Prescription Drug and Heroin Abuse Taskforce
Data/Monitoring Workgroup Meeting Agenda
April 29, 2015, 10:00 A.M.-2:00 P.M.
Perimeter Center Conference Center
Training Room 1
Henrico, Virginia

Welcome and Introductions: Dr. Carol Forster and Katya Herndon

Review Minutes from April 14, 2015 meeting (pages 1-7)

Discussion:

Discuss possible recommendation to support placement of PMP report in the medical or prescription record of the patient

- Amend §54.1-2525 to specify that reports received from the PMP may be placed in the medical or prescription record of the patient. (pages 8-10)

Discuss outstanding item from December 2014 Task Force meeting: *"expand mandatory requests to include acute treatment"* (pages 11-18)

Discuss area of concern from December 2014 Task Force Meeting: *"Send "Unsolicited" reports indicating indiscriminate prescribing or dispensing (i.e. geographic distribution)"* (pages 19 -28)

Discuss implementation plan for recommendations:

Next steps:

Governor's Task Force on Prescription Drug and Heroin Abuse

Data and Monitoring Workgroup
Data-Sets Subcommittee
Minutes (DRAFT)
April 14, 2015

Members/Staff Present:
Subcommittee Chair: Baron Blakley, Research Analyst, Department of Criminal Justice Services
Workgroup Co-Chair: Katya Herndon, Chief Deputy Director, Department of Forensic Science
Staff: Ralph Orr, Director, Virginia Prescription Monitoring Program
Rosie Hobron, MPH, Statewide Forensic Epidemiologist, VDH-OCME
Major Rick Jenkins, Deputy Director, BCI, Virginia State Police
Amanda Wahnich, MPH, Enhanced Surveillance Analyst, VDH
Deborah Waite, Ops Manager, Virginia Health Information

Members/Staff Absent:
Anne Zehner, MPH, Epidemiologist, VDH

Meeting Agenda:
Welcome and Introductions
Review Minutes from previous meeting
Explore and identify specific data points by agency
Develop Recommendations for Workgroup to consider
Dataset Subcommittee Report to present to Workgroup
Discuss Need for Additional Meetings

Welcome & Introductions:
The meeting was called to order at 9:05 a.m.

Review of Minutes:
Mr. Blakley asked members if there were any suggested changes to or comments about the draft minutes from the previous meeting, which had been distributed. Being none, the minutes were approved as presented.

Discussion:

Develop Recommendations for Workgroup to Consider:
As discussed in the meeting on March 31, the Data-Sets Subcommittee proposed the creation of a "Data" group comprised of data analysts from relevant agencies who would meet on an ongoing basis. This recommendation is how the Subcommittee envisioned an action item proposed by the Data and Monitoring Workgroup, and approved by the Task Force on December 16, 2014, be implemented (i.e., "Direct applicable agencies to share data on prescription drug and heroin abuse, overdoses, drug seizures, arrest information, etc to analyze information to mitigate harm from prescription drug and heroin abuse"). Mr. Blakley and Major Jenkins recommended that this ongoing "Data" group take a broad view of existing data to inform and evaluate policies/initiatives as well as identify trends in terms of how health issues intersect with criminal justice issues. The Subcommittee agreed that it is

important to look at the data more generally, rather limiting the group's scope to heroin and prescription drugs. This broader view is important so the "Data" group can continue its work and be responsive to other issues that arise down the road.

Discussion confirmed 3 types of data needs:

1. Current (real-time) data (as represented by the Fusion Center) that is designed for action by law enforcement.
2. Data points from various entities represented in graph/chart form to be presented on Resource Website.
3. Data analysis of the data points held by the various data holders.

The "Data" group would be primarily focused on #2 and #3 above.

Explore and Identify Specific Data Points by Agency:
The Subcommittee discussed standardizing the geographical representation of data, including the potential use of Federal Information Processing Standards (FIPS) codes or other already identified regions. Some geographic representations already used by members of the Subcommittee include: State Police Divisions, Health Planning Regions or Districts, and Office of the Chief Medical Examiner Regions. Representation of data may have to be addressed in agreements for use of data between agencies.

In addition to the agencies/entities currently represented on the Subcommittee, Mr. Blakley suggested the following other data sources: Department of Corrections, Department of Juvenile Justice, and Courts or Sentencing Commission. Another source discussed was data that may be available from the Department of Medical Assistance Services.

Mr. Blakley suggested that the general parameters of the data sharing would be:

- Aggregated data (e.g., sum totals of activities, averages, rates)
- If individual level data were to be used, the data would all be de-identified
- Locality-level data when possible, broader regions when necessary
- Data would be broken out by month when possible, by fiscal or calendar year when necessary

Mr. Blakley suggested that when, where, and in what manner the "Data" group would meet should be determined by the group itself, as limitations on data availability will be a practical consideration. Broadly, it was suggested that members of the group would share data monthly, meet quarterly, and produce a yearly report to be provided to the Secretaries of Health and Human Resources and Public Safety and Homeland Security or some other entity as recommended by the Task Force and implemented by the Governor. Some agencies might participate only by sharing data, while others would also attend the quarterly meetings. The report might be prepared by a single agency (such as the Criminal Justice Research Center at the Department of Criminal Justice Services), but then reviewed and approved by members from other agencies.

Consideration should be given to the possible need for leadership/oversight of the group and the development of agreements for sharing and use of data between agencies, and the possible impact on available resources.

The meeting adjourned at 10:10 a.m.

Governor's Task Force on Prescription Drug and Heroin Abuse

Data and Monitoring Workgroup

Meeting Six, Minutes (DRAFT)

April 14, 2015

Members/Staff Present:
Co- Chair: Carol Forster, M.D., Mid-Atlantic Permanente Medical Group
Co- Chair: Katya Herndon, Chief Deputy Director, Department of Forensic Science
Staff: Ralph Orr, Director, Virginia Prescription Monitoring Program
Baron Blakley, Research Analyst, Department of Criminal Justice Services
Timothy Coyne, Public Defender
Greg Cherundolo, ASAC, Richmond DEA-US DOJ
Rosie Hobron, MPH, Statewide Forensic Epidemiologist, VDH-OCME
Major Rick Jenkins, Deputy Director, BCI, Virginia State Police
Rusty Maney, RPh, Richmond District Pharmacy Supervisor, Walgreens
Lisa Miller, DVM
David Sarrett, DMD, MS, Dean, VCU School of Dentistry
Mike Shawver, Chief of Operations Tazewell County Sheriff's Office (representing Sheriff Brian Hieatt)
David Trump, M.D., Chief Deputy Commissioner, Virginia Department of Health (representing Dr. Levine)
Amanda Wahnich, MPH, Enhanced Surveillance Analyst, VDH
Deborah Waite, Ops Manager, Virginia Health Information

Members Absent:
Delegate Charniele Herring, Virginia House of Delegates
Brian Hieatt, Sherriff, Tazewell County
Marissa Levine, M.D., State Health Commissioner,
Marty Mooradian, Impacted Family Member
Anne Zehner, MPH, Epidemiologist, VDH

Guests:
Captain Steven Lambert, Virginia State Police, Virginia Fusion Center
Emily Womble, Child Fatality Review Coordinator, Office of the Chief Medical Examiner

Meeting Agenda
Welcome and Introductions
Review Minutes from previous meeting
Presentations

- Maternal Mortality Review Team Report: Emily Womble (page 4)
- Child Fatality Review Team Report: Emily Womble (page 5)
- Fusion Center: Captain Steve Lambert (pages 6-9)
- Virginia Youth Survey: Anne Zehner (page 10)
- Role of Veterinarians in Reducing Prescription Drug Abuse: Dr. Lisa Miller (pages 11-13)
- Virginia Health Information: Deborah Waite (page 14)

Discussion Topics and Reports:

- Dataset Subcommittee Report: Baron Blakely
- Final Recommendations (pages 15-27)
  - Recommendations Completed
  - Short Term Recommendations
  - Long Term Recommendations
  - Legislative Recommendations
  - Recommendations for Further Review and Consideration
- Implementation Plan Development

Workgroup mission: To advance solutions to share and integrate data among relevant licensing boards, state and local agencies, law enforcement, courts, health care providers and organizations, and programs such as the PMP, in order to clarify and address public safety and public health concerns, understand emerging trends, and utilize data-driven decision-making to mitigate harm.

Welcome and Introductions

The meeting was called to order at 10:35 a.m.

Review of Minutes from March 12, 2015 Meeting

Dr. Forster asked Workgroup members if there were any suggested changes to or comments about the draft minutes from the previous meeting, which had been distributed. Being none, the minutes were approved as presented.

Presentations:

Maternal Mortality Review Team Report:

Ms. Womble presented information from the Virginia Maternal Mortality Review Team (Meeting Materials and Agenda Packet page 4), highlighting system factors contributing to overdose deaths due to overdoses as well as several recommendations from the Review Team, some of which have already been considered by the Governor's Task Force.

Child Fatality Review Team Report:

Ms. Womble presented preliminary findings from the Child Fatality Review Team (Meeting Materials and Agenda Packet page 5), highlighting a review of poisoning cases and noting issues such as isolated families and children and lack of coordinated response.

