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

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Agenda of Meeting
June 7, 2017
10:00 AM
Training Room 1
TOPIC

Call to Order: Holly Morris, Chair
- Welcome and introductions
- Reading of emergency evacuation script: Ralph Orr
- Approval of agenda
- Approval of minutes

Public Comment:

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

Legislation and Regulation Update: Elaine Yeatts

Discussion: Possible Legislative Proposals
- Authorize prescriber to request PMP report of parent or caregiver of child in certain cases
- Reporting of dispensing of naloxone to PMP
- Reporting of Schedule V controlled substances to PMP
- Reporting of information relating to person picking up controlled substances to PMP

Program Update:
- Integration report: NarxCare Project
- Interoperability report
- Gabapentin as a drug of concern
- Communications update
- Statistics

PMP Enhancement Initiatives:
- Prescriber reports
- TABLEAU

Annual Report:
- Legislative requirement
- Sample State reports

Election of Chair and Vice-Chair for FY2018

Meeting Dates for FY 2018:

Adjourn:

DRAFT

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

Friday, March 31, 2017

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 10:10 a.m.
PRESIDING	Holly Morris, RPh, Crittenden's Drug, Chair
MEMBERS PRESENT:	John Barsanti, M.D., Commonwealth Pain Specialists, L.L.C. Randall Clouse, Office of the Attorney General Jeffrey Gofton, M.D., Office of the Chief Medical Examiner Kate Neuhausen, M.D., Chief Medical Officer, DMAS Mellie Randall, Representative, Department of Behavioral Health and Developmental Services Harvey Smith, 1SG, Virginia State Police
MEMBERS ABSENT:	Brenda Clarkson, Executive Director, Virginia Association for Hospices and Palliative Care Carola Bruflat, Family Nurse Practitioner, Vice Chair
STAFF PRESENT:	Dr. David Brown, Director, 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, DHP Ralph A. Orr, Program Director, Prescription Monitoring Program Carolyn McKann, Deputy Director, Prescription Monitoring Program
WELCOME AND INTRODUCTIONS	Ms. Morris welcomed everyone to the meeting of the Advisory Committee and all attendees introduced themselves.
APPROVAL OF AGENDA	The agenda was approved as presented.
APPROVAL OF MINUTES	Ms. Morris presented a motion to approve the minutes from the September 14, 2016 meeting of the PMP Advisory Committee and all were in favor. The minutes were approved as presented.
PUBLIC COMMENTS	No public comments were made.
Dr. Brown: DEPARTMENT OF HEALTH PROFESSIONS REPORT	Dr. Brown noted that Virginia's Commissioner of Health declared a public health emergency with regard to deaths from opioid overdoses. While there have been several initiatives implemented in this area; in 2015, there were 811 deaths from

	opioid overdoses and 1100 are expected for 2016, representing a 33% increase. While deaths from prescription opioids have leveled off, deaths from heroin and fentanyl have increased. Increased use of the PMP and other efforts related to information obtained prior to writing a prescription have made it more difficult to doctor shop. Along with an increase in heroin deaths, there has been an increase in the incidence of Hepatitis C, HIV, and NAS which may also be related to prescription drug abuse. Dr. Brown mentioned recent legislation involving the PMP. In 2016, the PMP was authorized to send to the Board of Medicine names of individuals and pharmacies associated with outlier prescribing and dispensing. Also in 2016, the General Assembling authorized Medicaid to be more aggressive in offering substance use treatment through their ARTS program. During the 2017 session, legislation was developed requiring prescribers to check the PMP when opioid prescribing exceeds a 7 days' supply. Both the Boards of Medicine (BOM) and Dentistry (BOD) were required by legislation to promulgate regulations regarding opioid prescribing. The BOM regulations are already in effect and the BOD regulations are currently at the Governor's office being reviewed. Electronic prescribing for certain controlled substances will be mandatory in 2020, as e-prescribing is less subject to fraud. Dr. Brown noted however that most physician offices do not meet requirements for electronic prescribing of controlled substances. Medicaid will expand coverage for more recovery programs, and a bill was passed allowing the Board of Health to have needle exchange programs in certain hard hit areas. Studies have shown that creating a mandated interaction with health care professionals as part of a person's participation in needle exchange programs increases entrance into treatment programs.
Elaine Yeatts: LEGISLATION AND REGULATION UPDATE	Elaine Yeatts presented the legislative update. Ms. Yeatts noted that updated regulations became effective on January 25, 2017. The reporting standard for the Virginia PMP was changed to the ASAP Version 4.2 (2011) given its ability to support e-prescribing, among other things. Several required data elements have been added including the gender code and species code. These requirements will be implemented July 1, 2017. Ms. Yeatts reviewed current legislation. Following are a few of the highlights. HB1767: Allows CSBs to get the controlled substance registration for the location itself to allow teleprescribing. This will allow the CSB to prescribe specific to telemedicine within applicable federal guidelines. Ms. Morris noted that difficulty to identify or confirm a bona fide practitioner-patient relationship concerns her as presenting a challenge for pharmacists.

	HB2046: BOP to develop guidelines for disposal of unused prescribed drugs (counseling to patients by pharmacies). HB2163: Places limitations on the prescribing of the buprenorphine mono-product. Bill will also be amended to include the BOVM. HB2164: Drug of concern gabapentin shall be reported to the PMP. HB2209: Emergency Department Care Coordination. Allows for emergency department coordination throughout the Commonwealth by allowing the Department of Health to provide a single statewide technology solution enabling real-time communication among health care providers. In year 1 will include Medicaid patients only, in year 2, other insurance carriers. Will include $3.3 M in HITECH matching funds and will integrate with the PMP. There will also be a smaller pilot with small practice groups. Mr. Orr noted that 10% of the cost will be paid up front by the PMP and 90% will be paid by CMS contingent on the approval and receipt of HITECH funds. Ms. Morris inquired whether hospitals are ready with the appropriate technology. Dr. Neuhausen noted that there is an existing legal framework, and that contracts will be required. SB848: Naloxone bill—This amended legislation passed last year expanding entities that can possess and dispense naloxone. SB1484: Expands authority for disclosure of PMP data to certain designees of a physician or pharmacist employed by the Virginia Medicaid managed care program.
DISCUSSION: Todd Prough, Group Supervisor Richmond Tactical Diversion Squad, DEA	Discussed mandatory reporting of information relating to the person picking up a controlled substance, and its use by law enforcement. Todd Prough, DEA Group Supervisor, talked about his experience with the use of this data in Massachusetts. Mr. Prough noted this information is very valuable and described an investigative situation in which an IT specialist who had authorized access to information was able to obtain names and numbers of legitimate physicians and patients as well as genuine prescription paper. He printed bogus prescriptions at his home and because he was using real people and real physicians it was difficult to detect any wrongdoing. However, as the investigation evolved, they noted 6 common driver's licenses. Because the identification information had been collected by the PMP, investigators could target their investigational efforts to specific prescription information, which they would not have had access to otherwise. Chuck Elliot, Special Agent Virginia State Police, also described a significant case in Virginia involving fraudulent prescription blanks. "Patients" are paid to pick up these fraudulent prescriptions. Because the information related to the individual picking up the prescription is not provided on the PMP report, investigators must actually observe someone "completing" the crime which may not actually move the investigation forward to the organizers of these rings. The

	perpetrators may ask a homeless individual to pick up the prescription; with information indicating who picked up the prescription, investigators can focus on their John Doe, not the homeless. Ms. Morris did note that she encounters a number of people who never have their ID with them, making it difficult to report this information. First Sergeant Smith noted this is also a great tool for prescribers and pharmacists. Dr. Barsanti asked about the possibility of limiting who could pick up the prescription, and Ms. Morris stated that she did not think this could be an option. Mr. Orr stated he would find out which states currently collect this information. Dr. Brown asked the group what types of mechanism we currently have in place to identify prescription fraud. Caroline Juran noted that there currently is nothing to specifically identify prescription fraud, but the BOP has provided a "Red Flags" video which can assist prescribers and pharmacists in identifying such. First Sergeant Smith says they have spoken as a group to pharmacy students for many years about how to recognize fraud. Ms. Morris noted that we will continue discussion about adding this data element at our next meeting.
Ralph Orr: Implementation of new AWARxE platform	Mr. Orr noted that the implementation of the new platform went well. With respect to data collection, the PMP still has some entities that are not yet reporting daily. It is evident that individuals are using the system because the PMP has already processed greater than 2 million requests this year to date compared to just over 5 million in 2016. There is no longer an alias feature, but use of the "partial name" feature for both first and last name greatly widens the scope of the search. Users have the ability to view all reports in either pdf or csv, which can easily be saved as an excel file. Mr. Orr noted that a patient alert is triggered when a patient sees 5 or more prescribers and pharmacists in a 90-day period.
Ralph Orr: Integration report	Mr. Orr then reviewed the NarxCare simulator. Dr. Brown inquired whether all the integration solutions will have NarxCare, and the response was that individual integration solutions must pay for access to this report solution. Individuals should check with their software vendor regarding NarxCare capability.
Ralph Orr: Interoperability Report	The PMP recently began sharing data with the District of Columbia bringing the total of PMPs Virginia is sharing with to 22. Pennsylvania will likely be the next state that Virginia will share with. There is still no timetable as to when NC will be interoperable with any state.
Ralph Orr: Reporting of Dispensing of Naloxone to the PMP	Mr. Orr noted that only 2 states require reporting of naloxone to its PMP and that new Board of Medicine regulations require the co-prescribing of naloxone when a patient is taking over

	120MME per day. Members discussed that it would be nice to know where it is being dispensed There is a perception that prescriptions for naloxone are often denied by insurance since it is written to an individual to keep on hand for a family member. Mr. Orr asked the membership if they would want to add this field to the PMP data. Mr. Orr noted this would require a legislative change. First Sergeant Smith noted that there is an illicit market for Narcan. Discussion will be continued at the next meeting.
Ralph Orr: Reporting of Schedule V Controlled Substances to the PMP	Mr. Orr reported that PMPs in 36 states collect Schedule II-V controlled substances and the Virginia is one of few that collects only Schedule II – IV. Mr. Orr asked committee members whether the PMP should begin collecting Schedule V as well (this includes cold and cough medications, Lyrica, and seizure medications, among others). Ms. Morris said it would not be difficult to report the additional drug Schedule, but wondered about overall interest in Schedule V drugs. However, Ms. Morris also noted that it is important to be consistent with other states.
Ralph Orr: Gabapentin as a Drug of Concern	Mr. Orr opened discussion by noting that Gabapentin will likely never be a controlled substance on its own. It is widely prescribed and there are synergistic effects in combination with either opioids or benzodiazepines making it an abused drug. This year's legislation originated from southwest Virginia and an emergency clause was developed requiring reporting of Gabapentin going back to February 23, 2017. For prescribers the PMP can enable the NPI to allow reporting since not all prescribers have DEA numbers. Of note, the NPI number will be a required data element beginning July 2017. Veterinarians also prescribe gabapentin and are not eligible for NPI numbers; the PMP will have to develop a method for their prescribing of gabapentin to be reported.
Ralph Orr: PMP ENHANCEMENT INITIATIVES: TABLEAU	TABLEAU is a reports program that will take data and create graphical representations of the data of interest. PMP staff will have access to TABLEAU beginning in mid-April. This will assist the PMP in developing an annual report to accommodate recent legislation and reports to the General Assembly
Ralph Orr: PMP ENHANCEMENT INITIATIVES: Prescriber Reports	The first prescriber reports summarizing a prescriber's prescribing history of controlled substances will be available by the end of May 2017. PMP staff may push this date back to June in order to review the reports, recommend changes and anticipate responses to comments. Prescribers have been asked to select their health care specialty as part of their user profile in PMP AWARxE. Users will receive an email that their prescriber report is ready to view.

