PRESCRIPTION DRUG MONITORING PROGRAMS (PMPS) IN THE UNITED STATES
OUR JOURNEY

• Definition and purposes

• Brief history

• Overview of selected research

• “Best” or “Recommended” practices

• State adoption of “Best” or “Recommended” practices
• Future trends

• Challenges to balanced improvement
DEFINITION AND PURPOSES

• Statewide electronic databases – collect specified data on prescription controlled substances from dispensers
  ➢ Sometimes drugs of concern – e.g., tramadol
  ➢ Includes dispensing practitioners

• Provide patient prescription data to prescribers, dispensers, regulatory officials, law enforcement/prosecutors, selected others
• Housed and administered by a state agency
  
  ➢ 39 States + D.C. - health departments, single state authority or Board of Pharmacy
  
  ➢ 5 states – law enforcement/Attorney General
  
  ➢ 2 states – professional licensing
  
  ➢ 1 state each – Department of Consumer Protection, Board of Pharmacy with Department of Public Safety, Narcotic Drug Agency with oversight by Board of Pharmacy
• 5 common purposes for a PMP

- Support access to controlled substances for legitimate medical use
- Help identify and deter diversion
- Help identify and intervene with persons abusing or addicted to prescription drugs
- Inform public health initiatives through trends
- Educate public about abuse, addiction and diversion
BRIEF HISTORY

• In the beginning…

  ➢ New York State - 1918

  ➢ California - 1939 Oldest continuous program

  ➢ Hawaii – 1943

• Paper prescriptions

• Law enforcement purpose – deter diversion
• The electronic era…

  ➢ Oklahoma - 1990 First electronic PMP

  ➢ Federal grants – plan, establish, enhance, improve

    ❖ Harold Rogers PMP Grants – 2003-2014

    ❖ Substance Abuse and Mental Health Services Administration (SAMHSA)

    ❖ Office of National Coordinator for Health Information (ONC)
• Electronic submission of data
• Health care and law enforcement purposes
• 49 states and D.C. – PMP laws
• 49 states operational
  • D.C. - adopting regulations
• Missouri – bills pending
OVERVIEW OF SELECTED RESEARCH

• What do we know? What don’t we know?

• State PMPs are information tools

• Most direct impact
  - Decision making process for professionals allowed to access and use data
  - Resulting actions from decision making
• Change in amounts and types of drugs prescribed
  ➢ More informed prescribing
  ➢ More appropriate prescribing
• Ohio PMP data – use by ER physicians (Baehren 2009)
  ➢ 62% of patients – fewer/no opioids than planned
  ➢ 39% of patients – more pain relief than planned
• Massachusetts PMP data – assessment of drug-seeking behavior in ER (Wiener 2013)

  ➢ 6.5% of patients – received prescriptions not previously planned

  ➢ 3.0% of patients – didn’t receive prescriptions planned

• Clinical factors predictive of drug-seeking behavior (Wiener 2013)

  ➢ Request medication by name
- Multiple visits for some complaints
- “Suspicious” history
- Symptoms out of proportion to exam
• Kentucky PMP prescriber/dispenser survey (2010)
  ➢ 70.8% - “very” or “somewhat” important in decisions

• Indiana prescriber/dispenser survey (2013)
  ➢ Over 90% prescribed fewer controlled substances in past 12 months
  ➢ Over 50% cited greater access to INSPECT
• Confirm suspicion of abuse or diversion

• Virginia outpatient psychiatry clinic (Sowa 2014)
  ➢ PMP data useful in screening new patient with prior benzodiazepine and opioid use, personality disorder, and/or chronic pain

• Oregon survey of prescribing clinicians (Irvine 2014)
  ➢ Most physicians use PMP when suspect abuse or diversion
• Correlations/associations not causation

• Reductions in supply of prescription drugs

• National survey of state PMPs 1999-2005 (Simeone 2006)
  ➢ Less increase in Schedule II opioid supply
  ➢ Reductions greater in states with proactive PMPs

• Survey of 14 states’ PMPs 1997-2003 (Reisman 2009)
  ➢ Significant reductions in rise of oxycodone shipments
• Slower rate of increase in opioid abuse/misuse

• Analysis of poison control center data (Reifler 2012)
  ➢ Rate of increase in opioid abuse less in states with PMPs

• Survey of 14 states’ PMPs 1997-2003 (Reisman 2009)
  ➢ Less increase in prescription opioid treatment admissions
• No apparent relationship between PMPs and overdose mortality?

