

FINAL

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

Monday, November 10, 2014

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

CALL TO ORDER:	A meeting of the advisory panel of the Prescription Monitoring Program was called to order at 1:10 p.m.
PRESIDING	Randall Clouse, Chair
MEMBERS PRESENT:	Holly Morris, RPh, Crittenden's Drug, Vice Chair Carola Bruflat, Family Nurse Practitioner Dr. Kathrin Hobron, Representing Dr. Amy Tharp, Office of the Chief Medical Examiner Mellie Randall, Representative, Department of Behavioral Health and Developmental Services John Barsanti, M.D., Commonwealth Pain Specialists, L.L.C. Harvey Smith, ISG, Virginia State Police S. Hughes Melton, M.D., Mountain Valley Health
MEMBERS ABSENT:	Brenda Clarkson, Executive Director, Virginia Association for Hospices and Palliative Care
GUESTS PRESENT:	William Gormley, M.D. Chief Medical Examiner
STAFF PRESENT:	David E. Brown, D.C., Director, Department of Health Professions (DHP) Jaime Hoyle, Chief Deputy Director, Department of Health Professions James Rutkowski, Assistant Attorney General, Office of the Attorney General Elaine Yeatts, Senior Policy Analyst Ralph A. Orr, Program Director, Prescription Monitoring Program Caroline Juran, RPh, Executive Director, Virginia Board of Pharmacy
WELCOME AND INTRODUCTIONS	Mr. Clouse welcomed everyone to the meeting of the advisory panel.
PUBLIC COMMENT:	No public comments were made.
APPROVAL OF AGENDA	The agenda was approved as presented.
ELECTION OF CHAIRMAN AND VICE-CHAIRMAN	Holly Morris nominated Randall Clouse and Mr. Clouse was subsequently unanimously elected Chairman of the Advisory Committee for the upcoming term. Mr. Randall Clouse

	nominated Holly Morris and Ms. Morris was subsequently unanimously elected as Vice-Chairman for the upcoming term.
<p>David E. Brown, D.C.: DEPARTMENT OF HEALTH PROFESSIONS REPORT Report on Governor’s Task Force on Prescription Drug and Heroin Abuse</p>	<p>Dr. Brown welcomed the Panel and thanked them for taking time from their schedules to do this important work. Dr. Brown explained that last year Virginia participated in a Policy Academy convened by the National Governors Association to develop a Prescription Drug Abuse Reduction Strategy. That strategy was completed in August 2013 and resulted in several pieces of legislation being considered and passed by the 2014 General Assembly. The strategy was the impetus for Governor McAuliffe’s Executive Order 29 creating a Prescription Drug and Heroin Abuse Task Force. The first meeting of the Task Force will be held on November 12, 2014. The Task Force consists of 5 workgroups to include Data/Monitoring which specifically includes the PMP. Workgroups are charged with developing immediate recommendations by December 31, 2014 that may result in legislation consideration by the 2015 General Assembly and longer term recommendations that may need further study.</p>
<p>PROGRAM UPDATE:</p>	Ralph Orr
<p>Unsolicited Reports</p>	<p>Mr. Orr gave a report on the current status of unsolicited reports performed by the PMP. The PMP currently has authority to send unsolicited reports on recipients meeting or exceeding certain criteria to prescribers of those recipients and to law enforcement. The criterion that is currently used is based on the number of prescribers and dispensers that a recipient uses in a certain time period. Statistics on these reports and broader indicators were discussed. It was suggested that the criteria needs to move towards more clinical impact issues such as a morphine equivalent dose over a certain amount per day, or prescribing of an opioid when a patient is receiving other controlled substances that may affect the use of the opioid. Information was presented on a project being done in Arizona where a “prescribing history” report is being sent to prescribers of controlled substances. (pages 7-9 in agenda packet) Mr. Orr pointed out that to do something similar in Virginia we would need to require the reporting of the prescriber’s National Provider Identification number (NPI) which has a specialty code attached to it. Dr. Melton and Dr. Barsanti felt this type of information may be helpful to practitioners if presented as information to assist the prescriber but to be cautious about applying labels to prescribing behavior.</p>
<p>Morphine Milligram Equivalent Dose</p>	<p>Mr. Orr presented information to the Panel regarding Morphine Milligram Equivalent Dose (MMED), pointing out that according to information from FDA that a substantial increase in</p>

