

Risk of Harm

Opioid-related Deaths and Non-fatal ODs

Advisory Committee on Healthcare Innovation and Evaluation
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Jaymie Mai, Pharm.D.
Pharmacy Manager



RCW 51.36.010

- (7) The department may permanently remove a provider from the network or take other appropriate action when the provider exhibits a pattern of conduct of low quality care that exposes patients to risk of physical or psychiatric harm or death.
- (8) The department may not remove a health care provider from the network for an isolated instance of poor health and recovery outcomes due to treatment by the provider.

(Effective on July 1, 2011)

<http://apps.leg.wa.gov/RCW/default.aspx?cite=51.36.010>



Risk of Harm - WAC 296-20-01100

- (1) It is the intent of the department, through authority granted by RCW [51.36.010](#) to protect workers from physical or psychiatric harm by identifying, and taking appropriate action, including removal of providers from the statewide network, when:
 - (a) There is **harm**; and
 - (b) There is a **pattern(s) of low quality care**; and
 - (c) The harm is related to the pattern(s) of low quality care.

<http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-01100>



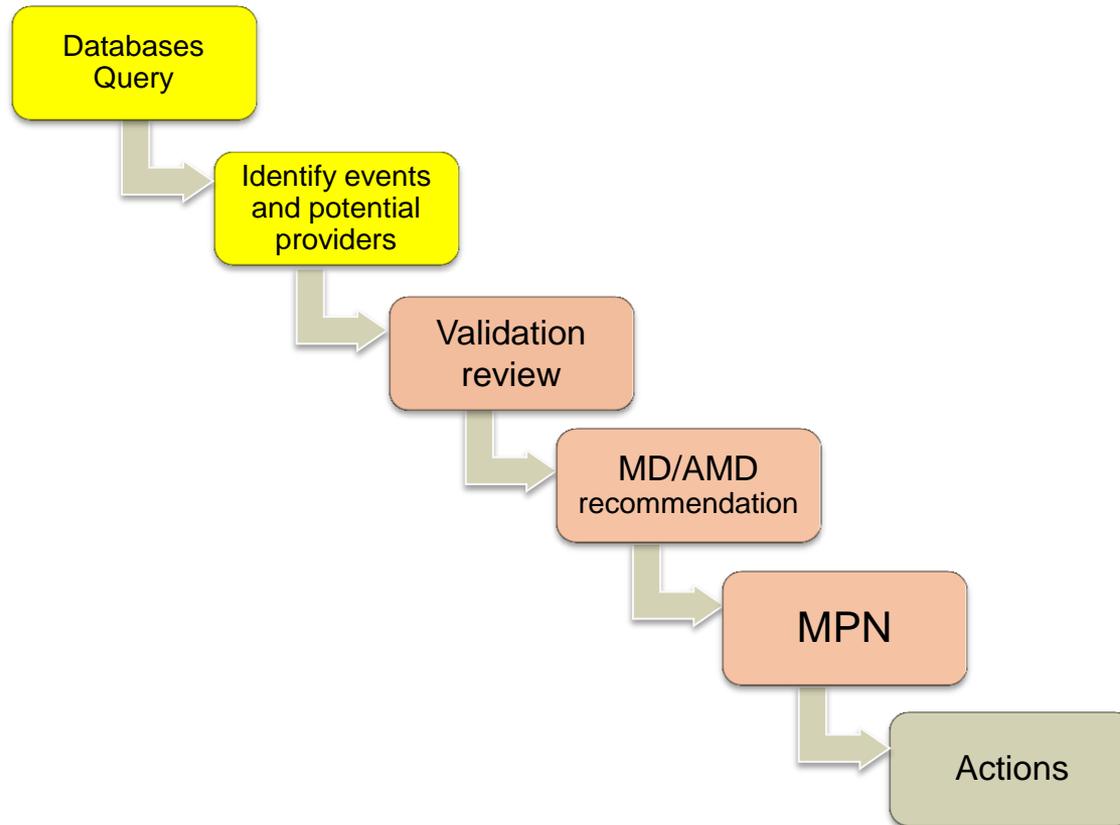
OPIOID: Mortality and Morbidity

- Harm: opioid related death and morbidity (e.g. overdose)
- Low quality care: various*
 - Overuse of treatment intervention (e.g. high dose and long term prescription of opioids)
 - Poor prescribing patterns (e.g. opioids + sedatives)
- Pattern(s):
 - Two or more deaths
 - or one death + an overdose event;
 - or one death + very high doses in other patients (risk of harm)

