Virginia Maternal Mortality Review Team Statement to the Governor's Prescription Drug and Heroin Abuse Task Force

- The Virginia Maternal Mortality Review Team is a multidisciplinary team which reviews all deaths to a woman who was pregnant when she died or who had been pregnant within one year of her death.
- For every 100,000 live births, 4.5 women who were pregnant or recently pregnant died from drug overdoses in Virginia.
- Two-thirds of the decedents who died from drug overdoses had toxicology results indicating at least one prescription drug was present.
- Almost half of the deaths were attributable to combined or mixed toxicity with at least one substance being a prescription drug.
- Using what has been learned from review of the circumstances surrounding these deaths, the Maternal Mortality Review Team has developed recommendations to reduce the incidence of similar deaths. One of these recommendations states, "The Maternal Mortality Review Team supports the proposed recommendations of the Governor's Prescription Drug and Heroin Abuse Task Force for action and/or study relating to providing additional clinical information in the Prescription Monitoring Program to prescribers and dispensers. These recommendations relate to improving logistics regarding use of Prescription Monitoring Program data which includes daily reporting of dispensed prescriptions and reviewing how drug overdose, dispensing and Prescription Monitoring Program information is available to law enforcement and regulatory boards."

Contact Information:
Victoria M. Kavanaugh, RN, PhD, Coordinator
Virginia Maternal Mortality Review Team
400 East Jackson Street
Richmond, VA 23219
Phone: 804.205-3853
Email: Victoria.Kavanaugh@vdh.virginia.gov

Virginia State Child Fatality Review Team Statement to the Governor's Task Force on Prescription Drug and Heroin Abuse

- The State Child Fatality Review Team is currently reviewing the deaths of all children aged 0-17 who died as a result of poisoning from 2009-2013. The Team just concluded its review of teens, aged 13-17. The Team has not yet begun reviewing the deaths of children aged 0-6. No children between the ages of 7-12 died from poisoning from 2009-2013.
- Prescription medication(s) caused death in 73% of the teenage cases. In the majority of these cases, all or some of the prescription medications came from the teen's home and were often prescribed to a parent or caregiver.
- Heroin caused the death of two teenagers in this review. Heroin was the only illicit drug that caused death in this review.
- The child's substance use was known to his or her parents or caregivers in almost all of the teen cases in this review. The Team identified many issues of parents enabling their children's substance use by supplying the substances to them, failing to recognize the risk of their child's misuse, or failing to follow through with recommended referrals for treatment.
- Many of the teens lived in homes where one or more parent and/or caregivers were abusing substances. In many cases, the Team found that the teens were from substance-abusing families. This meant that these children had little advocacy at home to protect them substance use, fully understand the risks of drug use, or seek adequate treatment.
- All of the teens in this review lived in a home with a parent or caregiver. The Team noted a prolific need for children to receive substance abuse treatment that involves the entire family. Individual treatment of a child who lives in a toxic environment is not conducive to recovery.
- The child population has unique opportunities for prevention because their involvement with systems is greater. Children are seen by pediatricians, schools, juvenile justice, etc., which allows for more risk identification and intervention opportunities to get involved in treating mental health and substance abuse.
- While many similarities exist between the child and adult population of substance abusers, there are unique characteristics of the child population that are not present in, or relevant to, the adult population. For this reason, the State Child Fatality Review Team fully supports the recommendations from the Governor's Task Force on Prescription Drug and Heroin Abuse but encourages the Task Force to also consider addressing these unique needs of substance-abusing children and children in substance-abusing families.

Contact Information:
Emily Womble, MPA
Child Fatality Review Coordinator
400 East Jackson Street
Richmond, VA 23219
Phone: (804) 205-3854
Email: Emily.Womble@vdh.virginia.gov

PMP Code and Regulation Related to Prescriber and Dispenser Access:

§ 54.1-2519. Definitions.
"Dispenser" means a person or entity that (i) is authorized by law to dispense a covered substance or to maintain a stock of covered substances for the purpose of dispensing, and (ii) dispenses the covered substance to a citizen of the Commonwealth regardless of the location of the dispenser, or who dispenses such covered substance from a location in Virginia regardless of the location of the recipient.

"Prescriber" means a practitioner licensed in the Commonwealth who is authorized pursuant to §§ 54.1-3303 and 54.1-3408 to issue a prescription for a covered substance or a practitioner licensed in another state to so issue a prescription for a covered substance.