overdose risk exists for patients receiving over 100 MMED per day. The MMED is computed by taking the strength of each opioid dispensed, multiplying that number by the multiplier (page 11 of agenda packet) for that drug, multiplying that number by the quantity dispensed and then dividing that result by the days supply. This provides the MMED for that specific dispensed drug. A review of several guidelines from several organizations followed as well as a discussion of guidelines developed by the State Medical Board of Ohio that relate to MMED information being placed on that State's PMP reports. Mr. Orr showed the Panel the MMED calculator posted on the Ohio PMP website and discussed the placement of the MMED score on the Ohio PMP report. The MMED score only reflects the narcotic prescriptions dispensed to the patient, it does not address other controlled substances the patient has received. Another type of clinical tool that is available is called NARxCHECK. This product provides a risk score for narcotics, sedatives, and stimulants based on an algorithm developed from a large data set and then compared to the patient's PMP report. (Pages 19-20 of agenda packet). Mr. Orr stated that placing an MMED score on the PMP report is a service that can be added to the PMP application while the NARxCHECK feature is something that would be added to a user's application and not under the control of the PMP. The Panel's consensus was that providing the MMED on the PMP report would be very beneficial and should be added. However, education and guidelines supporting this information needs to be developed and made available to users prior to implementation.

**PMP Outreach Efforts:
Presentations**

Mr. Orr provided a synopsis of program education activities over the past 2 years (pages 21-23 of the agenda packet). Dr. Melton was thanked for his participation in many of these training events. Presentations for healthcare providers represent the bulk of education activities and have changed over the years to be clinically applicable to actual scenarios a prescriber may see in his or her practice and to address how to read and understand the information contained in a PMP report. PMP staff also provides training on the PMP to law enforcement, regulatory investigators, and other interested parties.

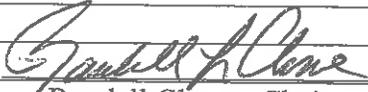
**PMP and Social Media
YouTube and Twitter**

Realizing the need to make more PMP information available on the internet the PMP has produced two YouTube videos to assist healthcare practitioners in registering for the PMP and to provide basic information about the program. The PMP has recently initiated a Twitter account which is showing some promise in providing information about prescription drug abuse to a much wider audience. Mr. Orr introduced Daniel Chait, an intern from VCU, who is assisting the program with improving its presence on Twitter and with the development of messages for upcoming projects such as the mandatory registration of prescribers which

<p>Utilization of Data</p>	<p>becomes effective in July 2015. Information and samples of YouTube and Twitter activity was discussed as well as a brief overview of a press release from June 2014 and a listing of recent articles about the PMP. Dr. Melton suggested adding trending topics to the Twitter account.</p> <p>Mr. Orr discussed the need for use of PMP data beyond the traditional use of an authorized user making a request and receiving information back. There is a need to detect changes in prescribing and dispensing patterns, to assist in developing policy solutions to prescription drug abuse and drug overdoses, and to provide data for resource allocation decisions. The PMP has the authority to provide de-identified data for research and education purposes but until recently mechanisms to develop this type of data was not available. The PMP has recently signed an MOU with the Department of Criminal Justice Services to provide de-identified data that can then be compared to their existing data sets to develop a more accurate picture of drug supply patterns in the Commonwealth. The PMP is working on an MOU with Brandeis University under a CDC/FDA/BJA grant to provide data sets to Brandeis, which will apply 43 measures and provide a report on these measures on a quarterly basis. The Department of Health (VDH) has approached the PMP with a desire to develop an MOU to obtain these de-identified data sets in order to compare to data sets held by VDH including drug death data and overdose data from emergency rooms among others. Early results from these collaborations should be available by June 2015.</p>
<p>Drug Death Data</p>	<p>Dr. Kathrin Hobron, Office of the Chief Medical Examiner: Dr. Hobron gave a presentation on Fatal Prescription Drug Overdoses in Virginia, 2007-2013 (Pages 33-43 of the agenda packet). In 2013 there were 912 drug deaths exceeding both the number of motor vehicle fatalities and firearm related deaths. Of these deaths, 634 were attributed solely to prescription drugs and 468 of those were attributed specifically to prescription opioid overdoses. The age groups with the highest number of prescription opioid overdoses were males aged 25-24, and females aged 45-54.</p>
<p>PMP Interoperability and Integration</p>	<p>Mr. Orr gave an update of interoperability with other states stating that the PMP is now connected with 17 other states and is working to connect with several more as there are now 26 states that have implemented the National Association of Boards of Pharmacy (NABP) PMPInterConnect®. This includes the 3 border states of Kentucky, Tennessee, and West Virginia. Requests from users in other states made up approximately 15% of all requests in the 2nd quarter of 2014. Integration into healthcare practitioner workflow is the next means to improve access of PMP information to healthcare</p>

