

## **MINUTES**

Opioid Epidemic Task Force Meeting  
October 31, 2017

### **Introduction: Representative Williamson**

Thank you all for being here and doing this work. November 21 is drafting deadline for legislative counsel to begin drafting any legislation that we hope to get passed in the short session. Our task today is to narrow down conversations that we've been having, research that we've been doing on some concepts that we can put into a bill for November 21<sup>st</sup>. Our hope today is to do a white boarding session to get some low-hanging fruit into the mix for an omnibus bill, do research between now and next meeting and go through the details next meeting so we know what we want in the bill. We do know that there are many things we want to do in the future, and larger conversations to have for 2019-20. Hoping to narrow down our conversation to very specific things that we can do in the next three weeks. Anything that is a longer conversation, we will put it on the table and get back to it, the task force will continue on into the future, having longer term conversations, setting some goals for what we want to have ready in the next long session. Hope for today is to get a concrete list of things that we can do right now in a variety of areas to move the needle, recognizing that it's not going to seem like that much, but we want to do something and continue the conversation for the longer term.

### **Introduction: Jeff Rhoades**

Review of opioid concepts that have been signed into law by other states that could potentially serve as a basis for some of our ideas as we talk through them today.

### **White Boarding Session – Policy Proposals: See attachment**

Want to figure out whether they are meaningful as well as achievable in the 2018 short session and thinking about their feasibility.

Four headings for policy proposals:

1. Overdose Intervention
2. PDMP/EHR (less pills)
3. Drug Takeback
4. Treatment/MAT

### **Overdose Intervention**

Don't want to duplicate efforts that we've already undergone or are currently underway.

Have heard we are currently having issues with CCOs requiring prior authorization for prescriptions of Naloxone.

Prior to a year ago, Care Oregon CCO's required prior authorization for nasal Naloxone, but it has been removed that – led by the pharmacists within the past year. Not sure about the other CCO's.

Does it need to be solved in legislation?

I think it can and will be solved without legislation. Can be solved by consensus agreement.

Unless anyone disagrees, let's set aside CCOs prior authorization.

Pricing and an effort to create a (inaudible) pricing. The curve is starting to go up dramatically. Is there anything that legislation can help?

In general the makeshift injectable being used in the nasal is the cheap way to go, so the question is: Is that legal? Is there anything we can do to facilitate?

Collective purchase arrangements. Is there anything legislation can do to help make that a reality?

State of Mass. has a statute that has the state doing bulk purchasing. Not sure about all the rules surrounding drug distribution. The outcome we want is that Naloxone is accessible in places where it is needed with minimal barriers. The cost is relevant because of how much you can have available. Many Naloxone kits will never be used.

From a first responder, emergency practitioner's standpoint, the nasal aerosol is the way to go.

It could be an "and." Those that can afford it – i.e. first responders can have that. Then at a community level, maybe have something that is less sophisticated.

First responders are having trouble getting a physician to sign off for a standing order to get Naloxone. (To Chief Ferraris) Is that something that you are hearing from first responders?

That is one of the difficulties about the way the system is currently set up is you have to have a prescribing physician sign off on it. When I was at Salem Police Department, we had the EMS medical director for Salem Fire sign off. That was a huge undertaking – had to go through a contract, it cost a lot of money. . . in the jurisdiction I'm in now, the doctor signed off gratis. We showed him what we were going to do on our training and accountability plan and he signed off. There is disparity out there, and some of it is driven by money because they want fees to pay liability.

(OHA?) Working on more sustainable solutions for law enforcement. There are a lot of barriers and there isn't requirement for (fire?) for that medical authorization and there is still a lot of confusion. We plan to do something at the beginning of next year to try and figure this all out.

