DC | HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Government of the District of Columbia
Department of Health

Prescription Drug Monitoring Program
Advisory Committee Meeting

899 North Capitol St. NE – 2nd Flr.
Washington, DC 20002

January 21, 2020

10:00am- 12:00 pm

Open Session Meeting Minutes

CALL TO ORDER:

PRESIDING:

COMMITTEE MEMBERSHIP/ATTENDANCE:

ADVISORY COMMITTEE MEMBERS:		
	Jacqueline Watson, DO, MBA, DC Health Chief of Staff	X
	Frank Meyers, JD, Board of Medicine Executive Director	X
	Shauna White, PharmD, RPh, MS, Board Of Pharmacy Executive Director	X
	Natalie Kirilichin, MD, MPH, Emergency Medicine Physician	X
	Sheri Doyle, MPH, Consumer Member	X
	Commander John Haines, Metropolitan Police Department	
	Lakisha Stiles, CPht – Pharmacy Technician	
PDMP STAFF:	Justin Ortique, PharmD, RPh, Supervisory Pharmacist	X
	Brittany Allen, MPH, Program Specialist	X
	Cathryn Mudrick, MPH, Public Health Analyst	X
LEGAL STAFF:	Carla Williams, Esq, Assistant General Counsel, PDMP Attorney Advisor	X
	Cale Coppage, Legal Intern	X
VISITORS:	Ryan Bramble, Senior Director, Product Development, Executive Director, CRISP DC	X

Open Session Agenda

Quorum: Yes

0121-O-01	**Welcome & Introductions** Dr. Jacqueline Watson opened the meeting with Committee member, staff, and visitor introductions. Dr. Watson thanked everyone for their great work, time, and dedication to the PDMP committee. She stated that she would like to kick off the new year/new decade by having the committee discuss/share their thoughts on how effective our meetings and actions have been thus far and if there is anything that we need to be doing differently to make meetings more interactive and engaging. Dr. Watson suggested that we could consider assigning members "homework/project research" that they report out/present on at the next meeting in order to facilitate more robust and productive dialogue during meetings. When the committee first got started in Jan 2018, members moved aggressively to take a pulse of the opioid epidemic in the District and nationally, reviewed national best practices on PDMPs, and due to the time sensitivity of the legal process, unanimously voted to submit recommendations to the DC Health Director requiring that DC Health licensees be mandated to both register and query the DC PDMP. The Director accepted mandatory registration and recommended deferring query until more systems were in place to support such a mandate. The law mandates that the committee meet a minimum of 2 times per year. However, due to the work that needed to be done, the committee agreed to meet 4 times per year. Dr. Watson asked that the committee consider whether meeting 2 times a year is now appropriate or some other preferred schedule. Dr. Watson also mentioned that the program staff has done quite a bit of outreach over the past two years. But there is reach and outreach and we should ensure that we are able to quantify and measure the effectiveness of both and make adjustments as the data directs us. She asked that everyone think through the points she has raised and some time will be left at the end of the meeting to discuss next step recommendations. **Charge of the Committee** The Committee shall convene at least two (2) times per year to advise the Director: (a) On the implementation and evaluation of the Program; On the establishment of criteria for indicators of possible misuse or abuse of covered substances; (b) On standardization of the methodology that should be used for analysis and interpretation of prescription monitoring data; (c) In determining the most efficient and effective manner in which to disclose the findings to proactively inform prescribers regarding the indications of possible abuse or misuse of covered substances;	

	(d) On identifying drugs of concern that demonstrate a potential for abuse and that should be monitored; and (e) Regarding the design and implementation of educational courses for: (1) Persons who are authorized to access the prescription monitoring information; (2) Persons who are authorized to access the prescription monitoring information, but who have violated the laws or breached professional standards involving the prescribing, dispensing, or use of any controlled substances or drugs monitored by the Program; (3) Prescribers on prescribing practices, pharmacology, and identifying, treating, and referring patients addicted to or abusing controlled substances or drugs monitored by the Program; and (4) The public about the use, diversion and abuse of, addiction to, and treatment for the addiction to controlled substances or drugs monitored by the Program.	

0121-O-02	**<u>Approval of October 2019 PDMP Advisory Committee Meeting Minutes</u>** (a) Minutes from October 29, 2019 Meeting **Motion** to approve the October meeting minutes by: Ms. Sheri Doyle **Seconded by**: Dr. Shauna White **Motion carries, minutes approved**	
0121-O-03	**<u>Report from Attorney Advisor</u>** (a) PDMP Legislative Update Ms. Carla Williams provided the legal update, stating that PDMP staff and legal staff met to discuss agreed upon measures from the last meeting (mandating that all licensees who have the ability to prescribe or dispense a Controlled Substance or drug of concern register for the PDMP), and finalized appropriate terms as approved by DC Health's Director. The legislation has been drafted and it is undergoing the review and approval process. Council will review the legislation and decide whether or not to enact it. The legislation may receive pushback—before it was limited to prescribers, now it will be mandated to anyone who has the ability to prescribe Controlled Substances and/or drugs of concern.	
0121-O-04	**<u>Program Updates</u>** (a) Program Statistics Dr. Shauna White shared the statistics below, noting that most providers that hold a Controlled Substance Registration are registered with the PDMP. She also noted that certain professions such as Advanced Practice Nurses and Naturopathic Physicians may need additional outreach in order to increase registration numbers. Dr. Watson noted that Physician Assistant PDMP registration is low. Mr. Frank Meyers noted that Physicians are the most involved group in the Board of Medicine and that communicating to other groups (i.e. Physicians Assistants and Naturopaths) could include letting them know that they need to register with the PDMP, even if they do not have a Controlled Substance Registration. He also noted that since 2020 is a renewal year, PDMP registration can be tied to the renewal (i.e. a reminder in the renewal letter). Dr. White noted that Dentist and Veterinarians recently completed their renewal season, and described the process of confirming PDMP registration before renewing Controlled Substance Registration for those professions. Staff will conduct outreach with the Board of Nursing as the renewal season for Advanced Practice Nurses will begin soon.	

