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KATE BROWN  
Governor

## Opioid Epidemic Task Force Meeting #9

August 20, 2018

3:00pm – 5:00pm

Location: DCBS; Labor & Industries Building; 350 Winter Street NE, Room F, Salem, OR 97301

- 1) Welcome
- 2) Updates from the Governor's Office

Jeff Rhoades: Governor has tasked me with writing a whitepaper with regards to addictions and recovery. Has met with some of the members for ideas. Whitepaper will be released in about a month, and will lay out the Governor's vision for the addiction and recovery space moving forward to 2019 and beyond. When the paper comes out, it will mirror a lot of the efforts that we have going on here and a lot of the good work that Oregon Recovers has been doing. There has been a lot for us to build on. It will be posted on the Governor's website and will come out before the Governor's Recommended Budget. Important time to send out our vision statement for what we want to do in the addictions and recovery space. If anyone has anything they would like to be in the paper, or would like us to at least consider for it, contact Jeff.

As part of the Children's Cabinet, Jeff is part of the Healthy Families workgroup, which is chaired by Sen. Steiner-Hayward. They are doing a lot of work that crosses over into that realm. Want to make sure the group is cognizant of that ongoing effort.

Question/Comment: Making sure that we deal with the heavy impact of opioid use disorder/substance use disorders. The population that includes young families is really important. We know that such a significant percentage of the families that intersect with child welfare do so because of ongoing mental health or substance use issues. We want to be sure that we provide appropriate treatment. There's obviously a clear intersection so we need to be sure that we coordinate the work in these areas.

Jeff Rhoades: We have been talking about addiction as a chronic illness in so many different contexts these days and something that I would like to have a discussion about today. There has been a suggestion that we have the legislature put something forward that basically makes the statement that addiction should be treated as a chronic illness. Support for the treatment community is another big piece.

The Governor spoke last Wednesday at the Hazelton/Betty Ford event that Oregon Recovers put on. She laid out some of what we will talk about today. She also signed a

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proclamation that declared September as Addiction Recovery Month, which is a great show of support. This is one of the core things the Governor will be talking about when she is out speaking to Oregonians.

### 3) Review of Whiteboarding Ideas from Previous Meetings (attachment A)

Jeff Rhoades: As I have done the policy paper and speaking to the Governor and our team about where we think the priorities lie, I went through and picked out these issues in an effort to bring things back to the 30,000 foot level. Everything on this paper is a fantastic idea and we are going to have to jettison some of those ideas. In review of the items, what speaks to you? What do you want to make certain that we are going to address in 2019? Would like it if we could come away with three concrete things.

Question/Comment: Reiterate what Pat Allen said at our meeting this morning, which is, as we think about treatment and harm reduction, we need to be thinking a lot about the timeliness of availability. We know that one of the challenges facing people who want to get into recovery is that when they are ready to do it, there isn't a treatment space available for them. Part of our conversation around treatment has to be not only about the breadth and geographic dispersion of programs. How those programs are delivered and whether they are available to people when the people are ready to get treatment. The other thing I don't see explicitly on here is harm reduction. Naloxone is a harm reduction strategy. There are several other things on here that could be seen as harm reduction strategy. So looking at the 30,000 foot view, I would argue pretty strongly that harm reduction ought to be on there. Then there are sub-sets of that. We can all have different perspectives on what qualifies as the kinds of harm reduction strategies we'd like to use. As an umbrella, that is something we ought to consider instead of specifically talking about Naloxone which is a piece of that.

Question/Comment: Getting to a rule of 3-4 around specific policies would be challenging because there are so many great nuggets of varying size in the OHA/DCBS report. I do think that you could do a rule of 3 around conceptual pieces or chapters. Whether it's harm reduction, recovery and prescribing. For example, the lower payment support for addiction (inaudible) in rural communities. That could easily slide into a bigger context of 3 chapters

Question/Comment: I'd like to second that in that there is a number of things that are almost at the housekeeping level that I would encourage us to take advantage of the legislative session to fix. Other states have done real omnibus bills on this topic that run many, many pages. We only have a long session every two years. I would be disappointed if we limited ourselves.

Question/Comment: I am not wedded to that idea at all. That was a short session strategy that worked so well and helped us achieve unanimity. Again, that is a good point.

Question/Comment: OHA along with external input from stakeholders came up with the strategy related to opioids and it was adequate treatment of people for pain. Not wanting people to do drugs in the first place, both physical and social support. Then there was the harm reduction, treatment as well as Naloxone. The third bucket was too many pills. Then there were two underlying. One had to do with data, one had to do with education, outreach provider, etc. But if we think about those 3 buckets, addiction as a chronic illness is in that middle, support for treatment communities in the middle, safe disposal of medication is too many pills in the community, so is PDMP. I don't see anything up there that really talks

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about that kind of support for non-opioid. I see it at the bottom of your whiteboard list, #7 – other issues like supportive housing and those kinds of upstream things. I would offer that as a framework that we spent a fair amount of time putting together. I can share it with the group. Thinking right now, do we broaden that beyond opioids? That is not purpose of this group. Again that kind of frame – how do you keep people from needing these in the first place and/or wanting them. How do you rescue – that’s the harm reduction of people who either are overdosing and/or need the treatment then how do you decrease the prescribing?

Question/Comment: That gets to Paul’s point of using those overarching (projects?) then it won’t limit us on what we want to put in them.

Question/Comment: I think #3 is great for actually being able to talk about it. But just making sure that we are willing to put a lot of sub items.

Question/Comment: As we talk about harm reduction, I don’t think we ever actually have debriefed publically about our trip to Vancouver BC. I think that is really important and that means that what is not on here is safe consumption facilities or any of the other strategies that we saw on that trip. I’m very reluctant to take them off the table too early. Personally, I don’t want to take them off the table at all, but I am very reluctant to take them off the table before we even get here and those definitely fall under the harm reduction rubric.

Question/Comment: That was an amazing trip. I feel like we learned so much and we shouldn’t lose the momentum that we all felt coming away from it. I think we have something scheduled in September. The difficulty there is that we had some members on that trip who aren’t officially on the task force. Like the ACLU, we’d love to have them participate with us.

Question/Comment: Kevin, there was one other issue we wanted to cover regarding HERC.

Question/Comment: I don’t know about other people but I have been receiving emails from people who think that I’m on this committee that made this OHA decision that we are going to stop coverage of opioids after a year. I wasn’t familiar with that committee or the background and I was hoping to get some information so I can redirect or inform people about it.

Question/Comment: To Katrina’s point, too many pills is one of the buckets we will talk about. Let’s get started with that bucket and give us an update as to what is going on.

