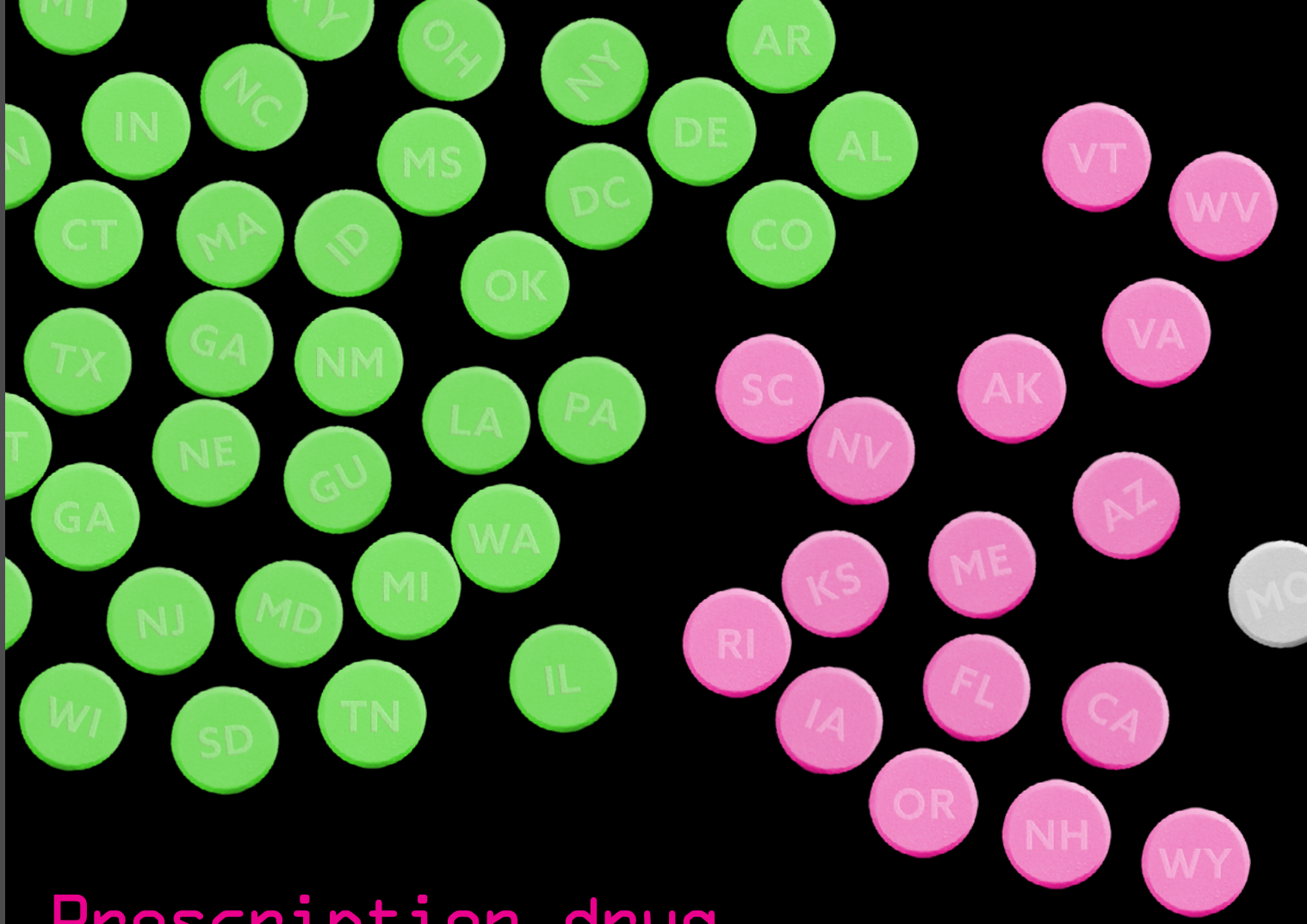

Prescription_drug (monitoring programs) + (the opioid epidemic)

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Prescription drug monitoring programs (PDMPs) are electronic data systems used by healthcare professionals at the state level to report prescribing and dispensing data of controlled substances for individual patients. PDMPs are used to deter abuse and misuse. Physicians and pharmacists can utilize this tool before prescribing or dispensing a medication to a patient. With the growing opioid epidemic and increasing number of deaths related to opioid overdose, PDMPs offer an intriguing solution to the overprescribing of opioids. When utilized correctly, PDMPs have shown to be effective in combatting the opioid epidemic.

For example, in Kentucky, Tennessee and New York, prescribers are legally required to check PDMP data when initially prescribing opioids. This has resulted in a decrease in the number of opioid prescriptions in each state of 8.5%, 7% and 9.5%, respectively, with a decrease only one year after the legislative mandate.[1] Data supports that PDMPs can be effective in combatting the opioid epidemic when used correctly. However, the current process is not easily accessible and has numerous potential flaws. Due to the severity and complexity of the opioid crisis, PDMPs cannot be relied upon solely to address this ongoing epidemic.