Ralph Orr: PMP ENHANCEMENT INITIATIVES: Advanced Analytics	PMP staff will not have access to this until July. Access to advanced analytics is made possible by a CDC grant through the Department of Health. Access to advanced analytics will allow PMP staff to provide obtain more detailed information about unusual instances of prescribing and dispensing as required by law.
ADDITIONAL MEETING DATES FOR 2017:	TBD September, 2017
NEXT MEETING	The next meeting will be held on June 7, 2017 from 10 a.m. to 2:00 p.m.
ADJOURN:	With all business concluded, the committee adjourned at 1:40 p.m.
	Holly Morris, Chairman
	Ralph A. Orr, Director

Draft language: Authorize prescriber to request PMP report of parent or caregiver of a child in certain cases

§ 54.1-2523. Confidentiality of data; disclosure of information; discretionary authority of Director.

C. In accordance with the Department's regulations and applicable federal law and regulations, the Director may, in his discretion, disclose:

2. Information on a specific recipient to a prescriber, as defined in this chapter, for the purpose of *a)* establishing the treatment history of the specific recipient when such recipient is either under care and treatment by the prescriber or *b)* the prescriber is consulting on or initiating treatment of such recipient *or c) the prescriber is providing or initiating care for a minor in which it is determined there is a need for a prescription history of the parent or caregiver.* In a manner specified by the Director in regulation, notice shall be given to patients that information may be requested by the prescriber from the Prescription Monitoring Program.

Draft Language: Require Dispensing of Naloxone to be Reported to PMP

§ 54.1-2519. Definitions.

As used in this article, unless the context requires a different meaning:

"Controlled substance" means a drug, substance or immediate precursor in Schedules I through VI of the Drug Control Act, Chapter 34 (§ 54.1-3400 et seq.) of this title.

"Covered substance" means all controlled substances included in Schedules II, III, and IV, *naloxone dispensed by a pharmacy*, and all drugs of concern that are required to be reported to the Prescription Monitoring Program, pursuant to this chapter.

"Drug of concern" means any drug or substance, including any controlled substance or other drug or substance, where there has been or there is the potential for abuse and that has been identified by the Board of Pharmacy pursuant to § 54.1-3456.1.

§ 54.1-2521. Reporting requirements.

A. The failure by any person subject to the reporting requirements set forth in this section and the Department's regulations to report the dispensing of covered substances shall constitute grounds for disciplinary action by the relevant health regulatory board.

B. Upon dispensing a covered substance, a dispenser of such covered substance shall report the following information:

1. The recipient's name and address.

2. The recipient's date of birth.

3. The covered substance that was dispensed to the recipient.

4. The quantity of the covered substance that was dispensed.

5. The date of the dispensing.

6. The prescriber's identifier number.

7. The dispenser's identifier number.

8. The method of payment for the prescription.

9. Any other non-clinical information that is designated by the Director as necessary for the implementation of this chapter in accordance with the Department's regulations.

10. Any other information specified in regulations promulgated by the Director as required in order for the Prescription Monitoring Program to be eligible to receive federal funds.

C. (Effective until January 1, 2017) The reports required herein shall be made and transmitted in such manner and format and according to the standards and schedule established in the Department's regulations.

C. (Effective January 1, 2017) The reports required herein shall be made to the Department or its agent within 24 hours or the dispenser's next business day, whichever comes later, and shall be made and transmitted in such manner and format and according to the standards and schedule established in the Department's regulations.

2002, c. 481; 2006, c. 167; 2012, cc. 21, 71; 2016, c. 309.

18VAC76-20-20. General provisions.

In accordance with Chapter 25.2 (§ 54.1-2519 et seq.) of Title 54.1 of the Code of Virginia and this chapter, the Director of the Department of Health Professions shall establish and administer a program for monitoring the dispensing of Schedules II, III, and IV controlled substances and any other drugs of concern identified by the Board of Pharmacy pursuant to § 54.1-3456.1 of the Code of Virginia.

E. Required data elements shall include those listed in subsection B of § 54.1-2521 of the Code of Virginia and the following:

1. The Drug Enforcement Administration (DEA) registration number of the dispenser;

2. The National Provider Identifier of the prescriber;

3. The total number of refills ordered;

4. Whether the prescription is a new prescription or a refill;

5. Whether the prescription is a partial fill;

6. The gender code;

7. The species code;

8. The Electronic Prescription Reference Number, and the Electronic Prescription Order Number if it is an electronic prescription; and

9. The date the prescription was written by the prescriber.

Draft Language: Require Dispensing of Schedule V Controlled Substances to be Reported to the PMP

§ 54.1-2519. Definitions.

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"Covered substance" means all controlled substances included in Schedules II, III, ~~and~~ IV, and V and all drugs of concern that are required to be reported to the Prescription Monitoring Program, pursuant to this chapter.

"Drug of concern" means any drug or substance, including any controlled substance or other drug or substance, where there has been or there is the potential for abuse and that has been identified by the Board of Pharmacy pursuant to § 54.1-3456.1.

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3. The total number of refills ordered;

4. Whether the prescription is a new prescription or a refill;

5. Whether the prescription is a partial fill;

6. The gender code;

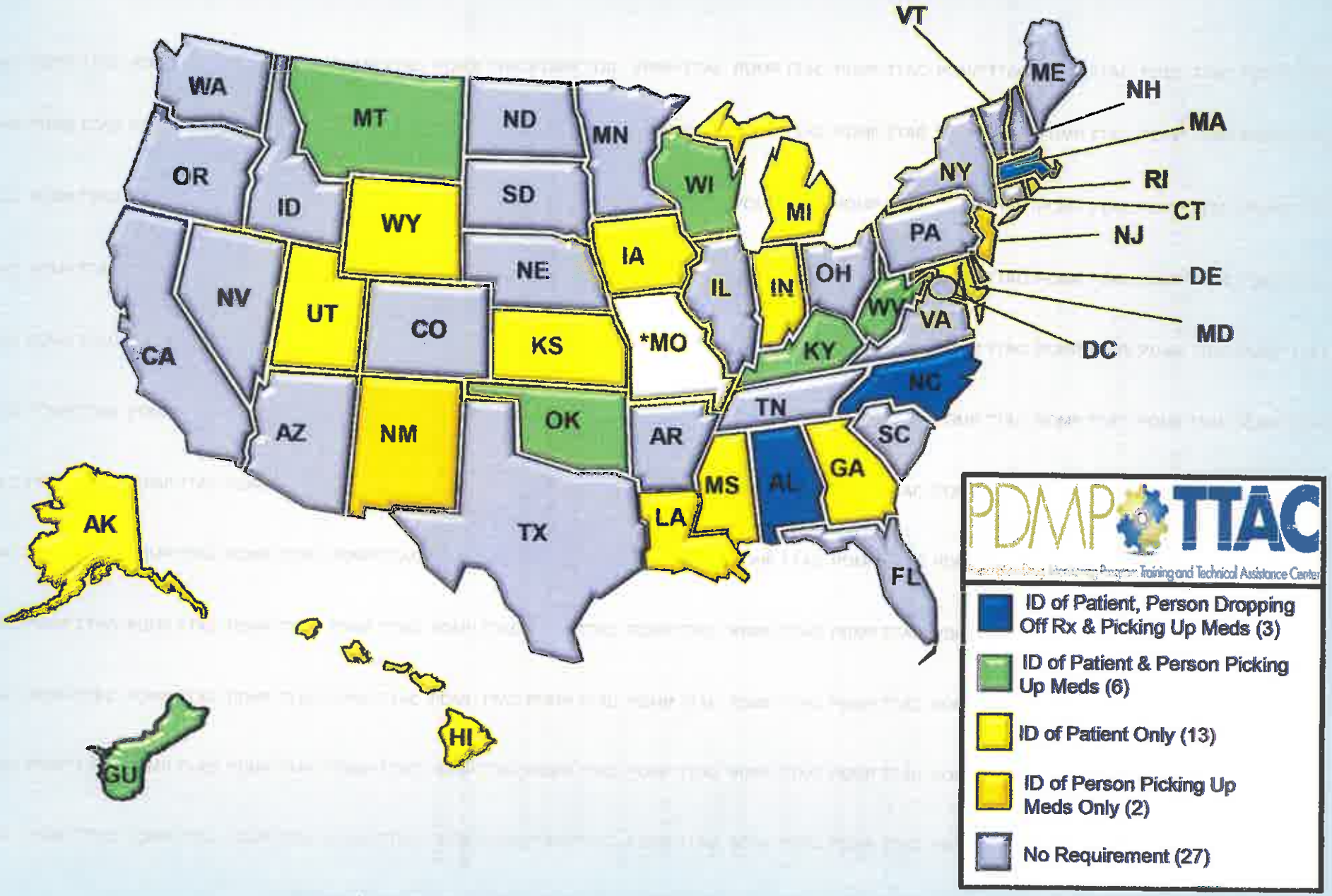
7. The species code;

8. The Electronic Prescription Reference Number, and the Electronic Prescription Order Number if it is an electronic prescription; and

9. The date the prescription was written by the prescriber.

Draft Language: Require Reporting of Information Related to Person Picking Up Controlled Substances to the PMP

PDMP Required Data Field: Positive Identification



Research is current as of October 18, 2016

*Missouri does not have PDMP legislation

MA PMP identifier code language

(c) customer identifier, as defined in 105 CMR 700.001;

(d) relationship of customer to patient;

(3) A pharmacy that dispenses a controlled substance subject to the requirements in 105 CMR 700.012 must report the customer identifier required by 105 CMR 701.004. A pharmacy may dispense a controlled substance without a customer identifier, provided it meets the requirements of 105 CMR 701.004(B) and provides to the Department those informational fields required by the Department

(4) The Commissioner or designee may waive or modify the requirement in 105 CMR 700.012(A)(1)(c) and/or (d), for a pharmacy to report a customer identifier and/or the relationship of the customer to the patient, for prescription refills, prescription deliveries and/or other activities/situations specified by the Commissioner or designee.

