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

Perimeter Center, 9960 Mayland Drive, Second Floor
Henrico, Virginia 23233

804-367-4566(Tel)
804-527-4470(Fax)

Agenda of Meeting
September 30, 2015
10:00 AM
Henrico Room II
Virginia Housing Center

TOPIC

Call to Order: Hughes Melton, M.D., Chairman

- Welcome and introductions
- Reading of emergency evacuation script: Ralph Orr
- Approval of Agenda
- Approval of minutes

Public Comment:

Legislation and Regulation Update: Ralph Orr

Review Task Force Recommendations: Ralph Orr

Update on Utilization of De-Identified Data: Neal Kauder, VisualResearch, Inc.

Report on the Use of PMP Reports by the Virginia State Police Drug Diversion Unit: First Sergeant John Welch

Unsolicited Reports – Update and criteria discussion: Carolyn McKann

Program Update: Carolyn McKann

- Program Statistics
- Interoperability with MD, RI; Kroger, EPIC
- Automated Registration Update

New Business

Adjourn

DRAFT

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

Wednesday, July 8, 2015

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

CALL TO ORDER:	A meeting of the Advisory Panel of the Prescription Monitoring Program was called to order at 10:18 a.m.
PRESIDING	Randall Clouse, Chair
MEMBERS PRESENT:	Holly Morris, RPh, Crittenden's Drug, Vice Chair John Barsanti, M.D., Commonwealth Pain Specialists, L.L.C. Carola Bruflat, Family Nurse Practitioner Dr. Amy Tharp, Office of the Chief Medical Examiner Mellie Randall, Representative, Department of Behavioral Health and Developmental Services Brenda Clarkson, Executive Director, Virginia Association for Hospices and Palliative Care S. Hughes Melton, M.D., Mountain Valley Health
MEMBERS ABSENT:	Harvey Smith, 1SG, Virginia State Police
STAFF PRESENT:	David E. Brown, D.C., Director, Department of Health Professions (DHP) James Rutkowski, Assistant Attorney General, Office of the Attorney General Ralph A. Orr, Program Director, Prescription Monitoring Program Carolyn McKann, Deputy Director, Prescription Monitoring Program
WELCOME AND INTRODUCTIONS	Mr. Clouse welcomed everyone to the meeting of the PMP Advisory Panel.
APPROVAL OF MINUTES	Dr. Melton presented a motion to approve the minutes from the March 30, 2015 minutes of the PMP Advisory Panel and all were in favor. The minutes were approved as presented.
PUBLIC COMMENT:	No public comments were made.
APPROVAL OF AGENDA	The agenda was approved as presented.
ELECTION OF CHAIR AND VICE-CHAIR FOR FY2016	Ms. Randall nominated Dr. Melton to serve as chair and was elected unanimously. Dr. Melton served as Chair for the remainder of the PMP Advisory Panel meeting. Mr. Clouse nominated Ms. Morris to continue to serve as Vice-Chair and was elected unanimously.

DEPARTMENT OF HEALTH PROFESSIONS REPORT	Dr. Brown stated that he did not have a Department of Health Professions report but would focus his discussion on the Governor's Task Force on Prescription Drug and Heroin Abuse.
David E. Brown, D.C.: Governor's Task Force on Prescription Drug and Heroin Abuse:	Dr. Brown welcomed the Panel and thanked them for taking time from their schedules. Dr. Brown noted that many individuals present currently serve on the Governor's Task Force. Dr. Brown serves on the task force, Mr. Orr serves as staff for the Data Monitoring Workgroup, Ms. Randall serves as staff for the Treatment Workgroup and Ms. Laura Rothrock, Dr. Brown's Executive Assistant, is lead staff for the entire task force. Dr. Brown noted that the task force will be completing its work soon, as only one more meeting is scheduled. He also noted that many recommendations have been sent forth from the committees and some have already been implemented. The Workgroup Dr. Brown serves on (the Education workgroup) is currently developing a web site for healthcare providers and consumers to use as a resource. There are already 2 recommendations with respect to the PMP being developed as proposed legislation for next year's General Assembly session. The first would allow pharmacists to access PMP data when consulting with a prescriber in a clinical capacity. The second would change reporting requirements to within 24 hours of dispensing. Dr. Hazel, Secretary of Health and Human Resources is planning a multistate conference in September in Wise, Virginia, to draw on the experience in other states with respect to addressing prescription drug and heroin abuse. The focus will be on the Appalachian region. There is another conference scheduled to be held in Roanoke, Virginia November 16 – 18 to highlight the work of the Governor's Task Force and implementation of its recommendations.
2015 Legislation and Regulations Update: Ralph Orr	Mr. Orr reviewed this year's new legislation related to the PMP. HB1841 allows the PMP to register licensed prescribers in bulk, not as part of the renewal process. Bulk registration will begin soon with the smallest group of licensed prescribers (optometrists) and will proceed through the end of 2015. The bulk registration generates the registration for the prescriber or pharmacist. It is then up to each licensee to activate their account. Dr. Barsanti inquired about query frequency and Mr. Orr stated that the way the law is written, it does not prescribe a required request interval other than the original request for situations described in the code. However, the law does say that "Nothing in this section shall prohibit prescribers from making additional periodic requests for information from the Director as may be required by routine prescribing practices."

	The second piece of legislation (HB 1810) specifically states that PMP records shall not be available for civil subpoena. The third and final piece of legislation (SB 817) will allow certain local probation and parole officers to register with the Virginia PMP. As with law enforcement, probation and parole officers are required to complete the Drug Diversion School (presented by NADDI and the Virginia State Police) held each October.
Utilization of PMP Data: Neal Kauder, Ralph Orr	Mr. Orr introduced Mr. Neal Kauder, President of VisualResearch, Inc., a consulting firm that specializes in predictive analytics. The PMP, until recently, has not had the capability to look at PMP data in bulk. Using new features to compile de-identified data sets; Mr. Kauder and his team reviewed over 100 million de-identified records. The team used considerable effort to review and clean up the data, resulting in a less than 1% error rate in the database. Mr. Kauder stated that very rarely has he had access to so much data with such a minimal error rate. The de-identified data sets contain the following data fields: de-identified patient, prescriber, and pharmacy information to include the birth year of the patient, zip code, county, NDC #, date written, date dispensed, # of refills, quantity, days supply, payment method, etc. Mr. Kauder has created additional variables (21 health planning districts or HPDs), and can aggregate them into even smaller regions. He could also use another grouping of regions currently utilized by the "Council on Virginia's Future". Using what is called "exploratory data analysis", Mr. Kauder will be able to identify trends and emerging patterns regarding prescribing in Virginia such as at the number of opiates prescribed in each region. Dr. Brown inquired whether we could look at data by provider type (e.g., what dentists are prescribing) and Mr. Orr indicated that would not be possible with the existing data elements, but that it may be possible in the future if we add NPI as a required reporting element. Dr. Melton asked Mr. Kauder if they are looking at PMP data from other states and he responded that no, they are not; this type of data is not at present publicly available. Mr. Orr mentioned that there is currently collaboration between the CDC and Brandeis University to collect PMP data sets from all participating states, but he in unaware of the progress of that initiative. Mr. Kauder suggested that it may possible to overlay overdose deaths from the OCME as well as diversion data from the state police to identify patterns and trends. Use of PMP data combined with these other data sets could be used to inform policy.
Recommendation of Criteria that May Trigger Unsolicited Reports to	Mr. Orr indicated that a recommendation from the Data Monitoring Workgroup is for the PMP to develop unsolicited reports addressing the clinical aspect of care, not simply possible

Prescribers on Their Specific Patients	doctor shopping. Mr. Orr noted that the placement of the MEDD on the PMP reports provides well-documented information on the PMP report. As requested by the panel at the last meeting, the PMP has provided an MEDD score on each report and placed a statement on each report from the CDC indicating that a significant increase in risk for overdose death exists among patients with an MEDD greater than 100. Mr. Orr inquired whether the panel would want the PMP to be able to query a list of individuals with an opiate/benzo combination for example. He also inquired whether the panel would want to stop utilizing the existing doctor shopping indicators. The consensus was that we should continue to utilize our current doctor shopping indicators. Ms. Randall noted that she is very concerned about the numbers of individuals using both opiates and benzodiazepines, and suggested we track that. Dr. Tharp stated that while many people are able to wean off the opiates and stimulants, many still stay on the benzos. Dr. Brown wondered if the unsolicited reports could be sent as a general email. Discussion centered on thresholds generating too many notifications for particular specialties, namely pain management, and Dr. Barsanti noted that perhaps there could be a limit to the total number of notifications sent within a given time period. Mr. Kauder noted that we will be able to use the data to determine the types of questions we need to ask in order to generate the appropriate reports/notifications. Dr. Melton suggested a report which shows patients travelling the longest distance between prescriber and dispenser. However, Mr. Clouse noted that we have many snowbirds in Virginia who live in Florida part of the year - a long distance between prescribing and dispensing. Dr. Barsanti emphasized that we need to keep it very simple – perhaps just stick with the MEDD for the time being. Ralph agreed to discuss the threshold reports with our vendor. The panel asked that MEDD and combination therapy criteria be explored with the vendor and the program to continue running reports indicative of doctor shopping.
Development Recommendation for Information to Be Included in Prescriber Feedback Report: Ralph Orr	Mr. Orr stated that prescriber feedback reports are a long term goal of the Virginia PMP. He stated that perhaps the report could include the total number of patients in a prescriber's panel that are receiving opiates. Another consideration would be the # of patients receiving greater than 120 MEDD. The panel discussed that the report should show a snapshot of the practice. Mr. Orr asked the panel whether the report should go to everyone or to just outliers. Dr. Tharp was concerned that if the report went to everyone every month, most would stop looking at it. Dr. Brown suggested we include a measure of how often each prescriber uses the PMP. The panel also considered that it could be an annual report; perhaps call it a "prescribing summary" instead of a "report card". Also included in the summary could be the average patient MEDD level, and it could be sent to all

