Oregon Prescription Drug Monitoring Program Clinical Review Subcommittee
April 05, 2018 Meeting Minutes
3:00 PM to 5:00 PM
Portland State Office Building
800 NE Oregon Street, **Room 1130**
Portland, OR 97232

ATTENDEES:

Subcommittee members Present: Jim Shames, Kathi Norman, Curt Hawkinson, Helen Turner, Tracy Muday, Noel Peterson
Advisory Commission Absent: Amit Shah, Joe Thaler, Safina Koreishi

OHA Staff: Katrina Hedberg, Drew Simpson, Josh Van Otterloo, Peter Geissert

Subcommittee Meeting Facilitator: Katrina Hedberg

Decisions
1. Criteria to determine which prescribers will receive letters following this meeting. 2. Next meeting to be held in June. 3. PDMP staff to research specialty within PDMP.

1. Member Introductions

Each subcommittee member introduced themselves.

2. Review of statute creating and directing the subcommittee

Simpson briefly discussed the intent of the legislation that created the subcommittee and invited comment or question from any subcommittee member. Simpson highlighted that the subcommittee is to identify providers that could benefit from training and education and that there is no punitive action intended against anyone selected.

Turner asked for clarification as to the age of the subcommittee and Hedberg explained that this is only the second meeting and this is the first meeting where decisions will be considered on who letters should be sent to.

3. Review and discuss draft of subcommittee charter

Hedberg raised the question of whether the subcommittee should have a chair. The role of the chair would be to help the PDMP staff prepare and run subcommittee meetings and would potentially act as the signatory on letters sent to prescribers however that is up for discussion by the subcommittee.

Hawkinson expressed that a letter will carry more weight if it comes from the subcommittee rather than the chair or anyone one person. Subcommittee members agreed.

Subcommittee voted to not have a chair but to have Hedberg act as the meeting facilitator.

Simpson reviewed changes to the charter since the first meeting. Including: broadening language to include all pain not just chronic, and adding two new members to the charter.

No other comments or concerns were discussed. Simpson will update the charter with the facilitator role and the subcommittee decision to send letters from the subcommittee rather than from OHA or from the subcommittee chair.

4. Review and discuss PDMP data

Van Otterloo presented 2017 data that was prepared according to the statute's requirements and the requests of the subcommittee from the previous meeting. He reminded the subcommittee that there are approximately 17,000 prescribers that are represented in the data therefore each 1% of prescribers represents 170 prescribers.

Van Otterloo presented the high dose prescribing measure and showed that the majority of prescribers do not frequently prescribe high dose opioids but there is a small number of prescribers that prescribe very high doses to a large number of patients.

Norman pointed out that many of those prescribers are likely oncologists or pain specialists; Hedberg explained that that is correct but that the PDMP does not have specialty of practice listed as one of its collected variable therefore it is impossible to know for sure. Hedberg says that the letter sent out to prescribers should include the disclaimer indicating the limitation of the PDMP in this regard.

Turner asked if there are any plans to expand what is collected in the PDMP. Hedberg commented that OHA does not propose legislation but there is an opioid taskforce that can recommend those type of changes. Van Otterloo explained the difficulty in adding specialty from the pharmacy side since it's not commonly added there, but that specialty is known for those that are registered with the PDMP. Currently about 50% of prescribers are registered but now that registration is required by legislation that information will be available to use in the future.

Hawkinson asked for Van Otterloo to explain the methodology for methadone included in these measures. Van Otterloo explained he used the 3:1 rather that the stair steps conversion for methadone and added that all buprenorphine containing drugs have been removed.

Co-prescribing measure was reviewed. If a prescriber gave both an opioid and a benzo to the same patient in the same month then they were included in this measure. About half of prescribers did not do this ever in 2017. There is a less extreme skew with this

measure. The subcommittee noted that there are specialties that co-prescribe intentionally.

Overlap between high dose prescribing and Co-prescribing. Those that were identified as a high dose prescriber in the first measure and as a prescriber who frequently co-prescriber. There were 103 prescriber that fit both measures.

Hedberg recommended that the subcommittee review all the data Van Otterloo prepared before they asked questions.

Opioid Initiation: A patient that did not have an opioid in 2016 but did in 2017 then the prescriber that wrote the first opioid in 2017 was counted. Van Otterloo explained that rather than looking at any opioid initiation the subcommittee had requested that he prepare opioid initiation at different levels and in different durations. High dose and high number of pills. This helps remove appropriate initiation for acute pain prescribing.

Doctor Shopping metric: Defined as a prescriber who sees a patient who has seen 4 or more prescribers in the last 6 months. This metric captures a large number of prescribers.

Hedberg asked the subcommittee for thoughts in considering who should receive the letter and what the letter should contain. Hedberg also commented that the last two measures are more interesting to her but wants the subcommittees opinion since it is ultimately their choice. Muday asked if it would be possible that the board would provide specialty for those identified. Hedberg commented that it wouldn't be allowed but that that would be a good topic for the governor's taskforce. Muday would like this option considered to help eliminate sending the letters to the wrong prescribers.

