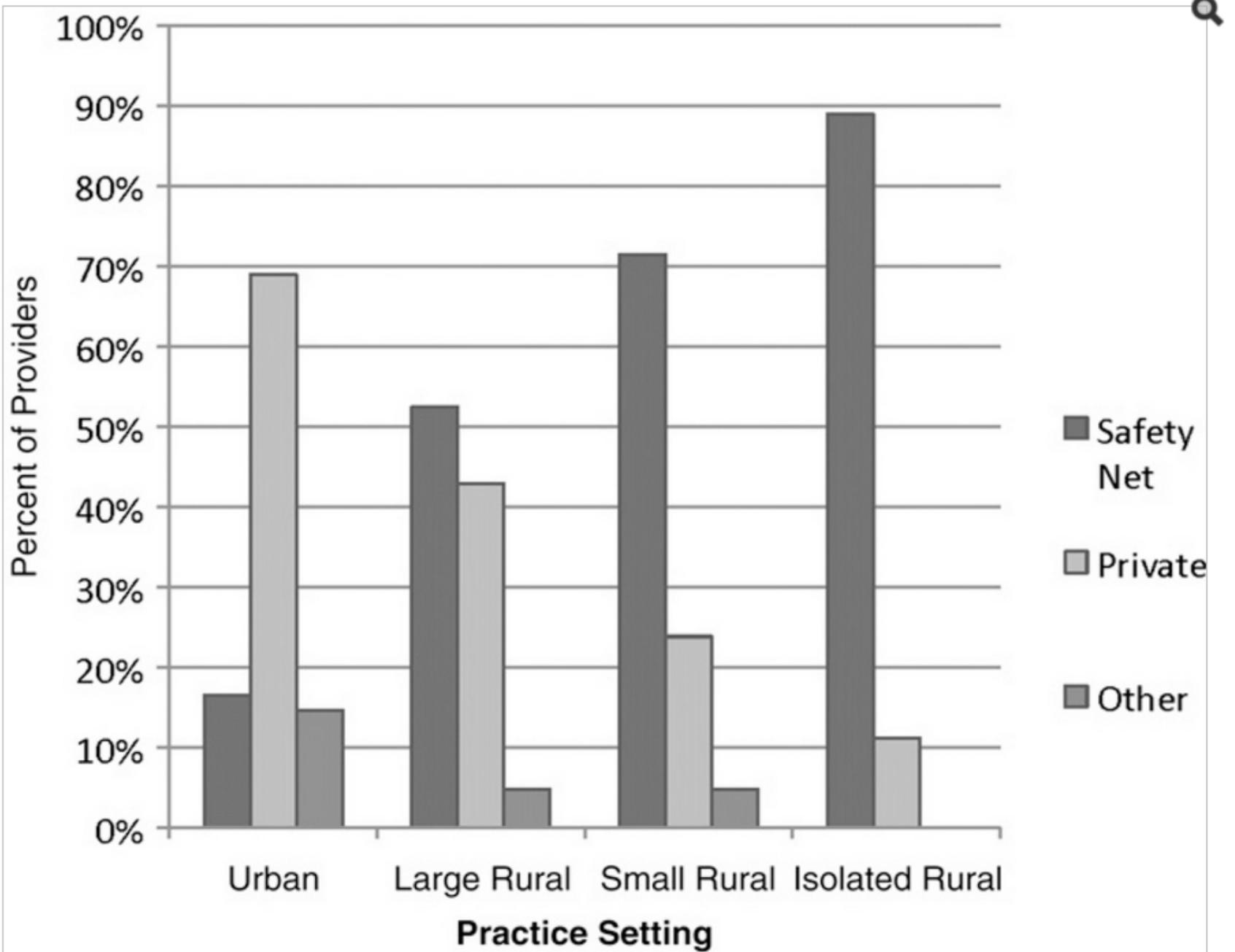
Kvamme E<sup>1</sup>, Catlin M, Banta-Green C, Roll J, Rosenblatt R.

### **⊕ Author information**

#### **Abstract**

We determined the specialty, geographic location, practice type and treatment capacity of waived clinicians in Washington State. We utilized the April 2011 Drug Enforcement Agency roster of all waived buprenorphine prescribers and cross-referenced the data with information from the American Medical Association and online resources. Waived physicians, as compared to Washington State physicians overall, are more likely to be primary care providers, be older, less likely to be younger than 35 years, and more likely to be female. Isolated rural areas have the lowest provider to population ratios. Ten counties lack either a buprenorphine provider or a methadone clinic. In rural areas, waived physicians work predominately in federally-subsidized safety-net settings, which underscores the need for continued governmental support of primary care and mental health in these settings.

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# Opioid Related Deaths (per 100,000 population) and Number of Buprenorphine Providers, by County

April 2011 DEA List



Source: April 2011 DEA List, DOH

Washington State counties with ORT options as of April 2011. In Washington State, 28% of the population lives in a county without MMT and 7% of the population lives in a county without MMT or BMT.

# Evidence and Support for Overdose Education &



[House of Delegates](#) [Physicians](#) [Residents](#)

[Home](#) [Membership](#) [Resources](#) [Education](#) [Advocacy](#) [Publications](#)

- National support-
  - Medical, Pharmacy, Public Health associations
  - Drug Czar/ONDCP; DOJ; DHHS/SAMHSA; CDC
- Research indicates
  - Saves lives
  - Cost effective
  - Limited implementation of laws to date

...ies at Annual Meeting

A | A Text size Print Email

## AMA Adopts New Policies at Annual Meeting

For immediate release:  
June 19, 2012

### Promoting Prevention of Fatal Opioid Overdose

Opioid addiction and prescription drug abuse places a great burden on patients and society, and the number of fatal poisonings involving opioid analgesics more than tripled between 1999 and 2006. Naloxone is a drug that can be used to reverse the effects of opioid overdose. The AMA today adopted policy to support further implementation of community-based programs that offer naloxone and other opioid overdose prevention services. The policy also encourages education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities.

"Fatalities caused by opioid overdose can devastate families and communities, and we must do more to prevent these deaths," said Dr. Harris. "Educating both physicians and patients about the availability of naloxone and supporting the accessibility of this lifesaving drug will help to prevent unnecessary deaths."



## Opioid Overdose Prevention Toolkit

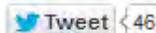
Average Rating: 5 out of 21 ratings.



[Comments](#)

**Price: FREE** (shipping charges may apply)

Equips communities and local governments with material to develop policies and practices to help prevent opioid-related overdoses and deaths. Addresses issues for first responders, treatment providers, and those recovering from opioid overdose.



Pub id: SMA13-4742

Publication Date: 8/2013

Popularity: 443

Format: Kit

**Audience:** Community Coalitions, Family & Advocates, Law Enforcement, Prevention Professionals, Professional Care Providers, People in Recovery as Audience

[Add To Favorites](#)

[Sign In!](#)

Sign in to access your favorites and other features.

 **Kit - ELECTRONIC ONLY**

 **Download Digital Version**

 [Facts for Community Members](#) (PDF, 625 KB)

 [Essentials for First Responders](#) (PDF, 465 KB)

 [Safety Advice for Patients](#) (PDF, 312 KB)

 [Information for Prescribers](#) (PDF, 478 KB)

 [Resources for Overdose Survivors and Family Members](#) (PDF, 323 KB)

<http://tinyurl.com/od-toolkit-2013>

# Background- Opiate overdoses

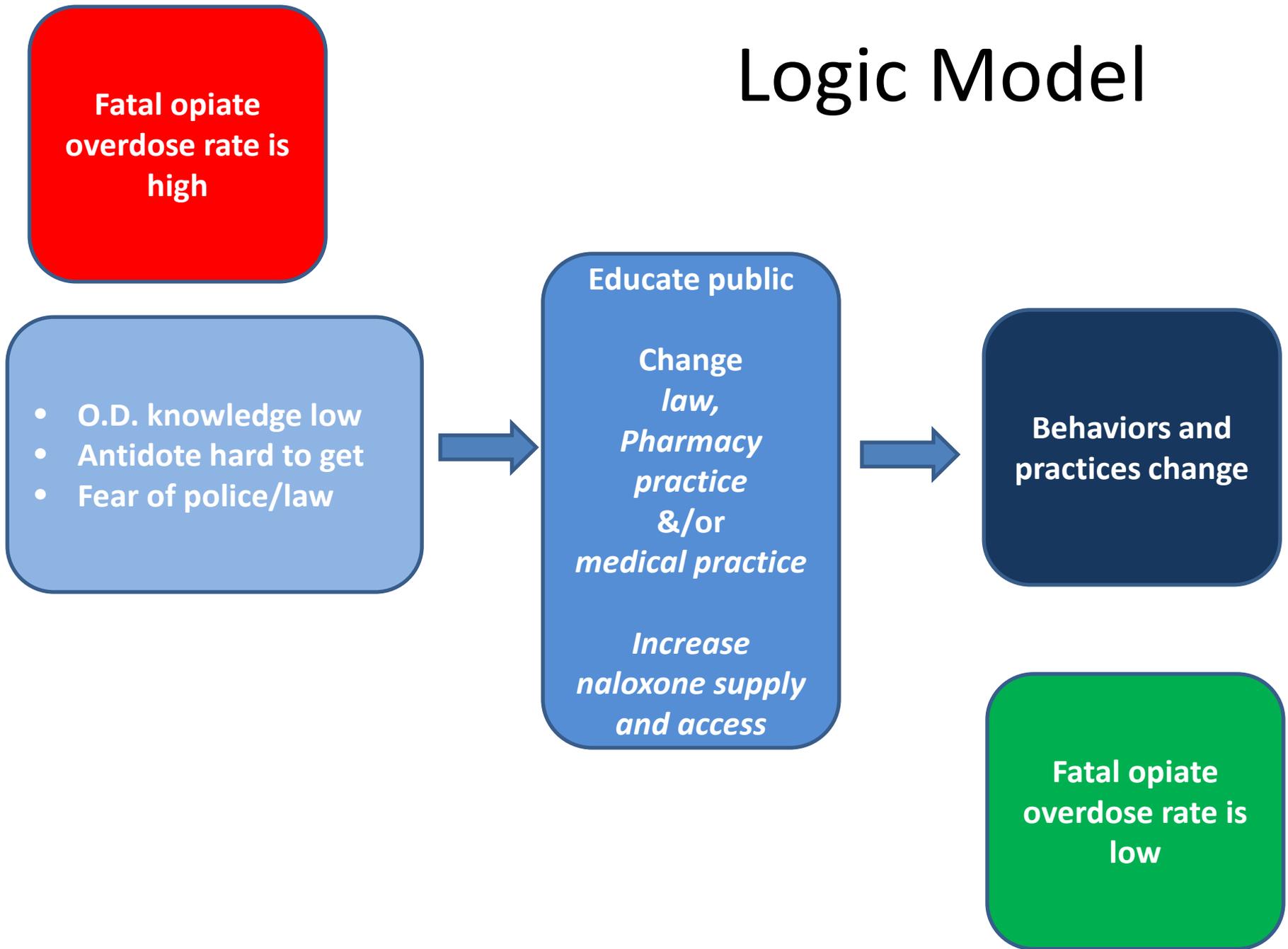
- Overdoses can be prevented
  - Most opiate (heroin and/or Rx) overdoses can be intervened upon before death ensues
- Low overdose knowledge
  - Risk factors; Signs of overdose; How to intervene
  - Audiences include users and family/friends as well as general population
- Bystander fear of police response may inhibit calling 911
  - Perceptions are powerful
- An antidote for opiate overdoses is available
  - Supply and access points are limited

# All overdoses can be prevented and many opiate reversed before they become fatal

- Overdose education and an opiate antidote are available (naloxone/Narcan)
- RCW 69.50.315
  - Legal immunity from drug possession charges for person who has overdose and person who seeks medical aid
  - Allows prescribing opiate antidote to person at risk for having and witnessing overdose
- Online training, printable materials, and an antidote locator are online at:

[www.stopoverdose.org](http://www.stopoverdose.org)

# Logic Model



# O.D. Knowledge

## How to increase

- General awareness needed that opiate overdoses can be *prevented* and if they occur they can be *reversed* with naloxone
  - National problem, need broad awareness
  - Supply and demand need to be built
- Regular user of opiates could receive overdose education and take-home naloxone
- Family/friends of regular opiate users should also receive overdose education including how to use take-home naloxone (and get THN if not already in household)
- SAMHSA OD Toolkit



