

Center for Substance Abuse Prevention (CSAP)
Substance Abuse and Mental Health Services
Administration

Meeting of the Drug Testing Advisory Board
Day Two - Open Session
June 12, 2019

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PROCEEDINGS (9:00 a.m.)

Agenda Item: Call to Order

Matthew Aumen, Designated Federal Officer

MR. AUMEN: Hello, everyone. My name is Matthew Aumen. I am the acting Designated Federal Officer for the CSAP Drug Testing Advisory Board. Ron, we do have a quorum and I now officially call the Center for Substance Abuse Prevention Drug Testing Advisory Board meeting to order. This meeting is being webcast online; it is being recorded and transcribed. So please be sure to state your name and speak directly into the microphone when you are speaking to ensure accurate reproduction and so folks on the phone can hear.

With that I will turn the meeting over to the DTAB chair, Mr. Ron Flegel.

MR. FLEGEL: Thank you, Matt. Thanks everyone for being here again today. It is a short open meeting this morning, so we are going to get started right away. Charlie is going to start off. The actual title is Regulatory Program Discussion and Requirements, Department of Transportation, Nuclear Regulatory Commission, Department of Defense and the Department of Health and

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Human Services.

What we wanted to start out with was some of the standard variables that we are looking at, which also works in, we believe, into the database for DOT, et cetera. Charlie is going to start out with that, and then there are just some questions that I had posed to the federal partners around looking at fentanyl from the presentation yesterday and what the thoughts were, if it is prescription or illicit user, et cetera. So maybe some of that discussion can be pursued after that. I am going to turn it over to Charlie to start, and then any discussion around that I think will be beneficial because laboratories, especially around the ECCF and the standard variables, are really important going forward.

Agenda Item: Regulatory Program Discussion and Requirements

U.S. Department of Transportation, Nuclear Regulatory Commission, Department of Defense, and Department of Health and Human Services

MR. LODICO: Thanks, Ron. This morning I am going to try to share with this audience some of the initiatives that we are trying to do in terms of standardizing laboratory reporting. Just as a brief history, the Mandatory Guidelines require that the

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reporting be conducted on a custody and control form. For those people who have been in the program long enough, they will recognize that the CCF is a five-part form. It is a paper form and on that form is actually a step five, which has a reporting element to it. A laboratory can check off the box whether it be a negative, a dilute, or a positive. The analyte that they discover, they can write the concentration of that analyte and that is now faxed as a PDF to the MRO and that is how it is reported out.

As new technologies come on board, specifically electronic chain of custody, it is important that, as the program develops and progresses forward that at a minimum, we need to start doing standardization of reporting elements. This presentation is going to try to give everybody a flavor of where the program is heading. I know there is a lot of interest with our sister department at DOT regarding the clearinghouse. So we are trying to facilitate a process where there is uniformity across the program, and the way to do that is by establishing some form of standardization.

Before I do that, I want to give everybody an update as to the electronic custody and control form, the review and approval process. One of the things that

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everybody should be aware of is that OMB has approved an electronic custody and control form. It has not mandated that our program is solely going to use electronic custody and control form. The comment was that they should. So that is the \$64,000 question.

Given that we are not mandating the labs to use ECCF, it should reconsider the possibility to require that future custody and control forms have to be in electronic format. But before we do that, I just want everybody to see that this is a spreadsheet. It has a lot of information on it. But the pertinent thing is that in the left side column is the laboratory, stated with a letter. But the process is that the laboratory submits their ECCF submission of information. It is sent to RTI, our contractor, and the NLCP reports to the lab based on that initial application submission. Then it does an on-site, or a remote, IT inspection of their facility and then follows with an onsite inspection.

Then once everything has been agreed on by RTI, this particular entity fulfills the security element, the PIA element of their electronic custom and control form and they send to SAMHSA a recommendation for approval. SAMSHA then reviews that and gives the approval to the laboratory.

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So it is not a simple turn on the switch and you get approval without any review. Beyond that there is further review with the inspectors.

So it is a time-consuming process, but it is important so that we maintain an integrity in the standardization as the activity of the laboratory. As a matter of fact, in several cases we have discovered that unauthorized collection sites were using unauthorized systems and it falls on the laboratory to verify that their collections and their system are reviewed and approved by SAMHSA.