(b) PDMP Registration Updates

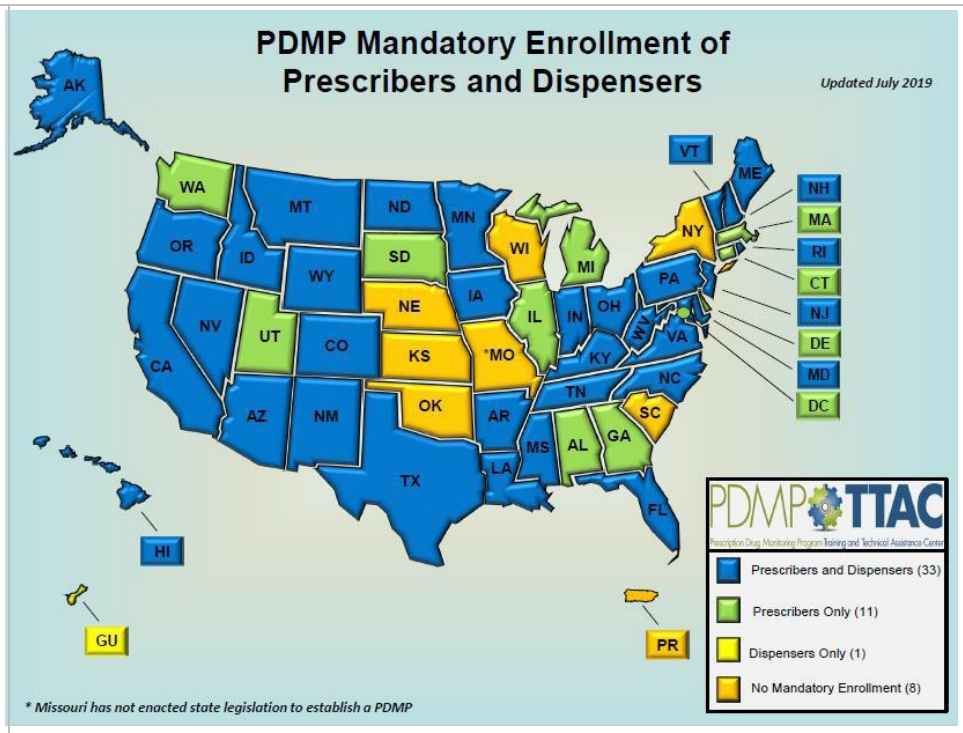
Dr. White shared the graphics below, which provide a visual representation of states that have mandated PDMP enrollment (map 1) and states that have mandated PDMP query (map 2). Washington, DC has mandated PDMP enrollment for prescribers only. Washington, DC has not mandated PDMP query.

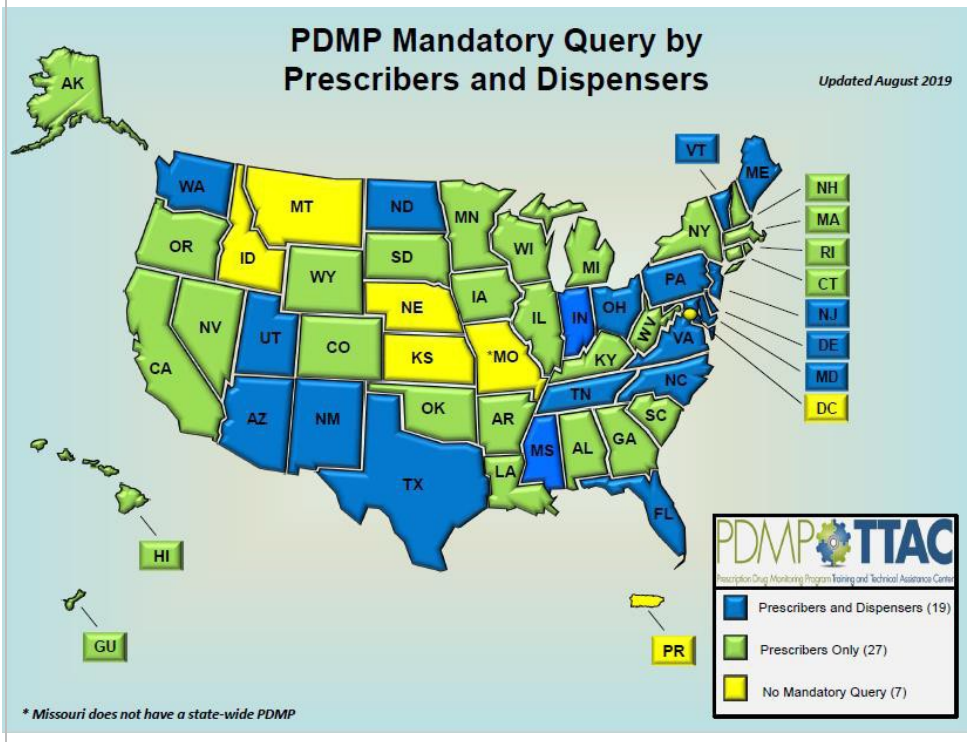
Mr. Meyers noted that the surrounding states have some form of mandatory query (Maryland and Virginia have mandatory query for prescribers and dispensers and West Virginia has mandatory query for prescribers), while Washington, DC does not. Ms. Williams asked if Washington, DC can pull data on the number of PDMP registrants who have voluntarily queried the PDMP and Dr. White noted that the data is available. Dr. Watson asked the PDMP staff to pull the data by the end of the week and have the data inform our recommendations so we can submit concrete evidence when moving any recommendations forward to the director.

Overview of Prescription Drug Monitoring Program User Registration Statistics

Licensed Professional	Total Number of DC Professional Licensees	# of Registered PDMP Users 01/17/2020	Percentage (%) of DC Licensed Professionals Registered with the PDMP	Total Number of DC Professionals with Controlled Substance Registration	Percentage (%) of DC Licensed Professionals with Controlled Substance Registration Registered with the PDMP
Physician (MD, DO)	11,245 (8,163 with a DEA)	10,689	95.1%	7,538	100%^
Physician Assistant	819	627	76.6%	573	100%^
Advanced Practice Nurses	2,686	1,551	57.7%	1,492	100%^
Pharmacist	2,153	2,061	95.7%	-	-
Dentist	1,515	1,126	74.3%	938	100%^
Veterinarian	346	302	87.3%	216	100%^
Podiatrist	159	133	83.6%	112	100%^
Optometrists	232	175	75.4%	-	-
Naturopathic Physician	59	30	50.8%	6	100%^
VA Prescriber	-	30	-	-	-
Pharmacy Technician (Delegate)*	-	16	-	-	-
Other (Licensing Board Investigators, Law Enforcement, Medical Examiner, Admin)	-	28	-	-	-
TOTAL		16,768			

* Pharmacy technicians can only register for the PDMP as delegates
- Not applicable to particular role
^ More professionals registered than controlled substance registrations issued





Motion to obtain voluntary query data from the DC PDMP to share with the Committee and couple with request to DC Health to mandate query of PDMP for prescribers and dispensers, or at least prescribers by Frank Meyers.

