National Drug Monitoring Program

Michael A. Moné, BSPharm, JD, FAPhA
VP Associate General Counsel – Regulatory
Cardinal Health
Chair, 2014-2015 APhA Policy Committee
Development

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- **Target Audience:** Pharmacists
- **ACPE Activity Type:** Knowledge-based
- **Learning Level:** 1
- **Fee:** There is no fee for this activity
Disclosures

• Michael A. Moné, BSPharm, JD, FAPhA declares no conflicts of interest.

• All APhA staff declare no conflicts of interest in any products or service mentioned, including grants, employment, gifts, stock holdings, and honoraria.
Learning Objectives

Upon completion of these knowledge-based activities, the pharmacist will be able to:

1. Discuss issues regarding the reporting and utilization of data within drug monitoring programs at the state and national levels.

2. Describe the need for interoperable drug monitoring systems and potentially a national drug monitoring program, and the potential benefits to patient and public health.

3. Identify the challenges in sharing data among providers and jurisdictions, including potential challenges in implementing a national drug monitoring program.
Assessment Question 1

Which of the following states is the only state that has not enacted prescription drug monitoring program legislation?

- a. Mississippi
- b. Oklahoma
- c. Missouri
- d. North Dakota
Assessment Question 2

Between 1990 and 2010, prescription opioid sales in the United States _____.
   a. Doubled
   b. Tripled
   c. Quadrupled
   d. Remained the same
Assessment Question 3

Prescription drug monitoring programs were initially created to ______.

a. Enable law enforcement to identify physicians who were over-prescribing narcotic pain medications
b. Act as a record keeping system for all controlled substances dispensed from pharmacies
c. Curtail the misuse and diversion of prescribed controlled substance medications
d. Increase the burden on prescribers and pharmacists to incentivize them to minimize the distribution of controlled substance prescriptions
Definitions

• **Prescription Drug Monitoring Program (PDMP):**
  • PDMP is a *statewide* electronic database which collects designated data on substances dispensed in the state.
  • Housed by a specified statewide regulatory, administrative or law enforcement agency
  • Agency distributes data from the database to individuals who are authorized under state law to receive the information for purposes of their profession.
Definitions

• *Controlled Substance:*  
  • A drug or chemical whose manufacture, possession or use is regulated by a government and whose general availability is restricted.  
  • They may include prescription medications and drugs or other substances, which are strictly regulated or outlawed, because of their potential for abuse or addiction.
Background Information

• Between 1999 and 2010, prescription opioid sales quadrupled.
  • As a result, there was also a rise in:
    • Opioid related deaths
    • Emergency department visits for opioid-related problems
    • Admissions to abuse treatment centers

• In response to the rise in opioid prescription abuse, misuse, and diversion, prescription monitoring programs (PDMPs) were developed.

• In 2011, through the increased focus on prescription monitoring by the White House Office of National Drug Control Policy, states received additional federal funding to create prescription drug monitoring programs (PDMPs).
Background Information

• Currently, participating states oversee their own drug monitoring programs.

• As of June 2014, 49 States and the District of Columbia have enacted PDMP legislation.

• Although use of the PDMP in most states is expected, no defined regulations have been created to ensure the appropriate, consistent, efficient and optimal use and access of PDMP data.

• The use of a national prescription monitoring program could assist with PDMP data sharing and interstate connectivity.

• No organizations or groups have published works outlining standards or recommendations for a national PDMP.
The **Purpose** of PDMPs

- PDMPs enable health care providers to review a patient’s medication history and utilize information to assist them with decisions concerning their patient’s medication regimen.

- For example:
  - PDMPs allow physicians to identify patients who may benefit from substance abuse counseling, prevent prescribing that may result in overdose, help coordinate patient care, and perhaps identify patients and practitioners who abuse or divert prescription drugs.
The **Benefits** of PDMPs

1. Support access to legitimate medical use of controlled substances.
2. Either prevent or identify and deter drug abuse and diversion.
3. Facilitate and encourage the identification of persons potentially involved in medication abuse, misuse, or diversion.
4. Inform public health initiatives through outlining of medication use and abuse trends.
5. Educate individuals about PDMPs and the use, abuse, diversion of, and addiction to prescription drugs.
The **Barriers** of Current PDMPs

- Many barriers currently prevent efficient and optimal use of PDMPs such as:
  - Ineffective communication
  - Inconsistency between individual state monitoring programs
  - Funding
  - Lack of incorporation into the patient care process.
National Drug Monitoring Program

- A National Drug Monitoring Program concept has been mentioned and supported by some health care providers, the Bureau of Justice Assistance, and the National Institutes of Health as a means to
  - Enhance the fight against prescription drug abuse, misuse, and diversion
  - Identify patients for abuse treatment programs
  - Provide a database for states not currently using a PDMP
  - Provide uniform expectations for prescribers, dispensers, and consumers

- Lack of support by the federal government and the Centers for Disease Control and Prevention (CDC).

- Creation of a National Drug Monitoring Program could require states to agree on national standards to regulate the PDMP.
National Drug Monitoring Program

• The abuse, misuse, and diversion of controlled substances is a nationwide problem that requires a nationwide solution
  • Patients move across jurisdictions
  • A national system may help curtail this problem

• Many inconsistencies in state-based monitoring programs exist
  • Frequency of data reporting
  • Individuals who have access to data
  • Utilization of data collected

• Use of these systems should not interfere with the delivery of legitimate patient care

• Data should be utilized in a meaningful way to deliver patient care, educate providers and communities, and prevent misuse
The **Challenges** Of Implementing a National PDMP

- **Who** will fund the creation and maintenance of the program?
- **Who** will have access to the information?
- **What** information will be collected?
- **Where** will the information be housed?
- **When** will information be reported?
- **How** will NPDMP be incorporated into existing workflow and software?
Funding

• Currently, states’ PDMPs are funded individually by general state revenues, licensing board fees, state controlled substance registration fees, health insurers’ fees, and state and federal grants.