Question/Comment: No decisions have been made. There is no new policy in place. The Health Evidence Review Commission is a statutorily created body that makes decisions on coverage for Medicaid in our state. They have, like you all, been very active in thinking about the state (inaudible) for addressing the opioid epidemic. One of the things we did several years ago is place new guidelines around treatment of chronic back and neck pain guidelines that looked to reduce the use of opioids for those where there is clear evidence of they are not appropriate and effective, and expand coverage for other benefits such as physical therapy, massage, acupuncture, etc. They are meting out work that they identified that they need to better understand. Other chronic pain conditions outside of back and neck pain and that the evidence related to what guidelines and coverage they might have. Currently, they are looking at 5 different chronic conditions and considering a proposal by a task force around 3 main elements. One is to expand again, alternative therapies for

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management of pain for these chronic conditions like acupuncture, massage, physical therapy. Also, trying to limit new starts of acute opioid prescribing for chronic pain conditions. Thirdly, if someone is on a chronic opioid use, tapering off the chronic opioid use. This is a task force that brought further recommendations for the first time to a subcommittee of the HERC last week. It will be going back to the task force for a revisit. There has been a lot of public input on this. The HERC process is very intentionally a public process. They are going to be revisiting more of the evidence and get more expert input to the process. It will be revisited again later this year or early next year depending on how the timeline of the evidence collection happens. No decisions have been made. There are a set of recommendations that have been initiated. Further work is to be done. You are welcome to defer any of the input or concerns or questions to OHA/myself and the HERC. I am more than happy to answer questions if anyone has them.

Question/Comment: Will there be another public input process to this?

Question/Comment: Two key things – the HERC is the final decision maker on these types of policies for Medicaid. I would anticipate that that decision making won't be happening until sometime in Feb/March 2019. The earliest any implementation would be happening is Jan. 1, 2020. I anticipate there will be 3-5 more public meetings, all of which are opportunities for public testimony. We can keep updated to the task force as those meetings are happening and an opportunity to disseminate information about the public testimony opportunities.

Question/Comment: In the legislature, we deal a lot with people who get completely bent out of shape about bills that those of us in the legislature know are not going pass. I'm not saying this policy won't move forward in some form or another, but I think what we are seeing is analogous to this. People hear some version and it gets passed fourth hand and exaggerated and it is a game of telephone we all played as children. I appreciate OHA keeping us informed and putting us in the right direction and we can point people in the right direction and say, the sky is not falling. Nothing is getting done precipitously, and we aren't trying to make people on OHP live in pain. We are going to try to give them evidence based health care that is going to optimize their well-being. I think that is the message we need to be sending. Frankly, I think it is a way that OHP is once again planning on providing better care than a lot of people get on commercial insurance because its evidence based and open to a public review process.

Question/Comment: The Acute Prescribing Guidelines Task Force, I hope everyone is familiar. A couple of years ago we put together a task force looking at prescribing opioids for chronic pain. It was modeled after CDC. We added some Oregon specific considerations to that. We are doing a similar process and the idea is that we would have an umbrella of opioid prescribing guidelines. Chronic would be under. Acute would be one. We also have some guidelines related to pregnancy. There is dental guidelines, etc. So they could be chapters under this broader category. That is the framework for it. The Oregon Health Leadership Council and Paul Lewis had helped come up with the draft. Now we have had two meetings looking at these acute prescribing guidelines. Many of these guidelines are not thou shall do x, y, z, but these are the things that you need to assess the patient. You need to look at types of pain, severity, expected duration and what are the alternative therapies. It is very similar, but not quite like the HERC process. We had the second meeting last Friday. These are all public documents that are all on the web. I am in the process of finishing up that input and we will put that out on the web. I bring this up in

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part because going along, we have also heard comments when it comes to these that whether it is pain or treatment, the bulk of the population that you hear from are the people that are the outliers. You often hear about people that are in severe pain who don't necessarily think that the guideline pertains to them or they are very concerned about it. For our guideline, both the chronic ones as well as the acute, will be things like if your consideration outside this. Document, document patient behavior, reasons for it. Make sure that you have a consult. Again, regarding the HERC, it is not that every patient will fit exactly in this cookie cutter, it is thinking about how it pertains. I think that is a little bit around the messaging which is, we hear about the people that are at one extreme – very, very concerned about things. Back to what Sen. Steiner Hayward said, if we get 98% of the population to get fewer opioids and to get non-opioid therapy, we'd be a long way there, even if what we are hearing from 2, 3, 5% who are a little bit exceptional.

Question/Comment: To that point, it is my understanding that the lower back and neck guidelines did not have so much consternation after they were implemented.

Question/Comment: The focus was on non-opioid. Again, for acute prescribing guidelines, we are going to have a category "0," which is acute pain with expected short duration, here are all the things you should consider offering. Again, it is a little bit like the HERC. It is focusing on the non-opioid. And, if you are prescribing an opioid, consider these things. Less is more. Shorter duration, fewer pills, short acting, etc. I think we need to switch the way to appropriate patient care is not equated with opioids. In fact, it is just the opposite. It is for patient safety, for evidence based care, etc.

Question/Comment: In addition, we have all the data to show the uptake in these additional modalities to help treat pain.

Question/Comment: Are we still in the bucket of fewer pills?

Question/Comment: Yes

Question/Comment: I do have a number of PDMP things that I think fall in the bucket of fewer pills. There has been a marked increase in the number of people who enrolled in PDMP. The next step is we want to make sure people are using the PDMP. There is some information that would be extremely useful from a public health standpoint. For example, cash payment is one. I know the pharmacists had made a comment about, are they billing insurance company? There is something related to a diagnosis code. I know that is difficult. I am not saying these things are easy. These are big concepts, not concrete ideas and it may be very difficult when it gets to the concrete language that wouldn't obviously be at a pharmacy level. That would be at the prescriber level. The specialty of providers. We have that in the new PDMP. A lot of the ones that were migrated over so we don't know the providers. Whether they are hospice physician who are prescribing opioids. That would be useful for us. One of the things I think would also be useful that has been recently show, is that, we know the prescribing changed when physicians were reporting if one of their patients had died. We then look at the PDMP. That kind of us pushing out information or what has been called a "provider report card." We have the Clinical Review Subcommittee. We are only sending letters out to a fraction. A report card could come to everybody. It could say you are in the top 5% or you are on the bottom 5% or whatever when it comes to prescribing practice. That is not something that is currently allowed in the PDMP. There are those kind of changes to the PDMP that I think would allow it to be used more for public health practice.

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Question/Comment: One of the things that I am curious about, for example, with the cash payments that Katrina mentioned. There is a very specific purpose for the PDMP in Oregon which is for the treatment of patients, not as a tool that is supposed to be punitive in any way. Do any of these run afoul of that?

Question/Comment: We could be changing the PDMP. Not for punitive. The two purposes for individual patient care and to protect the health and safety of the population. So it could be the best practices, not the punitive part. In none of these did we say that we specifically want to report any outliers to the Board or any of that. The patient report card might indicate that outliers because they could be a Hospice doctor and of course I do this. That might be changing the preamble to say that the PDMP is useful for individual patient care and for the safety and health of Oregonians as well.

Question/Comment: All of those seem very reasonable to me. Especially if we doing individual report cards compared to your specialty. I think that is where it is relevant. If you are a Hospice person, you are being compared to other Hospice people. If you are a primary care (inaudible). It's not very useful information. Whereas if you are a physician practicing in a pain clinic setting, comparing with other people practicing (inaudible) who see themselves in that specialty. Comparing with your practice partners could be helpful as well. Do we have data on how helpful any of those strategies have been in other states? Or, which states have implemented those strategies?

