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

Perimeter Center, 9960 Mayland Drive, Second Floor **804-367-4514(Tel)**
Henrico, Virginia 23233 **804-527-4470(Fax)**

Agenda of Meeting
September 14th, 2023
10:00 am
Board Room 4

Call to Order:
- Welcome and introductions
- Approval of agenda
- Approval of June 2, 2022 minutes

Public Comment:
Jesse Rabinowitz email

Department of Health Professions Report: Arne Owens/James Jenkins

Legislation and Regulation Update: Erin Barrett

Program Update:

PMP user survey findings

Program Operations:
- Integration status of Virginia hospitals

Program Director Report:
- Study on collecting/making available all meds
- Medical cannabis reporting on PMP
- DATA waiver elimination

Next Meeting Date: June 5th, 2024
Adjourn

McKann, Carolyn (DHP)

From: PMP (DHP) <PMP@DHP.VIRGINIA.GOV>
Sent: Wednesday, January 4, 2023 12:42 PM
To: Jesse Rabinowitz
Subject: Re: To the PMP Advisory Committee

Jesse Rabinowitz,

I anticipate the next PMP Advisory Committee meeting will take place in June; If you would like, I can include your letter during the Public Comment period.

The purpose of the advisory committee is to assist in the implementation and evaluation of the PMP; please be aware that this committee does not make treatment recommendations.

Best regards,

Carolyn R. McKann, CT(ASCP), MHA
Program Deputy for Operations
Virginia Prescription Monitoring Program
9960 Mayland Drive Suite 300
Henrico, Virginia 23232
804-597-4281

Virginia Department of
Health Professions
Prescription Monitoring Program

From: Jesse Rabinowitz <jessrab113@gmail.com>
Sent: Tuesday, January 3, 2023 3:26 PM
To: PMP (DHP) <PMP@DHP.VIRGINIA.GOV>
Subject: Re: To the PMP Advisory Committee

Dear Ms. McCann,

Thank you for your speedy reply. I appreciate the information on how to report medical mistreatment, and, if I thought any physician or health professional had committed malpractice in my own or a family member's care, I would not hesitate to report it. However, my original letter was not about the individual actions of any particular physician, but about what seems to me to be a systemic problem caused by the extreme and poorly-thought-out response to the opioid crisis.

In my view, physicians are now incentivized to under-treat pain, due to very real threats to their licensure, should they make extensive use of opiates in their treatments. I don't believe the answer to this problem is to further threaten or punish physicians for under-treatment, because they are caught in a Catch-22 not of their own making.

I don't know where the draconian treatment of physicians who prescribe opiates originates, whether it is because of inordinate pressure from the DEA or the State Medical Board, but I wrote to the advisory board of the PMP because I would hope that the board is in dialogue about this larger systemic problem. That was the purpose of my initial letter, to provide personal and professional feedback to the board, in hopes that they are addressing this issue.

I would be very curious to know if my letter was distributed to the entire board, and whether they consider the concerns raised to be important, valid, and within their purview as an advisory board in the larger system that governs how pain medication is prescribed.

Thank you for your consideration of this.

Jesse Rabinowitz, Ph.D.

On Jan 3, 2023, at 1:12 PM, PMP (DHP) <PMP@DHP.VIRGINIA.GOV> wrote:

Good Afternoon Dr. Rabinowitz,

I am sorry to hear about the difficulties that your wife is experiencing to address the management of her pain. If you feel that your wife has been medically mistreated or diminished in any way by someone in the medical community that holds a license issued by one of the Department of Health Profession's regulatory boards, I would recommend that you file a complaint with our Enforcement Division.

There are several ways to do this. You may call the Enforcement Division and speak with one of our Intake Analysts. This method will allow you to get immediate feedback about the complaint process and also whether the Intake Analyst has identified a law or regulation that has been violated. You may also submit your complaint via email. There is an online complaint form which can be accessed on the DHP website. For more information about any of these methods, please click on the link below.

Virginia Department of Health Professions - Enforcement Division

Virginia Department of Health Professions Enforcement Division

The Enforcement Division is responsible for assessing complaints of misconduct and conducting investigations.

www.dhp.virginia.gov

While the Virginia PMP does offer resources to our registered users including the CDC's guidelines for tapering opioids and/or how to locate substance abuse services in Virginia, among others, the Virginia PMP's primary purpose is to provide dispensing data to healthcare providers to better inform their treatment and dispensing decisions. The data contained in the patient's PMP report is only part of the information that clinicians consider when making a treatment, prescribing, or dispensing decision.

I hope this information is helpful to you. If you have additional questions or if I can provide additional assistance, please do not hesitate to reach out to me.

