MINUTES
Opioid Epidemic Task Force Meeting
November 14, 2017

Reviewing the ideas from last month's white boarding session that we came to consensus on to move forward with in our 2018 legislative package. Items for review:

- PDMP Mandatory Registration for All Licensed Prescribers;
- Insurance Commissioner Report on Barriers to Accessing MAT;
- "Naloxone 2.0" and the Rhode Island Model;
- Technical Fixes

Technical fixes: Katrina and Holly. Fixes intended to help to maintain the confidentiality of the processes. So we can do those without worrying about the need to turn over materials – i.e. to the media.

Can we classify this as a technical fix, or not? Please explain in more detail to the group. Katrina will find information to explain to the group and come back later in the meeting.

Discussion: Mandatory PDMP Registration for All Licensed Prescribers

Currently, 22 of 49 states that have PDMP have a mandatory query of the program. That is not what we are talking about today. We are talking about mandatory registration, which is the step before query.

Amy – PDMP registration is much like creating an account with other organizations, you enter all of your credentials, medical license number and your state DEA number. One difficulty is that your username is your DEA number, which is not intuitive or can change based on things like a suboxone waiver, which adds a digit to the number. Aren't able to choose your own username. Password needs to be fairly complex. If you don't log in every 90 days you lose your access and have to re-register. If you are trying to do this on the fly, it isn't going to happen. It was difficult to use at the point of care with a patient because oftentimes you couldn't remember your credentials, and the website does not automatically remember. That has changed with the new vendor.

Katrina – The statute states that when you renew your license, that information does not have to be entered into the PDMP. The reason it can't be done at the same time is because you need a username and password. When I renew my licensure with the board, it doesn't ask you for a username and password, it asks you for your name and license number but there is no password. It is difficult to figure out how when renewing licenses can automatically mean you are registered in the PDMP. We can make it as easy as possible, but I don't see the automatic registration. Recap: Username being the DEA number is complicated and it needs to be easier. Not timing out after 90 days.

Migrating to a new vendor: what is the timeline?

Need to ask someone at the office of health information technology.

Since we are talking about mandating registration, should we make sure that that marries up with when we have completed the migration? If we could get a timeline, that would be great.

Timing is everything because we don't want to have it pass session, effective immediately (February) and not have the ability to do it next June or July.

Jeff will be meeting with Legislative Counsel after this meeting to have our first discussion about what is actually going to be in our legislative concept language.

Recap: 1. Do we have to do anything to make registration more easy and streamlined? Is that already being taken care of by migration to the new vendor? 2. What happens if you fail to register – what penalties will be associated with that, if any?

Paul Lewis – Is there a slightly different way to frame it as opposed to "mandating" it, vs putting the burden on the agencies to automatically register them. We have 4 boards: Naturopaths, nurses, dentists and the Oregon Medical Board that license people who are allowed to prescribe opioids. And we have an agency that administers the PDMP. Can we put the burden on those agencies to take care of the registration as opposed to putting the burden on the physician?

Katrina – The reason people have to register is that they have got to create a username and password. The username and password has to be done by an individual. Don't know that registration can be automatic.

Paul Lewis – Discussions have identified a solution, in that they are registered except for the password. Upon licensure, the PDMP sends them a notification to "click here" to set your password. So the burden is put on the agencies, not on the physicians.

That is akin to what Portland Public Schools does with my 11-13 year old, who are all registered for Google Classroom. They have a default password, then you have to set your own password.

What would that entail on how heavy the lift and how expensive would that be?

If we could make a list of those, we can get information back out to folks. As you know, everything with IT is easy in theory, but in practice seems to take a lot longer that we would all like.

It may be a complicated change, but Paul's point is well taken, and if it is something we could accomplish, perhaps that could be something we could look into.

There is the thought that there was a legislative intent in 3440 to do this. Could this fall under the category of "technical fixes" to make sure it actually works as opposed to a brand new thing.

My impression is that that is not the way 3440 has been interpreted thus far.

Katrina – Would agree, technical fixes need statutory change. I would agree that the intent was to make it as easy or seamless as possible. The language in 3440 specifically states that the actual registration still needs to happen by an individual. I understand that registration and making sure credentialing . . . it was like "transfer of credentials," or something like that. That might be semantics. If it really is just setting up a task where that is more of a technical fix, then a need for new legislation. Shannon O'Fallon said that she thought the intent was to have people automatically registered at the time they renew their licensure.

But a registrant would still have to go in and do a username and password and affirmatively log in to the system to start it up. Is that right.

Yes – that is my understanding. You need the username and password, basically like any other system.

So this is still a meaningful change, even if 3440 is interpreted that way because the user still has to go in and affirmatively access the system and make sure they are registered appropriately. Does that comport with what everyone else is understanding?

Something that you may want to address as well is the delegation. If you are actually looking for use of the PDMP. If I am registered, but it is difficult to delegate that to my staff, who is going to be doing the majority of the looking up I assume, then that process needs to be simplified as well. From the pharmacy side of things I have heard that the delegation access may be a problem.

Delegation piece is (inaudible), so there does need a bunch of validation documents to make sure that whoever the delegate is is truly a delegate, and not just a person who says they are a delegate. Right? Current language in 3440 says "The authority shall use licensing information to 'qualify' the licensee to report information, etc." So again, it qualifies – not quite the same as registering or needing the username and password. So I think that part may just be semantics. If it really is, then Paul's fix wouldn't need legislative . . . but I don't know if it is quite as easy to do the technical fix. I wish we had the PDMP folks here because I think that delegate piece will still require some extra (inaudible). Everyone is aware that when the statute first passed, there were lots of concerns about confidentiality. So the statute in Oregon is much more restrictive than it is in a lot of other states. We are trying to change that to make the system a little bit easier for everyone to use, but at the same time, be aware that the system is designed this way is because of the original legislation.

