DATA AND EVALUATION TASK FORCE

Governor's Commission on Alcohol and Other Drugs

Co-Chairs: Steve Ahnen and Jonathan Ballard

Monday, March 18th, 2019 – 1:00PM-3:00PM
Community Health Institute, 501 South Street, 2nd Floor, Bow, NH

Meeting Minutes

I. Welcome & Introductions (Jan minutes approved)	**Participants:** Steve Ahnen , Jonathan Ballard, Dave Mara, Helene Anzalone, Alex Casale, Benjamin Chan [on phone], Chris Chant, Chiahui Chawla, Mark Cioffi, Amy Costello [on phone], Kim Fallon, Helen Hanks [on phone], Joe Harding, Rachel Kohn, Joanne Lahaie [on phone], Allison Parent, Michelle Ricco Jonas, Jonathan Stewart, Dave Swenson [on phone].

Agenda Item	Discussion	Action Steps
II. Opioid Overprescribing Advisory Council/ Mitre project update **(Chris Teixiera, Mitre)**	1. Was originally discussed at January's meeting; this time from Mitre Corporation. 2. Establishing set of analytics and metrics for understanding opioid prescribing habits, and piloting this with the State of NH's collaboration. 3. Project is to set up an advisory council and a task force, and in addition share analytics and dashboard, which is being created. 4. Allow a set of metrics that can measure effect of implemented policies 5. New Hampshire Opioid Overprescribing and Misuse Project Advisory Council (OOMPAC) will assist in helping to identify what data are available; advise the Governor on policies and procedures that might help impact the opioid crisis – specifically prescribing habits. 6. Around 50 metrics identified; can be calculated from All-Payer Claims Database (provided by DHHS, with support from Insurance Dept.) 7. Advisory Council holds public meetings on monthly basis. 8. Other part of project is developing analytics to understand prescribing behavior patterns and to identify baseline for what is over-prescribing. 9. Task force (still being established) will then decide on what measures need to be taken. 10. Metrics taking on the form of questions (Why are we interested in this metric?) 11. Number of overdoses and fatalities are usually reported. This project, however, aims to look earlier in the life cycle of the challenge to understand what are leading indicators. 12. Rather than just say, "We will the calculate the number of *x*", this can be rephrased as a question. For example, one question being asked is: "What is the distribution of average Morphine Milligram	⇒ **Dave Mara to forward HIDTA presentation referenced in the meeting** ⇒ **C. Teixeira (Mitre) to forward Table of Common Opioids and Performance Characterization Framework Core Questions for OOMPAC**

	Equivalent dosing per patient encounter where an opioid was prescribed over the last three months?" 13. Sometimes there will be a simple, calculated number, sometimes a table of results, sometimes a line graph, or interactive data dashboard. 14. Not necessarily providing answers; rather, providing tools for NH to explore and understand some of the nuances. 15. OOMPAC comprises some members present in this (D&E TF) meeting, as well as members from Dartmouth College, UNH, NH Board of Pharmacy, Catholic Medical Center, NH Medical Society, and others (~19 organizations represented). 16. 13 years of All-Payer Claims dataset obtained (Medical, Dental, and Pharmacy claims). 17. Several reports being prepared for State of NH, including Data Preparation Notebook (preparation of data for analysis) and Data Quality Notebook by end of contract (September, 2019). 18. Of the 13 years of A-PCD data, some years are better than others, with respect to quality. Based on this, analysis will begin from 2015, onward (coinciding with change to ICD-10). 19. All-Payer Claims dataset does not include self-pay, uninsured, patients who have out-of-state insurance plans. Also, some issues with patient addresses; are they actually NH residents? 20. Also gaps where there have been cash payments. Coupons/Wellness Cards erroneously show up in Prescription Drug Monitoring Program (PDMP) as insurance claim. This can skew datasets. 21. This project, however, is only focusing on prescribers; main part of analysis is not on patients. 22. Some patient history from looking at opioids that are prescribed and result in addiction. 23. What is the relationship between the project task force and the efforts of the PDMP? Some overlap, but synchronicity, overall. AG's office will soon announce who is on task force. PDMP has developed metrics, based on rules that have in play around opioid prescribing; will be doing educational, clinical alerts to prescribers when patients have met certain thresholds. 24. After September, State of NH will own developed dashboard; potential then to input more data sources (e.g., stimulants). 25. There are still issues with being able to connect all available data sources in NH. Should make recommendations (similar to Chapter 55 legislation in MA). 26. Chapter 55 was signed by Gov. Charlie Baker (MA) to override some MA laws to bring together ~13 data sources (identifiable, maintained in silos) that could be joined together for public health surveillance in State of MA (mostly opioids). De-identified dataset also created by third party into a "data warehouse"; available to pre-qualified researchers. 35 research projects established under C55 to explore opioid overdoses in MA. Had to be on-site to access data, however. Provided a means to look at analytics that wouldn't normally be directly associated with opioid overdoses (e.g., homeless data). 27. Chapter 55 was extended for two extra years after initial year, but now expired. However, voluntary provision of data to system by agencies exists.	