Question/Comment: There was a recent study that was related to the notification of the fact of death. Your patient has died of an overdose (inaudible).

Question/Comment: I know that there are big data that show that reporting to physicians about how other providers, how their practice patterns compared to others can change behavior in other areas. I don't see any reason why it wouldn't be effective in this context as well. Do you have any sense of how you prioritize those strategies?

Question/Comment: I don't but we can look in to that. I don't know of direct studies that have to do with prescribing of opioids compared to some of these others. It was taking the general concept and getting it to the specific area of prescribing where you might be an outlier. I'd have to look to see if there is a concrete evaluation asking about that question.

Question/Comment: I have to go back and read the preamble, none of these suggestions seem incongruent, especially if they are used around provider education. Overall that is going to be helping the patients and that is the point. I don't see any of this incongruent.

Question/Comment: I think it would be difficult to change the preamble, in terms that there will be a lot of folks that are nervous about wanting to do that. Is there value in adding that public health component that Katrina mentioned? Or, is it better strategically that we just don't touch it, because as the Senator said, it seems like everything fits in that.

Question/Comment: (To Dr. Shames) Dr. Shames, do you have thoughts about these things.

Question/Comment: I actually did an unscientific study on this years ago. I reviewed the Medical Examiner data locally. They were reporting which physicians had pill bottles found at the scene. When I identified doctors that had more than one overdose death associated in that way, I paid them a visit and we sat down and talked about it. I didn't do it a lot, but it was a profound experience. At least a couple of the doctors made a significant change in

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their practice in part because of that conversation. It isn't scientific, but it makes a lot of sense to me that we have to close that loop and give that feedback to folks.

Question/Comment: It makes me wonder whether we have the opportunity to cross match vital statistic data, death certificate data, with PDMP? And, whether we could manage to make that work as an education tool. If we want to notify people about overdoses, then that is the way to do it is to cross reference. I might put that on the list of things we should consider. I don't know if that needs rule change or statutory change but we should consider that.

Question/Comment: We have our example, within six months we got an actionable report from DCBS. State of Mass. passed a bill where they required all relevant data systems in the state to be linked. You mentioned PDMP and vital records, but there is child welfare, justice, everything else. I believe that if that information would to be looked at in its totality, actionable policy solutions would come out of that.

Question/Comment: Because you asked for feedback on payment method – two things. I am not really sure of the value of knowing payment method and what that actually buys us from a public health perspective. The second piece of that is, the logistics of reporting that from a pharmacy perspective are extremely difficult and challenging. I don't think we will get what we want out of that. Reporting a drug is easy. Reporting a payment method is not. People don't pay the retail price that says "cash" in the computer anymore. Everyone uses some sort of discount program or discount card. It would be very difficult for us to report it.

Question/Comment: The reason I mentioned it, it is one of the "red flags" that the CDC said for people who are doctor shopping, if I want to go to multiple providers and get multiple prescriptions and get them filled at multiple pharmacies and pay cash, then there is no paper trail. It is seen as a red flag as a way to look at patients who might be doctor shopping.

Question/Comment: We have a trail because we have PDMP

Question/Comment: There is another task force about three doors down talking about the transparency of drug pricing. One of the things was talking about whether cash price would actually be cheaper for consumers. Try to remember that there is a lot of conversations going on.

Question/Comment: I would like to see a list of all the available options. I'd love to see some (inaudible). Even if we can't do everything that is on there, if we don't know it is an option, we are not going to consider it. Instead of putting safe consumption facilities on our list as an option, I don't want rule anything out until the task force has considered it.

Question/Comment: Trying thing about a rule 3, rule 4 framework, you could start grouping then start brainstorming out which pieces underneath at our next session. Or maybe you guys could do it in the interim. You could imagine treatment recovery, pills because the PDMP piece falls there and the disposal piece probably falls there too, harm reduction which we sometimes lump with treatment recovery but maybe we want to call it out, especially given the interest here. And then you can start to sort out both the recommendations from DCBH and Tim's remarks at the last meeting about certification. If you have those 4 heading you can start sorting out the different components that can go

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and then have the group decide which ones are worth biting off with the input from the legislators who know better than we do what makes sense.

Question/Comment: We've talked about mandatory use of the PDMP. We have mandatory registration and log-in. It sounds like from the reports that have come out that things are improving in terms of people being registered. Where are we as a group of being bold and mandating use of that system?

Question/Comment: Oregon remains an outlier by not having that in place. I don't know where folks are on this in thinking if we want to go down that road or not. I am sure there are different opinions in this room.

Question/Comment: I think it is an excellent opportunity and it is the right time. We made it through the mandatory registration part of it. Now it is time to follow-through. We are the outlier. Do we really want to be "that" state? I don't think we do.

Question/Comment: I don't think it is the norm around the country that they all require mandated use. I think it is actually less than half. We should be careful with our language

Question/Comment: If you go to PDMP assist, if you have internet you can check it out right now. It sure looks like from the national data that we are (inaudible).

Question/Comment: A lot of times they are lumping a lot of things into mandatory use. The other thing is, there is an important ongoing project that integrates our version of the PDMP with electronic health records. I don't think there is any practicing physician that thinks it is appropriate to have to log out of one system, log into another one that is not so swift, then log into another one. It is not a reasonable request for a practitioner. If and when that integration is actually functioning, then I think requiring use would be a reasonable request.

Question/Comment: As one professional to another, I am mandated by the State of Oregon and the federal government to use at least six different databases. My officers out on the street have to continually log in and out of different systems. There is no integration. If it's good enough for us, it is good enough for physicians because we are dealing with the public and customers and we are mandated to use those databases. I'm not very sympathetic if someone has to take a few minutes and log in and out of a database. I hear you, but I am not accepting that as a reasonable excuse to not mandate use.

Courtney Dresser, OMA/PDMP Integration and Steering Committee: We are working with a public/private partnership who are taking on a lot of the administrative roll of integration piece. Currently, we have a signed contract with the gateway vendor. About 21 regional ERs have their EDY integrated with the PDMP. What we are hearing from providers is that it is a game changer. It changes their whole workflow and allows them to have the information directly in front of them at the time of care and point of care in the room. The ERs that don't have it are grumpy and want it now. The other big piece of that is integrating with your regular systems and also integrating with all the pharmacies. We have a signed contract with one of the chain pharmacies. We are also working on Kaiser, Providence, OHSU, Legacy, OCHIN, Portland Clinic and Central Oregon IPA. All of those, hopefully within the next year will be integrated. Integration and Steering Committee has some pretty lofty goals. We are close to reaching our first goal already and are looking at getting 3000 providers up and running and integrated next year. There are no real

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resources for these other entities except for the time and IT piece that needs to happen. Once we get those resource taken care of its pretty much making the systems talk to each other, which we can do with the gateway now. Going back to the whole mandatory piece, we are now getting to a place where mandatory won't be necessary, it will be in their face. There is no way to miss the information. It is a one button portal. So, when the patient record pops up, you push the button and all the information is right there.