KY Code language:

(4) Data for each controlled substance that is dispensed shall include but not be limited to the following:

(a) Patient identifier;

WV Code language:

(8) If the prescription being dispensed is being picked up by someone other than the patient on behalf of the patient, the first name, last name and middle initial, address and birth date of the person picking up the prescription as set forth on the person's government-issued

photo identification card shall be retained in either print or electronic form until such time as otherwise directed by rule promulgated by the board; and

ASAP reporting fields for Patient Identifiers:

PAT01 **ID Qualifier of Patient Identifier (Situational)**
Code identifying the jurisdiction that issues the ID in PAT03.
Used if the PMP requires such identification.
See Appendix A for list of jurisdictions.

PAT02 **ID Qualifier (Situational)**
Code to identify the type of ID in PAT03. If PAT02 is used, PAT03 is required.
01 Military ID
02 State Issued ID
03 Unique System ID
04 Permanent Resident Card (Green Card)
05 Passport ID
06 Driver's License ID
07 Social Security Number
08 Tribal ID
99 Other (Trading partner agreed upon ID, such as cardholder ID.)

PAT03 **ID of Patient (Situational)**
Identification number for the patient as indicated in PAT02.
An example would be the driver's license number.

PAT04 **ID Qualifier of Additional Patient Identifier (Situational)**
Code identifying the jurisdiction that issues the ID in PAT06.
Used if the PMP requires such identification.
See Appendix A for list for jurisdictions.

PAT05 **Additional Patient ID Qualifier (Situational)**
Code to identify the type of ID in PAT06 if the PMP requires a second identifier. If PAT05 is used, PAT06 is required.
01 Military ID
02 State Issued ID
03 Unique System ID
04 Permanent Resident Card (Green Card)
05 Passport ID
06 Driver's License ID
07 Social Security Number
08 Tribal ID
99 Other (Trading partner agreed upon ID, such as cardholder ID.)

DRAFT LANGUAGE: collecting ID information of person picking up covered substance

§ 54.1-2521. Reporting requirements.

A. The failure by any person subject to the reporting requirements set forth in this section and the Department's regulations to report the dispensing of covered substances shall constitute grounds for disciplinary action by the relevant health regulatory board.

B. Upon dispensing a covered substance, a dispenser of such covered substance shall report the following information:

1. The recipient's name and address.

2. The recipient's date of birth.

3. The covered substance that was dispensed to the recipient.

4. The quantity of the covered substance that was dispensed.

5. The date of the dispensing.

6. The prescriber's identifier number.

7. The dispenser's identifier number.

8. The method of payment for the prescription.

9. The identification information of person picking up covered substance

~~9.~~ 10. Any other non-clinical information that is designated by the Director as necessary for the implementation of this chapter in accordance with the Department's regulations.

~~10.~~ 11. Any other information specified in regulations promulgated by the Director as required in order for the Prescription Monitoring Program to be eligible to receive federal funds.

C. (Effective until January 1, 2017) The reports required herein shall be made and transmitted in such manner and format and according to the standards and schedule established in the Department's regulations.

C. (Effective January 1, 2017) The reports required herein shall be made to the Department or its agent within 24 hours or the dispenser's next business day, whichever comes later, and shall be made and transmitted in such manner and format and according to the standards and schedule established in the Department's regulations.

2002, c. 481; 2006, c. 167; 2012, cc. 21, 71; 2016, c. 309.

18VAC76-20-20. General provisions.

In accordance with Chapter 25.2 (§ 54.1-2519 et seq.) of Title 54.1 of the Code of Virginia and this chapter, the Director of the Department of Health Professions shall establish and administer a program for monitoring the dispensing of Schedules II, III, and IV controlled substances and any other drugs of concern identified by the Board of Pharmacy pursuant to § 54.1-3456.1 of the Code of Virginia.

E. Required data elements shall include those listed in subsection B of § 54.1-2521 of the Code of Virginia and the following:

1. The Drug Enforcement Administration (DEA) registration number of the dispenser;

2. The National Provider Identifier of the prescriber;

3. The total number of refills ordered;

4. Whether the prescription is a new prescription or a refill;

5. Whether the prescription is a partial fill;

6. The gender code;

7. The species code;

8. The Electronic Prescription Reference Number, and the Electronic Prescription Order Number if it is an electronic prescription; and

9. The date the prescription was written by the prescriber.

From the Drug Control Act:

§ 54.1-3420.1. Identification required for filling prescriptions.

A. Before dispensing any drug listed on Schedules III through V, a pharmacist may require proof of identity from any patient presenting a prescription or requesting a refill of a prescription.

B. A pharmacist, or his agent, shall require proof of identity at the time of delivery from any person seeking to take delivery of any drug listed on Schedule II pursuant to a valid prescription,

unless such person is known to the pharmacist or to his agent. If the person seeking to take delivery of a drug listed on Schedule II pursuant to a valid prescription is not the patient for whom the drug is prescribed, and the person is not known to the pharmacist or his agent, the pharmacist or his agent shall either make a photocopy or electronic copy of such person's identification or record the full name and address of such person. The pharmacist shall keep records of the names and addresses or copies of proof of identity of persons taking delivery of drugs as required by this subsection for a period of at least one month. For the purposes of this subsection, "proof of identity" means a driver's license, government-issued identification card, or other photo identification along with documentation of the person's current address.

C. Whenever any pharmacist permitted to operate in the Commonwealth or nonresident pharmacist registered to conduct business in the Commonwealth delivers a prescription drug order for any drug listed on Schedule II by mail, common carrier, or delivery service to a Virginia address, the method of delivery employed shall require the signature of the recipient as confirmation of receipt.

(1988, c. 400, § 54-524.67:4; 2010, c. 193; 2011, cc. 262, 318.)

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Virginia's First Healthcare System Opts into Appriss Health's NarxCare Platform

Patients Benefit When Prescribers Save Time in the Fight Against Prescription and Opioid Abuse

RICHMOND—In the fight against prescription drug abuse and opioid addiction, prescribers at Tidewater's Bayview Physicians Group and their patients are among the first beneficiaries of NarxCare by Appriss Health offered by Virginia's Prescription Monitoring Program (PMP). In just seconds, this digital system integrates a patient's prescription history into the work flow of their provider to optimize treatment.

In January, Governor McAuliffe announced the $3.1 million grant from Purdue Pharma to stand up the NarxCare bridge between electronic health records systems and the PMP for use by practitioners when prescribing or dispensing controlled substances. PMP is a program of the Virginia Department of Health Professions (DHP).

DHP Director, David Brown, DC today says, "It is noteworthy that a physician's group the size of Bayview was able to opt into NarxCare in less than 90 days. It is our hope that both small and large healthcare systems will quickly follow suit to help safeguard 8 million Virginians against the opioid epidemic by making sure the prescribing history of patients is taken into account."

According to PMP Director Ralph Orr, "By 2018, PMP NarxCare is expected to improve the performance, access and usability of PMP data for 18,000 prescribers and 400 pharmacies in the Commonwealth. As a result, in the coming years, Virginia should anticipate a drop in prescription drug overdose deaths."

Bayview Director of Information Systems, Jeff Elmore reports, "NarxCare is not only ensuring proper prescribing but is already saving our providers minutes per patient. Compounded, that is a lot of found time now available to see additional people."

Also, in a move to improve use of PMP data among its physicians and pharmacists, Sentara Healthcare has announced adoption of a similar system.

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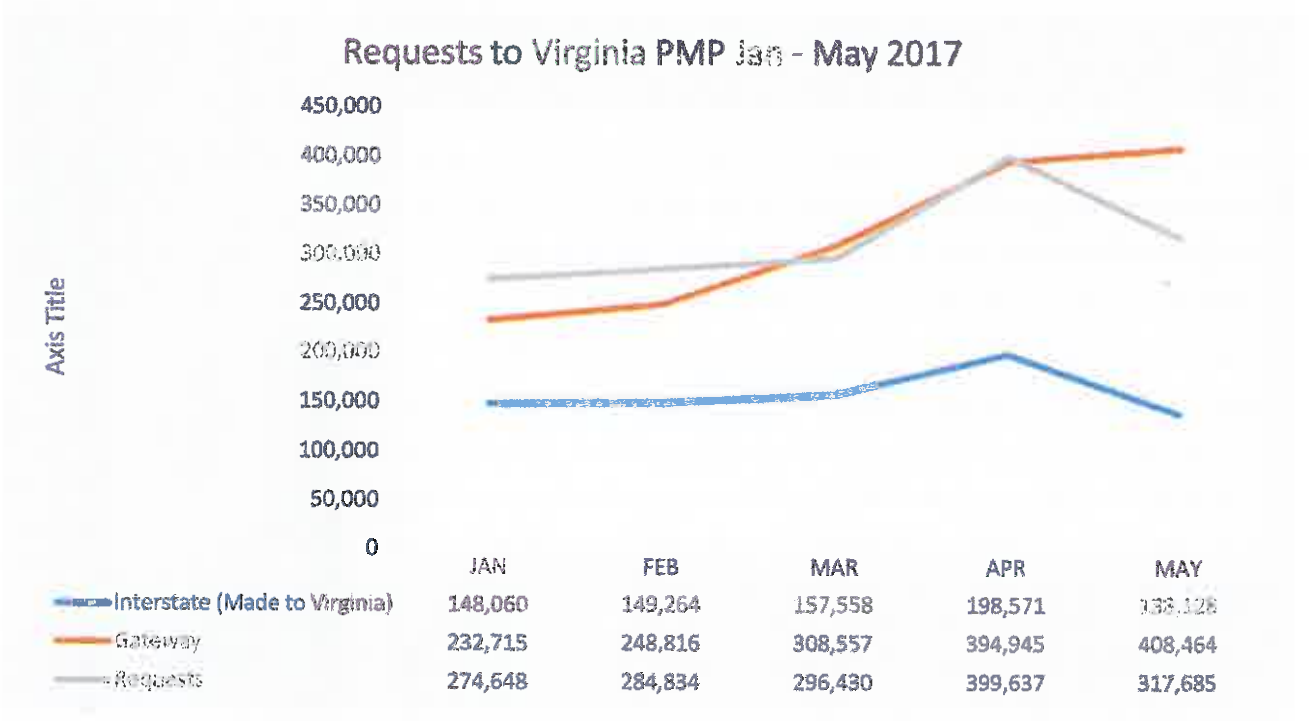
The Prescription Monitoring Program, a secure and confidential database maintained under law by the Department of Health Professions (DHP), is a repository of Schedule II – IV drugs prescribed for the use of authorized personnel responsible for making treatment decisions.

