

MINUTES

Opioid Epidemic Task Force Meeting
October 17, 2017

Attendees:

- Tim Hartnett, CODA
- Senator Elizabeth Steiner Hayward (Phone)
- Dr. Katrina Hedberg, Oregon Health Authority
- Holly Heiberg, Oregon Health Authority
- Elizabeth White for Dwight Holton, Lines for Life
- Dwight Holton, Lines for Life (Phone)
- Dr. Amy Kerfoot, Northwest Permanente
- Dr. Safina Koreishi, Columbia Pacific Coordinated Care Organization (Phone)
- Lexi Smith for Senator Jeff Kruse (Phone)
- Dr. Paul Lewis, Multnomah County Public Health
- Jeffrey Rhoades, Office of Governor Kate Brown
- Dr. James G. Shames, Jackson County Health and Human Services
- Representative David Brock Smith
- Anna Pycior for Representative Jennifer Williamson, House Majority Leader
- Aaron Knott
- Kevin Russell, Samaritan Health Services

Not Present:

- Judge Eric Bloch, Multnomah County Circuit Court
- Chief Jim Ferraris

Staff: Katherine Bartlett

Opioid Epidemic is becoming one of Governor Brown's chief issues for the coming short session. She would like to run a bill coming out of this task force.

On a tight timeline – need work to be completed by mid to late November so it can get to the Legislative Counsel.

News on opioids is never ending these days. Incident at Grant High regarding overdose – Xanax pill laced with Fentanyl. Anxious to hear from Chief Ferraris, who has been working closely on this issue. Article in Oregonian warning that these pills may be more widespread than recently thought.

Exposé in Washington Post resulted in a withdrawal from Trumps appointees. Take a look at that and see if there is anything that Oregon can do to help with the seizures and fill the gap where the DEA is struggling. Would like to have this on the agenda for future meeting.

Had correspondence from Senator Warren seeking information on partial pill prescription policy. OHA assisted in a quick response to Senator Warren’s office. Be aware that they are discussing this issue on Capitol Hill, and we can discuss it here if interested.

Would like to vet some of the ideas we discussed last meeting (and via white boarding). In particular, whether or not there will be barriers to those ideas.

Update from Oregon Health Authority – Dr. Katrina Hedberg, State Health Officer, OHA Public Health Division

See “The Oregon Opioid Initiative” handout

Oregon opioid overdose initiative. Difficult to figure out the scope. Fentanyl has been mentioned. It is an opioid and is related, but it has not been the main focus we’ve been working on so far, which is more related to the prescription drug overdose as we are talking about the DEA and FDA. The illicit drug market, including Fentanyl – we have to work closely with the medical examiner’s office as part of the State Police, as well as law enforcement, etc. and look at what is happening with those acute overdose. It is really drugs that have been bought on the street that are laced with Fentanyl that has been manufactured overseas. Understanding what we can do in terms of legislation around the prescription drug overdose issue – not putting Fentanyl to the side, but scoping has been a challenge for all of us.

Our overarching theme is to reduce deaths, non-fatal overdoses and harms from prescription overdoses – the framing was related more to prescription than to illicit drugs, while expanding use non-opioid pain.

Four main buckets (see “The Oregon Opioid Initiative” handout)

1. *Reduce risks to patients by making pain treatment safer and more effective, emphasizing non-opioid and non-pharmacological treatment.*
2. *Reduce harms for people taking opioids and support recovery from substance use disorders by making Naloxone rescue and medication-assisted treatment (MAT) more accessible and affordable.*
 - a. Questions around Naloxone. 3440 removed some of the Naloxone training requirements.
3. *Protect the community by reducing the number of pills in circulation through implementation of safe prescribing, storage, and disposal practices.*
 - a. There is a clinical review committee that is part of the PDMP.
4. *Optimize outcomes by making state and local data available for informing, monitoring, and evaluating policies and targeted interventions.*
 - a. Data underlie all of these efforts. It is important for us to see whether we are making a difference and to get that kind of feedback loop.