	prescribers during their renewal cycle. In order to use a comparison by specialty, the PMP will need to collect the NPI number which contains specialty codes.
Unsolicited Reports to Law Enforcement and Licensing Boards Related to the Indiscriminate Prescribing and Dispensing of Controlled Substances: Ralph Orr	Mr. Orr stated that this topic is still under discussion by the Data Monitoring Workgroup. The panel discussed that the PMP could refer names to the licensing boards, and the boards could simply utilize the processes already in place. For example, prescribers could be notified by CCA that their prescribing is outside the norm. Those notified could then be aware that their practice patterns need further scrutiny, and the notice is not publicly held information. The panel determined that panel members need to agree on appropriate data points that would signify standard of care vs. criminal behavior. The panel will continue discussion of this topic at the next meeting.
Mandatory Requests for PMP Information: Ralph Orr	Mr. Orr cited an Express Scripts study that showed individuals who are on opioids for greater than 30 days typically stay on them for three years or more. Mr. Orr also stated that the reference to *chronic* pain management in the law ignores the fact that overdose and death can occur as a result of prescribing in urgent care settings, dental offices, and for short term use. Ms. Morris stated that ER patients specifically are a big issue; they do doctor shop. The panel discussed how access to the PMP within each EHR would simplify the process and encourage use of the PMP. Incorporating PMP data in EHRs is work that is being explored at a national and state level. The panel will continue discussion of this topic at the next meeting.
Review Draft Form: Research Request for PMP Data: Carolyn McKann	Ms. McKann referred panel members to the draft research request form which incorporated components of several other state PMP's forms. Those forms were reviewed during the March advisory panel meeting. The draft form included a 2-year MOU, reference to approval by an institutional review board, and that any results of the associated study would be shared with the Virginia PMP before publication. Dr. Tharp asked that a requirement is added to destroy any and all PMP related data at the end of the term of the MOU. Dr. Melton suggested that someone with experience with institutional review boards take a look at the draft form for comment. Panel members agreed the form was fine if those elements are met.
PROGRAM UPDATE: Carolyn McKann Program Statistics	Ms. McKann reviewed the program statistics and stated that the PMP expects to process greater than 2.5 million requests in 2015. Ms. McKann noted that those prescribers writing the most prescriptions typically are the most likely to be registered with the program and that the percentage of registered prescribers continues to increase for each group. Additionally, the percentage of requests relative to new prescriptions written also continues to increase.

Morphine Equivalent Daily Dose Score on PMP Reports	Ms. McKann reviewed the MEDD sample report included in the agenda packet. Ms. McKann told panel members that response from prescribers to the MEDD score has been positive, and that most phone calls have been from patients expressing concern about their physician intending to reduce their MEDD to less than 100.
Addition of Dentists as Dispensers Reporting to the PMP	Ms. McKann shared with the panel the PMP's initiative to obtain information from all dentists regarding whether they dispense controlled substances from their office and to obtain a waiver form from those dentists who do not dispense from their office. Ms. McKann noted that the PMP still needs information from approximately 1,000 dentists, as the program has only received information from about 5,700 of the 6,700 or so current active licenses. Ms. McKann noted that the dentists were given the opportunity to claim their waiver status during online license renewal, but only 2,000 of the active licensees responded at that time that they did not dispense. The PMP is working with the Board of Dentistry to reassign the responsibility for determining the waiver status of the remaining 1,000 or so dental licensees.
PMP Interoperability and Integration -- Status	Ms. McKann noted that the next state interoperable with the Virginia PMP will be Maryland. Ms. McKann noted that the PMP is working with our software vendor and VITA to enable the PMP test region to allow for testing interoperability with states that do not have software functional in a production environment.
NEXT MEETING	The next meeting will be held on Wednesday, September 30, 2015 from 10 a.m. to 2 p.m.
ADJOURN:	With all business concluded, the committee adjourned at 2:15 p.m.
	Dr. S. Hughes Melton, Chairman
	Ralph A. Orr, Director

Governor's Task Force on Prescription Drug & Heroin Abuse

Data & Monitoring Workgroup Implementation Plan Updates

September 21, 2015

Data & Monitoring Workgroup Implementation Plan Updates

Accepted Recommendation

Expand mandatory requests to the PMP to include the initial prescribing of an opiate or benzodiazepine and periodic reports thereafter, not to exceed 90 days, with limited exceptions

- Accepted by Task Force at May 2015 meeting, but referred back to Workgroup for additional details (i.e., to develop recommendations for the limited exceptions to these mandatory requests)

Data & Monitoring Workgroup Implementation Plan Updates

Workgroup recommended exceptions to the expanded mandatory requests:

1. The opiate or benzodiazepine is prescribed to a patient currently receiving hospice or palliative care;
2. The opiate or benzodiazepine is prescribed to a patient as part of treatment for a surgical procedure and such prescription is not refillable; and
3. The PMP is not operational or available due to temporary technological or electrical failure or natural disaster.

Data & Monitoring Workgroup Implementation Plan Updates

Implementation Steps:

- Legislation to amend Code § 54.1-2522.1 is required to implement this recommendation expanding mandatory requests to the PMP
- The PMP will disseminate information about this change to all PMP registered users and interested entities prior to the legislation's effective date

Data & Monitoring Workgroup Implementation Plan Updates

Recommendation

Authorize "unsolicited" reports on outlier prescribing and dispensing to be sent to law enforcement and/or licensing boards

- Deferred by Task Force at May 2015 meeting for Workgroup to work out additional details (e.g., who will develop criteria for these reports)
- As presented in May, recommendation had PMP providing notice to prescriber or dispenser when outlier criteria is met and advising that, if continued, information may be forwarded to law enforcement or licensing board; this notice is no longer recommended
- Discussion in May included comment that the PMP's role is to manage data and is not to serve as a regulatory or law enforcement entity

Data & Monitoring Workgroup Implementation Plan Updates

Revised Recommendation:

Grant authority to the PMP, through the Director of the Department of Health Professions (DHP), to send unsolicited reports on egregious outlier prescribing and dispensing behavior to the Enforcement Division of DHP and/or to law enforcement, based on criteria developed by the PMP Advisory Panel in consultation with applicable licensing boards

Data & Monitoring Workgroup Implementation Plan Updates

Implementation Steps:

- Legislation to amend Code § 54.1-2523.1 is required to implement this recommendation addressing unsolicited reports on outlier prescribing and dispensing
- The PMP Advisory Panel, in consultation with the applicable licensing boards, will need to develop the outlier criteria
- The PMP will disseminate information about this change to all PMP registered users and interested entities prior to the legislation's effective date

Data & Monitoring Workgroup Implementation Plan Updates

Update on Health & Criminal Justice Data Committee Recommendation:

- Workgroup's Data Sets Subcommittee met and made recommendations for initial Committee membership
- Invitation letters from SPSHS and SHHR sent to agency heads
- Initial meeting of Committee anticipated to be held in October

Data & Monitoring Workgroup Implementation Plan Updates

Questions & Comments?

COMMONWEALTH of VIRGINIA

Department of Health

MARISSA J. LEVINE, MD, MPH, FAAFP
STATE HEALTH COMMISSIONER

PO BOX 2448
RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

Opioid Overdose Risk Mitigation

August 31, 2015

Dear Colleague:

In 2014, an average of 1.5 people died each day from a fatal prescription opioid overdose in Virginia. Fatal prescription opioid overdoses increased by 8.3% in 2014 (n=547) compared to 2013 (n=505). In addition, fatal heroin overdoses increased by 12.2% in 2014 (n=239) compared to 2013 (n=213). Although there is a lag time for confirmative toxicology results, preliminary data for the first six months of 2015 already show a 24.8% increase in the number of fatal heroin overdoses (n=126) compared to the first six months of 2014 (n=101).