The Virginia Department of Health Professions' 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.

# # #

INTEGRATION PROJECT



Bayview Physicians Group first to implement NarxCare in Virginia.

Sentara Health is integrated using GATEWAY and is looking to move to NarxCare at a later date

Over 30 additional electronic health record application users have expressed interest and are in various stages of review

Kroger Pharmacies have been integrated using first generation solution NarxCheck for well over a year.

Several pharmacy software applications are either capable now or very close to having ability to allow their clients to connect to NarxCare. These vendors are QS1, Pioneer, PDX, RX30, and Lagniappe. Individual pharmacies will have to sign a license agreement with Appriss. Another chain pharmacy is anticipating integrating with NarxCare in fall of 2017.

Disclosing State: Virginia
PDMP Integration Request/Responses by Licensee

Licensee	January 2017	February 2017	March 2017	April 2017	May 2017
Bayview Physicians - NarxCare		257	52,832	87,809	170,878
CVS Pharmacy	141	60	82	72	
Kroger	145,165	136,568	158,424	143,959	153,529
Sentara Healthcare				5,841	19,869
Total	145,306	136,885	211,338	237,681	344,276

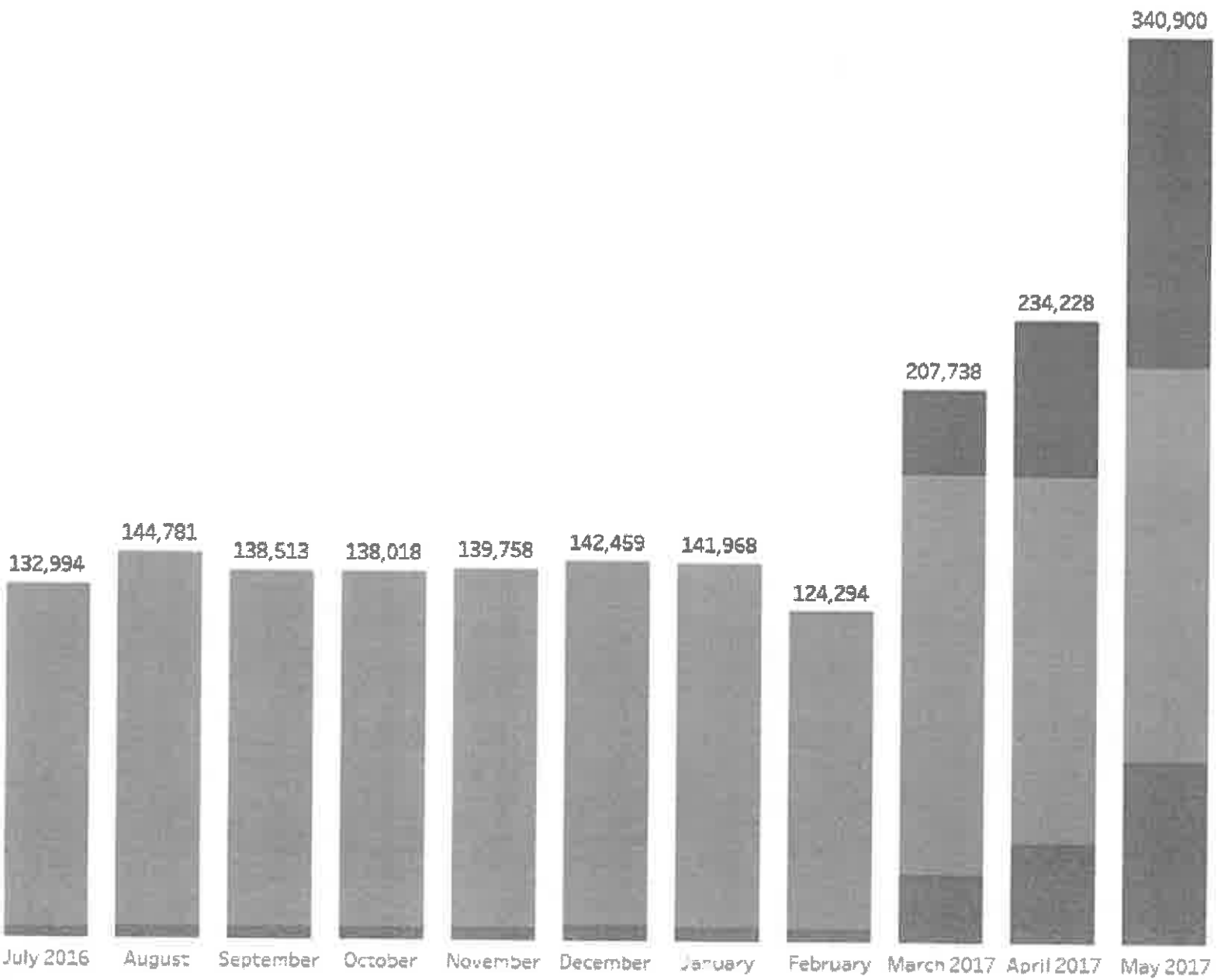
Originating State
Virginia

Role Group
All

Request Type
All

Response Type
All

Disclosing State: Virginia
PDMP Integration Request/Responses by Response Type



Originating State
Virginia

Role Group
All

Request Type
All

Response Type
Multiple values

Licensee Type
All

Licensee
All

Response Type
- Data
- NarxScore
- NoData

NABP PMP InterConnect®

Connecting State Prescription Monitoring Programs Nationwide

Developed by the National Association of Boards of Pharmacy® (NABP®), NABP PMP InterConnect® was designed to facilitate interoperability and interstate data sharing between state prescription monitoring programs (PMPs). The system was created at the request of several state PMPs to address a number of roadblocks states were experiencing in implementing a PMP data sharing solution. PMP InterConnect ensures that each participating state's data access rules are enforced every time a request to the system is made. All data is encrypted during the transfer process and no data is stored in PMP InterConnect. To further ensure that the process remains time and cost efficient, PMPs choosing to participate need only enter into a single memorandum of understanding (MOU) with NABP rather than having to develop separate contractual agreements with each participating PMP. The system became operational with data exchanges between Indiana and Ohio in August 2011. To date, 43 states have executed MOUs with NABP to participate and 41 of those states are now live. By enabling PMPs across the United States to be linked, PMP InterConnect provides a more effective means of combating drug diversion and drug abuse nationwide.

Governance

PMP InterConnect is governed by a Steering Committee comprised exclusively of representatives of the PMPs that are participating in the system. The Steering Committee serves as the governing and advisory body as it relates to the administration and function of PMP InterConnect. No outside organization, public or private, has access to PMP InterConnect, a vote about, influence over, or the ability to direct the administration and function of PMP InterConnect.

Cost/Funding

NABP has paid all costs associated with the development and implementation of PMP InterConnect and will continue to pay the annual fees for each participating PMP using, exclusively, its own revenues derived from program resources. NABP recognizes the financial constraints faced by states and believes this project is a logical place to assist in addressing prescription drug abuse.

More Information

Visit the Programs section of the NABP website to access additional information about PMP InterConnect.

NABP PMP InterConnect by the Numbers

- **41 PMPs are currently connected to PMP InterConnect:** Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, and Wisconsin.
- **2 more have signed an MOU and plan to be connected in 2017:** North Carolina and Pennsylvania. Another state PMP has an MOU under review: Wyoming.
- **Approximately 45 PMPs will either be connected to or working toward a connection to PMP InterConnect in 2017.**
- **PMP InterConnect is currently processing more than 7.3 million requests every month.**

Founded in 1904, NABP is the independent, international, and impartial Association that assists its member boards and jurisdictions for the purpose of protecting the public health.

GABAPENTIN

Top Drugs by Brand Name

Date Period	Dosage Units	DEA Schedule	AHFS Therapeutic Class
5/1/2017 12:00:00 AM to 5..	All	All	All

