



AGENDA

Marion County Public Safety Coordinating Council

Date: Tuesday, February 12, 2019
Time: 4:00 p.m. to 6:00 p.m.
Place: Commissioners' Board Room, 5th Floor
Staff: Hitesh Parekh, BOC Office
Phone: (503) 588-5212

Meeting At:
COURTHOUSE SQUARE
555 Court St. NE
Salem, Oregon

4:00 - 4:15 PM

1. Administrative (Information/Action)

Commissioner Cameron

- Welcome and introductions
- Approve January 8, 2019 minutes (**Action**)
- Announcements & upcoming events
 - Justice Reinvestment Summit February 13, 14, 15
- January 29, 2019 Legislative Debrief

4:15 - 4:35 PM

2. Federal and State Legislative Concepts 2019 (Discussion/Action)

Barb Young

- Review and approve federal legislative agenda (**Action**)
- Review 2019 state legislative agenda (**Possible Action**)
 - Review 2019 Legislative Agenda Priority Items
 - Senate Bill 7: Decrease legal blood alcohol limit (**Possible Action**)

All

4:35 - 5:35 PM

3. Opioid Epidemic: Secretary of State Audit
(Information/Discussion)

Kip Memmot and Jamie Ralls, Oregon Secretary of State, Audits Division; Laura Chisholm and Drew Simpson, Oregon Health Authority; Cary Moller, Marion County Health Department; Jill Dale, Prescription Drug Overdose Coordinator Marion/Polk/Yamhill counties; Chief Jim Ferraris, Governor's Opioid Task Force; Dr. Paul Coelho, Salem Health Pain Clinic Director

5:35 - 5:50 PM

4. Pre-Trial Justice WorkGroup Update
(Information/Discussion)

Commander Jeff Wood; and Commander Tad Larson, Marion County Sheriff's Office

5:50 - 6:00 PM

5. Emerging Issues/Problem Solving

All

6:00 PM

ADJOURN

- The next steering committee meeting is February 26, 2019 at noon
- The next full council meeting is on March 12, 2019 at 4:00 PM

MARION COUNTY PUBLIC SAFETY COORDINATING COUNCIL
MINUTES

January 8, 2019 4:00 PM
Courthouse Square
Salem, OR

MCPSCC: Mark Caillier, Kevin Cameron, Rob Carney, Paige Clarkson, Kim Doster, Jayne Downing, Don Frederickson, Tamra Goettsch, Troy Gregg, Roland Herrera, Jessica Kampf, Pete McCallum, Ed McKenney, Cary Moller, Diane Morse, Jason Myers, Tracy Prall, Mike Runyon, Cari Sessums, John Van Dreal, and Hitesh Parekh (recorder).

GUESTS: Jan Calvin, Cate Duke, Susana Escobedo, Dan Estes, Alison Kelley, Jolene Kelley, Rich Sebens, Colm Willis

1. ADMINISTRATIVE (INFORMATION/ACTION)

Meeting called to order at 5:05 P.M. by Commissioner Kevin Cameron.

Welcome and Introductions

Attendees introduced themselves.

Approve December 11, 2018 minutes (Action)

MOTION: Ed McKenney moved to approve the December 11, 2018 meeting minutes after Troy Gregg's name was added to the list of attendees. Seconded by Jason Myers. A voice vote was unanimous.

Announcements and upcoming events:

- January 29, 2019 Legislative Briefing at State Capitol
- Justice Reinvestment Summit, February 13, 14, 15. Still time to register.
- Marion County Juvenile Department's lumber mill is fully operational.

2. VICTIM SERVICES

Susana Escobedo, Victim Assistance Director, Marion County District Attorney's Office; Jayne Downing, Executive Director, Center for Hope and Safety; and Alison Kelly, Chief Executive Officer, Liberty House presented this item. Summary of presentation:

- Marion County has implemented many of the changes from the Casey Gwinn Alliance for Hope International Report recommendations.
 - A majority of the law enforcement agencies are already using a domestic violence checklist.
 - Restraining orders are also being filed electronically.
 - There is now a victim services advocate who is always in court.
 - Courts have implemented video conferencing so victim does not have to be in the courtroom with perpetrator.
 - Liberty House has a multidisciplinary team which provides medical assessments, Karly's Law assessments, forensic interviews, and trauma-informed mental health services for children.
- New victim services legislation in effect as of January 1, 2019 includes:
 - House Bill 4145 which closes the "boyfriend loophole" and expands Oregon's existing gun ban for those convicted of domestic abuse to include an abuser who may not be married to or living with the victims.
 - Senate Bill 1562 which will increase the crime of strangulation during domestic violence to a felony. The crime of strangulation is currently a misdemeanor in Oregon and only a felony under limited circumstances.
 - House Bill 4055 which requires drivers to return to the scene of a hit-and-run crash as soon as they know, or have reason to believe they hit a person or pet. ('Anna and Abigail's Law'.)

- License suspensions on non-driving “Possession of a Controlled Substance” has been removed. Prior to January 1, 2019, those with a drug conviction would automatically have had their license suspended.

Summary of Discussion:

- State statute requires Marion County to put 10% of its biennial Justice Reinvestment Initiative grant funding into victim services programs.
- Stewards of Children prevention training is provided by Liberty House. This nationally recognized workshop teaches adults five practical steps to help prevent, recognize, and respond responsibly to sexual abuse. District Attorney’s office requiring all employees to be trained.

3. IMPAIRED DRIVING/MADD

Cate Duke, Vice-Chair Governor’s Advisory Council on DUIIs, and Dan Estes, Impaired Driving Program Manager, Oregon Department of Transportation presented this item. Summary of Cate Duke’s presentation:

- Ms. Cate Duke is also the Volunteer Resources Specialist for Mothers Against Drunk Driving in the State of Oregon.
 - Hired in September 2017 to revitalize MADD in Oregon.
 - Prior to the 2007-8 recession MADD had a robust presence in Oregon:
 - 16 chapters throughout the state,
 - Youth education programs,
 - Victim impact panels, and
 - Legislative volunteers heavily involved in lobbying for better impaired driving laws.
- The recession saw MADD’s funding and donations erode, and donations being redirected to the national MADD office.
- The state office closed along with many of the local chapters.
- MADD in Oregon consisted of just ten volunteers.
- Since September 2017, Ms. Duke has been traveling around the state, recruiting volunteers and starting committees to rebuild MADD.
 - A task force was created and a strategic plan completed.
 - Volunteers are being recruited on Craigslist, United Way, and senior centers.
 - MADD Oregon is looking at partnering with driver education to add an impaired driving message to the curriculum.
 - Working on getting the message into schools, and recruiting volunteers to testify before the state legislature.
 - Other programs on the agenda include creating a court monitoring system and recruiting people to work actively as victim advocates.
 - Victim stories make a difference to state legislators.
 - Governor’s Advisory Committee has been very supportive.

Summary of Dan Estes’s presentation:

- Governor’s Advisory Committee on DUII is one of approximately 200 advisory committees, councils, and commissions to the governor. The DUII committee consists of representatives from the courts, victims, defendants, prosecutors, victim advocates, and legislators.

Oregon’s DUII Data

- DUII is the most commonly crime committed in Oregon.
 - Oregon’s DUII cases have trended at approximately 17,000 cases annually since 2016.
 - In 2017, impaired driving resulted in:
 - 21 fatalities;
 - 105 crashes; and
 - 146 injured persons.
- Trends are increasing compared to 2013 when Marion County only had 7 fatalities.
 - Arrests are decreasing but fatalities are increasing and law enforcement resources are shrinking. This is consistent with the national trend.
- 80-90% of individuals pulled over are sent to receive substance abuse treatment.
 - Data shows a person had driven impaired more than 80 times before being stopped.
 - Legalization of marijuana made things more complicated.

- Alcohol is a very physical impairment.
- Marijuana is a cognitive impairment, time and distance perception.
- Oregon has been able to learn from Washington and Colorado since they legalized marijuana before Oregon.
- Oregon was able to double the number of drug recognition experts, and increase advanced roadside impaired driving enforcement that recognized drug impairment in drivers.
- Oregon wants to train as many troopers as possible on this. In preparation for the legalization of recreational marijuana in Oregon, the state doubled the traffic safety resource prosecution team at the Oregon Department of Justice and added resources to the Oregon State Police Forensic Services Division.
- Some things were not done very well.
 - State did not capture traffic data before or after marijuana was legalized.
 - Oregon had a record marijuana harvest of 1.3 million pounds of marijuana in 2018.
 - Overproduction has caused some marijuana to be shipped out to other states and the price of marijuana to decrease.
 - Black market has not disappeared.
 - Marijuana appears as the most commonly detected substance after alcohol in a drug test.
 - It appears in 60 % of the toxicology reports.
- Every biennium, the Governor's Advisory Committee focuses on legislation.
 - In 2019 there is a legislative concept for an ignition interlock rule device fix.
 - Current law requires those convicted of driving under the influence of intoxicants to get an ignition device. Only 34% of those convicted complied.
 - Has been no oversight, control or coordination between courts and prosecutors.
 - Washington state has a 63% compliance rate so Oregon has mirrored their law in the legislative concept.
 - There is also new legislation dealing with sobriety checkpoints.
 - Oregon does not have checkpoints which is a key tool to fight impaired driving.
 - Asking voters through a referral from the legislature to allow this.
 - Checkpoints can reduce driving fatalities by about 12 percent.
 - Also a bill replacing the word "accident" from the motor vehicle code with the work "crash".
 - "Accidents" are behavior driven.
- ODOT is always looking for partnerships with local leaders.

Q: There is a move to decrease Oregon's blood alcohol content limit readings from .08% to .05%. Are there any other states that have done this?

A: Utah has a .05 % blood alcohol concentration. Oregon commercial drivers have a .04 % limit.

Q: Will moving to .05 % limit increase the traffic to the courts?

A: Will add approximately 700 cases per year statewide. This is from reviewing breathalyzer results. The most common breathalyzer test is a .015 %. Even if the limit is .05 %, deputies are looking at signs of impairment, so irrelevant if individual is on alcohol or drugs.

Q: How do you determine levels of impairment for marijuana?

A: The science is not there yet. We have 50 years of research on alcohol impairment. It is processed differently by each body type. Colorado law specifies that drivers with five nanograms of active tetrahydrocannabinol (THC) in their whole blood can be prosecuted for driving under the influence (DUI). However, no matter the level of THC, law enforcement officers base arrests on observed impairment.

4. FEDERAL AND STATE LEGISLATIVE CONCEPTS 2019

Federal Agenda

- Commissioner Cameron distributed a rough draft of the public safety items on Marion County's federal agenda.
 - Barbra Young, Government Relations Officer, Marion County, will work on this list and return to the board to present it at the council's February 12 meeting.
- Court Plaza project for the Center for Hope and Safety needs to be put on the federal agenda.

State Agenda

Proposed additions:

Funding for Oregon Network of Child Abuse Intervention Centers

- Oregon Network of Child Abuse Intervention Centers is seeking an allocation of \$6 million from the state general fund to support the services provided by child abuse intervention centers in Oregon.

DISCUSSION

This funding request will compete with other programs seeking state general funding.

MOTION: Pete McCallum moved to add a request for state general funds to support sustaining the Oregon Network of Child Abuse Intervention Centers to the 2019 Legislative Agenda. Seconded by Mark Callier. Judge Tracy Prall abstained. A voice vote was unanimous.

CourtCare

- CourtCare is free child care offered by the Marion and Polk County District Courts for children aged six weeks to twelve years.
 - Children are spared from witnessing adult conflict, hearing harsh words, and seeing potentially disturbing scenes which could traumatize or even re-traumatize them.
 - Since program started in September 2017, courts have served 837 children.
 - Funding came from a one-time legislative grant of \$100,000 each for Marion and Polk counties and will be depleted by June 30, 2019.
 - Courts are required to go back to the legislature to report back on the status of this project.
 - Will make another request for funding then.
- LC 2086 will fund *statewide* CourtCare through a surcharge on court filings. Funds would be administered by the Department of Education. This is a surcharge on filings for divorce.
- Multnomah County is funded exclusively through donations from big law firms.
- Marion County received \$20,000 from private donors, and has already spent this.

DISCUSSION

Two issues here. The first is that Marion and Polk Counties need to continue the grant that will expire in June 31, 2019. The second is for ongoing *statewide* sustainable funding for this program. Program will be funded from court filings This will make it difficult for victims to dissolve the marriage because of the court filing fee cost. Council could “watch” LC 2086 and not “support” it.

MOTION: Jayne Downing moved to support another biennium of grant funding for CourtCare through the extension of HB 3067 (2017). Seconded by Rob Carney. A voice vote was unanimous.

MOTION: Jason Myers moved to “watch” LC 2086 which would create statewide CourtCare and fund CourtCare based on a surcharge for domestic relations filings. Seconded by Don Frederickson. A voice vote was unanimous.

5. EMERGING ISSUES/OTHER BUSINESS

- Reception for newly elected Judge Dan Wren at the courthouse January 11, 2019.
- “Request For Applications” for the coordinated care organizations for 2020 have been released.

ADJOURNED 5:50 pm

JUSTICE REINVESTMENT SUMMIT AGENDA

WEDNESDAY, February 13

Workshops

THURSDAY, February 14

- 07:30 am Registration/Check-in
- 08:30 am **Opening Address:** Governor Brown
- 08:45 am **Keynote Address:** Vincent Schiraldi
- 09:30 am **General Session:** [Yellow Line Project](#)
- 10:15 am Break
Breakout Session: Gender Responsivity in Criminal Justice Systems
Breakout Session: Pre-Trial
- 10:30 am Breakout Session: [You Have Options – Sexual Assault Reporting](#)
Breakout Session: Understanding and Preventing Criminal Behavior Among People with Serious Mental Illness
- 11:30 am Lunch
- 12:00 pm **General Session:** Justice Reinvestment in Oregon
- 12:30 pm **General Session:** Understanding and Addressing Implicit Bias, Dr. Erik Girvan
- 01:15 pm Break
Breakout Session: Current Trends in Oregon Criminal Justice Data
Breakout Session: Understanding and Addressing Implicit Bias, Dr. Erik Girvan
Breakout Session: Gender Responsivity in Criminal Justice
Breakout Session: Judge Steve Leifman
- 01:30 pm
- 02:30 pm Break
Breakout Session: Pre-Trial
Breakout Session: Report from the Front: The 6th Amend Center assessment of Public Defense in Oregon
- 02:45 pm Breakout Session: National SWOT Analysis – Victim Services
Breakout Session: [Yellow Line Project](#)
- 03:45 pm Break
- 04:00 pm **Remarks:** Chief Justice Walters
- 04:05 pm **General Session:** [Judge Steve Leifman](#), Eleventh Judicial Circuit Court of Florida
- 05:00 pm **Reception**



FRIDAY, February 15

JOINT JUDICIARY LEGISLATIVE HEARING

US – European Criminal Justice Innovation Program: Lessons From Norway (Times are Tentative)

- 08:30 am **Opening Remarks:** Senator Winters
- 08:35 am **Keynote Address:** Dr. Craig Haney, U.C. Santa Cruz – Stanford Prison Experiment
- 09:30 am Break
- 09:40 am **Remarks:** Don Spector, Founder of Program
- 09:50 am **General Session:** Kim Ekhaugen, Norway, Director of International Programs
Tom Eberhardt, Norway, Governnor of Bastoy
- 10:45 am Break
- 11:00 am **General Session:** Exchange Officer Panel – Norway and Oregon
- 11:45 am Lunch (Served)
- 12:00 pm **Closing Remarks:** Colette Peters
- 12:30 pm Question and Answer: All Speakers



O R E G O N

Marion County 2019 Federal Agenda Public Safety Issues *Draft*

GRANT PROJECTS

Addressing the Housing Shortage

Marion County is facing a severe shortage of available housing for both “workforce” and “low-income” individuals. Recognizing the broad benefits that accessible housing provides towards enhancing individual financial stability and stemming the tide of problems associated with homelessness, Marion County is working to secure additional federal resources to address this crisis.

- ***Workforce and Affordable Housing*** – With a rental vacancy rate of less than 4 percent, there are few options for renters in the current market. Marion County is dedicated to address this significant need for affordable housing with its public and private partners in the community. The county is looking for federal resources to help increase the local housing supply as well as programs that loosen the barriers for individuals to locate and acquire housing, especially first-time homeowners.
- ***Low-Income Housing*** – Marion County also faces a severe shortage of low-income housing. The Oregon Housing Alliance’s 2017 report for Marion County found that for every 100 families with extremely low incomes, there are only 20 affordable units available in Marion County. The county would need to develop 7,215 new affordable units to meet the current shortfall. The county is partnering with the Marion County Housing Authority on several initiatives, including the expansion of VASH vouchers and Project-Based Vouchers, to increase the options available to low-income families and individuals.

POLICY PRIORITIES

Opioid Funding

Opioids, prescription and illicit, have become the main driver of drug overdose deaths in the United States. Opioids were involved in 42,249 deaths in 2016, and opioid overdose deaths were five times higher in 2016 than 1999. The county is taking steps locally to address the prevention and treatment of this growing threat, but more assistance is needed. While bipartisan legislation signed by the President in 2018 provided additional tools to confront this crisis, the County supports additional federal funding and coordination like equipping police officers with naloxone (Narcan). These tools will help Marion County and other communities across the country combat this epidemic.

Sobering Center Recognition as “Medical Treatment”

Marion County is working with local partners to establish a Sobering Center in Salem to provide a safe, supportive environment for homeless or marginally housed intoxicated individuals to become sober. By providing an alternative to jails and emergency rooms with service connection to detox and substance

treatment, sobering centers alleviate health care and law enforcement costs by addressing the underlying problems. However, the costs of providing these services is significant due to their exclusion from Medicaid reimbursements since CMS does not recognize them as “medical treatment.” As a result, local communities foot the bill alone despite the benefits they produce in decreasing overall health care costs. Marion County supports federal action to make these services reimbursable under federal programs like Medicaid.

COPS Technology Funding

Marion County supports funding for police equipment, including restoration of COPS Technology Grants that were eliminated in 2009. There are very few funding options at the federal level to help police departments purchase equipment despite the fact that federal mandates continue to require costly upgrades. The COPS Technology Program would allow Marion County to pursue competitive grant funding for the replacement of its \$1.5 million Police and Jail Records Management System.

Protect BYRNE Justice Assistance Programs and State Criminal Alien Assistance Program

Marion County supports maintaining funding levels for these critical public safety programs.

Repeal Inmate and Juvenile Corrections Exception for Federal Health Benefits

Under current law, governments are prohibited from billing federal programs like Medicaid for the health services provided to jail inmates prior to adjudication. Marion County supports federal legislation that would repeal the inmate exception for both juvenile corrections and adults in custody pending disposition of charges.

Congressional Directed Spending

Marion County is supportive of efforts to restore congressionally directed spending for individual projects sponsored by municipal governments and nonprofit organizations. The county and its partners have identified several initiatives that don't align with current federal grant programs, but could be swiftly completed with direct federal spending. One potential investment is the Center for Hope and Safety's Hope Plaza in Salem, which will feature transitional housing and job training opportunities for survivors of domestic violence.

Contacts:

Marion County – Barb Young, 503.589.3263

CFM Federal Affairs – Michael Skipper, 202.347.9170

CFM Federal Affairs – Kirby Garrett, 541.480.0938

Barbara Young - FW: Updates for CourtCare (HB 2244)

From: Stice Jeanine <Jeanine.Stice@oregonlegislature.gov>
To: Barbara Young <BYOUNG@co.marion.or.us>
Date: 2/11/2019 1:08 PM
Subject: FW: Updates for CourtCare (HB 2244)
Cc: Rep Boles <Rep.DenycBoles@OregonLegislature.gov>

Hi Barb,

Below is a summary of the conversation last Friday with sponsors of HB 2244, on the amendment they stated they would request for HB2244. Please let me know if you think anything additional should be added or if you have questions.

Jeanine

From: Rep Boles
Sent: Monday, February 11, 2019 9:02 AM
To: Stice Jeanine <Jeanine.Stice@oregonlegislature.gov>
Subject: FW: Updates for CourtCare (HB 2244)

From: Demoe, Brent <demoe.brent@co.polk.or.us>
Sent: Sunday, February 10, 2019 11:48 AM
To: Rep Piluso <Rep.CarlaPiluso@oregonlegislature.gov>; Rep Boles <Rep.DenycBoles@OregonLegislature.gov>
Subject: Updates for CourtCare (HB 2244)

Below are the key points we discussed on Friday regarding the new concepts for CourtCare (HB2244)

1. Remove all language that is currently in the bill
2. Substitute with language from the original bill from last session with some tweaks.
3. Include these new concepts as appropriate.

HB 2244 seeks to build upon the successful pilot program created by HB 3067 from the 2017 session by extending the pilot for Polk and Marion Counties and by expanding the pilot to add two more CourtCare sites. The original pilot asked the Legislature for \$200,000 to fund two sites for two years. New bill will ask for \$500,000 for four sites for 2 more years. There are two reasons for the increase: 1) to ensure continuity among the programs in the areas of marketing, data collection, quality and reporting and 2) the pilot showed that \$50,000 per site per year only ensures part-time operation of a high-quality CourtCare program. We recommend \$60,000 per site, this leaves \$20,000 for the continuity areas mentioned above. Polk County has taken the lead on this currently and is willing to accept the continuity funds and work with all four CourtCare sites until the program can be embedded in the appropriate state agency in the future. The current CourtCare steering committee is willing and able to develop criteria for readiness to add two more sites to the extended pilot.

All funded CourtCare sites must show a cash match amount of no less than 10% of the to grant award (minimum \$6,000 per year) and an additional 15% of in-kind support (this could be use of space, printing, marketing etc.)

HB 2244 directs the Early Learning Division and the Oregon Judicial Department to convene key partners and stakeholders and form a task-force or committee to look at ways to continue funding and adding CourtCare sites throughout Oregon. This committee shall include representative from the currently funded CourtCare programs, local court staff, Department of Humans Services and other appropriate local stakeholders. This body shall provide an in-depth report to the XXX committee of the Legislature by XXX of 2020.

Let me know if I missed anything or if I can provide anything further. I'm happy to look at the new draft when it's ready, too.

Brent

--

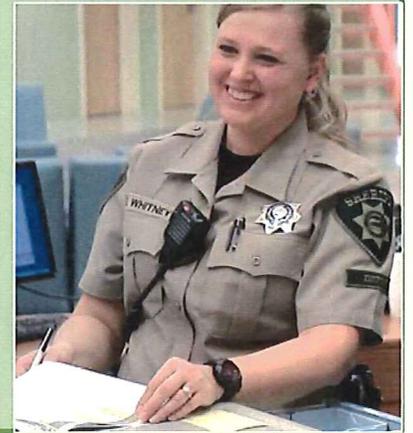
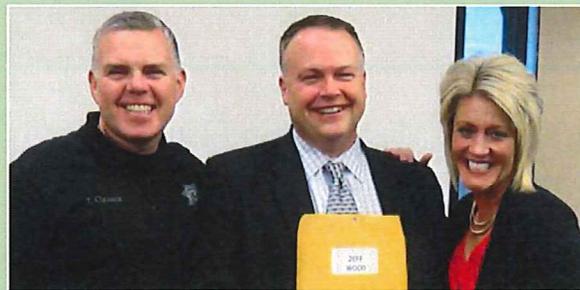
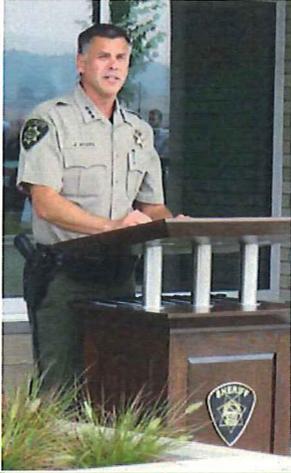
Brent DeMoe
Director, Polk County Family & Community Outreach Department
office 503-623-9664 ext 2118
cell 503-932-7434
<http://www.co.polk.or.us/fco>

Our Goal is that....All People are Empowered and Healthy

This message has been scanned for virus content by Symantec Anti-Virus, and is believed to be clean.
Viruses are often contained in attachments - Email with specific attachment types are automatically deleted.
If you need to receive one of these attachments contact Marion County IT for assistance.



Legislators' Public Safety Briefing With Marion County Civic Leaders



Tuesday, January 29, 2019
4:30 – 6:00 p.m.
Refreshments will be served!

State Capitol ♦ Room 350 ♦ 900 Court St. ♦ Salem, OR 97301

CONTENTS

MARION COUNTY PUBLIC SAFETY COORDINATING COUNCIL

2019 LEGISLATIVE PRIORITIES

What We Have Accomplished	3
Summary of Legislative Priorities.....	5
Detailed Legislative Priorities.....	9
Community Corrections	11
Juvenile Justice.....	15
Mental Health.....	17
Law Enforcement.....	19
Victim Services.....	23
Housing and Homelessness.....	25

MARION COUNTY PUBLIC SAFETY COORDINATING COUNCIL

Background.....	27
Public Safety Coordinating Council Membership List.....	31
Marion County Justice Reinvestment Council Membership List.....	35



Marion County Public Safety Coordinating Council 2019 Legislative Agenda

WHAT WE HAVE ACCOMPLISHED

The problem. Drug abuse, chronic health conditions, and homelessness are prevalent issues affecting the criminal justice system in Marion County (population 344,035 in 2018). Marion County continues to have one of the highest per capita rates of prison inmates of any Oregon county, with 600 inmates releasing to Marion County each year from state prisons and 3,300 people on parole or probation. Four of the 14 state correctional facilities are located in the county, along with the state juvenile corrections facility and the Oregon State Hospital for offenders with psychiatric diagnoses. The Marion County Sheriff's Office also operates the third largest jail in Oregon, with more than 16,000 annual bookings. More than 90% of prison inmates from Marion County will return to Marion County communities.

In a 2018 jail survey, 54% of Marion County inmates reported using methamphetamines or other stimulants and 32% abused opioids, with 45.8% diagnosed with a mental health condition. In Oregon, incarceration costs approximately \$84 per day, while intensive treatment programs cost \$39 per day. Marion County's public safety services provide hope and dignity to our clients. They also make financial sense.

A new way of doing business. Beginning in 2009, Marion County created a nationally-recognized Justice Reinvestment Initiative, with interwoven prison diversion and prisoner reentry strategies. Prior to this, parole and probation officers' assigned caseloads were overwhelming and compliance strategies were often based on trial and error, with sanctions commonly a long stay at the county jail. Treatment success rates were also dismal. After passage of Senate Bill 267 (2003) requiring evidence-based practices for Oregon's corrections programs, Marion County began implementing risk assessments and case planning, training staff in research-based practices, and assigning and managing officer caseloads by assessed risk. Under traditional parole and probation practices, Marion County's recidivism rates were as high as 40%. By 2014, the recidivism rate dropped to an all-time low of 14% and continues to hover around 20% in recent years.

In late 2009, the initiative was awarded two federal Second Chance Act grants. Parole and probation officers were trained in Effective Practices in Community Supervision, or EPICS in 2011, based on the work of Dr. Edward Latessa, University of Cincinnati. In 2012, the initiative was selected as one of seven projects across the nation to participate in a control group evaluation study by the U.S. Bureau of Justice Assistance. In 2013, Marion County was then one of nine locations in the nation to receive a Second Chance Act grant addressing co-occurring mental health and substance abuse disorders. In 2018, Marion County received two U.S. Bureau of Justice Assistance grants to expand Law Enforcement Assistance Diversion, or LEAD.

Marion County continues to change lives through the efforts of many people working together on cutting-edge community corrections programs. Justice Reinvestment Initiative key partner organizations include the Marion County Sheriff's Office Parole and Probation Division, Health and Human Services Department, Community Services Department, Housing Authority, and District Attorney's Office; Chemeketa Community College; Bridgeway Recovery Services; Union Gospel Mission; the Oregon Department of Corrections; Mid-Willamette Valley Community Action Agency; and Willamette Workforce Partnership. These agencies jointly execute a strategic plan under a collaborative governance structure, overseen by the Marion County Board of Commissioners and Sheriff, with engagement by civic, education, faith, and business leaders. More than 100 local employers open their doors to clients who are ready to work.

Results. Over the past decade, Marion County has achieved the following results.

Governance

- Memorandum of Understanding signed by 13 partners.
- Public Safety Coordinating Council prioritized needed Justice Reinvestment programs.
- Marion County Justice Reinvestment Council was formed.

Evidence-Based Practices

- Prison reach-ins reduced “no show” rates for clients immediately after release from 30% to 2%.
- Post-prison recidivism rates dropped to 14% in 2014, the lowest on record.
- More than half the highest risk clients are employed or in school, compared with the state benchmark of 39%.
- Jail Reentry graduates were 58.8% less likely to be arrested for a new offense and 38% less likely to have a new incarceration, compared with the general post-prison, high-risk population.
- Student Opportunity for Results, or SOAR, participants were 28.9% less likely to be arrested for a new offense and 20.9% less likely to be convicted of a new felony than other high-risk clients on supervision in Marion County. SOAR clients participate in an intensive 12-week treatment and employment program on the Chemeketa Community College campus.
- The De Muniz Resource Center, a one-stop reentry center operated by the Mid-Willamette Valley Community Action Agency, connected with nearly 6,000 clients since opening in 2011. Because of a 38% increase in caseloads, a second navigator joined the staff in April 2017.
- Marion County has led the state in reducing prison admissions for justice reinvestment offenses. The Senate Bill 416 Diversion Program has had the greatest impact on meeting state diversion targets, through client participation in evidence-based cognitive, motivation, and substance abuse treatment; case management; and mentoring services.
- Marion County recognized the importance of supporting victims through justice reinvestment, allocating not only the required ten percent designated for victim services, but also adding other funds that support a bilingual Court Support Advocate position housed at Center for Hope & Safety. The advocate assists victims at the Center for Hope & Safety and Victim Assistance offices with protection orders and is present in court during protection order hearings. Since the addition of this position, 1,675 victims have been assisted with crisis intervention, safety planning, and protection orders. This position has led to greater collaboration between the criminal justice system and the community-based advocacy program, increasing access to services and safety for victims in our community.

Policy

In the 2017 and 2018 legislative sessions, thanks to Marion County’s legislative delegation, the following council priorities were accomplished.

- *Justice Reinvestment Initiative budget* increased from a recommended \$32 million to \$41.2 million.
- *Baseline community corrections funding* was appropriated at \$272 million, not \$239 million as originally recommended.
- *Juvenile Crime Prevention, Basic, and Diversion funds* were appropriated at current service level, rather than reduced by 15% as originally recommended.
- *Marion County is a leader in behavioral health-public safety partnerships*, continuing to receive state grants for mobile crisis teams, jail diversion, and adults unable to “aid and assist” in their own defense.
- *\$250,000 was appropriated to create a sobering center* in the Salem area, diverting clients from the Salem Hospital and Marion County Jail, and connecting them to needed treatment services.
- *Senate Bill 682* changed how child support modifications for incarcerated persons are addressed.
- *Senate Bill 690* established Certificates of Good Standing to remove barriers to occupational licenses.
- *Senate Bill 26* was enacted, adding victim services providers to public safety coordinating councils.
- *Senate Bill 689* reestablishing the Task Force on Reentry, Employment, and Housing passed both chambers, but was vetoed. The body continued to meet as a work group.



Marion County Public Safety Coordinating Council 2019 Legislative Agenda

SUMMARY OF LEGISLATIVE PRIORITIES

COMMUNITY CORRECTIONS

1. SUPPORT Justice Reinvestment grants at the current service level of \$41.6 million, and Supplemental funding at \$7.2 million. The Governor's Recommended Budget is \$46.2 million for both grants. Marion County's Public Safety Coordinating Council spent months during the fall of 2017, reviewing and thoughtfully prioritizing strategies to divert appropriate property and drug offenders from prison to community supervision. Circuit Court judges, District Attorney trial team leaders, and Sheriff's Office Community Corrections Division officers have worked closely together to achieve the Oregon Criminal Justice Commission targets for prison use.

2. SUPPORT the time study recommendation for baseline community corrections funding which serves as the foundation for Marion County's community corrections initiatives, including supervision and jail space for sanctions. As required by ORS 423.486(1), every six years the Oregon Department of Corrections, in collaboration with the Oregon Association of Community Corrections Directors, must submit an "Actual Cost Study" to the legislature. The purpose of this study is to determine the time and monies spent on the 30,000 people under some type of formal supervision, which then recalculates what the "daily rate" per client should be. This exhaustive and almost two-year process resulted in an increase in the daily client cost calculation from \$11.69 to \$14.249, which increases the baseline funding to \$322 million for 2019-21. However, the Governor's Recommended Budget recommends only \$259 million, based on an inflation factor and a statutory change in Earned Discharge. **Marion County supports the current service level at \$322 million, based on the time study calculation.**

3. WATCH recommendations from the Behavioral Health Justice Reinvestment Steering Committee. Without access to effective community-based health care for substance addictions and mental illnesses, too many Oregonians wind up in crisis and then in emergency rooms or jail, leading to high costs and poor health and public safety outcomes.

JUVENILE JUSTICE

1. SUPPORT Senate Bill (SB) 299 prohibiting denial of medical assistance on basis that individual under 18 years of age is in detention pending adjudication. Requires Oregon Health Authority to seek federal approval for federal financial participation in costs of providing medical assistance to such individuals.

2. SUPPORT House Bill (HB) 2502 Modifying juvenile jeopardy law to describe hearings and proceedings that trigger jeopardy. Declares emergency, effective on passage.

3. SUPPORT SB1 establishing Statewide System of Care Task Force. Directs task force to make series of reports and recommend legislation to Legislative Assembly and Governor. Directs task force to make recommendations to Director of Oregon Health Authority, Director of Oregon Youth Authority and Director of Human Services regarding systems of care. Directs task force to create data dashboard regarding youths being served by Oregon Youth Authority, Oregon Health Authority and Department of Human Services. Appropriates moneys from General Fund to Oregon Health Authority for biennial expenses related to task force. Directs Oregon Health Authority, in consultation with Department of Human Services and Oregon Youth Authority, to prepare and publish requests for proposals for regional evaluation and care teams.

MENTAL HEALTH

1. WATCH recommendations from the Behavioral Health Justice Reinvestment Steering Committee.

Without access to effective community-based health care for substance addictions and mental illnesses, too many Oregonians wind up in crisis and then in emergency rooms or jail, leading to high costs and poor health and public safety outcomes.

2. SUPPORT LC 371 that supports staff and technology at the Oregon Health Authority for CCO 2.0. The Oregon Health Authority is currently undertaking a significant advancement of the coordinated care model with a focus on the following four areas to further transform CCOs. Policy Option Package 416 provides \$1.9 million to support this effort.

1. Improving the behavioral health system,
2. Increasing the use of value-based payments,
3. Controlling costs, and
4. Addressing CCO members' social determinants of health.

3. SUPPORT LC 383 to fund intermediate placement options for "aid and assist" misdemeanor defendants by the Oregon Health Authority. More than 40 percent of Oregon State Hospital Aid and Assist (or ".370") patients have been charged with only misdemeanors. This .370 population continues to increase. Legislative Concept 383 would amend ORS 161.370 so that misdemeanant patients are evaluated and treated in the community, unless a certified evaluator determines that the misdemeanant needs a hospital level of care. A successful implementation of LC 383 requires more intermediate placement options; i.e., middle ground between the hospital and living independently in the community, consistent with the U.S. Department of Justice's expectations. Funding amount in the Governor's Recommended Budget is \$ 7.6 million.

LAW ENFORCEMENT

1. SUPPORT HB 2476 requiring a Community Impact Fiscal Impact Statement that considers the statewide impacts of proposed public policy on the criminal justice system.

Will require an analysis of all proposals changing Oregon's public safety system to determine whether the cost (to victims, taxpayers, law enforcement agencies, prosecutors, public defenders, supervising authorities, the Oregon Judicial Department, etc.) outweighs the benefits of the proposed change. The legislation is based on the experience of the State of Washington.

2. SUPPORT HB 2328 strengthening prosecution of car thefts. In 2018, the Oregon District Attorneys Association, Oregon Department of Justice, and Oregon Criminal Defense Lawyers Association negotiated language in House Bill 4161 that would have made it easier to prosecute motor vehicle thefts. The bill died in committee, because of disagreements about the costs of implementing the bill. This legislation moves the negotiated language forward for adoption in 2019.

3. SUPPORT SB 480 clarifying endangering welfare of minor language. In *State of Oregon v. Hobbs*, the court found that possession and use of illicit drugs in a home where children reside is not enough to prove beyond a reasonable doubt that the defendant's home was a place where "unlawful activity involving controlled substances is maintained or conducted." Thus, drug use around minor children is not sufficient to prove a crime. This legislation would add the word "exposed" to an "unlawful controlled substance" in ORS 163.575 to allow for a charge when a person uses or possesses illegal drugs around children.

VICTIM SERVICES

1. SUPPORT legislation that funds victim services. This includes adding \$10 million to the Oregon Domestic and Sexual Violence Services Fund; HB 2570 that adds \$8.3 million for Court Appointed Special Advocates (CASA); and adding \$6 million to the Oregon Network of Child Abuse Intervention Centers budget.

2. SUPPORT extending funds through HB 3067 and continue funding for CourtCare programs for Marion and Polk counties. House Bill 3067 (2017) authorized Marion and Polk counties to establish CourtCare programs that provide quality child care to individuals and parents when they are attending court proceedings, including restraining order hearings. The grant will end on June 30, 2019, unless the Oregon legislature continues to fund it.

3. SUPPORT legislation limiting the access to examine child exploitation material to a safe and controlled environment. Current law requires prosecutors to copy and distribute images of child sexual abuse to defense counsel as required discovery material in any criminal case involving child pornography. This legislation would mirror federal law allowing access to and examination of the alleged illegal child exploitation material at a law enforcement agency, so that copies need not be made or distributed in any way.

HOUSING AND HOMELESSNESS

STILL UNDER DISCUSSION



OREGON

**THE
MARION COUNTY
PUBLIC SAFETY COORDINATING
COUNCIL**

2019 Legislative Agenda

DETAILED



Marion County Public Safety Coordinating Council 2019 Legislative Agenda

COMMUNITY CORRECTIONS

CONTACT: Commander Jeff Wood
Marion County Community Corrections Division

Phone 503-588-6824
jwood@co.marion.or.us

JUSTICE REINVESTMENT

SUPPORT Justice Reinvestment grants at the current service level of \$41.6 million, and Supplemental funding at \$7.2 million. The Governor's Recommended Budget is \$46.2 million for both grants. Marion County's Public Safety Coordinating Council spent months during the fall of 2017, reviewing and thoughtfully prioritizing strategies to divert appropriate property and drug offenders from prison to community supervision. Circuit Court judges, District Attorney trial team leaders, and Sheriff's Office Community Corrections Division officers have worked closely together to achieve the Oregon Criminal Justice Commission targets for prison use.

Marion County's 2017-2019 justice and supplemental reinvestment plan includes: Senate Bill 416 Prison Diversion (\$1.45 million), Jail Reentry (\$524,180), Marion County Specialty Court (\$20,000), Link Up treatment services for co-occurring disorders (\$431,004), Student Opportunity for Achieving Results or SOAR (\$513,842), De Muniz Reentry Resource Center (\$200,000), Transition Services/Housing (\$246,736), and Substance Abuse Treatment (\$78,090).

Through an agreement with the Oregon Department of Corrections, Marion County is expanding its transitional release program in an effort to reduce the number of men and women at state facilities, accepting up to 20 inmates due to release in Marion County.

Marion County community corrections deputies manage 3,200 people on post-prison supervision and probation. 600 adults are released annually from prison to Marion County custody. Under traditional parole and probation practices, Marion County's recidivism rates were as high as 36% in 2002. By 2014, this rate dropped to an all-time low of 14%. Today, persons released from prison participate in assessments to determine their motivation to change and risk to reoffend. Based on assessment scores, offenders are assigned supervision, mentors, substance abuse or mental health treatment, employment skill building, rental assistance, and even parenting classes. County officers connect with more than 100 local employers to open doors for clients who are ready to work.

The cumulative results of these collaborative efforts have resulted in an impressive decrease of over 10,000 prison months since 2014 as compared to our historical baseline.

COMMUNITY CORRECTIONS BASELINE FUNDING

SUPPORT the time study recommendation for baseline community corrections funding which serves as the foundation for Marion County's community corrections initiatives, including supervision and jail space for sanctions. As required by ORS 423.486(1), every six years the Oregon Department of Corrections, in collaboration with the Oregon Association of Community Corrections Directors, must submit an "Actual Cost Study" to the legislature. The purpose of this study is to determine the time and monies spent on the 30,000 people under some type of formal supervision, which then recalculates what the "daily rate" per client should

be. This exhaustive and almost two-year process resulted in an increase in the daily client cost calculation from \$11.69 to \$14.249, which increases the baseline funding to \$322 million for 2019-21. However, the Governor's Recommended Budget recommends only \$259 million, based on an inflation factor and a statutory change in Earned Discharge. **Marion County supports the current service level at \$322 million, based on the time study calculation.**

SUPPORT LC 2126 which provides state funding for misdemeanor assault IV, menacing, and harassment convictions. Baseline community corrections funding from the Oregon Department of Corrections provides for only the supervision of felony probation cases, local control sentences, and post-prison supervision. Absent misdemeanor funding, county community corrections agencies must manage domestic assault and harassment cases without the level of financial support necessary for this high-risk population. Providing state funding through the community corrections formula for misdemeanor assault IV, menacing and harassment convictions will supplement House Bill 4145 (2018), which closed the "boyfriend" loophole, keeping guns away from domestic abusers and stalkers.

MEASURE 57 FUNDING

SUPPORT Measure 57 funding. Oregon Ballot Measure 57 (2008) or Senate Bill (SB) 1087 was a legislatively-referred state statute that prohibits courts from imposing less than a presumptive sentence for persons convicted of specified drug and property crimes under certain circumstances, and requires the Oregon Department of Corrections to provide supplemental funding to local governments for addiction treatment purposes. The Governor's Recommended Budget is \$ 11.2 million. Marion County supports \$11.2 million for Measure 57 funding.

WORKGROUP ON REENTRY, EMPLOYMENT AND HOUSING LEGISLATION

WATCH the following bills endorsed by the workgroup on Reentry, Employment and Housing:

LC 955 requiring each professional licensing board to study criminal background criteria and character standards for licensure, certification or other authorization to provide occupational or professional service regulated by board. This bill addresses the barriers ex-offenders face when trying to get an occupational or professional license resulting from their criminal background or other rules or policies around character.

LC 960 creating a holistic criminal defense pilot program providing pre and post-conviction services in one urban and one rural county.

LC 1255 adopting the America Bar Association's Model Act Governing Confidentiality and Expungement of Juvenile Delinquency Records. Oregon's current expungement statutes lack clarity in language around which records can be expunged and require lengthy waiting periods. This bill would amend Oregon expungement statutes to more closely align with recent American Bar Association model legislation on confidentiality and expungement of juvenile delinquency records.

LC 1646 requiring all public entities to use Oregon State Police for background checks and incentivize private employers to use Oregon State Police by limiting liability with such use.

LC 2315 creating a civil right to an attorney (still being developed).

LC 2355 ending debt-based driver's license suspension. Over the past decade, 334,338 Oregonians have had their driving privileges suspended. These suspensions were not for traffic safety incidents, but because individuals could not pay fines associated with non-criminal traffic violations. Proponents of the legislation

assert that suspending a driver's license deprives people of transportation necessary to get to work, take children to school, keep medical appointments, and care for ill and disabled family members.

LC 2377 creating a task force on education and training opportunities within the Oregon Department of Corrections and requesting funding.

LC 2474 expanding certificates of good standing and prohibiting the denial of an occupational license based on criminal history for those holding a certificate

JUVENILE JUSTICE

CONTACT: Troy Gregg, Director
Marion County Juvenile Department

Phone 503-584-4806
tgregg@co.marion.or.us

WATCH recommendations from the Measure 11 workgroups:

LC 1039 provides that person in custody of Oregon Youth Authority for offense committed while person was under 18 years of age, for which person was sentenced to term of imprisonment with projected release date that falls after person attains 25 years of age but before person attains 27 years of age, is eligible for conditional release hearing.

LC 1040 requires court to include in judgement document age of defendant at time of committing offense if defendant sentenced to term of incarceration and physical custody of defendant is related to age of defendant at time of committing crime. Directs Department of Corrections to transfer person sentenced to term of incarceration for offense committed when person was under 18 years of age to physical custody of Oregon Youth Authority even if criminal proceedings were initiated after person attained 18 years of age.

LC 1405 prohibits person who was under 18 years of age at time of committing offense from being sentenced to life imprisonment without possibility of release or parole. Requires court to consider certain factors as mitigation when sentencing person who was under 18 years of age at time of committing offense.

SB 549 authorizes juvenile offender charged with offense subject to mandatory minimum sentence, who receives mandatory minimum sentence or other sentence of imprisonment, to be eligible for conditional release after serving at least one-half of sentence imposed.

HB 2295 establishes process of earned review for certain young offenders serving terms of imprisonment in custody of Oregon Youth Authority. Specifies eligibility benchmarks. Directs authority to establish Public Safety Panel to consider circumstances of offender and make recommendation to court. Authorizes court to conditionally release young offender upon making certain findings.

SUPPORT Juvenile Crime Prevention in the Governor's Recommended Budget to maintain and add a cost of living adjustment to the Juvenile Crime Prevention diversion funds.

SUPPORT SB 1 Establishing a Statewide System of Care Task Force. Directs task force to make series of reports and recommend legislation to Legislative Assembly and Governor. Directs task force to make recommendations to Director of Oregon Health Authority, Director of Oregon Youth Authority and Director of Human Services regarding systems of care.

SUPPORT SB 299 Prohibiting denial of medical assistance on basis that individual under 18 years of age is in detention pending adjudication. Requires Oregon Health Authority to seek federal approval for federal financial participation in costs of providing medical assistance to such individuals.

SUPPORT HB 2502 clarifying charging of probation violations. The Oregon Court of Appeals made a ruling in 2018 affecting the concept of "double jeopardy" with juveniles. The ruling has created confusion around how to approach a juvenile that is held in detention on a probation or parole violation, versus a new charge, when multiple incidents occur at the same time or shortly together. The Oregon Department of Justice, Oregon District Attorneys Association, and Oregon Juvenile Department Directors Association are forming a workgroup that may result in clarifying the court's ruling. The workgroup may also recommend legislation.

WATCH legislation on juvenile detention guidelines. These concerns came out of the report “Don’t Look Around: A Window Into Inhumane Conditions for Youth at NORCOR,” where concerns were documented about lack of mental health and social development needs of youth placed in juvenile detention (<https://droregon.org/investigative-report-conditions-youth-norcor/>). The Oregon Juvenile Department Directors Association and Disability Rights Oregon are working together to re-evaluate current detention guidelines to maintain best practices and a consistent approach to working with youth in detention.

