Oregon Prescription Drug Monitoring Program Advisory Commission

Oct 20, 2023 Meeting Minutes

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1. Introductions

Chair Armstrong began the meeting once it was confirmed that quorum had been reached and led introductions. The commission introduced themselves as called upon and indicated their relationship to this work, followed by OHA staff and other attendees.

Advisory Commission member attendees:
Laura Armstrong (Chair) – the Oregon Optometric Physicians Association
Kaley Bourgeois – Oregon Association of Naturopathic Physicians
Kathleen Hansen – Public Member
Leah Hickson – Oregon Dental association
John Hinton –Osteopathic Physicians and Surgeons of Oregon
Daniel Kennedy – Oregon Pharmacy Coalition
Maureen McAvoy – Public Member, Information Technology Specialist
John McIlveen – State Opioid Treatment Authority

OHA/PDMP staff attendees
Drew Simpson – Program Coordinator
Laura Chisholm – Injury and Violence Prevention Section Manager
Kim Waite – Program Manager
Stephanie Vesik – Program Analyst
Ariane Erickson – Data Analyst
Bryan Loy – Data Analyst
Elizabeth McCarthy – Epidemiology

2. Review of Previous Meeting's Minutes

Armstrong directed the commission to the previous meetings minutes and asked if there was a motion to accept them as written. Kennedy made the motion and Bourgeois seconded the motion.

Minutes will be posted to the public website following the meeting.

3. PDMP Overview and Discussion

Armstrong turned the time over to Simpson to lead the discussion on the operations of the PDMP. Simpson reminded the commission that this portion of the meeting was included to give the opportunity to the PDMP staff to explain aspects of the program that commission members as users do not interact with as commonly and may not be familiar with, as well as provide insight into history and philosophy behind features of the PDMP. Armstrong recommended that we use this time today to explain and examine differences between the Oregon PDMP and PDMPs of other states.

Simpson prepared information on national trends and attributes using national resources to give a picture of PDMPs today, if there are aspects the commission would like reviewed in more detail then he is willing to prepare additional info for future meetings.

PDMPs are mostly operated by health departments, boards of pharmacy, or department of justice. The Oregon PDMP is operated by the Oregon Health Authority and is the only PDMP housed within an injury prevention section. While it is common to operate from within a health department it has the disadvantage of having less regulatory power over the users and data submitters than those operated by Boards of pharmacy. In Oregon we have developed a close working relationship with each of the boards to overcome regulatory gaps to ensure compliance by pharmacies and end users.

The operations and policies of the PDMP are fairly similar regardless of which department houses the PDMP, even those located within the Department of Justice still require a court order or subpoena in order to access PDMP records.

As far as policy positions go, there are a number of best practices that all PDMP are moving toward. Mandatory use is now adopted in almost all states, Oregon is one of the only remaining voluntary states, although many individual healthcare entities have use policies for their practitioners. Use by Medicaid providers is mandatory nationwide.

Prescriber report cards were somewhat controversial just a few years ago and are now implemented in some form in 38 states, including Oregon.

Collection of schedule V drugs takes place in 45 states, Oregon will begin collection January 2025. This is the result of HB 3258 that passed last session. This bill also included the collection of veterinarian controlled substances in the OR PDMP, this was uncommon recently but already 36 states collect veterinarian drugs. Our approach to collecting veterinarian drugs is different from other states, we will only be collecting from retail pharmacies to reduce strain on vets.

Almost all states participate in interstate data sharing. Oregon differs from many states since it has decided to prioritize sharing only with nearby states and denying sharing requests from distant states or states with little seasonal travel to and from Oregon.

The OR PDMP makes its data available to external researchers and makes the process to receive that data more accessible than most states. Loy works consistently with external research to evaluate their research requests and prepare deidentified data for their work. 23 other states allow external researchers to use the data.

Armstrong asked about emerging legislative trends that Oregon was likely to follow in the near future. Simpson stated that Oregon is one of the most privacy focused states and has been more reluctant to expand its PDMP's scope than many other states. Simpson will attempt to find out what new legislation is emerging in other states to share at future meetings.

4. Standing Agenda Items

    a. Review quarterly metrics
        i. Quarterly Report

Erickson presented the quarterly metrics report for quarter 2 2023. Erickson reviewed each trend and statistic with the commission. Largely the metrics have plateaued, enrollment has not changed significantly in the last couple of years for all prescribers (88%), or top prescribers (98%).

