INSPECT OVERSIGHT COMMITTEE
Indiana Government Center South
402 West Washington Street, Room W064
Indianapolis, IN 46204

MINUTES OF MAY 2, 2016

Donna Wall, R.Ph., President, Indiana Board of Pharmacy, called the meeting to order at 8:37 a.m. and declared a quorum pursuant to public notice posted at the principal office of the board at least forty-eight (48) hours before the time of the meeting.

Members Present:

Donna Wall, R. Ph.—Chair
President of Board of Pharmacy
Jerome Adams, MD
Commissioner, ISDH
Gary Jacobi, R. Ph.
Senate Appointee
Larry Turner
Lieutenant Colonel, ISP
Mathew Whitmire, JD
Director Medicaid Fraud Control Unit, OAG

IPLA Staff Present:

Michael Brady
Director of INSPECT
Michael Minglin, JD
Interim Board of Pharmacy Director
Kristin Schwartz
Communications Specialist
Nicole Schuster, J.D.
Deputy Attorney General, OAG

Donna called the meeting to order at 8:37 a.m. and all stood for the pledge of allegiance. The group then went around and introduced themselves. The INSPECT staff was also reintroduced.

The Committee moved and passed the approval of the minutes from the December meeting.

Michael Brady gave an update on the INSPECT program. Indiana pharmacies now submit data within 24-hrs., which was mandated by statute. The transition has been overwhelmingly successful. Over 95% of pharmacies are compliant. Some are working on upgrades. They have a generous grace period to update their software. After May 1, they will not be able to submit data and will be subject to disciplinary action. Brady will inform committee if there are non-compliant pharmacies.

Donna noted that the Board of Pharmacy (BOP) issues warning letters before they have to come in.

Adams asked if there were any recurring themes with this noncompliance and whether it was an unfunded mandate.

Michael Brady responded that it was unfunded, and Adams asked if that was a problem for the pharmacies.

Michael Brady explained that it was a third-party vendor issue, and asked William Woodruff from the INSPECT team to explain.

Woodruff said that most of the pharmacies are dealing with third-party vendors. Even though ASAP 4.2 is the accepted protocol, the vendors have been slow getting it put into the Indiana system. INSPECT started notifying people last July. The May 1 deadline notifications seem to have caught the attention of those pharmacy that are not in compliance.

Gary Jacobi said he had depended on independent 3rd party. If they hadn't upgraded he would have been in a fix.

Woodruff said he had gotten some emails from pharmacies saying they cannot get their vendor to upgrade.

Brady then moved to the Veterans Affairs (VA) Medical Centers partnership. The VA is now sharing pharmacy data with INSPECT. He referred to an article released in November in the provided packet about the investigation of the Marion, IN VA Medical Center. Several articles were published saying VA does not submit data to INSPECT. INSPECT reached out to them to begin conversations, mostly technical. Through these conversations, INSPECT developed a strong working relationship and the IT support team worked closely with the INSPECT team to ensure a successful intiative. On March 7th Debbie Frye signed data use agreement with the

VA and INSPECT began receiving their data. INSPECT is now receiving data from the Roudebush VA through a pilot with the purpose of working out the kinks before going live with the other locations.

Donna asked when the Evansville location sends through Illinois, how do our practitioners know to pick Illinois if they want to see? We probably need something to let people know that it is through Illinois since it is an Indiana facility.

Brady said that was an option.

Matt Whitmire noted that the patients may go to places where they do not have a history of being seen.

Adams said we will have problems with the Allen county area for a while. There have been a couple of doctors there found to be running pill mills. It is a perfect storm of a couple of bad doctors and the VAs unwittingly contributing to the problem. ISDH is working with the Attorney General's office. Now there are a large amount of people in the area who are dependent on and still seeking drugs. He had a good conversation with the hospital director in Marion. They talked about acute prescribing rules—and the hospital's satisfaction went down. Someone from CMS says there is no correlation between prescribing and HCAP scores. ISDH has been monitoring the area for a while and they will talk more. Adams said we need to morph INSPECT from a law enforcement tool to a preventative action tool. We have to get to a place where we can let people know before we get to this point. ISDH has been working with PLA to come up with ideas. How can we do a better job of catching these issues before they become this big?

