Final/Approved

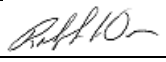
VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS
VIRGINIA PRESCRIPTION MONITORING PROGRAM
MINUTES OF ADVISORY COMMITTEE

Monday, July 18, 2015 — 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233-1463

CALL TO ORDER:	A meeting of the special advisory panel of the Prescription Monitoring Program was called to order at 2:05 p.m.
PRESIDING	Ralph Orr, Director, Prescription Monitoring Program
MEMBERS PRESENT:	Lori Conklin, M.D., Board Member, Board of Medicine David Taminger, M.D., Board Member, Board of Medicine Ryan Logan, Board Member, Board of Pharmacy Jody Allen, Board Member, Board of Pharmacy
MEMBERS ABSENT:	None
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 William L. Harp, M.D., Executive Director, Board of Medicine Caroline Juran, Executive Director, Board of Pharmacy Ralph A. Orr, Program Director, Prescription Monitoring Program Carolyn McKann, Deputy Director, Prescription Monitoring Program
WELCOME AND INTRODUCTIONS/READING OF EVACUATION SCRIPT	Mr. Orr welcomed everyone to the meeting of the advisory panel.
APPROVAL OF AGENDA	The agenda was approved as presented.
PUBLIC COMMENT:	No public comments were made.
DISCUSSION OF BACKGROUND MATERIAL: Ralph Orr, Director, Prescription Monitoring Program	Mr. Orr presented HB657 to the group. This new legislation directs the Director of DHP to develop, in consultation with an advisory panel, criteria for indicators of unusual patterns of prescribing or dispensing and based on analysis of data collected by the Prescription Monitoring Program; may disclose this information to the DHP enforcement division for investigation. Mr. Orr explained that once threshold criteria are set the Virginia PMP will send reports to the Enforcement

	Division for investigation. The Enforcement Division upon investigation may determine possible criminal activity and may forward to law enforcement for investigation under existing processes. Mr. Orr directed the panel's attention to pages 11 -15 of the PDMP Center of Excellence at Brandeis University publication entitled "Options for Unsolicited Reporting." The report summarizes the experience of several states with respect to unsolicited reporting. -Kentucky's PMP, KASPER, has forwarded 80 investigations to their licensing boards since the Fall of 2012. KASPER runs prescription history reports on the top prescribers of the most commonly diverted controlled substances which are then reviewed by investigators in the Inspector General's office for possible further investigation. -In North Carolina, staff examines daily doses exceeding 100 MME, co-prescribing of opiates and benzodiazepines, overlapping or redundant prescriptions, etc. -In Texas, the PMP is currently within the Department of Public Safety and generates about 20-25 prescription drug cases each month. -In New Jersey, staff conducts database searches based on select criteria. Cases are forwarded to law enforcement first, then to the appropriate licensing board. -In Tennessee the law requires PMP staff to identify, generate and send letters to the top 50 prescribes annually. Prescribers who receive these letters must respond and explain their prescribing to their respective licensing board. Mr. Orr discussed the outcome of a study where prescribers were asked, "how many patients on your panel are you prescribing opioids to?" The great majority of prescribers underestimated the number of patients receiving opioids. In light of this and other data, in conjunction with providing unsolicited reports to the Enforcement Division the PMP is planning to begin providing prescriber "feedback" reports as an educational effort to inform prescribers of their prescribing practices. Arizona has already begun to distribute these "feedback reports" to prescribers, starting with two counties and now expanding statewide. Response from prescribers has been positive. The Virginia Department of Health (VDH) has received a grant from the CDC to look at the process of sending report cards. Mr. Orr noted that the Virginia PMP currently has a lack of information regarding prescriber specialty, but a proposed regulation has been published to add the NPI code as a required data element, which will allow the PMP to determine the provider specialty which is crucial in

	providing these feedback reports.
NORTH CAROLINA EXPERIENCE: (UNC Injury Prevention Research Center):	Mr. Orr then directed the Panel's attention to the webinar slide deck explaining North Carolina's experience with developing unsolicited report criteria for the Board of Medicine. Mr. Orr pointed out that the document noted that currently most inappropriate prescribing is detected through the complaint process. The slide deck contained information on challenges confronted with use of PMP data to detect inappropriate prescribing. Candidates for metrics include rates of prescribing, MME dose, rates of co-prescribed benzodiazepines and opioids and other data points.
ASSORTED PMP DATA:	Dr. Conklin asked what our goal is. Is it to reduce deaths? Mr. Orr noted that about 4/5 of patients with heroin overdoses began their abuse with prescription opioids and while one goal is reduce deaths, ideally prevention of the misuse, abuse, and diversion of controlled substances is the primary goal. Mr. Orr directed the advisory panel to the PBSS tables, and noted the disturbing fact that over 21% of patients receiving a prescription for a LA/ER opiate (in the past quarter) did not had an opiate prescription in the last 60 days implying non-use of the PMP. Mr. Orr also pointed out Virginia's average PMP query rate of 9%. He also noted that a 9% query rate is reflective of a state with a PMP that has absolutely no query mandate. Dr. Conklin pointed out that overdoses seem to always involve a combination of several drugs. Dr. Taminger asked about our current thresholds for recipients exhibiting doctor-shopping behavior and whether we could lower them, and Mr. Orr said thresholds may be changed if desired. Virginia is currently interoperable with 19 states, and sixty-two pharmacies in Virginia have integrated PMP data into their daily workflow utilizing NarxCheck.
DRAFT RECOMMENDATIONS:	The group discussed possibly running a report on any patient with a daily MME over 1,000 to start. Ms. Allen noted that 1000 seems pretty high, perhaps we should go lower? Dr. Brown suggested a MME of 500 and only one prescriber. Mr. Orr noted that 7.9% of patients in the PMP database in the last quarter had an MME of 100 or more. This is a significant number of patients. The group discussed that method of payment (cash) may also be instructional. Dr. Conklin recommended looking those patients with a combination of benzodiazepines and opiates.

	Mr. Orr was asked to obtain more information about KASPER's threshold that resulted in 80 annual investigations. Dr. Harp noted that REMS guidelines states that prescribers should always start patients with short-acting opiates. The group then discussed criteria for dispensers. Group members discussed looking dispensers with prescriptions paid for predominantly in cash compared to peers may be a good indicator of egregious dispensing. Ms. Allen asked when the committee's report is due, and Dr. Brown noted that the law allowing us to develop the criteria passed on July 1, 2016, and all agreed that development of specific guidelines sooner than later would be optimal. He also noted that it is important that thresholds be set in such a manner so a report may be easily recognized as an outlier. The committee requested additional information before making a recommendation. The PMP Advisory Committee is scheduled for September 14, 2016, and Mr. Orr noted that this special Advisory Panel would probably not be ready to meet prior to the Advisory Committee's next meeting.
NEXT MEETING	The next meeting is yet to be determined.
ADJOURN:	With all business concluded, the committee adjourned at 4:15 p.m.
	
	Ralph A. Orr, Director