Oregon Prescription Drug Monitoring Program Advisory Commission

April 19, 2024 1:00 PM Meeting Minutes

Meeting Contact: Drew Simpson, drew.r.simpson@oha.oregon.gov, 971-352-5569

Advisory Commission Attendees:

Laura Armstrong, OD, MEd, FAAO – Chair, Optometrist, representing the Board of Optometry and Oregon Optometric Physicians Association
Katie Zinno – Public member and patient advocate, living with chronic diseases
John Hinton, DO – Physician, representing Osteopathic Physicians and Surgeons of Oregon
Dan Kennedy – Retired pharmacist, President of Oregon State Pharmacy Association
Maureen McAvoy Jemison – Public member with expertise in information technology
John McIlveen – Behavioral Health Unit, Oregon Health Authority (OHA), State Opioid Treatment Authority for Oregon
Lina Dorfmeister CRNA NSPM-c – Pain and addiction management clinic, Coos Bay, OR
Kaley Bourgeois, ND – Naturopathic physician representing the Oregon Association of Naturopathic Physicians
Tracy Klein - PhD, FNP, Representing Oregon Nurses Association

OHA Staff Attendees:

Laura Chisholm – Section Manager, Injury and Violence Prevention Program, Oregon Health Authority
Kim Waite – Program Manager, Prescription Drug Monitoring Program (PDMP)
Stephanie Vesik– Compliance Officer, overseeing pharmacy compliance and user registration
Tamara Ramirez – PDMP Operations and Coordination Specialist
Bryan Loy – Research Analyst, PDMP Data Stewardship
Ariane Erickson – Research Analyst, overseeing quarterly and annual metrics for PDMP.
Elizabeth McCarthy – Overdose Epidemiologist and PDMP Epidemiologist

1. Introductions

Armstrong called the meeting to order, beginning with introductions of Advisory Commission members and OHA staff. Quorum was met and the official meeting was allowed to begin.

2. Review of Previous Meeting's Minutes

Armstrong requested a motion to approve the previous meeting's minutes. Kennedy moved to approve the minutes. Hinton seconded the motion.
Minutes were approved without objection.

3. Standing Agenda Items

a. Review quarterly metrics
    i. Quarterly Report

Erickson, presented the quarterly report focusing on prescriber enrollment and usage trends. Key points include:

Prescriber Enrollment and Use Trends: Enrollment rates among all prescribers, top 4000, and top 2000 prescribers remain high and stable. The shift away from using web portal to submit queries to queries submitted through electronic health records (EHRs) continues however many users still rely on the web poral.
Data Quality Issues: There is an ongoing investigation with a vendor about the accuracy of certain data, which is marked as a draft until resolved.
Prescription Data: Gabapentin remains the top-prescribed drug, with trends being monitored for amphetamine, methylphenidate, oxycodone, and hydrocodone.
Questions and Clarifications: Following the presentation, there was discussion about whether pregabalin (Lyrica) data is being collected. Pregabalin, a Schedule V controlled substance, is not currently collected in Oregon's PDMP. Gabapentin, while not federally scheduled, is tracked in Oregon due to state legislation.

    ii. Pharmacy Compliance

Vesik presented on pharmacy compliance, specifically regarding issues with expired DEA (Drug Enforcement Administration) numbers being used by pharmacies to fill prescriptions. Vesik has been auditing pharmacy records for compliance issues, particularly focusing on expired DEA numbers being used for prescriptions. This issue arises from outdated information in pharmacy systems.

Vesik has reviewed data from the past three years, covering thousands of prescriptions per pharmacy, with a particular focus on pharmacies with notable compliance problems. The most common issue is expired DEA numbers being selected from dropdown menus or missing DEA numbers, leading to discrepancies between the records available to prescribers and those visible in patient records. Both independent and chain pharmacies exhibit these problems. Independent pharmacies, in particular, often face more challenges with maintaining up-to-date systems, whereas larger chains like Kaiser are more efficient due to their closed systems.

Vesik has been in discussions with software vendors and pharmacies to address these issues, aiming for better system controls to flag expired or missing DEA numbers. This issue does not focus on refills since they are valid under existing prescriptions, but rather on new prescriptions that are incorrectly processed due to outdated DEA information.

b. Research study updates

Loy presented research updates, highlighting the progress of multiple projects with data use agreements (DUAs) and the expectation of future publications. This portion was brief due to there being relatively few changes from the last AC meeting.

c. Subcommittee Activities Update

McCarthy reported on updates from the Prescribing Practice Review Subcommittee. The subcommittee has decided to adjust the prescription threshold for long-duration opioid dispensations to opioid-naive patients. The threshold is being reduced from 42 pills to 31 pills to be considered long duration.

McCarthy also announced a new measure focusing on the risky combination of opioids, benzodiazepines (or alternatives), and stimulants, and the intention to educate prescribers about the potential risks of prescribing these medications together.

Klein raised concerns about labeling such prescribing practices as "risky" without clear clinical justification, expressing worry that it might come across as overreach. Zinno added that complex disease management patients, who sometimes require multiple medications to function, may be unfairly flagged by these measures. She advocated for the creation of a new category for these patients to ensure they aren't penalized for legitimate treatment plans.

McCarthy assured the Advisory Commission that these concerns would be brought to the subcommittee at their next meeting and commented that a provider is only notified by letter if they frequently prescribe this combination. They would need to have at least 15 patients fitting this criterion to qualify.

4. Comagine Health Grant Stimulant Report presentation

Mary Gray from Comagine Health presented the stimulant prescribing report, which is part of a larger project funded through the Bureau of Justice Assistance's Harold Rogers Grant. The focus of this specific report is to analyze stimulant prescribing patterns in the state over a 10-year period, from 2012 to 2022.