This is the list of approved laboratories. I have broken it down into laboratory categories. The higher the number the greater or larger is the laboratory. So a category 2 is a small lab compared to a category 6. Category 6 typically does between 8,000 to 10,000 samples a day. If you will notice, I have listed on there the percent of total CCFs in '18 versus the percent of total CCFs in '19. You will see that in every one of those cases there has been an improvement of percentage of use, but it has not dramatically gone up to the point where it has gone from 20 percent to 80 percent.

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Also, on the far right, you will see there are three types of ECCFs -- contractors or vendors, a FormFox, an eScreen and a LabCorp. And you will see in some cases the laboratories have multiple vendors. So in some cases you will see that FormFox is in combination with eScreen. But LabCorp appears to only reside with the LabCorp system.

So I gave you the percentage. This table basically looks at the total CCFs for those laboratories that we listed. The reason why I didn't put all laboratories in the program was because I just wanted to capture the greatest percentage. If you look at the bottom you see there is an 84 percent total. That is the total samples performed by those labs listed.

If you have 6.5 million, of which 84 point whatever percentage of that 5.5 million is representative of the 84 percent. But if you look to the far right you will see down at the bottom 24.88 percent. That is the total of samples received at the lab using an ECCF. So only a quarter of the total are represented by 1.3 million samples or custody and controls using an ECCF. The point I am trying to make here is that you have 75 percent still using a paper form versus the 25 percent using the electronic form.

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I further broke this down into the total. Here is sort of an incremental improvement. The custody and control, ECCF, was approved by OMB during the 2015 approval process. We are now into year four of acceptance by OMB of an ECCF. In that year there was actually one lab, and they did about 3,000 custody and controls using ECCF. The following year, in 2016, when there were more labs included, that jumped to 110,000. In 2017, as more labs were approved, that number is now 473,000. In 2018, last year, when we had a majority of the big labs that are approved, it jumped to 1.19 million. If you look from January to March of 2019, the current year, we are only at about 388,000 samples, which is roughly a quarter. Times four you are looking at about 1.6 million.

Again, we are not seeing this vast volume of custody and controls that are ECCF. I just wanted everybody to get the flavor of the pace that these laboratories are going through in terms of switching over from paper to electronic.

One of the things that was done earlier I think this year was we sent out to the laboratories a notice of standard variables. Basically, what we are trying to do for the laboratories is a guidance directive as to how to

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report using electronic reporting. Specifically, when the laboratory produces a result, it typically sends an electronic report to the MRO. We wanted to create a standardized element, including some terms and also some definitions. That was an effort to gain everybody's attention as to what is required of them. If they are sending out an electronic report, we were trying to get them to do it in a manner that is standardized and consistent, and that there isn't a misunderstanding of what the terms are for the MRO.

The purpose of the alert was again to establish standard variables and agreement terminology. How do the standard variables cross between matrices, oral fluid and urine, and later on to hair. We are looking to add what are the minimum standard variables captured on the federal custody and control form. Currently, if you look at the form itself, minimally it has information regarding the employer, the collector, the donor and the report of the results, and the MRO's signature. So that is the wet signature, the wet part of the form.

When you convert that into electronic, I think there could be more specificity and a more standardized way of reporting that. The benefit to HHS laboratories,

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obviously, is standardized reporting. You have uniformity and the benefit to the regulated industry is again standard information. So what we are trying to do is establish a uniform way of looking at apples to apples, versus some apples and some bananas.

The next series of slides is basically, when you break these down into the variables as relates to specimen, in this area we are looking at the record ID, we are looking at employee category, reason, status, order date, schedule date, expiration date, electronic order ID and reconfirm.

Again, under the heading of specimen we have these fields. But that is not only the fields that we might want to review. One of the things that we are proposing is, as a matter of fact, we are going through a part of the initiation of a work group as a result of the oral fluid Mandatory Guidelines hopefully coming on board. We have undertaken to establish a technical working group for oral fluid and in addition to that we will have an oral fluid custody and control. And a subcommittee of that oral fluid technical working group is a standard variable working group.

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So that is going to work in concert with the custody and control, and the reason why again is that this is a good opportunity to establish program-wide some of these fields that are important in programming for the laboratories, so that their custody and control and their electronic reporting supports these types of specific fields and nomenclature.

Again, these are the fields that we have initially listed as the employer standard variables. This might not be, but I think it is important that we have a starting point so that when we have our meeting with the variables subgroup we can have discussions on whether these are valid, appropriate or need to be modified.

