April 9, 2015

The Honorable Lawrence J. Hogan, Jr.
Governor
State of Maryland
Annapolis, MD 21401-1991

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
Speaker of the House
H-101 State House
Annapolis, MD 21401-1991

Re: HB 255 (Chapter 92 of the Acts of 2014) – Prescription Drug Monitoring Program – Sunset
Extension and Program Evaluation

Dear Governor Hogan, President Miller and Speaker Busch:

Pursuant to Section 2 of Chapter 92 of the Acts of 2014 (HB 255), the Prescription Drug Monitoring Program within the Department of Health and Mental Hygiene (Department) shall submit this report on the Prescription Drug Monitoring Program. Specifically, HB 255 required the Department to conduct a direct full evaluation of the Prescription Drug Monitoring Program in accordance with requirements established under § 8–405(e) and (f) of the State Government Article.

This report is submitted in addition to the Department's 2014 Report of the Analysis of the Advisory Board on Prescription Drug Monitoring on the Impact of the Prescription Drug Monitoring Program under Health - General Article § 21-2A-05.

If you have any questions regarding this report, please contact Allison Taylor, Director of Governmental Affairs, at 410-767-6481 or at Allison.Taylor@maryland.gov.

Sincerely,

Van T. Mitchell
Secretary

Enclosure

cc: Gayle Jordan-Randolph, M.D.
Brian Hepburn, M.D.
Allison Taylor, J.D., M.P.P.
Sarah Albert, MSAR #10101

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BEHAVIORAL HEALTH ADMINISTRATION

Prescription Drug Monitoring Program (PDMP) – Chapter 92 of the Acts of 2014

Larry Hogan, Governor
Boyd Rutherford, Lt. Governor
Van T. Mitchell, Secretary

January 1, 2015

Introduction

This report is submitted by the Prescription Drug Monitoring Program (PDMP) within the Department of Health and Mental Hygiene (Department) pursuant to Section 2 of Chapter 92 of the Acts of 2014 on the PDMP, which requires the Department to:

1. Describe efforts to collect and make available, in real-time, prescription monitoring data;
2. Include recommendations for a long-term funding source to support the Program;
3. Provide the status of the Department of Health and Mental Hygiene's independent evaluation of the Program; and
4. Discuss the status of any plans to pursue unsolicited reporting or mandatory utilization of prescription monitoring data by health care providers.

Maryland's PDMP was established by Chapter 166 of the Acts of 2011 to implement monitoring of prescribing and dispensing of controlled dangerous substances on Schedules II through V in order to address the issues of prescription drug abuse and drug diversion. PDMP became operational in 2014, with users beginning to register in December 2013. PDMP is assisted by an Advisory Board on Prescription Drug Monitoring, which makes recommendations, provides annual reports, and provides oversight. PDMP information is available for use to certain groups of people; however, a five-member Technical Advisory Committee (TAC) is required for the review of certain requests for information.

More recently, Chapter 92 of the Acts of 2014 extended the PDMP termination date to July 1, 2019 and further authorized the disclosure of information to authorized administrators of another state's PDMP for disclosure to prescribers, dispensers, and patients without review by the TAC. It also requires a direct, full evaluation of the program in 2017, creates additional requirements for annual reports, and requires the submission of the following report.

I.   Efforts to Collect & Disseminate Prescription Drug Monitoring Program Data in Real-Time

Summary

From the outset of PDMP planning, the Department has sought to identify information technology approaches that would allow the program to collect and make available PDMP data to authorized users in the timeliest manner possible. Although a data collection process that includes some lag time is still very useful for supporting the PDMP's core function (*e.g.,* identifying patients with multiple provider episodes), the Department recognizes that the

provision of timely information is an important factor in perception of system usefulness. This factor can have a significant impact on uptake and use of the system.