Utilization continues to slowly increase as more entities integrate the PDMP into their EHR. Over 81% of prescribers utilized the PDMP in the last quarter.

Erickson reported that there were some decreases in utilization that were likely data artifacts from an incomplete data file from the IT vendor. Erickson and Simpson are working with the vendor to get the file backfilled.

The number of total prescriptions increased slightly over the last year (2.3%). Gabapentin is the most common prescription in the system but oxycodone and hydrocodone both increased their total counts. Other notable changes include the continued increase in stimulants which has been ongoing for the last 5+ years, and the increase in testosterone prescribing.

This report will be posted online following the meeting to reference.

Bourgeois asked for clarification in what constitutes an automated query vs a manual query. Simpson explained that many facilities have their EHR set up to query the PDMP before the provider requests to view the PDMP report. This allows the report to be available almost immediately. Sometimes the provider never requests to view the PDMP report, so while the system was queried it did not result in utilization of the PDMP. We distinguish these queries by queries that result in use manual queries.

Simpson added that there continue to be new entities onboarded each month and the number of prescribers with access to integration continue to go up.

        ii. User and Pharmacy Compliance

Vesik reported on the recent activities that she has undertaken to ensure registration compliance among board licensees. At least twice a year there is a push to increase registration and collaborate with licensing boards by providing identified lists of those enrolled in the PDMP. There is significant turnover among licensees, and registration has plateaued at 88%. There is much more interest in ensuring high prescribers (top 4K) are registered, among that group 98% are compliant.

Vesik reported that she recently conducted a crossed checking review between pharmacy DEA being used and what should have been used. There is an issue with expired DEA's populating in drop down menus that continue to be selected. From the investigation Vesik identified two pharmacies that need to be contacted to change this practice but a total of 3% of Pharmacy DEAs contained errors.

Kennedy asked if there was a significant difference in error rate or compliance between big chain pharmacies and small independent pharmacies. Vesik commented that the rate wasn't very different since both have rare problems but large chains do have more resources to become compliant.

Armstrong expressed surprise at the percent of bad DEAs being used.

b. Research study updates

Loy shared an update on open research projects utilizing PDMP data, as of this time there are eight research projects with open DUAs utilizing OR PDMP data. There is one new project out of OHSU which essentially is a comparison of a couple different procedures for abdominal pain related to pancreatic cancer.

For publications, there are 22 publications using PDMP data and 9 publications that are essentially about the PDMP directly. Interest in using PDMP data for research appears to be increasing with five papers in 2021 and five more in 2022.

Hansen asked if there had been any research related to the drivers behind the increase in stimulant prescribing. Loy commented that the OHA is currently using grant funds to investigate the increase in stimulant prescribing and will have a full report to release in 2024. There will also be a new stimulant specific data dashboard available for public use.

Kennedy asked whether there would be interest in including a discussion of MAT in the spring pharmacy meeting and reviewing the trend in prescribing post-relaxation of some DEA restrictions. McIlveen commented that the trend would be interesting, but he expects it will not be a large change from before the restrictions were lifted as there are other barriers to prescribing MAT. McCarthy also clarified that the PDMP does not distinguish between drugs prescribed for MAT and the same drugs prescribed for pain, so PDMP data can be misleading. Kennedy recommended that the pharmacy spring meeting, which is attended by approximately 300 pharmacists, be used to discussion some of the perceived barriers to MAT prescribing.

Hansen highlighted that OHP does not cover MAT medications outside of opioid use disorder. There are many challenges for patients to access appropriate treatment and Hansen has experienced firsthand.

c. Subcommittee Activities Update

McCarthy presented the changes to the coprescribing opioid and benzodiazepine medications measure. The previous criteria required a prescriber to have 25 or more patients with coprescriptions to qualify to receive a letter. The subcommittee has reduced the number to 15 and included non-benzo sedatives in the calculations. This change has significantly increased the number of providers who qualify for risky prescribing letters.

The subcommittee is also considering altering the criteria for the opioid naïve category and adding a stimulant measure. Those are open discussions and have not been formally decided yet.

Simpson commented that there had a been more push back than usual following the last batch of letters due to a large number of prescribers receiving a letter for coprescribing a single dose of benzodiazepine pre-procedure and an opioid script for recovery. It is likely that the subcommittee did not intend to single out this group and we will be discussing it with the subcommittee at the next meeting to add a dose minimum.