We are going to do the same thing with the collection standard variables. It is important that the collector represents critical important information of the location of that particular site where the sample is collected. I think Dr. Sample has shown through the Quest Diagnostics Drug Index the location of the collection is critically important to establishing patterns of use among states. And this is critically important so that now we can establish that if we want to through sort of a similar, data gathering, data mining on patterns of where the sample

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was collected and the outcome, and tie it into the prevalence rate of drug use within that location. That is helpful for our agency and then we share this with our treatment program and prevention program within SAMHSA.

Lastly, or semi-lastly, we have laboratory standard variables. These again are almost established, I would say. There are very little differentials between laboratories and how they report out some information. But that is not to say that we cannot make that more consistent, especially between the smaller laboratories, like a category 1 or 2, versus the big labs, the category 6. Because the smaller labs, and this is again one of the things I am very sensitive to, early on we had this notion of no digital divide. That is the term they used to establish that if you have electronic reporting, that should not prevent a small lab that does not have the capital equipment to do the reporting by that means, to allow them to send a report out as a mailed report.

Typically, early on the custody and control has all the information on it and it was sent to the MRO via mail or fax, and today it is PDF. So the digital divide was one of those things we were very sensitive about. But again the question I keep posing to everybody at this point

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is that is now a factor that needs to be not considered because of the need for uniformity and if you can't have uniformity of that service then we might have to somehow require it.

Then lastly, the MRO standards. Again, this is the area that I think is the most unknown, and I say it is unknown because as part of this program the MRO is the gatekeeper. We really don't have a good handle as to how many MROs are out there, how they are trained - well, we know how they are trained, but what their actual results in reporting are. How consistent are they in reporting their results regarding their duties, whether they review it through the lens of a doctor or through the lens of somebody who appears to have a subjective manner in reviewing the results.

I say subjective only because the donor does have an opportunity to have a conversation with the MRO as to why that result was positive. And could a donor sway the persuasion of the MRO to report it out as a verified negative? That is a possibility, and we all should be aware that it does exist. These are the current things that the variables regarding the MRO should be included as part of the discussion.

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This is the last slide regarding variables. This is drug report standards. As you know, in the custody and control form there are unique boxes for each of the analytes. There should be some consideration regarding how the future custody and control form looks when we are adding new specimens on board. I don't believe anybody would want to see multiple different types of CCFs out in the world. You don't want to see a urine CCF. You don't want to see an oral fluid CCF, and you don't want to see a hair CCF. So we need to consider possibly combining the different types of specimens into one particular unique CCF with a unique OMB number.

The last two slides are regarding analytes. This is where I think the alert was really meant to sort of standardize because, as I said earlier, you have certain laboratories with nomenclature and their description of their results are just slightly different from somebody else's. So that was the intent, to try to list all of the analytes, for urine specifically and for oral fluid and hair, and then look at the abbreviation that would be assigned to those particular analytes.

So again, this is a starting point. I think it helps for the subcommittee of the oral fluid

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standardization work group to be able to review, line by line, if this is acceptable and where there are differences, to have a discussion and then reach a concurrence as to what the final should be. That is really the goal of that particular committee.

This last slide is sharing with this audience the terms that are currently in play. Whether you are looking at the NLCP, as well as the CFR Part 40 of the DOT, you see that the terminologies are pretty much the same. I think the only difference is under the initial test analyte for DOT they have cocaine metabolite and, in quotes, benzoylecgonine and I think the NLCP has BZE as an abbreviation for benzoylecgonine.

In summary and finally, I am just giving everybody an understanding of what the intent was for us to do the standardization and also to give you an insight into what we are planning to do. I would encourage any one of you to come in and provide us with any feedback you like. Thank you.

MR. FLEGEL: Thank you, Charlie. I will just say really quickly, a couple of things. I wanted to also mention a few things within the standard variables. Again,

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since we are starting to look at new chain of custody forms, we did feel there was an opportunity to go down this road where we could both standardize the variables that are reported from laboratories and what is captured from the electronic.

