

Opioid Epidemic Task Force Meeting

September 19, 2017

3:00-4:00 p.m.

Attendees:

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

Not Present:

- Aaron Knott
- Judge Eric Bloch, Multnomah County Circuit Court

Staff: Katherine Bartlett

Issues to tackle - GKB:

1. Legislation for drug take-back was introduced in the 2017 session did not move forward. Hoping that this is something the OETF can take on. Representative Malstrom is working on this effort, anticipating she has legislation. Hoping with House majority work we can coordinate those efforts. Expectation is that legislation be introduced and moved forward through the 2018 Leg session.
2. Tackling the amount of pills in circulation. HB 3440 moves us in that direction but there is more work that needs done, but hopeful that this group can bring solutions to the table. If not in 2018, at least for the 2019 legislative session.

Discussion

- The timeline for the TF is short to get something accomplished by the 2018 session. Will need to come together quickly to decide which direction we will be taking the TF.
- Each member of the TF was selected because they have the ability to bring together a group of stakeholders and stakeholder groups. Want to allow time for other groups and sub groups to meet as appropriate.
- Suggestion to front load the meetings and get some ideas for the group to decide what to push in this session and what to develop over time.
- Wants time for smaller work groups to dig into things. Recognizing that there are some existing ideas that we can work through now, with the idea that the sub groups would work over longer term policy conversations
- 4 key objective areas that the Governor mentioned: Better pain management, less pills, better access to treatment, data and education. We could come up with ideas within each of these areas in the “white board” process.
- Group agrees to start a “white board” process and divide up what we can do now, and what is going to be longer term.
- Will also be circulating materials and other information via email during the interim between meetings. Group agrees. 2 meetings in October, 1 in November, meeting in Salem, phone and potentially video participation.
- If our immediate goal is to produce legislation in 2018 as the Governor said, is this idea feasible for the short timeline, or is this a better discussion to have in the long term for 2019 - after we have the opportunity to convene sub-groups?
 - Which things are already “in the can?”
 - What changes are going to be meaningful?
- Drug take-back could be something that we tackle in the short term - 2018.
- How do we get the people that prescribe the drugs to prescribe fewer of them? In the big picture it comes down to the boards and regulators for the prescribers.
- How can we empower the nursing and medical boards and get something into their hands so we can take some control back. Some states have legislated what the professionals have not done.

- HB 3440 has provisions to set up an advisory group for the prescription monitoring program that would work actively to identify outliers. Work with them directly in an educational way first, but with the capacity and permission already in statute to report them to their boards. What do we know about the implementation of the initiation and activities of that oversight group and how do we empower them to move quickly? We know that there is a tiny fraction of prescribers who prescribe a substantial percentage of the total doses. We could accomplish a lot if we started with getting this group going. Once done, we can then figure out if we need additional statutory change.
- The other piece is the PDMP revamp (Susan Otter's group), that is being done to make it more user friendly. There has been a gateway established that will allow a bridge to integrate into electronic health records systems. They are setting up a structure to fund that. PDMP should be integrated into electronic health records, the same as current immunization alerts. Needs supported and paid for.
- Do we require providers to access the PDMP prior to prescribing controlled substances?
- Only 75% of subscribers have PDMP accounts. Only a percentage of those have taken advantage of delegation. Have this information resource and people aren't using the way they should.
- Half our problem and probably more is non-medical drugs which are easily available and potent. Need adequate support for the recovery system. It does not have parity with mental health disorders, and mental health disorders don't have parity with physical health disorders. TF should have both a long and short term vision in order to address.
- For 2018 – looking at access to treatment, access to medication assisted treatment, per member per month spend by CCOs – are they spending what they are allocated for D&A treatment?
- Broad based Naloxone distribution is an inexpensive and effective way to save lives. Need to go from Naloxone 1.0 to 2. – connect people who have been administered Naloxone to recovery.
- Mandated usage of the PDMP when prescribing a narcotic pain medication. Is this something that can be achieved in 2018, or is it a 2019 issue?
- Group agrees that it should be 2018.
- Some of the work they have done in the Columbia Pacific CCO with data – would be useful for this group to see some of the data dashboard work they have done.
- Insurance folks would be an interesting group to bring into this conversation. 3440 had the piece about not allowing the requirement of prior authorization for drugs used for treatment, but there is a role for insurance companies to also provide data and dashboards.

- Could there be metrics for insurers, same as the CCOs of how much opiates adjusted for the appropriate risk. We hold the CCOs to this high standard, but 75% are not in the CCOs. There has been a lot of work done on what the good metrics are, could we make it that we have to have this available?
- Timing is good because in 2015 we passed SB 440 established a state-wide, all-payer TF to unify metrics among commercial and public payers for exactly that reason. Difficult for physicians to be responsive to multiple set of metrics and they aren't necessarily patient centered, which I think this one would be.
- Who else needs to be included?
- Our law enforcement and justice colleagues have a huge footprint here regarding drugs coming in, pre-trial and court, community corrections. Justice and corrections health would be a strong place to get something done.
- Justice and law enforcement are willing partners. Figuring out how we can hear from them and how we can be supportive for initiatives like providing medicated assisted treatment in jail.
- Need database that would indicate where and how many treatment beds there are available upon release from jail, they could take them directly to treatment.
- Does 3440 have a piece where OHA is putting together a database of treatment availability throughout the state geographically?
- Also need to make sure we aren't taking people to treatment that isn't effective. Public safety sub-committee charged CJC with evaluating outcomes on people who are involved in the criminal justice system and are going through treatment. Want to ensure that evidence based practices are being used to ensure they are having the highest rate of success. Need to dovetail those pieces.
- What does quality treatment look like? How is the treatment industry in this state supported? What does its workforce look like? Where is the future of treatment going? Worried when we are talking about getting access to beds, when our goal is opiates. For those who may be new to this knowledge, opiate treatment is different than alcohol treatment. Treatment is a primitive and young industry that has been hit with this epidemic.
- What can the state do to facilitate the rapid maturation of the industry? Can we play a role in helping to expand the programs that are working well? Can we be a resource for programs that want to enhance the quality of service that they are providing? Is that something that the state can or should be doing?

