Oregon Prescription Drug Monitoring Program Advisory Commission

October 18, 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, MPH – Physician, representing Osteopathic Physicians and Surgeons of Oregon
Maureen McAvoy Jemison – Public member with expertise in information technology
Kaley Bourgeois, ND – Naturopathic physician representing the Oregon Association of Naturopathic Physicians
Tracy Klein - PhD, FNP, Representing Oregon Nurses Association

OHA Staff Attendees:

Kim Waite – Program Manager, Prescription Drug Monitoring Program
Drew Simpson – Program Coordinator, Prescription Drug Monitoring Program
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 began the meeting with introductions. Each participant introduced themselves and their relation to the commission and the work.

2. Review of Previous Meeting's Minutes

After the introductions, Armstrong moved on to the review of the minutes from the previous meeting. Simpson commented that two members had reached out with minor

corrections to the minutes from those sent out prior to the meeting and he had already integrated them into this version.

Hinton made a motion to accept the minutes and Bourgeois seconded the motion.

3. Standing Agenda Items

    a. Review quarterly metrics
        i. Quarterly Report

Erickson presented the quarterly metrics for Q2 of 2024 and reminded the commission that the practice has been changed to present metrics with a longer lag as it gives the analysts more time to conduct analysis and resolve issues that frequently come up. The quarterly metrics are compared to the same quarter of the previous year when percent change is included.

Overall, there are few surprises in the current metrics; the enrollment in the PDMP has plateaued since about 2018 with 87% of all prescribers registered with the program. Of the top prescribers enrollment continues to be much higher, with 99% of the top 2,000 prescribers enrolled. Utilization of the program remains high, with 90% of top prescribers actively using this program during this quarter, either through the web portal or through EHR integration.

There has been a large increase in automated queries which is a strong sign that more entities continue to onboard with integration and build it into their clinical workflow.

There were some interesting trends in prescribing. There was a 3.5% increase in overall controlled substance prescribing this quarter compared to a year before. This number has generally trended down for the last many years. Gabapentin is the most commonly prescribed controlled substance. Amphetamine continues to increase and is now the second most commonly prescribed controlled. This continues the long standing increase in stimulant prescribing.

Erickson included some new changes to this report including charts showing number of facilities integrating the PDMP by quarter. This goes back to 2018 and shows sustained progress. Similarly she included active users charts which show overall increases over time but with more variability.

Klein asked which EHRs are compatible with integration, whether it had to be EPIC or one of the big players. Simpson stated that he had a list of the currently supported EHRs that he could share and that is was a fairly long list. Occasionally there is a new EHR that wants to integrate and for that there is often a fee that bamboo charges the entity for development work.

        ii. Pharmacy Compliance

Vesik presented the quarterly pharmacy and user compliance report. She noted that every June there is a noticeable decrease in the number of delegates because the program conducts a required re-verification of all delegates by master account holders. This means each master account holder must long into the web portal and indicate that the existing delegates assigned to them are still accurate. If they don't then they are automatically removed.

Collaboration with the boards continues to be strong. The medical board routinely works with the PDMP staff to ensure high registration rates and the pharmacy board is in close contact preparing for the Jan 2025 implementation of new drug collections.

b. Research study updates

Loy presented an update on the projects currently using OR PDMP data for research purposes. There are currently seven with DUAs and have received data. They are in the analysis and report writing phase. Two projects are currently under review to be considered for receiving data. One is to explore prescription stimulants and their potential impact on the opioid epidemic. This is NIH funded and will link several datasets. The project has a secondary objective to assess the therapeutic role of stimulants in preventing overdoses in individuals with opioid use disorder.

Loy shared a list of all publications that have used OR PDMP data, 31 total with four coming out in 2024 and selected a paper to share a detailed review with the commission. Titled effective integration of the prescription Drug Monitoring program data in the electronic health record on queries by primary care providers and was published in the Health Informatics Journal. The paper focused on OHSU which integrated in 2019 and like the title implies had the objective of evaluating the effect of integration on clinical use. The authors found that integration of the PDMP was associated with a nearly three fold increase in the number of pdmp queries requested overall. The scale of the effect varied by license type (MD vs NP or PA).

Zinno raised a concern on how to distinguish a patient who is using multiple pharmacies or clinics in good faith, for example because of a pharmacy closure or a drug shortage requiring use of multiple pharmacies. Simpson clarified that the PDMP doesn't flag any patients, ideally if a provider or pharmacists sees a patient with multiple pharmacies then it can lead to a discussion rather than an abstract decision. Pharmacy closures are common in rural areas and are a known issue, especially for complicated patients.

Zinno asked who decides where the line is when a patient is considered risky. Simpson stated that there is no Oregon statute or guidelines setting a standard but the PDMP subcommittee is authorized to review PDMP data and determine when a provider may benefit from additional training. Those providers receive a letter from the subcommittee and the recipients are confidential.

c. Subcommittee Activities Update

To reorient the commission to the subcommittee work, McCarthy reviewed the objective and history of the subcommittee and provided a more in-depth look at each measure.