§ 54.1-2523. Confidentiality of data; disclosure of information; discretionary authority of Director.
C. In accordance with the Department's regulations and applicable federal law and regulations, the Director may, in his discretion, disclose:
2. Information on a specific recipient to a prescriber, as defined in this chapter, for the purpose of establishing the treatment history of the specific recipient when such recipient is either under care and treatment by the prescriber or the prescriber is initiating treatment of such recipient. In a manner specified by the Director in regulation, notice shall be given to patients that information may be requested by the prescriber from the Prescription Monitoring Program.
3. Information on a specific recipient to a dispenser for the purpose of establishing a prescription history to assist the dispenser in determining the validity of a prescription in accordance with § 54.1-3303 when the recipient is seeking a covered substance from the dispenser or the facility in which the dispenser practices. In a manner specified by the Director in regulation, notice shall be given to patients that information may be requested by the dispenser from the Prescription Monitoring Program.

18VAC76-20-60. Criteria for discretionary disclosure of information by the Director.
2. The prescriber for the purpose of establishing a treatment history for a patient or prospective patient or for the purpose of obtaining a record of prescriptions issued by that prescriber, provided the request is accompanied by the prescriber's registration number with the United States Drug Enforcement Administration (DEA) and attestation that the prescriber is in compliance with patient notice requirements of 18VAC76-20-70. The prescriber may delegate the submission of a request for information, provided the delegation is in compliance with § 54.1-2523.2 of the Code of Virginia. The health care professionals to whom the prescriber has authorized access to information shall be registered with the program. Requests for information made by a delegated health care professional shall be made in his own name, using his own unique identifiers assigned by the program.
5. A dispenser for the purpose of establishing a prescription history for a specific person to assist in determining the validity of a prescription, provided the request is accompanied by the dispenser's license number issued by the relevant licensing authority and an attestation that the dispenser is in compliance with patient notice requirements of 18VAC76-20-70. The dispenser may delegate the submission of a request for information, provided the delegation is in compliance with § 54.1-2523.2 of the Code of Virginia. The health care professionals to whom the dispenser has authorized access to information shall be registered with the program. Requests for information made by a delegated health care professional shall be made in his own name, using his own unique identifiers assigned by the program.

National Alliance for Model State Drug Laws: MODEL PRESCRIPTION MONITORING PROGRAM (PMP) ACT REVISED 11-22-13

SECTION 4. DEFINITIONS.
For the purposes of this Act, unless the context clearly indicates otherwise, the following words and phrases shall have the meanings given to them in this Section.

(j) "Pharmaceutical care" means the responsible provision of drug-related care for the purpose of achieving definite outcomes that improve a patient's quality of life. These outcomes are (i) cure of a disease: (ii) elimination or reduction of a patient's symptomatology; (iii) arresting or slowing of a disease process; or (iv) preventing a disease or symptomatology.

(k) "Prescribe" means to direct, designate or order the use of a formula for the preparation of a controlled substance or drug of concern for a disease or illness and the manner of using the substance or drug of concern.
(l) "Prescriber" means a health care professional authorized in the jurisdiction in which the professional is practicing to prescribe a controlled substance or drug of concern.

SECTION 8. ACCESS TO AND USE OF THE PRESCRIPTION MONITORING INFORMATION; CONFIDENTIALITY.

(f) The following persons may access prescription monitoring information after successful completion of the applicable training, education or instruction regarding the PMP identified in Section 9(a) and in accordance with procedures adopted by the [designated state agency or entity]:
(i) A prescriber, or a representative designated by a prescriber pursuant to criteria established by the PMP, for the purpose of providing medical care to a patient with whom the prescriber has a bona fide patient relationship, or to inquire about the prescriber's own prescribing activity.
(ii) A dispenser, or a representative designated by a dispenser pursuant to criteria established by the PMP, for the purpose of providing pharmaceutical care to a bona fide patient, or to inquire about the dispenser's own dispensing activity.

National Association of Boards of Pharmacy
Report of the Task Force on Prescription Monitoring Program Standards
Proposed changes to Model Act 2014:

The following persons, after successful completion of the educational courses identified in Section 9(a), may access the Prescription Monitoring Program Information in the same or similar manner, and for the same or similar purposes, as those persons are authorized to access similar Protected Health Information under federal and State law and regulation:.

(1) Practitioners (or the agents thereof) who certify, under the procedures determined by the State, that the requested information is for the purpose of providing medical or pharmaceutical treatment or evaluating the need for such treatment to a bona fide current patient;

(2) Dispensers;

(3) Boards of Pharmacy or vendors/contractors establishing and maintaining the prescription monitoring program;

(4) State licensing, certification, or regulatory agencies that license, certify, or regulate health care professionals authorized to dispense controlled substances;

(5) local, State, or Federal law enforcement, narcotics control, licensure, disciplinary, or program authorities, who certify, under the procedures determined by the State, that the requested information is related to an individual investigation or proceeding involving the unlawful diversion or misuse of a Schedule II through V substance, and such information will further the purpose of the investigation or assist in the proceeding;

(6) other appropriate entities as determined by the Board of Pharmacy; and

(7) patients who certify, under the procedures determined by the State, that the requested information is for the purpose of obtaining and reviewing their own records.

