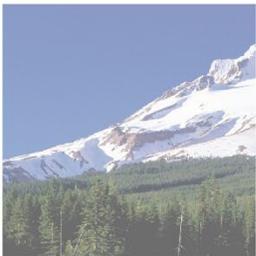
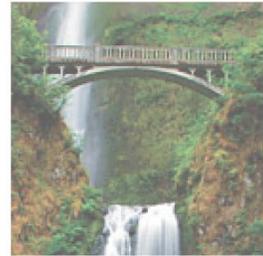




Secretary of State Oregon Audits Division



Oregon Health Authority **Constraints on Oregon's Prescription Drug Monitoring Program Limit the State's Ability to Help Address Opioid Misuse and Abuse**

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Secretary of State Dennis Richardson
Audits Division Director Kip Memmott

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Secretary of State Audit Highlights

December 2018

Oregon Health Authority

Constraints on Oregon's Prescription Drug Monitoring Program Limit the State's Ability to Help Address Opioid Drug Misuse and Abuse

Report Highlights

The Prescription Drug Monitoring Program provides an important tool to address prescription drug abuse, including opioid abuse, and help improve health outcomes. Oregon's laws have put constraints on the program that limit its effectiveness and impact. Restrictions are placed on what data are collected, analyses that can be done with the data, and with whom information can be shared. Correcting weaknesses in Oregon's program will maximize its potential and help address opioid and other substance abuse issues the state faces.

Background

Oregon has the highest rate in the nation of seniors hospitalized for opioid-related issues such as overdose, abuse, and dependence. The state also has the sixth highest percentage of teenage drug users. The Oregon Health Authority (OHA) manages the state's Prescription Drug Monitoring Program (PDMP), which collects information on controlled substance prescriptions within the state. The program was designed to promote public health and safety and to help improve patient care. It was also developed to support the appropriate use of prescription drugs.

Purpose

The purpose of this audit was to determine if Oregon can better leverage its PDMP to help with the opioid epidemic.

Key Findings

1. OHA could better use PDMP data to analyze trends in prescribed drugs, including identifying patterns of possible opioid misuse and abuse. State laws prevent OHA from sharing information on questionable activity with key stakeholders, such as health licensing boards and law enforcement. We found people who received opioid prescriptions from excessive numbers of prescribers, as well as instances of dangerous drug combinations and prescriptions for excessive drug dosages. One person who received an excessive amount of opioid prescriptions had some of those prescriptions paid for by Medicaid.
2. Oregon is one of only nine states that does not require prescribers or pharmacies to use the PDMP database before an opioid prescription is written or dispensed. Mandating use can be effective in reducing opioid misuse and other health related outcomes.
3. Due to statutory restrictions, Oregon's PDMP does not collect some prescription information that could be critical in preventing prescription drug abuse. This includes prescriptions filled by pharmacies other than only retail, veterinarian prescribed prescriptions, prescriptions for Schedule V drugs and drugs known to be abused or misused such as gabapentin, and prescription details such as method of payment, lock-in status, and diagnosis information.

Recommendations

Our report includes 12 recommendations to OHA for optimizing the state's PDMP. OHA can implement some of these within existing statutes and rules, and for others it needs to work with the Legislature. OHA agreed with all of the recommendations, but stated that because seven fall outside the scope of its statutory authority, its ability to implement them is limited. The agency's response can be found at the end of the report.

Introduction

Oregon, like the rest of the nation, is in the midst of an opioid epidemic. The Governor declared a public health emergency in March 2018 to address the opioid crisis as well as other substance misuse and abuse challenges facing the state.¹ The Legislature, Oregon Health Authority (OHA), health-related boards, and communities have undertaken efforts to address the epidemic. One example is the state's Prescription Drug Monitoring Program (PDMP), which is managed by OHA's Injury and Violence Prevention Program. The PDMP is a tool that tracks the dispensing of prescription opioids and other medications of concern across the state. The purpose of this audit was to determine how Oregon can better leverage its PDMP to help with the opioid epidemic.



Oregon has an opioid crisis and one of the highest rates of prescription opioid misuse in the nation

Many substances can be misused or abused, but opioids are of particular concern due to the significant danger posed by their misuse.² While opioids can be helpful in addressing pain with appropriate medical oversight, they are highly addictive. Dependence on prescription opioids can occur in less than a week, and taking a low dose prescription of an opioid for more than three months raises the risk of addiction 15-fold.

¹ Misuse occurs when a person takes a legal prescription medication for a purpose other than the reason it was prescribed, or when that person takes a drug not prescribed to them. Abuse occurs when a person takes a prescription medication to get a pleasant or euphoric feeling.

² Opioids, a class of drugs derived from opium, were increasingly prescribed starting about 20 years ago and are still prescribed for pain management of conditions such as injury, surgery, cancer care, chronic conditions, and end-of-life care. Opioids range from prescription pain relievers (e.g., oxycodone, hydrocodone, and morphine) to illegal substances (e.g., heroin). Opioids, natural or synthetic chemicals, interact with opioid receptors on nerve cells in the body and brain. While plenty of opioid pain relievers are taken safely as prescribed by a doctor, they carry the potential for abuse due to the euphoria that is often produced in addition to pain relief.

People who develop a substance use disorder and need more of the drug, in addition to those who are cut off from their pain medications, may turn to illicit drugs, such as heroin and fentanyl. A study found frequent prescription opioid users and those diagnosed with dependence or abuse of prescription opioids are more likely to resort to heroin.³

Many people who are severely addicted end up incarcerated at some point. Nationally, it is estimated that almost 90% of those incarcerated with substance use disorders do not receive addiction treatment.

Opioid and substance abuse is affecting Oregon's youth

Opioids and substance abuse are significantly impacting younger Oregonians. In 2016, almost 500 pregnancies were complicated by maternal opioid use and 280 infants were born with Neonatal Abstinence Syndrome.⁴ From 2015 to 2017, 314 more children entered foster care due to a parent's drug abuse.

In Oregon and across the nation, there are also cases of young children accidentally ingesting opioid pain relievers. According to the National Poison Data System, pain medications were the third most common substance involved in pediatric poisonings and were the most frequent substance involved in pediatric deaths from accidental ingestion in 2016.⁵

Most substance use disorders begin before or during adolescence. Nationally, Oregon has the sixth-highest percentage of teenagers with a substance use disorder. In 2017, over a quarter of Oregon eighth graders and a third of eleventh graders said it was easy to get prescription drugs not prescribed to them. More than 60% of Oregon Youth Authority adolescents have substance abuse or dependence issues, or have parents that use alcohol or drugs.⁶

57% of 12 to 17 year olds who misused prescription opioids got them from a friend or relative.

When it comes to providing access to treatment and recovery support for adolescents with substance use disorders, Oregon ranked nearly last (49th) nationwide.

Opioid and substance abuse is impacting Oregon's senior citizens

Oregon has the highest rate in the nation of seniors, categorized as those age 65 and older, hospitalized for opioid-related issues such as overdose, abuse, and dependence. Seniors' long-term use of prescription opioids increases the likelihood of falls and fractures. The U.S. Department of Health & Human Services Office of Inspector General found that 32% of Oregonians with Medicare Part D prescription drug coverage received prescription opioids in 2017. This figure was higher than 28 other states.

When it comes to providing access to treatment and recovery support for those with substance use disorders, Oregon was ranked last (50th) for adults.

³ Jones CM, Logan J, Gladden RM, Bohm MK. Vital signs: demographic and substance use trends among heroin users – United States, 2002-2013. *Morbidity and Mortality Weekly Report (MMWR)*. Atlanta, GA: Centers for Disease Control and Prevention; 2015.

⁴ Neonatal Abstinence Syndrome is a group of problems that occur when newborns withdraw from addictive opioids they were exposed to and became dependent upon while in the mother's womb.

⁵ David D. Gummin, James B. Mowry, Daniel A. Spyker, Daniel E. Brooks, Michael O. Fraser & William Banner (2017) 2016 Annual Report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 34th Annual Report, *Clinical Toxicology*, 55:10, 1072-1254, DOI: 10.1080/15563650.2017.1388087.

⁶ Oregon Youth Authority OYA Quick Facts January 2018.

Oregon ranks high for substance misuse and abuse

The national opioid crisis is estimated to cost hundreds of billions of dollars a year, factoring in the costs of healthcare, social services, education, criminal justice, and employment and wage losses. No economic class or locale is immune, and the impacts goes well beyond the individual to affect other family members, particularly children, and communities.

Americans consume more opioids, including prescription opioids, than any other country.

Prescription opioid abuse is part of a broader drug abuse problem in the state. Oregonians suffer more from substance use disorders than those in most other states. Mental Health America, a national nonprofit that helps address the needs of those living with mental illness, ranked Oregon as the state with the highest rate of mental health and substance use problems. Not only does Oregon rank high in many concerning areas related to drugs and alcohol, as shown in Figure 1, it also ranks the highest in all measures compared to nearby states.

Figure 1: Oregon consistently ranks high for drug misuse and abuse among nearby states

State	Pain Reliever Misuse in the Past Year	Substance Use Disorder	Illicit Drug Use Disorder in the Past Year	Illicit Drug Use Other Than Marijuana in the Past Month	Heroin Use in the Past Year	Alcohol Use Disorder in the Past Year	Needing But Not Receiving Treatment at a Specialty Facility for Alcohol Use in the Past Year	Needing But Not Receiving Treatment at a Specialty Facility for Substance Use in the Past Year
Oregon	51	49	48	48	41	46	46	50
Washington	50	33	41	36	39	24	32	35
Colorado	49	38	33	42	27	35	42	42
Idaho	48	22	25	22	22	18	20	22
Nevada	44	16	30	30	25	13	13	18
California	34	39	43	47	8	36	38	38

Source: Substance Abuse and Mental Health Services Administration's 2015-16 National Survey on Drug Use and Health. Survey includes the fifty states and Washington D.C.

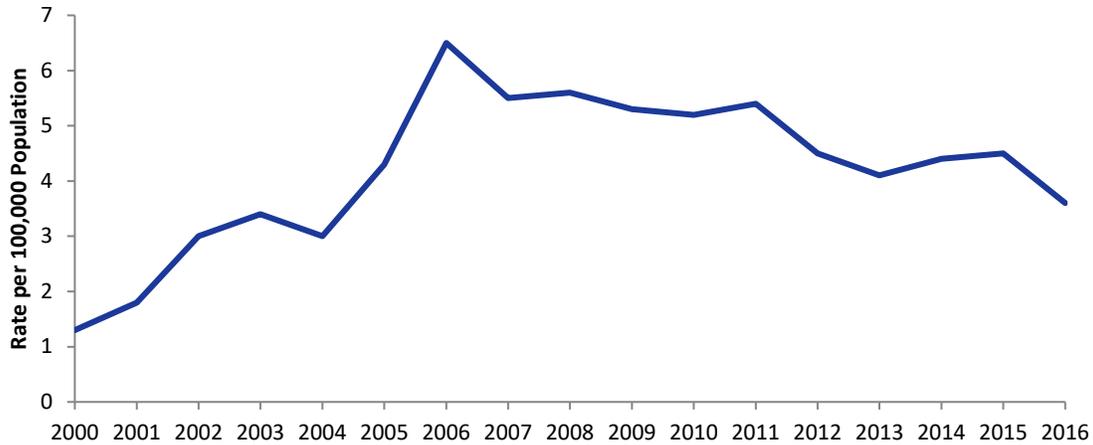
Oregon has seen opioid overdose hospitalizations generally increase since 2000, which includes prescription and illicit opioids. The median cost is \$13,000 for a hospitalization due to opioids, which lasts for two days on average.⁷

Prescription opioid painkillers contribute to a large portion of Oregon's drug overdose deaths. Prescription opioid overdose deaths in Oregon have decreased 45% since peaking in 2006, but are still higher than the early 2000s, see Figure 2. Deaths due to prescription opioids have decreased over recent years, but still equate to about one Oregonian dying every three days. These numbers may be even higher, as researchers say 20% to 35% of opioid-related overdose deaths are undercounted in the nation. Decreases in opioid overdoses are likely partially attributable to the increased availability and use of naloxone, a medication that reverses the effect of an opioid overdose and is increasingly being carried by law enforcement and first responders.