The working group, as Charlie mentioned, will have a sub working group, which are the standard variables. Dr. Barry Sample is going to lead that group or myself. Just as a practicality point of view, for instance, urine has BE. That is a standard variable. Oral fluid will have cocaine and BE. That is a standard variable. Hair will have cocaine, BE and it could have ecgonine methyl ester, it could have hydroxy cocaine. So those are things that we are going to have to capture and make sure they are basically in the same slots when they are reported over time, which is an IT nightmare, I am aware. Just sitting with programmers, myself, when we tried to look at standard variables across different things. But if we don't start going down that road now it is never going to get resolved.

I think to get it resolved for all laboratories it will make it easier to capture it in a database, whether it is DOT's or our non-negative specimen list, eventually it will make less work for the laboratories, and that is

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what we are hoping. We don't want to put a burden on the laboratories. We know it is an IT cost. It is a substantial IT cost, I think, in some ways. But again, we wanted to get started on this road so we could bring in the electronic part of also the forms so we could capture these variables.

Any questions from the board regarding these?

The working group, as Charlie said, we are going to start up. It has already been set. It is one of those things that hopefully will go relatively quickly. I think one of the first decisions we will look at is, do we maintain a single form for a single specimen? Or do we combine those forms and basically in the electronic format will it be as easy as you do a collection and you check off urine, you check off oral fluid. That would go right to the specific chain you are going to. It is a little bit different when you go to a hard copy form as compared to an electronic form.

All things we are trying to look at and get the information and we just wanted to make the public aware of the direction we are starting to look at. Actually, we have been going in this direction for a while. I will open it up to any board members or for questions.

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DR. SCHAFFER: We do a lot of electronic forms and the one disadvantage that I see is that there is not ever a good signature. I don't know if that is a problem on the urine side, but it is a big problem on the hair side. Because somebody will then go, after they get a positive test here, they will go somewhere else and oftentimes it could be their brother or sister or whatever that takes the test, uses an electronic form and we can't tell the difference.

Then we ask them if there is any way that there could be some identification going on and they say, oh, yeah, we have a video. Then we look at the video. The first person signed with the right hand and the second person signed with the left hand. There are these types of things that are occurring. We try. My background as medical examiner, death investigation, I have worked with investigators 14 years of my life. Just trying to get to the truth and get the best answer, for the client, for the country - you don't want to put drivers out there that cheat and you don't want to make it easy for people to cheat. Have you looked at this, thought about this?

MR. LODICO: If I understand the question correctly, the issue is -

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DR. SCHAFFER: We haven't done anything to address that type of cheat.

MR. LODICO: If I understand the question, the individual who is scheduled to be at the collection site might not necessarily represent the person who is supposed to be there. Correct?

DR. SCHAFFER: Correct.

MR. LO DICO: As you might be aware, the collection process begins with identification. Regardless of whether that is any proof or not, there are some elements of identifying the individual based on what is scheduled. So if you are scheduled to be at the collection site and your name is selected, and you have to be there, that collection site is notified that you are going to be arriving at that collection site. You either come with a custom and control form or they will have a custom and control form right there.

The first thing you do is you are supposed to produce a valid ID - a license, a driver's license, whatever that valid ID is supposed to be gives the collector the assurance that the individual is, in fact, who they represent to be. Beyond that, like I said, the

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system is not foolproof. You are right. There could be individuals who can suborn that, game that system, but as of right now that is the best thing we can offer.

MR. FLEGEL: I just offer one more thing, Mike. I think we need to look a little bit outside the box. For instance, if a person shows an ID, maybe we need to capture that ID electronically, with the form so that it goes with it. So there are other ways I think we can capture that, the person who is actually giving the specimen.

DR. SCHAFFER: At our collection sites we video every collection. Expensive, but we do it. In Brazil they ask for a fingerprint.

DR. GREEN: I just have one quick comment. I think it is probably obvious to everyone. I think the purpose of this is to standardize the fields that we electronically report, but we also have to remember that there are many, many clients out there that have to add those fields to their databases. I think that would probably be the largest hurdle to jump through, is dealing with all of those thousands of people who are already receiving electronic data.

MR. FLEGEL: I am glad you mentioned that, because

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that is what has occurred in the past, the mapping sequence. So variable one is actually variable eight in another lab, and so they map them across. But that gets extremely confusing and it is even going to get out of control when you start adding oral fluid and hair. The mapping sequences are never going to electronically line up.

I was also going to read real quick what Charlie had mentioned under the Patients and Communities Act, section 109: Electronic record keeping requires the HHS, not later than one year from the date of enactment of this bill to ensure each certified laboratory that requests the use of paperless electronic chain of custody forms receives approval.

