

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

Tuesday, September 21, 2010

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

CALL TO ORDER: A meeting of the advisory panel of the Prescription Monitoring Program was called to order at 10:17 a.m.

PRESIDING Kenneth Walker, M.D., Chair

MEMBERS PRESENT: Carola Bruffat, Family Nurse Practitioner
Randall Clouse, Office of the Attorney General, Medicaid Fraud Unit, Vice Chair
Brenda Mitchell, President, Virginia Association for Hospices
Holly Morris, RPh, Crittenden's Drug
Harvey Smith, ISG, Virginia State Police
Mellie Randall, Representative, Department of Behavioral Health and Developmental Services
Amy Tharp, M.D., Office of the Chief Medical Examiner

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

STAFF PRESENT: Arne Owens, Chief Deputy Director, Department of Health Professions
Diane Powers, Director of Communications, Department of Health Professions
Caroline Juran, Acting Executive Director, Board of Pharmacy
Dick Nicula, Database Administrator, Data Processing
Elaine Yeatts, Senior Policy Analyst
Ralph A. Orr, Program Director, Prescription Monitoring Program
Carolyn McKann, Deputy Director, Prescription Monitoring Program

WELCOME AND INTRODUCTIONS: Dr. Walker welcomed everyone to the meeting of the advisory panel.

PUBLIC COMMENT: No public comments were made.

APPROVAL OF AGENDA: The agenda was approved as presented.

APPROVAL OF MINUTES: The Panel reviewed draft minutes for the July 13, 2010 meeting. The minutes were approved as presented.

**DEPARTMENT OF
HEALTH
PROFESSIONS
REPORT:**

Mr. Owens stated that he was presenting the Department of Health Professions (DHP) report on behalf of Dianne Reynolds-Cane, M.D. Mr. Owens indicated that he has oversight for the VPMP and that he enjoys working with the program as the issue of prescription drug abuse has long been a professional interest.

Mr. Owens mentioned National Take-Back Day to be held this Saturday, September 25, 2010. He stated that Diane Powers and Ralph Orr have been working to promote this program as DHP is the lead agency for the Health and Human Resources Secretariat on this issue. A press release from the Governor on this topic was disseminated on Monday, September 20, 2010.

Mr. Owens referenced the Virginia Health Reform Initiative put forward by the Governor. The intent of the Secretariat at Health and Human Resources is that DHP will move forward to implement the Health Reform Act as some aspects of the reform legislation are already activated.

**DICK NICULA: Brief
Overview of DHP IT
support functions and
production of data reports
for the VPMP:**

Dick Nicula introduced himself and explained that he and a staff of twelve people provide support for all DHP IT applications to include the VPMP application. Mr. Nicula described the VPMP database as an off-the shelf application that has had two major releases since 2006. The first release was housed locally at DHP and the second release is hosted at the Northrop Grumman (NG) data center in Chesterfield County.

Mr. Nicula indicated that for each release there are several pre-release activities which must take place. First, staff must obtain specifications for hardware. Data staff received a great deal of input during the development of the program regarding network infrastructure and security requirements. Once the parameters are established, staff builds the production environment and does the installation work. Mr. Nicula described the VPMP as composed of three parts: 1) the manager component, which is the administrator interface, 2) the Web Center component, which is the user interface and 3) the data component which is the database itself. Once the system infrastructure is built, there is a test phase of all processes and components, also known as the user acceptance phase. During the user acceptance phase, data staff works (with input from VPMP staff) with Optimum Technology staff to tweak any deficiencies or shortcomings in the functionality. Data staff further works with Optimum to schedule the release of the final product.

Once the system is “live”, Optimum performs the collection of data from dispensers and downloads files to a secure FTP site from which data staff retrieve the file and uploads the data. Data staff performs database maintenance on all DHP applications to include rebuilding of indexes and back up of files. Data is also the team that applies patches to the system and performs

occasional data updates on prescription files. Furthermore, staff develops requested ad hoc reports from the data files. Data also performs maintenance on the PMP website that is used by registered users. Data coordinates all applications with NG. The services NG provides include providing and securing the network and building the servers.

There was a short discussion centered on the ability to pay for NG services such as storage and backup of data. The \$20 million trust held for the VPMP is the primary funding source for the program; which by terms of the trust may only utilize interest to operate the VPMP program. Mr. Owens noted that currently the Federal fund rate is near zero, and there is some concern that current low interest rates will not provide enough interest to provide the necessary funding the VPMP will need in the future. Mr. Clouse noted that if necessary, a court order could allow the VPMP to use part of the \$20 Million fund, not just the interest earned. Mr. Owens noted that the VPMP is on budget but funding revenue will have to be closely watched in order to meet future obligations.

COMMUNICATIONS

DIRECTOR: Program Marketing and Education Plan Update

Ms. Powers informed the committee that staff is currently in the process of carrying out the initiatives that were discussed during the last Advisory Committee meeting. Ms. Powers noted that going forward, the program shall be known as the “Virginia Prescription Monitoring Program”, or “VPMP” rather than just PMP in order to distinguish Virginia’s program from other programs.

Ms. Powers and Mr. Orr are coordinating an effort to develop better imagery to support the VPMP marketing effort. Both Ms. Powers and Mr. Orr have been coordinating with another state agency, the Office of Graphic Communication to develop the VPMP brand. The parties have decided to incorporate what Ms. Powers calls the “heartbeat line” coupled with the blue DHP color and a bright purple to be the VPMP logo. Ms. Powers indicated that the logo can be reduced small enough and legible enough to fit on a thumb drive, which the committee had agreed would be an appropriate marketing tool to distribute during specific educational events. Ms. Powers reminded the committee that we had previously discussed including VPMP content on the thumb drive which could be viewed by the end user. Ms. Powers asked the committee members to provide feedback on the logo.

Ms Powers stated that one of the big projects coming up in October within DHP is the orientation of new Board members. Ms. Powers solicited feedback from the committee members for one or two items that VPMP should share with new board members about the program. The new board members are composed of a group of approximately 60 people from multiple disciplines.

Ms. Powers also noted that Dr. Cane is extremely interested in the DEA initiative entitled National Take-Back Day. This event has generated news releases and informational documents that relate directly to the mission of VPMP. Additionally, DHP has leveraged its web site to help promote the message of the National Take-Back Initiative. Ms. Powers reminded advisory committee members to let us know about any other initiatives that relate to the issues of prescription drug abuse. With respect to the take-back initiative, First Sergeant Smith indicated that data collected by the Drug Enforcement Administration (DEA) regarding the collections will simply by a pound total. DEA will not differentiate, for example, between narcotics collected and antibiotics collected. The Virginia State Police is supplying empty boxes to collect the medications, both prescription and over-the-counter. Ms. Morris suggested more convenient rural sites, perhaps drop-off sites at pharmacies. Dr. Amy Tharp suggested that the take-back initiative not utilize drop sites at elementary schools, fearing that the security of the medications may be compromised. Ms. Morris stated the DEA initiative is definitely a step in the right direction. Dr. Walker concurred, stating that this first annual event will provide a baseline from which to make improvements.

RALPH ORR:
PROGRAM UPDATE:
New Version of Program
Software

Mr. Orr stated that the VPMP has purchased the software licenses for the new version of the software and the module that provides for interoperability between state programs. Mr. Orr explained that VPMP currently has a partial hosting solution with Optimum Technology. Optimum collects all data at a separate web site; DHP data staff then uploads the data to the VPMP database. Currently, VPMP is researching the possibility of converting to a full hosting solution where Optimum Technology would house the entire application at their secure site in Ohio. This option may provide substantial cost savings as VPMP would not be required to pay data storage and backup fees to VITA. Mr. Orr does not expect the new version or interoperability capability to be ready for use until 2011 but an implementation plan is currently being developed.

Interoperability with
Other State Programs

Mr. Orr reported that he has assisted in development work for interoperability with several work groups. The Institute for Justice Information Systems (JIS) was developed when several law enforcement agencies and other public safety entities realized they needed a system that would allow for communication between different software systems. JIS in partnership with its members develops universal standards which software programmers can apply to applications so information can be readily shared among different systems. Mr. Orr explained that when PMPs from different states share data, no data will be placed openly on the internet. Mr. Orr asked the committee to think of the process as a mailing system.