For pricing, there is Trevor Douglas who is their prescription drug subject matter expert, who could probably speak to bulk purchasing on behalf of OHA. Over the counter, everyone can get them, that increases access then we don't have any of these issues. But, it gets back to who is going to pay? So, when you have it by prescription behind the counter, it is still single prescriber for single patient, and is more likely that it will be paid for by insurance. That sets up barriers because of the distribution issue and who is going to oversee . . . the agencies who are carrying it, but not for specific patient, but (inaudible) the first responder. Easiest thing is to make it over the counter – except for the price, that increases access for everyone, but we need to weigh the

risk and benefits. Trying to keep the price down, make sure that it gets covered by insurance at the same time, increasing access in a way that isn't the single prescriber for the single patient model that we have for most drugs.

Can we task OHS with Marcus to come back to us promptly with an assessment of whether or not there could be statutory help in getting towards bulk pricing?

Yes, we will find the right people to do that.

Two issues here. One is the individual prescription for an individual patient and bulk distribution. If it is a prescription drug in bulk distribution, it enters a whole different stream and creates additional issues. If they allow a prescription drug to just be sold to anyone who wants it in any quantity they want, it opens up access for other things which is problematic. I think we can find a way to solved that. When you are actually distributing it, you are getting in the business of distribution. The solution may be: 1. Government contract pricing where you have a primary contact who can distribute it out to police departments or other first responders. 2. Leave it as a prescription for individual patient so there insurance can cover it.

Might be a dual model if you will. But we are mainly concerned that the pricing is what is decreasing access.

Is a bigger pipeline going to be individuals with a prescription of some sort?

Bigger pipeline will be community based through needle exchanges and law enforcement first responders.

Yes, that is the distribution we need.

First responders are lacking in the rural areas for police and emergency medical responder. Naloxone has an 18 month shelf life. If this is a one-time deal and not continuous, sustainable funding, will be a problem because those agencies won't re-up after 18 months. They just are not going to build it into their budgets. It needs to be a sustainable model, not an unfunded mandate.

Budgetary question vs statutory question. Suggest pilot around Naloxone 2.0 like the Rhode Island model. When you are administered Naloxone you are presented with a "Recovery Coach" and asked if you want to go into treatment. If so, they take you to treatment that day. I don't suspect we would need regulatory changes. Unsure if budgetary issues are potential or not in this environment. Supporting a Naloxone 2.0 pilot would be remarkably important.

Definitely something that this body could propose. Depending on the size of the pilot, what happens at the ballot in January, there may or may not be money. We can size it based on potential for funding. Pilot in a small county. Can we build it into the justice reinvestment work and the money that is already there? Figure out some way to 'prime the pump.'

At least build out what a pilot would look like.

Are we talking about mandated treatment if Naloxone is administered? If it is administered at the EMT or hospital and a person is given the opportunity for some treatment options.

In the RI model, when a person comes into emergency room and staff realizes you have been administered Naloxone, when they put that in the record, a prompt appears that says: “Ask the person whether or not they want to see a recovery coach.” 90% of patients say “yes.” The peer recovery coach shows up within 30 minutes and asks the person if they would like them to walk them over to the treatment center.

Who employs the recovery coach?

In the RI model, believe it is insurance companies that are currently paying because they think it will save them money down the road. Janet Meyer from Health Share Oregon presented at the Prevention and Recovery Association. Said the most expensive diagnosis code is opioid use disorder because it drives all these other impacts in the system.

So that is how we would sell it if insurance is footing the bill. It will actually cost them less in the long run. Are we talking about this for a 2018 pilot or is this a long term 2019 & ongoing OETF work?

There are budgetary implications, not legislative implications. Will we be in an environment in February where there is some money to go after? Do we develop an outline of a pilot, have it ready for February?

When we are talking about Naloxone and adding tools and options – what about Vivitrol? References a 10/30/17 CNN article with regards to Naloxone and how it reverses 93% of overdoses. So, when talking about treatment options, would like to have the ability to have the Vivitrol tool in the toolbox for an option for patients that want to get off of those opioids for good.

