Confronting the Opioid Crisis: Sharing Information May Be Key to Saving Lives

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From economic and workforce development, to infrastructure and education, any number of items could have dominated discussions during the winter meeting of the National Governors Association, or NGA, in February.

Yet, as the governors began to immerse themselves in committee reports and assemble a list of priorities for their meeting with President Barack Obama at the White House, it was the issue of opioid abuse and overdose deaths that dominated the agenda.

“In Massachusetts, we have invested more than $250 million and enacted several reforms in our multi-pronged approach to combating the opioid epidemic, but states need more tools to bend the trend for this public health crisis,” said Massachusetts Gov. Charlie Baker, who serves as the chair of the National Governors Association Health and Human Services Committee.

By investing more in treatment, mental health services and tools for law enforcement, states have risen to the challenge of combating an epidemic that the Centers for Disease Control and Prevention, or CDC, estimates is responsible for the deaths of 78 Americans every day.

Confronted by pill mills—an operation in which doctors, clinics or pharmacies prescribe or dispense narcotics inappropriately or for non-medical reasons—and pill pipelines—the routes of interstate travel taken by traffickers of opioids—states have developed various systems designed to aid law enforcement, health officials and health care providers in routing out bad actors.

One such type of system implemented by every state but Missouri is the Prescription Drug Monitoring Program, or PDMP, a state-run database used to analyze the prescribing and dispensing of controlled prescription drugs.

In many ways, the initial implementation of these programs—a collaborative effort between policymakers, law enforcement, providers and pharmacists—showed the significance of an epidemic that saw more than 165,000 Americans die from prescription opioid overdoses between 1999 and 2014, according to the CDC.

However, PDMPs are not all created or implemented equally. The programs, for instance, might be housed in health-related agencies, state boards of pharmacies, within law enforcement agencies, consumer protection agencies or professional licensing agencies.

There is also a lack of uniformity in sharing collected information across state lines. This often means
that even if a state collects and shares information with doctors, law enforcement and pharmacies, once traffickers or abusers cross state lines, the information does not follow the person.

In the fall of 2009, the CSG National Center for Interstate Compacts began development of a Prescription Drug Monitoring Program Compact designed to respect the sovereignty of each member state and its existing PDMP and create an infrastructure that would allow data to be shared across state lines.

The compact mechanism offered states not only sovereignty in existing programs, but also flexibility to adapt to the needs of law enforcement, health care providers and pharmacies, especially in terms of ever-changing technological needs.

In 2010, shortly after the PDMP compact was announced, the Obama administration released the National Drug Control Strategy, which was, in part, a plan to combat prescription pill mills and prescription pill trafficking. The plan not only called for every state to develop a prescription monitoring program, but also encouraged states to begin sharing prescription drug data, acknowledging that the lack of data allows dealers and drug runners to move without detection from one state to another.

Ultimately, the Prescription Drug Monitoring Compact was not enacted, but other solutions have found success throughout the nation.

In 2011, the National Association of Boards of Pharmacy introduced Interconnect, a national PDMP shared data model. To date, 31 states participate in the system.

Joining Interconnect requires states to sign memorandums of understanding directly with the National Association of Boards of Pharmacy, and each state agrees to both participate in the system and to investigate reports of prescription drug abuse within member states.

The success of Interconnect is a testament to what can happen when states agree to work together. Yet, memorandums, unlike compacts, do not require legislative approval and often lack the structure of the interstate compact mechanism.

“Unfortunately, because the program (Interconnect) is voluntary any state is free to drop out at any time and there is neither an enforceable agreement or a governing structure in place, among the states, binding them to continue to participate in the program or to enforce reporting requirements of necessary modifications to the data exchanged”, said Rick Masters, one of the nation’s most prominent authorities on interstate compacts.

As state leaders have concluded, there is no magic bullet for ending the opioid abuse epidemic. “As a pharmacist, I see all too often how damaging prescription drug addiction can be to individuals and families,” said Kansas state Sen. Vicki Schmidt, chair of the compact advisory committee. “I have witnessed firsthand how drug abuse can tear lives apart. As a state legislator, I recognize the time for action to reduce this problem is now.”
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