The envelope tells the technology infrastructure (HUB) who the sender of the request is and to whom the request is being sent. The contents of the envelope containing personal identifying information are encrypted and cannot be read without decryption. Once the receiving PMP processes the requests, the process reverses except that the envelope now contains the encrypted PMP report instead of the request information.

Mr. Orr briefly mentioned the Global Federated Identity and Privilege Management (GFIPM), a national initiative to improve the state of information sharing between state and local law enforcement agencies and across legal jurisdictions within the U.S. This project will standardize the authentication process. For instance, if one agency has authenticated an individual according to GFIPM standards, then other agencies may accept that authentication. This could have wide implications, allowing unrelated applications to accept “authenticated users” improving ease of access for users among different software applications to include PMPs.

Mr. Orr serves on the drafting committee that is charged with developing draft language for an Interstate Compact for Prescription Monitoring Programs. The effort is being coordinated by the National Center for Interstate Compacts, a component of the Council of State Governments. The committee is currently putting the finishing touches on the interstate compact agreement which is a piece of legislation. If a state becomes a member of the compact by enacting the legislation, the state agrees to follow the rules of the compact. The compact may take some time to finalize and enact so those states that choose to enter into interstate agreements prior to the finalization of the compact will need to use Memorandums of Understanding (MOU) in the interim.

Other Program Notes:

Mr. Orr noted that the on-line course advertised on the VPMP web site has added a pediatric pain module. Licensees who choose to take the course may now earn up to 6.5 hours of CE credit. Licensees are reminded to check with their particular Board for CE requirements.

Mr. Orr reported that the Maternal Mortality Review Team (MMRT), a group housed in the Office of the Chief Medical Examiner was interested in several aspects of the VPMP, and he spoke at a recent meeting. The MMRT is developing several recommendations that will be part of the annual report of the Office of Chief Medical Examiner. Some of these recommendations may relate to promoting the use of the VPMP.

The VPMP had a booth and a presence at the annual Virginia Pharmacists’ Association Meeting in August.

Mr. Orr will speak about the VPMP to the Virginia Association of Medication-Assisted Recovery Programs on September 22, 2010.

In October, Mr. Orr will speak about the VPMP in Norfolk, Virginia at the annual State Police Drug Diversion School. This is an internationally recognized program, with agents from all over the United States attending the event.

In late October, Ms. Carolyn McKann will speak about the VPMP in Abingdon, Virginia at an “AwarXe” program presented by the Appalachian College of Pharmacy.

Mr. Orr noted that the Association for Standards in Automation in Pharmacy have been working on addendums to the ASAP 2007 Version 4.1 released earlier this year. The additional features are for automating “zero” reports and providing clearer error reports for PMPs which should bring an added value to updating to ASAP 2007.

VPMP Statistics:

Mr. Orr announced that last week the VPMP received almost 10,000 requests. The VPMP has processed 284,000 requests in 2010, and will process over 300,000 requests by the end of September or 4 times that which was processed in 2009. The VPMP currently has 7,700 registered users, 1,300 of which are pharmacists, over 6,100 are prescribers. The VPMP currently adds 70-80 additional new users per week.

SJR 73/75:

VPMP staff reviewed data and charts that will form the basis for its response to SJR73/75. This resolution from the 2010 General Assembly is a request for data regarding the utilization of the VPMP. Each question and the accompanying data were reviewed with the advisory committee members.

Regarding the notifications of indication of potential misuse, abuse or diversion, VPMP staff report that very few responses to these notifications are received. Mr. Orr stated that Elizabeth Carter, Board Executive, Board of Health Professions, suggested sending a survey asking registered participants what action they took as a result of receiving one of these reports to help determine impact. Elaine Yeats, Senior Policy Analyst suggested that a mechanism to contact those individuals who are not registered but received an unsolicited report would also be helpful in evaluating the provision of the reports.

Mr. Orr asked Dr. Tharp whether the medical examiner’s office ran a VPMP report on all deaths, and Dr. Tharp noted that the total ME requests for patient profiles in Figure 7 of the handout does not seem to reflect all deaths in the Commonwealth; therefore medical examiners in other regions must not typically run VPMP reports on each death. Ms. Randall asked if there

should be a state requirement that a VPMP report be requested in all Medical Examiner death cases.

Mr. Orr reported that in regard to delinquent reporting of prescription data, other states are having much more difficulty keeping data current than the Commonwealth of Virginia. Mr. Orr briefly described the current process which is very successful in ensuring reporting compliance. Ms. Yeatts suggested specific information about what triggers notification to the Board of Pharmacy when an entity is delinquent in reporting is included in the report.

Other Statistics:

The committee discussed other statistics that may be included in the report to the General Assembly. A graph showing the number of individuals receiving controlled substances indicates no chilling effect of the VPMP on prescribing because the numbers of persons receiving controlled substance in each schedule continues to increase over time. Ms. Randall suggested replacing the term drug "class" with the term drug "schedule", as this terminology has replaced the previous use of the word. Mr. Orr noted that now that the program has 24/7 access and auto-response features operational it does appear to adversely affect the ability of doctor shoppers to obtain prescriptions, as there has been a significant drop in the number of patients using both 10 prescribers and 10 pharmacies and 15 prescribers and 15 pharmacies during the last six-month grant reporting period.

The committee reviewed the table showing the number of patients in each zip code region who meet the indications of misuse, abuse, or diversion of controlled substances. This table simply shows total numbers of persons identified per region. Ms. Morris suggested that a representation of this data using mapping software may be very useful. Ms. Yeatts suggested that we compare the total numbers to the population density in each region. Discussion centered on the fact that the pure numbers could be misleading because they do not reflect the per capita rate in the respective regions.

The committee reviewed the tables indicating that those practitioners who prescribe a greater number of controlled substances are also registered with the VPMP at a greater rate. Ms. Yeatts suggested that if a bill is resurrected next year requiring prescribers to register with VPMP that VPMP recommend that registration only be required for those prescribers who write at a consistently higher rate than other prescribers.

Ms. Yeatts also reminded VPMP staff and the committee that the response to SJR 75/73 shall come from DHP, not VPMP, and that the committee's role is to advise the department about the response.

The committee briefly reviewed some of the suggested changes in reporting requirements and other elements that would allow VPPMP to be eligible for federal grant funding such as going to weekly reporting, moving to using ASAP 2007 as the standard for reporting data to the program, and other elements listed in the handout.

Ms. Morris suggested that pharmacies generally would prefer that reporting requirements be restricted to specific schedules, rather than having to add specific drugs to report. The committee recommended that tramadol and carisoprodol be added to Schedule IV as proposed by the Board of Pharmacy. The committee also recommended, after discussion, that the definition of covered substance in the VPPMP code be expanded to incorporate changes the Board of Pharmacy may make in regulation related to the scheduling of controlled substances.

NEXT MEETING

The next meeting will be held on a date yet to be determined in February, 2011.

ADJOURN:

With all business concluded, the committee adjourned at 2:05 p.m.


Kenneth Walker, M.D., Chairman


Ralph A. Orr, Program Director

Materials for Response to Senate Joint Resolution No. 75 Request for Data and Information about Utilization of the PMP

Senate Joint Resolution No. 75 requests the Department of Health Professions to collect data and information about utilization of the Prescription Monitoring Program by prescribers and dispensers of controlled substances and responses to notifications sent by the Department to prescribers and dispensers. SJR No. 75 requests that certain data be provided for each month of 2010 and report this data with recommendations to the 2011 General Assembly.

Following are components of the draft of the Department of Health Professions' response to that request.

(i) *the number of registered users eligible to receive reports from the Prescription Monitoring Program.*

October of 2009 represented the first month that users could log onto the new 24/7 system, input a request for patient history, and view the report via our automated system. Prior to October, requests input into the VPMP DataCenter required a PMP staff member to manually select the patient profiles that matched and then process the request for viewing. The requestor had to wait until PMP staff viewed and responded their request in the queue. Below is the number of new users added during each month since October 2009 as a cumulative total. In February of 2010, VPMP mailed approximately 39,000 brochures describing the VPMP to all prescribers and pharmacists licensed in Virginia. This explains the spike in registrations during March 2010. The VPMP has added an average of 432 registered users each month since October. In March, 959 users were added.

