COMMONWEALTH OF VIRGINIA
Meeting of the Virginia Prescription Drug Monitoring Advisory Committee

Perimeter Center, 9960 Mayland Drive, Second Floor   804-367-4566(Tel)

Henrico, Virginia 23233   804-527-4470(Fax)

Agenda of Meeting
September 14, 2016
09:50 AM
Board Room 3
TOPIC

Public Hearing: Proposed Regulations: Updating reporting format and additional data elements

10:00 AM: Advisory Committee Meeting

Call to Order: Holly Morris, Vice-Chair
- Welcome and introductions
- Reading of emergency evacuation script: Ralph Orr
- Approval of Agenda
- Approval of minutes (1-5)
- Election of Chair and Vice Chair for FY17

Public Comment:

Department of Health Professions Report: David E. Brown, D.C., Director

Legislation and Regulation Update: Elaine Yeatts (7)

State Police Drug Diversion Presentation: SA Charles Elliot

PMP Education Toolkit: Matt Treacy, DHP Communications Office (9-18)

PMP Enhancement Activities:
- Enhanced Delegate Module (19)
- PMP AWARxE Platform Implementation (21-28)
- New reporting requirements

PMP Advisory Panel Overview: (29)

Program Update: (31-37)
- Automated Registration Update
- Interoperability and Integration update
- Program Statistics

Meeting Dates for 2017:

Adjourn

DRAFT

VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS
VIRGINIA PRESCRIPTION MONITORING PROGRAM
MINUTES OF ADVISORY COMMITTEE

Wednesday, March 2, 2016   9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

CALL TO ORDER:	A meeting of the advisory committee of the Prescription Monitoring Program was called to order at 10:09 a.m.
PRESIDING	S. Hughes Melton, M.D., Chair
MEMBERS PRESENT:	John Barsanti, M.D., Commonwealth Pain Specialists, L.L.C. Carola Bruflat, Family Nurse Practitioner Randall Clouse, Office of the Attorney General Dr. Amy Tharp, Office of the Chief Medical Examiner Brenda Clarkson, Executive Director, Virginia Association for Hospices and Palliative Care Holly Morris, RPh, Crittenden's Drug, Vice Chair Mellie Randall, Representative, Department of Behavioral Health and Developmental Services
MEMBERS ABSENT:	Harvey Smith, 1SG, Virginia State Police
STAFF PRESENT:	David E. Brown, D.C., Director, Department of Health Professions (DHP) Lisa Hahn, Deputy Director, Department of Health Professions (DHP) James Rutkowski, Assistant Attorney General, Office of the Attorney General Elaine Yeatts, Senior Policy Analyst Ralph A. Orr, Program Director, Prescription Monitoring Program Carolyn McKann, Deputy Director, Prescription Monitoring Program
WELCOME AND INTRODUCTIONS	Dr. Melton welcomed everyone to the meeting of the advisory committee.
APPROVAL OF AGENDA	The agenda was approved as presented.
APPROVAL OF MINUTES	Dr. Melton accepted a motion to approve the minutes from the January 6, 2016 minutes of the PMP Advisory Committee. The minutes were approved as presented.
PUBLIC COMMENT:	No public comments were made.
David E. Brown, D.C.: **DEPARTMENT OF** **HEALTH**	Dr. Brown welcomed the committee members and deferred to Elaine Yeatts for an overview of current legislation and regulation updates. Dr. Brown noted that he would make further comments about specific

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PROFESSIONS REPORT	bills following her overview.
Elaine Yeatts: **2015 LEGISLATION AND REGULATION UPDATE:**	Ms. Yeatts provided an overview of legislation related to the Prescription Monitoring Program. Ms. Yeatts indicated that it was a very active session and that DHP was following 88 bills of interest to the Department. She noted that 15 of the bills were DHP or Secretary HHR bills.
	Ms. Yeatts noted that she would not cover HB293 presented by Delegate Herring because it has an identical companion bill (SB 513). Ms. Yeatts also noted that Dr. Brown will review HB657.
	HB829: This bill authorizes the Director to disclose to the Board of Medicine those individuals who meet certain thresholds for the purpose of requiring CE for prescribing opioids and pain management.
	HB1044: This bill provides access to physicians and pharmacists employed by health plans access to the PMP to determine eligibility for and to manage patients in a Patient Management Safety Program.
	HB1242: Adds eluxodoline as a Schedule IV drug.
	SB287: This requires reporting of PMP data within 24 hours of dispensing and allows access to the PMP by consulting prescribers and pharmacists. It also provides that a prescriber may include information from the PMP in the recipient's medical record.
	SB480: Adds certain chemicals to Schedule I.
	SB481: Same bill as HB1044.
	SB513: Will require prescriber to check PMP for prescribing of opiates 14 days or more and list 6 specific exemptions. The legislation has a 2019 sunset.
	SB701: Not yet passed; would allow process facilities in Virginia to produce marijuana oil for intractable epilepsy. The bill which would allow marijuana oil for treatment of cancer was carried over to 2017.
Dr. Brown: 2016 LEGISLATION UPDATE:	Dr. Brown stated that this year several legislative enhancements included changes in mandatory use requirements of the PMP, added CE requirements for licensees of the Board of Medicine, and required 24-hour reporting along with adding authority for unsolicited reports to be sent to DHP's Enforcement Division. Dr. Brown applauded efforts of the Medical Society of Virginia for working on the language for many of these bills. Dr. Brown elaborated on HB657: This bill involves unsolicited report disclosure; allows the disclosure only to DHP's Enforcement Division. If enforcement staff determines there is probable criminal activity involved, the issue can be forwarded to law enforcement. Dr. Brown also noted that the Department will create, by policy, an advisory panel specifically for data analysis purposes to assist in developing the criteria for these reports. The panel will have representatives of staff and members from the Boards of Pharmacy and Medicine as well as the Chair of this committee. The purpose of the panel will be to identify unusual patterns of prescribing or dispensing, and may also include individuals from various stakeholders and resource experts.
	Dr. Brown explained that the current Advisory Committee composition would have 2 additions: a second pharmacist member and another representative from the Medicaid agency. The term is also changing. Current terms are four years; the new term will be 2 years in order to allow for more flexibility. Dr. Brown then asked for input from committee members. He asked if there were any questions about the

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	composition of the advisory panel. None were stated. He then asked if there any questions about the composition of the advisory committee. None were stated. Dr. Tharp reported that this would be her last meeting and that Dr. Gormley would be reaching out to Dr. Brown as to designating a replacement. Dr. Brown explained that state employees were selected to serve by their respective agencies heads and therefore there are no specific term limits for these members.
Neal Kauder: UPDATE ON UTILIZATION OF PMP DATA	Neal Kauder from Visual Research, Inc., reported on the analytics requested during the last advisory committee meeting. Mr. Kauder said they had results for every KPI the advisory committee requested. After reviewing the data, they obtained the KPI results for the 3rd quarter of 2015 which consisted of approximately 3.6 million cases. He noted that they looked at adults only and changed the suggested rate of per 100 to per 1000, which is more consistent with the way other researchers handle their data. Mr. Kauder distributed maps of the Health Planning Regions (HPR) and Health Planning Districts (HPD) and noted that they determined the number of scripts written by HPD, determined by either pharmacy zip code, prescriber zip code or recipient (patient) zip code. Additionally, they created two databases: 1) a prescription database and 2) a person database. They removed the outliers in an appropriate way. Graphic 1 showed opioid rates by HPR, the Northern region showing the lowest rate and the Southwest region showing the highest rate. Graphic 2 shows opioid rates by HPD, with rural areas demonstrating higher rates and higher variations (of prescribing, dispensing and receiving). The more populated areas have much more even sets of bars. Graphic 4 show the % of adults with MMEs greater than 100, which are approximately 22.6% of the population in the database; less outliers the rate is 21.6% of the population in the database. Regardless of how the outliers were treated, the median and the mode remained the same. Mr. Kauder noted that rural areas have increased prescribing rates. Dr. Tharp noted that the OCME is going to begin capturing the MME from the PMP reports and input them in the database alongside their other death data.
Ralph Orr: PBSS MEASURES OVERVIEW	Mr. Orr reviewed PBSS measures and noted that tramadol was added to Schedule IV in 2014, and possibly responsible for the increase in dispensing of opiates. Prescribing of stimulants continues to rise. Page 2 shows the rates per 1000 citizens by drug class and age group. Ms. Morris noted that once a patient is started on benzodiazepines, they are likely on the medication for a long time. Mr. Orr noted that persons age 65 and over have the highest rates for opioids and benzodiazepines. Ms. Randall noted that it is dangerous for individuals to withdraw from benzodiazepines without medical support. Page 6 of the handout shows numbers of individuals who obtain controlled substances using both Medicaid and cash. Dr. Brown inquired whether the PBSS measures are static, or could the PMP ask for more analysis. Mr. Orr stated that he did not know the answer to that question, but that he could find out. Dr. Brown specifically wanted to know whether the prescribers on page 3 were living in Virginia; this table compares the number of prescribers licensed to the PMP registration rate as well as the PMP utilization rate. Table 7 showed the average MME for

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	patients in the database by year. Page 10 shows the percent of individuals (opiate naïve) prescribed a long acting/extended release (LA/ER) opiate. Dr. Tharp noted that they see people in the ER all the time that are prescribed methadone, the patient takes as prescribed and ends up dead. Lisa Hahn asked Neal Kauder what he thought about the validity of the PBSS measures and he said he didn't have enough information about their methodology to know or evaluate. He noted that any slight nuance could give you an entirely different picture.
Ralph Orr: HEALTH AND CRIMINAL JUSTICE DATA COMMITTEE UPDATE	Mr. Orr discussed four slides from a recent report of the Health and Criminal Justice Data Committee. The formation of this committee was a major recommendation of the Governor's Task Force on Prescription Drug and Heroin Abuse. The first slide compared hospitalizations to fatal overdoses related to prescription opioids. Mr. Orr suggested that this data may represent an opportunity for an offer of substance abuse treatment to be given before discharge from a hospitalization for overdose. In reviewing the second slide, Dr. Tharp noted that for heroin, these individuals do not end up in the hospital or call for rescue because they don't want to get arrested. Deaths from prescription opioids and heroin continue to increase. Dr. Tharp also noted that drug deaths are caused by (in order) hydrocodone, oxycodone, methadone and fentanyl, which doesn't exactly match those prescribed (in order): hydrocodone, oxycodone, tramadol and buprenorphine. The third slide shows submissions to the Virginia Department of Forensic Science for prescription opioids and heroin. The last slide shows the top six opioid drugs prescribed in Virginia for the first half of 2015. Mr. Orr commented that data by itself does not always tell the complete story; for instance tramadol was not a mandatory report to the PMP until the fall of 2014.
Ralph Orr: RESEARCH REQUESTS REVIEW:	Mr. Orr discussed research requests, reporting to the committee that the PMP does not have the authority to charge a fee for providing research data. Mr. Orr noted that we have received inquiries about possible requests for research data, but no formal applications have been received for the committee to review. Mr. Orr inquired whether the committee members felt the research should only be allowed under certain circumstances. How much control should the PMP have over the final results of research? Mr. Kauder noted that what is in the database is not research ready. Dr. Carter noted that the data Mr. Kauder has prepared is research ready. Mr. Orr explained that the final decision for approving a research request is at the discretion of the Director. Dr. Brown stated that creating a panel to look at this specific issue would be helpful.
PROGRAM UPDATE: Carolyn McKann: AUTOMATED REGISTRATION UPDATE:	Ms. McKann noted that the automated registration of prescribers and pharmacists is nearly complete. Ms. McKann also noted that the PMP sent a letter in January requesting current email addresses from those we were unable to automatically register, and Dr. Levine's email, sent in December, requested the same. At some point in the near future, automated registration will generate more registered users from these valid emails that PMP staff has collected.
Carolyn McKann: INTEROPERABILITY	Ms. McKann indicated that the implementation of an integration solution with Kroger Pharmacies was responsible for a majority of the