Deaths due to prescription opioids equate to about one Oregonian dying every three days.

⁷ OHA's Opioid Overdose in Oregon Report to the Legislature, September 2018.

Figure 2: Accidental opioid overdose deaths in Oregon have declined, but are still higher than early 2000 rates



Note: The category ‘prescription opioids’ includes deaths due to natural and semi-synthetic opioids, methadone, and synthetic opioids other than methadone and does not differentiate between illicit vs. legal.

Source: Oregon Health Authority’s Opioid Overdose in Oregon Report to the Legislature September 2018.

Oregon has been working to address its opioid crisis

Though addiction and substance abuse were declared a public health crisis in Oregon by the Governor in March 2018, there have been previous efforts in Oregon to try to curb the state’s opioid epidemic. Some of the key efforts can be seen in Figure 3.

To help with the high costs of dealing with opioid abuse, Oregon, along with other states and counties, has filed lawsuits against drug companies to hold them responsible for misleading claims on the harm of opioid medications. Settlement funds have been allocated toward efforts such as increasing opioid addiction services, implementing best practices in pain management, and expanding outreach and educational components of treatment programs.

Reducing the amount of unwanted and unused pills helps to reduce the risk of abuse. Oregon does not have a coordinated, statewide drug take-back program intended to reduce the number of pills in circulation. There are collection sites in multiple locations across the state for disposing of unused opioid and other prescription drugs, located in some pharmacies and at most police stations. Additionally, there are nationally coordinated drug take-back days held twice yearly.

Oregon has made progress in dispensing fewer opioid prescriptions over recent years. This may be from guidelines to help curb overprescribing, and state and national efforts to educate doctors. Even so, Oregon is still prescribing opioids at a rate of 13% more than the national average, and the U.S. prescribes more than other comparable countries. According to the 2019 drug threat assessment by the Oregon-Idaho High Intensity Drug Trafficking Area program, the availability and misuse of prescription drugs remain at a high level even though some indicators suggest a recent decline in misuse.⁸

OHA reported approximately 7 million prescriptions for controlled substances (e.g., opioids, Attention Deficit Hyperactivity Disorder medications, and sedatives) were dispensed annually for Oregonians. Over half of these were opioids, with hydrocodone being the most common.

⁸ The Oregon-Idaho High Intensity Drug Trafficking Area program was established by the White House Office of National Drug Control Policy in June 1999. It consists of 14 counties and the Warm Springs Indian Reservation. Counties in Oregon include Clackamas, Deschutes, Douglas, Jackson, Lane, Linn, Malheur, Marion, Multnomah, Umatilla, and Washington counties.

Figure 3: Timeline of some key efforts taken to address opioid issues in Oregon



Prescription drug monitoring programs are state-level tools to improve opioid prescribing, inform clinical practice, and protect patients

All fifty states have prescription drug monitoring programs (PDMPs), with program data used in a variety of ways to address the opioid epidemic and substance abuse issues.⁹ PDMPs maintain an electronic database of prescription information collected directly from pharmacies in an

⁹ Missouri is the only state without a statewide prescription drug monitoring program. However, within Missouri, St. Louis County started its own PDMP in April 2017 and more than 80% of Missouri doctors and pharmacists participate on a voluntary basis.

effort to provide physicians and pharmacists with critical information regarding a patient’s prescription history. These databases also allow state tracking of physician prescribing practices to inform guidelines and efforts to improve addiction prevention and treatment.

All PDMPs, at a minimum, collect prescription information on drugs federally classified as controlled substances per Schedule II, III, and IV; see Figure 4. Most states go further and collect information on Schedule V substances. Oregon is not among them.

Figure 4: The Controlled Substances Act has divided drugs and other substances considered controlled substances into five schedules

	Potential for Abuse	Description	Examples
Schedule I	High	Substances with no currently accepted medical use in the U.S., and a lack of accepted safety for use under medical supervision, and are therefore never prescribed	LSD, heroin, marijuana, and peyote
Schedule II	High	Substances that have a high potential for abuse, which may lead to severe psychological or physical dependence	Oxycodone (OxyContin®, Percocet®), methadone (Dolophine®), fentanyl, morphine, codeine, amphetamine (Dexedrine®, Adderall®), methamphetamine (Desoxyn®), methylphenidate (Ritalin®), and pentobarbital
Schedule III	Moderate	Substances that have a potential for abuse less than Schedule I or II substances, and abuse may lead to moderate or low physical dependence or high psychological dependence	Buprenorphine (Suboxone®), products with no more than 90 milligrams of codeine per dosage unit (Tylenol with Codeine®), benzphetamine (Didrex®), ketamine, and anabolic steroids (Depo®-Testosterone)
Schedule IV	Low	Substances that have a low potential for abuse relative to Schedule III substances	Alprazolam (Xanax®), carisoprodol (Soma®), clonazepam (Klonopin®), diazepam (Valium®), and temazepam (Restoril®)
Schedule V	Low	Substances that have a low potential for abuse relative to Schedule IV substances	Ezogabine, lacosamide, and pregabalin (Lyrica®)

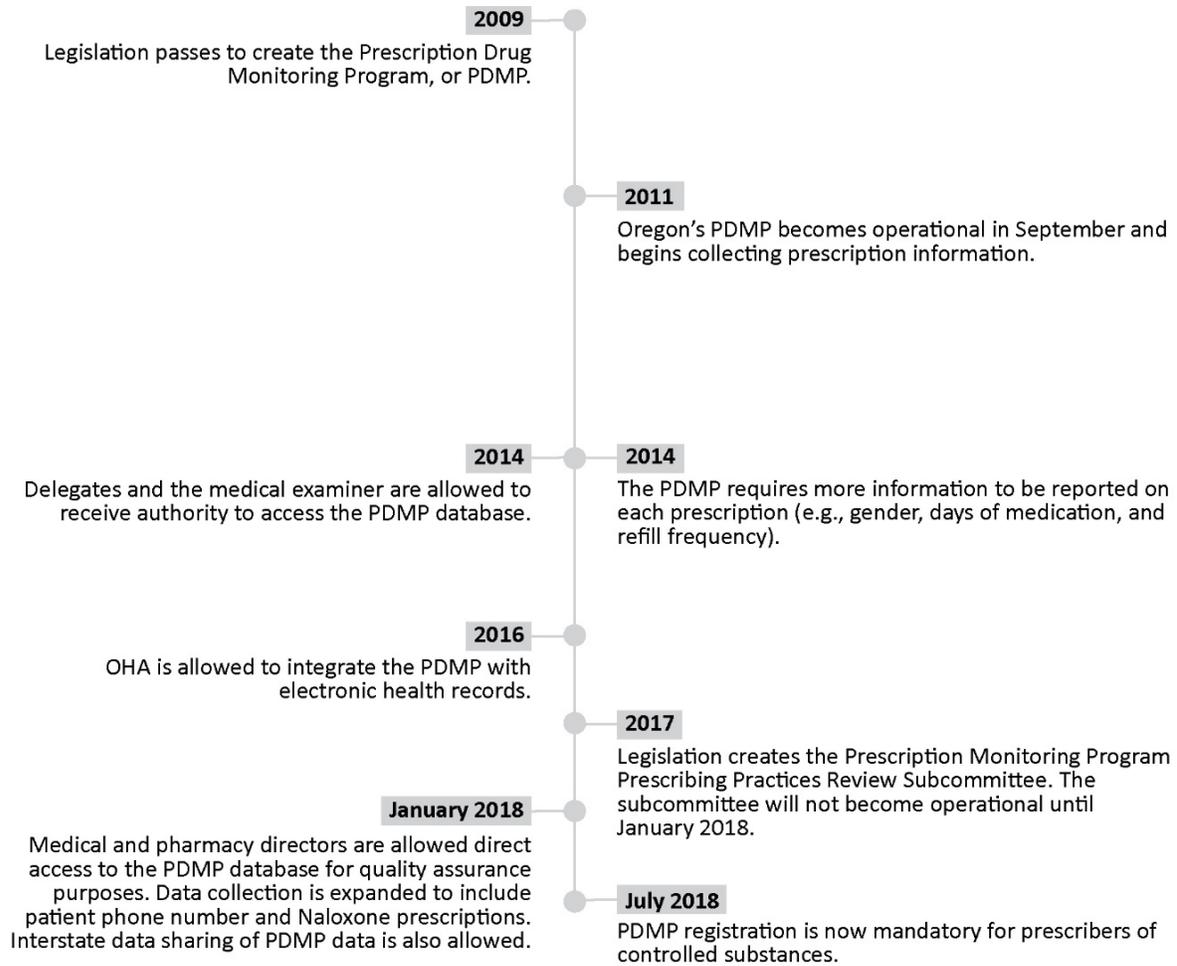
Source: U.S. Department of Justice Drug Enforcement Administration

Oregon’s PDMP was created to help with patient health and safety when using controlled substances

The Oregon PDMP, enacted in 2009, started collecting prescription information in late 2011, making it among the last dozen of states to implement a PDMP. Oregon designed the program to promote public health and safety and help improve patient care by providing healthcare prescribers and pharmacists with information to better manage patients’ prescriptions. It was also developed to support the appropriate use of prescription drugs.

Over the last few years, state legislation has allowed the program to expand the information collected and those who can access that information; see Figure 5.

Figure 5: Timeline of the key legislative changes to Oregon’s PDMP



PDMP information collected in Oregon

- Patient receiving the prescription (name, DOB, address, sex, and phone number)
- Prescriber (name and DEA number)
- Date medication prescribed
- Prescription number
- Pharmacy DEA number
- Date medication dispensed
- Drug prescribed (name, national drug code number, quantity, days’ supply, and number of refills)

Like many other states, Oregon’s PDMP collects information on controlled substance prescriptions dispensed from state-licensed retail pharmacies to its residents. Retail pharmacies are required to report the prescription information to the PDMP within 72 hours. Prescriptions collected in Oregon are for Schedule II, III, and IV controlled substances, pseudoephedrine, and, starting in 2018, naloxone.¹⁰ The PDMP database maintains prescription information for three years that is accessible to authorized users. Besides system users, others can receive some PDMP data. For example, patients may request a copy of their own prescription information and, under certain circumstances, law enforcement and licensing boards may request PDMP data. Researchers may be granted de-identified data for approved studies.

An advisory commission is charged with studying issues related to the PDMP, making recommendations to OHA for operating the PDMP, and developing criteria to evaluate program data. In January 2018, the Clinical Review Subcommittee was formed that uses PDMP

¹⁰ Pseudoephedrine is used for the temporary relief of stuffy nose and sinus pain.

information to identify healthcare prescribers who should receive education or training on prescribing opioids.

OHA administers Oregon's PDMP

Oregon's PDMP is housed within the Office of Injury and Violence Prevention Program, located within the Public Health Division of OHA. OHA has an opioid initiative to reduce deaths, non-fatal overdoses, and harm to Oregonians from prescription opioids, while expanding use of non-opioid care.

Since 2011, PDMP personnel have typically consisted of a manager and four staff. Staff register users, perform some quality assurance and analysis, and coordinate efforts with the advisory commission, boards, and other health entities.

Figure 6: Oregon's organization of its PDMP is similar to nearby states

State	Full Time Equivalent (FTE) Staff	Agency Type	Number of Prescribers
Oregon	4	Department of Health	24,000
California	11+	Law Enforcement	188,000
Colorado	0-1	Board of Pharmacy	31,000
Idaho	2-5	Board of Pharmacy	8,000
Nevada	2-5	Board of Pharmacy	12,000
Washington	11+	Department of Health	44,000

Source: Prescription Drug Monitoring Program Training and Technical Assistance Center, Brandeis University. Some states have additional responsibilities within their program that others do not.