Is anything that we are planning on changing in the PDMP requirements . . . does current practice have anything to do with the initial ACLU concerns? Are they on the phone? Do they know how we feel about this? I want to make sure we aren't going to hit a roadblock after this discussion.

We aren't talking about data sharing or anything like that, we are talking about physicians . . .

Right, I just wanted to make sure there wasn't a *reason* it was optional that had to do with concerns of the ACLU. I'm hard pressed to imagine how. I'm just covering the bases.

They were neutral on 3440.

It is a smart point to raise. They have a broad concern about access to large amounts of data. So, the fact that we are requiring more people to have access (inaudible). I they will be fine, but you are right.

Or, the data being used for criminal law enforcement use.

One of the things that Chiefs and Sheriffs tell me is that we'd like some sharing of information out to the PDMP with respect to suspected pill mills. Information that might help us deal with those issues. There is probably a way to do that if we think through it, but if we are talking about some change to PDMP, let's not forget that.

There is a lot that we need to do with the PDMP to make it more functional and more appropriate for what we are trying to use it for. This is our first step to it. As I started this meeting with there are 22 of 49 states that have a mandatory query provision for their PDMP. Which is significantly more than we are talking about here. That means the prescriber has to affirmatively query the system or else they are

subject to a wide swath of penalties which vary from state to state. That may be where this is going, but for the short session, we decided that this is a more achievable step that we can take in the interim. And really, it is step #1 – we have to have everyone registered first. We do need to shop this around to other interested parties once we get coalesced around what the language is going to be.

What are folks thinking of for the language here. Especially those of you that have worked on 3440 and were part of that work group. Would love to hear anything that we are missing in terms of penalties. What happens when you actually don't go in and register? Is there going to be a penalty? The way other states have done it runs the gambit. Some just say if you don't query the system or don't register, then that will be something that can implicate you in a civil suit for negligence and increases your liability. Some have action against licensure. Some do have criminal penalties. We have the option of remaining silent on the issue. What does the group think about what the penalty should be if we don't actually follow through with this legislation?

Paul Lewis – If the language or technical fix had to do with "The Boards shall . . . "provide all the information to the PDMP. And, "The PDMP shall . . . "register people and provide them with the opportunity to set a username and password, then I don't think there is a need for penalties. Not every practitioner that is licensed is getting username and password relevant. For example, me – I am a hospital doctor. That isn't part of my practice. Again, I don't think we want to burden or antagonize practicing physicians to do something that is not relevant to their practice. Once this step is in place, then when there is the integration with the electronic medical record, what you really want is that the PDMP . . . information is available each time someone makes a prescription. I think it's very (inaudible) that we are not at that point yet.

I think that is why we decided that it is not the time to say "mandatory query," because there is a lot more going on.

Yes, but someday.

Potentially for 2019, depending on how things go. However, what happens if you have somebody who does prescribe narcotic pain medication. Let's say for the sake of argument we do "The Board shall . . ." or "The PDMP shall . . . ." They get an email that says you have to register to get your username and password, and they ignore it all, they don't go through the system, and they prescribe someone pain pills, who then overdoses.

This is where the check in, once we've done this, is there still a problem? Lack of registration was much more severe in 2014 than it is in 2017. Can you throw some numbers at that Katrina?

Katrina – I think it is something like of the 20% of prescribers who are writing 80% of the prescriptions . . . and again, you understand that . . . ophthalmologists aren't writing many prescriptions for pain meds. I think the majority of those – 75-80% are registered in the PDMP, so they are enrolled. Back to this point, I am reading 3440, and the exact section that we are concerned about does say "The Board shall provide OHA with licensing information," and "the Authority shall use the licensing information to qualify the licensee." So again, we could say "qualify/register" the licensee, but it still gets to the point that this is a technical fix. Once a person is signed up, what do you do about getting that username and password? We have had much more of this targeted approach trying to get those providers who are writing

prescriptions to register for the PDMP and to use it. So, again, it is hard to figure out how to have this targeted approach when it is every provider including those who don't write prescriptions.

Why couldn't it just be for anyone that prescribes narcotic pain medication, you have to be registered for the PDMP?

That would be one additional clause that we would add to section 16 – the last clause. Right now, it says "The Board shall . . ." and "The Authority shall quality . . ." and then the final sentence would be "a provider or practitioner who prescribes controlled substances shall register for the Oregon PDMP." I heard what was said about not wanting to put the onus on the provider, but it seems like we have done already what we can at the level of the Board and the level of OHA, but still there has to be something. The provider does have to take a step. It can't be entirely seamless. They do have to take a positive step in getting that username and password.

Can we hear from OMA on that proposal? Adding that third piece, saying that the 4 Boards have to do this, and that OHA can't say "No, they have to do everything but the username and password." Could we put that final step on the opioid prescriber?

As I understand it, the OMA would still be opposed to that final step.

I think the piece that we are missing is, whether the department can send that email to the practitioners to say, here is your final step – go get your login and password. I don't think you need that final sentence if that can happen. If that happens then part of the language in that email could be you need to do this.

I disagree, because if you don't do it, then there needs to be something that says this is mandatory in statute, and it is very important.

Or, licensure is not completed until you have chosen your password.

Or that there is a Board action consequence, whether it is CME or some kind of consequence.

Katrina – having just renewed my medical license, I did get a follow up email from them saying thanks for renewing . . . maintain for your records in case . . . then that follow up email could say something . . . so again, that's the Board, but I don't know about the other boards besides the Medical Board. But in that it could say "And, to complete registration for PDMP, click this link and sign up." That might be relatively easy for the boards to do since they are already sending out those automatic emails to licensees. It is hard for me to envision how the PDMP would do that at the time, but it begs the question, 1. What if the prescriber doesn't prescribe medication – do they ignore it? What if someone who does still ignores that email? What is the follow-up?