Fusion Center:

Captain Lambert presented information on Virginia's Fusion Center (VFC) established out of needs identified after the 9/11 attacks in 2001 (Meeting Materials and Agenda Packet pages 6-9). The Fusion Center is designed to collect data from various sources in a timely manner and make the information available to law enforcement from a central access point. Among entities the Fusion Center communicates with are the regional Virginia Poison Control Centers, the Virginia Department of Health (VDH), and the Office of Emergency Medical Services in VDH. The VFC is developing communication methods for dissemination of heroin related intelligence to the medical community.

Virginia Youth Survey:

Ms. Zehner was unable to attend the meeting but provided a presentation for discussion (Meeting Materials and Agenda Packet page 10). Mr. Orr expressed that there is a lot of data captured by the survey but the specific information of prescription drug abuse is very alarming with percentage of

students who have taken a prescription drug without a doctor's prescription one or more times during their life, starting at about 10% in 9th grade and increasing to 20% by 12th.

Role of Veterinarians in Reducing Prescription Drug Abuse:
Dr. Miller discussed the memorandum addressed to the Workgroup (Agenda Packet pages 11-13). Dr. Miller pointed out that veterinarian prescriptions may be dispensed by the practice or sent to a pharmacy to be dispensed and that currently the PMP cannot easily identify prescriptions filled for a pet versus one filled for a human patient. Additionally, there are differences in prescribing for animals versus humans which may not be universally known.

Virginia Health Information:
Ms. Waite gave a presentation on information collected and made available by Virginia Health Information (Meeting Materials and Agenda Packet page 14). Of particular interest was information derived from the All Payer Claims Database (APCD) showing inpatient discharges related to drug dependence from acute hospital care or psychiatric care and the average charge for both of these institution types. Ms. Waite also highlighted how inpatient discharges for opioid abuse and dependence increased from 14.44% in 2009 to 21.59% in 2013.

Discussion Topics and Reports:
Dataset Subcommittee Report:
Mr. Blakley provided an overview of subcommittee discussions as recorded in the minutes of the April 14, 2015 meeting.

Final Recommendations: (Agenda Packet pages 15-27)
Ms. Herndon explained the schedule for Workgroup and Task Force actions as disseminated to Workgroup staff.

- Workgroups will present their final recommendations to the Task Force at the May 12th meeting for approval.
- An implementation plan based on the recommendations will be developed and presented to the Task Force at the June 16 meeting.
- The Workgroups will continue to meet over the summer, and final reports, etc. will be presented at the Task Force meeting on September 21st, which will be held in Charlottesville.
- The Data Monitoring Workgroup has a meeting scheduled for April 29th to finalize its recommendations in advance of the May Task Force meeting.

Mr. Orr presented the slide template to be used for the presentation to the Task Force on May 12th, explaining that some slides are already complete but that there is space for additional recommendations.

- There are two completed legislative recommendations from the Workgroup which Governor McAuliffe signed at a bill signing event in Winchester on April 7th.
- There are currently five additional accepted recommendations from the Workgroup:
  - The recommendation for requiring reporting of the prescribers' National Provider Identifier (NPI) code and "Species Code" will be implemented through regulation
  - The recommendation for the placement of Morphine Equivalent Doses per Day (MEDD) scores on PMP reports is expected to be completed by July 1st
  - The recommendation for unsolicited reports to prescribers is being explored by the PMP and its vendor

- The recommendation for individual prescriber feedback reports is being explored by PMP and its vendor
- The recommendation for sharing data between agencies is being implemented as described in the Subcommittee report from Mr. Blakley.

The Workgroup discussed two other areas of interest:

- Requiring licensing boards to mandate continuing education on issues related to prescription drug abuse by licensing boards. It was pointed out that the Board of Pharmacy has the authority to identify specific continuing education that must be completed during a license period; it is not an ongoing requirement but allows the Board to recognize a topic of great need at a specific time. This could be a model to be used by other licensing boards.
- Given the presentations from the two mortality review teams, the Workgroup discussed the fact that women, children and teenagers need special consideration and coordination of responses to effectively address their substance abuse. This need spans across schools, law enforcement, treatment providers, and healthcare providers.

The consensus of the Workgroup was that Data & Monitoring was not the appropriate Workgroup to make recommendations regarding these areas, and it was suggested that staff from the Education and Treatment Workgroups be contacted so that these topics could be suggested to be placed on the agenda for discussion at the upcoming joint meeting of the Education and Treatment Workgroups.

The Workgroup also discussed the need for a group or entity to provide oversight on the implementation of Task Force recommendations on a going forward basis.

The Workgroup endorsed the following additional Legislative Recommendations:

- Amend §54.1-2523 Paragraph C to expand access to PMP information to clinical (non-dispensing) pharmacists and consulting physicians (not necessarily the prescriber) involved in "care team" of the patient. Note: Also a Recommendation approved by the Prescription Monitoring Program Advisory Panel.
- Amend §54.1-2521 to shorten the timeframe in which dispensers must report to PMP (currently, within 7 days) to within 24 hours of dispensing. Note: Also a Recommendation approved by the Prescription Monitoring Program Advisory Panel.

The Workgroup discussed the following additional legislative recommendation:

- Amend §54.1-2525 to specify that reports received from the PMP may be placed in the medical or prescription record of the patient. Note: A member of the Workgroup asked why the PMP report cannot be placed in the medical record. Current language is unclear on this point but does state that "It shall be unlawful for any person having access to the confidential information in the possession of the program or any data or reports produced by the program to disclose such confidential information except as provided in this chapter." Placing the PMP report in the medical or prescription record can back up notes or comments made based on review of the report. Mr. Maney stated that pharmacists would find it helpful to have the PMP report placed in the record.

The Workgroup will have further discussion on this recommendation at its meeting on April 29.

Mr. Orr presented information on two outstanding recommendations and areas of concern not acted upon at the December 2014 Task Force meeting:

1. Expanding mandatory PMP requests to include acute treatment

2. Sending "Unsolicited" reports indicating indiscriminate prescribing or dispensing (i.e. geographic distribution)

Mr. Orr discussed a handout (Meeting Materials) reflecting Kentucky's experience when mandatory requests were implemented. The data from the program reflect significant decreases in the number of prescriptions and doses for certain opiates and benzodiazepines. A complete evaluation of the impact of this legislation is due within the next two weeks. If available for the next meeting, Mr. Orr will provide a summary of the report and other information related to mandatory requests to the PMP from other states. At issue is the fact that the current law does not cover controlled substances prescribed in emergency departments, urgent care centers or dental offices where patients may be inappropriately accessing care and receiving these medications.

Mr. Orr explained that the PMP cannot currently share any information indicative of inappropriate prescribing or dispensing with either a regulatory board or with law enforcement. The PMP does currently have authority to send unsolicited information to prescribers and to law enforcement on patients. Information from the National Alliance for Model State Drug Laws was presented (Agenda Packet Pages 22-24) showing the distribution of states with authority for unsolicited reports and model language providing authority for unsolicited reports to law enforcement and licensing entities. Mr. Orr was asked to provide some more information for the next meeting of the Workgroup.

Next Meeting: April 29, 2015 in Training Room 1, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, VA 23233

The meeting adjourned at 3:50 p.m.

Ohio faces an epidemic of prescription drug abuse and overdose. Since 2007, there are more deaths from drug overdose than from motor vehicle traffic crashes in Ohio. Ohio legislators have vowed to reverse this alarming trend. Recent revisions to the Ohio Automated Rx Reporting System (OARRS) regulations aim to do just that. This article highlights some of the key changes affecting health care providers.

What is OARRS?

OARRS is Ohio's Prescription Monitoring Program (PMP) administered by the Ohio State Board of Pharmacy. OARRS is a web-based system that tracks outpatient prescriptions for controlled substances in order to curb substance abuse. OARRS regulations apply to all licensed prescribers — for example, physicians, dentists, nurse practitioners (NPs), physician assistants (PAs), etc. — and pharmacies in Ohio.

What's New with OARRS?

Beginning January 1, 2015, all providers who prescribe or personally furnish opioid analgesics or benzodiazepines[1] (Prescribers) and pharmacies that dispense controlled substances must register an OARRS account.[2] In the past, Prescribers only had to access OARRS history if they suspected drug abuse. The requirements now apply to all patients. Beginning April 1, 2015, Prescribers must request, assess, and document receipt of an OARRS history report for every patient as follows:

(8)

- Request OARRS information covering at least the previous 12 months before initially prescribing or personally furnishing an opioid analgesic or benzodiazepine.
- Request periodic OARRS updates at intervals not exceeding 90 days if the prescription is for more than 90 days. Prescribers must document receiving and assessing OARRS information in the patient's medical report.

What Are the Exceptions?

Mandatory checks do not apply in the following provider-specific circumstances:

- All Prescribers — OARRS is not available
- All Prescribers except optometrists — prescription period does not exceed 7 days
- Physicians, NPs, PAs, but not dentists and optometrists — (i) Patient is terminally ill or in hospice; (ii) Patient is being treated for cancer; (iii) Drug is prescribed in a hospital, nursing home, or residential care facility
- Physicians only — Drug is prescribed to treat acute pain following surgery, invasive procedure, or delivery

Documentation — What's Sufficient?

Prescribers must document in the medical records that they have accessed and interpreted the OARRS report. Beginning March 20, 2015, Prescribers may also include a copy of the OARRS report in the medical records. This is not a requirement. Once a part of the medical records, the report becomes subject to disclosure.[3] Providers should consult their legal advisor before including the OARRS report in the medical records.