Question/Comment: I think you will find that the majority of states do have a mandate, but the mandate varies from state to state in what terms of what is being mandated. I suggested that we do some sort of sunrise which would dovetail with what Courtney was saying, when we get things up and running then people shall use it because it is in their face. There are other ways to narrow it too. Some states are focused heavily on the prescribing of opioids to manage chronic pain and mandate that.

Question/Comment: I am wondering how close we are to checking the PDMP before prescribing opioids being a standard of care anyway?

Question/Comment: In addition to the marked increase we have seen in registrations, we have also seen a marked increase in the number of people who are checking it. The Clinical Guidelines Review Committee, part of the letter we send out to the outliers . . . there is a few categories like co-prescribing, but we've seen the use go up. One of the things in the letters is we say they aren't registered for the PDMP or they don't check the PDMP. So, we are able to look at the queries into the PDMP and they have gone up. My feeling is that if we have a certain amount of capital and we want to use it where it is really going to be effective. Because we see queries going up, and because there are a number of issues around integration, I am not sure we are quite ready. I don't know that mandating look-up is going to have the same kind of step-wise increase that we're expecting. We are already going in the right direction. The things I mentioned about PDMP were more related to what I think is actually going to change and improve provider practice. We are hoping the act of registering will make people want to use it. Our chronic guidelines and the acute guidelines both, all say check the PDMP. It is one of the key elements as do the CDC guidelines. That gets to the point that it is standard practice and I don't know how impactful it to mandate that. I am not sure it will make any difference.

Question/Comment: That is an important calculus to make, is it worth marching up that hill with all the other things we also want to accomplish.

Question/Comment: Moving in the direction of many more people already checking it.

Question/Comment: Is there resource or policy that this group would want to take forward that would help move forward, how quickly the integration could happen. Maybe getting outside the mandatory and making it more readily accessible.

Question/Comment: I think some of those resources are, what do we do for our smaller clinics or smaller hospitals? The hospital association has provided some grant dollars for some of the smaller hospitals to get connected. There are still some hospitals who only take paper fax still for the PDMP. We are light years behind. There are still, independent practitioners out there who are going to need some help. They have been spending an lot of resources and money on EMRs and now we are asking them to do something else, it could get costly for them. It is not that they don't want to, it is that they may not have the

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resource to do it. So, what else can we provide to help them? There might be some opportunity for some grant dollars for these things too.

Question/Comment: It would be great for all of us to see a quick graphic on how many more prescribers are using the PDMP and where we are in the targets. Jim's urgency is one we have all shared. I've seen the numbers and they are impressive. We are moving in the right direction. I don't think that takes us away from the mandate, but I think it could be helpful.

Question/Comment: We can also send an update about what is happening integration wise.

## 4) Support for the Treatment Community

Tim Hartnett: Alcohol and drug treatment became part of health care about 15 minutes ago. We are sort of a third world health care entity. Now that we are in the thick of this epidemic, everyone wants first world remedies. They want evidence based practice. Evidence that specific programs work. What I am suggesting is that we put in law/rule, that anyone who is licensed in the state, be accredited. Because we are new to health care, one of the things that is substantially missing is infrastructure. In meeting like this, people want to talk about a specific type of intervention that they want to make available. I think that is good, productive and useful, but I am making a point about how those interventions will be housed. We have some doctors in the room who I am sure have been through joint commission or other accrediting reviews. As much as a pain as they are, I think we all know that they generally contribute to a growing operational integrity. They look at life safety facilities, clinical practices, credentialing kinds of things. Much of which, in the publically funded addictions treatment system, those kinds of reviews don't happen in the depth and substance that they need to on a go forward basis. I am particularly interested in promoting this now, given where OHA is starting to sort out where they want this alcohol and drug activity to be housed. The Governor's Commission on alcohol and drug abuse is now just gathering some momentum. The usual vehicles are anywhere from 18-24-36 months away from maturing and being able to bring a product forward that would make the system better. I think this is something near term that could be done that would really drive quality forward. It would also legitimize the industry in the eyes of health care. We would have to meet some of the same kind of benchmarks that hospitals and other health care entities have to.

Question/Comment: How would others in the treatment community, where it can be already difficult to run those types of operations, feel about the extra hurdles?

Tim Hartnett: Almost everyone, payer, regulator, provider, will find a reason to oppose this. Most of those reasons won't be all that strong, but they will all oppose them. Regulators will feel like they lose some of their regulatory responsibility. Payers won't want to pay because they will have to pay a little more to make a provider ready. I see no real simple path towards improvement without doing something like this.

Question/Comment: Are there models of accreditation that we could copy?

Tim Hartnett: There are two states to my knowledge – Connecticut and Alaska. If you open an MAT program, if you are providing Methadone maintenance treatment, you already have to be joint commission or (inaudible) accredited by virtue of federal law. It is not unprecedented in the field either.

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Question/Comment: I want to echo what Tim said. I am concerned that in the short term, what we don't want to do is have fewer beds in a short period of time by trying to improve the quality of those beds. We are at such a crisis level. We are last in the country in access to treatment. Figuring out some sort of grant program or something to go hand in glove with it so that some of the operational or capital investments that a DePaul or VOA or someone like that would have to make just to get there. LA County is a county of 10 million people. They have gone through transformational process over the past 5 years. They were particularly concerned about when raising the bar for the treatment providers, culturally specific treatment providers that had the smallest level of resources, was going to impact them. They anticipated that and had teams to go out and provide technical assistance and coaching and some grant money to bring them along with the rest of the folks. I would direct you towards LA County which has done a really impressive transformation process.

Question/Comment: Mechanically, what do we think this looks like? Who is coming up with the standards?

Tim Hartnett: The Joint Commission already has those standards. It is really just requiring providers to meet those standards and giving them a reasonable time to prepare for the site visits, etc. that are attached to it.

Question/Comment: Isn't there a register of payment parity?

Question/Comment: Yes there is. If we are done with this we can move to other topics within support for treatment community.

Question/Comment: I'd be interested on how much willingness or appetite there is from this group for the idea of accreditation. It is an unpleasant experience. You will run into people who will not want us to do this. But, I've been in this racket for a while, and I don't know of a single thing we can do that will change things as quickly as this will.

Question/Comment: I think all the physicians in the room can attest that (inaudible). I think we also can attest that the effort proves that we are committed to a discipline and that we are committed to upholding the highest standards. It commits to a certain standardization of the kinds of care that we provide. It also allows for (inaudible) our (inaudible) in a way that non-licensed, non-accredited professionals can't be, which is really important because the pay parity issue is real. One of the reasons it is real is because we don't have enough licensed/accredited providers who can be (inaudible). I am not a huge fan of setting up infrastructure for infrastructure sake or setting up hurdles for hurdles sake. This is not that. The more we can provide for a clear structure where everyone is held accountable in the same ways, the more likely we are to provide successful treatment to those who are seeking it and increase access to it. I think the vast majority of your peers, when they step back from it and recognize some of the barriers that they themselves have faced in providing the kinds of care and treatment support they want to be able to provide will recognize the rationale for it.