Summary of Key Findings

Prescribing Patterns:

- Concentration of Prescribers: 80% of stimulant prescriptions are written by just 15% of providers, a trend that has remained stable over time.
- Provider Distribution: In 2022, 81% of providers prescribed 100 or fewer stimulant prescriptions per year, with 24% writing only one prescription.

Patient Trends:

- Increase in Patients: The number of patients receiving stimulant prescriptions has doubled over a ten-year period, with 35% of them being stimulant naive.
- Stimulant-Naive Patients: There has been a twofold increase in stimulant-naive patients over the same period.

Population Control:

- Population Increase: The state's population increased by about 10%. When controlling for this, there is still a twofold increase in stimulant prescriptions and a 1.8-fold increase in patients receiving prescriptions per 1,000 residents.

Demographic Variations:

- Age Trends: The 30 to 44 age group saw the most significant increase in stimulant prescriptions, while the under-18 group had the lowest increase.
- Sex Differences: Female patients had a greater increase in stimulant prescriptions (1.6 times) compared to males (1.4 times). Intersectional data shows that four out of six female age groups experienced a higher than average increase.

Impact of the Pandemic:

- There was a notable spike in stimulant prescriptions following the pandemic. In 2022, nearly 200,000 patients received prescriptions, compared to an expected 150,000 based on pre-pandemic trends.
- The number of providers also increased post-pandemic, with around 18,000 providers prescribing stimulants.

Geographical Variations:

- The highest increase in stimulant prescriptions was noted in urban areas (972 area code), with a 2.1-fold increase, while the lowest increase was seen in more rural regions.

Drug Type Trends:

- Adderall: Experienced a significant increase (2.2-fold) in prescriptions, with more providers prescribing it as their primary stimulant.
- Ritalin: Showed the least dramatic increase, with a notable drop in the percentage of providers prescribing it as their main stimulant.

Kennedy, raised a question about whether Oregon's rates are unique compared to other states. Gray responds that Oregon's trends are consistent with national trends, noting similarities seen at a recent summit in Atlanta.

Additionally, Dorfmeister asked about prescriber types for these stimulants, but Kendra clarifies that the dataset used did not include prescriber information.

5. Annual Report – 2021

Annual reports, Vesik discussed delays in publishing the 2021 report due to backlog issues within the Oregon State Public Health Publications division. She notes the team's plan to catch up on reports for 2022 and 2023 and resolve the delays. Armstrong emphasized the importance of updating the reports, especially since the website is still showing data from 2018.

6. Old Business

    a. Data sharing with the Tribal Epidemiology Center

Data-sharing issue related to the Tribal Epidemiology Center's request to link data from the Northwest Tribal Registry with Oregon's Prescription Drug Monitoring Program (PDMP). Loy provided a detailed explanation of the challenges they face due to legal restrictions, which prevent the sharing of personally identifiable data between the Oregon PDMP and the Indian Health Board due to privacy rules and state statutes.

Loy discussed how a potential legislative change could enable data linkage without sharing prescription information linked to names. He provided a demonstration of how the process would work using unique identifiers to maintain privacy while still allowing the linkage of drug dispensation data. Loy emphasized that the request is to gather a position on whether the Advisory Commission would support, not support, or take no position on this legislative change allowing for the sharing of identified data for the purpose of linkage.

Klein raised a question about the necessity of the names, expressing that researchers typically don't require names but need other identifying data like birth dates. Loy clarified that in this case, names are crucial because the Indian Health Board cannot share their specific population's data, and someone needs to link prescription information with the relevant population.

There was a discussion about the challenges of accessing tribal health data for research and public health purposes. Klein expressed difficulty in understanding the purpose of needing such specific and sensitive information, like the names of tribal members, while acknowledging the importance of following strict privacy protections.

Loy explained that their inability to provide the requested data stems from legal and privacy restrictions that prevent them from sharing lists of names of tribal members. Loy noted that even though the research might not require specific names, the data required for matching tribal membership and health records is blocked by these privacy measures. Vesik added that the reason for needing such specific data might stem from

trying to analyze health outcomes among tribal populations, but they are restricted from doing so without having access to identifiable tribal membership data.

McIlveen commented that the research likely seeks to analyze health trends or correlations specifically within tribal populations, which is why they would need tribal enrollment data. However, this is protected under privacy rules, complicating the research efforts. McIlveen pointed out that tribal data, especially health information, is heavily protected by entities like the Northwest Portland Area Indian Health Board for valid reasons.

Ultimately, the discussion revolved around the tension between the need for specific health data for research and public health purposes, and the legal protections that prevent sharing such data due to privacy concerns surrounding tribal membership.

McIlveen raised a point about historical injustices that have often targeted tribes and native communities, particularly regarding the collection and analysis of health data. His comment reflected the challenge of addressing these communities' needs without perpetuating mistrust or systemic bias. He also mentions how data patterns might relate to geography or specific healthcare providers, but privacy concerns limit the ability to analyze these patterns effectively.

The advisory commission is cautious about sharing large datasets without clear safeguards, as even anonymized data can potentially expose personal health information. The group is considering whether it’s worth pursuing legislation to allow for the linkage of PDMP data with tribal health data, weighing the benefits of research against the risks of violating privacy protections.

Ultimately, the group is divided but there's a consensus that while increased access to PDMP data could be beneficial for research and public health efforts, careful thought is needed regarding security, compliance, and who has access to the data.

7. New Business

No new business.

8. Open Issues

No open issues

9. Public Comment

No public comment.

10. Next Meeting Date: October 18th, 2024

11. Member Wrap-Up

12. Adjournment by 3:15 PM