MINUTES, MEDCHI OPIOID, PAIN & ADDICITON COMMITTEE, 7-15-2025

MARYLAND OPIOID ACADEMIC DETAILING (AD) & THE PDMP PROGRAM

GUEST SPEKER: **ANA LAZARIDES, Director, PDMP** Staff also present:
Brian Ricci, PDMP Coordinator, and. **Nicole Sealfon, MPH**, Associate Director,
Behavioral Health Resources & TA (BHRT) at U of M Schl of Pharmacy,

The Slide Deck is on the MedChi website, OPA Committee section:

Summary Points:

Trained detailers guide Maryland's PCP providers, with messages on opioid-alternatives, and naloxone, etc. The program appears to have reduced high dose prescriptions.

Maryland's AD Program, launched 2019, delivers tailored, interactive, non-commercial outreach, grounded in behavior change principles, that is practice-specific, evidence-based, over multiple visits, with CME credits.

AD is provided through local health depts, supported by the state AD Program (within the PDMP program), U of M School of Pharmacy (BHRT program), and federal grants.
19 of MD's 24 subdivisions participate. (All but Baltimore City, Montgomery, PG and Charles counties).
Currently undergoing a re-evaluation.
Uses standardized materials, such as the CIAO Guidebook, tailored to Maryland.
(The Ctr for Innovative AD on Opioids & Stimulants)

Some messages to prescribers:
As the first line for acute or chronic pain, use non-opioid treatment.
If opioids are needed, start prescribing at the lowest effective dose.
Query the PDMP
Avoid concurrent sedatives with opioids, and provide safe storage and disposal guidance.
Co-prescribe naloxone.
Offer treatment if OUD is suspected.
Detailers received training through CIAO: The Ctr for Innovative AD on Opioids & Stimulants.

DISCUSSION:
Q: Can addressing sedative dependence be included in AD? And how can we get info to Pharmacies on available treatment resources (such as Brightwell Healthcare).
A: We address benzodiazepines, and are always looking for input on expansion.
The guidebook for detailers is being updated. Detailers suggested tapering benzos, and have met with MACS (MD Addiction Consultation Service) on this.

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A: It is challenging to make appointments with busy pharmacists. In focus-groups, pharmacists are often hesitant to contact prescribers.
Pinnacle Communications is helping to develop a guide for pharmacists.

Q: Can detailers help prescribers with difficult cases? (Outside benzo prescribers e.g.?)

A: The program refers prescribers to MACS. [Note from Dr. A: I believe that MACS doe not provide advice on pain management

Q: Do prescribers commonly fail to check the PDMP when prescribing opioids?

A: We are looking into ways of measuring compliance with the PDMP use mandate.

Q: Which prescribers get notified by the PDMP?

A: The TAC: (Technical Advisory Committee; physicians) determine which alert letters are sent, taking into consideration the setting (e.g., Healthcare for the Homeless, oncology), and no longer reviews records of hospice patients.

FYI: By statute, AD detailers cannot use PDMP data to identify prescribers for detailing (but can discuss prescribing if the prescriber brings it up), although this is done in some other states.

FYI: The PDMP program, guided by the TAC, can refer a case to OCSA (The MD Office of Controlled Substances Administration), who in turn could refer it to the relevant professional board (or not). By law, the prescriber is notified of this in advance (done ~ 5 days in advance).

Q: Wouldn't it be helpful to notify prescribers of a possible OCSA referral well in advance, which might encourage a change in practice?

A: This could be seen as an enforcement activity, which the PDMP cannot do.

Q: The fact that prescribing software and most medical records are outside of CRISP, is a challenge.

A: A delegate can review CRISP for the prescriber.
(FYI, CRISP *medical records* are those from Maryland only).

Q: Specialty addiction practices which advance best practices (may use mono-product bup, or bup doses higher than 24 mg., per published evidence) could be unfairly scrutinized. They see the challenging patients that other practices discharge.
This physician is interested in a meeting with PDMP BOP, OCSA about this.

A: There are no current addiction medicine members of the TAC, or the Board of Physicians, but the TAC has an opening: only four 2-hour meetings a year.
This addiction Medicine physician is interested. FYI, there are no palliative medicine doctors on either the TAC or the BOP.

For further questions, PDMP staffers made themselves available to connect.

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Committee Chair **Joe Adams MD presented on AD published literature and resources. This slide deck** is on the MedChi website in the OPA Committee section.

Summary Points:

In an RCT, AD reduced over-prescribing by 14% of propoxyphene for pain, & other meds (P=0.0001).
More recent studies have shown in a 5 - 10 fold increase in naloxone prescribing.
A 2020 study showed that, after AD, patients were discharged from hospital without opioids 70% more often.
A 2025 review found that, among studies with a low risk of bias, 70% showed significant reduction in prescriptions consistent with recommendations.

Public domain resources from the VA Academic Detailing Service, for both patients and prescribers, were presented, including a patient information guide: 'Safe and Responsible Use of Opioids for Chronic Pain.'
Excerpts:

- Opioids usually only "take the edge off" chronic pain for a short time.
- Higher doses usually cause more side effects, without reducing your pain.
- Daily use of opioids can actually make your pain worse over time.
- When carefully assessed, 25% to 40% of patients on long-term opioid therapy >0 days have an opioid use disorder.
- If you and your provider decide to reduce your opioids, your provider will try to prevent or lessen any withdrawal symptoms.
- Decreasing slowly makes it easier to stop opioid medicines. . .

Public domain training resources from the Center for Innovation in Academic detailing on Opioids and Stimulants (CIAO) were shared, including an excellent 5-minute video on supporting patients who have lost their opioid prescriber, and other resources on avoiding patient abandonment through abrupt discontinuation of opioids.

In a critique of the 2022 'CDC ... Guidelines for Prescribing Opioids for Pain,' Dr. Adams explained why he believes that most of the 12 recommendations are vague and not helpful to providers.
Information from the AHRQ was presented on a surprising lack of evidence for common recommendations (such as many presented in academic detailing, or practice guidelines) on mitigation strategies to reduce opioid harms, including: patient education, urine drug screening, monitoring, instruments, more frequent monitoring intervals, pill counts, or abuse-deterrent formulations.

Minutes by Dr. Adams

ADJOURNED