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AND INTEGRATION UPDATE:	program's growth in 2015. Ms. McKann noted that no other states have been added for interoperability since December after Rhode Island and New Jersey were added last fall. Ms. McKann reported that 36 states now have Memorandums of Understanding (MOUs) with NABP's PMPi and that Virginia is interoperable with 19 of those. Mr. Orr noted that our neighboring state, North Carolina, still has not obtained the capability to share data with other states. PMPi growth continues to be sustained by Gateway requests from Kroger pharmacies in Virginia. Mr. Orr added that the pharmacists love the NarxCheck reports generated by the Gateway system as part of the agreement.
Carolyn McKann: PROGRAM STATSTICS	Ms. McKann reviewed year-end 2015 program statistics, pointing out that the program processed nearly 5 million requests in 2015 and over 2 million during the last quarter alone. Ms. McKann noted that the PMP added over 45,000 registered users to the program by automated registration in 2015, and the database currently holds over 126 million prescription records. Ms. McKann showed the query rate for groups of prescribers based on the number of prescriptions for controlled substances they wrote in the last quarter of 2015. The average query rate for all registered users is just over 9% of the number of prescriptions actually written. Dr. Barsanti asked how the measure is affected by episodes of care where a prescriber may write, for example, five prescriptions. Ms. McKann noted that the rate only represents a rate per prescription, not per encounter but the rate is tracked over time providing a usable measure of utilization of the program. Ms. McKann also showed a chart that showed the significant impact of a single integration implementation on the volume of requests processed by the Virginia PMP in 2015.
NEXT MEETING	The next meeting will be held on June 15, 2016 from 10 a.m. to 2:00 p.m.
ADJOURN:	With all business concluded, the committee adjourned at 1:20 p.m.
	S. Hughes Melton, M.D., Chairman
	Ralph A. Orr, Director

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2016 PMP LEGISLATION

- Chapter 406 of the 2016 Acts of Assembly: Mandatory requests by prescribers and expanded delegate authorization

- Chapter 309 of the 2016 Acts of Assembly: Daily reporting requirement (Eff. 1/1/2017), PMP reports may be placed in Patient Medical Record, Expand access for certain prescribers and pharmacists

- Chapter 98 of the 2016 Acts of Assembly: Authorize unsolicited reports of unusual patterns of dispensing or prescribing to the Enforcement Division of the Department of Health Professions

- Chapter 447 of the 2016 Acts of Assembly: Authorizes the PMP to provide information for the purpose of selecting prescribers who will be required to complete relevant continuing education

- Chapter 410 of the 2016 Acts of Assembly: Authorizes physicians or pharmacists employed by Virginia Medicaid managed care program to request information on specific recipients who are members of the program. Such information shall only be used to determine eligibility for and to manage the care of the specific recipient in a Patient Utilization Management Safety or similar program.

Program Overview

As a national leader in technology, Virginia recognizes pharmacists and prescribers serve on the front lines of the nation's fight against prescription drug abuse. Today, the Prescription Monitoring Program (PMP), a cutting edge digital database, is among the chief tools of healthcare practitioners to keep people safe from drug addiction and drug related death. PMP is a secure database that centralizes the prescription history of patients prescribed controlled substances. The information on PMP's database is available to authorized users such as physicians and patients. PMP, in partnership with several states, has leveraged advances in technology to enable the sharing of prescription information across state lines. The implementation of this technology comes at a time when prescription drug abuse is the fastest growing drug problem in the United States. PMP works to control and   regulate the distribution of prescription medication and has been described by physicians as a risk management tool to combat the drug abuse problems society faces today. It is the mission of Virginia's Prescription Monitoring Program's (PMP) to promote the appropriate use of controlled substances for legitimate medical purposes while deterring the misuse, abuse and, diversion of controlled substances.

Cover Letter

More people die from prescription drug abuse than from car accidents. That puts prescribers and pharmacists on the front lines of the nation's fight to keep people safe from drug overdose and death. In Virginia, the Prescription Monitoring Program (PMP), a secure digital database and risk management tool for prescribers and pharmacists, centralizes the dispensing history of patients prescribed Schedule II – IV controlled substances.

Use the links under "Contents" of this PMP education toolkit to learn more about the mission of Virginia's PMP to promote the appropriate use of controlled substances for legitimate medical purposes while deterring the misuse, abuse and diversion of controlled substances.

Find fast PMP facts on topics including—
- New developments such as work flow integration and delegation making it easier to use PMP
- Interoperability with other state Prescription Monitoring Programs
- Legislative updates

PMP's regularly updated education toolkit also includes statistical data including charts and graphs, changes in regulation for registered users of the system, feature articles for patients and quotes for news organizations that are just a click away.

BENEFITS OF
VIRGINIA'S PRESCRIPTION MONITORING PROGRAM

WHO
- Virginia's Prescription Monitoring Program (PMP) is among the top digital patient management tools available to prescribers and pharmacists who write or fill prescriptions for schedule II - IV drugs as part of each medical treatment plan. Acessible 24/7, the software provides complete controlled substance dispensing histories, minimizing the risk of duplicating prescriptions and is instrumental in reducing potential illegal activity.
- PMP is used by prescribers and pharmacists to better inform their treatment and dispensing decisions.
- In 2015, nearly 5 million inquiries were made to the PMP by users of the system

WHY
- PMP helps prescribers and pharmacists make safe prescribing and dispensing decisions for more than 8 million Virginians.
- Morphine milligram equivalent (MME) daily dose ratings have been added to PMP reports, and are used by prescribers and pharmacists to identify patients at risk for overdose.

WHAT
- The PMP database provides prescribers with quantitative data to monitor patient compliance with their treatment plan.
- PMP prescription information is available to other authorized users of the database who assist with disciplinary investigations conducted by health regulatory boards and, when appropriate, law enforcement entities.

HOW
Interoperability
- Virginia's PMP is a member of the National Association of Boards of Pharmacy Prescription Monitoring Interconnect Program (PMPi). This network allows practitioners to share prescription information across state lines. As of July 2016 Virginia's PMP is connected with 20 other state PMPs, including four border states.

Integration
- Virginia's PMP is presently integrated into the work flow of pharmacists at one national pharmacy chain, and work is underway in collaboration with several health systems to integrate PMP data into their Electronic Medical Records.
- Changes in law allow pharmacists and prescribers to select and authorize delegates from their practice to retrieve patient information from the PMP database on their behalf.

RESULTS
- Over the last four years, Virginia has experienced a substantial decrease in "doctor-shopping" indicators.
- PMP has become a major resource for prescription data used to inform public policy decisions toward safeguarding the health and wellbeing of all Virginians.

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Virginia's Prescription Monitoring Program (PMP): Making it Easier for Pharmacists and Prescribers to Keep Patients Safe
PMP Enters Its Second Decade of Service

By
Ralph Orr

At a time when drug deaths outnumber motor vehicle fatalities, Virginia's Prescription Monitoring Program (PMP) leads the way in the nationwide fight against the prescription drug abuse epidemic. PMP is a secure, digital risk management database for prescribers and pharmacists and works by providing information and patient histories of citizens receiving controlled substances or Schedule II through IV drugs as part of medical treatment. PMP also minimizes the risk of duplicating prescriptions and eliminates potential illegal activity. The database is accessible 24/7, and is only available to authorized users.

Ralph Orr

PHP Program Director

As of January 2016, PMP registration is automatic for select licensees of Virginia's health regulatory boards, and practitioners are required to consult the database before writing an opioid prescription for longer than 14 consecutive days.

Recognizing the time constraints on healthcare providers, new 2016 policy allows practitioners to appoint delegates or alternates in their practice to query the PMP database on behalf of a supervising prescriber or pharmacist. PMP alternates are eligible to have their own accounts in the system.

Along with (number) states, Virginia's PMP is a member of the National Association of Boards of Pharmacy Prescription Monitoring Interconnet (PMPi). These states work together in partnership to share prescription information across state lines to aid in the fight against the nationwide epidemic against prescription and heroin abuse. A nationally connected resource for prescribers and pharmacists is also on the horizon. The future is expected to bring new pharmacy software to better integrate use of PMP data into the everyday workflow of healthcare practitioners.

PMP is a program of the Virginia Department of Health Professions (DHP) which licenses 320,000 healthcare practitioners across more than 80, professions including those who prescribe or dispense controlled substances.

DHP's mission is to ensure safe and competent patient care by licensing health professionals, enforcing standards of practice and providing information to health care practitioners and the public.