The PDMP contracts with a vendor to maintain the database of prescription information. Oregon uses the same vendor for its PDMP that 42 other states and territories use for theirs.

OHA does not receive state funding for operating Oregon's PDMP. Rather, it is funded through licensing fees. This is similar to California and 20 other states.¹¹ Having a stable funding source, like licensing fees, is considered a leading practice among PDMPs. All Oregon-licensed healthcare prescribers and pharmacists pay a \$25 annual fee included in their board licensing fees. For two recent fiscal years, 2017 and 2018, funding for the program totaled approximately \$1.6 million.

¹¹ Other primary funding sources for states' PDMPs come from federal grants (e.g., Washington and Nebraska), regulatory board funds (e.g., Kansas and South Dakota), and other funding such as health insurance licensing fees (e.g., New York) and legal settlements (e.g., Virginia).

Objective, Scope, and Methodology

Objective

Our audit objective was to determine if Oregon can better leverage its PDMP to help with the opioid epidemic.

Scope

The audit covers PDMP efforts since its inception, and program data for calendar years 2015 through the first quarter of 2018.

Methodology

To address our objective, we conducted interviews with multiple stakeholders, including PDMP staff, OHA personnel, members of the Legislature, members of the PDMP Advisory Commission, members of licensing boards (the Board of Pharmacy, the Board of Optometry, the Oregon Medical Board, the Board of Dentistry, the Board of Naturopathic Medicine, and the Board of Nursing), representatives of the Oregon Medical Association and Oregon Society of Health-System Pharmacists, staff of other government agencies, other states' PDMP staff, practicing prescribers and dispensers, staff from the Oregon Pain Commission, and staff from Lines for Life.¹²

We reviewed state laws and administrative rules related to the program and our audit objective. We also reviewed the program's quarterly and annual reports, Oregon PDMP user surveys conducted by OHA, as well as the website materials relevant to our audit objective. We also reviewed the program's policies and procedures.

We identified leading practices for PDMPs through a review of materials from the Prescription Drug Monitoring Program Training and Technical Assistance Center at Brandeis University, materials from the Substance Abuse and Mental Health Services Administration Center, the National Governor's Association, the National Alliance for Model State Drug Laws, and academic research studies through various medical publications.

We obtained PDMP data from the Oregon Health Authority and performed limited data reliability testing and analyzed data to identify questionable activity such as doctor shopping and prescriptions for risky drug combinations.¹³ We performed testing to determine the completeness of the data with other state prescription claims datasets. We obtained Medicaid pharmacy claims and Oregon Prescription Drug Program data from OHA. We also obtained Workers' Compensation pharmacy claims data from the State Accident Insurance Fund Corporation (SAIF), Oregon's nonprofit workers' compensation insurance company. All data sets covered calendar years 2015 through 2017.

We reached out to the U.S. Department of Treasury to gain access to the Social Security Administration's Death Master File to look for potentially inappropriate payment of prescription drugs (e.g., prescriptions recorded as written by deceased prescribers and prescriptions dispensed to deceased recipients) but we were unable to gain access in time to perform testing.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain

¹² Lines for Life is a nonprofit organization that manages crisis lines and programs to help prevent substance abuse and suicide.

¹³ Doctor shopping occurs when a patient receives controlled substance prescriptions from multiple healthcare prescribers without the prescribers' knowledge of the other prescriptions.

sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

We sincerely appreciate the courtesies and cooperation extended by officials and employees of the Oregon Health Authority and SAIF during the course of this audit.

Audit Results

Oregon deliberated through multiple legislative sessions to establish its PDMP and designed this tool to focus on helping with patient health and safety. For the seven years it has been operating, Oregon's PDMP has been voluntary, informational, and educational for medical professionals. In March 2018, the Governor declared a public health emergency around addiction, responding to Oregon's challenges in combating substance use disorders.

A PDMP is not the sole solution to the opioid crisis or other drug misuse and abuse, but it is a key tool that can help in combating drug epidemics. Following the example set by other states, Oregon can take more robust action to optimize its PDMP. The limited scope of Oregon's PDMP is due mainly to constraints put on the program by the Legislature. These limit the PDMP's efficiency, effectiveness, and impact. Correcting limitations in Oregon's PDMP will maximize its potential to help address opioid and other substance abuse issues in the state.

Our recommendations to OHA detail processes that can be implemented in the short term, as well as recommendations to work with the Legislature on statutory changes. We believe some of these processes can be implemented using existing resources and therefore would not require an increase in the program fee healthcare licensees pay. There is also the potential for reducing drug and medical costs within Medicaid by implementing recommendations that focus on better monitoring of patients' prescriptions.

PDMP data shows questionable activity has been occurring for years, but state laws limit OHA's ability to investigate and mitigate such activity

PDMPs are a great source of information that could be better used to delve into prescribing and dispensing practices. OHA has started to use PDMP data to examine questionable practices, but little action has been taken to address the concerns. State laws limit the examination of practitioners' activities and do not allow analyses focused on patients.¹⁴ More robust analyses about the nature and extent of prescribing and dispensing practices would better inform decision-making about substance abuse in Oregon.

Oregon's PDMP does some prescribing analysis, but more can be done

For the past seven years, Oregon's PDMP has focused its data analyses on overall prescription trends, the most frequently prescribed drugs, prescriptions related to the treatment of substance use disorders, and the use of the PDMP database by healthcare prescribers and pharmacists. These analyses are completed on a monthly and quarterly basis, and PDMP produces an annual report for its program's advisory committee. The PDMP has also contributed data to OHA's prescribing and drug overdose data dashboard, which is an interactive tool that contains state and county level data on controlled substance prescribing and drug overdose health outcomes.

While OHA is performing some analyses at the county and state level, these metrics are typically siloed and not layered together for patterns. A promising practice for PDMPs is to use data to identify hot spots, or areas likely to see higher rates of opioid hospitalizations or overdose deaths. By identifying hot spots within Oregon, OHA could better help municipalities target their limited prevention and intervention resources.

Looking at high-level prescribing trends is valuable, yet PDMP data can be better leveraged to identify patterns of possible opioid misuse and abuse. Behaviors like doctor shopping and over-

¹⁴ ORS 431A.850-900 and OAR 333-23.

prescribing are often associated with increases in opioid misuse and overdose. Examples of possible patterns include:

- prescribers who are prescribing controlled substances in excessive quantities;
- pharmacies that are dispensing controlled substances in excessive quantities;
- individuals who are prescribed dangerous combinations of drugs;
- individuals who may be addicted and receiving multiple prescriptions for commonly misused drugs from multiple prescribers or pharmacies; and
- geographic locations of patients who are receiving dangerous combinations of drugs or are engaged in doctor and pharmacy shopping.

Historically, PDMP data has not been used in Oregon to identify risky or questionable prescribing and dispensing behaviors of prescribers. In 2018, the Clinical Review Subcommittee was created to review prescribers' histories and identify areas where prescribers may need additional training or education on prescribing opioids.¹⁵ Areas of concern the subcommittee is looking at include prescribers with a history of prescribing a high volume of opioids, an above-average amount of opioids, or co-prescribing opioids with certain other scheduled drugs.

When prescribers are identified in one or more of these areas, a letter is sent to them that recommends further training or education. In 2018, letters were sent to 160 individual prescribers identified by the subcommittee after the first review of prescriber histories. However, prescribers are not required to respond to the letter, nor are they required to actually take any additional training or education.

Additionally, the subcommittee cannot share the results of its reviews with any of the health licensing boards who oversee the prescribers. There is no sharing at an aggregate level so boards can proactively work with their licensees on issues. Questionable prescribing habits seen within the data, even those that are egregious, cannot be elevated to any regulatory or enforcement entities to directly look into those situations.

This limitation in data analysis is due to the specific limitations in the law that created the PDMP. Current analyses done by the PDMP and the subcommittee could be much more robust if the laws were changed to allow for expanded use and sharing of the data. These statutory deficiencies are covered in greater detail later in this report.

Doctor shopping is an issue that continues in the state

Doctor shopping occurs when a patient receives controlled substance prescriptions from multiple healthcare prescribers without the prescribers' knowledge of the other prescriptions. For example, a person visits one healthcare prescriber and receives a prescription. Then, the patient visits a different prescriber for the same condition and receives another similar or exact prescription. Some people who engage in this behavior may be misusing the prescriptions or selling them to others in a process called diversion. People who exhibit doctor shopping behavior typically represent a small portion of the general population.

Tennessee's overprescribing team

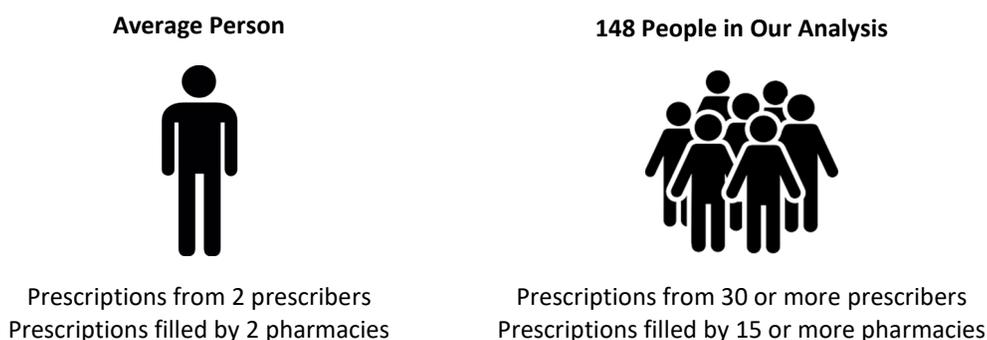
Tennessee's overprescribing team annually identifies the top 50 opioid prescribers in the state and the top 10 opioid prescribers of each county. The prescribers are sent a letter to which they have to respond, explaining why they are using those treatments so frequently in their practice. If the overprescribing team does not agree with a prescriber's explanation, an investigation with the related licensing board is opened. In the last few years, Tennessee has seen a decrease in opioid prescribing for top prescribers.

¹⁵ The Clinical Review Subcommittee is organized under the PDMP's Advisory Commission. Members of the subcommittee are experienced healthcare prescribers who are able to prescribe Schedules II-IV controlled substances.

Doctor shopping, a concern for over a decade, was discussed during multiple legislative hearings leading up to the creation of the PDMP. Some broad analyses were conducted on this activity until 2018 and, even then, efforts to curb this behavior by using PDMP information have been limited by statute.

We looked at three years of data from Oregon’s PDMP and found multiple instances of potential doctor shopping. While there can be legitimate reasons to see multiple prescribers for the same or similar type of medication, we found cases where that seemed extremely unlikely. We identified 148 people who received controlled substance prescriptions from 30 or more different prescribers and filled their prescriptions at 15 or more pharmacies within our three-year time frame. In contrast, the average person received controlled substance prescriptions from two different prescribers and filled their prescriptions at two different pharmacies.

Figure 7: Individuals in potential doctor shopping cases far exceeded the average number of prescribers and pharmacies over three years



Source: OAD analysis using PDMP data, calendar years 2015 through 2017, provided by OHA PDMP staff.

Out of those 148 people, we examined the transactions of five people who exhibited the most egregious behavior of potential doctor shopping, as depicted in Figure 8. Hydrocodone, which is the most commonly dispensed opioid medication in Oregon, was the common drug filled by each of the five individuals.