Can't the legislation direct OHA, the Board, and OMA to sort this out so that there is seamless automatic registration as a part of your initial licensure or licensure renewal process?

I suppose it could. It sounds like that is what is going on now, Right?

No. We are not quite there with the stage where the doctors are getting an email saying "click here" to change your password.

That is not happening yet. So the qualifying information that the Board collects is supposed to then go to the PDMP. The provider would then have to go to the PDMP to log in, all of this information should already be populated in there for you, except for your log-in. What is not happening, and what we thought would happen, it that there would be that seamless part where that information would just go to the prescriber to say go get your username. Instead, they are still having to go to the PDMP, log-in, and cautiously think about doing that themselves instead of having someone prime them up to do it with an email. There is still something the provider has to do right now. I am not saying that providers shouldn't have a roll and do something. We are trying to make it so it would just happen and they would log in and be done. I think if we can figure out that there is an email that could happen from the PDMP. I think that is the piece that is missing.

We've gone from this place of just talking about registration and not mandatory query as 22 other states do. Those states put the onus on the prescriber. And, it sounded like at the last meeting, I didn't hear that OMA had objections to this, so that would be a surprise to me here.

Isn't that the goal? Mandatory registration for mandatory query?

Yes.

So why are we not talking about that? They go hand in hand. It's one thing. You register so you can query.

If this group wants to go there, I am happy to talk about it. The feeling from both the legislators who are unfortunately tied up today, was that is not something that is feasible in the short session.

That gets back to what we talked about at the last meeting. I think Tim or Rob said that part of this Task Force's mission is to be bold. Let's be bold. If we are going to mandate registration, we better mandate use. If I got mandated to register, and not mandated to use it, I might register but I wouldn't use it. We only do what we are told to do. That's human nature.

To clarify at least my boss's earlier comments on mandatory registration was concern that stakeholders would not support it and that would complicate its passage during a short session. It is not that it was a non-starter for identifiable legislators, at least in the house.

Would a mandatory query for non-cancer opioid prescription, (inaudible) of non-cancer pain opioid prescription be something that you guys could get behind?

I think at this point we are not at the place for mandatory query. Just because we are still in the process of getting everything integrated. We are so close to having that piece done that that's going to make this process so much easier for all prescribers. We've been working on getting the EDIE piece done in our ERs for a while now. So it feels like, as Susan keep on telling us, we're close. But that also means, not just for the ERs, but for our pre-managed and other vendors. If we can get to that place where it is there, in front of their faces, it is going to be very hard for them to ignore the PDMP data when it is right there on their screen. We are so close. I would like to see that happen before we force something on the physician on this one piece that they have been waiting for.

Judge Block - Obviously the goal is to have every prescriber, at some point, engage in the query process. My experience in court – I am amazed at some of the people who are not only addicted to opioids, but who have actually gotten to the point where they have committed crimes. This idea that somehow we can limit the query process who act a certain way or have certain histories is a really difficult position to maintain. If we are trying to get to that end state, and we are taking this first step of registration, the question is why wouldn't somebody register? It seems that one reason why a practitioner or prescriber wouldn't register is that they feel like they are unlikely, for whatever reason, to be prescribing opioids for their patients under certain circumstances that may be considered high risk or problematic. Make it a mandatory registration for practitioners who would reasonably anticipate engaging in the prescription of opioids in certain circumstances in the next licensure period or something like that. Those are the folks who we really want to make sure are registered. Because if you are not registered, you are far less likely, on a case by case basis or globally to be engaging in the query process. If we can get those folks who are the most likely to be prescribing to register, I think those people are more likely to take the next step to actually query. Maybe there is no way to define that category of person. Maybe the physicians in the room are saying . . . every physician, whatever their discipline . . . or every other potential prescriber is equally likely to be prescribing these type of medications. It seems like we are really trying to target prescribers who are in certain circumstances where they are more likely to be prescribing in these higher risk or more problematic circumstances.

Holly - For the sake of time, I think that some of what we are talking about here are the mechanics and not the legislation. As OHA, I look around the table of stakeholders and can see who we need to work with on the mechanics. This is not new. We don't have to recreate the wheel. As you said, 44 states are already doing some form of requirement on prescribers, so we can figure this out. I am not worried about that. If you are going to the drafting table today, as long as we keep it as a level to understand what that clear mandate is, I think we can work out the mechanics.

I was thinking of something along similar lines of, we work out the registration kinks, and that takes effect sooner. Maybe the enforcement for the actual query is a year down the road, but that can still be in there. I understand what Judge Block was saying about the clump of prescribers that are doing a lot of the volume. But there is also a long tail of primary care doctors, people out in rural areas, who are maybe not doing a large volume. But you can get fooled anytime. Any doctor can. You may not know what a patient may be hiding or what medications they are getting elsewhere unless you look. If you are taking on the liability of prescribing a dangerous medication, you already would review your patient's medical records, why not take that extra step.

So the question for OMA would be – could we do something with a sunrise in 2019 and mandatory query?

We'd like to first see when the integration is going to take place. Dr. Steiner-Hayward mentioned this too. If we could have the timing integrated with the integration piece and how that is going to function for all providers. We still don't know how the integration piece will work for a provider in rural Oregon who is not based in the hospital system. Or a dentist – as a reminder it is not just physicians that we are talking about and I don't know if we have everybody at this table too who are also prescribers. So, we need to figure that piece out.