Program Quotes

"The issues surrounding chronic pain management are quite complex and often involve the collaborative efforts of numerous health professionals. This program is an excellent resource that will hopefully encourage appropriate therapy and discourage abusive practices."
– John Beckner (need approval)

"Today prescription drug abuse impacts every citizen in the Commonwealth."
–2012 Annual Report of the Office of the Chief Medical Examiner

"The PMP is the single most effective tool I use in my practice to ensure the medications I prescribe are used to relieve human suffering – and not diverted for monetary or recreational purposes. I use it often in my practice.
– A Virginia Practitioner

VIRGINIA'S PRESCRIPTION MONITORING PROGRAM

VISIT PMP ONLINE

RX DRUG AND HEROIN DEATHS
OUTNUMBER
AUTOMOBILE DEATHS IN VIRGINIA

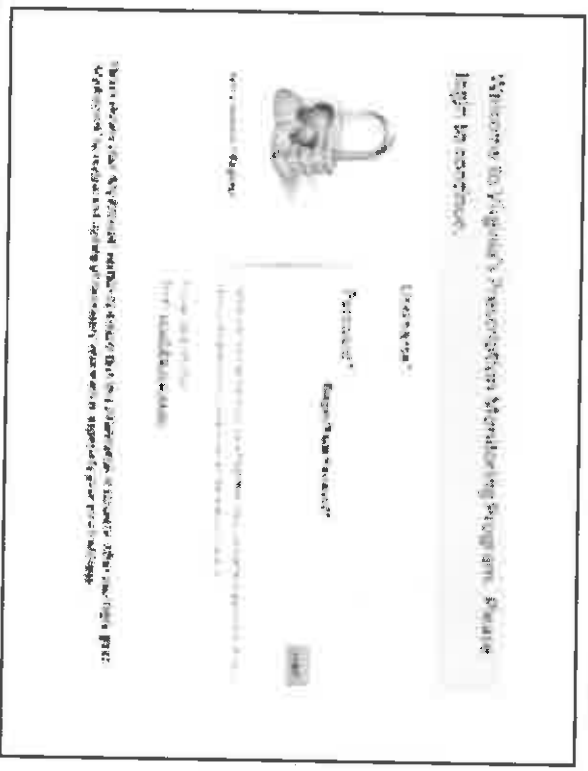## THOUSANDS OF FAMILIES
ARE IMPACTED EACH YEAR

PRESCRIPTION DRUG DEATHS
HAVE BEEN
ON THE RISE
IN VIRGINIA
SINCE 1996

THE SOLUTION FOR SAFE PRESCRIBING IN VIRGINIA

A DIGITAL DATABASE OF
PRESCRIPTION AND PATIENT HISTORIES

Welcome to the Virginia's Prescription Monitoring Program. Please login to continue.

Username:

Password:

Forgot your password?

DIGITALLY CONNECTED WITH 19 OTHER STATES

Arizona
Connecticut
Delaware
Illinois
Indiana
Kansas
Kentucky
Maryland
Michigan
Minnesota
New Jersey
New Mexico
New York
North Dakota
Ohio
Rhode Island
South Carolina
South Dakota
Tennessee
Virginia
West Virginia

As of 2016 there are more than 55,000 prescribers and 13,000 pharmacists registered to use PMP

WHAT DOES PMP DO?

PMP is authorized with specific powers and duties by the code of Virginia. PMP's mission is to promote the appropriate use of controlled substances for legitimate medical purposes while deterring the misuse, abuse and diversion of controlled substances.

The prescription monitoring program collects prescription data for Schedule II-IV drugs into a central database which can then be used by authorized users to assist in deterring the illegitimate use of prescription drugs.

NEW DEVELOPMENTS

AUTOMATIC REGISTRATION

As of January 2016, all newly licensed practitioners are automatically registered for the PMP Program.

NEW LEGISLATION

New legislation passed by the 2016 General Assembly requires doctors and other prescribers to check the PMP database before writing an opioid prescription for longer than 14 days.
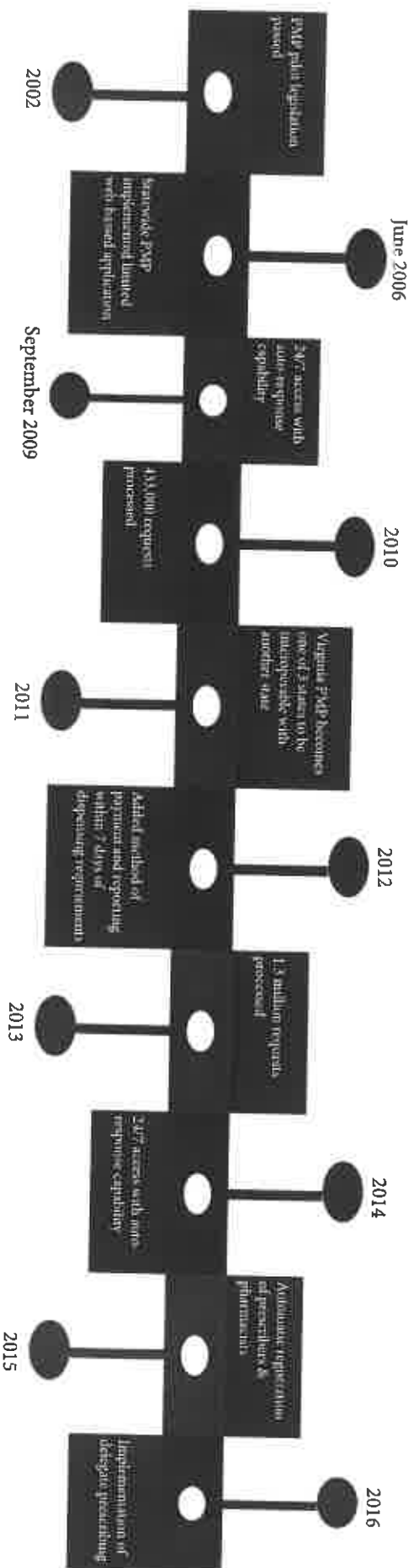
CDC Guidelines

2016 CDC guidelines for opioid prescribing include: use of non-opioid therapies for chronic pain; and use of the lowest possible effective opioid dose.

KEEP UP WITH THE PROGRAM

Visit Virginia's PMP Online

View the CDC Guidelines for Prescribing Pain Medication

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PMP Timeline of Events

- **2002** — PMP pilot legislation passed
- **June 2006** — Statewide PMP implemented, limited web-based application
- **September 2009** — 24/7 access with auto-response capability
- **2010** — 455,000 requests processed
- **2011** — Virginia PMP becomes one of 3 states to be interoperable with another state
- **2012** — Added method of payment and reporting within 7 days of dispensing requirements
- **2013** — 1.3 million requests processed
- **2014** — 24/7 access with auto-response capability
- **2015** — Ambulance registration of prescribers & pharmacists
- **2016** — Implementation of delegate credentialing

Prescriber Delegates

Virginia's Prescription Monitoring Program (PMP) will implement new functionality simplifying a potential Prescriber Delegate's registration process on September 7, 2016. Previously, these Prescriber Delegates (delegates) could only gain access to the PMP using a paper registration process. Much like existing processes available for prescribers, each potential Prescriber Delegate will be able to register at the PMP login screen by clicking on the "Register" button and then selecting the "Prescriber Delegate Job" (Licensed or Unlicensed) that applies and following the prompts. **Please note that this enhancement will not affect existing delegate accounts.**

Once the delegate has submitted the online application, the delegate's Prescriber Supervisor (supervisor) will be notified via email that an application has been submitted. The supervisor then has the opportunity to review and approve the pending delegate user's application. If the potential delegate receives the following notice: **"Add Failed: Supervisor not found for the given License information"**, the delegate will need to inform the Supervisor that it is necessary for the supervisor to enter their DEA number on the "My Account" screen before the potential delegate can complete the registration. Once the supervisor has approved the application, the new delegate user will receive an email indicating that the registration has been approved by the supervisor, and also providing information on how to access the account.

Each time a supervisor logs into the account, they will have the ability to see all the patient profiles requested on their behalf by all of his delegates. Supervisors will have the ability to better manage and supervise their delegates, featuring easy removal of delegates that are no longer employed at their facility, no longer under their supervision, or whose job requirements have changed. Each supervisor may have as many delegates as they choose, though each delegate user may only use their own username and password since access to the PMP may not be shared for security reasons and in accordance with regulation.

Authorizing language:

§ 54.1-2523.2. (Effective until July 1, 2019) Authority to access database

Any prescriber or dispenser authorized to access the information in the possession of the Prescription Monitoring Program pursuant to this chapter may, pursuant to regulations promulgated by the Director to implement the provisions of this section, delegate such authority to individuals who are employed or engaged at the same facility and under the direct supervision of the prescriber or dispenser and (i) are licensed, registered, or certified by a health regulatory board under the Department of Health Professions or in another jurisdiction or (ii) have routine access to confidential patient data and have signed a patient data confidentiality agreement.

CDC Opioid Guidelines

Use of Virginia's PMP supports the CDC's guidelines on prescribing opioids for chronic pain management.

BOX 1. CDC recommendations for prescribing opioids for chronic pain outside of active cancer, palliative, and end-of-life care

Determining When to Initiate or Continue Opioids for Chronic Pain

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Assessing Risk and Addressing Harms of Opioid Use

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

* All recommendations are category A (apply to all patients outside of active cancer treatment, palliative care, and end-of-life care) except recommendation 10 (designated category B, with individual decision making required); see full guideline for evidence ratings.

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Authorizing language:

§ 54.1-2523.2. (Effective until July 1, 2019) Authority to access database

Any prescriber or dispenser authorized to access the information in the possession of the Prescription Monitoring Program pursuant to this chapter may, pursuant to regulations promulgated by the Director to implement the provisions of this section, delegate such authority to individuals who are employed or engaged at the same facility and under the direct supervision of the prescriber or dispenser and (i) are licensed, registered, or certified by a health regulatory board under the Department of Health Professions or in another jurisdiction or (ii) have routine access to confidential patient data and have signed a patient data confidentiality agreement.
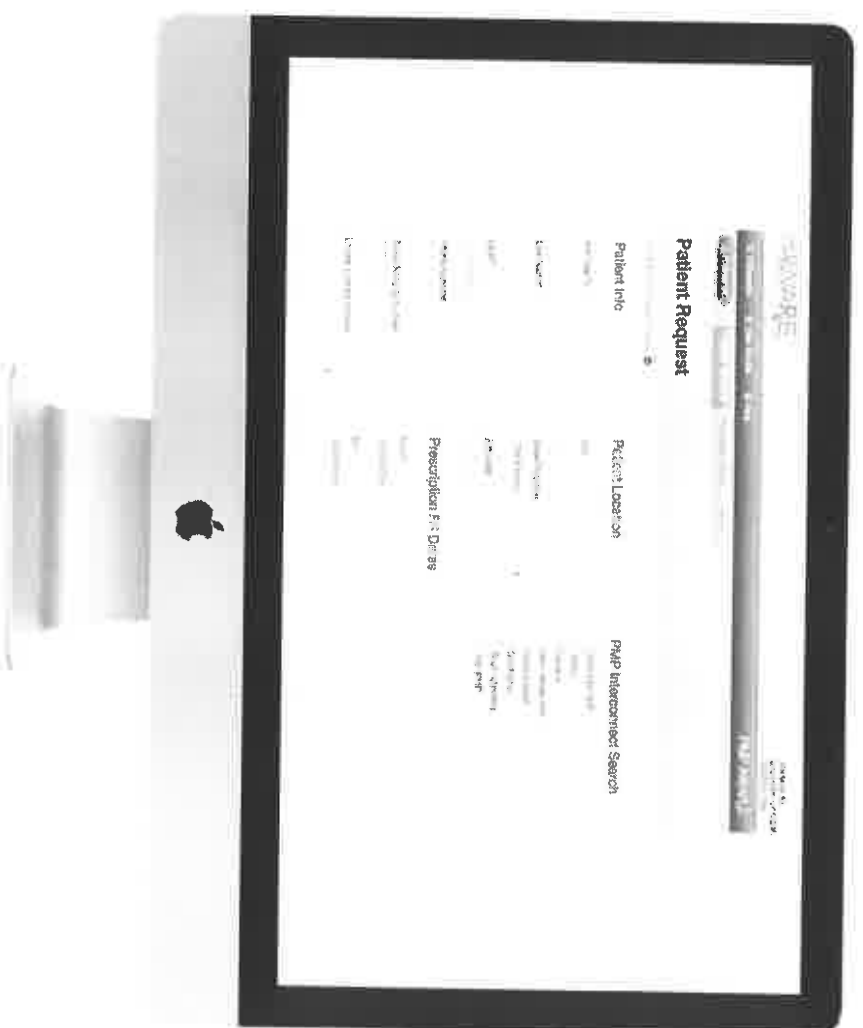
Virginia Department of Health Professions

PMP AWARE™

PRESCRIPTION MONITORING PROGRAM

Appriss | CONFIDENTIAL

Major Needs Addressed for VA PMP Stakeholders

INFORMATION REQUESTERS

- Fast response times

- Reliable patient-linking

- Tablet compatibility

- Most up-to-date availability of records

- Secure delegate workflow

- Available in physician workflow

# Major Needs Addressed for VA PMP Stakeholders

DATA SUBMITTERS

- Flexible data submission methods for pharmacies, large and small

- Automated workflow for error correction

- Tools for online error correction

- Easier rollout of new data format standards

- A single account and user interface to manage all data submissions for multi-state pharmacy chains

Major Needs Addressed for VA PMP Stakeholders

ADMINISTRATORS

- Automated patient linking with ability for administrators to override

- 100% online registration to eliminate paperwork

- Pharmacy and physician compliance reports

- Delegate-physician linking for compliance checks

- Business intelligence and ad hoc reporting capabilities

PMP AWARE - Demo
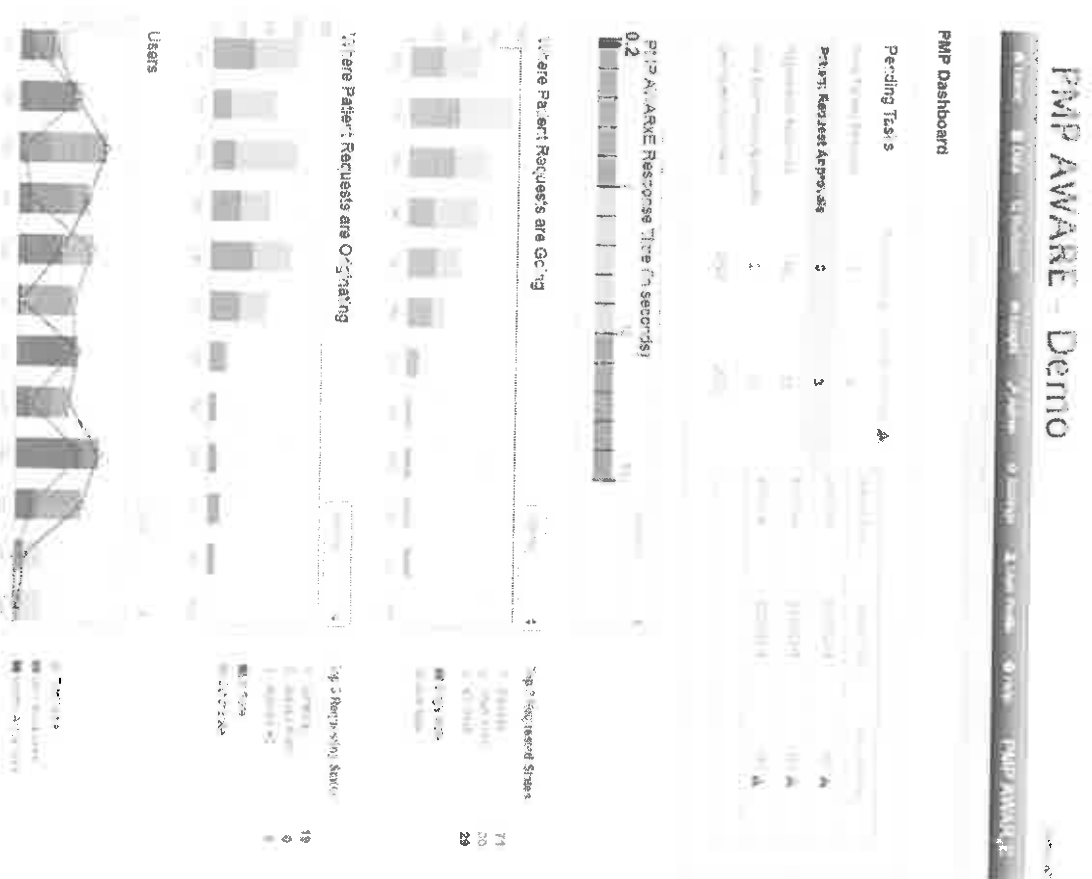
PMP AWARE – Demo

PMP AWARxE

10401 Linn Station Road
Suite 200
Louisville, KY 40223
1-866-Appriss

Log In

Email

✉

Password

✱

Reset Password

[Login]

Create an Account

Appriss | CONFIDENTIAL

My Dashboard

Patient Alerts

Patient Full Name	DOB	Alert Date	Alert Letter
ALICE TESTPATIENT	01/01/1900	01/19/2016	PDF
BOB TESTPATIENT	01/01/1900	01-17-2016	PDF
BOB TESTPATIENT	01/01/1900	12-17-2015	PDF
ALICE TESTPATIENT	01/01/1900		PDF
JOHN DOE	01/01/1900	11/03/2015	PDF

Recent Requests

Patient Name	DOB	Request Date	Delegate
Bob TestPatient	01/01/1900	01/01/2016 1:51 PM	
ALICE TESTPATIENT	01/01/1900	01/17/2016 9:57 AM	
Jane Doe	01/01/1900	01/21/2016 9:44 AM	
Jane Doe	01/01/1900	01/13/2016 12:25 PM	
Jane Doe	01/01/1900	01/12/2016 6:36 PM	

Delegates

Delegate Name	Status	Request Date
Dave Delegate	approved	01/12/2016
Dmetri Delegate Delegate Unapproved	pending	11/04/2015

Announcements

New Dashboard   01/20/2016

A new dashboard has been developed to bring more information to the user's attention. To learn more about the various sections ... [may]

New Dashboard

A new dashboard has been designed to give you more information to the various details ...

Quick Links

Patient Request

Patient Info

First Name*

Last Name*

DOB*

Phone Number

Patient Location

City

State/Province
State Select

Zip Code

PMP Interconnect Search

☑ Kansas
☐ KY PMP
☐ Utah PMP
☐ Wisconsin

Prescription Fill Dates

From*
No earlier than 4 years from today

02/10/2015

To*
02/10/2015

Please field limit at Genesee.com

Search

PMP AWARE – Demo

PMP AWARE

Home | **Research** | **Insight** | **User Profile** | **Help** | **Log Out**

Patient Request

▼ John Doe

Summary

Prescribers | Pharmacies | Prescriptions

Prescriptions

▼ Filled

Written	Drug	QTY	Days	Prescriber	Filled

▶ Prescribers

▼ Dispensers

Physician (MD, DO);
Physician ... to patient request.

PMP Advisory Panel Update

- Executive Directors of Boards of Medicine and Pharmacy
- Two Board members from each Board
- Next meeting October 28, 2016
- Criteria that may be considered:
  — High prescribing, no use of PMP
  — Prescribers and Dispensers with large percentage of private pay for prescriptions
  — Prescribing and dispensing related to extremely high Morphine Equivalent doses

Total Number of Requests by Prescribers August 2015 - August 2016

Month	Value
Aug-15	124260
Sep-15	126559
Oct-15	129598
Nov-15	123805
Dec-15	129098
Jan-16	122261
Feb-16	136654
Mar-16	150234
Apr-16	145402
May-16	159913
Jun-16	170363
Jul-16	165575
Aug-16	192484

Total Prescription Records Uploaded to PMP from Aug 2015 - Aug 2016

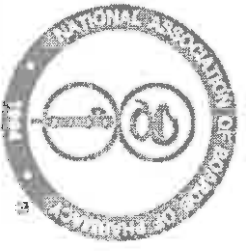| Month	Value
Aug-15	1186036
Sep-15	1196730
Oct-15	1231043
Nov-15	1153629
Dec-15	1257504
Jan-16	1156241
Feb-16	1159064
Mar-16	1252237
Apr-16	1175643
May-16	1177466
Jun-16	1147459
Jul-16	1114624
Aug-16	1184404