Best regards,

Carolyn McKann

Carolyn R. McKann, CT(ASCP), MHA
Program Deputy for Operations
Virginia Prescription Monitoring Program
9960 Mayland Drive Suite 300
Henrico, Virginia 23232
804-597-4281

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From: Jesse Rabinowitz <jessrab113@gmail.com>
Sent: Sunday, December 25, 2022 11:27 AM
To: PMP (DHP) <PMP@DHP.VIRGINIA.GOV>
Subject: To the PMP Advisory Committee

To the PMP Advisory Committee,

I am writing to you to provide feedback from both a professional and a personal perspective on the subject of the PMP and its impact on prescribing practices of pain medications.

Professionally, I am writing as a clinical psychologist who has practiced in Richmond for over 35 years. In that time, I have treated many patients with substance abuse disorders, as well as many who have had chronic or acute pain disorders. Since the advent of the opioid crisis and the institution of the PMP, I have had several patients with chronic, intractable pain problems, whose pain had been well-managed for many years on steady, unvarying doses of opiates, including tramadol, morphine, and Vicodin. These patients had not exhibited any of the signs of addiction, such as need for increased dosages, drug-seeking behaviors outside of their prescribed dosages, or the corollary life dysfunctions that drug-addicted or substance-abusing patients demonstrated. Nevertheless, in all their cases, once the PMP was instituted, their doctors cut or weaned them off of their pain medications, with terrible effects in terms of debilitating pain and diminishment of life quality. An examination of their life and medical histories easily distinguished them from patients who were addicts or abusers, but they were all treated as if they were in danger of addiction or, worse, as if they were suspect of being secret addicts, doctor-shoppers, or drug-seekers. Although the PMP should have provided their physicians with ample evidence that they were not drug-seeking addicts, they were lumped in with substance abusers and mistreated.

Personally, I am writing of my experiences over the past month and a half, witnessing my wife, Brenda, go through the agony of acute sciatica, likely caused by spinal stenosis, be treated in exactly the same manner. Although Brenda has no history of drug addiction or substance abuse, every physician in the chain of diagnosis of her sciatica has refused to prescribe any more than diclofenac and flexeril. Their refusal was not a function of her medical or psychological history, but was framed as their absolute policy, ie. "we do not prescribe opiates". On the first visit with a PA in the neurosurgical practice she consulted, I made my case to the PA about both her lack of history of substance abuse, and my experience of the agonizing pain and extreme debilitation that she was suffering. The PA relented and prescribed 15 tramadol. The doc she PAs for made it clear at the next visit that he would not provide any refills on that prescription and told my wife she had to see a pain specialist. As she has begun what looks like will be a long process of getting in to see a pain specialist, she has used the

tramadol sparingly, because it is the only thing that has cut through her pain when it becomes unbearable, and she is terrified of running out. Consequently, she has been suffering for over a month now and is likely to continue to suffer greatly, and, in my opinion, needlessly, until she can finally land an appointment with a pain specialist who might, if she is lucky, dare to adequately prescribe medication for her pain. During this entire ordeal, she has acted the good soldier, attending physical therapy and doing the prescribed exercises faithfully, but to little avail. The impact of this period of debilitating pain has been enormous in terms of her emotional well-being, her ability to do the volunteering that she was actively-engaged in prior to this, and her social and familial life.

Watching my patients go through what they endured, and now watching my wife be so painfully-diminished and medically-mistreated has been horrific. I have read many articles about the undertreatment of pain in women and in chronic pain patients, and my reactions to this have been validated by professional colleagues who similarly decry the extreme, black-and-white nature of the regulatory reaction to the opioid crisis. We seem to have gone from what might have been over-prescribing to under-prescribing, with no attention to the differences between pain patients and addicts. This is appalling on both a professional and personal level.

I have chosen to write to you all, as presumably the use of the PMP and the recommendations being given to the prescribing community come under your aegis. I implore you to consider the devastating consequences of this situation for many like my wife and patients, and to find some way to thaw the obviously-chilled atmosphere that pervades the prescribing community. We know a lot about how to distinguish addicts from pain sufferers, and that knowledge should be part of prescribing decision trees, rather than the current and widespread practice of treating anybody with a pain problem as an actual or potential drug abuser. I would appreciate the PMP advisory committee taking these concerns seriously and moving to make the treatment recommendations more-humane, wise, and effective.

I appreciate your consideration of my feedback.

Sincerely,

Jesse Rabinowitz, Ph.D.
Licensed Clinical Psychologist

Virginia Department of Health Professions

PMP Advisory Committee

September 14, 2023

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Virginia Department of Health Professions

Call to Order

- **Welcome**
- Introductions
- Approval of Agenda
- Approval of Minutes

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Virginia Department of Health Professions

Department of Health Professions Report

Arne Owens, Director, Department of Health Professions
James Jenkins, Chief Deputy Director, Department of Health Professions

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Virginia Department of Health Professions

Legislation and Regulation Update

Erin Barrett, Director of Legislative and Regulatory Affairs

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PMP User Survey

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PMP User Survey

- Winter 2023
  - Last survey conducted in 2004
- Conducted by VCU's Survey Evaluation Research Laboratory (SERL)
- Total survey invitations: 23,211
  - Dispensers: 8,211 (all registered)
  - Prescribers: 15,000 (sampled from 52,649 registered)
- Pre-notification letters were sent to all dispensers and 60% of surveyed prescribers