Is there something that we can do legislatively in 2018 as part of this that would incentivize MAT? In particular, we know that Representative Brock Smith is interested in Vivitrol, but there are a lot of different types of MAT.

Does the CCOs spending reflected in this area the priority (inaudible). Is the CCOs per member per month allotment that they are getting for substance abuse being spent on substance abuse? Can we legislate some budget earmarks?

We don't know enough about what that spend looks like. A few years ago we did and it has sort of become a mystery with local budgets.

Is this a 2019 or something a little further out? Right now, we have Safina, but without the other CCOs here worried that we will be walking into something that we can't move forward in the short session.

It would be smart for us to be talking about this legislatively and not waiting.

We need to bring treatment providers into the Naloxone distribution discussion. Have people that will leave detox who we know will resume their drug consumption. They are at high risk for overdose. Why we wouldn't have them exit with Naloxone is bad medicine.

Corrections may be a good place to put that, You are something like 14 times more likely to die of an overdose if you have just been released. Director Peters (DOC) would be interested.

Is there something that we can build in 2018 that would help us in that area legislatively?

Why don't we have Naloxone available for treatment providers?

It is available. Some treatment providers take it on, but some won't. But there is nothing to prevent it.

So maybe there isn't something legislatively that we can do to remove a barrier. We need to incentivize it more on the treatment end of things?

Because we are talking about costs – again, with the different CCOs around the state, they have different demographics. So when we are talking about rural Oregon, and their demographics . . . when we are talking about costs and you have folks coming out to the justice system for example, who are clean at that point, and we're giving them Methadone treatment on a daily basis. Is that more expensive in the long-run because you are basically supplementing drug use vs trying to cure the problem. When it comes to a productive member of society being able to move forward in a drug free environment, the overall cost is much less in the long vs the initial costs to do so in the short run. Know that the Naloxone might be more expensive, but if we could transition them from the Naloxone to Vivitrol, for those that want it, we are actually saving money in the long run. Think we need to have that conversation with the CCOs but could possibly see that without incentives up front. In the long run they are going to be saving money.

Suggest again that we should have some subject matter experts on medication assisted treatment. These medicines have different goals. Some of them are shorter term, some longer term and it is easy to co-mingle them. It will be useful for us so we can be deliberate and disciplined in our discussions.

Follow up on the “spend” by the CCOs and how much they are spending and what they are willing to authorize and spend for. In the drug court with 150 opiate dependent individuals per day . . . in the Portland metro area we have at least 3 CCOs that we are dealing with, and they all have different policies with respect to what they will pay for relative to MAT. It would be great if everyone could somehow see the light and see the right answer and coalesce around that, but just don't see that happening without some sort of push legislatively, etc. In the last session, with respect to drug courts, we actually had a piece of legislation that said that no one could be denied access to or participation in drug court solely for the reason that they either are participating in medicated assisted treatment or wish to. I think that was a big step forward relative to allowing the opiate dependent individuals to access that medication. It is difficult when we have people who are struggling and the CCO they happen to be assigned to saying before they can have

access to Vivitrol, you have to try three other things, when we are dealing with an individual who is at risk from dying of an overdose at any time.

All CCOs don't do the same thing. In terms of prior authorization removal, whether it is Naloxone or things like that. I know for Vivitrol our CCO and the three other CCOs that I am familiar with do require prior authorization for opioids, but not for alcohol. There is better data for Vivitrol treatment in alcohol than there is for opioids. Will provide that data to everyone. In terms of drug court we have fast track. There is a fast track way to go around a prior authorization so that the patient can get the Vivitrol after drug court if that is what the drug court desires. Have to balance the cost but for right now, it is not systematically approved without a prior authorization. Don't know any CCO that does Vivitrol systematically approved without a prior authorization. It is important to talk about CCOs, standardizing, coverage, removal of prior authorization, making access to Naloxone and Vivitrol and MAT more available. Just as important to talk about it in relation to private insurances. CCOs don't cover all the people in the state. Should discuss.

