Oregon Health Authority

Oregon Prescription Drug Monitoring Program Advisory Commission
Prescribing Practice Review Subcommittee

March 25, 2024 Meeting Minutes

Meeting Contact: Drew Simpson, drew.r.simpson@oha.oregon.gov, 971-673-1033

Subcommittee Attendees:
Dean Sidelinger, State Health Officer
John Mahan, Jackson County Chief Medical Office HHS
Helen Turner, School of Nursing at OHSU
David Farris, Oregon Medical Board

OHA Attendees:
Drew Simpson, PDMP Coordinator
Elizabeth McCarthy, Epidemiologist

1. Welcome and introductions

Simpson acted as facilitator for this meeting and opened the meeting asking each subcommittee member to introduce themselves.

2. Continued Presentation, Long duration prescriptions to opioid naïve patients

McCarthy shared a presentation that was a continuation from the previous subcommittee meeting. There were outstanding questions regarding the long duration opioid dispensations, the stimulant measure, and an update on the measures that have been revised.

The coprescribing measure was expanded to include non-benzo sedatives and gabapentin. Initially this ended up flagging almost 1,000 prescribers in one quarter. From feedback that we received it was discovered that many of the flagged prescribers had only prescribed a single dose of benzodiazepine to be given pre-procedure for anxiety. Based on this information the subcommittee elected to add a 3 dose threshold and a minimum gabapentin dose to eliminate those prescribers. These changes effectively reduced the number of flagged prescribers to half the previous number.

Regarding the opioid naïve measure, the subcommittee previously requested information about reducing the number of doses to qualify and more information regarding the specialty of the flagged prescribers for this measure. The most common specialties flagged for this measure were surgery, pain medicine, and family practice. Farris commented on the updated guidelines for pain meds following various surgical procedures. Some recommend between zero and thirty pills, total knee zero to fifty. The

subcommittee discussed whether the threshold should be lowered to 30 to qualify as long duration.

McCarthy showed a graphic of what lowering the threshold to 30 pills would do and how it would change by adjusting the number of patients at that level to qualify for a letter. A key takeaway is that lowering to 30 pills and increasing the number of patients to qualify from 10 to 20 would mean the number of prescribers receiving letters would only increase a small amount while keeping the patients at 10 would effectively double the number.

Mahan asked if there was a target for number of prescribers that the subcommittee has tried to reach by letter. Simpson commented that there is not an existing target philosophy, but the subcommittee started off with the intent to have a soft touch and then increase once more was understood. Mahan stated that there was likely no wrong answer between the thresholds presented. Turner agreed and stated that 30 pills to 10+ patients seems reasonable.

After additional discussion the subcommittee agreed that the focus should be on identifying prescriber with large populations of patients receiving potentially risking prescribing rather than prescribers with small populations. In a compromise of options, the subcommittee opted to decrease the threshold to 30 pills and increase the number of patients to qualify to 15.

3. Discussion of potential changes to criteria

McCarthy continued with a second presentation the subcommittee had requested regarding the stimulant measure. The were nearly 900 prescribers who prescribed an opioid, a sedative, and a stimulant to a single patient in a quarter. The most common specialties to do so were family med hospitalist and internal med.

The subcommittee was surprised by the number of prescribers who fit this definition. McCarthy pointed out that in this case the majority only prescribed this combo to a single patient, if a threshold was established with a minimum number of patients, then it would eliminate most from receiving a letter.

Examining the graphic McCarthy provided the subcommittee discussed where to set the threshold and settled on 5 patients in a quarter. This will result in approximately 50 providers receiving letters.

Mahan asked for confirmation that hospice providers would be excluded from receiving these letters. Simpson confirmed that hospice and palliative care providers do not receiving letters. There are times that a provider does not have their specialty accurately captured in the PDMP and do receive letters, when that happens their profile is updated and they are excluded going forward.

The subcommittee hopes to further refine this measure based on any feedback received by Simpson before the next meeting. There may be clinical situations that justify these practices that the subcommittee is not aware of.

The subcommittee also discussed potentially analyzing use of PDMP by providers when prescribing to patients who have received all three categories of drugs, overlapping or

not, in the same quarter. No immediate request to integrate that metric but may be explored in the future.

Mahan added on additional comment regarding the increase in the number of telehealth practices that are supplying just the stimulant. This may be a good reason to look at multiple prescribers prescribing to the same patient. His primary concern remains with a single prescriber doing all three of these.

4. Follow up items from previous meeting

No additional items

5. Public Comment

No public comment

6. Adjournment