Brady explained that INSPECT has been doing educational outreach. The packet included a handout with charts indicating events INSPECT had attended since the last meeting, as well as upcoming events. The different stakeholders in the program include practitioners and law enforcement. He asked for people to make suggestions if other events could be attended.

Wall asked if INSPECT had done anything with physician assistants or advance practice nurses. If they have their own conferences it would be nice to reach out and get INSPECT involved since they are major prescribers.

Trent Fox, Communications and Legislative Director for the Professional Licensing Agency, gave a legislative update from the 2016 legislative session.
HEA 1278 is effective July 1, 2016. Practitioners will be allowed to include INSPECT reports in patient's medical file. That is the only method that patients will have access to the report. County Coroners will have access to INSPECT. The biggest provision in the act is the prescribing norms and the dispensing guidelines. This requires that boards overseeing professions with prescriptive authority have to issue guidelines for prescribing. There is a deadline of December 1, 2016. Once they learned of the bill PLA gathered stakeholders together to craft this. The plan is to get

a similar group together with representatives from each board this affects to make sure there is consistency and IT support.

Adams said ISDH is seeing a push for private vendors providing IT algorithms to the hospitals. He does not have strong feelings one way or the other. But he asked whether there is a process in place to monitor what is going on. There is a consistency concern if they are all using a different method. Our ability to affect prescribers flows through their boards. There cannot be one type of prescriber having vastly different rules than another. People will find the weakest link. Adams suggested trying to use HIEs and said we need to put more pressure on the vendors. It needs to be easy for doctors to access the data. It is not easy right now. He said we need to make sure we are giving doctors the access to INSPECT they need.

Wall said we have to balance interconnection with patient privacy.

Fox also mentioned PSE legislation. Starting in July, ephedrine and pseudoephedrine will be tracked in INSPECT if it is with a prescription. The route of the bills was interesting. SB 161 was amended SB 80. PLA were told that PSE was a controlled substance for reporting only. PLA told them they have to say prescription only. If it is made a controlled substance, it will have a lot of other consequences if it isn't fixed. Stakeholders came together and made sure that only Rx only PSE is tracked. PLA is not opposed to that policy and it would have been quite a burden to track over-the-counter PSE in both INSPECT and NPLEX.

Brady noted that INSPECT will be attending the Indiana Coroner's conference to make sure they are all educated since they have use of INSPECT now.

Wall transitioned the meeting to new business.

Brady thanked Adams for the segue to the topic of Gateway. He informed the Committee about a successful integration pilot with Kroger that used part of the SAMHSA grant. The Gateway product was useful. All 105 Krogers in Indiana received the data into the EMR how they wanted it. INSPECT received positive feedback, and surveyed all the stores with 95% positive response. The negative things were out of INSPECT's control, such as bad internet connection. He introduced Carl Flansbaum and Jacob Cooper from Appriss, and Travis Acker was on the phone to explain more about the Gateway product.

Donna said the goal of the presentation was to get a motion to vote on what the Committee would like to recommend to the pharmacy board about integration.

Adams asked what needed to be waived from the pharmacy board and why this needed special approval.

Wall said the board wants to be transparent and make sure everyone is on the same page and has their questions answered.

Adams said he asked because there are other types of programs. Is the suggestion that each option would have to go before the board?

Wall responded that all of those entities would interconnect with Appriss. They are basically the gateway. They have a secure system set up that would meet our concerns with security and at the same time allow that interconnectibility. They have a contract with Cerner and other large computer systems.

Adams said he was trying to get the committee to a point where everyone understands where the obstacles are.