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PMP User Survey

- Survey logic customized questions based on prescriber or dispenser
- Survey responses: 3,543 (response rate 15%)
  - Dispensers: 1,515 (18%)
  - Prescribers: 2,028 (14%)

- Professional role of respondents
  - Pharmacist: 43%
  - Physician: 32%
  - Nurse Practitioner: 12%
  - Physician Assistant: 5%
  - Dentist: 6%
  - Medical Resident: 1%
  - Podiatrist: 1%

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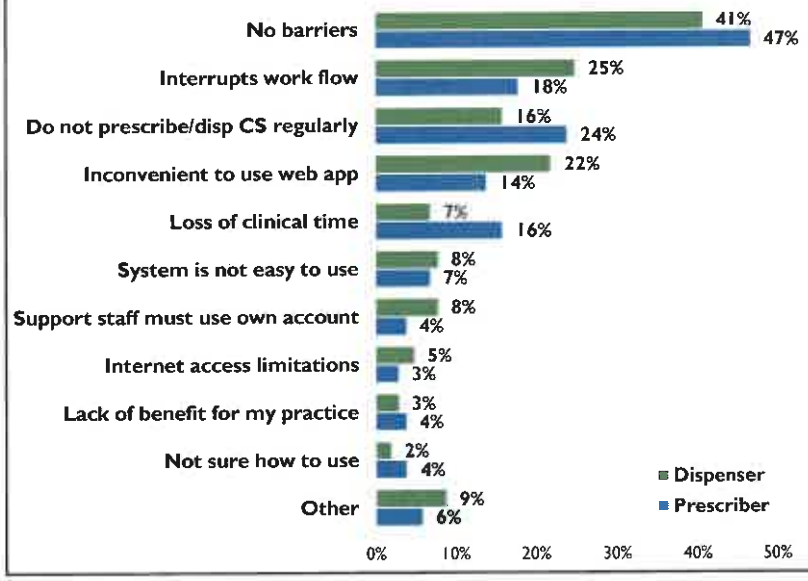
Barriers to PMP use



- Most respondents indicated no barriers to use of PMP
- Primary barrier identified was interruption to workflow

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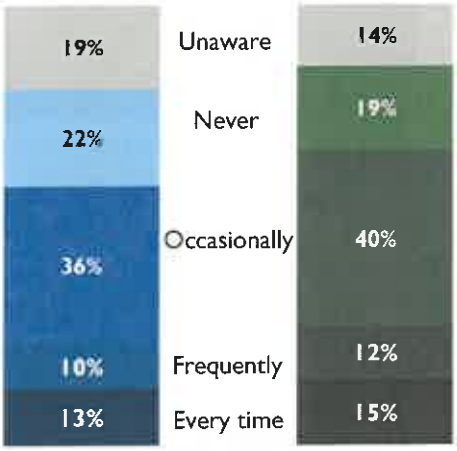
Interoperability

- Virginia is interoperable with 40 other states/jurisdictions allowing users to query them simultaneously
- About two-thirds of prescribers (59%) and dispensers (67%) query other PMPs

How often do you query other state systems?



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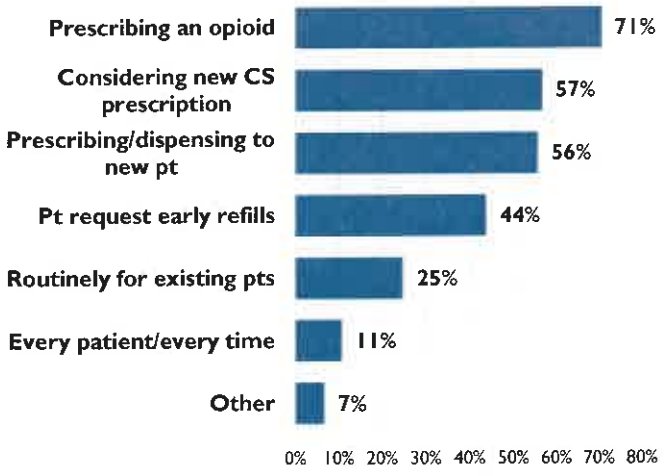
Prescribers: Use of PMP

- 56% of prescribers using the PMP do so daily/weekly
  - Most often when prescribing an opioid, considering a new CS prescription *and/or* before prescribing/dispensing to new patients
- 63% prescribe CS daily/weekly
  - 24% less than once/month
  - 4% never

When do you typically use the PMP?



