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

Tuesday June 10, 2008

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

CALL TO ORDER: A meeting of the advisory panel of the Prescription Monitoring Program was called to order at 11:15 a.m.

PRESIDING: Kenneth Walker, M.D, Chairman

MEMBERS PRESENT: Randall Clouse, Office of the Attorney General, Medicaid Fraud Unit
Amy Tharp, M.D., Office of the Chief Medical Examiner
Brenda Mitchell, President, Virginia Association for Hospices
Mellie Randall, Department of Mental Health, Mental Retardation, and Substance Abuse Services for James Evans, M.D.,
Holly Morris, RPh, Crittenden's Drug
Harvey Smith, 1SG, Virginia State Police

MEMBERS ABSENT: John Barsanti, M.D., Commonwealth Pain Specialists

STAFF PRESENT: Sandra Ryals, Director, Department of Health Professions (DHP)
Emily Wingfield, Chief Deputy Director, DHP
Betty Jolly, Director for Policy Education, DHP
Howard Casway, Senior Assistant Attorney General
Scotti Russell, Executive Director, Board of Pharmacy
Dr. William Harp, Executive Director, Board of Medicine
Ralph A. Orr, Program Manager, Prescription Monitoring Program

INTRODUCTIONS: Ms. Ryals welcomed the committee and thanked Dr. Walker and Dr. Tharp for agreeing to continue serving on the committee for another 4 years. Ms. Ryals announced that Virginia has again been rated as a best managed state for performance management, increasing expectations, including expectations for the Prescription Monitoring Program (PMP). Ms. Ryals discussed organizational changes for the program announcing that the program now falls under the direct supervision of Emily Wingfield, Chief Deputy Director for DHP.

PUBLIC COMMENT: No comments were received.

ELECTION OF CHAIRMAN AND VICE-CHAIRMAN: By unanimous consent, Dr. Kenneth Walker was re-elected as Chairman. Randall Clouse was re-elected as Vice-Chairman.

PROGRAM MANAGER UPDATE: Data and Marketing #1. 2006 National Survey on Drug Use and Health data (Attachment 1) shows past year initiates for nonmedical use of pain relievers exceeded those for marijuana. Youth are abusing pharmaceutical drugs from medicine cabinets, prompting a major media campaign by the Office of National Drug Control Policy and the issuance of guidelines on

disposal of prescriptions drugs (Attachment 2)

#2. PMP records are added to the database at approximately one million records a month. Requests continue to rise with over 17000 requests this year to date compared to just over 22000 requests in 2007. However, the number of registered users still remains below targets with just over 1200 prescribers and 400 pharmacists registered to use the program. Various ways to improve utilization of the program were discussed by the Panel including differentiating between different types of users, one benefit of which would be to allow for more direct marketing of associations and boards.

#3. PMP "unsolicited" reports are increasing due to an increase in the number of patients being identified using the criteria search. The increase is similar to an increase seen in the same time period in 2007. The March reports generated over 800 letters on 135 patients being sent to prescribers and preliminary data for Aprils shows over 1000 letters for 164 patients. A certain percentage of these letters are returned because of bad addresses in the DEA database used to identify the prescriber. The Panel asked about a program move to the National Provider Identifier (NPI) to identify the prescriber or if a crosswalk between the information in the DHP's licensing system and DEA could be developed. Mr. Casway asked if it was time to consider mandatory registration for the PMP by prescribers and pharmacists.

#4. Online Chronic Nonmalignant Pain Management Course was reviewed. This e-learning CEU opportunity, a partnership with VCU, has been the subject of a number of national presentations.

#5. Educational activities the program has participated in include a one-day seminar in Norfolk sponsored by Sentara Optima Health which was attended by over 160 practitioners and a trip to southwest Virginia in conjunction with Project Remote that reached well over 100 participants including pharmacy students and interns and residents. Responsible Opioid Prescribing was mailed to over 19000 physicians in Virginia in early May. The books were donated to DHP by the Federation of State Medical Boards and sent to these prescribers using federal funds for the PMP. The PMP received a surge in registrations in the weeks immediately following the mailing of the books. The letter that accompanied the book also highlighted the state resources available to them such as the PMP and the online Chronic Nonmalignant Pain Management Course.