III. Update Task Force purpose and objectives **(S. Ahnen / J. Ballard, group discussion)**	1. Review existing objectives; are they in line with what the D&E TF wants to achieve? 2. The D&E TF reviewed the existing objectives (document e-mailed out prior to meeting). 3. R. Kohn: Objectives have more of a reactive scope; not much language centered on approaching and identifying future trends/issues. Is this a separate objective? 4. What are the mechanisms for reporting the data? How did this come about? Whom are they going to? Center for Excellence has a role in this, as contracted by the Bureau for Drug and Alcohol Services (BDAS). Role of D&E TF is to make interpretations, recommendations, and conclusions, based on available data sources through group. 5. Data/information exists in silos, and so group can convene to monitor and review these sources. 6. Imperative that TF educates and makes recommendations (policy/procedures/legislation) to legislature regarding availability, linking, and sharing of data sources from around the State (similar to Chap. 55, MA). 7. D&E TF reviewed old objectives at last meeting. There has now been an official GC process regarding membership; list of members was approved by GC Chair, Patrick Tufts. This will be annual process, going forward. Members have voting privileges, and meetings are public.	⇒ **Re-think/re-work objectives to bring to May's meeting for approval**
IV. NH Prescription Drug Monitoring Program data update **(M. Ricco Jonas, M. Cioffi)**	1. PDMP is currently preparing annual report. 2. Questions will probably be asked about "What does this [data] mean?" Response will likely be that reasons are manifold; could be explored further if other data sources were available. 3. MRJ presented her slides to the D&E TF. 4. Database registration has increased, despite existing challenges with licensing system faced by licensing board. PDMP registration for those only licensed in NH and DEA membership associated with license. 5. >16,000 registered users, but only ~5,000 active users (2018). 6. Delegates make up a large proportion of users. What/who are delegates? Could be, for example, somebody from an office – licensed or non-licensed – typically Medical Assistant, or Registered Nurse. Must be registered in the system, and approved by provider. Up to providers to manage changes in delegate status. One delegate could represent multiple providers. 7. Overall prescription count: 4.1% reduction (2017); 2.2% reduction (2018); two-year reduction: 7.6%. 8. Overall reduction of opioid prescriptions; fluctuating results for non-opioids. 9. Looking for some consensus with neighboring states regarding certain measures for data-sharing opportunities. 10. VT, by comparison, has more prescription guidelines. 11. PDMP currently doesn't have ICD-10 coding, but there is future potential. Some states have added these codes, however. 12. Prescriber Report Card coming out in April; communication will go out to all registered licensees beforehand. Extra provider/physician specialties can be added. Provider Report Card will provide	