There is language from HB 3440 which includes CCOs and other insurers. Some other states have taken an approach which requires a standardization across all HC payers, both in classification of substance use disorder, and in treatment. The Institute of Medicine just came out with report on this problem, and it is going to be expensive. Not sure there is a cost cutting way of doing this. We are in a deep hole and they think it is going to take decades, and billions to get out of it.

Under MAT, add specialized licensure and when is that a barrier for things like Suboxone?

What about a directive to the insurance commissioner to examine barriers to MAT and addiction treatment more broadly. Embedded in the way we reimburse for addiction treatment are all sorts of assumptions that it is acute care as opposed to chronic care. Would like an insurance subject matter expert to look at the way we reimburse for substance use disorder and acute care vs chronic condition. Have them report back to the legislature. Basically, to examine the way we reimburse for substance use disorder to determine what barriers are and should be removed. And to assess what ways we treat substance use disorder as an acute condition, when it is in fact a chronic condition. Reimbursement structure should reflect that.

We now pay for services for people when they are really sick into their alcohol and drug use. Part of the reason we put it into the ACA and (inaudible) primary care is that we want to identify people earlier in their alcohol and drug using careers so it moves it away from acute care and gets us to identify people sooner. Want to begin to look at opportunities like that to fund.

The easy example: When you have diabetes, and your glucose levels are imbalanced and you end up in the ER, they don't have to re-diagnose you with diabetes before you move forward. If you are in recovery and you relapse, you have to go through re-diagnosis to get treatment.

Back to the discussion of first responders and community level investments. Particularly in rural Oregon. There is a lot of law enforcement and the traditional folks who would administer these medicines. Want to remind the group that we are in the middle of discussing what the

expectations are for the next 5 year contract for CCOs. So there is an expectation around community investment and reinvesting (reserves?). This would be an appropriate time in 2018. Public process for commenting is January 1<sup>st</sup> and will end sometime in December. The criteria will be formalized in the late fall of 2018. Procurement process will begin Jan 1.

Could legislature support the agency and setting expectations. That may be a bit more polarizing to their main constituency (inaudible) CCOs.

Not all first responders and/or police departments are willing to carry Naloxone. If we do something legislatively language on that end should be part of it also.

Regarding PDMP and Electronic Health Records: Require PDMP registration by all licensed prescribers, mandate PDMP query before prescribing or refilling, application of the chronic disease paradigm and making overdose a reportable disease. Shannon, please let us know if we are implicating 42 CFR part 2. Certainly, those would have downstream impacts by changing the classification there in various areas.

Require PDMP registration by all licensed prescribers – data: Can see anyone who prescribed a controlled substance. Only half of them were signed up for the PDMP. Of the 4000 highest prescribers, 75% are enrolled. Is enrollment going to make that much different, or is the fact that you are mandating enrollment and checking the PDMP. Is that a teaching tool, that you are changing the social norm around people understanding, etc., which is part of the broader picture. Want to be clear that we are most of the way there with the high prescribers, so it might not have that direct impact. But the legislation around mandating, at least the enrollment part. We are working to decrease the barriers so that at the time physicians renew license, or license for the first time that the requirements are part of the PDMP. We are trying to facilitate the enrollment.

Requiring PDMP registration by all licensed prescribers – is it achievable, is it meaningful. Is that something that we want to undertake for 2018. Keep in mind we've had presentations on a number of ongoing changes with EHRs and have talked about EDIE, and the fact that those are still ongoing.

From the PDMP folks - with the new software they are going to have for the PDMP, they really need to have the required registration for it to work with some of the functionality.

It is hard to see that there are major drawbacks to requiring registration. There are other prescribers besides physicians.

That was part of 3440 to clear the hurdle and make it easy during your licensing. Basically, the next renewal should be automatic. They would almost have to opt out of the PDMP.

Does 3440 have that auto(?) integrated into licensure?