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Prescribers: Mode of PMP access

82% are not able to access via EHR

57% were interested integration and directed to more information

- 51% of respondents use integration, survey overrepresents users of the web application
- Prescriber penetration exceeds 70% (percent of CS prescribers accessing PMP via integration)

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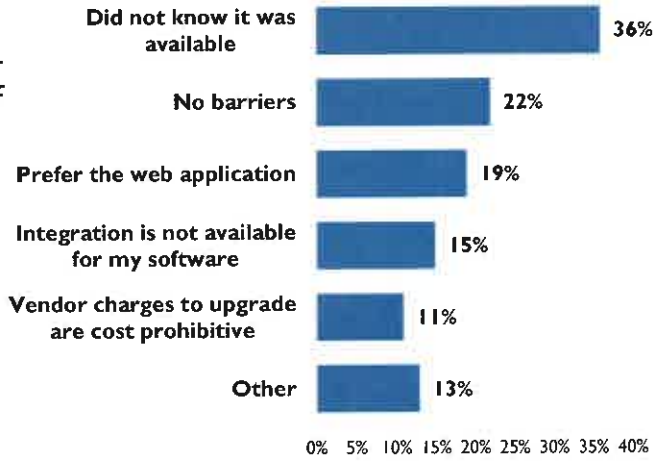
Prescribers: Barriers to integration

- Most frequent barrier to integrating the PMP into EHR/e-prescribing software was lack of awareness (36%) *and/or*
- Preference for the web application (19%)
- Other: lack of control/not authorized to make decision



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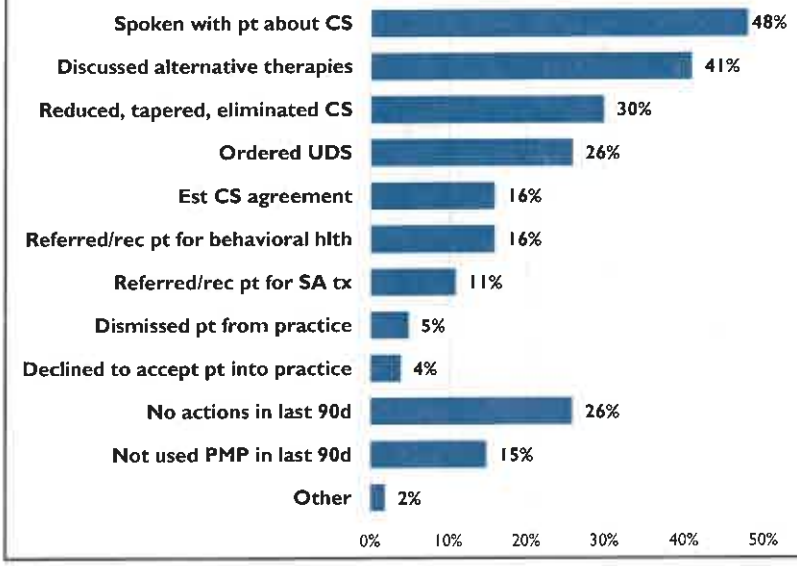
Prescribers: Impact on decision making for treatment



- Question: In the past 90 days, which of the following actions have you taken as a result of using PMP?
  - Most often the PMP spurred a conversation with the patient about their CS (48%) *and/or*
  - Precipitated a discussion of alternative therapies (41%)

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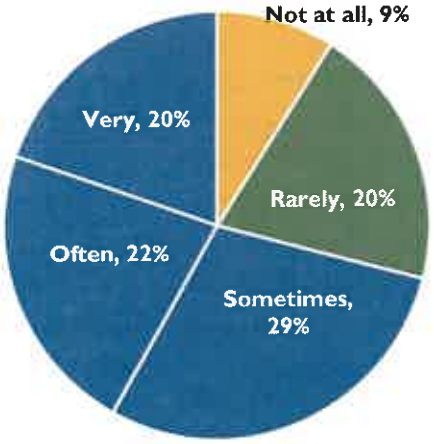
Prescribers: Quarterly Prescriber Reports

- 78% of prescribers said they received a Prescriber Report
  - Prescribed at least one opioid, buprenorphine, sedative, or stimulant in 6-month period
- 91% said they were helpful (very, often, sometimes, rarely)

How helpful do you find the Prescriber Reports?



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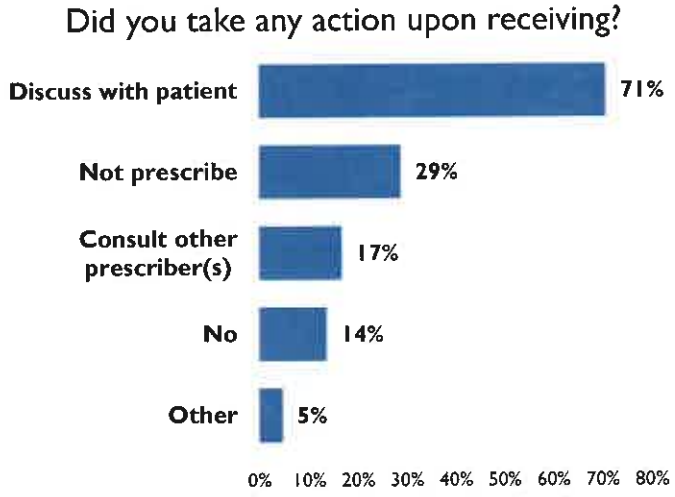
Prescribers: Opioid/Benzo Combo alert