Hansen provided insight into some of the unintended consequences of these risky prescribing letters. Namely that doctors who are treating complicated patients, of which there are already too few, are feeling discouraged or unable to prescribe to complicated patients due to the pressure these letter place on them.

Simpson commented that the subcommittee is concerned about unintended consequences and tries to make it clear from language in the letter that it does not apply to hospice or palliative care and those specialties are excluded from receiving letters in the first place but some do slip through that are not captured accurately in the PDMP. Simpson recognized that this is not a complete answer to Hansen's concern and that the subcommittee should continue to weigh this aspect of their work. Simpson invited Hansen to attend the next subcommittee meeting as a patient advocate.

5. CMS Certification

Simpson provided a brief update on the CMS certification work. The OHA has submitted an OAPD which has been reviewed and approved by CMS. This will allow PDMP to pay a portion of their costs through CMS federal funds. The cost allocation is significantly lower than was anticipated (35%), which means despite receiving these funds the PDMP budget remains unsustainable long term.

With the approved OAPD the PDMP can now move forward with the full certification which will marginally increase the amount of funds.

6. Prescriber Report Focus Group Findings

Simpson presented the evaluation of the peer comparison reports focus group findings. This is part of a larger evaluation that is taking place of both the peer comparison reports and the EHR integration projects. Simpson displayed an example of the peer comparison reports and reviewed the metrics included, the metrics focus on the same four risky prescribing practices typically used by the PDMP, high dose, long day supply to opioid naïve, multiple prescribers, and coprescribing opioids and benzodiazepines.

374 responded to the survey and of those 19 participated in a more in-depth focus group discussion. Focus groups are more helpful when attempting to understand complex issues that cannot be completely captured by survey responses. All of the focus group participants were below the mean for their specialty which is unfortunate since these reports are most useful to outlier prescribers.

Simpson commented that we have heard from some providers that this report is comforting since it confirms that they are prescribing inline with their specialty which can be difficult to assess elsewhere.

There were several respondents that indicated that they found the report to be confusing or lacked useful details. The PDMP is considering transitioning to a bamboo health provided tool that includes significantly more details and has been successful in other states. That will be decided when this evaluation is complete.

Overall this focus group echoed what we had heard previously, there is some use for the report but many providers do not find it useful.

7. Old Business

Erickson used this time to address a question that the Advisory Commission asked at the last meeting. The commission had asked if dental practices were commonly integrated into the PDMP, Erickson shared a list of integrated dental practices. Many large dental groups are integrated and many small practices, there are still many unintegrated small dental practices.

8. New Business

Simpson reminded the commission that the next legislative session will begin in January 2024 and that the opinion of the Commission will be useful for topics related to the PDMP. Simpson shared that there is one likely bill that will impact the PDMP, as of now there is no official language to review but he would like the commission to be aware and to discuss what we do know now. The bill will allow PDMP data to be used to identify providers who have prescribed to a patient who later went on to have a fatal or non-fatal overdose. This information can be used to notify the prescriber of the overdose event that often they never become aware of. The rationale for this bill is that prescribers may alter their prescribing practice if they are made aware of overdoses that occur in their patients.

Simpson reminded the commission that the OHA does not have a position for or against bills but focuses on the feasibility and costs associated. This bill is feasibly but the cost is largely unknown currently.

The commission did not take an official position at this time and will discuss this in more detail once a bill with official language is available. McIlveen commented that since the epidemic has changed so much in even the last few years to manufactured fentanyl that this may not have the intended impact. Armstrong commented that she could see these letters fueling the already prevalent burnout among prescribers.

9. Open Issues

No open issues discussed.

10. Public Comment

Gordana Nichols provided a public comment for the record. She commented that Bamboo Health data specifically NarxCare has been detrimental to patients especially those in rural areas. It often flagged patients as overdose or diversion risk inappropriately and led to difficulties accessing care. She commented on the veterinarian drugs that are going to be collected in the PDMP and recommended a flag be included to show which are administered in house and which are from a pharmacy. She also reminded the PDMP staff that there will be a new public member added to the Advisory Commission.

11. Next Meeting Date: April 19th, 2024

12. Member Wrap-Up

13. Adjournment by 3:15 PM