Total Number of Requests by Pharmacists August 2015 - August 2016
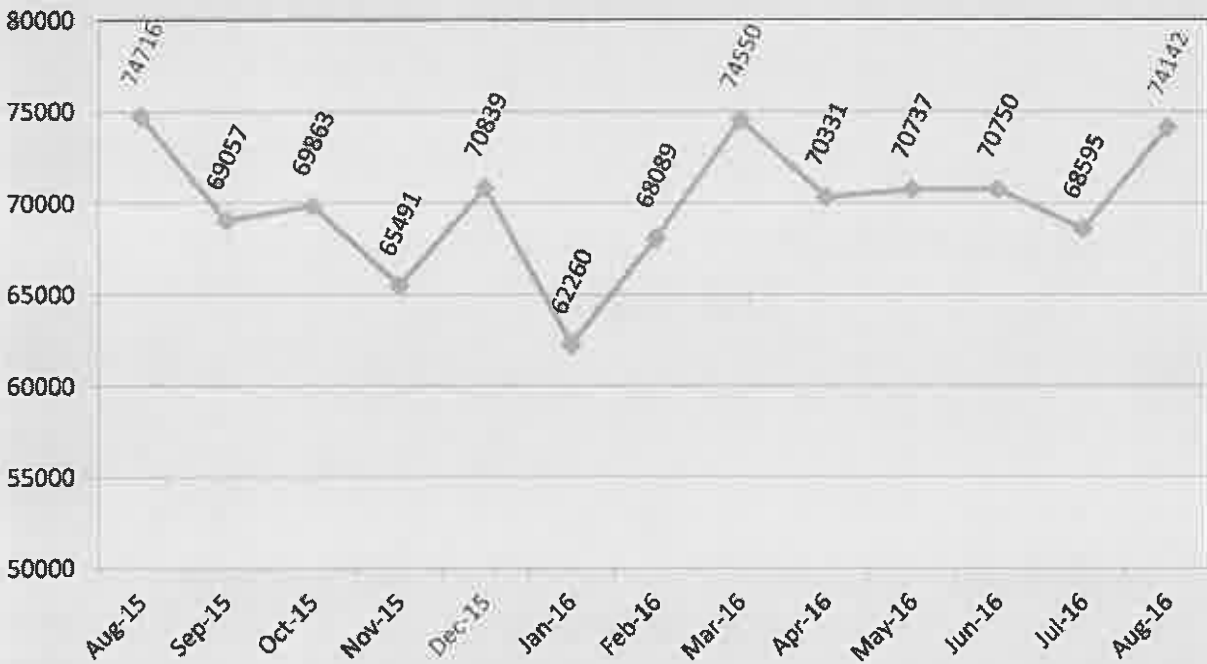
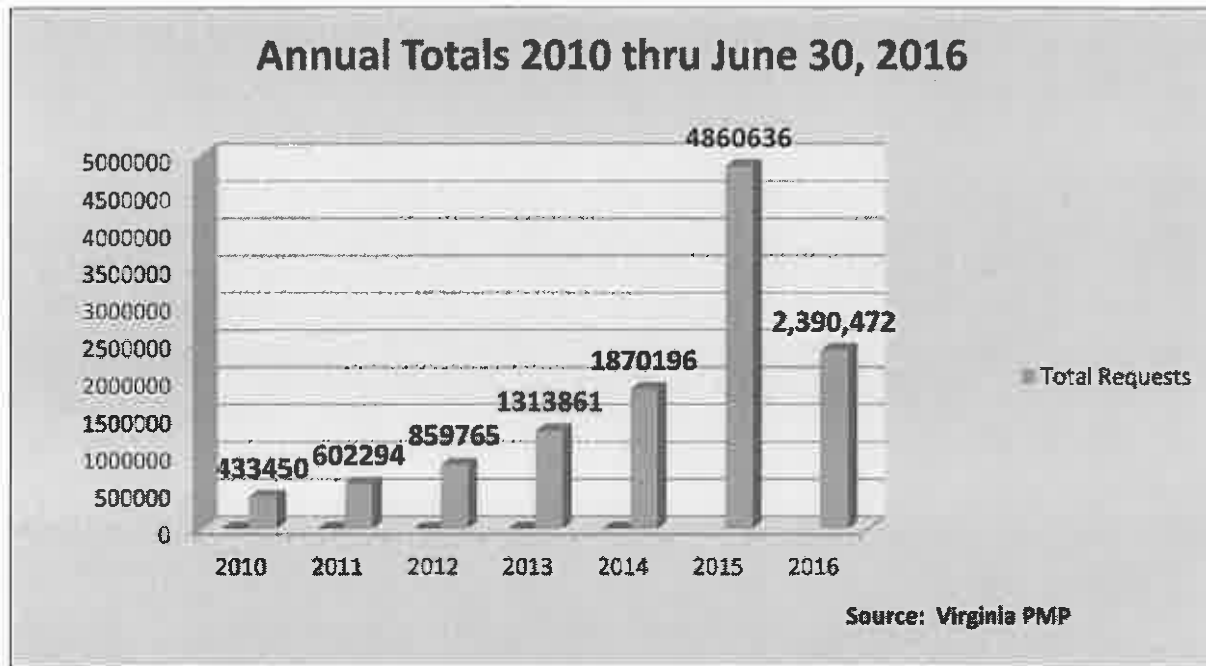Total Number of PMPi Requests August 2015 - August 2016
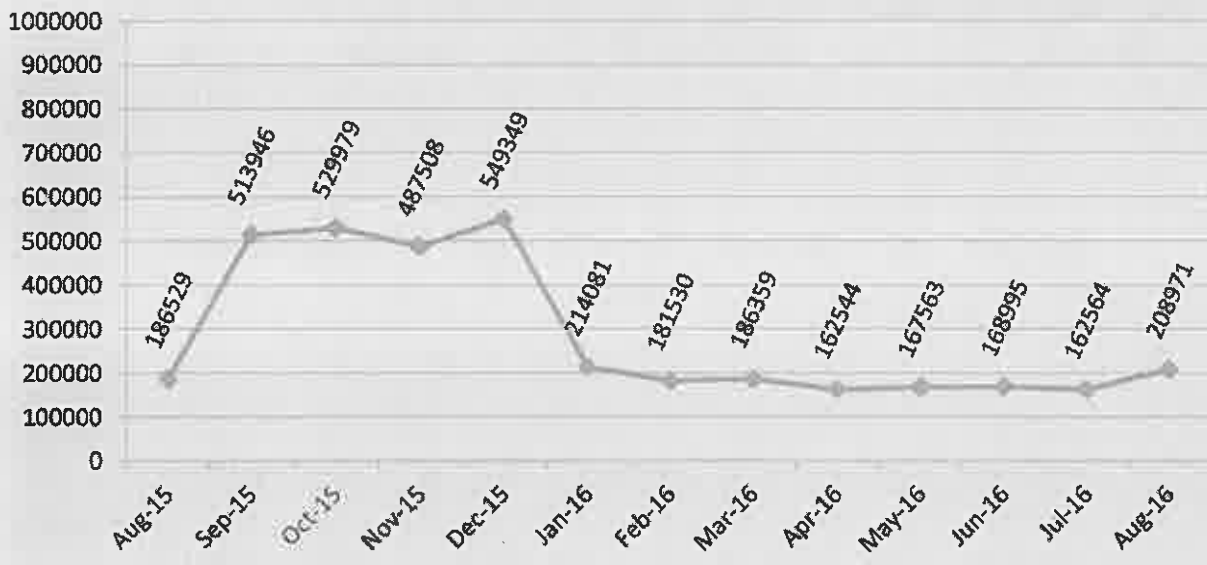
PMP INTERCONNECT®

## Legend

- ■ NABP PMP InterConnect Participant (System Live)
- ▨ Memorandum of Understanding Executed
- □ Pending NABP PMP InterConnect Participant
- ▦ Prospective NABP PMP InterConnect Participant
- ■ No PMP in Place

Annual Totals 2010 thru June 30, 2016

Source: Virginia PMP

The Virginia PMP processed nearly 5 million requests during 2015 and is projecting approximately the same in 2016. The program processed over 1.8 million requests in 2014.

PMP Requests by Qtr 2012 through June 2016

Source: Virginia PMP
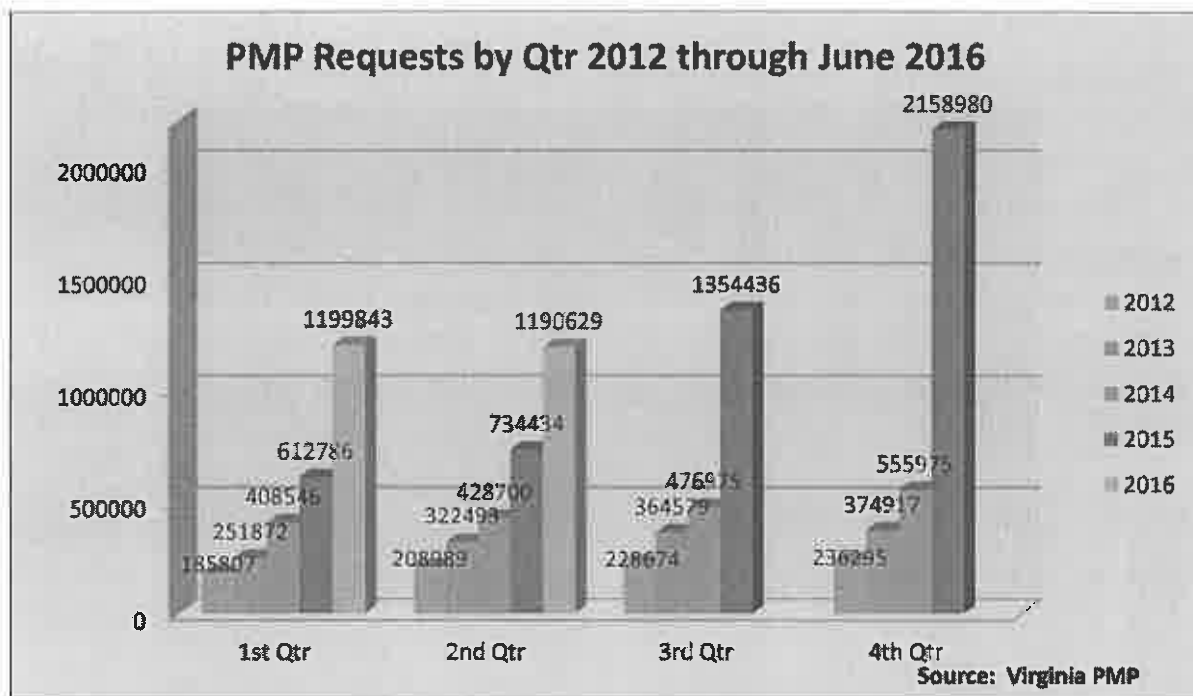
The large increase in requests for the last two quarters of 2015 were primarily due to an integration solution being implemented for pharmacies in VA, WV, and OH. In January 2016, the OH connection was turned off.