It is separate, but it is going to be an integrated system in the sense that the same data will be there.

I want to make sure we've heard from the Board on that. I feel like I've heard a different message from the board that they are not necessarily going to connect the (players? wires?).

The qualifications are transferable. The firewalls around the PDMP data system are separate. That has been one of the issues.

The easier it is, the more palatable it will be.

We are now just talking about the registration part, not about the (inaudible). At least for 1.0 it doesn't seem to me that there are many drawbacks.

Do you guys have an official position that you can tell us on mandated registration?

I don't think we have an official position yet. I think we've done everything we can to make it as easy as possible for people to get registered.

I would say we highlight mandated registration with the understanding that Courtney can come back (inaudible) if she wants (inaudible) consider.

So mandating the query before filling is slightly more difficult. When talking to the PDMP staff, they are able to see. You could have a check boxes (inaudible) this issue about a prescriber vs. a delegate or someone else. Again, we want somebody to check it whether it is the person writing the prescription themselves or the delegate who is giving that information. That is a little more than a lift.

We've got EDIE. Isn't there ongoing updates to a number of EHRs right now? What are the plans?

The PMP gateway is up and active that allows for integration of your health IT system. That is live and available. Putting it into the hospitals for physicians to have access . . . the first hospital comes online this week – Asante in Medford. It is slow going because there are requirements around credentialing and being able to make sure all the prescribers are signed up for the PDMP. So we anticipate the work will take a full year for any hospitals to come on with the EDIE notification (inaudible). For the rest of the health systems, which include hospitals, we are working on a statewide gateway subscription that would allow their EHRs to integrate with the PMP gateway. We anticipate that (inaudible) will take quite some time for all systems, if they choose, to integrate (inaudible). There will be people who are still going out to the web portal, and still be querying. And there will also be the option to integrate their health IT system to have the PDMP information in there (inaudible).

The people who are getting prescribed over 120 MED, has gone down by 20% over the past year. We are moving in the right direction, but we are not where we were 15 years ago. The answer is “no”, we are not content but we are making headway.

If that downward trend was going to tank in the next 24 months, I'd say why are we bothering with this? We have been at this well over 10 years. I would like us to take steps that would just hammer this thing right to the floor.

Don't disagree that we should be making faster inroads, but the flip side of that is that there are a lot of patients, so our analysis of PDMP data is crude. There are a lot of legacy patients. Making sure we don't have new patients start – that is where we want the prescribing to “tank.” The patients who are on higher doses and chronic pain . . . we need to make sure there are other things to offer them. It is a crude measure, many of those patients that are on high doses are being tapered off. We want to support that. Need to make sure we are looking at the entire picture. It is the bulk of patients who are chronic pain patients who may be on high doses of opioids. We need other modalities, and we need to taper them off and start to see that (inaudible) trend.

I think there is good data from the states that have mandated it. Correct?

PDMP (inaudible) has evidence based practice around PDMP. It is hard to know what the specific intervention that is making the difference is. Believe it is a gamut of things. Whether it is prescribing guidelines, (inaudible) that Dwight is involved with for Naloxone, etc. It is very hard to pinpoint a specific thing. Don't want PDMP mandates to outrun our technology. We will get a lot of people frustrated who want to do it but find it difficult. Wondering if the requiring or registration would be something we could do in the short session. Then, thinking about whether or not we want to mandate, looking at PDMP as something that could be done over the next . . . or more thought about what that would mean, how that would look, how we would monitor, how we could gather feedback, what would the repercussions be? If someone prescribes without checking the PDMP, then what? Does this go straight to the licensing board . . . we have to figure out, when you mandate something, how the enforcement works and who is going to provide those data to whom, etc.

We need to be bold. Prohibit prescribing for non-cancer patients, and mandatory PDMP for prescribing opioids.

We need more accurate data to guide us. Need to start getting better data to inform our actions.