It does not say requires; it says basically if they request it. So again, we want to move in that direction to make it more beneficial, but we don't want to put the burden on the HHS-certified labs, especially the smaller labs. So it is one of those things we have to consider.

DR. SAMPLE: Perhaps a couple of comments on a variety of topics. It certainly is complex because, as Dr.

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Green pointed out, it is not just the laboratories, it is really all of the service providers. Quite frankly it could even start out on the employer side. So there are a number of stakeholders who all need to be brought into this process. There are probably some learnings, some resources that are out there that would help up, or already some standards.

For example, there is an HR-XML drug testing standard. So rather than reinvent the wheel we should perhaps look to some of those standardization groups that have already started to tackle some of this, and leverage what they are doing. It may be the same, it may be different, but there is certainly information out there. Really going back in time maybe we can dust off what we did with the federal advisory committee, with DOT, however many years ago that was, looking to standardize electronic variables. That was 17 years ago we were working on this.

The other point I wanted to make, just to make everyone aware of it, going back to the beginning of Charlie's presentation. It would be interesting to see what degree of deployment or penetration ultimately will occur with ECCF. Speaking for ourselves, thirty percent, thirty-five percent of all of the specimen collections are,

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quote, in network. If they are in network, they are electronic. If they are out of network because the employer or the TPA has their own collection network that they prefer to use, based on relationships or costs or logistics, it is going to be hard perhaps to get them to be more electronic. I am not sure that we will ever get to that nice place where it is totally electronic from soup to nuts just because there are so many independent collection groups out there that really are not affiliated in any way with any particular laboratory. Paper may remain longer than any of us would like.

MR. FLEGEL: And I think that remains the challenge for us, where we have to maintain a paper form, whether it is a paper form that encompasses all matrices so you can check off what it was, or it encompasses different separate change, which again, from OMB's point of view that wants to get to basically a paperless type of transmission.

MS. KELLY: Just to clarify, the statute and OMB want us all to provide an option for completely paperless, not that that would become the sole option. We have several other processes at DOT that are paperless, but not the sole option because once in a while you are going to hit a very small business that just does not have the same

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electronic access a everyone else does. So the statute was clear in this as an option. When we talk to the congressional staffers, they were actually really surprised that the ECCF wasn't a completely paperless option already. Again, it is one more option available to laboratories, employers and others.

MS. BURKE: I don't know if this is semantics. I don't know if I am splitting hairs here, but I am coming from a different perspective, forensic science or forensic toxicology. How set in stone are you with your reporting terminology? It sounds like you are open, especially with alternate matrices coming into play. When I look at marijuana metabolites maybe another option when that comes into play, like cannabinoids in general, is you are going to be testing for that component?

MR. FLEGEL: This is not set in stone. It is just an example, more or less. We have done a lot of the variables. There is mapping to a bunch of things. As Barry mentioned, with some of the labs that have purchased other labs and brought them out, there are all types of mapping sequences that they have done. But the hard part about that, on the other side, is also what Barry mentioned, you have to bring in the third party affiliates

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on the other side, because we cannot ever close that loop. What is a reported positive, what is a confirmed positive. So it is very difficult for us to go in and look at what has been overturned as a positive result from an MRO.

So those are some of the things we hope to close that whole loop so that we can tell almost instantaneously from the database what is going on. But yes, these are just examples that we put down. They really are going to have, within an analyte, there could be six, eight, ten different standard variables within that analyte. And when you go to the confirmatory side, you are going to have a quantitative result on BE. You are going to have a quantitative result on cocaine. So those are all going to have to be other possible standard variables.

MS. BURKE: When I see marijuana it almost implies that you are indicating metabolites and you know that you are testing a bodily fluid. But I just think we are not testing plant matter; we are testing components in biological fluids. So that is why I am thinking cannabinoids and I don't know if some the laboratories are actually testing for CBD.

MR. FLEGEL: You have just been elected to be on

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the working group. That is actually a very good point because as we further go in this direction with other issues around marijuana, for instance, we may have to put in other standard variables. Marijuana metabolites may not be a good standard variable here. It could have to be broken down to THC, THCA, et cetera, across CBD. There are multiple different things. So we are going to have to look at all those.

MS. BURKE: You are not indicating heroin

MR. FLEGEL: No

MS. BURKE: So that would be kind of the same thing.