I believe Steiner-Hayward was actually just saying that when you electronically prescribe a controlled substance there is usually a separate identification – a fingerprint or some other biometric thing, that

we can just use that mandate . . . you are already going to that extra step that you prescribe a controlled substance so that could roll into the mandate to be looking at the PDMP when you are doing that. That might be vendors at individual organizations (inaudible) EHR.

I thought that we had heard that they EDIE integration would be completed by the middle of the year in 2018?

With (inaudible – aperis?) you mean? With the query of out of state PDMPs?

That was my understanding. So a 2019 sunrise would be six months after that integration was done.

I was on a call with a salesperson from (inaudible – aperis?) who was talking to Keiser about doing this with their PDMP. He was showing us screen shots about what it would look like. It is querying every other state which is on their system – which I think is 42 other states.

What happens then? We'd have to address if you don't query the system once it sunrises, what penalty?

I think that is when we talk to the different boards about different board actions.

I think that is an appropriate thing for the boards to determine – not us. Do we have any one from the boards on the phone? (just dentistry). I would suggest taking to the Governor or legislators, the sense of this room, that there are a bunch of people here who think we ought to be looking more ambitiously than on registration, people ought to be told . . . the right people to make it automatic. That ought to be what the legislation says. With respect to mandatory query, there is a strong sense in the room that we ought to be figuring out a way to do that with reservations that, gosh, it really is going to get simpler. And figuring out a way to make the mandatory thing trigger after we eliminate some of these technical obstacles would be easier. What I am saying is, the gravity of this room is much more aggressive than what the legislators, I think, have said so far to us, but I think you (Jeff) should reflect that to them.

Katrina – We are going to have our Clinical Review Sub-Committee look at prescribing and who is prescribing outside the guidelines. That is going to be providing those providers with information. I think that is the first step. I'll have to ask the program, but we may be able . . . looking at the prescribers who are way outside the guidelines, and see whether or not they are actually checking the PDMP. One of the teaching moments I see is both, we have CDC/Oregon guideline for prescribing, and you are potentially prescribing outside these. And it is in both the CDC guidelines and Oregon that you have to check the PDMP so we should be able to at least start with that information piece for that Clinical Review Committee. There are steps that are potentially going to be in place even before we have this mandated review of the PDMP.

That is our hesitation to put something in legislation in 2018, is that there are things we have passed these last few sessions that aren't even up and running or working yet. Once those things work, we are going to see what we are already seeing. The work that has been done by the provider community and advocacy community, is that we are seeing less drugs prescribed. So, we are seeing that happen, and we haven't even hit all of these other benchmarks that we've passed in legislation, including the Review Committee, or the EDIE integration. I think that is why OMA holds their hands up, because we've been pushing for these things to happen. Once they happen I think you are going to see the results we want to see.

Just to say if we don't do it now, I think the prevailing feeling in the group is that, then we are waiting until the long session and then, even if it has and e-clause, we don't get to sunrise our mandatory query until the middle of the year 2019. All of the data shows that the 22 states who have mandated query, have seen a positive result. It has been a game changer for a lot of them. I understand Dwight's point, Jim's point, and others that we are in the middle of an opioid epidemic and they want to do something now.

The provider group is well aware of this epidemic. They see it every day too.

If you are worried about sun rising, you could sun rise it July 1 2019 instead of January 1, so if there is an issue, you have a legislative session that could take that . . . .

We already have the "shalls" for the boards and for OHA. OHA needs to deliver because there has been resistance there, but there is a "shall" there. Then maybe you say that those who prescribe opioids "shall" complete their registration, but don't put any enforcement in now. Get it out there – it's the law. As we do our education, it's the law, then when Katrina's review committee is looking at someone, and they aren't even registered, it says here you "shall" be registered, so you need to get in compliance with the law. My guess is you don't need to put penalties in there yet. Just put that this is what our stance is.

My only question would then be is there still liability for the prescriber?

Yes, there already is liability for the prescriber.

If they were proven to not have checked?

Sure.

In medical psychology, all of us in practice are thinking about how it will play if something goes sideways. Educationally, if there is a "shall" in there, like a formal penalty or enforcement, you wouldn't want to have a death on your record and not having registered (inaudible).

To that point, a lot of states do have mandatory registration for the PDMP. That is how they handle it. They say it is in the law that you have to do it and if you don't, when you are sued, sorry. You are in trouble at that point. There is pretty good evidence that that works.

Katrina – Data from earlier: Among the top 4000 prescribers, 75 are signed up. That means thousands are not signed up for the PDMP. And so one of the top prescribers . . . we can also again if the Clinical Review Committee . . . and the first step I think is to provide education . . . you know, you are one of the top prescribers and you haven't signed up . . . so again, I think we need to put some responsibility . . . but just saying there are a thousand people out there who should be signed up for the PDMP, and are not. At a minimum.

Discussion: Insurance Commissioner Report on Barriers to Accessing MAT

Dwight – I think we might want to broaden it a bit from MAT to a look at 3rd party payer, or reimbursement practice barriers, to access to addiction treatment. One important amendment . . . Paul and I met with Janet Meyer from HealthShare Oregon, and she reminded us that the Insurance

Commissioner doesn't regulate them. So it may make sense that the Insurance Commissioner be the organizer of the (inaudible - look?) but it ought to include the CCO world as well to take a hard look at what reimbursement structures we have that create barriers towards access to effective addiction treatment. The example is the fact that many of our reimbursement systems don't treat addiction as a chronic illness. Once you are diagnosed with diabetes, you don't have to get re-diagnosed for diabetes when your insulin levels go off and you need adjustment to your treatment . . . you have diabetes. Whereas, if you are in recovery from alcohol addiction, or opioid addiction or anything else, once you've been through recovery, if you relapse or are having challenges down the road, you have to be re-diagnosed. It creates hurdles. I cite that only as an example of what I suspect are a fairly complex web of reimbursement structures that are based on old data where we didn't understand that addiction is a chronic condition, and other things that create barriers to treatment.