Brand Name	Generic Name	AHFS Therapeutic Class	Rx Count
HYDROCODONE-ACETAMINOPHEN	HYDROCODONE BITARTRATE/ACETAMINOPHEN	OPIATE AGONISTS	[illegible]
GABAPENTIN	GABAPENTIN	ANTICONVULSANTS, MISCELLANEOUS	[illegible]
ALPRAZOLAM	ALPRAZOLAM	BENZODIAZEPINES (ANXIOLYTIC,SEDATIV/HYP)	[illegible]
OXYCODONE-ACETAMINOPHEN	OXYCODONE HCL/ACETAMINOPHEN	OPIATE AGONISTS	[illegible]
TRAMADOL HCL	TRAMADOL HCL	OPIATE AGONISTS	[illegible]
CLONAZEPAM	CLONAZEPAM	BENZODIAZEPINES (ANTICONVULSANTS)	[illegible]
ZOLPIDEM TARTRATE	ZOLPIDEM TARTRATE	ANXIOLYTICS,SEDATIVES,AND HYPNOTICS,MISC	[illegible]
DEXTROAMPHETAMINE-AMPHETAMINE	DEXTROAMPHETAMINE SULF SACCHARATE/AMPHE..	AMPHETAMINES	[illegible]
LORAZEPAM	LORAZEPAM	BENZODIAZEPINES (ANXIOLYTIC,SEDATIV/HYP)	[illegible]
OXYCODONE HCL	OXYCODONE HCL	OPIATE AGONISTS	[illegible]
DIAZEPAM	DIAZEPAM	BENZODIAZEPINES (ANXIOLYTIC,SEDATIV/HYP)	[illegible]
VYVANSE	LISDEXAMFETAMINE DIMESYLATE	AMPHETAMINES	[illegible]
DEXTROAMPHETAMINE-AMPHET ER	DEXTROAMPHETAMINE SULF SACCHARATE/AMPHE..	AMPHETAMINES	26,975
METHYLPHENIDATE ER	METHYLPHENIDATE HCL	RESPIRATORY AND CNS STIMULANTS	21,681
PHENTERMINE HCL	PHENTERMINE HCL	AMPHETAMINE DERIVATIVES	21,051
ACETAMINOPHEN-CODEINE	ACETAMINOPHEN WITH CODEINE PHOSPHATE	OPIATE AGONISTS	18,788
SUBOXONE	BUPRENORPHINE HCL/NALOXONE HCL	OPIATE PARTIAL AGONISTS	16,759
BUPRENORPHINE-NALOXONE	BUPRENORPHINE HCL/NALOXONE HCL	OPIATE PARTIAL AGONISTS	13,788
METHYLPHENIDATE HCL	METHYLPHENIDATE HCL	RESPIRATORY AND CNS STIMULANTS	12,460
MORPHINE SULFATE ER	MORPHINE SULFATE	OPIATE AGONISTS	10,727
HYDROMORPHONE HCL	HYDROMORPHONE HCL	OPIATE AGONISTS	10,386
	HYDROMORPHONE HCL/PF	OPIATE AGONISTS	186
TEMAZEPAM	TEMAZEPAM	BENZODIAZEPINES (ANXIOLYTIC,SEDATIV/HYP)	10,284
FENTANYL	FENTANYL	OPIATE AGONISTS	8,697
ESZOPICLONE	ESZOPICLONE	ANXIOLYTICS,SEDATIVES,AND HYPNOTICS,MISC	6,988

<u>Announcement for pharmacists and pharmacist delegates:</u>

Gabapentin must now be reported to the Virginia Prescription Monitoring Program:
This is the result of legislation passed by the 2017 General Assembly (House Bill 2164) and signed into law by the Governor.

Typically records submitted to the VA PMP require a dispenser/pharmacy DEA and prescriber DEA. Gabapentin is not a scheduled drug and as such may be obtained from prescribers or dispensers that do not have a DEA registration. Refer to these scenarios and if you have any questions, please reference the VA PMP Dispenser Guide.

Scenario 1 (Effective May 31, 2017) – Pharmacy that does not dispense controlled substances but does dispense drugs of concern such as gabapentin. Clinic does not have DEA number but does have NPI number.
Guideline – Leave the dispenser/pharmacy DEA number section blank in the controlled

substance report. Input the dispenser/pharmacy NPI number in the appropriate field of controlled substance report.

Scenario 2 (Currently in effect) – Prescriber does not prescribe controlled substances (scheduled drugs) but does dispense drugs of concern such as gabapentin.
Guideline – Leave the prescriber DEA number section blank in the controlled substance report. Input the prescriber NPI number in the appropriate field of the controlled substance report.

Scenario 3 (Currently in effect) – Prescriber is a veterinarian who does not prescribe drugs in Schedules II – V, but does prescribe "drugs of concern" such as gabapentin. Because CMS will not issue an NPI to a veterinarian, the prescriber does not have an NPI.
Guideline – Leave the prescriber DEA registration field blank in the controlled substance report. Insert "1234567893" in the prescriber NPI field and "02" in the species code field.

Follow-up email and announcement:
Scenario 1 (Effective June 15, 2017) – Pharmacy that does not dispense controlled substances but does dispense drugs of concern such as gabapentin. Clinic does not have DEA number but does have NPI number.
Guideline – Leave the dispenser/pharmacy DEA number section blank in the controlled substance report. Input the dispenser/pharmacy NPI number in the appropriate field of controlled substance report.

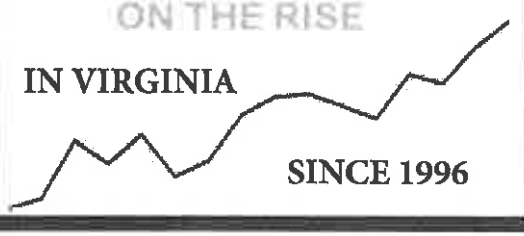
VIRGINIA'S PRESCRIPTION MONITORING PROGRAM

VISIT PMP ONLINE

RX DRUG AND HEROIN DEATHS
OUTNUMBER
AUTOMOBILE DEATHS IN VIRGINIA

THOUSANDS OF FAMILIES
ARE IMPACTED EACH YEAR

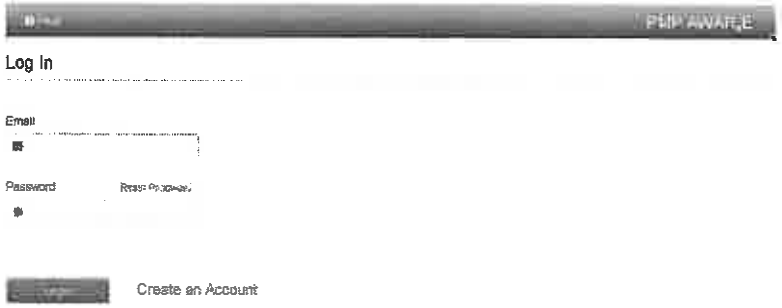
PRESCRIPTION DRUG DEATHS HAVE BEEN
ON THE RISE
IN VIRGINIA



SINCE 1996

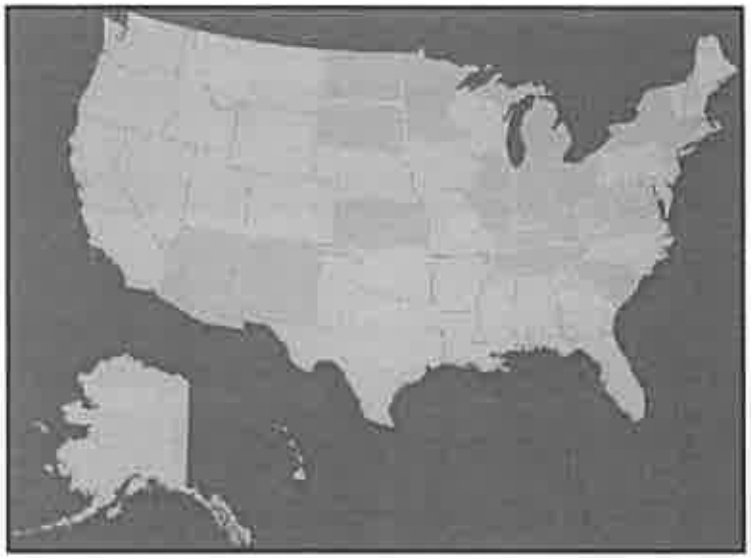
THE SOLUTION FOR SAFE PRESCRIBING IN VIRGINIA

A DIGITAL DATABASE OF PRESCRIPTION AND PATIENT HISTORIES



Practitioners may click above to log into the PMP database.

DIGITALLY CONNECTED WITH 21 OTHER STATES AND THE DISTRICT OF COLUMBIA



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

Currently there are more than **52,000** prescribers and **12,000** 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 prescribers and pharmacists are automatically registered for the PMP.

NEW LEGISLATION

New legislation passed by the 2017 General Assembly increases requirements for using the Prescription Monitoring Program as well as requiring the reporting of dispensing of all gabapentin products.

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 PMP Online

View the CDC Guidelines for Prescribing Pain Medication

Total User Accounts by User Type (As of 6/5/2017)

User Type	Number of Users
Physician (MD, DO)	31892
Pharmacist	12195
Dentist	5624
Nurse Practitioner / Clinical Nurse Specialist	5338
Prescriber Delegate - Licensed	3097
Physician Assistant	2743
Medical Intern with Prescriptive Authority	2415
Optometrist	1242
Prescriber Delegate - Unlicensed	1072
Pharmacist's Delegate - Licensed	565
Medical Resident	296
Local	111
Licensing Board Investigator	72
Probation	69
Medical Examiner/Coroner	39
DEA	37
Podiatrist (DPM)	30
FBI	26
State Medicaid Program	25
State Police	24
Pharmacist's Delegate - Unlicensed	19
Medical Intern	14
Medicaid Fraud Units	14
Medical Resident with Prescriptive Authority	7
Peer Assistance Program / Recovering Health Professions Program	3
Military Police	2
Pharmacy Technician	1
TOTAL	66972

PMP Queries by User Type January - June 2017
(as of June 5, 2017)

	Jan	Feb	March	April	May	June	TOTAL BY TYPE
Prescriber Delegate - Unlicensed	14884	16255	22141	22894	27758	2608	106540
Prescriber Delegate - Licensed	37538	35743	43055	41737	48254	4403	210730
Podiatrist (DPM)	21	10	38	33	44	2	148
Physician Assistant	17146	15548	20648	20489	21916	1965	97712
Physician (MD, DO)	125739	120429	140666	132981	152184	14571	686570
Pharmacy Technician	2	1	0	0	0	0	3
Pharmacist's Delegate - Unlicensed	28	16	146	126	82	10	408
Pharmacist's Delegate - Licensed	6115	6786	8934	8789	10086	1143	41853
Pharmacist	85217	80594	93728	88481	94011	10850	452881
Optometrist	0	5	1	1	6	0	13
Nurse Practitioner / Clinical Nurse Specialist	22494	21400	25230	24943	29014	2834	125915
Medical Resident	216	308	410	455	374	64	1827
Licensing Board Investigator	137	196	200	164	174	5	876
Dentist	1142	1176	1197	1309	2227	187	7238
TOTAL By MONTH	310679	298467	356394	342402	386130	38642	**1732714**

Total Dispensations of Schedules II, III and IV Drugs to Virginia PMP

Month	Daily Average Dispensation Count	Monthly Dispensation Total	Class II Monthly Total	Class III Monthly Total	Class IV Monthly Total
January	105,072	1,155,489	555,231	84,035	484,170
February	107,343	1,073,177	510,190	78,372	427,194
March	116,687	1,277,940	576,444	89,033	488,640
April	106,949	1,069,355	468,978	74,706	407,907
May	109,655	1,161,861	501,229	81,074	440,301
		5,737,822	2,612,072	407,220	2,248,212

Unsolicited Reports - 2017

Unsolicited Reports to Prescribers (3 or more prescribers, 3 or more pharmacies, 9 or more Rx, one month time frame)		
	# of Patients	# of Email Notifications to Prescribers (May not be unique prescribers)
February	90	384
March	146	658
April	109	471

Quarterly Performance Measure Highlights: 4th Quarter CY16-1st Quarter CY17

The number of adults with prescriptions for painkillers with a morphine equivalent greater than 100 per day decreased from 168204 in the fourth quarter of 2016 to 162751 in the 1st quarter of 2017.

