MARYLAND ADVISORY BOARD ON PRESCRIPTION DRUG MONITORING (PDMP)
March 7, 2016
4:00PM to 6:00 PM
BEHAVIORAL HEALTH ADMINISTRATION
VOCATIONAL REHABILITATION BUILDING
55 WADE AVENUE
CATONSVILLE, MD 21228

Attendees

Advisory Board
Gayle Jordan-Randolph, MD
Dale Baker, CPRS/RPS
Rimple Gabri, RPh
David Sharp, Ph.D.
Thelma B. Wright, MD JD
Janet M. Beebe, CRNP
Gail Amalia B. Katz, MPH
Janet Getzey Hart (phone)
David Sharp, PhD (phone)
Captain Daniel D. Alioto (phone)

Advisory Board Not Present
Shirley Devaris, RN JD
Vinu Ganti, MD
Orlee Panitch, MD
Celeste M. Lombardi, MD
Daniel M. Ashby, MS, FASHP

Board Adjunct: Linda Bethman, JD, MA, Office of the Attorney General, DHMH

CRISP Representative: Michael Banfield, CRISP Project Manager

Technical Advisory Committee (TAC)
Marcia Wolf, MD
Joseph Adams, MD (phone)

DHMH Staff
Kate Jackson, MPH, PDMP Manager, BHA
Michael Baier, Overdose Prevention Director
Tryphena Barnes, PDMP Secretary, BHA
Vani Subramanian, PDMP Data Analyst, BHA
Kathy Rebbert-Franklin, LCSW-C, Deputy Director, Population-Based Behavioral Health, BHA
Christina Trenton, LCSW-C, CAC-AD, Assistant Director, Population-Based Behavioral Health, BHA

Public
Sheena Siddiqui
Justine Springer
Kelly Wagner
Richard DeBenedette
Lonny Samuels

Minutes

I. Agenda Review and Approval of Minutes: Kate Jackson reviewed the topics of discussion in the agenda. Any changes to the September 10th meeting minutes should be emailed to Kate.

II. PDMP Activities

PDMP/CRISP User Registration, Use & System Performance: Mike Banfield shared the following PDMP access numbers. During the week of January 24-31, 2016, the PDMP surpassed 10,000 active users. Presently, there are 10, 133 active users; users are comprised of 7,090 prescribers, 1, 246 prescriber delegates, 1, 652 pharmacists, and 81 pharmacy delegates. The Maryland PDMP is averaging approximately 89 new users per week. The system sees an average of 20,000 weekly queries, an 11% increase in query volume from last quarter.

Mike presented new CRISP tools to assist clinical providers accessing PDMP data, including Single Sign-On, PDMP Integrations, and use of Care Profiles in the Query Portal.

New Projects:

Single Sign-On (SSO) is an approach that will enable faster and more efficient access to the query portal through the electronic health record (HER), by securely sending a local user's credentials and the current patient medical record (or other demographics) to CRISP. Then, CRISP can send the user directly to the patient summary screen within the Patient Query portal, skipping the steps of signing into CRISP and looking up a patient.

A **Care Profile** is a new tab that will be available when viewing patient data in the Patient Query Portal. Under this tab, there will be a listing of organizations, or care facilities, that 'subscribe' to a patients, whether an organization has uploaded a Care Plan document executed between an organization's provider and the patient, any care managers assigned to this patient, whether the patient has a CDS prescribing relationship established with a subscribing provider, and any Event Notification System (ENS) Encounters (admissions, discharges, or transfers) in the last 60 days. This will allow providers to know who has engaged in sustained and formalized care with a patient, how to get in contact with the those providers, and the agreements in place (if shared).

In-Context Notifications and Alerting is intended to provide key information to clinical decision-makers at the most effective point in their clinical workflow. In-Context notifications are inclusive of a range of alert types sent to the point of care provider or to a care manager. The notifications pertain to critical information about patient, identify care gaps, indicate when post-discharge follow-up care has not occurred, or other clinical or patient management situations of interest. For example, an in-context alert may push information to a hospital ED when the ED workflow registers a new patient as presenting for emergency care and that individual has a Care Plan uploaded by a provider and available for view in CRISP.

Finally, Mike provided a copy of the CRISP marketing handout for these services and asked if any Board member has feedback to please contact him.

Interstate Interoperability Expansion: Discussions have been ongoing with some states interested in connecting, and Kate is hopeful that by the next Board meeting to have more states on board. So far, Maryland is connected with Virginia, West Virginia, Connecticut, and Arkansas. There was a question about whether the Veterans Administration (VA) system is reporting dispensed prescriptions to the PDMP. Kate confirmed that the VA has been reporting data to the PDMP since March 2015; a Board member confirmed that some VA system prescriptions that are known to be dispensed are not showing up in the PDMP. Kate will look into this with the VA and report back.