I quite like this idea. Particularly, because we can then use that to drive what we want to do in 2019. My corollary question to this idea is, I am assuming we are going to have the Insurance Commissioner produce a report. When would that report be produced? We want to make sure we have enough time, such that we can use that appropriately to do anything that we are trying to do in 2019 to help with this (inaudible).

On behalf of Representative Williamson, I know that one of the major barriers that will be identified by the Commissioner is likely to be the lack of the ability to use MAT in the Department of Corrections. There are questions about whether we need them to report that back or whether the Governor can address that. Do we need to hear that from the commissioner, or can it be addressed through Governor action?

It may be able to be (inaudible) through executive action. Are we thinking like PERS UAL Task Force, where a report is then produced that is shared with the public . . .

That identifies the challenges and the fixes.

I am just saying that I don't know if the public is aware that you can't access medical treatment in the Department of Corrections and I think we need the report on other barriers. I am just saying that I don't know that that needs to wait on a report back.

I wondered if my colleague Brian had anything to say. We had talked before about contract negotiation with CCOs and how this report may weigh into that, and timing.

OHS regulates the CCOs so that piece you are talking about with DCBS, I wouldn't be able to speak to that. I think it is still relevant to find out what CCOs are doing in that regard. But also keep in mind that this would be an area we're discussing through what will be a public process, starting in January or soon thereafter for what the next 5 year contract will look like. If there are adequate provisions around this now, then that would be an opportunity to do that outside of legislation. RECAP: on the CCO piece, I think it's worth looking at, since the OHA does regulate those plans . . . there is an opportunity to put that stuff in contract, and we are going to be doing a pretty extended public process beginning next year for what those contracts will look like. Including, areas where we think there are improvements. There is an opportunity to also look at using that vehicle to put in some changes, at least on the CCO/Oregon Health Plan side that potentially wouldn't require a statute change.

Safina and I spoke about that. She is reaching out to all the CCOs to get that information. As I understand it, they are currently complying.

Safina – I am asking all of the CCOs to get a sense of coverage for MAT – Suboxone and Vivitrol, but also Naloxone, which is a little bit different, and get a sense of coverage. We also had a discussion yesterday about Vivitrol in general from a medical perspective. So, if and when it ever comes back up for 2019 regarding coverage for Vivitrol through the legislature, we have good experts and opinion and consensus regarding that as well. That is what we are going to put together. The only other thing regarding Dwight's idea – I think assessment we were just talking about – I think it should include not only reimbursement regarding barriers to MAT and looking at it regarding that, but I think it should also include barriers to access in general. I think especially in the behavioral health world there is a lot of requirements to opening a case, closing a case, having to do XYZ in terms of documentation that's a really big barrier to addiction services and also a barrier to integrating between behavioral health and primary care. That is just as much a barrier as coverage for medication.

So we are asking the Insurance Commissioner to do this? Do we need language in there that says something like: "The Commissioner shall consult with OHA (or others) . . . ?"

Yes, there other players. The treatment community, recovery community, who can tell you more about what the barriers are. That crowd and their families spent a lot of time trying to figure out how to navigate them.

That begs the question, is it still appropriate for the Insurance Commissioner to be in charge of this? I think yes because that is ultimately (inaudible).

Or is it joint? There is one assumption out there that for the opioid use disorder problem that (inaudible – Medicaid?) is the major player. This idea that the Insurance Commissioner is over the private plans – you really want it to be the CCOs and the Insurance Commissioner.

It would be easy to put in either lap as the lead, but in coordination with the other agency. So, DCBS in coordination with OHA. We do this stuff all the time, given that split in oversight.

I'd say give it to the Insurance Commissioner in coordination with OHA. Because with OHA, we have put a lot on their plate. And because I think the Insurance Commissioner has some other levers to pull that would be helpful.

I've heard some good language on what should be in here. Before we move on, does anyone have additional input on language that I should bring to Legislative Counsel on this issue?

Just the timing – so it informs contracts.

Do you have an idea there?

The usefulness of identifying these barriers for CCO contract negotiation. Would this be something that if it was (inaudible) in the summer?

We are talking about having enough information that would potentially inform the 2019 session? The one thing to think about it that we have different timelines that we operate under so filings for

commercial market plans (inaudible) in the spring of next year. We will be looking for the next round of 5 year contracts beginning 2020, so will be developing that actual contract language in late 2018 or early 2019. Summer of next year, you could then have a comprehensive look that would affect both markets.

I think that is enough time.

Dwight – Suggests to Jeff that he speak to Judge Block, AKA Chair of the Alcohol and Drug Policy Commission, to see what role they might play in assisting in this.

Is it limited to MAT or is it addiction treatment beyond . . .

No, we broadened it.

Is it drugs other than opioids? Because again, there is a lot of poly, multi-substance use. I think we have to move against that. We have to constrain ourselves a little bit, but I think more broadly. Jim might now the right language . . .

Access to treatment . . .

Access to substance use disorder treatment.

I would like a few minutes at the end of the meeting to reopen the disposal question.

Will you please give us a primer on Naloxone 2.0 and what we are talking about there?

Discussion: "Naloxone 2.0" and the Rhode Island Model

Dwight - The concept here is that every week, something on the order of . . .

Paul – We have a new surveillance system, but in the Medford area there is minimum of 20-40 emergency department opioid overdose responses each week.