The Department has identified potential real-time data collection approaches; however, they all include significant logistical and costs barriers to implementation. Therefore, the Department has decided to focus limited resources on improving the speed and ease of access to PDMP data for system users rather than increasing the frequency of data collection and entry beyond the current "within 3 business days" requirement. Investment of scarce program resources in improving system access is more likely to promote greater use of the system and translate into a broader public health impact than implementing real-time data collection.

Background

When Maryland's PDMP law passed in 2011, most states with PDMPs in place required dispensers to report on a weekly basis. When additional data processing time was factored in, this meant that the data available to system users in these states reflected prescriptions dispensed more than a week prior to the query. Many other states required only monthly reporting. A few states required, or were in the process of requiring, daily reporting. Only one state (Oklahoma) was in the process of implementing "real-time" reporting directly from dispensers in an attempt to collect data within five minutes of dispensing. The Department consulted with Oklahoma's PDMP administrator on multiple occasions to determine whether Maryland could implement a real-time data collection system in a similar manner. Oklahoma advised that their approach to system enhancement was years in the making and could not likely be duplicated in a timely and efficient manner by a startup program. Given this advice and that, during initial PDMP development, the Department prioritized a novel PDMP/CRISP (Chesapeake Regional Information System for Our Patients) integration project that was expected to present unforeseen costs and logistical challenges, the Department decided to explore other data collection approaches besides real-time reporting during the implementation process.

The PDMP regulations adopted by the Department in December 2012 included a requirement that dispensers report data "within 3 business days" of dispensing. The "within 3 business days" timeframe represented a compromise between the importance of establishing timely data collection and the concerns of pharmacy industry stakeholders that, given uncertainty about the ability of current IT systems to support daily or real-time reporting, a more frequent data collection requirement could impose undue costs on pharmacy operations.[1] Nevertheless, the Department decided to continue investigating real-time reporting, should an approach prove feasible for some pharmacies on a pilot or permanent basis.

After receiving funding for PDMP implementation, CRISP released a Request for Proposals (RFP) for potential vendors to support certain PDMP services, including data

---

[1] Health-Gen. Art.§ 21-2A-04(b)(2) prohibits the program from imposing undue workload or expense on dispensers.

collection. The RFP included a requirement that bidders detail any approach to real-time data collection that they could support. CRISP received two responses to the RFP and both included proposals for real-time data collection that hinged on partnerships between well-established PDMP vendors that provide "off the shelf" data collection services and companies that operate real-time data exchange networks supporting claims processing and other services for pharmacies. Both proposals included plans to leverage these electronic claims adjudication networks (colloquially known as "switches") to allow pharmacies to satisfy the PDMP reporting requirement.

The switch operators proposed to route dispensing data contained in the claims messages to the PDMP. One proposal included likely, significant, unsustainable costs, which would have ultimately be supported by State funding, for reconfiguring the PDMP vendor's and switch operator's technologies. The other proposal included plans to shift the development costs onto pharmacy clients of the switch operator by allowing them to pay a fee for the optional service of having the switch handle PDMP reporting for them. Although the latter proposal was included in the RFP response that was ultimately selected by CRISP for contract, the switch operator, upon further assessment of the business environment, declined to pursue the project during final contract negotiations. CRISP and the Department pursued discussions with both switch operators to see if any agreement could be reached to continue investigation of this approach. However, these discussions were not successful in maintaining the switch operators' interest in the project.

In light of the difficulty of identifying a workable and cost effective approach to real-time data collection, the Department decided to move forward with a data collection process based on periodic, batch reporting of dispensing records. This process is used by almost every other state PDMP and has worked well to support the basic functionality of these programs. Although dispensers in Maryland must report data "within 3 business days," in reality, most pharmacies are reporting more frequently. As of December 2014, the program estimates that over half of all pharmacies reporting to the PDMP are averaging 24 or more submissions per month, indicating close to daily reporting for the majority of pharmacies.