Is Delegation Permitted?

Prescribers may designate one or several delegates on their personal OARRS account. Using their own OARRS account (not Prescriber's), delegates may run reports on behalf of Prescribers who supervise or employ them. Delegates are, however,

(9)

prohibited from assessing or documenting the results on behalf of Prescribers.

Prescribers beware! In tackling prescription drug abuse and overdose, Ohio legislators have made significant changes in OARRS. Become familiar with these updates and take appropriate actions to become compliant.

Isabelle Bibet-Kalinyak is an attorney with the full-service corporate law firm of Brouse McDowell in Akron OH. Her practice focuses on health care and immigration.

Isabelle Bibet-Kalinyak

References:

1. "Benzodiazepine" does not include sleep medications such as Ambien or Lunesta.
2. See www.ohiopmp.gov.
3. See Ohio Revised Code Section 3701.74.

Source: *MD News* May/June 2015, Cleveland Edition

COMMENT ON THIS ARTICLE

Name

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Comment

Add A Comment

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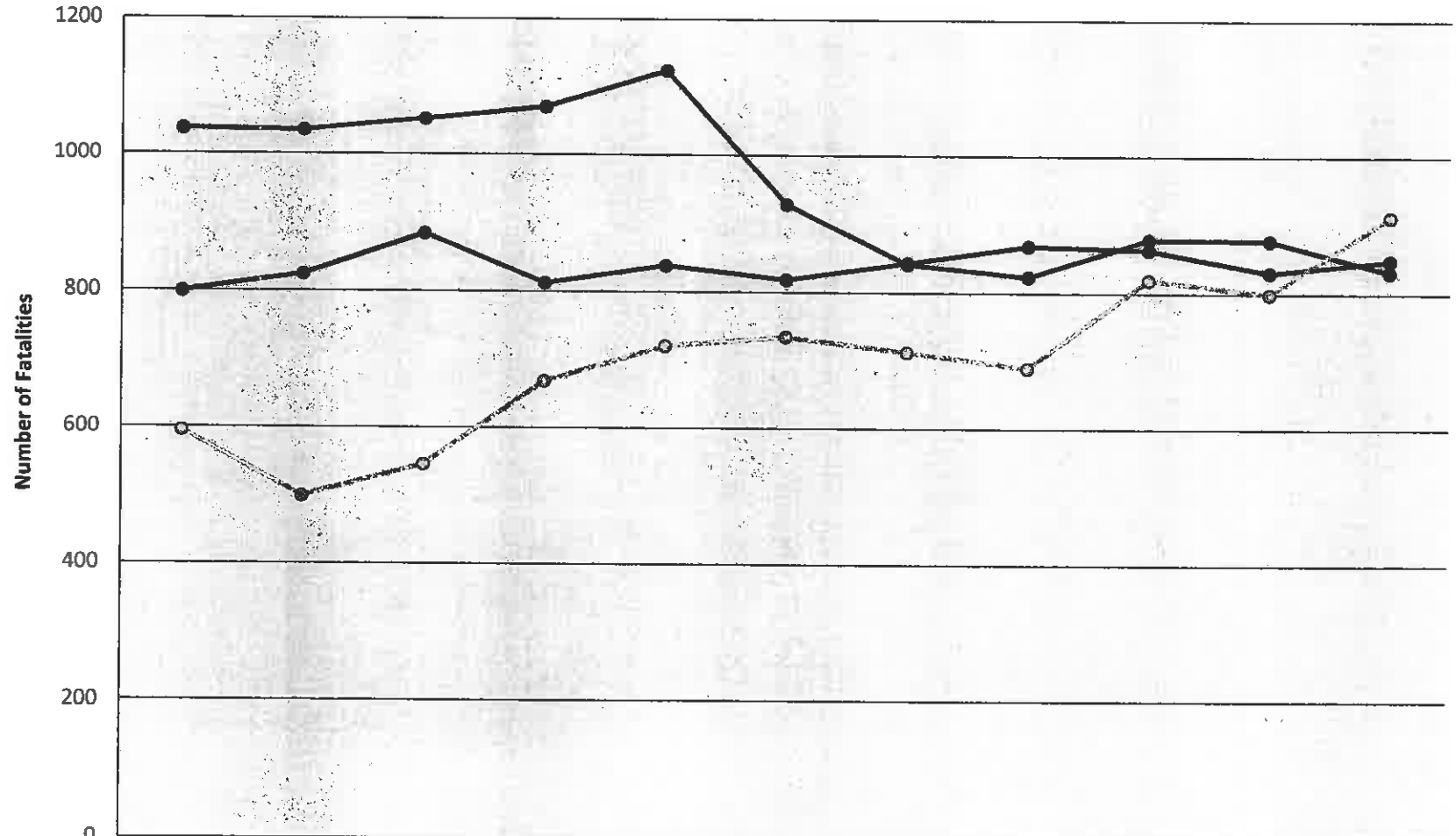
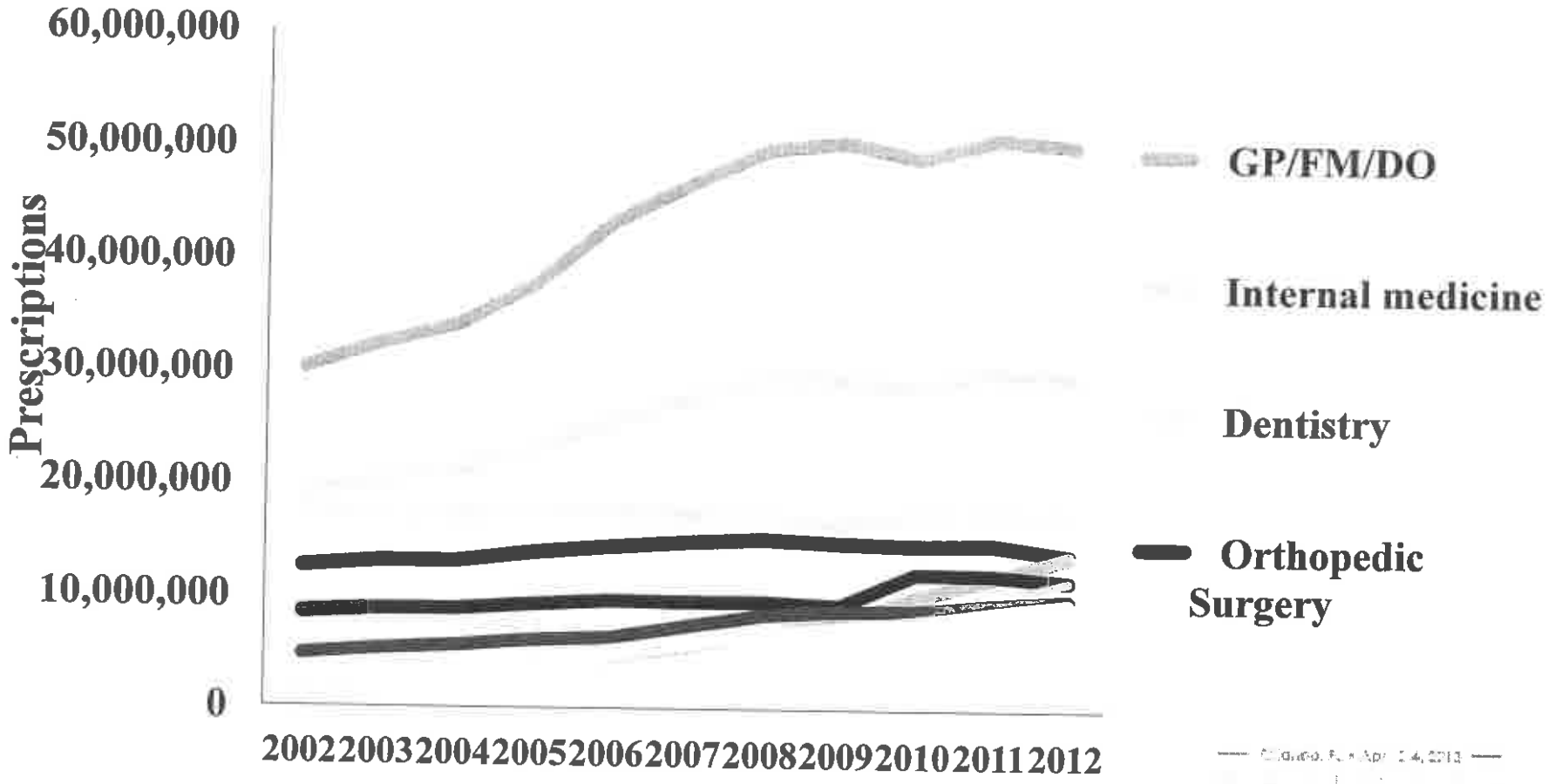
OCME's Top 3 Methods of Death by Number and Year of Death, 2003-2013



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Motor Vehicles	1037	1035	1052	1070	1124	928	841	823	878	877	831
Guns	799	824	884	812	838	818	843	868	863	830	848
Drug/Poisons	595	498	545	669	721	735	713	690	819	799	912

VDH VIRGINIA DEPARTMENT OF HEALTH

Top Prescribers of Opioid Analgesics in 2012



RX DRUG ABUSE SUMMIT

IMS Health, Vector One® National

Performance Measure

Agency

Department of Health Professions (223)

Measure Name

The number of queries to the Prescription Monitoring Program as a percent of prescriptions added

Measure Last Modified	Measure Last Published	Measure Status
Oct 15 2014 01:35	Feb 19 2015 10:44	Active

Measure ID	223.0002
Measure Class	Agency Key
Measure Type	Output
Year Type	State FY
Preferred Trend	Increase
Frequency	Quarterly
Cumulative Data	No
Statistical Unit	query

Data Source and Calculation

The Prescription Monitoring Program collects the number of queries for prescription history and the number of prescriptions added by date. This measure is calculated by dividing the number of queries per quarter by the number of prescriptions added per quarter.

