

RULES FOR REPORTING OF POISONINGS  
DUE TO THE USE OF PRESCRIPTION OR  
ILLCIT DRUGS, PUBLIC HEARING

March 12, 2019

Prepared by

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[depos@networkreporting.com](mailto:depos@networkreporting.com)

Phone: 800.632.2720

Fax: 800.968.8653

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STATE OF MICHIGAN  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
BUREAU OF EPIDEMIOLOGY AND POPULATION HEALTH

PUBLIC HEARING  
RULES FOR REPORTING OF POISONINGS DUE TO THE USE OF PRESCRIPTION  
OR ILLICIT DRUGS

333 South Grand Avenue, Lansing, Michigan

Tuesday, March 12, 2019, 1:00 p.m.

PANEL: SARAH LYON-CALLO  
MATTHEW BUCK  
JARED WELEHODSKY  
MARY BRENNAN

RECORDED BY: Marcy A. Klingshirn, CER 6924  
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1                   Lansing, Michigan

2                   Tuesday, March 12, 2019 - 1:02 p.m.

3                   MS. LYON-CALLO: Good afternoon, everyone. Thank  
4 you for coming. It is now 1:02 p.m. on Tuesday, March 12th,  
5 2019. My name is Sarah Lyon-Callo and I'm the state  
6 epidemiologist and director for the Department of Health and  
7 Human Services, Bureau of Epidemiology and Population  
8 Health. I'd like to introduce Mr. Matthew Buck. He is my  
9 state assistant administrator within the Bureau, as well as  
10 Jared Welehodsky. Can you share your title?

11                   MR. WELEHODSKY: I work in the Policy Planning  
12 Division at MDHHS.

13                   MS. BRENNAN: Good afternoon. I'm Mary Brennan.  
14 I'm the DHHS Regulatory Affairs officer, and my only purpose  
15 here is to make everyone here behave.

16                   MS. LYON-CALLO: Okay. So we are on the record  
17 for the public hearing for the administrative rules  
18 involving reporting of poisonings due to the use of  
19 prescription or illicit drugs. So we have a brief  
20 presentation today regarding these draft rules.

21                   As you know, nationally there have been more than  
22 400,000 deaths from opioid overdose between 1999 and 2017.  
23 There are basically three waves during this epidemic, the  
24 most recent being due to illicit Fentanyl use. Michigan has  
25 followed the national trends depicted in this slide.

1           Unfortunately, we expect there to be new drugs involved in  
2           epidemic of overdose, whether it be fatal or nonfatal  
3           overdoses, and that these drugs will continue to change over  
4           time.

5                       Surveillance of drug poisoning in Michigan is  
6           currently somewhat limited. We are able to look at data on  
7           fatal drug poisonings through use of death certificates and  
8           using some federal dollars, we're able to conduct some  
9           extractions of medical examiner records. Our understanding  
10          of nonfatal drug poisonings is through the use of syndromic  
11          surveillance or chief complaint data, and through the use of  
12          a purchase data set from the Michigan Health and Hospital  
13          Association, their inpatient and outpatient discharge data.

14                      These are both very important and valuable data  
15          sources, however, each have their own limitations. Our  
16          syndromic or chief complaint data are quickly available, but  
17          are relatively incomplete and at times nonspecific. The  
18          inpatient and outpatient discharge data are a very rich data  
19          set and we've used these for retrospective surveillance and  
20          evaluation purposes, but they are not timely enough for  
21          rapid response.

22                      These draft rules are intended to fill this gap.  
23          The rules would allow the Department to gather information  
24          on drug poisonings for medical practitioners, so it'd enable  
25          us to have more timely analyses for our local communities

1 and provide us the ability to investigate outbreaks of drug  
2 poisonings.

3 I want to be clear that these rules do not require  
4 health care practitioners to immediately report to the  
5 department upon their passage. What these rules do is allow  
6 MDHHS to ask for information, but also requires the  
7 department to create a mechanism for coordinating collection  
8 of that data and sharing of that data with local public  
9 health and others in order to minimize reporting burden. I  
10 also wanted to point out that the rules -- that under the  
11 rules, submitted reports are not FOIAable.