In 2017, House Bill 3440 created the prescribing Practice Review Subcommittee as a way to provide education to prescribers in Oregon. The subcommittee members targeted four risky prescribing practices to provide education and reduce the amount of risky opioid prescribing. The education comes in the form of physical letters mailed to each selected provider with resources and an appeal from the subcommittee to evaluate their practices.

In 2022, the subcommittee expressed interest in updating some of the risky prescribing measures to better reflect current knowledge and practices. In 2023, two of the four measures were updated with new criteria which significantly altered the number of providers qualifying for letters. In Q1 2024, a fifth measure was added to address the rise in stimulant prescribing.

The five measures included high dose opioid prescribing, overlapping opioid benzo prescribing, initiating opioid naïve patients on opioids with long day supply, prescribing to patients with four or more opioid prescribers, and prescribing a stimulant, a benzo, and an opioid to one patient.

The coprescribing measure was updated to lower the number of coprescribed patients a provider had in a quarter to qualify for a letter from 25 to 15. This approximately doubled the number of providers receiving letters for this measure.

The opioid naïve measure was updated to reduce the number of pills required to be considered long duration and the number of patients. The pills were lowered from 42 to 31 and the number of patients from 25 to 15.

Zinno commented that the CDC guidelines no longer refer to the 90 MME limit and it should not be considered a high prescribing benchmark. McCarthy promised to look into this and share it with the subcommittee.

4. EHR Integration Evaluation Report

Simpson and Loy presented the findings of a recent BJA grant funded evaluation project of the EHR and risky prescribing. Simpson provided some background into the integration initiative including the role that EDIE alert enabled emergency departments played in being early adopters. After that the focus was on large health networks and pharmacy chains. In recent years it has been primarily small practices with 1-5 prescribers coming onboard.

Integration solved two significant barriers to use. Switching from the EHR to a secure web browser, navigating to the PDMP, logging on and looking up the patient could take 4-6 minutes which for busy provider was often prohibitive. Secondly, OHA requires the providers password be changed every 90 days which tacks on additional clicks and time. Integration removed both barriers and provided PDMP data at point of need nearly instantly.

Loy presented the data preparation that went into this evaluation project and the interrupted time series analysis that the contract Comagine Health was able to utilize thanks to the drawn out implementation time of the integration project. This evaluation looked at the same four risky prescribing metrics discussed previously.

Loy explained the format of the analysis charts for each risky prescribing metric that displayed the trend line for that metric prior to integration and post integration. Under each graphic there is a conclusion or takeaway section that points out key finds and interesting differences among subgroups and Simpson briefly reviewed each risky metrics trend.

The impact of integration was mild for most risky metrics. There are a number of explanations for why there was not a large change, most likely there is a floor effect to opioid prescribing, meaning that it is not reasonable to expect prescribing to decrease forever as there is an expected level of appropriate but risky prescribing. It is also difficult to evaluate a single intervention when there are many cooccurring interventions related to opioid prescribing taking place. Zinno commented that many prescribers have decreased their prescribing to limit their liability, not because they think their prescribing is inappropriate.

5. Old Business

    a. Legislative implementation for January 2025

Simpson and Vesik reviewed the items that become operative Jan 2025. This includes the collection of schedule V drugs which was requested by each board and then passed by the Oregon legislature, and collection of veterinarian prescribed drugs.

Simpson explained that Oregon is attempting to make collection of veterinarian prescribed drugs the least disruptive possible for veterinarians by only requiring collection of drugs dispensed through retail pharmacy. Vets will not have to use the PDMP and will not be required to enter drugs dispensed through their practices.

Simpson also relayed that the overdose notification initiative that the commission discussed and supported previously had passed the legislature but when planning for implementation found there was more funding required that anticipated. That initiative is not moving forward unless there is new funding secured as the PDMP is not in a position to fund it.

6. New Business

    a. Military System PDMP Sharing
    b. Veteran Health Admin sharing

Both the military health system data sharing and the VHA (outside Oregon facilities) require legislative changes and are not likely to be heard this next coming session.

Simpson promised to provide more info before the following session when they might be able to make changes.

c. PDMP System RFP

Simpson commented that the PDMP contract ends Jan 2026 and that the program would be going through a full RFP to select a vendor to continue to provide the PDMP system. This will be a significant amount of work but with over a year to complete it should not be an issue and will not be disruptive to the system.

7. Open Issues

Hinton commented that Zinno has raised valuable points about pharmacy desserts especially in rural areas. It is not just small independent pharmacies that have closed but large chains as well. The patient needs in those comm

8. Public Comment

No public comment.

9. Next Meeting Date: January 17th, 2025

10. Member Wrap-Up

The commission thanked Kim for her time with the PDMP as it was her last meeting.

11. Adjournment by 3:15 PM