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

Meeting Date:

September 9, 2019, 9–11 AM

Action Items:

#	Description	Owner	Status	Target Due Date	Status/ Resolution
1	Upload PowerPoint slides from meetings to PCF site for member access	Chris Teixeira	Open	ASAP	In process
2	Resend link and instructions for accessing and using the PCF	Chris Teixeira	Open	Closed	In process
3	Send MITRE OPAC report to Dave for sharing with Council	Chris Teixeira	Open	9/30/19	In process
4	OPAC Report to Governor	Council	Open	11/30/19	In process

Key Decisions:

Decision to be made	Assigned to	Due date	Final Decision	Date of Decision	Who finally made the decision
Approval of August meeting minutes	Council	9/9/19	Minutes Approved	9/9/19	Council: 9:07 AM Motion to accept minutes (David), second by (Michelle). Motion passed by acclamation.

Agenda:

- Welcome and call to order
- Vote to approve minutes from August 2019 meeting
- Review of action items
- Presentation/discussion: Pattern of Life
- Presentation/discussion: Characterization of Key States of Opioid Use
- Next steps
- Closing remarks and adjourn

Call to Order

Dave Mara called the meeting to order at 9:06 AM. Roll call attendance was taken. Alex Casale attended by phone.

Administrative Details and Logistics

Dave asked Council members to review the minutes of the August meeting. With no comments or questions raised during the review, Dave asked for a motion to approve the minutes; at 9:07 AM, David Strang moved and Michelle Ricco-Jonas seconded. All in attendance voted aye. David asked for clarification about whether the approval of the minutes was for both the open and closed August sessions. J.D. Lavallee indicated that because the closed session minutes were not sealed at the end of the meeting and were thus public, the approval applied to both sets of minutes.

Review Action Items

OPAC November report

Dave noted that MITRE's report will be given to OPAC for review and comments before it is sent to the governor. Chris said the report would comprise a summary of the work MITRE performed; an overview of the analytics, dashboard, and topics discussed at OPAC and PITF meetings; and MITRE's recommendations for next steps. Kathy asked whether OPAC is required to deliver a report and what the process for that would be. Dave felt that OPAC's report, in conjunction with MITRE's report, should make recommendations re: policy and legislative changes based on the data sets to encourage data sharing and interchange. OPAC's report will be NH's take, while MITRE's report is focused more on its contract with CMS. Sean asked about the timeline for the report, and J.D. read from the governor's executive order, which states that OPAC's report is due November 30.

OPC Status

Dave noted that he has talked with the governor, who wants OPAC to continue as a group. Dave said that NH is pursuing a year-long extension with MITRE to transition the PCF to NH, connect various data sets, and develop expertise to be able to use the data for other things, not just prescription drugs (e.g., treatment, public health, helping identify state policies, etc.).

Michelle asked how MITRE's database is different from the CDC/HHS database, and how much redundancy there is. Dave noted that the all claims/all payer data MITRE used is accessible to other NH agencies, but that MITRE has brought out different things with the data so there may not be a lot of redundancy. The group talked about where to house MITRE's data and how to determine where it fits, which Dave said can be discussed during the transition. Bob Quinn noted that discussion has begun in the state about a new data warehouse for all the data coming in; several members noted issues related to infrastructure, privacy, and the need for better policies on data sharing.

There was also discussion about changing OPAC's name/mission/bylaws, which would require the governor to change the executive order. Dave announced that he will be taking on a new task as Assistant Attorney General to the Hillsborough Attorney's office; he will remain an OPAC member but will be stepping away from the chairperson role.

Presentation/discussion: Pattern of Life Analysis

At 9:30, Chris presented MITRE's pattern of life analysis, which he described as a more holistic view into prescribing behavior patterns to identify overdoses or addictions that may have resulted. He noted the data MITRE used was restricted to what was in the all claims/all payer

database, and excluded cancer/hospice patients. MITRE developed two separate models for OUD vs. OD, although Chris acknowledged there are overlaps between the two groups. MITRE looked back three years from an "event" for information: when the first opioid prescription was written, the average MMEs/day, whether the patient saw multiple doctors or visited multiple pharmacies, dose increases, classes of drugs, and other prescriptions or diagnoses. The goal was to determine what the indicators of an adverse event might be as a way to forecast such events and to provide educational resources for prescribers to help better understand and identify risk factors in patients.

He also noted there was no way for MITRE to identify adverse events that ended in death, which led to a discussion of the importance of knowing about deaths, that the PDMP has death data but it can't be released, that medical examiners feel names of the deceased are not public record, and the status/activity of various NH mortality review committees.

Chris said that MITRE's model predicted three out of four cases correctly, which might not be as useful as desired at the individual patient level, but is useful for determining overall risk factors. The model would need more refinement and validation for doctors to be able to use these risk factors with individual patients. MITRE then wanted to determine what factors drove OD/OUD events the most. For OUD, key factors were the number of prescriptions written, the average days' supply, and increased opioids use over time. Age did not seem to be a factor initially, but several members and MITRE noted it would be an interesting side study to conduct a deeper dive into the data re: age. For OD, key factors were the presence of other addictions (especially nicotine vs. alcohol/other drugs), a previous mental health diagnosis, years between the first and last opioid prescription, the number of prescribers, etc.