MENTAL HEALTH

CONTACT: Cary Moller, Administrator
Marion County Health & Human Services Department
Justin Hopkins, Executive Director
Mid-Valley Behavioral Care Network

Phone 503-361-2695
cdmoller@co.marion.or.us
Phone 503-585-4935
jhopkins@mvcn.org

BEHAVIORAL HEALTH JUSTICE REINVESTMENT STEERING COMMITTEE

WATCH recommendations from the Behavioral Health Justice Reinvestment Steering Committee. Without access to effective community-based health care for substance addictions and mental illnesses, too many Oregonians wind up in crisis and then in emergency rooms or jail, leading to high costs and poor health and public safety outcomes.

During the summer of 2018, state and county leadership requested and received support for a behavioral health justice reinvestment approach from the public-private partners in the federal Justice Reinvestment Initiative, the U.S. Department of Justice's Bureau of Justice Assistance, and the Pew Charitable Trusts. This approach will focus on developing a statewide policy framework to help support tribal government, county, and local systems in improving recidivism and health outcomes for the small, but important, group of people who repeatedly cycle through both the public safety and health systems.

State leaders have established a Behavioral Health Justice Reinvestment Steering Committee, co-chaired by Oregon Health Authority Director Pat Allen and Sheriff Jason Myers. The 28-member committee includes designees from all three branches of government, as well as state, tribal nation, and county criminal justice and health stakeholders. Additionally the Council of State Governments Justice Center will provide analytical support and health and justice system expertise.

The committee will likely propose policy recommendations to the 2019 legislature.

CRIMINAL JUSTICE-BEHAVIORAL HEALTH PARTNERSHIP

SUPPORT state funds for mental health programs. The Governor's Recommended Budget includes \$16 million to continue community mental health services, previously funded through marijuana tax revenues in 2017-19 (Policy Option Package 408). The council also supports Policy Option Package 413, covering a \$9 million shortfall financed by tobacco tax revenues in 2017-19, that pays for rental assistance, mobile crisis services, and outpatient substance use disorder services.

SUPPORT the following Policy Option Packages in the Governor's Recommended Budget.

402 – Expand Behavioral Health Services, including suicide intervention and prevention, in schools for children and youth; develop adult suicide prevention, intervention and post-intervention plan (\$13,103,059).

403 – Create and expand Intensive Community-Based In-Home Behavioral Health Services for Oregon children (\$6,575,316). Due to a lack of intensive community-based services, many Medicaid-eligible youth are referred to residential care instead of receiving treatment in their home community. Creating and funding new community-based intensive care opportunities would increase diversity of services and provide alternatives available to Medicaid-eligible youth.

409 – Develop Opioid Alternate Pain Education modules and expand resources for Substance Use Disorder analysis (\$312,700).

OREGON HEALTH AUTHORITY “370” AID AND ASSIST POPULATION

SUPPORT LC 383 to fund intermediate placement options for “aid and assist” misdemeanor defendants by the Oregon Health Authority. More than 40 percent of Oregon State Hospital Aid and Assist (or “.370”) patients have been charged with only misdemeanors. This .370 population continues to increase. Legislative Concept 383 would amend ORS 161.370 so that misdemeanant patients are evaluated and treated in the community, unless a certified evaluator determines that the misdemeanant needs a hospital level of care. A successful implementation of LC 383 requires more intermediate placement options; i.e., middle ground between the hospital and living independently in the community, consistent with the U.S. Department of Justice’s expectations. Funding amount in the Governor’s Recommended Budget is \$ 7.6 million.

CIVIL COMMITMENTS

WATCH LC 749 mental health holds. Proponents of this legislation maintain pre-commitment staff have five court days from the time a hold is placed on an individual up until the time the person needs to be in court. This is insufficient time for staff to evaluate whether the client should be sent to community diversion or the Oregon State Hospital. This legislation would allow an emergency certification or petition for the immediate hold of an individual for up to fifteen days, or holding an individual for ten or more days, if probable cause for an involuntary emergency hold is found. Opponents of this legislation maintain that increasing the hold time is costly, placing a significant demand on the number of psychiatric beds available in the community. An individual may be unnecessarily placed in a secure setting and have his or her civil liberties suspended.

SUPPORT LC [number] establishing community commitment and alternative outpatient treatment for civil commitments discharged from a hospital or a treatment facility.

- Upon discharge from a hospital or treatment facility (following stabilization), a client must appear at court within two weeks and as frequently as the court requires thereafter;
- Community commitment would be mandatory for at least three months following initial commitment, unless treating psychiatrist ends earlier;
- Psychiatrist can request initial commitment period of more than 3 months but less than 24 months;
- Diagnosis and treatment remain with psychiatrist, including ending commitment;
- Extensions beyond three months are at the recommendation of the psychiatrist and have a specific court hearing, both patient and psychiatrist must appear;
- Client expends no more than 24 months on community commitment;
- Model includes robust and coordinated case management, along with robust and coordinated communication among all partners, including psychiatrist service providers, housing providers, and courts.

OREGON HEALTH PLAN/MEDICAID

SUPPORT LC 371 that supports staff and technology at the Oregon Health Authority for CCO 2.0.

The Oregon Health Authority is currently undertaking a significant advancement of the coordinated care model with a focus on the following four areas to further transform CCOs. Policy Option Package 416 provides \$1.9 million to support this effort.

1. Improving the behavioral health system,
2. Increasing the use of value-based payments,
3. Controlling costs, and
4. Addressing CCO members’ social determinants of health.

LAW ENFORCEMENT

CONTACTS:

Marion County Sheriff Jason Myers	503-589-3233	jmyers@co.marion.or.us
Marion County District Attorney Paige Clarkson	503-588-5485	pclarkson@co.marion.or.us
Salem Police Chief Jerry Moore	503-588-6308	gmoore@cityofsalem.net
Woodburn Police Chief Jim Ferraris	503-982-2350	jim.ferraris@ci.woodburn.or.us
Oregon State Police Lt. Michael Iwai	503-569-5379	michael.iwai@state.or.us

PROSECUTION

SUPPORT legislation amending the felony sex crimes statute. In *State v. Carlton*, 361 Or 29 (2017), the Oregon Supreme Court reversed a life sentence imposed pursuant to ORS 137.719 (third strike for felony sex offense), because one of the defendant's felony sex offense convictions in California was not "comparable" to a felony sex offense in Oregon. The court looked at the defendant's felony conviction in California for "lewd and lascivious conduct upon a child" which did not specifically require proof that the defendant had contact with a "sexual or intimate part" of the child, as Oregon's Sex Abuse I standards would require. Thus the two offenses were not "comparable" and the defendant's California felony sex abuse conviction could not count as a predicate for purposes of ORS 137.719. The Carlton court commented on the "sparse" legislative history of ORS 137.719. This change in law will allow an Oregon court to consider all felony sex crimes that occur outside of the state.

SUPPORT legislation modifying qualified interpreter hearsay rules so that they can be admissible in court. Case law makes it nearly impossible to use competently interpreted statements for victims and defendants in court. Counties with large Hispanic populations are significantly impacted by these limitations. This bill will make otherwise inadmissible qualified interpreted statements admissible in court.

SUPPORT legislation requiring testimony by defendants to be sworn. ORS 135.095 allows a defendant to make an unsworn statement at a preliminary hearing at the close of the state's evidence, while victims are required to give sworn testimony. This bill would require a defendant's voluntary statement to be under oath and thus potentially subject to the penalty of perjury or used for impeachment purposes in future hearings.

SUPPORT SB 377 adding "contempt" to eligible offenses. Currently police officers cannot apply for a search warrant for "contempt" as it is not defined as a "crime." Thus, charges resulting from conduct like the violation of a restraining order often lack proper investigation. The legislation adds "contempt" to the search warrant statute and also adds "criminal contempt violence restraining order" to the definition of "offense" in ORS 161.505.

SUPPORT HB 2328 strengthening prosecution of car thefts. In 2018, the Oregon District Attorneys Association, Oregon Department of Justice, and Oregon Criminal Defense Lawyers Association negotiated language in House Bill 4161 that would have made it easier to prosecute motor vehicle thefts. The bill died in committee, because of disagreements about the costs of implementing the bill. This legislation moves the negotiated language forward for adoption in 2019.

SUPPORT SB 362 requiring reasonable and timely notice in guilty except insanity defenses. Prosecutors need proper notice to meet this complicated defense requiring expert testimony. Current statutes allow a defendant to raise this defense as late as the morning of trial. In *State v. Robinson*, 288 Or App 194 (2017), the Court of Appeals noted a fix for this situation "would not be difficult for the legislature to remedy" and further offered the opinion that the court was "mindful of the realities of current criminal practice, and of the practical effect of this decision. Although ORS 161.309 notice provisions may have been consonant with Oregon criminal

practice 80 years ago when the 1937 legislature adopted them, or 46 years ago when the 1971 legislature decided to continue them, they are not today.” This bill would require defense counsel to provide timely and reasonable notice to prosecutors when they intend to pursue a Guilty Except Insanity Defense.

SUPPORT SB 480 clarifying endangering welfare of minor language. In *State of Oregon v. Hobbs*, the court found that possession and use of illicit drugs in a home where children reside is not enough to prove beyond a reasonable doubt that the defendant's home was a place where "unlawful activity involving controlled substances is maintained or conducted." Thus, drug use around minor children is not sufficient to prove a crime. This legislation would add the word “exposed” to an “unlawful controlled substance” in ORS 163.575 to allow for a charge when a person uses or possesses illegal drugs around children.

POLICE EVIDENCE

SUPPORT legislation expediting Oregon testing for DUI evidence. The Oregon State Police and law enforcement partners are working under an expiring grant that funded blood testing in driving under the influence cases and current testing backlog. The current urine sample backlog is more than 2,200 samples. Locally, we are experiencing a backlog wait time for lab results of 12-18 months. This is a significant problem for both provability of these cases and the safety of our roads, as the backlog even includes cases of Felony DUII and circumstances in which victims are killed or suffer serious injury. The expiring grant expedited testing, so that prosecutors could expedite charging decisions. This bill eliminates the need to rely on a grant to test necessary evidence, allows prosecutors to make timely charging decisions, and thus keeps untreated, impaired drivers off the roads. Defendants will benefit from a lessened time of uncertainty in knowing whether charges will be filed.

SUPPORT legislation requiring LEDS entry for prohibited purchasers of firearms. Someone who has been found unfit to proceed in a court proceeding because of a mental illness is disqualified under current statutes from purchasing a firearm. However, that information is not always entered into Law Enforcement Data System (LEDS). This bill would require these findings to be reported by the courts to LEDS and would therefore be evident as a disqualifier during the attempted purchase of a firearm, thus keeping guns out of the hands of mentally unstable individuals.

COST OF CRIME IMPACT STATEMENTS

SUPPORT HB 2476 requiring a Community Impact Fiscal Impact Statement that considers the statewide impacts of proposed public policy on the criminal justice system. Will require an analysis of all proposals changing Oregon’s public safety system to determine whether the cost (to victims, taxpayers, law enforcement agencies, prosecutors, public defenders, supervising authorities, the Oregon Judicial Department, etc.) outweighs the benefits of the proposed change. The legislation is based on the experience of the State of Washington.

ENFORCEMENT

SUPPORT LC 413, expanding Oregon State Police patrols. This legislation would provide that the Oregon State Police patrol maintain a patrol trooper staffing level of at least 15 troopers per 100,000 residents. The Oregon State Police has eight troopers per 100,000 population and ranks 48th out of the 49 states with highway patrols in the United States.

SUPPORT LC 644 reforming campus public safety (Kaylee’s Law). Kaylee Sawyer was murdered by a campus security officer whom she mistook for a police officer. This legislation provides that campus public

safety officers and private security professionals do not have stop and frisk authority. The legislation also creates restrictions on the types of vehicles, uniforms, and equipment campus security officers can use. It exempts retired members of the Public Employees Retirement System from limitations on reemployment, if the member is reemployed by a public university as a special campus security officer.

SUPPORT LC 1407 Oregon Schools Safe to Learn Act. This measure establishes a statewide school safety and prevention system, based on Marion County's threat assessment team model.

SUPPORT LC 1773 reforming redemption rights. This measure addresses unscrupulous individuals and companies that aggressively persuade judgment debtors or their heirs to sell their property and/or redemption rights by taking advantage of the debtors' lack of knowledge or understanding of those rights. These same aggressive individuals and companies may also obtain excess funds, due to the debtor after foreclosure sale, without debtors knowing they may have been entitled to those funds. These individuals and companies are acting as foreclosure consultants without being subject to the Mortgage Rescue Fraud Protection Act under ORS 646A.700 et seq.

SUPPORT LC 1777 concealed handgun license FBI fingerprint background check fee. This measure increases from \$50 to \$65 the sheriff's concealed handgun license background check fee. The \$50 fee has been the same since 1994. The measure also allows sheriffs to collect the fee.

SUPPORT LC 2121 augmenting Search and Rescue funding. A coalition including sheriffs, outdoor recreation organizations, Mt. Hood Meadows, Oregon Parks and Recreation Office of Outdoor Recreation, Oregon Emergency Management, Oregon Restaurant and Lodging Association, and Travel Oregon are developing legislation to create an Oregon Outdoor Recreation Search and Rescue Fund through voluntary donations by individuals purchasing recreation passes.

SUPPORT LC [number] addressing "zombie house" nuisance properties. This legislation is patterned after a similar law in the state of Washington that addresses vacant or unoccupied properties where squatters create a neighborhood nuisance.

SUPPORT legislation criminalizing the threat of a mass casualty event. Oregon Revised Statutes do not make it a crime to threaten a mass shooting or similar mass casualty event, if the individual is actually intending to follow through. This legislation would make it a crime to threaten a mass shooting or similar mass casualty event, if the individual intends to follow through.

VICTIM SERVICES

CONTACTS:

Jayne Downing, Executive Director Center for Hope and Safety	503-378-1572	jayne@hopeandsafety.org
Susana Escobedo, Victim Assistance Director Marion County District Attorney's Office	503-361-2652	sescobedo@co.marion.or.us
Alison Kelley, CEO, Liberty House	503-540-0288	akelley@libertyhousecenter.org

SUPPORT adding \$10 million to the Oregon Domestic and Sexual Violence Services Fund. The Oregon Domestic and Sexual Violence Services Fund was created in 2001 and is managed by the Oregon Department of Justice. This is the most flexible source of funding available for victims of domestic violence and sexual assault shelter programs. Marion County's domestic violence programs received \$485,948 in 2017-19 from the fund and used the proceeds for activities, such as 24-hour crisis line in English and Spanish, emergency confidential shelter, support groups, walk-in advocacy services, and culturally-specific services to the Latino/Hispanic community. This legislative proposal would dedicate additional dollars to this fund for prevention, allowing increased staffing, shelter space, services to survivors in crisis, and trauma-informed training for law enforcement responders. The proposal is to add \$10 million to the fund, bringing the total amount for 2019-21 to \$20.16 million.

WATCH legislation prioritizing housing funds for survivors of domestic violence and protecting tenants from unfair evictions and extreme rent increases. Four in ten Oregonians rent their homes and are at risk of displacement from rent spikes or unfair eviction at any time. Renters who pay rent on time and comply with the rules are still at risk of displacement with 30 to 90 days' notice of no-cause eviction or extreme rent increase. Available, affordable units are increasingly hard to find, which means many families and even whole communities are being displaced.

WATCH SB 608 creating a just-cause eviction standard, requiring a legitimate reason for termination, (such as a tenant violating a lease or a landlord's business or family necessity) and protect tenants from extreme rent spikes during a tenancy by limiting increases to 7% plus the CPI per year, with certain exceptions.

WATCH funding for housing navigation services at domestic violence shelters to help survivors navigate the rental market and find safe, stable, affordable housing.

SUPPORT SB 296 and HB 2480 allowing digital hearsay/private audio recordings to be admissible as evidence. Many victims of crimes, such as domestic violence, sexual assault, child abuse, and sexual harassment, are now secretly recording crimes and confessions to crimes by perpetrators on their phones. These recordings are not currently admissible as evidence. This bill would allow certain recordings to be admissible as evidence in trial.

SUPPORT legislation allowing for multiple jurisdiction/same crime victim cases. When a defendant is charged in multiple jurisdictions for crimes against the same victim, and the victim is vulnerable (a child or an elderly person), this legislation would allow all incidents to be tried in one county, so that the victim is protected from the trauma of multiple trials in different jurisdictions. Currently, victims must face the rigors of trial and the trauma of confronting their abusers multiple times in order to obtain a full measure of justice.

SUPPORT legislation limiting the access to examine child exploitation material to a safe and controlled environment. Current law requires prosecutors to copy and distribute images of child sexual abuse to defense

counsel as required discovery material in any criminal case involving child pornography. This legislation would mirror federal law allowing access to and examination of the alleged illegal child exploitation material at a law enforcement agency, so that copies need not be made or distributed in any way.

SUPPORT legislation increasing the crime classification for assault of a toddler. Several recent court cases have highlighted a gap in sentencing under the current crime categories for Assault I of a child under the age of six years. This legislation would direct the Oregon Criminal Justice Commission to classify Assault I of a child under six to be a crime category 11. Through this legislation, the state would provide discretion to a judge when the facts merit a lengthier prison sentence for toddler assault.

SUPPORT legislation staying civil proceedings against victims during a criminal case. Ancillary civil proceedings against victims can be used to force victims to testify before or during a criminal proceeding. This legislation mirrors Michigan law that prohibits a defendant in a criminal action for criminal sexual conduct from commencing or maintaining a civil action against a victim of the crime for which the defendant is charged, if the criminal action is pending and is based on statements or reports that pertain to the criminal action.

SUPPORT legislation establishing victim rights to be notified of release decisions. While a victim has a constitutional right to be present at a release hearing, this right does not extend to administrative release decisions made by jails outside of a court process. Further, the presence of the victim at a release hearing does not ensure that court is required to weigh victim and public safety when making a release decision. This legislation would require notice to victims, and a meaningful court hearing, before release could be granted or a reduction in bail be set in cases of certain person crimes.

SUPPORT HB 2570 adding \$8.3 million for Court Appointed Special Advocates (CASA). CASA received \$2.67 million in the 2017-19 biennium to support trained volunteers who advocate in court for the best interests of children involved in the child welfare system. The Governor's Recommended Budget adds \$3 million, totaling \$5.67 million for 2019-21. The additional funding would recruit, train, and supervise new CASA's to serve more than 6,000 Oregon children in foster care, providing \$237,000 to Marion County's CASA program.

SUPPORT adding \$6 million to the Oregon Network of Child Abuse Intervention Centers budget. There are a number of mandates and state laws requesting child abuse intervention centers provide assessments for children. The current level of state funding covers 17% of the cost to run these centers. An additional \$6 million will increase the funding level to 30% of the cost.

SUPPORT extending funds through HB 3067 and continue funding for CourtCare programs for Marion and Polk counties. House Bill 3067 (2017) authorized Marion and Polk counties to establish CourtCare programs that provide quality child care to individuals and parents when they are attending court proceedings, including restraining order hearings. The grant will end on June 30, 2019, unless the Oregon legislature continues to fund it.

WATCH LC 2086 which contemplates creating a statewide CourtCare program. Funding will be based on a surcharge on court filings.

HOUSING AND HOMELESSNESS

CONTACT: James LaBar, Housing Policy Advisor
Oregon Governor's Office

Phone 971-209-8341
james.labar@oregon.gov

WATCH the Oregon Housing Stability Council's 2019 legislative agenda.

Strategies include:

- Acquisition of multi-family housing (\$20 million in Lottery Revenue Bonds)
- Creating a capital gains tax exemption for owners who sell properties to an affordable housing provider
- Dedicating funding to address child homelessness (\$8 million General Fund)
- Raising the Current Service Level for Emergency Housing Assistance (\$21.2 million General Fund) and State Homeless Assistance Program (\$8.8 million General Fund)
- Increasing the annual Individual Development Account (IDA) tax credit from \$7.5 million to \$15 million
- Dedicating new funds for the Local Innovation and Fast Track Housing (LIFT) program (\$80 million in XI-Q bond proceeds)
- Allowing LIFT funds to be used for low-subsidy housing or service-enriched housing
- Establishing permanent supportive housing through a fund that allows for rental assistance, services, and operations (\$18.7 million in Lottery Revenue Bonds)
- Allowing local governments to access resources to develop multifamily housing serving low and moderate income renters and homebuyers
- Modifying statutory provisions surrounding the Housing Development Guarantee account to allow interest to be used for administration, increasing income limits for clients served, and allowing the program to be used for single family purposes
- Dedicating funds to support preservation of existing, publicly-supported affordable housing (\$20 million in Lottery Revenue Bonds)
- Dedicating funding for "Ready to Rent" and "Rentwell" classes for low income Oregonians (\$5 million General Fund)
- Allowing qualified affordable housing developers and individual property owners to replace pre-1976 or pre-HUD code mobile or manufactured homes

WATCH the Oregon Housing Alliance legislative recommendations.

Proposals include:

- Funding for emergency rent assistance, emergency shelter, and rapid rehousing (\$50 million General Fund)
- Increasing supply of supported housing (\$18.7 million in Lottery Revenue Bonds)
- Amending statutes to remove ability of landlords to exercise "no cause" evictions
- Creating protections from economic evictions through unlimited rent increases
- Increasing funds to develop affordable housing through the Local Innovation and Fast Track (LIFT) program (\$200 million in general obligation bonds)
- Increasing resources to preserve existing affordable housing
- Expanding Oregon Individual Development Accounts



OREGON

**THE
MARION COUNTY
PUBLIC SAFETY COORDINATING
COUNCIL**

2019 Legislative Agenda

BACKGROUND



MARION COUNTY PUBLIC SAFETY COORDINATING COUNCIL BACKGROUND

MEASURE 11 AND SENATE BILL 1145

In 1995, Oregon voters passed Measure 11 to increase prison time for violent crimes, sending more people to state prisons for longer sentences. To ease the overcrowding of state prisons and manage offenders more effectively, the Legislative Assembly also enacted Senate Bill 1145 (1995) and House Bill 3489 (1996 Special Session), which transferred responsibility for the incarceration of people committing felony offenses sentenced to less than one year from the Oregon Department of Corrections to counties. In the past, the penalty for committing a felony was the possibility of incarceration in excess of a year in a state penitentiary, while people committing misdemeanors could get a jail sentence of one year or less in the county jail. Under Senate Bill 1145, counties assumed responsibility for people on parole, probation, post-prison supervision, sentenced to twelve months or less incarceration, or sanctioned by a court or the state Board of Parole and Post-Prison Supervision to twelve months or less for violating a condition of parole or post-prison supervision.

Counties now became responsible for increasing access to community-based corrections and treatment services, and enhancing supervision and accountability in communities. The distinction between state and county responsibility for an inmate now came to be based upon the length of a sentence, not if the individual had committed a misdemeanor or a felony.

Senate Bill 1145 allowed counties to impose sanctions other than incarceration, so that counties could design treatment programs for people released back into the community, since studies showed these types of reentry programs make it less likely that individuals will reoffend.

LOCAL PUBLIC SAFETY COORDINATING COUNCILS

Senate Bill 1145 also required all counties in Oregon to form local public safety coordinating councils. Oregon Revised Statutes 423.560 defines the roles and responsibilities of local public safety coordinating councils which are advisory councils to county boards of commissioners. These include:

1. Developing and recommending to the county board of commissioners:
 - (A) Plans for the use of state resources to serve the local adult offender population;
 - (B) Plans for the use of state and local resources to serve local offenders 15-18 years old: Plan must coordinate community-wide services involving prevention, treatment, education, employment resources and intervention strategies;
 - (C) A plan designed to prevent criminal involvement by youth. Plan must include coordination of community wide services involving treatment, education, employment and intervention strategies aimed at crime prevention; and
2. Coordinate local criminal justice policy for both adults and juveniles among the appropriate criminal justice entities.

The *Marion County Public Safety Coordinating Council* was formed in 1997. Today there are 32 members on the council. Membership includes public safety, education, social services, civic and business leaders, and practitioners representing law enforcement, prosecution, community corrections, public defense, judiciary, domestic violence, public and mental health, substance abuse, veterans, and juvenile justice. The group meets monthly to carry out its responsibilities. In addition to the mandated requirements, the council works to forge

long-term partnerships in the public safety system through an environment of collaboration, leadership, data-driven policy, transparency, and accountability.

JUSTICE REINVESTMENT INITIATIVE

The passage of House Bill 3194 in 2013 transformed the level of engagement that local public safety councils have with the State of Oregon. Justice Reinvestment invests in community public safety by controlling the growth of Oregon’s prison population. Beyond “baseline” community corrections funding based upon caseloads and workload, local public safety councils now receive state Justice Reinvestment grants that reward success through evidence-based corrections program strategies that deter recidivism and crime and increase community safety.

Marion County, through the exemplary groundwork laid by the Marion County Justice Reinvestment Council, effectively targeted these Justice Reinvestment funds. Since 2009, the Marion County Reentry Initiative has built and refined a continuum of services to address the criminogenic needs of the adult reentry population. The initiative has targeted high to medium risk offenders—who are the most likely to recidivate—transitioning back to the county.

Annually more than 600 adults are released from prison to Marion County custody. Under traditional parole and probation practices, Marion County’s recidivism rates were as high as 36% in 2002. Through the reentry initiative, the recidivism rate declined to an all-time county low of 14% in 2014. Recidivism reduction strategies include: Link Up for co-occurring disorders; Student Opportunity for Achieving Results (SOAR), a cohort-based, intensive program on the Chemeketa Community College campus; and the De Muniz Reentry Resource Center, a one-stop center for employment, housing, and other resources.

Through justice reinvestment, certain non-violent property and drug offenders are no longer sent to prison. Prison diversion strategies include: Senate Bill 416 Prison Diversion Program; Jail Reentry program; specialty courts; and other enhancements, such as the Family Sentencing Alternative Program. Through an agreement with the Oregon Department of Corrections, Marion County is expanding its work release program in an effort to reduce the overall number of inmates in prison, accepting up to 25 inmates to ease crowding in state prisons.



MARION COUNTY PUBLIC SAFETY COORDINATING COUNCIL

2019 Membership Roster and Contact Information

NAME	AFFILIATION/ADDRESS	WORK PHONE	EMAIL
Mark Caillier	Citizen Member	503-930-7481	markcaillier@comcast.net
Commissioner Kevin Cameron, Chair	Board of Commissioners' Office 555 Court Street NE PO Box 14500 Salem, OR 97309	503-588-5212	kcameron@co.marion.or.us
Robert Carney	Councilor City of Woodburn 270 Montgomery Street Woodburn, OR 97071	503-982-5228	carneyrj@wbcable.net
Paige Clarkson	Marion County District Attorney 555 Court Street NE PO Box 14500 Salem, OR 97309	503-588-5596	pclarkson@co.marion.or.us
Kim Doster	Veterans' Representative	503-463-0134	kimb@tntmanagement.com
Jayne Downing	Executive Director Center for Hope and Safety 605 Center Street NE Salem, OR 97301	503-378-1572	jayne@hopeandsafety.org
Chief Jim Ferraris	City of Woodburn Police Department 1060 Mount Hood Avenue Woodburn, OR 97071	503-982-2350	jim.ferraris@ci.woodburn.or.us
Don Frederickson, Vice-Chair	Business Representative Skyline Ford Sales Inc., 2510 Commercial Street SE Salem, OR 97302	503-581-2411 x127 503-551-4975	skyford@aol.com
The Honorable Courtland Geyer	Marion County Circuit Court 100 High Street NE Salem, OR 97301	503-588-5135	courtland.geyer@ojd.state.or.us
Tamra Goettsch	Director Marion County Community Services Department 555 Court Street NE PO Box 14500 Salem, OR 97309	503-589-3200	tgoettsch@co.marion.or.us
Troy Gregg	Director Marion County Juvenile Department 3030 Center Street NE Salem, OR 97301	503-584-4806	tgregg@co.marion.or.us
Levi Herrera-Lopez	Director Mano a Mano Family Center 3850 Portland Road, Suite 214 Salem, OR 97301	503-315-2290	levi@manoamanofc.org



MARION COUNTY PUBLIC SAFETY COORDINATING COUNCIL

2019 Membership Roster and Contact Information

NAME	AFFILIATION/ADDRESS	WORK PHONE	EMAIL
Councilor Roland Herrera	Citizen Member	503-779-9512	rolandherrera@comcast.net
Justin Hopkins	Executive Director Mid-Valley Behavioral Care Network 550 Hawthorne Avenue SE, Suite 140 Salem OR 97301	503-585-4991	jhopkins@mvbcn.org
Lt. Michael S. Iwai	Albany Area Command Oregon State Police 3400 Spicer Drive SE Albany, OR 97322	503-569-5379	michael.iwai@state.or.us
Jessica Kampfe	Marion County Public Defender 198 Commercial Street SE, Suite 240 Salem, OR 97301	503-480-0521	jkampfe@pdm Marion.org
Pastor Garland King	Citizen Member	971-283-2345	garvin1115@gmail.com
Greg Leo	Citizen Member	503-804-6391	greg@theleocompany.com
Representative Rick Lewis	House District 18 State Capitol 900 Court Street NE, H-479 Salem, OR 97301	503-986-1418	rep.ricklewis@oregonlegislature.gov
Pete McCallum	Citizen Member	503-982-5741	pimac@web-ster.com
Todd McCann	Public Defender/Attorney 1795 Commercial Street SE Salem, OR 97302	503-566-2822	tcmpe@comcast.net
Ed McKenney	Business Representative President, Gem Equipment 1010 N. Main Street Mt. Angel, OR 97362	503-845-1903	gem@gemequipment.com
Cary Moller	Administrator Marion County Health and Human Services Department 3180 Center Street NE Salem, OR 97301	503-585-4978	cdmoller@co.marion.or.us
Chief Jerry Moore	City of Salem Police Department 555 Liberty Street SE Salem, OR 97301	503-588-6308	jmoore@cityofsalem.net
Sheriff Jason Myers	Marion County Sheriff's Office 100 High Street NE Salem, OR 97301	503-589-3216	jmyers@co.marion.or.us
Diane Morse	Trial Court Administrator Marion County Circuit Court 100 High Street NE Salem, OR 97301	503-584-4752	diane.m.morse@ojd.state.or.us



MARION COUNTY PUBLIC SAFETY COORDINATING COUNCIL

2019 Membership Roster and Contact Information

NAME	AFFILIATION/ADDRESS	WORK PHONE	EMAIL
The Honorable Tracy Prall	Presiding Judge Marion County Circuit Court 100 High Street NE Salem, OR 97301	503-373-4445	tracy.a.prall@ojd.state.or.us
Michael Runyon*	Supervisor OYA Marion Parole/Probation Unit 2001 Front Street, Suite 100 Salem, OR 97301	503-378-6804 x225 503-400-2966	michael.runyon@oya.state.or.us
Cari Sessums	Alcohol and Drug Planning Committee Representative	503-767-3945	billyandcari@wbcable.net
John Van Dreal	Director Safety and Risk Management Services Salem-Keizer School District 2450 Lancaster Drive NE Salem, OR 97305	503-881-1915	vandreal_john@salkeiz.k12.or.us
Mayor Kim Wallis	City of St. Paul 20239 Main Street NE St Paul, OR 97137	503-633-8231	mayor@stpaultel.com

* NON-VOTING MEMBER



MARION COUNTY
JUSTICE REINVESTMENT INITIATIVE COUNCIL
2019 Membership Roster and Contact Information

NAME	AFFILIATION/ADDRESS	WORK PHONE	EMAIL
Patrice Altenhofen	Executive Director Family Building Blocks 2425 Lancaster Drive NE Salem, OR 97305	503-566-2132	patrice@familybuildingblocks.org
Ann-Marie Bandfield	Health Program Manager Acute & Forensic Behavioral Health Marion County Health & Human Services Department 3180 Center Street NE Salem, OR 97301	503-585-4949	amandfield@co.marion.or.us
Sherry Bensema	EMS Coordinator Lyons Rural Fire Protection District 1114 Main Street Lyons, OR 97358	503-859-2410	lyonsambulance@gmail.com
Kevin Cameron	Marion County Commissioner Board of Commissioners' Office PO Box 14500 555 Court Street Salem, OR 97309	503-588-5212	kcameron@co.marion.or.us
Paige Clarkson	Marion County District Attorney PO Box 14500 555 Court Street Salem, OR 97309	503-588-5596	pclarkson@co.marion.or.us
Dan Clem	Executive Director Union Gospel Mission 745 Commercial Street NE Salem, OR 97301	503-967-6388	danclem@ugmsalem.org
Erik Andersson	President SEDCOR 626 High Street NE, Suite 200 Salem, OR 97301	503-588-6225	eandersson@sedcor.com
Tamra Goettsch	Director, Marion County Community Services Department PO Box 14500 555 Court Street Salem, OR 97309	503-589-3200	tgoettsch@co.marion.or.us
Julie Huckestein	President Chemeketa Community College 4000 Lancaster Drive NE Salem, OR 97305	503-399-5050	julie.huckestein@chemeketa.edu
Jessica Kampfe	Marion County Public Defender 198 Commercial Street SE, Suite 240 Salem, OR 97301	503-480-0521	jkampfe@pdm Marion.org
Alison Kelley	Executive Director Liberty House 2685 4 th Street NE Salem, OR 97301	503-540-0288	akelley@libertyhousecenter.org
Michael Laharty	Executive Director Creekside Counseling 2586 12 th Place SE Salem, OR 97302	503-371-4160	jmlaharty@live.com



MARION COUNTY
JUSTICE REINVESTMENT INITIATIVE COUNCIL
 2019 Membership Roster and Contact Information

NAME	AFFILIATION/ADDRESS	WORK PHONE	EMAIL
Skip Miller	Deputy Chief Salem Police Department 555 Liberty Street SE Salem, OR 97301	503-932-4919	smiller@cityofsalem.net
Tina Morris	Administrator of Care Management Salem Hospital 890 Oak Street Salem, OR 97301	503-814-1804	tina.morris@salemhealth.org
Tim Murphy	Chief Executive Officer Bridgeway Recovery Services PO Box 17818 Salem, OR 97305	503-363-2021	tmurphy@bridgewayrecovery.com
Sheriff Jason Myers	Marion County Sheriff's Office 100 High Street NE Salem, OR 97301	503-589-3216	jmyers@co.marion.or.us
Jeff Steeprow	Project Director Worksource Oregon 605 Cottage Street NE Salem, OR 97301	503-378-8093	jeff.l.steeprow@oregon.gov
Dick Withnell	Withnell Motors 2650 Commercial Street SE Salem, OR 97302	503-364-0184	dick@withnellauto.com
Jeff Wood, Chair	Commander Parole and Probation Division Marion County Sheriff's Office 4000 Aumsville Highway SE Salem, OR 97317	503-588-5094	jwood@co.marion.or.us

Senate Bill 7

Sponsored by Senator COURTNEY (Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure as introduced.

Provides that person commits offense of driving while under influence of intoxicants or offense of operating boat while under influence of intoxicants if person drives vehicle or boat and has 0.05 percent or more by weight of alcohol in person's blood.

A BILL FOR AN ACT

1
2 Relating to offenses committed while under the influence of intoxicants; creating new provisions; and
3 amending ORS 811.182, 813.010, 813.130, 813.131, 813.210, 813.300, 813.410, 813.602 and 830.510.

4 **Be It Enacted by the People of the State of Oregon:**

5 **SECTION 1.** ORS 813.010 is amended to read:

6 813.010. (1) A person commits the offense of driving while under the influence of intoxicants if
7 the person drives a vehicle while the person:

8 (a) Has ~~0.08~~ **0.05** percent or more by weight of alcohol in the blood of the person as shown by
9 chemical analysis of the breath or blood of the person made under ORS 813.100, 813.140 or 813.150;

10 (b) Is under the influence of intoxicating liquor, cannabis, a controlled substance or an inhalant;
11 or

12 (c) Is under the influence of any combination of intoxicating liquor, cannabis, a controlled sub-
13 stance and an inhalant.

14 (2) A person may not be convicted of driving while under the influence of intoxicants on the
15 basis of being under the influence of a controlled substance or an inhalant unless the fact that the
16 person was under the influence of a controlled substance or an inhalant is pleaded in the accusatory
17 instrument and is either proved at trial or is admitted by the person through a guilty plea.

18 (3) A person convicted of the offense described in this section is subject to ORS 813.020 in ad-
19 dition to this section.

20 (4) Except as provided in subsection (5) of this section, the offense described in this section,
21 driving while under the influence of intoxicants, is a Class A misdemeanor and is applicable upon
22 any premises open to the public.

23 (5)(a) Driving while under the influence of intoxicants is a Class C felony if the current offense
24 was committed in a motor vehicle and the person has, at least three times in the 10 years prior to
25 the date of the current offense, been convicted of, or been found to be within the jurisdiction of the
26 juvenile court for an act that if committed by an adult would be, any of the following offenses in
27 any combination:

28 (A) Driving while under the influence of intoxicants in violation of:

29 (i) This section; or

30 (ii) The statutory counterpart to this section in another jurisdiction.

31 (B) A driving under the influence of intoxicants offense in another jurisdiction that involved the

NOTE: Matter in boldfaced type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in boldfaced type.

1 impaired driving or operation of a vehicle, an aircraft or a boat due to the use of intoxicating liquor,
2 cannabis, a controlled substance, an inhalant or any combination thereof.

3 (C) A driving offense in another jurisdiction that involved operating a vehicle, an aircraft or a
4 boat while having a blood alcohol content above that jurisdiction's permissible blood alcohol con-
5 tent.

6 (b) For the purposes of paragraph (a) of this subsection, a conviction or adjudication for a
7 driving offense in another jurisdiction based solely on a person under 21 years of age having a blood
8 alcohol content that is lower than the permissible blood alcohol content in that jurisdiction for a
9 person 21 years of age or older does not constitute a prior conviction or adjudication.

10 (6) In addition to any other sentence that may be imposed, the court shall impose one or more
11 of the following fines on a person convicted of driving while under the influence of intoxicants as
12 follows:

13 (a) For a person's first conviction, a minimum of \$1,000.

14 (b) For a person's second conviction, a minimum of \$1,500.

15 (c) For a person's third or subsequent conviction, a minimum of \$2,000 if the person is not sen-
16 tenced to a term of imprisonment.

17 (d) For a person who drives a vehicle while the person has 0.15 percent or more by weight of
18 alcohol in the blood of the person as shown by chemical analysis of the breath or blood of the per-
19 son made under ORS 813.100, 813.140 or 813.150, a minimum of \$2,000.

20 (7) Notwithstanding ORS 161.635, \$10,000 is the maximum fine that a court may impose on a
21 person convicted of driving while under the influence of intoxicants if:

22 (a) The current offense was committed in a motor vehicle; and

23 (b) There was a passenger in the motor vehicle who was under 18 years of age and was at least
24 three years younger than the person driving the motor vehicle.

25 **SECTION 2.** ORS 811.182, as amended by section 13, chapter 76, Oregon Laws 2018, is amended
26 to read:

27 811.182. (1) A person commits the offense of criminal driving while suspended or revoked if the
28 person violates ORS 811.175 and the suspension or revocation is one described in this section, or if
29 the hardship permit violated is based upon a suspension or revocation described in subsection (3)
30 or (4) of this section.

31 (2) Affirmative defenses to the offense described in this section are established under ORS
32 811.180.

33 (3) The offense described in this section, criminal driving while suspended or revoked, is a Class
34 B felony if the suspension or revocation resulted from any degree of murder, manslaughter,
35 criminally negligent homicide or assault resulting from the operation of a motor vehicle, if the sus-
36 pension or revocation resulted from aggravated vehicular homicide or aggravated driving while
37 suspended or revoked or if the revocation resulted from a conviction for felony driving while under
38 the influence of intoxicants.

39 (4) The offense described in this section, criminal driving while suspended or revoked, is a Class
40 A misdemeanor if the suspension or revocation is any of the following:

41 (a) A suspension under ORS 809.411 (2) resulting from commission by the driver of any degree
42 of recklessly endangering another person, menacing or criminal mischief, resulting from the opera-
43 tion of a motor vehicle.

44 (b) A suspension under ORS 813.410 resulting from refusal to take a test prescribed in ORS
45 813.100 or for taking a breath or blood test the result of which discloses a blood alcohol content

1 of:

2 (A) ~~[0.08]~~ 0.05 percent or more by weight if the person was not driving a commercial motor ve-
3 hicle;

4 (B) 0.04 percent or more by weight if the person was driving a commercial motor vehicle; or

5 (C) Any amount if the person was under 21 years of age.

6 (c) A suspension of commercial driving privileges under ORS 809.510 resulting from failure to
7 perform the duties of a driver under ORS 811.700.

8 (d) A suspension of commercial driving privileges under ORS 809.510 (6) where the person's
9 commercial driving privileges have been suspended or revoked by the other jurisdiction for failure
10 of or refusal to take a chemical test to determine the alcoholic content of the person's blood under
11 a statute that is substantially similar to ORS 813.100.

12 (e) A suspension of commercial driving privileges under ORS 809.520.

13 (f) A revocation resulting from habitual offender status under ORS 809.640.

14 (g) A suspension resulting from any crime punishable as a felony with proof of a material ele-
15 ment involving the operation of a motor vehicle, other than a crime described in subsection (3) of
16 this section.

17 (h) A suspension for failure to perform the duties of a driver under ORS 811.705.

18 (i) A suspension for reckless driving under ORS 811.140.

19 (j) A suspension for fleeing or attempting to elude a police officer under ORS 811.540.

20 (k) A suspension or revocation resulting from misdemeanor driving while under the influence
21 of intoxicants under ORS 813.010.

22 (L) A suspension for use of a motor vehicle in the commission of a crime punishable as a felony.

23 (5) In addition to any other sentence that may be imposed, if a person is convicted of the offense
24 described in this section and the underlying suspension resulted from driving while under the influ-
25 ence of intoxicants, the court shall impose a minimum fine of at least \$1,000 if it is the person's first
26 conviction for criminal driving while suspended or revoked and a minimum fine of at least \$2,000 if
27 it is the person's second or subsequent conviction.

28 (6)(a) The Oregon Criminal Justice Commission shall classify a violation of this section that is
29 a felony as crime category 4 of the rules of the commission.

30 (b) Notwithstanding paragraph (a) of this subsection, the commission shall classify a violation
31 of this section that is a felony as crime category 6 of the rules of the commission, if the suspension
32 or revocation resulted from:

33 (A) Any degree of murder, manslaughter or criminally negligent homicide or an assault that
34 causes serious physical injury, resulting from the operation of a motor vehicle; or

35 (B) Aggravated vehicular homicide or aggravated driving while suspended or revoked.

36 **SECTION 3.** ORS 813.130 is amended to read:

37 813.130. This section establishes the requirements for information about rights and consequences
38 for purposes of ORS 813.100 and 813.410. The following apply to the information about rights and
39 consequences:

40 (1) The information about rights and consequences shall be substantially in the form prepared
41 by the Department of Transportation. The department may establish any form it determines appro-
42 priate and convenient.

43 (2) The information about rights and consequences shall be substantially as follows:

44 (a) Driving under the influence of intoxicants is a crime in Oregon, and the person is subject
45 to criminal penalties if a test under ORS 813.100 shows that the person is under the influence of

1 intoxicants. If the person refuses a test or fails, evidence of the refusal or failure may also be offered
2 against the person.

3 (b) The person will fail a test under ORS 813.100 for purposes of criminal penalties if the test
4 discloses a blood alcohol content of [0.08] **0.05** percent or more by weight. The person will fail a test
5 for purposes of the Motorist Implied Consent Law if the test discloses a blood alcohol content of:

6 (A) [0.08] **0.05** percent or more by weight if the person was not driving a commercial motor ve-
7 hicle;

8 (B) 0.04 percent or more by weight if the person was driving a commercial motor vehicle; or

9 (C) Any amount if the person was under 21 years of age.

10 (c) If the person refuses or fails a test under ORS 813.100, the person's driving privileges will
11 be suspended. The outcome of a criminal charge for driving under the influence of intoxicants will
12 not affect the suspension. The suspension will be substantially longer if the person refuses a test.

13 (d) If the person refuses a test or fails a breath test under ORS 813.100 and has an Oregon
14 driver license or permit, the license or permit will be taken immediately and, unless the person does
15 not currently have full valid driving privileges, a temporary driving permit will be issued to the
16 person.

17 (e) If the person refuses a test under ORS 813.100, the person is not eligible for a hardship
18 permit for at least 90 days, and possibly for three years, depending on the following factors set forth
19 in ORS 813.430:

20 (A) Whether the person is presently participating in a driving while under the influence of
21 intoxicants diversion program in this state or in any similar alcohol or drug rehabilitation program
22 in this or another jurisdiction; or

23 (B) Whether within the five years preceding the date of arrest any of the following occurred:

24 (i) A suspension of the person's driving privileges under ORS 813.410 or 482.540 (1981 Replace-
25 ment Part) became effective;

26 (ii) The person was convicted of driving while under the influence of intoxicants in violation of
27 ORS 813.010 or the statutory counterpart to ORS 813.010 in another jurisdiction, as described in
28 ORS 813.430;

29 (iii) The person was convicted of driving while under the influence of intoxicants in violation
30 of a municipal ordinance in this state or another jurisdiction, as described in ORS 813.430; or

31 (iv) The person commenced participating in a driving while under the influence of intoxicants
32 diversion program in this state or in any similar alcohol or drug rehabilitation program in this or
33 another jurisdiction, as described in ORS 813.430.

34 (f) If the person refuses a breath test under ORS 813.100, or refuses a urine test under ORS
35 813.131 and 813.132, the person is subject to a fine of at least \$500 and not more than \$1,000.

36 (g) After taking a test under ORS 813.100, the person will have a reasonable opportunity, upon
37 request, for an additional chemical test for blood alcohol content to be performed at the person's
38 own expense by a qualified individual of the person's choosing.

39 (h) The person has a right to a hearing to challenge the validity of the suspension before the
40 suspension becomes effective. The person must make a written request to the department for such
41 a hearing. If the person wins at the hearing, the person's driving privileges will not be suspended.
42 If the person loses at the hearing, the suspension will remain in effect during any court review of
43 the hearing.

44 (i) If the person is issued a temporary driving permit under ORS 813.100, the information pro-
45 vided to the person shall include the number of hours before the driving permit will be effective and

1 the number of days the permit will be effective.

2 (j) The information provided to the person shall include the number of days within which a
3 person must request a hearing under ORS 813.410.

4 (k) The information provided to the person shall include the number of days within which a
5 hearing under ORS 813.410 will be held.

6 (L) The person may possibly qualify for a hardship permit in 30 days if the person fails a test,
7 depending on the person's driving record.

8 (3) If the person is driving a commercial motor vehicle, the information about rights and con-
9 sequences shall include, in addition to the provisions of subsection (2) of this section, substantially
10 the following:

11 (a) If the person refuses a test under ORS 813.100 or submits to a breath or blood test and the
12 level of alcohol in the person's blood is 0.04 percent or more by weight, the person's commercial
13 driving privileges or right to apply for commercial driving privileges will be suspended and no
14 hardship permit authorizing the person to drive a commercial motor vehicle will be issued. The
15 suspension will be substantially longer if the person refuses a test.