• Columbia University study of state PMPs and overdose mortality data 1999-2008 (Li, Brady 2014)
  ➢ PMPs did not reduce overdose mortality in most states

• Analysis of PMPs and state-level mortality and drug consumption data 1999-2005 (Paulozzi 2011)
  ➢ No discernible impact of PMP on drug overdose mortality rate
• Result of Columbia University study attributed to factors:

  ➢ Severely limited use of PMPs by physicians and pharmacists – difficult accessibility

  ➢ Barriers to interstate sharing

  ➢ Inadequate provider training on prescribing controlled substances
“BEST” OR “RECOMMENDED” PRACTICES

• 14 organizations, agencies and groups

  ➢ Center of PMP Excellence – Brandeis University

  ➢ University of Wisconsin Pain and Policy Studies Group

  ➢ National Safety Council

  ➢ National Conference of Insurance Legislators

  ➢ Trust for America’s Health
• Increase efficiency/effectiveness of PMPs as health care delivery tools

• National survey of primary care physicians (Rutkow 2015)
  ➢ Mandate registration and use
  ➢ Provide more prescriber education and outreach
  ➢ Improve ease of access
  ➢ Present data in a more user-friendly format
• **Top 5 “Best” or “Recommended” practices**

  - Real time reporting
  - Interstate data sharing
  - Expand user access
  - Integrate PMP data into electronic health systems
  - Proactive/unsolicited alerts and reports
STATE ADOPTION
“BEST” OR “RECOMMENDED” PRACTICES

• Real time reporting of data by dispensers

• More frequent the reporting = more current the data

• Data reporting intervals

  ➢ Goal - real time (within 5 minutes) – Oklahoma

  ➢ Common - Weekly/7 days – 25 states

  ➢ Trend – daily/24 hours – 16 states + D.C.; WY bill passed House & Senate
• Interstate data sharing

• 46 states + D.C.

• 3 PMP Interstate sharing hubs

  ➢ PMP Interconnect (PMPi)

    ➢ Administered and funded by National Association of Boards of Pharmacy (NABP)

    ➢ 28 states (1/26/15)
- RxSentry
  - Administered by Health Information Designs (HID)
  - HID clients

- RxCheck
  - Administered by IJIS Institute
  - Funded by Bureau of Justice Assistance
  - 3 states
• Expanding user access

• 2 primary methods

- Increase types of professionals who can access and use PMP data

- Increase number of prescribers/dispensers who do access and use PMP data
• Increase types of professionals

• Delegates

  ➢ 34 states + D.C.; WY bill passed House & Senate

• Medicaid/Medicare/state insurance officials

  ➢ 33 states + D.C.

• Substance abuse/mental health professionals or peer review/quality improvement committees

  ➢ 13 states
• Increase number of prescribers/dispensers

• Focus on information being available

• Mandated registration/enrollment

  ➢ 21 states

  ➢ Utah PMP use before/after mandate

    ❖ Prescribers active on PMP – 35% growth

    ❖ Searches/searches per login – 61% growth
• Mandated use

- 24 states

- Mandates in Kentucky, Ohio, New York and Tennessee (Brandeis COE 2014)

  - Increased enrollment and requests

  - Increased use associated with decrease in opioid prescribing

  - Increased use associated with decrease in doctor shopping in New York, Ohio and Tennessee
• **Focus on information being available AND ACTIONABLE**

• Automated registration
  
  ➢ Application for or renewal of license
  
  ➢ Maine, Massachusetts and Virginia

• Integration into electronic health records
  
  ➢ 2012 and 2013 pilots – Office of National Coordinator for Health Information Technology (ONC)
Results of 13 state pilots

- More prescribers/dispensers used PMP
- Streamlined workflow – no separate PMP access
- More automated tasks - more satisfaction

2014 ONC pilots - 17

- Focus – effective translation between Health IT technical language and PMP technical language
Substance Abuse and Mental Health Services Administration (SAMHSA)

- 16 state grantees

Key areas of integration focus

- Single sign-on
- Automated PMP query upon admission to ER
• Institutional/facility accounts

  ➢ Kentucky hospital or long-term care facility

    ❖ Chief medical officer or designee – account holder

    ❖ Delegates

    ❖ Institutional account agreement

    ❖ Policy for managing PMP data and reports
• Proactive/unsolicited alerts and reports

• 45 states + D.C.

• PMP Administrator gives notice of unusual or “suspicious” activity

• Common triggers for alert
  
  ➢ Reason to believe violation of law/standards

  ➢ Patient visits certain number of prescribers/pharmacies within specific period of time
Criteria for triggers vary by state

- Peer review committees
- PMP capacity to send reports and alerts
- Indicators of abuse/diversion

Prescribers and dispensers – most common recipients of alerts
FUTURE TRENDS

• More mandated registration and use

• More categories of professional who can use

• More authorization for delegates

• More integration initiatives

• More proactive alerts and other risk assessment tools for PMP data
CHALLENGES TO BALANCED IMPROVEMENT

- Lack of policymakers’ understanding of health care practice
  - Pressure to “do something” sometimes leads to doing anything
- Lack of financial support for a more comprehensive and integrated patient approach
- Lack of ongoing, comprehensive study and evaluation to determine benefits/effectiveness of various approaches
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Q & A?