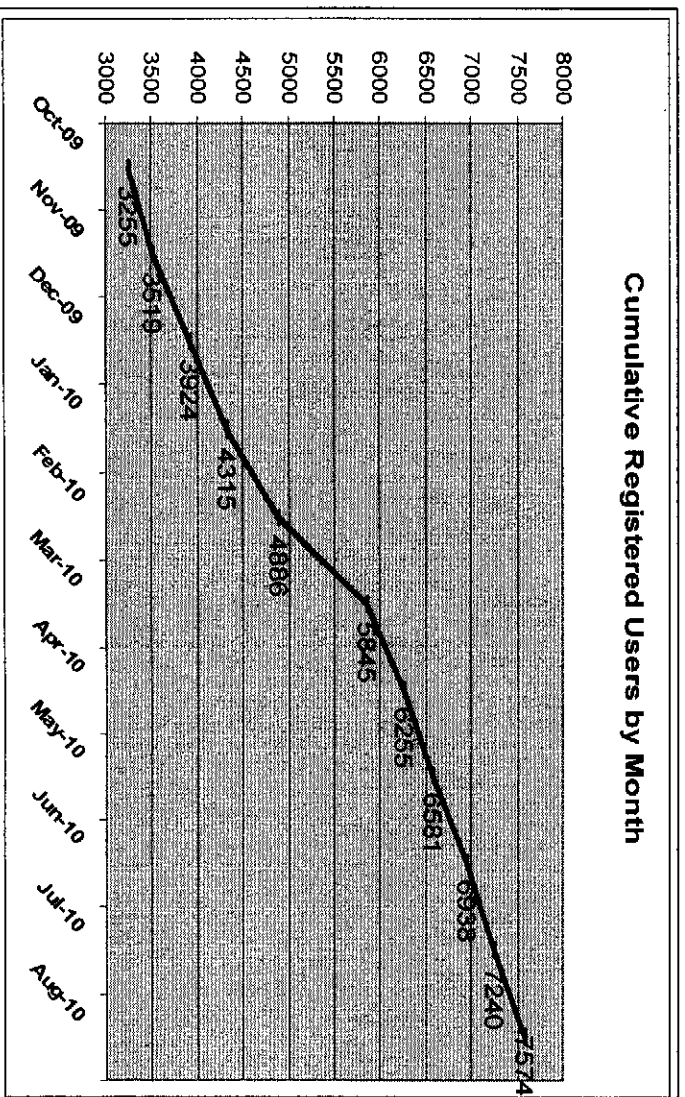


Figure 1.

Materials for Response to Senate Joint Resolution No. 75 Request for Data and Information about Utilization of the PMP

(ii) *The number of reports of dispensing of covered medications submitted to the Prescription Monitoring Program.*

The Virginia Prescription Monitoring Program (VPMP) requires pharmacies and physicians licensed to dispense controlled substances to report their records of dispensed medications twice monthly. All data from the 1st through the 15th of each month is due to VPMP by the 25th of the same month and all data from the 16th through the 31st of each month is due by the 10th of the following month.

The number of prescriptions reported to the VPMP each month has historically been, and continues to be, approximately one million records per month.

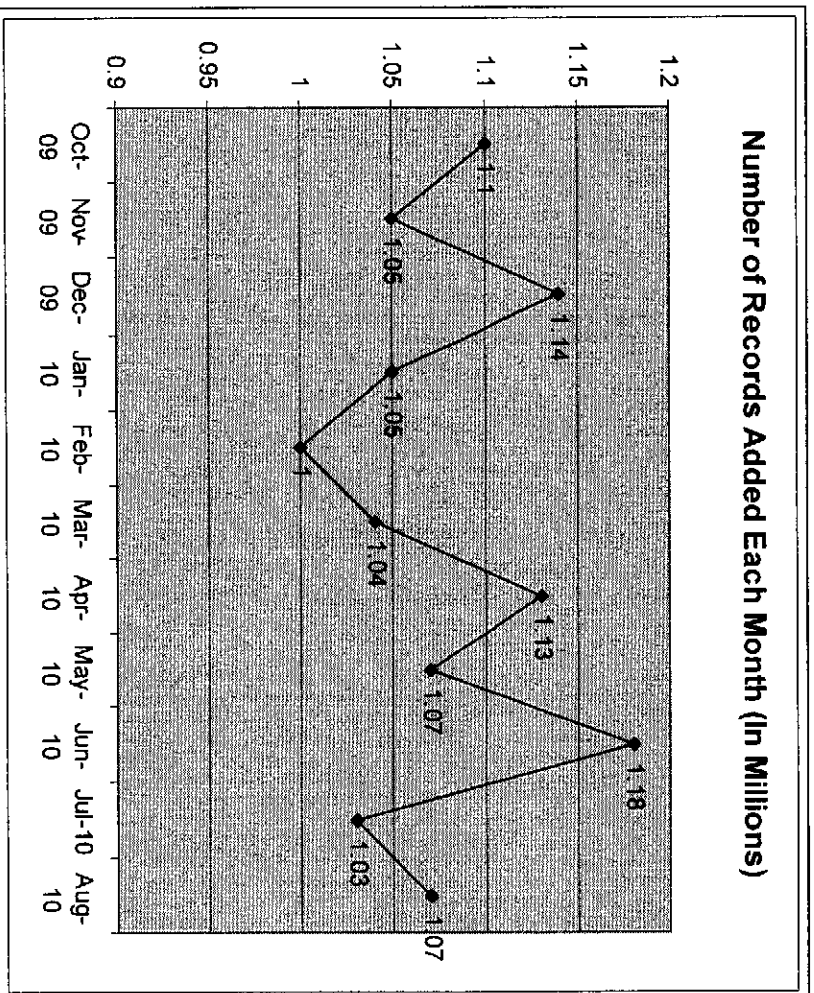


Figure 2.

Materials for Response to Senate Joint Resolution No. 75 Request for Data and Information about Utilization of the PMP

(iii) the number of exemptions from reporting requirements authorized.

On a monthly basis, the VPMP exempts or waives a relatively small number of pharmacies and/or physicians licensed to dispense controlled substances. Pharmacies that are waived have attested that they dispense no Schedule II-V prescriptions and may or may not be located in Virginia. Physicians licensed to dispense controlled substances who are waived generally are members of a large group practice whereby the employing entity submits the dispensed controlled substances to VPMP on their behalf.

Pharmacies that are exempt from reporting are exempt due to the fact that they fall into one of the categories listed in the Virginia Code. These entities must apply for the exemption. These exemptions include dispensing exclusively to inpatients in hospices, dispensing by veterinarians to animals and dispensing covered substances within an appropriately licensed narcotic maintenance treatment program, among others.

As of September 2010, there are 1707 resident pharmacies, 397 non-resident pharmacies and 343 physicians licensed to sell controlled substances. Currently, 140 of the resident pharmacies are waived or exempted from reporting (8.2%); 145 of the non-resident pharmacies are waived or exempted from reporting (36.5%); and 249 physicians licensed to sell controlled substances are waived. The majority of physician licenses to sell are waived, as indicated previously, because they are members of a large group practice that submits controlled substance data on their behalf.