#6. The Program Director called on Ms. Jolly who reviewed the marketing plan being designed with the Virginia Office of Graphic Communication in the Department of General Services. Products include brochures for the PMP and the online Chronic Nonmalignant Pain Management Course, certificates for registered users of the PMP, PowerPoint templates and other communication tools. A fall conference in northern Virginia in conjunction with INOVA Health System with a November target date is planned.

PROGRAM MANAGER UPDATE: Planned System Improvements

#6. PMP database to Virginia Information Technology Agency's (VITA) Chesterfield centralized computer facility is in the works, the reason for the move is the current servers the PMP is operating on are no longer sufficient for the needs of the program with over a million records being added each month and over 24 million records already in the database. Additionally, the program has been approached by representatives of Portsmouth Naval Hospital and surrounding military treatment facilities about the possibility of sending prescription data to the PMP. This will require additional data storage space. Ms. Ryals explained that all state agencies are in the process of moving computer systems to the Chesterfield centralized facility but the need to enhance the PMP moves it up on the schedule.

Ms. Ryals also announced that approval for the purchase of PowerSearch software had just been received. This software will give the program the capability to provide 24/7 access to the database. The upgrade will make this crucial information for making informed treatment decisions on prescribing controlled substances available to those prescribers working in Emergency Departments, pharmacists working in 24 hour pharmacies or any provider needing fast and reliable prescription history on their patients. Enhancements will include a new report format to help identify prescriber and pharmacy names and address easier; request status can be reworded to be more user friendly and some users will be able to determine whether they would like their reports in pdf or Excel format which will be very useful for law enforcement and regulatory personnel.

PROGRAM MANAGER UPDATE: Review Legislative Proposals

#7. Data from DEA shows that several of our bordering states are very high on the list for several drugs of concern in Virginia. Additionally, news reports seem to show that people are routinely crossing borders to obtain controlled substances fraudulently and return with those drugs to Virginia. Currently, if a prescriber in Kentucky would like to receive PMP information from Kentucky and Virginia, he would have to register with both programs and submit 2 separate requests which are very time consuming. This is promoting an effort for state PMPs to become "interoperable". The centerpiece of this project will be the creation of a "data hub" that would route requests for information to the appropriate PMP program for processing and then route the completed reports back to the originating program. For example, a prescriber would access the Virginia PMP portal to make a request for information on a patient. Since the patient lives in extreme southwest Virginia, the prescriber would like PMP information from Kentucky, Tennessee, and North Carolina and would check those boxes. The request is sent to the Virginia program and then forwarded to the "data hub" for further routing to each selected states' PMPs. Based on a Memorandum of Agreement or other mechanism between each state, the request is processed and returned to the "data hub" to the originating program and then back to the requestor. This "data hub" is in its infancy with a pilot of the technology slated to take place this year between Kentucky and Ohio PMPs. The current consent

requirement for prescribers to use the Virginia program would be a roadblock for optimal utilization of an interoperability project if authorized by legislation. Ms. Russell asked if this would require a change in the current reporting format used by pharmacies to report dispensing data to the program. Mr. Orr stated that according to information obtained from members of the working group a change to a format other than ASAP 95 would not be required to participate in the "data hub" project. If, in the future, a change to a newer format is required, it would fall under the regulatory process as prescribed by law.

The current effort with unsolicited reports appears to meet the goal for which the reports were authorized originally. Most of the patients that are identified by the criteria do not show back up on the list for further mailings. It appears that in these cases the prescribers are intervening; the patients are ceasing the behavior that caused them to show up on the list. However, there are some patients that continually show up on the list month after month no matter how many prescriber letters and reports have been sent. These patients continue to find new prescribers for controlled substances. The Panel was polled to determine if sending unsolicited reports to current authorized law enforcement agents of the State Police would be recommended. Mr. Clouse remarked that it may also be worthwhile to send this information to Virginia's Medicaid program for possible fraud investigation. It was suggested this merited a follow up.