*Some patterns of low quality care (very high doses of opioids) constitute risk of harm

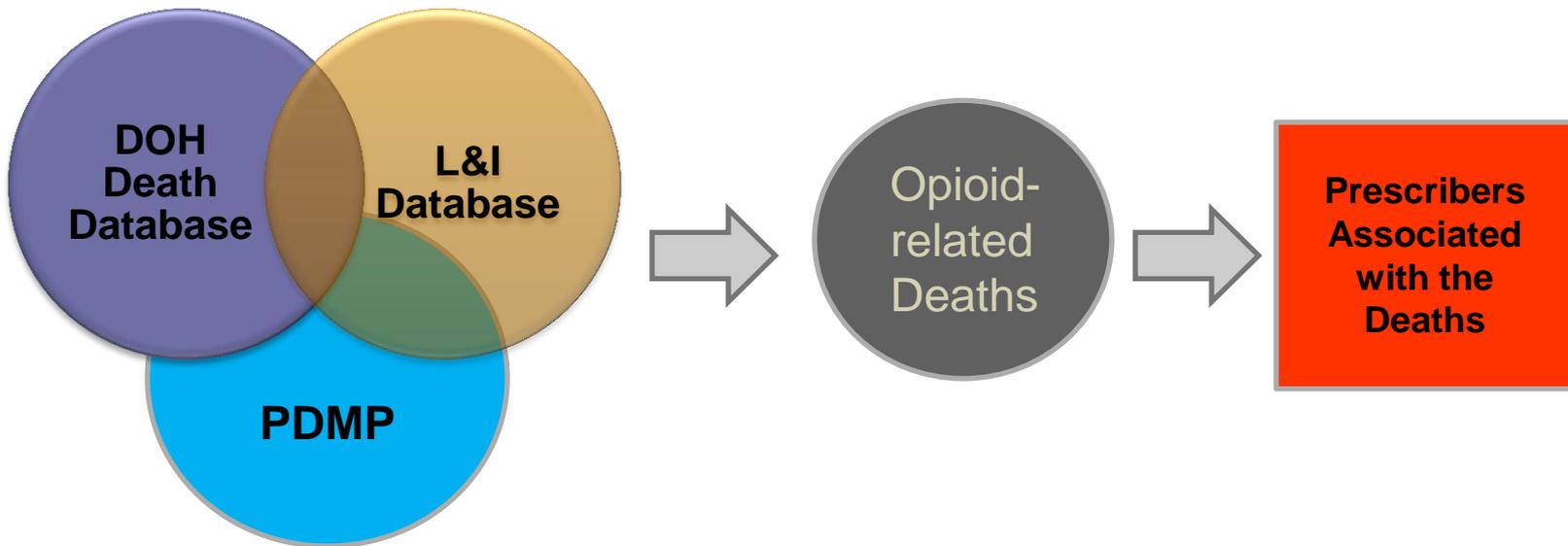


A Data-driven and Evidence-based Process



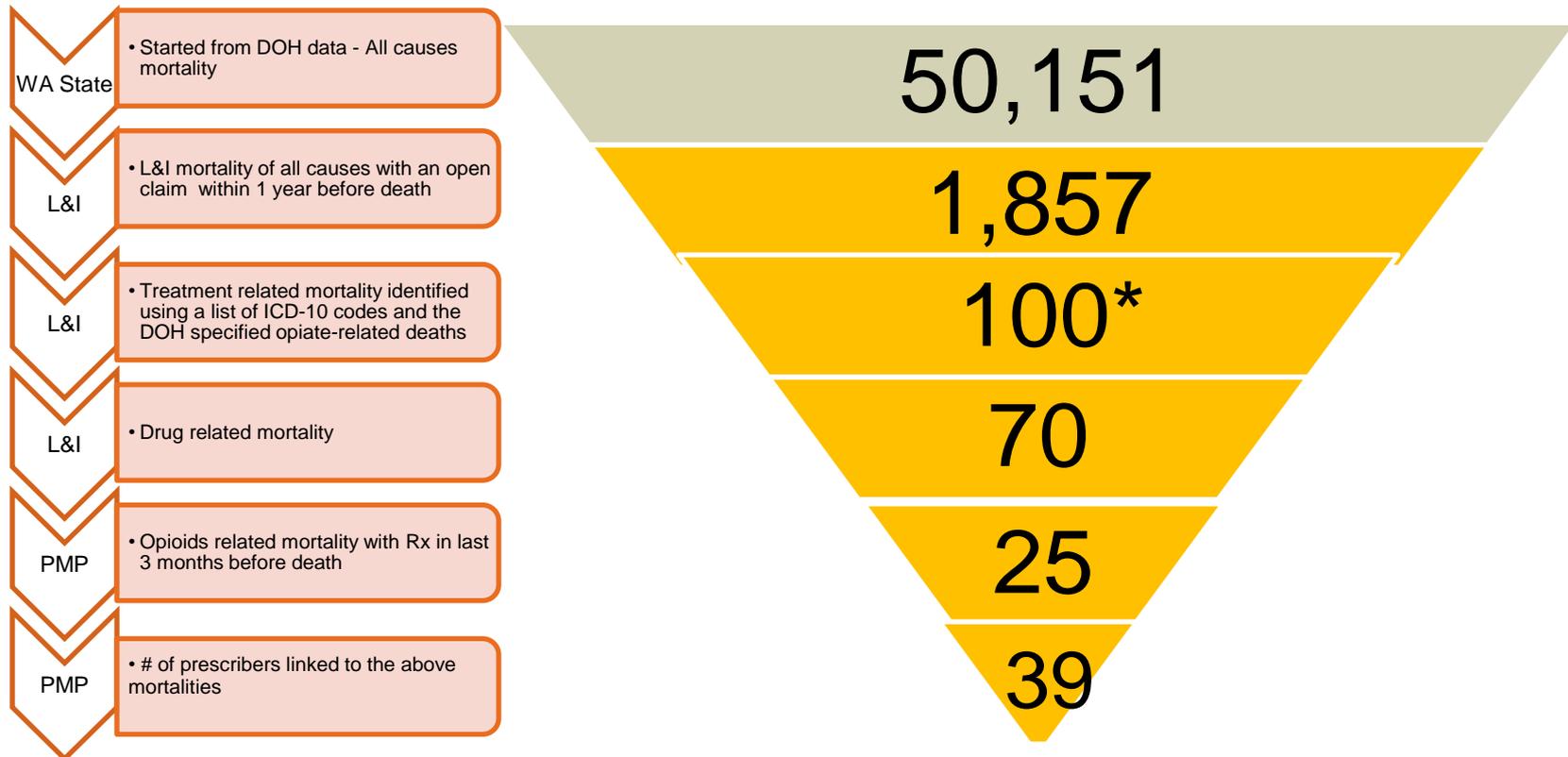


Database Query and Identification of Outlier (Zone 4) Providers





Outcomes: 2012 Mortality Data (linking DOH Death, L&I and PMP data)



*Suicides were excluded



Clinical Validation Review: Opioid-related deaths

- Cause of death - Did IW die of the prescribed drug?
 - Medical treatments received and chain of events
 - IW's behavior (e.g. substance use, compliance issues)
 - IW's health status prior to death
- Low quality care determination
 - Prescription patterns (dosage, frequency or combinations) in both the subject IW and other patients
 - Did the prescriber follow the guidelines/rules (e.g. how closely did the prescriber monitor patient health status and compliance)?



2012 Results of Validation Review

- 25 opioid-related deaths (39 prescribers) with at least 1 opioid prescription filled 3 months prior to event
- 21 *confirmed prescription* opioid-related deaths (25 prescribers)
 - 13 classified as “definite” (17 prescribers)
 - 8 classified as “possible”
- 3 deaths were from self-insured



2012 Results Continue...

- Prioritization of review was based on death category, access to medical record, network status and multiple events
- 10 cases reviewed (9 “definite” + 1 “possible”)
 - 1 network prescriber had 2 opioid-related deaths (“definite” + “possible”) in 2012
 - 1 provisional prescriber had a “definite” death in 2012 and “definite” in 2010
- Referred 4 providers to MPN



Process for Death & Overdose Review