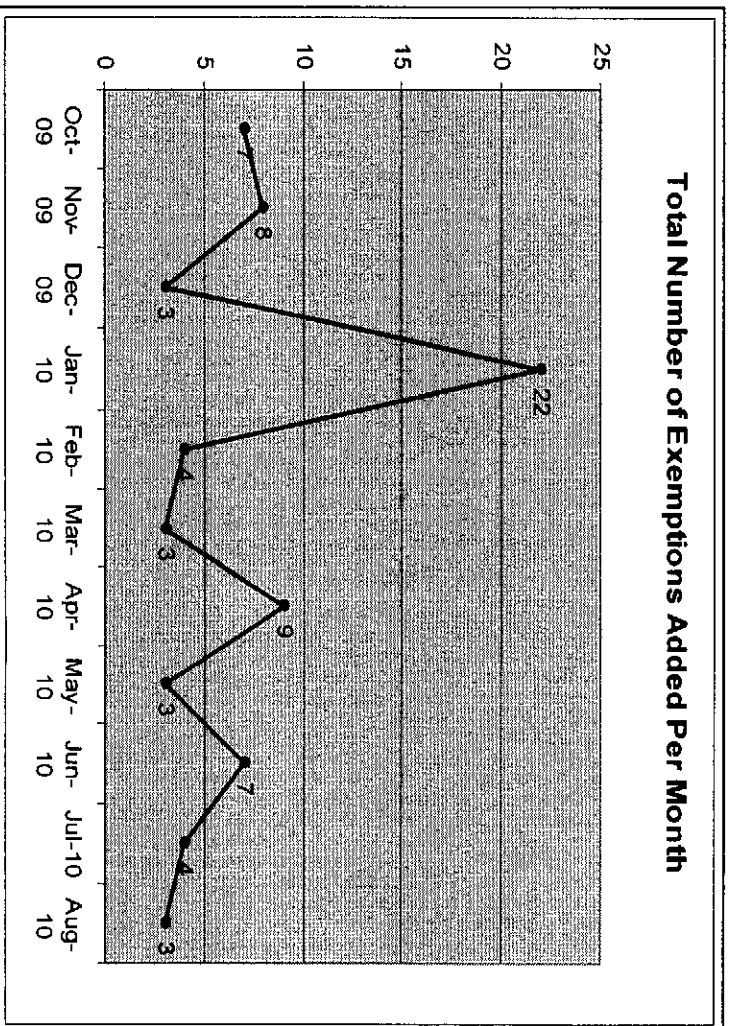


Figure 3.

Materials for Response to Senate Joint Resolution No. 75 Request for Data and Information about Utilization of the PMMP

(iv) *the number of requests for information from registered users made and responded to*

Patient profile requests from registered users have increased several fold on a monthly basis since the introduction of our automated response feature, which was introduced in October 2009. Another surge of requests followed the distribution of VPMP brochures in February of 2010 to all prescribers and pharmacists licensed in Virginia.

Prescribers submit the majority of requests for patient information. Practitioners submitted 90.2% of all requests submitted so far in 2010. Pharmacists submitted 7.6% of the total volume, and both medical examiners and the Virginia State Police submitted slightly less than 1% of the total. Combined, these four categories of users accounted for 99.5% of all requests submitted in 2010.

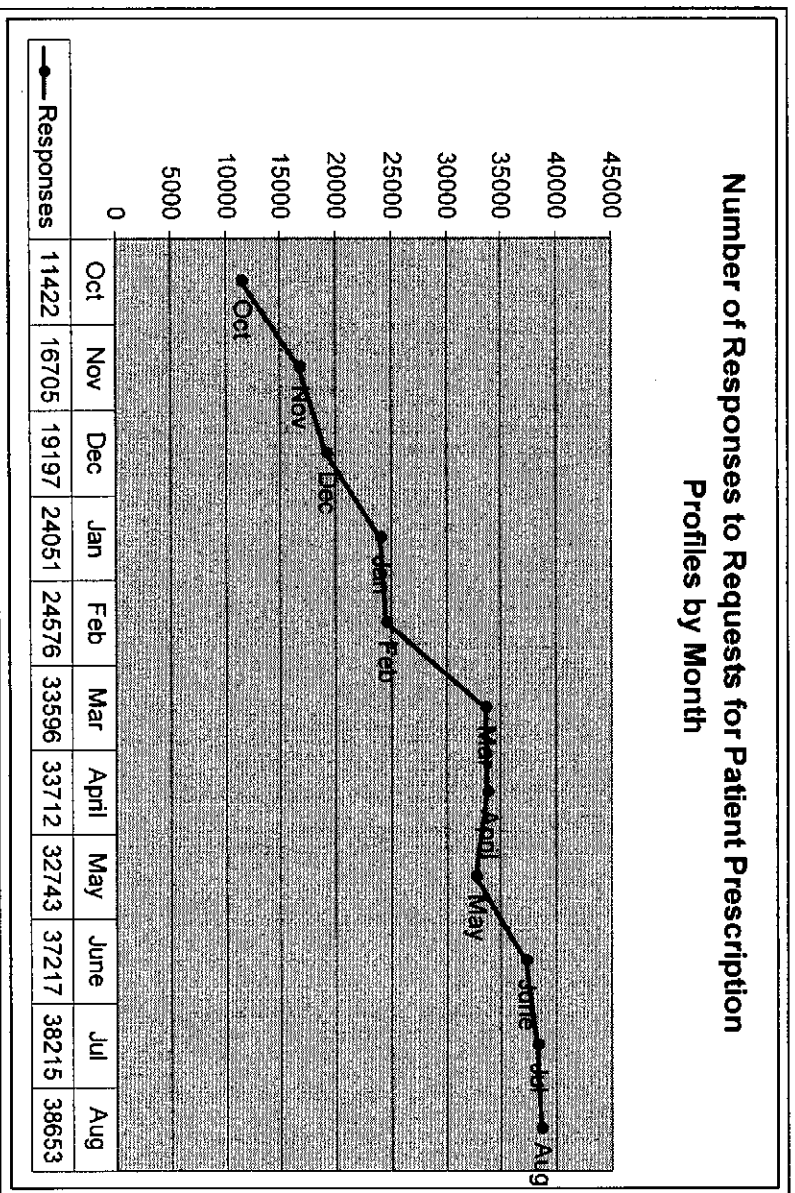


Figure 4.

Materials for Response to Senate Joint Resolution No. 75 Request for Data and Information about Utilization of the PMP

(v) *the number of notifications of indications of potential misuse [for abuse] of covered substances sent to prescribers and the number and nature of responses to such notifications*

Beginning in February of 2010, VPMP staff began evaluation of the 2010 prescription data for indicators of potential misuse, abuse or diversion. Queries were completed requesting the names of individuals who had received prescriptions from at least seven prescribers and dispensed from at least three pharmacies in one month's time. Reports were then generated for each of those patients for the month in question; the report is sent to each prescriber on the patient's report to alert the prescriber that he or she does not appear to be the only practitioner from whom the patient is seeking medical treatment or evaluation.

The data in Figure 5 below represents letters sent during each month. The prescription data in question was collected for the time period at least six to eight weeks earlier than the date the letters are sent. This is because there is an approximate 3 ½ week lag time inherent in the VPMP's required data collection schedule. Therefore, VPMP staff typically waits at least six weeks following the end of the report period in order to assure that the vast majority of prescription data for the notifications (e.g., "unsolicited reports") has been received and uploaded. For example, the majority of notifications sent in August included prescriptions dispensed in May and June only.

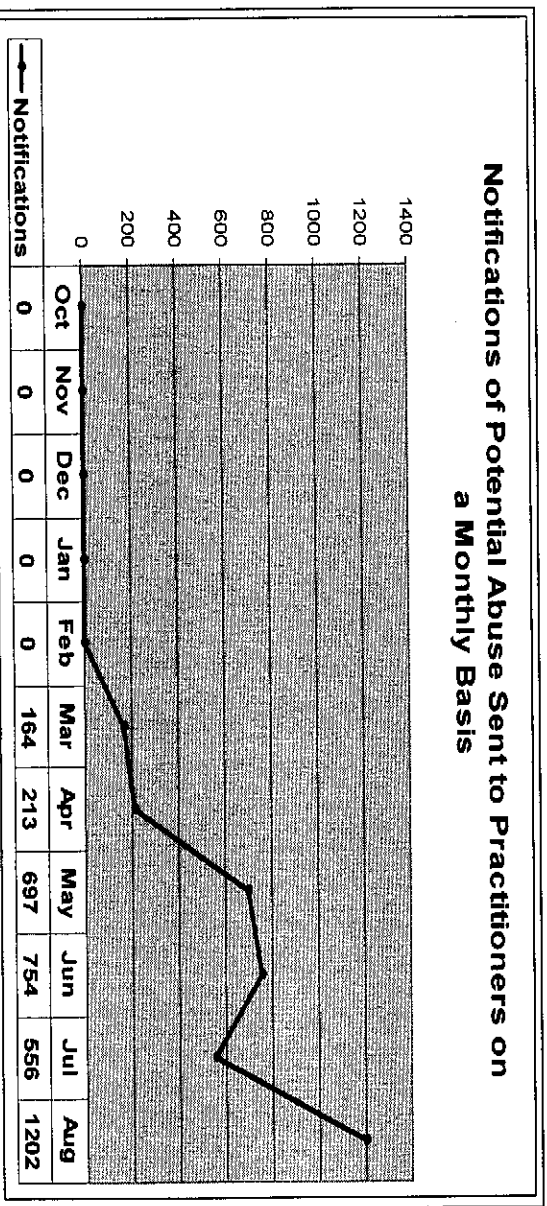


Figure 5.