1

Registered Users of PMP DataCenter 1/1/13 - 6/30/2016
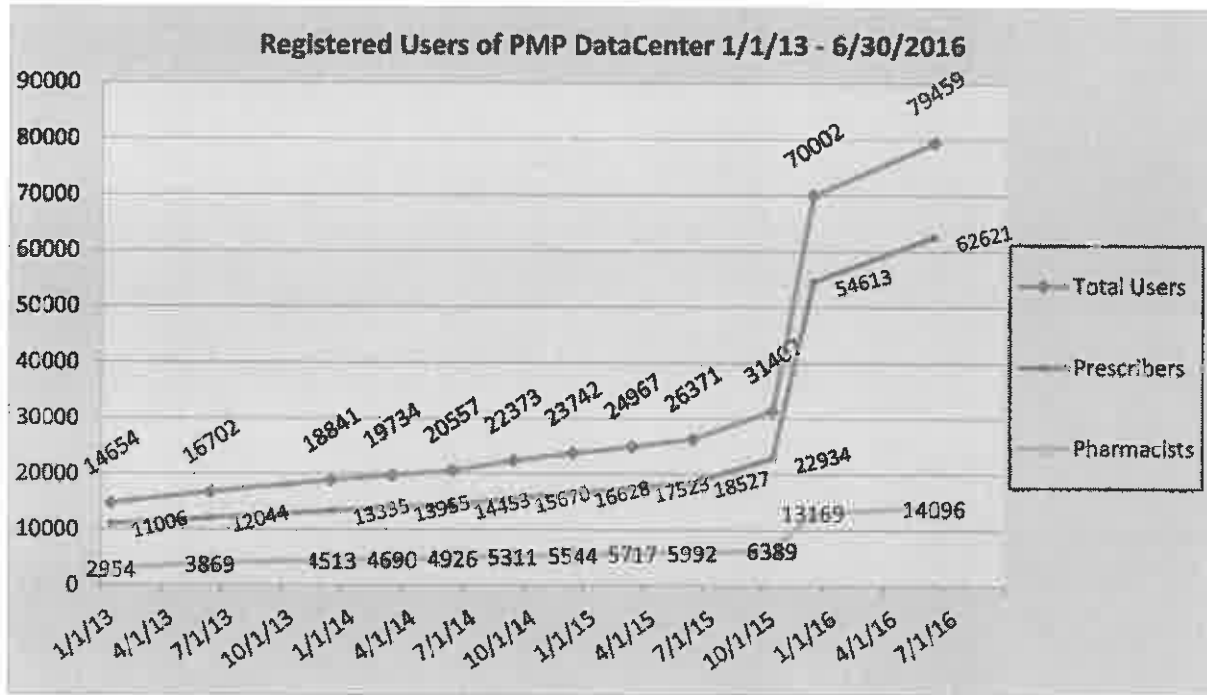
The Virginia PMP added 46,260 users in 2015 due to implementation of automated registration and 9,457 users in the first half of 2016.

Total Prescription Records for 7/1/2013 through 6/30/2016
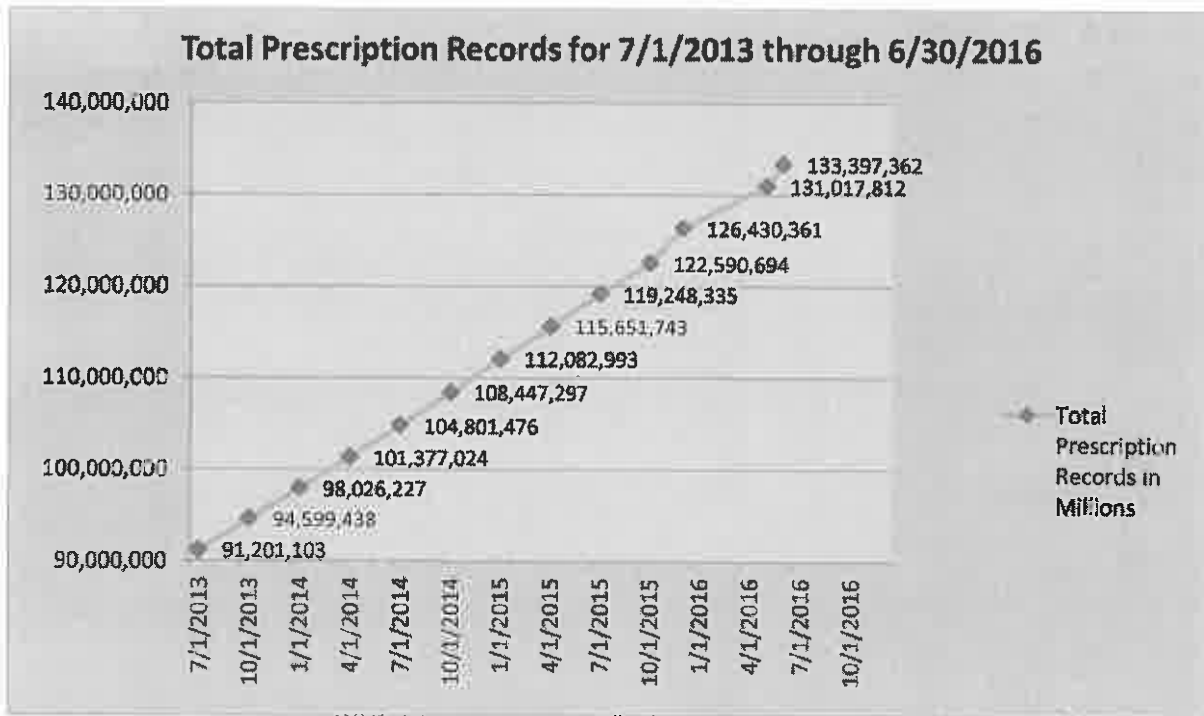
The Virginia PMP continues to add over 1 million prescription records each month.

Percentage of Requests by User Type Jan - Jun 2016

PMPi = 45.22
Pharmacist = 17.43
Prescriber = 37.02
0.16
0.16
0.05
0.11

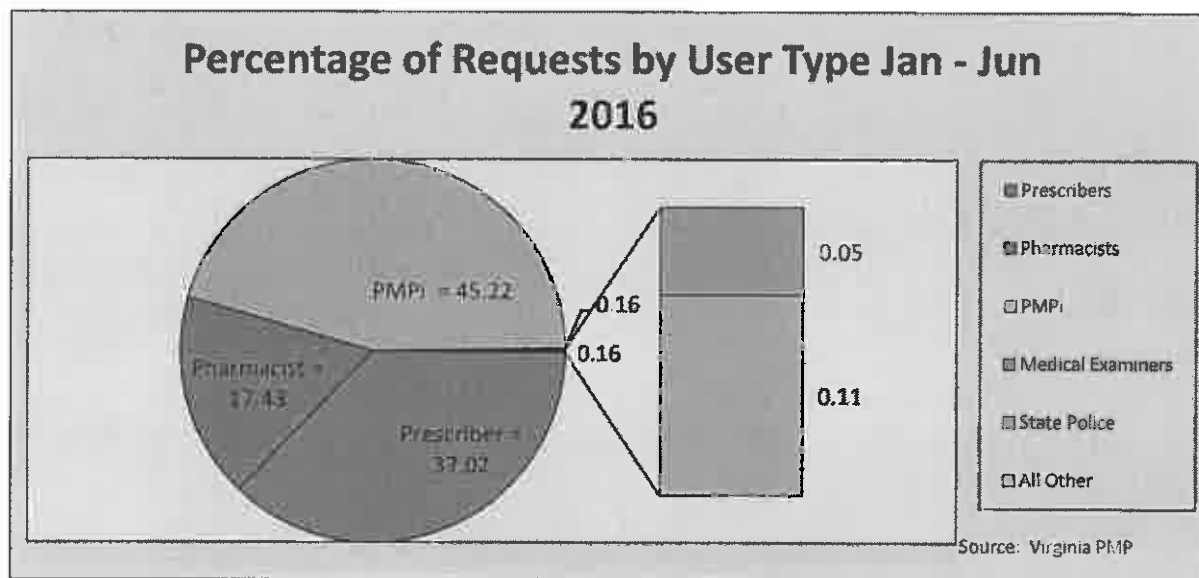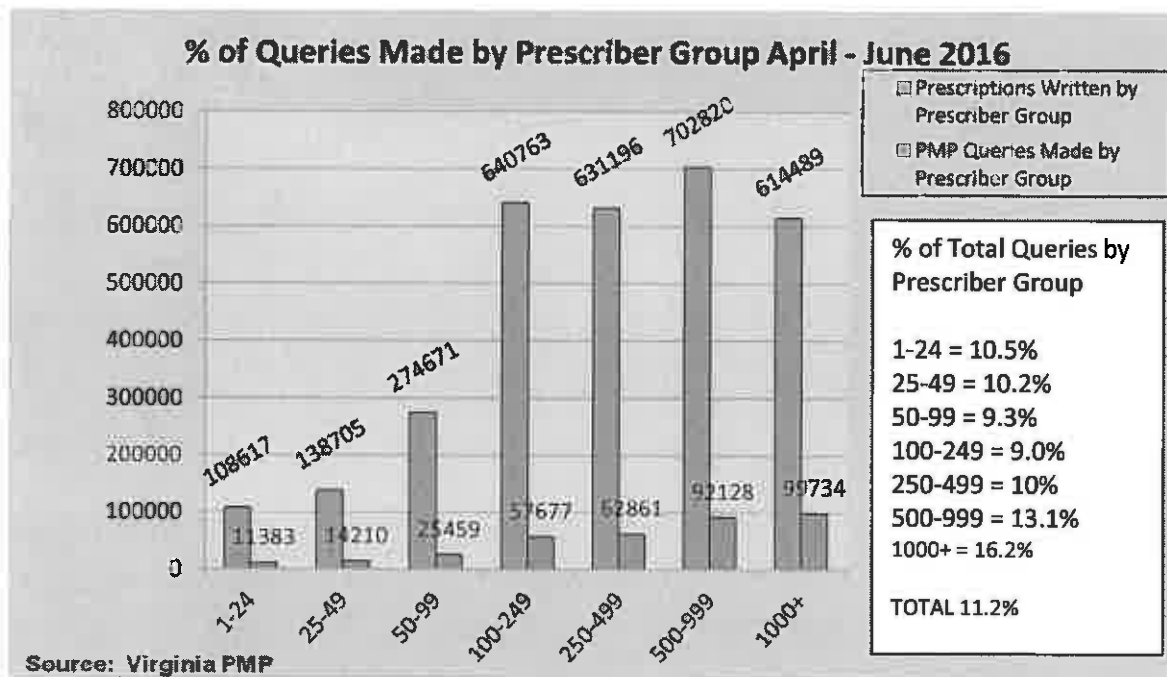Legend: Prescribers, Pharmacists, PMPi, Medical Examiners, State Police, All Other

Source: Virginia PMP

Prescribers submitted 37% of the queries to the PMP database, pharmacists submitted 17% of the requests and another 45% were submitted by users of our data interchange from either other states or from pharmacy networks, making 99.67% of the total. All investigative types submit about 1/3 of 1% of the total.