The committee was also asked if it would recommend changing the requirement for a prescriber to have consent to the prescriber providing notification similar to what pharmacies currently do now. Ms. Morris stated that there is confusion as to what type and how much communication can take place between health care professions that have received a PMP report. Mr. Orr pointed out that the current brochure does provide information as to what a prescriber can disclose or discuss with another provider including a pharmacist and vice versa. However, it is not permissible to send or share actual copies of the PMP report with other health care professionals. An unforeseen issue with the current regulation for access to the program by pharmacist in other states exists. The regulation allows access for pharmacists outside Virginia that have a current active Non-resident Pharmacy permit with the Virginia Board of Pharmacy. The problem is that there are many pharmacies that are near the border with Virginia that really have no need to have a Virginia Non-resident Pharmacy permit. The law would seem to allow access to a dispenser such as these pharmacies but the regulation prevents that access. The Panel suggested that changing the registration for access from a pharmacist to the pharmacy and using the pharmacy's DEA registration number similar to what is required for prescribers would solve this problem.

Committee recommendations as a result of Panel discussions on increasing usage of PMP:

-Establish mandatory registration for prescribers.

-Adopt language to allow the program to enter into interoperability agreements with other state PMPs.

-Remove specific consent requirement for prescribers. Change to notification requirement identical to what pharmacies provide now.

-Explore possible language to clarify allowed health-care professional communication in reference to PMP reports

-Explore regulatory relief to allow pharmacies outside Virginia to have access to the PMP without requiring a Non-resident Pharmacy permit from the Board of Pharmacy

NEXT MEETING: The next meeting date was not determined at this time.

ADJOURN: With all business concluded, the committee adjourned at 2:30 pm.

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Kenneth Walker, M.D, Chairman

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Ralph A. Orr, Program Manager

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ATTACHMENT 1

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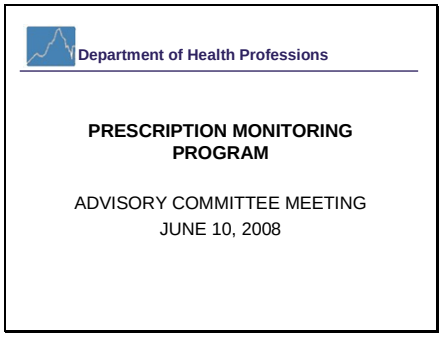

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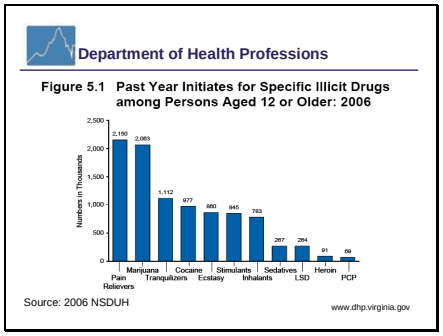

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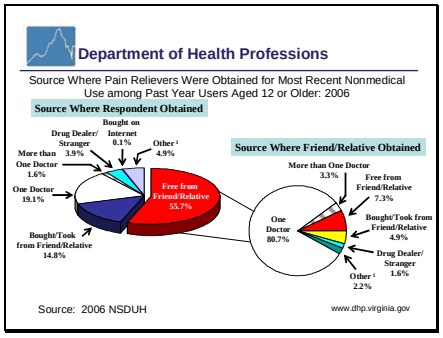

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Department of Health Professions

Risk Management Tool

Protection for the patient

– provides the practitioner with information needed to make informed decisions about prescribing

Protection for the practitioner

– Provides an alert for possible abuse, misuse, or diversion that can protect against "duping" that can lead to disciplinary action or prosecution

www.dhp.virginia.gov

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Department of Health Professions

ACCESS TO OTHER PROGRAMS

- West Virginia: https://65.78.228.163
- Kentucky: https://ekasper.chfs.ky.gov/accessrequest
  - www.chfs.ky.gov/kasper
- Tennessee: https://prescriptionmonitoring.state.tn.us
- North Carolina

http://www.ncdhhs.gov/mhddsas/controledsubstance/index.htm

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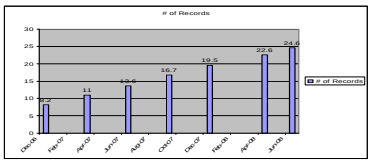
Department of Health Professions

PROGRAM UPDATE
Prescriptions in Database



(in Millions)

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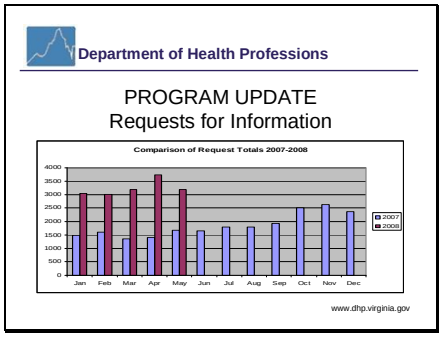

