New Hampshire Opioid Prescribing Advisory Council (OPAC) Monthly Meeting Minutes

Meeting Date:

January 6, 2020, 9–11 AM

Action Items:

Description	Owner	Status	Target Due Date	Status/ Resolution
Final MITRE report to Council	Chris Teixeira	Open	1/10/20	In process. Chris will send final version to Dave by 1/10/20.
OPAC Report to Governor	Council	Open	TBD	In process. Dave will send revised draft to Council by 1/10/20.

Key Decisions:

Decision to be made	Assigned to	Due date	Final Decision	Date of Decision	Who finally made the decision
Next steps to complete OPAC report	Council	1/6/20	Council members to accept recommendations discussed; Dave to draft report	1/6/20	Council; Jim moved and David seconded. The motion passed unanimously.

Agenda

- Welcome and call to order
- Status update of MITRE report
- OPAC Report to the Governor
- Closing remarks and adjourn

Call to Order

Dave Mara called the meeting to order at 9:07 AM and asked for a roll call of phone attendees; no OPAC members attended by phone. He asked Council members to review the two sets of minutes from November and asked if there were corrections or comments. David Strang noted that he was incorrectly marked as attending the November 26 meeting. Michael Auerbach moved and Bill Goodman seconded to accept the minutes as amended.

MITRE Report to New Hampshire

Dave asked Chris Teixeira about the status of MITRE's report. Chris noted that suggestions from the last meeting were incorporated, and a limitations section was added based on the last round of comments. The report is in final review now. Chris expects it to be completed this week and he will send the final digital copy to Dave to post on the OPAC website.

OPAC Report to Governor

Dave noted that the Governor definitely wants the OPAC to continue. He said that MITRE's recommendations were added to the draft OPAC report, and he distributed for discussion a page of additional recommendations received from OPAC members. General discussion items on the handout included:

- Explain in the report why the Council changed its name. There was also discussion about evolving the name further to reflect drugs beyond opioids, although moving beyond the Council's mandate would require discussion with the Governor.
- Acknowledge issues related to patients with chronic pain and the need for higher doses for these patients.

Related to Code of Federal Regulations Title 42 (42 CFR) language taken from a federal roundtable discussion Dave participated in:

- Integrating all types of healthcare information into HIPAA would be a positive move, with everything consistent under one umbrella.
- The focus needs to go beyond abuse to addictions/SUD. The 42 CFR language is stigmatizing these issues in a way that OPAC doesn't want to.

Dave suggested for the paragraph related to data use agreements that the OPAC report recommend support for Senator Giuda's proposed data sharing legislation (LSR 2975). There was general agreement among Council members, and Dave will include language in the report indicating this support.

Related to unique patient identifiers:

- Need to stress that the patient ID would be unidentifiable.
- Some providers like dentists aren't integrated into health data. Legislation that promotes identifying areas that are not integrated and finding a way to connect them would help. Would prescribing data be included?
- While a unique ID makes sense, it might be hard to get to in NH. There is no national-level ID, although it's been discussed for some time, due to fears of being able to link back to specific information. There is already controversy around sharing non-identified data.
- Some states have health information exchanges, but not necessarily a unique ID number. Some states have such information in their PDMPs, and there are models in other states where only emergency departments share data. NH has a voluntary exchange with some hospitals only.

- Although there are many potential complications, it's a lofty goal and worth exploring further. OPAC could recommend starting a state-wide discussion on creating such an ID. It could be initially restricted to state-controlled databases only.

Related to including overdoses in the PDMP:

- EMS data is brought in thru 911 calls, but there are information silos. Data is collected by DHHS for ED visits and shows ODs, even direct ones (i.e., not coming in through 911).
- Having a registry of ODs would be a huge policy change in NH because it would skip the patient release step, and there would likely be a huge amount of opposition.
- There should be a way to promote sharing when consent is given – even if consent is given now, there's no way to share the data.
- Each group in NH has its own way of classifying patient identifiers, and there is a need to promote an approach to break down silos that prohibit data sharing and ensure all groups are talking about the same patient across systems.
- There has been discussion about adding a comments section in PDMP – e.g., if a patient lies to a provider to get a prescription.
- It would be worthwhile to look at what other states are doing, since providers want to make decisions with as much information as possible, without overthrowing privacy concerns.

There was also discussion related to the need for more information in general on overdose deaths:

- Dave distributed a drug death data sheet and noted that the state-wide effort comes under the death review board. The review board would like to be able to access any data that is state-controlled to help determine such things as what led up to the OD, was the person ever treated with opioids and why, did the person touch the criminal justice system, were they homeless, etc.
- Michelle noted it's also important to look at overdoses that did not result in death and at OUD.
- Dr. Barth's comments for the report discuss a program at Dartmouth-Hitchcock that is trying to answer such questions to determine if the hospital's quality improvement system related to opioids is working, but they need more data.
- Bob Quinn noted that the Intelligence and Analysis Center exists by statute to disseminate information. The Drug Monitoring Initiative (DMI) has both classified and unclassified information. The DMI is sharing as much as they can collect, but could more information be added to it and thus shared?
- Some of the decrease in overdose deaths is likely due to the more widespread availability and use of naloxone, but there are growing issues related to methamphetamines, and there are still large amounts of fentanyl on the street.