Question/Comment: From OHA's perspective, I have heard a lot of discussion early on, and I am anxious to hear about what the other states have done, examples and what the learning lessons are. If we can be of assistance in reaching out to these states, please let us know.

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Question/Comment: The quality reasons that Tim sites, the establishing the basis for pay parity reasons that Sen. Steiner Hayward mentioned, and a broader attack on stigma, all warrant this approach. The stigma reality is, put broadly, the accreditation would serve in the community at large. Undercut the addiction treatment and recovery stigma in the criminal justice system where you have judges who think that addiction treatment is Hokum. Even in the health care system where folks like Dr. (inaudible) at OHSU tell us this transformation she enjoys whenever she takes a patient from a doctor from another field up there and helps them with their addiction. The doctor all of a sudden says wait, this actually works? I think accreditation would go to great lengths in all of those pieces.

Question/Comment: For clarification, is this accreditation of the providers or the facilities?

Tim Hartnett: I think it would be the agencies. Because they accredit different levels of care. If you have outpatient and residential treatment detox, you would want to be accredited in all.

Question/Comment: The accreditation will bear on reimbursement from commercial payers. So, I think you need who is being accredited and what for.

Question/Comment: This is the appropriate time to segway into that discussion. The point that was just raised that we need to talk about parity in this context as well. As I've heard in this space, a lot of the ideas that is the one that seem to me is going to have a gigantic impact on the ability to . . . One of the things you had mentioned Tim is just keeping folks working in the field and how difficult that is. I'm curious to know if there is something we can do there meaningfully and something that is possible to accomplish.

Tim Hartnett: I think they dovetail nicely. You are going to pay more, but you are going to get something more.

Question/Comment: What are folk's thoughts on that issue?

Question/Comment: I think it has standards around evidence based practice. The more we can have a level playing field, I think it is really important. What is it you are measuring people against in accrediting? You tell people what the expectations are. It is a little bit outside of public health, but I would be supportive of the idea.

Question/Comment: Isn't there work going on with this now?

Question/Comment: We have actually selected a venue to carry out some of the work around SB 860. We've got a contract with a provider. We are starting the scope of work to begin the process of doing the exams with the carriers. SB 860 is specific to pay rates between physical health providers and mental health professionals. I don't know if it is going to scope far enough to look at MAT, but certainly you are looking at pay parity around outpatient office visits, utilization management procedures, reimbursement for time based procedure codes. Methodologies to figure out the reimbursement rate schedules. So the vendor that we are working with will help scope the work for the eventual report that the legislature in 2019. We have a bit of time yet before that work will be completed.

Question/Comment: One of the things I think was in your report was the continuing and expanding work of SB 860. Is that enough to meaningfully accomplish what we want to here or not?

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Question/Comment: What are the cost impacts associated with this that could negatively impact rural Oregon providers?

Question/Comment: I don't think you can proceed with accreditation without building in (inaudible). They go hand in hand. I don't think you have much of a choice but to do something like this. I'll just speak for the metro area, but we are on an unsustainable path. It is not going to work. The turnover rates from employees is just too high. You can't sustain, let alone build a high quality practice.

Question/Comment: I think we are also facing a reality of essentially, pirates coming into this field in a way that is really unhelpful. Because, there is tons of money being thrown at it. Where there is tons of money being thrown at a problem, people try and take advantage of it.

Question/Comment: Politically, I know there is something that we have to do. We have to be careful moving forward with something like that. You take this bi-partisan piece of legislation and you start getting negative things that could impact it in the bill. I am trying to avoid that from happening.

Question/Comment: I appreciate your concern about this. One of the ways to frame this is, Oregonians deserve to be confident that they are getting (inaudible) at accredited facilities from accredited programs. As legislators, it is our job to ensure that when an Oregonian seeks treatment for this chronic illness, that just as when they seek treatment for

Question/Comment: that they are seeking it from someone who is licensed and held accountable for standard of care. They should be getting the same quality of care when they are seeking treatment for this chronic illness, i.e. addiction. I think if we are careful about how we frame it, we are going to be able to manage that. Yes, we are going to get some blow-back, and we're going to get blow-back about pretty much everything from some group or another. Ultimately, I think this is going to (inaudible), so I think we are all just going to have to be pretty united about this. I am not in favor of excessive regulation. I didn't chime in on the conversation about mandatory PDMP use because everyone else said all of the things I was going to say. I appreciate Chief Ferraris concern about this, but I think given everything else, it includes some other ways to skin that cat. In this case, I am not sure we do. To frame it and talk about consumer protection and optimizing outcomes and reducing cost because we are not putting people through programs where they are not getting optimal care. Does that ring plausible to you Representative?

Question/Comment: It certainly does. I am concerned that if there is not some assistance, that rural Oregon in not going to be able to attract individuals to provide the necessary services.

Question/Comment: I think that is a very valid point. This also came up this morning in the Healthy Families group. We were talking about ways of expanding the provision of tele-health services. I think that is something else that we need to put on the list. It is going to come out of the health families workgroup as well so there will be some synergy there. Frankly, I think we need tele-health services in the entire state, not just the rural parts of our state. And, I think they can be particularly useful in the less populated areas in our state where it is harder for people to drive the distances they need to get to a provider. It is harder to have the population necessary to support a program or provider. I do think we need to be taking those issues in serious consideration and taking advantage of technology to offer opportunities there. Part of that is going to relate to reimbursement. Some of the

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statute we have on the books . . . during my tenure in legislature we have expanded access to telehealth services in a range of ways, including taking away the requirement that it can only be for services that are not available in a particular location. When we passed that legislation, it included some provisions that said it could be reimbursed at a lower rate. That is reasonable for certain kinds of services where part of reimbursement goes for overhead. For some of these things like group therapy, or more mental health and addiction treatment where there aren't physical overhead issues the way there are with a physical health provider. I don't think we should be making those distinctions, so we may need to update that statute about reimbursement to make sure the parity is there for tele-health services in this arena.

Question/Comment: Which bucket does this fit into?

Question/Comment: The middle bucket. The first two are patient focused. The first is making sure that patients have their pain treated and psycho-social report those (inaudible) in non-drug ways. The middle one is patient safety around both Naloxone and MAT. The third one is the too many pills. I will send a copy of the framework around to folks so everyone.

## 5) Addiction as a Chronic Illness

This is something I think we all agree on. The Governor has been talking about it quite a bit. It is something that we are talking about a lot but I would like to have some kind of action that we can take that we can point to to show that we are actually moving in the right direction. One of the thing that was suggested is just having the legislature say this is how we should be looking at addiction. I am curious if there are any other ideas that fit under this heading that produce something actionable? To be clear, I haven't been able to think of any myself other than the one that was already suggested. You could also make the case that a lot of what we are talking about is wrapped up into this.

Question/Comment: If you are going to do that, you could say something about stigma at the same time.