# Antidote/Naloxone

## Increasing access

- Medical providers could prescribe to potential overdose
  - and to potential witnesses
  - Settings- Primary care, Emergency Dept, Pharmacy, drug treatment, jail
- Insurance (public and private) could cover Rx costs
- Pharmacists could directly prescribe and dispense
  - lowers \$ and increases access tremendously in terms of time burden and geography
  - Collaborative practice agreement
- Overdose education and prescribing time could be reimbursed
  - SBIRT codes should allow reimbursement for education
  - Pharmacists' time educating could be reimbursed

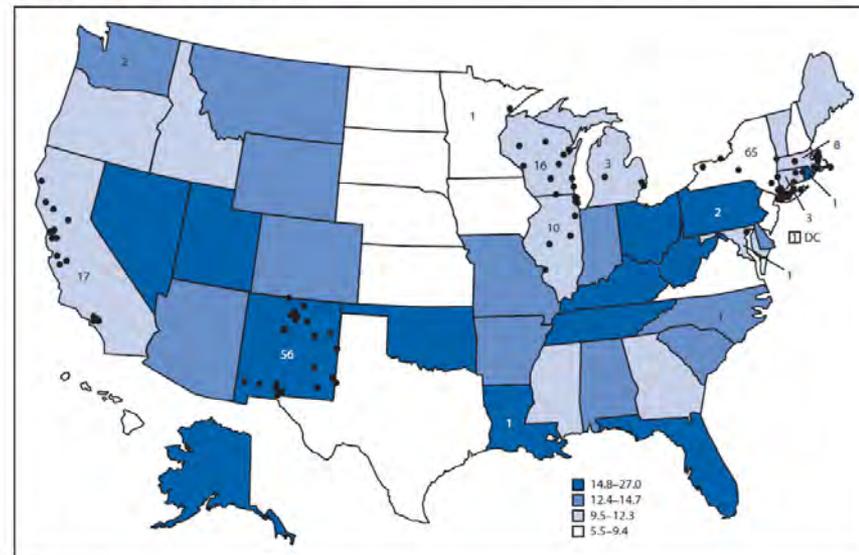
# Antidote/Naloxone

## Increasing access

Maintain, support and expand community, syringe exchange, social service agency based education and delivery models

Non-licensed persons e.g. PH educators, could *dispense* depending on local rules and with prescriber oversight

FIGURE 2. Number (N = 188) and location\* of local drug overdose prevention programs providing naloxone in 2010 and age-adjusted rates† of drug overdose deaths‡ in 2008 — United States



\* Not shown in states with fewer than three local programs.

† Per 100,000 population.

‡ Source: National Vital Statistics System. Available at <http://www.cdc.gov/nchs/nvss.htm>. Includes intentional, unintentional, and undetermined.

# Naloxone for Overdose Prevention

patient name

patient phone

patient address

patient's email address (if any)

**Rx**

Naloxone HCl 0.4 mg/mL (Narcan)  
1 x 10 mL as one fliptop vial (NDC 0409-1219-01) OR  
2 x 1mL single dose vials (NDC 0409-1215-01)

Refills: \_\_\_\_\_

Intramuscular (IM) syringe, 23 G, 3cc, 1 inch

Qty: \_\_\_\_\_ Refills: \_\_\_\_\_

Sig: For suspected opioid overdose,  
inject 1mL IM in shoulder or thigh.  
Repeat after 3 minutes if no or minimal response.

patient ID



## Are they breathing?

Signs of an overdose:

- Slow or shallow breathing
- Gasping for air when sleeping or weird snoring
- Pale or bluish skin
- Slow heartbeat, low blood pressure
- Won't wake up or respond (rub knuckles on sternum)



## Call 911 for help

All you have to say:

"Someone is unresponsive and not breathing."  
Give clear address and location.



## Airway

Make sure nothing is inside the person's mouth.



## Rescue breathing

Oxygen saves lives. Breathe for them.

One hand on chin, tilt head back, pinch nose closed.  
Make a seal over mouth & breathe in  
1 breath every 5 seconds  
Chest should rise, not stomach



## Evaluate

Are they any better? Can you get naloxone  
and prepare it quickly enough that they won't  
go for too long without your breathing assistance?



## Prepare naloxone

- Remove cap from naloxone and uncover needle
- Insert needle through rubber plug, with bottle upside down
- Pull back on plunger and take up 1 cc into the syringe
- Don't worry about air bubbles (they aren't dangerous in muscle injections)



## Muscular injection

inject 1cc of naloxone into a big muscle (shoulder or thigh)



## Evaluate + support

- Continue rescue breathing
- Give another shot of naloxone in 3 minutes if no or minimal breathing or responsiveness
- Naloxone wears off in 30-90 minutes
- Comfort them; withdrawal can be unpleasant
- Get them medical care and help them not use more opiate right away
- Encourage survivors to seek treatment if they feel they have a problem

## How to Avoid Overdose

- Only take medicine prescribed to you
- Don't take more than instructed
  - Call a doctor if your pain gets worse
- Never mix pain meds with alcohol
- Avoid sleeping pills when taking pain meds
- Dispose of unused medications
- Store your medicine in a secure place
- Learn how to use naloxone
- Teach your family + friends how to respond to an overdose

For More Info  
[PrescribeToPrevent.com](http://PrescribeToPrevent.com)

Poison Center  
1-800-222-1222  
(free & anonymous)

# Naloxone access

- **Q. Who can be prescribed naloxone?**
- A. A prescriber can prescribe take-home naloxone to anyone who is at risk for opioid overdose.
  - WA state explicitly allows for the prescription of take-home naloxone to persons at risk for witnessing an overdose.
- **Q. Where can naloxone be obtained?**
- A. Naloxone availability varies by city/town. Generally very limited.
  - To locate overdose education & prevention and naloxone programs <http://hopeandrecovery.org/locations/>
  - Current efforts to get in community based pharmacies

# ***Q. What has research shown to be the impacts of distributing Naloxone to potential overdose bystanders?***

- Naloxone administration has not resulted in dangerous health outcomes;<sup>(b)</sup>
- Drug users are willing to administer naloxone to each other;<sup>(c)</sup>
- Naloxone availability does not increase drug use;<sup>(d)</sup>
- Evaluation data suggests that many who receive overdose education and take-home naloxone decrease their own risk for overdose by reducing drug use and/or entering drug treatment;<sup>(e,f)</sup>

# Cont.

- More than 10,000 opioid overdoses have been reversed with naloxone given by bystanders in the U.S.
  - Naloxone distribution programs generally provide overdose prevention and recognition training combined with the dispensing of take-home Naloxone (THN).
  - More than 100 programs that distribute naloxone to opioid users are operating in at least 15 states. <sup>(g)</sup>
- As of 2012, two studies in the United States have recently received funding to conduct studies of overdose education and take-home naloxone distribution to populations at high risk for overdose. <sup>(h)</sup>

## RESEARCH

# Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis

 OPEN ACCESS

Alexander Y Walley *assistant professor of medicine, medical director of Massachusetts opioid overdose prevention pilot*<sup>1,3</sup>, Ziming Xuan *research assistant professor*<sup>2</sup>, H Holly Hackman *epidemiologist*<sup>3</sup>, Emily Quinn *statistical manager*<sup>4</sup>, Maya Doe-Simkins *public health researcher*<sup>1</sup>, Amy Sorensen-Alawad *program manager*<sup>1</sup>, Sarah Ruiz *assistant director of planning and development*<sup>3</sup>, Al Ozonoff *director, design and analysis core*<sup>5,6</sup>

<sup>1</sup>Clinical Addiction Research Education Unit, Section of General Internal Medicine, Boston University School of Medicine, Boston, MA, USA;

<sup>2</sup>Department of Community Health Sciences, Boston University School of Public Health, USA; <sup>3</sup>Massachusetts Department of Public Health, USA;

<sup>4</sup>Data Coordinating Center, Boston University School of Public Health, USA ; <sup>5</sup>Design and Analysis Core, Clinical Research Center, Children's Hospital Boston, USA ; <sup>6</sup>Department of Biostatistics, Boston University School of Public Health, USA

Reduction in population death rate when 150/100,000 population were trained

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Hillary S. Connery, MD,  
PhD; Roger D. Weiss,  
MD

Division of Alcohol and  
Drug Abuse, McLean  
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Weiss, and Ms. Rice);  
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and Weiss)

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*The authors reported no  
potential conflict of interest  
relevant to this article.*

# Diagnosing and treating opioid dependence

The surge in opioid abuse highlights the importance of questioning patients about their use of prescription analgesics—and knowing when and how to intervene.

## PRACTICE RECOMMENDATIONS

- › Ask all patients about the inappropriate use of substances, including prescription opioids. (A)
- › Recommend pharmacotherapy for patients entering treatment for opioid dependence. (A)
- › Warn patients who are opioid dependent about the risk of accidental fatal overdose, particularly with relapse. (A)

**CASE ▶** Sam M, age 48, is in your office for the first time in more than 2 years. He has gained a considerable amount of weight and appears a bit sluggish, and you wonder whether he's depressed. While taking a history, Sam reminds you that he was laid off 16 months ago and had been caring for his wife, who sustained a debilitating back injury. When you saw her recently, she told you she's back to work and pain-free. So you're taken aback when Sam asks you to refill his wife's oxycodone prescription for lingering pain that often keeps her up at night.

If Sam were your patient, would you suspect opioid dependence?

**D**ependence on opioid analgesics and the adverse consequences associated with it have steadily increased during the past decade. Consider the

## Cost-Effectiveness of Distributing Naloxone to Heroin Users for Lay Overdose Reversal

Phillip O. Coffin, MD, and Sean D. Sullivan, PhD

**Background:** Opioid overdose is a leading cause of accidental death in the United States.

**Objective:** To estimate the cost-effectiveness of distributing naloxone, an opioid antagonist, to heroin users for use at witnessed overdoses.

**Design:** Integrated Markov and decision analytic model using deterministic and probabilistic analyses and incorporating recurrent overdoses and a secondary analysis assuming heroin users are a net cost to society.

**Data Sources:** Published literature calibrated to epidemiologic data.

**Target Population:** Hypothetical 21-year-old novice U.S. heroin user and more experienced users with scenario analyses.

**Time Horizon:** Lifetime.

**Perspective:** Societal.

**Intervention:** Naloxone distribution for lay administration.

**Outcome Measures:** Overdose deaths prevented and incremental cost-effectiveness ratio (ICER).

**Results of Base-Case Analysis:** In the probabilistic analysis, 6% of overdose deaths were prevented with naloxone distribution; 1

death was prevented for every 227 naloxone kits distributed (95% CI, 71 to 716). Naloxone distribution increased costs by \$53 (CI, \$3 to \$156) and quality-adjusted life-years by 0.119 (CI, 0.017 to 0.378) for an ICER of \$438 (CI, \$48 to \$1706).

**Results of Sensitivity Analysis:** Naloxone distribution was cost-effective in all deterministic and probabilistic sensitivity and scenario analyses, and it was cost-saving if it resulted in fewer overdoses or emergency medical service activations. In a "worst-case scenario" where overdose was rarely witnessed and naloxone was rarely used, minimally effective, and expensive, the ICER was \$14 000. If national drug-related expenditures were applied to heroin users, the ICER was \$2429.

**Limitation:** Limited sources of controlled data resulted in wide CIs.

**Conclusion:** Naloxone distribution to heroin users is likely to reduce overdose deaths and is cost-effective, even under markedly conservative assumptions.

**Primary Funding Source:** National Institute of Allergy and Infectious Diseases.

# Evidence base

- We know naloxone works physiologically
  - Used by EMS and in OR's and ED' for decades
- Community based OD education and take-home naloxone shown to impact death rates at population level
- Evaluations of existing programs not had \$ for rigorous research...

# Fear of police/law

## How to minimize

- Good Samaritan laws at State level can change practice OR perception
- Prosecutorial/Police policy at municipal level can be changed or made explicit [blessing by others may catalyze]
- Police could be trained and allowed to administer naloxone e.g. Quincy Mass
- *I, believe we have spread the word that no one should fear calling the police for assistance and that the option of life is just a 911 call away. We have also re-inforced with the community that the monster is not in the cruiser but indeed the officer represents a chance at life. Lt. Glynn*
- PH/LE communication and coordination
- [to discuss overdose as public safety issue to change practice and in turn perceptions](#)
- Training police and public essential
  - [Transparency will help build trust](#)



WATCH Seattle Police training video about Washington's 911 Good Samaritan law and Narcan.

# Naloxone- medical access

Firefox

StopOverdose.org - Opioid Overdose Pr...

www.stopoverdose.org

Most Visited Getting Started Suggested Sites Web Slice Gallery

Bookmarks

 **StopOverdose.org**  
*Opioid overdoses can be prevented and reversed!*

Home / Opioid OD Education

Where to Get Naloxone / FAQ

Sources for Help

Law Enforcement

Evaluation of WA Law

Pharmacy/Prescribers

Other Drugs and Overdose

News

### Opioid Overdose Prevention Education

Learn how you can save a life:  
**WATCH** a video, **REVIEW** the steps, then **TAKE A QUIZ**.

