Addressing The 21st Century Opioid Epidemic: The Role of Prescription Drug Monitoring Programs

Jay C. Butler, MD, FAAP, FACP, FIDSA
Chief Medical Officer, and Director, Division of Public Health
Prescription Opioid Sales and OD Deaths, US, 1999-2013

Sources:

aAutomation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 2012 data not available.
Opioid Dose and OD Risk (n=51) Among 9940 Persons Receiving ≥3 Prescriptions for Non-Cancer Chronic Pain, Group Health

Morphine Milligram Equivalent Dose (MED, Daily)

Rate per 100,000 person-years

Risk of OD Death by Opioid Dose and Co-Administration of Benzodiazepines, VA, 2004-09

Counterfeit Norco®
(325mg acetaminophen/10mg hydrocodone)

Counterfeit Norco® containing 3.5mg fentanyl, 2.3 mg promethazine, 39mg acetaminophen, and trace cocaine

MMWR April 26, 2016

Drug Overdose Deaths, Alaska, 2010-2015

Source: Alaska Division of Public Health
People who abuse prescription painkillers get drugs from a variety of sources

- Obtained free from friend or relative: 55%
- Prescribed by one doctor: 17.3%
- Bought from friend or relative: 11.4%
- Took from friend or relative without asking: 4.8%
- Got from drug dealer or stranger: 4.4%
- Other source: 7.1%
Proportion of All Prescriptions That Are For Opioids and Total Number of Opioid Prescriptions, US, 2012

Opioid OD Death: Chain of Causation

Healthy person → Misuse and Self-Medication → Opioid Use Dependence/Addiction → Overdose → Death

Addictive Substance

Susceptibility, e.g.
- ACEs
- Stress/PTSD
Opportunities for Prevention

Healthy person

Misuse and Self-Medication

Safer pain management
Judicious prescribing

Addictive Substance

Reduce opioids in communities

Opioid Use

Dependence/Addiction

Reframe “addiction”
Screening and Dx
Treatment/MAT

Susceptibility, e.g.
• ACES
• Stress/PTSD

Healthy families
Resiliency

Overdose
Naloxone
Death
CDC Pain Management Guideline: Three Key Principles

1. Non-opioid therapy is preferred for chronic pain except in active cancer, palliation, or end-of-life care

2. For acute pain, use the lowest effective dose
   • <50 MME of immediate release formulation; avoid doses ≥90 MME
   • ≤3 days usually sufficient; > 7 days rarely needed
   • Discuss risks/benefits, storage/disposal

3. Monitor patients on long-term therapy closely
   • Review PDMP prior to starting opioids and periodically (every 3 months)
   • Avoid co-administration of opioids and benzos
   • Urine drug screen prior to starting and periodically (at least annually)

*MMWR* 2016; 65(suppl 1):1-49
Prescription Drug Monitoring Programs (PDMPs)

• Centralized database of prescriptions for controlled substances

• Purpose
  – Safer prescribing and dispensing
  – Early intervention and prevention
  – Evidence-based education
  – De-identified data analysis (e.g., geospatial analysis, total dosage)
  – Prevent drug diversion

• In 49 states

• Great variability in administration and access
  – Most administered by state health agency
Opioid abuse is a public health crisis. Is your state’s prescription drug monitoring program up to par?

The American Medical Association Task Force to Reduce Opioid Abuse strongly urges all physicians who are considering whether to prescribe an opioid analgesic to check their state prescription drug monitoring program (PDMP) to help ensure they are making fully informed prescribing decisions.

But not all PDMPs are created equal. That is why the task force urges each state to review whether its state PDMP does the following:

- Provides **real-time information** about a patient’s prescription history
- Has patient **prescription history from other states**
- Allows the physician to **review his/her own prescribing history**
- Identifies potential red flags and other information when the physician may want to refer the patient for **additional treatment** and counseling
- Has the **full funding required** to ensure the PDMP is up to date – and this includes **full funding of the federal National All Schedules Prescription Electronic Reporting Act program**
- Enables all prescribers to **easily and seamlessly register** to use the PDMP
- Allows the physician to create **alerts** when a patient reaches certain thresholds for prescriptions, dosage or quantity
- Emphasizes recognized **best practices** – as determined by physicians in the same or similar practice – to help guide prescribing decisions
- Allows an assigned **delegate**, such as a nurse, physician assistant or other trained staff, to access the database on the physician’s behalf
- Provides **prompts** for co-prescribing naloxone when clinically indicated
- Protects **patient confidentiality** and requires court approval for accessing data
- Supports a **public health focus** that enables researchers to use de-identified information to help identify hot spots for public health education
- Is housed in a **public health agency** that works with physicians to support appropriate prescribing as well as overdose prevention and treatment

**“**

Physicians need to be sure that they are prescribing appropriately and taking necessary precautions, including consulting PDMPs when clinically indicated.”

Patrice A. Harris, MD, MA, Chair, AMA Task Force to Reduce Opioid Abuse, Committee on Energy & Commerce Subcommittee on Oversight and Investigations, United States House of Representatives, April 23, 2015

Continued on next page.
Since passage of KY HB 1 (2012), requiring use of the PDMP before prescribing:

• 13% decline in prescriptions for opioids
• 25% decline in OD deaths
Alaska’s PDMP

• Established in 2008
• Purpose (defined in AS 17.30.200), to identify:
  – Prescribing and dispensing practices for Schedule II-V medications
  – Practitioners prescribing in an unprofessional or unlawful manner
  – Persons receiving controlled substance in quantities or frequency inconsistent with recognized standards
  – Persons presenting forged, false, or altered prescriptions
• Housed in and managed by Dept of Commerce and Economic Development, Board of Pharmacy
• Online registration, produces printable form that requires notarization
PDMP Best Practices

• Increase utilization:
  – >22 states mandate registration and/or have various requirements for utilization
• Delegate access: permitted in 36 states
• Timely reporting: 22 states require daily reporting; only 1 has monthly reporting
• Integrate PDMP with EHRs and HIE
• Proactive epidemiologic analysis of de-identified data
• Establish criteria for questionable activity
• Issue unsolicited reports in response to situations meeting these criteria
• Institute rigorous confidentiality protections

http://www.astho.org/Rx/Brandeis-PDMP-Report/
https://secure.shatterproof.org/page/-/Shatterproof_WP_FINAL.pdf
Alaska PDMP: Opportunities for Improvement

• In 2015, only 13.5% of prescribers and 40% of dispensers are registered
  – Many providers unaware
• Delegation not permitted
• SOA not allowed to notify prescribers or dispensers of high-risk situations
  – ~100 individuals with 5 prescribers/5 pharmacies in 3 months in 2015
• Updates required only monthly
• Access not permitted: Medicaid Pharmacy Program Director, Medicaid DUR Committee, DPH (SME or Epi)