Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

September 13, 2023

The Honorable Wes Moore
Governor
100 State Circle
Annapolis, MD 21401-1991

The Honorable Bill Ferguson
President of the Senate
State House, H-107
Annapolis, MD 21401-1991

The Honorable Adrienne A. Jones
Speaker of the House
State House, H-101
Annapolis, MD 21401-1991

RE: Health-General § 21-2A-05(f)(3) – Annual Prescription Drug Monitoring Program Report (MSAR # 12181)

Dear Governor Moore, President Ferguson, and Speaker Jones:

Pursuant to Health-General § 21-2A-05(f)(3), Annual Prescription Drug Monitoring Program Report, the Maryland Department of Health respectfully submits the attached report detailing the status of the Prescription Drug Monitoring Program on behalf of the Advisory Board on Prescription Drug Monitoring.

If you have any questions or comments concerning the report, please contact Megan Peters, Acting Director, Office of Governmental Affairs, at megan.peters@maryland.gov.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary

cc: Nilesh Kalyanaraman, Deputy Secretary, Public Health Services
Marie Grant, Assistant Secretary of Health Policy
Megan Peters, Acting Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (MSAR # **12181**)

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Introduction

Title 21, Subtitle 2A of the Health-General Article [enacted by Senate Bill (SB) 883, Chapter 166 of the Acts of 2011] requires that the Maryland Department of Health (Department) create a Prescription Drug Monitoring Program (PDMP or Program) to reduce the misuse, abuse, and diversion of prescription drugs throughout the State. The duties of the PDMP, as outlined in the PDMP law, include:

- Monitoring dispensed prescriptions that contain controlled dangerous substances (CDS);
- Maintaining an electronic database of CDS prescription information; and
- Making these data available to statutorily-defined groups of individuals and entities responsible for ensuring the health and welfare of patients and the lawful use of CDS.

Section 21-2A-05 of the Health-General Article provides for the creation of the Advisory Board on Prescription Drug Monitoring (Board). The Board is composed of a diverse array of stakeholders. The Board has met regularly since the membership was first appointed in autumn 2011 and has provided feedback and recommendations on several topics, including regulations, information technology (IT), interstate data sharing and interoperability, program evaluation, funding, and educational initiatives. The current Board membership is listed in **Attachment A**.

Section 21-2A-05(f)(3) of the Health-General Article requires the Board to provide annually to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly a report that includes:

I. The number of prescribers and prescriber delegates registered with and using the Program
II. The number of pharmacists and pharmacist delegates registered with and using the Program
III. The number of disclosures made to federal, state or local law enforcement agencies
IV. An analysis of the impact on the Program on patient access to pharmaceutical care and on curbing prescription drug diversion in the State; and
V. 1. The number of providers, by provider type, who received outreach and education from the Program
   2. The number of cases for which the providers received outreach and education from the Program
VI. 1. The number of cases that were identified for Technical Advisory Committee review before referral to the Office of Controlled Substances Administration (OCSA)
   2. The number of providers, by provider type, involved in the cases
VII. 1. The number of cases that were referred to OCSA for further evaluation and the outcomes of OCSA evaluations
   2. The number of providers, by provider type, involved in the cases
VIII. Any recommendation related to modification or continuation of the Program.

Clinical User Registration and Access of PDMP Data

The first two requirements of the report rely on registration and user statistics as follows:

I. The number of prescribers and prescriber delegates registered with and using the Program

II. The number of pharmacists and pharmacist delegates registered with and using the Program

As the largest group of end users, Maryland clinicians are key PDMP stakeholders. The Chesapeake Regional Information System for our Patients (CRISP), the State-designated health information exchange (HIE), provides registration and access services for healthcare providers to view PDMP data. Clinical users access PDMP data through CRISP's clinical query portal in a view called 'PDMP Search'; or, institutional providers may increasingly access Maryland PDMP data through an integration within an electronic health record (EHR). Integrations can take multiple forms and may navigate a registered PDMP clinical user to the PDMP search view from their EHR or may display PDMP data in a view without any further clicks. In 2022, the Program continued to implement enhancements to clinical user access to PDMP data. The program enhancements, funded by a combination of Federal grants and State general funds, were necessary to support clinical user adoption of the use mandate, build clinical tools to support prescribing practices, and improve the quality and timeliness of PDMP data.

Under HB437 (Chapter 147, 2016), all CDS prescribers and pharmacists licensed to dispense CDS in Maryland are subject to the registration mandate and must be registered with the PDMP by July 1, 2017. Effective February 15, 2018, a prescriber must be PDMP-registered before being issued a new or renewal CDS Registration by the Office of Controlled Substances Administration (OCSA). Prescribers must renew their CDS registration every three years. Delegates, for both prescribers and pharmacists, are not subject to a registration mandate.

Table 1 shows the total number of registered users subject to the registration mandate by user type. Of those prescribers and pharmacists subject to the registration mandate, 93% of prescribers and 81% of pharmacists are registered. **Table 2** shows the number of total registrants by user type as of October 2022 including providers who are licensed out of state but work in a federal facility in Maryland or dispense to Maryland residents. These providers are not subject to the registration mandate but they may register with the PDMP. **Table 3** shows the number of registered prescribers and pharmacists by jurisdiction of the registrant.

The use mandate impacting both prescribers and pharmacists went into effect July 1, 2018. Prescribers and pharmacists are required to query the PDMP in certain prescribing and dispensing situations. Delegates, for both prescribers and pharmacists, are not subject to the use mandate. **Table 4** shows the total monthly clinical PDMP queries across all user categories between January 2021 and June 2022. Clinical users may access PDMP data in two ways: through an integration with a healthcare facility's EHR system or through CRISP's web-based portal. The "Data Calls through EHRs" column in **Table 4** lists the number of queries from a healthcare facility's EHR for the PDMP data. The EHR then places the PDMP data within the patient's record for review by the clinician. The "PDMP Search" by Prescribers, Pharmacists, and their respective Delegates lists the number of queries by role through CRISP's web-based portal. These are unique counts of queries to the PDMP.