16 (b) The suspension of the person's commercial driving privileges or right to apply for commercial
17 driving privileges will be for the person's lifetime if the person refuses a test under ORS 813.100 or
18 submits to a breath or blood test and the level of alcohol in the person's blood is 0.04 percent or
19 more by weight and:

20 (A) The person previously has been convicted of failure to perform the duties of a driver;

21 (B) The person previously has been convicted of a crime punishable as a felony and the person
22 was driving a motor vehicle at the time the offense was committed;

23 (C) The person previously has been convicted of driving a commercial motor vehicle while the
24 person's commercial driving privileges or right to apply for commercial driving privileges was sus-
25 pended or revoked for offenses committed while operating a commercial motor vehicle;

26 (D) The person previously has been convicted of any degree of murder, manslaughter or
27 criminally negligent homicide resulting from the operation of a commercial motor vehicle or assault
28 in the first degree resulting from the operation of a commercial motor vehicle;

29 (E) The person previously has been convicted of driving while under the influence of intoxicants;

30 (F) The person's commercial driving privileges previously have been suspended or revoked for
31 refusal to submit to, or failure of, a breath or blood test under ORS 813.100; or

32 (G) The person's right to apply for commercial driving privileges previously has been suspended
33 or revoked for refusal to submit to, or failure of, a breath or blood test under ORS 813.100 resulting
34 from the operation of a commercial motor vehicle.

35 (4) Nothing in this section prohibits the department from providing additional information con-
36 cerning rights and consequences that the department considers convenient or appropriate.

37 **SECTION 4.** ORS 813.131 is amended to read:

38 813.131. (1) Any person who operates a motor vehicle upon premises open to the public or the
39 highways of this state shall be deemed to have given consent, subject to the Motorist Implied Con-
40 sent Law, to a chemical test of the person's urine for the purpose of determining the presence of
41 cannabis, a controlled substance or an inhalant in the person's body if the person is arrested for
42 driving while under the influence of intoxicants in violation of ORS 813.010 or of a municipal ordi-
43 nance and either:

44 (a) The person takes the breath test described in ORS 813.100 and the test discloses a blood
45 alcohol content of less than [0.08] **0.05** percent; or

1 (b) The person is involved in an accident resulting in injury or property damage. A urine test
 2 may be requested under this paragraph regardless of whether a breath test has been requested and
 3 regardless of the results of a breath test, if one is taken.

4 (2) A police officer may not request a urine test unless the officer is certified by the Department
 5 of Public Safety Standards and Training as having completed at least eight hours of training in re-
 6 cognition of drug impaired driving and the officer has a reasonable suspicion that the person ar-
 7 rested has been driving while under the influence of cannabis, a controlled substance, an inhalant
 8 or any combination of cannabis, a controlled substance, an inhalant and intoxicating liquor.

9 (3) A person asked to give a urine sample shall be given privacy and may not be observed by
 10 a police officer when producing the sample.

11 (4)(a) At the trial of any civil or criminal action, suit or proceeding arising out of the acts
 12 committed by a person driving a motor vehicle while under the influence of intoxicants, a valid
 13 chemical analysis of a person's urine is admissible as evidence and may be used with other evidence,
 14 if any, to determine whether the person was driving while under the influence of intoxicants.

15 (b) A chemical analysis of a person's urine is valid under this subsection if analysis is performed
 16 in an accredited or licensed toxicology laboratory.

17 **SECTION 5.** ORS 813.210 is amended to read:

18 813.210. (1) After an accusatory instrument has been filed charging the defendant with the of-
 19 fense of driving while under the influence of intoxicants, a defendant may file with the court a pe-
 20 tition for a driving while under the influence of intoxicants diversion agreement described in ORS
 21 813.200. The petition:

22 (a) Must be filed within 30 days after the date of the defendant's first appearance on the sum-
 23 mons, unless a later filing date is allowed by the court upon a showing of good cause. For purposes
 24 of this paragraph, the filing of a demurrer, a motion to suppress or a motion for an omnibus hearing
 25 does not constitute good cause.

26 (b) Notwithstanding paragraph (a) of this subsection, may not be filed after entry of a guilty plea
 27 or a no contest plea or after commencement of any trial on the charge whether or not a new trial
 28 or retrial is ordered for any reason.

29 (c) Notwithstanding paragraph (a) of this subsection, may be filed up to 14 days after the date
 30 the prosecuting attorney sends the laboratory test results of the defendant's urine or blood sample
 31 analysis to the defendant's attorney or, if the defendant is unrepresented, the defendant, if:

32 (A) The accusatory instrument alleges that the defendant was driving under the influence of
 33 intoxicants and alleges that at the time the conduct occurred the defendant was under the influence
 34 of a controlled substance or an inhalant;

35 (B) The defendant has not received notice of what the defendant's blood alcohol content was at
 36 the time the conduct occurred or if at the time the conduct occurred the defendant had less than
 37 [0.08] **0.05** percent by weight of alcohol in the blood; and

38 (C) A police officer obtained a urine or blood sample from the defendant.

39 (2) The defendant shall pay to the court, at the time of filing a petition for a driving while under
 40 the influence of intoxicants diversion agreement, a filing fee established under ORS 813.240. The
 41 court may make provision for payment of the filing fee by the defendant on an installment basis.
 42 The court may waive all or part of the filing fee in cases involving indigent defendants. The filing
 43 fee paid to the court under this subsection shall be retained by the court if the petition is allowed.
 44 The filing fee shall be distributed as provided by ORS 813.240.

45 (3) The defendant shall pay to the agency or organization providing the screening interview, at

1 the time the petition is allowed, the fee required by ORS 813.240 (3).

2 (4)(a) Unless otherwise provided under paragraph (b) of this subsection, the defendant shall pay
3 to the court any court-appointed attorney fees agreed to under ORS 813.200 (4)(i). Payments shall
4 be made prior to the end of the diversion period on a schedule determined by the court.

5 (b) The court may waive all or part of the court-appointed attorney fees agreed to under ORS
6 813.200 (4)(i).

7 (5) The defendant shall begin paying to the court any restitution ordered under ORS 137.108.
8 Payments shall be made during the diversion period on a schedule determined by the court.

9 (6) The defendant shall cause a copy of the petition for a driving while under the influence of
10 intoxicants diversion agreement to be served upon the district attorney or city attorney. The district
11 attorney or city attorney may file with the court, within 15 days after the date of service, a written
12 objection to the petition and a request for a hearing.

13 **SECTION 6.** ORS 813.300 is amended to read:

14 813.300. (1) At the trial of any civil or criminal action, suit or proceeding arising out of the acts
15 committed by a person driving a motor vehicle while under the influence of intoxicants, if the
16 amount of alcohol in the person's blood at the time alleged is less than [0.08] 0.05 percent by weight
17 of alcohol as shown by chemical analysis of the person's breath or blood, it is indirect evidence that
18 may be used with other evidence, if any, to determine whether or not the person was then under the
19 influence of intoxicants.

20 (2) Not less than [0.08] 0.05 percent by weight of alcohol in a person's blood constitutes being
21 under the influence of intoxicating liquor.

22 (3) Notwithstanding subsection (2) of this section, for purposes of the Motorist Implied Consent
23 Law as defined in ORS 801.010, for a person who is under 21 years of age, any amount of alcohol
24 in the blood constitutes being under the influence of intoxicating liquor.

25 (4) Percent by weight of alcohol in the blood shall be based upon grams of alcohol per 100
26 milliliters of blood or based upon grams of alcohol per 210 liters of breath.

27 **SECTION 7.** ORS 813.410 is amended to read:

28 813.410. (1) If the Department of Transportation receives from a police officer a report that is
29 in substantial compliance with ORS 813.120, the department shall suspend the driving privileges of
30 the person in this state on the 30th day after the date of arrest or, if the report indicates that the
31 person failed a blood test, on the 60th day after receipt of the report, unless, at a hearing described
32 under this section, the department determines that the suspension would not be valid as described
33 in this section. A suspension of driving privileges imposed under this subsection shall be for a period
34 of time established under ORS 813.420.

35 (2) If the department receives from a police officer a report pursuant to ORS 813.120 and the
36 person holds commercial driving privileges and the person was driving a motor vehicle or commer-
37 cial motor vehicle and refused to submit to a test under ORS 813.100 or the person was driving a
38 commercial motor vehicle and submitted to a breath or blood test and the person's blood, as shown
39 by the test, had 0.04 percent or more by weight of alcohol, the department shall suspend the person's
40 commercial driving privileges on the 30th day after the date of arrest or, if the report indicates that
41 the person failed a blood test, on the 60th day after receipt of the report, unless, at a hearing de-
42 scribed under this section, the department determines that the suspension would not be valid as
43 described in this section. A commercial driving privileges suspension imposed under this subsection
44 shall be for a period of time established under ORS 809.510 or 809.520.

45 (3) If within 10 days from the date of arrest, or, if the person fails a blood test, within 10 days

1 from the date the department sends notice of suspension, the department receives a written request
2 for a hearing from a person whose driving privileges or commercial driving privileges the depart-
3 ment proposes to suspend under this section, the department shall provide a hearing in accordance
4 with this section. Except as otherwise provided under this section, a hearing held by the department
5 under this section shall be subject to the provisions for contested cases, other than appeal pro-
6 visions, under ORS chapter 183. The applicable appeal provisions are as provided under ORS 813.450
7 and section 24, chapter 672, Oregon Laws 1985. Notwithstanding ORS 809.430, the department is
8 not required to give any notice of intent to suspend or suspension in addition to that provided under
9 ORS 813.100.

10 (4) Except as provided in subsection (5) of this section, a hearing required by this section is
11 subject to all of the following:

12 (a) The hearing shall be conducted by an administrative law judge assigned from the Office of
13 Administrative Hearings established under ORS 183.605.

14 (b) The administrative law judge shall conduct the hearing by telephone or other two-way elec-
15 tronic communication device.

16 (c) The department may authorize the administrative law judge to issue a final order in any
17 case.

18 (d) A person who requests a hearing under this section and who fails, without just cause, to
19 appear personally or through an attorney waives the right to a hearing. If a person waives a right
20 to a hearing under this paragraph, the department is not required to make any showing at hearing.

21 (e) Except as provided in ORS 813.440 or upon remand under ORS 813.450, the department shall
22 hold the hearing and issue a final order within 30 days of the date of the arrest or, if the person fails
23 a blood test, within 60 days from the date the department received the report of the failure.

24 (f) In connection with the hearing, the department or its authorized representative may admin-
25 ister oaths and shall issue subpoenas for the appearance of witnesses by telephone or other two-way
26 electronic communication device at the hearing requested by the person or the department and the
27 production of relevant documents.

28 (g) The hearing shall be recorded by whatever means may be determined by the department and
29 shall include testimony and exhibits, if any. The record of the proceedings may not be transcribed
30 unless requested by a party to the proceeding.

31 (5)(a) A person or a police officer may request that a hearing required by this section be con-
32 ducted in person.

33 (b) The department, by rule, shall establish the manner and time limitation requirements by
34 which a person or a police officer may request that a hearing be conducted in person.

35 (c) Unless there is an agreement between the person and the department that the hearing be
36 conducted elsewhere, a hearing requested under this subsection shall be held either in the county
37 where the alleged offense occurred or at any place within 100 miles of the place where the offense
38 is alleged to have occurred, as established by the department by rule.

39 (d) In connection with the hearing, the department or its authorized representative may admin-
40 ister oaths and shall issue subpoenas for the attendance of witnesses at the hearing requested under
41 this subsection by the person and the production of relevant documents.

42 (6) This subsection shall be narrowly construed so as to effect the legislative purpose of limiting
43 the scope of hearings under this section. The scope of a hearing under this section shall be limited
44 to whether the suspension is valid as described in this subsection. A suspension under this section
45 is valid if all of the following requirements have been met:

1 (a) The person, at the time the person was requested to submit to a test under ORS 813.100,
2 was under arrest for driving while under the influence of intoxicants in violation of ORS 813.010 or
3 a municipal ordinance.

4 (b) The police had reasonable grounds to believe, at the time the request was made, that the
5 person arrested had been driving under the influence of intoxicants in violation of ORS 813.010 or
6 of a municipal ordinance.

7 (c) The person refused a test under ORS 813.100, or took a breath or blood test and the test
8 disclosed that the level of alcohol in the person's blood at the time of the test was:

9 (A) [0.08] 0.05 percent or more by weight if the person was not driving a commercial motor ve-
10 hicle;

11 (B) 0.04 percent or more by weight if the person was driving a commercial motor vehicle; or

12 (C) Any amount if the person was under 21 years of age.

13 (d) If the report under ORS 813.120 indicates that the person was driving a commercial motor
14 vehicle, the vehicle was in fact a commercial motor vehicle as defined in ORS 801.208.

15 (e) The person had been informed under ORS 813.100 of rights and consequences as described
16 under ORS 813.130.

17 (f) The person was given written notice required under ORS 813.100.

18 (g) If the person arrested submitted to a test under ORS 813.100, the person administering the
19 test was qualified to administer the test under ORS 813.160.

20 (h) If the person arrested submitted to a test under ORS 813.100, the methods, procedures and
21 equipment used in the test complied with requirements under ORS 813.160.

22 (7) A suspension imposed under this section shall remain in effect pending any appeal or remand
23 of a final order issued under this section and there shall be no stay of the suspension pending appeal
24 or remand.

25 (8) Unless a person fails, without just cause, to appear personally or through an attorney at a
26 hearing requested under this section, a person shall have the right to appeal any final order by the
27 department after a hearing under this section by filing a petition. The following apply to this sub-
28 section:

29 (a) The person shall file the petition in the circuit court for the county where the person resides
30 or, if the person does not reside in Oregon, in the circuit court of the county in which the arrest
31 took place within 30 days after issuance of the final order of the department.

32 (b) The court upon receipt of the petition shall set the matter for hearing upon 10 days' notice
33 to the department and the petitioner unless hearing is waived by both the department and the
34 petitioner.

35 **SECTION 8.** ORS 813.602 is amended to read:

36 813.602. (1) Subject to subsection (2) of this section, when a person is convicted of driving while
37 under the influence of intoxicants in violation of ORS 813.010 or of a municipal ordinance, the De-
38 partment of Transportation, in addition to any other requirement, shall require that the person have
39 installed and be using an approved ignition interlock device in any vehicle operated by the person:

40 (a) Before the person is eligible for a hardship permit. The requirement is a condition of the
41 hardship permit for the duration of the hardship permit.

42 (b) For a first conviction, for one year after the ending date of the suspension or revocation
43 caused by the conviction. Violation of the condition imposed under this paragraph is a Class A
44 traffic violation.

45 (c) For a second or subsequent conviction, for two years after the ending date of the suspension

1 or revocation caused by the conviction. Violation of the condition imposed under this paragraph is
2 a Class A traffic violation.

3 (2) When a person is convicted of a crime or multiple crimes as described in this subsection, the
4 department, in addition to any other requirement, shall require that the person have installed and
5 be using an approved ignition interlock device in any vehicle operated by the person for five years
6 after the ending date of the longest running suspension or revocation caused by any of the con-
7 victions. Violation of the condition imposed under this subsection is a Class A traffic violation. A
8 person is subject to this subsection when the person is convicted of:

9 (a) Driving while under the influence of intoxicants in violation of ORS 813.010 or of a municipal
10 ordinance and any of the following crimes as part of the same criminal episode:

- 11 (A) Any degree of murder.
- 12 (B) Manslaughter in the first or second degree.
- 13 (C) Criminally negligent homicide.
- 14 (D) Assault in the first degree.

15 (b) Aggravated vehicular homicide.

16 (c) Driving while under the influence of intoxicants in violation of ORS 813.010 or of a municipal
17 ordinance and the person's driving privileges are revoked under ORS 809.235 (1)(b) and later ordered
18 restored under ORS 809.235 (4).

19 (3)(a) Except as provided in paragraph (c) of this subsection, as a condition of a driving while
20 under the influence of intoxicants diversion agreement:

21 (A) The court shall require that an approved ignition interlock device be installed and used in
22 any vehicle operated by the person during the period of the agreement when the person has driving
23 privileges if:

24 (i) The person submitted to a chemical test of the person's breath or blood as required under
25 ORS 813.100 and the test disclosed a blood alcohol content of ~~[0.08]~~ **0.05** percent or more by weight;

26 (ii) The person refused to submit to a chemical test of the person's breath or blood; or

27 (iii) The person submitted to a chemical test of the person's breath, blood or urine as required
28 under ORS 813.100 or 813.131 and the test disclosed a blood alcohol content of more than 0.00 per-
29 cent by weight but less than ~~[0.08]~~ **0.05** percent by weight and disclosed the presence of cannabis,
30 a controlled substance or an inhalant.

31 (B) The court may require that an approved ignition interlock device be installed and used in
32 any vehicle operated by the person during the period of the agreement when the person has driving
33 privileges if the person submitted to a chemical test of the person's breath, blood or urine as re-
34 quired under ORS 813.100 or 813.131 and the test disclosed a blood alcohol content below ~~[0.08]~~ **0.05**
35 percent by weight.

36 (b) In addition to any action taken under ORS 813.255, violation of the condition imposed under
37 this subsection is a Class A traffic violation.

38 (c) A court may exempt a person from the condition in a diversion agreement to have installed
39 and be using an ignition interlock device if the court determines that the person meets the re-
40 quirements for a medical exemption in accordance with rules adopted by the department under this
41 section. A person granted a medical exemption under this paragraph shall carry proof of the medical
42 exemption with the person while operating any vehicle.

43 (4) The department shall adopt rules permitting medical exemptions from the requirements of
44 installation and use of an ignition interlock device under this section.

45 (5) When a person is required to install an ignition interlock device under subsection (2) of this

1 section, the service center providing the device shall provide notice of any installation or removal
2 of the device or any tampering with the device to:

3 (a) The supervising court or to the court's designee, including but not limited to an agency or
4 organization certified by the Oregon Health Authority under ORS 813.025; and

5 (b) The district attorney or the city prosecutor.

6 **SECTION 9.** ORS 830.510 is amended to read:

7 830.510. (1) At the trial of any civil or criminal action, suit or proceeding arising out of the acts
8 committed by a person operating a boat while under the influence of any intoxicants, if the amount
9 of alcohol in the person's blood at the time alleged is less than [0.08] 0.05 percent by weight of al-
10cohol and shown by chemical analysis of the person's breath or blood, it is indirect evidence that
11 may be used with other evidence, if any, to determine whether or not the person was then under the
12 influence of intoxicants.

13 (2) Not less than [0.08] 0.05 percent by weight of alcohol in a person's blood constitutes being
14 under the influence of intoxicating liquor.

15 (3) Percent by weight of alcohol in the blood shall be based on grams of alcohol per 100 milli-
16liters of blood or based on grams of alcohol per 210 liters of breath.

17 (4) For purposes of ORS 830.505 to 830.545, "boat" means a motorboat or sailboat.

18 **SECTION 10.** The amendments to ORS 811.182, 813.010, 813.130, 813.131, 813.210, 813.300,
19 813.410, 813.602 and 830.510 by sections 1 to 9 of this 2019 Act apply to conduct occurring on
20 or after the effective date of this 2019 Act.
21

House Bill 2239

Introduced and printed pursuant to House Rule 12.00. Pre-session filed (at the request of Chief Justice Martha L. Walters for Judicial Department)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure as introduced.

Increases number of circuit court judges in certain judicial districts.
Takes effect on 91st day following adjournment sine die.

A BILL FOR AN ACT

1
2 Relating to the establishment of circuit court judge positions; creating new provisions; amending
3 ORS 3.012; and prescribing an effective date.

4 **Be It Enacted by the People of the State of Oregon:**

5 **SECTION 1.** ORS 3.012, as amended by section 1, chapter 631, Oregon Laws 2017, is amended
6 to read:

7 3.012. (1) The judicial districts, the counties constituting the judicial districts and the number
8 of circuit court judges for each judicial district are as follows:

9 (a) The first judicial district consists of Jackson County and has *[nine]* **10** judges.

10 (b) The second judicial district consists of Lane County and has *[15]* **17** judges.

11 (c) The third judicial district consists of Marion County and has *[14]* **15** judges.

12 (d) The fourth judicial district consists of Multnomah County and has *[38]* **40** judges.

13 (e) The fifth judicial district consists of Clackamas County and has *[11]* **12** judges.

14 (f) The sixth judicial district consists of the counties of Morrow and Umatilla and has five
15 judges.

16 (g) The seventh judicial district consists of the counties of Gilliam, Hood River, Sherman, Wasco
17 and Wheeler and has four judges.

18 (h) The eighth judicial district consists of Baker County and has one judge.

19 (i) The ninth judicial district consists of Malheur County and has *[two]* **three** judges.

20 (j) The tenth judicial district consists of the counties of Union and Wallowa and has two judges.

21 (k) The eleventh judicial district consists of Deschutes County and has *[seven]* **eight** judges.

22 (l) The twelfth judicial district consists of Polk County and has three judges.

23 (m) The thirteenth judicial district consists of Klamath County and has *[five]* **six** judges.

24 (n) The fourteenth judicial district consists of Josephine County and has five judges.

25 (o) The fifteenth judicial district consists of the counties of Coos and Curry and has *[six]* **seven**
26 judges.

27 (p) The sixteenth judicial district consists of Douglas County and has *[five]* **six** judges.

28 (q) The seventeenth judicial district consists of Lincoln County and has three judges.

29 (r) The eighteenth judicial district consists of Clatsop County and has three judges.

30 (s) The nineteenth judicial district consists of Columbia County and has three judges.

31 (t) The twentieth judicial district consists of Washington County and has *[15]* **16** judges.

NOTE: Matter in **boldfaced** type in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted. New sections are in **boldfaced** type.

1 (u) The twenty-first judicial district consists of Benton County and has three judges.

2 (v) The twenty-second judicial district consists of the counties of Crook and Jefferson and has
3 three judges.

4 (w) The twenty-third judicial district consists of Linn County and has *[five]* **six** judges.

5 (x) The twenty-fourth judicial district consists of the counties of Grant and Harney and has one
6 judge.

7 (y) The twenty-fifth judicial district consists of Yamhill County and has four judges.

8 (z) The twenty-sixth judicial district consists of Lake County and has one judge.

9 (aa) The twenty-seventh judicial district consists of Tillamook County and has two judges.

10 (2) The Secretary of State shall designate position numbers equal to the number of judges in
11 each of the judicial districts established by this section. The positions shall reflect any qualifications
12 established by ORS 3.041.

13 **SECTION 2.** The amendments to ORS 3.012 by section 1 of this 2019 Act become operative
14 on the first Monday in January 2021, except that the provisions for new circuit court judges
15 are operative on the effective date of this 2019 Act for the purposes of nominating and
16 electing new judges in 2019 and 2020 to assume the duties of the office on the first Monday
17 in January 2021.

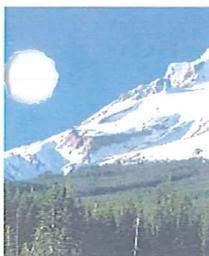
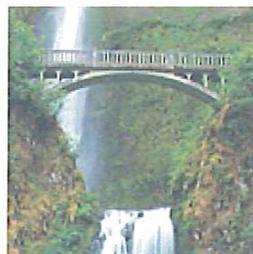
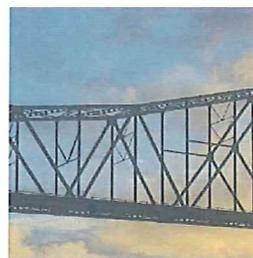
18 **SECTION 3.** In addition to and not in lieu of any other appropriation, there is appropri-
19 ated to the Judicial Department, for the biennium beginning July 1, 2019, out of the General
20 Fund, the amount of \$_____, which may be expended to pay the salaries and benefits for
21 the new judicial positions created by the amendments to ORS 3.012 by section 1 of this 2019
22 Act, the salaries and benefits for the support staff required for those positions and the cost
23 of equipment and furnishings necessary for those positions.

24 **SECTION 4.** This 2019 Act takes effect on the 91st day after the date on which the 2019
25 regular session of the Eightieth Legislative Assembly adjourns sine die.

26



Secretary of State Oregon Audits Division



Oregon Health Authority

Constraints on Oregon's Prescription Drug Monitoring Program Limit the State's Ability to Help Address Opioid Misuse and Abuse

December 2018
2018-40

Secretary of State Dennis Richardson
Audits Division Director Kip Memmott

This page intentionally left blank



Secretary of State Audit Highlights

December 2018

Oregon Health Authority

Constraints on Oregon's Prescription Drug Monitoring Program Limit the State's Ability to Help Address Opioid Drug Misuse and Abuse

Report Highlights

The Prescription Drug Monitoring Program provides an important tool to address prescription drug abuse, including opioid abuse, and help improve health outcomes. Oregon's laws have put constraints on the program that limit its effectiveness and impact. Restrictions are placed on what data are collected, analyses that can be done with the data, and with whom information can be shared. Correcting weaknesses in Oregon's program will maximize its potential and help address opioid and other substance abuse issues the state faces.

Background

Oregon has the highest rate in the nation of seniors hospitalized for opioid-related issues such as overdose, abuse, and dependence. The state also has the sixth highest percentage of teenage drug users. The Oregon Health Authority (OHA) manages the state's Prescription Drug Monitoring Program (PDMP), which collects information on controlled substance prescriptions within the state. The program was designed to promote public health and safety and to help improve patient care. It was also developed to support the appropriate use of prescription drugs.

Purpose

The purpose of this audit was to determine if Oregon can better leverage its PDMP to help with the opioid epidemic.

Key Findings

1. OHA could better use PDMP data to analyze trends in prescribed drugs, including identifying patterns of possible opioid misuse and abuse. State laws prevent OHA from sharing information on questionable activity with key stakeholders, such as health licensing boards and law enforcement. We found people who received opioid prescriptions from excessive numbers of prescribers, as well as instances of dangerous drug combinations and prescriptions for excessive drug dosages. One person who received an excessive amount of opioid prescriptions had some of those prescriptions paid for by Medicaid.
2. Oregon is one of only nine states that does not require prescribers or pharmacies to use the PDMP database before an opioid prescription is written or dispensed. Mandating use can be effective in reducing opioid misuse and other health related outcomes.
3. Due to statutory restrictions, Oregon's PDMP does not collect some prescription information that could be critical in preventing prescription drug abuse. This includes prescriptions filled by pharmacies other than only retail, veterinarian prescribed prescriptions, prescriptions for Schedule V drugs and drugs known to be abused or misused such as gabapentin, and prescription details such as method of payment, lock-in status, and diagnosis information.

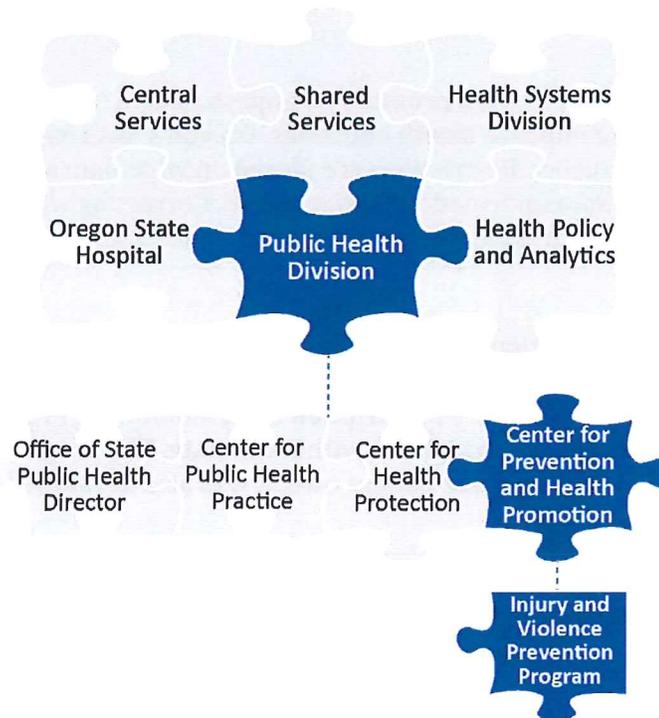
Recommendations

Our report includes 12 recommendations to OHA for optimizing the state's PDMP. OHA can implement some of these within existing statutes and rules, and for others it needs to work with the Legislature. OHA agreed with all of the recommendations, but stated that because seven fall outside the scope of its statutory authority, its ability to implement them is limited. The agency's response can be found at the end of the report.

Introduction

Oregon, like the rest of the nation, is in the midst of an opioid epidemic. The Governor declared a public health emergency in March 2018 to address the opioid crisis as well as other substance misuse and abuse challenges facing the state.¹ The Legislature, Oregon Health Authority (OHA), health-related boards, and communities have undertaken efforts to address the epidemic. One example is the state's Prescription Drug Monitoring Program (PDMP), which is managed by OHA's Injury and Violence Prevention Program. The PDMP is a tool that tracks the dispensing of prescription opioids and other medications of concern across the state. The purpose of this audit was to determine how Oregon can better leverage its PDMP to help with the opioid epidemic.

Oregon Health Authority



Oregon has an opioid crisis and one of the highest rates of prescription opioid misuse in the nation

Many substances can be misused or abused, but opioids are of particular concern due to the significant danger posed by their misuse.² While opioids can be helpful in addressing pain with appropriate medical oversight, they are highly addictive. Dependence on prescription opioids can occur in less than a week, and taking a low dose prescription of an opioid for more than three months raises the risk of addiction 15-fold.

¹ Misuse occurs when a person takes a legal prescription medication for a purpose other than the reason it was prescribed, or when that person takes a drug not prescribed to them. Abuse occurs when a person takes a prescription medication to get a pleasant or euphoric feeling.

² Opioids, a class of drugs derived from opium, were increasingly prescribed starting about 20 years ago and are still prescribed for pain management of conditions such as injury, surgery, cancer care, chronic conditions, and end-of-life care. Opioids range from prescription pain relievers (e.g., oxycodone, hydrocodone, and morphine) to illegal substances (e.g., heroin). Opioids, natural or synthetic chemicals, interact with opioid receptors on nerve cells in the body and brain. While plenty of opioid pain relievers are taken safely as prescribed by a doctor, they carry the potential for abuse due to the euphoria that is often produced in addition to pain relief.

People who develop a substance use disorder and need more of the drug, in addition to those who are cut off from their pain medications, may turn to illicit drugs, such as heroin and fentanyl. A study found frequent prescription opioid users and those diagnosed with dependence or abuse of prescription opioids are more likely to resort to heroin.³

Many people who are severely addicted end up incarcerated at some point. Nationally, it is estimated that almost 90% of those incarcerated with substance use disorders do not receive addiction treatment.

Opioid and substance abuse is affecting Oregon's youth

Opioids and substance abuse are significantly impacting younger Oregonians. In 2016, almost 500 pregnancies were complicated by maternal opioid use and 280 infants were born with Neonatal Abstinence Syndrome.⁴ From 2015 to 2017, 314 more children entered foster care due to a parent's drug abuse.

In Oregon and across the nation, there are also cases of young children accidentally ingesting opioid pain relievers. According to the National Poison Data System, pain medications were the third most common substance involved in pediatric poisonings and were the most frequent substance involved in pediatric deaths from accidental ingestion in 2016.⁵

Most substance use disorders begin before or during adolescence. Nationally, Oregon has the sixth-highest percentage of teenagers with a substance use disorder. In 2017, over a quarter of Oregon eighth graders and a third of eleventh graders said it was easy to get prescription drugs not prescribed to them. More than 60% of Oregon Youth Authority adolescents have substance abuse or dependence issues, or have parents that use alcohol or drugs.⁶

57% of 12 to 17 year olds who misused prescription opioids got them from a friend or relative.

When it comes to providing access to treatment and recovery support for adolescents with substance use disorders, Oregon ranked nearly last (49th) nationwide.

Opioid and substance abuse is impacting Oregon's senior citizens

Oregon has the highest rate in the nation of seniors, categorized as those age 65 and older, hospitalized for opioid-related issues such as overdose, abuse, and dependence. Seniors' long-term use of prescription opioids increases the likelihood of falls and fractures. The U.S. Department of Health & Human Services Office of Inspector General found that 32% of Oregonians with Medicare Part D prescription drug coverage received prescription opioids in 2017. This figure was higher than 28 other states.

When it comes to providing access to treatment and recovery support for those with substance use disorders, Oregon was ranked last (50th) for adults.

³ Jones CM, Logan J, Gladden RM, Bohm MK. Vital signs: demographic and substance use trends among heroin users – United States, 2002-2013. *Morbidity and Mortality Weekly Report (MMWR)*. Atlanta, GA: Centers for Disease Control and Prevention; 2015.

⁴ Neonatal Abstinence Syndrome is a group of problems that occur when newborns withdraw from addictive opioids they were exposed to and became dependent upon while in the mother's womb.

⁵ David D. Gummin, James B. Mowry, Daniel A. Spyker, Daniel E. Brooks, Michael O. Fraser & William Banner (2017) 2016 Annual Report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 34th Annual Report, *Clinical Toxicology*, 55:10, 1072-1254, DOI: 10.1080/15563650.2017.1388087.

⁶ Oregon Youth Authority OYA Quick Facts January 2018.

Oregon ranks high for substance misuse and abuse

The national opioid crisis is estimated to cost hundreds of billions of dollars a year, factoring in the costs of healthcare, social services, education, criminal justice, and employment and wage losses. No economic class or locale is immune, and the impacts goes well beyond the individual to affect other family members, particularly children, and communities.

Americans consume more opioids, including prescription opioids, than any other country.

Prescription opioid abuse is part of a broader drug abuse problem in the state. Oregonians suffer more from substance use disorders than those in most other states. Mental Health America, a national nonprofit that helps address the needs of those living with mental illness, ranked Oregon as the state with the highest rate of mental health and substance use problems. Not only does Oregon rank high in many concerning areas related to drugs and alcohol, as shown in Figure 1, it also ranks the highest in all measures compared to nearby states.

Figure 1: Oregon consistently ranks high for drug misuse and abuse among nearby states

State	Pain Reliever Misuse in the Past Year	Substance Use Disorder	Illicit Drug Use Disorder in the Past Year	Illicit Drug Use Other Than Marijuana in the Past Month	Heroin Use in the Past Year	Alcohol Use Disorder in the Past Year	Needing But Not Receiving Treatment at a Specialty Facility for Alcohol Use in the Past Year	Needing But Not Receiving Treatment at a Specialty Facility for Substance Use in the Past Year
Oregon	51	49	48	48	41	46	46	50
Washington	50	33	41	36	39	24	32	35
Colorado	49	38	33	42	27	35	42	42
Idaho	48	22	25	22	22	18	20	22
Nevada	44	16	30	30	25	13	13	18
California	34	39	43	47	8	36	38	38

Source: Substance Abuse and Mental Health Services Administration’s 2015-16 National Survey on Drug Use and Health. Survey includes the fifty states and Washington D.C.

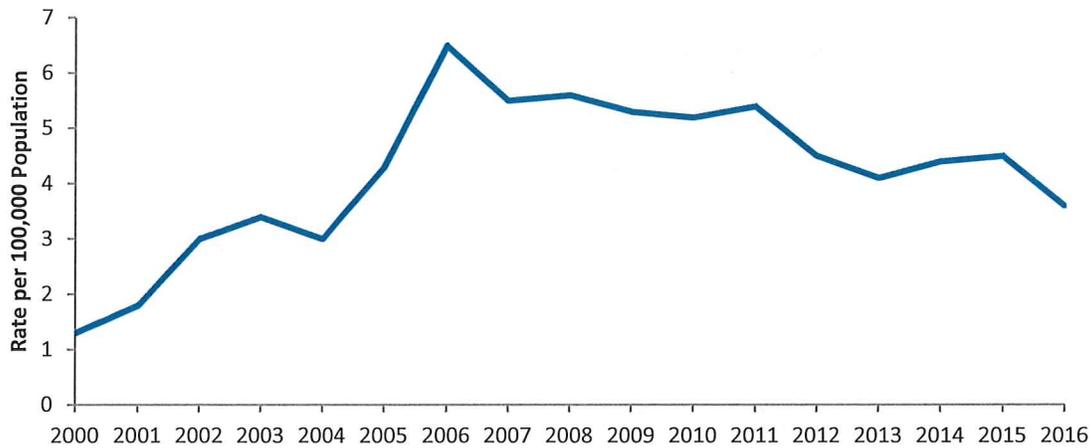
Oregon has seen opioid overdose hospitalizations generally increase since 2000, which includes prescription and illicit opioids. The median cost is \$13,000 for a hospitalization due to opioids, which lasts for two days on average.⁷

Prescription opioid painkillers contribute to a large portion of Oregon’s drug overdose deaths. Prescription opioid overdose deaths in Oregon have decreased 45% since peaking in 2006, but are still higher than the early 2000s, see Figure 2. Deaths due to prescription opioids have decreased over recent years, but still equate to about one Oregonian dying every three days. These numbers may be even higher, as researchers say 20% to 35% of opioid-related overdose deaths are undercounted in the nation. Decreases in opioid overdoses are likely partially attributable to the increased availability and use of naloxone, a medication that reverses the effect of an opioid overdose and is increasingly being carried by law enforcement and first responders.

Deaths due to prescription opioids equate to about one Oregonian dying every three days.

⁷ OHA’s Opioid Overdose in Oregon Report to the Legislature, September 2018.

Figure 2: Accidental opioid overdose deaths in Oregon have declined, but are still higher than early 2000 rates



Note: The category 'prescription opioids' includes deaths due to natural and semi-synthetic opioids, methadone, and synthetic opioids other than methadone and does not differentiate between illicit vs. legal.

Source: Oregon Health Authority's Opioid Overdose in Oregon Report to the Legislature September 2018.

Oregon has been working to address its opioid crisis

Though addiction and substance abuse were declared a public health crisis in Oregon by the Governor in March 2018, there have been previous efforts in Oregon to try to curb the state's opioid epidemic. Some of the key efforts can be seen in Figure 3.

To help with the high costs of dealing with opioid abuse, Oregon, along with other states and counties, has filed lawsuits against drug companies to hold them responsible for misleading claims on the harm of opioid medications. Settlement funds have been allocated toward efforts such as increasing opioid addiction services, implementing best practices in pain management, and expanding outreach and educational components of treatment programs.

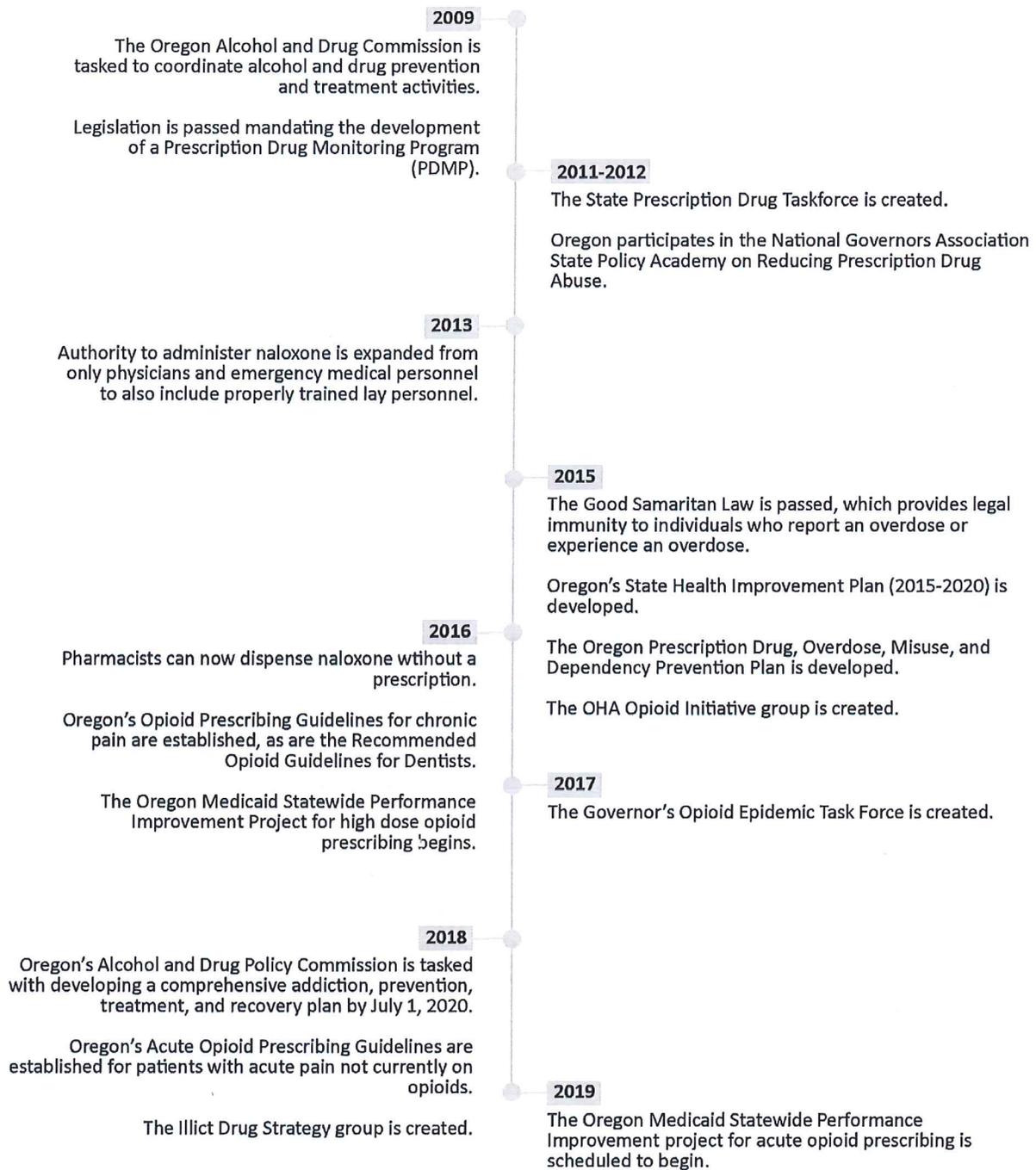
Reducing the amount of unwanted and unused pills helps to reduce the risk of abuse. Oregon does not have a coordinated, statewide drug take-back program intended to reduce the number of pills in circulation. There are collection sites in multiple locations across the state for disposing of unused opioid and other prescription drugs, located in some pharmacies and at most police stations. Additionally, there are nationally coordinated drug take-back days held twice yearly.

Oregon has made progress in dispensing fewer opioid prescriptions over recent years. This may be from guidelines to help curb overprescribing, and state and national efforts to educate doctors. Even so, Oregon is still prescribing opioids at a rate of 13% more than the national average, and the U.S. prescribes more than other comparable countries. According to the 2019 drug threat assessment by the Oregon-Idaho High Intensity Drug Trafficking Area program, the availability and misuse of prescription drugs remain at a high level even though some indicators suggest a recent decline in misuse.⁸

OHA reported approximately 7 million prescriptions for controlled substances (e.g., opioids, Attention Deficit Hyperactivity Disorder medications, and sedatives) were dispensed annually for Oregonians. Over half of these were opioids, with hydrocodone being the most common.

⁸ The Oregon-Idaho High Intensity Drug Trafficking Area program was established by the White House Office of National Drug Control Policy in June 1999. It consists of 14 counties and the Warm Springs Indian Reservation. Counties in Oregon include Clackamas, Deschutes, Douglas, Jackson, Lane, Linn, Malheur, Marion, Multnomah, Umatilla, and Washington counties.

Figure 3: Timeline of some key efforts taken to address opioid issues in Oregon



Prescription drug monitoring programs are state-level tools to improve opioid prescribing, inform clinical practice, and protect patients

All fifty states have prescription drug monitoring programs (PDMPs), with program data used in a variety of ways to address the opioid epidemic and substance abuse issues.⁹ PDMPs maintain an electronic database of prescription information collected directly from pharmacies in an

⁹ Missouri is the only state without a statewide prescription drug monitoring program. However, within Missouri, St. Louis County started its own PDMP in April 2017 and more than 80% of Missouri doctors and pharmacists participate on a voluntary basis.

effort to provide physicians and pharmacists with critical information regarding a patient's prescription history. These databases also allow state tracking of physician prescribing practices to inform guidelines and efforts to improve addiction prevention and treatment.

All PDMPs, at a minimum, collect prescription information on drugs federally classified as controlled substances per Schedule II, III, and IV; see Figure 4. Most states go further and collect information on Schedule V substances. Oregon is not among them.