Section 7 of 3440 did relate to OHA developing a web-based, searchable inventory of dependency. We know that this is a high priority. That is a work in progress – have some funding from (SAMSA?) to help with the State Targeted Response (STR) grant to improve treatment.

OHS Public Health have been involved with the annual reporting of data:

<http://www.oregon.gov/oha/ph/PreventionWellness/SubstanceUse/Opioids/Pages/data.aspx>

Able to track prescribing practices, and we are seeing a steady decline over the past year, about 20% below what we were a year ago – in terms of specifically prescribing for opioids.

Believe we are hitting the right age. The PDMP does not list the reason people are being prescribed opioids. Not trying to take these drugs away from people who are palliative, end of life care, cancer, etc. It really is, using opioids for chronic pain or acute pain. High risk groups for this chronic pain are generally middle-aged adults 45-75. That is the group that we have seen the largest decline in prescribing. Over 75, not much decline and the very young are not getting much opioids, but we have seen a decline in the right age group. Believe we are making an impact when it comes to prescribing.

Death data and hospitalization data are only available once a year, and there is a lag time. Working closely with the Medical Examiner's office and law enforcement to see if we can do better tracking (real time or close to), of some of these overdose deaths. Law enforcement may be familiar with the OD map (high intensity drug trafficking).

Section 19 of 3440, the Prescribing Practices Review Committee. Have invited primarily physicians to be on that committee, but also included nurse practitioners and others who can prescribe. Are really looking for prescribers for chronic pain, outside the scope of the guidelines. Pulling together this group, will have a charter for us to use the PDMP data to look at which prescribers are prescribing way outside the guidelines that have been endorsed in Oregon and that we are in the process of implementing.

There is a bill that has to do with the incorporating of the PDMP into the Emergency Department Information Exchange (EDIE). OHA is in the process of implementing. Looking for hospital agreements to be able to start using it – it's an IT process. Hoping to implement some of the hospital systems by next month. This will allow emergency department to see whether or not patients have a history of getting opioids from other providers.

EDIE is the first step of getting information shared between people who have the information and the people who need it. How about the bigger topic of medical records in general?

Legislation does not particularly call out EDIE. It refers to medical records, so I think that is the idea.

Steiner Hayward: Yes, we were focused on medical record integration. There have been some good examples of doing this already. Immunization alert has been integrated into electronic health records so don't believe it would be particularly challenging to integrate the PDMP access directly into the EHRs – EPIC and some of the bigger ones. EPIC would capture a significant percentage of providers of the state.

Timeline for the Prescribing Practices Review Committee? Committee members are currently under review. Letters have gone out, and we have received affirmative responses. Hope to have first meeting in early January, after we figure out what the charter is, etc.

Re: integration of EDIE and PDMP data. Is the goal to have the data be integrated as discreet medication data or will it be textual data?

The idea is that when you are in the electronic record, you can push a button and it will get you into the past prescription history for that particular patient. Not necessarily real time or full integration.

Helpful downstream for us to know how much we are spending in terms of treatment? How we are spending? How is it sourced? A lot of innovation happening in different parts of the state and some places where there isn't much innovation. Went from budgets that were based on per member, per month. Now we have broader budgets that are meant to spur innovation. What does that translate to spending-wise?

One of the things from our last meeting is the idea to have the TF tackle the PDMP and look at whether or not we would make registration mandatory or data entry for narcotic pain medication mandatory, and the feasibility of doing that and what obstacles came up. There was also some discussion about the fact that this integration with EDIE is going on and how that may make it easier for physicians to access the PDMP and make the changes a bit more palatable.

This is a really big change, and need to vet it quickly because of our timeline. (To Dr. Kerfoot) want to know how OMA feels about this. Have been strong feelings about making these changes in the past. Where we sit now, and what it looks like moving forward will be helpful. Who else is out there that we need to include in the conversation? Who else might be upset that we aren't thinking of, etc.?

By next OETF meeting, Dr. Kerfoot will have gone to the OMA annual meeting and board of trustees meeting – giving an opportunity to discuss this in greater detail.