% of Queries Made by Prescriber Group April - June 2016

Legend: Prescriptions Written by Prescriber Group; PMP Queries Made by Prescriber Group

Values: 108617, 11383 (1-24); 138705, 14210 (25-49); 274671, 25459 (50-99); 640763, 57677 (100-249); 631196, 62861 (250-499); 702820, 92128 (500-999); 614489, 99734 (1000+)

% of Total Queries by Prescriber Group

1-24 = 10.5%
25-49 = 10.2%
50-99 = 9.3%
100-249 = 9.0%
250-499 = 10%
500-999 = 13.1%
1000+ = 16.2%

TOTAL 11.2%

Source: Virginia PMP

Prescribers queried the database for an average of 11.2% of prescriptions written during the past quarter. The prescriber group that wrote greater than 1000 prescriptions during the quarter had the highest query rate (16.2%).
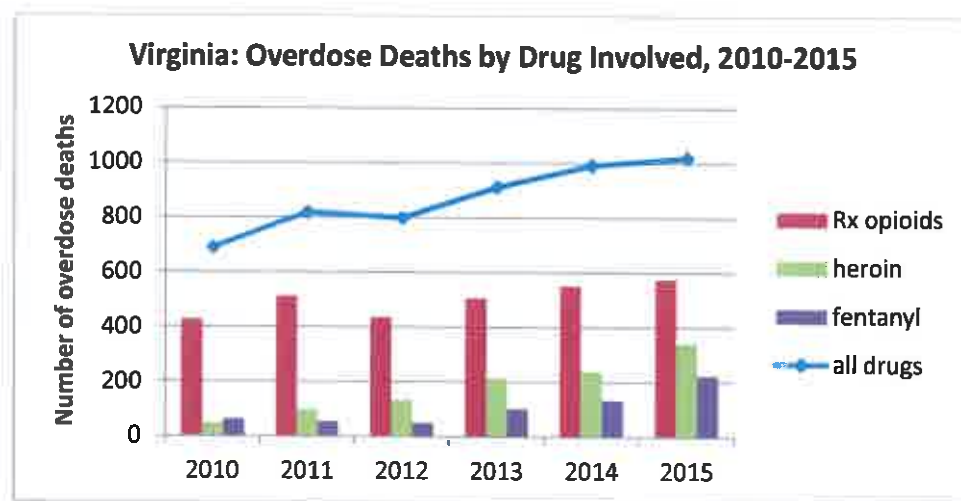
Virginia Department
of Health Professions

PBSS Prescription Behavior
Surveillance System

DRAFT Brandeis University, Waltham, MA

July 2016

PBSS Data Brief

Overdose Deaths and Prescription Risk Measures in Virginia

Summary: Drug overdose deaths in Virigina have increased from 2010 to 2015, driven in part by a rise in heroin and illicit fentanyl-related overdoses,[1] but with prescription opioids still the largest factor in opioid-related deaths (Figure 1). Analyses of patient risk measures associated with opioid misuse and abuse were conducted using Virginia prescription data reported to the Prescription Behavior Surveillance System (PBSS). Since 2010, the average daily dose of opioids in morphine milligram equivalents (MMEs) prescribed to Virginians has declined, as has the percentage of patients receiving over 100 MMEs daily (Figure 2). However, the percentage of those prescribed long-acting or extended-release opioids who were "opioid naïve" (had not been dispensed opioids in the past 60 days) has ranged between 34 and 41 percent between 2010 and 2015, and such prescriptions averaged 113 MMEs in 2015 (Figure 3). Overlapping prescriptions for opioids as a class and for benzodiazepines as a class declined somewhat from 2012 to 2015, but those for stimulants and for overlapping opioid and benzodiazepine prescriptions have remained level (Figure 4). As has been the case in previous years, prescription rates for opioids in 2015 were sharply higher for older age groups (Figure 5). These data suggest that although some progress has been made toward safer controlled substance prescribing in Virginia, more remains to be done to reduce medically uncessary opioid and benzodiazepine exposure, especially among older adults. Steps toward safer prescribing include increasing PDMP utilization by prescribers and pharmacists; providing prescriber feedback reports and use of data analytics to improve educational efforts

Figure 1. Overdose deaths in Virginia from all drugs, licit and illicit (blue line), have increased since 2010, with an increasing proportion involving heroin and fentanyl (most fentanyl found in overdose decedents is believed to be of illicit manufacture, thus non-prescription). Prescription opioids remain the most common category of opioids involved in overdose deaths.[2]

Source: Virginia Dept. of Health, Office of the Chief Medical Examiner.

Virginia's PDMP

Virginia's Prescription Drug Monitoring Program, housed in the Virginia Department of Health Professions, is one of 12 PDMPs currently participating in PBSS. For further information, please visit http://www.dhp.virginia.gov/dhp_programs/pmp/default.asp

About PBSS

The Prescription Behavior Surveillance System (PBSS) provides epidemiological analyses of de-identified data from state prescription drug monitoring programs to help target and evaluate interventions aimed at reducing prescription drug abuse and diversion. For further information, see the PBSS webpage at http://www.pdmpexcellence.org/.

Figure 2. The mean daily dosage of opioids in morphine milligram equivalents (MMEs[3]) declined in Virginia between 2010 (84.7 MME) and the first quarter of 2016 (64.7 MME), as did the percentage of patients receiving over 100 MME daily, from 13.5% to 7.9%. Being prescribed over 100 MME daily is considered a risk factor for opioid overdose and death.[4]
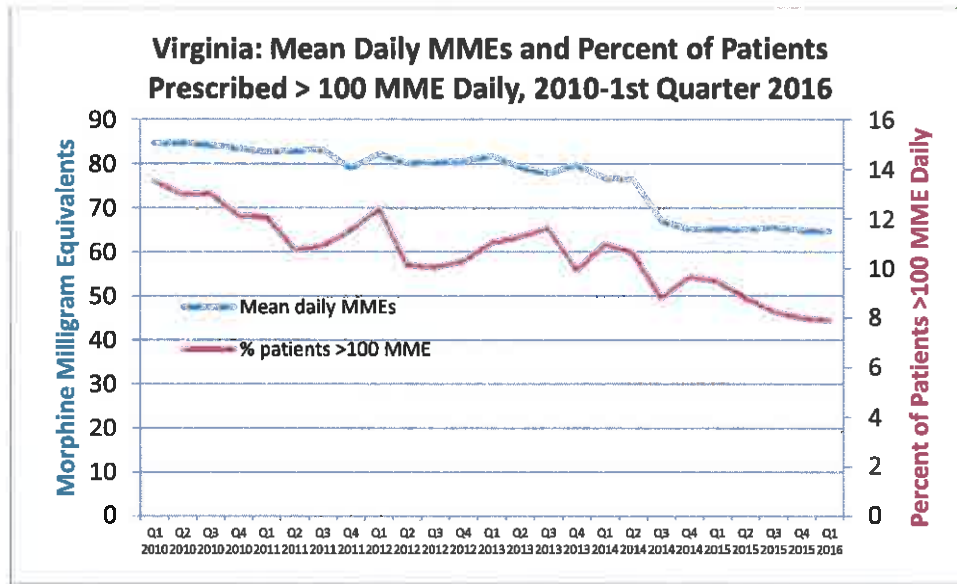

Figure 3. Of patients in Virginia that were prescribed long acting (LA) or extended release (ER) opioids from 2010-2015, between 34% (2013) and 41% (2011) were "opioid naïve" (had not been prescribed opioids in the prior 60 days) (blue bars). The daily dose in morphine milligram equivalents (MMEs) for LA/ER prescriptions (red line) declined from 131 MMEs in 2010 to 113 MMEs in 2015.[5]
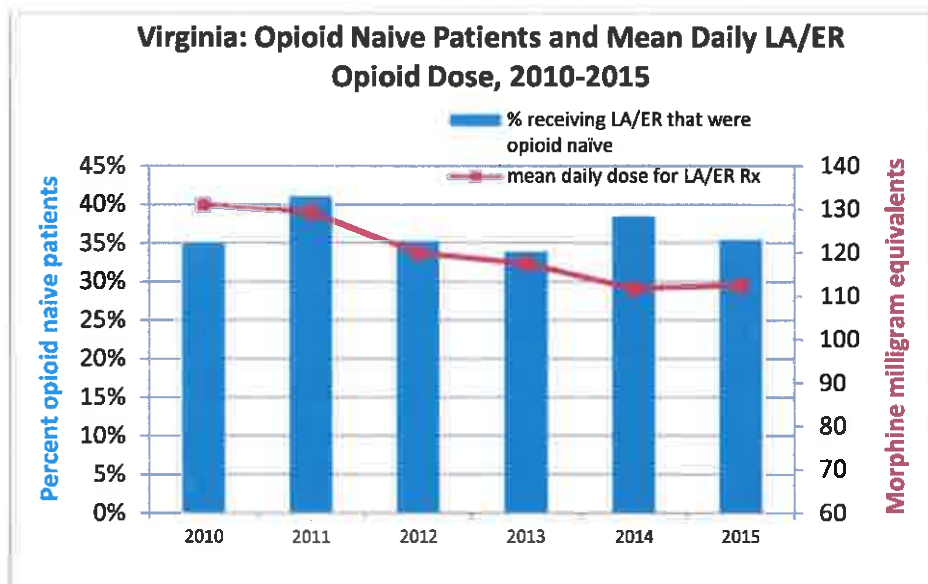
Figure 4. After increasing from 2010 to 2012, the percent of prescribed days with overlapping opioid prescriptions (blue line) and overlapping benzodiazepine prescriptions (purple line) decreased from 2012 to 2015. However, overlapping prescriptions for opioids and benzodiazepines (red line) and for stimulants (green line) remained nearly level after 2012.[6]