The types of responses from prescribers receiving the notification reports generally fall into 2 broad categories: the person listed in the report is not a patient of the prescriber or the patient is no longer a patient of the prescriber. VPMP does not generally receive a great number of comments and for this reason is developing a survey mechanism that will ask registered prescribers the following: 1. Did you receive the report? 2. If you received the report how did this impact your treatment? a. no change, b. discharged patient, c. counselled patient and made referral for substance abuse treatment, d. counselled patient and made referral to pain management, e. other. 3. Did you report matter to law enforcement?

Materials for Response to Senate Joint Resolution No. 75 Request for Data and Information about Utilization of the PMP

(vi) *the number of responses to requests for information relevant to an investigation of a specific recipient, prescriber, or dispenser made, and the agency or entity to which such information was released*

Registered users of the VPMP who utilize the program for purposes other than to make treatment decisions may only access prescription history for specific individuals that have an open investigation. The Department of Health Professions (DHP) investigates complaints on licensees, both the Virginia State Police (VSP DDU) and Drug Enforcement Administration (DEA) investigate suspected drug diversion and Medical Examiners (ME) request a VPMP report on deceased individuals according to protocol in order to assist them in specifying the types of drug screens to order and assist in making cause of death determinations. The Health Practitioners' Monitoring Program (HPMP) monitors for drug utilization as specified in a Board Order. Figure 7 below shows the exact totals of requests.

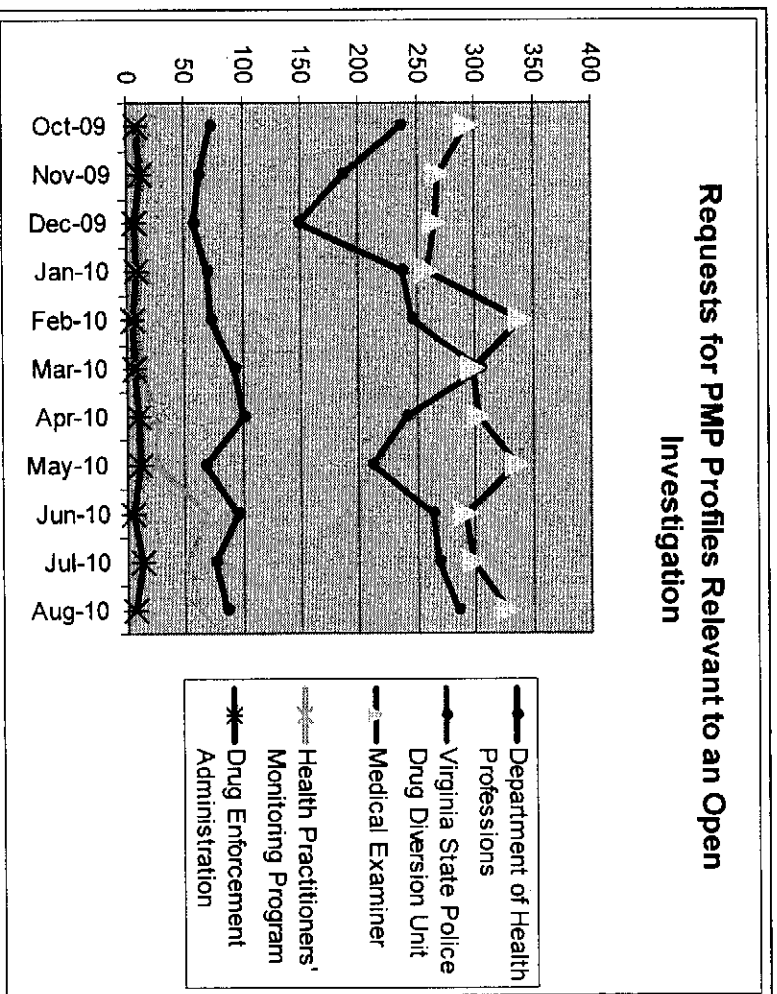


Figure 6.

	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10
DHP	73	63	57	69	72	93	100	68	95	76	85
DDU	235	186	148	237	246	305	241	211	264	268	285
ME	293	269	265	258	339	298	303	335	291	298	328
HPMP	14	13	9	11	9	12	27	26	69	52	63
DEA	8	11	6	8	5	6	10	11	5	13	7

Figure 7.

**Materials for Response to Senate Joint Resolution No. 75 Request for Data
and Information about Utilization of the PMP**

(vii) *The number of disciplinary proceedings initiated by a health regulatory board against a person required to report dispensing of a covered substance to the Prescription Monitoring Program for failure to report as required.*

During 2010, one pharmacy was identified as consistently delinquent in reporting controlled substance data to VPMP. VPMP referred this case to the Board of Pharmacy for disciplinary action.

In an effort to address delinquent reporting, VPMP initiated a process in late 2009 whereby any pharmacy delinquent in reporting data in a reporting period exceeding four weeks' time or greater shall receive a certified letter in addition to the traditional letter sent by regular mail. Notification is sent two days following the end of the report period, during which time a delinquent report is generated from the data collection site. Consistently sending certified letters has improved the timely reporting of controlled substance data to the VPMP. Below is a table indicating the number of certified letters sent each month (on a bimonthly basis) to pharmacies that have failed to report some data. Historically, it appears that summer vacation and the Christmas holiday season adversely impact reporting of controlled substance data.

CERTIFIED LETTERS SENT	
October 2009	0
November 2009	3
December 2009	12
January 2009	22
February 2009	8
March 2009	17
April 2009	4
May 2009	1
June 2010	2
July 2010	6
August 2010	15
September 2010	NA

Figure 8.

Materials for Response to Senate Joint Resolution No. 75 Request for Data and Information about Utilization of the PMP

OTHER STATISTICS

Figure 9 below shows the total number of individuals receiving (a) Class II, (b) Class II and/or III and (c) Class II, Class III and/or Class IV prescriptions during the respective time periods. This demonstrates that the existence of VPMP does not prevent individuals from receiving controlled substances for legitimate medical purposes, nor does its existence appear to have a “chilling effect” on the prescribing habits of physicians treating those individuals.