12 So how would we implement these rules? Using  
13 federal grant dollars, MDHHS is building a surveillance  
14 module for routine reporting. We're leveraging an existing  
15 data system we use for communicable disease reporting and  
16 existing flow of admission discharge transfer HL7 messages.  
17 Therefore, we expect the burden of collection of nonfatal  
18 poisonings to be minimized for this reason.

19 So as an overview, at the request of MDHHS, a  
20 health care professional and facility would submit reports  
21 of prescription and/or illicit drug poisonings. The rules  
22 permit MDHS to request reporting elements such as those  
23 which relate to evidence of drug poisoning, for example,  
24 diagnoses codes, as well as patient information and  
25 demographics, reporting provider, health care facility

1 and/or laboratory findings. And, again, the rule permits  
2 MDHHS to further investigate referrals of drug poisonings.

3 So one example of use of the rule would be that  
4 MDHHS would set up a standing request for health care  
5 providers to submit referrals to the department. This would  
6 be MDHS mining existing ADT messages for indicators of drug  
7 poisonings or overdoses, health care providers could  
8 regularly conduct quality assurance on submitted referrals,  
9 and health care providers that do not participate in regular  
10 transmission of ADT messages would have an ability to  
11 manually submit all referrals to MDHHS as they do now for  
12 communicable disease.

13 Another example would be if the department had  
14 identified a potential outbreak or hot spot of drug  
15 poisoning activities. The department or its local health  
16 department partner could conduct active outreach to the  
17 health care providers to investigate this outbreak. This  
18 could include outreach to individuals or their  
19 representatives, outreach to health care providers and/or  
20 facilities, completion of case report forms, or record  
21 abstraction. So very similar to how we investigate  
22 communicable disease outbreaks today.

23 I wanted to provide some -- just the references  
24 that we used in this presentation. And then just briefly  
25 state that formal questions and comments must be filed -- on



1 Michigan Medical -- the Michigan State Medical Society. Our  
2 formal written remarks will be e-mailed by Friday's deadline  
3 to make sure everything that we go over has a little bit  
4 more of a detailed component to it.

5           Upon review of the rules for consideration there's  
6 been some confusion within the health care community of  
7 whether or not these rules apply exclusively to controlled  
8 substances and opioids. We respectfully request a  
9 clarification on that just to better facilitate the  
10 satisfaction of what is being asked in the requirements.  
11 The title of the rules in the definition section seem to  
12 imply to us that providers in health facilities would be  
13 reporting on all accidental or intentional poisonings for  
14 both controlled substances and non-controlled substances.  
15 One example of this is such as insulin. If that's not the  
16 case, we request the title of the rules be updated to  
17 include the term "opioid" in them to help the confusion be  
18 cleared with the health care community. In addition, we  
19 also are hoping that a definition of "drug" and "poisoning"  
20 could be updated.

21           We would request that a formal definition of "drug  
22 overdose" be included in the rules, if possible. Without  
23 the formal definition, the interpretation of drug overdose  
24 has been interpreted by some who we ask to review the rules  
25 as a continuum of care or side effects of over medication

1           that has happened. So without this clear definition,  
2           facilities and health care providers raise the fact that  
3           they didn't know if it was related and what you wanted  
4           reported had to do with medication toxicity, medication side  
5           effects, poly pharmacy, or sedation due to opioid use. Was  
6           that something that was intended to be included in these  
7           rules and reports or not? There also currently is not an  
8           ICD-10 code for those instances and at a minimum, we  
9           requestfully respected (sic) -- would ask that the drug  
10          overdose definition would be included in the public health  
11          code because that would help clear up some of the confusion  
12          that has been created.

13                   Our understanding is that the intent is to have  
14          the system automated that wouldn't require health  
15          professionals to enter data, use the list of ICD-10 codes,  
16          or retain files for future use. And while we're extremely  
17          supportive of this approach and we think it does create and  
18          ensure that there's less administrative burden on both  
19          facilities and providers, we would appreciate if the rules  
20          would provide a little bit more clarity to address the  
21          situations in which the automated data sharing, if it's  
22          unavailable, could be collected from existing information  
23          feeds.

24                   We also respectfully request both the inclusion of  
25          a state plan to provide a form that would be able to ensure

1 to capture all necessary information at the initial request  
2 from the department or delay the implementation until the  
3 automated data collection system is operational. And this  
4 was before your presentation, so just a side note on that.  
5 We also do appreciate the current flexibility that would  
6 allow the reporting format to keep the option of being --  
7 data being pulled for those facilities and providers who  
8 have it available to them. We do understand that some  
9 providers and facilities would not have the ability to have  
10 the information be pulled.