My communication today will highlight three topics related to **our collective efforts to address the epidemic of opioid abuse and overdose in Virginia.**

- Adoption of the *SAMHSA Opioid Overdose Prevention Toolkit: Information for Prescribers* as risk mitigation guidelines for the prescription of opioid analgesics in Virginia
- Expanded access to naloxone in Virginia
- Statewide, regional and local initiatives to address prescription drug and heroin abuse

SAMHSA Opioid Overdose Prevention Toolkit: Information for Prescribers

The Virginia General Assembly during its 2015 Session directed the Virginia Department of Health (VDH) in collaboration with the Department of Health Professions (DHP) to issue *"risk mitigation guidelines on the prescription of the class of potent pain medicines known as extended-release and long-acting (ER/LA) opioid analgesics to include co-prescription of an opioid antagonist."* Just as the clinical community's response to opioid abuse and overdose is not only in the hands of specialists in addiction medicine, the Department of Behavioral Health and Developmental Services (DBHDS), DHP and VDH share in the public health response.

DBHDS, DHP and VDH are **adopting as risk mitigation guidelines for the prescription of opioid analgesics the *SAMHSA Opioid Overdose Prevention Toolkit: Information for Prescribers*** (HHS Publication No. (SMA) 14-4742. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014), which is available at http://store.samhsa.gov/shin/content//SMA14-4742/Toolkit_Prescribers.pdf

The *Information for Prescribers* stresses that physicians and other healthcare providers can

reduce the toll of opioid overdose through the care they take in prescribing opioid analgesics and monitoring the patient's response, as well as by identifying and addressing overdose. When considering use of an opioid analgesic:

- Assess the patient, and take special precautions with new patients
- Use the Virginia Prescription Monitoring Program (http://www.dhp.virginia.gov/pmp/)
- Select an appropriate medication
- Educate the patient and obtained informed consent
- Execute the prescription order carefully
- Consider prescribing naloxone along with the patient's initial opioid prescription

Then

- Monitor the patient's response to treatment
- Decide whether and when to end opioid therapy
- Consider prescribing naloxone to a patient at high risk of overdose

Information for Prescribers, under the heading Resources for Prescribers, provides links to additional information and courses on prescribing opioids for chronic pain. CME credits are available.

We still have the option to develop Virginia-specific opioid abuse and overdose risk mitigation guidelines. Developing these guidelines would require the collective effort of the state agencies, professional boards, professional associations and interested healthcare professionals. **To help us determine the need for Virginia-specific guidelines, we ask that you complete this short online survey (https://www.surveymonkey.com/r/VDHOpioid), which will remain open for 60 days.**

Expanded access to naloxone

The General Assembly also passed legislation this year to expand access to naloxone so that family members and other individuals can possess and use naloxone to reverse an opioid overdose at home or in the community.

> Per the Code of Virginia §54.1-3408 X, *"Notwithstanding the provisions of § 54.1-3303, pursuant to an oral, written, or standing order issued by a prescriber, and in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health, a pharmacist may dispense naloxone or other opioid antagonist used for overdose reversal and a person may possess and administer naloxone or other opioid antagonist used for overdose reversal to a person who is believed to be experiencing or about to experience a life-threatening opiate overdose."*

The Board of Pharmacy has approved a "Protocol for the Prescribing and Dispensing of Naloxone" (https://www.dhp.virginia.gov/pharmacy/). The DBHDS Office of Substance Abuse Services has established **REVIVE! as the Opioid Overdose and Naloxone Education (ONE) program for the Commonwealth of Virginia**. REVIVE! provides training to professionals, stakeholders, and others on how to recognize and respond to an opioid overdose emergency with the administration of naloxone (http://www.dbhds.virginia.gov/individuals-and-

families/substance-abuse/revive). Both sources include guidance on prescribing and dispensing naloxone for intranasal administration, as well as by auto-injector.

Statewide, regional and local initiatives on prescription drug and heroin abuse

Virginia's response to the epidemic of opiate abuse and overdose is not limited to a healthcare response. In September 2014, Governor McAuliffe signed Executive Order 29 establishing the Governor's Task Force on Prescription Drug and Heroin Abuse. The Task Force is co-chaired by the Secretary of Health and Human Resources and Secretary of Public Safety and Homeland Security and includes representatives from the Office of the Attorney General, legislature, and judiciary, as well as relevant state and local agencies, law enforcement, health and behavioral health care professionals, providers, community advocates, and individuals with personal experience with addiction. The Task Force was created to recommend immediate steps to address a growing and dangerous epidemic of prescription opioid and heroin abuse in Virginia, with the ultimate goal of improving public safety and public health. See the Task Force website (http://www.dhp.virginia.gov/taskforce/) for information on its activities and recommendations.

At the local and regional level, clinicians and other healthcare professionals are encouraged to engage with local agencies, law enforcement, community advocates, community service boards, and other community partners to create local solutions to address substance abuse prevention and treatment, as well as respond to the epidemic of opioid overdose. Regarding opioid overdose, the *SAMHSA Opioid Overdose Prevention Toolkit* also provides: Facts for Community Members; Five Essential Steps for First Responders; Safety Advice for Patients & Family Members; and Recovering from Opioid Overdose. All documents are available at: http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2014/SMA14-4742.

Thank you for your efforts as clinicians to prevent or reduce the risk of opiate abuse by the patients under your care and as members of your community to support efforts to stem the epidemic of opioid prescription drug and heroin abuse, overdose and overdose deaths in Virginia.

Sincerely,

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner
Department of Health

David Brown, DC
Director
Department of Health Professions

Debra Ferguson, PhD
Commissioner
Department of Behavioral Health & Developmental Services

A pdf version of this letter is available on the VDH Resources for Health Care Professionals web page.

DEFINITIONS OF PBSS MEASURES

SECTION 1: PRESCRIPTION RATES

1.1 Prescription rates by quarter and year, by drug class and sex

- Reported by quarter and year per 1,000 state residents. Limited to prescriptions to state residents in state's PDMP.

1.2 Prescription rates by quarter and year, by drug class and age group

- Reported by quarter and year per 1,000 state residents. Limited to prescriptions to state residents in state's PDMP.

1.3 Prescription rates by year, by drug class, sex and age group

- Reported by quarter and year per 1,000 state residents. Limited to prescriptions to state residents in state's PDMP.

1.4 Prescription rates by quarter and year, by major opioid drug category

- Reported by quarter and year per 1,000 state residents. Limited to prescriptions to state residents in state's PDMP.

1.5 Prescription rates by quarter and year, by major stimulant drug category

- Reported by quarter and year per 1,000 state residents. Limited to prescriptions to state residents in state's PDMP.
- Includes amphetamine-dextroamphetamine.

1.6 Prescription rates by quarter and year, by major benzodiazepine drug category

- Reported by quarter and year per 1,000 state residents. Limited to prescriptions to state residents in state's PDMP.

1.7 Prescription rates by quarter and year, by miscellaneous drug category

- Reported by quarter and year per 1,000 state residents. Limited to prescriptions to state residents in state's PDMP.

SECTION 2: DAILY DOSAGES

2.1 Mean daily dosage per patient in morphine milligram equivalents (MMEs) by quarter and year, by major opioid drug category

- Mean daily dosage is calculated for subjects that have a 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).
- Limited to prescriptions to state residents in state's PDMP.

- The % of patients receiving >100 MMEs daily refers to the % of patients with > 100 MMEs per day prescribed for all drugs used by the patient, calculated using the average daily MMEs over the three month period.

SECTION 3: OVERLAPPING PRESCRIPTIONS

3.1 Percentage of prescribed days overlapping with another prescription from the same drug class, by quarter and year

- Calculated as the number of days with more than 1 prescription in the same drug class divided by the total number of prescription days for that drug class per quarter. Thus, a day with 2 overlapping prescriptions is counted the same as one with 3 overlapping prescriptions. The total number of prescription days for a drug class only includes any day with 1 or more prescriptions.
- Limited to prescriptions to state residents in state's PDMP.

3.2 Percentage of days with overlapping prescriptions across opioid and benzodiazepine drug classes and across opioid release-forms, by quarter and year

- Long acting includes both naturally long acting drugs such as methadone and drugs elsewhere labelled as extended-release.
- Limited to prescriptions to state residents in state's PDMP.
- Percentage of all opioid days prescribed overlapping with a benzodiazepine prescription calculated as the number of days with both an opioid and benzodiazapine prescription divided by the total number of opioid rx days.
- Percentage of prescribed days for Long Acting (LA)/Extended Release (ER) formulations that overlap with Short Acting (SA) formulations. Denominator is the total days of LA/ER prescriptions.
- Percentage of prescribed days for LA/ER formulations that overlap with other LA/ER formulations. Denominator is the total days of LA/ER prescriptions.
- Percentage of prescribed days for SA formulations that overlap with other SA formulations. Denominator is the total days of SA prescriptions. The denominator of total prescription days is calculated for each measure to include only any day with one or more prescription.

SECTION 4: MULTIPLE PROVIDER EPISODE RATES

4.1 Multiple provider episode rates by quarter and year, by drug schedule and age group

- Multiple provider episode rate is defined as use of 5 or more prescribers and 5 or more pharmacies within 3 months and is based on the current 3 months. The controlled substance Schedule II category includes all schedule II drugs. The Schedule II and III category includes Schedule II or III drugs, and Schedule II, III, IV includes Schedule II, III or IV drugs.

