PDMP TTAC

Prescription Drug Monitoring Program Training and Technical Assistance Center

Prescription Drug Monitoring Program

PDMP Policies and Capabilities: 2023 Assessment Results

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Prescription drug monitoring programs (PDMPs) ease the collection, analysis, and reporting of information on the prescribing, dispensing, and use of prescription drugs within a state, district, commonwealth, or territory (SDCT). The primary goal of PDMPs is to uphold both the SDCT laws ensuring access to pharmaceutical care by citizens and the SDCT laws deterring diversion. PDMPs are tools for enforcement and regulation, providing data to officials who oversee the prescription and dispensation of drugs by healthcare professionals. Although this role persists in all current PDMPs, the emphasis has now changed to improve patient care and help create drug abuse prevention and treatment plans.

With support from the Bureau of Justice Assistance, the PDMP Training and Technical Assistance Center (TTAC) at the Institute for Intergovernmental Research (IIR) has performed ten PDMP assessments since 2010. Through the assessments, TTAC collected data on PDMP statutes, regulations, policies, and procedure. TTAC assessments change as they incorporate additional PDMP data on regulations and procedures that identify trends (for a list of the 2023 assessment questions, see Appendix A). PDMP administrators responded to the 2023 assessment, with 47 of the 54 PDMPs completing the survey. TTAC compiled the results into individual, comprehensive PDMP reports and posted them on the TTAC website.

Recently instituted PDMPs adopt the proven practices and policies of established PDMPs, using the latest technology, and addressed the needs of a wider group of stakeholders. Comparing the 2023 information provided by PDMPs with information from previous assessments, PDMPs continue to develop and are becoming more homogeneous. Website visitors can compare changes using an interactive Power BI visualization available on TTAC's website.

This document summarizes the status of PDMPs, based on the results of the 2023 assessment, related to operations, policies/procedures, and technological capabilities.

General PDMP Information

Status of PDMPs

The US has 54 operational PDMPs, which include one for each state plus DC, Guam, Puerto Rico, and the Northern Mariana Islands. In 1918, New York established the first PDMP to regulate prescriptions for opium, cocaine, codeine, heroin, and morphine, which was terminated in 1921. In 1939, California became the next state to pass legislation for a PDMP. Between 1939 and 1999, there were 16 PDMPs; with 24 added from 2000 through 2009; another 14 states implemented PDMPs between 2010 and today.

Health Record Integration Status

The seamless portability of information across organizations, regions, and nations is referred to as health record integration, which is crucial for optimizing health outcomes. The integration of PDMPs with health information exchanges (HIEs), electronic health records (EHRs), and/or pharmacy dispensing systems (PDSs) is the most significant recent development in PDMPs.

Type of Integration	No. of PDMPs
EHR, HIE, and PDS	18
EHR, and PDS	28
EHR and HIE	3
EHR only	1

In 2022, 48 PDMPs directly integrated with at least one type of integration. That number now stands at 50. PDMPs engaged in integration with all three integration types increased approximately 143% from 2022 to 2023. Besides the increased use of PDMP access via integrations, the number of healthcare entity partners for EHRs, HIEs, and PDSs increased in seven, one, and four PDMPs, respectively.