Rather than invest program resources in new technologies that may only marginally increase the timeliness of data reporting or the eventual public health impact, the Department believes that improving ease of access and use of PDMP data through the CRISP query portal and, potentially, other health IT systems will be a more effective means of meeting the public health goals of the program. Priority has been given to improving the way the CRISP portal displays PDMP data to reduce the amount of "clicks" system users must make to access a patient's complete prescription profile, an issue that has been identified as a barrier to more regular use in hospital emergency departments. Also, broader use of the data will be promoted by systems integration projects that allow data to be displayed within the end user's electronic

health record system or that provide a streamlined method for accessing PDMP data within the CRISP portal. Such initiatives have been highlighted nationally as PDMP best practices and will require resource investments that may be unavailable should real-time reporting be prioritized.

II.　　　Recommendations for a Long-Term Funding Source to Support PDMP

Summary

From the beginning of development, the Department, with the support and assistance of the Governor's Office of Crime Control & Prevention, has been able to secure consistent funding to plan, implement, and operate the PDMP through targeted federal grants. As the Program gains significant uptake and use across the State, and multi-year Program budgets have been developed, stable long-term funding opportunities should now be considered.

Many states report difficulty securing such funding for their PDMP, but a number of solutions have been identified as successful in certain states and should be considered within the legal and regulatory landscape of Maryland. These funding sources or revenue streams include controlled substance registration and professional licensure fees, fees on health insurers, funds from legal settlements, Medicaid fraud fines, private donations, fines imposed on healthcare practitioners by licensing boards, law enforcement asset seizure/forfeiture funds, tax assessments on pharmaceutical manufacturers, voluntary contributions from health insurers and others. The Program has discussed this issue with the PDMP Advisory Board and will continue to do so in 2015.

Background

In its 2013 report "Funding Options for Prescription Drug Monitoring Programs," the PDMP Training and Technical Assistance Center at Brandeis University noted that, despite the growing evidence that PDMPs are an effective tool for reducing prescription drug misuse and diversion, "many PDMPs struggle to stay operational. Limited and uncertain funding has made it difficult for PDMPs to enhance their operations and achieve their full potential." To date, Maryland has been fortunate in its ability to access both State and federal funding to implement and operate its PDMP. To support program implementation, the Department, in cooperation with the Governor's Office of Crime Control & Prevention, aggressively pursued grant opportunities in order to minimize reliance on State general funds. In total, the State has received funding through five federal grants to plan, implement and operate the program. All five grants have come from the US Department of Justice, Bureau of Justice Assistance, through the Harold Rogers PDMP grant program or the Byrne Justice Assistance Grant program. These grants are summarized in the table below.

Grant	Amount	Purpose	PDMP Components Supported (in whole or in part)
2009 Harold Rogers PDMP	$50,000	Planning	Advisory Council on Prescription Drug Monitoring; draft legislation
2011 Byrne Justice Assistance Grant	$500,000	Implementation	PDMP personnel, information technology
2011 Harold Rogers PDMP	$400,000	Implementation	PDMP personnel, office equipment, travel, information technology, misc. expenses
2012 Harold Rogers PDMP	$400,000	Implementation & operations	Information technology, program evaluation
2013 Harold Rogers PDMP	$400,000	Multi-disciplinary PDMP data use projects	This grant does not directly support PDMP operations but provides funding for other programs that seek to use PDMP and other data to reduce prescription drug misuse and overdose, including Local Overdose Fatality Review Teams and the Controlled Dangerous Substance Integration Unit.
Total	**$1,750,000**		

Although federal grants have provided a significant source of funding to date, in the future federal funding is unlikely to be available at comparable levels to support most program activities. The Harold Rogers PDMP grants are primarily made available to fund program implementation or enhancement, not to support ongoing maintenance of core operations. The Department will continue to apply for these grants to support novel enhancements. However, other sources of funding will have to be utilized to maintain current operations. No other significant federal or non-governmental grant programs are available to support these costs.