The number of youth with prescriptions for painkillers with a morphine equivalent greater than 100 per day decreased from 942 in the fourth quarter of 2016 to 719 in the 1st quarter of 2017.

Doses dispensed during 4th Quarter CY16

Schedule of Medication Filled	Pain Relievers	Tranquilizers	Stimulants	Sedatives
Schedule II	65186270	0	23732906	300
Schedule III	4983693	0	188951	239279
Schedule IV	Under additional review	43867895	2676272	10993882

Doses dispensed during 1st Quarter CY17

Schedule of Medication Filled	Pain Relievers	Tranquilizers	Stimulants	Sedatives
Schedule II	61986364	0	23846322	210
Schedule III	4990589	0	204650	218349
Schedule IV	Under additional review	40347445	2808059	10642718

The number of patients with Schedule II prescriptions dispensed decreased from 768592 in the fourth quarter of 2016 to 762673 in the 1st quarter of 2017.

The number of patients with Schedule II, III and/or IV prescriptions dispensed decreased from 1,304,607 in the fourth quarter of 2016 to 1,293,123 in the 1st quarter of 2017.

The number of persons receiving prescriptions in Schedules II, III, and/or IV from five or more prescribers and five or more pharmacies decreased from 809 in the fourth quarter of 2016 to 641 in the 1st quarter of 2017.

1. Subject: Introducing Your Personalized Virginia Prescriber Report

2. Body:

Dear Prescriber,

Attached is your personalized PMP Prescriber Report which provides you with a snapshot of your prescribing of covered substances from 10/31/2016 – 3/31/2017.

1. This report will let you know how many patients you have prescribed opioids to and provide a comparison to the prescribing of peers within your specialty
2. Morphine Milligram Equivalent (MME) dosing information is broken out so you can readily see whether (or where) your opioid prescribing falls within several MME ranges
3. Treatment duration is another metric that is meaningful and corresponds to legislation requiring PMP use as well as number of patients under treatment for "chronic" pain
4. PMP usage: shows exactly how much you and your delegates are using the PMP
5. Multiple Provide Episodes (MPE) thresholds—provides a look at your patients with multiple provider episodes over the time period. This could be indicative of continuity of care issues or misuse/abuse or diversion of covered substances
6. Dangerous combination therapy—provides details of combination therapy that may increase a patient's risk for overdose.

Please take some time to review this information as well as the attached document explaining the metrics behind the report.
Here are some links that you may find useful as you review this document: CDC Resources: https://www.cdc.gov/drugoverdose/prescribing/resources.html; Board of Medicine Emergency
Regulations: http://www.dhp.virginia.gov/medicine/leg/PrescribingOpioidsBuprenophine_03152017.doc; Department of Health Professions Website: http://www.dhp.virginia.gov/

The PMP hopes that you find this information helpful in your practice. If you have questions or comments related to the contents of the report please email pmp@dhp.virginia.gov.

Respectfully,

Ralph A. Orr
Program Director

Virginia Department of Health Professions

VIRGINIA PRESCRIPTION MONITORING PROGRAM

APPRISS HEALTH

PMP Prescriber Report

DATE: 5/30/2017

DATE COVERED BY THIS REPORT: 10/01/2016 - 03/31/2017

NAME: Carl Flansbaum

DEA #: MP2994425

ROLE: Nurse Practitioner / Clinical Nurse Specialist

SPECIALTY: Specialist/Technologist, Health Information

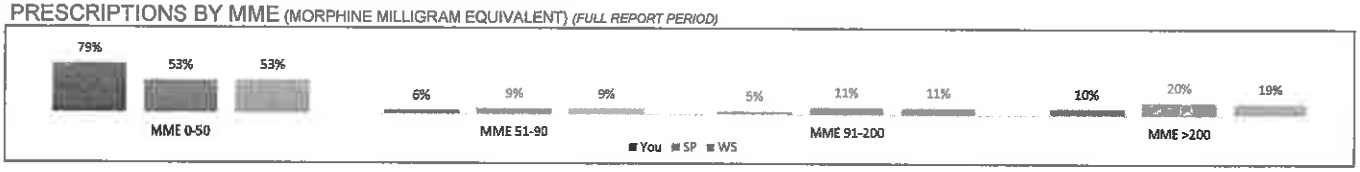
MEMBER NUMBERS IN YOUR PEER GROUPS: SIMILAR PRESCRIBER (SP): 81 WITHIN YOUR SPECIALTY (WS): 98

NUMBER OF PERSONS FOR WHICH YOU PRESCRIBED OPIOIDS *(MONTHLY AVERAGE)*			NUMBER OF PRESCRIPTIONS YOU WROTE FOR OPIOIDS *(MONTHLY AVERAGE)*		
88	7	7	638	13	14
You	Similar Prescriber (SP)	Within your Specialty (WS)	You	Similar Prescriber (SP)	Within your Specialty (WS)

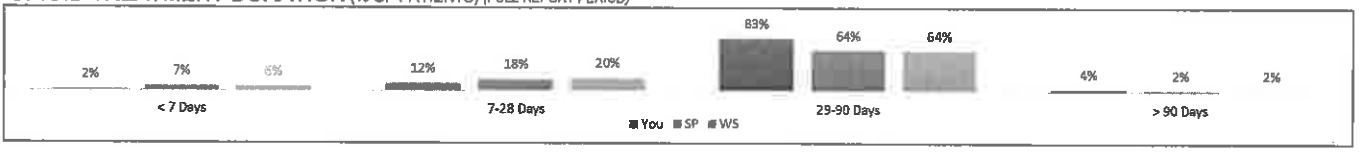
TOP MEDICATIONS PRESCRIBED *(FULL REPORT PERIOD)*

DEXTROAMPHETAMINE SULF-SACCHARATE/AMPHETAMINE SULF-ASPARTATE	HYDROCODONE BITARTRATE/ACETAMINOPHEN	ACETAMINOPHEN WITH CODEINE PHOSPHATE

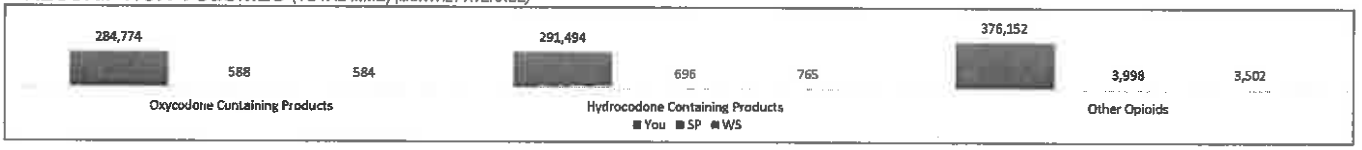
PRESCRIPTIONS BY MME (MORPHINE MILLIGRAM EQUIVALENT) *(FULL REPORT PERIOD)*



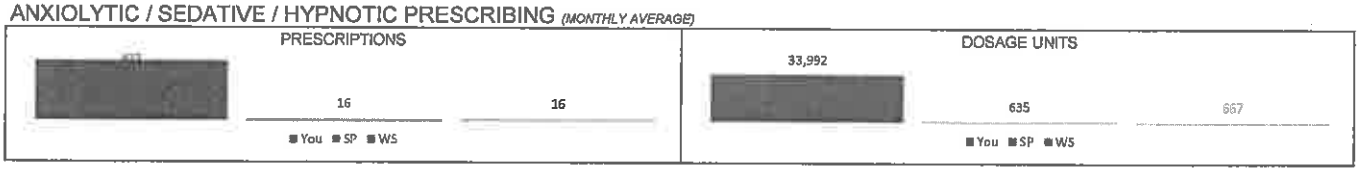
OPIOID TREATMENT DURATION (% OF PATIENTS) *(FULL REPORT PERIOD)*



PRESCRIPTION VOLUMES (TOTAL MME) *(MONTHLY AVERAGE)*



ANXIOLYTIC / SEDATIVE / HYPNOTIC PRESCRIBING *(MONTHLY AVERAGE)*



PDMP USAGE *(MONTHLY AVERAGE)*

PDMP REQUESTS BY YOU	PDMP REQUESTS BY YOUR DELEGATE(S)	SIMILAR PRESCRIBER AVERAGE	SPECIALTY FIELD AVERAGE
5	0	4	3

PATIENTS EXCEEDING MULTIPLE PROVIDER THRESHOLDS *(FULL REPORT PERIOD)*

PATIENTS EXCEEDING MULTIPLE PRESCRIBER THRESHOLD	PATIENTS EXCEEDING MULTIPLE PHARMACY THRESHOLD
25	15

DANGEROUS COMBINATION THERAPY

PRESCRIPTIONS FOR OPIOID + BENZO IN SAME MONTH		PRESCRIPTIONS FOR OPIOID + BENZO + CARISPORODOL IN SAME MONTH	
25	35	15	20
BY YOU	BY YOU + OTHER PRESCRIBERS	BY YOU	BY YOU + OTHER PRESCRIBERS

APPRISS HEALTH

Specific Metrics for PDMP Prescriber Reports for Virginia Prescription Monitoring Program

Metric Values Generation

- The PDMP Prescriber Reports is reflective on any/all opioid and anxiolytic/sedative/hypnotic medications as reported to the state PMP during the report period as noted.

- Metrics are reported either as values covering the full report period or the average of monthly metrics (which are referred to as "Monthly Average".)

- Some metrics additionally include comparisons to median values of prescriber peer groups; these are defined as follows:

    - Similar Prescriber (SP): The same role + the same healthcare specialty of the prescriber.
    - Within Specialty (WS): The same healthcare specialty as the prescriber.

