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**2020 SESSION
POSITION PAPER**

BILL NO: HB 1486
COMMITTEE: Health and Government Operations Committee
POSITION: SUPPORT with Amendment

TITLE: Public Health – Non–Controlled Substance Prescription Record System Program

BILL ANALYSIS:

House Bill 1486 (HB 1486), as proposed, requires the Maryland Health Care Commission (the “Commission”) to establish a non-controlled substance prescription record system (the “program”). The program would collect and make available to treating health care providers and dispensers (collectively referred to “authorized users”) information on non-controlled substances (NCS) dispensed in Maryland.¹ The bill requires the Commission to establish standards for selecting a prescription information system vendor and identifying standards to be used in the transmission of NCS information in the program. The State-Designated Health Information Exchange (HIE) is required to establish and maintain the technical infrastructure. The HIE is also required to make the program technology available to authorized users. The Commission is required to convene an Advisory Committee to make recommendations regarding program policy and technology to the Commission. The Advisory Committee consists of public and private stakeholders and includes strong consumer representation. The Advisory Committee is required to meet at least quarterly. The Commission, in consultation with the Secretary of Health, is required to adopt regulations for the program. The Commission to annually report on the program to the House Health and Government Operations Committee and the Senate Finance Committee.

POSITION AND RATIONALE:

The Commission supports the passage of HB 1486 with an amendment intended to ensure that a broad spectrum of NCS dispensers are covered by the bill. In 2019, the Commission submitted a

¹ NCS includes medications prescribed to treat medical conditions such as high blood pressure, diabetes, and bacterial infections, not classified as a CDS.

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report to the General Assembly on a NCS Electronic Prescription Records System.² The Commission was required to submit this report under House Bill 115 (2018), *Maryland Health Care Commission – Electronic Prescription Records System – Assessment and Report*.³ This bill directed the Commission to conduct a study to assess the benefits and feasibility of developing an electronic NCS prescription record system. In July 2018, the Commission convened a stakeholder workgroup that included providers, dispensers, consumers, payers, and technology vendors. The workgroup issues related to the implementation of the electronic NCS prescription record system, including consumer privacy and education, governance, and funding. The workgroup concluded that a statewide NCS system in Maryland could bridge gaps in medication reconciliation, improving patient safety. The system would collect and make available to authorized users information on NCS dispensed in Maryland.

Currently, the Prescription Drug Monitoring Program (PDMP) makes available information on prescription controlled dangerous substances (CDS) on Schedules II through V that are dispensed in Maryland.⁴ The State-designated HIE serves as the access point to authorized users for viewing filled CDS prescriptions.⁵

There is no similar repository for NCS prescription information. Providing health care providers with access to an electronic medication record can inform clinical decision making about diagnosis and treatment and help providers manage potential drug-drug interactions⁶ and other types of adverse drug events (ADEs). For example, some NCS drugs (such as cardiovascular drugs, sedatives, antibiotics, antithrombotic drugs and analgesics) can result in serious or potentially fatal drug interactions.⁷ Newer drug classes (e.g., novel oral anticoagulants or NOAC commonly used today) can result in potentially fatal consequences when administration is disrupted.⁸ Drugs with varying dose ranges (e.g., 10-20mg) and frequency of administration

² The report is available on the Commission's website:

https://mhcc.maryland.gov/mhcc/pages/hit/hit/documents/HIT_EPRS_Rpt_072219.pdf

³³ Governor Larry Hogan approved House Bill 115 on May 8, 2018.

⁴ The PDMP was established in Chapter 166, 2011. CRISP developed the technical infrastructure for the PDMP.

⁵ The Maryland Health Care Commission and the Health Services Cost Review Commission (HSCRC) designate the HIE for the State of Maryland under Health-General §19-143. The HIE is responsible for building and maintaining the technical infrastructure that can support the secure exchange of electronic health information statewide. The Chesapeake Regional Information System for our Patients (CRISP) is the current State-Designated HIE.

⁶ A change in a drug's effect on the body when the drug is taken together with a second drug that results in an unexpected side effect. U.S. FDA. Available at: www.fda.gov/drugs/resources-you/drug-interactions-what-you-should-know.

⁷ Fitzgerald RJ. Medication errors: The importance of an accurate drug history. *British Journal of Clinical Pharmacology*. 2009;67(6):671-5.

⁸ Diagnostic and Interventional Cardiology, Advantages and Disadvantages of Novel Oral Anticoagulants, July 2016. Available at: www.dicardiology.com/article/advantages-and-disadvantages-novel-oral-anticoagulants.