Does the TF want to move forward with this?

It would be good to get an update about what fraction of how prescribers are not currently registered. Does this rise to the level of making this (Inaudible)?

Requirements for checking PDMP seem completely rational. The medical community needs to step up and take a lead and responsible role in this but the need to have the tools available to them. How do you actually plug things in together? Once it is all plugged in, seems that that would be the time to say it is now required. Scary to require something that is still being developed.

20% of the providers are writing 80% of the prescriptions. Oncologists or palliative care are writing most of those. Those folks need to be prescribing opioids as part of end of life care. It means that PDMP itself is a slightly imperfect tool to do exactly what we want to do. Anyone

who is a licensed clinician pays. Don't forget about delegates who can check the PDMP – it isn't necessarily the clinician so we need to see what that looks like.

Timeline for EDIE – first hospitals are online this fall. May be some difficulty with some of the rural hospitals.

MD, DO, and PA licensure is on a two year cycle. Registration will open in December, which means it will come up again in Dec. 2019. Any changes to the system will need to be made by the end of 2018 – two year cycle, but don't really have the full two years.

Prescribing Practices Review Committee – confidentiality of the proceedings is potentially something. When we are reviewing providers, we want to be sure that their confidentiality is protected.

Don't want to be hasty until we really understand what we are doing. Getting the review committee up and running so we have a clearer understanding of the scope of the problem. Are there just a few people who are (inaudible) the worst of this vs a much wider spread problem. We should not be afraid to do things that aren't popular. No one in the medical community likes to be told what to do. When 2019 rolls around, once we have a clearer handle on the situation, we may want to implement mandatory checking of the PDMP.

Under the PDMP umbrella from 3440, there was a new review committee. One gap in that is that the intervention there is education. It's non punitive for quality improvement to keep people in practice and make them better. Feel like there would be extra protection for OHA running this process, to be able to do it with that intention, and not have it subject to public records requests. Feel like that is something we missed when that bill came forward. OHA is going to be hesitant to use the process and people are going to hate going through it if it isn't confidential.

Do we need to create a public records exception?

Yes, but we believe that the exception would need to be spelled out.

Difficult time for public records exception, but we should be careful not to tell everyone who is doing the worst. It is not the way to get people to (inaudible).

We discussed palliative care and oncology, but in rural areas that may be the family practitioner who is seeing patients for chronic pain, and we don't know why that patient is getting those drugs. So, you can easily see that primary care providers could be under review because they are prescribing "outside the guidelines." So again, it is not as simple to identify offenders.

Regarding privacy concerns. Want to make sure that whatever we do is as well thought through and as primed as possible. Should be bring ACLU into the conversation? They have been actively involved, or should be.

Presentation from Oregon Community Health Information Network (OCHIN) Regarding Data and How They Can Interface with the TF.

Jennifer Stoll and Eric Geissal

Single largest host of safety-net data in the nation.

How data moves & some of the challenges around safety-net providers and moving some of the data in the opioid space – what it means from a practitioner perspective.

OCHIN has a data set on opioid use. Looking at aggregating the data and providing it to the State for evidence-based policy decisions around opioid use.

One study is looking at Oregon Medicaid, opioid use and lower back pain.

OCHIN serves 33 organizations, including a number of important counties. Serve FQHCs that are not county clinics. OHSU's FQHCs and others are on EPIC.

Provide PDMP access through a web portal that opens within EPIC. There is room for improvement.

Access to opioid related data is a priority for those of us in the health IT space. EDIE is a step in the right direction to see the read only data. However, we should be talking about the functionality, not just the viewing of data. Need discreet medication codes, dosages and frequencies in order to do calculations like med-med interaction checks, med-allergy interaction checks, morphine equivalent doses, etc. Allows clinician to ask “Is this an appropriate prescription for me to be writing?”

Recommends any kind of contract that the state has with a vendor who promises to interface data from the PDMP to an EHR – EHR should be involved in that discussion to make sure it jives with their technology to make sure it actually works.