To Dr. Hedberg: You said there was a 20% decrease, and that that data is aggregated between legacy prescriptions as well as new prescriptions. Is there disaggregated information available so we can see what is happening with respect to the newly prescribed treatment?

PDMP has limited data – it only maintains three years' worth of data and it has a little bit of demographic characteristics on patient, name of provider and drug/dose. We don't know whether you are getting it for cancer, or got some at the dentist, or you sprained your ankle. No data on the reason for the prescription. We can look at an acute event and how many of those patients move to chronic, and are still on an opioid sometime later. But the 20% has to do with the number of patients that over a threshold, 120 md, but it is very, very crude. Oregon's PDMP is actually one of the more restrictive in the country in terms of the data we collect. PDMP is

restricted and limited both in terms of what data we can collect, and how we can use it. Larger discussion for the group. Just be aware that we don't have as much data as other states do.

Is there something we can do about that? It seems like a longer term discussion.

Have not been involved in conversations around the EHR integration piece. However, want to mention that although we are looking a statewide subscription to help cover the cost, that those who are integrating with their EHR, they might have cost on their side for connecting. Their EHR vendor might require that they pay for certain builds and configurations. When you are thinking about the EHR integration piece, there are other components than just the statewide subscription to help them pay for the (inaudible).

Think that boldness is required. If we don't have data currently, to even know at the extent of which the gains in reducing prescriptions is real, is meaningful, then we should at least be dealing with something in this session to start getting some better information to make decisions moving forward.

If there is something we can achieve there, we'd love to do it. The problem is November 21 is the deadline for legislative concepts.

What about requiring checking the PDMP when prescribing opioids for non-cancer pain? Does anyone think it is a good idea to prescribe for non-cancer pain without checking the PDMP?

Great idea, but agree with what was said earlier – there is so many process, workflow, training and awareness implications, that doing that in a short session might not be the best idea vs requiring registration for it which is a huge step and a big learning tool, then doing that as a next step afterwards.

Are people being trained that before they prescribe opioids? It ought to be in the chart that someone has checked the PDMP.

Yes. Difficulty of creating those workflows and processes within an organization. Now talking about outreaching to dentists and surgeons, which a lot of this opioid work hasn't even gotten to yet. Depends on when the rules are written and when it would be required to start. It is one thing to pass legislation, and another about when is it going to start being required. We've got to fix that.

My point is that registration will fix that first.

Prescribing limits has happened in more than half of the states and it addresses what Dr. Hedberg talked about acute prescribing (inaudible) the attention of the surgeons prescribing for non-cancer pain. Think it should at least be on the list. It is actually pretty easy legislatively.

To OHA: We had the issue with OHP and the 7 day cap. What exactly happened there?

CCOs vs fee for service. Fee for service has a committee that discusses what it is that would be for patients that are covered . . . this would be the fee for service patients not CCOs. The committee decided that they would need prior authorization . . . if a patient . . . that doesn't mean that it couldn't be done . . . it means it would have to be checked. So that was interpreted as perhaps . . . (inaudible) read the memo and it wasn't completely clear as necessarily doing . . . covering all CCOs and covering everyone, etc. Limiting the number of pills that are prescribed for an acute event is really important. So again, it was sort of the right direction that that memo was misinterpreted . . . it was only focused on fee for service. It wasn't mandating what the CCOs needed to do.

It was more how it was rolled out. There was a misunderstanding, not whether the idea was good or bad. Apparently, partial fills are allowed. Get a 30 day prescription, but only want 10 pills. The pharmacy can do that but the question becomes is that 2 fills (one prescription, two fills). Is there a co-pay for the second time? Don't want to disincentive to get half now, half later and have to pay two co-pays instead of one for the single prescription. Not sure if that is statutory or how that is done.

Clarification on the point of having physicians check the PDMP: Are we talking about only if they are prescribing for chronic issue, or are we going to require that at emergency rooms as well. Is it quick for them to get on or are we talking about significant delays when people are in the emergency room?