Seconded by: Ms. Sherri Doyle

Motion carries, data request and recommendation are approved.

Ms. Doyle asked if the Committee wanted to discuss the specifics of the mandate. She recommended mandatory query for all covered substances with queries conducted every 3 months or 90 days, depending on the patient's history.

Ms. Doyle offered to share a web resource that she created for the Pew Charitable Trusts that details PDMP mandate laws in every state. Dr. White noted that the resource will be helpful for creating a chart for Washington, DC. Dr. Watson requested that all information is submitted to her by the first week of February for review in order to move things forward with the Director. She noted that this is an opportune time to submit this information to the Council, as the legislation has not been completely fleshed out and changes can still be made. Ms. Williams recommended including the query mandate in the legislation and including the details in the regulation.

Dr. Watson asked the PDMP staff to pull the data by the end of the week and have the data inform our recommendations so we can submit concrete evidence when moving any recommendations forward to the director.

(c) Outreach Activities

Past

Dr. White shared the chart below, which outlines past DC PDMP outreach activities.

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Prescription Drug Monitoring Program Outreach Activities	
Location/Event	Date
2016 Activities	
Medstar Georgetown (Registration Clinic)	November 2016
2017 Activities	
GW Medical Faculty Associates Meeting	May 2017
United Medical Center	September 2017
2018 Activities	
Howard University Hospital (Registration Clinic)	Wednesday, March 7, 2018 (Physician's Lounge)
	Friday, March 9, 2018 (Cafeteria)
Nurse Practitioner Association of the District of Columbia Meeting	May 2018
Board of Dentistry Meeting	July 18, 2018
Board of Veterinary Medicine Meeting	Thursday, August 16, 2018. Additional support and Technical Assistance provided by Appriss.
Office of the Chief Medical Examiner	September 2018
Board of Nursing Meeting	September 5, 2018

Board of Medicine Meeting	September 26, 2018
Pharmacist and Pharmacist Technician Reminder Mailing	December 2018
Newsletter (Mailed to the Board of Nursing, Board of Veterinary Medicine, Board of Pharmacy, and Board of Medicine)	December 2018
2019 Activities	
DC Pharmacy Visits – visited 10 pharmacies to bring informational postcard about registering for and checking the PDMP • CVS (NoMA) • Harris Teeter (NoMa) • Giant (H St NE) • CVS (H St NE) • CVS (Bladensburg Rd) • CVS (Eastern Market) • Foer's Pharmacy (Farragut) • Tschiffely Pharmacy (Farragut) • CVS (Farragut) • Foer's Pharmacy (West End)	January 2019
Physician PDMP Check Reminder Postcard (mailed to a sample of 50 physicians)	January 2019
Presentation at Stoddard Baptist Nursing Home	April 2019
Presentation at United Medical Center to Physicians and Pharmacists	April 2019
Meeting at DCHA and Appriss about Gateway Integration and NarxCare	July 2019
Board of Medicine – Appriss NarxCare Presentation	July 31, 2019

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19 participants	
Board of Podiatry 9 participants	October 2, 2019
Grubbs Pharmacy 4 participants	October 29, 2019
DC Health (Outreach Coordinator and Clinical Coordinator) Opioid Trainings (DC Health and United Medical Center) 10 dates/12 sessions 92 participants 19 Pharmacists 28 Physicians 5 Physician Assistants 11 Dentists 3 Nurse Practitioners 6 Registered Nurses 1 Veterinarian 1 Family Practice (Clinic) 1 Investigator 1 Student 16 Unknown Comments: "Good information and very useful to us as practitioners." "Good presentation." "Great presentation. Thank you." (3) "I really have learned a lot." "I was looking for CE." "Very informative." (5)	October—November 2019 (Total of 12 Sessions) Dates October 28, 2019 October 30, 2019 October 30, 2019 (UMC) November 4, 2019 November 14, 2019 November 18, 2019 November 19, 2019 (Noon Session) November 19, 2019 (Evening Session) November 21, 2019 November 25, 2019 November 26, 2019 (Noon Session) November 26, 2019 (Evening Session)

"Please consider offering these trainings as webinars." "Excellent presentation." (2) "Awesome presentation. Very helpful." "Less reading of the slides. Starting on time and ending at the time advertised." "Excellent presentation and good interpersonal skills during discussions with participants." "Very interactive and informative presentation." "Would have been great to have presenter in front close to the slides than behind the room. Overall great presentation." "More handouts on the CDC websites would be nice...excellent presentation. Thank you. Very informative." "I enjoyed the presentation. Very informative. Thank you.	
NarxCare Webinars 4 dates 232 participants 48 Pharmacists 147 Prescribers 38 Non-Dispensing Role/Unknown Did you learn something new that will assist you in your daily practice? 124 Yes 8 No 92 No Answer 8 Question was not asked during the first session	December 2019 (Total of 4 Webinars) Dates December 2, 2019 December 6, 2019 December 11, 2019 December 19, 2019

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Board of Medicine Appriss Presentation 15 participants	December 11, 2019
Board of Dentistry Presentation 15 participants	December 18, 2019

Future

Dr. White shared the chart below, which outlines upcoming PDMP outreach activities. Dr. Watson asked to be kept abreast of internal presentations (those given to health licensing boards), so that she can participate and/or provide input as necessary as a part of the inter-professional collaboration workgroup activities. She also noted that all DC Health presentations (including Appriss presentations need to be branded as DC Health webinars.

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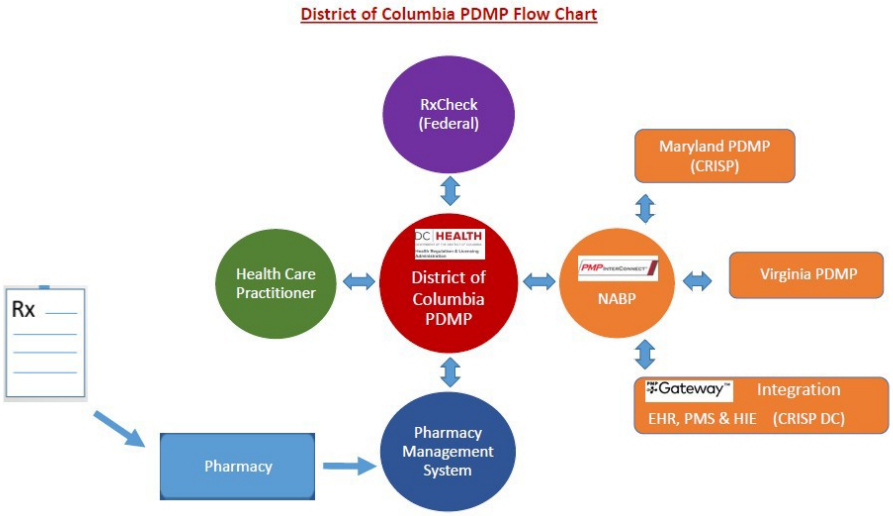
Planned Activities (FY2020)	
DC PDMP Presentation at DEA Practitioner Diversion Awareness Conference	February 22, and 23, 2020
Appriss Prescriber Report Webinar	2020 Q2
Howard University College of Pharmacy PDMP Presentation Howard University College of Medicine PDMP Presentation	2020 Q2
Medical Society of DC Focus Group	2020 Q2
DC Primary Care Association Presentation	2020 Q2
DC Hospital Association Presentation	2020 Q2
Nurse Practitioner Association of DC Presentation	2020 Q2