Table 1. Registered Clinical PDMP Users Subject to the Registration Mandate.

Type of User	# of Registered Users	# Individuals subject to Registration Mandate	% of Individuals who are PDMP Registered
Prescriber	37,401	40,304	93%
Pharmacist	10,248	12,687	81%

Table 2. CRISP Registrants by User Category as of August 2022

Number of Registered Users	Prescriber	Prescriber Delegate	Pharmacist	Pharmacist Delegate
77,114	51,486	12,104	12,338	1,186

Table 3. Prescriber and Pharmacist Registration Rates by Local Jurisdiction

Jurisdiction*	Prescriber Registration Rate (# registered active CDS prescribers / # active CDS prescribers)	Pharmacist Registration Rate(# licensed pharmacists/ # registered licensed pharmacists)
Allegany	**94.9%** (480/506)	**92.9%** (52/56)
Anne Arundel	**94.3%** (2,839/3,012)	**91.2%** (613/672)
Baltimore	**94.0%** (5,312/5,649)	**92.6%** (942/1017)
Baltimore City	**91.3%** (8,014/8,776)	**79.0%** (414/524)
Calvert	**95.9%** (302/315)	**98.1%** (52/53)
Caroline	**93.2%** (55/59)	**100%** (12/12)
Carroll	**95.8%** (611/638)	**94.7%** (196/207)
Cecil	**85.6%** (480/561)	**91.1%** (41/45)
Charles	**93.9%** (611/651)	**91.8%** (67/73)
Dorchester	**94.7%** (72/76)	**100%** (23/23)
Frederick	**92.7%** (1,231/1,328)	**91.6%** (305/333)
Garrett	**95.3%** (141/148)	**92.0%** (23/25)
Harford	**95.8%** (1,038/1,084)	**94.4%** (306/324)
Howard	**94.3%** (1,817/1,927)	**91.3%** (1,056/1,157)
Kent	**96.9%** (62/64)	**88.9%** (8/9)
Montgomery	**93.5%** (7,068/7,560)	**86.5%** (1,372/1,587)
Prince George's	**92.4%** (3,420/3,703)	**83.9%** (674/803)
Queen Anne's	**95.3%** (102/107)	**94.7%** (36/38)
Saint Mary's	**93.8%** (378/403)	**93.2%** (41/44)
Somerset	**94.6%** (53/56)	**83.3%** (10/12)
Talbot	**94.9%** (352/371)	**95.6%** (43/45)
Washington	**92.9%** (810/872)	**91.9%** (79/86)
Wicomico	**93.7%** (725/774)	**92.4%** (134/145)
Worcester	**97.2%** (243/250)	**95.7%** (67/70)

* Registered prescriber and pharmacist jurisdiction is assigned based on the zip code of the address self-reported to OCSA and the MD Board of Pharmacy

Table 4. Number of PDMP Queries by Month

Month	Data Calls through EHRs[1]	PDMP Search - Prescribers[2]	PDMP Search - Prescriber Delegates[2]	PDMP Search - Pharmacists[2]	PDMP Search - Pharmacist Delegates[2]
2021					
January	1,103,638	81,129	53,572	39,096	3,535
February	1,180,136	75,702	53,735	35,420	3,305
March	1,325,623	88,843	67,850	38,572	3,701
April	1,561,374	80,509	61,447	35,015	3,565
May	1,281,545	74,486	57,424	36,239	3,405
June	1,220,320	80,347	67,083	38,763	4,248
July	1,532,116	82,700	69,699	43,783	4,796
August	1,222,820	77,001	65,961	38,565	4,522
September	1,533,735	76,912	62,373	37,575	4,487
October	1,332,466	72,358	61,110	35,072	4,259
November	1,199,326	73,748	62,194	34,584	4,174
December	1,578,558	72,515	65,881	35,143	4,243
2021 Total	**16,071,657**	**936,250**	**748,329**	**447,827**	**48,240**
2022					
January	1,287,328	74,925	62,232	35,777	3,996
February	1,361,037	73,293	62,232	37,369	3,918
March	1,731,981	85,645	72,244	45,987	4,234
April	1,355,150	79,255	65,580	40,190	3,444
May	1,390,977	81,689	63,033	41,490	3,065
June	1,846,229	82,063	65,629	41,739	3,613
2022 6-Month Total	**8,972,702**	**476,870**	**391,615**	**242,552**	**22,270**

1. Data calls through EHR integrations include all calls for PDMP data from a 'zero-click' integration by a registered PDMP clinical user, **regardless** of whether PDMP data was returned and displayed.
2. 'PDMP Search' totals include queries made by a user in the PDMP Search user interface hosted within the CRISP clinical query portal.

Interstate Data Sharing

In 2022, the Program facilitated data sharing through two interstate data-sharing hubs. Maryland now shares data with 31 states (an increase from 20 states in 2020), Puerto Rico, Washington, D.C., the Military Health System, and the Veterans Health Administration. Maryland shares data with Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, Florida, Illinois, Iowa, Kentucky, Maine, Massachusetts, Minnesota, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin.

In September 2020, the Program began sharing Maryland PDMP data with EHRs and pharmacy management systems in other states. Before Chapter 364 and regulations promulgated in 2020, the Program only shared data with other state's PDMPs and not directly with authorized users of other state's PDMPs through EHR integrations. Integrating Maryland PDMP data into the EHRs and pharmacy management systems in other states allows prescribers and pharmacists access to relevant clinical data when making prescribing or dispensing decisions for Maryland patients. EHRs and pharmacy management systems in 561 healthcare facilities, including 84 pharmacies, outside of Maryland have been approved to receive Maryland PDMP data.