- Reported by quarter and year per 100,000 state residents. The annual rate is calculated as the average quarterly rate for the specified year. Limited to prescriptions to state residents in state's PDMP.

4.2 Multiple provider episode rates by quarter and year, by drug class and age group

- Multiple provider episode is defined as use of 5 or more prescribers and 5 or more pharmacies within 3 months and is based on the current 3 months. Rates are calculated by drug class for those receiving a prescription in the drug class.
- Reported by quarter and year per 100,000 state residents. The annual rate is calculated as the average quarterly rate for the specified year. Limited to prescriptions to state residents in state's PDMP.

4.3 Percentage of total prescriptions for a type of opioid that were involved in a multiple provider episode, by quarter and year

- Multiple provider episode is defined as use of 5 or more prescribers and 5 or more pharmacies within 3 months and is based on the current 3 months. When a prescription for a type of opioid was involved in any MPE, that prescription was counted as being involved.
- Limited to prescriptions to state residents in state's PDMP.

4.4 Percentage of total prescriptions for a type of stimulant that were involved in a multiple provider episode, by quarter and year

- Multiple provider episode is defined as use of 5 or more prescribers and 5 or more pharmacies within 3 months and is based on the current 3 months.
- Limited to prescriptions to state residents in state's PDMP.
- Includes amphetamine-dextroamphetamine.

4.5 Percentage of total prescriptions for a type of benzodiazepine that were involved in a multiple provider episode, by quarter and year

- Multiple provider episode is defined as use of 5 or more prescribers and 5 or more pharmacies within 3 months and is based on the current 3 months.
- Limited to prescriptions to state residents in state's PDMP.

4.6 Percentage of total prescriptions for a specific drug that were involved in a multiple provider episode, by quarter and year

- Multiple provider episode is defined as use of 5 or more prescribers and 5 or more pharmacies within 3 months and is based on the current 3 months.
- Limited to prescriptions to state residents in state's PDMP.

4.7 Percentage of patients with oxycodone and alprazolam in combination who engaged in a multiple provider episode, by quarter and year

- Having a drug combination in the previous 3 months means being dispensed both drugs at any time during the 3 months.

- Multiple provider episode is defined as use of 5 or more prescribers and 5 or more pharmacies within 3 months and is based on the current 3 months.
- Limited to prescriptions to state residents in state's PDMP.

4.8 Multiple provider episode rates by half-year and year, by drug schedule and age group

- Multiple provider episode rate is defined as use of 5 or more prescribers and 5 or more pharmacies within 6 months and is based on the current 6 months. The controlled substance Schedule II category includes all schedule II drugs. The Schedule II and III category includes Schedule II or III drugs, and Schedule II, III, IV includes Schedule II, III or IV drugs.
- Reported by half-year and year per 100,000 state residents. The annual rate is calculated as the average half-year rate for the specified year. Limited to prescriptions to state residents in state's PDMP.

4.9 Multiple provider episode rates by half-year and year, by drug class and age group

- Multiple provider episode is defined as use of 5 or more prescribers and 5 or more pharmacies within 6 months and is based on the current 6 months. Rates are calculated by drug class for those receiving a prescription in the drug class.
- Reported by half-year and year per 100,000 state residents. The annual rate is calculated as the average half-year rate for the specified year. Limited to prescriptions to state residents in state's PDMP.

4.10 Number and percentage of unique patients with controlled substance prescriptions (Rxs) paid for by Medicaid and by cash, by quarter and by year

- The number of unique patients with controlled substance prescriptions paid for by Medicaid and by cash which were (i) less than 10 days apart and within the same quarter, (ii) for the same drug, (iii) from a different prescriber, and (iv) where the number of days supply for the earlier prescription was greater than the number of days between the prescription fill dates. The percentage of unique patients is defined as the number of unique patients who meet the criteria above divided by the number of unique patients with at least one prescription paid for by Medicaid in the quarter.
- Reported by quarter and year. The annual rate is calculated as the average quarterly rate for the specified year. Limited to prescriptions to state residents in state's PDMP.

SECTION 5: PILL MILL MEASURES

5.1 Mean number per day and percentage of Schedule II-IV controlled substance (CS) prescriptions (Rxs) by prescriber decile, based on daily prescribing counts, by quarter and year

- Limited to in-state prescribers of the drug type(s) shown in this table. Includes out-of-state-residents. Based on the total number of days in a quarter.
- Tied values that overlapped deciles were randomly assigned to the higher or lower decile so that all deciles are equal-sized.

- Mean refers to the mean number of controlled substances prescriptions written per day per prescriber percentile rank. % refers to the percentage of all controlled substance prescriptions written per day per prescriber percentile rank.

5.2 Mean number per day and percentage of opioid prescriptions (Rxs) by prescriber decile, based on daily prescribing counts, by quarter and year

- Limited to in-state prescribers of the drug type(s) shown in this table. Includes out-of-state-residents. Based on the total number of days in a quarter.
- Tied values that overlapped deciles were randomly assigned to the higher or lower decile so that all deciles are equal-sized.
- Mean refers to the mean number of opioid prescriptions written per day per prescriber percentile rank. % refers to the percentage of all opioid prescriptions written per day per prescriber percentile rank.

5.3 Mean number per day and percentage of prescriptions (Rxs) for stimulants by prescriber decile, based on daily prescribing counts, by quarter and year

- Limited to in-state prescribers of the drug type(s) shown in this table. Includes out-of-state-residents. Based on the total number of days in a quarter.
- Tied values that overlapped deciles were randomly assigned to the higher or lower decile so that all deciles are equal-sized.
- Mean refers to the mean number of stimulant prescriptions written per day per prescriber percentile rank. % refers to the percentage of all stimulant prescriptions written per day per prescriber percentile rank.

5.4 Mean number per day and percentage of prescriptions (Rxs) for benzodiazepines by prescriber decile, based on daily prescribing counts, by quarter and year

- Limited to in-state prescribers of the drug type(s) shown in this table. Includes out-of-state-residents. Based on the total number of days in a quarter.
- Tied values that overlapped deciles were randomly assigned to the higher or lower decile so that all deciles are equal-sized.
- Mean refers to the mean number of benzodiazepine prescriptions written per day per prescriber percentile rank. % refers to the percentage of all benzodiazepine prescriptions written per day per prescriber percentile rank.

5.5 Mean number per day and percentage of prescriptions (Rxs) for carisoprodol by prescriber decile, based on daily prescribing counts, by quarter and year

- Limited to in-state prescribers of the drug type(s) shown in this table. Includes out-of-state-residents. Based on the total number of days in a quarter.
- Tied values that overlapped deciles were randomly assigned to the higher or lower decile so that all deciles are equal-sized.
- Mean refers to the mean number of prescriptions for specified drug written per day per prescriber percentile rank. % refers to the percentage of all prescriptions for specified drug written per day per prescriber percentile rank.

5.6 Mean number per day and percentage of prescriptions (Rxs) for zolpidem by prescriber decile, based on daily prescribing counts, by quarter and year

- Limited to in-state prescribers of the drug type(s) shown in this table. Includes out-of-state-residents. Based on the total number of days in a quarter.
- Tied values that overlapped deciles were randomly assigned to the higher or lower decile so that all deciles are equal-sized.
- Mean refers to the mean number of prescriptions for specified drug written per day per prescriber percentile rank. % refers to the percentage of all prescriptions for specified drug written per day per prescriber percentile rank.

5.7 Mean daily dosage for opioids in MMEs by prescriber decile, based on daily prescribing counts, by quarter and year

- Limited to in-state prescribers of the drug type(s) shown in this table. Includes out-of-state-residents.
- Tied values that overlapped deciles were randomly assigned to the higher or lower decile so that all deciles are equal-sized.

5.8 Mean distance in miles from patient to prescriber by prescriber decile, based on mean distance in miles from patient to prescriber, for CS II-IV prescriptions, by quarter and year

- Limited to in-state prescribers of the drug type(s) shown in this table. Includes out-of-state-residents.
- Tied values that overlapped deciles were randomly assigned to the higher or lower decile so that all deciles are equal-sized.

5.9 Mean distance in miles from patient to prescriber by prescriber decile, based on mean distance in miles from patient to prescriber, for opioid prescriptions, by quarter and year

- Limited to in-state prescribers of the drug type(s) shown in this table. Includes out-of-state-residents.
- Tied values that overlapped deciles were randomly assigned to the higher or lower decile so that all deciles are equal-sized.

5.10 Percentage of patients with a multiple provider episode among all patients seen, by prescriber decile, based on mean distance in miles from patient to prescriber, by quarter and year

- Multiple provider episode is defined as use of 5 or more prescribers and 5 or more pharmacies within 3 months and is based on the current 3 months.
- Limited to in-state prescribers of the drug type(s) shown in this table. Includes out-of-state-residents.
- Tied values that overlapped deciles were randomly assigned to the higher or lower decile so that all deciles are equal-sized.