.....



**A community health worker** explains overdose prevention and demonstrates how to administer intra-nasal naloxone (Narcan™) in an overdose. Available in [Spanish](#) and [Russian](#). Alternate version showing use of [intra-muscular naloxone](#). Produced by NYC Department of Health.



**A doctor** teaches patients, their families and friends, what to do in case of overdose from prescription opioids, including how to administer the opioid antidote naloxone (Narcan™). Produced by Project Lazarus.

.....

### Review: Overdose and Good Samaritan Law

1. Rub to wake.
2. Call 911.





Firefox

StopOverdose.org - For Pharmacists and...

www.stopoverdose.org/pharmacy.htm

Most Visited Getting Started Suggested Sites Web Slice Gallery

Bookmarks



# StopOverdose.org

Opioid overdoses can be prevented and reversed!

Home / Opioid OD Education

Where to Get Naloxone / FAQ

Sources for Help

Law Enforcement

Evaluation of WA Law

Pharmacy/Prescribers

Other Drugs and Overdose

News

## For Pharmacists and Prescribers

- [Who can prescribe naloxone \(Narcan®\)?](#)
- [How do I prescribe naloxone?](#)
- [How can my pharmacy start to dispense naloxone...?](#)
- [How can I enter into a collaborative drug therapy agreement \(CDTA\)...?](#)
- [Is prescribing take-home naloxone controversial?](#)

### Who can prescribe naloxone (Narcan®)?

*Physicians, nurse practitioners and physician assistants* in Washington State who have prescriptive authority may prescribe take-home-naloxone to anyone at risk for having or witnessing an opioid overdose (prescription opioids or heroin) according to WA law RCW 69.50.315.

*Pharmacists* can dispense naloxone directly to the public if the pharmacist has a protocol in place signed by a legal prescriber. This protocol is part of a collaborative drug therapy agreement (CDTA) also known as a collaborative practice agreement.

### How do I prescribe naloxone?

For sample prescriptions, see <http://www.prescribetoprevent.org/prescribe-naloxone-now/>.

If naloxone is not available in your area, your pharmacy may first need to order the medication.

## How can my pharmacy start to dispense naloxone directly to persons at risk of an overdose?

---

### Decide which naloxone to carry intranasal, intramuscular, or both.

Order intramuscular naloxone HCL, either:

- 1 X 10 ml as one fliptop vial (NDC0409-1219-01)
- 2 X 1 ml single dose vial (NDC 0409-1215-01)

Order intranasal naloxone HCL, both parts:

- 2 X 2 mL as pre-filled Needleless Luer Jet Prefilled Syringe (NDC# 0548-3369-00)
- 2 X intranasal mucosal Atomizing Device (MAD 300)

**Verify which insurance companies** in your area will cover naloxone. For example Medicaid in Washington State pays for naloxone for a person at risk of an overdose (but, not a potential bystander who is not at risk, e.g. a family member who does not use opioids).

**Decide if your pharmacy** wishes to fill orders from other prescribers or would like to dispense directly to the public with a [collaborative drug therapy agreement](#).

**Design patient education materials** for each route of administration. Sample patient education materials are available from many sources. One source for printed educational materials is: <http://www.prescribetoprevent.org>.

**Prepare an overdose rescue kit** with the naloxone, nasal applicator or intramuscular syringe, overdose education materials, perhaps a rescue breathing mask, and a list of local social and health services providers. Set a price.

**Prepare a teaching kit** so patients can demonstrate that they understand the instruction by practicing drawing up the medication and selecting an injection site, or practicing squirting with the nasal applicator. Hands-on practice is important.

**Let your local prescribers know** that you are carrying naloxone. [If you would like to be included in the naloxone locator on this website, email: [info@stopoverdose.org](mailto:info@stopoverdose.org)]

**Overdose education**, such as that available on this website, is very important in addition to instruction on how to use naloxone. Most people are unaware that opioid overdoses are due to respiratory depression (breathing slows down) and therefore that rescue breathing (and calling 911) is very important to maintain oxygen supply to prevent brain damage or death. Many may also be unaware of [WA State's Good Samaritan overdose law](#) that provides immunity from drug possession prosecutions during overdose situations.

**Train the pharmacy team** so all members know that take-home-naloxone is available, which pharmacists are authorized on the CTDA, the education to provide, and where to find answers to frequently asked questions.

## How can I enter into a collaborative drug therapy agreement (CDTA) so that I, as a pharmacist, can dispense naloxone without the patient having to see a medical provider for a prescription?

---

If your pharmacy wants pharmacists to prescribe naloxone you will need to create a collaborative drug therapy agreement (CDTA), identify a provider to sign off on the agreement, and then submit it for review by a pharmacist consultant at the WA Board of Pharmacy. A sample CDTA may be [downloaded here](#).

Contact information for the WA State Board of pharmacy is available here: <http://www.doh.wa.gov/LicensesPermitsandCertificates/ProfessionsNewReneworUpdate/Pharmacy/BoardInformation.aspx>

## Is prescribing take-home naloxone controversial?

---

**No.** The WA State Board of Pharmacy released a [letter of support](#) for take-home naloxone CDTA's (March 2012).

The American Medical Association and the American Public Health Association both have policies supporting availability of take-home naloxone:

- o <http://www.ama-assn.org/ama/pub/news/news/2012-06-19-ama-adopts-new-policies.page>
- o <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1443>

Professional research articles suggest prescribing take-home naloxone to those at risk for having an opioid overdose. For example: [Diagnosing and treating opioid dependence](#) (Hill KP, Rice LS, Connery HS, Weiss RD. *Journal of Family Practice* 2012;61(10):588-597).

This information made available by the UW Alcohol & Drug Abuse Institute  
<http://stopoverdose.org/pharmacy.htm>

[Contact us](#) || Updated 1/2013 || [Privacy](#) · [Terms](#)

# To conclude, medical providers can...

- Educate patients about hazards of opioids, treatment of problem use, OD prevention
- Become buprenorphine prescribers
- Prescribe naloxone
- Collaborate with pharmacists and community organizations on OD education and naloxone distribution
- Help educate the community about addiction, stigma, medical condition with medical responses available
- ***No other addiction has such a well proven medication assisted treatment or available antidote***



Stopoverdose.org Timeline Recent

September 6

Public health relevance of WA's overdose law and implementation thus far [http://fridayletter.aspph.org/article\\_view.cfm?FLE\\_Index=261&FL\\_Index=6](http://fridayletter.aspph.org/article_view.cfm?FLE_Index=261&FL_Index=6)

ASPPH Friday Letter #6 - 06 September 2013

fridayletter.aspph.org

Opioid overdose – from heroin or pharmaceuticals – is an epidemic in the U.S., but fear of police is a common barrier to calling 911. In 2010, Washington became the second state to pass a Good Samaritan law providing immunity from drug possession charges for victims or

Like Comment Share

Ramese Mac likes this.



Write a comment...



31 people saw this post

Boost Post



Stopoverdose.org shared a link. September 4

Remember: WA's Good Samaritan law applies to all drugs & [www.stopoverdose.org](http://www.stopoverdose.org) has information about stimulant/hallucinogen overdoses



Electric Zoo Festival Cut Short by Two Deaths

# Twitter

## @nomoreoverdose



stopoverdose.org

@nomoreoverdose

Overdoses can be prevented. Educational information on laws, policy, public health, health care and treatment.

WA State · stopoverdose.org

TWEETS  
51

FOLLOWING  
29

FOLLOWERS  
31

Edit profile

### Tweets



stopoverdose.org @nomoreoverdose · 5h

Overview & encouragement for many access points for naloxone/Narcan JAMA News [jama.jamanetwork.com/article.aspx?a...](http://jama.jamanetwork.com/article.aspx?a...)

Expand

Reply Retweet Favorite More



Retweeted by stopoverdose.org



U.S. Drug Policy @ONDCP · Apr 3

Joining @HHSgov Sec. Sebelius and @US\_FDA Commissioner Hamburg to announce a new, lifesaving #naloxone autoinjector. [pic.twitter.com/J50QYLvzAx](http://pic.twitter.com/J50QYLvzAx)





# **Washington Health Benefit Exchange**

## **Exchange Update**

**Washington Medical Quality Assurance Commission**  
**October 2, 2014**

**Molly Voris, Policy Director**

# Presentation Topics

- Enrollment Information
- Lessons Learned from Year One
- Looking Forward to Year Two



# Key Enrollment Numbers

Since Oct. 1, 2013, nearly 1.3 million people enrolled in health coverage through Washington Healthplanfinder.

- ✓ QHP enrollments: 147,888
- ✓ New MAGI Medicaid: 352,386
- ✓ Medicaid previously eligible but not enrolled: 199,631
- ✓ Medicaid renewals: 583,765
- ✓ New MAGI Medicaid enrollment exceeded target for January 2018.



# Enrollment Highlights

- **Washington Healthplanfinder attracted a wide variety of consumers**
  - ✓ “Young Invincibles” (ages 18-34) accounted for 25% of enrollments, 29% in March; grows to more than 35% when including Medicaid
- **People relied on consumer assistance**
  - ✓ 43% of new enrollments assisted by in-person assisters or agents/brokers
- **The Exchange has leveraged federal dollars to benefit residents and the state**
  - ✓ More than \$300 million in federal tax credits have gone to residents to reduce their premium costs
  - ✓ Residents have also received over \$30 million in federal cost-share reductions to reduce the cost of hospital and provider visits
- **The Exchange is already having a big impact**
  - ✓ Uninsured population reduced by more than 370,000
  - ✓ Harborview Medical Center recently reported that uninsured patient dropped from 12% last year to 2% this spring



# What Worked Well

- ✓ Early start, structural set up, bipartisan support from elected officials, Board
- ✓ Managing scope, governance in a transparent manner
- ✓ Key stakeholder engagement
- ✓ Strong marketing and outreach, engaged community partners
- ✓ Collaboration and coordination among key state agencies



# Key Learnings

- ✓ Seismic shift to the health care landscape in WA
- ✓ New process generated new customer needs
- ✓ Remain nimble and execute changes as necessary
- ✓ Understanding and projecting volume (call center, renewals, etc.)
- ✓ Testing the system: limited time, real world environment



# Payment and Invoicing Issues

- Problems with transferring enrollment information to carriers which has prevented people from getting coverage
- Problems with people receiving incorrect invoices
- Resolution is top priority
  - Impacts to consumers, carriers, agents/brokers, providers, and consumer assisters
- Making Progress
  - Increased engagement with insurance carriers to identify top priority issues
  - Continuing to address known technical issues and fix individual accounts
  - Continued outreach to affected consumers and assisters
  - Recently terminated over 4,000 individuals



# Operational Requirements

## REQUIRED

Call Center  
Plan Certification  
Printing for required notices  
SHOP  
Consumer Rating System  
State Audit  
Data Reporting to Federal Government  
Reconciliation of enrollment information with carriers (834 files, ongoing, etc.)  
Streamlined application (QHP and Medicaid) & eligibility determination

Navigator Program  
Pediatric dental  
Translation/Interpreter Services  
Consumer Survey  
Appeals

## NOT REQUIRED

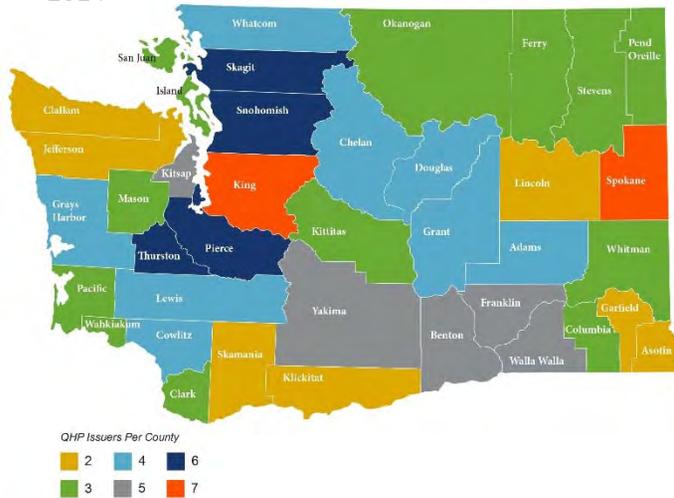
Outreach and Marketing  
Specialized broker support  
Post-eligibility referrals to WaConn (classic Medicaid, etc.)  
Consumer decision/shopping tools (plan display features, etc.)  
Provider directory  
Adult dental  
Premium aggregation and invoicing