Specific Metrics:

1. Number of persons for which you prescribed at least one (1) opioid
    - Monthly average value
    - Includes comparison with peer group median values

2. Number of opioid prescriptions written by you
    - Monthly average value
    - Includes comparison with peer group median values

3. Top medications prescribed by you
    - Top three (3) drugs based on # of prescriptions
    - By generic name and as reported to the state PMP

4. Percentage values of opioid prescriptions written by you divided into the following MME ranges:
    - MME 0-50
    - MME 51-90
    - MME 91-200
    - MME > 200

    - Full report period
    - Includes comparison with peer group median values

5. Percentage values of your patients where their opioid treatment duration falls into one of the following range of days (these values are based on the cumulative day's supply of a person's prescriptions during the report time.):
    - < 7 Days
    - 7-28 Days
    - 29-90 Days
    - > 90 Days

    - Full report period
    - Includes comparison with peer group median values

6. Total Morphine Milligram Equivalency (MME) of prescriptions written by you in the following groups:
    - Total MME of Oxycodone containing products
    - Total MME of Hydrocodone containing products
    - Total MME of all other opioids

    - Monthly average value
    - Includes comparison with peer group median values

7. Anxiolytic / Sedative / Hypnotic Prescribing
    - Number of Anxiolytic / Sedative / Hypnotic prescriptions (together as one group)
    - Quantity of dose units of all Anxiolytic / Sedative / Hypnotic prescriptions.

    - Monthly average value
    - Includes comparison with peer group median values

8. PDMP Usage
    - Number of PDMP Report requests by you (and your delegates, if appropriate)

    - Monthly average value
    - Includes comparison with peer group median values

9. Patient Exceeding Multiple Provider Thresholds
    - Number of patients with prescriptions from > 5 prescribers (including at least one written by you)
    - Number of patients having prescriptions filled at > 5 pharmacies (where you wrote at least one of these prescriptions.)

    - Full report period

10. Dangerous Combo Therapy
    - Number of patients receiving an opioid + a benzodiazepine* (in same month - both written for by you).
    - Number of patients receiving an opioid + a benzodiazepine* (in same month - where you wrote just one of the prescriptions).
    - Number of patients receiving an opioid, a benzodiazepine* + carisoprodol (in same month - all written for by you).
    - Number of patients receiving an opioid, a benzodiazepine* + carisoprodol (in same month - where you wrote just one of the prescriptions).

    * *This would also include any other Anxiolytic / Sedative / Hypnotic medications*

    - Full report period

"I just wanted to say thank you for sending out the PMP provider reports. This is such a great tool and I applaud the Commonwealths' commitment to this program.

I wondered if you could clarify for me how some of the data was produced.

When a patient is receiving prescriptions for controlled substances from multiple providers, does the system look to see if this is within the same practice or even the same provider? I have 2 DEA numbers and am listed separately in my two offices. I also have a partner and a midlevel. In other words, would a patient who gets Schedule 2 medication from just our practice be flagged in the system for multiple providers if the prescriptions came from multiple offices within our practice?"

"Upon review of my report and discussion with colleagues, we were quite surprised to see the report stating that similar providers prescribe controlled substances on average to 11 patients per month or 13 prescriptions per month compared to my 56 and 73 respectively.

Who are these "similar providers"? Do they see patients? How many patients do they see? Do they refer all their pain patients to pain specialists who do the prescribing on their behalf? I find difficult to believe that that the average primary care physician writes for only 10 opiates prescriptions a month including tramadol.

Could further clarification be provided so we can compare ourselves more accurately to our "similar providers"?"

"To my knowledge I have not prescribed opioids to any patient during the indicated timeframe 10/1/16-3/31/17. Is there any way to identify which person received the opioid medication so that I can verify this was not in error?"

"I received and reviewed my PMP Prescriber Report. I noted that my specialty listed was Surgery when actually my specialty is Physical Medicine and Rehabilitation - Pain Management. I updated my profile so the specialty is appropriately listed and the next quarterly report will compare me to my peers in Pain Management as opposed to Surgery."

"Thank you for the information in my report. I am a hospice medical director. I was very concerned with my numbers but when I consider that I am a hospice medical director I am a little less worried. How can we find out the list of patients that we have prescribed for in the last few months so I can correlate those names with my hospice patients and my practice patients. I thought I was doing a good job with limiting my prescribing but the numbers are very worrisome to me?"

Generic PMP response:

We appreciate your comments and I can provide the following information in response to your comments:

This report will be provided to you once every six months via email.

Your "my rx" now goes back to 10/1/2016 if you so choose. This will allow you to review your dispensing for the same time frame as the recent prescriber report you received.

You may select any specialty that most closely represents the type of medicine you practice (under your profile settings in your account). The way you select your specialty is no different than the way other practitioners select their own specialty, and that is how the peer groups are formed. We do not collect information regarding whether the practice setting is in a tertiary care hospital, university medical center, urgent care center, small rural practice, etc. The PMP database contains no clinical information on the patients contained within the database.

Please keep in mind that the PMP is limited to the information submitted by the dispensing pharmacies and dispensing practitioners. Furthermore, this report is for your own personal use and is not shared with your peers or your licensing board. We hope the report is informative.

We are taking note of all feedback provided by our registered users in order to improve upon the prescriber reports as they evolve over time.

TABLEAU

Demonstration

VIRGINIA ACTS OF ASSEMBLY -- 2017 SESSION

CHAPTER 291

An Act to amend the Code of Virginia by adding in Article 1 of Chapter 27 of Title 54.1 a section numbered 54.1-2708.4 and by adding in Article 2 of Chapter 29 of Title 54.1 a section numbered 54.1-2928.2, relating to Board of Dentistry and Medicine; regulations for the prescribing of opioids and buprenorphine.

[H 2167]

Approved March 3, 2017

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 1 of Chapter 27 of Title 54.1 a section numbered 54.1-2708.4 and by adding in Article 2 of Chapter 29 of Title 54.1 a section numbered 54.1-2928.2 as follows:

§ 54.1-2708.4. Board to adopt regulations related to prescribing of opioids.

The Board shall adopt regulations for the prescribing of opioids, which shall include guidelines for:

1. The treatment of acute pain, which shall include (i) requirements for an appropriate patient history and evaluation, (ii) limitations on dosages or day supply of drugs prescribed, (iii) requirements for appropriate documentation in the patient's health record, and (iv) a requirement that the prescriber request and review information contained in the Prescription Monitoring Program in accordance with § 54.1-2522.1;

2. The treatment of chronic pain, which shall include, in addition to the requirements for treatment of acute pain set forth in subdivision 1, requirements for (i) development of a treatment plan for the patient, (ii) an agreement for treatment signed by the provider and the patient that includes permission to obtain urine drug screens, and (iii) periodic review of the treatment provided at specific intervals to determine the continued appropriateness of such treatment; and

3. Referral of patients to whom opioids are prescribed for substance abuse counseling or treatment, as appropriate.

§ 54.1-2928.2. Board to adopt regulations related to prescribing of opioids and buprenorphine.

The Board shall adopt regulations for the prescribing of opioids and products containing buprenorphine. Such regulations shall include guidelines for:

1. The treatment of acute pain, which shall include (i) requirements for an appropriate patient history and evaluation, (ii) limitations on dosages or day supply of drugs prescribed, (iii) requirements for appropriate documentation in the patient's health record, and (iv) a requirement that the prescriber request and review information contained in the Prescription Monitoring Program in accordance with § 54.1-2522.1;

2. The treatment of chronic pain, which shall include, in addition to the requirements for treatment of acute pain set forth in subdivision 1, requirements for (i) development of a treatment plan for the patient, (ii) an agreement for treatment signed by the provider and the patient that includes permission to obtain urine drug screens, and (iii) periodic review of the treatment provided at specific intervals to determine the continued appropriateness of such treatment; and

3. The use of buprenorphine in the treatment of addiction, including a requirement for referral to or consultation with a provider of substance abuse counseling in conjunction with treatment of opioid dependency with products containing buprenorphine.

2. That an emergency exists and this act is in force from its passage.

3. That the Prescription Monitoring Program at the Department of Health Professions shall annually provide a report to the Joint Commission on Health Care on the prescribing of opioids and benzodiazepines in the Commonwealth that includes data on reporting of unusual patterns of prescribing or dispensing of a covered substance by an individual prescriber or dispenser or on potential misuse of a covered substance by a recipient, pursuant to § 54.1-2523.1.

Virginia Department of Health Professions

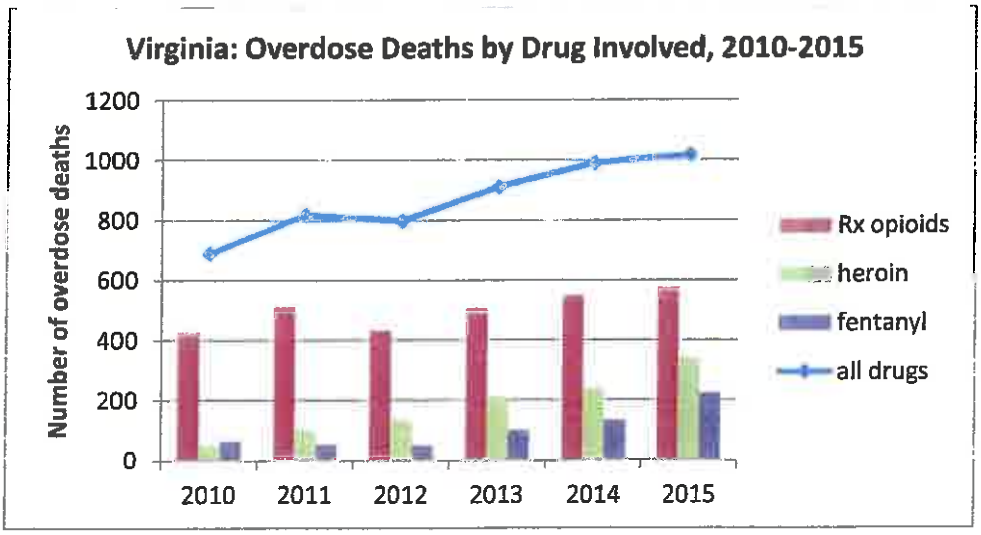
PBSS Prescription Behavior Surveillance System
Brandeis University, Waltham, MA
October 2016

PBSS Data Brief

Overdose Deaths and Prescription Risk Measures in Virginia, 2010-2015

Summary: Drug overdose deaths in Viriginia increased during 2010 to 2015, driven in part by a rise in heroin and fentanyl-related overdoses,[1] but with prescription opioids still playing the largest role in opioid-related deaths overall (Figure 1). Analyses of opioid prescribing indicators associated with risk of opioid use disorders were conducted using Virginia PDMP data reported to the Prescription Behavior Surveillance System (PBSS). Since 2010, the average daily dose of opioids to Virginians has declined, as has the percentage of patients receiving over 100 morphine milligram equivalents (MMEs) of opioids 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 opioid prescriptions and overlapping benzodiazepines prescriptions declined somewhat from 2012 to 2015, but those for overlapping stimulants and overlapping opioid/benzodiazepine prescriptions remained level (Figure 4). As in previous years, prescription rates for opioids in 2015 were sharply higher for older age groups (Figure 5). These data suggest that although progress has been made toward safer controlled substance prescribing in Virginia, more remains to be done to reduce opioid and benzodiazepine exposure, especially among older adults. Steps toward safer prescribing include increasing PDMP utilization; providing prescriber feedback reports; and use of data analytics, including prescription risk meaures, to inform education of prescribers and dispensers.