- 48% of prescribers said they received the Opioid/Benzo combination alert
  - Patient overlap of active prescriptions for an opioid and benzodiazepine
- Most often discussed with the patient (71%) *and/or* altered prescribing decision (29%)
  - Other: Provide/ensure Narcan is available



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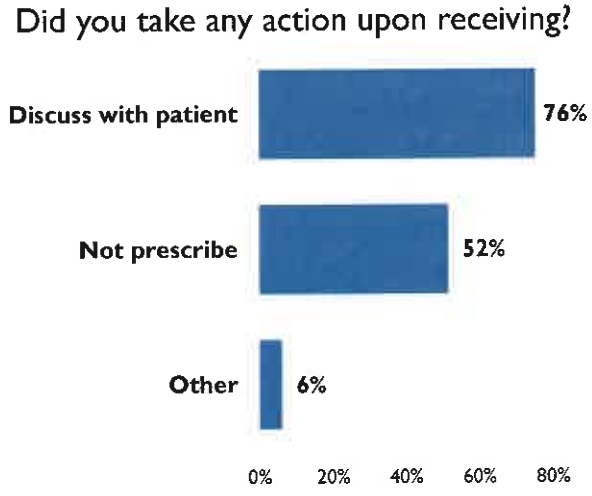
Prescribers: Prescriber/Pharmacy threshold alert

- 20% of prescribers said they received the Prescriber/ Pharmacy threshold alert
  - Patient receives CS from ≥6 prescribers and ≥6 pharmacies within 60 days
- Most often discussed with the patient (76%) *and/or* altered prescribing decision (52%)



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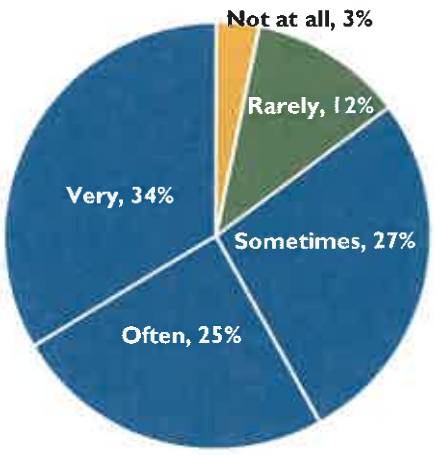
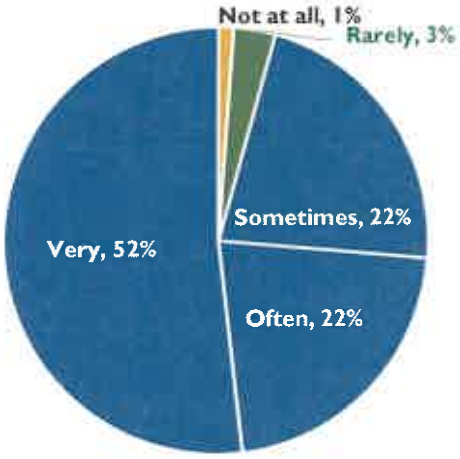
Prescribers: How helpful do you find the alert?



Opioid/Benzo combo



Threshold

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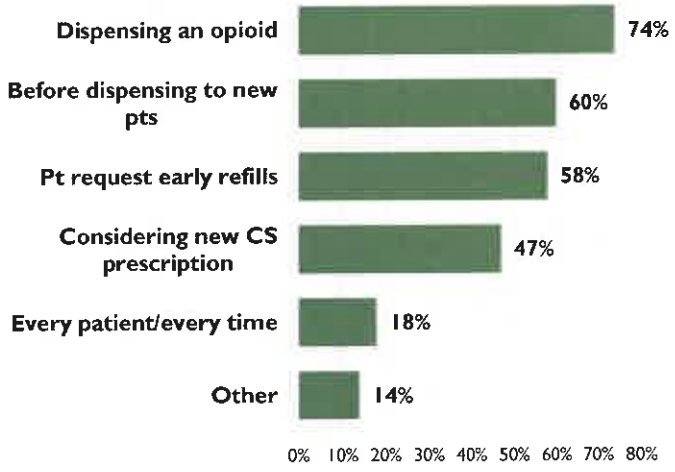
Dispensers: Use of PMP

- 68% of dispensers using the PMP do so daily/ weekly
  - Most often when dispensing an opioid *and/or* before dispensing to new patients
  - Other: medication reconciliation, outpatient/inpatient use confirmation

When do you typically use the PMP?



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Dispensers: Communication

- Most dispensers indicated that PMP use *improved* communication, particularly with prescribers and patients

Does your PMP usage increase and/or improve communication?