The Department's budget has included State general funds totaling $512,000 in FY2014 and $502,434 in FY2015 to support the PDMP. Based on a preliminary assessment of program costs, the Department estimates that supporting core PDMP operations on an ongoing basis will require at least $550,000 annually. This includes roughly $200,000 for three PDMP full time staff (including salary, fringe and incidental expenses like travel, equipment, etc.) and at least $350,000 to support CRISP's IT and project management costs. This estimate does not include costs related to establishing interoperability with other states' PDMPs, infrastructure costs

related to mandatory PDMP registration or use for healthcare practitioners (described below) or any other program enhancements.

Brandeis' report, referenced above, details funding sources other than federal grants and state general funds that are currently being utilized by other state PDMPs. These include controlled substance registration and professional licensure fees, fees on health insurers, funds from legal settlements, Medicaid fraud fines and private donations. The report also identifies other potential sources, including fines imposed on healthcare practitioners by licensing boards, law enforcement asset seizure/forfeiture funds, tax assessments on pharmaceutical manufacturers, voluntary contributions from health insurers and others. Of the sources currently being utilized, controlled substance registration and licensing fees appear to be the most common funding source. According to the National Association for Model State Drug Laws, in 2014, 18 states relied on fees to support all or part of their PDMP costs. However, Maryland is one of 10 states with a statutory prohibition against the assessment of licensing or other fees to support the PDMP.[2] Statutory change would therefore be required to use funding from Maryland's Controlled Dangerous Substances permit fee or fees collected by the health occupations licensing boards to support the PDMP.

The Department has consulted with the Advisory Board on Prescription Drug Monitoring about the potential for other sources of funding to be tapped, including law enforcement asset seizure/forfeiture funds. However, to date a clear path forward for securing other funding sources has not been identified. The Department will continue its discussions with the Board in 2015 to identify potential supplemental sources of funding for PDMP operations and enhancement.

III. Status of the Department's Independent Evaluation of PDMP

Summary

A statutory requirement for an ongoing program evaluation was created in Health-General Article §21-2A-05(4)(iii), which states that the Advisory Board for Prescription Drug Monitoring shall "provide ongoing advice and consultation on the implementation and operation of the Program, including recommendations relating to … the design and implementation of an ongoing evaluation component of the Program." In order to appropriately address this requirement, the Program solicited proposals for program evaluation services. A research team has been contracted for completion of an initial program evaluation scope of work that focuses on understanding baseline and immediate post-implementation prescribing and dispensing

---

[2] Health Gen. Art. § 21-2A-04(b)(3)(II) states that the Department "may not impose any fees or other assessments on prescribers or dispensers to support the operation of the Program."

patterns, prescriber uptake of PDMP and identifiable barriers to and facilitators of PDMP use, population-level impact of PDMP and unintended consequences. Initial evaluation activities began in late 2014.

Background

The Department has entered into an agreement with the University of Maryland, School of Pharmacy, which, along with research colleagues at the Johns Hopkins School of Public Health, are designing and conducting an ongoing evaluation of PDMP impact and outcomes. The Memorandum of Understanding (MOU) for this evaluation project was fully executed on October 20, 2014. An initial kick-off meeting between researchers and the Department occurred on October 30, 2014 and evaluation activities are expected to occur through December 2015. Bi-weekly team meetings are held, with the evaluation team and representatives from the program in attendance.