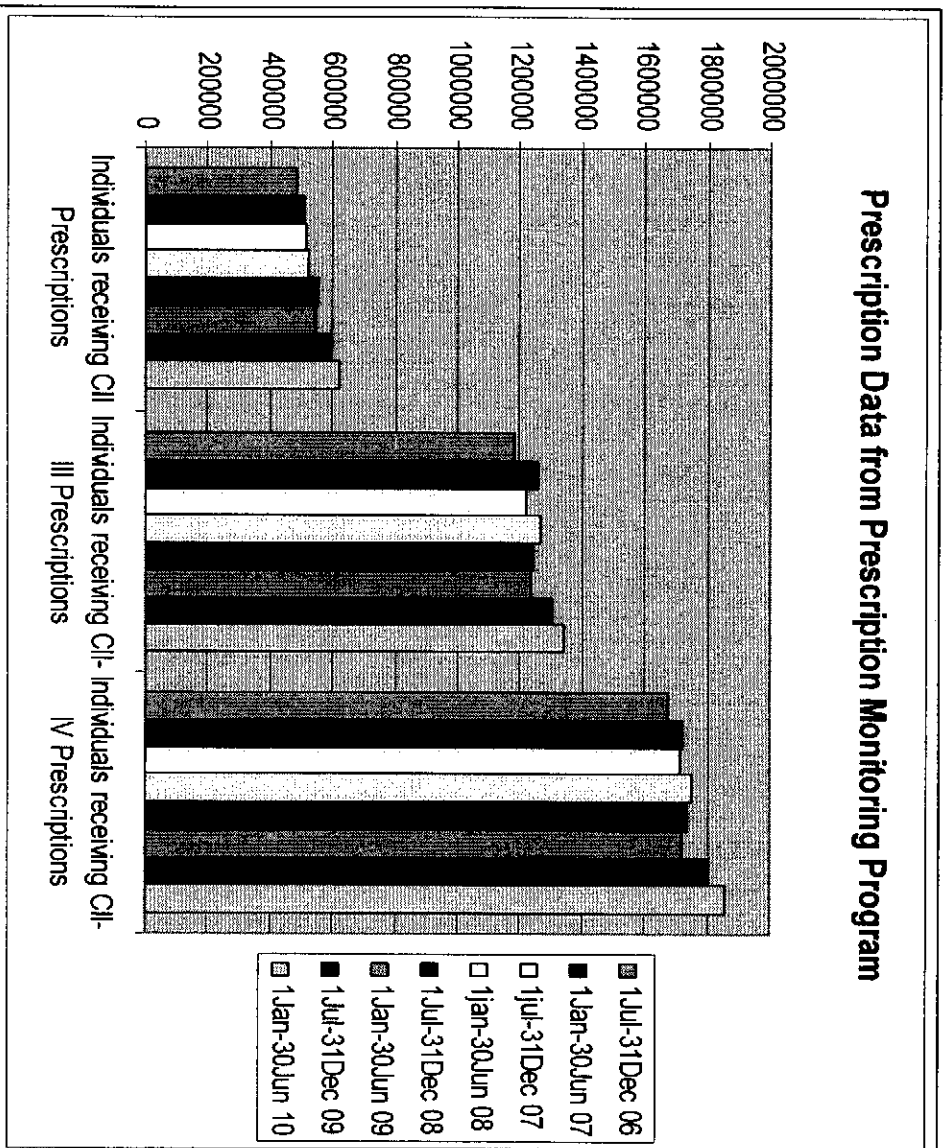


Figure 9.

Materials for Response to Senate Joint Resolution No. 75 Request for Data and Information about Utilization of the PMP

The following tables show the number of persons in the VPMP who have utilized pharmacies and prescribers in the following numbers: 5 & 5; 10 & 10; 15 & 15 during six-month periods dating back to the second half of 2006

Figure 10 shows a decline in persons utilizing five prescribers and five pharmacies during the most recent six month period. This is presumably due to the ability of prescribers to have 24/7 access to data provided by the VPMP. The utilization of five prescribers and five pharmacies is not necessarily an indication of prescription misuse, abuse or diversion, but may be a reflection of individuals either seeking care from specialists or receiving care from different prescribers within the same practice.

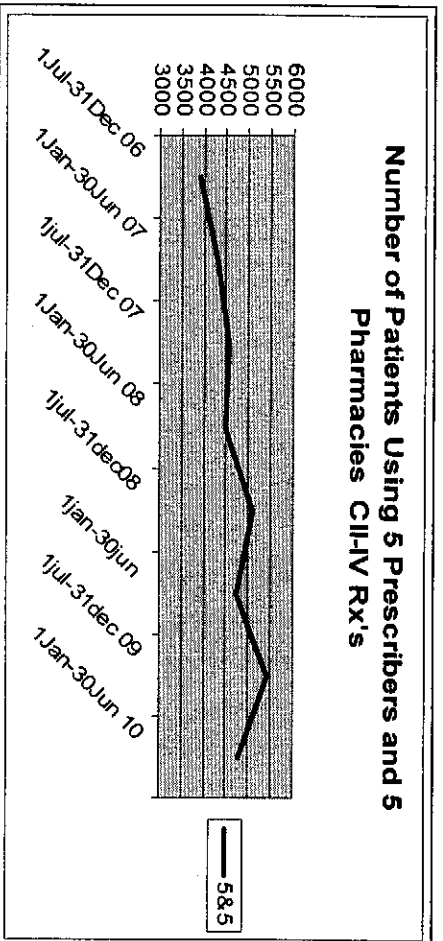


Figure 10.

Figure 11 demonstrates that access to VPMP has had an impact on those persons seeking care from ten and fifteen prescribers and pharmacists. Utilization of services at these levels is more likely an indicator of prescription drug misuse, abuse or diversion.

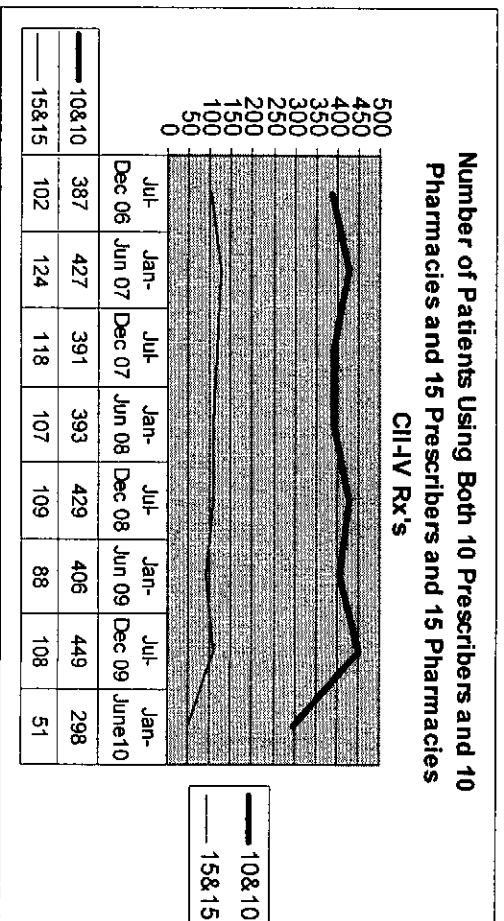


Figure 11.

Materials for Response to Senate Joint Resolution No. 75 Request for Data and Information about Utilization of the PMIP

For notification purposes, the thresholds used by the VPMP are not the same as those referenced in Figures 10, and 11. Figure 12 below shows the total number of patients identified each month as a result of the VPMP's threshold search. During the first six months of 2010, an average of 83 patients met the designated thresholds of at least seven physicians consulted and at least three pharmacies dispensing their medications in a one month period. These individuals utilized on average per month; 7 (seven) pharmacies and 9 (nine) prescribers to obtain 12 (twelve) prescriptions.

As indicated in Figure 12, there is a decline in the number of persons meeting the thresholds referenced in the paragraph above. Again, this is presumably due to the ability of prescribers and pharmacists to utilize the VPMP prior to making a treatment/dispensing decision.