Unsolicited Reporting Pilot and Overdose Notifications to Providers: Kate mentioned that the Program has adopted the policies and procedures reviewed by the Advisory Board at the last meeting and that the TAC is actively reviewing data reports generated from the initial pilot thresholds.

III. Legislation Update

Two Bills Introduced-Mandatory Registration & Use:

A summary was provided of the Heroin and Opioid Task Force activities, including the recommendation for legislation to move the PDMP to mandatory registration and use. Kate and Michael Baier provided an update on two bills affecting the PDMP that were introduced during the 2016 Legislative Session. Additional funds were also allocated in

the Governor's budget that would be used for Program enhancements to support the new legislation.

The first bill, SB382 (cross-filed as HB456) was introduced by the Administration and the second bill, HB437 was introduced by Delegate Barron (cross-filed as SB537 by Sentator Klausmeier). The Administration Bill requires prescribers and pharmacists who prescriber or dispense any Schedule II-V CDS to register with the PDMP. Pharmacists must be registered by 7/1/2017. Prescribers must be registered with the PDMP prior to obtaining a new or renewal CDS permit with DDC, or by 7/1/2017, whichever occurs first; CDS permit renewal is on a rolling, multi-year basis. The Department must provide a course of training to registrants. Both bills contain these provisions.

Under both bills, prescribers will also be required to check the PDMP before prescribing or dispensing an initial opioid or benzodiazepine prescription and then at least every 90 days in the duration of treatment with an opioid of benzodiazepine extends longer than 90 days. There are exceptions to this requirement outlined in the statute and the ability for the DHMH Secretary to create additional exceptions in regulations. The exceptions vary between the two bills but consensus is being found for a single bill to move forward. Under the compromise bill, pharmacists will be required to check the PDMP before dispensing a prescription they believe is being obtained in any part for something other than treatment of an existing medical condition.

The bills also expand the definition of a delegate to access PDMP data on behalf of a prescriber or pharmacist. Right now, prescribers and pharmacists may authorize a licensed health care provider to serve as a delegate to request prescription drug monitoring data. Both bills include the provision to expand the delegate definition to include unlicensed healthcare staff. The PDMP plans to

These bills each had hearings in the House Health and Government Operations Committee and the Senate Finance Committee. The Senate Finance Committee created a workgroup to find consensus on the bill between legislators, the Administration, and stakeholder groups. Kate and Michael have been in attendance at these meetings to provide factual input and inform decision-makers on key issues. Kate and Michael solicited feedback from the Board about the bills during the meeting.

<u>Feedback summary</u>:

- One Board member thought that these mandates were appropriate given that prescribers do contribute to the opioid epidemic and this is a tool they are not, as a whole, utilizing regularly.
- There was a concern about whether someone who was unable to access PDMP data for IT reasons, as allowed under one of the use exceptions, would have to document that reason in the medical chart.
- A TAC member in attendance thought that requiring the prescriber to access PDMP data at least every 90 days for ongoing use was not appropriate. They argued that the greatest need to check the PDMP is within the first few months of starting a new prescription and that ongoing checks should be left to the discretion of the provider.

Michael suggested that Board members should take a look at the bill after the meeting and send feedback.

Unsolicited Reporting Scope-Technical Advisory Committee and Education: Delegate Barron's bill not only addressed mandatory registration and use of PDMP by clinicians, but also expands the Program's unsolicited reporting activities. The original bill would require the Program to analyze PDMP data for indicators of violations of law or breaches of professional standards by prescribers or dispensers, and if found, those violations would be required to be reported to law enforcement or licensing boards. During the workgroup process, alternatives have been discussed, including reporting violations of law and breaches of professional standards to prescribers and dispensers for the purpose of education and only after this step failed would law enforcement or licensing boards be notified. The specifics of the unsolicited reporting activity expansion are still being finalized.

Unsolicited Reporting Activity: Kate mentioned that an educational approach aligns with the current Program activities around unsolicited reporting and Behavioral Health Administration (BHA) and DHMH plans around provider education. The first round of unsolicited reporting notifications were identified and the TAC reviewed the recipients who met or exceeded the threshold that was used; the threshold was set to identify individuals who received prescriptions from at least 15 prescribers and at least 10 dispensers over a three month period of time (October – December 2015). As was discussed at a previous Advisory Board meeting, a letter explaining the notification is accompanied by a more extensive FAQ document providing information about how to register for PDMP access, what an unsolicited reporting notification is, how to review and utilize PDMP data, what to do if a prescriber believes a patient needs treatment or recovery services, or if the prescriber suspects fraud. The document also provides links to other DHMH resources for overdose and opioid misuse prevention. Three recipients met this initial threshold.

