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KATE BROWN
Governor

Opioid Epidemic Task Force Meeting #10

August 20, 2018

10:00pm – 12:00pm

Location: League of Oregon Cities; 1201 Court St. NE, Room 113, Salem, OR 97301

- 1) Alcohol & Drug Policy Commission Statewide Framework – Dr. Richardson
- 2) Question/Comment: How does this dovetail with the work within the health care system? I get the treatment part for substance abuse disorder. What we are finding around prescription drug is people may be dependent or tolerant, but not necessarily have a diagnosis of substance use disorder. How does this fit with the prescription part of it and the work within health systems?

Dr. Richardson: We have partnered with health systems. The OHA provides our administrative end budget. We spend a lot of time with our partners at health systems, including public health. The work on prevention that they are doing, we've had lots of conversations about that and some has been reflected in our framework and we will continue to have discussions about how we make sure that we are working together. Specifically, we are still trying to figure out how we are going to make sure what OHA is already in the process of doing. We should have a strategic plan and not necessarily dictate how things are going to happen. All of that process is under discussions of how best to do that. That is why we have this 8 member group to help when we do our RFP to have the strategic plan and make sure we are getting State perspective as well as other partners.

Questions/Comment: Focusing on prescription opioids is extremely important. (Inaudible) there prescription and illicit drugs and alcohol is very important. (Inaudible) but it [alcohol] is the one that has the highest impact, both morbidity, mortality. (Inaudible) they do require somewhat different interventions.

- 3) PDMP Review & Potential Statutory Changes – Dr. Katrina Hedberg

Dr. Hedberg: We have a statute now and people are complying with it. There has been a sharp uptick in registrations in the first quarter of 2018. Some people have a DEA license but don't necessarily prescribe more than occasionally. We may not actually expect to get 100%, but our efforts have gone to the "high-prescribers." We do not have mandatory look-up prior to prescribing in Oregon. It does appear that people are using the PDMP. Moving ahead with the integration of the PDMP into various electronic health records.

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Brittany Matero from the Office of Health IT: We are moving forward with our integration efforts. We have more than 700 physicians who are now accessing PDMP directly from their electronic health record. With EDY integrations we have 25 hospitals who are up and integrated. We have two other facilities in Oregon who are integrated. Walmart and Providence have both integrated their pharmacies. We anticipate that starting this month we will have about 19 organizations in queue to integrate. Courtney Dresser is the Chair for the PDMP Integration Initiative. She is always happy to answer questions.

Dr. Hedberg: The question was how we can require people to use it [PDMP] if it is so cumbersome? We are moving to a new platform.

Question/Comment: If you do require the diagnosis codes to be a part of the prescription, if that is lacking, it is not a valid prescription and will require the pharmacist to contact the prescriber. That is one land mine that we want to be careful with.

Question/Comment: With regards to Gabapentin – why would we want this? I am not aware of any data showing that Gabapentin actually contributes to opioid related death. It can be a secondary drug of abuse. It sometimes goes along with some of these other drugs, but I'm not sure what we would do with that information if it was collected. What actionable items would a physician take based (inaudible) items and is that worth it to collect that data? This is a very commonly prescribed drug so it would fill up a PDMP profile.

Dr. Hedberg: It is because other states have seen that people are using them in order to strengthen and work synergistically with other drugs. It has been sold as a black market drug in other states. I don't think we have seen it as much in Oregon yet but it has been seen.

Question/Comment: Just because they are being used with illicit substances doesn't necessarily mean the drug itself is leading to a bad outcome or is an indicator of anything you'd action on.

Question/Comment: I believe there are some studies out of Ohio that show (inaudible) use causes a higher death rate. There are a number of states that have made Gabapentin a controlled substance.

Question/Comment: I don't object to including it in the registry. I do object to making it a controlled substance. It is a commonly prescribed drug when we are trying to avoid opioids altogether.

Question/Comment: Creating a controlled substance would create a regulatory burden for pharmacies and physicians.

Question/Comment: We figured it out for Naloxone, we can figure it out for Gabapentin.