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. See the PBSS webpage at http://www.pdmpassist.org/content/pbss

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]

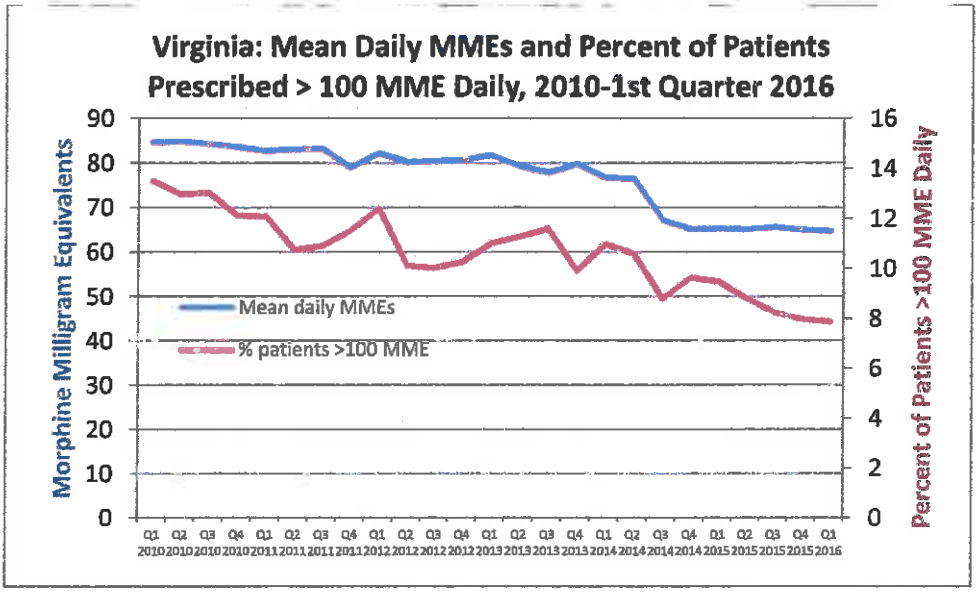


Figure 3. Of patients in Virginia that were prescribed long acting (LA) or extended release (ER) opioids from 2010-2015, between 34% (2013) and 41% (2011) were "opioid naïve" (had not been prescribed opioids in the prior 60 days) (blue bars). The daily dose in morphine milligram equivalents (MMEs) for LA/ER prescriptions (red line) declined from 131 MMEs in 2010 to 113 MMEs in 2015.[5]

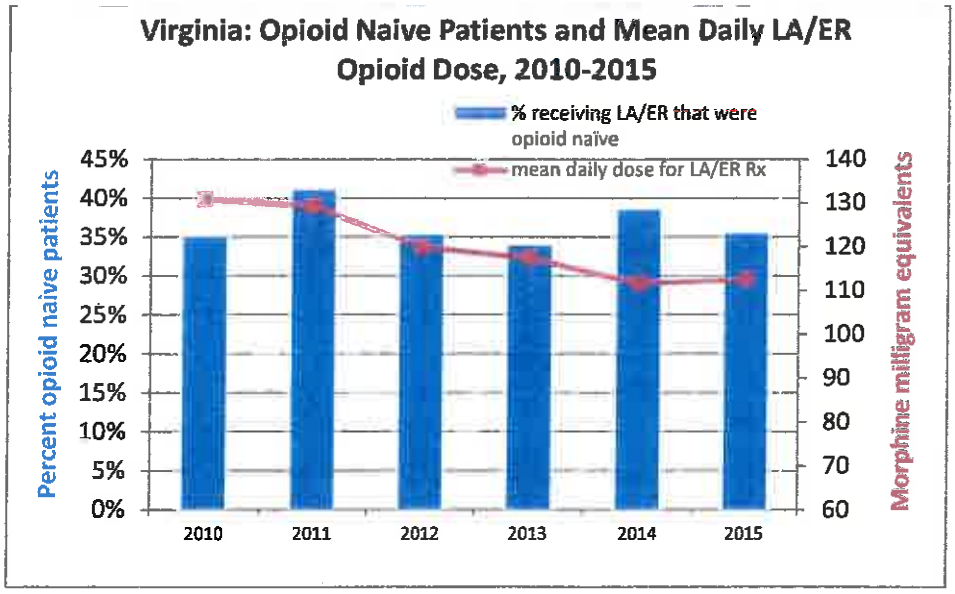


Figure 4. After increasing from 2010 to 2012, the percent of prescribed days with overlapping opioid prescriptions (blue line) and overlapping benzodiazepine prescriptions (purple line) decreased from 2012 to 2015. However, overlapping prescriptions for opioids and benzodiazepines (red line) and for stimulants (green line) remained nearly level after 2012.[6]

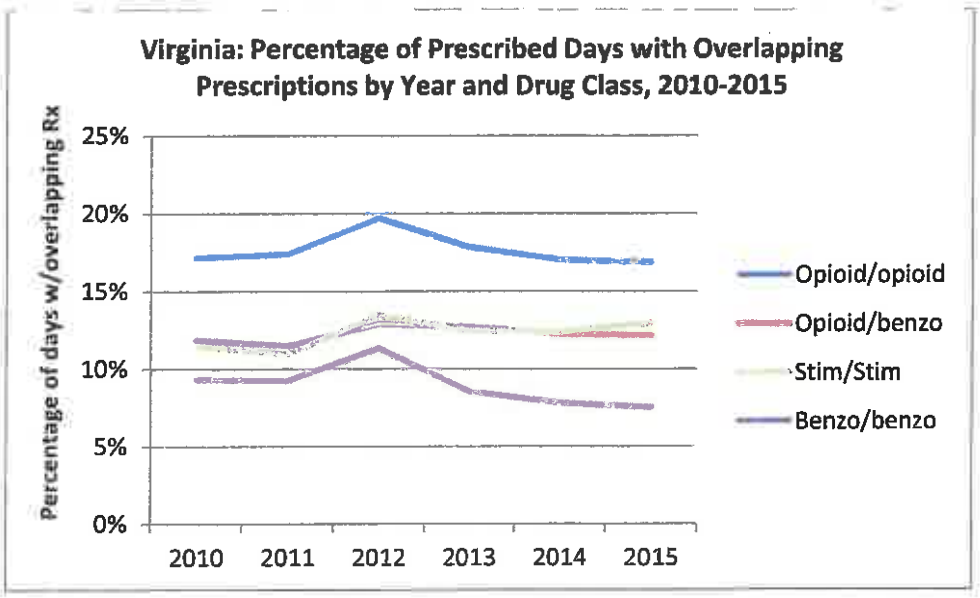
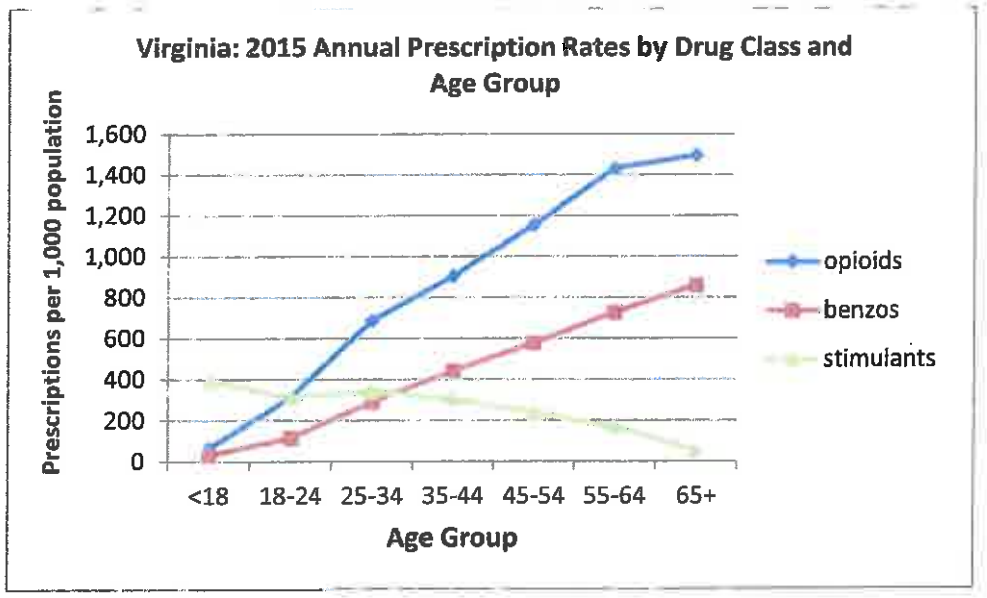


Figure 5. Prescription rates for opioids in Virginia in 2015 increased sharply by age group, with those 65 and over receiving 1,495 opioid prescriptions per 1,000 population, over twice the rate for those aged 25 to 34 (687 per 1,000). Rates for benzodiazepines exhibited the same pattern, but at lower 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 http://www.pdmpassist.org/content/pbss.

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] Being prescribed over 100 MME daily is considered a risk factor for opioid overdose and death; see note 4 above.

[6] Percentage of overlapping prescriptions is calculated as the number of days with more than one prescription in the same drug class (or opioid and benzodiazepine classes) divided by the total number of prescription days for that drug class (or opioid class for opioid – benzodiazepine combinations). Please see PBSS website for additional methodological details. Overlapping prescriptions are a risk factor for overdose and death, see Yang, Z. et al., Defining risk of prescription opioid overdose: pharmacy shopping and overlapping prescriptions among long-term opioid users in Medicaid, *J Pain.* 2015 May;16(5):445-53. doi: 10.1016/j.jpain.2015.01.475. Epub 2015 Feb 11.

[7] See Walsh, N., "Opioids Pose Hazards in the Elderly," *MedPage Today*, http://www.medpagetoday.com/geriatrics/painmanagement/23888.