	Increases communication	Improves communication
Prescribers	56%	66%
Other Pharmacists	45%	55%
Internal Pharmacy Staff	44%	53%
Patients	50%	62%

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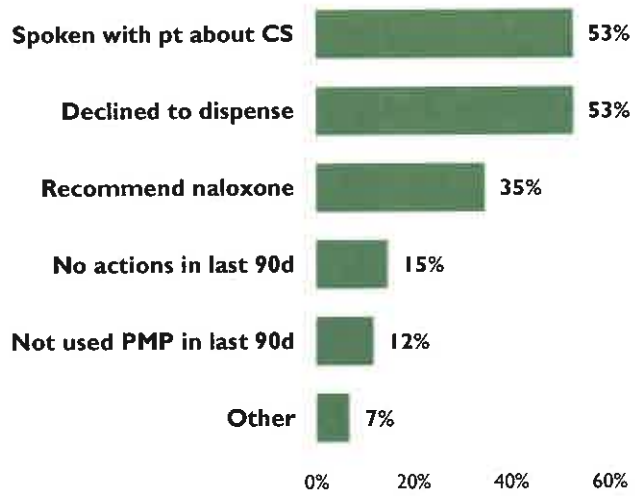
Dispensers: Impact on decision making for treatment



- Question: In the past 90 days, which of the following actions have you taken as a result of using PMP?
  - Most often PMP use resulted in a conversation with the patient *and/or* altering dispensing decision

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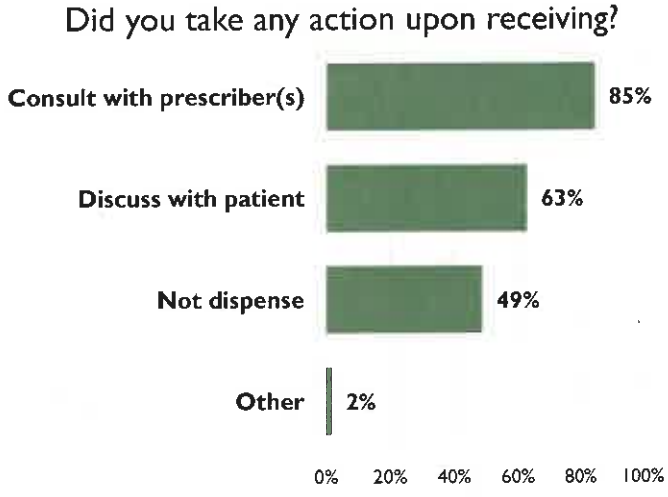
Dispensers: Prescriber/Pharmacy threshold alert

- 13% of dispensers said they received the Prescriber/ Pharmacy threshold alert
  - Patient receives CS from ≥6 prescribers and ≥6 pharmacies within 60 days
- Most often consulted with prescriber(s) (85%) and/or discussed with patient (63%)



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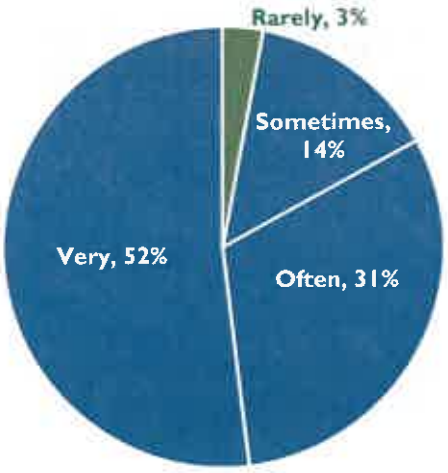
Dispensers: How helpful do you find the threshold alert?



- All respondents found the Prescriber/Pharmacy threshold helpful

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I use the PMP to inform my clinical decisions.

The PMP has helped me monitor patients' CS prescriptions for possible adverse drug interactions.

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I use the PMP to improve management of my patients' CS prescriptions.

PMP has a positive impact on reducing prescription drug misuse, abuse, and diversion.

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Program Operations Update

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By the numbers:

72k
registered users

1.2M
average prescriptions reported monthly (2022)

57.5M
requests for prescription history (in state, 2022)

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Integration

- ~5,200 facilities in Virginia have PMP integrated into their clinical workflow
  - Electronic Health Record (EHR),
  - Pharmacy Dispensing System (PDS), *or*
  - e-prescribing software
- Marketing campaigns
  - May 2023: Dental practices
  - One additional in 2023

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Integration status of Virginia health systems

2017	2018	2019	2020	2021	2022	2023
•Riverside Health •Sentara	•Carilion •INOVA •Valley Health •Virginia Hospital Center	•Fauquier Hospital •HCA •Mary Washington •Novant Health	•Augusta Health •Ballad Health •Bon Scours/Mercy Health	•Chesapeake Regional •CHKD •Lifepoint Health •UVA •VCU	•Buchanan General Hospital •Centra	•**Bath Community Hospital**

