



PRESCRIPTION DRUG MONITORING PROGRAMS

RECOMMENDATION:

The American Academy of Family Physicians (AAFP) supports 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 to develop prescription drug monitoring programs and 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 at the crux of the issue, balancing care of people who have chronic pain with the challenges of managing opioid misuse and abuse. Pain is one of the oldest challenges for medicine. 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 in the treatment of 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 topic 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. On a state by state basis and under other specific circumstances other authorized groups—such as law enforcement, professional licensing or regulatory boards, state Medicaid/Medicare programs, coroners, etc.—can also access PDMP information.

There are presently 49 states and the District of Columbia who have passed legislation creating a PDMP. Missouri continues to be the only state that has not passed legislation to establish a PDMP. As Missouri lawmakers continue to fail to establish a prescription drug-monitoring program, St. Louis and St. Louis County have adopted legislation to implement their own PDMP at the city and county level.

Lawmakers have begun to mandate use of the PDMP. Currently, 37 states require prescribers and/or dispensers to access a PDMP database in specific circumstances. These circumstances are on a state by state basis. For example, in Nevada, a practitioner, before initiating a prescription for a controlled substance listed in schedule II-IV, must obtain a patient utilization report regarding the patient 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.¹ In Massachusetts, a registered individual practitioner must utilize the Massachusetts Prescription Awareness Tool (MassPAT), each time the practitioner issues a

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prescription to a patient for any Schedules II and III narcotic drug. Additionally, prescribers must continue to check MassPAT the first time they prescribe to a patient 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.ⁱⁱ

States have varying laws regulating various aspects of their PDMPs. Different substances are monitored by different PDMPs, some states only monitor [Schedules II-IV](#) and others monitor Schedule 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 Connecticut, New York, Oklahoma, and Utah require real time reporting of controlled substances in their PDMPs. Weekly reporting is required in 11 states (AR, CA, FL, GA, HI, IA, MT, NJ, SD, TX, and WA) while family physicians in Alaska are only required to report PDMP data monthly at least until July, 2017. To help decrease the reporting burden, states have begun to pass legislation which allows doctors to designate delegates to use the system on their behalf, an option that 40 states have now enacted.

Interoperability

Providers often care for patients in border areas, making interoperability between PDMPs critical. Patients sometimes “doctor shop” across state lines, obtaining prescriptions from multiple healthcare practitioners without the prescribers’ knowledge. As of October 2016, 35 states (AK, AR, AZ, CO, CT, DE, IA, ID, IL, IN, KS, KY, LA, MA, MD, MI, MN, MS, ND, NJ, NM, NV, NY, OH, OK, RI, SC, SD, TN, TX, UT, VA, VT, WI, WV) 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, providing a more effective means of combating drug diversion and drug abuse nationwide. PMP InterConnect currently processes more than 3.5 million requests every month.ⁱⁱⁱ 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 can continue to that follow their own interoperability procedures.

PDMP Integration into Electronic Health Records

Massachusetts recently passed [legislation](#) revamping their prescription drug monitoring program. The legislation created a system that aims to enable providers easier access and better data sharing between states. A crucial component of this system is the ability to sync with a patient’s electronic medical record. Health Affairs noted that nationwide in 2014, only 53% of doctors reported using a prescription drug monitoring program.^{iv} Family physicians know that reporting to a PDMP can cut into time with the patient and creates an additional administrative burden on a provider. Other stakeholders agree that the administrative burden is a valid concern, and in 2016, 43 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. The CDC 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 providers to register with the PDMP.

ⁱ Nev. Rev. Stat. § 639.23507(2015)

ⁱⁱ MA Code Regs 105 - 700.006 and .012

ⁱⁱⁱNABP PMP InterConnect. Connecting State Prescription Monitoring Programs Nationwide. <https://nabp.pharmacy/wp-content/uploads/2016/10/NABP-InterConnect-Flyer-102016A.pdf>

^{iv}Rutkow, Lainie, etc. Most Primary Care Physicians Are Aware of Prescription Drug Monitoring Programs, But Many Find The Data Difficult To Access. *Health Affairs* 34, no.3 (2015):484-492. Doi: 10.1377/hlthaff.2014.1085.

<http://content.healthaffairs.org/content/34/3/484>