(d) PDMP Annual Report (final draft)

Dr. White shared the annual report. The report has been approved and will be uploaded to the DC PDMP website once the appropriate signatures are added.

(e) PDMP Update
Flow Chart

Dr. Justin Ortique shared the flowchart below, which describes the DC PDMP information exchange.



(f) Flow Chart Key

Dr. Ortique shared the DC PDMP Flow Chart Key below, which provides a written description of the DC PDMP information exchange. Mr. Meyers asked about the sharing process with RxCheck. Dr. White stated that each state has an MOU with RxCheck detailing the state's sharing restrictions. She also noted that each state works together to determine what they will share with each state. For example, if Washington, DC wants to share data with Virginia, the states will work together to determine the data they will share with each other. This process occurs each time a state decides to connect with another state. Dr. Natalie Kirilichin asked if RxCheck requires a separate login and Dr. White answered yes and noted that the staff is still working on the details.

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District of Columbia PDMP Flow Chart

Prescriptions are entered at pharmacies and input into the Pharmacy Management System (an example would be RxConnect for CVS Pharmacies). All prescriptions dispensed by a pharmacy must be reported to DC PDMP within 24 hours through the Pharmacy Management System. Once the information is submitted to DC PDMP, information flows bi-directionally via three pathways: Healthcare Practitioners, PMP Interconnect and RX Check.

- **Healthcare Practitioners** are able to login to the DC PDMP to access prescription information directly. Healthcare Practitioners who dispense medications for patients to take home are also required to report to the DC PDMP.

- **PMP Interconnect** (PMPi) is a data-sharing hub which is owned by the National Association of Boards of Pharmacy (NABP) and operated by Appriss Health (DC PDMP vendor). PMPi allows DC PDMP information to be shared with other state PDMPs. PMP Interconnect also acts as a sharing hub to integrate directly into electronic health records (EHRs), Pharmacy Management Systems (PMS) and Health Information Exchanges (HIEs).

  → Gateway Integration is a managed service enabling a single point of connectivity between state PDMPs, EHR vendors, and Health Systems. Gateway Integration supports direct incorporation of DC PDMP into EHRs, PMS, and HIEs to allow prescribers and dispensers access within their workflow.

- **RxCheck** acts as a data-sharing hub similar to PMP interconnect. RxCheck is the federal PDMP sharing system that is a requirement of the Overdose Data to Action Grant. To date the DC PDMP has established the initial connection with RxCheck and the connection is being tested to ensure security before going live.

*Chesapeake Regional Information for our Patients (CRISP)

*CRISP DC is a health information exchange specific to the District of Columbia which allows health care professionals and patients to appropriately access and securely share a patients medical information electronically.

* Maryland CRISP is separate from CRISP DC and is formally designated as Maryland's statewide health information exchange by the Maryland Health Care Commission. Maryland CRISP also houses Maryland's PDMP.

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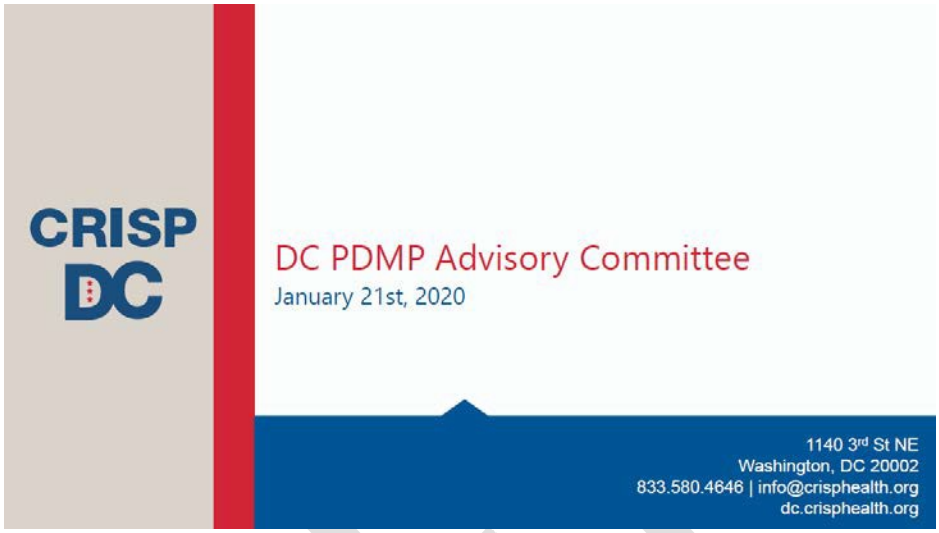
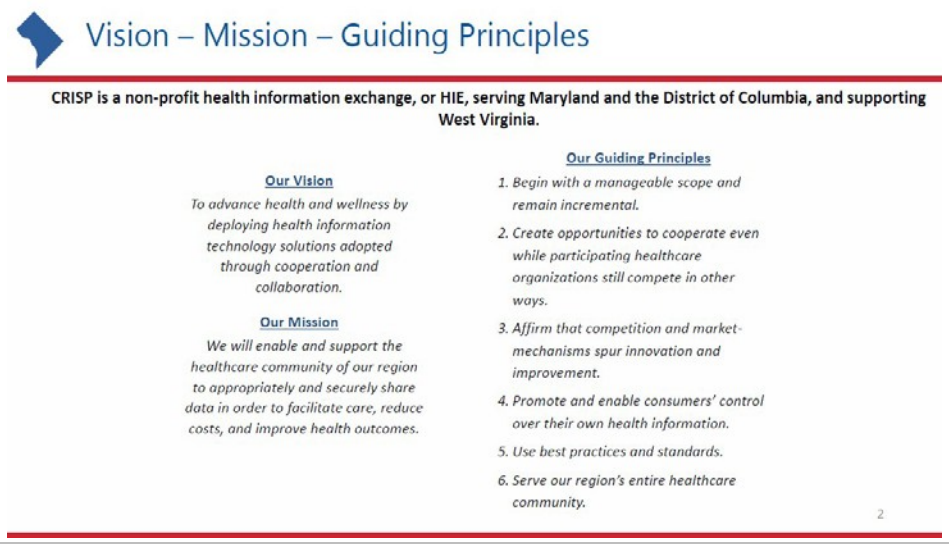
0121-O-05	**Presentation** CRISP DC Presentation, Ryan Bramble, Senior Director, Product Development Executive Director, CRISP DC	