# Breakdown of 2015 Exchange Plan Offerings

## Individual QHP Market – Issuers per County

2014



2015



### Individual Market

2014: 8 issuers, 46 plans

2015: at least 10 issuers, 90 plans  
(8 multi-state plans)

New: More choice

### Healthplanfinder Business/SHOP

2014: 1 Issuer, 5 plans

2015: 2 Issuers, 23 plans

New: Statewide market

### Individual Pediatric Dental Market

2014: 5 Issuers, 5 Plans

2015: at least 5 issuers, 6 plans

New: High-level plans (85% AV)



# Breakdown of 2015 Participating Issuers

Individual Market:	Healthplanfinder Business/SHOP:	Individual Pediatric Dental Market:
BridgeSpan Health Company	Kaiser Permanente	Delta Dental of Washington
Columbia United Providers*	Moda Health Plan*	Dental Health Services
Community Health Plan of Washington		Kaiser Permanente
Coordinated Care Corporation		LifeWise of Washington
Group Health Cooperative		Premera Blue Cross
LifeWise of Washington		
Moda Health Plan*		
Molina		
Premera Blue Cross		



*\*New issuers in 2015*

*All 2014 issuers are continuing in 2015*

# QHP Renewal Timeline

- Issuers send letter on non-renewed QHPs by October 1
  
- Exchange sends QHP renewal letter in late October
  - Informs consumer about renewal plan for 2015
  - Tax credit amount (based upon second lowest cost silver plan) for 2015
  - Enrollee's premium contribution for renewal plan in 2015
  
- Open Enrollment begins November 15



# Provider-Related Issues

- Grace period issues related to system problems
- Narrower networks in QHPs
- Doctor availability and longer wait times



# Resources

[www.wahealthplanfinder.org](http://www.wahealthplanfinder.org)

[www.wahbexchange.org](http://www.wahbexchange.org)

1-855-WAFINDER (1-855-923-4633)

TTY/TTD for Deaf : 1-855-627-9604

[info@wahbexchange.org](mailto:info@wahbexchange.org)



[WAHealthplanfinder](https://www.facebook.com/WAHealthplanfinder)



[@waplanfinder](https://twitter.com/waplanfinder)



[waplanfinder](https://www.youtube.com/waplanfinder)





washington  
**healthplanfinder**

click. compare. covered.



# Integration: Primary Care and Public Health

October 2, 2014

Washington Medical Quality Assurance  
Conference

John Wiesman, DrPH, MPH

Secretary, Washington Department of Health

**PUBLIC HEALTH**  
ALWAYS WORKING FOR A SAFER AND  
HEALTHIER COMMUNITY



# Outline

- Context setting
- Health Transformation: Integration of primary care and public health
- Washington's Health Innovation Plan



# Strategy

- Department of Health Strategy:

Through collaborations and partnerships, we will leverage the knowledge, relationship and resources necessary to influence the conditions that promote good health and safety for everyone.



# Traditional Public Health

- Works on a population-basis
- Prevents disease and injury
- Promotes good health
- Protects food, water, air
- Prepares for/Responds to health emergencies



# Traditional Primary Care

- Works on a individual-basis
- Responds to health needs and provides care on a broad range of health needs
- Prevents illness with vaccines
- Acts as a point of entry for accessing specific health services



# Population-based Approach

- Distinguishing attribute between public health and primary care
- Community-level interventions
- Complementary strategies: individual and community
- Incorporates:
  - Behavioral science
  - Biological science
  - Environmental science
  - Social science



# Significant Challenges

- Health disparities
- Rising costs
- Increasing obesity
- Silo-ing behavioral health



# Requirements

- Build partnerships – Population-based health transformation
- Create place-based policy systems
- Integrate physical and mental health



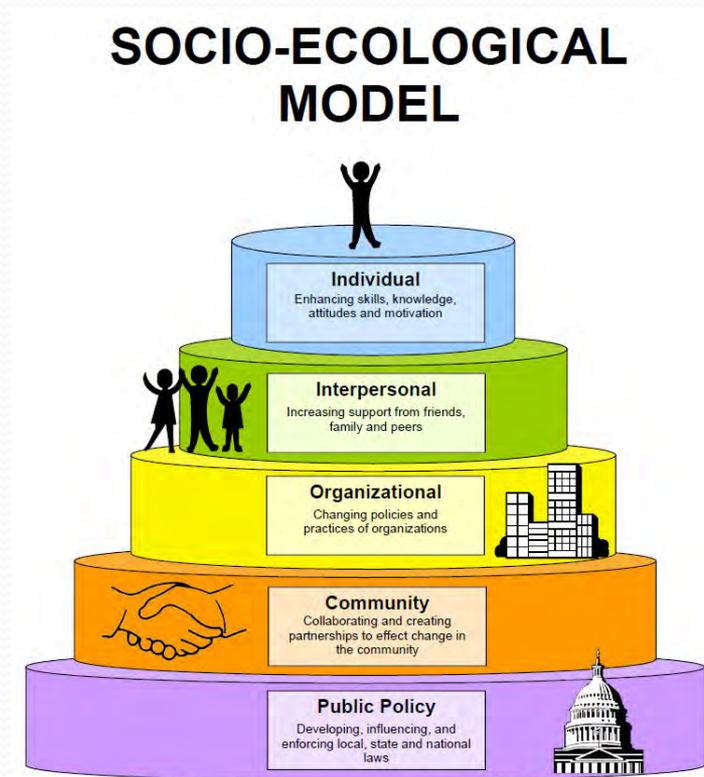
# Health Transformation

## Determinants of health



ick, S; Inman, K; Hoskins, S. Clark County Public Health, 2011. Adapted from Determinants of Health, Healthy People 2020, US Department of Health and Human Services. [www.healthypeople.gov/2020/about/DCHAbout.aspx](http://www.healthypeople.gov/2020/about/DCHAbout.aspx). Accessed 9/6/11; Social Determinants of Health, World Health Organization. [http://www.who.int/social\\_determinants/en/](http://www.who.int/social_determinants/en/). Accessed 9/6/11; and Social Determinants of Health, Centers for Disease Control and Prevention. <http://www.cdc.gov/socialdeterminants/Definitions.html>. Accessed 9/6/11.

# Socioecological Model



Kendrick, S. Inman, K., Hopkins, S. Clark County Public Health, 2010. Adapted from McLeroy, K. R., Bibeau, D., Sletkier, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly*, 15(4), 351-377. Bronfenbrenner, U. 1978. *The Ecology of Human Development: Experiments by Nature and Design*. Cambridge, MA: Harvard University Press.

# State Health Care Innovation Plan

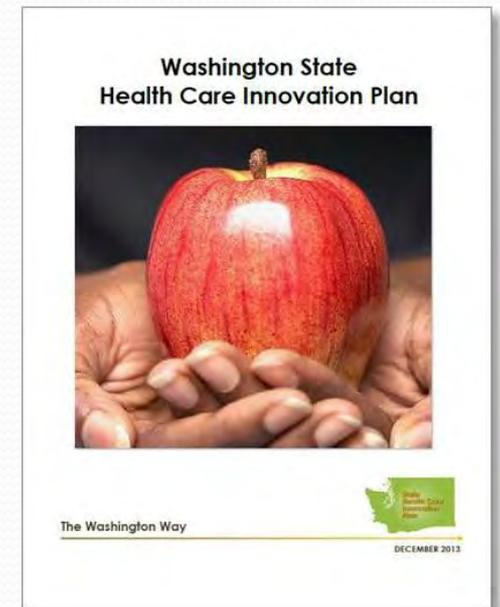
## Goal - a Healthier Washington

- **Pay for value and outcomes** starting with the State as “first mover”
- **Empower communities** to improve health and better link with health delivery
- **Integrate physical and behavioral health** to address the needs of the whole person

## Critical - Legislation Enacted

- **E2SHB 2572** – Purchasing reform, greater transparency, empowered communities
- **E2SSB 6312** – Integrated whole-person care

## Potential - Federal Financing (Round 2)



# Questions

- What questions or comments do you have?



## Aligning Incentives

Clinical Integration  
and Patient Safety



Partners



# A Glimpse at Our Market Situation

# EvergreenHealth

EvergreenHealth  
Partners



Partners

# EvergreenHealth

EvergreenHealth  
Partners



# Partners

# EvergreenHealth

Kirkland, WA

900 providers

80 specialties

400,000 primary service area

800,000 total service area



# LOCATIONS



EvergreenHealth Medical Center and EvergreenHealth Home Care and Hospice

24-hour Emergency Care in Kirkland and Redmond

Urgent Care - Redmond and Woodinville

Primary Care - Canyon Park, Duvall, Kenmore, Redmond, Monroe, Sammamish & Woodinville

Specialty Care—12 in Kirkland and 6 satellites in Redmond

# RECOGNIZED FOR QUALITY

## Distinguished Hospital For Clinical Excellence

- ~ Healthgrades
- ~ 5 of the past 6 years

## Best Regional Hospitals

- ~ US News & World Report
- ~ #2 Best Hospital - in the Seattle area
- ~ #3 Best Hospital – in Washington state
- ~ Recognition in 9 specialty areas

# PURPOSE, MISSION & VALUES



## **Purpose ~ shared commitment**

Working together to enrich the health and well-being of every life we touch.

## **Mission ~ why we exist**

EvergreenHealth will advance the health of the community it serves through our dedication to high quality, safe, compassionate, and cost-effective health care.

## **Vision ~ what we will become**

EvergreenHealth will create an inclusive community health system that is the most trusted source for health care solutions.

Partners

# The Circumstances the Health Care Industry Faces

## Why EvergreenHealth Partners?

## Host of Pressures Pushing Physicians, Hospitals Together

- Driving Factors for Alignment



Hospitals



Physicians



### *Aging Population*

- Shift to public payers
- Deteriorating case mix



### *Changing Market Demands*

- Competing on value
- At risk for outcomes



### *Future Threats*

- Expected reduction in volumes
- Proposed Medicare cuts
- Market share loss



### *Shifting Workforce Demographics*

- Premium on work-life balance
- Interest in team-based care



### *Worsening Financials*

- New reimbursement cuts
- Rising practice costs



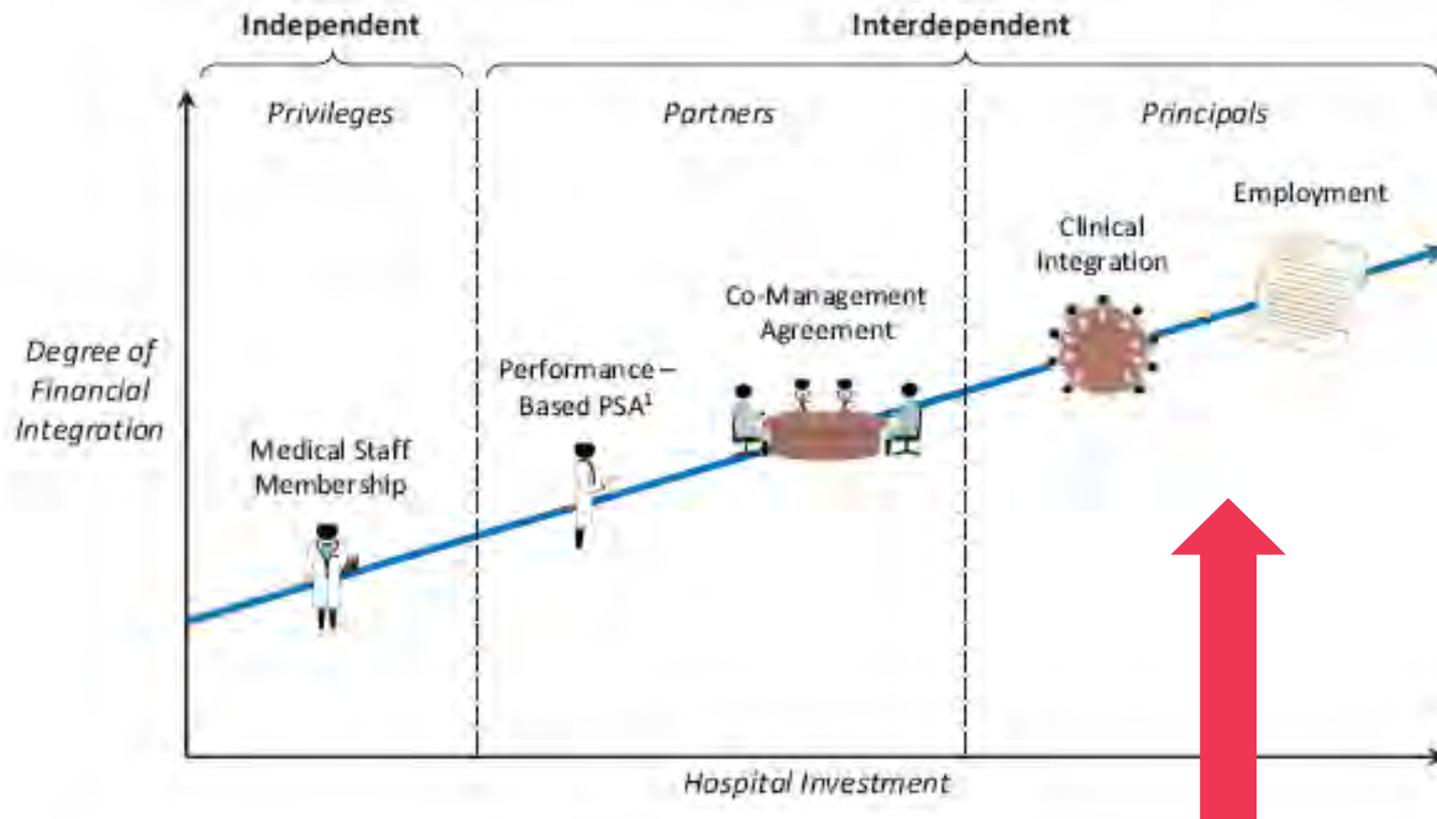
### *Reform Uncertainty*

- Unable to cover investment in care management resources
- Fear of referral stream loss

Source: Health Care Advisory Board interviews and analysis.