The use of standardized data transfer mechanism like HL-7, IHE-USA, etc. – make sure it is vendor neutral as possible.

Data should be able to flow seamlessly between the EHR and the PDMP.

Put the responsibility on the provider to set up access to the PDMP, but would be nice to leverage the technology to do it for us. As soon as we log into the patients chart, the connection is made and the data flows.

Would like to see the PDMP registries flow across state lines, especially for border cities like PDX and Vancouver. Clinicians have to log into two separate PDMPs. Should be able to log into one, or not log in at all – just log into the chart and it queries as many (inaudible) registries as we can. Care Everywhere in EPIC is the health information exchange tool in EPIC automatically queries a radius around the patients domicile so that it knows to look for any kind of health information exchange connections at any hospital that is around where the patient lives. Believe we can do something similar with PDMP.

Think about hospital and ambulatory setting workflows when we are talking about any kind of data exchange to do with opioids.

Key point is that we are long past the stage in terms of technology that we should have to be struggling to do this. The technology should be serving us.

Health systems need to be held accountable in some appropriate ways for the misprescribing of opioids. Stakeholders need to come together so we have a seamless interface of systems that will do some of the things described here. We need to be insistent on this for the sake of Oregonians.

Regarding privacy – we will need to be ready to deal with that. When you talk about introducing bi-directionality into the PDMP and broadening who can get what information, there is going to be a correlating concern about privacy. Need to hear more about why privacy is not a concern and how we can trust the integrity of this data – even in an environment where we may be looking at federal agency subpoenas, public records requests. Need to have the assurance of what to say to concerned stakeholders to put this to bed.

Don't think anyone is asking for increased access to this data or being able to provide it to more people. It might actually limit data access and limit risk of inadvertent disclosure of data more if it were integrated directly in the EHR. At that point you'd only be accessing the record. When a provider logs into PDMP, they can request data on anyone, and we can audit who has been asking to access which records. Conversely, if you are in EPIC, and you log into immunization alerts, the only records you have access to are those of the patient you are logged into in EPIC. So it actually tightens access to information. It also means you don't need separate passwords, which means there is less of an opportunity for a data breach because of passwords being lost or shared.

It could well be the case that this improves the integrity of the data, lowers the chances of a data breach, and generally improves the privacy environment. Anticipate that issue around privacy will be a common concern, so we need to be on common footing in terms of how we describe the impacts on privacy. ACLU will ask about this ASAP.

Can limit who sees what data by each user's role/profile, so it actually tightens the access.

Does PDMP have a good track record in terms of avoiding a data breach?

OHA: Yes, has good track record.

Need to keep in mind the demographics – in particular, those who are from rural communities. What might work in larger cities might not work in rural area. While we have the opportunity and are doing this work, need to make sure that we are looking at the tools and the ability to use them. Remind ourselves of the various demographics and the complexities and differences around the State and expand the tools necessary in the toolbox to treat the broad spectrum of citizens in the State. Need the tools to give people a hand up, rather than continuing a daily hand-out.

Next Steps:

White boarding exercise to be discussed at next meeting.

Come prepared to have a discussion about the PDMP issue, the pitfalls, and what we can do to make improvements. Do we tackle it now or is it better left until 2019.

The Oregon Opioid Initiative

Aim: Reduce deaths, non-fatal overdoses, and harms to Oregonians from prescription opioids, while expanding use of non-opioid pain care

1

REDUCE RISKS TO PATIENTS BY MAKING PAIN TREATMENT SAFER AND MORE EFFECTIVE, emphasizing non-opioid and non-pharmacological treatment

2

REDUCE HARMS FOR PEOPLE TAKING OPIOIDS AND SUPPORT RECOVERY FROM SUBSTANCE USE DISORDERS by making naloxone rescue and medication-assisted treatment (MAT) more accessible and affordable

3

Protect the community by REDUCING THE NUMBER OF PILLS IN CIRCULATION through implementation of safe prescribing, storage, and disposal practices

4

OPTIMIZE OUTCOMES BY MAKING STATE AND LOCAL DATA AVAILABLE for informing, monitoring, and evaluating, policies and targeted interventions



OCHIN Overview

Jennifer Stoll

*OCHIN VP of Government
Relations & Public Affairs*

October 17, 2017

WE ARE **OCHIN**



The OCHIN Mission

- OCHIN is a nonprofit health care innovation center designed to provide knowledge solutions that promote quality, affordable health care to all.