Who We Are - CRISP D.C. Board of Directors

- **Chair**: Mark Schneider, MedStar Health
- Karen Dale, Amerihealth Caritas DC
- Jackie Bowens, DC Hospital Association
- Don Blanchon, Whitman-Walker
- Dr. Hasan Zia, Sibley Memorial Hospital
- Dr. Brendan Furlong, Georgetown University Hospital
- Dr. LaQuandra Nesbitt, DC Health
- David Horrocks, CRISP

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Who We Are - CRISP D.C. Clinical Committee

- **Chair**: Dr. Andrew Robie, Unity Health Care
- Dr. Brian Choi, GWU Medical Faculty Associates
- Dr. Pamela Riley, DC DHCF
- Dr. Yavar Moghimi, Amerihealth Caritas DC
- Dr. Ira Rabin, MedStar Washington Hospital Center

Purpose: Approve new use cases and ideas for CRISP D.C. to pursue in the District above and beyond Core HIE capabilities.

4

Building Effective Partnerships Our Theme for FY2020

CRISP works with the following non-profits and associations to help identify and implement important use cases

- Medical Society of the District of Columbia
- DC Primary Care Association
- DC Connected Care Network
- Ward 8 Health Council
- DC Hospital Association
- DC Behavioral Health Association

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Building Effective Partnerships Our Theme for FY2020

CRISP is now implementing use cases with the following agencies:

- DC Department of Health Care Finance
- DC Health
- DC Office of the Chief Medical Examiner
- DC Department of Behavioral Health
- DC Public Schools
- DC Fire & EMS
- DC Department of Energy and the Environment

CRISP is working with the following agencies to execute agreements

- DC Department of Disability Services (Summer 2019)

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Three Important Principles

- Users inform our product strategy and roadmap – we don't make decisions without multi-stakeholder user input and focus group feedback
- We aren't here just to be here
  - We support innovation – ours or someone else's – and encourage our participants to use the technology that makes the most sense
  - No one is mandated to use CRISP in DC. Our mission is to provide tools that help you and that you like to use
- We belong to D.C.
  - We are **your** Health Information Exchange
  - We aren't only rehashed Maryland use cases. We seek to implement District-specific innovation

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Core HIE Services Currently Available

1. **POINT OF CARE: Clinical Query Portal & In-context Information**
   - Search for your patients' prior hospital records (e.g., labs, radiology reports, etc.)
   - Determine other members of your patient's care team
   - Be alerted in your EHR to important conditions or treatment information
2. **CARE COORDINATION: Encounter Notification Service (ENS)**
   - Be notified when your patient is hospitalized in any regional hospital
   - Receive special notification about ED visits that are potential readmissions
   - Know when your MCO member is in the ED
3. **POPULATION HEALTH:**
   - Use Medicaid claims data to:
     - Identify patients who could benefit from services
     - Measure performance of initiatives for QI and program reporting
     - Coordinate with peers on behalf of patients who see multiple providers
4. **PUBLIC HEALTH SUPPORT:**
   - Support initiatives at D.C. Health
   - Equip public health teams with interoperability tools
   - Support the research initiatives of our participant organizations

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Utilization of CRISP D.C.

- CRISP D.C. services are utilized in more than 300 individual locations of care throughout the District
- Twice the number of District locations now participate with CRISP D.C compared to January 2019
- Integrations into EMRs at all of the hospitals and many of the large practices has led to easier and more frequent utilization

More than 100 users attended our 1st Annual CRISP D.C. User Conference in November

CRISP Encounter Notification Service (ENS)

- CRISP currently receives information pertaining to **visits and admissions** in real-time from acute care providers in the region.
  - All D.C. acute care hospitals plus DC Fire & EMS ambulance runs
  - All Maryland acute care hospitals
  - All Delaware acute care hospitals (in partnership with DHIN)
  - 17 Northern Virginia acute care hospitals (in partnership with ConnectVA)
  - Most West Virginia acute care hospitals
- If you send us a list of patients, we can send you an alert:
  - When your patient encounters at a hospital
  - When your patient re-admits at another hospital
  - When your patient is discharged or passes away
  - When your patient is transferred to rehab or long term care

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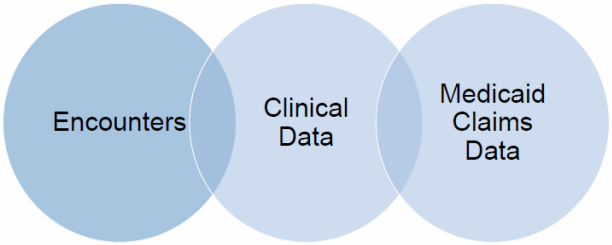
Claims, Encounter, and Clinical Data in a single application

Access HIE Services through the Unified Landing Page with one username and password.



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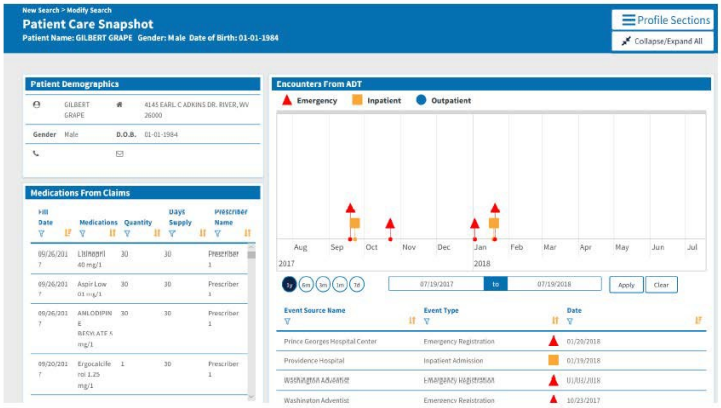
Patient Care Snapshot