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create opportunities for errors in administration. Enabling access to longitudinal prescription records in real-time can reduce ADEs and subsequent health care utilization.^{9, 10}

Medication reconciliation is a key patient safety tool across the care continuum.¹¹ Medication reconciliation is a significant challenge for providers. Manual medication reconciliation processes often require lengthy conversations with patients and/or their caregivers along with multiple calls to pharmacies. An incomplete or inaccurate medication history can follow a patient throughout their treatment, leading to harmful medication errors and increased costs for patients and providers. Electronic access to comprehensive patient medication histories has great potential to improve the medication reconciliation process.^{12, 13} Medication discrepancies can lead to interrupted or inappropriate drug therapy during and after a hospitalization. Medication errors¹⁴ are among the most common causes of morbidity and mortality in a hospital.^{15, 16}

Access to comprehensive electronic patient medication histories is particularly important for hospital emergency departments, the origin of at least half of all hospital admissions in Maryland and the nation.^{17, 18, 19} Clinical information about a patient is often times lacking or incomplete in an emergency department,²⁰ a major challenge since decisions need to be made quickly in that setting.

⁹ Agency for Healthcare Research and Quality, *Advances in Patient Safety and Medical Liability*, August 2017. Available at: www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/liability/advances-in-patient-safety/medical-liability/neumiller.html.

¹⁰ Anthem and The Network for Excellence in Health Innovation, *Reducing Hospital Readmissions through Medication Management and Improved Patient Adherence*. Available at: www.nehi.net/writable/publication_files/file/anthemreducinghospitalreadmissions-digital-final.pdf.

¹¹ Barnsteiner JH. Medication Reconciliation. In: Hughes RG, editor. *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 38. Available at: www.ncbi.nlm.nih.gov/books/NBK2648/.

¹² Frisse ME, Tang L, Belsito A, Overhage JM. Development and use of a medication history service associated with a health information exchange: architecture and preliminary findings. *AMIA Annu Symp Proc*. 2010; 2010:242–245. Published 2010 Nov 13.

¹³ Medication reconciliation is a process of creating the most accurate list possible of all medications a patient is taking — including drug name, dosage, frequency, and route. More information is available at: www.ihi.org/Topics/ADEsMedicationReconciliation/Pages/default.aspx.

¹⁴ The Mayo Clinic defines medication errors as mistakes in prescribing, dispensing, and administering medications.

¹⁵ Institute of Medicine (US) Committee on Quality of Health Care in America; Kohn LT, Corrigan JM, Donaldson MS, editors. *To Err is Human: Building a Safer Health System*. Washington (DC): National Academies Press (US); 2000. 2, Errors in Health Care: A Leading Cause of Death and Injury. Available at: www.ncbi.nlm.nih.gov/books/NBK225187/.

¹⁶ Drug classifications have grown in complexity and volume in the last twenty years; drug products approved by the U.S. Food and Drug Administration (FDA) have more than doubled. More information is available at: www.fdalawblog.net/2015/02/delving-into-the-bowels-of-the-orange-book-what-do-the-data-reveal/.

¹⁷ Percent of hospital admissions originating from the ED in Maryland: FY 2017 (56.68 percent), FY 2018 (56.63 percent), FY 2019 through March (56.53 percent).

¹⁸ Schuur JD, Venkatesh AK. The Growing Role of Emergency Departments in Hospital Admissions. *N Engl J Med*. 2012;367(5):391–393.

¹⁹ Tamblyn R, Poissant L, Huang A, et al. Estimating the information gap between emergency department records of community medication compared to on-line access to the community-based pharmacy records. *J Am Med Inform Assoc*. 2014; 21(3):391–398.

²⁰ Hripcsak G, Sengupta S, Wilcox A, Green RA. Emergency department access to a longitudinal medical record. *J Am Med Inform Assoc*. 2007;14(2):235–238.

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Comprehensive medication histories are particularly important as the population of the State is aging. Older adults are more likely to take multiple medications and are more prone to transitions between health care settings with interventions from multiple providers.²¹ These transitions of care pose risks for ADEs if providers do not have access to a complete medication history. Access to electronic medication histories will benefit providers and patients by minimizing the potential for medication errors, discrepancies, and other medication-related problems, while improving efficiencies.

HB 1486 will enable treating providers to have electronic access to a comprehensive medication history. This bill has great potential to improve patient safety across the care continuum. The Commission recommends that the Committee report this bill favorably with amendment (see below). The introduced language unintentionally limited to definition of “dispenser” to dispensers of controlled substances (current PDMP participants), and not all dispensers of NCS are dispensers of controlled substances. The Commission’s proposed amendment broadens this definition to cover a broader spectrum of NCS dispensers.

AMENDMENT NO. 1 [*Correcting definition of “Dispenser”*]

On page 3, line 4, strike **“HAS THE MEANING STATED IN § 21–2A–01 OF THIS TITLE”** and insert **“MEANS A PERSON WHO DISPENSES A PRESCRIPTION OR NONPRESCRIPTION DRUG OR DEVICE, AS PROVIDED IN 01(D) OF THIS SUBTITLE”**

²¹ Goen, LG. Medication reconciliation in long-term care and assisted living facilities: opportunity for pharmacists to minimize risks associated with transitions of care. *Clinical Geriatric Medicine*. 2017; 33(2): 225-239. Available at: www.ncbi.nlm.nih.gov/pubmed/28364993.