Question/Comment: Regarding #3, method of payment. To be clear, are you talking about when we actually adjudicate the claim in our system, whether it actually goes to cash based collection or to insurance, that's the data you are trying to collect, not how they are paying at the counter. Like credit card vs cash.

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Dr. Hedberg: The way that other states have said the things that cause red flags are multiple providers, multiple different pharmacies cash payment that this is a way to flag people who are either getting drugs (inaudible) or perhaps misusing them. They go to a variety of providers and not leaving a paper trail. That is the intent.

Question/Comment: Whatever happens at the counter is not trackable, but how we bill a prescription is trackable. The caveat to that is that some computer systems treat the insurance billing as a separate data set of the software that is the prescription record is there (inaudible) to be added to the PDMP if we wanted to do that. Billing method is not always part of the prescription record, so it would require quite a build in some cases to try to collect that piece of data. One of the problems with this could be you are going to oftentimes use drugs (inaudible) with narcotics they require a prior authorization. A standard process in a pharmacy would be to actually process and adjudicate the claim as cash, fill the prescription, put it on the shelf, get a PA so we can authorize through their insurance. When we get the PA we go back and rebill to the insurance company at that point in time. We download PDMP overnight so all these claims will show up as cash when they are actually not cash, they are just things we are waiting for prior authorizations for the insurance company. You will get some false-positives there that may be misinterpreted.

Question/Comment: You may get more data than you want. You may end up with everyone (inaudible) that might be cheaper to buy their drugs with cash than through the insurance benefit might end up being in the system which is a lot more data than anticipated.

Dr. Hedberg: They are all in the system anyway. Because they are in the PDMP they are getting a controlled substance. It is one additional variable. That is why I was saying that we can already look at how many different pharmacies are they going to, and how many different clinicians. This would be one additional piece. It is only one variable in the database. It is not like we are suddenly getting everyone who has cash payment for any drug. It is for a controlled substance that needs to be entered into the PDMP at the pharmacy level. This is one additional piece of information. Other states have used this and CDC says it is a best practice. We have other things in place here in Oregon so I really can't tell you how important this is or (inaudible) identify X number more people, or is this confirming what we already know by the people who are doctor shopping.

Sen. Steiner-Hayward: We have a meeting of the prescription drug task force leadership right after this. One of the things that is likely to come out of that meeting is a recommendation that when people pay cash for prescriptions, if they are willing to submit the paperwork to their insurance company to count towards their deductible. You may suddenly see a significant increase in people willing to pay cash. My guess is that for a lot of these generic opioids and controlled substances, it is going to be cheaper to pay cash than to put it on their insurance and pay the co-pay. If we structure it in the right way so that we are (inaudible) responsibility for submitting it to their insurance company, then that is probably a path we can take forward.

Dr. Hargunani: We want to be mindful of those kinds of changes and be mindful of the impact of (inaudible) this data. As changes are made in policy about coverage that may impact opioid

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prescribing. Any shifts in cost payment vs coverage on your insurance plan – you could try to correlate any changes, and are we getting to the right impact, or are we just shifting in how it is being paid. This could be a way to evaluate policy changes that are happening in coverage. That is one thing we can't track right now. It would add value in that way, but I think there are a lot of variables that need to be considered.

Sen. Steiner-Hayward: That is part of the problem. It is hard to understand the motivations of people who are paying cash. If the baseline concern is people pay with cash to avoid having it tracked by their insurance company, then we may have some confounding factors. The flip-side is the point that Dana makes.

Question/Comment: If there are hazards around the diagnosis codes, it would be wonderful to resolve them. As we make more progress on prescribing, being able to drill into exactly what diagnosis codes are driving what appears to be challenging prescribing, will help equip folks like the (inaudible) teams to do a better job of educating.

Question/Comment: I think that having that code is critical. Just doing it in a way that the transition would allow for it not being a barrier to care in the meantime.