There are places like Rhode Island where they have started to figure out how to take these moments where people are recovered from death, literally, and connect them with treatment. In RI, if you are administered Naloxone, and when you get to the hospital, when the medical assistant inputs into the computer that you have been administered Naloxone, a prompt appears that says "ask the patient if they would like to see a recovery coach." Ninety percent of the people say yes. When they do, within 30 minutes a peer recovery coach is there, ready to walk the person to treatment. "Naloxone 2.0" is just a nickname, but the concept is turning our Naloxone efforts into a Naloxone treatment effort. In Mass. 10% of the people who are administered Naloxone are dead within a year. There is no reason to believe that that percentage is any different here. We've got to do better and make that an upstream prevention moment. The idea is identifying a handful of test/pilot sites. I'd suggest, in a perfect world we do 4 pilots so we can have a Metro, Southern Oregon, Valley and maybe either a Coast or Central Oregon pilot.

In Multnomah County for example, do we have the capacity? Say these are 20 unique people a week. Do we have the beds for an extra thousand or so a year.

And the same question for Southern Oregon as well.

I just don't want to place a mandate that . . .

It wouldn't necessarily be a bed. It goes back to number 2, which is about our system of substance use disorder treatment. A capacity, the access. These are entangled problems.

Absolutely, I just don't want to place a mandate that people will . . .

OHA is currently looking at creating a real-time database of available beds as part of their response to the (inaudible) from last year. What we have encouraged them to do . . . the (inaudible) operates the Alcohol and Drug line. We've suggested to just amend the contract to require us to keep that database, amend your contract with treatment providers to provide it to us on a daily basis, and we will keep a central database so we know where the beds are. I think the answer to your question is, that if we manage capacity, and know better what capacity is, we will be able to meet this need. If not, then we will know more about the problem.

Jim Shames- Just a reminder, we've got somebody with opioid use disorder, who has just woken up in severe withdrawal from Naloxone. They are desperate to get the heck out of there and find some drugs. I think if we can get medication assisted treatment, specifically Buprenorphine, into the ED, then you really have (inaudible). The second thing is, it isn't really a bed. It is a hub and spoke. I got you started, I'm now going to take you down the road tomorrow or the next day. I think it is really doable. I think it will free up some of the beds. It will probably get the clearly most effective treatment at that moment for the individual. And, if a bed is the issue, two weeks down the road you've got time to put those pieces together.

Just to put a sad anecdote to what Jim said – we had someone revived with Naloxone, taken to the emergency department. Brother came to pick him up, they went to the bathroom and he actually died in the hospital bathroom doing exactly what Jim said – you are now in total withdrawal and you are desperate to get out of withdrawal and actually have a second overdose in the same period in the hospital. I think what Jim is providing the pathway for is, treat withdrawal and start treatment.

What can we do statutorily to accomplish that?

We could organize the creation of pilots. More so than anything we've talked about, it's got a fiscal. So it is a question of what you all think you can do. There are willing EDs in at least 4 parts of Oregon if not more, to go and try to make this work.

(Inaudible) you've got the waiver (inaudible) treat the withdrawal (inaudible).

We could help you with language that specifies what the standards would look like for the pilot that would meet Jim's suggestion (inaudible) and Hartnett too. It would be incredibly innovative and smart. We are hosting at the Oregon Coalition for the Responsible Use of Meds that the people from Rhode Island are coming virtually to our next meeting to brief us on how they do it. Nov 29th, 9:30 at Lines for Life.

The only thing left on the table for that . . . obviously the money piece is huge. I've been talking internally about that. This is an opioid epidemic that we are in, and let's (inaudible) to get dollars.

We can ask Paul Collelo? at Salem Hospital. He has been thinking about this. He may have an idea about (inaudible).

The other question is that you threw out some pilot locations. We'd have to decide where we think it would be most meaningful.

Or, you could say that we are going to fund 4 pilots that need to meet these standards. OHA will figure out where they will go. Or not. I am not sure what is legislatively more appealing. The way you could craft it is by population size.

I am at a good place there to talk to LC. Anyone else on Naloxone 2.0?

Was there a component on the front end to get more people treated with Naloxone in the field to get them to the ED? Was there more on the front end with first responders to get more Naloxone in first responder's hands, to have more saved, to get more people to the ED so we can offer them those options.

I had heard that that problem was solved by past legislation. If not, (inaudible).

Fiscally, it is not solved. What we have currently is where progressive police departments like Woodburn, Salem, and Sheriffs around the state, including here in Marion County, are stocking Naloxone . . . But it has a shelf life, it needs replaced, and it gets used, it needs to be replaced, and there is no current mechanism to pay for it.

We can make that a component too.

For the purposes of branding and shopping within the building I would agree with James. Something along the lines of emergency department intervention . . . my members may not know "Naloxone 2.0." They would be like, "we did Naloxone."

What about overdose to treatment. We are talking about the incident is the overdose and the link is to treatment.

Yes, it is a link thing.

Yes, overdose to treatment . . .

We can come up with a better name.

Naloxone gets put under this overdose intervention umbrella, but I don't think that necessarily captures it.

What I like about Dwight's rhetoric around it is yes, we did the Naloxone for saving lives, now what else can we do. But for non-insiders . . .

That is something we can figure out a little bit down the line.

Katrina, I am going to put you on the spot again. Are you still there?

I am here. Were you asking about the language, the confidentiality language?

Yes, so this is quick technical fixes. Really, what I am getting at is, are these technical fixes. Is this something that we are going to get the ACLU up in arms about confidentially and things like that?