5.11 Percentage of all Schedule II-IV controlled substance (CS) prescriptions (Rxs) and all opioid Rxs by payment type and percentage of prescribers with 10% or more CS Rxs and opioid Rxs paid for in cash, by quarter and year

- Limited to in-state prescribers of the drug type(s) shown in this table. Includes out-of-state-residents. This table is populated only if the PDMP collects source of payment. Other payment types not shown; thus, totals may not sum to 100%.

SECTION 6: LONG-ACTING / EXTENDED RELEASE OPIOID MEASURES

6.1 Percentage of patients prescribed long-acting/extended release (LA/ER) opioids who were opioid-naïve and mean daily dosage per LA/ER prescription, by quarter and year

- Defined as one with no opioid prescriptions in the previous 60 days.
- Limited to prescriptions to state residents in state's PDMP.
- Calculated as the number of opioid-naïve patients receiving at least 1 LA/ER opioid Rx per quarter, divided by the total number of patients who received an LA/ER opioid Rx per quarter and multiplied by 100.
- Calculated as the average daily dosage in MMEs per LA/ER opioid Rx to opioid-naïve patients as defined above.

SECTION 7: PHARMACY-BASED MEASURES

7.1 Mean number per day and percentage of Schedule II-IV controlled substance (CS) prescriptions (Rxs) dispensed, by pharmacy decile, based on daily dispensing counts, by quarter and year

- Limited to in-state pharmacies. Includes out-of-state residents.
- Tied values that overlapped deciles were randomly assigned to the higher or lower decile so that all deciles are equal-sized.
- Mean refers to the mean number of controlled substances prescriptions dispensed per day per pharmacy percentile rank. % refers to the percentage of all controlled substance prescriptions dispensed per day per pharmacy percentile rank.

7.2 Mean number per day and percentage of opioid prescriptions (Rxs) dispensed, by pharmacy decile, based on daily dispensing counts, by quarter and year

- Limited to in-state pharmacies. Includes out-of-state residents.
- Tied values that overlapped deciles were randomly assigned to the higher or lower decile so that all deciles are equal-sized.
- Mean refers to the mean number of opioid prescriptions dispensed per day per pharmacy percentile rank. % refers to the percentage of all opioid prescriptions dispensed per day per pharmacy percentile rank.

7.3 Mean number per day and percentage of prescriptions (Rxs) for stimulants dispensed, by pharmacy decile, based on daily dispensing counts, by quarter and year

- Limited to in-state pharmacies. Includes out-of-state residents.

- Tied values that overlapped deciles were randomly assigned to the higher or lower decile so that all deciles are equal-sized.
- Mean refers to the mean number of stimulant prescriptions dispensed per day per pharmacy percentile rank. % refers to the percentage of all stimulant prescriptions dispensed per day per pharmacy percentile rank.

7.4 Mean number per day and percentage of prescriptions (Rxs) for benzodiazepines dispensed, by pharmacy decile, based on daily dispensing counts, by quarter and year

- Limited to in-state pharmacies. Includes out-of-state residents.
- Tied values that overlapped deciles were randomly assigned to the higher or lower decile so that all deciles are equal-sized.
- Mean refers to the mean number of benzodiazepine prescriptions dispensed per day per pharmacy percentile rank. % refers to the percentage of all benzodiazepine prescriptions dispensed per day per pharmacy percentile rank.

7.5 Mean number per day and percentage of prescriptions (Rxs) for carisoprodol dispensed, by pharmacy decile, based on daily dispensing counts, by quarter and year

- Limited to in-state pharmacies. Includes out-of-state residents.
- Tied values that overlapped deciles were randomly assigned to the higher or lower decile so that all deciles are equal-sized.
- Mean refers to the mean number of prescriptions for specified drug dispensed per day per pharmacy percentile rank. % refers to the percentage of all prescriptions for specified drug dispensed per day per pharmacy percentile rank.

7.6 Mean number per day and percentage of prescriptions (Rxs) for zolpidem dispensed, by pharmacy decile, based on daily dispensing counts, by quarter and year

- Limited to in-state pharmacies. Includes out-of-state residents.
- Tied values that overlapped deciles were randomly assigned to the higher or lower decile so that all deciles are equal-sized.
- Mean refers to the mean number of prescriptions for specified drug dispensed per day per pharmacy percentile rank. % refers to the percentage of all prescriptions for specified drug dispensed per day per pharmacy percentile rank.

7.7 Mean daily dosage for opioids in MMEs by pharmacy decile, based on daily dispensing counts, by quarter and year

- Limited to in-state pharmacies. Includes out-of-state residents.
- Tied values that overlapped deciles were randomly assigned to the higher or lower decile so that all deciles are equal-sized.

7.8 Mean distance in miles from patient to pharmacy by pharmacy decile, based on mean distance in miles from patient to pharmacy, for all CS-II-IV prescriptions dispensed, by quarter and year

- Limited to in-state pharmacies. Includes out-of-state residents.
- Tied values that overlapped deciles were randomly assigned to the higher or lower decile so that all deciles are equal-sized.

7.9 Mean distance in miles from patient to pharmacy by pharmacy decile, based on mean distance in miles from patient to pharmacy, for opioid prescriptions dispensed, by quarter and year

- Limited to in-state pharmacies. Includes out-of-state residents.
- Tied values that overlapped deciles were randomly assigned to the higher or lower decile so that all deciles are equal-sized.

7.10 Percentage of patients with a multiple provider episode among all patients dispensed to, by pharmacy decile, based on mean distance in miles from patient to pharmacy, by quarter and year

- Multiple provider episode is defined as use of 5 or more prescribers and 5 or more pharmacies within 3 months and is based on the current 3 months.
- Limited to in-state pharmacies. Includes out-of-state residents.
- Tied values that overlapped deciles were randomly assigned to the higher or lower decile so that all deciles are equal-sized.

7.11 Percentage of all Schedule II-IV controlled substance (CS) prescriptions (Rxs) and all opioid Rxs by payment type and percentage of pharmacies with 10% or more CS Rxs and opioid Rxs paid for in cash, by quarter and year

- Limited to in-state pharmacies. Includes out-of-state residents.
- This table is populated only if the PDMP collects source of payment. Other payment types not shown; thus, totals may not sum to 100%.
- The number of pharmacies that filled CS Rxs paid for by Medicaid and by cash is defined as the number of pharmacies which filled CS Rxs paid for by Medicaid and by cash for the same patient where the Rxs were: (i) less than 10 days apart and within the same quarter, (ii) for the same drug, (iii) from a different prescriber, and (iv) where the number of days supply for the earlier prescription was greater than the number of days between the prescription fill dates.
- The percentage of pharmacies that filled CS Rxs paid for by Medicaid and by cash is defined as the percentage of all pharmacies who met the criteria above.

APPENDIX

A.1 Annual estimates of state resident population, by sex and age groups

Population estimates as of July 1 of the specified year. Population estimates for 2012 were not available as of 5/29/2013. The previous year's population was used when population estimates for a given year are not yet available. Source: Table 2. Annual Estimates of the Resident Population by Sex and Age for Maine: April 1, 2010 to July 1, 2011 (SC-EST2011-02-12), U.S. Census Bureau, Population Division. Release Date: May 2012.

Virginia Prescription Monitoring Program: Research and Analytics Plan

Purpose

This plan outlines a conceptual framework and data analytics plan to identify prescription patterns using Virginia's PMP data; the plan will ultimately recommend Key Performance Indicators (KPIs) to be used by the PMP Advisory Panel and staff to help inform a wide variety of strategic decisions. Leveraging the basic assets that PMP "Big Data" provides gives health-care stakeholders the best chances to improve policy, and to consider regulations or laws that best aid the health and safety of Virginia's citizens.

