State prescription drug monitoring programs are used to control drug misuse that cause the epidemic of accidental deaths. CSG’s interstate compact will enable efficient data sharing between states for public health and law enforcement purposes.

Misuse of prescription drugs intended to alleviate disease often causes addiction and even death for Americans. Prescription drug overdoses are a national epidemic more deadly than crack or heroin use, and in 16 states more deadly than car crashes, according to the U.S. Centers for Disease Control and Prevention.\(^1\) The worst national prescription drug overdose rates are among those ages 35 to 54; death rates in that age group exceed deaths from motor vehicle crashes, according to the CDC’s most recent statistics from 2006.\(^2\)

Prescription drugs being used for patients and uses for which they were not prescribed is at the core of the prescription drug overdose epidemic. Prescription drug monitoring programs are one tool states are using to allow law enforcement and medical practitioners to prevent or investigate prescription misuse. In some states, the state-run information system enables physicians to determine if a patient is abusing prescription drugs by going to several doctors—known as doctor shopping. In others, law enforcement officials use a monitoring program to investigate patient or physician misuse of prescriptions and a number of states allow both physicians and law enforcement officials to access the system.

Since patients frequently travel across state lines to obtain prescriptions or medical care, the prescription drug monitoring programs respond individually to information requests from physicians or law enforcement in other states. But if these systems worked together across state lines, it would be the most effective way to ensure prescription medications are properly distributed.

Despite the significant accomplishments made in the states to develop monitoring programs, there is still a lack of uniformity and information-sharing procedures among the monitoring programs across the country. The Council of State Governments, through its National Center for Interstate Compacts, is working with an expert advisory committee to develop interstate compact legislation enabling state programs to electronically share prescription information. If adopted by the states, the compact would promote interstate cooperation and information sharing among state prescription drug monitoring programs.

**Similarities and Differences in State Programs**
State prescription drug monitoring programs collect information and operate databases on prescriptions dispensed within their state, specifically for Schedules II through V controlled substance prescriptions. Legislation in each state authorizing the programs specifies (1) the state agency that maintains and distributes the prescription information, (2) the controlled substance schedules or categories of prescriptions to be collected [see sidebar], and (3) the types of professionals who may request and receive prescription information.

**SIDEBAR: What are Schedule II, III, IV and V Controlled Substances?**
The U.S. Drug Enforcement Agency assigns prescription drugs to one of five controlled substances categories based on the drug’s potential to be abused and to cause psychological or physical dependence. Schedule I substances have a high potential for abuse but are not currently used for accepted medical treatment in the U.S., and include LSD and heroin. Schedules II-V are described below, and all drugs assigned to these schedules are currently used for medical treatment in the U.S.

**Schedule II**
- high potential for abuse, which may lead to severe psychological or physical dependence
- examples: Oxycontin®, Percocet®, morphine, methadone, amphetamine

**Schedule III**
- less potential for abuse than Schedule II drugs
- abuse may lead to moderate or low physical dependence or high psychological dependence
- examples: anabolic steroids, Vicodin®, ketamine, codeine or hydrocodone combined with aspirin or Tylenol®

**Schedule IV**
- low potential for abuse compared to Schedule III drugs
- abuse of the drug may lead to limited physical dependence or psychological dependence relative to those in Schedule III
- examples: Valium, Xanax, Darvocet®, most prescription sleeping pills or prescription diet pills

**Schedule V**
- low potential for abuse relative to Schedule IV drugs
- abuse of the drug may lead to limited physical dependence or psychological dependence relative to those in Schedule IV
- examples: Lyrica®, Lomotil®, some nonprescription drugs such as pseudoephedrine (in some states) or cough medicines with codeine


As of April 2010, legislation authorizing prescription drug monitoring programs had passed in 41 states, with programs operating in 33 states and suspended operations in Washington state due to budget limitations [see Figure 1]. State monitoring programs are funded in a variety of ways using a combination of federal funds, state general funds, medical professional licensing fees and program user fees. [4]
Prescription drug monitoring programs in 30 states are housed in a health-related agency, including the state health or human services department, board of pharmacy or a single state authority on drugs and alcohol. Another six state laws have the programs in a law enforcement agency. The remaining four states assign the program to a professional licensing or consumer protection agency, or jointly to the board of pharmacy and the public safety investigation division.

The categories of approved users of prescription information vary from state to state, but most often include:

- licensed physicians or other medical practitioners authorized to write prescriptions,
- pharmacists authorized to dispense prescriptions,
- authorized federal, state and local law enforcement officials,
- members of boards, commissions or agencies responsible for professional licensing, certification or regulation, and
- patients whose prescriptions have been included in the database.

Nearly half the state monitoring programs require the use of an advisory committee or council, task force or working group, and sometimes members of these groups are authorized to access the information in the database.

The database systems monitor prescriptions for drugs designated as controlled substances, and 37 state programs are authorized to monitor drugs in Schedules II, III and IV. Of these, 23 state programs also monitor selected drugs that are either Schedule V or not controlled substances. [See Table 1.]

Participation in the programs by prescribing physicians and other practitioners is largely voluntary because states usually encourage, but do not require, prescribers to check a patient’s prescription history in the database before writing a new prescription for a controlled substance. In addition, state laws often provide immunity from civil liability for prescribers and dispensers related to use of the database. To protect confidentiality and patient privacy, states commonly exempt the program data from public records or open records laws, specify who is allowed to access the information and under what circumstances, develop precise procedures for requesting information and distributing the responses, and penalize those who access or disclose program information inappropriately.