Carl Flansbaum presented to the Committee about how Gateway works:

Appriss right now has PMP solutions in 28 locations. PMP Aware software, OTECH platform INSPECT is on, and PMP interconnect for NABP, which connects 34 different states. Indiana is using it to connect to 21 different states. Appriss has been around since 1995.

A year ago we acquired Optimum Technology (OTECH), which was the PMP platform that 13 states are still on. Appriss is bringing them over to the Aware platform. Both platforms connect into PMP Interconnect.

PMP Gateway is an Appriss product. It works with PMP Interconnect. It is like a 51st state. It connects like any other state. It allows health IT companies to be able to connect to one place to get the data. We support all the different health IT computer languages.

The contract mechanism is the chain of contracts: the State and NABP have an MOU.
NABP has a contract with Appriss for operation of PMP
Appriss has a license agreement with Licensee (hospital, pharmacy or authorized partner to their customer)

How Gateway works: Health IT system connects to Gateway, which connects to the PMP interconnect to the states.

1. Physician requests PMP report on a patient.
2. Healthcare system sends a request to PMP gateway
3. Request info on the patient, the prescriber and the facility the request came from
4. PMP gateway makes sure that the state has authorized the entity.
5. Then the request goes from Gateway to PMP interconnect. The information is encrypted and so is patient information. States can decide which roles of requestors can receive data.
6. There are different levels of access that PMP director can allow. And even if you've approved all states, it still uses border state logic to search. May not search all of them.

7. Once it goes through interconnect through a state. It is processed the same way a request would come from another state. Then back to Gateway and Gateway transfers back to the health IT system and it is automatically in the EMR . The whole thing takes a couple seconds.

Appriss can provide audit information to the administrator.

Another production is called Narxcheck. It takes all the PMP information, looks at about 5 different variables, dosage level, etc. and calculates Narxcheck score, and gives options for how to address that person. Also gives graphical representation of the data. That is an add-on for Gateway, the algorithm and scoring helps them look at a glance. The health IT system buys it.

Jacobi asked whether it tracks and shows the use if there is a recent history of people checking the report?

Flansbaum said you could look at that in the INSPECT system and would have to ask the administrator at this time, although that may be coming down the pike.

Adams said since this is a report card on the patient, one thing we are hearing is that providers need a report card too. ISDH would like to know if there is the ability to use the system to do that, and are other states doing that?

Flansbaum said that is something separate from Integration, but we are going to be offering prescriber report cards.

Brady asked if they would be piloting that program.

Flansbaum said they have a good sense now because they have been working for 2-3 years and hearing the request from across the nation, so they will probably just go forward.

Wall asked who had access.

Carl said the idea is to have them sent to the prescribers. The way he has thought of it is the prescribers want to know before they get a call from someone else, they want to know how they are actually doing. They can reach out if they need more information or education.

It has taken longer than people would like, you want people in their own specialty fields to be compared to each other, and we now have a good way to do that.

Wall asked how this could be done in Indiana since the state does not collect that data.

Flansbaum said Appriss would probably require Indiana to move to the Aware platform. Whenever someone registers or logs in, they have to choose their specialty field. Those are tied to their NPI number. Once Appriss works with the state to find critical mass for the field that provides the information.

Michael Minglin said PLA had been struggling with developing algorithms to differentiate between specialty fields. Would this be useful?

Flansbaum said he thought for higher license types it would not be needed. But it is useful for specialties within MD. Jumbling those specialties together would confuse things. As more analytics and reporting are accomplished that will allow more analytics to be run.

Adams asked whether health departments or other entities outside the prescriber chain have access to the data. Who has access to the data?

Flansbaum said they see that when an epidemiologist works closely with the PMP or the PMP is in the health department. You could get reports, and states want a mechanism to take PMP data and merge it with other sources. It is something we are working on right now.

Adams asked how big of a concern data protection is. There is a fear that if we let more people have access to the data, we are putting ourselves at risk. Have other places given more access? Have there been issues?