Figure 8: The most egregious cases of potential doctor shopping saw hundreds of prescriptions filled

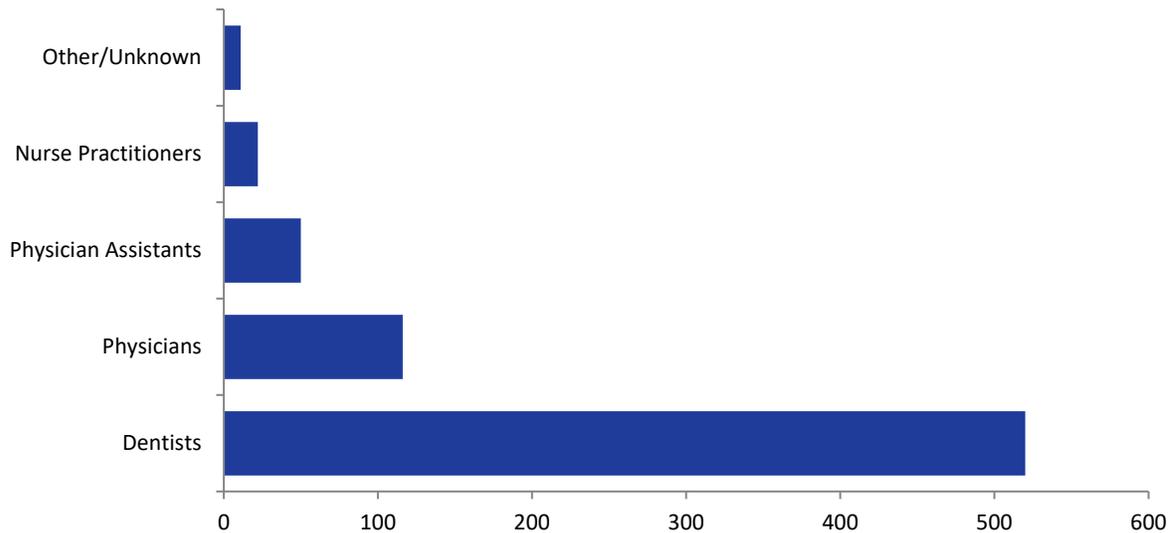
	Person 1	Person 2	Person 3	Person 4	Person 5
Total Opioid Prescriptions Filled	290	315	140	207	156
Most Frequent Drug(s)	Hydrocodone	Hydrocodone	Hydrocodone, Oxycodone	Hydrocodone	Hydrocodone, Oxycodone
Different Prescribers	232	207	102	98	80
Different Pharmacies	75	40	57	36	21
Other Information	32 opioid prescriptions paid by Medicaid	Prescription for buprenorphine in late 2017, indicating may have a substance abuse disorder	Prescription for buprenorphine in 2017, indicating may have a substance abuse disorder	N/A	N/A

Source: OAD analysis using PDMP data, calendar years 2015 through 2017, provided by OHA PDMP staff.

In a review of Medicare Part D prescriptions in other states, the Office of Inspector General found four prescribers who wrote opioid prescriptions to over 136 patients who exhibited doctor shopping behaviors. The 2,823 prescriptions cost the program \$336,000.

Most of the prescriptions for these five people were for short durations, providing them with medication to last for three to five days.¹⁶ When we analyzed the prescribers who wrote these prescriptions, we found most of them were dentists. In two cases, almost all of the prescribers were dentists. For example, Person 1 was prescribed opioids by 218 different dentists, out of 232 total prescribers.

Figure 9: Dentists prescribed most of the opioids in our five cases of potential doctor shopping



Source: OAD analysis using PDMP data, calendar years 2015 through 2017, provided by OHA PDMP staff.

Risky prescribing habits are occurring in the state

The risk of overdose is much higher when mixing different types of drugs. Though healthcare prescribers often prescribe multiple drugs together to treat medical and physical conditions, certain combinations of prescription drugs can be dangerous, even deadly, when taken concurrently.

One such combination involves opioids, benzodiazepines, and muscle relaxants. Benzodiazepines, commonly referred to as “benzos,” are some of the most commonly prescribed medications. They can be used to treat anxiety, insomnia, muscle spasms, and seizures. Two familiar brand names of benzos include Valium and Xanax. Muscle relaxants may be used to alleviate muscle spasms and pain.

Opioids, benzos, and muscle relaxants have some overlapping side effects. In combination, the total effect of these three drugs is greater than the sum of the individual effects. This drug combination can cause respiratory depression that could lead to death. Many patients have reasonable needs for these drugs separately and sometimes in different combinations, but there are very few reasons why a patient would be legitimately prescribed all three drugs at the same time. Using Oregon’s

Some medical literature states the combination of opioids, benzos, and muscle relaxants is known to be favored by individuals suffering from substance abuse and by those seeking to resell pills.

¹⁶ Oregon Opioid Prescribing Guidelines for Dentists recommend that opioids only be prescribed in small dosages, and usually not for more than three days.

PDMP data, we found about 4,270 people who were prescribed all three of these drugs in the same month at least once. Specifically, over the course of 36 months:

- 10 people received all three drugs for the entire time;
- 113 people had all three for 30 to 35 months; and
- 741 people had all three for 10 to 29 months.

People who had these drugs for 30 or more months received their prescriptions from six different prescribers on average. We looked at the detailed history for five people who received all three drugs for at least 12 months and saw a higher than average number of prescribers. These people saw, on average: five prescribers for benzos; four for muscle relaxants; and 13 for opioid prescriptions. Receiving these three drugs from different prescribers suggests that either the care for these people was not coordinated, or more likely, some prescribers were unaware of the other concurrent prescriptions.

According to the National Institute on Drug Abuse, more than 30% of drug overdoses that involve opioids also involve benzos.

Benzos and opioids are sometimes prescribed concurrently. This combination is less dangerous than including muscle relaxants, but still poses concerns if not closely monitored by a healthcare prescriber. Our analysis found almost 34,690 people received both of these drugs in the same month for 10 or more months, out of 36 months. Plus, 5,230 people received these drugs for 30 to 35 months and 740 people received them for the entire 36 months.

The drug gabapentin is also a concern. Recent reports have shown the abuse of this drug, which is used to treat epilepsy and painful nerve diseases, is on the rise. When taken with prescription or illicit opioids, it enhances their euphoric effects. When taken alone in high doses, gabapentin can produce a marijuana-like high. A study of heroin users in Europe concluded that combining opioids and gabapentin potentially increases the risk of acute overdose death by hampering breathing and reversing users' tolerance to heroin and other powerful opioids.¹⁷

In 2017, prescriptions for gabapentin within Oregon's Medicaid program rose by 50% from the prior year and followed closely behind prescriptions for oxycodone. Other states have seen increased abuse of gabapentin, such as Illinois, Ohio, Minnesota, and Virginia, and track this drug in their PDMPs. Gabapentin is not a scheduled controlled substance; however, another drug in the same class, Lyrica, is a Schedule V drug. Over 70% of states have included tracking of Schedule V drugs in their PDMPs. By statute, Oregon does not.

Another type of drug that warrants further review is stimulants. Oregon is seeing a concerning trend for prescription stimulants that is occurring in many age groups. Due to its rapid growth nationally, addiction to stimulants is forecasted to be the next drug epidemic. Stimulants increase alertness, attention, and energy in addition to elevating blood pressure, heart rate, and respiration.

Reports suggest stimulants are being abused for nonmedical cognitive enhancement among some groups (e.g., academic professionals, athletes, performers, and both high school and college students). A new survey of U.S. undergraduate, graduate and professional students found nearly 16% of college students say they misuse prescription stimulants primarily to get better grades, and the majority of students who misuse prescription medications

Prescriptions to Oregonians for amphetamines, a type of stimulant, have increased by about 10% from the first half of 2017 to 2018. Amphetamines were the third most commonly dispensed controlled substance collected by the Oregon PDMP for the first three quarters of 2018.

¹⁷ Lyndon A, Audrey S, Wells C, Burnell ES, Ingle S, Hill R, Hickman M, Henderson G. "Risk to heroin users of polydrug use of pregabalin or gabapentin," *Addiction* 112 (9) (September 2017): 1580-1589.

obtained them from friends.¹⁸ High doses of stimulants can potentially lead to cardiovascular failure, seizures, or death among other side effects. Repeated abuse of some stimulants can lead to hostility, paranoia, and psychosis. There are currently no overdose reverse medications or medication assisted treatment to curb the abuse of stimulants.

Louisiana’s Board of Pharmacy recently raised concerns about the prescribing trends of two medications: Zolpidem, which has been used as a date rape drug, and promethazine with codeine, a prescription cough medicine that can be used to make a street drug. Zolpidem is commonly prescribed under the brand name Ambien and is the fifth most commonly prescribed controlled substance in Oregon.

The Office of Inspector General identified a doctor who prescribed excessive amounts of opioids to 125 of their patients. Medicare Part D paid \$1.6 million for these prescriptions.

In analyzing Oregon’s PDMP data, we found troubling instances of potentially excessive quantities of zolpidem. For example, one person received a 1,545 days’ supply of zolpidem from five prescribers in a single year. While zolpidem prescriptions are collected by Oregon’s PDMP, some prescription cough syrups with codeine are classified as a Schedule V drug and are therefore not required to be reported to the PDMP.¹⁹

Oregon’s PDMP is not allowed to evaluate prescriber practices and prescribing habits among peers

Some states, but not Oregon, produce prescriber report cards using PDMP data. These show a practitioner how their prescribing practices compare to their peers within their medical specialty. For example, a family physician can compare their prescribing behaviors to the average family doctor.

Prescriber report cards contain summaries of patient prescriptions, risk status, and other relevant information (see Appendix B and C for an example). They can be solicited, unsolicited, or both. Solicited means that the prescriber needs to request the report and unsolicited means that all prescribers would receive a report. The use of prescriber report cards is a promising practice that gives prescribers a tool to self-examine their behaviors and can positively influence their prescribing of controlled substances.²⁰ Oregon’s statute prevents report cards, as these would be considered evaluating a prescriber’s practice, which is prohibited.²¹

Figure 10: Most nearby states provide prescribers with report cards

State	Prescriber Report Cards?
Oregon	
California	
Colorado	•
Idaho	•
Nevada	•
Washington	•

Source: Prescription Drug Monitoring Program Training and Technical Assistance Center.

Oregon also does not have health specialty information on all the prescribers in the state. In Oregon’s PDMP, when practitioners registered prior to mid-October 2017, they were not required to provide health specialty information and many thousands of practitioners left that information blank. Those registering after that time have been required to report their

¹⁸ Phillips, Erica L. & McDaniel, Anne E. (2018). College Prescription Drug Study Key Findings Report. Center for the Study of Student Life, Ohio State University: Columbus, Ohio.

¹⁹ The Drug Enforcement Agency states that cough preparations containing no more than 200 milligrams of codeine per 100 grams are classified as a Schedule V controlled substance.

²⁰ See Appendix B and C for an example of Washington’s prescriber report card and the accompanying email sent to prescribers.

²¹ ORS 431A.865 (1)(b) states the “prescription monitoring program may not be used to evaluate a practitioner’s professional practice” except for “a health professional regulatory board that certifies in writing that the requested information is necessary for an investigation related to licensure, license renewal or disciplinary action involving the applicant, licensee or registrant to whom the requested information pertains.”

health specialty. PDMP staff said they are starting to work on getting complete specialty information on prescribers.

Out of 53 states and territories, 26 PDMPs provide their prescribers with report cards and 35 PDMPs send both solicited and unsolicited reports to prescribers. Nationally recognized experts believe report cards would be beneficial to prescribers in evaluating their prescribing practices. Arizona, Kentucky, and Ohio have received positive feedback from providers on their report cards.

Oregon statutes hamper use of the state's PDMP information to effectively address opioid use and misuse

If properly structured and administered, PDMPs can be a powerful tool that provide valuable information for mitigating substance abuse risks and outcomes. However, current Oregon statutory requirements limit the impact potential of the PDMP. Pharmacies make a great effort to submit prescription information and PDMP personnel put great effort into maintaining the database for prescribers and pharmacies to use. However, no one is required to access the PDMP database, voluntary usage is mediocre, and some key stakeholders can only access limited information and under very specific circumstances.

State law does not require prescribers to use the PDMP database

Prescribers with an active U.S. Drug Enforcement Administration (DEA) license were required to register with the PDMP by July 1, 2018. However, when the state rule was established, no repercussions were included for a practitioner who did not register, making participation in the program essentially voluntary. According to PDMP staff, about 77% of the required prescribers had registered as of early November.