Enterprise Priorities and Strategies

Enterprise Initiative	Enterprise Priority	Enterprise Strategy
Health and Family	Healthcare Innovation	Embrace innovative models of care and new technologies to improve health outcomes and lower costs.
Public Safety and Homeland Security	Public Safety	Protect our citizens and ensure everyone lives in a safe community.

Associated Service Areas

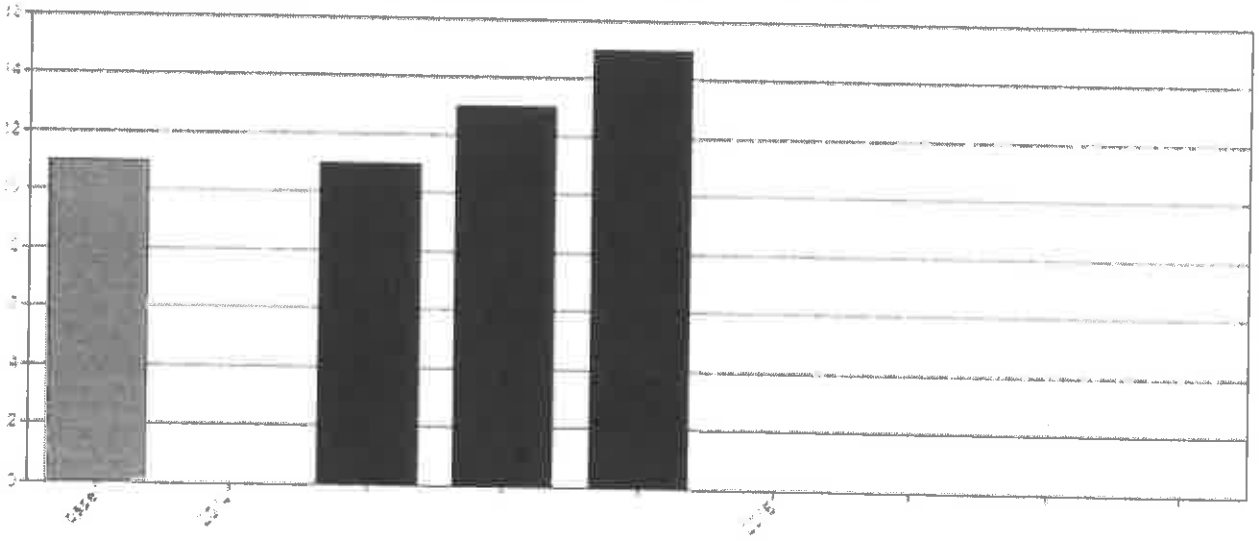
SA Code	SA Name
56044	Technical Assistance to Regulatory Boards

Baseline and Targets

Target Name	Date	Result	Note
Baseline	12/31/2013	11	The baseline reflects the percentage at the end of the calendar year 2013. Beginning FY15 calculations will be done on a quarterly basis
Short Target 2016	06/30/2016	19	As of July 1, 2015 all prescribers will be required to register as a user of the Prescription Monitoring Program. Based on historical information we estimate that 2016 and 2018 targets will show a significant increase in queries per prescription added
Long Target 2018	06/30/2018	25	

Measure Results

Year	Q1	Q2	Q3	Q4	Explanatory Note
2014		11	13	15	The baseline reflects the percentage at the end of the calendar year 2013. Beginning FY15 calculations will be done on a quarterly basis
2015					



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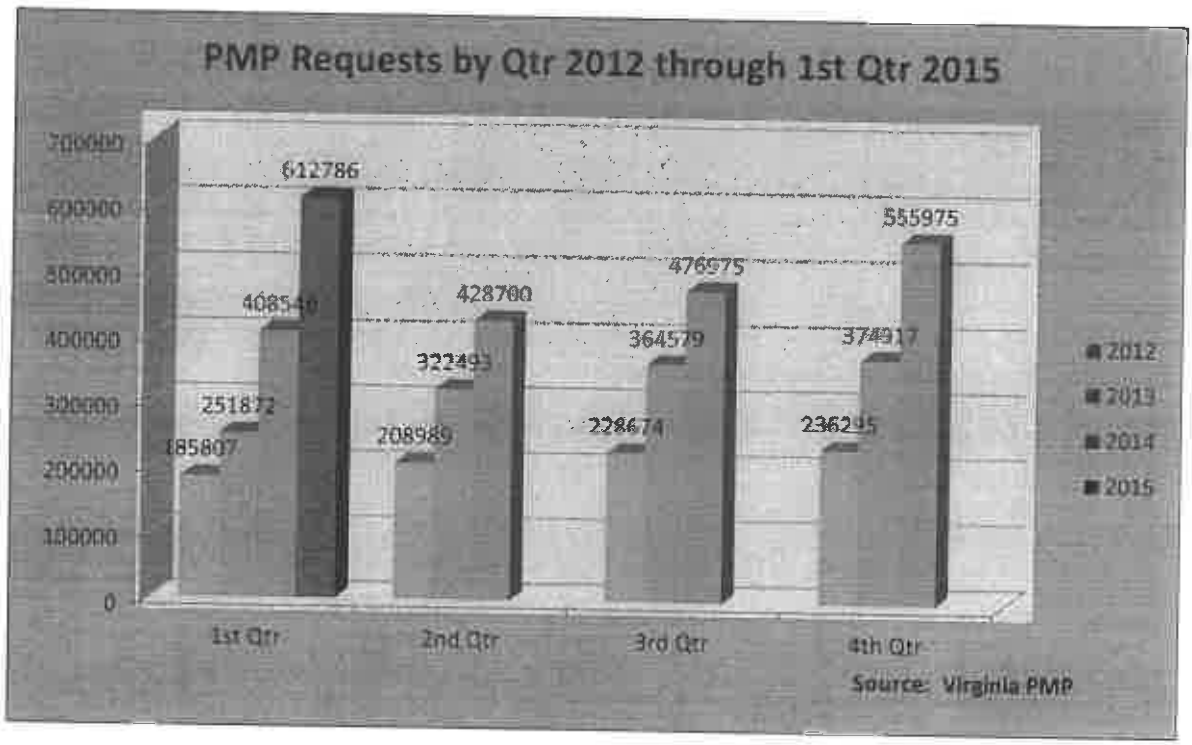
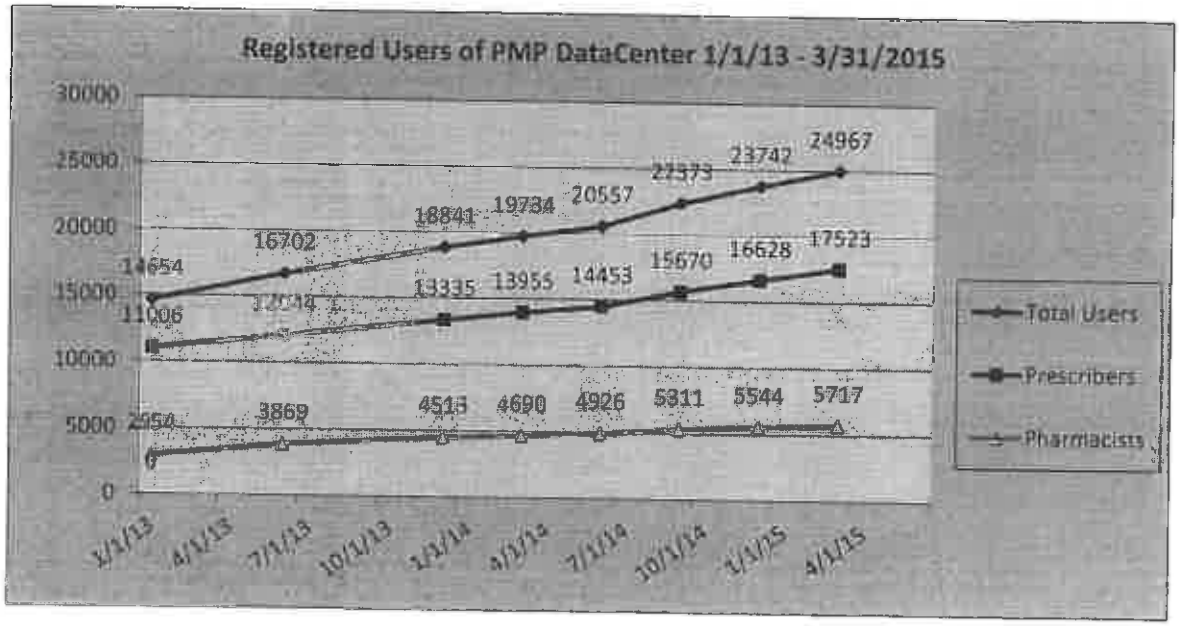
First Quarter 2015 Statistics



The Virginia PMP expects to process greater than 2 million requests in 2015. The program processed over 1.8 million requests in 2014.