Related to linking data sets:

- It would be useful to contract with an outside entity, i.e., an experienced third party, to evaluate data sharing in the state and report on what is preventing NH from getting all the data into one place and using it as a state health model.
- Andrew Chalsma explained that DHHS has several data sets flowing into the same data repository. They are linked together for analytics and then can be queried to generate data for a dashboard. He said the platform could take in other data sets.
- There is a need to look at the whole landscape in NH to focus on both analytic and operational needs and develop a roadmap/blueprint to show where NH should be.
- Legislation should give explicit permission to allow certain kinds of data sharing and make clear what linkages are OK in NH – e.g., what can you use to link, and for what purposes? For analytics, for example, people can be linked probabilistically to show trends without being identified.
- NH agencies are afraid to share data, even within agencies, because they don't know what's allowed. Broad language is harder for legislators to deal with/approve – but very narrow language and examples might be more likely to be approved.

Related to routine information sharing between medical entities and law enforcement:

- Isn't the PDMP doing this now with prescriber report cards?
- Prescribers and law enforcement should be meeting to see what's on the street vs. what's in hospitals, so everyone can understand trends and to alert prescribers to what's being seen on the street and by pharmacies.
- There needs to be a common agency/dissemination point to ensure the same type of data is being shared.
- Maybe the concept needs more structure than just a meeting – e.g., an agenda, goals, and statewide approach. For example, Manchester has such a group now that discusses all sorts of issues. It would also help law enforcement to build trust and provide education.
- Maybe OPAC could formulate a suggested plan to implement this kind of idea – how often, who the players should be (EMS, dentists, fire, police, regional vs. statewide) etc. to make it more specific.

There was general discussion about OPAC's role going forward, and issues related to staffing and budgets.

- A big part of OPAC's mission is determining how to use the MITRE framework – where to house it, how to integrate it with the DHHS data dashboard. If the framework went to DHHS, identifiable data would need to go there too. There is a need for all state-run data to go to one source. DHHS doesn't have cash payments or commercial claims, which are in PDMP, but it does have a program integrity unit.
- Look at OPAC's mission again. Are there overlaps with other groups – e.g., the Governor's commission on alcohol and other drugs. Where are the gaps, what needs to be done that isn't being done today? Make sure what isn't being captured is living at/being considered by OPAC.

- Determine how OPAC interrelates with other groups, and what reporting is needed back and forth between groups. SMEs from other state groups, e.g., the treatment and opioid task forces, can be invited to OPAC meetings.
- If data sharing is going to work, there needs to be staff able to do it. For example, the program integrity group has only one person, but data needs to be reviewed before doing education, referring to a board, etc. to be sure the reasons are warranted. Boards aren't staffed well either and would be overwhelmed with more cases to investigate.
- Sean Gill noted that the first sentencing of a provider investigated by the Program Integrity Unit recently occurred, related to overbilling home health care costs, but no providers/physicians have been prosecuted or convicted.
- OPAC has learned that NH does not have enough resources – for education, board reviews, fraud review, etc. Resources are needed to operationalize the framework, decide where the data goes, who manages it, etc.
- Dave would like to make a specific recommendation in the report regarding staffing. It may be that a new agency/structure needs to be formed, e.g., two - three people in a specialized unit.
- Dave will add to the report that resources are a concern and that OPAC will review this further over the next year.

Next Steps

Dave asked for a motion to accept the recommendations discussed at today's meeting and draft the report. Jim moved and David seconded; the motion passed unanimously. Dave will incorporate comments from today's meeting, and any other comments members send him, into the draft report. He will then send the draft to Council members by the end of the week for review.

Adjournment

Dave called for a motion to adjourn; David moved, and Bill seconded; the motion passed unanimously. The meeting adjourned at 11:00 AM.

Next Meeting Date, Time, and Location:

Dave asked if Mondays are still good for Council members moving forward, and there was general agreement that they are. He also suggested asking Kim Fallon in to discuss the drug death data information.

The next regular meeting was scheduled for February 10, 9-11 AM.

Council Members:

In Attendance	Name	Email
☒	David Mara, Esq NH Governor's Advisor on Addiction and Behavioral Health	David.Mara@nh.gov
☒	Michael P. Auerbach NH Dental Society	mauerbach@nhds.org
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In Attendance	Name	Email
	NH Medical Society	
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Persons appearing before the Council:

☒	Chris Teixeira, MITRE	cteixeira@mitre.org