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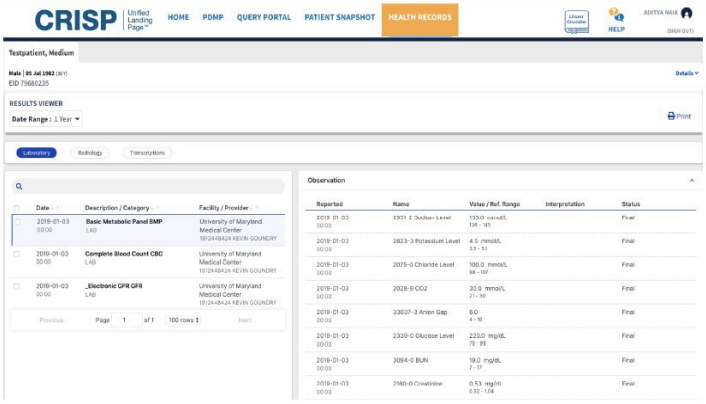
Health Records



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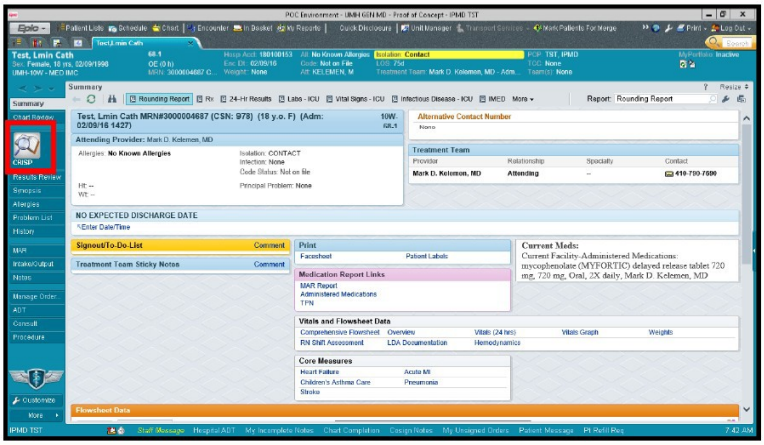
Clinical Query Portal - Single Sign-on



- A "CRISP Button" can be embedded in most major EMR systems to send the user directly to that patient's chart inside CRISP's Unified Landing Page
- Live at Sibley, MedStar, GWU, GWU-MFA, FQHCs, Kaiser

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CRISP Embedded Application and In Context

- CRISP's new Embedded App puts data directly into the EMR without forcing a provider to click anything at all
- The App loads automatically alongside your own facility's clinical information without having to log-in or do a separate patient search

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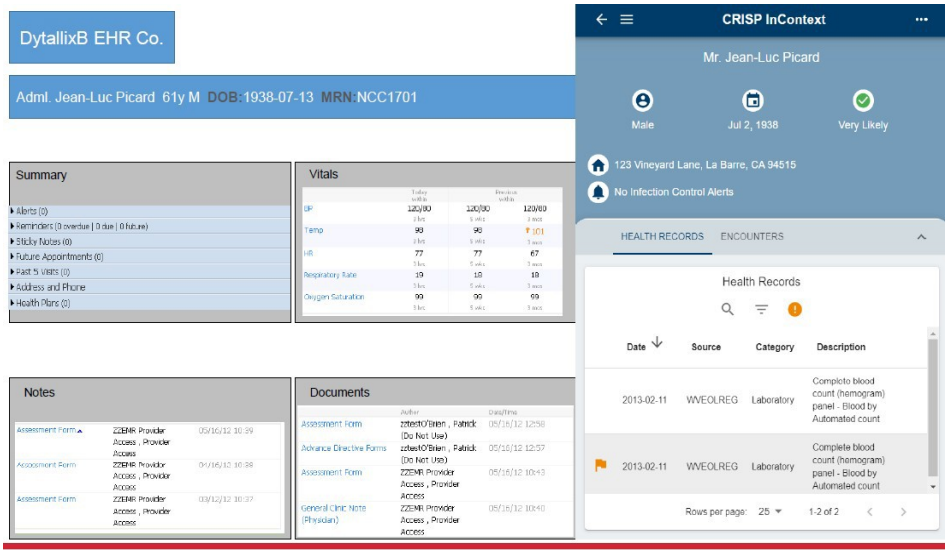

CRISP Integration with DC PDMP

- Work completed to integrate with the Appriss API service
- CRISP development underway to display the data in Patient Care Snapshot and InContext App
- CRISP must work with all of its participants as the participants must accept Appriss Terms and Conditions to use the PDMP through CRISP
- Integration will be single sign on – no need to log-in again or search for a patient

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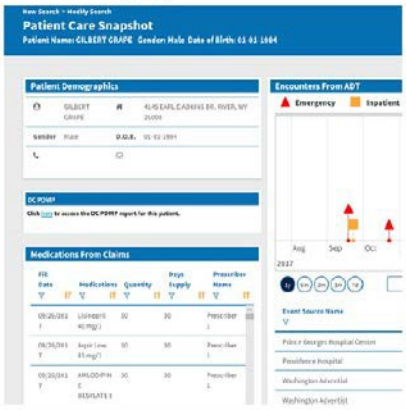
CRISP PDMP Mock-ups

Unified Landing Page



CRISP Embedded App

Links will only appear if the user meets minimum access requirements for each jurisdiction.

Multiple state links may appear if a provider meets access requirements of multiple states

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Takeaways

- CRISP is free for ambulatory practices and most other groups.
  - It is paid for by health plans, hospitals, and through grants
- All DC hospitals are participants and have contracts. Hospital users can use CRISP today.
- We can alert and provide you with clinical information about your patient in near real-time – including images
- We want your feedback to tell us what we should do next.
- We have separate DC governance that allows us to prioritize DC-specific use cases.