• The annual cost of a state PDMP is $125,000 to $1 million.

• A national PDMP could require even greater funding.
  • A potential revenue source could be the National All Schedules Prescription Electronic Reporting, which could require Congress to restore funding.
  • It may also be beneficial to consider funding from pharmaceutical companies that have a significant stake in appropriate use of controlled substances.
Accessibility of Information

• The majority of states allow access by the following entities:
  • Licensing and regulatory boards
  • Practitioners
  • Authorized agents
  • Law enforcement officials (pursuant to an active investigation)
  • Judicial and prosecutorial officials
  • Medicare, Medicaid and State Health Insurance Programs
  • Patients
  • Parents (either with or without a consent form)
  • Prescribers and Dispensers

• It may be most beneficial to utilize a web-based PDMP in order to provide immediate access of data to the allowed entities.
Information Collected

• Currently variability among states exists with regard to controlled substance scheduling and what controlled substance data is being captured by state PDMPs.

• Standardization of the medications being monitored could prevent the abuse of some controlled substances from going unidentified.

• All states could be required to ensure accuracy of data and information placed into the system.

• Data recorded in the system should be linked to the health care provider, their credentials necessary and contact information for validity and accuracy of information, but also to ease communication among providers.
Storage of Information

- The majority of states PDMP information is housed in
  - Health departments
  - Single state authorities
  - The state board of pharmacy
- Alternatively, the PDMPs of 5 states are regulated and housed by law enforcement agencies.
- For example:
  - Georgia’s PDMP is regulated by the Narcotic and Drug Agency under the direction and oversight of the Board of Pharmacy.
- A national PDMP could need one universal storage site and overseeing agency responsible for the information.
Length of Reporting Time

• Time Delays
  • The majority of states require submission of data within 1 week.
  • A few states process the information within 1-3 days.
  • Only one state (Oklahoma) processed the information in real time.

• Daily or real-time reporting may be burdensome and monthly reporting may be suboptimal, it may be most appropriate for pharmacies to report information to the PDMP every week.

• Determining a standard reporting time could need to be agreed upon nationally and could most likely require further evaluation.
Incorporation Into Workflow

• Allowing for better incorporation of PDMP into workflow is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA).
  • Recommend allowing physicians to access the information via medical records and allowing for unsolicited alerts inside the medical record to highlight potential abuse or misuse situations.

• Implementing education and training requirements in order to ensure program awareness as well as an understanding of the protocols and procedures regulating the program may be necessary.
National Drug Monitoring Program

Why is a national drug monitoring program necessary for the profession of pharmacy?

• Consistency and connectivity may help to curtail controlled substance abuse, misuse, and diversion.

• Patients with inadequate pain control have difficulty finding appropriate treatment.

• Pharmacists are helpless in addressing abuse, misuse, and diversion if systems are not connected.

• Prescription drug abuse continues to be a major concern for the profession to address.
Related APhA Policy

1989 *Multiple Copy, Prescription Order Programs*

1. APhA opposes federally mandated, multiple copy, prescription order programs.
2. APhA supports the right of individual states to develop programs to prevent drug abuse and drug diversion.
JCPP statement and principles on pharmacists’ role in addressing prescription medication misuse and abuse
Approved August 2014

Prescription Drug Monitoring Programs:
• Prescription drug monitoring programs are useful clinical tools to identify, prevent and manage prescription medication abuse and misuse.
• JCPP supports pharmacist access to and use of prescription monitoring programs and dispensing systems
  • that provide timely, bi-directional and, seamless data collection tools to help identify potential abuse and misuse of prescription medications, and
• support access to current relevant medical information that will allow them to make appropriate decisions regarding medication therapy.

*JCPP was established in 1977 and serves as a forum on matters of common interest and concern to national organizations of pharmacy practitioners and invited liaison members. JCPP Members are: AMCP, AACP, ACA, ACCP, ACPE, APhA, ASCP, ASHP, NABP, NCPA, and NASPA
National Association of Boards of Pharmacy (NABP)

• NABP InterConnect was designed to facilitate interoperability and interstate data sharing between PMPs.

• Launched nationwide July 27, 2011

• States agreeing to participate must complete a single memorandum of understanding (MOU).
  • The MOU allows for the transfer of data between state programs and places responsibility on NABP to ensure compliance with state rules.

• As of February 2014, 26 states have joined the program.

Arizona    Indiana    Nevada
Arkansas    Kansas    New Jersey
Colorado    Kentucky    New Mexico
Connecticut  Louisiana    North Dakota
Delaware    Michigan    Ohio
Idaho        Minnesota    South Carolina
Illinois     Mississippi    South Dakota

Tennessee
Utah
Virginia
West Virginia
Wisconsin
Conclusion

• Because prescription abuse, misuse, and diversion is a nationwide issue, it is vital that states work together to share PDMP data and provide a national solution to prescription abuse issues.

• It is important to define standards for drugs monitored, identify persons who will have access, determine funding options to ensure a national prescription drug monitoring program is successful.

• Pharmacists are well-positioned to provide valuable information for PDMPs and also to identify and recommend patients to abuse treatment centers.

• As standardized methods for incorporating prescription monitoring data becomes available, it is important for pharmacists to continue to have an active role in prescription use monitoring.
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QUESTIONS?
What’s your perspective?

• What components of your state’s current drug monitoring program do you have consider to be efficient and effective?

• Who should have access to PDMPs?

• What are some strategies to address the inconsistencies across states?

• What challenges do you currently face or experience with existing drug monitoring programs?
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