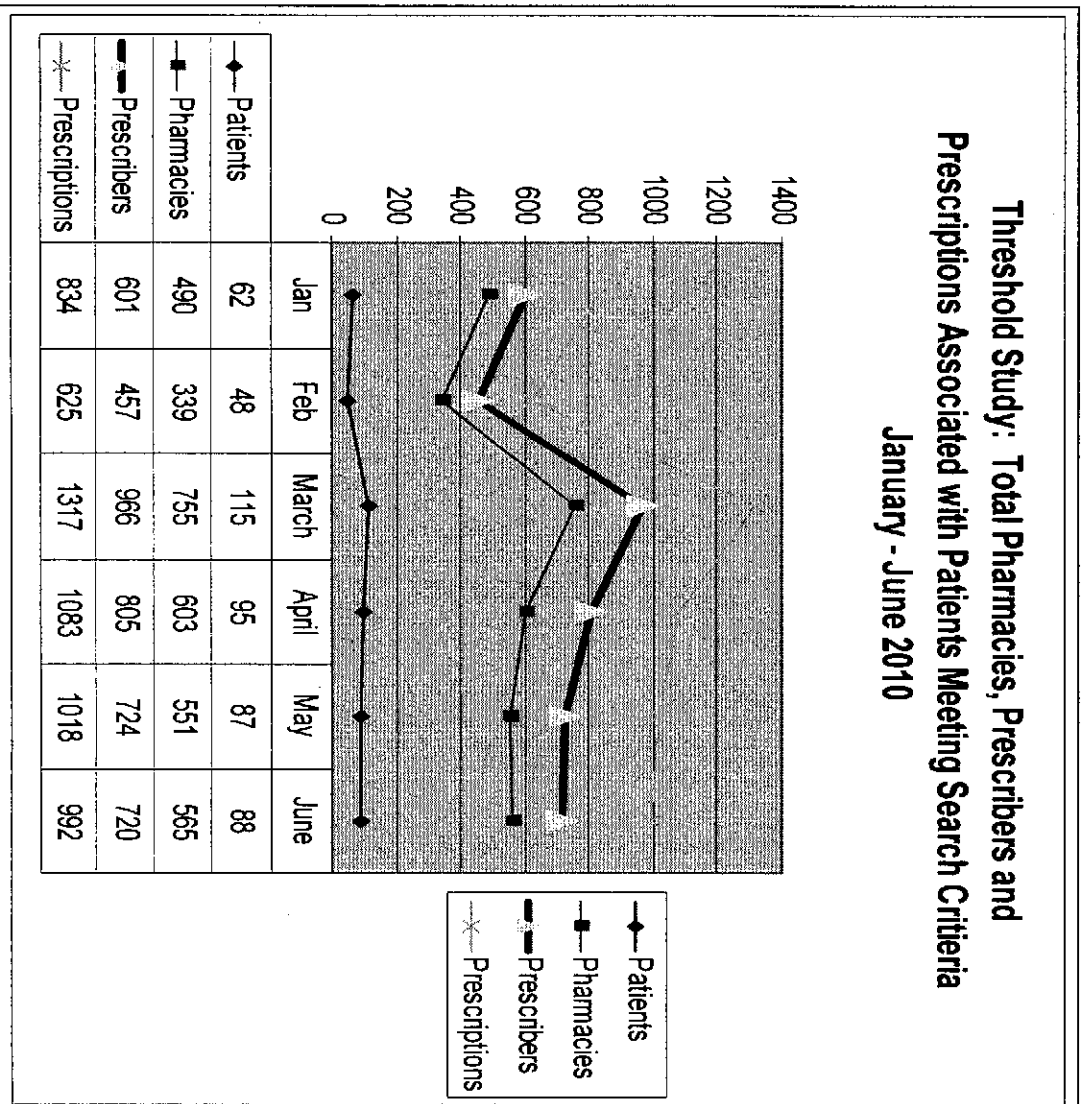


Figure 12.

Materials for Response to Senate Joint Resolution No. 75 Request for Data and Information about Utilization of the PMP

During analysis of the notifications sent to prescribers, we also tracked the distribution of patients by zip code. While the PMP pilot project was initiated as a result of a public health crisis in Southwest Virginia, in the first half of 2010 only 7.3% of the 491 patients identified appeared to have a primary residence in Southwest Virginia. The majority of patients identified (exactly 50% of the total) identified their primary residence as located in Northern Virginia. Figure 14 shows the distribution by zip code of those patients identified in our threshold study (i.e., unsolicited reports.)

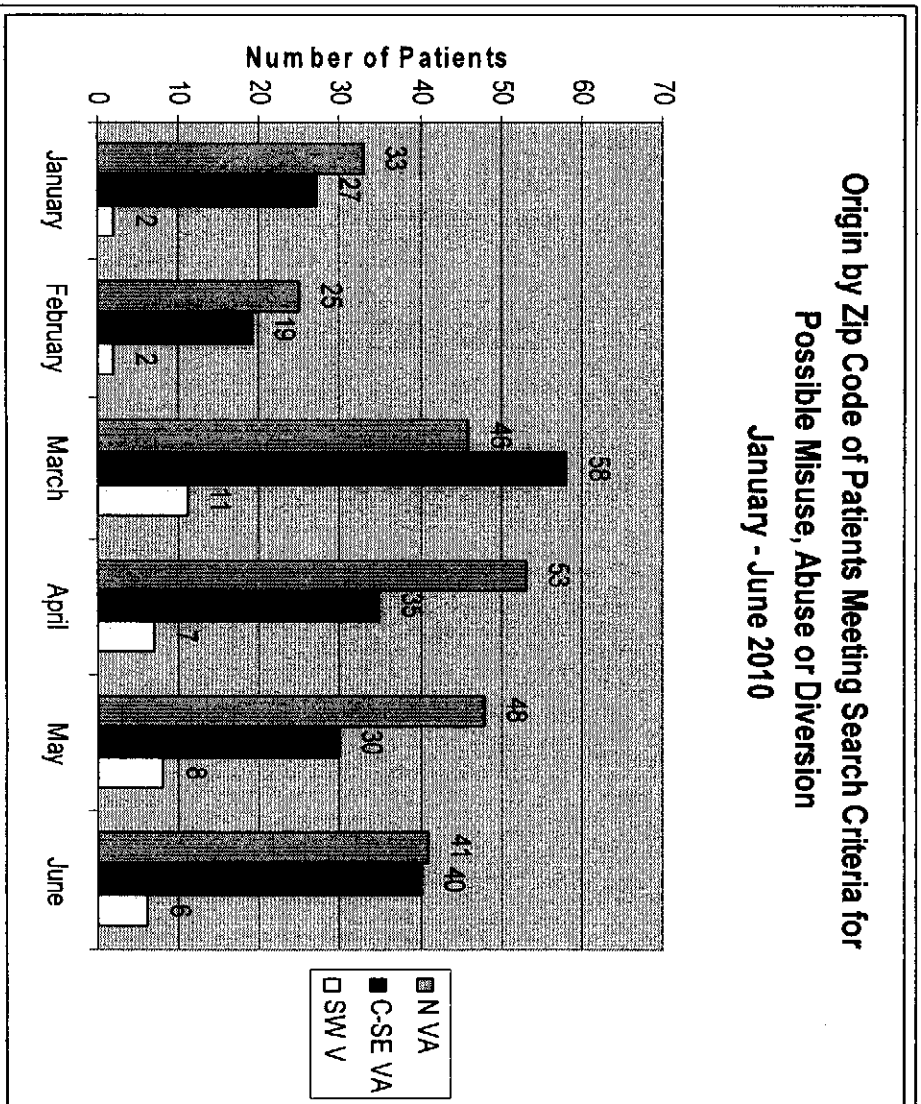


Figure 13.

Materials for Response to Senate Joint Resolution No. 75 Request for Data and Information Regarding the Utilization of the Virginia Prescription Monitoring Program

The majority of prescribers write less than 100 controlled substance prescriptions each quarter, 30% of Virginia prescribers write more than 100 controlled substance prescriptions per quarter. Currently approximately 20% of Virginia prescribers are registered users of the VPMP.