- Delaware: 59 facilities
- Pennsylvania: 60 facilities
- Virginia: 382 facilities
- Washington, DC: 57 facilities
- West Virginia: 59 facilities (+ WV's HIE)
- Facilities Located in Multiple States: 29

Veterinarian Reporting and Access

In 2022, the Program continued to work towards addressing the reporting gap of controlled substances dispensed in Maryland to address the opioid epidemic by convening a PDMP Advisory Board ad hoc committee to review veterinarian dispenses. On June 28, 2021, the PDMP Advisory Board approved the following recommendations:

1. Reporting requirements should be updated to ensure consistent reporting to the PDMP of certain data elements to distinguish CDS dispenses written for pets. Consistent reporting will allow clinical users, investigators, and Program staff to easily distinguish between CDS dispenses written for pets and for humans.
2. A data visual should be added in the PDMP to distinguish CDS prescriptions written for pets based on improved reporting requirements.
3. CDS prescription dispenses from a veterinarian's office should be reported to the PDMP.
4. After implementing recommendations 1-3, the ad-hoc committee will reconvene to continue discussion of whether veterinarian clinical query access to the PDMP is appropriate and/or necessary.

Beginning in May 2022 the PDMP added a data visual, a paw print, to the clinical interface to distinguish CDS prescriptions written for Maryland pets that are filled at a community pharmacy or mailed into the state. The Program has drafted regulations to guide dispensers on how to consistently enter pet dispensing data, and the Program met with the Board of Veterinary Medical Examiners on May 26, 2022 to discuss the legislative recommendations from the PDMP Advisory Board. A legislative proposal was submitted by the Department but was not selected by the Governor's Office to move forward during the 2022 legislative session.

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Impact of the Program

This section of the report addresses the following reporting requirements:

III. The number of disclosures made to federal, state or local law enforcement agencies

IV. An analysis of the impact on the Program on patient access to pharmaceutical care and on curbing prescription drug diversion in the State

Key components of the Program include enabling end users to make better use of the PDMP data in decision-making or actions to combat the opioid crisis.

Investigative and Case Review User Registration and Use

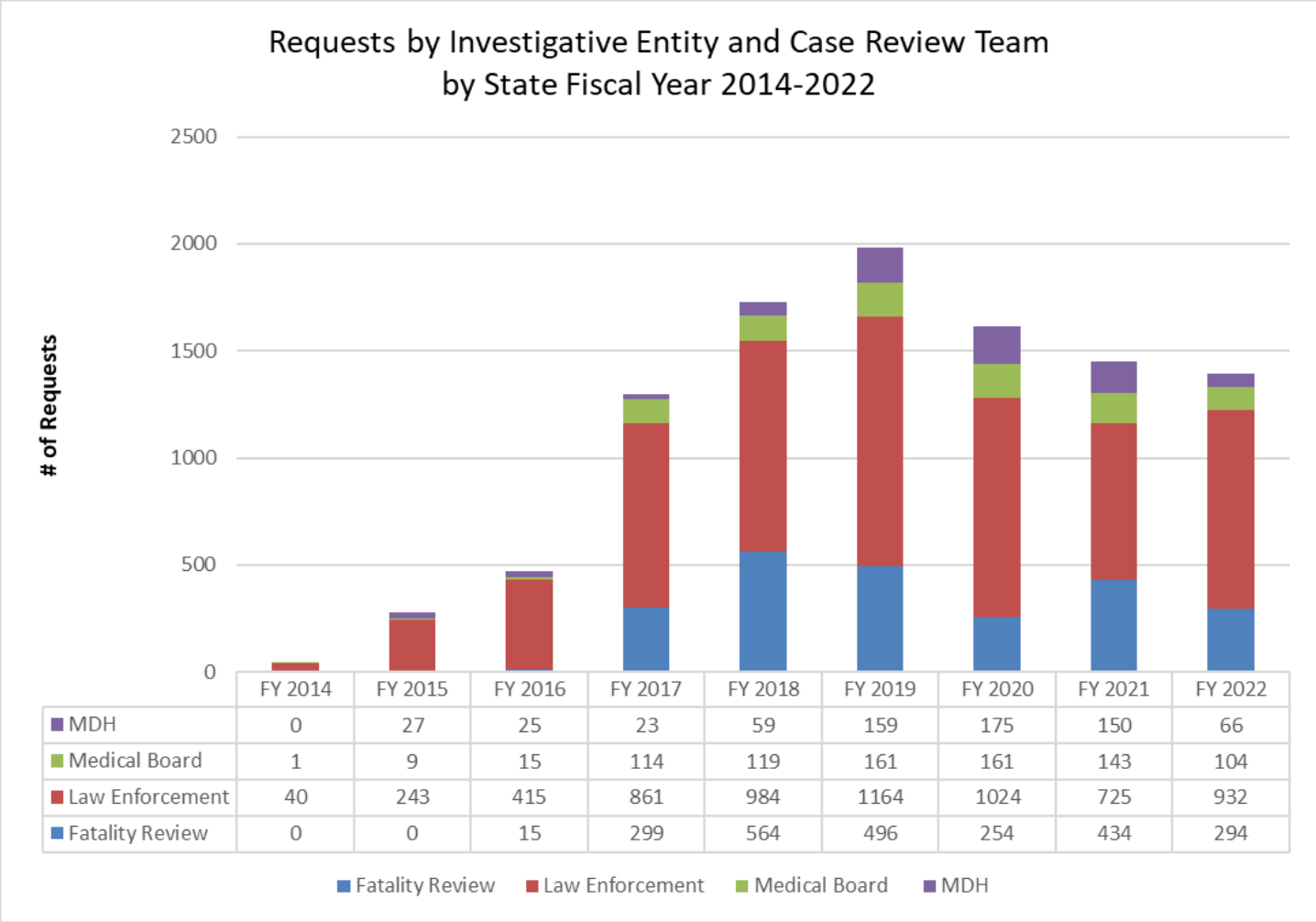
Under the PDMP law, the Program may disclose PDMP data to local, State, or Federal law enforcement agencies, certain Maryland health professional licensing boards, and four agencies within the Department (Office of the Inspector General, Office of Health Care Quality, Medicaid, and OCSA), to further existing, bona fide, individual investigations. Under HB466 (Chapter 364, 2019), the Office of the Chief Medical Examiner (OCME) was moved from the above list of Departmental agencies to a separate provision that allows for more direct access to prescription monitoring data in accordance with §5-309 of the Health General Article. PDMP data is also disclosed to fatality review teams to further existing case reviews.