# TRANSITIONING FROM INDEPENDENT TO INTERDEPENDENT

*Hospitals, Physicians Strengthening Formal Relationships*

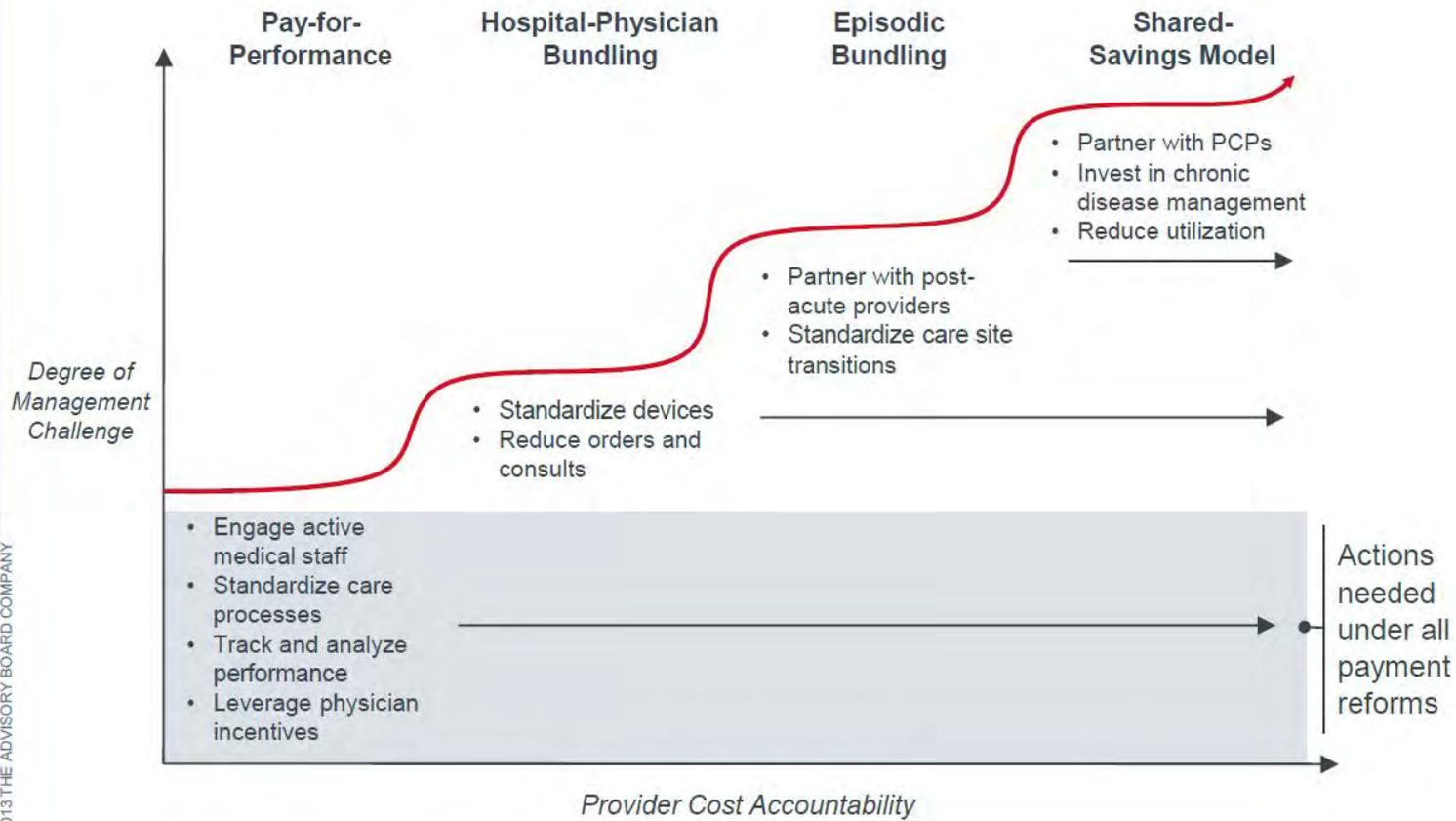


<sup>1</sup> Professional services agreement.

Partners

# SUCCESS REQUIREMENTS LINKED TO PAYMENT ENDGAME

Common Foundation of Physician/Hospital Initiatives for Success



# IN NEED OF A HOSPITAL/PHYSICIAN INTEGRATION PLATFORM

## Current Contracting Models Insufficient

### Employed Physicians

#### Limited Scale

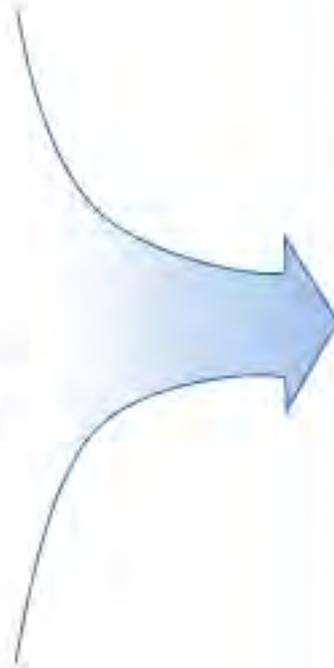
- Represent fraction of medical staff; restrained by hospital resources, physician interest
- Often lack strategy-aligned compensation model, performance improvement infrastructure



### Independent Physicians

#### Limited Levers

- Antitrust, regulatory barriers restrain financial incentives
- Limited data sharing, performance improvement infrastructure
- Collection of stakeholders too diffuse for organized performance achievements



## Performance-Focused Integration Platform



### Key Characteristics

- Selective, scalable membership
- Commitment to evidence-based, standardized care
- Care coordination infrastructure
- Performance management system
- Legal, meaningful performance-based incentives
- Capable of joint contracting with commercial payers

# Our Response: Clinical Integration

# CLINICAL INTEGRATION IS...

- Physician-led strategy to improve quality, control costs and bring value to patients across the continuum of care
- Means for physicians to contract collectively with fee-for-service health plans
  - Without violating antitrust laws
- Undertaken in conjunction with a sponsoring hospital such as EvergreenHealth

# A FOUNDATIONAL STRATEGY

## Clinical Integration is...

- A network of physicians, working (most often) in collaboration with a hospital
- A program of initiatives, developed and managed by physicians, to improve the quality and efficiency of patient care and supported by a performance management infrastructure
- A legal basis for collective negotiation by independent physicians for improved reimbursement on the basis of improved clinical outcomes and efficiency

## Clinical Integration is not...

- Physician employment by another name
- A return to capitation
- EMR implementation
- IPA / PHO Messenger Model
- Gimmick to bypass anti-trust law
- Program led by the hospital

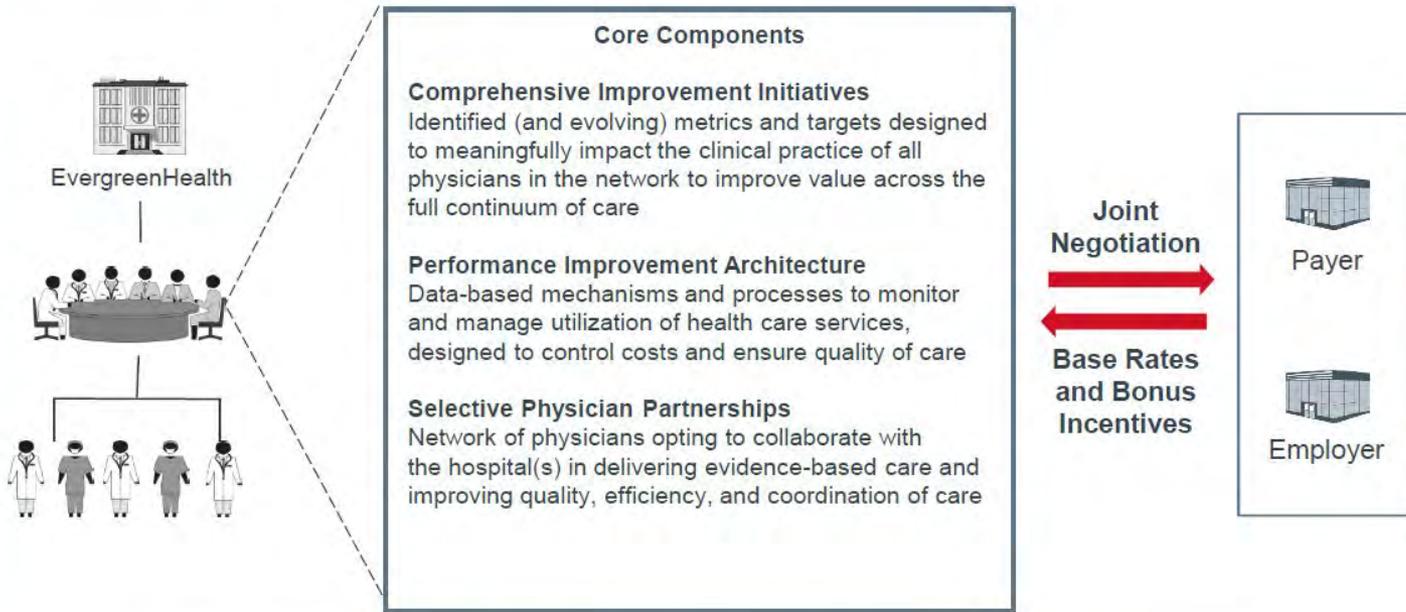
## Legal Compliance at Core of Success

“Clinical Integration is an active and ongoing program to evaluate and modify practice patterns by a network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.” - **FTC Definition**

- Recognizes joint contracting may be acceptable on the basis of value creation for patients and payers
- Establishes a “Clinical Integration” concept as a defense against price-fixing challenges
- Allows for layering CI-related contracts on top of existing models of economic alignment
- Provides general concepts but limited detail on desired CI program structure

# A MEANS TO ALIGN PHYSICIANS

## Clinically Integrated Organization



### Benefits to Independent Physicians

- Access to coordination infrastructure
- Access to technology
- Data visibility across full continuum of care
- Leadership opportunities
- Enhanced community impact
- Potential for better reimbursement

# REQUIRES MULTI-PRONGED EFFORT

## Typical CI Program Components



### Selective Physician Partners

- Right specialty mix to advance care delivery
- Clear participation requirements



### Physician Oversight

- Broad engagement in governance, management
- Platforms for shared hospital-physician decision making



### Meaningful Performance Metrics

- Program-wide and specialty-specific measures
- High-yield targets and objectives



### Payer Engagement

- Early involvement in initiative selection
- Joint contracts that recognize CI value



### Support for Clinical Redesign

- Scalable care coordination infrastructure
- Principled referral management policies



### Optimized IT Infrastructure

- Platforms for seamless data exchange
- Disease registry and other clinical tools