MR. FLEGEL: Exactly. This could expand very quickly.

DR. SAMPLE: Another consideration, because there are many, is cutoff. Cutoffs are not static. At least the way we handle that, particularly for the screening, the cutoff is tied to the screening analyte. So forever and ever and ever a certain analyte code, whether it be numeric or mnemonic or alphanumeric or whatever it is, always represents that drug or drug class and that cutoff that was

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used for screening. If cutoffs change, and they have in the program, what are you going to do? Are you going to keep it the same name?

So from a data mining, from a database perspective for being able to look back historically and understand what was done and what the results were, you need to tackle that as part of this whole process. So it is not as simple as just having one analyte across all cutoffs over time, and all matrices.

MR. FLEGEL: Barry reminded me of something. One of the times is when we went to institute the opioid testing, the synthetics, the federal partners didn't change at exactly the same time, which was an IT nightmare and we realized that. But I think going forward that was beneficial because we don't know if we are necessarily going to change at the same time when it comes to oral fluid or it comes to hair. So keeping those panels exactly as a federal panel now has been differentiated, which I think is a benefit in the long run for laboratories. In the federal agencies we use the words "they are authorized to test." It doesn't necessarily mean they are going to test for that analyte, but they are authorized to test.

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Again, it puts a little more burden on the lab and the IT systems, but I think at least we have the capability now between laboratories to change federal panels, whether it is an NRC panel, or a DOT panel, or an HHS panel to change.

DR. GREEN: Just one real quick comment to piggyback onto what Barry was talking about. Different laboratories have different ways of handling the cutoffs and that maybe the drug cutoff would not change for one laboratory but may have to change for another laboratory. It may just be a numeric result.

The other piece that is brought to mind, Barry mentioned the HR-XML, I think this process probably needs to require that the fields get transmitted with each record. They are on the decline but there are still interfaces that do not transmit the field names with every transmission. I think that is something we probably need to outlaw at some point if we are going to go to the standard.

MR. FLEGEL: That was the last comment, and then I am going to ask a question.

DR. MULLALLY: There are initiatives at the agency to try to harmonize laboratory codes in the United States

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and internationally. Should this move forward as an interest you could reach out to those groups.

MR. FLEGEL: That is good to know. Always good not to reinvent the wheel. The last comment I want to make before we close is again, we saw the fentanyl presentation of what we looked at as far as what we see in the federally-regulated program, but I just wanted to ask federal partners and DTAB if there was any concern - I think Mike voiced a concern yesterday. This information has to be looked at in a number of different ways, but there are some issues. A lot, when it comes to medical staff, are tested for fentanyl diversion out of that. There is the fentanyl that are prescription patches. But again, that doesn't alleviate the fact that it could be a safety issue. I just wanted to open it up to any federal partners or DTAB members who may have comments on that.

(No response)

I see none. Again, it is going through the process of approval to be looked at under the Patients and Communities Act. If fentanyl were to be added to the Mandatory Guidelines it would be, I believe, added as a supplemental. That way it would go into the Mandatory

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Guidelines, but it would go by itself basically as fentanyl to be approved through a Federal Register Notice with comment. So that is how I think we would handle it.

With that we will close the meeting. I want to thank everybody for being here. I want to thank stakeholders and the public. I believe we are also going to ask for a comment period here, and then we are going to close out and reconvene as a closed session DTAB from that point. So I will turn it over to Matt for public comment.

Agenda Item: Public Comment

MR. AUMEN: At this time anyone from the public who would like to make a comment is invited to address the advisory board at this time. Anyone in the room, please state your name, make sure you speak clearly into the microphone so that your comments are heard and recorded. Please also limit comments to five minutes or less. Are there any comments from those in the room at this time?

(No response)

Seeing none, operator are there any comments from folks on the phone at this time?

OPERATOR: I am currently showing no comments at

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this time. Press star one if you would like to make a comment.

(Pause)

Again, I am showing no comments from the phone lines.

MR. AUMEN: Thank you. That concludes the public comment period. We can now move to adjourn unless there are any comments from Ron.

MR. FLEGEL: No comments from me.

MMR. AUMEN: With no further business at this time the Center for Substance Abuse Drug Testing Advisory Bboard meeting is adjourned.

(Whereupon, at 9:55 a.m., the open session was adjourned)