Flansbaum said his personal viewpoint is as we start merging PMP data with other healthcare data, security gets better. Healthcare has been dealing with patient confidentiality on deeper levels than government. PMP databases are the only government database used for clinical decision making. As soon as we talk about integration and security, healthcare has already been doing it. They are very aware of the fact that you do not have outside access to anyone other than your patients. That takes care of a lot of the security and access concerns. He also knows people who have looked at a record they were not supposed to look at and were fired on the spot. Healthcare has no tolerance for that.

Wall asked how the program knows that someone is looking at data they should not have been looking at in the integration model.

Flansbaum said with integration only the pharmacists will see the screen, and only when they are filling an opioid prescription. They do not have access otherwise.

Michael Minglin mentioned there had been two incidents last week of pharmacists pulling INSPECT reports on the artist, Prince Nelson.

Flansbaum said the ability to search by name and date of birth could be removed. In the hospital, only the people coming as patients could be searched. The physician can only see it when they are pulling up that patient's EMR.

Adams said they drop the hammer if you access a record that is not yours.

Brady noted that Gateway has the auditing feature that allows us to go back and verify proper use of the program.

Flansbaum said what the state has to do to authorize had already been discussed. Appriss's role as facilitator is to bring the groups together and facilitate how they work together. States get a notification about requests for access. Then the administrator can go in and approve that. That is really all that has to happen.

Minglin said PLA has to make sure state IOT signs off on the contracts to make sure it complies with their security requirements.

Wall said when an entity signs up, it is only the people who are signed up with the state to have access to the program who have access, not everyone who is in their employ.

Flansbaum said they are not giving access to any more people, it is just an easier way of getting the information for the people who do have access.

Ackerman on the phone is a compliance officer for Appriss. He maintains comprehensive security program, auditing, response to issues. Everyone goes through HIPAA training, and they use different scanning and auditing throughout the year.

Donna asked when connecting with programs, whether they do security checking on the program for a new connection.

Ackerman answered that when it comes to connections in interconnect program, Appriss acts as 3rd party. So they rely on asymmetric cryptography. They are relying on states to make sure they are choosing secure keys. This assures that Appriss does not have access to the data. All changes are reviewed through change management process.

Wall asked for discussion on the Appriss program. If the Committee likes it, she asked that someone make a motion to move it forward.

Adams said he liked it, and he liked the potential of the program more. It is easy to use and access and has good potential according to CDC guidelines. He mentioned that the CDC does not rank Indiana very high as a state right now, and this could help. He moved to recommend to the BOP to approve the new Appriss integration method.

Jacobi seconded.

Michael Rinebold from ISMA offered ISMA's support of the measure to recommend to the BOP this option to allow providers to integrate INSPECT into their EMR. He asked about the cost to the state and suggested that he would like to see the budget cover it if necessary.

Flansbaum said the model is based on no cost to the state and is covered by healthcare systems. He said there are times when the state will cover the cost for a pilot especially if they have grant dollars, but goal is for it to be no cost to the state.

Wall asked about funding for report cards.

Flansbaum said the states would also pay for the report cards, but it has not been worked out yet since they are just starting to work on that. He said it might be an opportunity to bring all the licensing boards in because it is benefitting the licensing holders, not the PMP itself. He will share about that at the BOP meeting.

The vote was unanimous and the motion passed.

Brady said the Committee would touch on data sharing briefly because it is an important topic for INSPECT due to the CDC joint grant with ISDH.

Adams said he thinks INSPECT still needs to be a law enforcement tool. ISDH has been working with PLA about obstacles for the grant because of state law. Some things may need to be changed to be able to better share data to help protect Hoosiers.

Katie from ISDH shared a presentation about the CDC grant.

The reason for the grant: drug overdose deaths have surpassed motor vehicle deaths. CDC's goal is to reduce abuse and overdose of drugs and other prescription drugs, ensuring that patients with pain are still effectively treated.

