



## Patient Safety Quarterly

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### Prescription pain reliever deaths down, heroin deaths up

Prescription pain reliever overdose deaths in Washington continued to decline in 2014, but an ongoing increase in heroin-caused deaths led to little overall change in the state's opioid-related death total.

Prescription drug overdoses killed 319 people in Washington during 2014, Washington State Department of Health figures indicate. That's down from 381 in 2013. Such deaths spiraled from 24 in 1995 to a peak of 512 in 2008 before beginning a continuous year-to-year decline. The highest prescription drug overdose death rate is in the 45- to 54-year-old age group.

Heroin deaths in Washington rose from 227 in 2013 to 293 in 2014. That's nearly double the 2010 total of 150. The largest increase in heroin overdose deaths is in the 15- to 34-year-old age group, which corresponds with age group trends in overall heroin use. Heroin use has increased as its availability has spread and

because it's less expensive than prescription pain relievers.

Overall, opioid-related deaths in Washington rose slightly from 608 in 2013 to 612 in 2014. The top figure for such deaths was 658 in 2008.

Although some parts of the trend may be favorable, overdose deaths remain a problem in Washington. By way of comparison, motor vehicle traffic deaths took 545 lives in Washington during 2014, fewer than died as a result of overdoses.

Researchers see a link between heroin and misuse of prescription pain relievers, many of which contain potentially addictive medications classified as opioids. Hydrocodone and oxycodone fall into this category. Many heroin users misused opioids first, research indicates, and many drug users take both heroin and opioids.

The department's [Prescription Monitoring Program](#) allows practitioners to track their patients' controlled substances prescriptions, thus reducing the chances of patients receiving multiple or inappropriate prescriptions. In addition, prescribers must follow [pain management rules](#) designed to reduce the potential for dependence and abuse. [Prescribing guidelines](#) (updated June 2015), education and Medicaid efforts are also involved in battling a prescription drug abuse epidemic that dates back to pain management changes in the 1990s.

Naloxone/Narcan, an overdose antidote, is available. Opioid users and their friends or family members can get prescriptions. It's also available [directly from pharmacies](#) in some parts of Washington.

## **Medical marijuana rules on track for July 1 implementation**

With passage of the Cannabis Patient Protection Act in 2015 (2SSB 5052), the Department of Health is working to adopt rules starting July 1, 2016, to ensure high-quality, safe products are sold to patients. The department is focusing on rules for three aspects of the law, which was codified into chapter 69.51A RCW. They are product compliance standards, developing a medical marijuana authorization database, and a certification program for the medical marijuana consultant.

The department is committed to working with key stakeholders in the community to ensure that the rules meet their needs while keeping with the intent of the law. Our web pages, ListServ, and customer service email and phone line have allowed the public to stay on top of our activities. Recently, the department has completed the following:

### **Product Compliance**

The proposed medical marijuana product compliance rules were filed on February 17, 2016, with public hearings scheduled for March 22 in Spokane and March 25 in Tumwater.

The official logo to be used by those producers and processors who follow the department's product compliance rules have been developed. Instruction for use will be accessible on the medical marijuana web pages.

### **Medical Marijuana Authorization Database**

The proposed medical marijuana authorization database rules were filed on February 17, 2016, with public hearings scheduled for March 22 in Spokane and March 25 in Tumwater.

The department has contracted with a database administrator, CloudPWR. We are working closely to incorporate all requirements needed for authorization card administration and system access to ensure the system is up and running by July 1, 2016.

### **Medical Marijuana Certified Consultant**

The department held the public hearing for the medical marijuana certified consultant rules on January 26, 2016. The expected effective date of the rules is April 1, 2016. This will allow two months for those wanting to apply to be a certified consultant to attend the approved training and to send in an application.

The goal is to have the application packet for those educational entities who want to offer the training program available in mid-March. This should allow the department time to review and approve those programs that meet the requirements and to have training options available in April.

### **Governor Requested Reports**

In addition to the rules, the department has been working on two reports requested by the Governor within 2SSB 5052:

#### **Medical Marijuana Specialty Clinics**

Section 41 of requires the Department of Health (department) to “develop recommendations on establishing medical marijuana specialty clinics that would allow for the authorization and dispensing of marijuana to patients of health care professionals who work on-site of the clinic and who are certified by the department in the medical use of marijuana.” The department does not support establishing medical marijuana specialty clinics in Washington at this time for the following reasons:

- Health care practitioners cannot legally prescribe or dispense schedule I controlled substances and would potentially risk criminal prosecution, as well as civil and financial liability.
- Injured patients may be left without an adequate remedy if malpractice does occur.
- Further research using accepted scientific protocols is needed.
- Significant changes to existing licensing laws for commercial marijuana would be needed. Without such changes, practitioners at specialty clinics would not be able to access the marijuana they would later dispense to patients, which could present issues with supply.