	analysis of prescribing patterns over a period of time, with relationship to all physicians and peer group. 13. De-identified reports will eventually go out. 14. NH is seeing a rise in stimulants (Adderall), particularly among young adults, and especially among college populations. 15. Young children on prescription stimulants are transitioning into young adulthood still on these stimulants. 16. A rise of methamphetamines in the State, too.	
V. Governor's Commission 2019 Mid-Year Report **(J. Stewart)**	1. Review of attachment given out prior to meeting. 2. GC releasing a much more concise report, and moving more toward online dashboard. 3. In October 2018, 2,334 individuals received SUD-related services through Standard Medicaid and an additional 4,333 received SUD-related services covered by Expanded Medicaid. The total of 6,667 individuals receiving SUD-related services per month through NH Medicaid in October 2018 is more than 5 times as many people who received such services at the beginning of 2012. 4. Decrease in EMS cases involving Narcan administration (-4.3%, 2017; -19.5%, 2018). 5. Reduction and flattening number of ED visits related to opioid use, especially in 2018. 6. Reduction in drug overdose deaths (per Chief Medical Examiner data). 7. What can these reductions be attributed to? There are many contributors; collective group efforts; hard to isolate. 8. Increase in individuals in treatment and recovery. 9. It's hard to know how many unrecorded, treated overdoses there are, owing to more available Narcan. No data for those who overdosed, but didn't get treated at hospital/didn't contact EMS. 10. Because of overdose deaths, is there now just a smaller pool of at-risk individuals? 11. Are reductions in opioid use also because of people transitioning to other illicit drugs? Instances of drugs laced with opioids (e.g., cocaine). 12. Comm. Hanks: use of provided Narcan being tracked among women and men (harm-reduction model) on probation/parole. More efforts going into tracking, post-release (more Re-entry Coordinators). 13. Other drugs (e.g., methamphetamine) not necessarily a replacement for opioids, owing to activation of different brain receptors by these other drugs. 14. Instances of people on medication-assisted treatment (MAT) significantly relapsing because of returning to level of intake prior to MAT. This is a big risk factor for overdose/death. 15. Consideration for Narcan (J Lahaie): Narcan isn't exclusively used for overdoses; could be for seizures, altered mental status, or severely suppressed respiratory conditions. Caution, therefore, should be exercised when looking at Narcan administration data.	

VI. Barriers to inter-agency data exchange **(J. Ballard, group discussion)**	1. Considerations for this and next meeting. 2. Cost is a big barrier for integrating databases. Cost of hiring people to monitor this integration. One-off government grants don't necessarily solve this problem. 3. Legal authority is a barrier in NH; NH statute has restrictions on data (e.g., hospital discharge data) that can be shared between NH Departments. 4. However, SB111 has been introduced, which aims to repeal and replace RSA 126:25 (Health Care Data; Data Collection) and RSA 126:28 (Health Care Data; Availability of Data). *"The department [DHHS], department of justice, and the department of health and human services shall enter into a memorandum of understanding for collaboration in the development of a comprehensive health care information system, the sharing of submitted data fields, and the role of each in the security of transferred health care data."* 5. With (42 CFR) Part 2 programs, data can be shared, and you can have de-identified data or not (e.g., for program evaluation). A (licensed/official) program evaluator wouldn't share identifiable data, but a treatment agency/provider (under Part 2) can give data to program evaluator, but there have been instances where treatment agencies *can* but won't give patient data. Difficult, therefore, to conduct cost-effectiveness/recidivism studies, for example. 6. Data migration from old to new systems (time, fidelity, cost, etc.).	⇒ **Group to think about questions related to opioid epidemic that they want answered before next meeting. Submit questions to Jonathan Stewart before next meeting.**
VII. Future Task Force Meetings and Agenda Topics **(Ahnen/Ballard, group discussion)**	Discussion of unanswered questions related to the opioid epidemic in NH and potential data sources	

Next Meeting: **Monday, 20th May, 2019 (1:00 PM – 3:00 PM).**
Please note the change of venue for this meeting:

New Hampshire Hospital Association (Room 1)
125 Airport Rd,
Concord, NH 03301.

Call-In Information: Dial-in number: **719-284-5327**
PIN: **68316**