All individuals who receive prescription data on behalf of the investigative entity or case review team are trained by the Program on the purposes and uses of the PDMP data and how to electronically submit requests. This training is required prior to receiving a unique user account.

Table 5 shows the breakdown of investigative user accounts and total number of data requests by user type: Federal, State, or local law enforcement; licensing board; Department agency; and fatality review teams. **Figure 1** shows the investigative requests by requestor type submitted to the Maryland PDMP from state fiscal year 2014 through 2022.

Table 5. Number of Registered Users and Requests, Current and Cumulative since 2014

Investigative Agency and Case Review Type	Current Credentialed Users Aug 2022	# of Requests Total	
		Fiscal Year 2022	March 2014-June 2022
Federal, State, Local Law Enforcement	102	932	6388
Licensing Board	20	104	827
Department Agency	6	66	684
Overdose Fatality Review	89	293	2284
Other Fatality Review	7	1	72
Total	**224**	**1396**	**10,255**



	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
MDH	0	27	25	23	59	159	175	150	66
Medical Board	1	9	15	114	119	161	161	143	104
Law Enforcement	40	243	415	861	984	1164	1024	725	932
Fatality Review	0	0	15	299	564	496	254	434	294

Figure 1. Investigative Data Requests by Investigative Entity and Case Review Team by State Fiscal Year

Dispensed Prescriptions

Tracking population-level changes in the volume of prescriptions dispensed in or into Maryland is important for assessing the impact of the Program. The number of Schedule II – V CDS prescriptions dispensed in or into Maryland and reported to the PDMP in corresponding time periods of state fiscal years 2018 - 2022 are shown in **Figure 2**. Prescription fills reported to the PDMP that are dispensed in or into Maryland to a recipient with a Maryland address could have been prescribed by a provider who practices outside of Maryland. Breakdowns of prescription fills by therapeutic classes can be found in **Figures 3-6** for fiscal years 2018-2022. Data are reported in the total number of prescriptions filled, which should not serve as a surrogate for the number of patients. Additionally, changes from fewer prescriptions for a greater quantity of pills to more frequent smaller quantity prescriptions, as well as diagnosis or age-specific differences in prescribing trends, may skew reports based on total number of prescriptions.

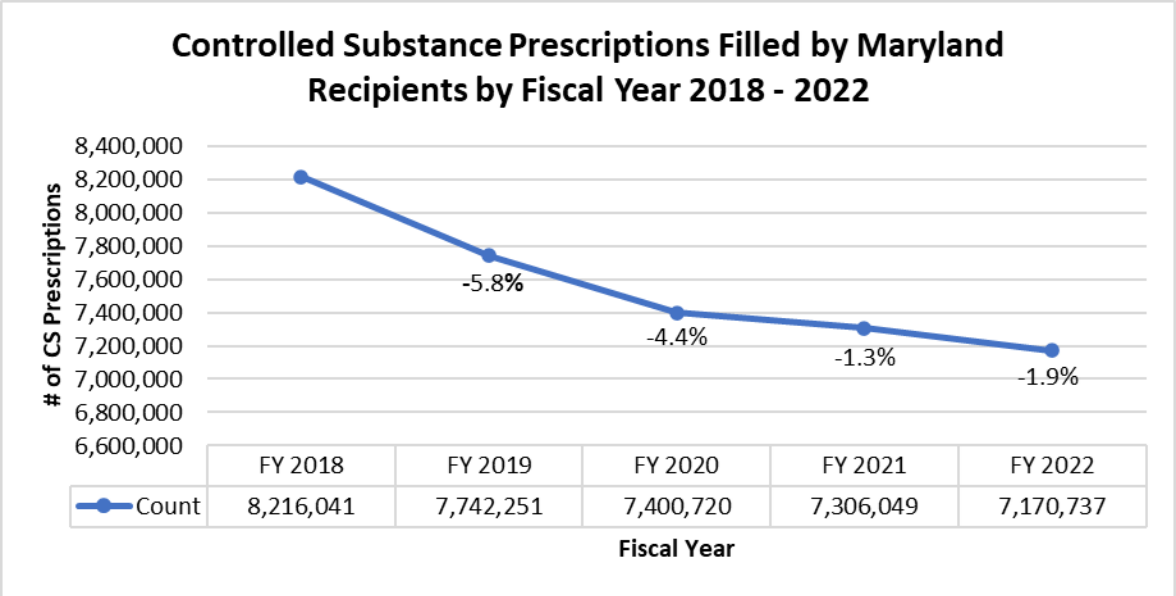


Figure 2. Controlled Substance Prescriptions Filled by Maryland Recipients by State Fiscal Year (July 1 – June 30).