Instead, the department recommends that individual practitioners become, to the extent possible given limited scientific research, educated and knowledgeable about the risks and benefits of the medical use of marijuana so they can provide their patients with accurate information and safe, competent care. This report is available on the [medical marijuana web page](#).

#### **Scheduling of Marijuana**

The Governor vetoed Sections 42 and 43, which would remove from schedule I of Washington State’s Controlled Substances Act any medical marijuana product the Department of Health (department) identifies in rule as “appropriate for sale to qualifying patients and designated providers in a retail outlet that holds a medical marijuana endorsement.”

In his veto message, the Governor noted that rescheduling just medical marijuana “may cause serious problems such as having the unintended effect of limiting the types

of marijuana that are considered medicine.” Therefore, he directed the department to “thoroughly consider this idea in consultation with medical professionals and stakeholders, and bring an appropriate resolution to me and the Legislature by next year.”

The department held a stakeholder meeting, collected public comment and presented implications of several options to the Pharmacy Quality Assurance Commission for input. The report is being reviewed by the Governor’s office prior to its release to the Legislature.

## **Recent legislation changes medical marijuana law; improves patient safety**

From 1998 when the medical use of marijuana was first authorized by Washington State voter Initiative 692 to today there have been multiple legislative changes. Washington voters passed Initiative 502, in November of 2012, legalizing the purchase and possession of small amounts of marijuana for all adults. It also created a taxed and highly regulated system for the production, processing and retail sale of marijuana.

In 2015, the Legislature reconciled the medical and recreational markets with the passage of 2SSB 5052 – the Cannabis Patient Protection Act - and HB 2136. Beginning July 1, 2016, the changes to chapter 69.51A RCW created by 2SSB 5052 will integrate the medical market with the regulated market put in place under I-502.

The primary goals of the Act are to clarify what is meant by the medical use of marijuana, and to:

Bring medical marijuana products under the same regulations in place for recreational use to ensure a safe, adequate and consistent supply, and thus better protect qualifying patients.

Allow for tax breaks for medical marijuana patients who are entered into the authorization database.

Provide protection from arrest and prosecution for patients who are entered into the authorization database.

Under the act, the Department of Health is directed to adopt product compliance rules regarding marijuana products sold to patients; create a medical marijuana authorization database; and develop a certification program for the Medical Marijuana Consultant that will be required in each licensed retail store when the law goes into effect on July 1, 2016.

The primary goals of the Act are to clarify what is meant by the medical use of marijuana, and to:

The Medical Marijuana website has been updated to provide key information and continues to be the best place to get the latest on our progress in implementing the law.

A standard authorization form has been developed.

An online method has been implemented so practitioners who authorize more than 30 patients in a month can report that as required.

Emergency product rules were filed on October 5, 2015.

Rulemaking stakeholder meetings have been held for the authorization database, consultant certificate and product compliance.

The successful vendor for the authorization database has been chosen and contract negotiations are complete.

Drafted two required reports. One relating to specialty clinics and the other to consider the current scheduling of marijuana as a controlled substance.

We continue working on rulemaking activities, implementing the authorization database and preparing licensing processes for the consultant certificate and the consultant training programs.

## **Programs help impaired practitioners get back on track**

Alternative-to-discipline programs – sometimes called “impaired practitioner” programs – were developed in the early 1980s to address the issue of alcohol or other substance use disorders among nurses, but soon expanded to include other healthcare professions. These programs are designed to encourage health professionals to seek help before their substance use results in patient harm or avoid disciplinary action and potential loss of their credential.

These programs’ goal is to allow a return to practice under strict guidance and supervision that ensures public safety and holds the healthcare professional accountable. To date, 41 states, the District of Columbia, and the Virgin Islands have such programs. Washington has four such programs available to virtually all Department of Health-credentialed healthcare providers.

Washington Physicians Health Program (WPHP) provides services to physicians, osteopaths, physician assistants, veterinarians, and dentists. Washington Recovery Assistance Program for Pharmacy (WRAPP) serves all pharmacy professions. Nursing professions are served by Washington Health Professional Services (WHPS). Washington Recovery and Monitoring Program (WRAMP) provides service to all credentialed healthcare professionals not covered by the other programs.

Prospective participants can enter such programs through voluntary self-referral, as an alternative to credential discipline, or as part of a disciplinary process.