Our Strategy

- We provide innovative technology, research, and professional services to our customers and partners in Oregon and nationwide with a focus on underserved populations.

What Does OCHIN Do?

UCHIN offers customized technology, research, and knowledge solutions health centers need to best serve their patients and communities.

1. OCHIN provides advanced security, compliance, and reliability
2. OCHIN has invested in expertise, integration, and technology
3. OCHIN improves health outcomes through innovation, research, and shared learning
4. OCHIN can augment workforce development and professional service needs
5. OCHIN prioritizes the unique needs of the safety net

OCHIN's Offering is Focused on Innovation and Transformation

Technology

Best-of-breed technologies targeted to the needs of the safety net and health care transformation

Data Analytics

Electronic Health Records

Networking & Broadband

Telehealth

Research

Research focused on improving the health of underserved populations, enhancing quality of care and informing health policy

Chronic Pain & Opioids

Diseases Affecting the Safety Net

Health Equity & Health Policy

Social Determinants of Health

Services

Professional services that range from clinic operational support to strategic planning

Billing

Compliance & Security

Consulting

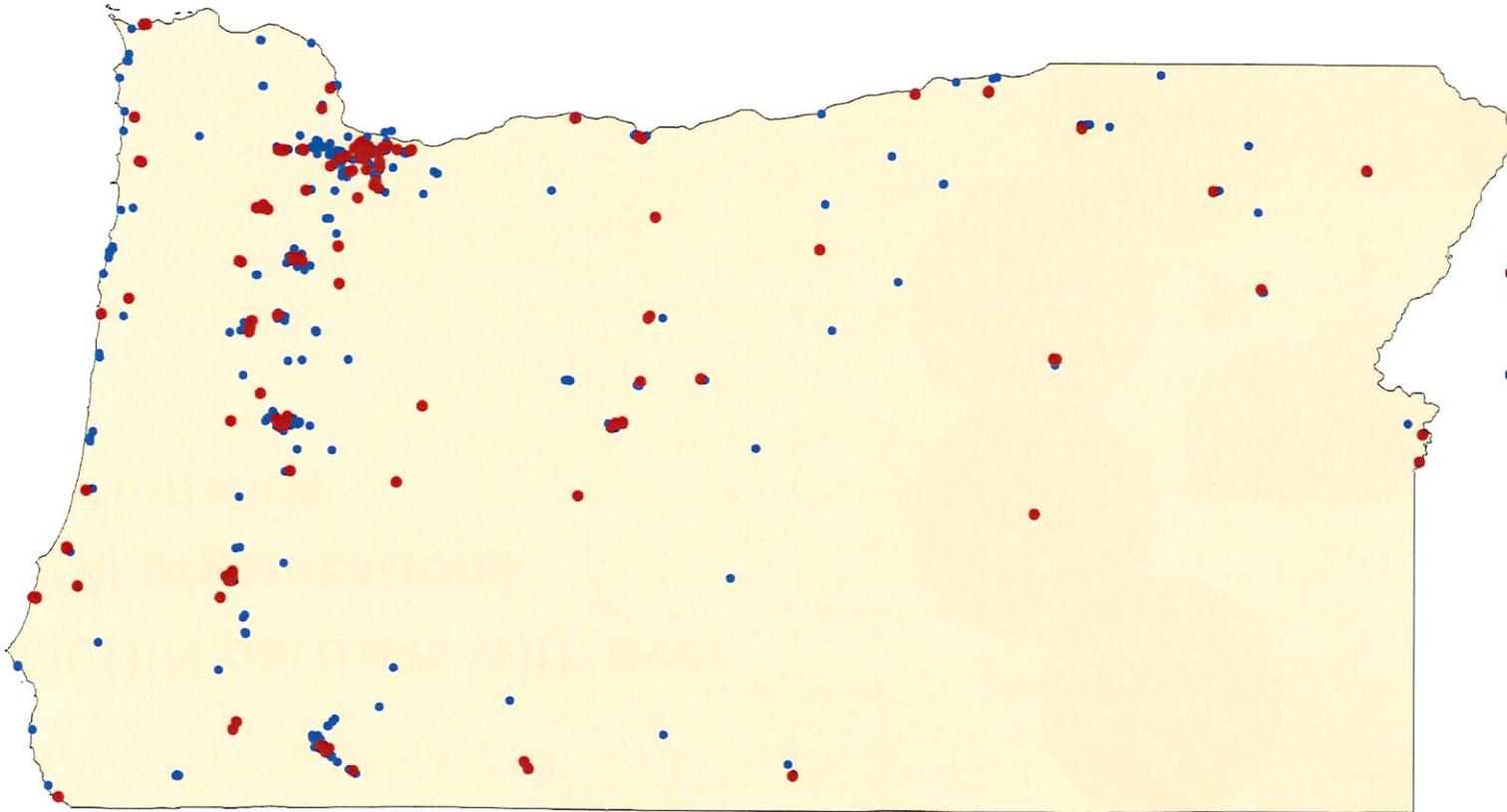
Staff Augmentation

Who Are Our Clients

OCHIN partners with over **400 organizations** nationwide



Where is OCHIN in Oregon?



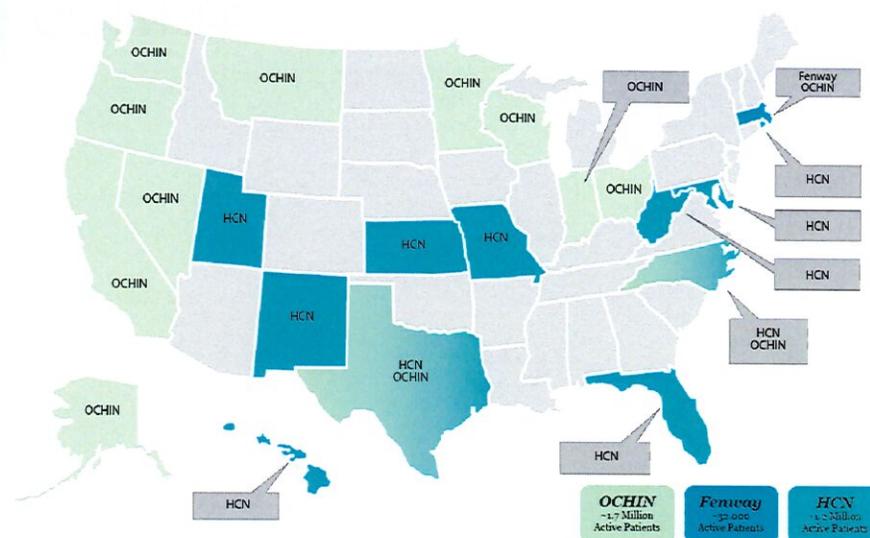
- OCHIN Member/Partner Headquarters (188)
- OCHIN Member/Partner Sites (>700)

*Many members/partners operate in multiple locations and in multiple states

We're a Leader in Research

- **Accomplishments Since Inception in 2008:**
 - 120 total publications
 - \$50.3M in total awards (46.3% award rate)
 - 16 completed research projects
 - 22 research partners (Kaiser, Fenway, OHSU, etc.)
 - 3.8M patients in research database
- **2017 Activities**
 - 44 proposal submitted totaling \$29.9M
 - \$8.3M in new awards
 - 32 active projects
 - 6 completed research projects
 - 21 new publications
 - 44 members participating in research
 - Multiple Opioid projects published and ongoing

OCHIN is 1 of 13 CDRNs in the nation, and the only one that is safety-net led





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