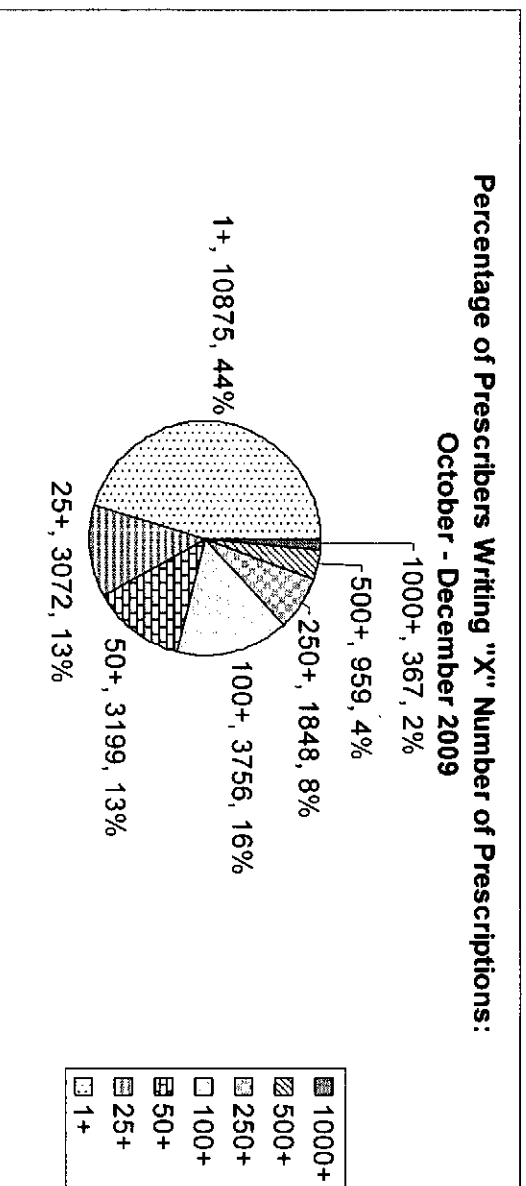


Figure 14

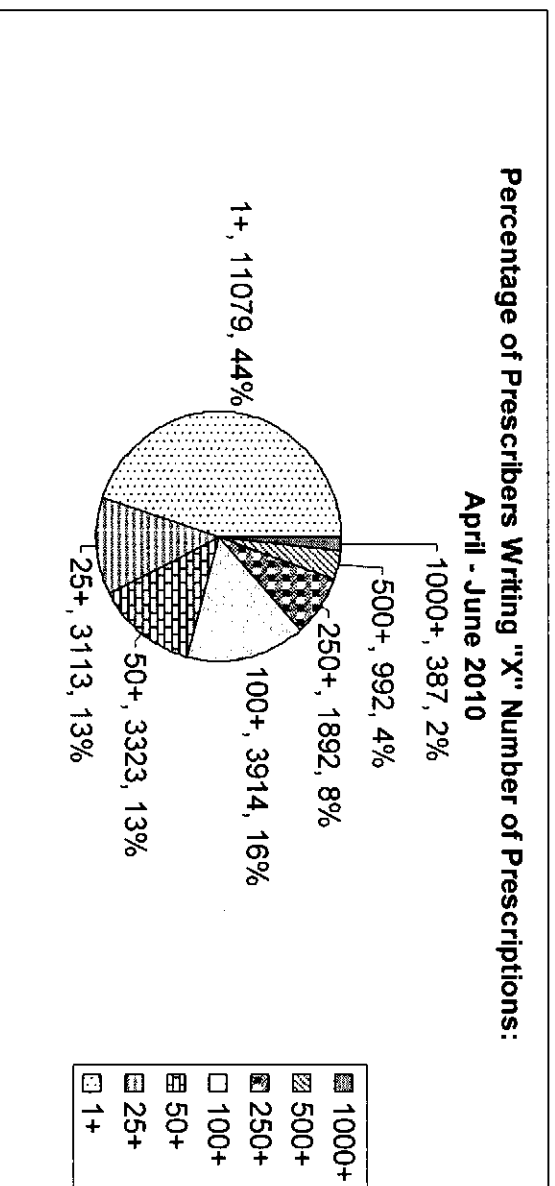


Figure 15

Materials for Response to Senate Joint Resolution No. 75 Request for Data and Information Regarding the Utilization of the Virginia Prescription Monitoring Program

Prescribers writing the greatest number of controlled substance prescriptions quarterly are more likely to be registered users of the Virginia Prescription Monitoring Program (VPMP). The percentage of those prescribing 1000 or more controlled substance prescriptions that were also registered users of the VPMP during this quarter was almost 68%. Conversely, prescribers writing the least number of controlled substance prescriptions quarterly were least likely to be registered with the VPMP.

VPMP proposes sending targeted educational material to those prescribers that are not registered and tracking this data on a quarterly basis.

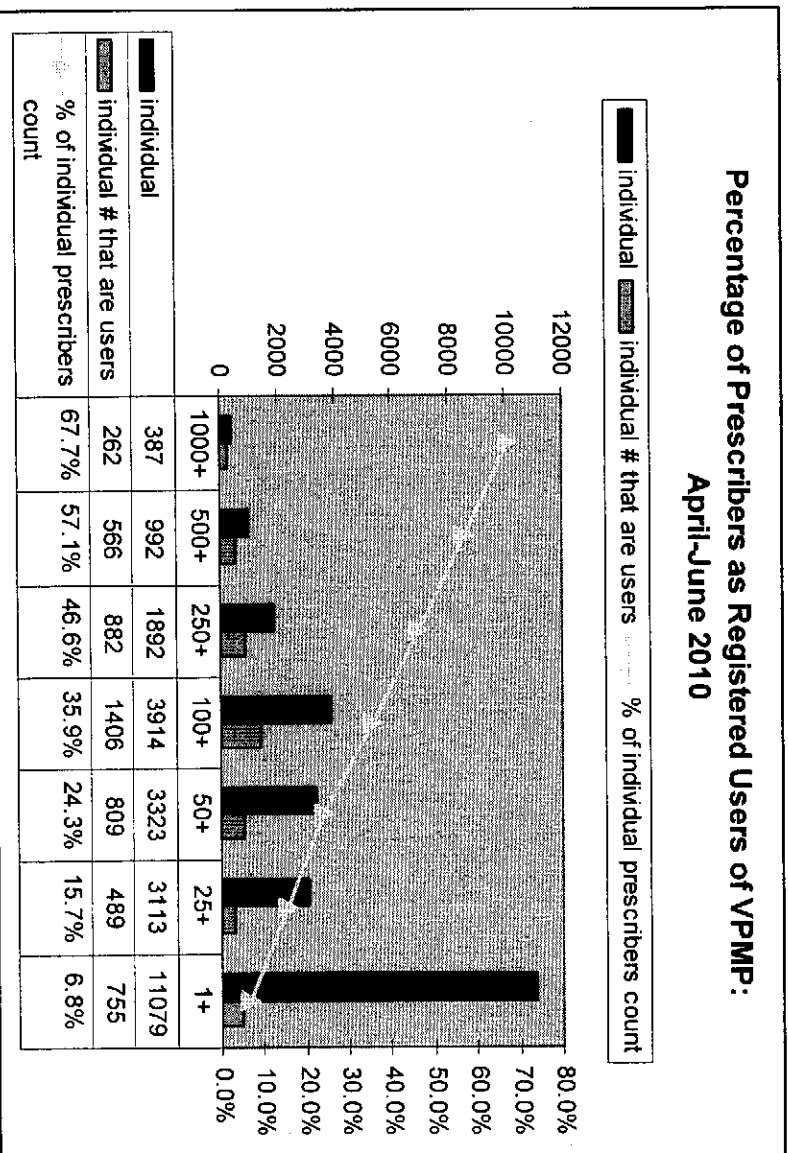


Figure 16

Recommendations for Consideration

DESCRIPTION OF RECOMMENDATION	TYPE OF CHANGE REQUIRED
Add Schedule V controlled drugs as covered substances of the program	Code
Add tramadol as a covered substance of the program	Code
Add carisprodol as a covered substance of the program	Code
Add authority to add additional drugs of concern through a regulatory process	Code
Expand access to include additional federal law enforcement (FBI, Agents of FDA, HHS, Veteran's Affairs, etc) and other States' law enforcement entities	Code
Expand access to include authority for medical reviewers for workman's compensation programs	Code
Expand the number of allowed delegates per supervising prescriber and add an bi-annual renewal or re-authorization requirement	Code
Add authority to provide unsolicited information to law enforcement and regulatory agencies	Code
Change reporting requirement to "within 7 days of dispensing"	Code or regulatory
Change reporting format to ASAP version 2007, provide mechanism for Director to change reporting format by providing timeframe to come into compliance.	Regulatory
Add requirement of notarized application for prescribers, dispensers, and delegates	Regulatory
Add method of payment to reporting requirements (Cash, Medicaid, other)	Reporting Manual update
Require dispensers to report the DEA registration of the dispenser (Note: change from NCPDDP#)	Reporting Manual update
Require dispensers to report the number of refills ordered	Reporting Manual update
Require dispensers to report whether the prescription was a new or refill	Reporting Manual update
Require the dispenser to report the date the prescription was written	Reporting Manual update
Require estimated number of days for which prescription should last	Reporting Manual update
Add requirement of notarized application for Law Enforcement and Regulatory personnel	Regulatory