Task Plan

Phase 1: Understand PMP Data, Descriptive Analysis, Assess Current Analytical Capacity ***(Complete)***

- Gain all required access and permissions to "de-identified" PMP data
- Understand the PMP data collection and storage system and identify the three V's for Big Data
    - Volume - quantity of data generated
    - Velocity - how fast data is being generated/processed
    - Veracity - quality of data being captured
- Mine data and conduct initial descriptive data analytics
    - Write syntax and code generate descriptive statistics and graphical displays
    - Determine need for sampling, weighting, or other data treatment(s)
    - Meet with PMP staff as needed
- Articulate a more detailed conceptual framework for analysis
    - Determine overall goals of measurement system
    - Assess measures currently used and identify potential new measures
- Present findings/meet with staff

Phase 2: Predictive Analytics ***(Current to do)***

- Conduct more rigorous predictive analytics and develop data and statistical models
    - Advisory Panel and staff identify "mission critical" research questions to address through mining and analyzing data
        - Prioritize (or rank) research questions into a manageable number
    - Geographical/spatial mapping
        - By *FIPS* code, By 21 *Health Planning Districts* (HPD), re-grouped if needed
    - Exploratory analysis to identify strategically important patterns/trends in the PMP data
        - Concentrate on Opiates and MME values >100 (the CDC established threshold)
- Map spatial and graph trend results to reveal distribution of prescribers and dispensers across various areas of the state.
- Key Performance Indicators
    - Design Methodology, Build Stakeholder Engagement, Recommend Performance Measures
    - Metrics should encompass:
        - Measurability (truly measure what is intended to be measured)
        - Sustainability (remains important over the long-term)

- Linkage to key principles of PMP purpose: *"Virginia's Prescription Monitoring Program (PMP) is a system in which controlled prescription drug data are collected in a database to promote the appropriate use of controlled substances for legitimate medical purposes,* ***while deterring the misuse, abuse, and diversion of controlled substances"***
- Metrics should be "Balanced and a Practical Few in Number" (roughly 10 or fewer measures)
- Measures should be Output-Orientated; they can track change management
- Measures should contain levels (hierarchies) of indicators
- Measures should be reported using data-based graphics; data visualization standards to promote easily accessible and understandable measures
- Measures should be relevant and assessed against what other State or Federal PMP systems or standards suggest

- KPI development and goals should be guided by data analysis results; "normative" decisions and goals can then be assessed against empirical result or impact.

- Possible Key Performance Indicators
  1. **Average Morphine Milligram Equivalent (MME):** Average Mean daily dosage per patient in morphine milligram equivalents (MMEs) by quarter and year, by major opioid drug category
  2. **High-Level Morphine Milligram Equivalent (MME):** Percent of patients with > than XXX MME within a given quarter. Possible MME threshold levels (120, 100, 80, etc.) will be examined with PMP data
  3. **Number of days supply for most likely drugs of abuse:** Average number of days supplied for Opiates and Benzodiazepines
  4. **Combination drugs (Opiates focused):** Percent of patients with more than X drugs prescribed within quarter
  5. **Percent (or rate per 1,000 persons) of drugs prescribed by region:** Region likely to be HPD or HPD regrouping (regrouped if makes sense conceptually, or to preserve anonymity of pharmacy or prescribers); determine need to standardize by population age
  6. **Percent of scripts filled outside FIPS (county, city) or HPD region in which script was written.**
  7. **Raw Number of Measure, per quarter:** Scripts written, patients served (all scripts combined), prescribers writing scripts (may also standardize by population rates)
  8. **Up to 3 additional measures:** TBD.

- Unsolicited reports: PMP office sends info to prescribers, or law enforcement, AFTER pattern finding, alert threshold (flagging) – *The actual initiation of "Unsolicited Reports" and any accompanying analysis, is identified by DHP PMP staff as a* ***Next Step*** *– that would be outlined outside of this document or scope of work*

Deploy Policy solutions:

- **List and define final Key Performance Indicators (KPIs),** recommend *Best Practice* graphical displays
- Transfer KPI analytical logic to DHP/PMP in-house "Dashboard" system as requested for software integration

Summary of Unsolicited Reports at Various Thresholds

- Unsolicited reports are run for each month following the receipt of all prescription data.
- Two types of threshold reports are run for each month:
  - 1. POSSIBLE DOCTOR SHOPPING

Summary of Threshold Reports at Different Levels					
	At least 3 Pharmacies and 3 Prescribers	At least 3 Pharmacies and 4 Prescribers	At least 3 Pharmacies and 5 Prescribers	At least 3 Pharmacies and 7 Prescribers*	4 or more pharmacies
July 2015	2,419 patients	844 patients	306 patients	32 patients	Not tracked
	8,583 prescribers	3,858 prescribers	1,706 prescribers	254 prescribers	
	7,912 pharmacies	2,969 pharmacies	1,158 pharmacies	138 pharmacies	
	12,187 prescriptions	5,239 prescriptions	2,266 prescriptions	326 prescriptions	
	580,395 doses	213,455 doses	80,171 doses	9,807 doses	
August 2015	2,062 patients	758 patients	229 patients	32 patients	Not tracked
	7,291 prescribers	3,435 prescribers	1,295 prescribers	255 prescribers	
	6,784 pharmacies	2,700 pharmacies	896 pharmacies	158 pharmacies	
	10,126 prescriptions	4,587 prescriptions	1,649 prescriptions	310 prescriptions	
	471,509 doses	183,497 doses	57,005 doses	7,925 doses	
June, July and August 2015 Combined; 4 or more pharmacies	Not tracked	Not tracked	Not tracked	Not tracked	7,412 patients
					26,361 prescribers
					33,053 pharmacies
					70,939 prescriptions
					4,045,693 doses

*This is what we currently use to generate threshold reports indicative of possible doctor shopping.

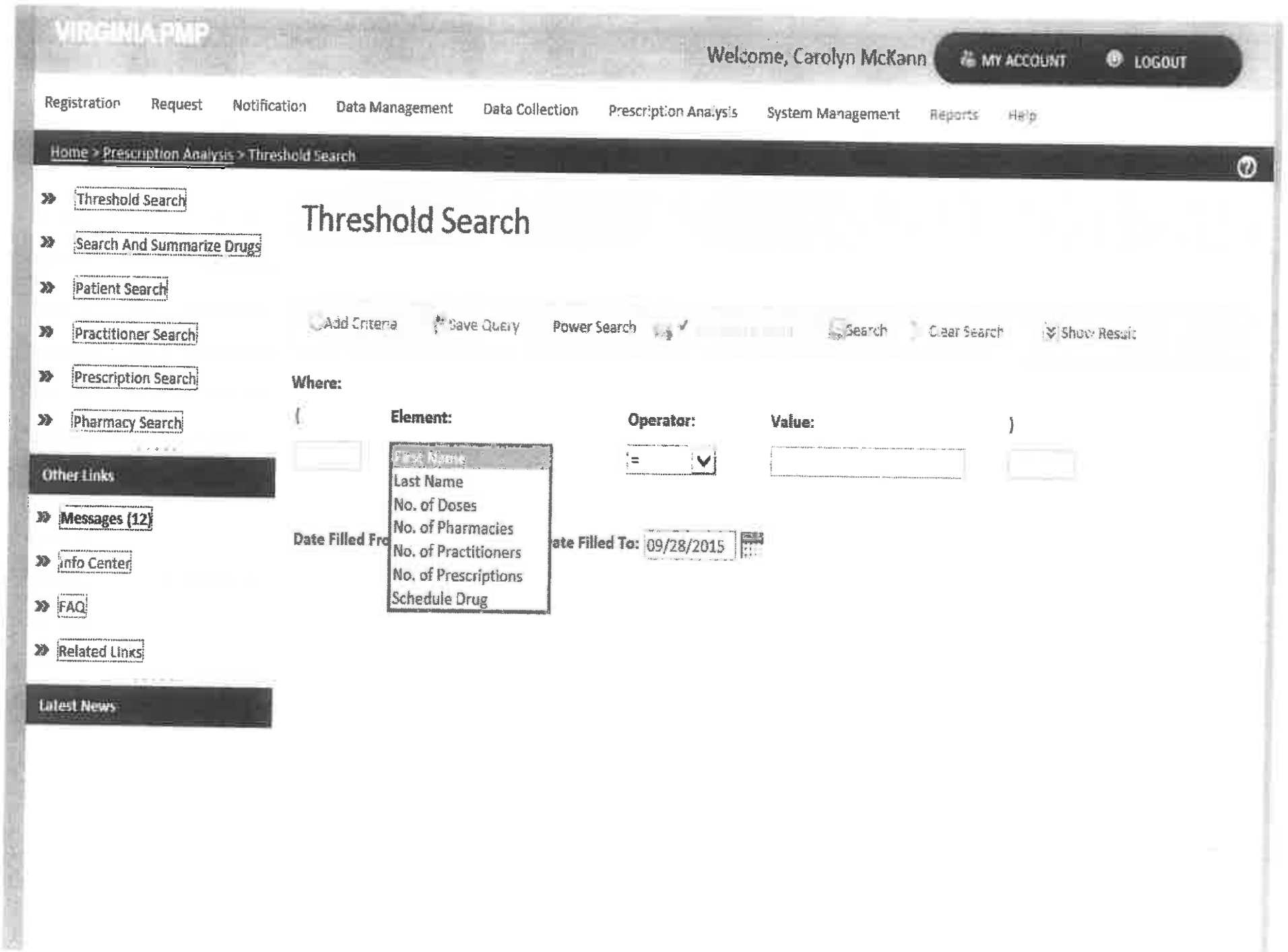
  - 2. POSSIBLE FORGERY

Summary of Threshold Report Indicative of Doctor Shopping	
	At least *5 Pharmacies* and *Only One Prescriber*
July 2015	8 patients
	1 prescriber
	42 pharmacies
	102 prescriptions
	6,239 doses
August 2015	4 patients
	1 prescriber
	20 pharmacies
	26 prescriptions
	1,228 doses

Top 25 Individuals (by Total Number of Prescriptions) Using 4 or More Pharmacies June – August 2015