### Performance Monitoring

- Systems to track physician performance
- Process to remedy underperformance

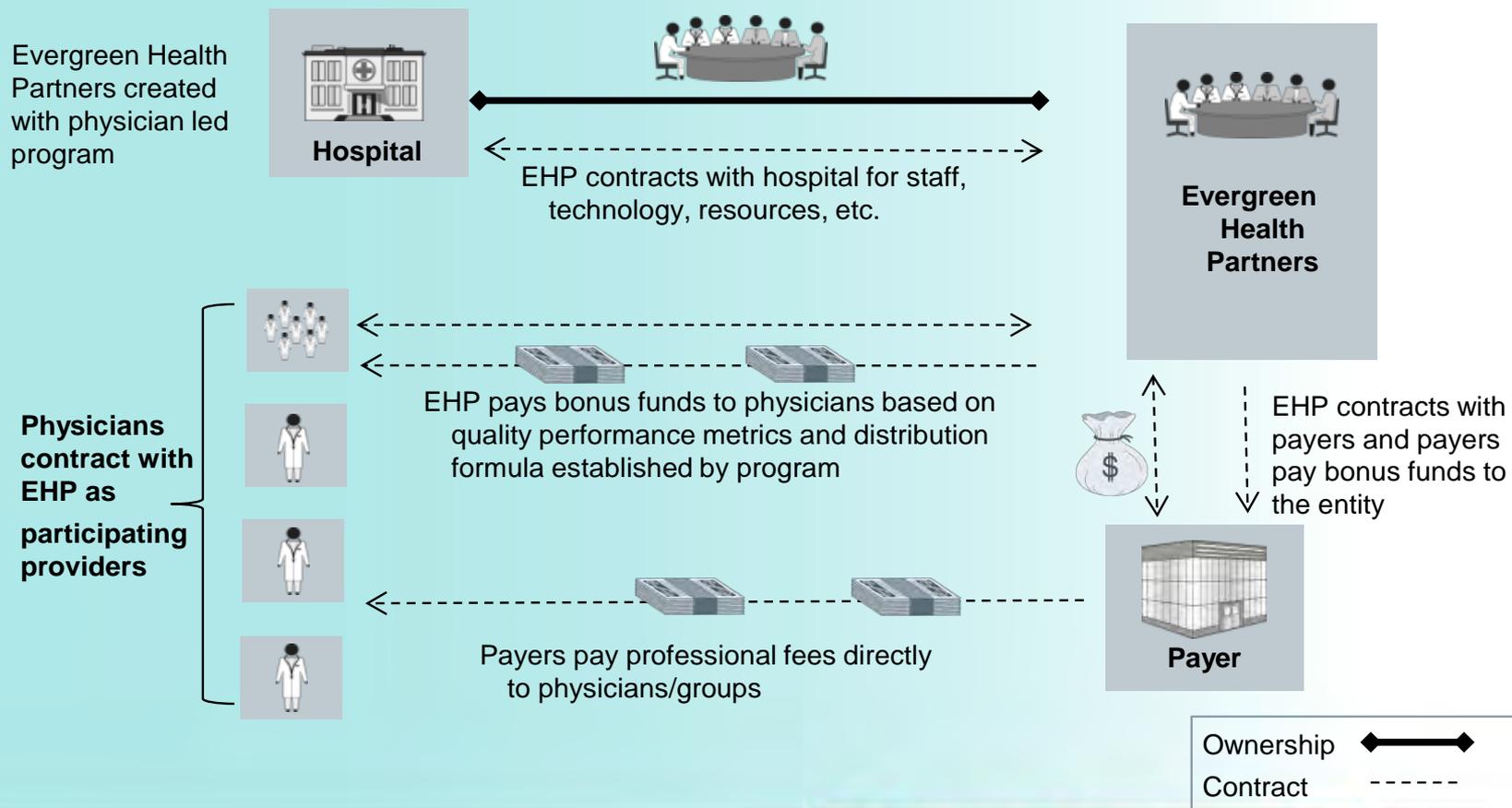


### Performance Incentive Pool

- Bonus structure tied to program goals, physician performance

# BUILDING EHP

## Organizational Structure and Funds Flow Supporting Clinical Integration



# CI BENEFITS PHYSICIANS, HOSPITAL & COMMUNITY

- Focus on clinical outcomes
- Demonstrated cost savings
- Coordinated care for patients



- Integrated presence in the community
- Compensation incentives for additional work
- Single interface with multiple payer organizations

- Foundation for physician partnership
- Improvement of quality and efficiency of patient care
- Focus on shared goals with physicians

# VISION

Redefining Healthcare

# MISSION

EvergreenHealth Partners provides our community with high quality, safe health care through an integrated network of health care providers delivery the best service and value.

# MEMBERSHIP

515 Participants

97 Practices

45 Specialties

*Oct. 1, 2014*

# GOVERNANCE

## Board of Managers

## Committees

- Quality
- Payer Relations & Finance
- Education & Remediation

# QUALITY PROCESS & MONITORING

- Public reporting of indicators: chosen by Board from over 600 available
- At least 5 metrics per specialty
- Claims data from every practice fed across all payers to business intelligence tool: internal benchmarking

# QUALITY PROCESS & MONITORING

- Commitment to internal transparency: “airing our laundry.” Specialty specific transparent review.
- Flexibility: metrics can be changed by the Board as able and needed

# CONTRACTS

- ~ First Choice / EvergreenHealth
- ~ First Choice / High-Value Network
- ~ Cigna
- ~ Regence Accountable Health Network
- ~ Many to follow....

# HOW DOES CI IMPROVE PATIENT SAFETY?

- Incentive alignment toward relevant goals and metrics
- Reducing waste = reducing error = patient safety
- Standard work = reliability = improved patient experience

# HOW DOES CI IMPROVE PATIENT SAFETY?

- Improved value = competitive advantage; others have to follow, or we earn the loyalty of their patients
- Metrics from more robust data than any payer
- The ability to spread improvement out from the mother ship and in from the grassroots

# BASIC QUALITY PLANNING FRAMEWORK



# ANNUAL QUALITY & SAFETY PLAN



## 2014 CLINICAL OUTCOMES & ABSOLUTE SAFETY PLAN

2014 INITIATIVES	
<b>TRANSFORM CARE BY EXCELLING AT THE COORDINATION AND TRANSITIONS OF CARE</b>	
1. Follow Up Visits Within 7 Days of Discharge	Nancee Hofmeister*, Greg Allen
<p><b>Opportunity:</b> Currently no system in place to schedule patient for follow up visits within 7 days of discharge</p> <p><b>Desired Outcome:</b> Design a process to schedule patients recommended by the Inpatient Hospitalists for a follow up visit within 7 days of discharge</p> <p><b>Timeline:</b> Continuation of 2013 Handoffs/Transitions Initiative, begin Q2, complete Q3</p> <p><b>Measurement:</b> X % of recommended patients discharged from Hospitalist's Service have appointments scheduled with primary provider within 7 days; X% of patients were seen in 7 days by primary provider</p>	
2. Intensive Chronic Disease Management of High/Moderate Risk Patients Across the Continuum	Monique Ruyle*, Stacy Olinger
<p><b>Opportunity:</b> First Choice and other Total Cost of Care contracts provide us with data so that we are able to identify particular high utilizers or those at risk for high utilization of services, which we can use to focus our care coordination activities more effectively.</p> <p><b>Desired Outcome:</b> Help patients to access the right type of service, at the right time in the right location. Decrease in cost for our self-insured and shared savings patients.</p> <p><b>Timeline:</b> Continuation of 2013 Diabetes and Behavioral Health Initiatives; begin work Q1, plan in place by Q3.</p> <p><b>Measurement:</b> Decrease total cost of care while improving health maintenance indicators; reduce ED visits and hospitalizations; increase access to primary care.</p>	
3. Create a Perioperative Surgical Home	Neil Johnson*, Sean Kincaid
<p><b>Opportunity:</b> Deliver high quality medical care to the surgical patient in a cost-effective and coordinated manner through the perioperative period that decreases the potential for complications such as readmissions, surgical site infections and perioperative cardiac events.</p> <p><b>Desired Outcome:</b> Develop an algorithm for the preoperative process that embraces the complexity of the numerous variables such as the urgency of the procedure and the service line; implement smoking cessation resource for preoperative patients; implement a better process for glucose management in the perioperative period; develop multimodal pain management plan for hip fracture patients.</p> <p><b>Timeline:</b> Q1 develop plans, Q3 complete implementation of plans; Q4 evaluate results</p> <p><b>Measurement:</b> Fewer day or surgery cancellations, better glycemic management, decreased opioid use in hip fx patients</p>	
4. Create a Preventative Health and Health Maintenance Infrastructure	Greg Allen*, Milton Curtis
<p><b>Opportunity:</b> Develop the infrastructure for EvergreenHealth Primary Care for a Standard Patient Preventative Assessment to be reviewed during all visits based on best practice guidelines and individual patient needs.</p> <p><b>Desired Outcome:</b> Higher perceived quality for EvergreenHealth primary care providers as reflected in patient satisfaction scores, perform better than Puget Sound Health Alliance (PSHA) competitors in the marketplace; generate additional office visits and related services and referrals as a result of increased loyalty.</p> <p><b>Timeline:</b> Started in Q4 2013; infrastructure complete by Q3 2014</p> <p><b>Measurement:</b> Improved Puget Sound Health Alliance clinical scores for all EvergreenHealth primary care practices that have access to the Evergreen Cerner IT platform; raise performance scores to PSHA average score by 2015, and all clinics to above average by 2017. Improved Patient Satisfaction scores and market preference.</p>	

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ADVANCE NURSING PRACTICES THROUGH MAGNET PRINCIPLES	
5. Increase Use of Evidence-Base Practice in Nursing	Nancee Hofmeister*
<p><b>Opportunity:</b> Improve the overall quality outcomes related to nursing care</p> <p><b>Desired Outcome:</b> Improve patient outcomes and patient satisfaction specific to nursing sensitive indicators</p> <p><b>Timeline:</b> Continuation from 2013 of Magnet Journey Initiative</p> <p><b>Measurement:</b> All measures at or below mean: Falls, Falls with Injury, Falls with Moderate to Severe Injury; Pressure Ulcers; Central line associated blood stream infections; Catheter associated urinary tract infections; HCAHPS pain score (above mean)</p>	
ELEVATE A CULTURE OF TRANSPARENCY AND ACHIEVING ABSOLUTE SAFETY	
6. Develop a Community of Safety	Kay Taylor*, Kathy Schoenrock
<p><b>Opportunity:</b> Broaden focus from patient safety to absolute safety - develop a Community of Safety; build pride, ownership and inspiration with all stakeholders (employees, physicians, volunteers) and understanding and motivation for their personal and collective part to play. Just Culture is how we do our work. Event reporting is an individual accountability.</p> <p><b>Desired Outcome:</b> Every stakeholder (employees, physicians, volunteers) understands their role in the Community of Safety. We are best practice in safety results compared to the past and in the market.</p> <p><b>Timeline:</b> Continuation of the Optimize the Patient Safety Reporting System Initiative begun in 2013</p> <p><b>Measurement:</b> Stakeholders "own" safety, understand their role and responsibility, and are inspired by the organization's commitment to and results in being absolutely safe. Improve key measures on 2014 Culture Survey; increase reporting of events and near misses.</p>	
EFFECTIVELY LEVERAGE OUR IT SYSTEMS TO REDUCE HUMAN ERROR AND IMPROVE QUALITY	
7. Achieve Safe Practices Through Improvements in Documentation	Nancee Hofmeister*, Tony Yen
<p><b>Opportunity:</b> When Cerner was implemented we allowed and encouraged many custom builds, today this is discouraged as customization has a significant impact on the functionality of the EMR to work as a system. We need to realign our documentation to increase the flow of information across the system (inpatient, outpatient and ambulatory).</p> <p><b>Desired Outcome:</b> Safer care practices for our patients demonstrated by improved communication among the teams and a better handover of the patient to the next step in the continuum of care with a focus on family/social history, housewide discharge process/Krames education, Care Compass, Plan of Care and IView functionality.</p> <p><b>Timeline:</b> Ongoing, with a goal to have changes implemented by end of Q 2.</p> <p><b>Measurement:</b> Improved communication among the care team through individualized plans of care and improved compliance with documentation requirements to support care standards.</p>	
8. Early Detection and Warning of the Deteriorating Patient	Jeff Tomlin*, Nancee Hofmeister
<p><b>Opportunity:</b> Early detection modules are available through Cerner and other vendors; through evaluation of these options we can develop systems that will provide early detection and warning to clinicians to enable timely intervention in the deteriorating patient.</p> <p><b>Desired Outcome:</b> Patient outcomes will be enhanced through timely intervention</p> <p><b>Timeline:</b> Continuation of 2013 Initiative to develop a Clinical Decision Support Structure</p> <p><b>Measurement:</b> Deploy Early Detection Tool(s) in 2014; satisfy one or more of the 5 Meaningful Use Criteria</p>	

Dept: I/GM/Clinical Outcomes & Absolute Safety Plan/2014/2013/November 22, 2013

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# Partners

# Operating System (v. 1.0)



# The Four SMS Components

**Safety Policy**  
Establishes senior management's commitment to continually improve safety; defines the methods, processes, and organizational structure needed to meet safety goals

**Safety Assurance**  
Evaluates the continued effectiveness of implemented risk control strategies; supports the identification of new hazards



**Safety Risk Management**  
Determines the need for, and adequacy of, new or revised risk controls based on the assessment of acceptable risk

**Safety Promotion**  
Includes training, communication, and other actions to create a positive safety culture within all levels of the workforce

# NURSE CARE COORDINATOR

## GOAL:

Provide high quality, cost effective care to high risk patient populations.