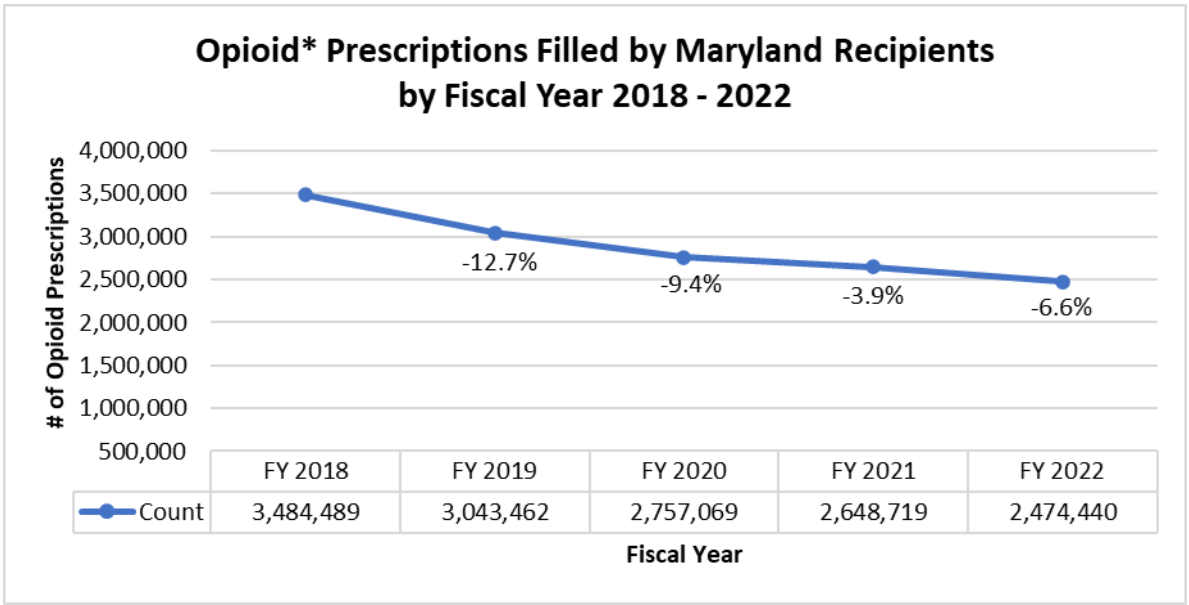


Figure 3. Opioid Prescriptions Filled by Maryland Recipients by State Fiscal Year (July 1 – June 30).

* Opioids include all prescriptions containing a medication in the opioid class of drugs except medications containing buprenorphine in a formulation indicated for the treatment of opioid use disorder. Indication was determined based on FDA indication for approved use for treatment of opioid use disorder. Strict adherence to approved indications may not occur. Prescriptions were not compared with diagnoses for patients to whom they were prescribed as PDMP does not have this information, and thus this measurable proxy was used.

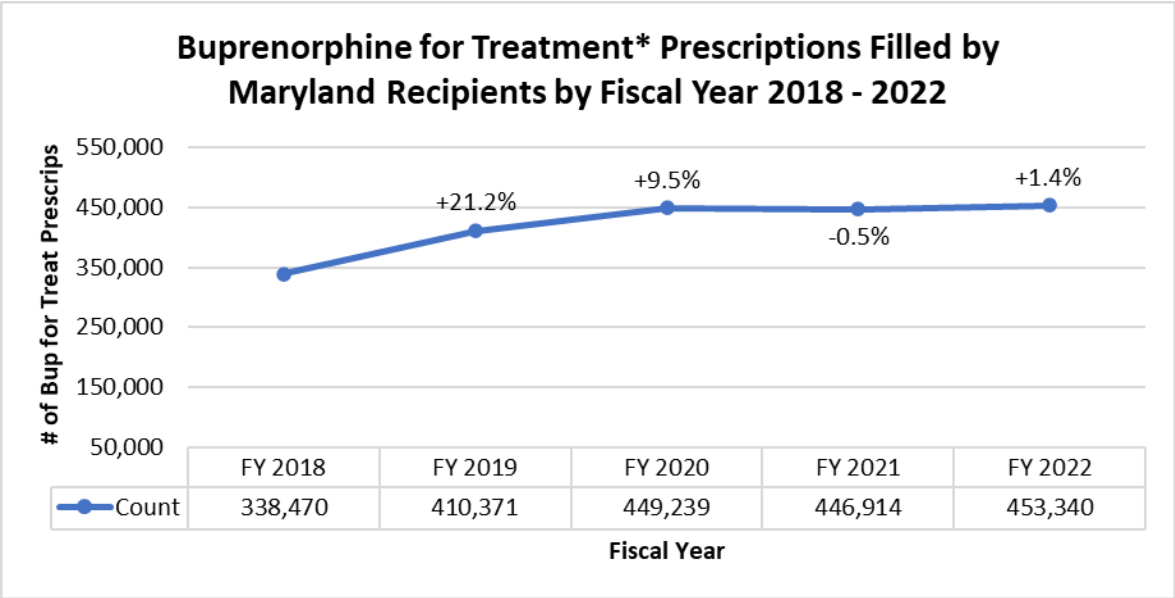


Figure 4. Buprenorphine for Treatment Prescriptions Filled by Maryland Recipients by State Fiscal Year (July 1 – June 30).
* Buprenorphine is a medication within the opioid class of drugs, but which is prescribed in specific formulations for the treatment of pain as well as for the treatment of opioid use disorder (OUD). Indication was determined based on FDA indication for approved use for the treatment of OUDs. Strict adherence to approved indications may not occur. Prescriptions were not compared with diagnoses for patients to whom they were prescribed as PDMP does not have this information, and thus this measurable proxy was used.

