STATE PRESCRIPTION DRUG MONITORING PROGRAMS (PMPs):

A NATIONAL PERSPECTIVE
PRESENTATION
ON BEHALF OF THE
NATIONAL ASSOCIATION OF STATE
CONTROLLED SUBSTANCES
AUTHORITIES (NASCSA)

BY

SHERRY L. GREEN
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
More informed prescribing

More appropriate prescribing

Change in amounts and types of drugs prescribed
• Ohio PMP data - use by ER physicians (Baehren 2009)

✓ 61% of patients received fewer/no opioids
✓ 39% of patients received more pain relief than planned
• Massachusetts PMP data – assessment of drug-seeking behavior in ER (Wiener 2013)

✓ 6.5% of patients received prescription not previously planned

✓ 3.0% of patients did not receive prescription originally 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 substance 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
Reductions in Investigation times for Drug diversion

- Kentucky 90% reduction
- Nevada 83% reduction
- Utah 80% reduction

Kentucky law enforcement survey (2010)

- Over 2/3 strongly agreed PMP was excellent investigative tool
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 through 2008

• 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 practices”

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

• Trust for America’s Health

• National Conference of Insurance Legislators
Increase efficiency/effectiveness of PMPs as Healthcare delivery tools
Top 5 priorities

• Real time reporting

• Expand user access

• Integrate PMP data into electronic health systems

• Proactive/unsolicited alerts and reports

• Interstate data sharing
Expanding access

• ↑ types of professionals who can access and use PMP data

• ↑ # of prescribers and dispensers who do access and use PMP data
↑ Types of professionals

- Delegates
  - Prescriber/dispenser remain accountable
  - Audits of delegate activity
- Medicaid/Medicare officials
- Substance abuse/addiction treatment
↑  # of Prescribers/dispensers

• Focus on information being available

✓ Mandated use

✓ Mandated registration/enrollment
Mandated use

- 2014 review of Kentucky, Ohio, New York and Tennessee (Brandeis COE)
- ↑ enrollment and requests for PMP data
- ↑ use associated with ↓ in opioid prescribing
- ↑ use in New York, Ohio and Tennessee associated with ↓ in doctorshopping measures
Mandated registration

- Review of Utah PMP use before/after
- Prescribers active on PMP – 35% growth
- Searches/searches per login – 61% growth
# of Prescribers/dispensers

- Focus on information being available AND actionable
  
  
  ✔ Automated registration

  ✔ Integrate PMP data into electronic health systems

  ✔ Institutional/facility accounts
Automated registration

- Application for or renewal of license
- Massachusetts, Virginia and Maine
Integrate PMP data into electronic health records

• 2012 pilots – Indiana, Michigan, North Dakota, Ohio, Washington state

✓ More prescribers/dispensers used PMP

✓ Streamlined workflow – no separate PMP access

✓ More automated tasks – more satisfaction
2014 integration pilots – 17 teams

- Translation of EHR information into PMP query and PMP response into EHR information
- April/May 2015? – revised technical Implementation Guide

SAMHSA integration grantees – 16 states
• Basic steps:

✓ Single sign-on or one click access

➢ Maine HealthInfoNet

✓ PMP hyperlink in EMR/EHR

➢ Washington state OTP pilot
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

• Notice of unusual or “suspicious” activity

• Common triggers
  ✓ Reason to believe violation of law/standards
  ✓ Specific # of prescribers/pharmacies within specific period of time

• Criteria for triggers vary
✓ Peer review committees
✓ Capacity to send reports and alerts
✓ Indicators of abuse/diversion

• Preferred delivery method
  ✓ Indiana – direct, secured email pilot
  ✓ Kansas – automated delivery to patient screen for ED admissions pilot
• Peer led alerts

✓ Indiana – practitioners email alerts to other prescribers/dispensers

✓ New Mexico – practitioners create alerts that trigger when accessing patient prescription history
Common funding options

• Grants
  ✓ Federal – Harold Rogers PMP grants
  ✓ Private – NASCSA

• Appropriations/general revenue

• Fees
✓ Controlled substance registration
✓ Professional licensing
✓ PMP specific – Oregon
Uncommon funding options

• Nonprofit support organization – Florida

• State legal settlements – Maine, Virginia

✓ Medicaid fraud

✓ Tobacco, drug manufacturers
SHERR Y L. GREEN
CEO and Manager
Sherry L. Green & Associates, LLC
P.O. Box 2530
Santa Fe, NM 87504

sgreen586@gmail.com
505-692-0457 (cell)
NATIONAL ASSOCIATION OF STATE CONTROLLED SUBSTANCES AUTHORITIES (NASCSA)

Kathy Keough
Executive Director
72 Brook Street
Quincy, MA 02170
617-472-0520 (Ph.)
617-472-0521 (Fax)
Kathykeough@nascsa.org