1. improve data quality
2. strengthen state efforts
3. give healthcare providers resources to improve patients safety

It has a goal of targeting the main driver of the epidemic, which is problematic prescribing. The grant has three main activities, the largest of which is to enhance and maximize INSPECT.

PDMP integration with electronic health records: reduces data reporting, supports effective clinical decision making.

Propose in Indiana to collect poisoning overdose module in the National Violent Death Reporting System.

The key surveillance need is to be able to respond to emerging issues. We have challenges with death certificate data. Identifying drugs causing death. That timely information that is tied to interventions is key. Indiana ranked 3rd highest in having unspecified percentage in drug deaths.

Wall asked why the deaths are unspecified.

Duwve said many physicians use a generic code for mixed drug intoxication. The ER may not send out those tox screens. County budgets are shrinking and deaths just gets coded as a drug overdose without being specified.

Minglin said we often know that someone died of overdose, but the death certificate says respiratory failure. How is that addressed as an education issue for coroners?

Duwve said it is part of the NVDR coroner education.

Katie Hokanson said ISDH is starting to complete cases for that system. Then ISDH can let them know how complete their data is based on the rest of the state.
Duwve said it is also a hospital problem—they are a bigger issue than coroners.

Adams said ISMA can help and all groups have to come together. We cannot act if we do not know. We all need to come together and get better data and track trends so we can identify problems before they become better.

Jacobi asked if there are some drug tests that have been done that the coroner can have access to rather than something he would have to spend money for?

Duwve suggested that it could be linked with doctor information.

Katie showed the proposal to link death certificates with coroner and medical examiner information.

The NVDRS platform collects vast majority of needed information to respond to a need expressed by some NVDRS states. It uses a separate tab to collect drug overdose specific information

Minglin said sometimes you do not know which drug caused the death.

Hokanson said the CDC has proposed collecting elements: history of overdose, substance abuse treatment, history of heroin/opioid abuse, Prescription history
Data elements specific to INVDRS: use of Rx morphine, prescription morphine narrative, number of opioid prescriptions in last 30 days.

Concerning INSPECT data sharing: in states with high opioid pain reliever sales, there are higher overdose deaths. Prescriber report cards prevent deaths. There is PDMP data sharing in other states: Ohio is a good example with their automated Rx

reporting system. The Ohio Department of Health uses PMP data to evaluate prescribing guidelines, etc. ISDH also did an analysis of other states' use of PMP data.

Adams said he understands that Indiana is a state that is very concerned with patient privacy. But Indiana needs to compare with other states. ISDH is not asking to be out in front, but they are asking to catch up. Other states have more open data sharing agreements to face the opioid epidemic. They are not seeing egregious breaches of the data. They are not seeing problems with data sharing agreements.

Hokanson said on the topic of the CDC grant that ISDH is working on how to coordinate intensive prevention efforts. They are doing a lot of data reports for local counties, also Naloxone education, and increase awareness.

Adams said the horse is not dead yet: they cannot do any of this if we do not have access to the data.

Duwve mentioned they were also looking at the data for children because prescribing is inconsistent across the state. They want to use the data to focus efforts to the counties that are at risk in order to prevent prescribing and dispensing to vulnerable populations.

Hokanson said ISDH is working with IU Fairbanks to evaluate pain prescribing.

She said the portion of the grant maximizing INSPECT is focused on data sharing between ISDH and INSPECT, providing data for prescribing practices for prescribers, sharing de-identified data with researchers, and moving toward integration with HIEs.

She also mentioned that the NVDS is incident based, not victim based. Cases can be linked that occur together, but data can also be collected based on the victim.

Matt Whitmire clarified that it is not a statistical report, it is an individual report.

Hokanson said the data that goes into the national system is de-identified. They try to capture enough information to know it is the specific person, but it is not identifiable to the incident. ISDH is also working to get a certificate of confidentiality from the CDC.