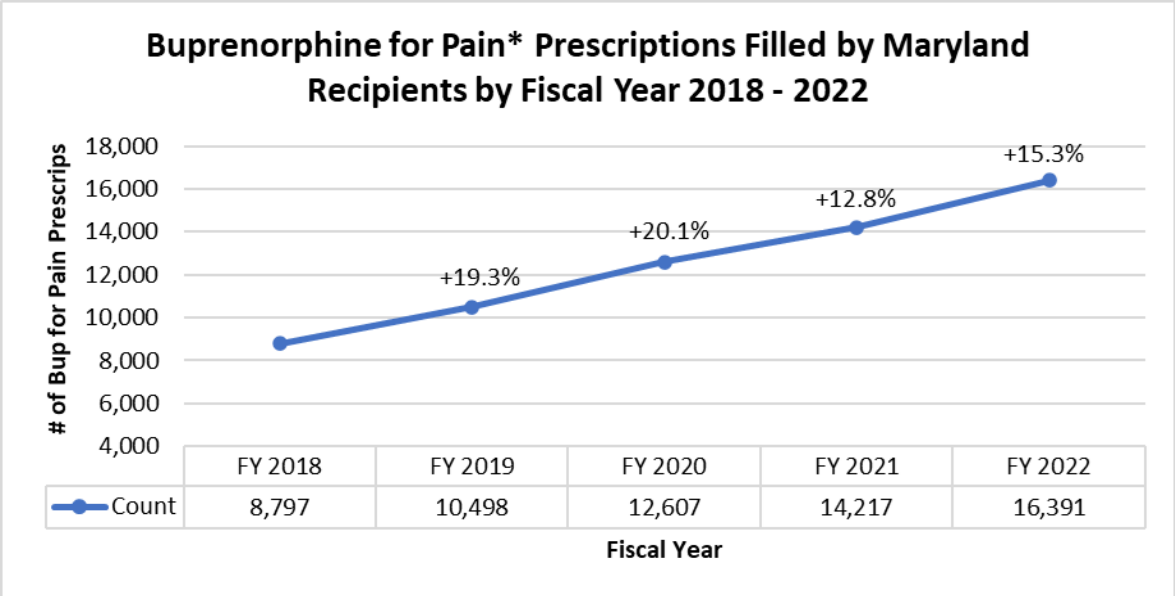


Figure 5. Buprenorphine for Pain Prescriptions Filled by Maryland Recipients by State Fiscal Year (July 1 – June 30).
* Buprenorphine is a medication within the opioid class of drugs, but which is prescribed in specific formulations for the treatment of pain as well as for the treatment of opioid use disorder (OUD). Indication was determined based on FDA indication for approved use for the treatment of pain. Strict adherence to approved indications may not occur. Prescriptions were not compared with diagnoses for patients to whom they were prescribed as PDMP does not have this information, and thus this measurable proxy was used.

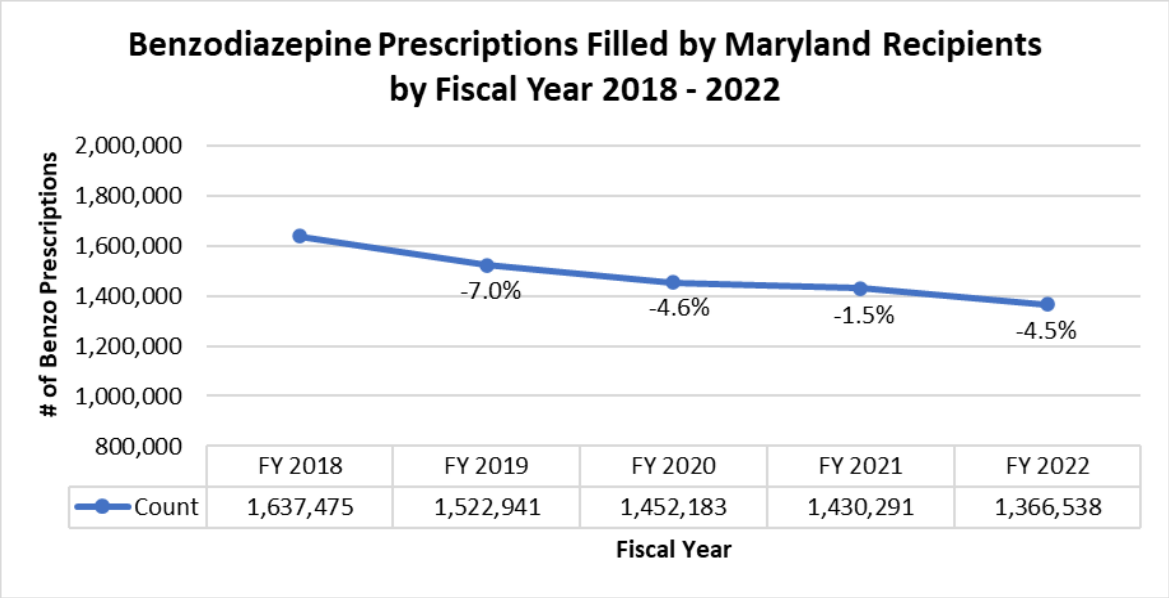


Figure 6. Benzodiazepine Prescriptions Filled by Maryland Recipients by State Fiscal Year (July 1 – June 30).

Provider Education and Referral for Investigation

This section of the report is intended to address the following reporting requirements:

V. 1. The number of providers, by provider type, who received outreach and education from the Program
2. The number of cases for which the providers received outreach and education from the Program

VI. 1. The number of cases that were identified for Technical Advisory Committee review before referral to OCSA
2. The number of providers, by provider type, involved in the cases

VII. 1. The number of cases that were referred to OCSA for further evaluation and the outcomes of the evaluations
2. The number of providers, by provider type, involved in the cases

HB025 (Chapter 531, Prescription Drug Monitoring Program – Revisions, 2019) expands the scope and responsibilities of the Program and establishes reporting requirements V-VII. Unsolicited Reporting Notifications are a key component of the Program's responsibilities and the primary method in which the Program offers education to providers.