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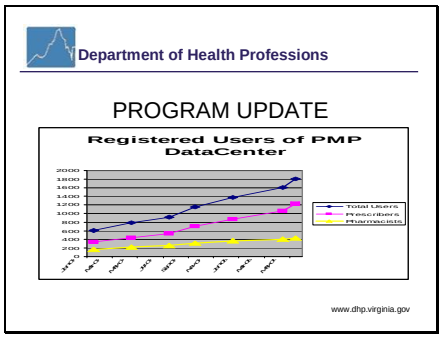

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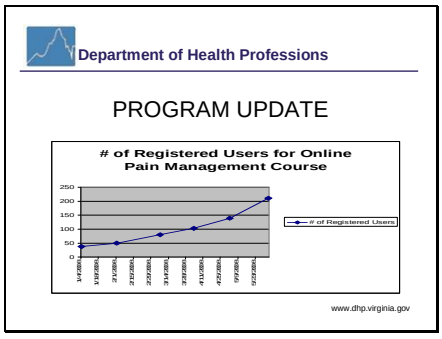

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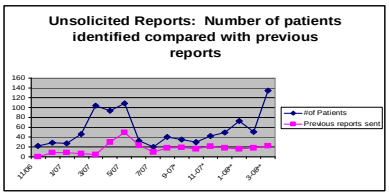
Department of Health Professions

PROGRAM UPDATE:



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Department of Health Professions

THE NEED FOR PAIN MANAGEMENT EDUCATION

- Managing Pain is challenging
  - Spans professions and specialties
  - Variation in chronic pain syndromes
  - Limited evidence-based guidelines
  - Limited provider training
  - Provider fears of legal ramifications

Upshur et al 2006; Chen et al 2006; Adams et al 2001

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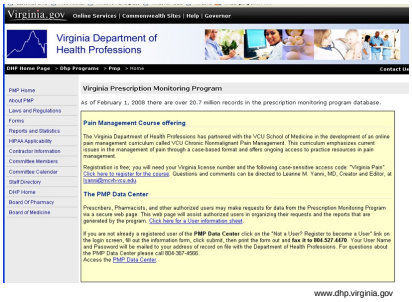

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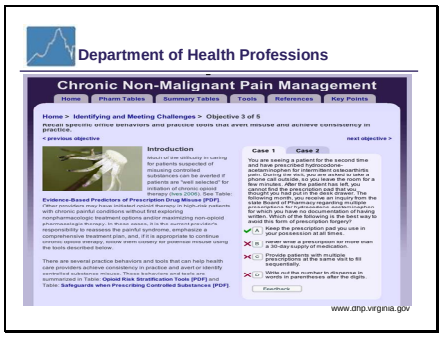

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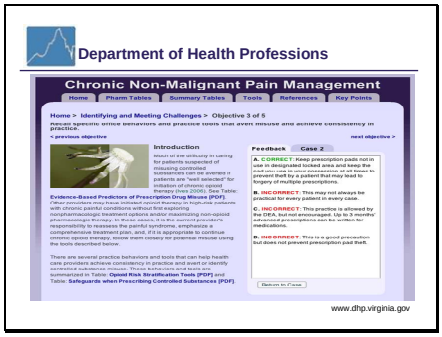

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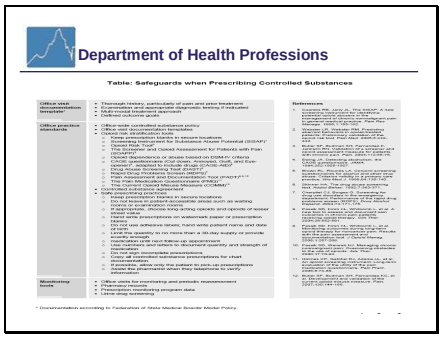

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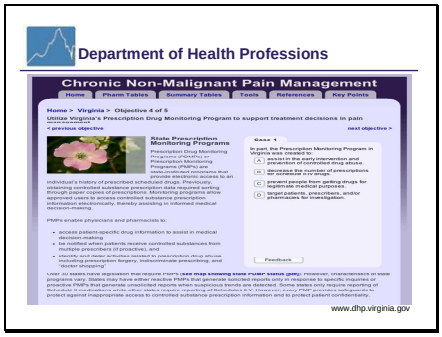