Mandated use has been discussed in Oregon but has never been required. According to a recent study, states that have mandated healthcare providers to access the PDMP prior to prescribing a controlled substance have been effective in reducing opioid misuse and other related health outcomes.²² Further, prescriber use of PDMPs has also been associated with reduced crime rates (mainly violent crimes, particularly homicide and assault). According to the FBI's Uniform Crime Reporting Program, Oregon's violent crime rates increased by 6.3% in 2017.

Prescriber querying has generally increased since 2014, which is expected as more prescribers register and as Oregon's PDMP database is integrated with electronic health records. In the recent PDMP quarterly report, almost 39% of enrolled prescribers queried the PDMP database during the third quarter of 2018. These prescribers have worked in the time to check the PDMP database for one or more of their patients.

The common argument against accessing the PDMP database is the time it takes to access it, which is a separate system requiring a separate log in, detracting from the limited time with a patient. Yet it can help practitioners identify any problematic prescription habits and determine the appropriate treatment and medication to prescribe, which is important for patient health and safety. Some patients may not recall their prescriptions or may intentionally not share the prescription medications they are taking. Oregon rules do allow practitioners to designate delegates who can look up patient information on a doctor's behalf.²³ Vigilantly checking the

²² Dave, Dhaval, and Deza, Monica and Horn, Brady. *Prescription Drug Monitoring Programs, Opioid Abuse, and Crime* (August 2018). NBER Working Paper No. w24975.

²³ Delegates are defined in ORS 431.865 (2)(a) as a "member of the practitioner's or pharmacist's staff." Even if a practitioner or pharmacist authorizes a delegate, by statute the practitioner or pharmacist remains responsible for the use or misuse of the information by the staff member.

PDMP database prior to prescribing controlled substance medications would help ensure patients receive appropriate doses of opioids and other concerning drugs.

Increasing access and use of the PDMP database is a high priority for the program. The PDMP has conducted some outreach to Oregon prescribers to encourage them to use the database and to inform them about how to integrate use of the database into their clinic practices. From 2014 to 2015, the PDMP had temporary staff working with prescribers on how to weave use of the PDMP database within the daily workflow. This mainly focused on encouraging the top prescribers and their delegates to register and use the database, which the vast majority do.

To make the PDMP database easier to use, OHA has been working on integrating the database with electronic health records in the state. Integrating PDMP data into electronic health records is considered a leading practice. As of July 2018, 21 Oregon hospital emergency departments, or 34%, have integrated with the PDMP database. The PDMP is working on expanding this further and looking at integration opportunities with other health information systems. Smaller practices and those that use paper files would still need to integrate checking the PDMP database separately into their daily workflow.

Figure 11: Most nearby states require prescribers to use their PDMP

State	Mandatory Use for Prescribers?
Oregon	
California	•
Colorado	•
Idaho	
Nevada	•
Washington	•

Source: Prescription Drug Monitoring Program Training and Technical Assistance Center.

Oregon’s PDMP database has a dashboard that prescribers can review when accessing the database. This dashboard displays an alert if a patient exhibits doctor shopping behavior, is receiving a high dose opioid prescription, or has received a prescription for an opioid and a benzo within a set time frame. These alerts are visible only to the prescriber, who is not required to review them. A prescriber would know they have a patient alert only if they accessed the PDMP database and viewed that specific page on their dashboard.

Leading practices require all prescribers who can write prescriptions for controlled substances to register and query the PDMP database. The U.S. Department of Health and Human Services Office of Inspector General recommends that prescribers and dispensers be required to check the PDMP database before prescribing and dispensing opioids. There are 41 states with PDMP mandatory use requirements; 27 of them,

like Washington and California, require that of only their prescribers, while the other 14 require it of both prescribers and dispensers. Mandatory use requirements seem to have had a great impact on the program in other states. Requirements vary widely from state to state. Examples include:

- Louisiana mandates prescribers query the PDMP before any opioids are prescribed and every 90 days during treatment;
- California prescribers are required to view a patient’s data in the PDMP prior to prescribing a Schedule II-IV controlled substance for the first time, and at least every four months thereafter if the substance is still being prescribed;
- Illinois requires prescribers to view PDMP data for new Schedule II prescriptions, but only if they are for more than seven days’ supply and the treatment is not for cancer or palliative care; and
- Alaska requires both prescribers and dispensers to review PDMP data when any Schedule II or III controlled substance is prescribed or dispensed, with some limited exceptions, such as hospice or inpatient treatment.

New federal rules will require providers to query PDMPs when prescribing controlled substances for Medicaid and Medicare patients starting in 2020.

State laws block access to PDMP data for some key players

The inappropriate use of prescription opioids is of increasing concern for both public health professionals and law enforcement authorities, and requires collaborative partnerships to maximize the use of information to proactively fight the opioid epidemic. Yet entities that could benefit from expanded access to PDMP information currently only receive very limited information and under very specific circumstances.

Two of those entities include health licensing boards and law enforcement. In addition to their regulatory and enforcement functions, both of these entities have missions that center on the health and safety of Oregonians. Oregon statutes, however, only allow health licensing boards to request PDMP information for an active investigation into a licensee. Law enforcement entities are further restricted by statute, as they may only request PDMP data if it is needed as a part of an active drug-related investigation and is accompanied by a valid court order.²⁴

Delegates, who can be non-licensed staff, were allowed by statute in 2014 to access the PDMP on behalf of a prescriber, pharmacist, or medical examiner. Access was again expanded in January 2018 to allow a medical or pharmacy director access to the PDMP for overseeing their entity's operations to ensure the delivery of quality health care. With that access, medical directors can see reports that show a summary of prescriptions by a specific healthcare provider and the corresponding patient and pharmacy information. Similarly, pharmacy directors can access the dispenser activity report that shows a summary of prescriptions dispensed at a certain location and the corresponding patient and prescriber information. Like medical and pharmacy directors, health licensing boards are tasked with ensuring patient safety and quality of care by their licensed practitioners, but they have not been granted the same access. Rather, they have to wait to receive a complaint about one of their licensees and open an investigation in order to look into prescribing and dispensing practices.

Figure 12: Most nearby states allow law enforcement access during an active investigation

State	Law Enforcement Access During an Active Investigation?
Oregon	
California	•
Colorado	
Idaho	•
Nevada	•
Washington	•

Source: Prescription Drug Monitoring Program Training and Technical Assistance Center.

Oregon State Police (OSP) and the Department of Justice both focus on public safety, which is one of the PDMP initiatives. Representatives from law enforcement agencies are involved with the Governor's opioid task force and the Alcohol and Drug Policy Commission.²⁵ However, when it comes to accessing data that could help all state bodies direct efforts at reducing opioid abuse, OSP stated that they have not used the PDMP for investigative purposes. Research has shown that PDMPs save law enforcement officials time in investigations if they have access to PDMP information. Thirty-five other states allow law enforcement access to PDMP reports and information when it comes to active investigations. According to the U.S. District Attorney's Office, obtaining an administrative subpoena for PDMP data is cumbersome and inefficient, which keeps Oregon from more effectively eliminating

potential suspects and addressing concerning cases of extreme quantities of prescription drugs

²⁴ See Footnote 15 for disclosure of PDMP information to a health professional regulatory board. Per ORS 431A.865 (2)(a)(G), PDMP information shall be disclosed "pursuant to a valid court order based on probable cause and issued at the request of a federal, state or local law enforcement agency engaged in an authorized drug-related investigation involving a person to whom the requested information pertains."

²⁵ The Alcohol and Drug Policy Commission is an independent state government agency that was created by the Oregon Legislature to improve the effectiveness and efficiency of state and local alcohol and drug abuse prevention and treatment services. The Commission is to establish priorities and policies for alcohol and drug abuse prevention and treatment services as part of a long-term strategic prevention and treatment plan for this state per ORS 430.242.

such as pill mills.²⁶ Law enforcement officials from other states have found that having PDMP access has been invaluable to their investigations and has helped save time and money.

PDMP information is intended to be used for determining the course of treatment for a patient, and should be rightfully protected. Yet it is also intended to help ensure appropriate use of prescription medications. There is training on how to use the database and penalties for those that do not adhere to rules in using the PDMP database. As with any repository of patient information, privacy and security concerns have been at the center of restrictions to that information.

Figure 13: Many nearby states send unsolicited reports to prescribers

State	Unsolicited Reports Sent to Prescribers?
Oregon	
California	•
Colorado	
Idaho	•
Nevada	•
Washington	

Source: Prescription Drug Monitoring Program Training and Technical Assistance Center.

Leading practices recommend proactively providing data not only to prescribers and dispensers, but also to law enforcement and licensing boards regarding any individual who exhibits potential signs of abuse, misuse, or diversion. Twenty other states have their PDMP send unsolicited reports to regulatory agencies, and 18 send unsolicited reports to law enforcement. This practice informs users about the PDMP and assists in targeting drug diversion reduction efforts and helps ensure safe, effective, and legal practice of medicine.

The National Governor’s Association also recommends states grant law enforcement access to PDMP data for open investigations involving prescription opioids. With this, states should maintain privacy rights as well as ensuring that law enforcement investigators are tracked, trained, and

certified to access PDMP data. Such requirements could help mitigate concerns about law enforcement using it to investigate anyone potentially misusing controlled substances if given access to the data. The 9th U.S. Circuit Court of Appeals recently reversed a lower court ruling that had prohibited the DEA, a law enforcement agency, from accessing records in Oregon’s PDMP without a warrant. Through the DEA, the U.S. District Attorney’s Office said it has access to PDMP data, but those investigating large pill mills such as the FBI does not have this access.

Some states have laws more open than Oregon to allow access to PDMP databases by entities such as licensing boards, bureaus of investigation, and overprescribing teams. Tennessee allows this access to maximize the use of PDMP data and proactively address drug abuse. Tennessee’s laws require law enforcement applicants to be approved by the U.S. Department of Justice before receiving PDMP data and any information obtained is not considered a public record. Law enforcement access is also monitored by district attorneys or other officials to ensure that all information requests are relevant and pertinent to an investigation.²⁷ Louisiana has granted PDMP database access to professional licensing boards, Medicaid program representatives, drug treatment providers, and parole officers.²⁸ Louisiana law enforcement officials can request PDMP data related to an open investigation.

²⁶ The term “pill mill” is typically used to describe a doctor, clinic, or pharmacy inappropriately prescribing or dispensing controlled prescription drugs.

²⁷ See Tennessee Codes Ann. § 53-10-302, § 53-10-303, and § 53-10-306 for laws related to PDMP access and information confidentiality.

²⁸ See Louisiana Revised Statutes (R.S.) 40:1001-1014.

Oregon’s PDMP database information should be complete and timely

While Oregon’s PDMP appears to receive most of the required prescription information it should, not all prescriptions are being reported to the PDMP. The state should collect more information to better ensure patient health and safety, and the effectiveness of the program.

PDMP appears to be receiving most but not all the prescription information it should

Oregon rules require pharmacies to submit key information for certain drugs to the PDMP within 72 hours for each dispensed prescription. When pharmacies do not submit complete information, it reduces the effectiveness of the PDMP. In our conversations with PDMP users, we heard concerns about the PDMP database not having complete and timely information.

The PDMP does not have a process to identify whether required pharmacies are submitting all the required information to the PDMP within 72 hours. PDMP staff regularly check to ensure all required pharmacies are submitting prescriptions information and doing so timely throughout a month. As dispensing prescriptions can vary throughout and across months, staff look for large spikes in total prescriptions submitted. This, however, does not ensure that pharmacies report all required prescriptions filled on a given day to the PDMP. For example, if a pharmacy actually dispensed 50 prescriptions for opioids and only submitted information on 30 of them, but also reported more pseudoephedrine fills, there would be no apparent spike and the pharmacy would appear to be meeting the reporting requirements.

Pharmacies in Oregon

About 1,000 pharmacies report data to Oregon’s PDMP. Another 176 pharmacies are not required to report or have been granted a waiver exempting them from reporting.