When you come into an emergency you want to know if the patient is already on high doses. So even though there is a legitimate reason for prescribing an opiate, you want to know what their past history is, even if you are not prescribing.

Is that something that a doctor is going to be able to accomplish quickly?

The data says that if you are going to be checking the web portal, it takes about 4 minutes. But with the integration piece, it happens fairly instantaneously. So once the PDMP information is in EDIE, those notifications are (inaudible). Roll out is now hospital by hospital.

The 7 day cap on prescription meds – many states have done this, but would like to hear from OMA on this issue, and where they are with that.

The concern is that we are starting to legislate (inaudible) the practice of medicine. How practitioners work with their patients. It is a slippery slope to many other things – allowing government in (inaudible), so we have to be really careful. There are other things like prior authorization or insurance coverage (inaudible). We are seeing good results on the work that is happening. Have our clinical review committee from 3440 that is getting started soon to look at the data – no matter how crude the data is in the PDMP. As clinical practitioners they will be able to review it, understand it more, and educate providers who are outside the guidelines. As long as this is a 50 year problem and we want to fix it in a one year cycle, that doesn't always work. But what we can say, is that with a clinical review committee, make sure we can get everyone registered that we can, and with EHR integration (inaudible).

Is there a requirement through the Board of Medical Examiners that as part of their continuing medical education, attend these types of opiate prescription (inaudible) courses now?

There is a one-time pain management course for any new licensee in the State of Oregon. The CDC just (inaudible) the guidelines on prescribing opioids. State of Oregon just adopted those guidelines with a few additions and changes. Part of 2114 was that every practitioner board, and anyone who prescribes, all of their boards, to educate their prescribers on these new guidelines that just came into play around a year and a half ago. Part of those guidelines are 7 day limits.

Is there a medical reason why this is a bad idea? Why would you need to prescribe more than this for non-cancer patient having an acute episode?

We did have this discussion in the legislature on 2114. Started as a 7-day cap proposal. In that context there were certain caveats that were (inaudible) in amendments related to long-term care settings, geographically restricted (inaudible), and what instances would the 7-day cap apply or not apply, which led the licensing boards to take up this issue and create the guidelines, I don't think are implemented until January 1. How can we build on the conversation we already had. Maybe without getting in front of the work that hasn't yet been (inaudible) but how can we bolster it or make it more of a (inaudible) than a suggestion.

Regarding drug take back: Bill would have created the first statewide drug take back program in existence. There may be some political realities and funding issues that we will be running into for the short session.

Pharmacists are in support of this and having a depository in our lobbies is something we would support. It comes down to the cost of those systems because they are not cheap. Not all pharmacies are traditional pharmacies. We have to write it such that it's for the traditional pharmacies that do have public access and lobbies that these things can be put into.

Last session we had many advocates. It really came down to how to share costs. The bill that I (Representative Malstrom) had done was at no cost to the state and the cost to the drug manufacturers. Devlin's suggestion was that if we tried to do this again that we try to look at other ways to share cost. Have talked about deposit on the pill bottles, but doubtful the pharmacies are going to want to mess around with the deposit. Another idea was to have DEQ be the agency that runs it. Pharmacy makers could be doing some cost sharing in setting up the boxes. Don't see this as a short session bill but it is something I would like to see this task force continue to work on so we can get a bill that could pass in 2019.

