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Do Prescription Drug Monitoring Programs help in the Opioid Wars?

By Chuck Dinerstein — June 14, 2017

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One of the many responses to the opioid crisis has been the development of Prescription Drug Monitoring Programs (PDMP) - databases containing the drug utilization of patients based upon physician prescriptions. As a result, we have a lot of information on who is prescribing and who is taking opiates. In a paper from the National Bureau of Economic Research [1], a recent working paper by Thomas Buchmueller and Colleen Carey looked at The Effect of Prescription Drug Monitoring Programs (PDMP) on Opioid Utilization in Medicine.

PDMPs, permit physicians to view a patient's prescribing history. PDMP use are part of the controversial CDC guidelines,

Clinicians *should* review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at *high risk for overdose*. (emphasis added) [2]

Buchmueller and Carey make use of Medicare Part D, the prescription benefit, data to consider the words should and overdose. While nearly all (49 of 50) states have PDMPs, only 10 require a physician prescriber to consult the data before writing a prescription. Those states form the basis for 'should' versus required. They consider opioid use based on quantity. They consider doctor

shopping where a patient obtains opioid prescriptions from five or more physicians in a six month period along with a similar measure of pharmacy shopping. And they consider opioid poisonings or opioid overdoses based on medical coding.

While the Medicare Part D program is generally for patients 65 and older, rising opioid usage and opioid-related deaths in the US are reflected in this group. For the PDMPs requiring access before prescribing opioids to a patient, they found:

- Reduced quantities of opioids dispensed
- Reduced doctor and pharmacy shopping
- Use of cross-state pharmacies and physicians (not a part of the PDMP consulted) showed small, negligible reductions
- The reductions did not impact the use of opioids by patients with cancer, in many cases, opioid utilization increased
- No effect upon opioid poisoning
- None of these changes were seen in voluntary PDMP programs

What can we conclude from these findings? First, to have any effect, use of PDMPs must be mandated; should needs to be replaced with required. As a physician, I understand both the need and the additional time spent in accessing the system, etc. The benefit, in reducing doctor and pharmacy shopping, outweighs, to my mind, the cost in physician time. This ‘cost’ of physician time can be decreased if the software vendors who provide electronic prescribing would simply provide an interface to the PDMP. And unintended additional benefit would be that prescribers could see how compliant patients are with all their other medications [3]. Second, use of PDMPs do not impact opioid poisonings, they can identify potential abusers, but other factors contributing to opioid overdoses are at play. The authors suggested that PDMP use might increase out of state sources, substitution of street drugs or decreases in diversion. The data is silent on these issues.

[1] Founded in 1920, the NBER is a private, non-profit, non-partisan organization conducting and disseminating economic research among academics, public policy makers, and business professionals.

[2] https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm [2]

[3] Adherence to medications is a large issue. In one study [3], compliance with medications for Type 2 diabetes was about 60%.

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