First Name	Last Name	Number Of Prescriptions	Number Of Pharmacies	Number Of Doses	Number Of Practitioners
1. S	Y	104	7	763	1
2. D	P	81	6	1509	8
3. J	S	73	7	6860	2
4. D	C	72	4	520	3
5. J	M	61	5	175	2
6. C	E	56	4	463	2
7. B	W	48	4	230	2
8. K	R	48	4	572	2
9. E	J	47	4	511	4
10. J	S	44	4	430	3
11. R	M	43	4	1181	5
12. S	D	43	4	451	7
13. S	S	43	5	818	1
14. K	D	40	7	1242	18
15. W	J	40	6	694	12
16. A	C	39	7	1953	8
17. D	S	39	5	3858	1
18. S	C	39	15	1127	27
19. A	N	38	5	402	4
20. C	S	38	4	1937	6
21. G	G	37	5	368	1
22. R	N	37	5	894	4
23. P	E	35	5	1361	12
24. E	H	34	4	83	3
25. J	L	34	4	888	5
TOTAL		**1213**	**134**	**29290**	**143**

Emails and Letters Sent Regarding at least 3 Pharmacies and 7 Prescribers, August 2015							
F Name	L Name	# of Prescriptions	# of Pharmacies	# of Doses	# of Practitioners	# of Emails	# of Letters
B	M	8	6	204	7	5	2
C	R	11	3	1055	7	4	2
C	R	8	6	316	7	6	1
D	P	8	4	374	8	3	5
D	S	8	4	136	8	6	2
D	P	7	4	110	7	4	3
J	K	7	5	280	7	5	2
J	B	8	6	222	8	2	6
J	W	9	6	126	8	4	4
J	B	10	3	199	8	7	1
J	S	8	3	184	7	5	2
J	S	10	3	186	10	4	2
J	S	11	5	264	7	2	5
K	G	9	5	129	8	5	1
M	I	14	3	295	7	7	1
P	J	12	4	175	10	6	4
R	D	9	7	131	9	5	2
R	J	9	7	137	9	10	0
R	D	9	4	407	8	1	7
R	B	13	3	340	11	5	6
S	B	9	3	123	8	8	0
S	M	9	6	188	7	2	4
T	I	8	3	258	7	6	1
T	G	8	5	107	7	7	2
W	A	12	8	190	9	1	8
W	M	10	8	207	9	7	2
Z	A	8	8	120	7	5	2
TOTALS		**310**	**158**	**7925**	**255**	**132**	**77**


VIRGINIA PMP
Welcome, Carolyn McKann
MY ACCOUNT
LOGOUT
Registration
Request
Notification
Data Management
Data Collection
Prescription Analysis
System Management
Reports
Help
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Threshold Search
Search And Summarize Drugs
Patient Search
Practitioner Search
Prescription Search
Pharmacy Search
Other Links
Messages (12)
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FAQ
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Latest News
Threshold Search
Add Criteria
Save Query
Power Search
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Clear Search
Show Result
Where:
(
Element:
Operator:
Value:
)
Last Name
No. of Doses
No. of Pharmacies
No. of Practitioners
No. of Prescriptions
Schedule Drug
=
Date Filled To:
09/28/2015

Statistics for PMP Advisory Committee

September 30, 2015

Total Prescription Records in Database (as of September 25, 2015): **122,312,853.**

Requests:

- **2,564,144** total requests for 2015 (as of 9/24/2015).). (The 2014 total was 1,870,196).
- **165,025** (for the week ending 9/24/2015

Registered Users:

- **28,297** registered users as of 9/25/2015.
- **4,555** have been added during 2015 so far.
- Around **60,000** registered users when the automated registration is complete.

Prescriber Self-Reports:

- **43** requests this past week.
- **2334** requests so far in 2015.
- **2641** total in 2014.

Interoperability/Data Sharing

Statistics:

- Interstate (for the week ending September 24, 2015):
  - Virginia to Tennessee: 1884
  - Virginia to West Virginia: 3182
  - Virginia to Kentucky: 1309
  - Virginia to Maryland: 1331
  - Tennessee to Virginia: 5734
  - West Virginia to Virginia: 105
  - Kentucky to Virginia: 6289
  - Maryland to Virginia: 1007

- PMP Gateway®:
  - 107,654 total requests (for the week ending September 24, 2015).
  - PMP Gateway® is an integration solution which allows pharmacy management applications as well as electronic medical record applications to make requests by "translating" their specific standards' fields so PMPs can process the

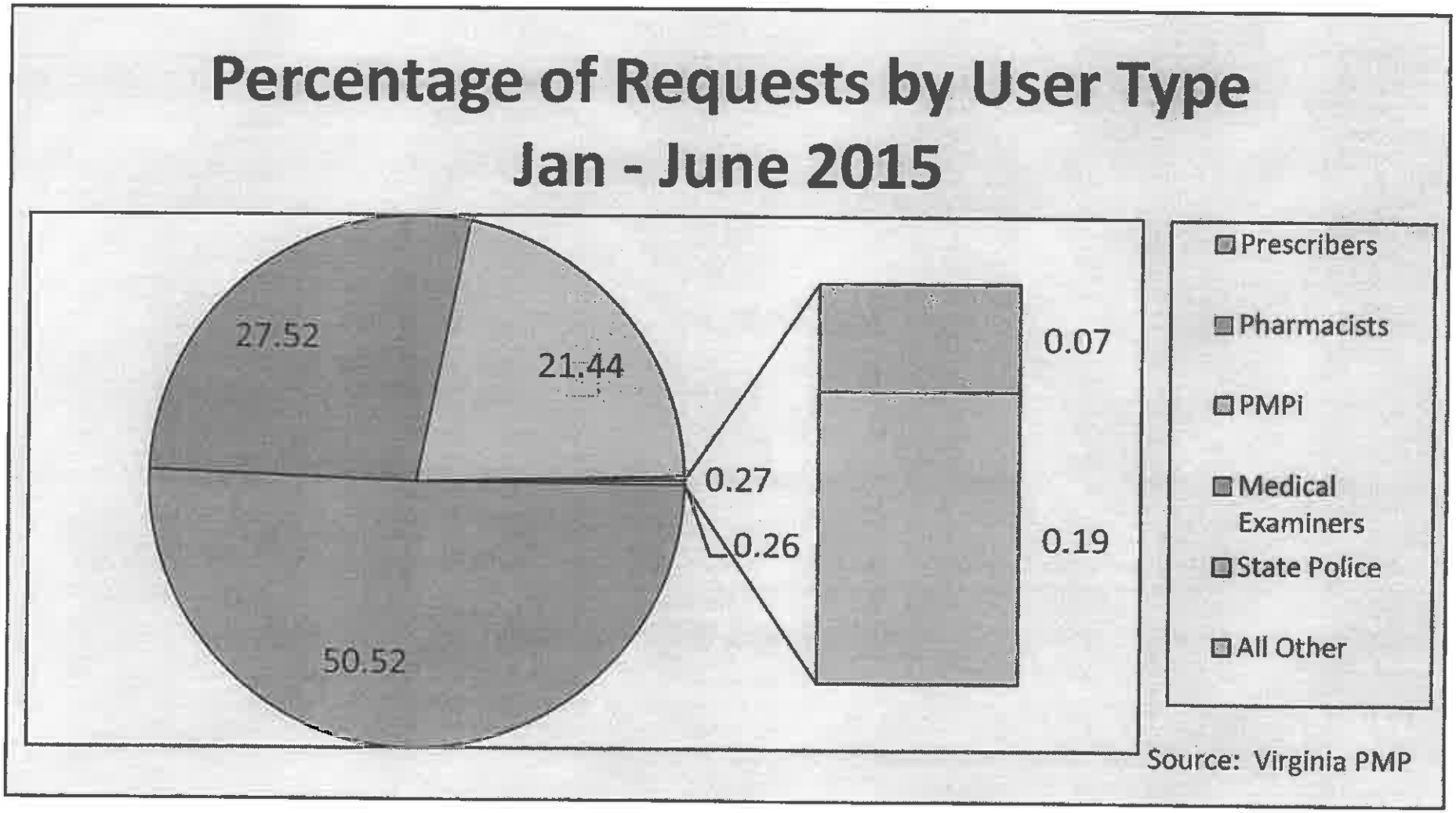
information. Then Gateway translates the completed PMP report information so the receiving application can read and incorporate the data to be viewed by the authorized end user. PMP Gateway has enabled Virginia's PMP to share data with Kroger pharmacies in Virginia, Ohio and West Virginia. There are 62 Kroger pharmacies in Virginia.

- During the first full week of integration between VA's PMP and Kroger, 131,685 requests were processed. Of those, 18,224 requests were from Virginia pharmacies (14% of the total). The remaining 113,461 requests were from OH and WV Kroger pharmacies.

