AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

PRESCRIPTION DRUG MONITORING PROGRAMS

AAFP Position

The American Academy of Family Physicians (AAFP) supports the implementation and use of prescription drug monitoring programs (PDMPs) and greater physician input into pain management regulation and legislation. The AAFP will work with state and national partners to improve the functionality, utility, and interoperability of PDMPs, and develop best practices for their use and implementation. The AAFP supports programs that would provide funding to all states to continue or further develop PDMPs to make the interstate exchange of monitoring information easily available to prescribers and dispensers.

The Complexity of the Problem

The intertwined public health issues of chronic pain management and the risks of opioid use and misuse continue to receive national attention. Family physicians find themselves having to balance care of patients with chronic pain with the challenges of managing opioid misuse and abuse. Despite advances in evidence and understanding of its pathophysiology, chronic pain continues to burden patients in a medical system that is not designed to care for them effectively. Opioids have been used to treat pain for centuries, despite limited evidence and knowledge about their long-term benefits, but there is a growing body of clear evidence regarding their risks. As a result of limited science, external pressures, physician behavior, and pharmacologic development, we have seen significant consequences from opioid overprescribing, misuse, diversion, and dependence.

The State of PDMPs

PDMPs continue to be a popular strategy among policy makers and a key mechanism to combat the prescription drug epidemic. The goal of PDMPs is to collect, monitor, and analyze electronically transmitted prescribing and dispensing data submitted by pharmacies and dispensing practitioners. The data is used to support states' efforts in education, research, enforcement, and abuse prevention. States and various state agencies manage PDMPs, but states also allow providers and pharmacists to view PDMP reports on patients under their care. Other authorized groups, including law enforcement, professional licensing or regulatory boards, state Medicaid/Medicare programs, coroners, and others, can also access PDMP information under certain circumstances in certain states.

While Missouri still doesn't have a state PDMP, despite former Governor Eric Greitens' (R) executive order establishing a statewide monitoring system, all other 49 states and DC now have a PDMP. As a next step, lawmakers have now begun to mandate use of state PDMPs. As of May 2018, 41 states require, on some level, prescribers and/or dispensers to access a PDMP database prior to an initial opioid prescription. 25 states have PDMP mandates that apply to all prescribers and initial opioid prescriptions while 16 additional states have mandates for certain prescribers.[1] For example, in Nevada, before initiating a prescription for a controlled substance listed in schedule II-IV, a practitioner must obtain a patient utilization report from the PDMP if the patient is a new patient of the practitioner or if the prescription is for more than seven days and is part of a new course of treatment. In Massachusetts, a registered individual practitioner must utilize the Massachusetts Prescription Awareness Tool (MassPAT) within 24 hours or the next business day each time the practitioner issues

[1] *Pew Charitable Trusts.* (2018). "When Are Prescribers Required to Use Prescription Drug Monitoring Programs?" Web.

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a prescription to a patient for any Schedules II and III narcotic drug. Additionally, prescribers must continue to check MassPAT the first time they prescribe a benzodiazepine or any controlled substance in Scheduled IV or V which the Department of Health and Human Services has designated in guidance as a drug that is commonly abused and may lead to dependence.

States have varying laws regulating various aspects of their PDMPs. Different substances are monitored by different PDMPs, with some states only monitoring Schedule II-IV controlled substances, while others monitor Schedules II-V. Additionally, some states require data on certain non-controlled or non-scheduled substances such as products containing acetaminophen. Data collection intervals also vary. Currently, only Oklahoma requires real time, point-of-sale reporting of controlled substances in their PDMPs. Weekly reporting is required in two states (CA, HI) while 45 states, St. Louis County, MO, and DC have switched to daily reporting.[2] To help decrease the reporting burden, 40 states have passed legislation allowing doctors to designate delegates to use the system on their behalf.

Interoperability
Prescribers often care for patients in border areas between the states, making interoperability between PDMPs critical. Patients sometimes "doctor shop" across state lines, obtaining prescriptions from multiple healthcare practitioners without the prescribers' knowledge. As of August 2019, 47 states (excluding CA, MO, NE), and DC have joined the National Association of Boards of Pharmacy PMP InterConnect. This system facilitates the transfer of PDMP data across state lines. It allows participating state PDMPs across the United States to be linked and share PDMP data with programs operated by other jurisdictions, providing a more effective means of combating drug diversion and drug abuse nationwide. PMP InterConnect currently processes 47 million requests every month.[3] Before PMP InterConnect, each state had to sign separate agreements with every other state in order to share data. PMP Interconnect is effective but is only accessible to states that execute a single memorandum of understanding with the National Association of Boards of Pharmacy and build an interface to connect with the system. States that are not connected to PMP InterConnect follow their own interoperability procedures.

PDMP Integration into Electronic Health Records
Family physicians and other stakeholders agree that the administrative burden of reporting to a PDMP is a valid concern, and in 2016, 46 Governors signed a Compact to Fight Opioid Addiction which included a commitment to build on their efforts to fight opioid addiction by integrating use of PDMPs into electronic health records. This is also a recommendation of the CDC which provided a list of issues states need to address with PDMPs and encouraged states to make PDMPs easier to use. Model practices, CDC noted, include the integration of PDMPs into electronic health record systems, permitting prescriber and dispenser delegates, and streamlining the process for prescribers to register with the PDMP. The Centers for Medicare and Medicaid Services (CMS) voiced support for integrating PDMPs with electronic health records, particularly by way of a June 2018 letter from Acting CMS Director for Medicaid Tim Hill to state Medicaid directors encouraging states to reduce provider burden and allow health care organizations to easily track patient information related to opioid use. The letter provided guidance to states about which funding authorities can support this initiative.

Tools for Providers
In June 2018, CMS released an opioid roadmap that provides strategies to reduce opioid overuse among Medicaid and Medicare beneficiaries through a three-pronged approach: prevention, treatment, and data utilization to ensure these efforts target the correct populations. Providers can use both the Medicaid and Medicare prescribing maps to build community awareness among providers and local public health officials. These maps also allow CMS to easily identify which areas are most in need of coordinated PDMPs or more safe prescribing strategies.

Updated: **November 2019**

[2] National Alliance for Model State Drug Laws. (2019). "Frequency of Prescription Drug Monitoring Program (PMP) Data Reporting – Map." Web.
[3] National Association of Boards of Pharmacy. (2019). "Connecting State Prescription Monitoring Programs Nationwide." Web.