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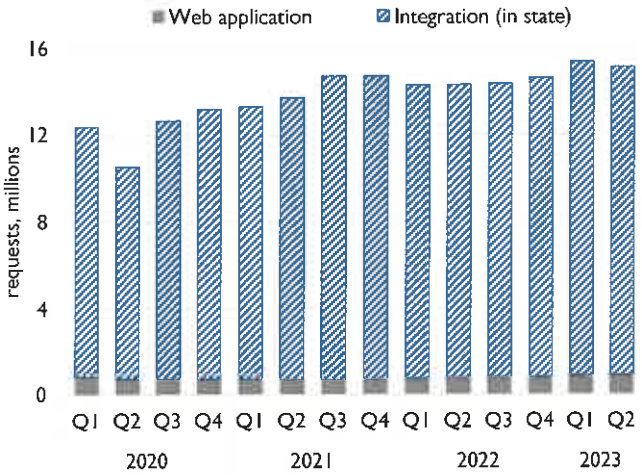
Prescription history requests by mode of access



95%
requests were via integrated application

71%
prescribers can access via integrated EHR

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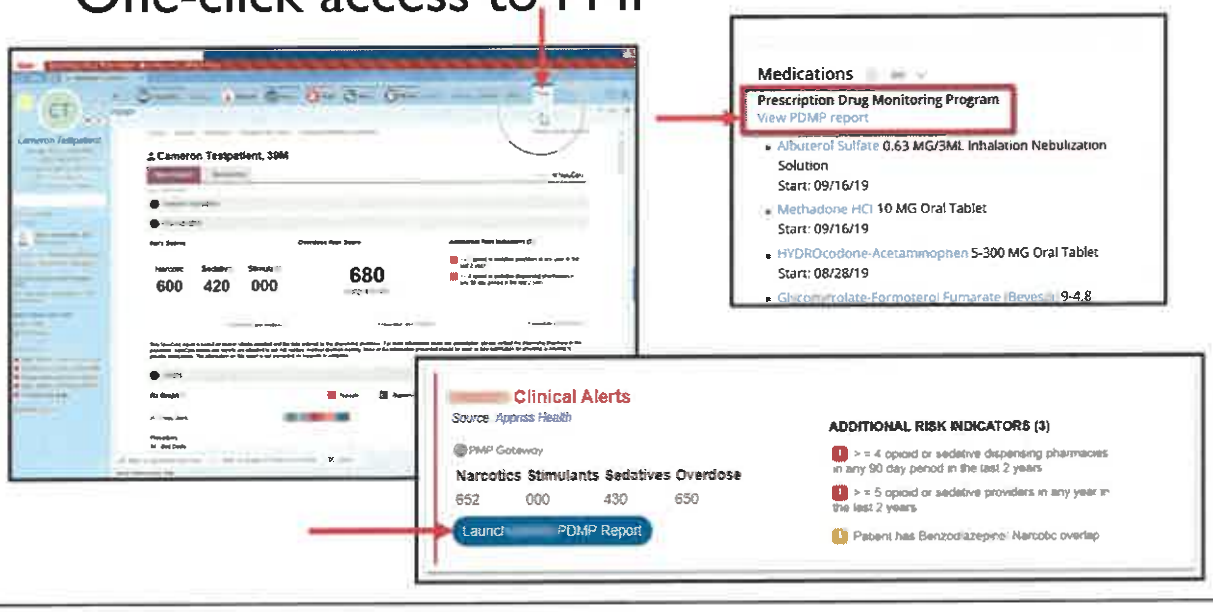
One-click access to PMP



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Program Director Report

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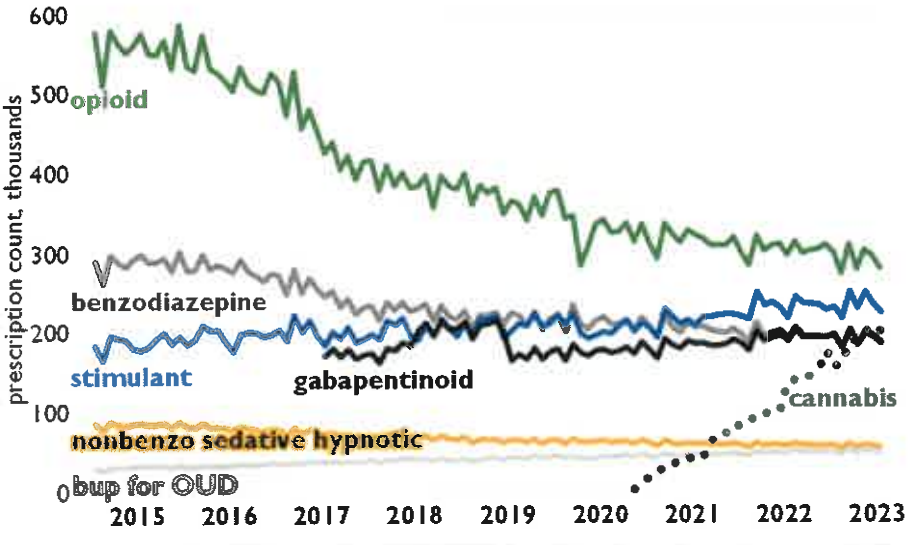
Prescriptions dispensed by drug class, 2015-2023H1