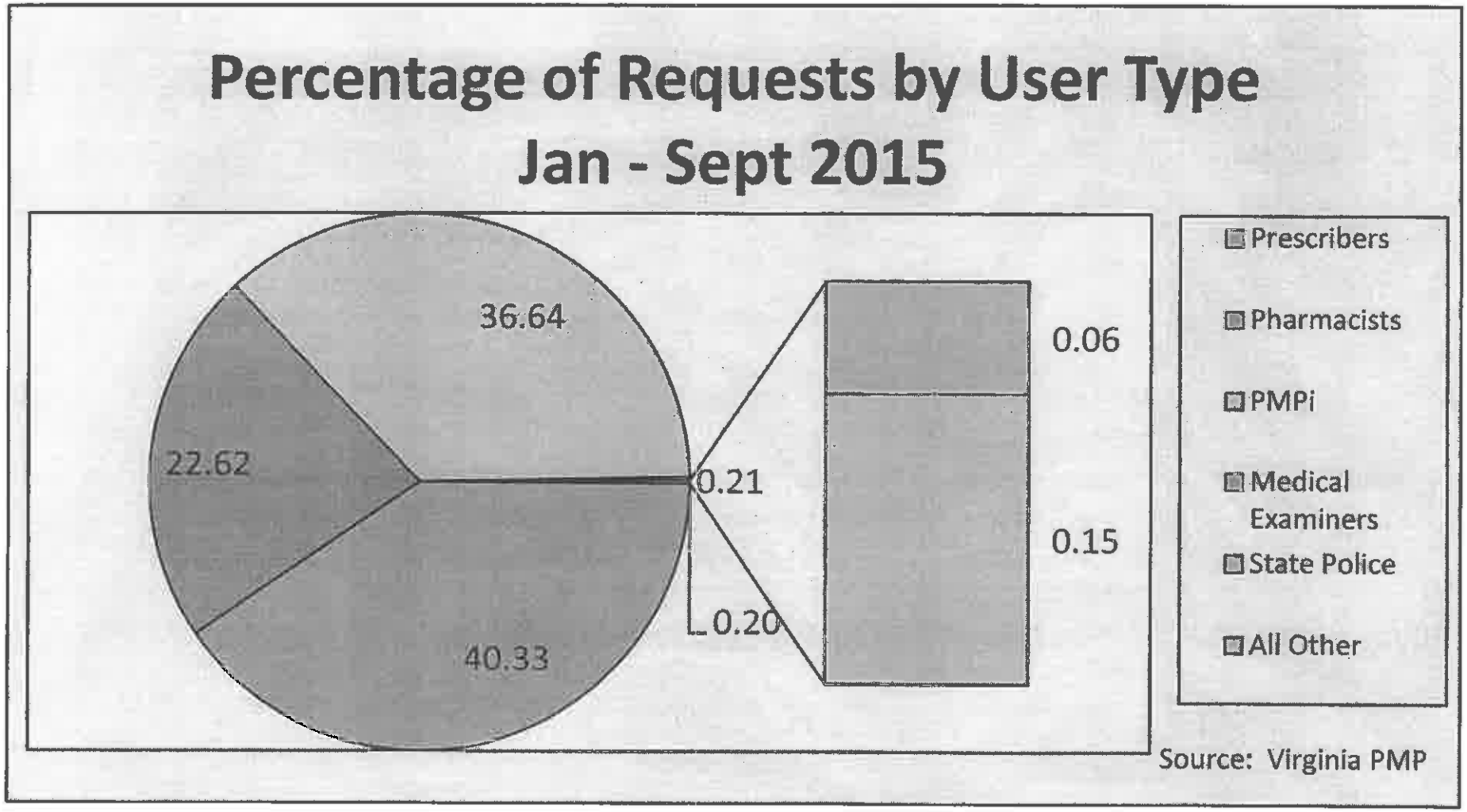
Other

- Maryland:
  - Sharing with the state of Maryland began the week ending July 30, 2015.
- Rhode Island:
  - During the first week of August, Virginia's PMP sent a copy of Virginia's NABP PMP Interconnect Participant Worksheet. Virginia has not yet received from Rhode Island a copy of their PMP Interconnect Participant Worksheet.
- EPIC:
  - Testing between Virginia's PMP and EPIC took place during the month of August. The testing was successful in returning test data from Virginia's PMP to the test site.

	DHP	DDU	Prescribers	RECIPIENTS	ME	HPMP	DEA	RPH	MFCU	PMPi	US ATTY	Law Enforcement	FBI	TOTAL
JANUARY	92	183	108132	2	619	94	69	49651	1	47057	0	157	26	206083
FEBRUARY	92	160	98673	3	532	96	36	44186	2	40767	0	206	34	184787
MARCH	93	148	117835	13	640	100	31	53623	26	49226		160	21	221916
APRIL	72	128	118386	1	602	120	56	71193	2	48406		138	25	239129
MAY	59	163	112743	0	652	70	44	75389	1	48155		138	37	237451
JUNE	83	122	124815	4	633	118	28	76692		55173		173	13	257854
JULY	78	250	126967	5	551	64	155	78398	5	50420		131	14	257038
AUGUST	99	186	124260	2	617	99	40	74716	14	186529		141	20	386723
Sep														573144
OCT														0
NOV														0
DEC														0
TOTAL	668	1340	931811	30	4846	761	459	523848	51	525733	0	1244	190	2564125



Source: Virginia PMP



Source: Virginia PMP

Tentative Automated Registration Timeline

Sept. 22, 2015: Optometrists: Identified 1501 email addresses for optometrists (45 have no email addresses). Filtered out 474 email addresses; last names beginning with A-F.

Sept. 24, 2015: Optometrists: First batch of Optometrists (A-F) uploaded for first batch to process.

Sept.24, 2015: Physician Assistants: Began work on Physician Assistant list for email notification of automated registration.

Sept. 24, 2015: Optometrists: Email sent to remaining Optometrists (G-Z, about 1027 total).

Sept. 28, 2015: Optometrists: Batch file processed to register remaining optometrists.

Sept. 28, 2015: Physician Assistants: Send email to all Physician Assistants.

October 1, 2015: Physician Assistants: Batch file processed to register Physician Assistants.

October 5, 2015: Pharmacists: Send email out to all pharmacists.

October 8, 2015: Pharmacists: Batch file processed to register all pharmacists.

October 12, 2015: Dentists: Send email out to all dentists.

October 15, 2015: Dentists: Batch file processed to register all dentists.

October 19, 2015: Podiatrists and Osteopaths: Send email out to all podiatrists and osteopaths.

October 22, 2015: Podiatrist and Osteopaths: Batch file processed to register all podiatrists and osteopaths.

October 26, 2015: Interns and Residents: Send email out to all interns and residents.

October 29, 2015: Interns and Residents: Batch file processed to register all interns and osteopaths.

- The same date pattern will be used to register the remaining prescribers in the Board of Medicine, but due to the large volume will be processed in several batches.
- Those licensees (all types) without email addresses will be notified by letter that they need to provide an email address for DHP to register them with the PMP program.

If you are a prescriber with a current-active license not already registered with Virginia's Prescription Monitoring Program (PMP), you will receive an email within the next 3 business days regarding registration in the program. The registration requirement is the result of legislation (HB1841) passed during the 2015 General Assembly. If you are already a registered user of the PMP, you will not receive any additional emails about this issue.

Please note that a valid personal email address is required for the creation and use of a PMP account.

To confirm that DHP has a current valid email address, please do the following ***now***:

1. Go to http://www.dhp.virginia.gov/
2. Under the heading: "Services for Practitioners" on the left side: Select "Update Your Information"
3. Select "Continue to the Login Page"
4. Once logged in, Click on "Mailing Address Change", then "Address of Record". Update or add your *email address* as necessary.

The registration process will proceed automatically to those with the authorization to prescribe and a valid email address, with the end result issuance of a username and temporary password that will be sent via *email*. Once this email is received the following are the simple steps needed to activate the PMP account:

1. Go to the DHP website and select "Prescription Monitoring Program" on the left side.
2. Go to "Access the PMP DataCenter" and enter your username and temporary password.
3. You will be directed to a screen to finish activating your account, which includes adding your DEA registration number or other information and selecting answers to security questions needed for password reset features.

Once these steps are complete, the PMP account is active and ready to be used. The account can only be activated by accessing the system with the provided username and temporary password.

The PMP is an excellent tool that provides the prescription history of a patient to inform prescribing decisions. Each individual's PMP report will list controlled substances in Schedules II, III and IV dispensed to that individual within a twelve month period. The report can be used to monitor compliance with a treatment plan, may indicate that this individual has not yet obtained medication for the condition for which treatment is being initiated, and will show prescriptions obtained through other prescribers. The PMP report can be used in conjunction with other tools such as treatment agreements, urine drug screens and pill counts. A prescriber may also use the PMP to request their own specific prescribing history for the past 90 days.

Respectfully,

Ralph A. Orr
Director, Prescription Monitoring Program

For more information about the PMP please go to http://www.dhp.virginia.gov/pmp
Email: pmp@dhp.virginia.gov
Call: 804-367-4409/4514/4566