By the end of the first quarter of 2015, the Virginia PMP had nearly 25,000 registered users. When mandatory registration is complete, the Virginia PMP will have approximately 60,000 users.

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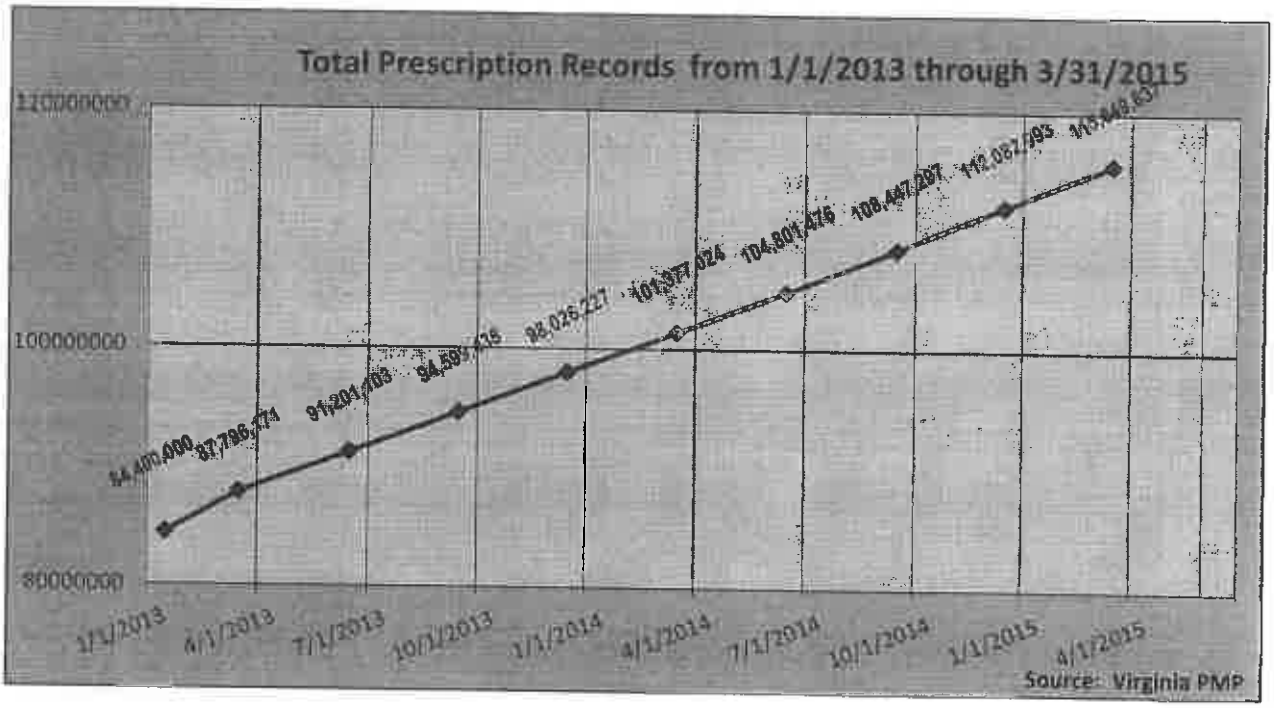
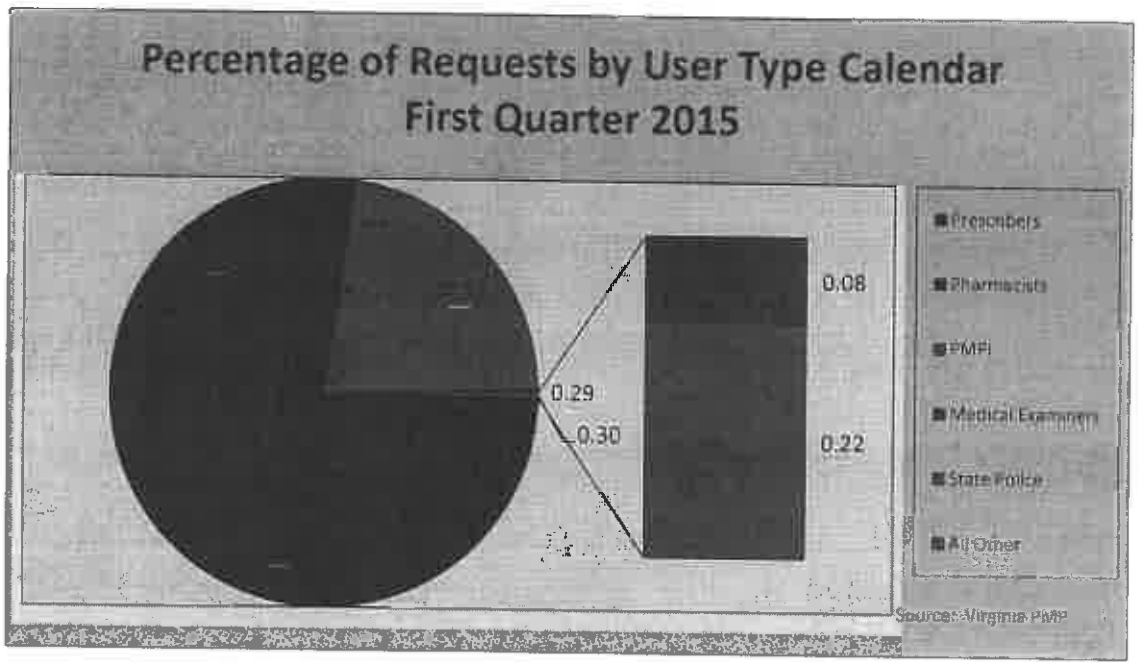
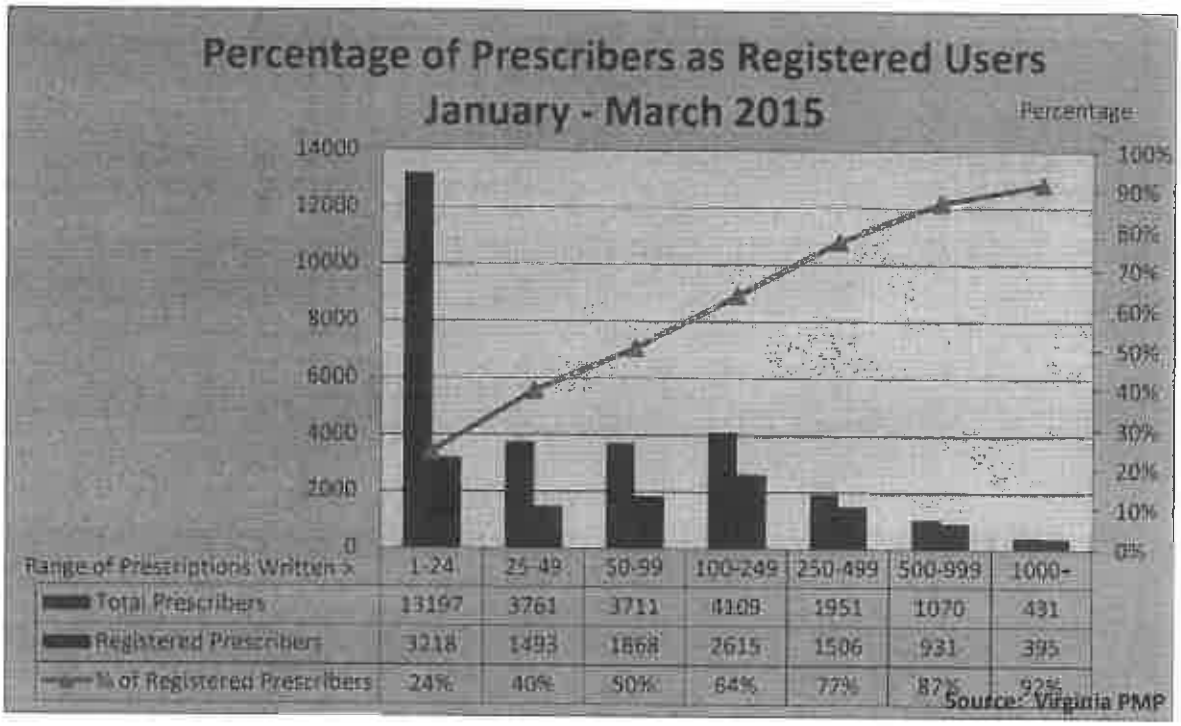


By the end of March 2015, the PMP database contained over 115 million prescriptions records.