Question/Comment: As far as diagnosis codes, most prescriptions are being transmitted to pharmacies electronically now. Most of those electronic prescriptions carry a diagnosis code. That goes automatically into the patient profile and would easily pass through and be reportable. The problem is that for the 20-30% of prescriptions that don't carry a diagnosis code, if we made it required, that would be a real big barrier. We couldn't dispense the drug until we got ahold of the doctor and got a diagnosis code. Could be a burden for the providers as well as the patient care. Passing through what we are getting now? That would be fairly easy.

Question/Comment: I understand a diagnosis code for a controlled substance, you don't need it for the others. Presumably, you are getting diagnosis code for all the medications that a person is getting. I can see that there are this many, and a fraction of them are the controlled substance. It sort of feeds into the prior authorization. This could be one where it is scalable.

Sen. Linthicum: In terms of a pre-check on history of controlled substances coming from the provider/prescriber, is there thinking along the lines that noticing cash payments for that kind of prescription would make a difference? Or, is this more of an investigative thing almost all the way down to #7 with regard to PDMP data being used for research and analysis vs flagging that kind of prescription. I am curious how you might think that might work?

Dr. Hedberg: I was thinking about all of these at least at this point it was more related to what we would have data on and who is at risk, etc. The example that we currently do with our Clinical Review Sub-Committee is these providers who have multiple patients who have seen 4 providers and have gone to 4 pharmacies. We flag the patient, but that information does not go to the patient. The information goes to the providers who have multiple ones of these patients. To this point, this would not be [flagging a patient who pays in cash only] therefore you can't get your prescription. That was not the intent behind it. More around using these data to

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improve public health, and helping providers, but not necessarily directly back to the patient themselves. The data come from what is happening to the patient, but the focus of the PDMP (inaudible) is a tool to help providers improve health and safety of their patients and to prescribe appropriately. There has not been any indication that this should be used to target/focus on the patients themselves.

4) Department of Corrections – Craig Prins, Inspector General, Oregon Department of Corrections and Joe Weir

A lot of the Inspector General's job historically at DOC has been drug intervention, trying to keep drugs out of the institutions. Our visiting is contact visiting, not like a jail where it is behind glass. We encourage contact visits. Studies show that it really helps with reentry and reducing recidivism. Loved ones are sending mail, and that is another way that Suboxone and other things that are easily concealable behind a stamp or things like that. In our minimum security, a lot of our folks are out cleaning the parks and things like that. So, if you have a girlfriend or boyfriend who knows where you are going to be, and you can do a little drop for a little care package. Those are all ways that drugs get into a prison.

We put out a policy option package, 124, Overdose Prevention package. It is broader than MAT. It includes mail standards to scan mail.

Sen. Steiner Hayward: The woman who worked with us when we went to Vancouver to look at the overdose prevention sites said, if you have someone who is going through a divorce, that is not the time to ask them to quit smoking. You want to support them to get through it and maybe offer nicotine substitution as a way to decrease it but you are not going to ask them to quit. At some point I'd like to hear some thoughts about whether using MAT as a bridge at the very least, even if we don't think we can afford to do it long term, to help people not go through withdrawal right when they come into custody.

5) Legislative Prioritization Matrix – Dwight Holton & Dr. Paul Lewis;

Dwight discusses plan to move forward on a comprehensive proposal from this group. Took the recommendations from the DCBS report, and ideas from the OETF, and a couple of other ideas from the community, and sorted them among the three key buckets that Dr. Hedberg identified at the last meeting: Reducing harm, improving pain management, and addressing opioids.

Sen. Steiner Hayward: Regarding reclassifying drug paraphernalia, because of collecting used needles and how that becomes drug paraphernalia. I would love to see that come back on the list. Second, we may need to modify the definition of "state of emergency." Last, the issue of requiring all State licensing boards and degree granting programs to provide opioid use disorder treatment training. State licensing boards should not be in the business of prescribing ongoing community education. It has not worked in the past and it is not going to work in the future. To require all degree granting programs, then you get the question of residency, there are a lot of residencies where they never prescribe (inaudible). It is really tough to tailor mandatory provider education.