Question/Comment: Oregon Recovers talks about chronic illness in addition to requiring a lifetime of support. I actually think five years of recovery management is probably a more clinical way and reflects the science of, once you are in recovery five years, supposedly, statistically your chance of relapse is as much as someone who is not in addiction. I think helping define a chronic illness requiring a (inaudible) level of attention while we are trying to both education the medical community and the larger policy community about addiction as a chronic illness would be an enriching conversation.

Question/Comment: I think this is where the continuity of care for an illness, whether it is metabolic or respiratory. The in and out of the justice system is one of those key points there. If we can somehow get that vision of having uninterrupted care for substance use disorder before, during and after an encounter with the justice system.

Question/Comment: I think it fits in under support for the treatment community. But the point is that the Governor was very articulate on this at the Hazelton gathering, and Corrections is thinking about how they can do MAT. There are a couple of counties thinking about how they can do MAT and better treatment in jail. I think that ought to be something that fits under the second one.

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Question/Comment: The concrete thing is that there is this interruption of the Oregon Health Plan and in and out of the justice system. It seems that it is always somebody else's fault, but it seems that the vision should fix that so it isn't a bureaucratic reason.

Question/Comment: Some of that relates to federal law, and we are stuck. If someone is incarcerated they can't be on OHP. There are a few exceptions, but largely, that is the law. We have managed to fix it so that if someone is hospitalized outside of the Corrections system that they can be back on OHP.

Question/Comment: What do we do for our state so that the reason that someone's treatment is not continued is not because of some decision in Washington.

Question/Comment: That gets to the point of talking about promoting MAT in the criminal justice system and while people are in custody, regardless of who pays for it. In the analogy we heard in Vancouver, if a physician has a patient who is going through a divorce and moving, it is not the time to tell them to quit smoking. If you have someone who is dealing with substance use disorder, and they are incarcerated, having them go cold turkey at that particular time, even with the right medical support, is not exactly in their best interest. It is not going to set them up for long term sobriety and recovery. We need to help change that conversation. Talking about addiction as a chronic illness is a way to change that conversation. Just like we wouldn't say to somebody who has Diabetes, you are incarcerated so you are just going to have to stop. You don't really need your Diabetes medicine.

Question/Comment: One of the things we might want to pursue executively, is the possibility of a waiver that allows further Medicaid use for payment for incarcerated (inaudible). I was on a panel with the former medical director of (inaudible) and he said they are granting those waivers if Republican congressmen bring them or advocate for them. That might be something Craig can help us with. Andy (inaudible) says that these Republican congressmen from Kentucky are coming, and they got a waiver to have their Medicaid paying . . . (inaudible).

Question/Comment: We have a (inaudible) waiver underway but I think it is getting at a slightly different . . . we'll have to connect if it is (inaudible).

Question/Comment: Since we are talking about the Corrections piece and treatment. Once again, in rural Oregon we are having difficulty when it comes to treatment, especially when it comes to Methadone. When you have folks that are in the cycle of addiction, I go back to the Vivitrol conversation and tie it to the justice piece, as an option for folks coming out of incarceration and wanting to go into treatment. Especially for rural Oregon. My understanding is that opening up a possible dispensary for Methadone in Coos Bay. Again, it's Roseburg which is 2 ½ hours away from anyone who lives in Gold Beach and 3 hours away for anyone who lives in Brookings. And these folks don't have the most reliable transportation. Nor do we have public transit. Anyway, it is not feasible. Where are we at with the conversation of things that will add various treatment, such as the Vivitrol as a component in this legislation? Especially for those folks that are coming out of incarceration?

Question/Comment: How would we incentivize that? I know we have talked about POP 124 for DOC. As I understand it, that is for funding for treatment access and also EHRs. (To

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DOC staff in room) Do you know whether or not that would include expanding the menu of options available for MAT such as Vivitrol or anything like that?

DOC staff: It does. It includes expanding treatment beds as well. Residential level treatment facilities but yes, MAT is part of that.

Question/Comment: It sounds like from DOC that is currently included in the policy options package as we work through the budget. I don't know if there is something else we can do to be supportive in that arena. Katrina, you have been waiting forever, so I don't know if this gets to that?

Question/Comment: Not directly to DOC, it had to do with the chronic illness.

Question/Comment: I always get the jail and DOC stuff mixed up. I'm guessing that that is related to the state prison system and not the county jail system. I know that a lot of people do some or (inaudible) at the county level. I suspect that is what Sen. Brock Smith is talking about too.

Question/Comment: I understand that it could be part of the DOC model, but it's not being prescribed because of the cost associated with it. The providers, the CCO (inaudible) pay for it.

Question/Comment: We are doing CCO 2.0 right now. Does anybody have any ideas about this? It is injectable (inaudible) which is why it is not covered?

Question/Comment: The pricing of Vivitrol is a little misleading. It is very expensive, but nobody stays on it as a medicine unless they really want to. Because you can't get high on it. Unless you are unbelievably committed, you won't stay on it. You will take the first injection, and then you won't come back for the 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup>.

Question/Comment: This is a problem we run into a lot with medications. Sometimes a more expensive medication has benefits, especially for a certain sub-population that it is hard to articulate in a set of guidelines. I think about something as simple as a blood pressure medication, like an ACE inhibitor, the cheap ones are the ones you have to take 4 times a day. No one is going to take a drug 4 times a day. We lose compliance when people have to take medication twice a day. It is worth going for a fairly more expensive one so that people actually take their medication and use it. Those are part of the conversations we need to have, and whether there are ways to cover these medicines.

Question/Comment: At least in the metro area we have found some payers are willing to pay for Vivitrol because they have learned that they are not going to have these runaway costs. You have a good candidate for it and that is why we encourage that people understand that there are 3 medicines we can use: Methadone, Suboxone and Vivitrol. It is really a physician-based discussion. It is a decision that you make with your provider, not necessarily through statute.

Question/Comment: We need all the tools in the toolbox and readily available so that they can prescribe. These are for folks who want to change their lives and move forward. If there is 1 out of 6 or 2 out of 10, the cost overall is a bigger picture. Reducing recidivism is great and worth the option.

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Question/Comment: Regarding CCO 2.0, pharmaceuticals has been discussed in the realm of cost control as one of the major goals in addition to others in our health system transformation. We recently received a 3<sup>rd</sup> party analysis of opportunities for alignment around prioritized drug lists. While specifically, these cost of drug weren't called out, we are currently continuing to analyze that. Our Pharmacy and Therapeutics Committee, which is appointed by our director of OHA is the one who helps inform and provides recommendations for our prior authorization requirements around the fee for service population. Every other CCO has their own P&T committee that informs their (inaudible). That is currently how it stands but we are looking at other opportunities for alignment and that analysis that's underway, and has been incorporated into CCO 2.0 work.