We obtained paid pharmacy claims information tracked by two other programs within OHA, Medicaid and the Oregon Prescription Drug Program (OPDP), as well as from SAIF to see if their prescriptions were in the PDMP database.²⁹ Although most of the prescriptions from these three sources were in the PDMP database, some were missing, as shown in Figure 14.

Figure 14: Most prescriptions tracked in other programs were in the PDMP database but we found gaps were in PDMP prescription histories for certain individuals

	Medicaid	OPDP	SAIF
Applicable Prescription Claims	3,936,843	786,595	87,104
Claims Initially Not Matched with PDMP	389,114	10,613	3,848
Individuals whose Prescriptions Were Tested	50	25	25
Prescriptions Tested	207	218	113
Prescriptions Tested Not in PDMP	113 (55%)	170 (78%)	92 (81%)

Note: We considered matches between PDMP and the listed datasets to include those with slight name spelling variations and prescription fill dates if they had the same date of birth, a similar timeframe for the same medication and dosage prescribed by the same doctor from the same pharmacy. Also, SAIF applicable claims were reduced by those that were OPDP prescription fills.

Source: OAD analysis using PDMP data, calendar years 2015 through 2017, provided by OHA PDMP staff.

²⁹ The Oregon Prescription Drug Program is the state’s prescription discount card program for Oregonians who are uninsured or underinsured for prescription drug coverage.

Of the 538 prescriptions we tested, 375 prescriptions for 71 individuals should have been in the PDMP database. These prescriptions were dispensed from many pharmacies who did not have all of their information in the PDMP database. While the total of these missing prescriptions may not seem substantial when compared to the millions of prescriptions the PDMP receives, the missing prescriptions could impact the practitioners' treatment decisions for those individuals.

While other states we spoke with have procedures similar to Oregon's for ensuring that pharmacies are reporting information, leading practices state that PDMP management should compare reported prescriptions to prescriptions dispensed by the pharmacy. In lieu of having the Board of Pharmacy's annual site visits or PDMP staff conduct this verification, data sharing with other programs' pharmacy information would provide further assurance the PDMP has complete information. Further, the U.S. Department of Health and Human Services encourages states to allow data sharing with other programs like Medicaid.

Prescriptions exempted pose a patient safety concern and should be collected

Oregon's PDMP requires only prescriptions dispensed by retail pharmacies to be collected. This excludes other pharmacies, such as long-term care and residential treatment facility pharmacies, from having to participate. Nothing prevents an individual from getting prescriptions concurrently, such as from both retail and long-term care pharmacies. In those cases, PDMP only shows one part of a patient's prescription history.

We found instances where patients were getting the same medication at different types of pharmacies. In one case, over the course of one month, an individual was prescribed 242 tablets of oxycodone and 87 tablets of clonazepam by two different doctors. These were filled by an exempt, long-term care pharmacy so the prescriptions were not included in the patient's PDMP prescription history. Later, within that same month, that individual was prescribed 112 tablets of oxycodone and 84 tablets of clonazepam by another doctor, and these were filled at a retail pharmacy. The third doctor would not have seen a history of that patient receiving those medications in the database. Going forward, the PDMP prescription history for that month only shows a third of the oxycodone pills and half of the clonazepam pills the individual actually received.

Figure 15: Instance of patient's medication received during a month from exempt and retail pharmacies

Date Dispensed	Generic Drug Name	Drug Class	Days' Supply	Quantity	Doctor	Pharmacy
8/12/2015	Clonazepam	Benzodiazepine	9	27	Doctor #1	Exempt Pharmacy
8/12/2015	Oxycodone	Opioid	7	40	Doctor #1	Exempt Pharmacy
8/17/2015	Oxycodone	Opioid	7	84	Doctor #2	Exempt Pharmacy
8/17/2015	Oxycodone	Opioid	7	28	Doctor #2	Exempt Pharmacy
8/21/2015	Clonazepam	Benzodiazepine	20	60	Doctor #2	Exempt Pharmacy
8/22/2015	Oxycodone	Opioid	15	60	Doctor #2	Exempt Pharmacy
8/22/2015	Oxycodone	Opioid	3	30	Doctor #2	Exempt Pharmacy
8/24/2015	Oxycodone	Opioid	28	112	Doctor #3	Pharmacy #1
8/24/2015	Clonazepam	Benzodiazepine	28	84	Doctor #3	Pharmacy #1

Source: Created by Audits Division staff using PDMP and Medicaid dispensed prescription data.

In another example, an individual had a prescription from a doctor for a 30-day supply of fentanyl patches that was filled on the same day at both a retail pharmacy and a long-term care pharmacy. This happened twice. During a different month, the individual had the same medication filled at a retail pharmacy and then, two days later, had it filled at a long-term care pharmacy. A doctor accessing the PDMP database would only see half of the fentanyl patches that were actually obtained by the individual for these instances.

In addition to some pharmacies being exempt from reporting to the PDMP, veterinarian-prescribed controlled substances are also exempt. Nationally, veterinarians have reported cases of pet owners intentionally harming their pets to get prescription drugs. This has occurred in multiple states, including Oregon. Although some veterinary prescriptions were found in Oregon’s PDMP database, the state does not make this a requirement. Eighteen other states do have this requirement. Some states also require veterinarians to check the prescription history of pet owners and their pets in their PDMPs, while other states have set limits on the amount of opioids veterinarians can prescribe.

Most states, not including Oregon, require prescriptions for controlled substances that practitioners directly dispense to patients be reported to their PDMP. Nebraska is the first state to expand from all controlled substances to requiring all prescriptions dispensed in the state be reported daily to its PDMP. This expansion allows for the examination of drug interactions and prescribing trends. Nebraska also requires veterinarians to report dispensed prescriptions of controlled substances to its PDMP.

Processes and data system issues hinder the usefulness of PDMP for users

The absence of some data in the PDMP database limits the effectiveness of the information. We found that even though most Oregon data appeared to have been submitted as required, controls in the system have kept some prescriptions unavailable to those querying the PDMP database. Also, the timing and potential delays in reporting can hinder the usefulness of PDMP data.

By statute, when accessing the PDMP database, a user is able to see the last three years of a patient’s prescription history. However, there have been concerns from Oregon’s PDMP practitioner surveys that information in the PDMP seemed incomplete. Similarly, PDMP users told us that prescription histories were sometimes incomplete. When we compared PDMP data provided to us with what practitioners see when querying the database, we found relevant prescription data were not always displayed in patient queries. Two reasons for this were revealed through conversations with PDMP staff and a review of cases.

Figure 16: Most nearby states collect data for the PDMP within 24 hours or the next day

State	Pharmacy Data Collected within 24 Hours or Next Day?
Oregon	
California	
Colorado	•
Idaho	•
Nevada	•
Washington	•

Source: Prescription Drug Monitoring Program Training and Technical Assistance Center.

The first reason relates to buprenorphine, a drug used to treat opioid addiction. Only a physician with a special “X” number issued by the DEA can prescribe this medication. However, PDMP system edits do not recognize that type of a DEA number, and pharmacists do not feel they can modify a prescription to list the prescriber’s other DEA number. According to PDMP staff, this is a national issue. Because of this system edit, those prescriptions are not visible in database queries.

The second reason relates to correcting errors in pharmacy data submissions. When pharmacies send in their prescription data, the system checks it for errors. If errors hit certain thresholds, the pharmacy is informed

and the erroneous records are put into a hold, not viewable from queries, until they are corrected.

Oregon rules require pharmacies to correct and resubmit erroneous data within one week from when the data was first submitted. PDMP staff have increased their focus on pharmacy compliance to get errors corrected within the required timeframe. They reach out to pharmacies to have them resubmit required information, but we were told that after nine weeks, it is difficult for pharmacies to send the information. Pharmacies are not penalized if errors are not corrected, and we found some data submissions that had been on hold for years. The delay in processing errors expands the window of opportunity from four to more than 11 days in which a person can doctor shop before prior fills show up in the database.

Leading practices recommend collecting prescription data daily or in real-time. Of the 50 states and three U.S. territories, 47 have moved to daily or next business day reporting. Three of those states collect the prescription data at the point of sale or within 24 hours. By not having prescription data collected and updated in real-time, doctor and pharmacy shopping continues to be a possibility for those misusing and abusing prescription drugs.

Oregon does not require useful prescription detail to be collected

Other states collect prescription details beneficial to understanding and addressing substance misuse and abuse issues that Oregon does not.

Figure 17: All nearby states collect at least one other prescription detail that Oregon does not

State	Method of Payment Collected?	Schedule V Collected?	Veterinarian Data Collected?
Oregon			
California	•		•
Colorado	•	•	
Idaho	•	•	
Nevada	•		
Washington	•	•	•

Source: Prescription Drug Monitoring Program Training and Technical Assistance Center.

Forty-six state PDMPs collect the method of payment information in their programs (e.g., paid by Medicare, Medicaid, private insurance, or an individual). Collecting payment information is a noted leading practice identified by the Brandeis PDMP Center of Excellence. Collecting the method of payment was considered within a bill during Oregon’s 2017 legislative session but was removed. Some states, like Maine and Pennsylvania, require their pharmacies to check the PDMP prior to dispensing an opioid or benzo medication if the person is paying cash when they are known to have insurance.

As mentioned previously, Oregon’s PDMP collects Schedules II through IV medications, as well as two other drugs of concern. Nearly 40 states have expanded the dispensed prescriptions they collect to also include all Schedule V drugs. This allows them to monitor for trends of all the controlled substances listed in the Controlled Substances Act.

Another detail that would be useful to collect is patients who have a “lock-in” to a single prescriber and a single pharmacy for obtaining controlled substances.³⁰ This allows prescribers and pharmacists to take steps to ensure prescribing and dispensing are appropriate. Even if the pharmacist does not see this detail prior to dispensing, the PDMP could detect a prescription was issued and dispensed by an unauthorized prescriber or pharmacy. Further, if the PDMP could make the data available to Medicaid or other third-party payer, those entities could better

³⁰ “Lock-ins” are a tool used by Medicaid and other insurers to protect patients from receiving harmful amounts and combinations of opioids and other controlled substances. Typically, a patient is required to obtain future prescriptions only from a designated pharmacy, or a designated prescriber and pharmacy.

monitor the prescription behavior of their clients who have this restriction and evaluate the effectiveness of restricted lock-in programs. Washington's PDMP accomplishes the latter by providing data to its Medicaid program through bulk data transfers.

Lastly, the diagnosis code is key to monitoring trends in the prescribing of controlled substances. This detail is not captured in Oregon's PDMP database. Tennessee recently required prescribers to include diagnosis codes on prescriptions and that information to be sent to its prescription drug monitoring program. Diagnosis codes help provide a link to understand the treatments being used for different conditions. With Oregon's PDMP data not knowing the practitioner's health specialty and a patient's illness or injury that is being treated, it is challenging to understand prescribing trends.

Recommendations

We recommend OHA take the following actions to more effectively operate the PDMP within existing state statutes and rules.

1. Maintain an ongoing partnership with health licensing boards to target outreach efforts to get all required prescribers registered with the PDMP.
2. Provide guidance, including examples, to prescribers on ways to integrate accessing the PDMP database into their daily workflow.
3. Verify practitioner specialty information with the respective health licensing board and update the PDMP database with this information.
4. Develop a process for, and facilitate the sharing of, data between PDMP and Medicaid to help ensure completeness of PDMP prescription history and to allow Medicaid to better monitor the prescription behavior of its clients.
5. Identify and propose drugs of concern, such as gabapentin, to the Board of Pharmacy and Legislature that should be added to the state's controlled substance schedule and collected by the PDMP.
6. Work with the PDMP vendor and the Board of Pharmacy to make sure prescriptions made by X-waivered prescribers are included in the PDMP database.

We also recommend that OHA work with the Legislature to take the following actions to better optimize the state's PDMP. These will further promote the use, collection, and analysis of PDMP prescription information, which will help ensure the appropriate use of prescription drugs.

