EXECUTIVE SUMMARY -
Prescription Drug Abuse, Addiction and Diversion: Overview of State Legislative and Policy Initiatives
A Three Part Series
Part 1:
State Prescription Drug Monitoring Programs (PMPS)

Part 1 of this series addresses the recommended practices for state prescription monitoring programs based on a review of the recommendations of the following organizations: the Prescription Drug Monitoring Program Center of Excellence at Brandeis University; the School of Medicine and Public Health at the University of Wisconsin-Madison; the MITRE Corporation; NAMSDL's Model PMP Act; the Alliance of States with Prescription Monitoring Programs Model PMP Act; and the American Cancer Society.

Upon reviewing the recommended practices from each of the above organizations, NAMSDL compiled a list of the most frequently recommended practices and focused on those practices for this Part 1. Those practices are as follows: monitoring of all scheduled controlled substances and certain non-controlled substances, providing de-identified data for research purposes, expanding the categories of authorized users, requiring authorized users to undergo some type of training regarding the PMP, interstate sharing of PMP data, maintaining data confidentiality, mandatory use of the PMP for certain authorized users, mandatory enrollment in the PMP, proactive or unsolicited PMP reports when patients surpass a certain threshold, evaluation of the PMP, and moving toward real-time data collection.

Thirty-one (31) states monitor Schedule II-V controlled substances with Arizona, California, Florida, Iowa, Kansas, Maine, Nevada, New Hampshire, Oregon, South Carolina, South Dakota, Vermont, Virginia, and Wyoming tracking Schedule II-IV controlled substances; Pennsylvania tracking Schedule II's only; and Rhode Island tracking Schedule II and III controlled substances.

Fifteen (15) states – Connecticut, Delaware, Hawaii, Idaho, Illinois, Kansas, Louisiana, Massachusetts, Mississippi, New Jersey, North Dakota, Ohio, Washington, Wisconsin, and Wyoming – monitor certain non-scheduled substances.

Thirty-eight (37) states provide de-identified data to certain requestors. Those states that don't currently provide de-identified data are Alabama, Alaska, Florida, Hawaii, Iowa, Michigan, Minnesota, New Hampshire, New York, Pennsylvania, and Tennessee.

Forty-seven (47) states provide data to prescribers and dispensers, with Pennsylvania being the lone state that does not. Forty-eight (48) states also provide data to law enforcement officials. Nebraska is the only state that does not. Forty-six (46) states provide data to licensing entities, while Hawaii, Nebraska, and Pennsylvania do not.

Thirty-seven (37) states provide data to patients, parents or guardians of minor children, health care agents, attorneys on behalf of patients, or third parties with a signed consent form. Those states that do not provide such data are Alabama, California, Connecticut, Hawaii, Indiana, Michigan, Nebraska, New Jersey, Oklahoma, Pennsylvania, Texas, and West Virginia.

Thirty-six (36) states provide data to judicial/prosecutorial officials. Alabama, Alaska, Connecticut, Maine, Maryland, Minnesota, Montana, Nebraska, New Hampshire, Oregon, Rhode Island, Vermont, and Wyoming do not.

Thirty-one (31) states provide PMP data to Medicare, Medicaid, state health insurance programs, and/or health care payment/benefit providers or insurers. Those states that do not are Alaska, Arkansas, California, Colorado, Connecticut, Georgia, Hawaii, Illinois, Iowa, Nebraska, New Hampshire, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Wisconsin, and Wyoming.

Twenty-eight (28) states allow the use of a delegate or authorized agent by a prescriber or dispenser to access PMP information on their behalf, typically using their own user name and password. Those states that do not currently allow the use of delegates are Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Michigan, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, Oklahoma, Pennsylvania, Rhode Island, South Carolina, and Wyoming.

Twenty-one (21) states – Arkansas, Delaware, Indiana, Kansas, Kentucky, Maine, Maryland, Minnesota, Mississippi, Montana, New Mexico, New York, North Carolina, North Dakota, Oregon, Tennessee, Virginia, Vermont, Washington, West Virginia, and Wisconsin – provide data to county coroners, medical examiners, or state toxicologists.

Ten (10) states provide data to mental health/substance abuse professionals, peer review committees, or the quality improvement committee of a hospital – Delaware, Indiana, Kansas, Maryland, North Dakota, Oklahoma, South Dakota, Tennessee, Utah, and Virginia. Six (6) states provide data to worker's compensation specialists – Arizona, Montana, North Dakota, Ohio, Utah, and Washington. Five (5) states also provide data to the Department of Health or Commissioner of Public Safety – New Mexico, New York, Oklahoma, Utah, and Vermont.

Five (5) states specifically allow access to physician's assistants or resident physicians – Alabama, Colorado, Hawaii, New Mexico, and Texas. Finally, three (3) states provide data to probation/parole officers and/or the Department of Corrections – Kentucky, Washington, and Wisconsin.

Fourteen (14) states require authorized users to undergo some type of training before being allowed to access PMP data – Arizona, Kentucky, Louisiana, Massachusetts, Montana, Nevada, New Jersey, New Mexico, Ohio, Pennsylvania, South Carolina, Utah, Vermont, and West Virginia.

Forty-four (44) states either share data with PMPs in other states, authorized users in other states, or both. The five states that do not authorize interstate sharing at this time are Florida, Georgia, Nebraska, Oklahoma, and Pennsylvania.

Sixteen (16) states require users to access PMP data in certain circumstances. Those states are Colorado, Delaware, Kentucky, Louisiana, Massachusetts, Minnesota, Nevada, New Mexico, New York, North Carolina, Ohio, Oklahoma, Rhode Island, Tennessee, Vermont, and West Virginia. Thirteen (13) states – Alabama, Arizona, Connecticut, Delaware, Kentucky, Maine,

Massachusetts, Mississippi, New Hampshire, New Mexico, Tennessee, Utah, and Vermont – require certain users to register with the PMP.

Forty-two (42) states send unsolicited reports or alerts to certain authorized users (typically prescribers, dispensers, law enforcement, and licensing boards) to alert them that a patient, prescriber, or dispenser may be in need of substance abuse treatment or counseling or may be committing a crime. Those states that do not currently send unsolicited reports/alerts are Colorado, Georgia, Iowa, Maryland, Minnesota, Nebraska, and Oregon.

Twenty-nine (29) states have an advisory council, working group, task force, or working group. They are Alabama, Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New York, North Dakota, Oregon, South Dakota, Tennessee, Texas, Vermont, Virginia, and West Virginia. Nineteen (19) states require the PMP to report to the legislature – Alaska, Delaware, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, New York, Ohio, Oregon, Tennessee, Utah, Vermont, and West Virginia.

At this time, only two (2) states have real time data collection – Oklahoma and New York. Six (6) states require submission of data within 24 hours or daily – Delaware, Kansas, Kentucky, Minnesota, North Dakota, and West Virginia. Two (2) states – Maryland and North Carolina – require submission of data within three days. Colorado, Michigan, and New Jersey require submission twice monthly, and Alaska, Pennsylvania, Rhode Island, and South Carolina require submission monthly. Finally, the remaining thirty-one (31) states require submission of data weekly.

Part 1 also includes detailed maps for each of the recommended practices as well as two charts. The first chart reflects which states follow a particular practice, while the second chart indicates the statute, regulation, or other authority for the practice.