The evaluation's scope of work includes the following components:

1. Conduct a prescriber-level study of the adoption, implementation and maintenance of the Maryland PDMP. Document and evaluate the uptake of the PDMP by prescribers in key clinical settings, including hospitals, emergency departments, urgent care clinics, pain management clinics, behavioral health treatment providers, *etc*. Assess: a) barriers and facilitators to PDMP use; b) retention and/or adaptation of key features and uses of the PDMP; and c) capacity-building for successful program implementation in key settings.
2. Identify baseline and post-PDMP implementation prescribing and dispensing patterns for pharmaceutical controlled substances with a focus on opioids and benzodiazepines.
3. Measure the effectiveness of the Maryland PDMP, from a population health perspective, by analyzing longitudinal data to assess the effect of the program on: a) rates of hospital inpatient stays for poisoning related to pharmaceutical controlled substances; b) emergency department visits for poisoning related to pharmaceutical controlled substances; c) poisoning deaths related to pharmaceutical controlled substances; and d) access to/use of treatment and recovery services for individuals with prescription drug-related substance use disorders.
4. Evaluate whether the Maryland PDMP has had unintended consequences, including reducing legitimate access to pharmaceutical care and increase in use of illicit substances. Evaluation activities are designed to meet the statutory requirement for ongoing evaluation of the program under Health-General Article §21-2A-05(4)(iii) and will inform the Department on the impact of the program on patient access to pharmaceutical care and on curbing prescription drug diversion in the State.

IV. Plans to Pursue Unsolicited Reporting and Mandatory Utilization of PDMP by Health Care Providers

Summary

With PDMP implementation complete, it is an appropriate time to consider possible Program modifications, such as unsolicited reporting and/or mandatory use. Many states have begun adoption of unsolicited reporting, the activity of proactively providing PDMP data to specific users. House Bill 1296 (Chapter 651 of the Acts of 2014) was passed and authorizes unsolicited reporting activity. Regulations mandated by the statutory amendment were posted for public comment on January 9, 2015 and once they are promulgated, the Program intends to begin activities under this new authority.

Laws mandating registration and use of PDMPs are also being considered for adoption by many states. Under the current PDMP law in Maryland, prescribers and dispensers are explicitly not required to access the PDMP as part of their clinical care of a patient. However, proposed regulations put forth by the Department mandate CRISP/PDMP user registration as a criterion for a new or renewed Controlled Dangerous Substances permit through the Division of Drug Control. This regulatory change supports the PDMP program goals by educating prescribers about the PDMP through an education module about Controlled Dangerous Substances, prescribing, and use of the PDMP, as part of the registration process and by creating a database of accurate contact information for planned unsolicited reporting activities.

There is increasing support for mandatory use laws based on a growing, though still small, body of literature supporting this activity. However, a lack of formal consensus on the most effective method of deploying this mandate in the clinical workflow and the unknown, though likely significant, costs associated with implementing and accommodating the increased IT burden of mandatory use, has led the Department to pursue mandatory registration alone at this time.

Background

Unsolicited Reporting

Unsolicited reporting is the proactive dissemination of PDMP data or notification of PDMP users about aberrant drug prescribing, dispensing or use patterns that may indicate inappropriate prescribing or dispensing or the presence of patient misuse of controlled dangerous substances. Unsolicited reporting is considered a best practice by the US Department of Justice, Substance Abuse and Mental Health Services Administration and the PDMP Center of Excellence at Brandeis University and has been or is currently being adopted by a majority of states. Proactive reporting to prescribers and dispensers will allow the program to better support

clinical decision-making around prescribing controlled dangerous substances and assist prescribers and dispensers in identifying prescription drug misuse and diversion. House Bill 1296 (Chapter 651 of the Acts of 2014) authorized the Program to review PDMP data for indications of possible misuse or abuse, and if a review indicates possible misuse or abuse, the Program may provide a proactive report to the prescriber or dispenser. In addition, the PDMP's existing Technical Advisory Committee (TAC) must review the data prior to it being released to the prescriber or dispenser.