Figure 4: The Controlled Substances Act has divided drugs and other substances considered controlled substances into five schedules

	Potential for Abuse	Description	Examples
Schedule I	High	Substances with no currently accepted medical use in the U.S., and a lack of accepted safety for use under medical supervision, and are therefore never prescribed	LSD, heroin, marijuana, and peyote
Schedule II	High	Substances that have a high potential for abuse, which may lead to severe psychological or physical dependence	Oxycodone (OxyContin [®] , Percocet [®]), methadone (Dolophine [®]), fentanyl, morphine, codeine, amphetamine (Dexedrine [®] , Adderall [®]), methamphetamine (Desoxy [®]), methylphenidate (Ritalin [®]), and pentobarbital
Schedule III	Moderate	Substances that have a potential for abuse less than Schedule I or II substances, and abuse may lead to moderate or low physical dependence or high psychological dependence	Buprenorphine (Suboxone [®]), products with no more than 90 milligrams of codeine per dosage unit (Tylenol with Codeine [®]), benzphetamine (Didrex [®]), ketamine, and anabolic steroids (Depo [®] -Testosterone)
Schedule IV	Low	Substances that have a low potential for abuse relative to Schedule III substances	Alprazolam (Xanax [®]), carisoprodol (Soma [®]), clonazepam (Klonopin [®]), diazepam (Valium [®]), and temazepam (Restoril [®])
Schedule V	Low	Substances that have a low potential for abuse relative to Schedule IV substances	Ezogabine, lacosamide, and pregabalin (Lyrica [®])

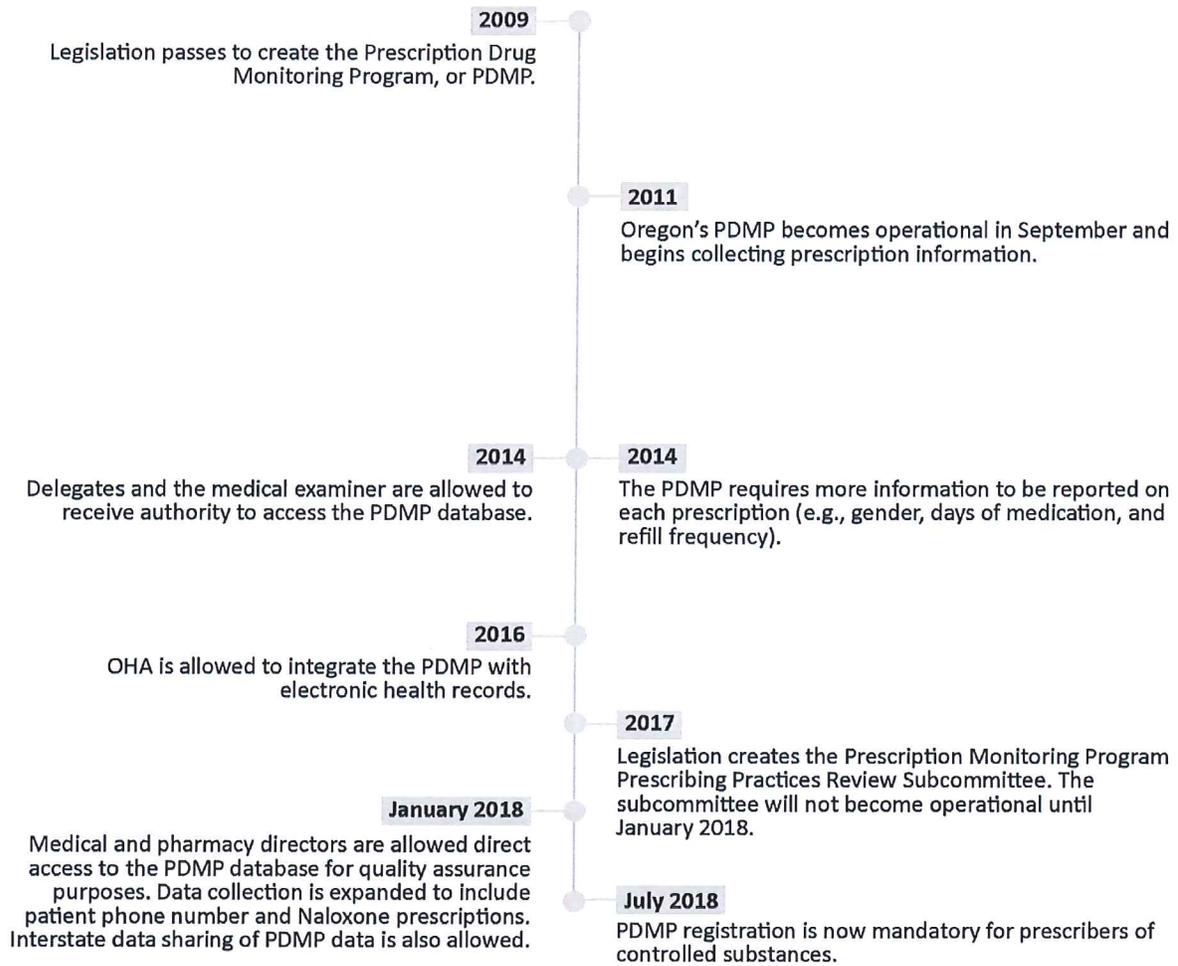
Source: U.S. Department of Justice Drug Enforcement Administration

Oregon's PDMP was created to help with patient health and safety when using controlled substances

The Oregon PDMP, enacted in 2009, started collecting prescription information in late 2011, making it among the last dozen of states to implement a PDMP. Oregon designed the program to promote public health and safety and help improve patient care by providing healthcare prescribers and pharmacists with information to better manage patients' prescriptions. It was also developed to support the appropriate use of prescription drugs.

Over the last few years, state legislation has allowed the program to expand the information collected and those who can access that information; see Figure 5.

Figure 5: Timeline of the key legislative changes to Oregon's PDMP



PDMP information collected in Oregon

- Patient receiving the prescription (name, DOB, address, sex, and phone number)
- Prescriber (name and DEA number)
- Date medication prescribed
- Prescription number
- Pharmacy DEA number
- Date medication dispensed
- Drug prescribed (name, national drug code number, quantity, days' supply, and number of refills)

Like many other states, Oregon's PDMP collects information on controlled substance prescriptions dispensed from state-licensed retail pharmacies to its residents. Retail pharmacies are required to report the prescription information to the PDMP within 72 hours. Prescriptions collected in Oregon are for Schedule II, III, and IV controlled substances, pseudoephedrine, and, starting in 2018, naloxone.¹⁰ The PDMP database maintains prescription information for three years that is accessible to authorized users. Besides system users, others can receive some PDMP data. For example, patients may request a copy of their own prescription information and, under certain circumstances, law enforcement and licensing boards may request PDMP data. Researchers may be granted de-identified data for approved studies.

An advisory commission is charged with studying issues related to the PDMP, making recommendations to OHA for operating the PDMP, and developing criteria to evaluate program data. In January 2018, the Clinical Review Subcommittee was formed that uses PDMP

¹⁰ Pseudoephedrine is used for the temporary relief of stuffy nose and sinus pain.

information to identify healthcare prescribers who should receive education or training on prescribing opioids.

OHA administers Oregon’s PDMP

Oregon’s PDMP is housed within the Office of Injury and Violence Prevention Program, located within the Public Health Division of OHA. OHA has an opioid initiative to reduce deaths, non-fatal overdoses, and harm to Oregonians from prescription opioids, while expanding use of non-opioid care.

Since 2011, PDMP personnel have typically consisted of a manager and four staff. Staff register users, perform some quality assurance and analysis, and coordinate efforts with the advisory commission, boards, and other health entities.

Figure 6: Oregon’s organization of its PDMP is similar to nearby states

State	Full Time Equivalent (FTE) Staff	Agency Type	Number of Prescribers
Oregon	4	Department of Health	24,000
California	11+	Law Enforcement	188,000
Colorado	0-1	Board of Pharmacy	31,000
Idaho	2-5	Board of Pharmacy	8,000
Nevada	2-5	Board of Pharmacy	12,000
Washington	11+	Department of Health	44,000

Source: Prescription Drug Monitoring Program Training and Technical Assistance Center, Brandeis University. Some states have additional responsibilities within their program that others do not.

The PDMP contracts with a vendor to maintain the database of prescription information. Oregon uses the same vendor for its PDMP that 42 other states and territories use for theirs.

OHA does not receive state funding for operating Oregon’s PDMP. Rather, it is funded through licensing fees. This is similar to California and 20 other states.¹¹ Having a stable funding source, like licensing fees, is considered a leading practice among PDMPs. All Oregon-licensed healthcare prescribers and pharmacists pay a \$25 annual fee included in their board licensing fees. For two recent fiscal years, 2017 and 2018, funding for the program totaled approximately \$1.6 million.

¹¹ Other primary funding sources for states’ PDMPs come from federal grants (e.g., Washington and Nebraska), regulatory board funds (e.g., Kansas and South Dakota), and other funding such as health insurance licensing fees (e.g., New York) and legal settlements (e.g., Virginia).

Objective, Scope, and Methodology

Objective

Our audit objective was to determine if Oregon can better leverage its PDMP to help with the opioid epidemic.

Scope

The audit covers PDMP efforts since its inception, and program data for calendar years 2015 through the first quarter of 2018.

Methodology

To address our objective, we conducted interviews with multiple stakeholders, including PDMP staff, OHA personnel, members of the Legislature, members of the PDMP Advisory Commission, members of licensing boards (the Board of Pharmacy, the Board of Optometry, the Oregon Medical Board, the Board of Dentistry, the Board of Naturopathic Medicine, and the Board of Nursing), representatives of the Oregon Medical Association and Oregon Society of Health-System Pharmacists, staff of other government agencies, other states' PDMP staff, practicing prescribers and dispensers, staff from the Oregon Pain Commission, and staff from Lines for Life.¹²

We reviewed state laws and administrative rules related to the program and our audit objective. We also reviewed the program's quarterly and annual reports, Oregon PDMP user surveys conducted by OHA, as well as the website materials relevant to our audit objective. We also reviewed the program's policies and procedures.

We identified leading practices for PDMPs through a review of materials from the Prescription Drug Monitoring Program Training and Technical Assistance Center at Brandeis University, materials from the Substance Abuse and Mental Health Services Administration Center, the National Governor's Association, the National Alliance for Model State Drug Laws, and academic research studies through various medical publications.

We obtained PDMP data from the Oregon Health Authority and performed limited data reliability testing and analyzed data to identify questionable activity such as doctor shopping and prescriptions for risky drug combinations.¹³ We performed testing to determine the completeness of the data with other state prescription claims datasets. We obtained Medicaid pharmacy claims and Oregon Prescription Drug Program data from OHA. We also obtained Workers' Compensation pharmacy claims data from the State Accident Insurance Fund Corporation (SAIF), Oregon's nonprofit workers' compensation insurance company. All data sets covered calendar years 2015 through 2017.

We reached out to the U.S. Department of Treasury to gain access to the Social Security Administration's Death Master File to look for potentially inappropriate payment of prescription drugs (e.g., prescriptions recorded as written by deceased prescribers and prescriptions dispensed to deceased recipients) but we were unable to gain access in time to perform testing.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain

¹² Lines for Life is a nonprofit organization that manages crisis lines and programs to help prevent substance abuse and suicide.

¹³ Doctor shopping occurs when a patient receives controlled substance prescriptions from multiple healthcare prescribers without the prescribers' knowledge of the other prescriptions.

sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

We sincerely appreciate the courtesies and cooperation extended by officials and employees of the Oregon Health Authority and SAIF during the course of this audit.

Audit Results

Oregon deliberated through multiple legislative sessions to establish its PDMP and designed this tool to focus on helping with patient health and safety. For the seven years it has been operating, Oregon's PDMP has been voluntary, informational, and educational for medical professionals. In March 2018, the Governor declared a public health emergency around addiction, responding to Oregon's challenges in combating substance use disorders.

A PDMP is not the sole solution to the opioid crisis or other drug misuse and abuse, but it is a key tool that can help in combating drug epidemics. Following the example set by other states, Oregon can take more robust action to optimize its PDMP. The limited scope of Oregon's PDMP is due mainly to constraints put on the program by the Legislature. These limit the PDMP's efficiency, effectiveness, and impact. Correcting limitations in Oregon's PDMP will maximize its potential to help address opioid and other substance abuse issues in the state.

Our recommendations to OHA detail processes that can be implemented in the short term, as well as recommendations to work with the Legislature on statutory changes. We believe some of these processes can be implemented using existing resources and therefore would not require an increase in the program fee healthcare licensees pay. There is also the potential for reducing drug and medical costs within Medicaid by implementing recommendations that focus on better monitoring of patients' prescriptions.

PDMP data shows questionable activity has been occurring for years, but state laws limit OHA's ability to investigate and mitigate such activity

PDMPs are a great source of information that could be better used to delve into prescribing and dispensing practices. OHA has started to use PDMP data to examine questionable practices, but little action has been taken to address the concerns. State laws limit the examination of practitioners' activities and do not allow analyses focused on patients.¹⁴ More robust analyses about the nature and extent of prescribing and dispensing practices would better inform decision-making about substance abuse in Oregon.

Oregon's PDMP does some prescribing analysis, but more can be done

For the past seven years, Oregon's PDMP has focused its data analyses on overall prescription trends, the most frequently prescribed drugs, prescriptions related to the treatment of substance use disorders, and the use of the PDMP database by healthcare prescribers and pharmacists. These analyses are completed on a monthly and quarterly basis, and PDMP produces an annual report for its program's advisory committee. The PDMP has also contributed data to OHA's prescribing and drug overdose data dashboard, which is an interactive tool that contains state and county level data on controlled substance prescribing and drug overdose health outcomes.

While OHA is performing some analyses at the county and state level, these metrics are typically siloed and not layered together for patterns. A promising practice for PDMPs is to use data to identify hot spots, or areas likely to see higher rates of opioid hospitalizations or overdose deaths. By identifying hot spots within Oregon, OHA could better help municipalities target their limited prevention and intervention resources.

Looking at high-level prescribing trends is valuable, yet PDMP data can be better leveraged to identify patterns of possible opioid misuse and abuse. Behaviors like doctor shopping and over-

¹⁴ ORS 431A.850-900 and OAR 333-23.

prescribing are often associated with increases in opioid misuse and overdose. Examples of possible patterns include:

- prescribers who are prescribing controlled substances in excessive quantities;
- pharmacies that are dispensing controlled substances in excessive quantities;
- individuals who are prescribed dangerous combinations of drugs;
- individuals who may be addicted and receiving multiple prescriptions for commonly misused drugs from multiple prescribers or pharmacies; and
- geographic locations of patients who are receiving dangerous combinations of drugs or are engaged in doctor and pharmacy shopping.

Historically, PDMP data has not been used in Oregon to identify risky or questionable prescribing and dispensing behaviors of prescribers. In 2018, the Clinical Review Subcommittee was created to review prescribers' histories and identify areas where prescribers may need additional training or education on prescribing opioids.¹⁵ Areas of concern the subcommittee is looking at include prescribers with a history of prescribing a high volume of opioids, an above-average amount of opioids, or co-prescribing opioids with certain other scheduled drugs.

When prescribers are identified in one or more of these areas, a letter is sent to them that recommends further training or education. In 2018, letters were sent to 160 individual prescribers identified by the subcommittee after the first review of prescriber histories. However, prescribers are not required to respond to the letter, nor are they required to actually take any additional training or education.

Tennessee's overprescribing team

Tennessee's overprescribing team annually identifies the top 50 opioid prescribers in the state and the top 10 opioid prescribers of each county. The prescribers are sent a letter to which they have to respond, explaining why they are using those treatments so frequently in their practice. If the overprescribing team does not agree with a prescriber's explanation, an investigation with the related licensing board is opened. In the last few years, Tennessee has seen a decrease in opioid prescribing for top prescribers.

Additionally, the subcommittee cannot share the results of its reviews with any of the health licensing boards who oversee the prescribers. There is no sharing at an aggregate level so boards can proactively work with their licensees on issues. Questionable prescribing habits seen within the data, even those that are egregious, cannot be elevated to any regulatory or enforcement entities to directly look into those situations.

This limitation in data analysis is due to the specific limitations in the law that created the PDMP. Current analyses done by the PDMP and the subcommittee could be much more robust if the laws were changed to allow for expanded use and sharing of the data. These statutory deficiencies are covered in greater detail later in this report.

Doctor shopping is an issue that continues in the state

Doctor shopping occurs when a patient receives controlled substance prescriptions from multiple healthcare prescribers without the prescribers' knowledge of the other prescriptions. For example, a person visits one healthcare prescriber and receives a prescription. Then, the patient visits a different prescriber for the same condition and receives another similar or exact prescription. Some people who engage in this behavior may be misusing the prescriptions or selling them to others in a process called diversion. People who exhibit doctor shopping behavior typically represent a small portion of the general population.

¹⁵ The Clinical Review Subcommittee is organized under the PDMP's Advisory Commission. Members of the subcommittee are experienced healthcare prescribers who are able to prescribe Schedules II-IV controlled substances.

Doctor shopping, a concern for over a decade, was discussed during multiple legislative hearings leading up to the creation of the PDMP. Some broad analyses were conducted on this activity until 2018 and, even then, efforts to curb this behavior by using PDMP information have been limited by statute.

We looked at three years of data from Oregon’s PDMP and found multiple instances of potential doctor shopping. While there can be legitimate reasons to see multiple prescribers for the same or similar type of medication, we found cases where that seemed extremely unlikely. We identified 148 people who received controlled substance prescriptions from 30 or more different prescribers and filled their prescriptions at 15 or more pharmacies within our three-year time frame. In contrast, the average person received controlled substance prescriptions from two different prescribers and filled their prescriptions at two different pharmacies.

Figure 7: Individuals in potential doctor shopping cases far exceeded the average number of prescribers and pharmacies over three years



Source: OAD analysis using PDMP data, calendar years 2015 through 2017, provided by OHA PDMP staff.

Out of those 148 people, we examined the transactions of five people who exhibited the most egregious behavior of potential doctor shopping, as depicted in Figure 8. Hydrocodone, which is the most commonly dispensed opioid medication in Oregon, was the common drug filled by each of the five individuals.

Figure 8: The most egregious cases of potential doctor shopping saw hundreds of prescriptions filled

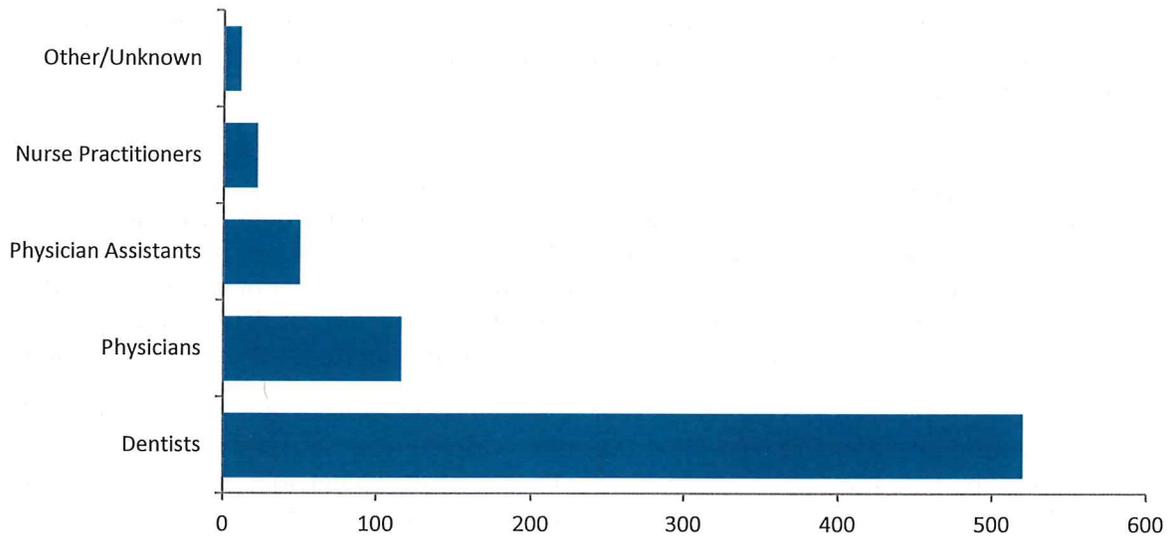
	Person 1	Person 2	Person 3	Person 4	Person 5
Total Opioid Prescriptions Filled	290	315	140	207	156
Most Frequent Drug(s)	Hydrocodone	Hydrocodone	Hydrocodone, Oxycodone	Hydrocodone	Hydrocodone, Oxycodone
Different Prescribers	232	207	102	98	80
Different Pharmacies	75	40	57	36	21
Other Information	32 opioid prescriptions paid by Medicaid	Prescription for buprenorphine in late 2017, indicating may have a substance abuse disorder	Prescription for buprenorphine in 2017, indicating may have a substance abuse disorder	N/A	N/A

Source: OAD analysis using PDMP data, calendar years 2015 through 2017, provided by OHA PDMP staff.

In a review of Medicare Part D prescriptions in other states, the Office of Inspector General found four prescribers who wrote opioid prescriptions to over 136 patients who exhibited doctor shopping behaviors. The 2,823 prescriptions cost the program \$336,000.

Most of the prescriptions for these five people were for short durations, providing them with medication to last for three to five days.¹⁶ When we analyzed the prescribers who wrote these prescriptions, we found most of them were dentists. In two cases, almost all of the prescribers were dentists. For example, Person 1 was prescribed opioids by 218 different dentists, out of 232 total prescribers.

Figure 9: Dentists prescribed most of the opioids in our five cases of potential doctor shopping



Source: OAD analysis using PDMP data, calendar years 2015 through 2017, provided by OHA PDMP staff.

Risky prescribing habits are occurring in the state

The risk of overdose is much higher when mixing different types of drugs. Though healthcare prescribers often prescribe multiple drugs together to treat medical and physical conditions, certain combinations of prescription drugs can be dangerous, even deadly, when taken concurrently.

One such combination involves opioids, benzodiazepines, and muscle relaxants. Benzodiazepines, commonly referred to as “benzos,” are some of the most commonly prescribed medications. They can be used to treat anxiety, insomnia, muscle spasms, and seizures. Two familiar brand names of benzos include Valium and Xanax. Muscle relaxants may be used to alleviate muscle spasms and pain.

Opioids, benzos, and muscle relaxants have some overlapping side effects. In combination, the total effect of these three drugs is greater than the sum of the individual effects. This drug combination can cause respiratory depression that could lead to death. Many patients have reasonable needs for these drugs separately and sometimes in different combinations, but there are very few reasons why a patient would be legitimately prescribed all three drugs at the same time. Using Oregon’s

Some medical literature states the combination of opioids, benzos, and muscle relaxants is known to be favored by individuals suffering from substance abuse and by those seeking to resell pills.

¹⁶ Oregon Opioid Prescribing Guidelines for Dentists recommend that opioids only be prescribed in small dosages, and usually not for more than three days.

PDMP data, we found about 4,270 people who were prescribed all three of these drugs in the same month at least once. Specifically, over the course of 36 months:

- 10 people received all three drugs for the entire time;
- 113 people had all three for 30 to 35 months; and
- 741 people had all three for 10 to 29 months.

People who had these drugs for 30 or more months received their prescriptions from six different prescribers on average. We looked at the detailed history for five people who received all three drugs for at least 12 months and saw a higher than average number of prescribers. These people saw, on average: five prescribers for benzos; four for muscle relaxants; and 13 for opioid prescriptions. Receiving these three drugs from different prescribers suggests that either the care for these people was not coordinated, or more likely, some prescribers were unaware of the other concurrent prescriptions.

According to the National Institute on Drug Abuse, more than 30% of drug overdoses that involve opioids also involve benzos.

Benzos and opioids are sometimes prescribed concurrently. This combination is less dangerous than including muscle relaxants, but still poses concerns if not closely monitored by a healthcare prescriber. Our analysis found almost 34,690 people received both of these drugs in the same month for 10 or more months, out of 36 months. Plus, 5,230 people received these drugs for 30 to 35 months and 740 people received them for the entire 36 months.

The drug gabapentin is also a concern. Recent reports have shown the abuse of this drug, which is used to treat epilepsy and painful nerve diseases, is on the rise. When taken with prescription or illicit opioids, it enhances their euphoric effects. When taken alone in high doses, gabapentin can produce a marijuana-like high. A study of heroin users in Europe concluded that combining opioids and gabapentin potentially increases the risk of acute overdose death by hampering breathing and reversing users' tolerance to heroin and other powerful opioids.¹⁷

In 2017, prescriptions for gabapentin within Oregon's Medicaid program rose by 50% from the prior year and followed closely behind prescriptions for oxycodone. Other states have seen increased abuse of gabapentin, such as Illinois, Ohio, Minnesota, and Virginia, and track this drug in their PDMPs. Gabapentin is not a scheduled controlled substance; however, another drug in the same class, Lyrica, is a Schedule V drug. Over 70% of states have included tracking of Schedule V drugs in their PDMPs. By statute, Oregon does not.

Another type of drug that warrants further review is stimulants. Oregon is seeing a concerning trend for prescription stimulants that is occurring in many age groups. Due to its rapid growth nationally, addiction to stimulants is forecasted to be the next drug epidemic. Stimulants increase alertness, attention, and energy in addition to elevating blood pressure, heart rate, and respiration.

Reports suggest stimulants are being abused for nonmedical cognitive enhancement among some groups (e.g., academic professionals, athletes, performers, and both high school and college students). A new survey of U.S. undergraduate, graduate and professional students found nearly 16% of college students say they misuse prescription stimulants primarily to get better grades, and the majority of students who misuse prescription medications

Prescriptions to Oregonians for amphetamines, a type of stimulant, have increased by about 10% from the first half of 2017 to 2018. Amphetamines were the third most commonly dispensed controlled substance collected by the Oregon PDMP for the first three quarters of 2018.

¹⁷ Lyndon A, Audrey S, Wells C, Burnell ES, Ingle S, Hill R, Hickman M, Henderson G. "Risk to heroin users of polydrug use of pregabalin or gabapentin," *Addiction* 112 (9) (September 2017): 1580-1589.

obtained them from friends.¹⁸ High doses of stimulants can potentially lead to cardiovascular failure, seizures, or death among other side effects. Repeated abuse of some stimulants can lead to hostility, paranoia, and psychosis. There are currently no overdose reverse medications or medication assisted treatment to curb the abuse of stimulants.

Louisiana’s Board of Pharmacy recently raised concerns about the prescribing trends of two medications: Zolpidem, which has been used as a date rape drug, and promethazine with codeine, a prescription cough medicine that can be used to make a street drug. Zolpidem is commonly prescribed under the brand name Ambien and is the fifth most commonly prescribed controlled substance in Oregon.

The Office of Inspector General identified a doctor who prescribed excessive amounts of opioids to 125 of their patients. Medicare Part D paid \$1.6 million for these prescriptions.

In analyzing Oregon’s PDMP data, we found troubling instances of potentially excessive quantities of zolpidem. For example, one person received a 1,545 days’ supply of zolpidem from five prescribers in a single year. While zolpidem prescriptions are collected by Oregon’s PDMP, some prescription cough syrups with codeine are classified as a Schedule V drug and are therefore not required to be reported to the PDMP.¹⁹

Oregon’s PDMP is not allowed to evaluate prescriber practices and prescribing habits among peers

Some states, but not Oregon, produce prescriber report cards using PDMP data. These show a practitioner how their prescribing practices compare to their peers within their medical specialty. For example, a family physician can compare their prescribing behaviors to the average family doctor.

Prescriber report cards contain summaries of patient prescriptions, risk status, and other relevant information (see Appendix B and C for an example). They can be solicited, unsolicited,

Figure 10: Most nearby states provide prescribers with report cards

State	Prescriber Report Cards?
Oregon	
California	
Colorado	•
Idaho	•
Nevada	•
Washington	•

Source: Prescription Drug Monitoring Program Training and Technical Assistance Center.

or both. Solicited means that the prescriber needs to request the report and unsolicited means that all prescribers would receive a report. The use of prescriber report cards is a promising practice that gives prescribers a tool to self-examine their behaviors and can positively influence their prescribing of controlled substances.²⁰ Oregon’s statute prevents report cards, as these would be considered evaluating a prescriber’s practice, which is prohibited.²¹

Oregon also does not have health specialty information on all the prescribers in the state. In Oregon’s PDMP, when practitioners registered prior to mid-October 2017, they were not required to provide health specialty information and many thousands of practitioners left that information blank. Those registering after that time have been required to report their

¹⁸ Phillips, Erica L. & McDaniel, Anne E. (2018). College Prescription Drug Study Key Findings Report. Center for the Study of Student Life, Ohio State University: Columbus, Ohio.

¹⁹ The Drug Enforcement Agency states that cough preparations containing no more than 200 milligrams of codeine per 100 grams are classified as a Schedule V controlled substance.

²⁰ See Appendix B and C for an example of Washington’s prescriber report card and the accompanying email sent to prescribers.

²¹ ORS 431A.865 (1)(b) states the “prescription monitoring program may not be used to evaluate a practitioner’s professional practice” except for “a health professional regulatory board that certifies in writing that the requested information is necessary for an investigation related to licensure, license renewal or disciplinary action involving the applicant, licensee or registrant to whom the requested information pertains.”

health specialty. PDMP staff said they are starting to work on getting complete specialty information on prescribers.

Out of 53 states and territories, 26 PDMPs provide their prescribers with report cards and 35 PDMPs send both solicited and unsolicited reports to prescribers. Nationally recognized experts believe report cards would be beneficial to prescribers in evaluating their prescribing practices. Arizona, Kentucky, and Ohio have received positive feedback from providers on their report cards.

Oregon statutes hamper use of the state's PDMP information to effectively address opioid use and misuse

If properly structured and administered, PDMPs can be a powerful tool that provide valuable information for mitigating substance abuse risks and outcomes. However, current Oregon statutory requirements limit the impact potential of the PDMP. Pharmacies make a great effort to submit prescription information and PDMP personnel put great effort into maintaining the database for prescribers and pharmacies to use. However, no one is required to access the PDMP database, voluntary usage is mediocre, and some key stakeholders can only access limited information and under very specific circumstances.

State law does not require prescribers to use the PDMP database

Prescribers with an active U.S. Drug Enforcement Administration (DEA) license were required to register with the PDMP by July 1, 2018. However, when the state rule was established, no repercussions were included for a practitioner who did not register, making participation in the program essentially voluntary. According to PDMP staff, about 77% of the required prescribers had registered as of early November.

Mandated use has been discussed in Oregon but has never been required. According to a recent study, states that have mandated healthcare providers to access the PDMP prior to prescribing a controlled substance have been effective in reducing opioid misuse and other related health outcomes.²² Further, prescriber use of PDMPs has also been associated with reduced crime rates (mainly violent crimes, particularly homicide and assault). According to the FBI's Uniform Crime Reporting Program, Oregon's violent crime rates increased by 6.3% in 2017.

Prescriber querying has generally increased since 2014, which is expected as more prescribers register and as Oregon's PDMP database is integrated with electronic health records. In the recent PDMP quarterly report, almost 39% of enrolled prescribers queried the PDMP database during the third quarter of 2018. These prescribers have worked in the time to check the PDMP database for one or more of their patients.

The common argument against accessing the PDMP database is the time it takes to access it, which is a separate system requiring a separate log in, detracting from the limited time with a patient. Yet it can help practitioners identify any problematic prescription habits and determine the appropriate treatment and medication to prescribe, which is important for patient health and safety. Some patients may not recall their prescriptions or may intentionally not share the prescription medications they are taking. Oregon rules do allow practitioners to designate delegates who can look up patient information on a doctor's behalf.²³ Vigilantly checking the

²² Dave, Dhaval, and Deza, Monica and Horn, Brady. *Prescription Drug Monitoring Programs, Opioid Abuse, and Crime* (August 2018). NBER Working Paper No. w24975.

²³ Delegates are defined in ORS 431.865 (2)(a) as a "member of the practitioner's or pharmacist's staff." Even if a practitioner or pharmacist authorizes a delegate, by statute the practitioner or pharmacist remains responsible for the use or misuse of the information by the staff member.

PDMP database prior to prescribing controlled substance medications would help ensure patients receive appropriate doses of opioids and other concerning drugs.

Increasing access and use of the PDMP database is a high priority for the program. The PDMP has conducted some outreach to Oregon prescribers to encourage them to use the database and to inform them about how to integrate use of the database into their clinic practices. From 2014 to 2015, the PDMP had temporary staff working with prescribers on how to weave use of the PDMP database within the daily workflow. This mainly focused on encouraging the top prescribers and their delegates to register and use the database, which the vast majority do.

To make the PDMP database easier to use, OHA has been working on integrating the database with electronic health records in the state. Integrating PDMP data into electronic health records is considered a leading practice. As of July 2018, 21 Oregon hospital emergency departments, or 34%, have integrated with the PDMP database. The PDMP is working on expanding this further and looking at integration opportunities with other health information systems. Smaller practices and those that use paper files would still need to integrate checking the PDMP database separately into their daily workflow.

Figure 11: Most nearby states require prescribers to use their PDMP

State	Mandatory Use for Prescribers?
Oregon	
California	•
Colorado	•
Idaho	
Nevada	•
Washington	•

Source: Prescription Drug Monitoring Program Training and Technical Assistance Center.

Oregon’s PDMP database has a dashboard that prescribers can review when accessing the database. This dashboard displays an alert if a patient exhibits doctor shopping behavior, is receiving a high dose opioid prescription, or has received a prescription for an opioid and a benzo within a set time frame. These alerts are visible only to the prescriber, who is not required to review them. A prescriber would know they have a patient alert only if they accessed the PDMP database and viewed that specific page on their dashboard.

Leading practices require all prescribers who can write prescriptions for controlled substances to register and query the PDMP database. The U.S. Department of Health and Human Services Office of Inspector General recommends that prescribers and dispensers be required to check the PDMP database before prescribing and dispensing opioids. There are 41 states with PDMP mandatory use requirements; 27 of them,

like Washington and California, require that of only their prescribers, while the other 14 require it of both prescribers and dispensers. Mandatory use requirements seem to have had a great impact on the program in other states. Requirements vary widely from state to state. Examples include:

- Louisiana mandates prescribers query the PDMP before any opioids are prescribed and every 90 days during treatment;
- California prescribers are required to view a patient’s data in the PDMP prior to prescribing a Schedule II-IV controlled substance for the first time, and at least every four months thereafter if the substance is still being prescribed;
- Illinois requires prescribers to view PDMP data for new Schedule II prescriptions, but only if they are for more than seven days’ supply and the treatment is not for cancer or palliative care; and
- Alaska requires both prescribers and dispensers to review PDMP data when any Schedule II or III controlled substance is prescribed or dispensed, with some limited exceptions, such as hospice or inpatient treatment.

New federal rules will require providers to query PDMPs when prescribing controlled substances for Medicaid and Medicare patients starting in 2020.

State laws block access to PDMP data for some key players

The inappropriate use of prescription opioids is of increasing concern for both public health professionals and law enforcement authorities, and requires collaborative partnerships to maximize the use of information to proactively fight the opioid epidemic. Yet entities that could benefit from expanded access to PDMP information currently only receive very limited information and under very specific circumstances.

Two of those entities include health licensing boards and law enforcement. In addition to their regulatory and enforcement functions, both of these entities have missions that center on the health and safety of Oregonians. Oregon statutes, however, only allow health licensing boards to request PDMP information for an active investigation into a licensee. Law enforcement entities are further restricted by statute, as they may only request PDMP data if it is needed as a part of an active drug-related investigation and is accompanied by a valid court order.²⁴

Delegates, who can be non-licensed staff, were allowed by statute in 2014 to access the PDMP on behalf of a prescriber, pharmacist, or medical examiner. Access was again expanded in January 2018 to allow a medical or pharmacy director access to the PDMP for overseeing their entity’s operations to ensure the delivery of quality health care. With that access, medical directors can see reports that show a summary of prescriptions by a specific healthcare provider and the corresponding patient and pharmacy information. Similarly, pharmacy directors can access the dispenser activity report that shows a summary of prescriptions dispensed at a certain location and the corresponding patient and prescriber information. Like medical and pharmacy directors, health licensing boards are tasked with ensuring patient safety and quality of care by their licensed practitioners, but they have not been granted the same access. Rather, they have to wait to receive a complaint about one of their licensees and open an investigation in order to look into prescribing and dispensing practices.

Figure 12: Most nearby states allow law enforcement access during an active investigation

State	Law Enforcement Access During an Active Investigation?
Oregon	
California	•
Colorado	
Idaho	•
Nevada	•
Washington	•

Source: Prescription Drug Monitoring Program Training and Technical Assistance Center.

Oregon State Police (OSP) and the Department of Justice both focus on public safety, which is one of the PDMP initiatives. Representatives from law enforcement agencies are involved with the Governor’s opioid task force and the Alcohol and Drug Policy Commission.²⁵ However, when it comes to accessing data that could help all state bodies direct efforts at reducing opioid abuse, OSP stated that they have not used the PDMP for investigative purposes. Research has shown that PDMPs save law enforcement officials time in investigations if they have access to PDMP information. Thirty-five other states allow law enforcement access to PDMP reports and information when it comes to active investigations. According to the U.S. District Attorney’s Office, obtaining an administrative subpoena for PDMP data is cumbersome and inefficient, which keeps Oregon from more effectively eliminating

potential suspects and addressing concerning cases of extreme quantities of prescription drugs

²⁴ See Footnote 15 for disclosure of PDMP information to a health professional regulatory board. Per ORS 431A.865 (2)(a)(G), PDMP information shall be disclosed “pursuant to a valid court order based on probable cause and issued at the request of a federal, state or local law enforcement agency engaged in an authorized drug-related investigation involving a person to whom the requested information pertains.”

²⁵ The Alcohol and Drug Policy Commission is an independent state government agency that was created by the Oregon Legislature to improve the effectiveness and efficiency of state and local alcohol and drug abuse prevention and treatment services. The Commission is to establish priorities and policies for alcohol and drug abuse prevention and treatment services as part of a long-term strategic prevention and treatment plan for this state per ORS 430.242.

such as pill mills.²⁶ Law enforcement officials from other states have found that having PDMP access has been invaluable to their investigations and has helped save time and money.

PDMP information is intended to be used for determining the course of treatment for a patient, and should be rightfully protected. Yet it is also intended to help ensure appropriate use of prescription medications. There is training on how to use the database and penalties for those that do not adhere to rules in using the PDMP database. As with any repository of patient information, privacy and security concerns have been at the center of restrictions to that information.

Figure 13: Many nearby states send unsolicited reports to prescribers

State	Unsolicited Reports Sent to Prescribers?
Oregon	
California	•
Colorado	
Idaho	•
Nevada	•
Washington	

Source: Prescription Drug Monitoring Program Training and Technical Assistance Center.

Leading practices recommend proactively providing data not only to prescribers and dispensers, but also to law enforcement and licensing boards regarding any individual who exhibits potential signs of abuse, misuse, or diversion. Twenty other states have their PDMP send unsolicited reports to regulatory agencies, and 18 send unsolicited reports to law enforcement. This practice informs users about the PDMP and assists in targeting drug diversion reduction efforts and helps ensure safe, effective, and legal practice of medicine.

The National Governor’s Association also recommends states grant law enforcement access to PDMP data for open investigations involving prescription opioids. With this, states should maintain privacy rights as well as ensuring that law enforcement investigators are tracked, trained, and

certified to access PDMP data. Such requirements could help mitigate concerns about law enforcement using it to investigate anyone potentially misusing controlled substances if given access to the data. The 9th U.S. Circuit Court of Appeals recently reversed a lower court ruling that had prohibited the DEA, a law enforcement agency, from accessing records in Oregon’s PDMP without a warrant. Through the DEA, the U.S. District Attorney’s Office said it has access to PDMP data, but those investigating large pill mills such as the FBI does not have this access.

Some states have laws more open than Oregon to allow access to PDMP databases by entities such as licensing boards, bureaus of investigation, and overprescribing teams. Tennessee allows this access to maximize the use of PDMP data and proactively address drug abuse. Tennessee’s laws require law enforcement applicants to be approved by the U.S. Department of Justice before receiving PDMP data and any information obtained is not considered a public record. Law enforcement access is also monitored by district attorneys or other officials to ensure that all information requests are relevant and pertinent to an investigation.²⁷ Louisiana has granted PDMP database access to professional licensing boards, Medicaid program representatives, drug treatment providers, and parole officers.²⁸ Louisiana law enforcement officials can request PDMP data related to an open investigation.

²⁶ The term “pill mill” is typically used to describe a doctor, clinic, or pharmacy inappropriately prescribing or dispensing controlled prescription drugs.

²⁷ See Tennessee Codes Ann. § 53-10-302, § 53-10-303, and § 53-10-306 for laws related to PDMP access and information confidentiality.

²⁸ See Louisiana Revised Statutes (R.S.) 40:1001-1014.

Oregon’s PDMP database information should be complete and timely

While Oregon’s PDMP appears to receive most of the required prescription information it should, not all prescriptions are being reported to the PDMP. The state should collect more information to better ensure patient health and safety, and the effectiveness of the program.

PDMP appears to be receiving most but not all the prescription information it should

Oregon rules require pharmacies to submit key information for certain drugs to the PDMP within 72 hours for each dispensed prescription. When pharmacies do not submit complete information, it reduces the effectiveness of the PDMP. In our conversations with PDMP users, we heard concerns about the PDMP database not having complete and timely information.

The PDMP does not have a process to identify whether required pharmacies are submitting all the required information to the PDMP within 72 hours. PDMP staff regularly check to ensure all required pharmacies are submitting prescriptions information and doing so timely throughout a month. As dispensing prescriptions can vary throughout and across months, staff look for large spikes in total prescriptions submitted. This, however, does not ensure that pharmacies report all required prescriptions filled on a given day to the PDMP. For example, if a pharmacy actually dispensed 50 prescriptions for opioids and only submitted information on 30 of them, but also reported more pseudoephedrine fills, there would be no apparent spike and the pharmacy would appear to be meeting the reporting requirements.

Pharmacies in Oregon

About 1,000 pharmacies report data to Oregon’s PDMP. Another 176 pharmacies are not required to report or have been granted a waiver exempting them from reporting.

We obtained paid pharmacy claims information tracked by two other programs within OHA, Medicaid and the Oregon Prescription Drug Program (OPDP), as well as from SAIF to see if their prescriptions were in the PDMP database.²⁹ Although most of the prescriptions from these three sources were in the PDMP database, some were missing, as shown in Figure 14.

Figure 14: Most prescriptions tracked in other programs were in the PDMP database but we found gaps were in PDMP prescription histories for certain individuals

	Medicaid	OPDP	SAIF
Applicable Prescription Claims	3,936,843	786,595	87,104
Claims Initially Not Matched with PDMP	389,114	10,613	3,848
Individuals whose Prescriptions Were Tested	50	25	25
Prescriptions Tested	207	218	113
Prescriptions Tested Not in PDMP	113 (55%)	170 (78%)	92 (81%)

Note: We considered matches between PDMP and the listed datasets to include those with slight name spelling variations and prescription fill dates if they had the same date of birth, a similar timeframe for the same medication and dosage prescribed by the same doctor from the same pharmacy. Also, SAIF applicable claims were reduced by those that were OPDP prescription fills.

Source: OAD analysis using PDMP data, calendar years 2015 through 2017, provided by OHA PDMP staff.

²⁹ The Oregon Prescription Drug Program is the state’s prescription discount card program for Oregonians who are uninsured or underinsured for prescription drug coverage.

Of the 538 prescriptions we tested, 375 prescriptions for 71 individuals should have been in the PDMP database. These prescriptions were dispensed from many pharmacies who did not have all of their information in the PDMP database. While the total of these missing prescriptions may not seem substantial when compared to the millions of prescriptions the PDMP receives, the missing prescriptions could impact the practitioners' treatment decisions for those individuals.

While other states we spoke with have procedures similar to Oregon's for ensuring that pharmacies are reporting information, leading practices state that PDMP management should compare reported prescriptions to prescriptions dispensed by the pharmacy. In lieu of having the Board of Pharmacy's annual site visits or PDMP staff conduct this verification, data sharing with other programs' pharmacy information would provide further assurance the PDMP has complete information. Further, the U.S. Department of Health and Human Services encourages states to allow data sharing with other programs like Medicaid.

Prescriptions exempted pose a patient safety concern and should be collected

Oregon's PDMP requires only prescriptions dispensed by retail pharmacies to be collected. This excludes other pharmacies, such as long-term care and residential treatment facility pharmacies, from having to participate. Nothing prevents an individual from getting prescriptions concurrently, such as from both retail and long-term care pharmacies. In those cases, PDMP only shows one part of a patient's prescription history.

We found instances where patients were getting the same medication at different types of pharmacies. In one case, over the course of one month, an individual was prescribed 242 tablets of oxycodone and 87 tablets of clonazepam by two different doctors. These were filled by an exempt, long-term care pharmacy so the prescriptions were not included in the patient's PDMP prescription history. Later, within that same month, that individual was prescribed 112 tablets of oxycodone and 84 tablets of clonazepam by another doctor, and these were filled at a retail pharmacy. The third doctor would not have seen a history of that patient receiving those medications in the database. Going forward, the PDMP prescription history for that month only shows a third of the oxycodone pills and half of the clonazepam pills the individual actually received.

Figure 15: Instance of patient's medication received during a month from exempt and retail pharmacies

Date Dispensed	Generic Drug Name	Drug Class	Days' Supply	Quantity	Doctor	Pharmacy
8/12/2015	Clonazepam	Benzodiazepine	9	27	Doctor #1	Exempt Pharmacy
8/12/2015	Oxycodone	Opioid	7	40	Doctor #1	Exempt Pharmacy
8/17/2015	Oxycodone	Opioid	7	84	Doctor #2	Exempt Pharmacy
8/17/2015	Oxycodone	Opioid	7	28	Doctor #2	Exempt Pharmacy
8/21/2015	Clonazepam	Benzodiazepine	20	60	Doctor #2	Exempt Pharmacy
8/22/2015	Oxycodone	Opioid	15	60	Doctor #2	Exempt Pharmacy
8/22/2015	Oxycodone	Opioid	3	30	Doctor #2	Exempt Pharmacy
8/24/2015	Oxycodone	Opioid	28	112	Doctor #3	Pharmacy #1
8/24/2015	Clonazepam	Benzodiazepine	28	84	Doctor #3	Pharmacy #1

Source: Created by Audits Division staff using PDMP and Medicaid dispensed prescription data.

In another example, an individual had a prescription from a doctor for a 30-day supply of fentanyl patches that was filled on the same day at both a retail pharmacy and a long-term care pharmacy. This happened twice. During a different month, the individual had the same medication filled at a retail pharmacy and then, two days later, had it filled at a long-term care pharmacy. A doctor accessing the PDMP database would only see half of the fentanyl patches that were actually obtained by the individual for these instances.

In addition to some pharmacies being exempt from reporting to the PDMP, veterinarian-prescribed controlled substances are also exempt. Nationally, veterinarians have reported cases of pet owners intentionally harming their pets to get prescription drugs. This has occurred in multiple states, including Oregon. Although some veterinary prescriptions were found in Oregon’s PDMP database, the state does not make this a requirement. Eighteen other states do have this requirement. Some states also require veterinarians to check the prescription history of pet owners and their pets in their PDMPs, while other states have set limits on the amount of opioids veterinarians can prescribe.

Most states, not including Oregon, require prescriptions for controlled substances that practitioners directly dispense to patients be reported to their PDMP. Nebraska is the first state to expand from all controlled substances to requiring all prescriptions dispensed in the state be reported daily to its PDMP. This expansion allows for the examination of drug interactions and prescribing trends. Nebraska also requires veterinarians to report dispensed prescriptions of controlled substances to its PDMP.

Processes and data system issues hinder the usefulness of PDMP for users

The absence of some data in the PDMP database limits the effectiveness of the information. We found that even though most Oregon data appeared to have been submitted as required, controls in the system have kept some prescriptions unavailable to those querying the PDMP database. Also, the timing and potential delays in reporting can hinder the usefulness of PDMP data.

By statute, when accessing the PDMP database, a user is able to see the last three years of a patient’s prescription history. However, there have been concerns from Oregon’s PDMP practitioner surveys that information in the PDMP seemed incomplete. Similarly, PDMP users told us that prescription histories were sometimes incomplete. When we compared PDMP data provided to us with what practitioners see when querying the database, we found relevant prescription data were not always displayed in patient queries. Two reasons for this were revealed through conversations with PDMP staff and a review of cases.

Figure 16: Most nearby states collect data for the PDMP within 24 hours or the next day

State	Pharmacy Data Collected within 24 Hours or Next Day?
Oregon	•
California	
Colorado	•
Idaho	•
Nevada	•
Washington	•

Source: Prescription Drug Monitoring Program Training and Technical Assistance Center.

The first reason relates to buprenorphine, a drug used to treat opioid addiction. Only a physician with a special “X” number issued by the DEA can prescribe this medication. However, PDMP system edits do not recognize that type of a DEA number, and pharmacists do not feel they can modify a prescription to list the prescriber’s other DEA number. According to PDMP staff, this is a national issue. Because of this system edit, those prescriptions are not visible in database queries.

The second reason relates to correcting errors in pharmacy data submissions. When pharmacies send in their prescription data, the system checks it for errors. If errors hit certain thresholds, the pharmacy is informed

and the erroneous records are put into a hold, not viewable from queries, until they are corrected.