11 We would also request a list of ICD diagnosis  
12 codes for facilities and providers that they're expected to  
13 report on. Wanted to make a quick note that it's important  
14 that ICD-10 doesn't have a specific code for Fentanyl, and  
15 we do think that is something you guys were interested in  
16 capturing. So just be aware that our facilities and  
17 providers would need an adequate way to ensure the state  
18 would be able to capture Fentanyl moving through that  
19 process.

20 Currently the rules specify actions required of  
21 health professionals and health facilities when a report is  
22 requested. However, there isn't the criteria in the actual  
23 report to see when it's requested. Unlike some of the  
24 frequently asked question documents that was prepared by  
25 DHHS, there were two specific scenarios that were mentioned

1 and we would respectfully request that those parameters be  
2 included in the rules, if possible.

3 The last request was just very technical in  
4 nature. It had to do with the provision 3C, which requires  
5 the reporting entity, if they are a clinical laboratory.  
6 The way the statement appears we believe that it's missing  
7 the term "if applicable." As currently written, the  
8 language requires both logical observation identifier names  
9 and codes and SnoMed. "And" is in there and underlined.  
10 There is a little bit of a technical nature for us in this  
11 fact because this rule is problematic since some health  
12 facilities no longer use SnoMed codes and do not have  
13 interfaces linking SnoMed to electronic medical records  
14 anymore. So with that, we would request and urge the  
15 department to replace that current language to allow that  
16 reporting only if it's available for those particular health  
17 care organizations and providers.

18 So thank you for your comments -- thank you for  
19 allowing us to comment, and I will submit this written this  
20 week with just some more detail. Thank you so much.

21 MS. LYON-CALLO: Thank you. So the person who  
22 came in late, we're at the stage of the hearing where if  
23 you'd like to make a comment regarding proposed rule  
24 changes, you're welcome to do so at the mic. Please  
25 introduce yourself and spell your name for our reporter.

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AMANDA KOGOWSKI

MS. AMANDA KOGOWSKI: Thank you for the opportunity to speak today. My name is Amanda Kogowski. I am the project manager of the System for Opioid Overdose Surveillance.

REPORTER: Can you spell your last name, please?

MS. AMANDA KOGOWSKI: Oh. K-o-g-o-w-s-k-i.

So this is a CDC funded project working to increase the timeliness of opioid overdose data across the state of Michigan. So the current standard for tracking overdoses in Michigan involves reporting that lags up to 18 months. And while such data can be useful for retrospective analysis of changes in overdoses, they are fully insufficient for informing rapid public health and law enforcement responses that are required for reducing opioid overdoses. Thus, the state of Michigan has great need to increase the timeliness of fatal and nonfatal opioid overdose reporting to move to rapid surveillance of opioid overdoses for public health and law enforcement response. Near realtime surveillance have provided currently missing basis for identifying when and where resources are currently needed. An example of this is near realtime opioid overdose surveillance will provide an empirical basis for specifying optimal naloxone distribution to community organizations and EMS workers. Another example is overdose death spike alerts

1           may provide law enforcement with timely and spatially  
2           specific information about lethal illicit opioids  
3           circulating.

4                       We envision the most effective strategies as those  
5           that rely on coordination between multiple organizations  
6           such as public health, law enforcement and emergency medical  
7           services that could all benefit from surveillance and that  
8           does not have such a time lag. Thank you.

9                       MS. LYON-CALLO: Thank you.

10                      MS. BRENNAN: Ma'am, did you sign in when you came  
11           in?

12                      MS. AMANDA KOGOWSKI: Yeah. Thank you.

13                      MS. BRENNAN: Thank you.

14                      REPORTER: Do you want to go off the record while  
15           we're waiting for anybody else who shows up or --

16                      MS. BRENNAN: Pending further public comment, we  
17           are off the record.

18                      REPORTER: Thank you.

19                      (Off the record)

20                      MS. BRENNAN: It is 3:30 p.m. There have been no  
21           testimony nor any written testimony provided. The meeting  
22           or the public hearing on these rules has concluded.

23                      (Proceedings concluded at 3:30 p.m.)

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