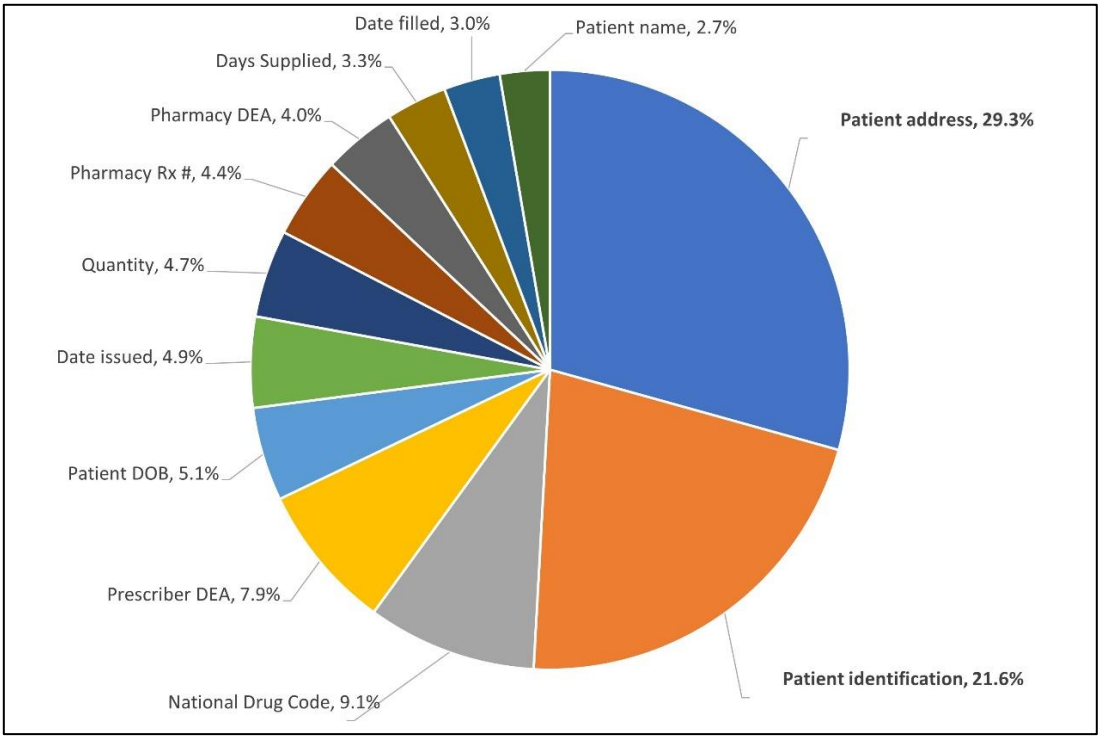
Academic Detailing Engagement

Academic detailing is a type of educational intervention that uses evidence-based information to promote appropriate prescribing practices. Academic detailing uses a 1-on-1 outreach education technique to improve clinical care, resulting in better health outcomes for patients. Academic detailing is an effective way to change prescribing practices and can address a variety of issues, such as reducing opioid prescribing and improving patient safety. PDMPs use academic detailing to provide healthcare providers with evidence-based information on the use of opioids and potential risks associated with their prescription and how to use PDMP data to identify potential misuse of opioids by their patients. This year's assessment reveals that 14 PDMPs are involved in academic detailing:

Connecticut	Illinois	Iowa
Maine	Maryland	Northern Mariana Islands
Oklahoma	Pennsylvania	Rhode Island
South Carolina	Texas	Utah
Vermont	Virginia	

Data Submission Errors

Complete and accurate prescription drug information is important to support efforts to reduce the incidence of prescription drug misuse and diversion. Health care providers (prescribers and dispensers) have a vested interest in ensuring that quality data is submitted to PDMPs. Unintentional data errors may occur anywhere in the process of prescribing or dispensing a reportable medication. Prescription data errors may result from a prescriber's illegible handwriting, data entry errors at the pharmacy, or procedural flaws, to name a few. PDMPs have processes in place to identify errors before the prescription records become part of the PDMP database. This year's assessment sought to find out the most common types of data errors that PDMPs encounter quarterly.



Expansion of E-prescribing

Electronic prescribing or e-prescribing is the computer-based electronic generation, transmission, and filling of a medical prescription, taking the place of paper and faxed prescriptions. E-prescribing allows a prescriber to electronically transmit a prescription to a pharmacy. E-prescribing was developed to reduce the risks associated with traditional prescription script writing. In 2020, there were 13 SDTCs requiring the electronic prescribing of controlled substances (EPCS). By 2023, the number had risen to 37 SDTCs; a 185% increase. Statistics provided on this year's assessment on the number of prescriptions received by the PDMPs show that 78% of the Schedule II controlled substance prescriptions, 69% of the Schedule IIIs, 71% of the Schedule IVs, and 79% of the Schedule Vs were electronically prescribed. Note: the deadlines for full implementation and compliance with EPCS statutes varies across jurisdictions.

Overdose Fatality Review (OFR) Participation

The purpose of an OFR is to effectively identify system gaps and innovative community-specific overdose prevention and intervention strategies. OFRs involve a series of confidential individual death reviews by a multidisciplinary team. A death review overview examines a decedent's life cycle in terms of drug use history, comorbidity, major health events, social-emotional trauma, encounters with law enforcement and the criminal justice system, treatment history, and other factors, including local conditions, to facilitate a deeper understanding of the missed opportunities for prevention and intervention that may have prevented an overdose death. By conducting a series of OFRs, jurisdictions begin to see patterns of need and opportunity, not only within specific agencies but across systems. Blending input from public health, public safety, providers, and the community, OFR teams develop program and policy recommendations to improve coordination and collaboration between agencies and community conditions to prevent future overdose deaths. These recommendations are presented to a governing committee that supports and provides resources for implementation and a framework for accountability for action. OFR teams are multidisciplinary and include individuals who can share information about a decedent or contribute to the analysis of available data to make recommendations that will prevent future overdose deaths. The following chart details the level of participation of PDMPs with OFR teams:

PDMP	Data Shared with OFR Team	PDMP on OFR Team
Arizona	Identified patient data	
Arkansas	not listed	
Connecticut	De-identified patient data; Aggregate patient data	Yes
Indiana	Identified patient data	
Kansas	Identified patient data	
Maine	Aggregate patient data	Yes
Maryland	Identified patient data	
Nebraska	identified patient data; De-identified patient data	Yes
New Jersey	Identified patient data	Yes
North Carolina	Aggregate patient data	
Ohio	Identified patient data	
Oklahoma	Identified patient data	Yes
Oregon	De-identified patient data	Yes
Rhode Island	De-identified patient data	Yes
Texas	De-identified patient data	
Utah	Identified patient data	
Vermont	De-identified patient data	Yes
Virginia	Identified patient data	
Wisconsin	De-identified patient data; Aggregate patient data	

Appendix A—2023 Assessment Questions

2023 Assessment (54 operational PDMPs, 47 responses received)
1. Name of person completing the survey.
2. Select the state, district, commonwealth, or territory of the PDMP represented in the survey responses.
3. Please provide the name(s), title(s), telephone number(s), and email address(es) for the PDMP employee(s) you wish to have listed on TTAC's PDMP Contact webpage.
4. List the total number of registered PDMP-system users by applicable type. • MD/DO • DDS • Veterinarian • Podiatrist • Mid-level Practitioner (i.e., nurse practitioner, physician assistant) • Prescriber delegate (licensed) • Prescriber delegate (unlicensed) • Pharmacy • Pharmacist • Pharmacy delegate (licensed) • Pharmacy delegate (unlicensed) • Law enforcement agency or investigator • Licensing/Regulatory Board agency or investigator
5. Is the PDMP's user/enrollment database linked to DEA's Controlled Substance Registration file for provider validation? If "yes", how frequently is the data refreshed/downloaded?
6. Is the PDMP's user/enrollment database linked to a regulatory board's (i.e., Medical, Pharmacy, Dental, Podiatry) licensing file for provider validation? If "yes", how frequently is the data refreshed/downloaded?
7. Is the PDMP's user/enrollment database linked to the National Provider Index (NPI) file for provider validation? If "yes", how frequently is the data refreshed/downloaded?
8. Do you allow PDMP access for practitioners without a DEA controlled substance registration number? If "yes", detail the procedures for validating the authenticity of the practitioner.
9. Is training on the PDMP system provided? If "yes", identify the training format(s) available.
10. Is the PDMP training required prior to use of the system?
11. Is the PDMP staff engaged in Academic Detailing?
12. Are you able to identify a prescriber's specialty (i.e., anesthesiology, pediatrics, addiction, immunology) within the PDMP data?
13. Has your State, District, Commonwealth, or Territory enacted a law requiring the reporting of information from substance use disorder treatment programs to the PDMP as detailed in 42 CFR Part 2? If "yes", provide details on how the PDMP plans to process, store, and maintain that information.
14. Has your State, District, Commonwealth, or Territory proposed a law requiring the reporting of information from substance use disorder treatment programs to the PDMP as detailed in 42 CFR Part 2?
15. Is PDMP data allowed to be shared with Overdose Fatality Review (OFR) Teams? If "yes", identify the applicable format that the PDMP data can be shared.
16. With how many OFRs are you sharing PDMP data?
17. Does the PDMP have a representative on an OFR Team?
18. Has your State, District, Commonwealth, or Territory explored the possibility of requiring the reporting of all prescription medications to the PDMP?
19. How likely is your State, District, Commonwealth, or Territory to begin requiring the reporting of all prescription drugs to the PDMP in the next 5 years?

2023 Assessment (54 operational PDMPs, 47 responses received)
20. If your State, District, Commonwealth, or Territory were to begin requiring the reporting of all prescription drugs to the PDMP, what overall effect do you believe this would have on public health in your State, District, Commonwealth, or Territory?
21. Select the estimated percentage of healthcare providers integrated with a HIE, EHR, or PDMS.
22. Please provide the number of controlled substance prescriptions that were filled during the most recent quarter (3-month period) that the statistics are available.
23. Please provide the number of controlled substance E-prescriptions that were filled during the most recent quarter (3-month period) that the statistics are available.
24. Please provide the number of prescription errors identified during transmission from dispensers during the most recent quarter (3-month period) that the statistics are available. • Patient name • Patient address • Patient date of birth • Patient identification number • Medication National Drug Control Number • Medication quantity • Medication days supplied • Prescriber DEA controlled substance registration number • Pharmacy DEA controlled substance registration number • Prescription date issued/written • Prescription date filled/dispensed/sold
25. Please provide the number of PDMP patient prescription history requests (i.e., hard-copy, electronic file, on-line) generated during the most recent quarter (3-month period) that the statistics are available. Requests made by delegates should be included with the number for the primary account holders. • MD/DO • DDS • Veterinarian • Podiatrist • Mid-level Practitioner (i.e., nurse practitioner, physician assistant) • Pharmacy • Pharmacist • Law enforcement agency or investigator • Licensing/Regulatory Board agency or investigator