Oregon rules require pharmacies to correct and resubmit erroneous data within one week from when the data was first submitted. PDMP staff have increased their focus on pharmacy compliance to get errors corrected within the required timeframe. They reach out to pharmacies to have them resubmit required information, but we were told that after nine weeks, it is difficult for pharmacies to send the information. Pharmacies are not penalized if errors are not corrected, and we found some data submissions that had been on hold for years. The delay in processing errors expands the window of opportunity from four to more than 11 days in which a person can doctor shop before prior fills show up in the database.

Leading practices recommend collecting prescription data daily or in real-time. Of the 50 states and three U.S. territories, 47 have moved to daily or next business day reporting. Three of those states collect the prescription data at the point of sale or within 24 hours. By not having prescription data collected and updated in real-time, doctor and pharmacy shopping continues to be a possibility for those misusing and abusing prescription drugs.

Oregon does not require useful prescription detail to be collected

Other states collect prescription details beneficial to understanding and addressing substance misuse and abuse issues that Oregon does not.

Figure 17: All nearby states collect at least one other prescription detail that Oregon does not

State	Method of Payment Collected?	Schedule V Collected?	Veterinarian Data Collected?
Oregon			
California	•		•
Colorado	•	•	
Idaho	•	•	
Nevada	•		
Washington	•	•	•

Source: Prescription Drug Monitoring Program Training and Technical Assistance Center.

Forty-six state PDMPs collect the method of payment information in their programs (e.g., paid by Medicare, Medicaid, private insurance, or an individual). Collecting payment information is a noted leading practice identified by the Brandeis PDMP Center of Excellence. Collecting the method of payment was considered within a bill during Oregon’s 2017 legislative session but was removed. Some states, like Maine and Pennsylvania, require their pharmacies to check the PDMP prior to dispensing an opioid or benzo medication if the person is paying cash when they are known to have insurance.

As mentioned previously, Oregon’s PDMP collects Schedules II through IV medications, as well as two other drugs of concern. Nearly 40 states have expanded the dispensed prescriptions they collect to also include all Schedule V drugs. This allows them to monitor for trends of all the controlled substances listed in the Controlled Substances Act.

Another detail that would be useful to collect is patients who have a “lock-in” to a single prescriber and a single pharmacy for obtaining controlled substances.³⁰ This allows prescribers and pharmacists to take steps to ensure prescribing and dispensing are appropriate. Even if the pharmacist does not see this detail prior to dispensing, the PDMP could detect a prescription was issued and dispensed by an unauthorized prescriber or pharmacy. Further, if the PDMP could make the data available to Medicaid or other third-party payer, those entities could better

³⁰ “Lock-ins” are a tool used by Medicaid and other insurers to protect patients from receiving harmful amounts and combinations of opioids and other controlled substances. Typically, a patient is required to obtain future prescriptions only from a designated pharmacy, or a designated prescriber and pharmacy.

monitor the prescription behavior of their clients who have this restriction and evaluate the effectiveness of restricted lock-in programs. Washington's PDMP accomplishes the latter by providing data to its Medicaid program through bulk data transfers.

Lastly, the diagnosis code is key to monitoring trends in the prescribing of controlled substances. This detail is not captured in Oregon's PDMP database. Tennessee recently required prescribers to include diagnosis codes on prescriptions and that information to be sent to its prescription drug monitoring program. Diagnosis codes help provide a link to understand the treatments being used for different conditions. With Oregon's PDMP data not knowing the practitioner's health specialty and a patient's illness or injury that is being treated, it is challenging to understand prescribing trends.

Recommendations

We recommend OHA take the following actions to more effectively operate the PDMP within existing state statutes and rules.

1. Maintain an ongoing partnership with health licensing boards to target outreach efforts to get all required prescribers registered with the PDMP.
2. Provide guidance, including examples, to prescribers on ways to integrate accessing the PDMP database into their daily workflow.
3. Verify practitioner specialty information with the respective health licensing board and update the PDMP database with this information.
4. Develop a process for, and facilitate the sharing of, data between PDMP and Medicaid to help ensure completeness of PDMP prescription history and to allow Medicaid to better monitor the prescription behavior of its clients.
5. Identify and propose drugs of concern, such as gabapentin, to the Board of Pharmacy and Legislature that should be added to the state's controlled substance schedule and collected by the PDMP.
6. Work with the PDMP vendor and the Board of Pharmacy to make sure prescriptions made by X-waivered prescribers are included in the PDMP database.

We also recommend that OHA work with the Legislature to take the following actions to better optimize the state's PDMP. These will further promote the use, collection, and analysis of PDMP prescription information, which will help ensure the appropriate use of prescription drugs.

7. Expand statutes to allow the PDMP to conduct and share analyses on prescription data, including:
 - a. analyzing prescriber, pharmacy, and patient prescription practices;
 - b. making prescriber report cards available; and
 - c. preparing and issuing unsolicited reports to licensing boards and law enforcement.
8. Seek legislative action to address the issue of prescribers not registering with the PDMP as required and pharmacies not submitting corrected data within statutory requirements.
9. Provide further authority to the Clinical Review Subcommittee to require the justification of practices deemed concerning, and allow the collaboration with licensing boards and law enforcement for concerning practices.
10. Expand authority for other professional and state entities authorized access to PDMP information.
11. Require and set parameters for when prescribers must query the PDMP database to review a patient's prescription history. This should include, at a minimum, requiring the querying of the PDMP database prior to prescribing controlled substances and

substances of concern, and for dispensers to query the database prior to issuing a medication and periodically while the patient is taking those medications.

12. Allow for additional information to be collected by the PDMP. This should include:

- a. prescriptions for Schedule V controlled substances and other drugs of concern;
- b. applicable prescriptions from other types of pharmacies, not solely retail pharmacies;
- c. applicable prescriptions prescribed by veterinarians;
- d. method of payment used to pay for the prescription;
- e. patients who are restricted or have a "lock-in" to a single prescriber and a single pharmacy for obtaining controlled substances; and
- f. diagnosis codes related to the prescription.

Appendix A: Oregon Compared to Nearby States for Certain PDMP Features

State	Prescriber Report Cards?	Mandatory Use for Prescribers?	Law Enforcement Access During an Active Investigation?	Unsolicited Reports Sent to Prescribers?	Pharmacy Data Collected within 24 Hours or Next Day?	Veterinarian Data Collected?	Schedule V Collected?	Method of Payment Collected?
Oregon								
California		•	•	•		•		•
Colorado	•	•			•		•	•
Idaho	•		•	•	•		•	•
Nevada	•	•	•	•	•			•
Washington	•	•	•		•	•	•	•

Source: Prescription Drug Monitoring Program Training and Technical Assistance Center, Brandeis University.

Appendix B: Washington Prescriber Report Card Example



WASHINGTON PRESCRIPTION MONITORING PROGRAM PMP Prescriber Report



DATE: 3/29/2018

DATE COVERED BY THIS REPORT: 7/1/2017 - 12/31/2017

NAME:

DEA #

ROLE: Physician and Surgeon License (MD)

SPECIALTY: Family Medicine

MEMBER NUMBERS IN YOUR PEER GROUPS: SIMILAR PRESCRIBER (SP): 243 WITHIN YOUR SPECIALTY (WS): 340

NUMBER OF PERSONS FOR WHICH YOU PRESCRIBED OPIOIDS (MONTHLY AVERAGE)			NUMBER OF PRESCRIPTIONS YOU WROTE FOR OPIOIDS (MONTHLY AVERAGE)		
19	21	20	25	24	24
You	Similar Prescriber (SP)	Within your Specialty (WS)	You	Similar Prescriber (SP)	Within your Specialty (WS)

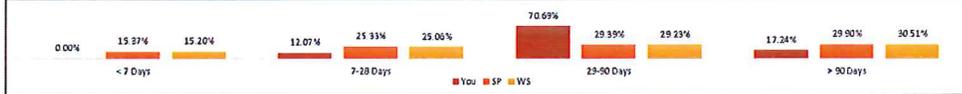
TOP MEDICATIONS PRESCRIBED (FULL REPORT PERIOD)

OXYCODONE HCL	ALPRAZOLAM	HYDROCODONE BITARTRATE/ACETAMINOPHEN
---------------	------------	--------------------------------------

PRESCRIPTIONS BY DAILY MME (MORPHINE MILLIGRAM EQUIVALENT) (FULL REPORT PERIOD)



OPIOID TREATMENT DURATION (% OF PATIENTS) (FULL REPORT PERIOD)



PRESCRIPTION VOLUMES (TOTAL MME) (MONTHLY AVERAGE)



ANXIOLYTIC / SEDATIVE / HYPNOTIC PRESCRIBING (MONTHLY AVERAGE)



PDMP USAGE (MONTHLY AVERAGE)

PDMP REQUESTS BY YOU	PDMP REQUESTS BY YOUR DELEGATE(S)	SIMILAR PRESCRIBER AVERAGE	SPECIALTY FIELD AVERAGE
15	0	9	9

PATIENTS EXCEEDING MULTIPLE PROVIDER THRESHOLDS (FULL REPORT PERIOD)

PATIENTS EXCEEDING MULTIPLE PRESCRIBER THRESHOLD	PATIENTS EXCEEDING MULTIPLE PHARMACY THRESHOLD
0	0

DANGEROUS COMBINATION THERAPY

PRESCRIPTIONS FOR OPIOID + BENZO IN SAME MONTH		PRESCRIPTIONS FOR OPIOID + BENZO + CARISOPRODOL IN SAME MONTH	
15	15	2	2
BY YOU	BY YOU + OTHER PRESCRIBERS	BY YOU	BY YOU + OTHER PRESCRIBERS

Appendix C: Washington Prescriber Report Card Email Example

Please do not reply to this email, the mailbox is not monitored. If you have questions or comments related to the contents of the report please email prescriptionmonitoring@DOH.WA.GOV

Dear Prescriber,

Attached is your personalized PMP Prescriber Report, which provides you with a snapshot of your prescribing of covered substances from July 1st, 2017 to December 31st, 2017.

1. This report is a summary of your prescriptions within the WA PMP database and a comparison to others within your specialty.
2. Morphine Milligram Equivalent (MME) dosing information is broken out so you can readily see whether (or where) your opioid prescribing falls within several MME ranges. Treatment drugs are included in this metric (Suboxone, Buprenorphine products, etc.).
3. Treatment duration is another metric that is meaningful and corresponds to PMP use as well as number of patients under treatment for chronic pain.
4. PDMP usage: shows how much you and your delegates are using the PMP web portal (does not include query activity via EHR-HIE integrations)
5. Multiple Provider Episodes (MPE) thresholds provides a look at your patients with multiple prescriber's episodes over the time period. This may indicate continuity of care issues or misuse, abuse or diversion of covered substances.
6. Dangerous combination therapy provides details of combination therapy that may increase a patient's risk for overdose.

Please take some time to review this information as well as the attached document explaining the metrics behind the report. This prescriber report is provided as an informational tool in support of the PMP's mission to improve healthcare quality and effectiveness by reducing abuse of controlled substances, reducing duplicative prescribing and overprescribing, and improving prescribing practices. It is not meant to be interpreted in isolation, or be used to impede the appropriate prescribing of controlled substances for legitimate medical purposes.

The Washington Department of Health has resources and tools for prescribers on our website at <https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionalsandFacilities/PrescriptionMonitoringProgramPMP/Resources>.

Additionally, the Centers for Disease Control and Prevention have information for prescribers at <https://www.cdc.gov/drugoverdose/prescribing/resources.html>.

The WA PMP hopes that you find this information helpful in your practice. If you have additional questions, please contact us at prescriptionmonitoring@DOH.WA.GOV or 360-236-4806.

Respectfully,

WA PMP Admin

Please do not reply to this email, the mailbox is not monitored.



OFFICE OF THE DIRECTOR

Kate Brown, Governor

Oregon
Health
Authority

500 Summer St NE E20
Salem OR 97301
Voice: 503-947-2340
Fax: 503-947-2341
www.Oregon.Gov/OHA
www.health.oregon.gov

December 4, 2018

Kip Memmott, Director
Secretary of State, Audits Division
255 Capitol St. NE, Suite 500
Salem, OR 97310

Dear Mr. Memmott,

This letter provides a written response to the Audits Division's final draft audit report titled "Constraints on Oregon's Prescription Drug Monitoring Program Limit the State's Ability to Help Address Opioid Misuse and Abuse," dated November 27, 2018.

Thank you for the opportunity to review and respond to the final draft report. I appreciate your close attention to Oregon's Prescription Drug Monitoring Program (PDMP) and your commitment to producing an accurate audit. The final draft report identifies several areas for improvement, and OHA agrees with all recommendations. However, recommendations 4 and 7-12 fall outside the scope of OHA's current statutory authority. In the absence of statute change, the agency's ability to complete them is limited. OHA is aware of the PDMP's current limitations and is actively engaged in policy discussions regarding potential legislative changes to add to the PDMP's capabilities and increase access to the system and its data. To address those recommendations that would require change in statute, OHA will continue to serve on the Governor's Opioid Task Force, and will continue to provide information to legislators on evidence-based recommendations to improve the PDMP and health outcomes.

Given the large impact of the opioid epidemic nationally, it is also important to contextualize the PDMP within the larger landscape of substance misuse in Oregon. While deaths and overdoses associated with illicit opioids are rising, opioid prescribing and prescription opioid-related deaths have been steadily decreasing in Oregon over the last few years. The PDMP was an important factor in these improved outcomes. However, it is one of many initiatives that comprise the Oregon Health Authority's multifaceted approach to addressing the opioid crisis.

In addition to its work with the PDMP, OHA has led development and promotion of consensus prescribing guidelines that are changing standard medical practice and culture around pain management; provided coaching and technical assistance for health care systems as they implement the guidelines; offered pain education training for clinicians through the Oregon Pain Management Commission; and encouraged safe prescribing practices within the Oregon

Health Plan. OHA also supports safe and effective non-opioid pain management and is actively increasing access to medication-assisted treatment (MAT) and naloxone rescue for opioid overdose. In addition, the agency collects and reports a variety of opioid-related data to inform policy decisions.

Below is our detailed response to each recommendation in the audit.

RECOMMENDATION 1		
Maintain an ongoing partnership with health licensing boards to target outreach efforts to get all required prescribers registered with the PDMP.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	May 31, 2019	Drew Simpson, PDMP Coordinator 971-673-1033

Narrative for Recommendation 1

Partnerships between the PDMP, prescribers, and licensing boards regarding opioid prescribing are a key means of ensuring patient safety. OHA has partnered with health licensing boards and medical associations to promote use of the PDMP for several years. In response to HB 4143’s requirement for all prescribers to register as PDMP users, OHA supported licensing boards in conducting provider outreach. With the help of medical licensing board promotion of PDMP registration and utilization, as of early November 2018, 92.7% of the 4,000 highest-volume prescribers of Schedule II-IV medications (which includes opioids) had registered for the PDMP. This is a substantial increase from March 2018 when only 55.4% of this group had registered. PDMP provider queries have increased more than fourfold since 2012. This effective work will continue.

RECOMMENDATION 2		
Provide guidance, including examples, to prescribers on ways to integrate accessing the PDMP database into their daily workflow.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	May 31, 2019	Laura Chisholm, Interim Manager Injury & Violence Prevention Section (guidance/examples) 971-673-0987

		<p>Susan Otter, OHA Director of Health Information Technology (technical system integration) 503-373-1817</p>
--	--	---

Narrative for Recommendation 2

OHA provides guidance and assistance to providers to integrate PDMP use into their work flows in several ways.

Tools for clinicians: In collaboration with the PDMP, in 2017 Oregon Opioid Prescribing Guidelines Taskforce members developed opioid prescribing guideline implementation tools. These materials are available on the Oregon Pain Guidance website at <https://www.oregonpainguidance.org>, which currently receives more than 30,000 unique visitors per month. These clinical tools include work flows, a PDMP electronic health record integration guide, a quality improvement reporting guide, a PDMP training video, and guidance on medical director access to the PDMP. The website also provides an opioid patient registry template that enables providers to use the PDMP to identify and track their patients with opioid and benzodiazepine prescriptions, as this functionality is limited within most electronic health records. In response to this recommendation, OHA will review and update the PDMP website to ensure the broadest possible reach of these resources.

Training and technical assistance on PDMP use in clinical workflows: OHA also provides training and in-person support for PDMP use in clinical workflows place under the auspices of the Public Health Division’s Prescription Drug Overdose prevention project, a sister program to the PDMP that is coordinated through the Injury and Violence Prevention Program. This work takes place via OHA contracts with members of the Pain Management Improvement Team, an expert interdisciplinary group of Oregon clinicians that assists health systems and clinics to improve opioid prescribing and treatment of pain and substance use disorder. One of the contractors is a health informaticist who specializes in assisting clinics in maximizing their use of the PDMP within clinical workflows. Clinics in need of assistance are identified in collaboration with the Oregon Medical Board. This work has been nationally recognized as a model for a team-based primary care approach to address the opioid epidemic. In response to this recommendation, OHA will continue its collaboration with the Oregon Medical Board and the Pain Management Improvement Team to identify and support clinics in need of assistance with PDMP/electronic health record integration.

Electronic medical record/PDMP integration: The statewide Prescription Drug Monitoring Program Integration initiative was launched in August 2018 by the Oregon Health Leadership Council, OHA, and other stakeholders under a public/private partnership called the HIT Commons. For the first time, authorized Oregon prescribers and pharmacists can have one-click access to PDMP data within their own electronic workflow. This initiative aligns with broader state and federal efforts to increase the use of PDMPs to reduce inappropriate prescriptions, improve patient outcomes, and promote more informed prescribing practices. Oregon emergency departments have already seen the benefits of PDMP Integration. Earlier this year, the PDMP Integration initiative targeted the Emergency Department Information Exchange (EDIE)/PDMP integration as its highest priority. As of September 2018, 25 Oregon hospital emergency departments (more than 600 prescribing clinicians) across Oregon are receiving PDMP data via EDIE. In response to this recommendation, this work will continue.

RECOMMENDATION 3		
Verify practitioner specialty information with the respective health licensing board and update the PDMP database with this information.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	February 28, 2019	Drew Simpson, PDMP Coordinator 971-673-1033

Narrative for Recommendation 3

Medical specialty information is an important element within the PDMP dataset and can help identify appropriateness of opioid prescribing. However, many prescriber types (e.g., naturopathic physician, dentist, nurse practitioner) do not have designated specialties, so it is not possible to identify specialty information for all PDMP users. Since October 2018, PDMP staff have been collecting available specialty information from licensing boards for upload into PDMP user profiles. This is a planned activity that is in process, one of the program's final steps in migration to the new PDMP platform. In response to this recommendation, this work will continue.

RECOMMENDATION 4		
Develop a process for, and facilitate the sharing of, data between PDMP and Medicaid to help ensure completeness of PDMP prescription history and to allow Medicaid to better monitor the prescription behavior of its clients.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree, but not allowed under current statute	June 30, 2019 (or sine die)	Laura Chisholm, Interim Manager Injury & Violence Prevention Section 971-673-0987

Narrative for Recommendation 4

Completeness of prescription history is an important component of high-quality PDMP data. In response to this recommendation, OHA will confer with the Oregon Department of Justice to clarify the scope of the program's authority for data sharing with the Medicaid program. Based upon that advice, OHA will continue to provide data and best practices to legislators to inform statutory change to enable implementation of this recommendation.

RECOMMENDATION 5		
Identify and propose drugs of concern, such as gabapentin, to the Board of Pharmacy and Legislature that should be added to the state's controlled substance schedule and collected by the PDMP.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation

	6 months)	
Agree	May 31, 2019	Drew Simpson, PDMP Coordinator 971-673-1033

Narrative for Recommendation 5

In response to this recommendation, OHA will continue to track emerging best practices regarding addition of drugs of potential abuse or misuse to Oregon’s PDMP. This ongoing work is informed by emerging medical and public health literature and program evaluations conducted within the community of agencies implementing PDMPs across the country. OHA will also continue its partnership with the Oregon High Intensity Drug Trafficking Area (HIDTA) program to stay current on trends in the local illicit drug market.

OHA will also continue to partner with the Board of Pharmacy as new drugs of concern emerge. Examples of previous partnership include OHA’s collaboration with the Board of Pharmacy on naloxone distribution and naloxone training, and the State Health Officer’s provision of data to inform discussions about the potential establishment of kratom as a scheduled medication (the Board of Pharmacy voted against this).

As new drugs emerge as potential additions to the PDMP, OHA will provide data and information to legislators.

RECOMMENDATION 6		
Work with the PDMP vendor and the Board of Pharmacy to make sure prescriptions made by X-waivered prescribers are included in the PDMP database.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	May 31, 2019	Drew Simpson, PDMP Coordinator 971-673-1033

Narrative for Recommendation 6

Complete prescription data within the PDMP is crucial for ensuring that the system enables clinicians to make safe and accurate prescribing decisions. OHA, like many other agencies that operate PDMPs across the country, recognizes the current gaps in X-waivered prescribing records as an area of focus for ongoing data quality improvement. Because identification of an up-to-date list of X-waivered providers has proved challenging, OHA is utilizing data from multiple sources, including the U.S. Drug Enforcement Agency and SAMHSA, to ensure that prescriptions filled under X-designated DEA numbers can be seen within the PDMP system. OHA is in the process of obtaining complete, current lists of X-waivered prescribers and as a response to this recommendation will continue to update PDMP records with this information as part of its ongoing data quality assurance activities.

RECOMMENDATION 7
Expand statutes to allow the PDMP to conduct and share analyses on prescription data, including:

<ul style="list-style-type: none"> a. analyzing prescriber, pharmacy, and patient prescription practices; b. making prescriber report cards available; and c. preparing and issuing unsolicited reports to licensing boards and law enforcement. 		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree, but not allowed under current statute	TBD, pending provision of statutory authority	Holly Heiberg, OHA Government Relations Director 971-207-7767

Narrative for Recommendation 7

Under PDMP’s current statutory authority, the legislatively mandated PDMP Clinical Review Subcommittee confidentially reviews prescriber, pharmacy, and patient prescription practices. Practice in other states has shown that peer comparison is an effective means of changing opioid prescribing practice. As guided by the Governor’s Office, OHA would support expansion of legislative authority to enable the full implementation of this recommendation. In response to this recommendation, OHA will provide data and best practices to legislators on evidence-based recommendations to improve the PDMP and health outcomes.

<p>RECOMMENDATION 8 Seek legislative action to address the issue of prescribers not registering with the PDMP as required and pharmacies not submitting corrected data within statutory requirements.</p>		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree, but under the scope of health licensing boards	TBD, pending provision of statutory authority	Holly Heiberg, OHA Government Relations Director 971-207-7767

Narrative for Recommendation 8

OHA agrees that complete, accurate PDMP data are important, and that routine use of the PDMP helps to reduce risky opioid prescribing and ensure patient safety. OHA awaits direction from the Oregon legislature regarding implementation of this recommendation and will support decision making with data and evidence-based practice.

<p>RECOMMENDATION 9 Provide further authority to the Clinical Review Subcommittee to require the justification of practices deemed concerning, and allow the collaboration with licensing boards and law enforcement for concerning practices.</p>		
Agree or Disagree with Recommendation	Target date to complete implementation activities	Name and phone number of specific point of contact

	(Generally expected within 6 months)	for implementation
Agree, but not allowed under current statute	TBD, pending provision of statutory authority	Holly Heiberg, OHA Government Relations Director 971-207-7767

Narrative for Recommendation 9

The PDMP Clinical Review Subcommittee has reviewed data, created risky opioid prescribing criteria, identified risky prescribers, and sent letters to these providers informing them of resources for improving their prescribing practices. OHA agrees that the ability to share more information about prescribing practices—especially among those providers prescribing the highest numbers of opioids—will enhance patient safety. OHA awaits direction from the Oregon legislature regarding implementation of this recommendation and will support decision making with data and evidence-based practice.

RECOMMENDATION 10 Expand authority for other professional and state entities authorized access to PDMP information.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree, but not allowed under current statute	TBD, pending provision of statutory authority	Holly Heiberg, OHA Government Relations Director 971-207-7767

Narrative for Recommendation 10

OHA agrees that expanding authorized access to specific groups—including dental directors and Coordinated Care medical and pharmacy directors—would enhance oversight of prescribing practices and improve patient safety. OHA awaits direction from the Oregon legislature regarding implementation of this recommendation and will support decision making with data and evidence-based practice.

RECOMMENDATION 11 Require and set parameters for when prescribers must query the PDMP database to review a patient’s prescription history. This should include, at a minimum, requiring the querying of the PDMP database prior to prescribing controlled substances and substances of concern, and for dispensers to query the database prior to issuing a medication and periodically while the patient is taking those medications.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree, but not allowed	TBD, pending provision of	Holly Heiberg, OHA

under current statute	statutory authority	Government Relations Director 971-207-7767
-----------------------	---------------------	--

Narrative for Recommendation 11

OHA agrees that routine use of the PDMP by providers and pharmacists is important for reducing opioid prescribing. The agency will await direction from the Oregon legislature regarding this recommendation and support decision making with data and evidence-based practice.

RECOMMENDATION 12		
Allow for additional information to be collected by the PDMP. This should include:		
<ul style="list-style-type: none"> a. prescriptions for Schedule V controlled substances and other drugs of concern; b. applicable prescriptions from other types of pharmacies, not solely retail pharmacies; c. applicable prescriptions prescribed by veterinarians; d. method of payment used to pay for the prescription; e. patients who are restricted or have a "lock-in" to a single prescriber and a single pharmacy for obtaining controlled substances; and f. diagnosis code related to the prescription. 		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree, but not allowed under current statute	TBD, pending provision of statutory authority	Holly Heiberg, OHA Government Relations Director 971-207-7767

Narrative for Recommendation 12

OHA agrees that complete, accurate PDMP data are important, and that routine use of the PDMP by providers and pharmacists is important for reducing opioid prescribing. The agency will await direction from the Oregon legislature regarding this recommendation and support decision making with data and evidence-based practice.

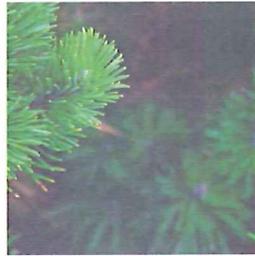
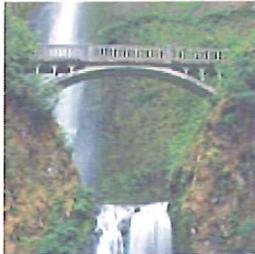
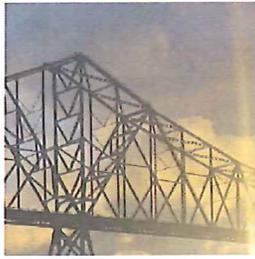
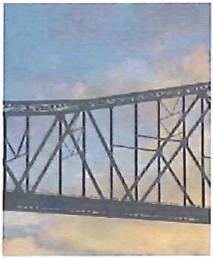
Please contact interim Injury and Violence Prevention Section Manager Laura Chisholm at 971-673-0987 with any questions.

Sincerely,



Kris Kautz, OHA Deputy Director

cc:



Audit Team

William Garber, CGFM, MPA, Deputy Director

Jamie Ralls, CFE, Audit Manager

Karen Peterson, Principal Auditor

Kathy Davis, Staff Auditor

About the Secretary of State Audits Division

The Oregon Constitution provides that the Secretary of State shall be, by virtue of his office, Auditor of Public Accounts. The Audits Division performs this duty. The division reports to the elected Secretary of State and is independent of other agencies within the Executive, Legislative, and Judicial branches of Oregon government. The division has constitutional authority to audit all state officers, agencies, boards and commissions as well as administer municipal audit law.

This report is intended to promote the best possible management of public resources.
Copies may be obtained from:

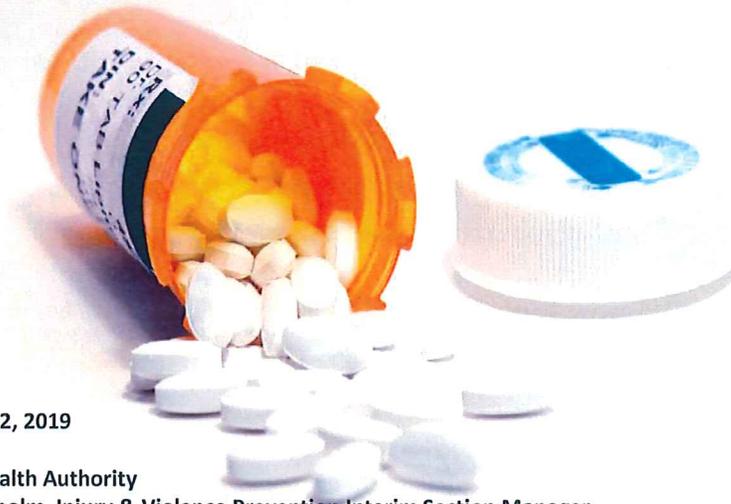
Oregon Audits Division

255 Capitol St NE, Suite 500 | Salem | OR | 97310

(503) 986-2255

sos.oregon.gov/audits

**Marion County Public Safety Coordinating Council
Opioid Epidemic and Secretary of State Audit**



February 12, 2019

Oregon Health Authority
Laura Chisholm, Injury & Violence Prevention Interim Section Manager
Drew Simpson, PDMP Program Coordinator

Prescription Drug Monitoring Program (PDMP) Overview

The PDMP collects prescription data for all controlled drugs schedule II-IV and drugs of interest that are dispensed in Oregon through retail pharmacies. This information is held in a secure database that authorized users are able to access.

Purpose:

Provide a comprehensive prescription history to health care professionals in order to improve patient safety and health outcomes.

How:

Authorized users (physicians, dentists, etc.) are able to access the PDMP through their web browser and view their patients prescription histories. PDMP data may also be integrated into a health information technology (IT) system.



Prescription Drug Monitoring Program (PDMP) History

In 2009 The Oregon Legislature created the PDMP with a well defined scope and purpose.

- PDMP is a healthcare tool to improve patient care
- PDMP is not a law enforcement or regulatory tool

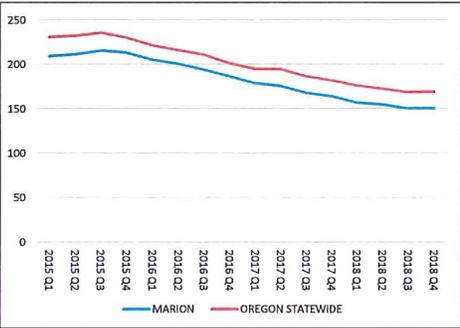
The Legislature has made changes over the years to improve the utility of the PDMP:

- Expanded access to new user types (delegates, medical/pharmacy directors)
- Added new fields and drugs collected
- Allowed interstate data sharing
- Created the Prescribing Practice Review Subcommittee
- Allowed PDMP integration into electronic health records



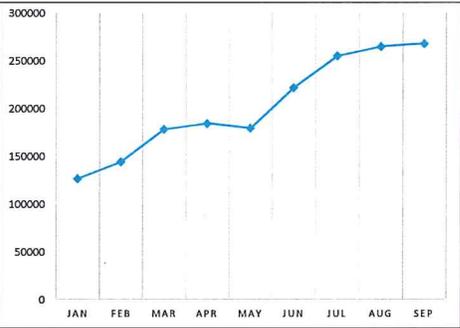
Prescribing Trends and PDMP Usage

**Opioid Fills per 1,000 Residents
2015-2018, PDMP**



Quarter	Marion	Oregon Statewide
2015 Q1	210	230
2015 Q2	215	235
2015 Q3	215	230
2015 Q4	215	230
2016 Q1	205	225
2016 Q2	200	220
2016 Q3	195	215
2016 Q4	190	210
2017 Q1	185	205
2017 Q2	180	200
2017 Q3	175	195
2017 Q4	170	190
2018 Q1	165	185
2018 Q2	160	180
2018 Q3	155	175
2018 Q4	150	170

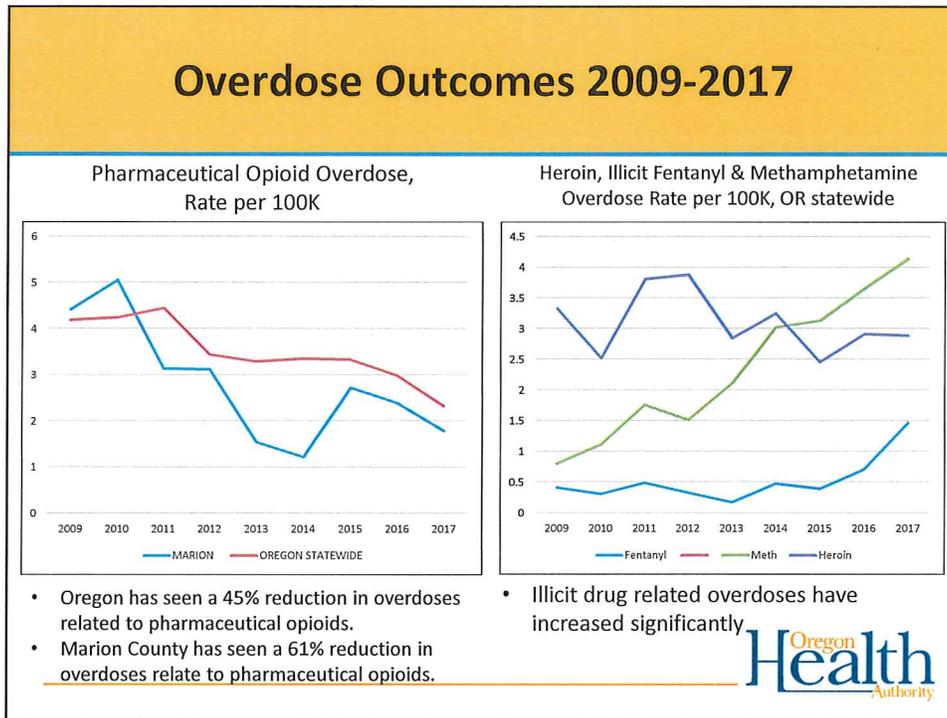
OREGON PDMP QUERIES BY MONTH 2018



Month	Queries
JAN	125,000
FEB	145,000
MAR	180,000
APR	185,000
MAY	180,000
JUN	225,000
JUL	255,000
AUG	265,000
SEP	270,000

- Opioid prescribing has decreased by 29% in the last 3 years.
- Between January and September 2018 PDMP utilization increased 111%





OHA Response to Secretary of State Audit

Recommendations from the Secretary of State fall into two categories.

1. Actions allowed under current statute and rules
 - OHA agrees with all five of these recommendations and is already actively pursuing improvements in those areas.
2. Actions that would require legislative intervention
 - OHA agrees with all seven of these recommendations but awaits the direction of the Oregon Legislature to make changes to existing statutes.

The PDMP has been an important factor in improving outcomes. It is one of many initiatives that comprise Oregon Health Authority's multifaceted approach to addressing the opioid crisis.

2019 Legislative Session

Several bills contain provisions related to the PDMP audit:

- Add gabapentin to list of drugs collected by PDMP
- Add diagnosis code to fields collected by PDMP
- Allow evaluation of prescribing practice using PDMP data under expanded conditions
- Adds dental directors and Coordinated Care Organization medical directors to authorized users



Recommendations Allowed Under Current Statute

All these recommendations are complete or on-going:

1. Maintain an ongoing partnership with health licensing boards to target outreach efforts to get all required prescribers registered with the PDMP.
2. Provide guidance, including examples, to prescribers on ways to integrate accessing the PDMP database into their daily workflow.
3. Verify practitioner specialty information with the respective health licensing board and update the PDMP database with this information.
4. Work with the PDMP vendor and the Board of Pharmacy to make sure prescriptions made by X-waivered prescribers are included in the PDMP database.
5. Identify and propose drugs of concern, such as gabapentin, to the Board of Pharmacy and Legislature that should be added to the state's controlled substance schedule and collected by the PDMP.



Secretary of State Recommendations Requiring Legislative Changes

6. Develop a process for, and facilitate the sharing of, data between PDMP and Medicaid to help ensure completeness of PDMP prescription history and to allow Medicaid to better monitor the prescription behavior of its clients.
7. Expand statutes to allow the PDMP to conduct and share analyses on prescription data, including:
 - a. analyzing prescriber, pharmacy, and patient prescription practices;
 - b. making prescriber report cards available; and
 - c. preparing and issuing unsolicited reports to licensing boards and law enforcement.
8. Seek legislative action to address the issue of prescribers not registering with the PDMP as required and pharmacies not submitting corrected data within statutory requirements.
9. Provide further authority to the Clinical Review Subcommittee to require the justification of practices deemed concerning, and allow the collaboration with licensing boards and law enforcement for concerning practices.
10. Expand authority for other professional and state entities authorized access to PDMP information.



Secretary of State Recommendations Requiring Legislative Changes

11. Require and set parameters for when prescribers must query the PDMP database to review a patient's prescription history. This should include, at a minimum, requiring the querying of the PDMP database prior to prescribing controlled substances and substances of concern, and for dispensers to query the database prior to issuing a medication and periodically while the patient is taking those medications.
12. Allow for additional information to be collected by the PDMP. This should include:
 - a. prescriptions for Schedule V controlled substances and other drugs of concern;
 - b. applicable prescriptions from other types of pharmacies, not solely retail pharmacies;
 - c. applicable prescriptions prescribed by veterinarians;
 - d. method of payment used to pay for the prescription;
 - e. patients who are restricted or have a "lock-in" to a single prescriber and a single pharmacy for obtaining controlled substances; and
 - f. diagnosis codes related to the prescription.



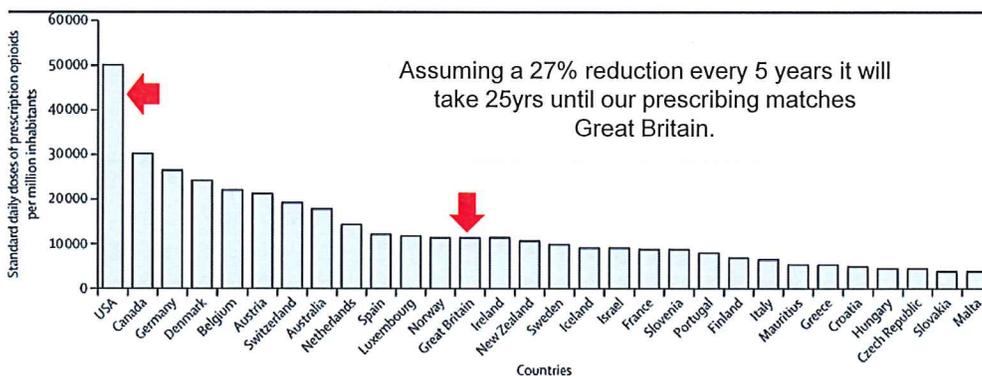
Salem Health Over-Dose Data Review

Paul Coelho, MD



International Opioid Prescribing for Chronic Non-Cancer Pain 2012

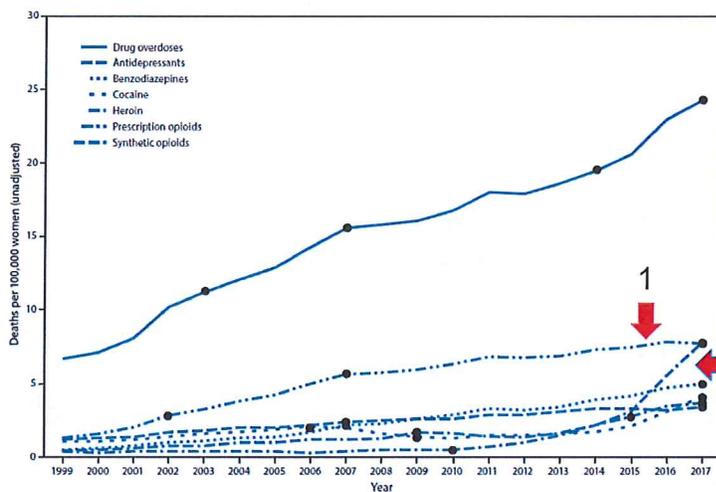
27% Decrease Since 2012



<https://www.ncbi.nlm.nih.gov/pubmed/28792397>



Drug Overdose Deaths Among Women Aged 30-64 Years – United States, 1999-2017

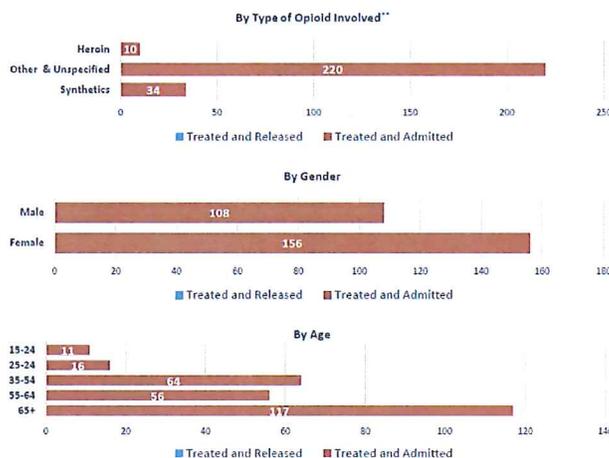


- 1 Prescribed opioid
2. Heroin/Fentanyl

https://www.cdc.gov/mmwr/volumes/68/wr/mm6801a1.htm?s_cid=mm6801a1_w



Analysis of patients treated at Salem Hospital ED June 2017-May 2018



Analysis of patients treated at Salem Hospital ED June 2017-May 2018

Cost of Care for Opioid ODs Treated in the ED

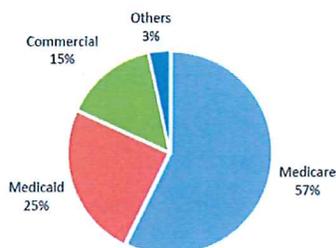
Total cost of care for opioid ODs treated in the ED are analyzed from two perspectives in this section. First, total costs for the opioid OD visit only are analyzed. Secondly, a broader perspective of costs for opioid ODs has been calculated by evaluating the cost of the OD visit in addition to all other encounters within the 12-month analysis timeframe.

Total Treatment Costs for Opioid OD's Treated in the ED

\$3,681,434

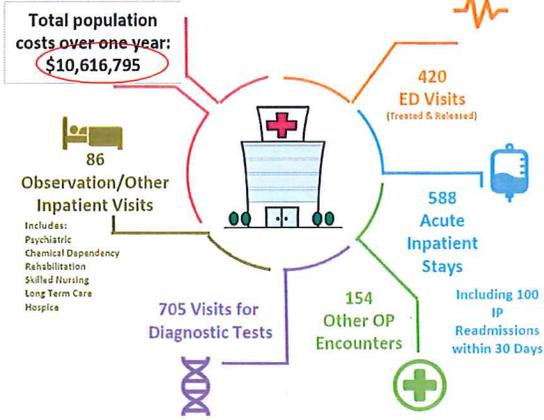
The number above represents the total cost for the visits in which the OD was coded and treated. (n=264)

Payer Mix for OD Visits Treated in the ED



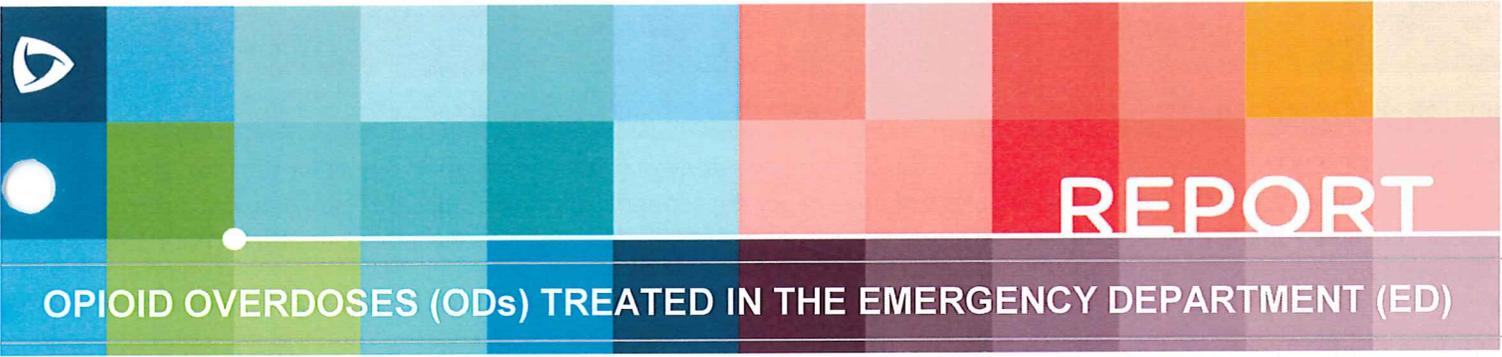
Analysis of patients treated at Salem Hospital ED June 2017-May 2018

Opioid OD Cases
Total Costs for All Encounters Occurring Within the 12 Month Analysis Timeframe*
This graph examines the overall cost of all visits made by the opioid overdose patients during the analysis timeframe. It is intended to show the total cost of treating the population which includes the cost of the opioid OD ED visit as well as cost to the facility for encounters before and after.



Thank You!
paul.coelho@salemhealth.org





Analysis of patients treated at Salem Hospital June-2017 - May-2018

Analysis Overview

The economic costs of the US opioid epidemic are staggering, one 2015 estimate puts the figure at \$504 billion.¹

In the US, visits to the ED for an opioid overdose (OD) rose 30% from July 2016 to September 2017². Annual opioid-associated overdose deaths increased nearly 57% from 2010 to 2015 with an alarming 219% increase in deaths attributed to synthetic opioids, such as fentanyl³. According to the CDC, illicitly manufactured fentanyl is the primary culprit.

Surviving a nonfatal opioid overdose carries increased risk of mortality within the next year; common causes of death include substance use-associated diseases, cancer, viral hepatitis and suicide, particularly suicides among females.⁴ Overdose patients treated and admitted are at higher risk for multiple organ failure, increased costs due to ICU stays and unplanned readmissions following discharge. Careful coordination of care and effective transitions are essential.

ODs can contribute to service and capacity burdens on the ED. Additionally, some of these patients will require admission to the acute hospital. It is imperative that the hospital understand the effects of opioid ODs on its critical care resources. These patients are complex and can have

Key Findings Across All Premier Hospitals

- Over the most recent twelve months, on average, a patient presented to a Premier member's Emergency Department with an opioid overdose **every 5 minutes**.
- Overall, 44 out of every 10,000 patients treated in all EDs were treated for an opioid overdose.



multi-organ involvement. In one study of opioid ODs on the intensive care unit, 25% had aspiration pneumonia and inpatient mortality was nearly 10%⁵. Having a firm grasp on these patients, their resource needs and outcomes, i.e., morbidity and readmissions, is essential for safe, effective and efficient operations.

Premier's new Opioid-associated Overdoses (ODs) in the Emergency Department (ED) report is designed to help organizational leaders assess the need to institute new (or reinforce existing) improvement efforts in the care and management of patients presenting to the ED with an opioid OD. Patients treated and released as well as admitted for inpatient care are considered in this analysis.