Think this can be simpler than we have previously gone about it. There are private sector solutions for this disposal. As a pharmacist, it is expensive in the grand scheme of things to have one of these things put in your pharmacy. Cost is around \$2000 per year. There are 600 retail pharmacies in the state (not all are walk-in retail). That is 1.2 million dollars. It is not a lot of money in the grand scheme of the pharmaceutical industry. Part of the challenges we had with the bill last session was putting it into DEQ and creating FTE. Write a bill that says pharma is going to put 2 million dollars into a fund every year. DAS is going to run it. When a pharmacist wants to get a box, they call one of the approved contractors. The contractor bills the fund. In the

meantime the rules have been written to make sure we are hitting the right pharmacists. DAS probably needs an extra .5 FTE, they ought to be able to absorb it. You've now made this a very market based, easy solution that doesn't require a big bureaucracy. Believe the reason there was push back on the funding is that the pharmaceutical industry does not want responsibility for this. If they are the only ones paying for it, they feel like they are the ones taking responsibility. That is all well and good that they don't want to be held accountable, but they need to be held accountable. They are making a wonderful product, which helps people, but has now killed 40,000 last year.

These are chemicals that need to be disposed of properly. So I think it is broader than just opioids. The chemical industry is making them. Like paint and motor oil, we have to dispose of it responsibly.

Rep Brock Smith: Appreciate the discussion but have to agree with my colleague that I don't know that we have the bandwidth in just a matter of a few weeks to craft something that could get through the short session because of all of the above that we have discussed. By no means should we stop having this conversation, because the program is necessary. Along with the PDMP with regards to legislating that out as far as making sure we have the data. What are we doing if we don't have the necessary data that show whether or not things are working? Getting the drug take back program in 18 days isn't viable in my opinion.

Rep Malstrom: I get constant letters and suggestions, but you can only fast track this so much. Not sure where this task force is going long term, but I would like to make that a priority issue for the long term. It is a big, heavy lift, and we would be the first in the nation. We could do something significant for the whole country if we could pull this off. It needs a lot of thoughtful work.

Rep Brock Smith: Appreciate the conversation about setting up an account and I believe that DAS could have the bandwidth to manage it. My only suggestion to that would be to see what it would cost to make sure we have all of the necessary boxes in all of the pharmacies in the state. Then, adjust the dollars in that account accordingly so that it doesn't turn into a "slush fund." That there is enough money in there to manage it, and that is it.

Summary: Why are we worried about taking on pharma for this dollar amount when they should be taking responsibility in this arena anyway?

Part of the reason pharma objected so much last time is that they didn't perceive there was a fair way to assess their cost. There is a methodology that can be used for that - there is a company that can do that. They can track the sales - by drug type, and the outlet it came from. It would be very easy to assess a percentage of a specific company's sales in the state through retail, and then assess a percentage of that. The pharmaceutical manufacturers have a greater responsibility for this. Through the pharmacies they have take-back programs where you can recoup the majority of your expense if it goes out of date and is still on your shelf. So, for them to say that once it goes outside the pharmacy's walls, that it isn't their responsibility, seems wrong. But I think there is a way to assess the true value. I don't get the argument why if they will reimburse a pharmacy for outdated drugs on their shelf, they won't (inaudible) that goes out to the patient.

It doesn't have to be as big as a statewide program. We could look at doing a pilot program as well.

I've talked to some of the commissioners in Multnomah and Washington county about doing that, and they would be up for it if that is the direction we want to go.

Overview of conversation and priorities:

1. Rhode Island Model – Naloxone 2.0. Talking about a potential pilot program. This has been highlighted as something we can do in the short session. All agree.
2. Require PDMP registration by all licensed prescribers. Realizing there is a much larger ongoing PDMP discussion, but let's start with this. All agree.
3. Ask Insurance Commissioner to evaluate barriers to be removed and to examine the acute vs. chronic paradigm and whether or not we are applying that correctly. All agree.

Did we have a consensus on the 7-day cap?

Yes, we suggest that the Governor ought to think seriously about it and we'd be happy to answer more questions about it. We need time to roll it out, but think about a total prescribing reform where you are adding the PDMP pieces and the 7 day cap. The cap has many off-roads the way it is written, and we wouldn't want the criminal piece (inaudible), but you could do a comprehensive set of reform that gets rolled out altogether.

November 9<sup>th</sup> meeting being changed to the week of November 13<sup>th</sup> – Leg days.