7. Expand statutes to allow the PDMP to conduct and share analyses on prescription data, including:
 - a. analyzing prescriber, pharmacy, and patient prescription practices;
 - b. making prescriber report cards available; and
 - c. preparing and issuing unsolicited reports to licensing boards and law enforcement.
8. Seek legislative action to address the issue of prescribers not registering with the PDMP as required and pharmacies not submitting corrected data within statutory requirements.
9. Provide further authority to the Clinical Review Subcommittee to require the justification of practices deemed concerning, and allow the collaboration with licensing boards and law enforcement for concerning practices.
10. Expand authority for other professional and state entities authorized access to PDMP information.
11. Require and set parameters for when prescribers must query the PDMP database to review a patient's prescription history. This should include, at a minimum, requiring the querying of the PDMP database prior to prescribing controlled substances and

substances of concern, and for dispensers to query the database prior to issuing a medication and periodically while the patient is taking those medications.

12. Allow for additional information to be collected by the PDMP. This should include:

- a. prescriptions for Schedule V controlled substances and other drugs of concern;
- b. applicable prescriptions from other types of pharmacies, not solely retail pharmacies;
- c. applicable prescriptions prescribed by veterinarians;
- d. method of payment used to pay for the prescription;
- e. patients who are restricted or have a “lock-in” to a single prescriber and a single pharmacy for obtaining controlled substances; and
- f. diagnosis codes related to the prescription.

Appendix A: Oregon Compared to Nearby States for Certain PDMP Features

State	Prescriber Report Cards?	Mandatory Use for Prescribers?	Law Enforcement Access During an Active Investigation?	Unsolicited Reports Sent to Prescribers?	Pharmacy Data Collected within 24 Hours or Next Day?	Veterinarian Data Collected?	Schedule V Collected?	Method of Payment Collected?
Oregon								
California		•	•	•		•		•
Colorado	•	•			•		•	•
Idaho	•		•	•	•		•	•
Nevada	•	•	•	•	•			•
Washington	•	•	•		•	•	•	•

Source: Prescription Drug Monitoring Program Training and Technical Assistance Center, Brandeis University.

Appendix B: Washington Prescriber Report Card Example



WASHINGTON PRESCRIPTION MONITORING PROGRAM PMP Prescriber Report



DATE: 3/29/2018

DATE COVERED BY THIS REPORT: 7/1/2017 - 12/31/2017

NAME:

DEA #

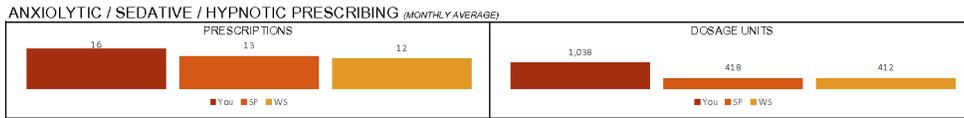
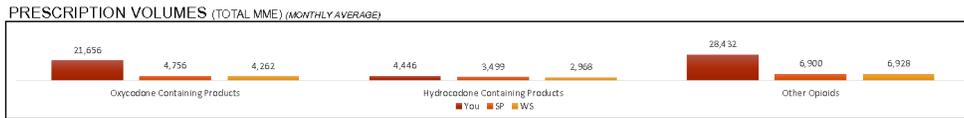
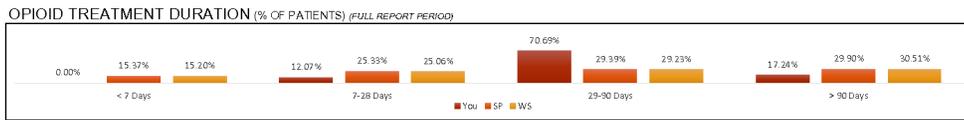
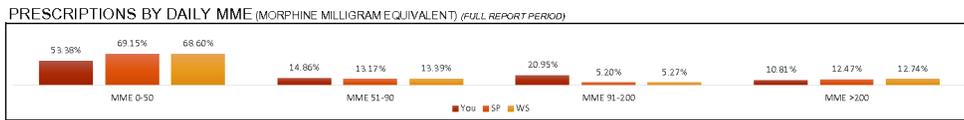
RCL: Physician and Surgeon License (MD)

SPECIALTY: Family Medicine

MEMBER NUMBERS IN YOUR PEER GROUPS: SIMILAR PRESCRIBER (SP) 243 WITHIN YOUR SPECIALTY (WS) 340

NUMBER OF PERSONS FOR WHICH YOU PRESCRIBED OPIOIDS (MONTHLY AVERAGE)			NUMBER OF PRESCRIPTIONS YOU WROTE FOR OPIOIDS (MONTHLY AVERAGE)		
19	21	20	25	24	24
You	Similar Prescriber (SP)	Within your Specialty (WS)	You	Similar Prescriber (SP)	Within your Specialty (WS)

TOP MEDICATIONS PRESCRIBED (FULL REPORT PERIOD)		
OXYCODONE HCL	ALPRAZOLAM	HYDROCODONE BITARTRATE/ACETAMINOPHEN



PDMP USAGE (MONTHLY AVERAGE)			
PDMP REQUESTS BY YOU	PDMP REQUESTS BY YOUR DELEGATE(S)	SIMILAR PRESCRIBER AVERAGE	SPECIALTY FIELD AVERAGE
15	0	9	9

PATIENTS EXCEEDING MULTIPLE PROVIDER THRESHOLDS (FULL REPORT PERIOD)	
PATIENTS EXCEEDING MULTIPLE PRESCRIBER THRESHOLD	PATIENTS EXCEEDING MULTIPLE PHARMACY THRESHOLD
0	0

DANGEROUS COMBINATION THERAPY			
PRESCRIPTIONS FOR OPIOID + BENZO IN SAME MONTH		PRESCRIPTIONS FOR OPIOID + BENZO + CARISOPRODOL IN SAME MONTH	
15	15	2	2
BY YOU	BY YOU + OTHER PRESCRIBERS	BY YOU	BY YOU + OTHER PRESCRIBERS

Appendix C: Washington Prescriber Report Card Email Example

Please do not reply to this email, the mailbox is not monitored. If you have questions or comments related to the contents of the report please email prescriptionmonitoring@DOH.WA.GOV

Dear Prescriber,

Attached is your personalized PMP Prescriber Report, which provides you with a snapshot of your prescribing of covered substances from July 1st, 2017 to December 31st, 2017.

1. This report is a summary of your prescriptions within the WA PMP database and a comparison to others within your specialty.
2. Morphine Milligram Equivalent (MME) dosing information is broken out so you can readily see whether (or where) your opioid prescribing falls within several MME ranges. Treatment drugs are included in this metric (Suboxone, Buprenorphine products, etc.).
3. Treatment duration is another metric that is meaningful and corresponds to PMP use as well as number of patients under treatment for chronic pain.
4. PDMP usage: shows how much you and your delegates are using the PMP web portal (does not include query activity via EHR-HIE integrations)
5. Multiple Provider Episodes (MPE) thresholds provides a look at your patients with multiple prescriber's episodes over the time period. This may indicate continuity of care issues or misuse, abuse or diversion of covered substances.
6. Dangerous combination therapy provides details of combination therapy that may increase a patient's risk for overdose.

Please take some time to review this information as well as the attached document explaining the metrics behind the report. This prescriber report is provided as an informational tool in support of the PMP's mission to improve healthcare quality and effectiveness by reducing abuse of controlled substances, reducing duplicative prescribing and overprescribing, and improving prescribing practices. It is not meant to be interpreted in isolation, or be used to impede the appropriate prescribing of controlled substances for legitimate medical purposes.

The Washington Department of Health has resources and tools for prescribers on our website at <https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionalsandFacilities/PrescriptionMonitoringProgramPMP/Resources>.

Additionally, the Centers for Disease Control and Prevention have information for prescribers at <https://www.cdc.gov/drugoverdose/prescribing/resources.html>.

The WA PMP hopes that you find this information helpful in your practice. If you have additional questions, please contact us at prescriptionmonitoring@DOH.WA.GOV or 360-236-4806.

Respectfully,

WA PMP Admin

Please do not reply to this email, the mailbox is not monitored.



OFFICE OF THE DIRECTOR

Kate Brown, Governor

Oregon
Health
Authority

500 Summer St NE E20
Salem OR 97301
Voice: 503-947-2340
Fax: 503-947-2341
www.Oregon.Gov/OHA
www.health.oregon.gov

December 4, 2018

Kip Memmott, Director
Secretary of State, Audits Division
255 Capitol St. NE, Suite 500
Salem, OR 97310

Dear Mr. Memmott,

This letter provides a written response to the Audits Division's final draft audit report titled "Constraints on Oregon's Prescription Drug Monitoring Program Limit the State's Ability to Help Address Opioid Misuse and Abuse," dated November 27, 2018.

Thank you for the opportunity to review and respond to the final draft report. I appreciate your close attention to Oregon's Prescription Drug Monitoring Program (PDMP) and your commitment to producing an accurate audit. The final draft report identifies several areas for improvement, and OHA agrees with all recommendations. However, recommendations 4 and 7-12 fall outside the scope of OHA's current statutory authority. In the absence of statute change, the agency's ability to complete them is limited. OHA is aware of the PDMP's current limitations and is actively engaged in policy discussions regarding potential legislative changes to add to the PDMP's capabilities and increase access to the system and its data. To address those recommendations that would require change in statute, OHA will continue to serve on the Governor's Opioid Task Force, and will continue to provide information to legislators on evidence-based recommendations to improve the PDMP and health outcomes.

Given the large impact of the opioid epidemic nationally, it is also important to contextualize the PDMP within the larger landscape of substance misuse in Oregon. While deaths and overdoses associated with illicit opioids are rising, opioid prescribing and prescription opioid-related deaths have been steadily decreasing in Oregon over the last few years. The PDMP was an important factor in these improved outcomes. However, it is one of many initiatives that comprise the Oregon Health Authority's multifaceted approach to addressing the opioid crisis.

In addition to its work with the PDMP, OHA has led development and promotion of consensus prescribing guidelines that are changing standard medical practice and culture around pain management; provided coaching and technical assistance for health care systems as they implement the guidelines; offered pain education training for clinicians through the Oregon Pain Management Commission; and encouraged safe prescribing practices within the Oregon

Health Plan. OHA also supports safe and effective non-opioid pain management and is actively increasing access to medication-assisted treatment (MAT) and naloxone rescue for opioid overdose. In addition, the agency collects and reports a variety of opioid-related data to inform policy decisions.

Below is our detailed response to each recommendation in the audit.

RECOMMENDATION 1		
Maintain an ongoing partnership with health licensing boards to target outreach efforts to get all required prescribers registered with the PDMP.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	May 31, 2019	Drew Simpson, PDMP Coordinator 971-673-1033

Narrative for Recommendation 1

Partnerships between the PDMP, prescribers, and licensing boards regarding opioid prescribing are a key means of ensuring patient safety. OHA has partnered with health licensing boards and medical associations to promote use of the PDMP for several years. In response to HB 4143’s requirement for all prescribers to register as PDMP users, OHA supported licensing boards in conducting provider outreach. With the help of medical licensing board promotion of PDMP registration and utilization, as of early November 2018, 92.7% of the 4,000 highest-volume prescribers of Schedule II-IV medications (which includes opioids) had registered for the PDMP. This is a substantial increase from March 2018 when only 55.4% of this group had registered. PDMP provider queries have increased more than fourfold since 2012. This effective work will continue.

RECOMMENDATION 2		
Provide guidance, including examples, to prescribers on ways to integrate accessing the PDMP database into their daily workflow.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	May 31, 2019	Laura Chisholm, Interim Manager Injury & Violence Prevention Section (guidance/examples) 971-673-0987

		<p>Susan Otter, OHA Director of Health Information Technology (technical system integration) 503-373-1817</p>
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Narrative for Recommendation 2

OHA provides guidance and assistance to providers to integrate PDMP use into their work flows in several ways.