Katrina - There are two. The first relates to . . . and I don't know what the exact language is . . . and Paul Lewis has been talking about this as well . . . but this has to do with the information from the sub-committee. The way that that sub-committee is going to work, is that we are hoping they will review, but anonymously, providers, practices, etc. And then they would get a letter from us. The question comes, it is a possibility for the news media under freedom of information, to say we want the names of all of the people you sent letters to. We would really like to give this process an opportunity to work. And those practitioners can say fine, there's a guideline, we need to change, etc. We were proposing some language around any information gathered by sub-committee that identifies patient/practitioner health care facility is confidential and not subject to public disclosure. Or identity of practitioner who meets criteria is confidential and no subject to public disclosure. So again, the idea here is that we really want to give this an opportunity to work and to educate providers.

My question is, and Aaron, I don't know if you are still on the phone or not but I would love to hear your opinion here because you are great with this confidentiality stuff. Does this implicate yet another public records exemption? Is that what we are talking about here?

Aaron – go ahead Katrina, because my answer is going to be a punt to Shannon O'Fallon.

Shannon had proposed some language, but I thought she was going to talk to you and Jeff about it to nail down the language. The idea is that, when the sub-committee reviews, we review, we send out letters and we let that process work . . . as opposed to . . . and again, it's going to be . . . if all of this ends up on the front page of the paper and it is a provider that has and educable moment . . . we are hoping that they will change behavior, etc. is sort of the first step.

I don't have an issue with the policy necessarily, but I do see injecting a public records discussion and additional exemption into this legislative effort as problematic for obvious reasons. So, that is something I am worried about.

There must be some form of exemption around a medical board inquiry . . . when they are just looking at someone. It must be that you can't obtain the record of the fact that they did an investigation that was resolved.

There is a process that you do have to follow to submit the request. It is evaluated for appropriateness and if it fits, then you are provided with it. But that does not apply to law enforcement. That's just for the regulatory boards.

It should be similar. Because there is no pre determination. The triggering factor that makes a public record out of a BME or OMB, or whatever we call them these days, finding . . . is that actual finding? Prior to that, the fact that somebody called up and said that my doctor is a quack and did all these bad things, and it turns out not to be true, that is never a public record.

So then it's not an exemption?

It is probably written as an exemption.

It's not an acceptation, it's an exemption?

We ought to be able to squeeze into the same exemption where this is a pre-determination look.

What I am envisioning that is scaring me is, I am blanking on the chapter number, but there is that long list of exceptions to public records.

Whenever you open that, people get mad.

Yes, it is a hot potato. That I would not want to talk about. But if it is something elsewhere in the code that is not going to implicate that, or (inaudible) a discussion within the legislature about that.

I think the idea was, rather than getting into the section that Jeff is alluding to, that this just be a technical fix to the law that was passed last year, explicitly stating that those are quality improvement or confidential.

The idea was that this would go into the language of 3440 to basically say that the work of the sub-committee is not subject to public disclosure. So, it wouldn't be opening up the public records piece. Again the analogy that I had used is that we also collect all of the reports on death with dignity. There is very clear language in the death with dignity statute that says these are not a public record. So those are strictly confidential. Again, something like that that is in the statute . . . the work of the sub-committee instead of the public records statute.

We sell it as a technical fix to 3440 and to Anna's point earlier, this is something that the ACLU needs to be brought in on and make sure . . .

It is also protecting patient information. So it is not just the providers, it is all patient information.

The ACLU should be an ally here.

This was always the intent of this committee.

If they are an ally on this, it may be a way to bring them along (inaudible) these two.

One more question . . . and this one might be . . . again, I'm throwing this out there and I am sorry if it is sort of at the 11th hour but it just came to light. As you know, at the public health agency we have all of the death certificates. We actually work with the MEs office and can look at their data so we know about all of the drug overdose deaths in the state. I would like to be able to, when there is a drug overdose, and we look at PDMP data, to provide information to the board that, in fact, not only was there prescribing . . . again similar to the clinical sub-committee, but the patient died. Right now, the PDMP statute does not allow me to provide any PDMP data or a basis to the board for (inaudible) . . . and again, it's not that they would sanction that provider, it's that they would look more into why the patient had overdosed, etc.

Is all the patient data de-identified in that instance?

No it would not be. Because, again, it's to the board. The purpose of this would be, dear doctor so & so, you prescribed outside the guidelines, and you had a patient who died of an overdose death. Again, we are not talking about review of all PDMP. There is this clinical sub-committee, etc. I am talking about the instances where the patient has died. When the patient has died, the medical examiner can open their investigation and do all this work . . . the board could . . . we could give names of all of these deaths but they don't necessarily have the capacity to review all the PDMP records.

In the interest of time, I want to make sure Dwight has some time to talk about drug take back, so Marcus, real quick.

I just want to touch base. I think, perhaps regarding confidentiality, technology has maybe surpassed what happened back in the 2000, 12-13 years ago, a lot of people were opposed to this information as confidential. But, since that time, there is a company out there that captures all of the data going through an electronic prescriptions, and most of the insurance billings. They captured that data and they are selling it to the health systems for their information. So if you are an epic in one of the hospitals that is purchasing this, you can go and log-in and see all of the prescriptions they have got at all the retail pharmacies. It is already available in a clinical system. Some of the concerns that were raised 12-13 years ago, probably aren't valid anymore.

We don't have any future meeting scheduled. My plan is to meet with LC, get the draft back, and once we have the language, we will set a meeting where we can all sit down and review the draft language and make sure everybody is OK with it, give any input for additional drafting, and move from there. As long as that sounds good with the group, look out for an email from us scheduling that meeting.

I would suggest that the last agenda item for the next meeting to be talking about the plan for going forward to (inaudible).

Absolutely. That is a great suggestion Dwight. Thank you, and we will certainly discuss that at the next meeting. I know there is a lot the folks in this room want to accomplish. I know there is some frustration that we haven't pushed a little bit harder on some things – though we still may. We'll see. We will certainly add that to the agenda.