No matter what the profession or the reason for entering a program, all participants first complete a thorough substance use evaluation from a licensed behavioral healthcare facility. This evaluation becomes the basis for determining if a person is appropriate for a monitoring agreement and, if so, the length and terms of participation.

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Typically, monitoring agreements consist of participation in substance use disorder treatment (if recommended); random alcohol and drug screening; participation in community-based recovery support meetings, such as Alcoholics Anonymous,

Narcotics Anonymous, Celebrate Recovery, Smart Recovery, etc.; practice monitoring; and participation in a professionally-facilitated peer support group. Depending upon the profession, there may be practice restrictions, such as no access to controlled substances for a period of time.

Once people begin monitoring, they are required to check in daily online or via phone to determine if they are required to complete a drug test. Participants are randomly tested between 12 and 24 times per year, and may incur additional tests for missed check-ins or any time there is reasonable suspicion of unauthorized substance use. Two episodes of unauthorized substance use will result in discharge from the program.

Along with recovery-oriented meetings in the community, professional peer support groups provide an opportunity to meet with other participants in the program under the guidance of a professional facilitator to discuss issues affecting their recovery.

Participants who are working under their healthcare credential need to have a worksite monitor (usually their direct supervisor) who submits monthly reports on the person's progress. If there is an episode of unauthorized substance use while working, participants agree to cease healthcare practice immediately and not to return to work until they have been re-evaluated.

In addition to monitoring participants, program staff members provide outreach to healthcare providers, substance use treatment facilities, professional associations, boards and commissions, schools, and any other group wanting education about addressing substance use in the workplace.

If you would like more information about these programs, please contact them directly.

Washington Physicians Health Program—206-583-0127

Washington Recovery Assistance Program for Pharmacy—360-629-9719

Washington Health Professional Services—360-236-2880 (Option 1)

Washington Recovery and Monitoring Program—360-236-2880 (Option 2)

## **Carbon Monoxide Poisoning Prevention**

When power outages occur after severe weather (such as high winds and flooding), using alternative sources of power can cause carbon monoxide (CO) to build up in a home, and poison the people and animals inside. If you don't have electricity:

Never use a charcoal or gas grill in an enclosed space, such as inside your home, garage, or in a tent or camper.

Don't burn charcoal in your fireplace. A charcoal fire will not create a chimney draft strong enough to push the carbon monoxide to the outside.

Never use a generator inside your home, garage, carport, basement, or near an outside window, door, or vent. One gas-powered generator can produce 100 times more carbon monoxide than a car's exhaust. Generators should be at least 20 feet away from buildings. Even at 20 feet away, air flow patterns could still blow carbon monoxide into

homes through attic vents, windows, or doors, so it's very important to have a working carbon monoxide detector inside the home.

Never use a gas range or gas oven to heat your home.

Never sleep in a room while using an unvented gas or kerosene heater.

Every year, at least 430 people die in the U. S. from accidental CO poisoning. Thousands of others are treated in emergency rooms.

Carbon monoxide, often referred to as “the invisible killer,” is an odorless, colorless gas that can enter your home through a number of ways -- leaky chimneys, furnaces, gas water heaters, wood stoves, gas stoves, fireplaces, ovens, clothes dryers, portable generators, lanterns, grills, vehicles running in attached garages, and cigarette smoke (first- or secondhand). CO poisoning symptoms include headaches, nausea, confusion, memory loss, fainting, and chest pains. CO poisoning can lead to death in both people and animals. People who are sleeping or who have been drinking alcohol can die from CO poisoning without waking.

The most important thing you can do to prevent CO poisoning is to properly install and maintain CO detectors in your home, particularly near bedrooms. Never use alternative means, such as ovens, grills, gas- or propane-powered devices to heat inside your home.

Other important carbon monoxide poisoning prevention tips:

Change the batteries in your CO detector according to the manufacturer's directions. If you don't have a battery-powered CO detector, buy one soon. In Washington State they are required by law in new homes, in homes being sold, and in apartment units.

Never leave the motor running in a vehicle parked in an enclosed or partially enclosed space, such as a garage.

Never run a motor vehicle, generator, pressure washer, or any gasoline-powered engine within 20 feet of an open window, door, or vent where exhaust can vent into an enclosed area.

Never use a charcoal grill, hibachi, lantern, or portable camping stove inside a home, tent, or camper.

If conditions are too hot or too cold, seek shelter with friends or at a community shelter.

If CO poisoning is suspected, leave the space immediately. Call 911, and contact your gas company. Don't go back into the home until the problem has been resolved.

**CO poisoning is entirely preventable.** You can protect yourself and your family by acting wisely in case of a power outage and learning the symptoms of CO poisoning.