The Department intends to implement unsolicited reporting as an important component of program operations. The program consulted with numerous states' PDMP administrators and national experts to review applicable laws and regulations and identify methods of unsolicited reporting currently in use. Regulations to implement HB1296 were developed by the Department during the summer of 2014, reviewed and approved by the Advisory Board on Prescription Drug Monitoring and were posted for public comment on January 9, 2015. The proposed regulations establish the authority for the program to review PDMP data (including TAC review) and issue reports to prescribers and dispensers as authorized by statute. In anticipation of adoption of the regulations, the program is currently assessing available resources and methods for analyzing PDMP data and issuing reports with a particular interest in utilizing CRISP's health IT infrastructure. The ideal methods for issuing unsolicited reports may change based on developments in the next year related to mandatory PDMP registration or use (described below).

Mandatory Registration or Use

There are two main ways in which states have used legislation or regulations to increase prescriber utilization of PDMPs: mandatory registration and mandatory use/access. Mandatory registration requires that prescribers and/or dispensers register for a PDMP user account that would allow them to query their patient's prescription history. Mandatory registration typically would include completion of any associated education or training process. Mandatory use laws require that certain prescribers and/or dispensers not only be registered users, but actually query their patients' prescription history using the PDMP in specifically defined situations (*i.e.*, when first prescribing a Controlled Dangerous Substance, when prescribing a Schedule II Controlled Dangerous Substance, when prescribing any Controlled Dangerous Substance annually, *etc.*).

The program conducted an informal review of mandatory use and mandatory registration laws in other states during the summer of 2014. As of June 2014, in addition to the 20 states with explicit statutory language mandating PDMP registration for prescribers, seven states (CA, IN, LA, MN, NC, ND, OK) require use/access of the PDMP under certain clinical situations, which carries an implicit requirement for PDMP registration in order to comply with the mandatory use laws. As of June 2014, 22 states require that specific individuals access PDMP information

under certain circumstances.[3] Of these 22 states, only seven do not also have some mandatory registration legislation enacted. There are 20 states in total that require that all licensed prescribers (and/or dispensers) register with the state's PDMP.[4] The trigger for required PDMP access varies widely between states, including: upon first visit with a new patient for whom controlled substances have been prescribed; each visit with a patient for whom a provider has prescribed a controlled substance; at the time that a new controlled substance prescription has been written for a patient; at minimum time intervals for sustained controlled substance prescribing. Additionally, mandated querying of the PDMP may be linked with any specific controlled substance, or with only certain schedules or identified classes of controlled substances.

There is a growing body of evidence supporting the impact of mandatory use of PDMPs on increased provider registration and access of PDMP data and decreased patient encounters with multiple (distinct) providers (*e.g.,* "doctor-shopping"). This literature indicates that the mandates often require PDMP IT infrastructure enhancements to handle the increased number of active users and queries, costs for implementation and compliance monitoring and enforcement, as well as increased monitoring of appropriate clinical use by those mandated to access patient information. States that have implemented mandatory use laws vary widely in when they require prescribers to access the PDMP, and there is no consensus in the literature on the specific point(s) in the clinical encounter at which access to the PDMP produces the desired effects.

Under current Maryland law, prescribers and dispensers are explicitly not required to access or use PDMP data.[5]   However, in January 2015, the Department published proposed regulations for the Division of Drug Control (DDC)[6] requiring that prescribing practitioners register with the PDMP for a user account and complete an education module on the substance use disorder treatment system, as conditions for receiving an initial or renewed Controlled Dangerous Substances permit. The PDMP registration requirement would take effect 90 days after the Secretary has made a written determination that the PDMP has the technological capacity to handle the additional processing load. The goals of this amendment are to increase awareness of the PDMP, provide education about Controlled Dangerous Substances prescribing and use of the PDMP, as well as to educate prescribers about substance use disorder treatment options, all of which would assist in providing access to legitimate pharmaceutical care while

---

[3] The 22 states are: AZ, CT, CO, DE, IN, KY, LA, MA, MN, MS, NC, ND, NM, NV, OH, OK, RI, TN, VA, VT, WA, WV; States that Require Prescribers and/or Dispensers to Access PMP Information in Certain Circumstances. National Alliance for Model State Drug Laws. June 2014: http://www.namsdl.org/library/4477511F-1372-636C-DDB1895D055F9D30/