The following analyses and resources are included in this report:

- Opioid OD Treatment Rate Comparison
- Cost of Care for Opioid ODs Treated in the ED
- Breakout of Opioid ODs by Treated and Released vs. Treated and Admitted
- What Can Be Done: Improvement Strategies and Resources





Opioid OD ED Treatment Rate

The "Opioid OD ED Treatment Rate" presented in this analysis was derived from a metric used by the Centers for Disease Control and Prevention (CDC) in its recent analysis of emergency department visits involving suspected opioid overdoses (ED visits involving opioid overdoses divided by total ED visits and multiplied by 10,000).² For purposes of this report, the CDC metric was modified for application to the QualityAdvisor™ dataset.

Opioid OD ED Treatment Rate Calculation

Numerator

264

Total coded opioid overdose* visits to your
Emergency Department (age 15 and older)

June-2017 - May-2018



Denominator

92,007

Total ED visits age 15 and over

X 10,000



Your Facility

28.7

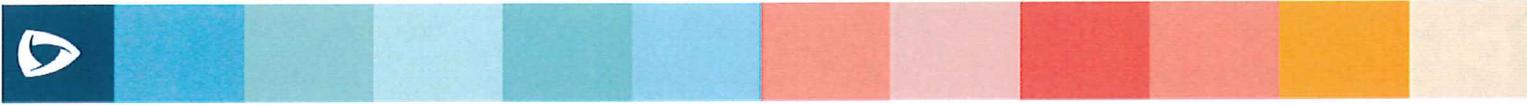
OD ED Patients per
10,000 ED Visits

All Premier Facilities

43.3

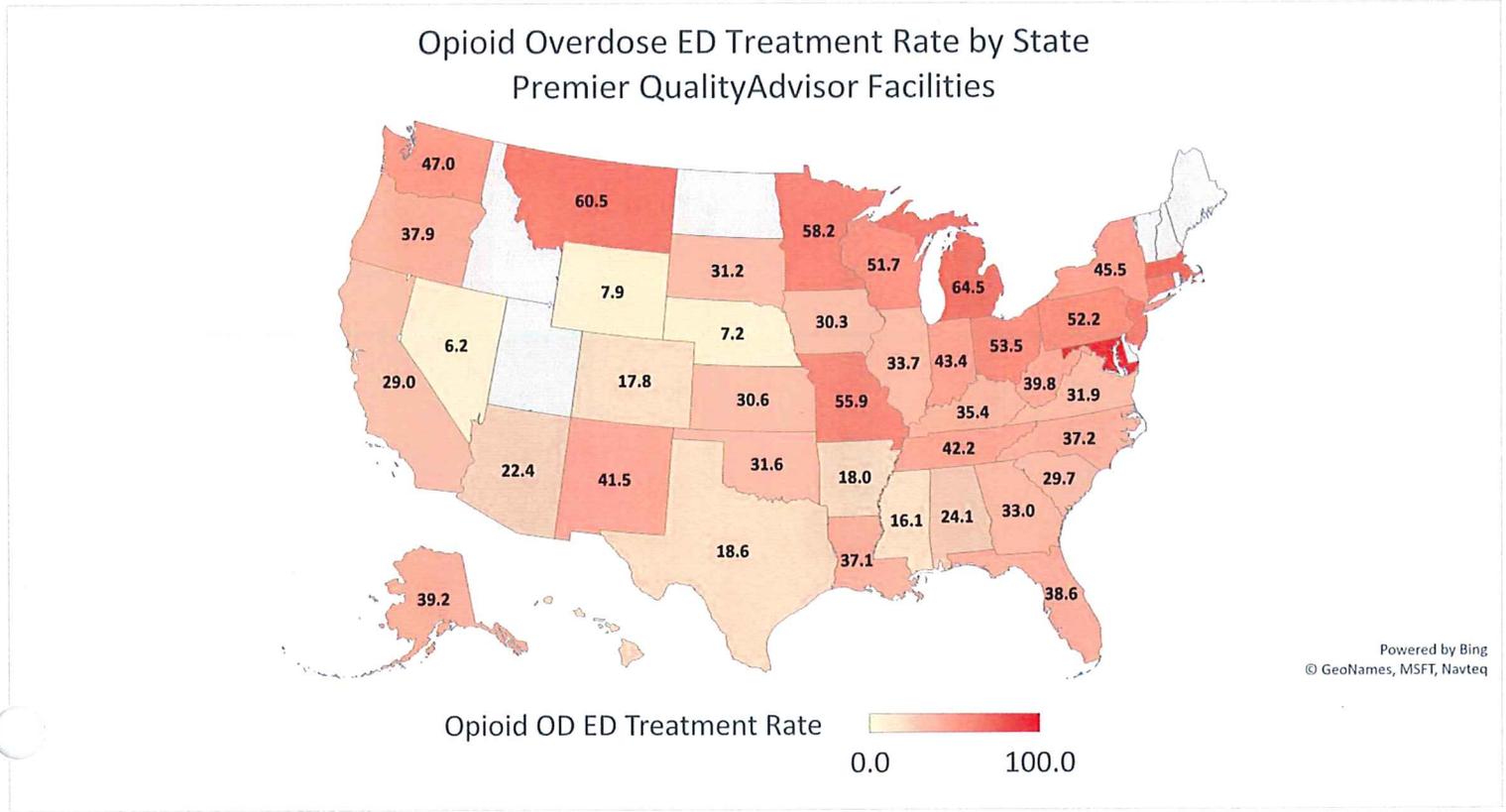
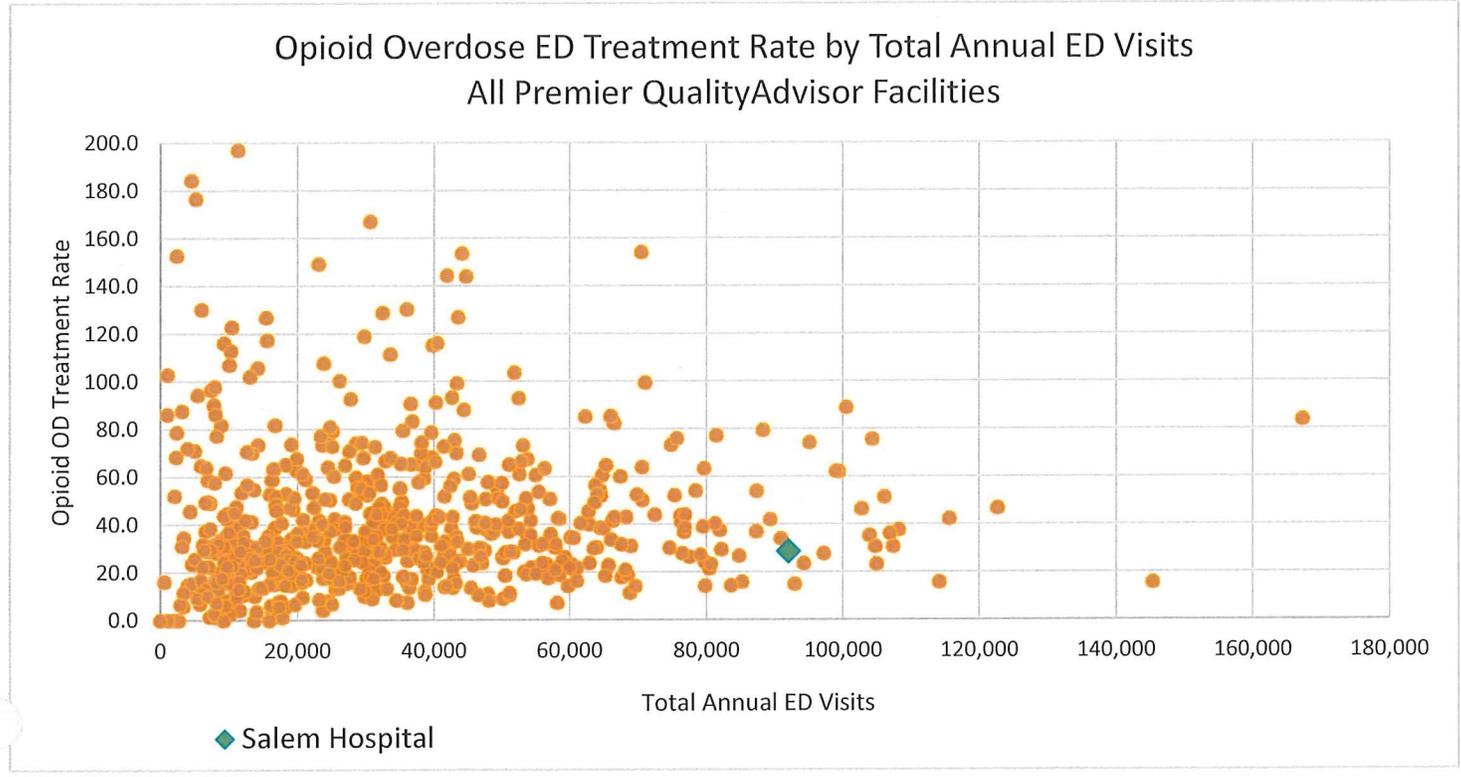
OD Patients per
10,000 ED Visits

* - See Appendix for definition of opioid overdose
Salem Hospital



Opioid OD Treatment Rate (Continued)

National comparisons highlight variation in the incidence of opioid overdoses across all facilities providing data for this analysis.

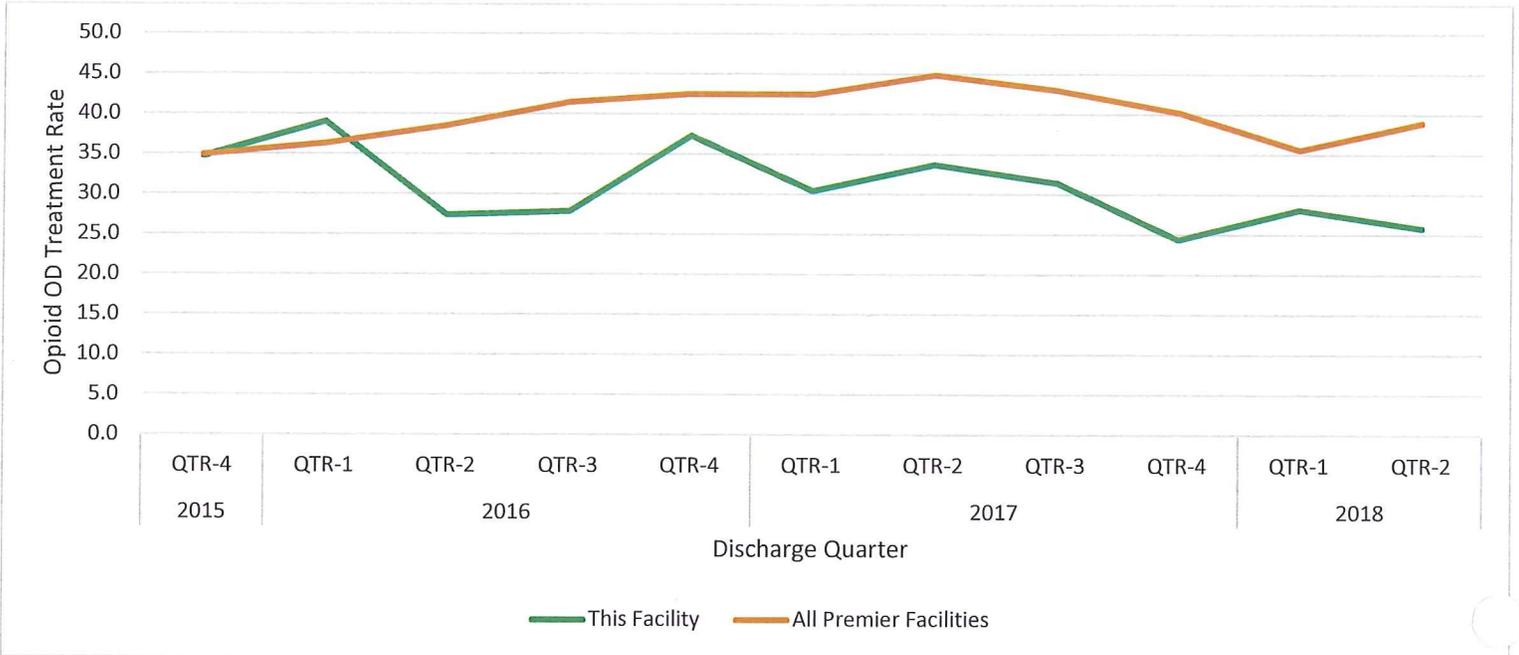




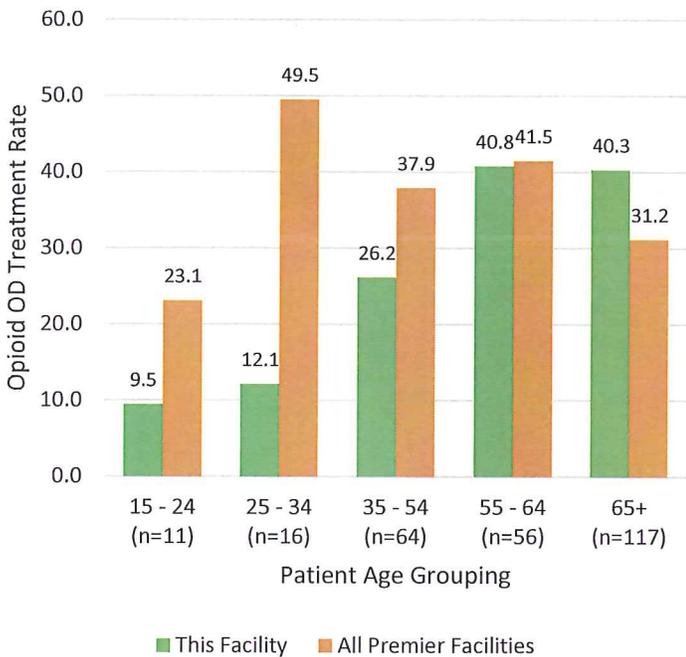
Opioid OD ED Treatment Rate (Continued)

These graphs provide comparisons of the Opioid OD ED Treatment Rate on a trended basis, and by age group and gender. The first graph below shows the treatment rate by quarter for your facility and all Premier Facilities from 4Q2015 through the most current available quarter. Additional graphs show the treatment rate by age group and gender for the most recent 12 months.

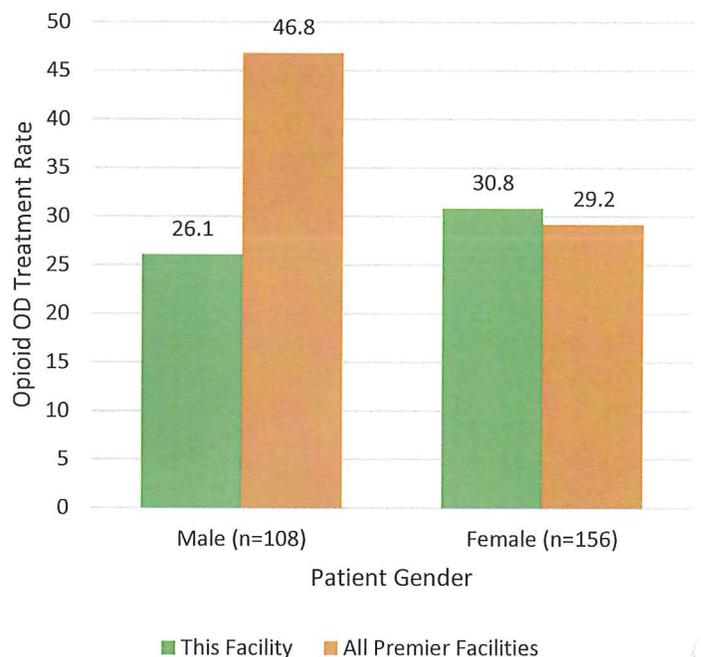
Opioid Overdose ED Treatment Rate Trend Comparison



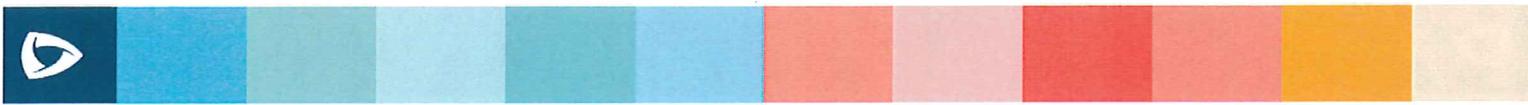
Opioid OD ED Treatment Rate Comparison by Age Grouping



Opioid OD ED Treatment Rate Comparison by Gender



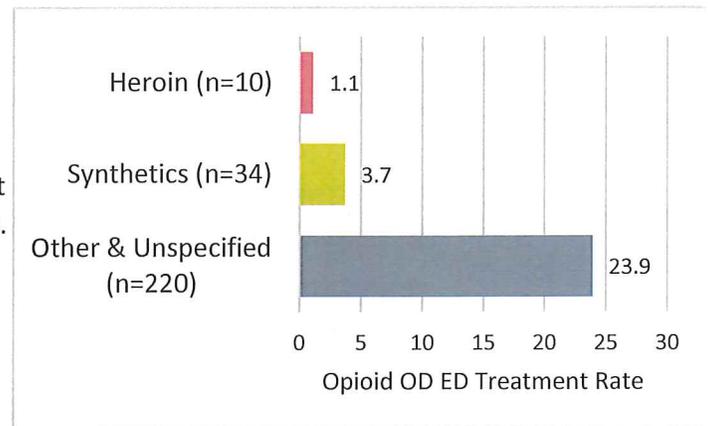
n refers to number of treated opioid overdose patients



Opioid OD ED Treatment Rate (Continued)

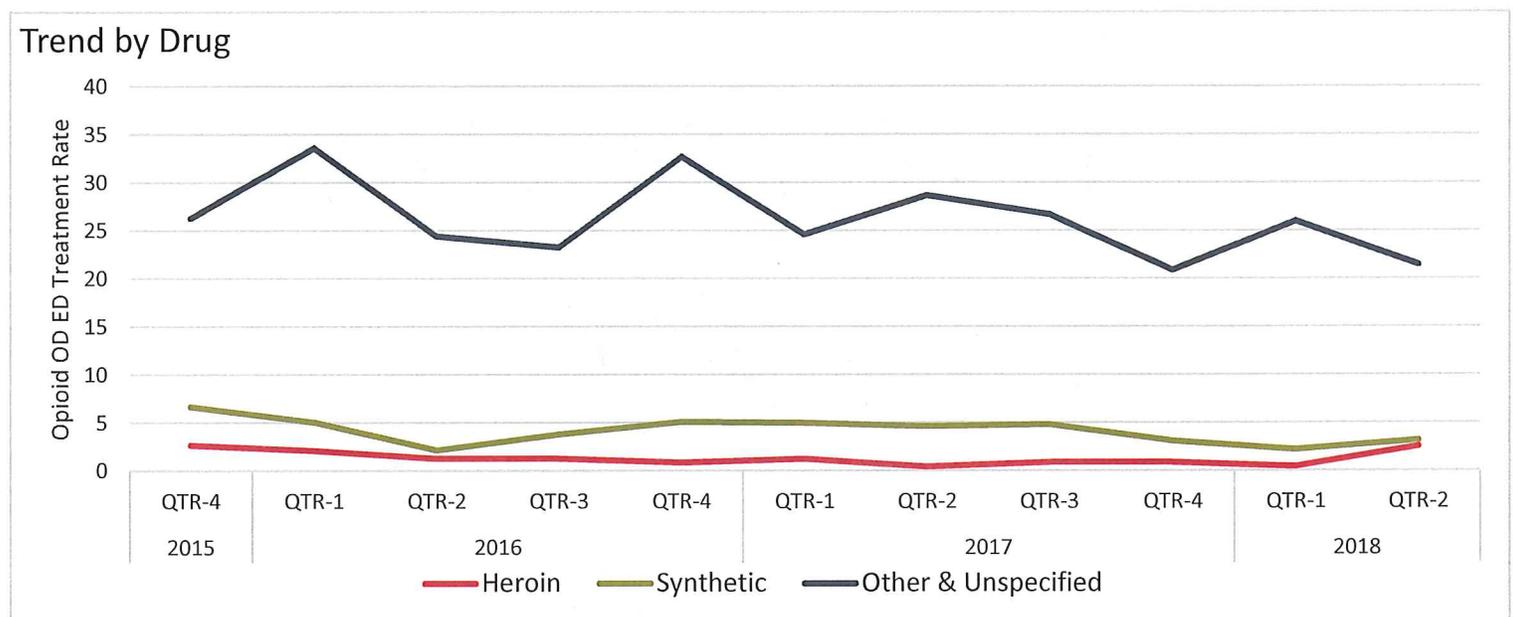
Opioid OD ED Treatment Rate By Type of Opioid Involved*

ICD-10 diagnosis codes that define overdose by the type opioid involved have been grouped into the following categories for this analysis: Heroin, Synthetics, and Other. Coded data are useful for evaluating potential causes of overdoses and complications. However, consideration should be given to the fact that it is difficult for ED clinicians to identify the specific opioids involved in OD cases. Opioids and other drugs are often used in combination. Cases with the following ICD-10 diagnosis codes in either the principal or secondary position were included in this analysis as opioid overdoses.



- Heroin
 - o T40.1x: Poisoning by, Adverse Effect of Heroin
- Synthetics: illegal and prescription opioids that most commonly include methadone, tramadol, meperidine, fentanyl and fentanyl analogs.
 - o T40.3: Poisoning by, Adverse Effect of Methadone**
 - o T40.4: Poisoning by, Adverse Effect of Other Synthetic Narcotics**
- All Other: all other/unspecified illegal and prescription opioids and narcotics
 - o T40.0: Poisoning by, Adverse Effect of Opium**
 - o T40.2: Poisoning by, Adverse Effect of Other Opioids**
 - o T40.6: Poisoning by, Adverse Effect of Other and Unspecified Narcotics**

The graph below shows a trend of the treatment rate by drug category for all available data from Q42015 to present.



See Appendix for ICD-10 Codes assigned to each drug category

** Excludes ICD-10 T40.x codes indicating "under-dosing"

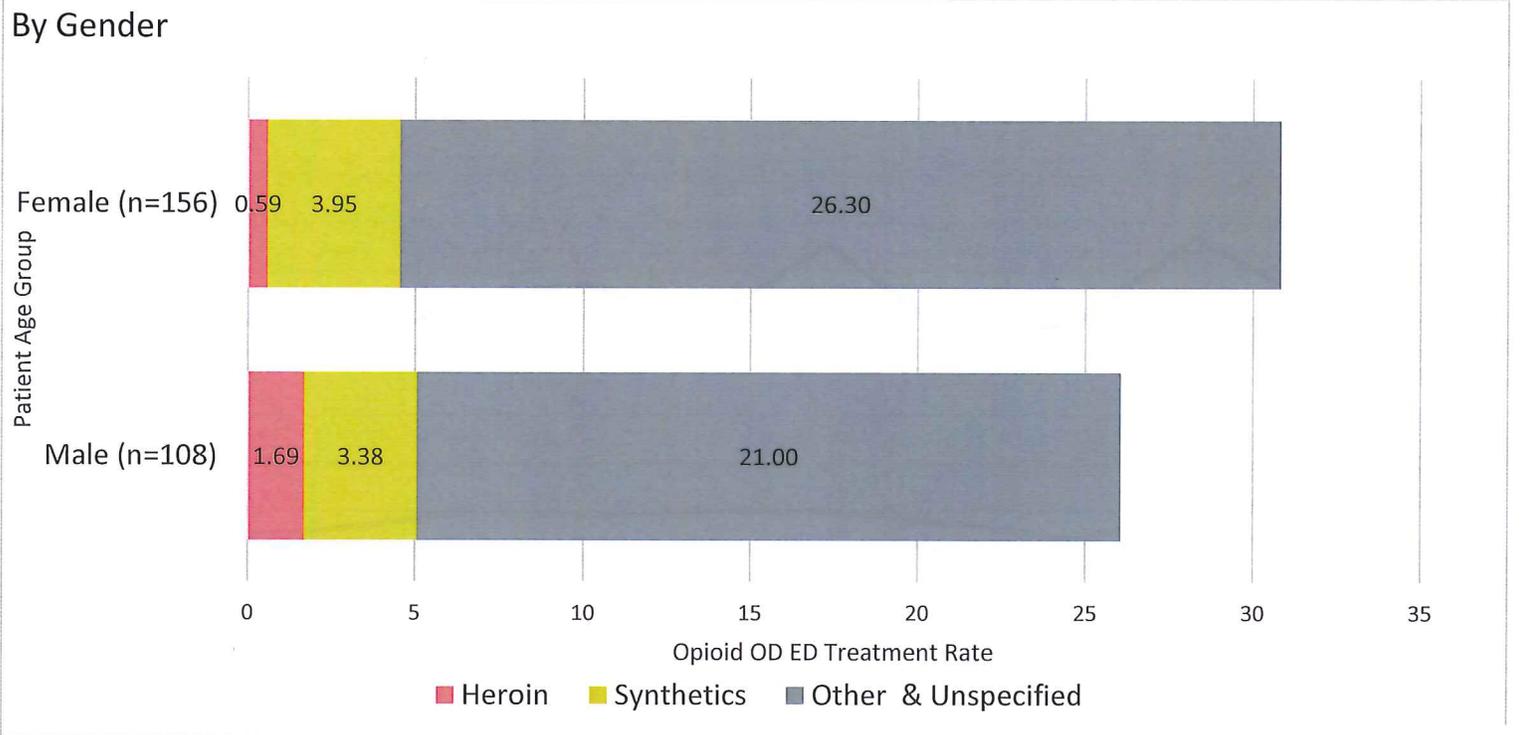
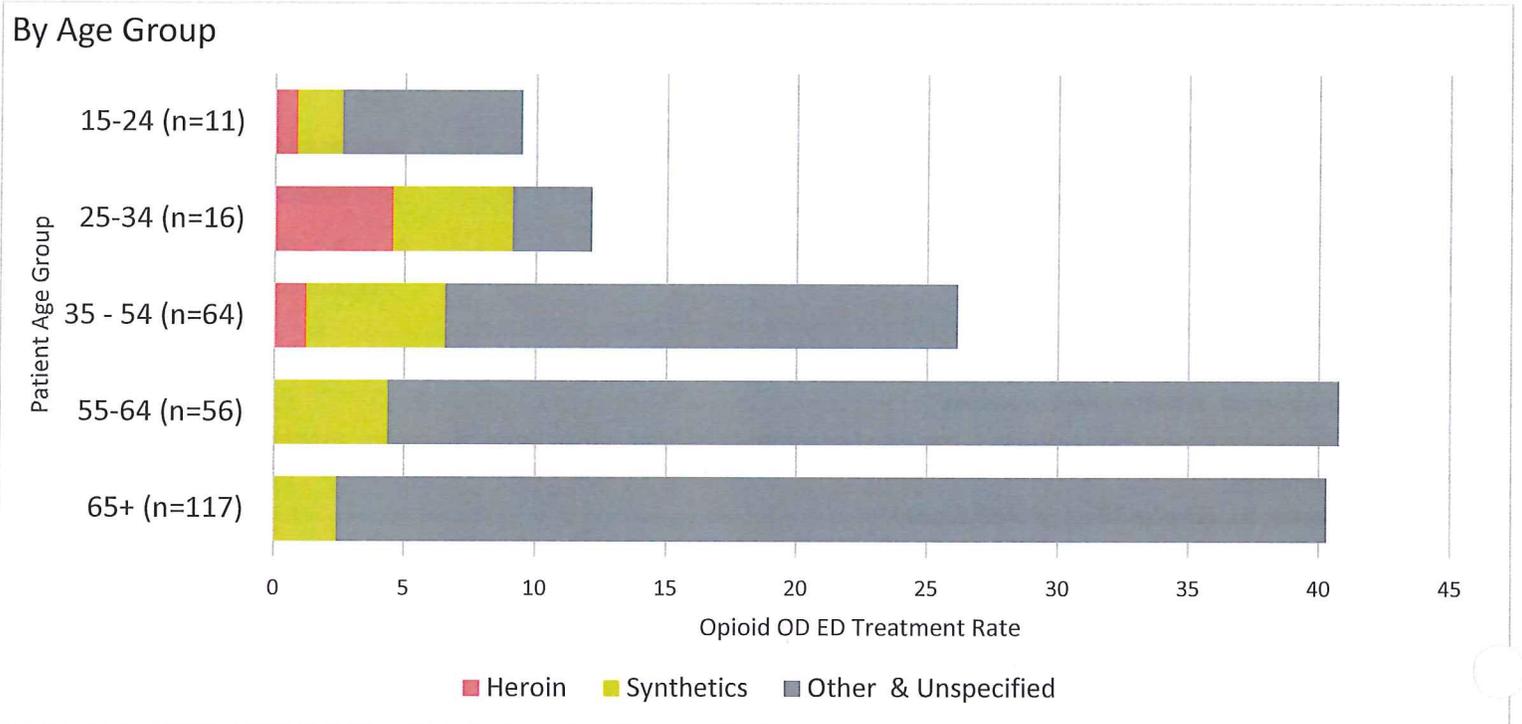
n refers to number of treated opioid overdose patients



Opioid OD Treatment Rate (Continued)

These graphs are designed to help you assess the types of opioids involved in OD cases based on patients' age group and gender.

Opioid OD Treatment Rate By Type of Opioid Involved*

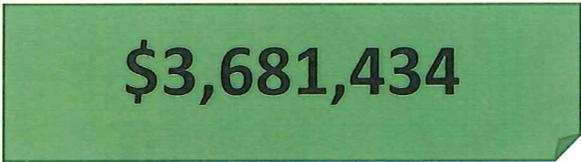




Cost of Care for Opioid ODs Treated in the ED

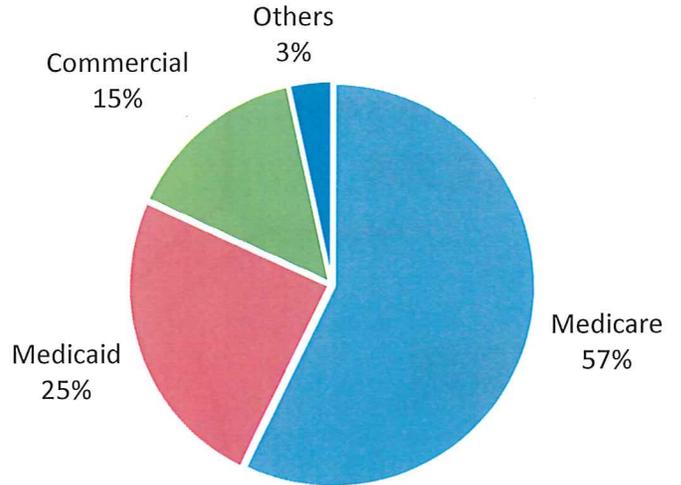
Total cost of care for opioid ODs treated in the ED are analyzed from two perspectives in this section. First, total costs for the opioid OD visit only are analyzed. Secondly, a broader perspective of costs for opioid ODs has been calculated by evaluating the cost of the OD visit in addition to all other encounters within the 12-month analysis timeframe.

Total Treatment Costs for Opioid OD's Treated in the ED



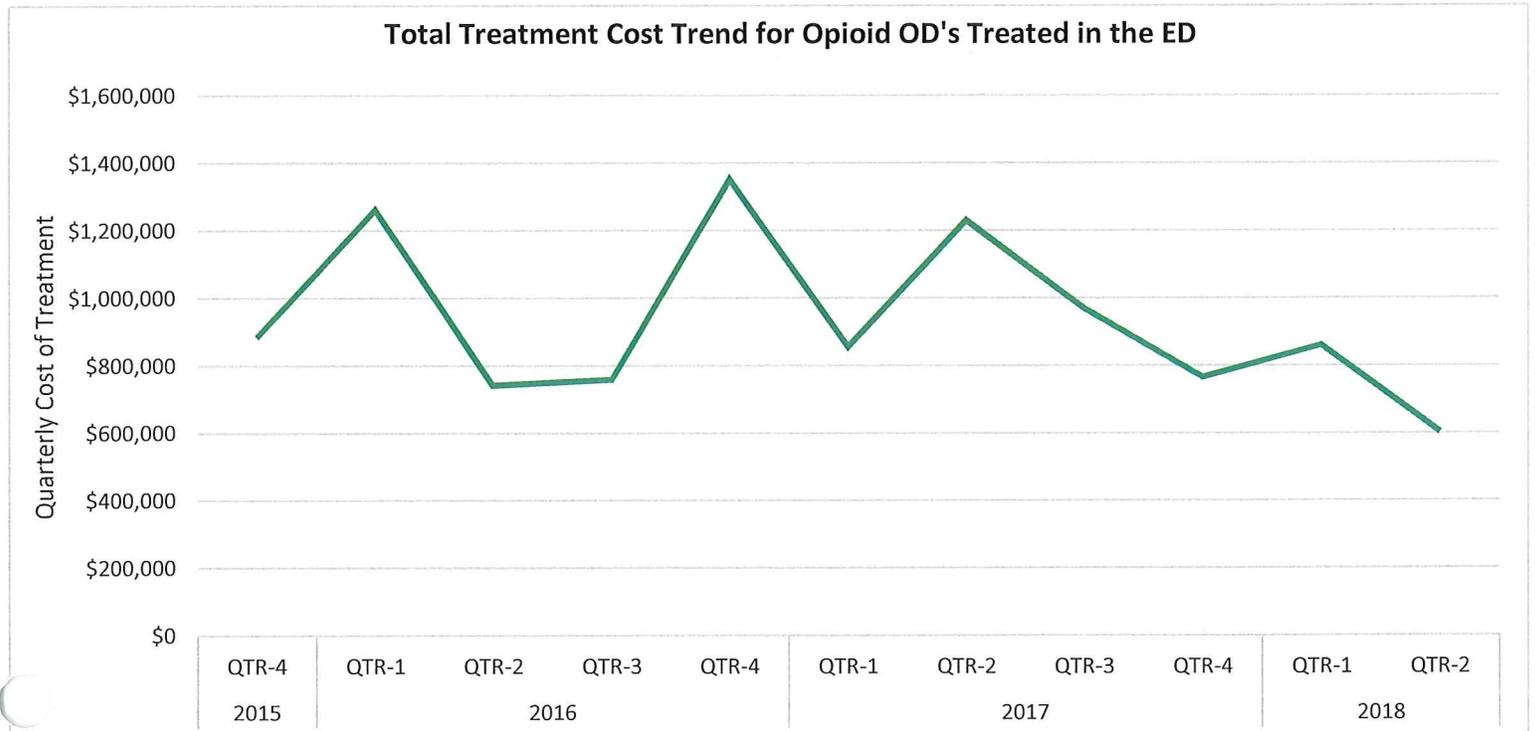
The number above represents the total cost for the visits in which the OD was coded and treated. (n=264)

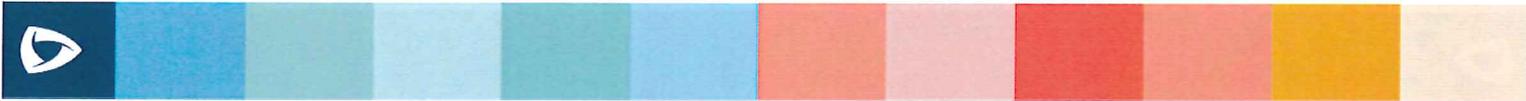
Payer Mix for OD Visits Treated in the ED



The graph below trends all ICD -10 coded data currently available in QualityAdvisor for your facility.

Total Treatment Cost Trend for Opioid OD's Treated in the ED



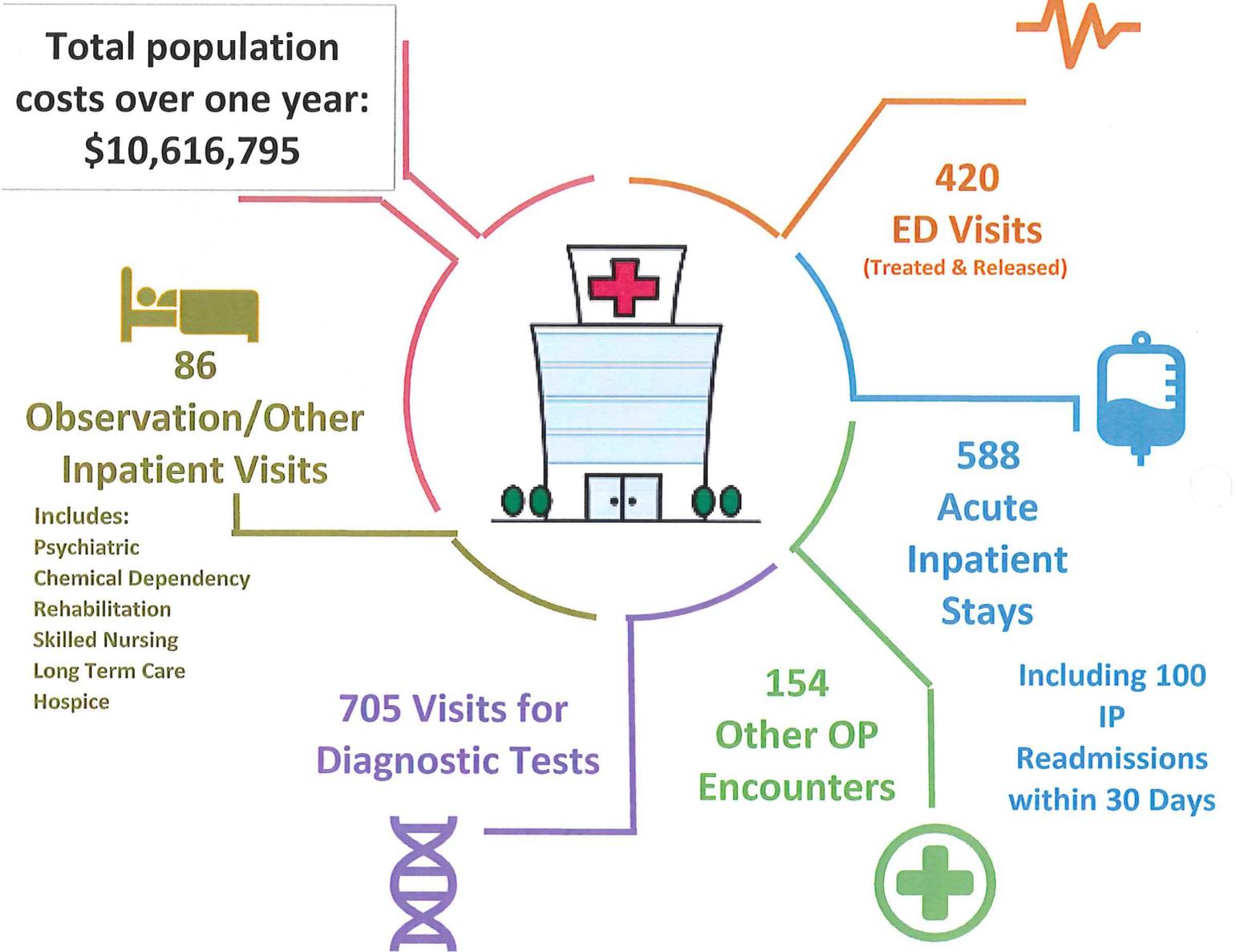


Cost of Care for Opioid ODs Treated in the ED (Continued)

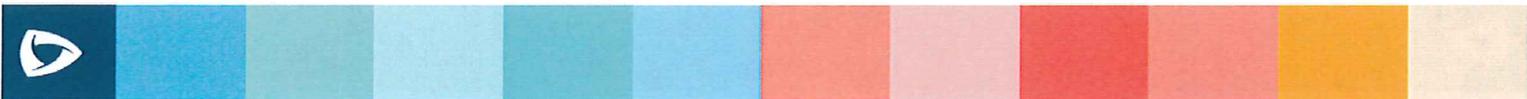
Opioid OD Cases

Total Costs for All Encounters Occurring Within the 12 Month Analysis Timeframe*

This graph examines the overall cost of all visits made by the opioid overdose patients during the analysis timeframe. It is intended to show the total cost of treating the population which includes the cost of the opioid OD ED visit as well as cost to the facility for encounters before and after.

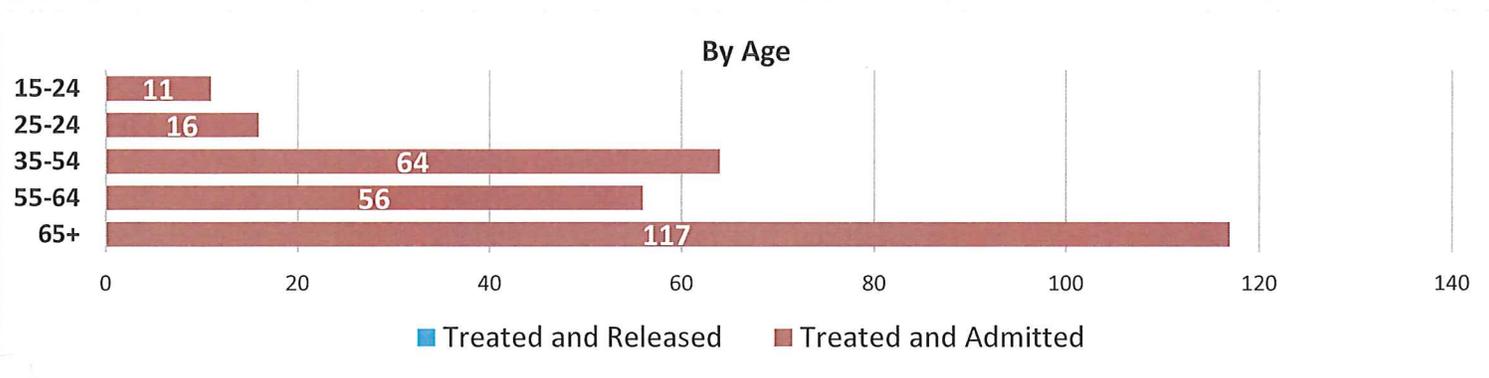
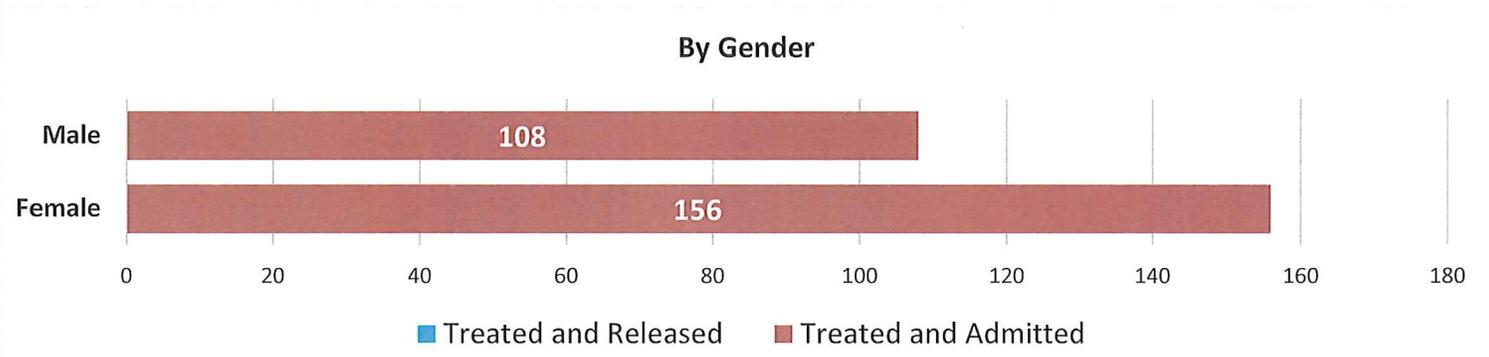
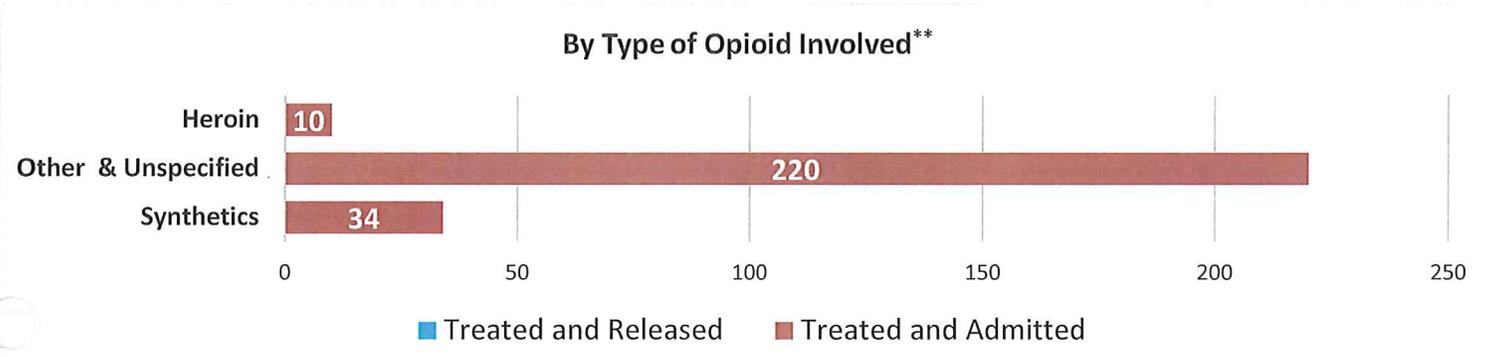
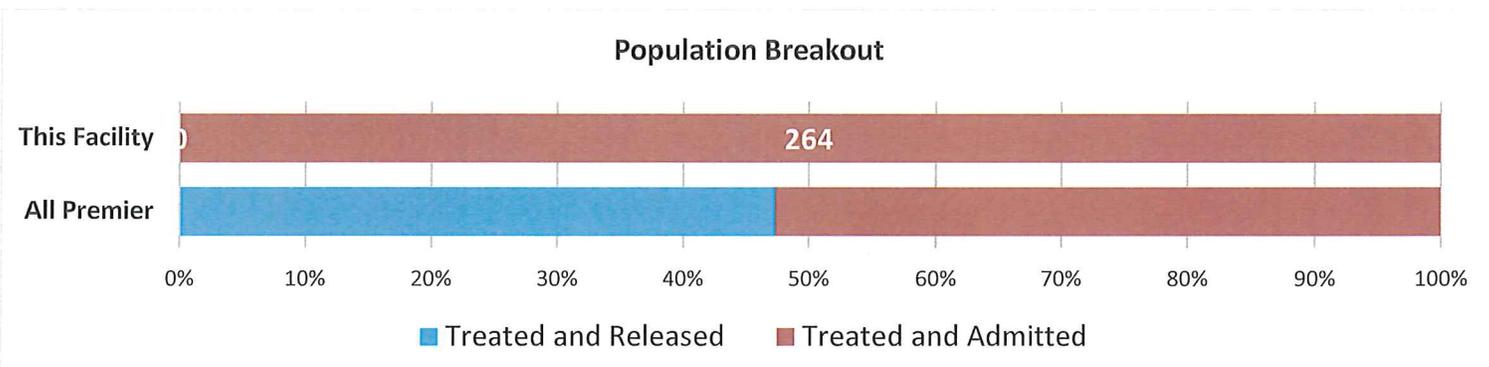


Patients with more than one encounter averaged one visit every 23. days.



