Department of Legislative Services

Maryland General Assembly
2017 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 988 (Delegate Kipke)
Health and Government Operations

Licensed Pharmacists - Risks of Opioid Addiction - Notifications

This bill requires a licensed pharmacist, if an opioid is dispensed by either the licensed pharmacist or an individual engaging in a professional experience program acting under the direct supervision of a licensed pharmacist, to notify the individual to whom the opioid is dispensed of the risks of opioid addiction. Notification may be made orally or in writing.

Fiscal Summary

State Effect: The bill does not directly affect governmental operations or finances.

Local Effect: None.

Small Business Effect: Potential meaningful operational impact on small business pharmacies to the extent such notification is not already provided by the licensed pharmacist.

Analysis

Current Law: In the operation of a pharmacy, only a licensed pharmacist (or an individual engaging in a professional experience program and acting under the direct supervision of a licensed pharmacist) may provide information to the public or a health care practitioner about prescription or nonprescription drugs or devices, including information on therapeutic values, potential side effects, and use in the treatment and prevention of diseases.

Chapter 166 of 2011 established the Prescription Drug Monitoring Program (PDMP) to assist with the identification and prevention of prescription drug abuse and the

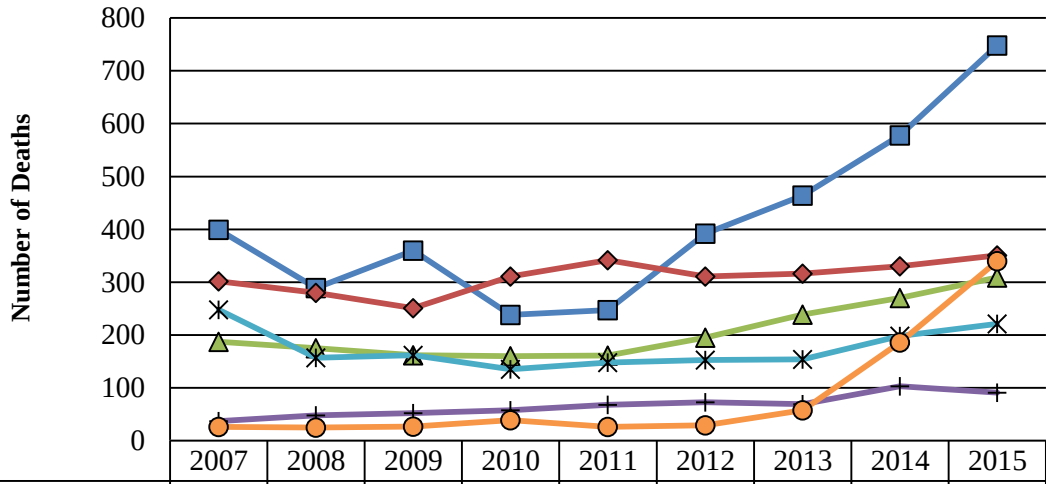
identification and investigation of unlawful prescription drug diversion. PDMP must monitor the prescribing and dispensing of Schedule II through V controlled dangerous substances. When a dispenser (including a pharmacist) fills a prescription for a monitored drug, the dispenser must electronically submit to PDMP identifying information for the patient, prescriber, dispenser, and drug within three business days of dispensing. A dispenser who knowingly fails to submit prescription monitoring data to PDMP is subject to a civil penalty of up to $500 for each failure to submit required information.

Background: Greater than 10% of patients started on opioids are likely to progress to chronic use, which is defined as treatment for more than three months or beyond the time of normal tissue healing. Nearly all patients who take long-term opioid medications develop tolerance, about 25% become nonmedical users, and about 10% show characteristics of addiction.

In February 2015, the Governor issued two executive orders establishing the Governor's Inter-Agency Heroin and Opioid Coordinating Council and the Heroin and Opioid Emergency Task Force to establish a coordinated statewide and multijurisdictional effort to prevent, treat, and significantly reduce heroin and opioid abuse. Additionally, Chapter 464 of 2015 established the Joint Committee on Behavioral Health and Opioid Use Disorders. The joint committee is required to monitor the activities of the coordinating council and the effectiveness of the State Overdose Prevention Plan; local overdose prevention plans and fatality review teams; strategic planning practices to reduce prescription drug abuse; and efforts to enhance overdose response laws, regulations, and training. In January 2017, the Governor issued another executive order establishing an Opioid Operational Command Center within the coordinating council to facilitate coordination and sharing of data among State and local agencies.

According to the Department of Health and Mental Hygiene's (DHMH's) 2016 report, *Drug and Alcohol-Related Intoxication Deaths in Maryland*, drug- and alcohol-related intoxication deaths in Maryland increased for the fifth year in a row, totaling 1,259 deaths in 2015 – a 21% increase since 2014 and an all-time high. Of all intoxication deaths, 1,089 deaths (86%) were opioid related, including deaths related to heroin, prescription opioids, and nonpharmaceutical fentanyl. Opioid-related deaths increased by 23% between 2014 and 2015 and have more than doubled since 2010. Heroin- and fentanyl-related deaths have risen particularly sharply. The number of heroin-related deaths increased by 29% between 2014 and 2015 and has more than tripled between 2010 and 2015. The number of fentanyl-related deaths increased by 83% between 2014 and 2015 and has increased nearly twelvefold since 2012. **Exhibit 1** shows trends in drug- and alcohol-related intoxication deaths in Maryland from 2007 through 2015.

Exhibit 1
Total Number of Drug- and Alcohol-related Intoxication Deaths
By Selected Substances in Maryland
2007-2015



	2007	2008	2009	2010	2011	2012	2013	2014	2015
Heroin	399	289	360	238	247	392	464	578	748
Prescription Opioids	302	280	251	311	342	311	316	330	351
Alcohol	187	175	162	160	161	195	239	270	309
Benzodiazepines	37	48	52	58	68	73	69	103	91
Cocaine	248	157	162	135	148	153	154	198	221
Fentanyl	26	25	27	39	26	29	58	186	340

Source: Department of Health and Mental Hygiene

Preliminary data from DHMH indicates that the number of intoxication deaths increased at an even steeper rate in 2016, with 1,468 deaths from January through September 2016 compared to 904 deaths during the same period in 2015 (a 62% increase). Additionally, for January through September 2016, the number of heroin-related deaths increased 72% and the number of fentanyl-related deaths increased nearly fourfold compared to the same period in 2015.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Medscape; Department of Health and Mental Hygiene; Department of Legislative Services

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Analysis by: Jennifer B. Chasse

Direct Inquiries to:
(410) 946-5510
(301) 970-5510