[4] The 20 states are: AL, AZ, CA, CO, CT, DE, ID, KY, MA, ME, MS, NH, NM, OH, RI, TN, UT, VA, VT, WV; States that Require All Licensed Prescribers and/or Dispensers to Register with PMP Database. National Alliance for Model State Drug Laws. June 2014: http://www.namsdl.org/library/44749A4C-1372-636C-DDC422A628F7B404/

[5] Health-Gen. Art.§ 21-2A-04(b)(4)

[6] COMAR 10.19.03.03

addressing prescription drug diversion, misuse and abuse. Additionally, mandatory registration supports the unsolicited reporting activities of the program by creating an accurate database of prescriber and dispenser contact information and ensuring that all prescribers who will be contacted by the program already have access to PDMP data in order to query patients identified in unsolicited reports. The Department reviewed the proposed registration with the Advisory Board on Prescription Drug Monitoring during the Board's meeting in November 2014. As stated in the Board's 2014 Annual Report, the Board generally supports the registration requirement, although concerns were expressed that implementing the requirement may overburden the DDC's Controlled Dangerous Substances permit registration process and exacerbate existing backlogs.

At this time, the Department estimates that implementing mandatory registration will require $99,750 in new funding for Year 1, with a three-year total of $237,250.[7] Relevant costs include procurement of user identity proofing services and additional registration personnel. A potential additional cost not included in this estimate is CRISP infrastructure costs to accommodate the increased registration volume. Given the uncertainty about the efficacy of mandatory use laws and their associated costs, the Department has decided to pursue mandatory registration alone as a first step in expanding the program under existing legal authority. The Department will continue to monitor the impact and outcomes of mandatory use laws in other states and review the available evidence with the Advisory Board.

Conclusion

Pursuant to Section 2 of Chapter 92 of the Acts of 2014, the Department of Health and Mental Hygiene (Department) submits this report on the PDMP. The Department identified potential real-time data collection approaches that unfortunately have significant logistical and cost barriers and offered only marginal timeliness and public health impact, as Maryland's PDMP already experiences delays in data entry. Therefore, the Department has chosen to focus on improving the speed and ease of access to PDMP through known PDMP best practices, including reducing the amount of "clicks" system users must make to access information as well as further integrating PDMP information with electronic health record systems.

Since PDMP's inception, the Department has secured funding for the program through targeted federal grants and state general funds. However, the Program is at a point where stable, long-term funding must be considered. Many possibilities have been identified based on other states' practices. While the Department and the Advisory Board on Prescription Drug Monitoring have not yet identified a clear path forward, the conversation will continue between the Department and the Board in 2015.

---

[7] Estimate provided by Chesapeake Regional Health Information System for our Patients (CRISP) via email correspondence, November 25, 2014.

In accordance with the statutory requirement for ongoing program evaluation, the Program solicited proposals for program evaluation services. Initial evaluation activities began in late 2014. The evaluation scope of work will focus on baseline and immediate post-implementation prescribing and dispensing patterns, prescriber uptake of PDMP and identifiable barriers and facilitators of PDMP use, population level impact, and unintended consequences. Chapter 651 of the Acts of 2014 authorizes unsolicited reporting activity by PDMP, which is the proactive dissemination of PDMP information to users about prescribing, dispensing, or use patterns and may indicate inappropriate prescribing and dispensing or patient misuse. Regulations have been posted for public comment and the program intends to implement unsolicited reporting activity once the regulations are promulgated. After careful consideration of mandated registration and mandated use, the Department decided to propose regulations that would mandate CRISP/PDMP user registration as a requirement for new or renewed Controlled Dangerous Substances permits. Mandated registration and the requirements attached to it would educate prescribers about PDMP and create a database of contact information that could be used for unsolicited reporting activities.