Opioid ODs Treated in the ED: Breakout by Treated and Released vs. Treated and Admitted*

The graphs below show whether patients at your facility were treated in the ED and released or treated in the ED and admitted. This helps to assess the acuity of the opioid OD population.



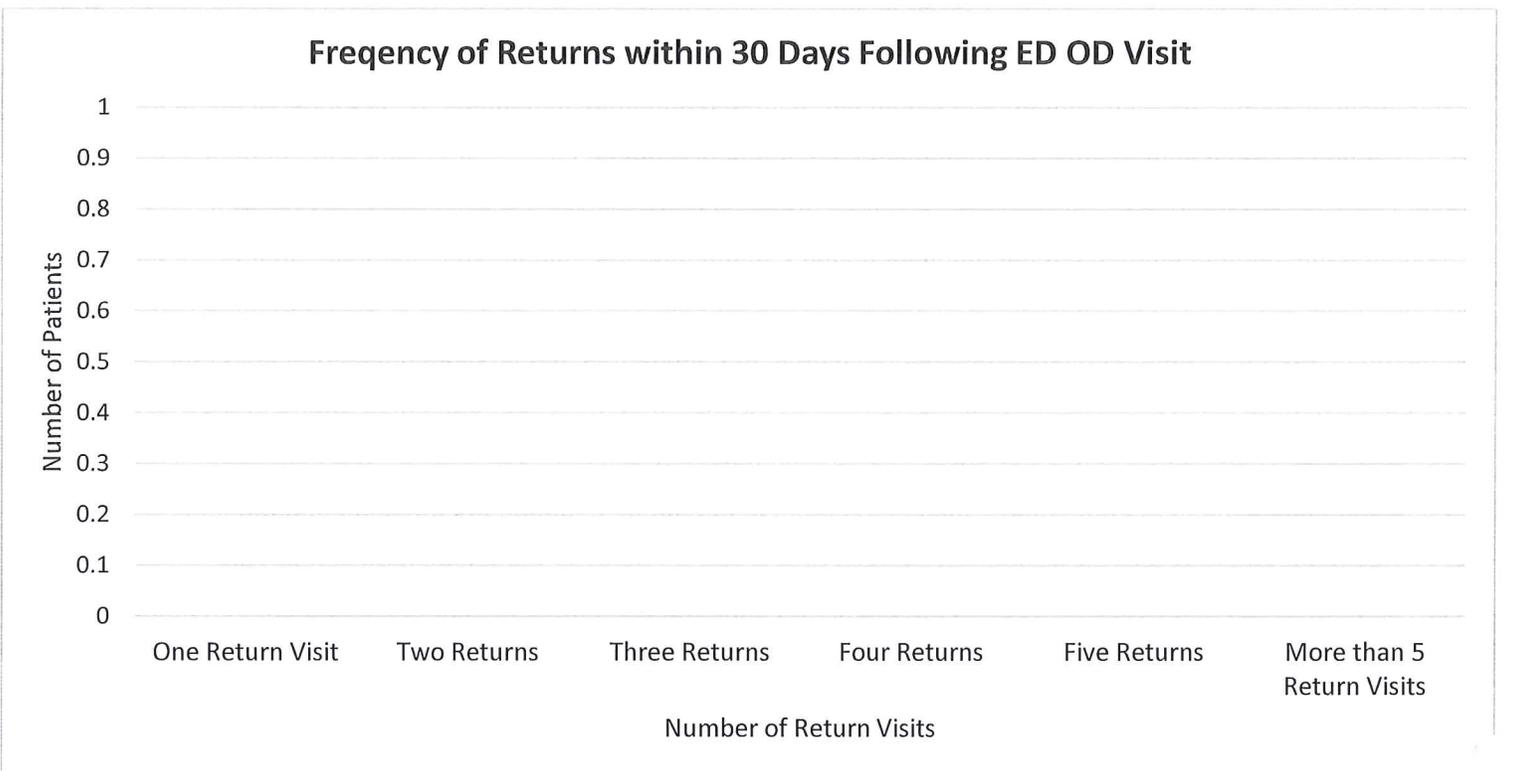
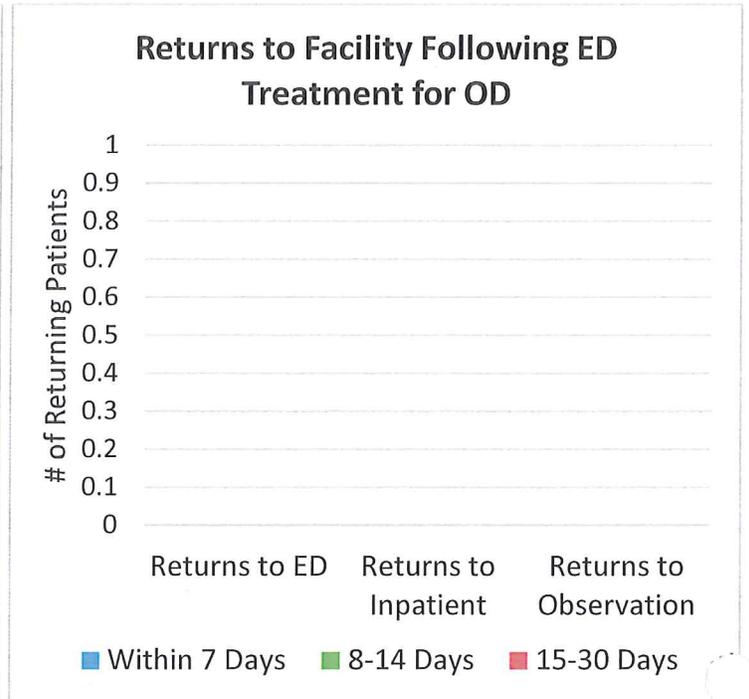
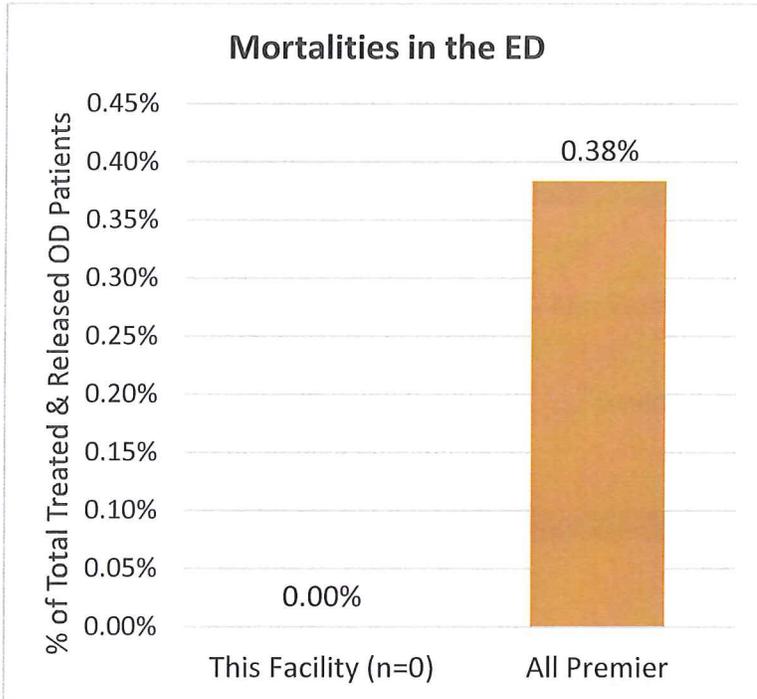
* See Appendix for admitted patient types

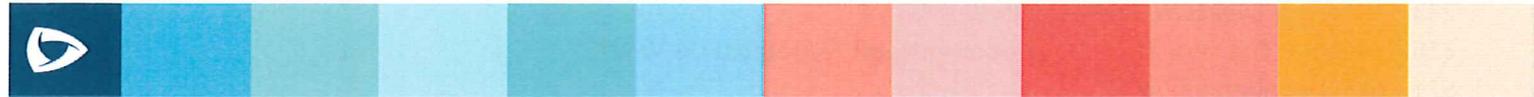
** - See Appendix for ICD-10 Codes assigned to each drug category



Opioid ODs Treated in the ED: Treated and Released vs. Treated and Admitted (Cont.)

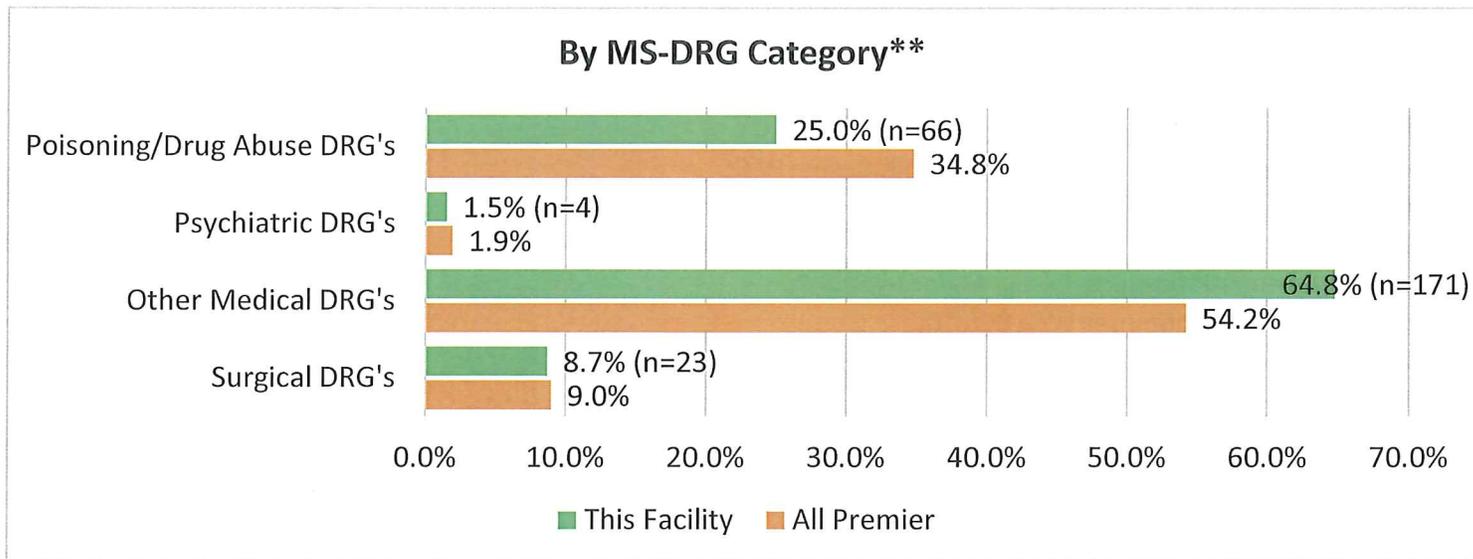
Opioid OD Treated in the ED and Released





Opioid ODs Treated in the ED: Breakout by Treated and Released vs. Treated and Admitted

Opioid OD Treated in the ED and Admitted*



MS-DRG Detail

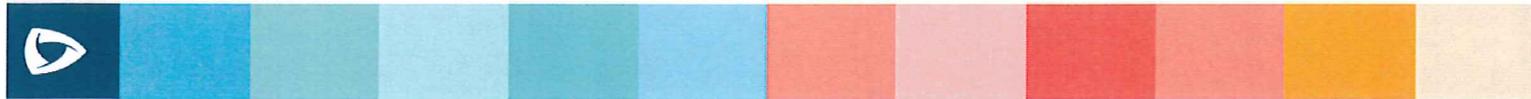
Top Ten MS-DRG's in each category (by Case Volume)

Category/MS-DRG	Total Cases
Poisoning/Drug Abuse DRG's	66
917 Poisoning & Toxic Effects Of Drugs W MCC	51
918 Poisoning & Toxic Effects Of Drugs W/O MCC	12
896 Alcohol/Drug Abuse Or Dependence W/O Rehabilitation Therapy W MCC	3
Other Medical DRG's	86
871 Septicemia Or Severe Sepsis W/O Mv >96 Hours W MCC	22
91 Other Disorders Of Nervous System W MCC	15
682 Renal Failure W MCC	11
92 Other Disorders Of Nervous System W CC	7
441 Disorders Of Liver Except Malig,Cirr,Alc Hepa W MCC	6
391 Esophagitis, Gastroent & Misc Digest Disorders W MCC	5
193 Simple Pneumonia & Pleurisy W MCC	5
189 Pulmonary Edema & Respiratory Failure	5
291 Heart Failure & Shock W MCC	5
208 Respiratory System Diagnosis W Ventilator Support <=96 Hours	5
Psychiatric DRG's	4
885 Psychoses	2
881 Depressive Neuroses	2
Surgical DRG's	23
907 Other O.R. Procedures For Injuries W MCC	3
981 Extensive O.R. Procedure Unrelated To Principal Diagnosis W MCC	2

See Appendix for admitted patient types

See Appendix for MS-DRG Category definitions

233	Coronary Bypass W Cardiac Cath W MCC	1
616	Amputat Of Lower Limb For Endocrine,Nutrit,& Metabol Dis W MCC	1
571	Skin Debridement W CC	1
253	Other Vascular Procedures W CC	1
853	Infectious & Parasitic Diseases W O.R. Procedure W MCC	1
353	Hernia Procedures Except Inguinal & Femoral W MCC	1
519	Back & Neck Proc Exc Spinal Fusion W CC	1
417	Laparoscopic Cholecystectomy W/O C.D.E. W MCC	1
579	Other Skin, Subcut Tiss & Breast Proc W MCC	1
463	Wnd Debrid & Skn Grft Exc Hand, For Musculo-Conn Tiss Dis W MCC	1
823	Lymphoma & Non-Acute Leukemia W Other Proc W MCC	1
480	Hip & Femur Procedures Except Major Joint W MCC	1
854	Infectious & Parasitic Diseases W O.R. Procedure W CC	1
166	Other Resp System O.R. Procedures W MCC	1
987	Non-Extensive O.R. Proc Unrelated To Principal Diagnosis W MCC	1
481	Hip & Femur Procedures Except Major Joint W CC	1
165	Major Chest Procedures W/O CC/MCC	1
492	Lower Extrem & Humer Proc Except Hip, Foot, Femur W MCC	1

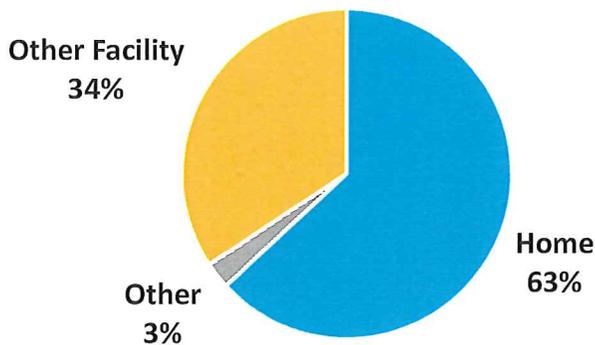


Opioid ODs Treated in the ED: Breakout by Treated and Released vs. Treated and Admitted (Cont.)

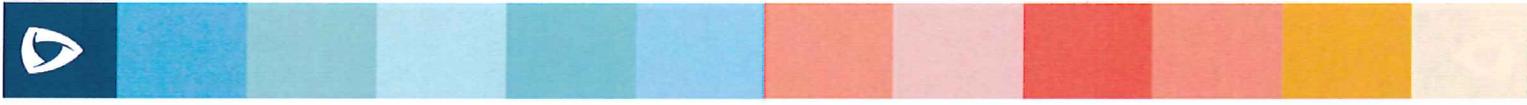
Opioid OD Treated in the ED and Admitted* Cases



Discharge Status for Readmitted OD Patients*

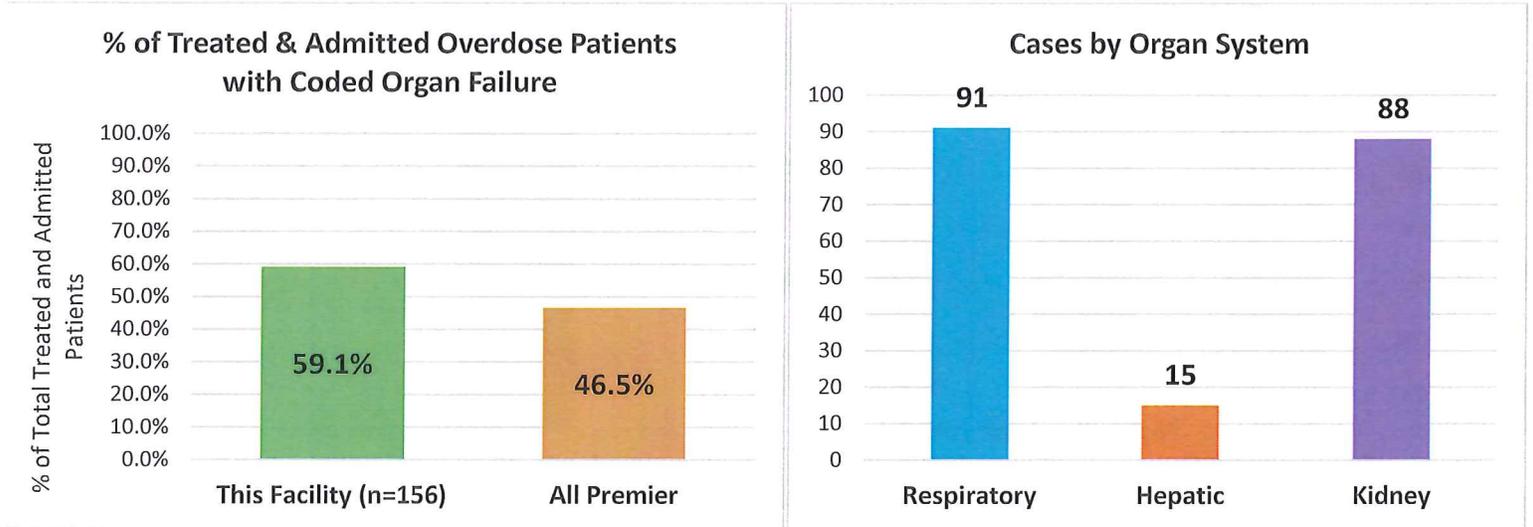


* See Appendix for admitted patient types

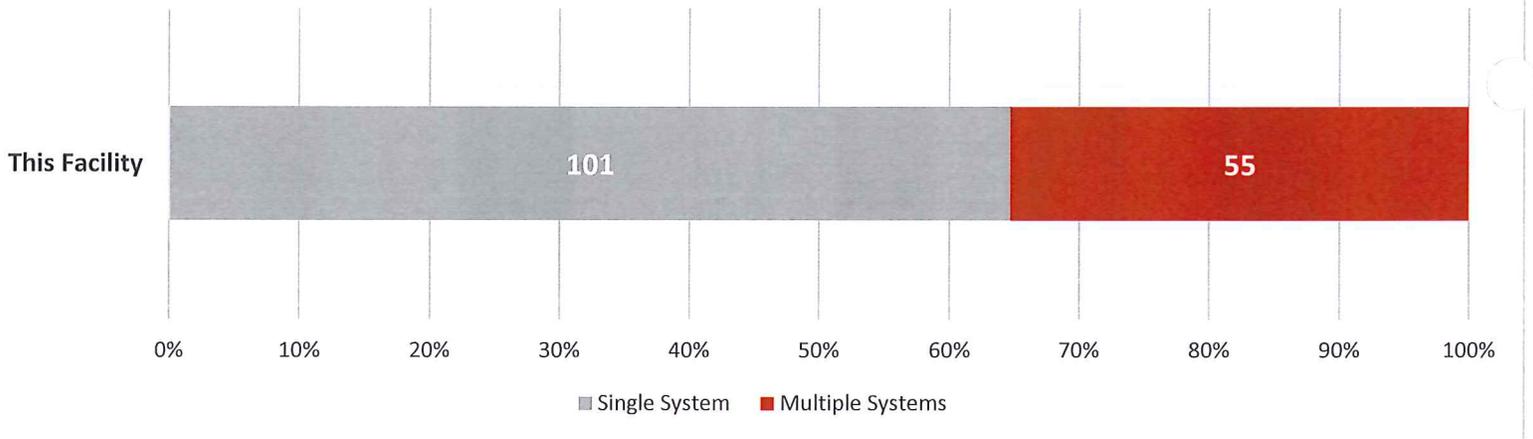


Opioid ODs Treated in the ED: Breakout by Treated and Released vs. Treated and Admitted (Cont.)

Opioid OD Treated and Admitted Cases Only



Single versus Multiple Organ System Failure

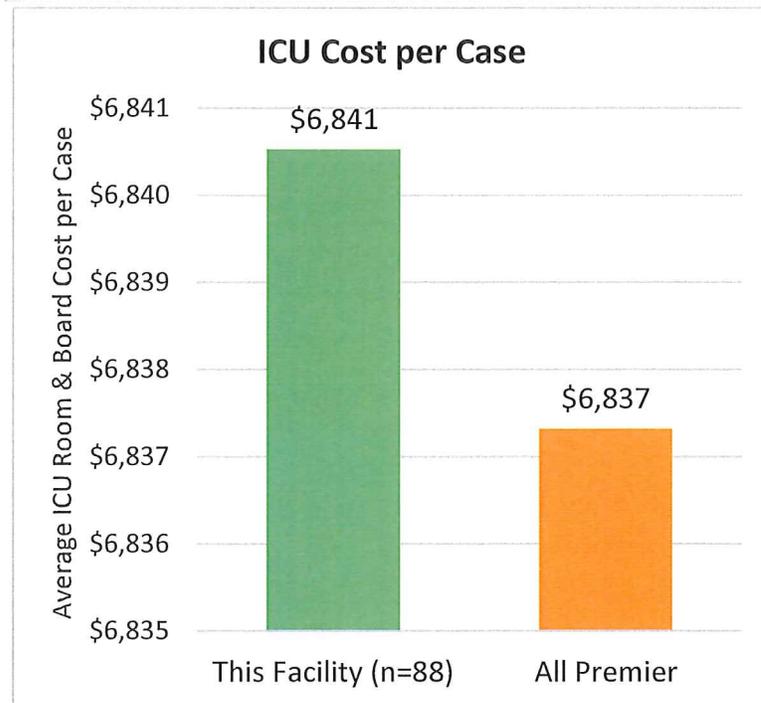
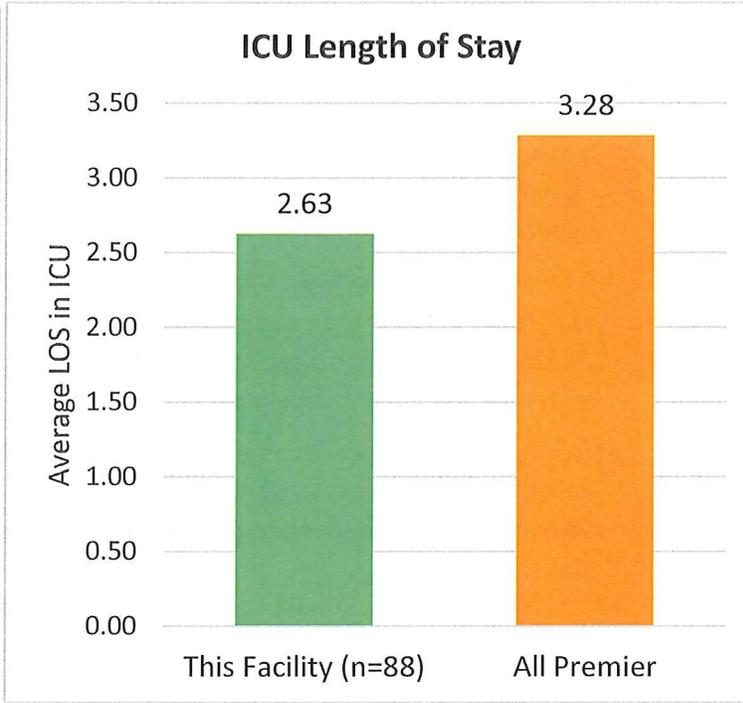
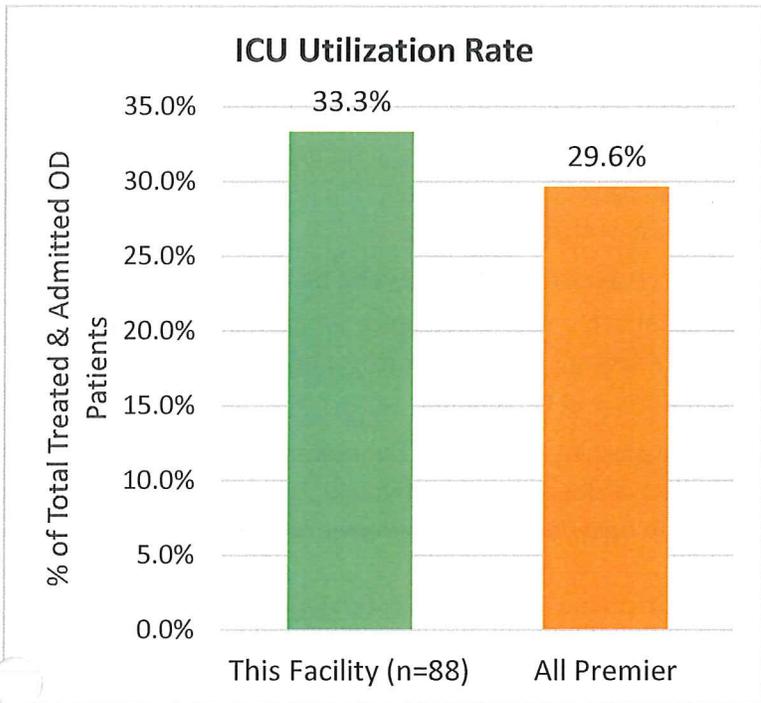




Opioid ODs Treated in the ED: Breakout by Treated and Released vs. Treated and Admitted (Cont.)

Opioid OD Treated and Admitted Cases Only

ED Treated and Admitted Patients - Key Indicators



For these two graphs, the values shown represent the ICU Length of Stay and Cost for those OD patients who were treated in the ICU, not including patients that did not receive treatment in the ICU.



What Can be Done

- ED providers/prescribers can use evidence-based, proven approaches to safer pain management – including both acute and chronic pain⁶ – that are opioid-sparing.
- Institute standardized evidence-based care management protocols for care in the ED, including a post-overdose protocol.
- For opioid ODs treated and released, initiate comprehensive, evidence-based treatment including mental health services and medication assisted therapy (MAT) for Opioid Use Disorder (OUD) or make referrals to treatment using a “warm hand-off”⁸ approach beginning in the ED. Assume any patient presenting with an opioid OD is “at risk”. One successful approach for transitioning to treatment is use of a “Recovery Coach” – a peer counselor or transition support based in the ED for those with a nonfatal opioid OD.
- A pregnant female with an opioid overdose presents an ideal opportunity to intervene for treatment, i.e., MAT, to help prevent the risks and costs associated with subsequent Neo-natal Abstinence Syndrome in the child⁷; consider screening for pregnancy for all females of child bearing age presenting with an opioid OD. Offering screening for HIV and hepatitis B and C; ensure or make referrals to treatment.
- Follow the US Surgeon General’s (SG) recommendation and prevent subsequent overdoses with naloxone – provide/expand access to persons at risk for opioid-related overdoses and their families; train on how to administer it. Recommend to people who use heroin/misuse opioids to keep a naloxone kit with them at all times.
- For those admitted, initiate comprehensive, coordinated care management with special attention to hand-offs at transitions of care to avoid unplanned readmissions.
- Educate providers and staff on language and behaviors that do not contribute to stigmatization; use clinically appropriate, medical accurate terminology.
- Leverage the ED’s existing synergies with community agencies, i.e., fire, ambulance/rescue and law enforcement to raise awareness and create a coordinated, standardized, evidence-based approach to local needs and priorities during this crisis.



Resources

Clinical Surveillance powered by TheraDoc®

If your facility has Premier Clinical Surveillance technology powered by TheraDoc, consider incorporating surveillance and decision support activities to improve the management of patients with opioid-related conditions or receiving opioids.

- Real-time alerts for admission (ED, outpatient) of high risk/frequent flyer/previous OD patients
- Medication utilization (DOT) reports for naloxone, buprenorphine, methadone, naltrexone, clonidine administration in ED



- Prompts for patient education or OUD-related consults
- Customized intervention documentation to track opioid initiatives (ex. naloxone education, distribution of naloxone kit, initiation of MAT, treatment center referral, warm handoff, recovery coach; include tracking for patient refusal of services)
- Medication utilization (DOT) reports for opioid order or administration trends at facility or unit-level
- Surveillance lists or alerts for high risk conditions (ex. opioids + benzodiazepines)

Other Resources

CDC Guidelines for Prescribing Opioids for Chronic Pain, United States, 2016. Recommendations and Reports / March 18, 2016 / 65(1); 1–49. [Link](#)

CDC Opioid Overdose resources. [Link](#)

Pennsylvania Department of Drug and Alcohol Programs. “Warm hand off”. [Link](#)

Premier Safety Institute®: Opioids and patient safety. [Link](#)

Substance Abuse and Mental Health Services Administration. SAMHSA Opioid Overdose Prevention Toolkit. HHS Publication No. (SMA) 18-4742. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018. [Link](#)

Substance Abuse and Mental Health Services Administration (SAMHSA). Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants. [Link](#)

Surgeon General’s Advisory on Naloxone and Opioid Overdose. April 10, 2018. [Link](#)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS). Help, Resources and Information National Opioids Crisis [Link](#)



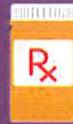
References

- 1) The Council of Economic Advisors. The Underestimated Cost of the Opioid Crisis. November, 2017.
- 2) Vivolo-Kantor AM, Seth P, Gladden RM, et al. Vital Signs: Trends in Emergency Department Visits for Suspected Opioid Overdoses — United States, July 2016–September 2017. *MMWR Morb Mortal Wkly Rep* 2018;67:279–285.
<http://dx.doi.org/10.15585/mmwr.mm6709e1>
- 3) CDC National Center for Injury Prevention and Control. Prescription Behavior Surveillance System (PBSS) Issue brief, July 2017.
<https://www.cdc.gov/drugoverdose/pdf/pbss/PBSS-Report-072017.pdf> (Site accessed 8.10.2018)
- 4) Olfson M, Crystal S, Wall M, Wang S, Liu SM, Blanco C. Causes of Death After Nonfatal Opioid Overdose. *JAMA Psychiatry*. 2018 Jun 20 doi: 10.001/jamapsychiatry.2018.1471. [Epub ahead of print]
- 5) Stevens JP, Wall MJ, Novack L, Marshall J, Hsu DJ, Howell MD. The Critical Care Crisis of Opioid Overdoses in the United States. *Ann Am Thorac Soc*. 2017 Dec;14(12):1803-1809. doi: 10.1513/AnnalsATS.201701-022OC
- 6) CDC Guidelines for Prescribing Opioids for Chronic Pain, United States, 2016. Recommendations and Reports / March 18, 2016 / 65(1);1–49.
<https://www.cdc.gov/drugoverdose/prescribing/guideline.html> (Site accessed 8.10.2018)
- 7) Substance Abuse and Mental Health Services Administration (SAMHSA). Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants.
<https://store.samhsa.gov/product/SMA18-5054> (Site accessed 8.10.2018)
- 8) Pennsylvania Department of Drug and Alcohol Programs. “Warm hand off”.
<https://www.ddap.pa.gov/Pages/Warm-Hand-Off.aspx> (Site accessed 8.10.2018)
- 9) Surgeon General’s Advisory on Naloxone and Opioid Overdose. April 10, 2018.
<https://www.surgeongeneral.gov/priorities/opioid-overdose-prevention/naloxone-advisory.html> (Site accessed 8.10.2018)

A rise in opioid overdoses is detected. What now?



Naloxone is a drug that can reverse the effects of opioid overdose and can be life-saving if administered in time.



Medication-assisted treatment (MAT) for opioid use disorder (OUD) can aid in preventing repeat overdoses. MAT combines the use of medication (methadone, buprenorphine, or naltrexone) with counseling and behavioral therapies.

- Offer naloxone and training to patient's family and friends, in case the patient has another overdose.
- Connect patients with hospital case managers or peer navigators to link them to follow-up treatment and services.
- Plan for the increasing number of patients with opioid-related conditions, including overdose, injection-related concerns, and withdrawal.

Local Emergency Department



First Responders | Public Safety | Law Enforcement Officers



- Get adequate supply and training for naloxone administration.
- Identify changes in illicit drug supply and work with state and local health departments to respond effectively.
- Collaborate with public health departments and health systems to enhance linkage to treatment and services.

Mental Health and Substance Abuse Treatment Providers



- Increase treatment services, including MAT for OUD.
- Increase and coordinate mental health services for conditions that often occur with OUD.

Coordinated, informed efforts can better prevent opioid overdoses and deaths

Community Members



- Connect with organizations in the community that provide public health services, treatment, counseling, and naloxone distribution.

Community-Based Organizations



- Assist in mobilizing a community response to those most at risk.
- Provide resources to reduce harms that can occur when injecting drugs, including ones that offer screening for HIV and hepatitis B and C, in combination with referral to treatment and naloxone provision.

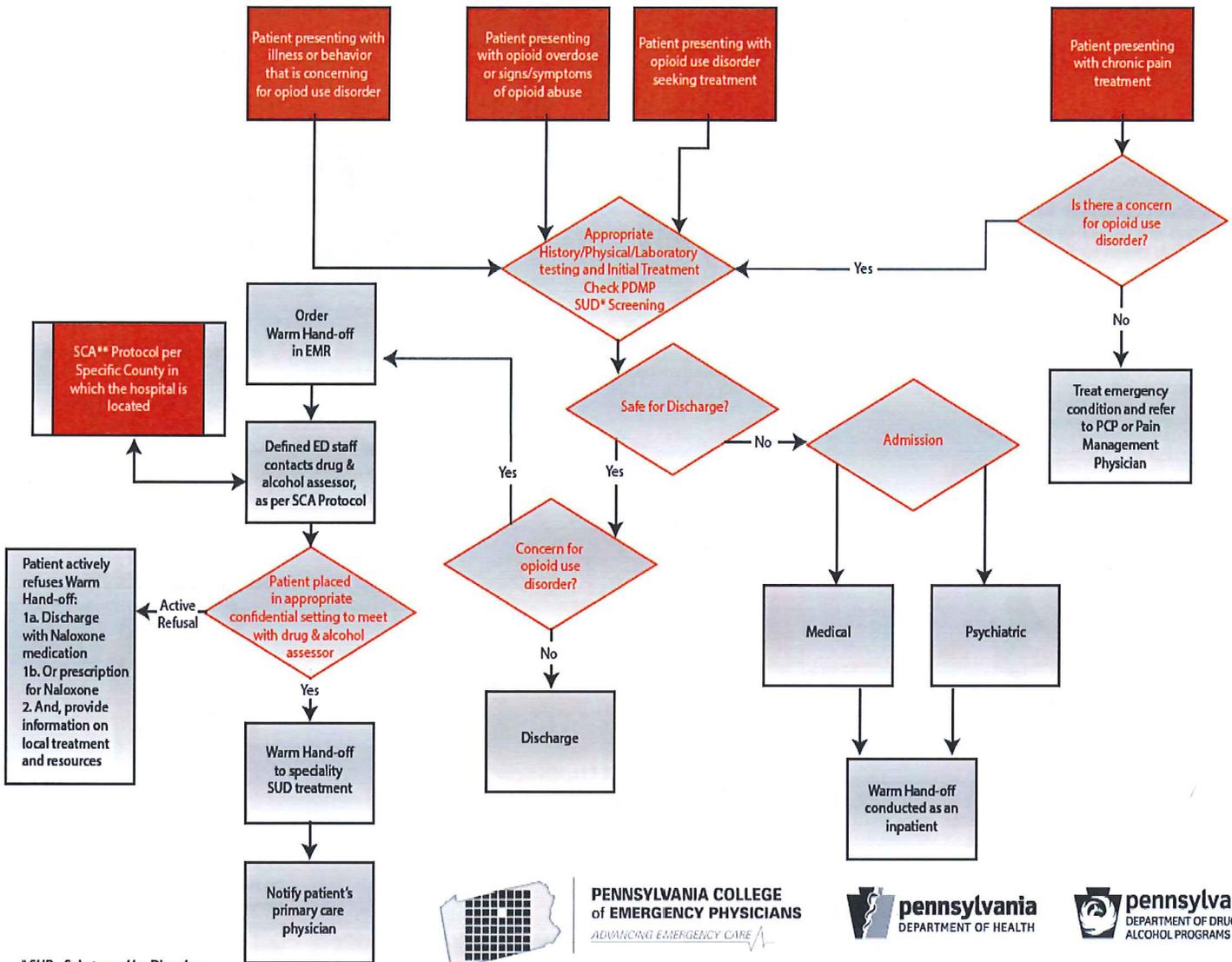
Local Health Departments



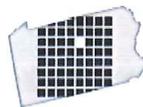
- Alert the community to the rapid increase in opioid overdoses seen in emergency departments and inform strategic plans and timely responses.
- Ensure an adequate naloxone supply.
- Increase availability and access to necessary services.
- Coordinate with key community groups to detect and respond to any changes in illicit drug use.



Emergency Department Warm Hand-off: For Opioid Use Disorder



* SUD - Substance Use Disorder
 ** SCA - Single County Authority/County Drug & Alcohol Office



PENNSYLVANIA COLLEGE
 of **EMERGENCY PHYSICIANS**
ADVANCING EMERGENCY CARE





APPENDIX

Definition of Opioid Overdose

Analysis Criteria

ICD-10 Codes (excluding all codes with a 6th digit value of 6, indicating "underdosing")

T40.0x	Poisoning by Adverse Effect of and Underdosing of Opium
T40.1x	Poisoning by Adverse Effect of and Underdosing of Heroin
T40.2x	Poisoning by Adverse Effect of and Underdosing of Other Opioids & Psychodysleptics/Hallucinogens
T40.3x	Poisoning by Adverse Effect of and Underdosing of Methadone
T40.4x	Poisoning by Adverse Effect of and Underdosing of Other Synthetic Narcotics
T40.6x	Poisoning by Adverse Effect of and Underdosing of Other Unspecified Narcotics

Other Criteria

Age 15+
ED Care

Sub-Populations for Analysis:

Treated and Released from ED: Patient Type EMERGENCY

Treated and Admitted through ED: Patient Type INPATIENT, OBSERVATION, PSYCHIATRIC, CHEMICAL DEPENDENCY, HOSPICE, REHABILITATION or SKILLED NURSING with ED VISIT flag of Yes. For facilities who do not submit the ED VISIT flag, use of a charge code with the Perspective Clinical Summary value of "EMERGENCY SERVICES" is used.

General Requirements

- All data must be Comparative Published and able to be included in a Peer type report in QualityAdvisor.
- Facility must submit Emergency type patients to Premier to receive a report, regardless of submitting other qualified patient types.

Drug Category Assignment

Patients with multiple qualifying codes were assigned to a drug category using the following methodology:

- Principle diagnosis code (if applicable) assigned first
- Secondary diagnosis codes sorted in coding order and the highest ranked code was selected for assignment.



APPENDIX

Specific ICD-10 Codes - Assignments to Drug Categories

ICD-10 Code		Category
T40.0X1A	Poisoning by opium, accidental (unintentional), initial encounter	Other Opioids
T40.0X1D	Poisoning by opium, accidental (unintentional), subsequent encounter	Other Opioids
T40.0X1S	Poisoning by opium, accidental (unintentional), sequela	Other Opioids
T40.0X2A	Poisoning by opium, intentional self-harm, initial encounter	Other Opioids
T40.0X2D	Poisoning by opium, intentional self-harm, subsequent encounter	Other Opioids
T40.0X2S	Poisoning by opium, intentional self-harm, sequela	Other Opioids
T40.0X3A	Poisoning by opium, assault, initial encounter	Other Opioids
T40.0X3D	Poisoning by opium, assault, subsequent encounter	Other Opioids
T40.0X3S	Poisoning by opium, assault, sequela	Other Opioids
T40.0X4A	Poisoning by opium, undetermined, initial encounter	Other Opioids
T40.0X4D	Poisoning by opium, undetermined, subsequent encounter	Other Opioids
T40.0X4S	Poisoning by opium, undetermined, sequela	Other Opioids
T40.0X5A	Adverse effect of opium, initial encounter	Other Opioids
T40.0X5D	Adverse effect of opium, subsequent encounter	Other Opioids
T40.0X5S	Adverse effect of opium, sequela	Other Opioids
T40.1X1A	Poisoning by heroin, accidental (unintentional), initial encounter	Heroin
T40.1X1D	Poisoning by heroin, accidental (unintentional), subsequent encounter	Heroin
T40.1X1S	Poisoning by heroin, accidental (unintentional), sequela	Heroin
T40.1X2A	Poisoning by heroin, intentional self-harm, initial encounter	Heroin
T40.1X2D	Poisoning by heroin, intentional self-harm, subsequent encounter	Heroin
T40.1X2S	Poisoning by heroin, intentional self-harm, sequela	Heroin
T40.1X3A	Poisoning by heroin, assault, initial encounter	Heroin
T40.1X3D	Poisoning by heroin, assault, subsequent encounter	Heroin
T40.1X3S	Poisoning by heroin, assault, sequela	Heroin
T40.1X4A	Poisoning by heroin, undetermined, initial encounter	Heroin
T40.1X4D	Poisoning by heroin, undetermined, subsequent encounter	Heroin
T40.1X4S	Poisoning by heroin, undetermined, sequela	Heroin
T40.2X1A	Poisoning by other opioids, accidental (unintentional), initial encounter	Other Opioids
T40.2X1D	Poisoning by other opioids, accidental (unintentional), subsequent encounter	Other Opioids
T40.2X1S	Poisoning by other opioids, accidental (unintentional), sequela	Other Opioids
T40.2X2A	Poisoning by other opioids, intentional self-harm, initial encounter	Other Opioids
T40.2X2D	Poisoning by other opioids, intentional self-harm, subsequent encounter	Other Opioids
T40.2X2S	Poisoning by other opioids, intentional self-harm, sequela	Other Opioids
T40.2X3A	Poisoning by other opioids, assault, initial encounter	Other Opioids
T40.2X3D	Poisoning by other opioids, assault, subsequent encounter	Other Opioids
T40.2X3S	Poisoning by other opioids, assault, sequela	Other Opioids
T40.2X4A	Poisoning by other opioids, undetermined, initial encounter	Other Opioids
T40.2X4D	Poisoning by other opioids, undetermined, subsequent encounter	Other Opioids
T40.2X4S	Poisoning by other opioids, undetermined, sequela	Other Opioids
T40.2X5A	Adverse effect of other opioids, initial encounter	Other Opioids
T40.2X5D	Adverse effect of other opioids, subsequent encounter	Other Opioids
T40.2X5S	Adverse effect of other opioids, sequela	Other Opioids



APPENDIX

Specific ICD-10 Codes - Assignments to Drug Categories

ICD-10 Code	Category
T40.3X1D Poisoning by methadone, accidental (unintentional), subsequent encounter	Synthetics
T40.3X1S Poisoning by methadone, accidental (unintentional), sequela	Synthetics
T40.3X2A Poisoning by methadone, intentional self-harm, initial encounter	Synthetics
T40.3X2D Poisoning by methadone, intentional self-harm, subsequent encounter	Synthetics
T40.3X2S Poisoning by methadone, intentional self-harm, sequela	Synthetics
T40.3X3A Poisoning by methadone, assault, initial encounter	Synthetics
T40.3X3D Poisoning by methadone, assault, subsequent encounter	Synthetics
T40.3X3S Poisoning by methadone, assault, sequela	Synthetics
T40.3X4A Poisoning by methadone, undetermined, initial encounter	Synthetics
T40.3X4D Poisoning by methadone, undetermined, subsequent encounter	Synthetics
T40.3X4S Poisoning by methadone, undetermined, sequela	Synthetics
T40.3X5A Adverse effect of methadone, initial encounter	Synthetics
T40.3X5D Adverse effect of methadone, subsequent encounter	Synthetics
T40.3X5S Adverse effect of methadone, sequela	Synthetics
T40.4X1A Poisoning by other synthetic narcotics, accidental (unintentional), initial encounter	Synthetics
T40.4X1D Poisoning by other synthetic narcotics, accidental (unintentional), subsequent encounter	Synthetics
T40.4X1S Poisoning by other synthetic narcotics, accidental (unintentional), sequela	Synthetics
T40.4X2A Poisoning by other synthetic narcotics, intentional self-harm, initial encounter	Synthetics
T40.4X2D Poisoning by other synthetic narcotics, intentional self-harm, subsequent encounter	Synthetics
T40.4X2S Poisoning by other synthetic narcotics, intentional self-harm, sequela	Synthetics
T40.4X3A Poisoning by other synthetic narcotics, assault, initial encounter	Synthetics
T40.4X3D Poisoning by other synthetic narcotics, assault, subsequent encounter	Synthetics
T40.4X3S Poisoning by other synthetic narcotics, assault, sequela	Synthetics
T40.4X4A Poisoning by other synthetic narcotics, undetermined, initial encounter	Synthetics
T40.4X4D Poisoning by other synthetic narcotics, undetermined, subsequent encounter	Synthetics
T40.4X4S Poisoning by other synthetic narcotics, undetermined, sequela	Synthetics
T40.4X5A Adverse effect of other synthetic narcotics, initial encounter	Synthetics
T40.4X5D Adverse effect of other synthetic narcotics, subsequent encounter	Synthetics
T40.4X5S Adverse effect of other synthetic narcotics, sequela	Synthetics
T40.601A Poisoning by unspecified narcotics, accidental (unintentional), initial encounter	Other Opioids
T40.601D Poisoning by unspecified narcotics, accidental (unintentional), subsequent encounter	Other Opioids
T40.601S Poisoning by unspecified narcotics, accidental (unintentional), sequela	Other Opioids
T40.602A Poisoning by unspecified narcotics, intentional self-harm, initial encounter	Other Opioids
T40.602D Poisoning by unspecified narcotics, intentional self-harm, subsequent encounter	Other Opioids
T40.602S Poisoning by unspecified narcotics, intentional self-harm, sequela	Other Opioids
T40.603A Poisoning by unspecified narcotics, assault, initial encounter	Other Opioids
T40.603D Poisoning by unspecified narcotics, assault, subsequent encounter	Other Opioids
T40.603S Poisoning by unspecified narcotics, assault, sequela	Other Opioids
T40.604A Poisoning by unspecified narcotics, undetermined, initial encounter	Other Opioids
T40.604D Poisoning by unspecified narcotics, undetermined, subsequent encounter	Other Opioids
T40.604S Poisoning by unspecified narcotics, undetermined, sequela	Other Opioids
T40.605A Adverse effect of unspecified narcotics, initial encounter	Other Opioids



APPENDIX

Specific ICD-10 Codes - Assignments to Drug Categories

ICD-10 Code	Category
T40.605S Adverse effect of unspecified narcotics, sequela	Other Opioids
T40.691A Poisoning by other narcotics, accidental (unintentional), initial encounter	Other Opioids
T40.691D Poisoning by other narcotics, accidental (unintentional), subsequent encounter	Other Opioids
T40.691S Poisoning by other narcotics, accidental (unintentional), sequela	Other Opioids
T40.692A Poisoning by other narcotics, intentional self-harm, initial encounter	Other Opioids
T40.692D Poisoning by other narcotics, intentional self-harm, subsequent encounter	Other Opioids
T40.692S Poisoning by other narcotics, intentional self-harm, sequela	Other Opioids
T40.693A Poisoning by other narcotics, assault, initial encounter	Other Opioids
T40.693D Poisoning by other narcotics, assault, subsequent encounter	Other Opioids
T40.693S Poisoning by other narcotics, assault, sequela	Other Opioids
T40.694A Poisoning by other narcotics, undetermined, initial encounter	Other Opioids
T40.694D Poisoning by other narcotics, undetermined, subsequent encounter	Other Opioids
T40.694S Poisoning by other narcotics, undetermined, sequela	Other Opioids
T40.695A Adverse effect of other narcotics, initial encounter	Other Opioids
T40.695D Adverse effect of other narcotics, subsequent encounter	Other Opioids
T40.695S Adverse effect of other narcotics, sequela	Other Opioids

MS-DRG Category Assignments

MS-DRG Category	Definition
Poisoning/Drug Abuse DRG's	MS-DRG's 894-897,917-918,923-927
Surgical DRG's	MS-DRG's 1-42, 114-116, 129-139, 163-168, 215-267, 326-358, 405-425, 453-533, 570-585, 614-629, 652-675, 707-717, 735-749, 765-770, 799-804, 820-829, 853-858, 876, 901-909, 927-928, 939-941, 956-959, 969, 981-989
Psychiatric DRG's	880-887
Other Medical DRG's	All Other MS-DRG's

NOTE: If desired, a detailed lookup table of these assignments can be supplied upon request.