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Top prescriptions by generic name, 2023H1

01 cannabis

02 gabapentin

03 dextroamphetamine/ amphetamine (Adderall)

04 hydrocodone/acetaminophen (Vicodin, Lortab, Lorcet)

05 alprazolam (Xanax)

06 oxycodone (Xtampza, Roxicodone)

07 tramadol (Ultram)

08 oxycodone/acetaminophen (Percocet)

09 clonazepam (Klonopin)

10 buprenorphine/naloxone (Suboxone)

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Medical cannabis reporting to PMP

- HB2368: PMP report will indicate the primary cannabinoid for all cannabis products dispensed
  - Tetrahydrocannabinol
  - Tetrahydrocannabinol-A
  - Cannabidiol
  - Cannabidiol-A

Prescriptions

Total: 15 | Private Pay: 8

Filled	Written	ID	Drug	QTY
07/10/2023	07/10/2023	10*	Cannabidiol (Cbd)	1.00
07/10/2023	07/10/2023	10*	Tetrahydrocannabinol Acid (Thc-A)	1.00
07/10/2023	07/10/2023	10*	Tetrahydrocannabinol (Thc)	1.00
02/24/2023	02/22/2023	11*	Gabapentin 100 Mg Capsule	60.00
02/02/2023	01/01/2023	5	Actiq 200 Mcg Lozenge	30.00
01/26/2023	01/19/2023	10*	Incredibles Tangahhrine 7	120.00
12/01/2022	11/25/2022	5	Vimpat 100 Mg Tablet	60.00
07/20/2022	07/20/2022	7*	Dharma Ingest (Blue Raspberry)	1.50
07/18/2022	07/15/2022	6	Fentanyl 100 Mcg/hr Patch	1.00
07/14/2022	07/07/2022	2	Alprazolam 0.5 Mg Tablet	120.00
07/09/2022	07/06/2022	3	Hydrocodone-Acetamin 5-325 Mg	60.00
07/07/2022	07/07/2022	1*	Animal Mints Ii Popcorn Buds	0.50
04/22/2022	03/31/2022	8	Tramadol Hcl 50 Mg Tablet	120.00
01/20/2022	01/09/2022	4*	Herambe Og Full Spectrum Extract Cartridge	4.00

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Collecting all meds

- HB2345/SB1255: convene a work group to study and establish a plan to develop/ implement a system to share information regarding a patient's prescription history for medication reconciliation
- Co-lead by Departments of Health and Health Professions
- Report due to General Assembly October 1, 2023
- Prioritize maintaining critical functions of PMP in detecting diversion, identifying "doctor shopping," and screening and referring patient to behavioral health
- Estimate controlled substances comprise 10% of dispensed medications

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Collecting all meds

- Two primary components to such a system
  - Data collection
    - Recommend using existing PMP infrastructure
  - Means by which to deliver data to eligible recipients, two proposed solutions
    - Expand PMP to all medications *or*
    - Maintain PMP for covered substances and expand HIE to deliver non-covered substances
- Recommendations for proposed legislation
  - Patient opt-out
  - Date sold
  - Interstate data sharing
  - Veterinarian prescriptions
  - Law enforcement/regulatory personnel access
  - Duration of medication history

HIE: health information exchange, administered by Virginia Health Information (VHI)

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Medications for OUD (MOUD)

- Congress eliminated the DATA waiver (X-waiver) as of 12/29/22
  - H.R. 2617 Consolidated Appropriations Act of 2023
- Removes other federal requirements (patient limits)
- DEA registrants, new or renewing, starting 6/27/23 must comply with educational requirements

- Need revision to *Code of Virginia* § 54.1-2522.1. Requirements of prescribers.

  …In addition, any prescriber ~~who holds a special identification number from the Drug Enforcement Administration authorizing the prescribing~~ of controlled substances approved for use in opioid addiction therapy shall, …

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Funding

- Trust Account
  - $11M remains (of $20M), project depletion by 2030
- Opioid Abatement Authority grants to state agencies
  - DHP/PMP awarded $361,219 (2023)
- Commonwealth Opioid Abatement and Remediation (COAR) funding budget request

- Centers for Disease Control and Prevention (CDC) grants with allocations for PMP
  - Overdose Data to Action (OD2A), ended 08/2023, $1.1M/year
  - Overdose Data to Action-States (OD2A-S), began 09/2023, $550k/year

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Looking forward

- HB1814, withdrawn by patron: would have eliminated the exemption from PMP reporting for narcotic treatment providers (i.e., methadone clinics)
  - Patient consent for reporting required per 42 CFR Part 2
- OTC Narcan, now available

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Adjourn

Next meeting: June 5, 2024

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