Question/Comment: Regarding actionable things, I don't know how important or useful it is to have a declaration. I know that the legislature often does that "X" day. That would be one place to have addiction as a chronic illness. The real reason is because of how it plays out. We talked about continuity of care and Corrections was part of that. Our pilot project that came as part of 4143 that we are in the process of rolling out. That is the idea, that you get rescued with Naloxone and it isn't one and done. It isn't an acute save and then back on the street. It is that warm hand-off to treatment. I don't know what impact it has, potentially, on what gets paid for. It isn't that you get treated for an illness for a short period of time, like an antibiotic. Instead, it is more like Diabetes where you do need some ongoing management potentially. I assume there are a number of different concrete things that could play out, but I don't know exactly how that goes. A declaration would be in place to start, then we could talk about whether there are pieces with continuity of care around Corrections, and I heard about the POP, again as it pertains to treatment. Once the pilot projects actually get implemented and evaluated, whether that is something that could be scaled up. That idea of having a warm hand-off would be another place where it is a chronic disease, and not we treat you and you are done.

Question/Comment: I've thought a lot about the pilot projects. I feel like we would have to have something to show efficacy. Especially given the data we have seen out a lot of these counties that we did not include in the pilots.

Question/Comment: We could certainly pair up a number of concrete steps together with a preamble in a bill. Preambles are still going to be reviewed by a court if it ever comes up as legislative intent.

Question/Comment: I can't see a reason why we wouldn't include some kind of declaration. Whether or not it is ultimately as much as want this, I can't see the downside of doing it unless everybody disagrees with that.

Question/Comment: Again, the point of the declaration is how it plays out in these other places around the receipt of service because it is a chronic disease, or the payment for them or the continuity.

## 6) Safe Disposal of Medication

This is something that we have had a number of discussions about already so I think we have fleshed out a little bit about where it is supposed to go. Dwight, I know you had some comments you wanted to make on this issue.

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Dwight Holton: This is something that we have pretty broad support for doing something on in the room given the risks and opportunity. I think it would be helpful to hear from some of the disposal companies who do this to invite them to come see us? Bring a box and show how it works. I think it would help us in thinking about the mechanics of it. I would suggest, that because it is something I think we have a degree of common ground on, we could kick that one out while we work out some of the other details in the next couple of meetings. Maybe in a couple of meetings schedule the waste disposal folks to come and have a discussion.

Question/Comment: Is that something everyone else thinks would be useful? Dwight, do you think you can help me in tracking those folks down and making certain we get them on. Abby, do you want to weigh in.

Abby: I think it would be a good conversation starter.

## 7) Naloxone for First Responders and Other Support to Law Enforcement

This is something that we have talked a lot about to make certain that this is readily available to our first responders. When I say “other” law enforcement support, we have talked about training, in particular, surrounding Fentanyl which is incredibly dangerous to be handled on the street and whether or not there is something we can do around that.

Question/Comment: The challenge on first responder Naloxone is that no one is paying for it. It isn't a lot of money, but it needs to be ongoing. They are saving tons of lives. I would suggest that we link into it, some support for community based distribution of Naloxone that is happening at Outside-In and the HIV Alliance. Maybe there are some folks in Medford (inaudible) admission folks. I'd love to see pharma pay for it. I think that is appropriate.

Question/Comment: When we say it is not a lot of money, what does that mean?

Question/Comment: Chief Ferraris and I came up with a million dollars (inaudible) support with law enforcement and community based.

Question/Comment: Like everything else in the pharmaceutical industry, there is the price and the price and the price. The question is, there are special contracts that apply to special people. For something like this at the state level, I am not quite sure what the mechanism would be. It is possible to spend a lot of money and not get very much.

Question/Comment: I've been working with this a lot in our community with supplying Naloxone. The one thing we ought to keep in mind is that the manufacturer themselves provide the program for communities to get to buy Naloxone directly from the company at half the acquisition cost that a pharmacy could buy it for. So you really are not going to get any cheaper than that. Any type of modalities that you have to try to give communities access to this, I think needs to be monetary. They can then take that money and buy it at half price vs coming somewhere else and saying let's see if we can get a deal together with the state to buy it for 20% off, but we can already get it for half price if they go through the manufacturer.

Question/Comment: How does that compare with bulk purchasing?

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Question/Comment: Is that wholesale acquisition or is it the average?

Question/Comment: The actual acquisition cost of a box of 2 is \$150. That is what we (pharmacy) pay for it. They can get it from the manufacturer at \$75 for a box of 2. Special rate for law enforcement or community agency or cities.

Question/Comment: But then you have Baker City contacting me and saying they don't have the money for it.

Question/Comment: Right? They don't have the \$75. That is the issue we have in our community. It is still \$10,000 you need to spend.

Question/Comment: Point #1: In the aggregate statewide, a million dollars is not much money. Point #2: Baker City or if you talk to Rep. Noble, one of the reasons he is so involved in the HB 4005, pharmaceutical pricing, is because of the cost of Naloxone to the McMinnville police force. He recognizes the life-saving value and wants every officer on the force to have it easily accessible and can't do it because it isn't in the budget. So that is the first piece of this. Frankly, the idea that Naloxone shouldn't be available at \$75. Even \$75 is a lot for the person who just wants to carry it on the street. The next problem is when I walk into my local pharmacy and they say they don't stock it because not enough people ask for it. I paid \$150 to carry it. It is worth it to me to have it in my pocket. I am pretty busy and if I am actually in my pharmacy and asking for it, I want to be able to get it while I'm there. I understand that stocking a lot of stuff that people don't buy, but it becomes a vicious circle. If I go in and I ask for it and they don't have it, and I never make it back and the pharmacist understandably assumes I wasn't really serious about it so they are not going to make the effort to stock it or call me. If we are talking about public relations campaigns to promote and to take away the stigma and talk about addiction as a chronic illness, we also ought to be talking about public relations campaigns to make sure that people understand that they can get Naloxone. We figure out a way to make it affordable. I don't understand why anyone should be making a profit on Naloxone. It is a life-saving drug that people only use in emergencies.

Question/Comment: It says for "first responders." I actually think it is "increasing the availability of Naloxone." I don't want to lose the idea that Naloxone is something that you can potentially distribute through needle exchange or to people who are users themselves. That is a harm reduction strategy that I think is really important. Price is certainly one of the pieces, figuring out how to distribute the drugs is another one. Law enforcement is one piece of it but there are others as well that have to do with harm reduction. Again, for legislation, what are the pieces that we are trying to fix? Is it getting more money? One of the things that had been floated about this is, do we need to have a stockpile? Our opioid deaths are going in the wrong direction (inaudible) Fentanyl. It appears with Fentanyl that there can be clusters of "hot drugs." A few months ago there was a cluster of deaths in Jackson County. Turned out that they were "run-of-the-mill" heroine, not from Fentanyl. At the time, we needed our medical examiner. They are really backlogged. They don't have enough resources to do real time tox testing to help us figure out, was this a cluster of Fentanyl that had come into the community. I'm just thinking resources to actually track down, and if what we are seeing is more of these overdoses from Fentanyl, then it might be that you have . . . Law enforcement broadly, the local police, the (inaudible) high intensity drug trafficking, they've got something they call OD Map where they are looking at mapping where some of these clusters might occur. If what we are doing is rescuing people

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who have overdosed, I think that is the big picture. Then we need to figure out who needs this and at what cost?