*“Right service, right patient,  
right time, right place”*

# NURSE CARE COORDINATOR

Identify the high-risk patients

- Uncontrolled diabetes, hypertension, depression, asthma, re-hospitalized within 30 days

Identify “rising risk” patients: chronically ill

Identify patients in the “care gap”

- No BMI in past year, or is over 50 without a colonoscopy, diabetic who hasn't been seen in 9 months

# NURSE CARE COORDINATOR

## METHODS

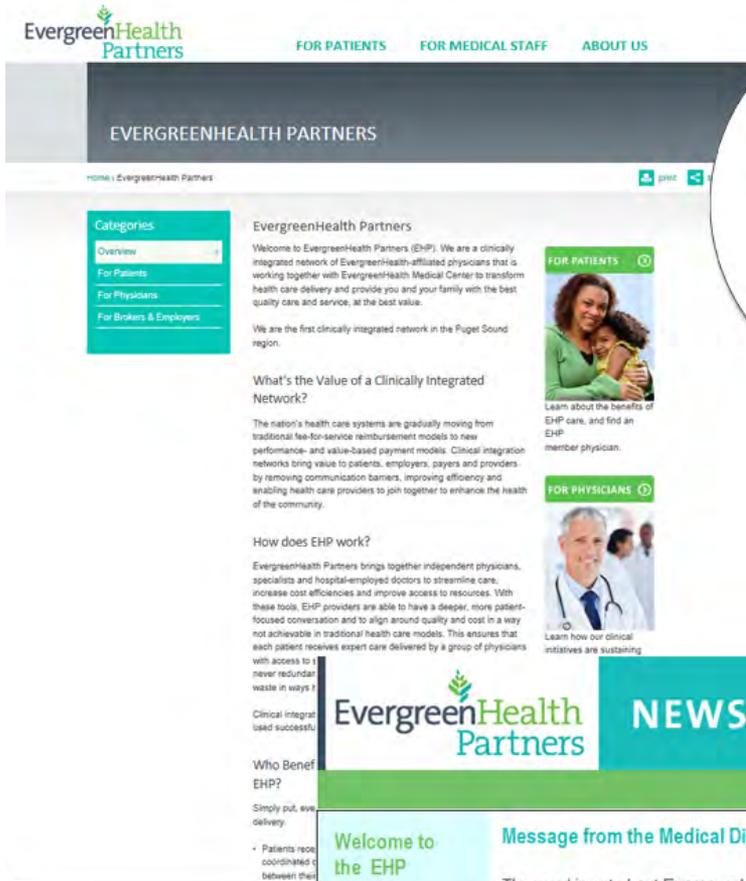
- Develop systems and processes to address these patient populations with minimal bureaucracy
- Collaborate with providers and their team, patients and families, and for payers
- Care Coordinator will serve as the “eyes and ears” for coordination of care and services

# NURSE CARE COORDINATOR

## BENEFITS

- Improve quality/safety/reduce error in handoffs
- Improved patient outcomes
- Clinical initiatives and care gaps addressed
- Improve coordination of care for payers
- Meet payer quality initiatives and financial incentive goals
- Serve as “eyes and ears” across the care spectrum

# MARKETING MATERIALS



**EvergreenHealth Partners:**  
**Combining Quality and Value**

You want—and deserve—the highest quality healthcare and service at the best value. That's exactly what you get when you choose an EvergreenHealth Partners (EHP) provider for your care.

EHP providers are members of the medical staff at EvergreenHealth or other Eastside providers, and are backed by the full resources of EvergreenHealth Medical Center.

**Higher Quality Care and Service**

When you receive care from an EHP provider, you can rest assured knowing that your care is being guided by proven, evidence-based standards and that your provider is meeting a high level of quality set and reviewed by them in partnership with his or her colleagues.

**Coordinated Specialty Care**

The EHP network includes more than 500 providers from more than 40 specialties. So when you need specialty care, your family physician can confidently refer you to EHP colleagues knowing that they share the same commitment to high quality care and service. Our coordinated plan for your care takes you from your family physician's office through specialty care and hospitalization.

**Increased Value for Your Healthcare Dollars**

We all want better value, but without reducing the quality of our care. That's why EHP providers are working together with EvergreenHealth to reduce the cost of providing the high quality care and service you deserve through streamlined processes, better communication and group purchasing.

**Find an EvergreenHealth Partners Provider**

EvergreenHealth Partners providers are ready to help you live your healthiest best.

Find your partner at [www.evergreenhealthpartners.org](http://www.evergreenhealthpartners.org).

**EvergreenHealth Partners NEWSLETTER**

Issue 2 - September 2014

**Welcome to the EHP Newsletter.**

Each quarter, we'll bring you the latest EvergreenHealth Partners news in an easy-to-read email digest.

**Message from the Medical Director**

The word is out about EvergreenHealth Partners, the first Clinical Integration Network in Washington - and there's been a lot of interest about this groundbreaking clinical partnership for our area.

[Read more >](#)

**Participant Update**

# Partners

# Questions?

# **Paul Buehrens, MD**

Medical Director

EvergreenHealth Partners

buehrenspe@comcast.net

[www.evergreenhealthpartners.org](http://www.evergreenhealthpartners.org)



I 502 Recreational Marijuana  
*“The Marijuana Market in Washington”*  
Medical Commission Education Conference

Presented by Randy Simmons, Deputy Director  
Washington State Liquor Control Board

October 2, 2014



# Today's Presentation

- Overview of I502
- Lessons Learned
- Consumer and Public Education
- Legal Issues
- Legislative Activity
- Tax Collections



# Overview of I502



# Marijuana Legalization

## Washington's Legalization at Glance

- Established by Initiative 502 on Nov. 6, 2012
- I-502 drafted by ACLU Drug Policy Director Alison Holcomb
- WSLCB charged with:
  - Drafting rules governing the new system
  - Licensing applicants
  - Enforcing the law at licensed locations
- 30-day window application period drew 7,000+ applications
  - No limit on producers and processors
  - Retail stores limited to 334 statewide
  - Retail lottery held in April to identify 334 “winners” out of 2,100 applicants



## Timeline

December 2012	I-502 effective date
October 2013	Rules effective
March 2014	First producer licenses
April 2014	Retail lottery
July 7, 2014	First retail licenses issued
July 8, 2014	First retail stores open



# Goals of Developing Washington's System

- Public safety is top priority
- Protecting children is focus
- Open and transparent system of rule-making and implementation
- Tightly regulated controlled marketplace
- Collect revenue for state of Washington



# Lessons Learned



## Lesson 1

There are many challenges of implementing a state law that is illegal federally.

- Schedule 1 controlled substance
- Banking
- Public agencies reluctant to cooperate
- Creating a controlled market, not open market
- Walking the line between federal expectations and state law requirements – DOJ memo



## Lesson 2

Be realistic about the time it takes to set up a comprehensive system of growing, processing, and retailing recreational marijuana.

- Public forums and hearings
- Right system is more important than being fast
- Brookings Institute
  - “If Colorado is the sizzle. Washington is the steak.”

### BROOKINGS

The Legalization of Marijuana

Report | August 25, 2014

Washington's Marijuana  
Legalization Grows Knowledge, Not  
Just Pot



## Lesson 3

The impact on agency and state resources is heavy. This is not normal business.

- Original OFM Fiscal Impact Statement
  - Estimated 100 producers
- WSLCB Application Window Nov. 2013
  - 7,000+ marijuana applications w/in 30 days
  - 2,600 producers and 2,500 processors
  - By comparison....
    - 5,534 grocery stores that sell alcohol licensed
    - 4,929 total spirits/beer/wine restaurants licensed
- Media
  - Top 5 statewide AP story
  - 3,000+ media contacts per year



## Lesson 4

It helps to know your license applicant base.

- Many marijuana license applicants are not used to operating any regulation.
- Basic technology, such as computer access or proficiency, can be challenging.
- Vocal



## Lesson 5

Limit each applicant to a single license per license category to get the system started

- Creating a restricted marketplace to avert diversion
- WSLCB rules allowed up to 3 licenses per category
- WSLCB had to later limit applicants to single license and refund fee or hold application.



# Consumer and Public Education



# Packaging / Labeling Requirements

**Child resistant packaging, and packaging must not appeal to kids**



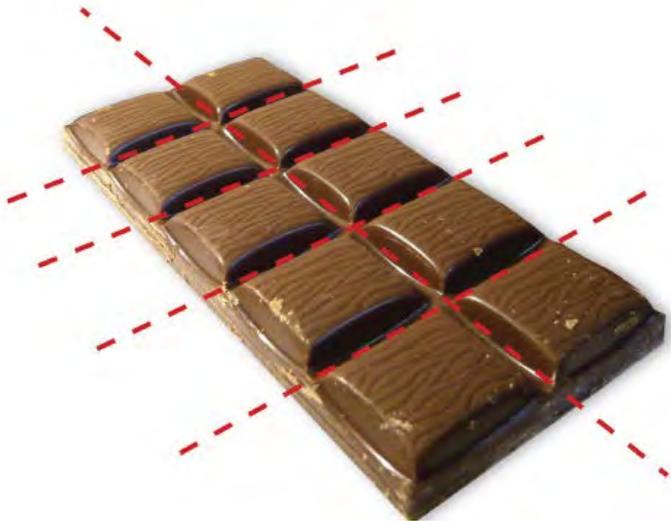
- 4 mil plastic minimum
- Sealed packaging
- No easy-open devices
- Poison Prevention Act compliant





# Packaging / Labeling Requirements

## Defined serving and dosage limits



- Serving = 10 mgs THC
- Maximum of 10 servings per unit
- Maximum 100mgs THC per unit
- Servings must be physically indicated
- All products must be tested



# Packaging / Labeling Requirements

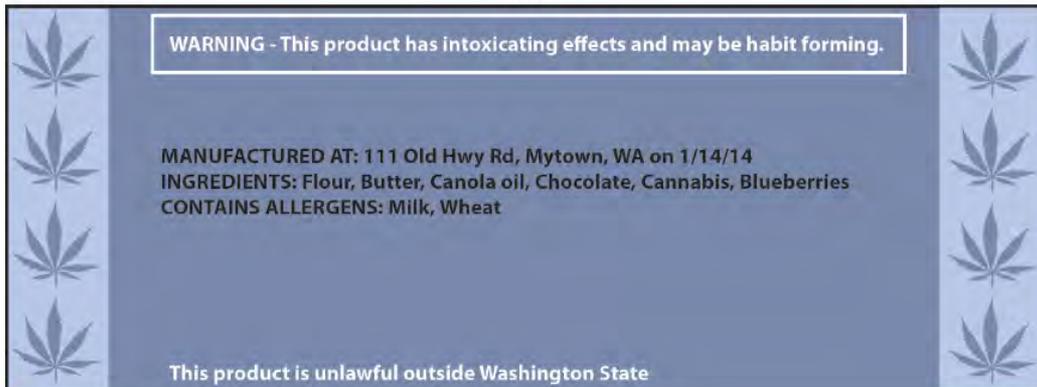
## Defined labeling requirements

### Sample Label

FRONT



BACK



- Business/trade name, UBI
- Lot number
- Batch number
- Manufacture date
- Best by date
- Recommended serving size
- Servings per unit
- Total milligrams of active THC
- Net weight
- All ingredients (incl. allergens)
- Warnings and cautions
- Identifier, “Product contains marijuana”
- All marijuana-infused products must be approved by the WSLCB



# Unregulated THC-Infused Products

Mimic popular brands, use colors, cartoons, and candies that may appeal to children, and have inconsistent potency/dosage





# Emergency Rule Changes

- Approval for all marijuana-infused products, labeling and packaging prior to offering items for sale
- Products in solid form must be scored to indicate servings
- Products must be homogenized to ensure uniform disbursement of cannabinoids
- Marijuana-infused products must state on label, “This product contains marijuana.”