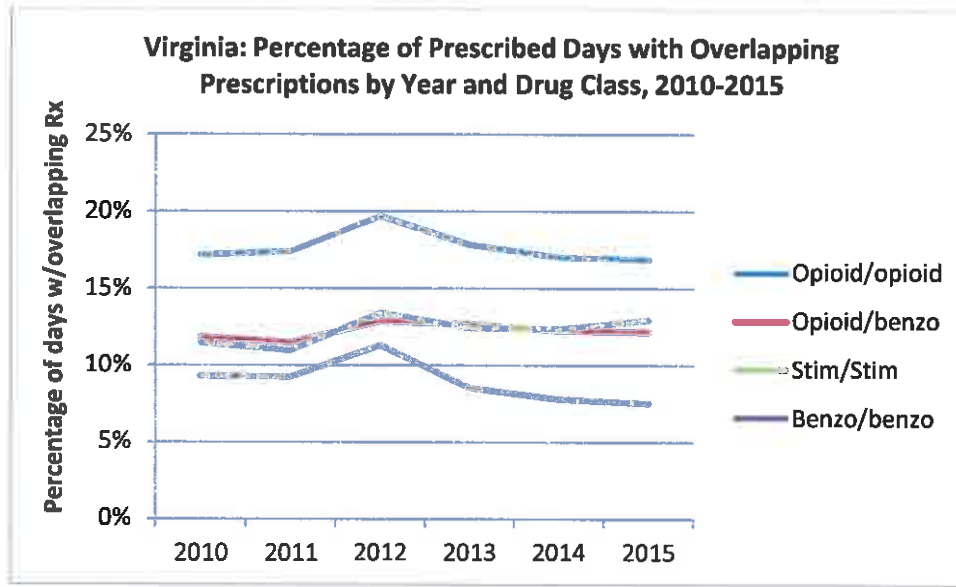**Figure 5**. Prescription rates for opioids in Virginia in 2015 increased sharply by age group, with those 65 and over receiving 1,495 opioid prescriptions per 1,000 population, over twice the rate for those aged 25 to 34 (687 per 1,000). Rates for benzodiazepines exhibited the same pattern, but at lower level, while rates for stimulants were highest for those younger than 18 and declined steadily for adults in older age groups. [7]
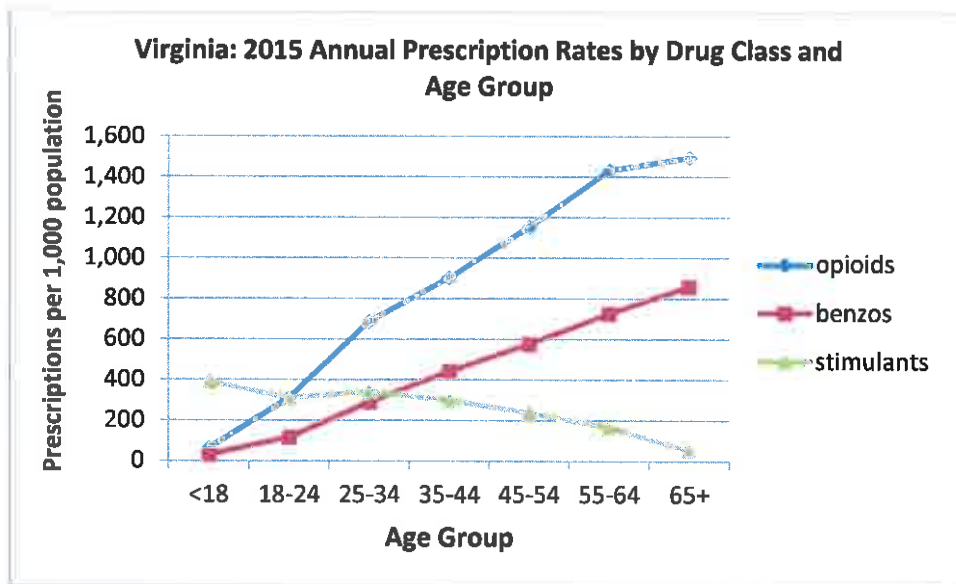
This Data Brief is a joint publication of PBSS, Brandeis University and the Virginia PDMP. It can be accessed online at ….

Endnotes

[1] See the CDC fact sheet on fentanyl overdoses at http://www.cdc.gov/drugoverdose/opioids/fentanyl.html, and the fact sheet on heroin overdoses at http://www.cdc.gov/drugoverdose/opioids/heroin.html.

[2] Virginia Dept. of Health, Office of the Chief Medical Examiner, Fatal Drug Overdose Quarterly Report, 1st Quarter, 2016.

[3] Daily morphine milligram equivalents (MMEs) is the daily dosage of morphine that would provide an equal amount of analgesia as the daily dosage of the opioid. Mean daily dosage is calculated for state residents in the PDMP that have an opioid prescription in a given quarter and refers to MMEs per day prescribed (total number of MMEs prescribed divided by the total number of prescription days). For definitions of PBSS measures, see http://www.pdmpexcellence.org/sites/all/pdfs/Definitions%20of%20PBSS%20Measures.pdf.

[4] Kate M. Dunn et al., "Opioid Prescriptions for Chronic Pain and Overdose," Annals of Internal Medicine, 152, no. 2, (2010):85-92, doi:10.7326/0003-4819-152-2-201001190-00006. http://www.ncbi.nlm.nih.gov/pubmed/20083827; Gwira Baumblatt et al., "High-risk use by patients prescribed opioids for pain and its role in overdose deaths," JAMA Internal Medicine, 174, no. 5 (2014):796-801 doi:10.1001/jamainternmed.2013.12711.

[5] Need cite on this as a risk factor.

[6] Need cite on overlapping RX as risk factor.

[7] Citation here on risks of opioid Rx to elders?

Average Number of Days Supply by Quarter Dispensed
Includes data from 2015, adults only, SOLs removed

	Opioids					Benzodiazepines				
	Total 2015	Q1 15	Q2 15	Q3 15	Q4 15	Total 2015	Q1 15	Q2 15	Q3 15	Q4 15
Number of Prescriptions Dispensed	6,905,262	1,718,203	1,736,685	1,735,611	1,714,763	3,375,833	831,103	841,294	851,685	851,751
Average Days Supply	16.7	16.6	16.7	16.7	16.9	27.4	27.4	27.4	27.3	27.5
Median Days Supply	14	13	14	14	15	30	30	30	30	30
Most Frequently Occurring Days Supply	30	30	30	30	30	30	30	30	30	30
Standard Deviation	13.5	13.4	13.5	13.5	13.5	16.0	16.0	16.1	15.9	16.0
Minimum	0	0	0	0	0	0	0	0	0	0
Maximum	703	703	572	572	600	930	365	930	365	903
Percentiles 10	3	3	3	3	3	8	8	8	8	8
20	4	4	4	4	3	15	15	15	15	15
25	5	5	5	5	4	20	20	20	20	20
30	5	5	5	5	5	20	20	20	20	20
40	8	8	8	8	8	30	30	30	30	30
50	14	13	14	14	15	30	30	30	30	30
60	22	20	22	22	23	30	30	30	30	30
70	30	30	30	30	30	30	30	30	30	30
75	30	30	30	30	30	30	30	30	30	30
80	30	30	30	30	30	30	30	30	30	30
90	30	30	30	30	30	30	30	30	30	30

Technical Note: Data is derived from the most recent version of each quarter. (Q1 v5, Q2 v5, Q3 v3 and Q4 v2)

Percent of Patients with More Combination Drugs Prescribed Within a Quarter

Includes data from 2015
adults only, SOLs removed

Number of Patients with an Opioid Prescription and a...

	Total Number of Opioid Prescriptions	Benzodiazepine	Percent with a Benzo	Sedative	Percent with a Sedative	Stimulant	Percent with a Stimulant	Muscle Relaxant	Percent with a Muscle Relaxant
Q1 2015	957180	167238	17.5%	45289	5%	29455	3.1%	7751	0.8%
Q2 2015	922028	164963	17.9%	43800	5%	30275	3.3%	7203	0.8%
Q3 2015	838972	161286	19.2%	43048	5%	30448	3.6%	6735	0.8%
Q4 2015	827931	159618	19.3%	42598	5%	30129	3.6%	6522	0.8%

Number of Patients with an Opioid Prescription and a...

	Total Number of Opioid Prescriptions	Benzodiazepine & Stimulant	Percent with a Benzo & Stimulant	Benzo & Sedative	Percent with a Benzo & Sedative	Benzo & Muscle Relaxant (Trifecta)	Percent with a "Trifecta"	Benzo, Stimulant & Sedative	Percent with a Benzo, Stimulant & Sedative
Q1 2015	957180	10601	1.1%	16972	1.8%	3402	0.36%	1626	0.17%
Q2 2015	922028	11256	1.2%	16766	1.8%	3223	0.35%	1712	0.19%
Q3 2015	838972	11781	1.4%	16888	2.0%	3060	0.36%	1909	0.23%
Q4 2015	827931	11797	1.4%	16747	2.0%	3009	0.36%	1855	0.22%

VA PMP opiate prescription writing, dispensing and receiving by HPD

Includes data from 2015, adults only, SOLs removed, drug type is an opioid

Number of filled prescriptions by HPD using the Prescriber's zip code, Pharmacy's zip code and Recipient's zip code.

Dispensed in 2015	Adult Population	Prescribers	Prescribing Rate	Pharmacy Dispensed Scripts	Pharmacy Dispensing Rate	Recipients	Recipients Receiving Rate
Accomack-Northampton	35,812	29,509	824	39,462	1,102	42,622	1,190
Central Shenandoah	235,933	255,122	1,081	275,926	1,170	276,055	1,170
Central Virginia	250,914	218,255	870	223,848	892	248,351	990
Crater	136,580	118,848	870	161,909	1,185	186,556	1,366
Cumberland Plateau	88,635	128,476	1,449	224,157	2,529	225,508	2,544
Fifth	220,174	447,150	2,031	381,917	1,735	322,340	1,464
Hampton Roads	1,285,203	1,406,478	1,094	1,346,259	1,048	1,342,884	1,045
Lenowisco	73,343	156,836	2,138	223,878	3,052	208,165	2,838
Lord Fairfax	178,623	170,085	952	222,915	1,248	229,448	1,285
Middle Peninsula	72,997	44,662	612	89,371	1,224	111,007	1,521
Mount Rogers	153,667	218,901	1,425	296,010	1,926	279,103	1,816
New River Valley	150,704	156,892	1,041	189,505	1,257	188,569	1,251
Northern Neck	41,314	25,315	613	36,201	876	52,963	1,282
Northern Virginia	1,928,825	1,026,889	532	1,052,008	545	992,982	515
Piedmont	83,039	46,823	564	66,164	797	92,968	1,120
Radco	160,190	262,745	1,640	266,151	1,661	294,135	1,836
Rapid	132,389	93,315	705	138,952	1,050	176,474	1,333
Richmond Regional	816,719	1,013,443	1,241	957,184	1,172	823,114	1,008
Southside	66,703	56,311	844	70,934	1,063	78,910	1,183
Thomas Jefferson	195,201	243,077	1,245	171,521	879	185,868	952
West Piedmont	150,209	198,607	1,322	249,114	1,658	285,285	1,899
Total	6,457,174	6,317,739	978	6,683,386	1,035	6,643,307	1,029