Tools for clinicians: In collaboration with the PDMP, in 2017 Oregon Opioid Prescribing Guidelines Taskforce members developed opioid prescribing guideline implementation tools. These materials are available on the Oregon Pain Guidance website at <https://www.oregonpainguidance.org>, which currently receives more than 30,000 unique visitors per month. These clinical tools include work flows, a PDMP electronic health record integration guide, a quality improvement reporting guide, a PDMP training video, and guidance on medical director access to the PDMP. The website also provides an opioid patient registry template that enables providers to use the PDMP to identify and track their patients with opioid and benzodiazepine prescriptions, as this functionality is limited within most electronic health records. In response to this recommendation, OHA will review and update the PDMP website to ensure the broadest possible reach of these resources.

Training and technical assistance on PDMP use in clinical workflows: OHA also provides training and in-person support for PDMP use in clinical workflows place under the auspices of the Public Health Division’s Prescription Drug Overdose prevention project, a sister program to the PDMP that is coordinated through the Injury and Violence Prevention Program. This work takes place via OHA contracts with members of the Pain Management Improvement Team, an expert interdisciplinary group of Oregon clinicians that assists health systems and clinics to improve opioid prescribing and treatment of pain and substance use disorder. One of the contractors is a health informaticist who specializes in assisting clinics in maximizing their use of the PDMP within clinical workflows. Clinics in need of assistance are identified in collaboration with the Oregon Medical Board. This work has been nationally recognized as a model for a team-based primary care approach to address the opioid epidemic. In response to this recommendation, OHA will continue its collaboration with the Oregon Medical Board and the Pain Management Improvement Team to identify and support clinics in need of assistance with PDMP/electronic health record integration.

Electronic medical record/PDMP integration: The statewide Prescription Drug Monitoring Program Integration initiative was launched in August 2018 by the Oregon Health Leadership Council, OHA, and other stakeholders under a public/private partnership called the HIT Commons. For the first time, authorized Oregon prescribers and pharmacists can have one-click access to PDMP data within their own electronic workflow. This initiative aligns with broader state and federal efforts to increase the use of PDMPs to reduce inappropriate prescriptions, improve patient outcomes, and promote more informed prescribing practices. Oregon emergency departments have already seen the benefits of PDMP Integration. Earlier this year, the PDMP Integration initiative targeted the Emergency Department Information Exchange (EDIE)/PDMP integration as its highest priority. As of September 2018, 25 Oregon hospital emergency departments (more than 600 prescribing clinicians) across Oregon are receiving PDMP data via EDIE. In response to this recommendation, this work will continue.

RECOMMENDATION 3 Verify practitioner specialty information with the respective health licensing board and update the PDMP database with this information.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	February 28, 2019	Drew Simpson, PDMP Coordinator 971-673-1033

Narrative for Recommendation 3

Medical specialty information is an important element within the PDMP dataset and can help identify appropriateness of opioid prescribing. However, many prescriber types (e.g., naturopathic physician, dentist, nurse practitioner) do not have designated specialties, so it is not possible to identify specialty information for all PDMP users. Since October 2018, PDMP staff have been collecting available specialty information from licensing boards for upload into PDMP user profiles. This is a planned activity that is in process, one of the program's final steps in migration to the new PDMP platform. In response to this recommendation, this work will continue.

RECOMMENDATION 4 Develop a process for, and facilitate the sharing of, data between PDMP and Medicaid to help ensure completeness of PDMP prescription history and to allow Medicaid to better monitor the prescription behavior of its clients.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree, but not allowed under current statute	June 30, 2019 (or sine die)	Laura Chisholm, Interim Manager Injury & Violence Prevention Section 971-673-0987

Narrative for Recommendation 4

Completeness of prescription history is an important component of high-quality PDMP data. In response to this recommendation, OHA will confer with the Oregon Department of Justice to clarify the scope of the program's authority for data sharing with the Medicaid program. Based upon that advice, OHA will continue to provide data and best practices to legislators to inform statutory change to enable implementation of this recommendation.

RECOMMENDATION 5 Identify and propose drugs of concern, such as gabapentin, to the Board of Pharmacy and Legislature that should be added to the state's controlled substance schedule and collected by the PDMP.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation

	6 months)	
Agree	May 31, 2019	Drew Simpson, PDMP Coordinator 971-673-1033

Narrative for Recommendation 5

In response to this recommendation, OHA will continue to track emerging best practices regarding addition of drugs of potential abuse or misuse to Oregon’s PDMP. This ongoing work is informed by emerging medical and public health literature and program evaluations conducted within the community of agencies implementing PDMPs across the country. OHA will also continue its partnership with the Oregon High Intensity Drug Trafficking Area (HIDTA) program to stay current on trends in the local illicit drug market.

OHA will also continue to partner with the Board of Pharmacy as new drugs of concern emerge. Examples of previous partnership include OHA’s collaboration with the Board of Pharmacy on naloxone distribution and naloxone training, and the State Health Officer’s provision of data to inform discussions about the potential establishment of kratom as a scheduled medication (the Board of Pharmacy voted against this).

As new drugs emerge as potential additions to the PDMP, OHA will provide data and information to legislators.

RECOMMENDATION 6 Work with the PDMP vendor and the Board of Pharmacy to make sure prescriptions made by X-waivered prescribers are included in the PDMP database.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree	May 31, 2019	Drew Simpson, PDMP Coordinator 971-673-1033

Narrative for Recommendation 6

Complete prescription data within the PDMP is crucial for ensuring that the system enables clinicians to make safe and accurate prescribing decisions. OHA, like many other agencies that operate PDMPs across the country, recognizes the current gaps in X-waivered prescribing records as an area of focus for ongoing data quality improvement. Because identification of an up-to-date list of X-waivered providers has proved challenging, OHA is utilizing data from multiple sources, including the U.S. Drug Enforcement Agency and SAMHSA, to ensure that prescriptions filled under X-designated DEA numbers can be seen within the PDMP system. OHA is in the process of obtaining complete, current lists of X-waivered prescribers and as a response to this recommendation will continue to update PDMP records with this information as part of its ongoing data quality assurance activities.

RECOMMENDATION 7 Expand statutes to allow the PDMP to conduct and share analyses on prescription data, including:
--

<ul style="list-style-type: none"> a. analyzing prescriber, pharmacy, and patient prescription practices; b. making prescriber report cards available; and c. preparing and issuing unsolicited reports to licensing boards and law enforcement. 		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree, but not allowed under current statute	TBD, pending provision of statutory authority	Holly Heiberg, OHA Government Relations Director 971-207-7767

Narrative for Recommendation 7

Under PDMP’s current statutory authority, the legislatively mandated PDMP Clinical Review Subcommittee confidentially reviews prescriber, pharmacy, and patient prescription practices. Practice in other states has shown that peer comparison is an effective means of changing opioid prescribing practice. As guided by the Governor’s Office, OHA would support expansion of legislative authority to enable the full implementation of this recommendation. In response to this recommendation, OHA will provide data and best practices to legislators on evidence-based recommendations to improve the PDMP and health outcomes.

<p>RECOMMENDATION 8 Seek legislative action to address the issue of prescribers not registering with the PDMP as required and pharmacies not submitting corrected data within statutory requirements.</p>		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree, but under the scope of health licensing boards	TBD, pending provision of statutory authority	Holly Heiberg, OHA Government Relations Director 971-207-7767

Narrative for Recommendation 8

OHA agrees that complete, accurate PDMP data are important, and that routine use of the PDMP helps to reduce risky opioid prescribing and ensure patient safety. OHA awaits direction from the Oregon legislature regarding implementation of this recommendation and will support decision making with data and evidence-based practice.

<p>RECOMMENDATION 9 Provide further authority to the Clinical Review Subcommittee to require the justification of practices deemed concerning, and allow the collaboration with licensing boards and law enforcement for concerning practices.</p>		
Agree or Disagree with Recommendation	Target date to complete implementation activities	Name and phone number of specific point of contact

	(Generally expected within 6 months)	for implementation
Agree, but not allowed under current statute	TBD, pending provision of statutory authority	Holly Heiberg, OHA Government Relations Director 971-207-7767

Narrative for Recommendation 9

The PDMP Clinical Review Subcommittee has reviewed data, created risky opioid prescribing criteria, identified risky prescribers, and sent letters to these providers informing them of resources for improving their prescribing practices. OHA agrees that the ability to share more information about prescribing practices—especially among those providers prescribing the highest numbers of opioids—will enhance patient safety. OHA awaits direction from the Oregon legislature regarding implementation of this recommendation and will support decision making with data and evidence-based practice.

RECOMMENDATION 10 Expand authority for other professional and state entities authorized access to PDMP information.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree, but not allowed under current statute	TBD, pending provision of statutory authority	Holly Heiberg, OHA Government Relations Director 971-207-7767

Narrative for Recommendation 10

OHA agrees that expanding authorized access to specific groups—including dental directors and Coordinated Care medical and pharmacy directors—would enhance oversight of prescribing practices and improve patient safety. OHA awaits direction from the Oregon legislature regarding implementation of this recommendation and will support decision making with data and evidence-based practice.

RECOMMENDATION 11 Require and set parameters for when prescribers must query the PDMP database to review a patient’s prescription history. This should include, at a minimum, requiring the querying of the PDMP database prior to prescribing controlled substances and substances of concern, and for dispensers to query the database prior to issuing a medication and periodically while the patient is taking those medications.		
Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree, but not allowed	TBD, pending provision of	Holly Heiberg, OHA

under current statute	statutory authority	Government Relations Director 971-207-7767
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Narrative for Recommendation 11

OHA agrees that routine use of the PDMP by providers and pharmacists is important for reducing opioid prescribing. The agency will await direction from the Oregon legislature regarding this recommendation and support decision making with data and evidence-based practice.

RECOMMENDATION 12

Allow for additional information to be collected by the PDMP. This should include:

- a. prescriptions for Schedule V controlled substances and other drugs of concern;
- b. applicable prescriptions from other types of pharmacies, not solely retail pharmacies;
- c. applicable prescriptions prescribed by veterinarians;
- d. method of payment used to pay for the prescription;
- e. patients who are restricted or have a "lock-in" to a single prescriber and a single pharmacy for obtaining controlled substances; and
- f. diagnosis code related to the prescription.

Agree or Disagree with Recommendation	Target date to complete implementation activities (Generally expected within 6 months)	Name and phone number of specific point of contact for implementation
Agree, but not allowed under current statute	TBD, pending provision of statutory authority	Holly Heiberg, OHA Government Relations Director 971-207-7767

Narrative for Recommendation 12

OHA agrees that complete, accurate PDMP data are important, and that routine use of the PDMP by providers and pharmacists is important for reducing opioid prescribing. The agency will await direction from the Oregon legislature regarding this recommendation and support decision making with data and evidence-based practice.

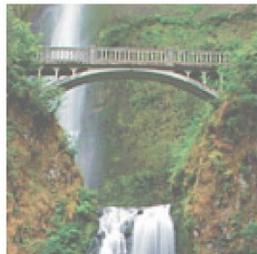
Please contact interim Injury and Violence Prevention Section Manager Laura Chisholm at 971-673-0987 with any questions.

Sincerely,



Kris Kautz, OHA Deputy Director

cc:



Audit Team

William Garber, CGFM, MPA, Deputy Director

Jamie Ralls, CFE, Audit Manager

Karen Peterson, Principal Auditor

Kathy Davis, Staff Auditor

About the Secretary of State Audits Division

The Oregon Constitution provides that the Secretary of State shall be, by virtue of his office, Auditor of Public Accounts. The Audits Division performs this duty. The division reports to the elected Secretary of State and is independent of other agencies within the Executive, Legislative, and Judicial branches of Oregon government. The division has constitutional authority to audit all state officers, agencies, boards and commissions as well as administer municipal audit law.

This report is intended to promote the best possible management of public resources.
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