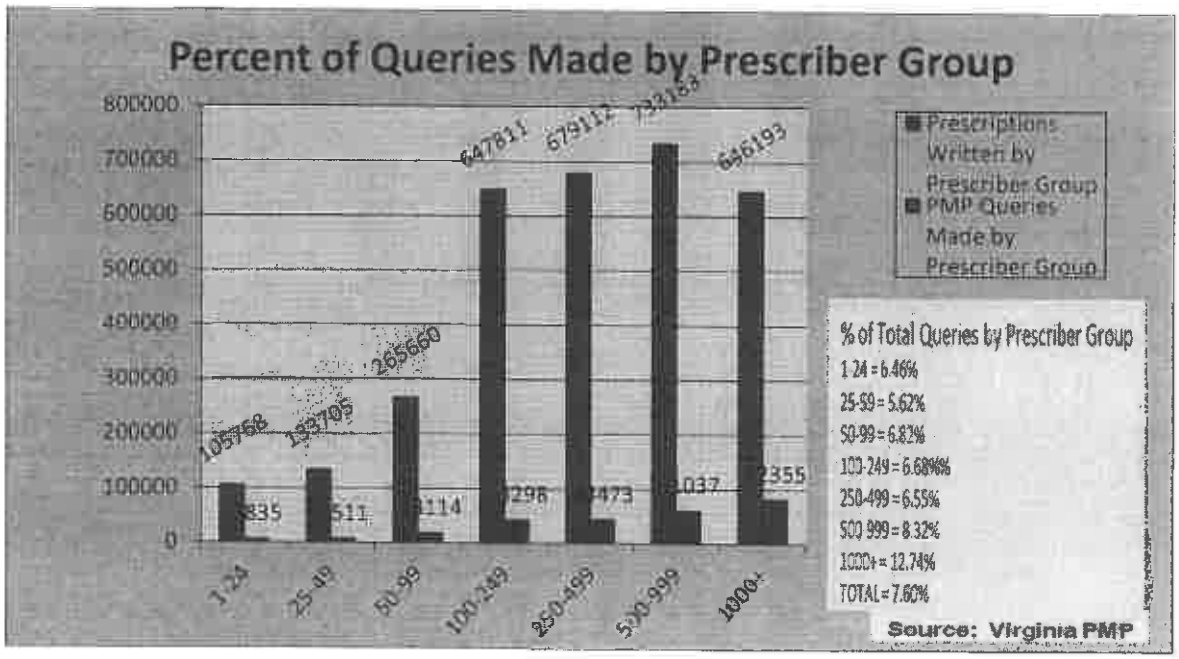


Over half of the queries to the PMP database were completed by prescribers, nearly one quarter were completed by pharmacists, and another 22% of the queries were performed by users of our data interchange from other states (primarily prescribers).



Range of Prescriptions Written >	1-24	25-49	50-99	100-249	250-499	500-999	1000+
Total Prescribers	13197	3761	3711	4109	1951	1070	431
Registered Prescribers	3218	1493	1868	2615	1506	931	395
% of Registered Prescribers	24%	40%	50%	64%	77%	87%	92%

The percent of prescribers registered to use the PMP database is directly related to the number of prescriptions for controlled substances that prescriber group writes.



Prescribers query the database for an average of 7.6% of prescriptions written. Those prescriber groups who wrote greater than 500 prescriptions for controlled substances per quarter demonstrated higher query rates ranging from 8 – 12%.

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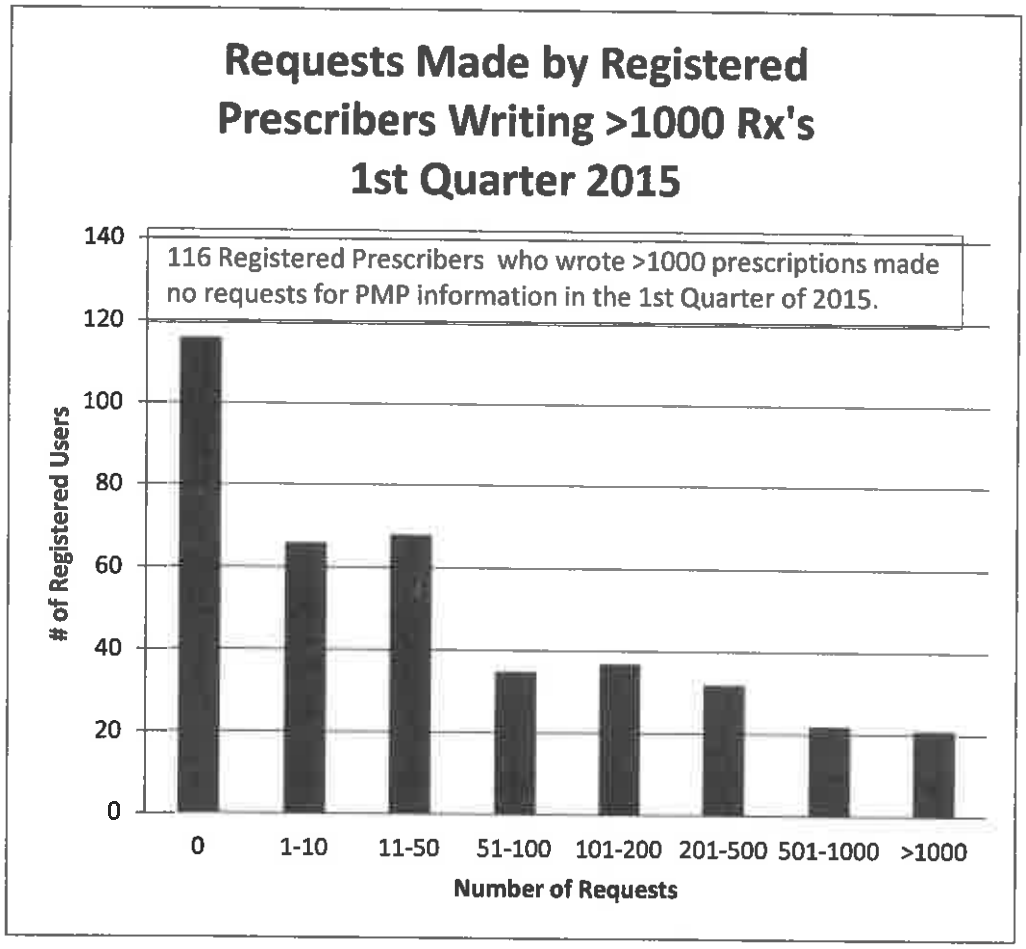
Registered Users Writing >1000 Prescriptions in 1st Quarter 2015

# of Requests	# of Registered Users
0	116
1-10	66
11-50	68
51-100	35
101-200	37
201-500	32
501-1000	22
>1000	21



Summary of Mandatory Use of PMP

The following states have some form of mandatory use of their PMP for either prescribers or dispensers or both (source: NAMSDL):

Arizona
Colorado
Delaware
Georgia
Indiana
Kentucky
Louisiana
Massachusetts
Minnesota
Mississippi
Nevada
New Mexico
New York
North Carolina
North Dakota
Ohio
Oklahoma
Pennsylvania
Rhode Island
Tennessee
Vermont
Virginia
Washington
West Virginia

PDMP CENTER OF EXCELLENCE Brandeis University The Heller School

Prescription Drug Monitoring Program Center of Excellence at Brandeis

Using PDMP Data to Guide Interventions with Possible At-Risk Prescribers

October 2014

This project was supported by Grant No. 2011-PM-BX-K002 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

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Using PDMP Data to Guide Interventions with Possible At-Risk Prescribers

The prescription drug abuse epidemic is driven in part by a minority of prescribers who over-prescribe or mis-prescribe controlled substances, especially opioids and benzodiazepines. In this report we will refer to prescribers who deviate from accepted standards of practice or whose prescribing is unusual or uncharacteristic for their specialty as *at-risk* prescribers. Identifying and intervening where appropriate with at-risk prescribers is a key strategy in efforts to control prescription drug misuse and diversion. The CDC has recently recommended focusing efforts on prescribers not following accepted medical practice.[1]

The Role of PDMPs in Identifying Possible At-Risk Prescribers

Because they collect comprehensive dispensing data, PDMPs are uniquely positioned to help identify prescribers at risk of over-prescribing or prescribing inappropriately. The top prescribers in a state as ranked by frequency of prescribing or dosage units prescribed often account for a high proportion of the total amount of dispensed controlled substances. For example, in the first three quarters of 2012 the top 8% of prescribers in Oregon accounted for 79% of all prescriptions for Schedule II - IV drugs.[2] In Florida in 2012, the top 10% of prescribers (top decile) were responsible for over 60% of opioid prescriptions.[3] While high frequency or dosage are not themselves indicators of inappropriate prescribing, it is one reason to consider further analysis and review by the PDMP or a licensing board. PDMP data analyses can readily identify the top 10% or 20% of prescribers for all controlled substances or for particular classes or combinations of drugs that are most involved in misuse or diversion.

Other criteria identifiable in PDMP data for possible problematic prescribing include having a high proportion of possible doctor shoppers in a practice, patients coming from long distances, and a high proportion of dispensed prescriptions paid for in cash.[4] When combined with data on prescriber license activity and specialty, analyses can also identify those prescribers who exceed the norm for their licensed profession, specialty, and standards of practice. Having identified possible at-risk prescribers with the help of the PDMP, professional licensing agencies and boards tasked with maintaining medical standards can intervene as appropriate, taking into

[1] The CDC writes that efforts to reduce the epidemic should include focus on "prescribers who clearly deviate from accepted medical practice in terms of prescription painkiller dosage, numbers of prescriptions for controlled substances, and proportion of doctor shoppers among their patients." CDC, Policy Impact: Prescription Painkiller Overdoses, at http://www.cdc.gov/homeandrecreationalsafety/rxbrief/.