Unsolicited Reporting Notifications

Unsolicited reporting is proactive reporting of summary prescription monitoring data to prescribers and pharmacists, allowing the Program to support clinical decision-making around safe CDS prescribing, improve legitimate patient access to pharmaceutical care, and assist prescribers and dispensers in identifying prescription drug diversion. Unsolicited reporting is considered a best practice by the Department of Justice Bureau of Justice Assistance's Prescription Drug Monitoring Program Center of Excellence at Brandeis University. Unsolicited reporting has been or is currently being adopted by a majority of states, and states vary on the types of PDMP users who may receive notifications and the types of patterns identified by the Program that are used to generate notifications. Chapter 651 (HB 1296, An Act concerning Prescription Drug Monitoring Program – Review and Reporting of Possible Misuse or Abuse of Monitored Prescription Drugs) was passed during the 2014 legislative session. The statute originally established the discretionary authority for the Program to review the PDMP for indications of possible misuse or abuse of a monitored prescription drug and proactively report to the prescriber or dispenser of the prescription drug if the review indicates possible misuse or abuse. Under HB 025 (Chapter 531, 2019), the Program is required to review prescription monitoring data for indications of possible misuse or abuse of a monitored prescription drug and possible violations of law and possible breaches of professional standards by a prescriber or a dispenser. The PDMP's Technical Advisory Committee (TAC) may review the prescription drug monitoring data regarding possible misuse or abuse of a monitored prescription drug by a patient prior to the issuance of a notification and education to prescribers or dispensers. Furthermore, the TAC must provide clinical guidance regarding the methods used to identify indications of possible violations of law and possible breaches of professional standards by a prescriber or a dispenser. Under HB 025 (Chapter 531, 2019), the Program is required to notify and provide education to providers who are identified during the data review process.

Unsolicited Reporting Notifications are the primary method by which the Program offers education to providers. The goal of the Unsolicited Reporting Notifications is to inform a provider about their prescribing practices, or patient-specific activities that could be addressed by a provider and offer resources to improve their CDS prescribing or dispensing decisions. The intended outcomes of Unsolicited Reporting Notifications include increased use of the PDMP, improved relationships between providers and patients, adoption of improved CDS prescribing and dispensing behaviors, and implementation of overdose prevention activities. Each Unsolicited Reporting Notification includes, but is not limited to, the following educational resources: Centers for Disease Control and Prevention (CDC) guidelines

and resources for prescribing opioids, information on naloxone, information on the PDMP, how to access the Maryland Addiction Consultation Services (MACS), how to implement Screening, Brief Intervention, and Referral to Treatment (SBIRT), and Substance Abuse and Mental Health Services Administration (SAMHSA) approved screening tools.

Implementation of this unsolicited reporting authority (under HB1296 / Chapter 651, 2014 and expanded under HB025/Chapter 531) occurred in 2016 and notifications are sent monthly. The Program currently sends five types of Unsolicited Reporting Notifications to providers: Multiple Provider Episodes, Fatal Overdose Notifications, Dangerous Drug Combinations, and two metrics specific to Morphine Milligram Equivalents. **Table 6** shows a breakdown of the 2,416 Unsolicited Reporting Notifications sent during Fiscal Year 2022. Effective October 1, 2016 (HB437 / Chapter 147, 2016 and expanded under HB025/Chapter 531), analysis of PDMP data for possible violations of law and possible breaches of professional standards by prescribers and pharmacists is used as the basis for proactive notification to prescribers and pharmacists for educational purposes.

Multiple Provider Episodes

The Program is using a standard approach deployed by many states to identify patients receiving prescriptions from the greatest number of prescribers and filled at the greatest number of pharmacies over specified time periods. Providers identified as having prescribed a controlled substance prescription to that patient during the specified period receive a notification that the patient met or exceeded the set threshold. The threshold used for multiple provider episodes is calculated by identifying unique individuals who have obtained CDS prescriptions from a certain number of prescribers and a certain number of dispensers in a three-month time period. This type of notification has been actively sent since 2016. These notifications are based on the prescriptions dispensed and may not have the benefit of other relevant information such as the prescriber's practice specialty or patient condition and therefore may lack clinical context. On January 12, 2022, the Program began sending this type of notification via email in an effort to streamline the process of sending these notifications.

Fatal Overdose Notifications

In 2019, the Program began sending a new type of unsolicited reporting notification when possible misuse or abuse of monitored prescription drugs is identified. The program informs providers about the death of a patient when the cause of death is opioid-related and the provider prescribed an opioid or a benzodiazepine within three months of the death. Through an agreement with OCME and the Vital Statistics Administration, the Program partners with CRISP to match OCME data with PDMP data. Depending on the time needed for the Medical Examiner to complete the investigation and the required time to match the data, prescribers receive a notification one to three months after the fatal overdose.

Dangerous Drug Combinations

In 2020, the Program began sending notifications to providers who wrote an opioid, benzodiazepine, and a muscle relaxer (specifically Carisoprodol) prescription to the same patient on the same day. This drug combination increases a patient's risk of experiencing an overdose. The TAC identified this drug combination as a possible indication of outlier prescribing practices. On May 12, 2022, the Program began sending this type of notification via email in an effort to streamline the process of sending these notifications.

Morphine Milligram Equivalent I

On February 28, 2021, the TAC approved two Morphine Milligram Equivalent (MME) metrics. Providers who wrote 500 or more prescriptions, within a three-month period, with an average daily MME of 90 or above receive the MME I notification. Per CDC prescribing guidelines, an MME value of 90 or more per day is associated with a higher risk of overdose or death. The TAC identified prescribers who write 500 or more prescriptions with an average daily MME of 90 or above as an indicator of possible outlier prescribing practices. On July 15, 2022, the Program began sending this type of notification via email in an effort to streamline the process of sending these notifications.

Morphine Milligram Equivalent II

Providers who wrote an opioid prescription(s) for a patient that contributed to an average daily MME greater than or equal to 500 receive the MME II notification. Per CDC prescribing guidelines, an MME of 90 or more is associated with a higher risk of overdose or death. The TAC identified prescribers who write opioid prescriptions which contribute to a higher than average daily MME as an indicator of possible outlier prescribing practices.