I did want to raise the suggestion that we put disposal back on our list for the short session. I am at a loss to understand why it is not on . . . and I can understand that there are political things that I don't get because I don't inhabit this space all that much . . . . The reality is that they were very close to getting it passed last session. And, it turns out that there is a much easier way to do this that removes some of the obstacles they had last session. For example, the system proposed last year would have required 5-6 FTE, that were largely going to be at DEQ, which raises concerns among some of our legislative friends. It was a very complex system based on the experiences of Snohomish, King and Alameda Counties down in California. It was well intentioned and based on evidence, but it turns out that there is a very easy market solution here. Two companies that I know of (inaudible) and Sharps will put these boxes in pharmacies. It costs about 2 thousand bucks a year. All the pharmacist has to do is take the cardboard liner out of the box, seal it with tape, and hand it to the UPS guy or gal, and the rest is done. There are 600 retail pharmacies in the state. Not all of them are walk-in, but just take that number as a starting point. If we were, in fact to require all of them, that is 1.2 million dollars a year. It is a tiny amount of money. You can envision a system . . . Marcus and Rob Bovette and I have been talking about this and they could turn it into a bill very easily I think, where you impose a fee on pharma to cover this cost. You

put it into a fund that DAS administers. The Freddies on Hawthorn, which is mine, contracts with one of the approved contractors – DAS approved or DAS and pharmacy together approved contractors . . . there will be two or three of them at a minimum. The Freddies then reaches out to one of the contractors on the approved list and says, I need my box. They install it, they send the bill to DAS, DAS pays the bill and we are done. Then, we have a private sector solution that requires very little . . . probably need half FTE or maybe a quarter FTE in DAS and a quarter in pharmacy to administer it, but probably not even that much. And, you've taken care of this problem and you've set the pace for the nation because no one else is doing it.

I would say that the setting the pace for the nation is one of the very reasons that there is more pushback than one might imagine in the building. Because it is a drop in the bucket in a state of this size. I will help Rep. Malstrom as much as possible but I don't know the political reality of getting it through.

I think that literally the only players that were opposed to it are pharma. I am unimpressed with their leadership on this issue so far, and don't really think we should take their call. The pharmacists are now on board. They were a little leery of it last year and they are not anymore.

We in the Governor's office haven't given up on the issue. In fact, I am meeting with pharma tomorrow with my legislative director to talk about this issue. Want to hear why there is opposition and drill down a little bit further on it to put some pressure on. That's not me saying that we are throwing it on the agenda for 2018, but saying that we are extremely interested in the idea. If you could write me an email that has . . .

Sure, I can write a quick summary of it.

I forwarded you an email, but starting last week, there are 7 pharmacies in the Portland area, Kaiser pharmacies available to the public. The kiosk, you can drop off, anyone can use those. They have mailers as well. They are free and you drop your medications in the mail. Right now they are saying those are only for members, but there is talk of even using community benefit dollars to make those available to the public as well.

I think one of the really important things to understand about the kiosks in the pharmacies . . . Rep Buehler . . . his proposal was to launch an education program. Because he is right. There are not that many people who know what they have to do. My response to him was, the single best educational tool is a kiosk sitting next to the pharmacist. So that she can say, when you get your drugs, the leftovers go in there next time you are here to pick up your kid's allergy medicine. Right? It will be breathtakingly cool if we do this.

I think also, the hospital in Bend has them too. So when you walk into St. Charles, there is a giant deposit.

And people use it. I think it is a real opportunity for us to do something very meaningful. Just as a reminder, ¾ of the people who have become dependent report starting out of a medicine cabinet. So, if we get those pills out, we are doing something important on the healthcare side and on the environmental side.

Local and federal law enforcement have been carrying this unfunded process for years.

They will be fierce allies in what could not be a more noble fight then to take on the pharma folks on this. I have huge respect for them. They make life saving drugs. They oppose this because they don't want to own this problem. They don't care a lick about the money. They will spend more lobbying against it than it will cost them to do. I swear that is true. It is all about whether or not own some responsibility and they don't want any responsibility for it, but guess what? When we go to Les Schwa to get new tires, we pay, and Les Schwab takes care of us and disposes of the tires. When we do Jiffy Lube, Jiffy Lube takes care of the oil. It is all about responsibility for the product you put in the market. We in Oregon have been leaders on this forever from the bottle bill on, and we ought to be leaders on it here.

I like the way that you have laid out a more simple path. That was one of the major problems with the past legislation.

As far as your talking points to pharma – I think one of the things that really stands out for me is that virtually every pharma company provides the reverse distributors, a process for a retail pharmacy that has an outdated drug on the shelf to return it and receive the majority of the credit for what they paid for it. They are giving credit if it doesn't get dispensed outside of the pharmacy. What's the difference between that and getting credit once it goes out to the patient that wants to get it off the street?

Why take responsibility for their drugs that don't get sold off the shelf, but not the ones that do get sold and are posing a threat to people. The ones that are sitting on the shelf are actually not posing a threat to anybody. That is just about their commercial relationship. The ones that are in our medicine cabinet are posing a threat.

Marcus, could you please email that information to me. The point is, Dwight and others have been very persuasive on this issue, so we are still trying to look into (inaudible) and recognizing what legislative hurdles there are and the realities (inaudible).

Lastly. Thank you all so much for what has been a difficult process. But we have come away with a great sweep of ideas here for 2018 to start moving the ball forward. Sincere thank you to everybody who has participated on this task force. It is a lot of work and it is a lot of your time. You are all very busy people, and I want you to know it hasn't gone unnoticed by myself or the Governor. Thank you again, especially those of you who have traveled so far away to be here for meetings. We will be in touch shortly after we get our drafts back from LC for our next meeting.