- Range of things: Looking at how CCOs are spending money that is allocated to be spent on alcohol and drug abuse. Rule writing - i.e. residential providers of treatment either have access or provide medicated assisted treatment.
- We need to keep it in front of us. Having been part of multiple groups like this, we do migrate to the PDMP. It's a good subject, and control point, it can serve the community wonderfully. However, we haven't been hit with Fentanyl like other areas of the country but we are going to be, and it is going to be an even larger jolt.
- What percentage of people who are currently misusing street drugs: i.e. Fentanyl that they didn't get from a doctor, or heroin, oxy that they obtained in an inappropriate way. What percentage of those got to place where they needed those drugs because they were started with a prescription from a licensed provider because they were appropriate? We have to address both now, but how much will we impact the street problem if we really work hard at preventing the addiction up front.
- There are at least 3 concurrent epidemics going on: Misuse of legally prescribed pills and illegally obtained pills. We have abundant and cheap black tar heroin that is cheaper than pills that you buy through networks and cartels. Online you can order these pure powders that are actually more poison than drugs.
- Fentanyl is in British Columbia and Seattle. It is very close. OHA and law enforcement have been looking at ways to create an early warning system for when Fentanyl arrives in force.
- We know about communicable diseases i.e. whooping cough & measles because they are reportable diseases. One idea is overdose or detection of poisonous drugs in the system – can this be a “reportable disease” that is counted and investigated.
- The silos in medicine can be a problem – 91% of those hospitalized for an overdose end up back on opioids within the year. 7% overdose again. 70% of the time it is the same provider. In our community, when someone overdoses, they don't get a warm hand-off to treatment. These are the folks who we should be aggressively trying to get into treatment and get them protected.
- Is there a way to use the Emergency Department Information Exchange (EDIE)?
- If people are doing “pre-manage” which is the outpatient version of EDIE, then they would be able to see it, if the emergency department documents the “what.”
- Not just pre-manage – automatically kicking out a report that gets sent to this list of people, that you don't have to count because . . . in the outpatient setting we aren't using pre-manage on routine visits, and we don't use it as a way to pull down recent emergency department visits or anything like that. So, can we use it as way to automatically kick out information in close to real time?

- Are there any privacy issues with that?
- Physicians get notified now if one of our patients gets admitted to the hospital. If an OHSU patient gets admitted to another hospital, we still get notified. There is no difference in saying your patient ended up in the emergency department with an overdose. That is needed to know.
- HB 3090 had some of the language that would be required in an emergency department and certain interventions around behavioral health to which some of this could potentially be defined.
- That does lead to the bigger idea of, if there are different levels of treatment - residential, intensive out-patient, office based and then detox, that there are broken links. Not sure if there is a legislative fix. It is sad that you could have treatment but it isn't at the right level or if next steps are left out.
- Traditional treatment is predicated on "remove, repair and return." What we know now in substance abuse treatment is that we need to have layers of care like in a hospital. Each of those levels of care knows what the functional/behavioral criteria are for someone to move through the system.
- Telemedicine is something that came up earlier.
- The shortage of people – primary care providers out in the rural parts of the state, who can do the medication assisted treatment for the right patient in an office model. We don't have enough people who can even or are comfortable prescribing those medications, and they make a huge difference. It is a medical condition as well as a behavioral one.
- The OPAL-K model that is being used to co-manage pediatric behavioral health issues, not only in rural counties but in Multnomah Co. You can see an analogous model for treatment that would be to everyone's benefit.
- Is there a model for the state to provide some type of support for that piece of it? Some of it may be that they actively need to be treated by the tele-remote person, but some of it might be that a physician enrolled practice wants mentoring for a couple of months.
- A similar version – the hub and spoke model is taking place in Multnomah Co. It could easily be bent to have telemedicine be a part of it.
- Telemedicine and support for pain docs trying to address pain in healthier ways, as well as treatment is a part of it. Project ECHO is the OHSU telemedicine.
- That will fill a very important support need, but it is not going to fill a gap in treatment. Primary care and behavioral health physicians are hesitant to enter in to the world so ECHO and OPAL-K is necessary but it is not sufficient in filling a huge gap in rural areas.

- There is a lot of community perceptions that you have to deal with when you are doing this work on the ground.
- Role for OMA, OHA, etc. to educate the public about substance misuse as a disease just as diabetes. Both for the public to see treatment, and for providers to provide that treatment. Then, if you really care about providing primary care, you should be treating their chronic illnesses. Substance abuse is a chronic illness. As with the communicable disease paradigm, we should be talking about publicizing that this is a chronic disease paradigm. These days, with the exception to HIV, communicable diseases are not chronic diseases. How do we have these conversations publicly? If you are putting out educational signs in downtown Portland warning of Fentanyl, maybe we need to be thinking about what OHA and the county public health systems need to be doing.

Action Items:

Start up an email chain exchanging information - some ideas for the short session.

Tim – Will send some of the treatment materials he referenced to be distributed

Holly – Has a long list of to do items for OHA

Meeting closes @ 4:02