Table 6. Unsolicited Reporting Prescriber Notifications, through August 2022

Type of Unsolicited Reporting Notification	Number of Unsolicited Reporting Notifications Sent in Fiscal Year 2022	Total Number of Unsolicited Reporting Notifications Sent Since Activity Started Through August 2022
Multiple Provider Episodes	983	5,625
Fatal Overdose Notification	802	2888
Dangerous Drug Combination	131	402
Morphine Milligram Equivalent I	15	33
Morphine Milligram Equivalent II	597	1214

Referral to OCSA

HB025 (Chapter 531, Prescription Drug Monitoring Program – Revisions, 2019) allows proactive data sharing with an investigative entity, OCSA. Updated regulations in response to Chapter 531 were promulgated May 8, 2020. The Program will continue to work with the TAC to discuss when outreach and education through an unsolicited reporting notification would be inadequate to address possible violations of law or breach of professional standards identified in a review of PDMP data and set parameters for referrals to OCSA. The Program continues to expand educational outreach by increasing the types of unsolicited reporting notifications sent to providers.

The Program did not refer a case to OCSA in fiscal year 2022. During this year, the Program worked with the TAC to expand the metrics used to send unsolicited reporting notifications. The TAC began discussing cases identified through CRISP's Protenus tool in which credentialed users may have accessed the PDMP inappropriately. The CRISP Protenus tool is an auditing mechanism that flags users for suspicious activity. CRISP sets the logic for suspicious activity which includes, but is not limited to, searches for famous people, people with the same last name, and people with the same work address. In 2023, the Program will continue to work with the TAC to establish policies and procedures to identify cases to refer to OCSA.

Recommendations on Modification or Continuation of the Program

This section of the report is intended to address the following reporting requirement:
VIII. Any recommendation related to modification or continuation of the Program

Board members support continuation of the Program and its activities, continuing to propose recommendations that were included in the 2021 report while identifying several areas for possible focus in the future:

- Increase in adoption of PDMP use by clinical users through the continued expansion of interstate data sharing to other priority states.
- Improve the clinical user interface to display relevant alerts based on PDMP data.
- Conduct analyses investigating the possible impact of PDMP on access to and utilization of substance use disorder treatment services.
- Ensuring systems performance on all ends, including integrating PDMP data into hospital and ambulatory providers' EHRs and other electronic provider tools.
- Supporting pediatric prescribers with respect to CDS prescribing.
- Increasing provider outreach specific to clinical resources available to pharmacists through the Health Information Exchange.
- Continuing the implementation of proposed recommendations by the ad-hoc committee on veterinary dispensing and veterinarian access to PDMP data. The Program will provide updates on Board recommendations during 2023 scheduled meetings.

Conclusion

During the past year, the Department made substantial progress implementing new Program activities, increasing visibility and uptake of the Program, and continues to work with the Board to increase the Program's ability to meet the evolving roles of the PDMP within the State's opioid strategy. Therefore, the Board recommends that the Governor and General Assembly continue to support ongoing development of the PDMP. Over the next year, the Board will continue to support the Department by providing ongoing advice about emerging stakeholder PDMP needs and issue guidance on key priority areas to improve health and safety outcomes related to CDS prescriptions in Maryland. These priorities include expansion of education and outreach to clinical users and other relevant stakeholders, implementing new referral for investigation protocols, and disseminating clinical tools to support healthcare providers.

Attachment A: Advisory Board on Prescription Drug Monitoring –Membership

Chair
Richard A. DeBenedetto, PharmD, MS AAHIVP
Assistant Professor of Pharmacy Practice & Administration
University of Maryland Eastern Shore School of Pharmacy & Health Professions

Current Members (As of December 2022)

Deondra P. Asike, MD
Physician
Johns Hopkins Hospital

Amit Bhargava, MD, MS, RMSK, Medical Director
Advanced International Pain & Sports Medicine

Thomas C.C. Bond, III
President & CEO
Summit Community Health, Inc.

Matthew Crisafulli
Worcester County Sheriff's Office

Aparna Duggirala, DPM, FACFAS
President's Designee, Board of Podiatric Medical Examiners

Peggy Funk, CAE
Executive Director, Hospice & Palliative Care Network of Maryland

Leslie E. Grant, DDS, MSPA
President's Designee, Board of Dental Examiners
General Dentist

Justin Gross, Captain
Commander
Maryland State Police, Enforcement Division

Lenna Israbian-Jamgochian, PharmD, RPh
District Pharmacy Manager
Albertsons Safeway Inc-Eastern Division

Sirosh Masuood, MD
Medical Director
Excel Psychiatric Consultation Outpatient Clinic

Kevin M. Morgan, PharmD
President's Designee, Board of Pharmacy

Stephen A. Nichols, MD, FAAP, FAAPMR
Senior Attending Physician for Rehabilitation Services
Mt. Washington Pediatric Hospital

Mark D. Olszyk, MD, MBA, CPE, FACEP, FACHE, FFSMB
Chair designee, Board of Physicians
Chief Medical Officer/Vice President Medical Affairs Carroll Hospital
Vice President Carroll County Health Group

Marcia Parris, MD
Family Physician, Comprehensive Women's Health
Director, Maryland Academy of Family Physicians

Laurence Polsky, MD, MPH
President's Designee, Maryland Association of County Health Officers
Health Officer, Calvert County

Dixit Shah, RPh
Deputy Director, Office of Pharmacy Services
Maryland Department of Health

David Sharp, Ph.D.
Chairman's designee, Maryland Health Care Commission
Director, Center for Health Information Technology & Innovative Care Delivery

D. Gail Shorter, DNP
Nurse Practitioner, University of Maryland Shore Medical Group

Heather Westerfield, RN
President's Designee, Maryland Board of Nursing

Vacant Seats

- Researcher/Academic
- Pharmacist