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)

This project was supported by Grant No. G1399ONDCP03A, awarded by the Office of National Drug Control Policy. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the Office of National Drug Control Policy or the United States Government.

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Research Current through July 2014

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; the American Cancer Society; the National Conference of Insurance Legislators; the National Safety Council; and the Trust for America's Health.

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 and D.C. monitor Schedule II-V controlled substances with Arizona, California, Florida, Iowa, Kansas, Maine, Minnesota, Nevada, New Hampshire, Oregon, Rhode Island, South Carolina, South Dakota, Vermont, Virginia, and Wyoming tracking Schedule II-IV controlled substances and Pennsylvania tracking Schedule II's only.

Sixteen (16) states – Connecticut, Delaware, Hawaii, Idaho, Illinois, Kansas, Louisiana, Massachusetts, Mississippi, New Jersey, North Dakota, Ohio, Virginia, Washington, Wisconsin, and Wyoming – and D.C. monitor certain non-scheduled substances.

Thirty-eight (38) states and D.C. 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, and Pennsylvania.

Forty-seven (47) states and D.C. provide data to prescribers and dispensers, with Pennsylvania being the lone state that does not. (Nebraska isn't counted since their system is entirely voluntary.) Forty-eight (48) states and D.C. also provide data to law enforcement officials. Forty-six (46) states and D.C. provide data to licensing entities, while Hawaii and Pennsylvania do not.

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Thirty-seven (37) states and D.C. 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, New Jersey, Oklahoma, Pennsylvania, Texas, and West Virginia.

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

Thirty-one (31) states and D.C. 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, New Hampshire, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Wisconsin, and Wyoming.

Thirty-three (33) states and D.C. 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, Arkansas, Connecticut, Florida, Georgia, Hawaii, Illinois, Michigan, Mississippi, Nevada, New Hampshire, New Jersey, Oklahoma, Pennsylvania, and Wyoming.

Twenty-two (22) states – Arkansas, Colorado, Delaware, Indiana, Kansas, Kentucky, Maine, Maryland, Minnesota, Mississippi, Montana, New Mexico, New York, North Carolina, North Dakota, Oregon, Tennessee, Vermont, Virginia, Washington, West Virginia, and Wisconsin – and D.C. provide data to county coroners, medical examiners, or state toxicologists.

Twelve (12) states provide data to mental health/substance abuse professionals, peer review committees, or the quality improvement committee of a hospital – Colorado, Delaware, Indiana, Kansas, Maryland, Minnesota, 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.

Six (6) states specifically allow access to physician's assistants or resident physicians – Alabama, Colorado, Hawaii, New Mexico, North Dakota, and Texas. Finally, four (4) states provide data to probation/parole officers and/or the Department of Corrections – Kentucky, North Dakota, Washington, and Wisconsin.

Thirteen (13) states require authorized users to undergo some type of training before being allowed to access PMP data – Kentucky, Louisiana, Massachusetts, Montana, Nevada, New Jersey, New Mexico, Ohio, Pennsylvania, South Carolina, Utah, Vermont, and West Virginia. Forty-five (45) states and D.C. either share data with PMPs in other states, authorized users in other states, or both. The states that do not authorize interstate sharing at this time are Florida, Georgia, and Pennsylvania. Pennsylvania currently has a bill pending which would authorize interstate sharing.

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Twenty-two (22) states require users to access PMP data in certain circumstances. Those states are Arizona, Colorado, Delaware, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, Nevada, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, Tennessee, Vermont, Virginia, Washington, and West Virginia. Twenty (20) states – Alabama, Arizona, California, Colorado, Connecticut, Delaware, Idaho, Kentucky, Maine, Massachusetts, Mississippi, New Hampshire, New Mexico, Ohio, Rhode Island, Tennessee, Utah, Vermont, Virginia, and West Virginia – require certain users to register with the PMP.

Forty-five (45) states and D.C. 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 Georgia, Iowa, and Oregon.

Twenty-eight (28) states and D.C. have an advisory council, working group, task force, or working group. They are Alabama, Arizona, Arkansas, Connecticut, 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. Twenty (20) states require the PMP to report to the legislature – Alaska, Colorado, Delaware, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, New York, Ohio, Oregon, Tennessee, Texas, Vermont, and West Virginia.

At this time, only Oklahoma has real time data collection. New York law requires data to be submitted in real time, but that provision has been interpreted to mean within 24 hours of dispensing. Twelve (12) states and D.C. require submission of data within 24 hours or daily. In addition to New York, the other states are Arizona, Delaware, Kansas, Kentucky, Louisiana, Michigan, Minnesota, North Dakota, Ohio, South Carolina, and West Virginia. Two (2) states – Maryland and North Carolina – require submission of data within three days. Colorado and New Jersey require submission twice monthly, and Alaska and Pennsylvania require submission monthly. Finally, the remaining twenty-nine (29) states require submission of data weekly.

Indiana will begin requiring the submission of data within three days by July 1, 2015 and within 24 hours by January 1, 2016. Tennessee will begin requiring daily reporting on January 1, 2016, and Connecticut requires marijuana dispensaries to report marijuana dispensing to the PMP daily.

Part 1 also includes detailed maps for each of the recommended practices as well as a chart indicating the statute, regulation, or other authority for the practice.

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