MINUTES
Opioid Epidemic Task Force Meeting
April 30, 2018

House Bill 4143 passed unanimously in both chambers. Jeff thanks group for their work.

Recap of 4143 – Three components:

1. Prescription Drug Monitoring Program (PDMP). Made registration mandatory for all licensed prescribers in the State of Oregon.

   Questions have been received regarding the definition of "prescriber" and who is encompassed by the definition. Dr. Kerfoot – Within the Keiser Permanente System, Certified Registered Nurse Anesthetist (CRNA), do not have their own DEA numbers – they practice under the supervision of an MD. Oregon is an opt-out state, so it isn't that way for every anesthesia provider. In anticipation of the messaging for all physicians within an organization about getting registered to be using the PDMP before the July 1 mandate, there is some concern among the anesthetists about whether they need to be registered. If so, how do they do that if they don't have their own DEA number?

   If there is no DEA number attached to a prescriber, in the rulemaking process do we envision them being exempt from the 4143 mandate?

   Dr. Hedberg will get clarification from staff. Wonders about the delegates and others. If it is a gap we should address it because the intent in not to have certain groups (i.e. anesthetists) opt out of the system.

   The other concern was inpatient clinician who are ordering opioids to be used in the hospital vs. outpatient prescribing. Will there be differentiation on this?

   Questions relate to legislative intent. It doesn't necessarily mean a statutory change. We could do more clarification in rule making.

   Understanding that the intent was everyone that will be prescribing will be registered.

   If they are practicing under the supervision of a licensed anesthesiologist, than don't see why the anesthesiologist couldn't delegate for the CNRA and let them use the PDMP that way. Possible solution for those who don't have a DEA number but are still prescribing.

   On the inpatient side, shouldn't have to look it up every single time. But at some point during the hospitalization, somebody should look it up. Think that needs to be clear in the rule. If they are going out with narcotics, we need to understand their history of use. Need to know if they have been misusing opiates, we should know about that while they are in the hospital. Should be part of gathering the complete medical history. It should be documented at least once during the hospital visit.

Legislative intent is to have everyone who is writing any prescription (whether or not they have a DEA number) register for the PDMP. We did not include mandatory look-up.

Dr. Kerfoot and Courtney – need proper input on this since we have been going back and forth. Need to talk about it.

2. Pilot Projects – overdose intervention, 19-21 biennium project. Two million dollars of general fund to four pilot counties – Multnomah, Marion, Jackson and Coos. Aim is to create a bridge between an overdose episode and getting someone into efficacious treatment as quickly as possible, potentially with the use of peer recovery mentors. Want each county to be able to tailor the pilot project to the specific needs that they have.

3. DCBS study done in conjunction with the Health Authority and the Department of Corrections. Looking at barriers to accessing treatment. We are looking at reimbursement systems and other associated barriers – geographic and so on. Rick Blackwell is leading and will have a report to the OETF July 1. For July meeting will have a report out and we will discuss actions we may want to take in 2019 based on recommendations from DCBS.

In early March, Governor Brown was on Capitol Hill testifying in front of Senate Health Committee. Can see the testimony online.

Governor Brown led a discussion with the Pacific Coast Collaborative (BC, Washington, Oregon and California). In the past, PCC has been aimed at energy concerns. This year they have taken up the opioid epidemic and we have a signed statement of cooperation.

Aaron Knott: Attorney General's Office has been working on putting together a trip to BC and tour the Canadian opiate treatment system. Preventative care, emergency response, transitional housing and social services model. Will bring back a robust report.

Presentation: Lane County here regarding barriers to Naloxone availability and ideas for 2019 session.

Good that all will be mandated to register for the PDMP, but need to know if they are actually using it.

Discrepancy among pharmacies regarding knowledge of Naloxone. Need to engage and educate pharmacy staff.

Dr. Shames: If the Governor could declare an emergency around this, it may free us up to do some things. Naloxone and Buprenorphine are critical but costly. Can we import the drug from elsewhere? Negotiate? Manufacture ourselves? CA has set a precedent.

Idea to provide a Naloxone kit in the hands of patients who have been admitted for overdose.

Pharmacy community is learning about this but will take a while for it to become standard practice. There are barriers in regards to varied insurance coverage – generic vs. brand name. Posters are good, but there are issues with limited space to post.

Question: Why can't there be a pamphlet that is distributed with each opioid prescription?

If we don't make posting/providing information mandatory, could run into problems with corporate decision makers, who could be out of state.

A lot of work to be done regarding Naloxone access.

Future meeting suggestions:

- Two hour meetings
- Once a month
- Time at meetings for brainstorming

Meeting closed.