</CURRENT STATE OF PDMPS>

Currently, every state except Missouri has an established PDMP; 16 states submit prescription data on Schedule II IV drugs, and 35 states and territories submit data regarding Schedule II V drugs. At this time, 40 states and the District of Columbia are mandated to report their prescription data within one business day, and the latest mandated reporting time is eight days in Montana. Significant progress is being made to link the states and allow interstate sharing of prescription data. As of Aug. 4, 2017, 42 states are linked through a program called PMP (prescription monitoring program) Interconnect.[3] PMP Interconnect links the states' prescription data together and the program is being fully integrated into the existing PDMPs of the states. Theoretically, this program should provide full access to prescription data in every state easily and with no added steps needed. However, data between many interconnected states is not easily accessible. Each state has its own set of user restrictions and types of providers who can gain access. There is also a lack of federal funding for these types of programs that makes it harder for states to operate within a limited allocated budget.

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While PDMPs are beneficial, the funding required to support them limits the potential benefits they may offer. Funding of a state's PDMP varies across the nation. Some states elect to receive funds granted to them solely through federal programs, while other states may also gather a portion of licensing fees from medical practitioners and dispensers to help fund their state's PDMP. There are numerous federal programs that grant funds to aid in the maintenance of state-run PDMP databases. The Centers for Disease Control and Prevention (CDC) has committed $20 million in an effort to aid 16 selected states over the course of four years.[2] The CDC will grant anywhere between $750,000 and $1 million each year,

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which will be used to enhance the PDMPs in the selected states. The Harold Rogers Prescription Drug Monitoring Program (HRPDMP) and the Substance Abuse and Mental Health Services Administration (SAMHSA) are among other federal programs that grant money to states to help enhance PDMPs. SAMHSA is a part of the Department of Health and Human Services, which is reported to have obtained close to $4 billion in the budget for the 2018 fiscal year. Of the reported $4 billion, $500 million is invested to combat the nation's opioid crisis.

Michigan utilizes a PDMP known as MAPS that was recently updated in April 2017 to integrate with the PMP Interconnect system. This allows Michigan providers to access prescription data for patients receiving a controlled prescription from one of the other 41 linked states. Limitations to this integration have been found because Texas and Tennessee, like some other states, are not fully integrated. Both of these states should be easily accessible since they are interconnected with Michigan via PMP Interconnect. When reached for comment, Michigan representatives of MAPS made it clear that all the states should be interconnected; however, each state still has the capability to restrict user access. This leaves out managed care organizations and law enforcement agencies, which still do not have total transparency into this data. This is a major flaw in regard to the overall connectedness of the system and illustrates the lack of access for all parties involved.

</HEALTHCARE PROFESSIONALS>

In clinics, hospitals and pharmacies throughout the country, healthcare professionals are not fully utilizing the data available to them through PDMP databases. In many of these situations, clinicians might not have the time or resources to inquire about the opioids or other controlled substance use. This could result in the continued prescribing and dispensing of opioids. PMP Interconnect is promising, but the lack of accessibility proves to be an issue. In a busy clinic setting, physicians are already limited for time to interact with the patients, and accessing PDMP data can take up to several minutes. For example, in a 15-minute appointment time with a patient, a physician might not be able to sacrifice limited time pulling up PDMP data. The current process is time consuming, and interrupts the physician's workflow. One way to address this issue is to allow prescribing physicians to assign delegates who can access the PDMP data. This would allow the delegates to access a patient's

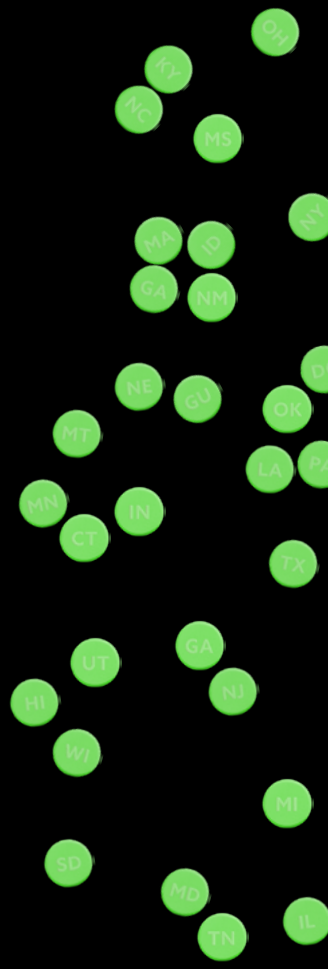
fill history and have it readily available for the physician at the beginning of the office visit. This process would integrate easily into the workflow, help decrease overprescribing of opioids, and allow physicians to provide opioid counselling. Currently, many states do allow delegates, but the process is not streamlined. There is not a clear rule on who can be deemed a delegate, and it varies between states. Clear and consistent labeling of authorized personnel would be beneficial.

As previously mentioned, among the very few states that require mandatory referencing of PDMPs, the process is not streamlined. Many states do not mandate that physicians address PDMPs before prescribing an opioid. Even though laws might not mandate that PDMPs be referenced, and there might be no legal penalties, healthcare professionals should still utilize PDMPs whenever prescribing dangerous and life threatening medications. In fact, chain pharmacies, such as CVS, have made accessing PDMPs a mandatory part of their best practice guidelines for dispensing pharmacists. [4] While workflow integration, legal penalties and other incentives are commendable ways to ensure utilization of PDMPs, saving a person's life should be the biggest incentive. With the current opioid epidemic, the risk of prescribing or dispensing unnecessary opioid prescriptions could extenuate the problem.