Discussion areas included:

- How to determine what caused deaths (e.g., fentanyl used as a street drug), and how to use the data pre-emptively to prevent patients from getting to the illegal drugs/OD stage.
- Better data sharing is needed to help determine causes of death and share specific risk factors with prescribers so they understand what drives OD/OUD, e.g., combining PDMP and HHS data, analyzing it, then de-identifying it.
- There is a need to access data on what/where illegal drugs come into NH, and a need for a public safety (police) database to help determine what crimes are related to drug-related behaviors.
- There is a need to look at overall substance use statewide (e.g., methamphetamines, fentanyl, bath salts, etc.) with a goal of using such data to arm the state so it can be in front of issues rather than chasing them (e.g., a statewide heat map, targeting resources and treatment to the right locations, etc.).
- Creating a statewide information-sharing group (i.e., data czar) for all data sets, not just drug information, would be helpful as a statewide resource.
- It would be helpful to look at ways other states have found to bring data together (e.g., Massachusetts and South Carolina have brought data together for public health uses, and NYC has a pretty good model) to produce reports more quickly and thus be able to spend more time analyzing data.

- Jim Potter noted that the current opioids crisis began as a reaction to underprescribing for pain, which led to over prescribing. He feels the issue is at a tipping point re: policy overlays and that the Council needs to beware of another underprescribing trough.
- Fear/stigma related to OUD and addictions still drives policymaking – these conditions need to be treated as medical conditions, and pain needs to be treated appropriately so as not to lead to OUD/OD.
- Helen noted that prescribed suboxone has become a commodity because it is being overprescribed. Michael noted that pharmacies are ordering buprenorphine in vast quantities because it is being prescribed at such high rates, ostensibly for treating OUD, but it is becoming an epidemic in itself.

Presentation/discussion: Characterization of Key States of Opioid Use and Report on Prescribing Patterns

At 10:22, Chris presented MITRE's analysis of key states of opioid use and prescribing patterns, which determined how patients move through different phases of opioids use in order to help define a person as being addicted to opioids. The analysis did not exclude any patients; it focused on claims data from 2016-2018, with lookback to 2015. The analysis looked at types of transition events – e.g., NDC prescription code, OUD diagnosis, OD, transition (recovery) – to determine how long it takes for a person to be considered non opioid-naïve, how many get OUD, how many have an OD, how many get MAT – and different combinations of these. Chris noted that one can argue the validity of different aspects of the assumptions, and that there are issues related to illegal prescriptions, those paid for with cash, MAT, etc., that can't be ignored.

The results showed that persons who transition between non-naïve and naïve states don't all follow the same path. 72% of patients stayed naïve, but 63% of addicted people stayed addicted. Patients with higher median MMEs were more likely to move into addiction vs. back to non-naïve. The length of time an opioid was prescribed was also a predictor for addiction.

Discussion topics included

- Recovery takes a lot of time, and applies to only a small percentage.
- Patients in recovery are sometimes still prescribed opioids. These patients need to be able to tell a doctor about previous addiction without fear of stigma.
- What is a reasonable goal for prescribing these patients opioids? Not zero, since there may be patients for whom an opioid is the only alternative for treating their pain.
- Consider policies around screening patients better, e.g., ask about previous SUD/OUD diagnoses.
- The PDMP could add information on ODs, or OUD diagnoses, but this would require legislation. Patient disclosure of SUD/OUD could be added as well, but also would require legislation.
- 42 CFR Part 2 is being revised to allow MAT information from methadone clinics to be uploaded to the PDMP.
- Definitions related to these issues are all highly debatable. Policies could be written to reduce certain definitions – e.g., is a person on MAT addicted, or in recovery? How one

defines buckets, calculates doses, etc., can affect how policy works – are people moving in the desired direction?

Chris noted that the PowerPoint slides from all the presentations will be available to Council members as part of the PCF dashboard. Several members noted difficulties with either accessing the site or being able to find materials; MITRE will email the link and instructions to everyone again.

Next Steps

- OPAC member bios will be posted to the website this week; any outstanding bios are due to Dave ASAP.
- After MITRE's report is approved, Chris will send it to Dave for sharing with the council; Chris said the expected timeline is before the end of September. Chris will also send Anne Wood's contact information so members can contact her if desired.

Adjournment

- Dave called for a motion to adjourn; Bob moved and David seconded; all members voted aye. The meeting adjourned at 11:04 AM.

Next Meeting Date, Time, and Location:

- Next regular meeting scheduled for October 7, 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
☒	Andrew Chalsma, designee of Jonathan Ballard, MD, MPH, MPhil NH Department of Health and Human Services	andrew.chalsma@ dhhs.nh.gov jonathan.ballard@dhhs.nh.gov
☐	Richard J. Barth, Jr., MD, Dartmouth-Hitchcock Medical Center	Richard.J.Barth@hitchcock.org
☒	Bob Quinn NH Department of Safety	Robert.Quinn@dos.nh.gov
☒	Kathy A. Bizarro-Thunberg, MBA, FACHE NH Hospital Association	kbizarro@nhha.org
☒	Michael Bullek	michael.bullek@oplc.nh.gov

In Attendance	Name	Email
	NH Board of Pharmacy	
☒	Alicia Guzman, designee of Alex Casale* NH Judicial Branch	Acasale@courts.state.nh.us
☐	Maryann Cooper, PharmD NH Pharmacists Association	maryann.cooper@mcphs.edu
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☒	Jay Schnitzer, MD, PhD VP, Chief Technology Officer MITRE	jschnitzer@mitre.org
☒	David Strang, MD NH PDMP Advisory Council	davidstrangmd@yahoo.com
☒	Jennifer A. Weigand NH Healthy Families/Centene	jennifer.a.weigand@centene.com

Persons appearing before the Council:

☒	Chris Teixeira, MITRE	cteixeira@mitre.org
☒	J.D. Lavallee, NH Attorney General's office	Jon.Lavallee@doj.nh.gov

*Indicates participant attended or presenter appeared by phone or VTC by prior arrangement and with Council approval.