NOTES:
1 Washington has temporarily suspended its PMP operations due to budgetary constraints. However, a bill has been proposed in the Legislature that would allow for the statewide operation of a privately funded PMP.
2 The proposed New Hampshire PMP bill failed to pass a committee vote and is unlikely to become law this session.

Interstate Information Sharing

In addition to sharing information with authorized users for medical treatment decisions or criminal investigations, states may share information on prescriptions where patient and physician names have been removed to monitor trends in drug abuse or for public health initiatives to address
prescribing and dispensing issues. Since the introduction of a prescription drug monitoring program or additional controls in one state may increase the abuse of prescription drugs in neighboring states, states may have greater need for sharing prescription information as they or other states institute new initiatives to control prescription drug misuse.

Since 2004 officials from state prescription drug monitoring programs have been working with the support of federal funds to design a legal framework as well as a technical solution for states to efficiently share information. Through these discussions and planning the electronic structure to share information, the states:

- Reviewed federal and state confidentiality and privacy laws and regulations to inform a list of explicit procedures needed before the exchange becomes operational. The procedures include defining how the prescription drug monitoring programs authorize users, request information, respond to requests and use the prescription information provided while maintaining security and confidentiality.
- Developed information technology system standards to enable data sharing to assure the efficient, secure transfer of information between state programs.
- Began a pilot project in Nevada and California to share data and to test the prototype for the information exchange package documentation. The prototype was modified to accommodate both states’ prescription monitoring program practices and legal authorization requirements.
- Designed and demonstrated—with test data—an electronic system solution to exchange information from several states in September 2009. A system to allow the electronic exchange of patient data between states is currently under development, and is expected to build on the relationship established between the systems in Kentucky and Ohio.
- Developed a model interstate legal agreement or memorandum of understanding for the direct electronic transmission and disclosure of prescription drug monitoring program data collected in one state to another state’s program.

Download "Table 1: Status of State Prescription Drug Monitoring Programs [7]"

CSG Supports Interstate Compact Development

As states increase efforts to prevent or investigate prescription misuse, they need to share prescription drug information more frequently and with more states, and to find more efficient ways to do so. Through the efforts described above, state programs have been pursuing a technology solution to facilitate this exchange of prescription information in real-time among the states for the past several years. However, the legal authority for data exchange for the pilot projects was obtained through a memorandum of understanding limited to the states directly involved.

Because an interstate compact is likely to be the most appropriate tool to promote lasting interstate cooperation, The Council of State Governments’ 21st Century Foundation endorsed the concept of an interstate compact in 2009 and funded CSG’s policy staff to convene a national advisory committee and explore the feasibility of such an agreement.

Developing an Interstate Compact

The Council of State Governments, through its National Center for Interstate Compacts, has been involved in the development of several national regulatory interstate compacts. Each project begins with an advisory committee, usually comprised of about 20 interested stakeholders. The advisory committee typically is asked to consider the merits of an interstate compact and to discuss what should and should not be included in model legislation.

After the advisory phase, a drafting team is convened. The drafting team is comprised of a subset of the advisory group, usually six to eight people, who draft the compact legislation based on the
advisory committee’s recommendations. Once the drafting team completes its work, the full advisory committee reviews and approves compact legislation before sending it to interested state legislatures for consideration.

During the adoption phase, CSG staff and other experts are available to answer questions and assist states considering the legislation. Although an interstate compact can operate with as few as two member states, most regulatory compacts establish a higher minimum threshold before the compact takes effect. This ensures involvement from a significant number of states before the compact’s commission establishes bylaws, passes rules and forms committees. But it also means the timeframe from passage to implementation may extend take over several years.

Once passed by the required number of states, most regulatory compacts are governed by a commission comprised of appointed officials from each of the member states. These commissioners represent each member state and vote on the states’ behalf during all official commission business. Depending on the compact, the commission may also be tasked with establishing a national office to assist the commission in carrying out its mission.

Interstate Compact on Prescription Drug Monitoring Programs
Development of the Prescription Drug Monitoring Program Compact has followed closely to the model outlined. In late fall 2009, CSG’s National Center for Interstate Compacts convened two advisory committee meetings to explore the feasibility of an interstate compact. The advisory committee’s membership included representatives from national organizations, state policymakers and state officials from prescription drug monitoring programs, as well as representatives from federal agencies and key stakeholder groups. During the two meetings, the group discussed the typical composition of an interstate compact, made recommendations about what provisions should be included in a prescription drug monitoring compact legislation, developed a purpose statement, and endorsed the formation of a drafting team.

The advisory group felt the compact legislation should include each of the following sections: governance and structure, authorized use and access of data, technology and security and funding. They believed these sections were essential for the compact to improve public health, while also protecting patient privacy. In addition, the group decided traditional components, such as definitions, enforcement, administration and powers and duties of the commission should also be included in the legislation.

Following the advisory committee meetings, an initial drafting team meeting was convened in early 2010. During the first meeting, the drafting team began considering the advisory committee recommendations on provisions to be included in the compact legislation. The drafting team will likely meet three to four more times to develop the compact legislation before returning the proposal to the advisory group for final review. Both the advisory committee and the drafting team hope to have the compact legislation ready for introduction to state legislatures during the 2011 session.

For more information on interstate compacts, please contact Crady deGolian at cdegolian@csg.org [8], (859) 244-8068 or visit http://www.csg.org/programs/policyprograms/NCIC [9].

REFERENCES:

2 CDC. National Vital Statistics Reports [10], Vol. 57, No. 14, April 17, 2009 , Table 11, p. 36.
4 BJA Center for Program Evaluation and Performance Measurement. What Are Prescription Drug Monitoring Programs? [12]
6 National Drug Intelligence Center, Department of Justice. National Prescription Drug Threat Assessment 2009, Combating Diversion [14].

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