</THIRD PARTY ADMINISTRATORS>

Clinicians working on behalf of third party administrators (TPAs) regarding workers' compensation cases are on the front lines in combatting the opioid epidemic. Due to the nature of the injuries presented in these cases, opioids are among the most prominent medications seen in workers' compensation cases. Workers' compensation clinicians and case managers handle cases across the nation, thus making the national PDMP system crucial. Healthcare professionals in workers' compensation work directly to lower excessive prescribing of opioids and follow state specific guidelines to facilitate care. Studies have shown that workers' compensation agencies are leaders in reducing over-prescription of opioids.[5] It is critical that we understand the importance of transparency across state lines in PDMP access for all involved parties including payers. Increasing PDMP access and providing training to these professionals will assist stakeholders in combatting the opioid epidemic.

Clinicians working in a TPA setting do not have the same privileges to prescription drug monitoring programs as prescribing physicians or dispensing pharmacists. Only five states (Michigan, North Dakota, Ohio, Utah and Washington) allow accessibility to workers' compensation clinicians. Even with these five states providing access, there still is a lack of consistency among these states regarding access criteria. Utah provides accessibility to PDMP data to managed care clinicians such as physicians, pharmacists, pharmacy interns and pharmacy technicians, as well as to law enforcement agencies. Despite increased access, the healthcare professionals would need to be licensed in the state of Utah in order to have access. Therefore, a third-party clinician licensed in any other state would not be able to view controlled-substance fill history for a Utah claimant through PDMP. Ohio allows an out of state clinician to be granted access if they request it through an application process that is not clearly outlined on their website. This process is not consistent among states, and in general, the limited accessibility to the database for payers is another flaw of the current PDMP system. While there are a few states that are trying to allow for greater accessibility, a lack of total transparency remains for payers, creating yet another hurdle in combatting the opioid epidemic.



</LOOKING AHEAD>

In an effort to create a more comprehensive and less cumbersome system for healthcare providers, some electronic medical record (EMR) systems have merged with state PDMPs. Michigan has announced that it is attempting to integrate their PDMP with EMRs. On June 19, 2017, Lt. Gov. Brian Calley announced that MAPS will be integrated with Henry Ford Hospital's delegated electronic medical record system (EPIC).[6] This new change, along with PMP Interconnect, will help combat opioid abuse in Michigan. The integration hopes to increase physician use as it provides a streamlined program. Prescribers will need to access only one system and use one login, which will help save time and give the prescriber an opportunity to discuss opioids concerns with the patient. Once a physician logs into their EMR, the PDMP will be integrated with the help of Appriss's NarxCare. Not only does NarxCare automatically link with PDMP, allowing prescribers' access, but it also provides a risk assessment of the patient. NarxCare evaluates the patient's health history along with their medications to generate patient reports. These patient reports include visualizations showing usage patterns and risk scores of

controlled substances, such as opioids.[7] NarxCare reports are thought to be a useful tool in preventing overprescribing of opioids.

Although Michigan's integration of Henry Ford Health System's EMR will be beneficial, it alone is not enough in combatting the opioid epidemic. Henry Ford's EMR is one of many EMRs that health systems in Michigan can utilize. The same issue of varying EMRs arises in other states as well. The integration of EMRs with PDMPs will be very valuable in gauging substance abuse once every EMR is integrated. It appears that cost is the main barrier preventing complete integration of systems. With the integration of EPIC and MAPS costing millions, the cost to integrate EMRs nationwide could be prohibitive. Cost and time are the two biggest challenges state and federal governments might not be willing to take. The benefits of such an undertaking substantially point to the necessity of funding a system to combat the growing opioid epidemic.

</C0NCLUSI0N>

The opioid epidemic is a major public health issue that is sweeping the United States. PDMPs can serve as a useful state level intervention in monitoring the prescribing and dispensing of abused drugs. PDMPs have proven to be a helpful resource in attacking the opioid epidemic, yet these tools are not without flaws and lack full participation. Funding for each state's PDMP will benefit dramatically if more money is allocated to support the opioid crisis, which will contribute to expansion and maintenance of PDMPs. Furthermore, if more states were to obtain a portion of the monies collected from licensing and other fees from the state's medical boards (board of medicine, pharmacy, dentistry, etc.), there will be more cash allotted to PDMP support. Additionally, the lack of accessibility granted to TPAs is alarming and warrants immediate attention. Giving access to payers is crucial, considering their role in addressing the opioid overutilization. Allowing healthcare professionals to designate delegates might assist in cutting time and make the use of PDMPs more attractive in the clinical setting. A comprehensive PDMP system that integrates EMRs will offer the best outcome for the prescriber and patient. Implementing all of these changes to current PDMP programs offers a comprehensive mechanism to combatting the opioid epidemic.

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