Overdose Notification Proposal: Michael Baier gave an overview of a possible new program activity to notify prescribers who have a history of having prescribed to individuals that experience an overdose. A Boston Medical Center study entitled, "Opioid Prescribing Effort Non-Fatal Overdose and Associated with Repeated Overdose" found that 91% (study population of approximately 2800) who had experienced an overdose and had been prescribed opioids before had were continued to be prescribed opioids after the overdose; even after subsequent overdoses. This type of study highlight s the reality that many prescribers may not be aware of medical events happening for their patients. Under the unsolicited reporting authority, the Program could notify prescribers of opioids about these events. The Board thought this was a potentially useful application of PDMP activities.

Kate gave an update on a statute change last legislative session that allowed the PDMP program to disclose PDMP data to overdose fatality review teams across the state, including maternal, child/infant and overdose, to aid in their case review process. The

regulations that were required by the statute went through the review process and were promulgated on February 29, 2016. Fatality review teams are allowed to request PDMP data to further an existing case review being conducted by the fatality review team or program, upon approval by the DMHM Secretary. This process is not unlike that for DHMH agencies authorized to request PDMP data for existing investigations, however TAC review is not required for fatality review team requests. The Program has been working with other Office of Overdose Prevention staff and members of the Office of the Secretary to come up with a process expedite the expected large number of requests. The Secretary will provide a 'blanket' approval for requests that meet the statutory and regulatory requirements, which will allow the Program to process all legitimate requests for data in a timely fashion without individual sign-off by the Secretary. Also, the Program has been working with the other fatality review teams across the state to ensure that they understand the process, are being trained, and can begin requesting data.

Investigative Requests Process Feedback: Kate announced that the final Technical Advisory Committee seat has been filled. This individual will join the TAC in reviewing investigative requests and unsolicited reporting notifications. Kate explained that an Advisory Board member requested that the topic of PDMP investigative requests be placed on the meeting agenda. In preparation, a document was prepared summarizing the current investigative data request process, who is authorized to request data, what is required by those individuals in order to be in compliance with the statute and regulations, and metrics on how this process has been going. Kate reviewed highlights from this document including responses from a survey of investigative users. This survey asked questions about the request process, the formats in which PDMP data are provided, as well as their review, use and utility of the TAC Report. For example, the Office of the Chief Medical Examiner (OCME) is legally authorized to request PDMP data but the current process allows the TAC up to 10 business days to provide their guidance, which creates a time lag that makes data requests of no use to their autopsy investigations. Law enforcement and regulatory boards also experience delays in receiving data due to the built in required TAC review of data. Many investigators report that they have their own clinical reviewers and data specialists that analyze the data received by the PDMP within the context of the investigation at hand. Therefore, the TAC Report does not deliver in practice the benefits expected by the legislators and stakeholders who included this in the original statute.

After these updates, the floor was opened for discussion on best practices for the TAC, and the Prescription Drug Monitoring Program overall moving forward to unsolicited reporting. The Maryland PDMP has created a policy when data requests span a large period of time for a dispenser or prescriber, resulting in a data report with thousands of records which cannot be adequately reviewed within the standard 10 business days. For these requests, which often have 5,000 -8,000 records, we offer the investigator the choice to re-submit the request with a far more limited timeframe, and/or allow the TAC 30 calendar days to review the data and submit their TAC report. Since policy was implemented in August, 2015 we have granted extension for 27 requests.

Feedback summary:

- Board members and a TAC member in attendance agreed that it made sense to expand the TAC membership.
- A Board member argued that shifting the TAC role away from reviewing investigative data requests was not in line with the original intent of the PDMP statute; they stated that the PDMP was originally intended as a clinical tool and not an investigative tool. They stated that TAC review of investigative requests ensures that the PDMP does not become a tool of law enforcement.
- PDMP staff mentioned that the PDMP has always served to support both clinical and investigative users, and that the intended utility of the TAC's role in the investigative request process has not panned out according to user feedback.

Again, Michael suggested that the Board members review the bill and provide feedback in writing to Kate Jackson, by Wednesday, March 9, 2016. Board members were asked to make the feedback as specific as possible. Kate will resend the bills after the meeting for review by the members.

IV. Open Discussion: Meeting ran long so no items addressed.

Next Board Meeting: Wednesday, April 06, 2016

Meeting Adjourned