Update to the Compilation of the Frequency of Collection of Data of Prescription Drug Monitoring Programs

1. Executive Summary

As the perceived value of prescription drug monitoring programs (PDMP) continues to increase, reporting frequency also continues to increase among state programs. Likewise, more individual state programs having been moving toward data sharing with other states, primarily through the National Association of Boards of Pharmacy's PMP Interconnect network.

This update to the Compilation of the Frequency of Collection of Data of Prescription Drug Monitoring Programs pursuant to SB 638 (2014) identifies the reporting time frames for each state as obtained from information provided by the National Alliance for Model State Drug Laws (NAMSDL). These reporting time frames are current as of December 2014. At the end of this update, please find the map of current reporting intervals as collected by NAMSDL.

II. Evaluation of Current Reporting Intervals

As of March 2015, all 50 states and the District of Columbia have either a functional PDMP or have legislation in place to establish one. At present, only one state requires reporting of prescription data in real time (Oklahoma). A summary of each state's reporting requirements is included in Table 1.

Table 1. Summary of State Reporting Requirements -- Frequency

State	Real Time?	Daily/Within 24 Hours	3 Days	Weekly/Within 7 Days	Bimonthly/Monthly
Alabama		X			
Alaska					X
Arizona		X			
Arkansas				X	
California				X	
Colorado		X			
Connecticut				X	
Delaware		X			
District of Columbia		X			
Florida				X	
Georgia				X	
Hawaii				X	
Idaho				X	
Illinois				X	
Indiana			X		
Iowa				X	
Kansas		X			
Kentucky		X			

Table 1. Summary of State Reporting Requirements -- Frequency					
Louisiana		X			
Maine				X	
Maryland			X		
Massachusetts				X	
Michigan		X			
Minnesota		X			
Mississippi		X			
Missouri	Pending Legislation				
Montana				X	
Nebraska ??			Does not Collect Data		
Nevada				X	
New Hampshire				X	
New Jersey				X	
New Mexico				X	
New York		X			
North Carolina			X		
North Dakota		X			
Ohio		X			
Oklahoma	X				
Oregon				X	
Pennsylvania					X
Rhode Island			X		
South Carolina		X			
South Dakota				X	
Tennessee				X	
Texas				X	
Utah				X	
Vermont				X	
Virginia				X	
Washington				X	
West Virginia		X			
Wisconsin				X	
Wyoming				X	
TOTAL/ Percentage	**1(2%)**	**16 (31%)**	**4 (8%)**	**26(51%)**	**2 (4%)**

Oklahoma continues to be the only state that requires reporting at the point of service (on-line, real time). New York requires reporting at the point of service by statute, but interprets the law by regulation to mean within 24 hours of dispensing. As of December of 2014, 16 states (31%) require reporting within 24 hours of dispensing (up from 11 in July of 2014). The number of states requiring reporting every 3 days has doubled from 2 to 4 during that time. Twenty-six, or about half of state PMPs still require reporting weekly/within 7 days of dispensing. This is down from 30 states (59%) in July of 2014. Only 2 states remain (Alaska and Pennsylvania) that require reporting bimonthly or monthly.

Those states that are now require daily reporting that had previously reported less frequently are the following: Alabama, Colorado, Louisiana, Mississippi, New Mexico and Ohio. Colorado indicates that they did not encounter any specific difficulties when moving to more frequent reporting, as many of the pharmacies were already doing daily reporting. Mississippi, which had moved from reporting within 7 days to within 24 hours about 18 months ago, also did not encounter major issues involving this change. In Mississippi, pharmacies were given about 12 months advance notice to make the change. Mississippi also indicates they don't expect to move toward reporting in real time. New Mexico is beginning daily reporting on March 16, 2015. Pharmacies and other entities were also given a year's notice in New Mexico, and there was very little resistance from any of their constituents. Ohio tried to anticipate any difficulties in reporting; they allow pharmacies to pre-schedule zero reports for upcoming holidays and vacations, for example. No states responding to our inquiry indicated any significant difficulties in moving toward daily reporting.

Both Indiana and Tennessee will begin reporting daily on January 1, 2016. This will bring the total number of states reporting daily to 19 (37%). Given that very few states by experience report any difficulties reporting daily, the benefit to registered users of PMP programs may outweigh the burden presented by having to do so.

III. Conclusion

Fifty-one percent of states require weekly reporting of PMP data, down from 59%. The trend continues to be toward shorter time frames. Likewise, as the perceived value of PMP data continues to increase, the expectation is that more states will provide their PMP data to registered users within reduced time frames. None of the states surveyed recently moving to daily reporting cited any specific or significant difficulties making that change.