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	Notes and Discussion from CRISP DC presentation: • CRISP DC was formed in 2017. • The Board of Directors focuses on strategic conversations regarding ways CRISP can be helpful to its clients. • The Clinical Committee discusses and approves new ideas. • CRISP's goal for the year is to build more effective partnerships. • Adding CRISP to EHRs (rather than requiring users to access a separate login portal) increases utilization 4x. • Many states are collapsing/combining HIE systems. • Private practices may contract with CRISP. They must make arrangements with Appriss to access the DC PDMP through CRISP. • A provider licensed in a different state would need to access DC PDMP through PMP Interconnect. • Maryland may not share PDMP data through the gateway because of a law stating that data cannot be stored on EHRs. • **Question**: Has DC DHCF mandated hospitals use DC CRISP? • **Answer**: No. All connectivity to DC CRISP is voluntary. There are some programs within DC DHCF that require some practices to look in DC CRISP to meet Medicaid requirements. Sending data to DC CRISP is voluntary. • **Question**: How detailed is EHR data? • **Answer**: It's all electronic. • **Question**: Can patients request HIE data? **Answer**: The big issue is the cost to validate the requestor's identity (there is no cost-effective way to authenticate a patient). However, CRISP can let patients know which organizations have looked at their record. The patient may be able to request records from the organization/hospital, if the records have been downloaded. Consent forms may be the next step. • **Question**: Who is CRISP <u>not</u> free for? • **Answer**: CRISP is not free for hospitals and insurance companies. • **Question**: What information is provided to insurance companies? Which insurance companies are you referencing? • **Answer**: Medicaid MCOs. Kaiser and CareFirst use CRISP as well (CareFirst also has its own HIE initiative). They receive alerts for their patients. • **Question**: How are queries "counted" (not numerically, but in regards to credit)? Especially in cases of teaching institutions when medical residents search the PDMP on behalf of their supervisor? • **Answer**: Medical residents have their own PDMP registration. • **Question**: In regards to attribution, how does this work? How do we account for the fact that a physician may be using CRISP, without	

	logging in (e.g. Dr. Kirilichin asks the medical resident to look up a patient on CRISP, but she is working directly with the resident and looking at that patient's records in CRISP)? How do we link the supervising provider to a patient's query? This could affect the query data that the PDMP collects and could make it difficult to enforce a mandatory query. • **Answer**: The most important aspect is the fact that the patient was queried and a decision was made regarding the patient as a result of the query. Currently DC PDMP is looking at the total number of queries, instead of individual provider queries. • **Question**: How will the mandatory query legislation affect this type of situation? How will the legislation be enforced? • **Answer**: Mandatory query will be enforced on a case-by-case basis. If a patient brings a case against a physician/healthcare organization, that individual's query information will be looked at more in depth.	
0121-O-06	**Grant Updates** (a) Districtwide Gateway Integration Dr. Ortique provided the following update on Districtwide Gateway Integration: 2 integrations added since October 2019, which include Unity Healthcare and Order My Steps Podiatry. So far, the DC PDMP has made connections with pharmacy management systems, EHRs, HIEs, all major pharmacy chains. There are a total of 26 integrations. (b) NarxCare Package (c) Opioid Indicator Dashboard (link) Dr. White noted that this is a collaboration with DC Health's Center for Policy, Planning and Evaluation (CPPE). (d) Opioid Awareness Communications Campaign (link) (Stage 3) Ms. Brittany Allen shared the following update on the Opioid Awareness Communications Campaign: The current campaign's running dates are from November 11, 2019 until February 2, 2020. Communications materials include 225 Metro ads (Car Cards, Backlit Dioramas, Digital Live Boards, Digital Mezzanine Network), 475 Bus ads (Kings, Tail Light Displays, Interior Bus Cards) + 200 Car Cards (Bonus). The campaign also features mobile geo-fencing, which is a virtual perimeter based on bus origins. When an individual enters one of the perimeters while accessing certain phone apps, they receive a banner ad on their phone, which provides a link the DC PDMP website, if clicked. The total number of impressions as of 1/10/2020 is 1,631,467. (This is the number of people who have seen the ad). A total of 3,483 people have clicked on the ad, and 8 people have used the click to call feature. There have also been 90 secondary engagement actions taken on the landing page, including 79 header clicks to the website.	

0121-O-07	**<u>PDMP Best Practice Checklist Updates and Discussion</u>** Review FY2020 1 pager activities Dr. White reviewed the FY2020 1 pager activities, noting that many of these activities will be conducted in collaboration with CPPE. She also noted that Ms. Cathryn Mudrick (DC PDMP's new Public Health Analyst) will be working to ensure pharmacy compliance reporting, determine other states' best practices, and communicating prescriber report updates. 1 **DC Prescription Drug Monitoring Program (DC PDMP) Best Practice Checklist** **FY 2020 Activities** **DATA COLLECTION AND DATA QUALITY** / **STATUS** / **LAST ACTION** Conduct epidemiological analyses for surveillance, early warning, evaluation, prevention — Planned — FY 2020 Q2 - Collaborate with Center for Policy, Planning and Evaluation (CPPE) Integrate electronic prescribing and PDMP data collection — Planned — FY 2020 Q2 - Will create readiness assessment for prescribers and pharmacies (currently researching stakeholders best practices to complete data connections) **DATA LINKING AND ANALYSIS** Conduct periodic analyses to identify at-risk patients, prescribers and dispensers — Planned — FY 2020 - Public Health analyst will develop this process. Will work with other states to determine best practices. Quarterly prescriber reports will be sent. Feedback from Health Care Professional Boards to evaluate new version of prescriber report. Revised 01/07/2020	

Integrate PDMP reports with... • health information exchanges • electronic health records • pharmacy dispensing systems	In Progress	2020 Q2 - via CDC grant funding through CRISIS Opioid Grant. Current funding through Overdose Data to Action. 26 integration requests by EHRs and Pharmacy dispensing systems as of January 10, 2020.
ENROLLMENT, OUTREACH, EDUCATION, UTILIZATION	**STATUS**	**LAST ACTION**
Proactive identification and outreach to enroll high impact users, e.g., top prescribers	Planned	Q2 - Mail PDMP post cards to top prescribers as well as outreach and clinical coordinator.
PDMP PRACTICE/POLICY		
Send PDMP notification letters to new prescribers	Planned	FY 2020 Q4- Streamline once one licensing system has been established. Currently sending monthly emails to new licensees.
Send unsolicited reports and/or alerts to... - prescribers - dispensers - licensure boards	Planned	FY 2020 Q4

Revised 01/07/2020

- Letters to top prescribers		
PDMP USABILITY, PROGRESS AND IMPACT		
Conduct audits of PDMP system utilization for appropriateness and extent of use	Planned	FY 2020- Q3
- Use PDMP data as outcome measures in evaluating program and policy changes	Planned	FY 2020- Q4 via collaboration with CPPE
Analyze other outcome data (e.g., overdoses, deaths, hospitalizations, ER visits) to evaluate the PDMP's impact	Planned	FY 2020 – Q4 collaboration with CPPE and OCME. Opioid Fatality Review Board.