Drug Overdose Deaths Among Women Aged 30–64 Years — United States, 1999–2017

Jacob P. VanHouten, MD, PhD¹; Rose A. Rudd, MSPH²; Michael F. Ballesteros, PhD¹; Karin A. Mack, PhD¹

The drug epidemic in the United States continues to evolve. The drug overdose death rate has rapidly increased among women (1,2), although within this demographic group, the increase in overdose death risk is not uniform. From 1999 to 2010, the largest percentage changes in the rates of overall drug overdose deaths were among women in the age groups 45–54 years and 55–64 years (1); however, this finding does not take into account trends in specific drugs or consider changes in age group distributions in drug-specific overdose death rates. To target prevention strategies to address the epidemic among women in these age groups, CDC examined overdose death rates among women aged 30–64 years during 1999–2017, overall and by drug subcategories (antidepressants, benzodiazepines, cocaine, heroin, prescription opioids, and synthetic opioids, excluding methadone). Age distribution changes in drug-specific overdose death rates were calculated. Among women aged 30–64 years, the unadjusted drug overdose death rate increased 260%, from 6.7 deaths per 100,000 population (4,314 total drug overdose deaths) in 1999 to 24.3 (18,110) in 2017. The number and rate of deaths involving antidepressants, benzodiazepines, cocaine, heroin, and synthetic opioids each increased during this period. Prescription opioid-related deaths increased between 1999 and 2017 among women aged 30–64 years, with the largest increases among those aged 55–64 years. Interventions to address the rise in drug overdose deaths include implementing the CDC *Guideline for Prescribing Opioids for Chronic Pain* (3), reviewing records of controlled substance prescribing (e.g., prescription drug monitoring programs, health insurance programs), and developing capacity of drug use disorder treatments and linkage to care, especially for middle-aged women with drug use disorders.

Mortality data for U.S. residents were obtained from the 1999–2017 National Vital Statistics System,* which is based

on information from all death certificates filed in the 50 states and the District of Columbia. Deaths of nonresidents (e.g., nonresident aliens, nationals living abroad) were excluded. Mortality data were provided to CDC's National Center for Health Statistics through the Vital Statistics Cooperative Program and coded according to the *International Classification of Diseases, Tenth Revision* (ICD-10). Analyses were restricted to deaths with an underlying cause of death based on the following ICD-10 codes for drug overdoses: X40–X44 (unintentional), X60–X64 (suicide), X85 (homicide), and Y10–Y14 (undetermined intent). Among deaths with drug overdose as the underlying cause, the type of drug involved was based on ICD-10 codes for antidepressants (T43.0–T43.2), benzodiazepines (T42.4), cocaine (T40.5), and opioids (all T40.0–T40.4 and T40.6, including those for heroin [T40.1],

INSIDE

- 6 Evaluation of State-Mandated Reporting of Neonatal Abstinence Syndrome — Six States, 2013–2017
- 11 Emergence of Extensively Drug-Resistant *Salmonella* Typhi Infections Among Travelers to or from Pakistan — United States, 2016–2018
- 14 Establishing Baseline Cervical Cancer Screening Coverage — India, 2015–2016
- 20 Notes from the Field: Respiratory Syncytial Virus Infections in a Neonatal Intensive Care Unit — Louisiana, December 2017
- 22 Notice to Readers
- 23 QuickStats

Continuing Education examination available at
https://www.cdc.gov/mmwr/cme/conted_info.html#weekly.

* <https://www.cdc.gov/nchs/nvss/deaths.htm>.



prescription opioids [T40.2–40.3], and synthetic opioids, excluding methadone [T40.4]). Deaths involving more than one type of drug were counted in multiple categories. Crude rates are reported as deaths per 100,000 population. Percent change was calculated on unrounded rates. Joinpoint regression[†] was used to test the significance of overdose trends from 1999 to 2017. Annual percentage change estimates that were statistically significant ($p < 0.05$) are presented to indicate the magnitude and direction of significant trends. Age distribution changes in drug-specific overdose deaths were calculated by 5-year age groupings, with average age of death analyzed for drug type for the years 1999 and 2017.

Among women aged 30–64 years, the crude drug overdose death rate increased 260%, from 6.7 deaths per 100,000 population (4,314 total drug overdose deaths) in 1999 to 24.3 (18,110) in 2017 (Figure 1). The rate of drug overdose deaths involving any opioid increased 492%, from 2.6 per 100,000 population in 1999 to 15.5 in 2017 (data not shown). During this time, rates of drug overdose deaths increased for those involving synthetic opioids (1,643%), heroin (915%), benzodiazepines (830%), prescription opioids (485%), cocaine (280%), and antidepressants (176%). Significant inflection points in trends of crude death rates of drug overdoses by drug indicate an increasing annual percentage change for all drugs except cocaine, for which crude death rates significantly decreased from 2006 to 2009.

[†] <https://surveillance.cancer.gov/joinpoint/>.

From 1999 to 2017, drug overdose death rates increased by approximately 200% among women aged 35–39 and 45–49 years, 350% among those aged 30–34 and 50–54 years, and nearly 500% among those aged 55–64 years (Figure 2). During 1999, overdose death rates were highest among women aged 40–44 years (9.6 deaths per 100,000 population), whereas during 2017, rates were highest among women aged 50–54 years (28.2).

The crude rate of overdose deaths involving antidepressants doubled from 1999 to 2017 among women aged 30–34 years and 40–49 years and increased approximately 300% among those aged 55–59 years, and nearly 400% among those aged 60–64 years. In 2017, rates were lowest among women aged 30–34 years (2.0) and highest among women aged 50–54 years (4.6). Rates of overdose deaths involving benzodiazepines increased in every age group examined (30–34 years, 1,225%; 40–44 years, 534%), with similar rates in 2017 among the 5-year age categories of those aged 35–49 years (range = 4.9–5.3). Similarly, the rate of overdose deaths involving cocaine in 2017 varied little by age category among women aged 30–54 years (range = 4.5–5.0). The crude rate of heroin-related overdose deaths among women aged 30–49 years ranged from 0.4 to 0.6 per 100,000 in 1999; in 2017, rates ranged from 1.3 among women aged 60–64 years to 5.6 among those aged 30–34 years. The crude rate for deaths involving prescription opioids increased from 1999 to 2017 for every age group, with the largest increases (>1,000%) among women aged 55–64 years. The crude rate also increased for every age group

The *MMWR* series of publications is published by the Center for Surveillance, Epidemiology, and Laboratory Services, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30329-4027.

Suggested citation: [Author names; first three, then et al., if more than six.] [Report title]. *MMWR Morb Mortal Wkly Rep* 2019;68:[inclusive page numbers].

Centers for Disease Control and Prevention

Robert R. Redfield, MD, *Director*
 Anne Schuchat, MD, *Principal Deputy Director*
 Leslie Dauphin, PhD, *Acting Associate Director for Science*
 Barbara Ellis, PhD, MS, *Acting Director, Office of Science Quality*
 Chesley L. Richards, MD, MPH, *Deputy Director for Public Health Scientific Services*
 Michael F. Iademarco, MD, MPH, *Director, Center for Surveillance, Epidemiology, and Laboratory Services*

MMWR Editorial and Production Staff (Weekly)

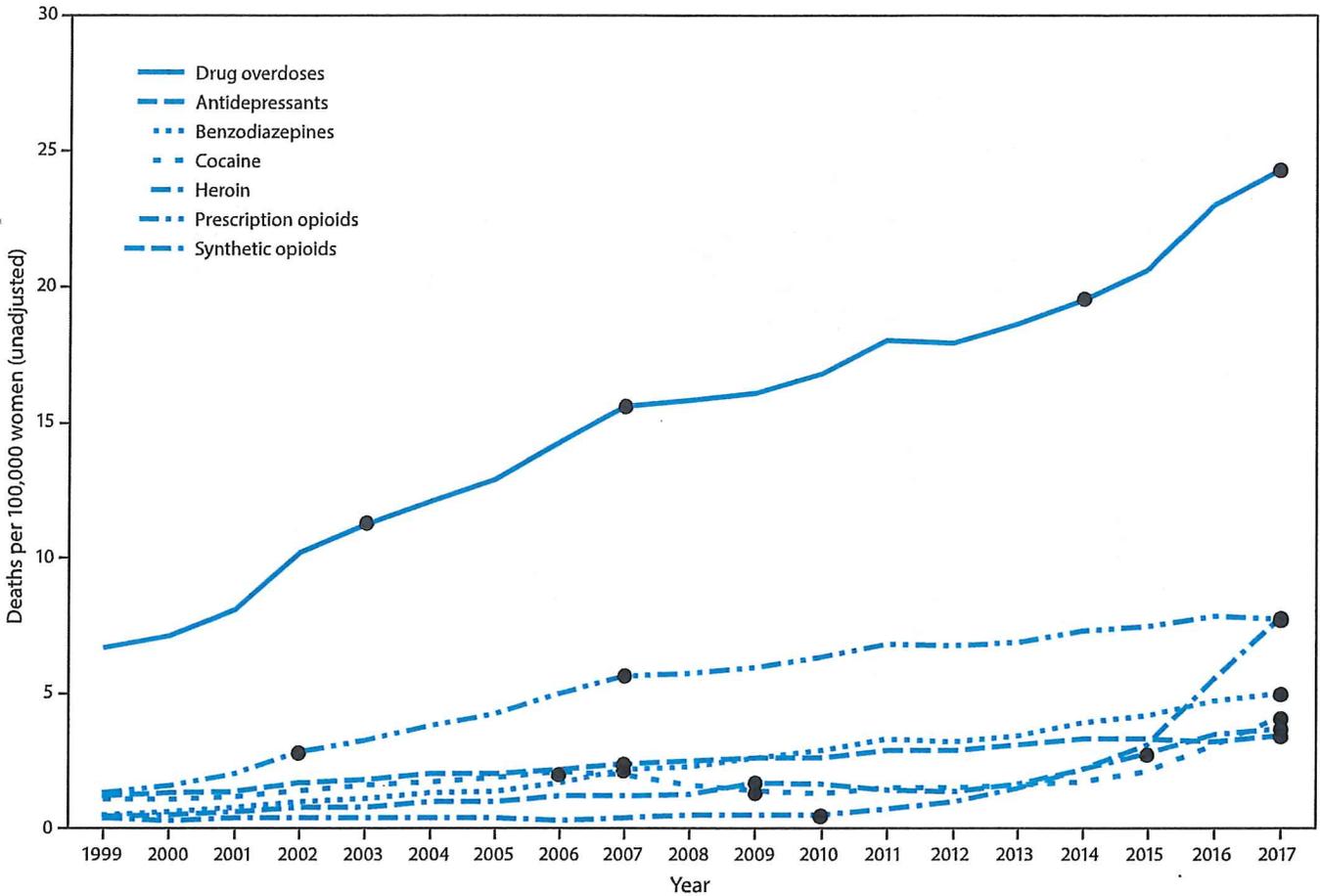
Charlotte K. Kent, PhD, MPH, *Acting Editor in Chief, Executive Editor*
 Jacqueline Gindler, MD, *Editor*
 Mary Dott, MD, MPH, *Online Editor*
 Teresa F. Rutledge, *Managing Editor*
 Douglas W. Weatherwax, *Lead Technical Writer-Editor*
 Glenn Damon, Soumya Dunworth, PhD, Teresa M. Hood, MS,
Technical Writer-Editors

Martha F. Boyd, *Lead Visual Information Specialist*
 Maureen A. Leahy, Julia C. Martinroe,
 Stephen R. Spriggs, Tong Yang,
Visual Information Specialists
 Quang M. Doan, MBA, Phyllis H. King,
 Terraye M. Starr, Moua Yang,
Information Technology Specialists

MMWR Editorial Board

Matthew L. Boulton, MD, MPH	Timothy F. Jones, MD, <i>Chairman</i>	Stephen C. Redd, MD
Virginia A. Caine, MD	Robin Ikeda, MD, MPH	Patrick L. Remington, MD, MPH
Katherine Lyon Daniel, PhD	Phyllis Meadows, PhD, MSN, RN	Carlos Roig, MS, MA
Jonathan E. Fielding, MD, MPH, MBA	Jewel Mullen, MD, MPH, MPA	William Schaffner, MD
David W. Fleming, MD	Jeff Niederdeppe, PhD	Morgan Bobb Swanson, BS
William E. Halperin, MD, DrPH, MPH	Patricia Quinlisk, MD, MPH	

FIGURE 1. Drug overdose deaths* (unadjusted) per 100,000 women aged 30–64 years, by involved drug or drug class — National Vital Statistics System (NVSS), 1999–2017†,§



* Drug overdose deaths were identified using *International Classification of Diseases, Tenth Revision* underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. The multiple cause-of-death code or codes for each drug were heroin: T40.1; prescription opioids: T40.2 for natural and semisynthetic opioids (e.g., oxycodone and hydrocodone) and T40.3 for methadone; synthetic opioids, excluding methadone (e.g., fentanyl and tramadol): T40.4; cocaine: T40.5; benzodiazepines: T42.4; and antidepressants: T43.0–43.2. Deaths might involve more than one drug; thus categories are not exclusive.

† NVSS mortality data.

§ Significant annual percent change indicated by dots. Antidepressants: 1999–2007 = 8.82; 2007–2017 = 3.63; benzodiazepines: 1999–2007 = 18.94; 2007–2017 = 8.91; cocaine: 1999–2006 = 11.59; 2006–2009 = -14.95; 2014–2017 = 36.71; drug overdoses: 1999–2003 = 14.68; 2003–2007 = 8.28; 2007–2014 = 3.31; 2014–2017 = 8.16; heroin: 1999–2010 = 4.17; 2010–2015 = 42.16; 2015–2017 = 12.79; prescription opioids: 1999–2002 = 30.97; 2002–2007 = 15.03; 2007–2017 = 3.47; synthetic opioids: 1999–2009 = 12.64; 2013–2017 = 52.81.

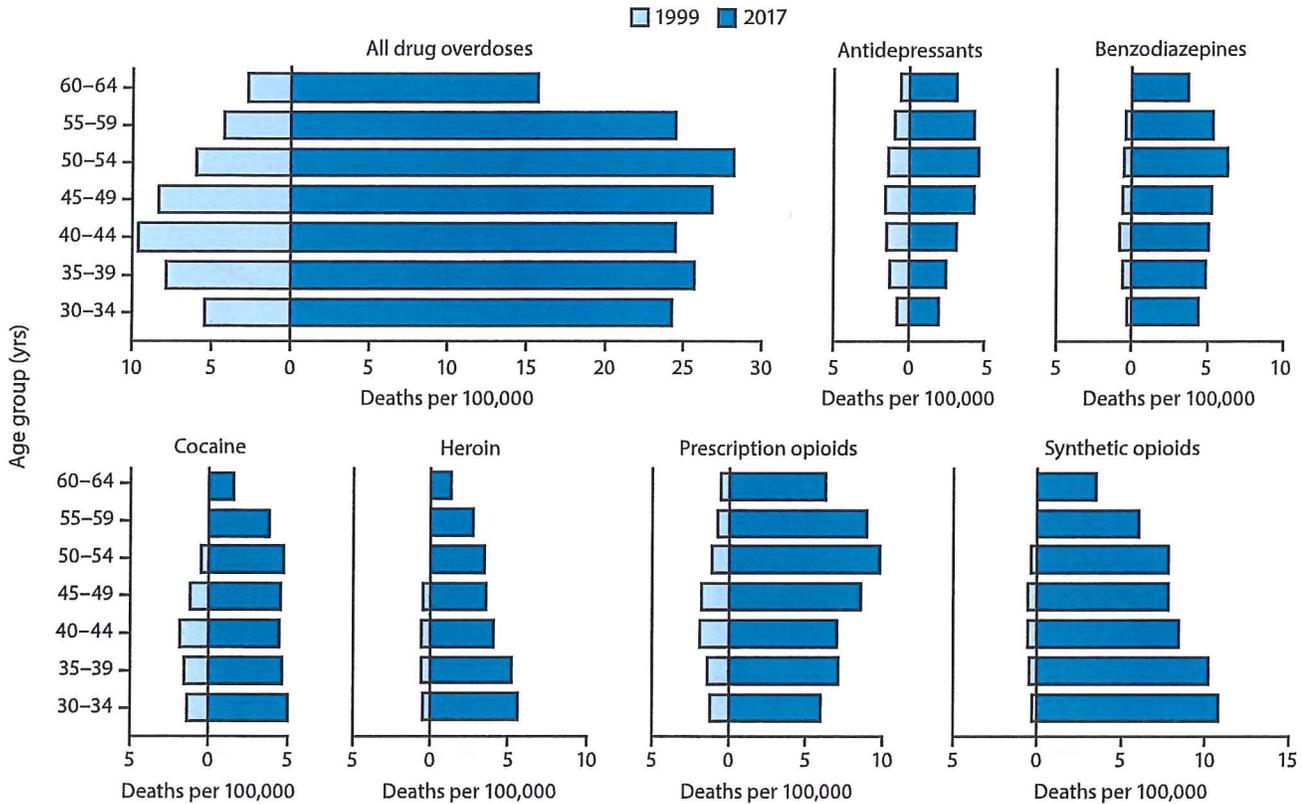
for deaths involving synthetic opioids excluding methadone, with the largest increase among women aged 30–34 years (3,500%).

The average age at death from overall drug overdoses among women aged 30–64 years increased by 2.8 years, from 43.5 years in 1999 to 46.3 years in 2017 (Table). The largest increase in average age of death was among cocaine-related deaths (4.7 years), followed by prescription opioid-related deaths (4.5 years). The average age of death among synthetic opioid-related deaths did not change.

Discussion

From 1999 to 2017, the crude rate of drug overdose deaths among women aged 30–64 years in the United States increased by 260%. The rates of overdose deaths increased for all drug categories examined, with a notable increase in rates of deaths involving synthetic opioids (1,643%), heroin (915%), and benzodiazepines (830%). These findings are consistent with recent reports highlighting an overall increasing trend in deaths involving drugs, especially with shifts in the type of drugs involved (e.g., heroin) (4).

FIGURE 2. Drug overdose deaths (unadjusted) per 100,000 women aged 30–64 years, by age group and involved drug or drug class — National Vital Statistics System (NVSS), 1999* and 2017†,‡



* Rates in 1999 for certain age groups are not displayed because counts were <20 deaths.

† NVSS mortality data.

‡ Drug overdose deaths were identified using *International Classification of Diseases, Tenth Revision* underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. The multiple cause-of-death code or codes for each drug were *heroin*: T40.1; *prescription opioids*: T40.2 for natural and semisynthetic opioids (e.g., oxycodone and hydrocodone) and T40.3 for methadone; *synthetic opioids, excluding methadone* (e.g., fentanyl and tramadol): T40.4; *cocaine*: T40.5; *benzodiazepines*: T42.4; and *antidepressants*: T43.0–43.2. Deaths might involve more than one drug; thus categories are not exclusive.

Other reports have highlighted the overall increase in overdose deaths and emergency department visits related to drug use, especially among women aged 45–64 years (1). In addition to demonstrating the varying drug overdose rate increases by age group, this study determined that the age distribution of decedents shifted from 1999 to 2017, and the average age of women aged 30–64 years dying from drug overdoses increased for every drug class analyzed except synthetic opioids. Prevention programs might need to shift response options as the overdose epidemic experiences demographic shifts. Further, as women progress through life, individual experiences can change in the type of substance used or misused and in the experiences of pain that might result in an opioid prescription (5–8).

The findings in this report are subject to at least three limitations. First, rate estimates of specific drugs involved with deaths might be affected by factors related to death investigation, such as the substances tested for or the circumstances under which

TABLE. Average age at death among women aged 30–64 years who died of a drug overdose,* by involved drug or drug class — National Vital Statistics System (NVSS), 1999 and 2017†

Drug/Drug class involved	Average age at death (yrs)		
	1999	2017	Increase 1999 to 2017
All drug overdoses	43.5	46.3	2.8
Antidepressant	44.8	48.9	4.1
Benzodiazepine	44.1	47.1	3.0
Cocaine	40.4	45.1	4.7
Heroin	40.8	43.5	2.7
Prescription opioid	43.3	47.8	4.5
Synthetic opioid	44.2	44.2	0.0

* Drug overdose deaths were identified using *International Classification of Diseases, Tenth Revision* underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. The multiple cause-of-death code or codes for each drug were *heroin*: T40.1; *prescription opioids*: T40.2 for natural and semisynthetic opioids (e.g., oxycodone and hydrocodone) and T40.3 for methadone; *synthetic opioids, excluding methadone* (e.g., fentanyl and tramadol): T40.4; *cocaine*: T40.5; *benzodiazepines*: T42.4; and *antidepressants*: T43.0–43.2. Deaths might involve more than one drug; thus categories are not exclusive.

† NVSS mortality data.

Summary**What is already known about this topic?**

The U.S. drug epidemic is evolving, including among women. Studies have highlighted rising rates of drug overdose deaths among women aged 45–64 years.

What is added by this report?

From 1999 to 2017, the death rate from drug overdose among women aged 30–64 years increased by 260%. Drug overdose deaths involving antidepressants, benzodiazepines, cocaine, heroin, prescription opioids, and synthetic opioids all increased. Among women aged 30–64 years, the average age at death for drug overdose deaths increased by nearly 3 years.

What are the implications for public health practice?

Overdose deaths continue to be unacceptably high, and targeted efforts are needed to reduce the number of deaths in this evolving epidemic, including those among middle-aged women.

tests are performed. For example, toxicology testing cannot distinguish between pharmaceutical fentanyl and illicitly manufactured fentanyl. Second, drug categories presented are not mutually exclusive, and deaths might have involved more than one substance. Increases in deaths involving certain drugs might be the result of increases in certain drug combinations. Finally, the percentage of deaths with specific drugs identified on the death certificate varies over time. Changes in testing and reporting of drugs might have led to observed increases in some drug entities involved in drug overdose deaths.

Substantial work has focused on informing women of child-bearing age about the risk and benefit of the use of certain drugs, particularly for the risk posed by neonatal abstinence syndrome as a result of opioid use during pregnancy (9,10). The current analysis demonstrates the remaining need to consider middle-aged women who remain vulnerable to death by drug overdose. A multifaceted approach involving the full spectrum of care services is likely necessary. For example, health care providers who treat women for pain, depression, or anxiety can discuss treatment options that consider the unique biopsychosocial needs of women (2). Providers can consider implementing the CDC *Guideline for Prescribing Opioids for Chronic Pain* (3), and Medicaid programs can also examine whether prescribing of controlled substances to their clients meets established guidelines. Access to gender-responsive substance

use disorder treatment services, especially for pregnant women and women with drug use disorders, can reduce harmful outcomes. Overdose deaths continue to be unacceptably high, and targeted efforts are needed to reduce the number of deaths in this evolving epidemic among middle-aged women.

Corresponding author: Karin A. Mack, kmack@cdc.gov, 770-488-4389.

¹Division of Analysis Research and Practice Integration, National Center for Injury Prevention and Control, CDC; ²Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, CDC.

All authors have completed and submitted the ICMJE form for disclosure of potential conflicts of interest. No potential conflicts of interest were disclosed.

References

1. CDC. Vital signs: overdoses of prescription opioid pain relievers and other drugs among women—United States, 1999–2010. *MMWR Morb Mortal Wkly Rep* 2013;62:537–42.
2. Mazure CM, Fiellin DA. Women and opioids: something different is happening here. *Lancet* 2018;392:9–11. [https://doi.org/10.1016/S0140-6736\(18\)31203-0](https://doi.org/10.1016/S0140-6736(18)31203-0)
3. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain—United States, 2016. *MMWR Recomm Rep* 2016;65(No. RR-1). <https://doi.org/10.15585/mmwr.rr6501e1>
4. Rudd RA, Seth P, David F, Scholl L. Increases in drug and opioid-involved overdose deaths—United States, 2010–2015. *MMWR Morb Mortal Wkly Rep* 2016;65:1445–52. <https://doi.org/10.15585/mmwr.mm65051e1>
5. Mowbray O, Quinn A. Prescription pain reliever misuse prevalence, correlates, and origin of possession throughout the life course. *Addict Behav* 2015;50:22–7. <https://doi.org/10.1016/j.addbeh.2015.06.006>
6. Fillingim RB, King CD, Ribeiro-Dasilva MC, Rahim-Williams B, Riley JL 3rd. Sex, gender, and pain: a review of recent clinical and experimental findings. *J Pain* 2009;10:447–85. <https://doi.org/10.1016/j.jpain.2008.12.001>
7. Greenspan JD, Craft RM, LeResche L, et al.; Consensus Working Group of the Sex, Gender, and Pain SIG of the IASP. Studying sex and gender differences in pain and analgesia: a consensus report. *Pain* 2007;132(Suppl 1):S26–45. <https://doi.org/10.1016/j.jpain.2007.10.014>
8. Hser Y-I, Longshore D, Anglin MD. The life course perspective on drug use: a conceptual framework for understanding drug use trajectories. *Eval Rev* 2007;31:515–47. <https://doi.org/10.1177/0193841X07307316>
9. Ko JY, Wolicki S, Barfield WD, et al. CDC grand rounds: public health strategies to prevent neonatal abstinence syndrome. *MMWR Morb Mortal Wkly Rep* 2017;66:242–5. <https://doi.org/10.15585/mmwr.mm6609a2>
10. Substance Abuse and Mental Health Services Administration. Clinical guidance for treating pregnant and parenting women with opioid use disorder and their infants. Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration; 2018. <https://store.samhsa.gov/system/files/sma18-5054.pdf>

MARION COUNTY PUBLIC SAFETY COORDINATING COUNCIL

2019 MEETING MATRIX

ISSUE/TOPIC	January 8	Feb 12	March 12	April 9	May 14	June 11
Justice Reinvestment Implementation/ Community Corrections	<ul style="list-style-type: none"> Quarterly update on CJC Dashboard Data 			<ul style="list-style-type: none"> Quarterly update on CJC Dashboard Data 		
Juvenile Justice					Hold meeting at Juvenile Department?	
Presentations of issues or programs/services (approx. 60 minutes)	Dan Estes: ODOT & Cate Duke, MADD Oregon	Secretary of State Prescription drugs/opioid audit	Debrief/Review from JRI Summit	Aid and Assists	TOUR	Traffic Safety & OSP: Car Care Program?
One-time presentations of issues or programs/services (approx. 30 minutes)			Taylor's House Update (Tricia Ratliff CAA)		Grand Jury Recordation (Paige)	
Federal & State Legislation	Federal Legislative Agenda Preview (Barb Young) State Legislative Meeting Debrief Prepare for legislative forum	Approve Federal Legislative Agenda (Barb Young) State Legislative Meeting Debrief (BOC approves Feb 20 or 27)	Legislative Updates	Legislative Updates	Legislative Updates	Legislative Updates
CJAC/Workgroup Updates	<ul style="list-style-type: none"> Victim Services Update 	<ul style="list-style-type: none"> Pre-Trial 	<ul style="list-style-type: none"> CJAC 	<ul style="list-style-type: none"> LEAD 	<ul style="list-style-type: none"> Stepping Up 	<ul style="list-style-type: none"> CJAC
Round Table Discussion – Future Direction						
Emerging Issues	<ul style="list-style-type: none"> Timely issues identified by Steering Committee Opportunity for networking, sharing 	<ul style="list-style-type: none"> Timely issues identified by Steering Committee Opportunity for networking, sharing 	<ul style="list-style-type: none"> Timely issues identified by Steering Committee Opportunity for networking, sharing 	<ul style="list-style-type: none"> Timely issues identified by Steering Committee Opportunity for networking, sharing 	<ul style="list-style-type: none"> Timely issues identified by Steering Committee Opportunity for networking, sharing 	<ul style="list-style-type: none"> Timely issues identified by Steering Committee Opportunity for networking, sharing
Problem Solving	<ul style="list-style-type: none"> Identify as problems arise Coordinate with CFC 	<ul style="list-style-type: none"> Identify as problems arise Coordinate with CFC 	<ul style="list-style-type: none"> Identify as problems arise Coordinate with CFC 	<ul style="list-style-type: none"> Identify as problems arise Coordinate with CFC 	<ul style="list-style-type: none"> Identify as problems arise Coordinate with CFC 	<ul style="list-style-type: none"> Identify as problems arise Coordinate with CFC

ADDITIONAL TOPICS TO BE SCHEDULED

- | | |
|--|--|
| <ul style="list-style-type: none"> Quarterly update on CJC Dashboard Semi-annual update on Alliance for Hope Monthly Workgroup Updates (CJAC, LEAD, Stepping Up, Pre-Trial Justice on alternate months) Grand jury recordation | <ul style="list-style-type: none"> Marijuana Suicides- SKSD spokesperson Ishawn Ealy; Marion County Health Dept. Veterans Update – Linda Strike, MWVCAA ICE Immigration Update College Inside, Chemeketa Community College (higher education for incarcerated adults) Oregon State Police: Car Care Program (Captain Tim Fox) Stewards of Children child abuse prevention training? |
|--|--|

DRAFT

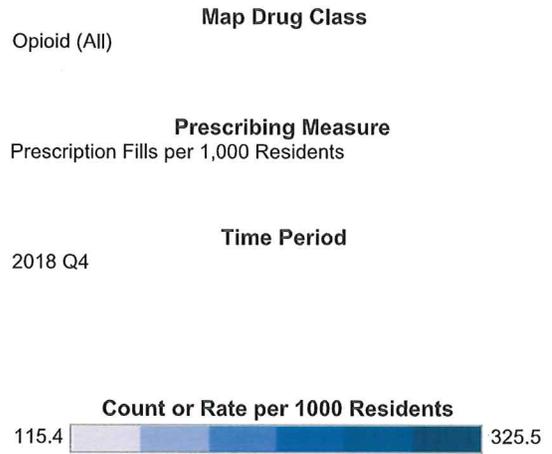
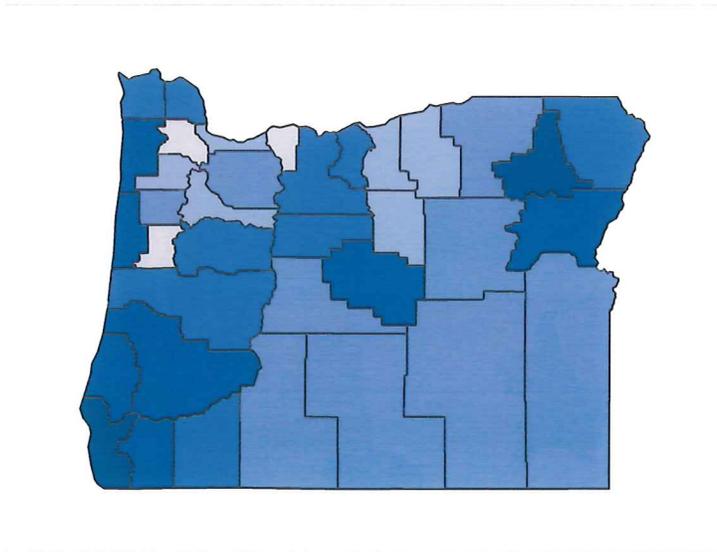
MARION COUNTY PUBLIC SAFETY COORDINATING COUNCIL

2019 MEETING MATRIX

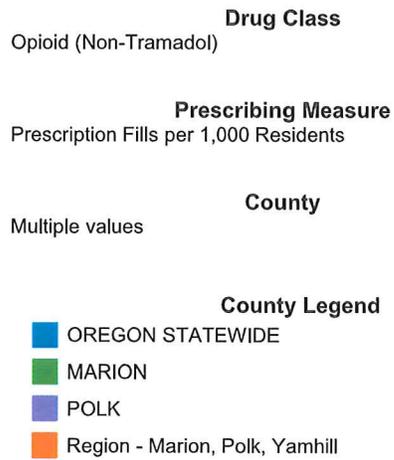
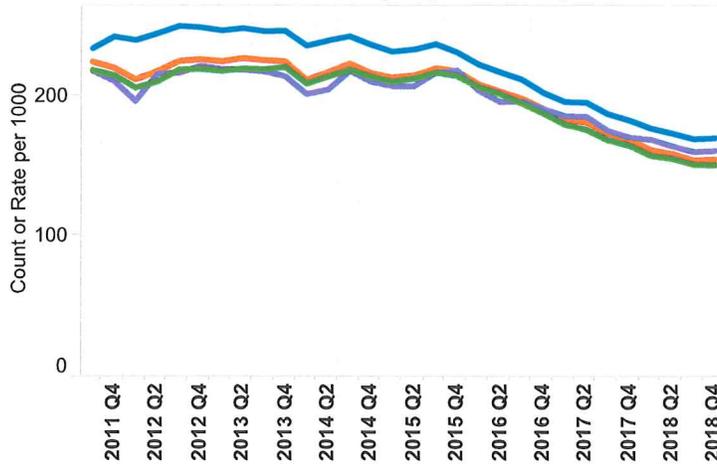
ISSUE/TOPIC	July 9	August 13	Sept. 10	Oct. 8	Nov. 12	Dec. 10
Justice Reinvestment Implementation/ Community Corrections					MEET AT NEW JUVENILE DEPARTMENT BUILDING	
Juvenile Justice						
Presentations of issues or programs/services (approx. 60 minutes)						
One-time presentations of issues or programs/services (approx. 30 minutes)						
Federal & State Legislation						
CJAC/Workgroup Updates						
Round Table Discussion – Future Direction						
Emerging Issues	<ul style="list-style-type: none"> Timely issues identified by Steering Committee Opportunity for networking, sharing 	<ul style="list-style-type: none"> Timely issues identified by Steering Committee Opportunity for networking, sharing 	<ul style="list-style-type: none"> Timely issues identified by Steering Committee Opportunity for networking, sharing 	<ul style="list-style-type: none"> Timely issues identified by Steering Committee Opportunity for networking, sharing 	<ul style="list-style-type: none"> Timely issues identified by Steering Committee Opportunity for networking, sharing 	<ul style="list-style-type: none"> Timely issues identified by Steering Committee Opportunity for networking, sharing
Problem Solving	<ul style="list-style-type: none"> Identify as problems arise Coordinate with CFC 	<ul style="list-style-type: none"> Identify as problems arise Coordinate with CFC 	<ul style="list-style-type: none"> Identify as problems arise Coordinate with CFC 	<ul style="list-style-type: none"> Identify as problems arise Coordinate with CFC 	<ul style="list-style-type: none"> Identify as problems arise Coordinate with CFC 	<ul style="list-style-type: none"> Identify as problems arise Coordinate with CFC

ADDITIONAL TOPICS TO BE SCHEDULED	
<ul style="list-style-type: none"> Quarterly update on CJC Dashboard Semi-annual update on Alliance for Hope Monthly Workgroup Updates (CJAC, LEAD, Stepping Up, Pre-Trial Justice on alternate months) Grand jury recordation 	<ul style="list-style-type: none"> Marijuana Suicides- SKSD spokesperson Ishawn Ealy; Marion County Health Dept. Veterans Update – Linda Strike, MWVCAA ICE Immigration Update College Inside, Chemeketa Community College (higher education for incarcerated adults) Oregon State Police: Car Care Program (Captain Tim Fox) Stewards of Children child abuse prevention training

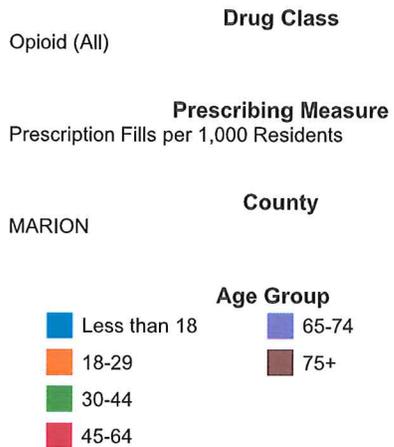
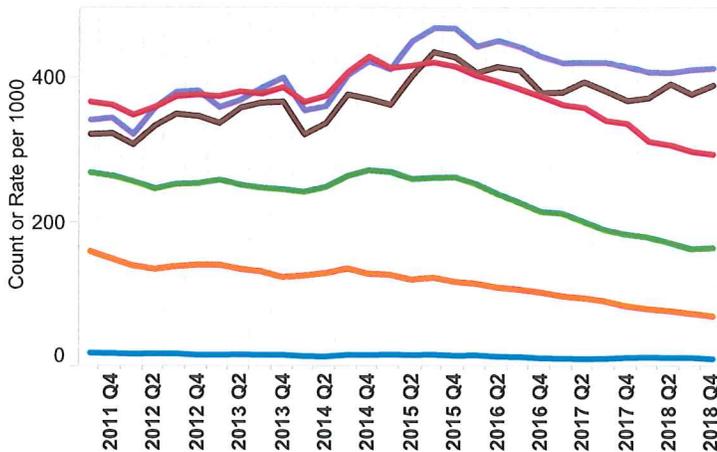
Oregon Controlled Substance Prescribing by Class



Prescribing by County



Prescribing by Age



MID-WILLAMETTE VALLEY PRESCRIPTION DRUG OVERDOSE PREVENTION PROGRAM

activities

- Prescribers, pharmacists and health systems are being convened to improve attentiveness to opioid related issues.
 - Learning- *Mid Willamette Valley Pain Summit* (200 attendees), 2018 *All About Opioids Pain Summit 4.0* (70 attendees). *Pain, Opioid & Addiction Summit, Fall, 2018*.
 - Expanded Medication Assisted Treatment & Education about Harm Reduction in Marion, Polk, Yamhill counties and Grand Ronde tribe.
 - Increase naloxone access- Promotion of co-prescribing Naloxone (NARCAN) for high opioid use patients. Uniform data collection on when it is administered is still a goal.
- Interagency partnerships.
 - To organize regional goals and needs- around pain and addiction. Mid-Willamette Valley PDO Regional Workgroup and –local alcohol and drug planning committees meet monthly.
- Reducing pills in circulation.
 - Reducing prescribing- Yamhill CCO Non-Cancer Pain Workgroup and TraQ at Willamette Valley Community Health [WVCH] in Marion/Polk groups encouraged and contracted prescribers to enroll in Prescription Drug Monitoring Program [PDMP]. With HB 4143 mandate to enroll, local prescribers are being encouraged to use PDMP as a tool.
 - Take Meds Seriously Oregon* - Health Education Campaign education and materials disseminated (English & Spanish) takemedseriouslyoregon.org publicizes 26 prescription disposal sites that were mapped in this region.

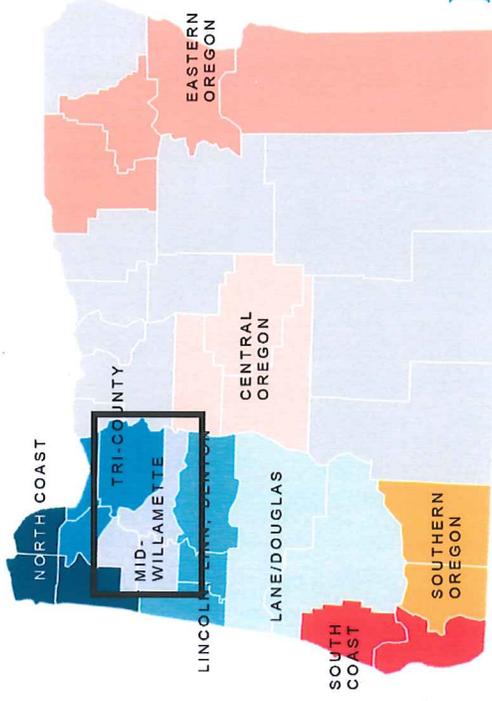


PDO REGIONS

Consist of 2-4 neighboring counties selected to receive federal funding from OHA. High burden regions were identified by a combination of indices on mortality, hospitalizations, prescribing data, opioid patient use, and county population.

PDO Regions work with stakeholders to create multi-disciplinary teams to address the Oregon Opioid Initiative. A **PDO Coordinator** is appointed within the region to work with physician champions, treatment centers, local public health authorities, health systems and other partners to reduce unnecessary opioid prescribing, and promote resources.

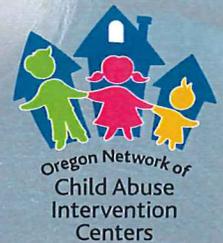
Regions are encouraged to assist clinicians with implementing the CDC Opioid Prescribing Guidelines; work with stakeholders and colleagues to guide the opioid prevention initiative; assist medical directors with increasing use of the PDMP (Prescription Drug Monitoring Program) by enrolling prescribers; and work with community partners to educate and inform the public, prescribers and others by arranging training, summits or conferences within the region.



<https://www.oregonpainguidance.org/regions/mid-willamette-valley/>

Vote YES to PROTECT KIDS

All children deserve immediate, expert intervention when there are concerns of abuse



The challenge



- Child abuse without intervention leads to poor health and economic outcomes which impact all Oregonians
- Child Abuse Intervention Centers (CAICs) stop abuse, collect sound evidence, and provide immediate trauma-focused therapy and referrals for the child and supportive family members
- Statute requires children have access to CAIC medical assessments, regardless of their family's ability to pay
- Despite improved outcomes for kids when local investigations involve a CAIC, state investment makes up only 17% of CAIC budgets

The gap and impacts



- Centers employ highly-trained and specialized medical providers and forensic interviewers. **When untrained or unpracticed providers assess children, especially young children, we risk further injury and in some cases, even death.** Interviews done without specialized training can also jeopardize a successful prosecution.
- In 2017, 32,000 investigations were completed in response to abuse allegations, and less than one in four kids received CAIC services²
- **The risk of lack of investment is too high** and affects children facing similar circumstances as those we are currently serving ---

Here's who we served in 2018



39% or 2,727
0-6 year olds

37% or 2,610
7-12 year olds

24% or 1,707
13-18 year olds

45% served for concerns of sexual abuse, 36% physical abuse, 10% witness to violence, and 9% neglect. 7% also reported drug endangerment.

Reaching more kids



Increasing direct funding to CAICs by only \$6M, will mean that **1,220** more children will receive the medical assessments, forensic interviews, and opportunities for healing they deserve (a 15% increase).

After this investment, 29% of CAICs budgets would be state supported, representing **a big step forward** for kids needing these services in Oregon.

Distributed by

Vote YES to PROTECT KIDS

All children deserve immediate, expert intervention when there are concerns of abuse



Why this issue?

Kids impacted by abuse, especially without intervention are...



59% more likely to be arrested as a juvenile, 28% as an adult³

30% more likely commit a violent crime³

25% more likely to become a teen parent⁴

A 2015 study in Portland Metro found that...

63% of medicaid utilizers reported a history of child abuse⁵

Child abuse concerns make up most adverse childhood experiences, which lead to some of Oregon's most cruel and enduring problems

The most recent estimate of the lifetime cost of child abuse is over **\$210,000** per person.⁶ Without intervention, 2017's confirmed victims alone could cost Oregon 2.3B. Helping youth enter adulthood protected, hopeful, and healing should be one of Oregon's top priorities.

Why CAICs?

CAICs intervene and reduce trauma, giving kids a better chance at a happy, healthy adulthood. 24 CAICs serve all 36 counties and require local buy-in to form and lead each community's child abuse response. They have strong partnerships with law enforcement, child welfare, schools, medical providers, and community-based nonprofits. CAICs are poised for increased services and growth, and want to serve more kids. For a stronger future, Oregon needs strong CAICs.

CAICs are also connected to rich resources, like the state chapter, national leader organization, and network of over 880 CAICs nationwide, which means investment is backed with cutting edge best practices. **Research has shown that:**

Involvement with a CAIC increases successful prosecutions, ensuring justice and protecting children from future harm⁷

CAICs have been shown to save up to \$1,000 per case⁸

CAICs use trauma-focused cognitive behavioral therapy which has been shown to reduce symptoms of post-traumatic stress disorder, in less visits than other models⁹

Partners supporting our 2019 ask

211Info
American Association of University Women of Oregon
Catholic Community Services, Mid-Willamette Valley
Causa
Clackamas Women's Services

College Possible
Foster Homes of Healing
Kinship House
NARAL Pro-Choice Oregon
Neighborhood House

New Avenues for Youth
Open Adoption & Family Services
Oregon Abuse Advocates & Survivors in Service
Oregon CASA Network
Oregon Foster Youth Connection

Oregon Primary Care Association
Oregon Trial Lawyers Association
Oregon Women's Rights Coalition
Prevent Child Abuse Oregon
Somali American Council of Oregon

(1) ORS 419B.022-024, ORS 418.782 (2) Child Welfare Data Book, 2017 (3) Safe Horizon, 2015 (4) Child Welfare Information Gateway, 2013 (5) Health Share, 2015 (6) Centers for Disease Control and Prevention, 2012 (7) Miller & Rubin, 2009 (8) National Children's Advocacy Center, 2005 (9) Ramirez de Arellano et. al, 2014, meta-analyses