



## HEALTH POLICY: PART II

# IT IS PAST TIME FOR A NATIONAL PRESCRIPTION DRUG MONITORING PROGRAM

Dianne Goede, MD, and Scott Joy, MD

*Dr. Goede (Dianne.Roberts@medicine.ufl.edu) is an assistant professor of medicine at the University of Florida College of Medicine and a member of the first class of Leadership in Health Policy (LEAHP) scholars. Dr. Joy (Scott.Joy@healthonecares.com) is medical director of the HealthONE Colorado Care Partners ACO in Denver Colorado and is a LEAHP Program Mentor.*

October 26, 2017, President Trump declared the opioid crisis a public health emergency. According to the CDC, 91 Americans die every day from an opioid overdose and, since 1999, the number of overdose deaths involving opioids including prescription opioids and heroin has quadrupled. The administration's plan to combat the opioid epidemic builds on previous efforts, including education, availability of reversal agents, such as Narcan, and continued funding for substance abuse treatment programs. As internists, we must ask ourselves what else we can be doing. From 2000-10, approximately 20.7% of ambulatory visits were associated with a primary symptom or diagnosis of pain.<sup>1</sup> Together, family practice, internal medicine, and general practice accounted for nearly half (44.5%) of all dispensed opioid prescriptions in 2012.<sup>2</sup> How do we ensure safe opioid prescribing for our patients without impeding physician workflow?

Prescription drug monitoring programs (PDMPs) play a crucial role in combating the opioid epidemic and enhancing safe prescribing. PDMPs are electronic databases that record when a controlled substance is dispensed to a patient. This data helps physicians ensure there is no duplicity prior to prescribing a controlled substance for a patient. Several states, including Ohio, Kentucky, New York, and Tennessee, have passed state legislation mandating that clinicians review PDMP data prior to prescribing a controlled substance. Following implementation of this legislation, Ohio and Kentucky saw the morphine milligram equivalence per capita decrease in most of their counties from 2010-15. In New York, a 75% drop in patients seeing multiple prescribers for the same drugs was observed following mandated PDMP review legislation. In Tennessee, a 36% decline in patients seeing multiple prescribers for the same drugs was seen.<sup>3</sup> Evidence is beginning to suggest that

when provided controlled substance dispensing information, prescribers initiate safer prescribing behaviors thus enhancing patient safety. Yet, several challenges with PDMPs remain.

PDMPs are managed at the state level and various roadblocks to seamless usage for physicians exist, including variable integration into electronic medical records, non-standardized pharmacy reporting practices (ranging from real time or batched monthly), and lack of interoperability between states. Physicians practicing in towns near state borders need access to neighboring state PDMP data, but data is not always shared between state databases. For example, Ohio shares and receives PDMP data from 17 states, and West Virginia shares and receives data from 10 states. Florida, while it receives data from other states, does *not* yet share PDMP data. However, Florida HB 21, effective July 1, 2018, authorizes the Department of Health to share and exchange PDMP data with other states provided certain provisions are met. A congressional briefing September 8, 2017, reviewed successes of PDMP implementation and Electronic Health Record integration featuring reports from three different states. This report highlighted that each state has differing legislation mandating PDMP use, variable PDMP database EHR integration, and variability in interstate PDMP data sharing.<sup>4</sup>

The successes reported from usage of PDMPs are promising and highlight a need to move in a national direction to ensure all states are adhering to the same high standard to protect patients from harm. In addition to increasing available data, a national PDMP database, or national standards for the use and interoperability of PDMP databases, would likely increase physician usage of PDMPs by streamlining the process for PDMP access. Currently, states differ in their requirements that

*continued on page 2*

**HEALTH POLICY: PART II** (continued from page 1)

prescribers utilize PDMP databases. States also differ in what clinical team members are granted access to PDMP databases. Increased access to these databases by standardizing PDMP access to medical assistants, physician assistants, nurse practitioners will also increase utilization of PDMPs and encourage incorporation into clinical workflow. A national PDMP database could also leverage EHR vendors to provide seamless integration into their products.

It is evident that PDMPs are proven and effective tools in combating the opioid epidemic. The time is now for general internists to work with professional organizations to advocate for a national

PDMP database that would provide a valuable tool for clinicians at the point of care to enhance patient safety and encourage prudent prescribing.

**References**

1. Daubresse M, Chang HY, Yu Y, et al. Ambulatory diagnosis and treatment of nonmalignant pain in the United States, 2000-2010. *Med Care*. 2013 Oct;51(10):870-8.
2. Levy B, Paulozzi L, Mack K. Trends in opioid analgesic-prescribing rates by specialty, U.S., 2007-2012. *Am J Prev Med*. 2015;49(3):409-4013.
3. PDMP Center of Excellence at Brandeis University. Mandating

PDMP participation by medical providers: Current status and experience in selected states. <https://olis.leg.state.or.us/liz/2015R1DownloadsCommitteeMeetingDocument/51774>. Published February 2014. Accessed May 25, 2018.

4. NAMSDL. Congressional briefing: Prescription Drug Monitoring Programs (PDMPs): Critical decision support tools to respond to the opioid crisis—September 8, 2017. <http://www.namsdl.org/library/Congressional%20Briefing%20-%20Final%20Agenda%20and%20Presentation/>. Published September 8, 2017. Accessed May 30, 2018.

**SGIM**