Chart Key

In Progress- Activities that have started but are not complete

Planned – Activities that have not been started

Revised 01/07/2020

0121-O-08 **Matters for Consideration**	**Action Items** • Potential Future meeting dates FY-2020: o April 21, 2020 o July 21, 2020 o October 20, 2020 o Discuss possibility of having one 2020 meeting offsite Dr. Watson noted that since a new year and a new decade has begun, it is a good time to discuss the meeting structure and whether it needs any updating. She stated that the regulations require 2 meetings per year and asked if the Committee should continue to meet 4 times a year, or scale it back to 2 or 3 meetings per year. She noted that the goal is ensure that everyone is able to attend the meetings, that the discussions are fruitful, and that recommendations are able to move forward. She opened the floor for discussion. Mr. Meyers stated that he is fine with the current meeting schedule, especially with pending legislation and regulations under review, but he's also comfortable with reducing the meeting schedule down to 2 meetings per year. He noted that he would like to see some PDMP data. Dr. Watson pointed out that there is big picture data in the Annual Report. Ms. Doyle stated that it would be helpful if Committee members could advise on the data elements that are utilized to measure success. She noted that Committee members receive data after the fact and ask questions later. She noted that Committee members can be more involved if there was a way to solicit input from Committee members in between meetings as a Word document, so that they can add comments. Dr. Watson noted that giving Committee assignments and reporting on best practices can help the program learn more from Committee members and build a program that is best for the city. She noted that she would like to see more interactivity within the Committee. Ms. Doyle noted that she finds the presentations to be very informative and helpful and stated that a presentation from the Virginia and/or Maryland PDMP could be really helpful, as we would learn more about their best practices, how they overcame hurdles, etc. She said that she is fine with the quarterly meeting session. Ms. Doyle also noted that the agendas are sometimes too jam-packed which causes the Committee to run out of time. Dr. Watson agreed, stating that we do want to allow the presenters enough time to give their presentation, and that staff should ensure that the agenda is stacked in such a way to accommodate the presentations. Dr. Kirilichin pointed out that the Committee members have different work styles (some prefer independent processing and work flow, external to a group setting, while others prefer group work). She noted that there is a lot of fantastic information being presented, and it's during that moment she is the most sparked. She said that it's one thing to read through it, but when she hears it articulated differently through Dr. White's lens, she can process the information differently than reading the information independently. She stated that she receives the information differently when the Committee is together in a unit and that she is most activated and able to provide while onsite. She noted that she would be on board with creating some balance (e.g. providing a WebEx space in between meetings for members to work on an assignment together, rather than working on independent assignments).

	Dr. Watson noted that there are a number of items that appear on the agenda that don't necessarily add any value. She asked Dr. Kirilichin if she recommends adding time on the agenda to allow the creative juices to flow while in person to work through a particular issue, in order to prevent it from becoming another activity to work on after leaving the meeting. Dr. Watson summarized the feedback as: • Paring down the agenda • Highlighting key issues to focus on from one meeting to the next • Work on a best practice checklist item that requires active engagement and input and allow ample time on the agenda for that activity Dr. Watson stated that she wants to make sure that everyone's time is well spent and that the Committee gets what it needs from members, so that the staff is able to internally make the program better. She noted that it is important to create the right forum to make that exchange of information occur. She reflected the feedback as: • Continue the quarterly meeting schedule • Review the agenda and determine what can be reviewed ahead of time by Committee members and quickly moved through during meetings • Include presentations of value on the agenda • Include space on the agenda for the Committee to work actively together around solving an issue and developing recommendations Ms. Williams provided an additional legal update. Ms. Williams said, "the Committee was able to take on a couple of additional roles in the newly enacted legislation, which include: (1) developing criteria for indications of possible violations of law or possible breach of professional standards by prescriber or dispenser and (2) developing a method for analysis of data collected by the program using the criteria for indications of a possible violation of law or a possible breach of professional standards by a prescriber or dispenser." She recommended that the Committee starts working on this, because upon the development of the of the criteria and data analysis, the program can begin reviewing prescription monitoring data for indications of possible misuse or abuse of a covered prescription drug and possible violations of law or breaches of professional standards. Ms. Williams noted that it's great that everyone is required to register, but pointed out that registrants are not required to even look at it (their PDMP profile). She noted that the Committee needs to think about how the data is analyzed so that it serves a purpose. Dr. Watson noted that this aligns with the DC Health Strategic priority number 5: to implement data driven and outcome oriented approaches to program and policy development. Dr. Kirilichin noted that she has always viewed the role of the DC PDMP Advisory Committee to be patient care oriented and that the moment that she hears that the focus is being shifted in a prescriber or dispenser punitive related manner, it gives her great pause. She stated that she does not know if that's the Committee's role.	

	Dr. Watson said that if it is given to the Committee as a directive or if it is a part of the Committee's responsibility, then it can be thought of from a different perspective: it is that it is good to have various points-of-view weigh in on topics, as an advisory committee. She noted that having the input of someone who is currently practicing is valuable, because they may see where certain behaviors may lead to a problem and make recommendations for awareness programs, remediation, etc., and could provide feedback on the impact the violations of the law could have on various settings. Ms. Williams stated that she would finish reading the law, saying, "if there is a finding of a possible violation, the program and the director may, in addition to any discretionary disclosure information, report the possible misuse or abuse via patient to the specific prescriber or dispenser, notify the prescriber or dispenser of a possible violation of law or professional standards, and provide education to the prescriber or dispenser." She noted that a possible violation may not necessarily result in a disciplinary action. She noted that the program exists to help prevent the abuse of these drugs and ensure that prescribers are aware. Ms. Williams stated that she would like to see the program and the Advisory Committee start working on this legislation. Dr. Watson noted that the program should start working on it and refer to the Advisory Committee for questions and feedback. Dr. Watson noted that if there is value in holding the meeting at a different location in order to bring in additional people that the Committee is trying to reach, then that is something the program can factor in; it should be tied in to the Communication and Outreach Strategy. She asked that when program staff sends the agenda out to members, there is also a proactive call made to Committee members to confirm their attendance. She stated that it is extremely critical that the Advisory Committee members are present for the meetings and the presentations, especially as we request of having external presenters attend meetings. She noted that allowing members to call in may be an option as well, in the rare event that a member is not able to attend. She noted that the police are extremely valuable to have at the table providing input.	

0121-O-09	Other news/highlights from Committee members	
Comments from the Public	None	
Motion to Adjourn the Open Session	Madam Chair, I move that the Committee close the Open Public session portion of the meeting. **Motion**: Frank Meyers **Seconded by**: Shauna White **Motion carried.** (Roll Call Vote)	

This concludes the Public Open Session of the meeting.

Open Session Meeting Adjourned at 12:16 PM