<p>Discussion of 2013-2014 Legislation</p>	<p>practitioners. Mr. Orr has been participating on an Office of National Coordinator, Standards and Integration Framework project to develop a mechanism that will allow electronic health records (EHR), e-prescribing applications, and pharmacy applications to have PMP data integrated into their applications. This is difficult because these entities all use different standards to do the functions related to their specific application. NABP and its technology partner, Appriss are developing a translation service, called Gateway to facilitate the sharing of PMP data across applications. The project is currently in its pilot implementation phase and Virginia is likely to be participating with a pharmacy application vendor as well as a major EHR vendor.</p>
<p>Program Statistics</p>	<p>Elaine Yeatts, Policy Analyst, Department of Health Professions: Ms. Yeatts gave a report on legislation passed in 2013 and 2014 affecting the PMP (Pages 48-49 of the agenda packet). Panel members expressed concern over the wording requiring mandatory requests being made only if a prescription was being initiated for chronic use and the prescriber and patient have entered into a treatment agreement. Ms. Yeatts explained that there was a bill that would have changed the reporting requirement from within 7 days of dispensing to within 3 days of dispensing. The bill (SB 638) was not moved from Committee but the Chair of Senate Education and Health requested a report on this topic detailing information on other state reporting requirements. This report has been submitted to the Committee. Ms. Yeatts stated that the majority of states require reporting within 7 days of dispensing but the movement is definitely towards daily reporting. Panel members felt this was an issue to be further explored with possible benefits from timelier reporting but did not want such a requirement to impact negatively on dispensers. Information on the naloxone pilot was also provided where lay rescuers may obtain and then use this medication to reverse an opioid overdose. Panel was supportive of expanding the pilot from its current coverage area.</p>
<p>NEW BUSINESS</p>	<p>Mr. Orr briefly discussed current program statistics (Pages 50-60 of the agenda packet) pointing out that the PMP expects to process approximately 1.9 million requests this year and add 5000 new users.</p> <p>Mr. Orr discussed possible enhancement recommendations that may be considered by the Governor’s Task Force on Prescription Drug and Heroin Abuse. These included:</p> <ol style="list-style-type: none"> 1. Require daily reporting of dispensed prescriptions to PMP—Panel consensus was to explore this issue 2. Automated mandatory registration for pharmacists (this was a recommendation from the strategy developed in

	<p>2013 through the NGA policy Academy)—Panel consensus was yes and to review existing code language for mandatory requests for possible update and clarification</p> <ol style="list-style-type: none"> 3. Add NPI of prescriber as a required data element—Panel consensus was yes as a means to support “peer comparison” reports for prescribers 4. Initiate “peer comparison” reports for prescribers—Panel consensus was yes but the emphasis was that this should focus on education and informing prescribers 5. Authorize PMP to report information indicating indiscriminate prescribing or dispensing to appropriate licensing board—Panel consensus was to explore with details needed for a review process and criteria setting. 6. Provide authority for prescriber and pharmacist access to PMP data that is not tied directly to a prescribing or dispensing function—Panel consensus was a definite yes to support the continuing evolution of a team approach to health care
NEXT MEETING	The next meeting will be held on a date yet to be determined in March 2015.
ADJOURN:	With all business concluded, the committee adjourned at 4:00 p.m.
	Randall Clouse, Chairman
	Ralph A. Orr, Director

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