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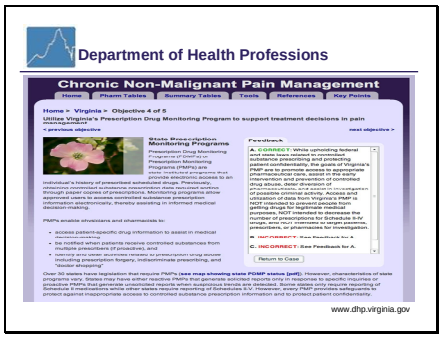

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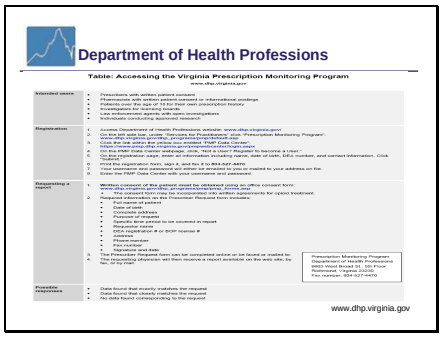

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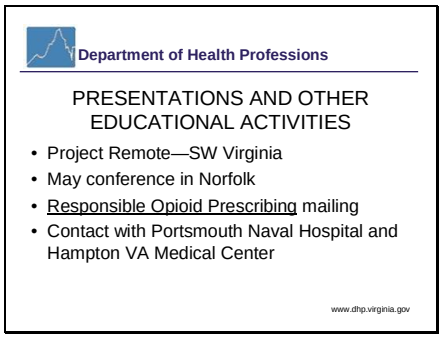

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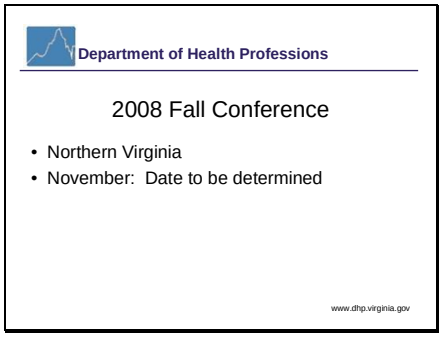

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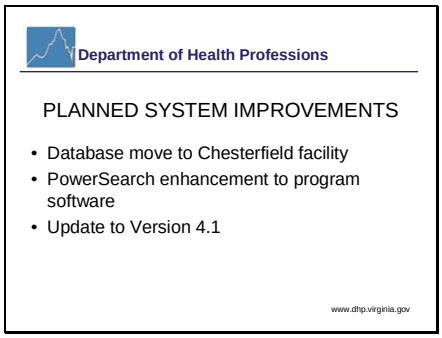

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ATTACHMENT 2

Proper Disposal of Prescription Drugs

Federal Guidelines:

Take unused, unneeded, or expired prescription drugs out of their original containers and throw them in the trash.

Mixing prescription drugs with an undesirable substance, such as used coffeegrounds or kitty litter, and putting them in impermeable, non-descript containers, such as empty cans or sealable bags; will further ensure the drugs are not diverted.

Flush prescription drugs down the toilet *only* if the label or accompanying patient information specifically instructs doing so (see box).

Take advantage of community pharmaceutical take-back programs that allow the public to bring unused drugs to a central location for proper disposal. Some communities have pharmaceutical take-back programs or community solid-waste programs that allow the public to bring unused drugs to a central location for proper disposal. Where these exist, they are a good way to dispose of unused pharmaceuticals.

The FDA advises that the following drugs be flushed down the toilet instead of thrown in the trash: **Actiq** (fentanyl citrate)**Daytrana Transdermal Patch** (methylphenidate)**Duragesic Transdermal System** (fentanyl)**OxyContin Tablets** (oxycodone)**Avinza Capsules** (morphine sulfate)**Baraclude Tablets** (entecavir)**Reyataz Capsules** (atazanavir sulfate)**Tequin Tablets** (gatifloxacin)**Zerit for Oral Solution** (stavudine)**Meperidine HCl TabletsPercocet** (Oxycodone and Acetaminophen)**Xyrem** (Sodium Oxybate)**Fentora** (fentanyl buccal tablet)Note: Patients should always refer to printed material accompanying their medication for specific instructions.

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www.WhiteHouseDrugPolicy.gov