Question/Comment: For the sake of argument, let's say it is one million dollars. Mechanically, do we set up a grant program that then allows people to apply to it to get that money provided they meet the certain requirements that allow them to take advantage of that half-off? What does that look like?

Question/Comment: It is probably both. It is police or first responders who need to carry it, and is there something around response to when you are suddenly seeing what appears to be a cluster of deaths. It is a little bit more like we would respond to an acute event as opposed to chronic heroin users or folks like that who overdose occasionally, but is more related to when their drug has been spiked with something like Fentanyl.

Question/Comment: Pricing is a complex issue to get down to what actually you price and how you actually analyze the cost because of the transparency issues about pricing. OHA is working hard and diving in more into opportunities around purchasing. Particularly bulk purchasing and leveraging tools that we have in particular in the face of public health crisis such as the opioid epidemic. It's not the short-term opportunity of a stockpile or immediate funds, but I think this is a strategy we are going to delve into much more deeply. The Oregon Prescription Drug Program and leveraging across state lines, purchasing is another area that I think is ample opportunity. I don't know if calling out public health crisis like this would be worthwhile within the drug transparency task force. It is something to think about if (inaudible) focus in an area. That could be an area of opportunity.

Question/Comment: (Inaudible) with health crisis. Because we are dealing with so many people not getting adequate treatment. I do think it is a legitimate way to frame this because it is a public health crisis.

Question/Comment: The umbrella over that is overdose response that includes the Naloxone. It also includes the investigation and analysis thereof. I don't think anyone would begrudge better funding for the State Police lab. The Oregonian had the lead article this week about drowning in urine. It is generic that is for traffic stops. Again, the same lab has to analyze all of this stuff, whether it is seized pills, post-mortem samples or urine. They are working 24-7 on this.

Question/Comment: I sit on the Public Safety Budget Committee – two things. One is we bumped their funding substantially this biennium. I know it is not enough, but we did. The second is that part of the challenge is technicians. Having technicians who are skilled. We have the same workforce issues in the State Police labs as we have in a lot of our healthcare workforce. We could give them all the money in the world, but if they can't hire the staff that they need it doesn't do us any good.

Question/Comment: The other thing is the outsourcing to private labs if necessary.

Question/Comment: The private labs can pay them slightly better but actually not a lot better because we pay our lab staff pretty well in the state because they are in such short supply. There are some real challenges, and money isn't going to solve all of it.

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## 8) Action on the DCBS Report

Question/Comment: My proposal is that we ask the OHA and DCBS team to come back to us with a proposal on how to meet out those things in the categories that Katrina articulates. With a recommended priority if they are prepared to do that. The recommendations were very well and very broadly received. It is a matter of looking to you for guidance on how we can best support implementation as the Task Force.

Question/Comment: I think we are already underway in this chart that we did. We had conversations about how are we going to come back to this Task Force with a timeline on what we are doing in the OHA list. Rick and I have had some chats about that DCBS list. I want to be sure I understand, on the steps that are in the middle here, those are recommendations that our agency has made for consideration for things under legislative budget. I think our agencies are prepared to talk about things underneath our bucket of work and what we are doing. But these two have to stay within the realm of this TF.

Question/Comment: Just take the two columns and decide how to prioritize which of the ones we want to do.

Question/Comment: I forgot about the matrix issue. We can report on the things that are on this side. We are listening carefully today and will come back. We were trying to come up with a more objective way as an agency to come back with all of these ideas and put it in ones that we have recommended out of our report. Come up with a way to say OHA prioritizes this because. We have to be thoughtful and deliberative in utilizing existing structures that we have to go through and sort that through a policy matrix. I will talk to Jeff more, but I think we have got to have the opportunity to bring that back once we've had the opportunity (inaudible).

Question/Comment: We don't have enough time to go through it comprehensively now. But, things like (inaudible) for example that Rick and I have talked about that does require legislative action. That is something that we couldn't do but may be able to make an impact.

## Opioid Epidemic Task Force Meeting #7 Whiteboard

- 1) **Addiction as a Chronic Illness:**
  - a. Shifting the paradigm;
  - b. Network adequacy and payment parity (clarify original legislative intent);
  - c. Raising public awareness.
- 2) **Treatment:**
  - a. Treatment capacity -> accredited treatment providers;
  - b. Foster care systems & intergenerational treatment (Children's Cabinet);
  - c. Jails & prisons must offer treatment (including MAT):
    - i. "menu of options;"
    - ii. "Pre-treatment" & tele-treatment.
  - d. Treatment connection center.
- 3) **Naloxone:**
  - a. Into the hands of 1<sup>st</sup> responders (funding mechanism?)
  - b. Strategic stockpile.
- 4) **Acute Prescribing Limits:**
  - a. Work ongoing with the HERC;
  - b. Exceptions to the rule?
  - c. Testing for chronic pain patients to prevent abuse;
  - d. Support for patients w/ chronic pain.
- 5) **Overdose Prevention Strategies:**
  - a. Fentanyl contamination;
  - b. Training (oxygen therapy, etc.)
- 6) **Prescription Drug Monitoring Program "Deep Dive:"**
  - a. Oregon as an outlier;
  - b. Privacy protection updates;
  - c. Public Health Lens, no "report card."
- 7) **Workforce:**
  - a. Building "world class" medical service;
  - b. Decreasing turnover rates;
  - c. Stigma reduction;
  - d. Metrics for success?
- 8) **Other issues:**
  - a. Supportive housing & addressing other social determinants;
  - b. NDs & prescribing rights;
  - c. Supporting the work of the Governor's Children's Cabinet.

## Opioid Epidemic Task Force Meeting # 8 Whiteboard

| DCBS  | LEGISLATIVE   | BUDGET   | OHA  |
|---|---|--|--|
| Ongoing care w/out need for acute symptoms (chronic disease paradigm) | Recognition of SUD as a chronic condition                                 | Incentivizing providers  | PCPCH standards advisory committee                         |
| Study the state of large group market in SUD                          | Continue & expand scope of SB 860   | Project ECHO   | BHH development & implementation                           |
| Network adequacy RAC (HB 2468)  | Tele-health fixes   | Behavioral Health workforce  | Work toward MH parity compliance                           |
| Pull together insurance carriers to ensure uniformity                 | Incentivizing providers to offer appropriate services                     | Treatment connection center -> app?                                    | Pay equity concerns  |
| Increase outreach to veterans out of network                          | Drug pricing (HB 4005)  | DOC funding for treatment access & electronic health records (POP 124) | Workforce (HB 4261)  |
|   | DCBS ability to regulate mid-year tiering                                 |  | Drug pricing (HB 4005)                                     |
|   | Prior authorization for public payers                                     |  | Preferred drug list  |
|   | Accreditation (Standards of Care)   |  | Work w/ HERC on prioritized list of services               |
|   | Support efforts w/ plea deal reform                                       |  | Leverage existing infrastructure for rural treatment needs |
|   | Require that rural health centers offer MAT through DATA waived providers |  | Working with Tribes & other persons of color               |
|   | County jail incentives for treatment                                      |  |  |