Hedberg asked if certain specialties should get exempt from receiving letters. Norman commented that in her opinion certain should be excluded. Turner commented that she did not think certain specialties should be excluded. Simpson commented that in the future once specialty is known the program could possibly send different types of letters depending on specialty.

Subcommittee directed PDMP to bring information to next meeting regarding the breakdown of specialties within the PDMP.

Hawkinson recommended cross referencing the doctor shopping prescribers with high dose prescribers. Van Otterloo will prepare for next meeting.

Muday recommended including recommendation of best practices in the letter and will send email of her thought to the entire group after meeting.

Shames commented that this first group to receive the letter will likely give feedback on how to adjust the approach. Recommends sending to a smaller group for the first round and then expanding once the situation is better understood.

Committee then reviewed each measure again to determine which threshold should receive letter.

Doctor shopping: Send letter to prescribers who had 50+ patients who saw at least 4+ prescribers in the last 6 months. Approx. 160 prescribers.

Opioid Initiation: Hedberg expressed concern that depending on how the group was selected using this measure a group of surgical prescribers might be the one getting the letter despite appropriate prescribing. Many surgeries give 6 week prescriptions for opioids for more invasive surgeries.

Van Otterloo will explore specialty within this group before next meeting.

Hawkinson questioned how the PA or NP will be impacted if they are the ones writing the discharge prescriptions. PDMP staff will explore PA/NP breakdown among those selected.

Muday stated that the aim should not be to only reach out to the tip of the tail of risky prescribers and prefers targeting the prescribers who frequently initiate with over 42 pills.

5. Record and review action items

Who will receive letter after this session:
Co-prescribing: Prescribers who co-prescribed opioid and benzo medication to 50+ patients in 2017.
Opioid Initiation: Prescribers with over 80 patients in the last year that they initiated with greater than 42 pills or initiating more than 28 long acting pills.
Doctor Shopping: Prescribers who had 50+ patients who saw at least 4+ prescribers in the last 6 months. Approx. 160 prescribers.

Muday recommends that a link to a survey be included with the letter in order to collect feedback from recipients. Subcommittee agrees.

OHA will prepare letters in accordance with subcommittee recommendations and send by end of April. Letter should be marked personal/confidential. Letter should be explicit that this is not punitive.

6. Adjournment

Van Otterloo asked subcommittee if they would prefer a shorter time frame to examine. This data set was for all of 2017 but Van Otterloo could do it by quarter and use a more recent quarter. Subcommittee would prefer that where possible.

Subcommittee recommends meeting again in June to review outcome of the last letter being sent and review the questions the Van Otterloo will be researching.

Appendix: Muday Email

Tracy Muday supplied her comments via email since it was sometimes difficult to interject comments over the phones. This email was sent to the subcommittee following the meeting:

I don't think that our goal is to reduce prescribing for chronic non-cancer pain, I think our goal is to reduce harms of opioids, recognizing that there are some circumstances where opioids are appropriate, and recognizing that there are some circumstances where risky prescribing may be clinically acceptable. I do think we need to focus also on opioid initiation and the number of pills in circulation.

I think that the intervention for oncologists is different for the ER docs, but there should be interventions appropriate for each. It would be very helpful to be able to compare within a specialty—e.g. "You are in the top 1% of oncologists for the number of prescriptions over 120 MED."

Sending a letter to the prescribers with multiple patients with 4 or more prescribers is reasonable. I would like to recommend that for this group, the intervention should be training on how to use the PDMP in your daily workflow, and what to do when a patient is identified that has multiple prescribers. I think we should ask for responses from the providers to help us guide our work.

Opioid initiation: I think that this is an important group to intervene with. Oregon has led the nation in non-medical use of opioids, and those pills come primarily from friends/family and unused pills. I think that targeting the 0.4% prescribing >42 pills for more than 100 patients or more than 80 patients is appropriate. In our CCO data, we have found a surprising number of fills over 90 MED acutely from surgeons (orthopedic and sometimes general surgery) writing Percocet 10 1-2 tabs q 4-6 hours. I think that as we gain some insight, we may want to cast a wider net.

I think that the letter should include a request to engage in a conversation. I think we could obtain a lot of information about the population of prescribers who we are reaching. Can we provide a survey monkey link that they could give us some feedback? We should specifically say "We need your help to make this information as helpful/meaningful as possible." Some information about practice, what would be additional information that the prescriber might want as a result of receiving this information, etc. We should think about what we'd like to know about the prescribers.

We should make sure that our language is around safety and does not insinuate that these are "bad" docs. The example of the child with seizures on benzos also receiving an opioid is a good example. This IS risky prescribing. It may be appropriate in this circumstance, the prescriber and family may have weighed risks and benefits, this may be an outstanding and caring professional, but it is still risky prescribing.

I would recommend snail mail marked personal and confidential. I would also recommend that we ask for a response via survey monkey (or some other mechanism that is simple) and we can compare how many responses we get with how many unique prescribers we sent letters to.