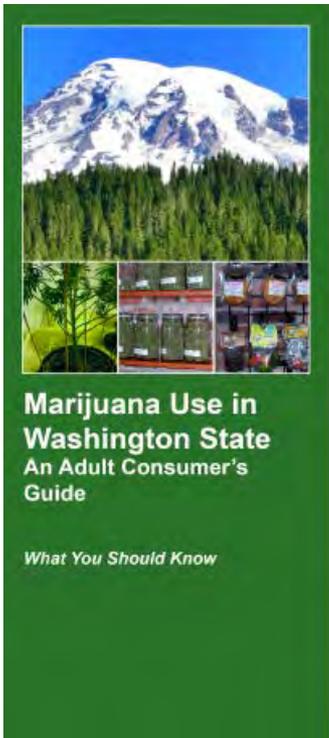
# Emergency Rule Changes

## Some of the types of foods that cannot be infused with marijuana:

- Any food that requires refrigeration, freezing, or a hot holding unit may not be infused with marijuana
- Any food that has to be acidified to make it shelf stable
- Food items made shelf stable by canning or retorting
- Fruit or vegetable juices
- Fruit or vegetable butters
- Pumpkin pies, custard pies, or any pies that contain egg
- Dairy products of any kind, such as butter, cheese, ice cream, milk
- Dried or cured meats



# WA State Liquor Control Board



## Consumer Education

- Consumer safety
  - Potency
  - Edibles
  - Driving/DUI
- Basic law facts
- Resource referral
- 40,000 copies, also available on-line



## Parent Education

- Health risks and laws
- Nine languages
- 55,000 copies printed to date



# WA State Dept. of Health

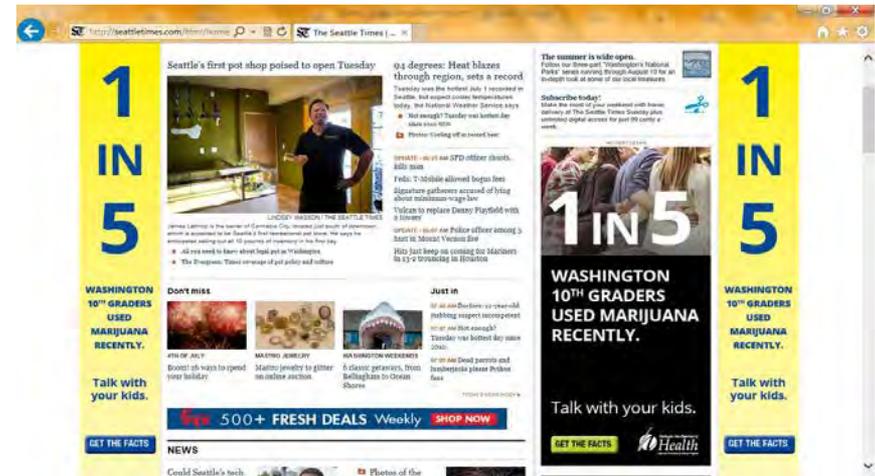
## Public Awareness: Paid Media

- Radio

- Statewide reach
- English, Spanish, cities and rural
- More than 3 million reached

- Digital

- Two ads
- Network sites (parenting/health/local news)
- Social media (Facebook)
- Paid search (Google, Bing)



More than 20 million impressions, more than 19,000 click-throughs



# WA State Dept. of Social and Health Services

## Div. of Behavioral Health and Recovery

- Toolkits for preventing underage use distributed to community coalitions, schools, and available on-line. Includes:
  - Parent guide
  - Parent information card (WSLCB)
  - “Marijuana and Teens” CD
- Updated StartTalkingNow.org website with resources for parents and community groups

Now that marijuana is legal for adults in Washington . . .



A parent's guide to preventing underage marijuana use



Seattle Children's<sup>®</sup>  
HOSPITAL • RESEARCH • FOUNDATION



SD  
RG Social Development  
Research Group



# WA Traffic Safety Commission

- “Drive High, Get a DUI” campaign
- TV ads from Colorado airing now
- Target Zero emphasis patrols





# University of Washington Alcohol and Drug Abuse Institute

Designated by I-502 to provide: **“Web-based public education materials with medically and scientifically accurate information about health and safety risks posed by marijuana use.”**

[www.LearnAboutMarijuanaWA.org](http://www.LearnAboutMarijuanaWA.org)

- Factsheets
- Information for Parents and Teens
- Policy and Law
- Research
- Adult Consumers



# Legal Issues



# Legalized Possession

- Limited possession 21 & over
  - 1 oz “useable” marijuana +
  - 1 lb marijuana-infused product in solid form +
  - 72 oz marijuana-infused product in liquid form +
  - 7 g marijuana concentrate
- Consuming in view of general public prohibited
- DUI *per se* limit: 5 ng active THC / mL blood





# Commercial Licensing

- Liquor Control Board licenses and regulates
  - Producers
  - Processors
    - Retail stores (sell only marijuana, paraphernalia)
- Licenses limited to 3-month state residents
  - Applies to all “members” of business entities
  - Criminal background checks for members and financiers
- Taxes
  - 25% excise tax on sales at each level
  - Earmarked for public health research and education



# Federal Response

## Department of Justice Memorandum to United States Attorneys (Aug. 2013)

- Applies to all states.
- 8 priorities “will continue to guide the Department’s enforcement of the CSA against marijuana-related conduct.”
- “If state enforcement efforts are not sufficiently robust to protect against the harms, **the federal government may seek to challenge the regulatory structure itself** in addition to continuing to bring individual enforcement actions, including criminal prosecutions, focused on those harms.”



# Supply and Demand

- 30-day application window
  - » Over 7,000 applications received
- » Producer/processor licenses
  - » Number of licenses not limited
  - » Square footage limited
  - » 109 producer/processors as of mid July
- » Retail licenses
  - » 334 stores allocated to cities/counties
  - » Lottery held to rank applicants for processing
  - » First 24 retail store licenses issued July 7



# Minors

- 1000' buffer from schools
  - No marijuana business locations
  - No advertising by licensees “in any form or through any medium whatsoever” within 1000’
- No products/advertising “especially appealing to children”
  - *Preapproval* for all edible products
  - Child-resistant packaging



# Public Health

- Quality assurance testing
  - WSLCB accredited 3<sup>rd</sup> party testing labs
- Food safety
  - WSLCB rules for hazardous foods that may not be infused
- Edibles
  - Limited to 10 mg THC serving & 10 servings/product
  - Scoring and labeling to indicate servings



# Local Jurisdictions

- Some cities/counties banned I-502 businesses
- Local authority
  - I-502 does not preempt local jurisdictions from banning marijuana businesses, per formal AG Opinion
  - I-502 does not give WSLCB authority to deny licenses based on local law
  - Lawsuits have been filed by licensees against cities with bans



# Banking Challenges

- Deposits to banking system = money laundering
- Cash business = crime target
- USDOJ/FinCEN banking guidance (Feb. 2014)
  - Authorizes filing special SARs
  - Requires bank due diligence - customer complying WSLCB rules
  - Banks waiting for guidance from federal regulators



# Medical Marijuana

- Unregulated
- Only sales tax (but illegal to sell)
- Possess 24X as much w/authorization
- No age limit
- Challenge for legislature



# Legislative Activity



# Marijuana: 2014 Legislative Session

What did the Legislature do in 2014?

- Senate Bill 6505 removed tax preferences otherwise applicable to the marijuana industry (PASSED)
- Engrossed Substitute House Bill 2304 added marijuana concentrates to list of products certain recreational marijuana licensees could manufacture and sell (PASSED)
- Engrossed 3<sup>rd</sup> Substitute Senate Bill 5887 would have brought medical marijuana under the licensing and taxation structure applicable to I-502 recreational marijuana (DID NOT PASS)



# What to expect for 2015 legislative session:

Federal issues will continue--

- Federal government will crack down if health and safety concerns especially for youth not addressed by state bringing medical marijuana under state regulatory umbrella
- Some movement to minimize impacts of federal income tax consequences on I-502 licensees by moving incidence of marijuana tax on retailers to buyers
- Lots of concern previously voiced about federal banking restrictions on illegal drug money forcing businesses to do business and pay taxes in cash.



# What to expect for 2015 legislative session --

At state level on medical side:

- Expect more proposals to regulate and tax medical marijuana like I-502 marijuana
- Likely to add equivalent of prescription drug sales tax exemption for medical marijuana
- Look for requirements for health care providers writing medical marijuana authorizations to be tightened up, and state registration of medical mj patients in some form
- Medical marijuana advocates will continue to make their case, but I-502 licensees will also be more visible, vocal
- Local government will again press for funding for enforcement

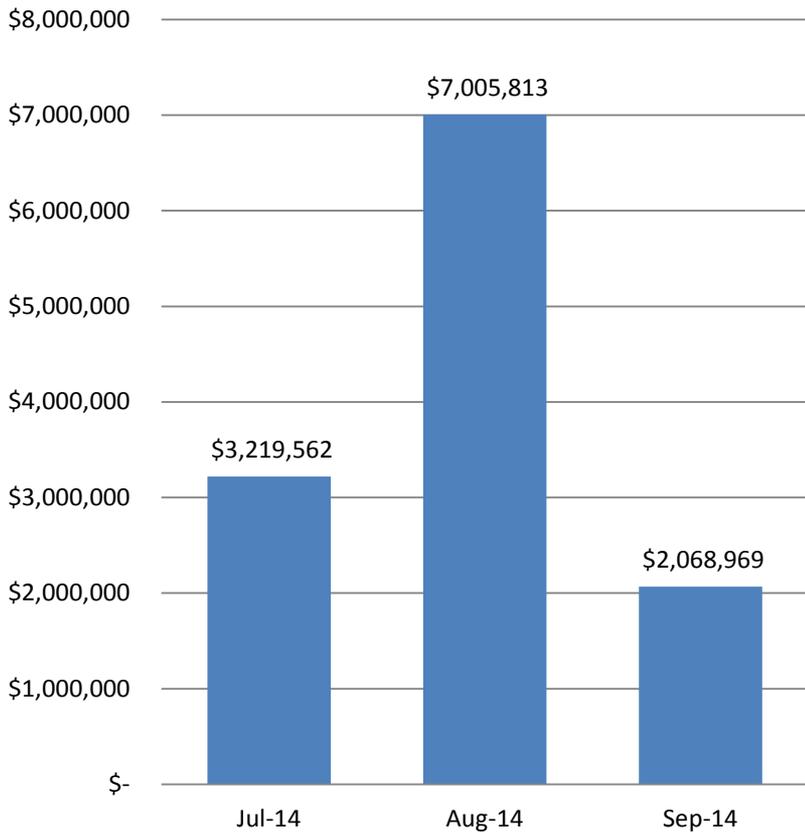


# Tax Collection

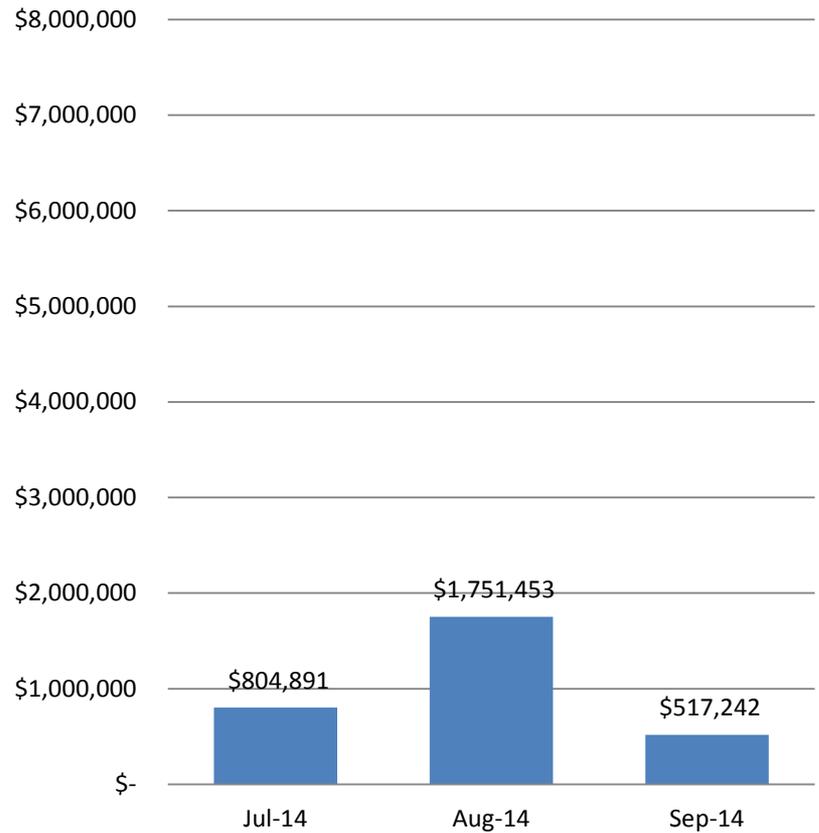


## Total MJ Sales and Excise Tax Due by Month

### Total Sales by Month



### Total Excise Tax Due by Month





Questions?



**Thank you**