[2] See Prescription Drug Dispensing in Oregon, October 1, 2011 – March 31, 2012, Figure 1, p. 30, http://www.orpdmp.com/orpdmpfiles/PDF_Files/Reports/Statewide_10.01.11_to_03.31.12.pdf.

[3] Data from the Prescription Behavior Surveillance System (PBSS) as presented by Dr. Len Paulozzi at the 2013 Harold Rogers PDMP National Meeting, see http://www.pdmpassist.org/pdf/PPTs/National2013/26-8-A%20Paulozzi.pdf slide 21.

[4] For a description of PDMP measures indicative of possible at-risk prescribing, see Definitions of Prescription Behavior Surveillance System (PBSS) Measures, Section 5: Pill Mill Measures, pp. 4-7, http://www.pdmpexcellence.org/sites/all/pdfs/Definitions%20of%20PBSS%20Measures%20112113.docx

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account all the evidence that bears on a case.[5] PDMPs may also be able to refer to law enforcement those prescribers potentially involved in illegal activities, including diversion of controlled substances.

PDMP data analyses can be used to track changes in prescribing by those who have been subjects of agencies' actions, thereby helping to assess the effectiveness of interventions.[6] Below are descriptions of initiatives undertaken or planned in Arizona, Tennessee, Kentucky, Texas, New Jersey, Massachusetts and New York. These can serve as models for other states to emulate or modify in their efforts to reduce prescription drug abuse and diversion. Some programs, for instance the Arizona report card, are directed at all prescribers who exceed norms for prescribing in a particular geographical area, while others such as Kentucky's are geared toward specific prescribers who are confirmed to be contravening good medical practice.[7] In Texas and New Jersey, data on both prescribers and dispensers are reviewed.

State Initiatives for Possible At-Risk Prescribers

Arizona: Prescriber report cards. In a pilot program planned for state-wide adoption, the Arizona PDMP conducts analyses to identify 'outlier prescribers', defined as those one standard deviation above the average for their specialty and county in prescribing commonly abused controlled substances, whether in numbers of prescriptions or total dosage units. Outlier prescribers are sent "report cards" that summarize in graphical format the prescriber's prescribing as compared to local averages for the past year (see Appendix A for a sample report card). Report cards were sent to over 1,000 prescribers in Yavapai, Pinal, Graham and Greenlee counties. Outcomes thus far are promising. In Pinal county after one year, the percentage of prescribers meeting the outlier criterion for total dosage units fell from 19.2 percent to 14.2 percent, a 26% decline, while the number of prescriptions for all controlled substances fell by over 5%.[8] These findings suggest that report cards alert prescribers that they are prescribing well above practice norms, leading them to re-examine their prescribing policies.

The report cards may also serve to increase prescriber awareness and participation in the Arizona PDMP. In the four pilot program counties, 39% of prescribers were enrolled in the PDMP as of June 2014, compared to 26% for the state, and enrollment in the PDMP for these counties increased 111% from June 2012 to June 2014, compared to an increase of 72% for the state. In Pinal County, prescriber use of the PDMP increased 14% after the first year of the pilot.[8] Research studies and surveys of prescribers indicate that they change their prescribing

[5] It is important in what follows to distinguish between *possible* at-risk prescribers and those actually confirmed to be prescribing outside standards of practice.

[6] The CDC has recently called for increased use of PDMP data for surveillance of possible excessive prescribing and for evaluation of initiatives to change prescriber behavior, see http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a2.htm?s_cid=mm6326a2_w.

[7] In general, PDMP data are only indicators, not proof, that a prescriber is engaging in medically unwarranted prescribing.

[8] Data courtesy of the Arizona PDMP.

behavior in response to viewing PDMP data, which may account for some of the decline in prescribing observed following the report cards.[9]

It should be noted that the report card initiative is only one facet of the pilot program carried out in these counties, so changes in prescribing and PDMP participation may be the result of factors in addition to the report cards themselves, such as prescriber trainings, community education, and media coverage of the problem. As part of its Prescription Drug Reduction Initiative, Arizona is seeking to expand the program, including prescriber report cards, to the entire state.

Tennessee: Letters to top prescribers and reports to licensing boards. In 2013, the Tennessee legislature adopted a requirement that, using the PDMP, the Tennessee Department of Health (TDH) identify and notify at least annually the top fifty prescribers in the past calendar year.[10] The notification letters include information about the practitioner's level of prescribing and ask the prescribers or their medical supervisors to justify the amounts prescribed as medically necessary, on pain of disciplinary action for non-compliance. Letters are not sent if the prescriber is a subject of an active investigation. TDH then determines, in consultation with medical experts on appropriate prescribing, whether the prescriber's explanation is justified, taking into account factors such as medical specialty and ages of patients. If the explanation leaves concerns about over-prescribing unaddressed, the prescriber or medical supervisor is given 15 days to produce additional supporting evidence that the level of prescribing is medically warranted. If concerns about excess prescribing still remain, TDH may contact the relevant licensing board for its review of the case, which may trigger an investigation should inappropriate prescribing seem likely. As of this report no data were available on numbers of prescribers contacted thus far or other outcomes of the letter initiative.[11]

In addition to the letter initiative, the Tennessee PDMP currently provides data to licensing board investigators on the most frequent prescribers, both for numbers of prescriptions and total dosage units of certain controlled substances. The PDMP is in the process of incorporating refinements to these criteria, such as data on how a provider's prescribing compares to norms for a particular specialty (e.g., general medicine or orthopedics) and how practices vary in the types and dosages of prescribed controlled substances. The PDMP has added staff with analytical and epidemiological expertise to develop these measures using PDMP data. As of this report, no data were available yet with respect to outcomes related to this initiative.

Kentucky: Reports to investigators on possible at-risk prescribers. As part of recent efforts in Kentucky to more effectively address prescription drug abuse, Kentucky's PDMP—the Kentucky All Schedule Prescription Electronic Reporting system (KASPER)— sends PDMP reports on prescribers to investigators at the Drug Enforcement and Professional Practices

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[9] See the COE Briefing on PDMP Effectiveness for studies and surveys on the impact of viewing PDMP data on prescribing.

[10] The relevant text of the legislation can be found at http://state.tn.us/sos/acts/108/pub/pc0396.pdf, pages 2-3.

[11] See http://www.psychsearch.net/tn-withholds-doctors-names/ and http://www.timesfreepress.com/news/2012/apr/18/tenncare-blocks-top-drug-prescribers/?news for news stories about an initiative by Iowa Senator Charles Grassley to identify the top ten prescribers billing to Medicaid in states. Some of those identified in Tennessee using TennCare (Medicaid) data have been barred from billing Medicaid because their prescribing was judged medically unwarranted.

Branch (DEPPB) of the Office of the Inspector General. Investigators then evaluate the reports to see if further inquiry into potentially inappropriate or illegal prescribing is warranted. Prescribers selected by KASPER for review and possible referral to DEPPB are identified using criteria recommended by the Governor's KASPER Advisory Council. Prior reviews included the top two percent of prescribers issuing prescriptions for oxycodone, hydrocodone, oxymorphone, methadone, alprazolam, and drug "cocktails" (e.g., hydrocodone, alprazolam, carisoprodol). Once the DEPPB receives a report from KASPER, investigators, who are registered pharmacists as well as certified peace officers in Kentucky, review the provider's prescribing history. The review includes types of controlled substances prescribed, prescribing unusually large quantities and/or medically questionable combinations, issuing new prescriptions before all refills are exhausted, and having patients who travel long distances. Investigators also take into account the practitioner's specialty, and, in consultation with licensure boards, any record of disciplinary action or known problems with the practitioner. If the review indicates a substantial likelihood of problematic prescribing, the information is forwarded to the appropriate board for further investigation. If criminal activity is suspected, cases are sent to law enforcement investigators.

From July 2012 (the start of this initiative) to November 2013, DEPPB had received 95 cases for review, and completed reviews of 76. Of these, 46 (60 %) were determined to meet criteria for referral to the Kentucky Board of Medical Licensure (KBML) or law enforcement. KBML took action in 23 (50 %) of the cases referred to it.[12] Actions thus far have resulted in retirements, agreed orders setting out sanctions and terms to be imposed upon the prescriber, and controlled substance license revocations. Thus, some problematic prescribers have modified their practices or have been removed from the system. The KASPER Advisory Council is now considering criteria for reviews of dentists prescribing large quantities of benzodiazepines, hydrocodone and oxycodone, high volume prescribing of Schedule II stimulants, and pharmacies dispensing high volumes of hydrocodone, oxycodone and Schedule II stimulants.