Duwve said it would be identifiable data and ISDH would keep it. ISDH has many identified databases already with a lot of data, but not the overdose data. ISDH is very conscientious about the data they have. There is a lot of monitoring to make sure there are no breaches. They also have HIPAA compliant security.

Adams said ISDH would like to also look at geographic trends. The grant needs event-based data, but ISDA would also like to get a look at geography and identify trends and be able to look at prescription in order to be able to intervene earlier.

Whitmire said the need has been identified, but asked what the problem was with acquiring the data. Is it access or use or proper authorization?

Minglin said it is the confidentiality language in the statute.

Wall said everything in INSPECT is statutory. BOP has not done anything else.

Duwve agreed that it was the language in the statute and noted that INSPECT has been very helpful to ISDH as it has been able.

Minglin said that in order to allow sharing of identifiable data, the statute will have to be more specific. INSPECT is prepared to make whatever recommendations we can come up with so we can address that in the next session. He wanted to point out that in all these releases of information, it is not just the IOC and BOP, the decision also has to go through IOT and make sure the security that is in place will work. They admit that there is no secure system, so breaches occur. Therefore the best protections possible must be in place.

Duwve asked whether ISDH would have different requirements from IOT than INSPECT.

Minglin explained that IOT has said INSPECT is the most sensitive data the state maintains, so others may not have to do the same requirements, so that would have to be figured out.

Wall noted that any time BOP wants to talk about INSPECT data, they have to go into executive session.

Adams said that is why Whitmire's question was important. ISDH wants to include another provision in the statute to include ISDH but not make the language so restrictive that it continually needs to be changed.

Whitmire asked if the CDC grant is something that can be started immediately.

Hokanson said the grant started on April 1, 2016, and goes through 2019.

Minglin said INSPECT can't provide identified data, but provides de-identified data all the time.

Whitmire asked if coroners could provide the overdose information to ISDH.

Minglin said if it is not part of the investigative report they cannot provide it.

Hokanson pointed out that there is no guideline about what must be included in the report, coroners do not have to send anything particular. There isn't a consistent reporting of information that went on with the death.

Whitmire asked whether the board could make rules for coroners to include that data in the report?

Minglin said PLA does not have that jurisdiction.

Duwve said ISDH does not either. They have some say over death certificates, but not much. It is just whatever is required in state law and national standards. And the death certificate is a distillation of the information in the coroner report.

Debbie Frye said coroners would be restricted from sharing the INSPECT report if they viewed it.

Adams said he was hoping to have a motion from the board to be able to include ISDH in the confidentiality of INSPECT while they are waiting for the ability to maximize the grant. It will help ISDH when talking to the CDC to be able to tell them about working to fix the issue. If ISDH could work with the coroners, that might help.

Minglin suggested there could be an amendment to the coroners' statute.

Wall suggested that IRB approved studies from local health departments be included, instead of being so specific with ISDH. She asked if the motion could be that the pharmacy board should look at what needs to be adjusted for various uses such as IRB studies. She suggested that the motion be that the board explore the option to recommend the statute for ongoing public health in various circumstances.

Adams said he would like to keep those two separate. There is one priority to need to keep in mind, that there needs to be data sharing with ISDH. While the language may put it under the same subdivision, he does not want to make them the same.

Donna said this would not make them the same, but for the sake of discussion she would like the motion to include talking about the other area also.

Brady clarified that one issue is ISDH and one is IRB approved studies, and both of them would be placed before the BOP.

Wall asked whether there were suggestions for other areas of consideration to be presented to the BOP.

Whitmire asked whether POI alerts could be an area, and what happened to them. He hadn't received one in a while.

Minglin responded that POI alerts had been discontinued for the present because of a lack of statutory authority to send them out. He said there was discussion about how that could be done in the future in accordance with statute.

Whitmire asked about the statute that mentioned POI alerts.