Texas: Reports to licensing boards and law enforcement. The Texas PDMP conducts frequent analyses of its database to detect possible problematic prescribing and dispensing that can be brought to the attention of appropriate authorities. Automated algorithms generate reports on providers meeting pre-defined criteria suggestive of at-risk practice, such as being among the most frequent prescribers or dispensers of widely abused controlled substances. Prescription data are reviewed to help rule out legitimate reasons for what seems to be problematic prescribing or dispensing, as well as to scan for indicators warranting further data analyses. When a provider is identified as reportable to law enforcement, staff decides whether to refer the case to investigators within the Department of Public Safety (home to the PDMP) or to another law enforcement agency—federal, state, county, or local. Investigators receive a complete prescription history report; in some cases, copies of prescriptions are included. Cases on medical providers not deemed appropriate for law enforcement investigation are referred to

[12] Data from DEPPB provided courtesy of KASPER.

licensing boards. Care is taken to coordinate with other agencies in order not to compromise investigations already underway (de-confliction) and to supply PDMP data relevant to those investigations. The Texas PDMP has produced an average of 20-25 prescription drug cases a month for law enforcement investigation, making it among the most active PDMPs for this type of intervention.[13]

New Jersey: Proactive reporting on risky prescribing and dispensing. The New Jersey PDMP conducts quarterly analyses to look for concerning patterns of prescribing and dispensing, such as identifying the state's top prescribers and pharmacies for controlled substances commonly encountered in cases of illegal prescribing. Database searches are conducted using drug therapeutic codes, dosage types (e.g., 30 mg Roxicodone) and payment type. If suspicious departures from normal prescribing practice are detected, the appropriate law enforcement agency or licensing board, depending on the level and type of activity, is contacted. Recent analyses related to possible diversion have focused on top prescribers of oxycodone where payments for prescriptions are made in cash. The PDMP also runs ad hoc analyses to further explore patterns identified in quarterly reviews or to investigate developments reported to the PDMP by other agencies. For example, law enforcement agencies may report that promethazine with codeine syrup is turning up on the street, so analyses are run for promethazine.[13]

Massachusetts: Outreach to prescribers with high proportions of possible doctor shoppers. In an initiative aimed at increasing awareness and utilization of its PDMP, Massachusetts analyzed its data to identify "high risk" prescribers, defined as those with relatively high proportions of possible doctor shoppers in their practices (i.e., patients meeting thresholds for numbers of prescribers and pharmacies in a six month period). Those high risk prescribers not enrolled in the PDMP were notified via letter about their status and encouraged to enroll. The initiative resulted in 150 notifications in 2012, and as of 2013 over 40% of the notified prescribers had enrolled in the PDMP. In a separate study of the top 50 high risk prescribers, those enrolled in the PDMP (n=12) had a 26 percent decline from 2010 to 2011 in the number of patients meeting criteria for doctor shopping, compared to a 7.5 percent decline for those not enrolled in the PDMP (n=38).[14] In a future initiative, Massachusetts plans to engage identified high risk prescribers via academic detailing – one-on-one provider education aimed at improving opioid prescribing.

New York: Identifying and contacting at-risk prescribers. In an initiative under consideration, New York PDMP data will be analyzed to identify at-risk prescribers, defined as those who frequently prescribe opioids in combination with benzodiazepines and/or prescribe high volume and high doses of opioids. These prescribers will receive a mailing from the New York State

[13] The text in this section has been adapted from the COE guidance document on unsolicited reporting at http://www.pdmpexcellence.org/sites/all/pdfs/Brandeis_COE_Guidance_on_Unsolicited_Reporting_final.pdf.

[14] These findings should be interpreted with caution since there may be bias in favor of more proactive scrutiny and modification of prescribing practices for those voluntarily enrolling in the PDMP. The initiative and study are described in a presentation by Leonard Young for the 2013 National Rx Abuse Summit; see http://www.slideshare.net/OPUNITE/new-focuses-forpdmpseffortsfinal, slides 58-9.

Department of Health indicating concern about potentially harmful prescribing practices. The mailing will also provide corresponding educational materials focused on risks and benefits of long-term opioid use and risks of combining opioids with other central nervous system depressants. Outcomes of the intervention will be measured by comparing pre-intervention prescribing history to post-intervention prescribing using PDMP data.

Conclusion

The initiatives summarized above illustrate some options states may wish to pursue in addressing a primary source of controlled substances implicated in the prescription drug abuse epidemic: practitioners who prescribe, intentionally or not, in excess of or otherwise inconsistent with good medical practice. PDMPs are critical tools in this effort, in their capacity to (1) identify prescribers who may be intentionally or unintentionally prescribing outside the standards of practice; and (2) track prescribing behavior longitudinally for assessing the effectiveness of interventions aimed at prescribing reform. As these initiatives continue, more data will become available to permit their evaluation and enhancement.

It should be noted that the initiatives described above are by no means exhaustive of those underway in states with active PDMPs. Future updates to this briefing will cover additional interventions and provide new information on their outcomes as measured by PDMP data, data on licensing board and law enforcement actions, and health indicators affected by controlled substance prescribing.

Acknowledgements: The COE gratefully acknowledges the expertise and editorial assistance of those PDMP staff consulted in the preparation of this report, including:

Dean Wright, Arizona

Dave Hopkins, Kentucky

Leonard Young, Massachusetts

Eric Rosen, New Jersey

Andrew Holt, Tennessee

Sherry Wright, Texas

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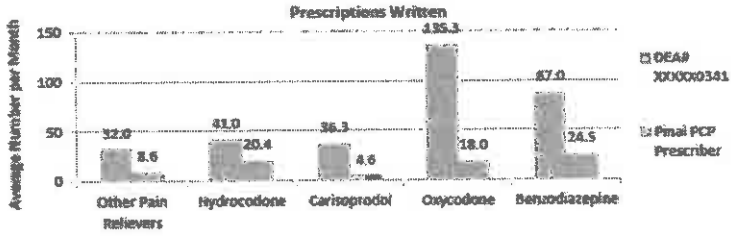
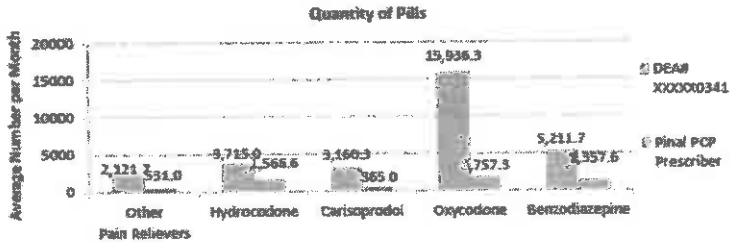
Appendix A
Arizona Prescriber Report Card*

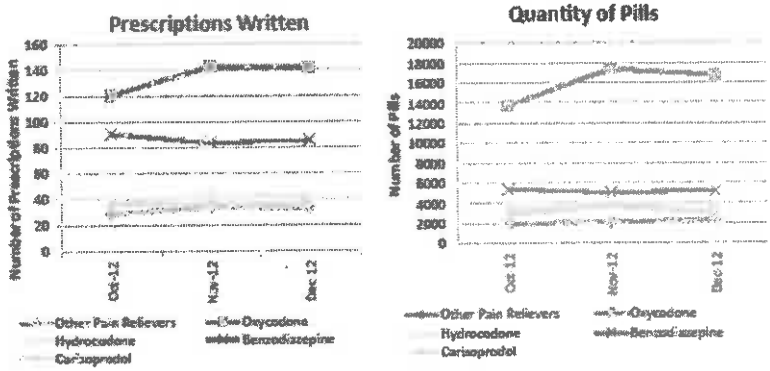
PRESCRIBER: DEA# XXXXX0341

A continuing review of the Prescription Drug Monitoring Program (PDMP) from 10/2012 through 12/2012 reveals the following about your prescribing habits: You have been identified as an outlier* with respect to the number of prescriptions written and the quantity of pills prescribed for Hydrocodone, Oxycodone, Other Pain Relievers, Carisoprodol and Benzodiazepine.

**Above average prescribing for your prescriber type in your county*







You are currently signed up for access to the Prescription Drug Monitoring Program (PDMP)
http://www.azpharmacy.gov/CS-Rx_Monitoring/practioner_procedures.asp
For additional information please contact the Arizona State Board of Pharmacy (602) 771-2744

*From slide 17 in the presentation available at
http://www.azcjc.gov/ACJC.Web/Rx/Presentations/RxInitiative_general.pptx

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Summary of PMPs Allowing Unsolicited Requests to Law Enforcement and Regulatory Entities

	Law Enforcement	Regulatory Entities
Alabama	NO	NO
Alaska	YES	YES
Arizona	YES	YES
Arkansas	NO	NO
California	YES	NO
Colorado	NO	NO
Connecticut	YES	YES
Delaware	YES	YES
Florida	YES	YES
Georgia	NO	NO
Hawaii	YES	NO
Idaho	YES	YES
Ilinois	NO	NO
Indiana	YES	YES
Iowa	NO	NO
Kansas	YES	YES
Kentucky	NO	YES
Louisiana	YES	YES
Maine	NO	NO
Maryland	NO	NO
Massachusetts	YES	YES
Michigan	NO	NO
Minnesota	NO	NO
Mississippi	YES	YES
Missouri	NO	NO
Montana	NO	NO
Nebraska	NO	NO
Nevada	YES	YES
New Hampshire	NO	YES
New Jersey	YES	YES
New Mexico	YES	YES
New York	YES	YES
North Carolina	YES	YES
North Dakota	YES	YES
Ohio	YES	YES
Oklahoma	YES	NO
Oregon	NO	NO
Pennsylvania	YES	NO
Rhode Island	YES	YES
South Carolina	YES	YES
South Dakota	YES	YES
Tennessee	NO	YES
Texas	YES	YES
Utah	YES	NO
Vermont	NO	YES
Virginia	YES	NO
Washington	NO	YES
Washington, D.C.	NO	NO
West Virginia	YES	YES
Wisconsin	YES	YES
Wyoming	YES	YES