Minglin said that statute actually talks about the exception report. If you read the section in entirety, it says you develop the altorithm, then it goes to board designee and they decide where it should go. It is not disseminated generally to the professions as was happening with the POI alerts.

Wall said it was something for the BOP looked at the numbers.

Minglin said there may be an alternative working with appriss that we may be able to explore, but for PLA to do it put a burden on the agency computer system.

Whitmire said since there were some changes coming to INSPECT on July 1 of 2016, the issues should be figured out before then.

Minglin said the agency is working on that.

Whitmire mentioned that the Attorney General's office thought the POI alerts were fine before.

Minglin said PLA is waiting for an advisory opinion from the Attorney General's office.

Wall mentioned that there were POIs on the patient and on the prescriber, and the Appriss report cards will help address the physician portion.

Minglin said the exception report in statute would be generated either way because either the patient or the practitioner is exceeding the prescribing or dispensing norm. So next all the committees with dispensing authority need to establish what their guidelines are. Then PLA can theoretically generate the algorithms to spit that out. The discussions are about how to do that. NPs have different collaboration agreements so it is not clear how they are writing the scrip. It is a more difficult undertaking than what was perceived.

Wall said patients jumping between different physicians and pharmacies might not be caught.

Minglin said PLA is getting all the stakeholders together to talk about what needs to be done. Then it may require going back to the General Assembly and asking them to do something different that may work better.

Wall said they still need to look at the patients who are falling outside as a different part.

Minglin said that will have to be found.

Whitmire asked who are the stakeholders are.

Brady mentioned physician associations, boards, hospital associations, and lots of other people.

Whitmire asked whether the Attorney General's Office and law enforcement would be included.

Brady said they would be included as well.

Whitmire asked who the designees were mentioned earlier.

Brad said it is the person chosen by the board.

Adams asked if some things could be checked off the Committee to do list. He made a motion to make a change to the confidentiality subsection to include the ISDH in the list of entities to receive information.

Whitmire seconded the motion and it passed unanimously.

Adams made another motion that the BOP make a list of recommendations for other entities that may also need to have changes made.

Wall added an addendum that the BOP have other stakeholders make suggestions.

Whitmire seconded the motion and it passed unanimously.

Adams asked whether the Committee needed a third recommendation about the POI question.

Donna said that would fall under the second motion just passed, and added that Brady will put it on the list and see whether we need to add it to Legislation.

Brady said INSPECT's next report would include information about the stakeholder meeting.

Adams said the POI alerts were valuable, so if they were not according to law, it needed to be figured out so they could be.

Whitmire asked if PLA and IOC would like an advisory opinion about the POI alerts.

Adams said although he didn't know much about the situation, an opinion would probably be helpful.

Whitmire made a motion that Attorney General give an advisory opinion about exception reports before the next meeting at the end of June.

Jacobi asked if the POI alerts were about people buying drugs?

Wall said yes, there were thresholds set in place.

Jacobi seconded Matt's motion, and it passed unanimously.

Adams wanted to say for the record that INSPECT should look at thresholds and comparisons with the Brandeis center for PDMP best practices. He noted that Indiana's thresholds are higher than national best practice. This was not negative, he said, but from a health point of view, Indiana is not where it needs to be, so it is part of the POI and larger discussion that Indiana look at its thresholds compared to national standards.

Wall said that would be discussed with INSPECT, and noted that another thing was data storage.

Brady mentioned that INSPECT data is all stored with state IOT, but the data may need to be stored in the cloud with the vendor. INSPECT will have the Appriss people back to meet with IOT to talk about security with that. He also asked for the Committee to set the next meeting date for IOC.

The group decided that the next meeting would be June 27th at 8:30 a.m. Michael Brady will send the calendar invitation, and noted that the meeting may be in a different room depending on the availability of the conference room.

Wall requested that ISDH share their presentation from IOC with the BOP during the next meeting.

The meeting was adjourned 10:57 am.