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# Prescription Monitoring Programs: Intended and Unintended Consequences

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## Editorial

In 2014, Massachusetts experienced a sharp increase in the number of opiate and opioid related deaths [1]. This was part of a national trend-opioid related deaths were climbing in almost every state across the country. My suburban community hospital, which serves a catchment area of eight to ten different communities and an annual ED visit rate of around 50,000 visits per year was affected by this trend and was highlighted by the deaths of several young individuals. Wanting to address the concerns of our communities, we put together a task force to identify issues pertaining to substance abuse and to address how the hospital could be engaged with community efforts. As part of this, I had the opportunity to ride along with detectives from the Southern Middlesex County Regional Drug Task Force. This is a multi-jurisdictional task force made up of drug detectives from several different communities. They had been engaged in the epidemic for many years, be it cocaine, oxycontin or the new emergence of fentanyl. They had worked closely with those afflicted with substance abuse, and had seen the successes and failures of a variety of different policing policies. These were the front line, boots on the ground detectives as well as social workers, family counselors and care providers in this epidemic.

The ride-along started with the surveillance of an individual well known to the detectives. We were across the street from a CVS, watching as she entered the store to pick up her 240-tablet prescription of 30 mg Oxycodone. We had a laptop opened to the Massachusetts Prescription Monitoring Program page for this individual and saw that every month for over a year, she had been prescribed this medication, by one sole provider and every month she picked up that prescription and filled it. We then followed her to her residence. From a vantage point of a parking lot across the street we watched as car after car came and went, buying 30 mg oxycodone tablets at \$1 per milligram. From there, another detective unit followed a vehicle leaving this location, the son of the woman we had followed earlier, as he drove to Lawrence Massachusetts to purchase heroin from the money they made selling oxycodone. When he returned, we watched new customers come and go, buying a gram of heroin for around forty dollars. I was back a week later when the detectives stormed in, arresting the woman and her son on charges of distribution. I have been out with the detectives many more times, and have seen this scenario repeated by an array of

individuals. The prescription is picked up, it's sold, and this is flipped for heroin. Repeat.

This experience is coupled with my working with Mike and Vin, Chiefs of Probation at the local court and founders of the Woburn District Court Heroin Education Awareness Task Force (HEAT). They will recount the rise and fall of the oxycontin epidemic and how after heavy and strict enforcement of oxycontin, another epidemic rose from the shadows [2]. Heroin and Fentanyl. Other law enforcement officials as well as the detectives I had been working with reinforce the same idea-that the battle against oxycontin was effective in getting this drug off the street, reducing overdose and deaths from oxycontin and reducing oxycontin-related crime such as larceny and violent crime. The cost of that, however, was the heroin and fentanyl epidemic.

Prescription monitoring programs (PMP) are state-based electronic databases used to track the prescribing of designated controlled substances. The purposes of PMPs are to: support access to legitimate medical use of controlled substances; identify and deter or prevent drug abuse and diversion; facilitate and encourage the identification, intervention with and treatment of persons addicted to prescription drugs; inform public health initiatives through outlining of use and abuse trends; and educate individuals about PDMPs and the use, abuse and diversion of and addiction to prescription drugs [3]. Currently forty-nine states, the District of Columbia and Guam have PMP programs, most of which are either monitored by the Board of Pharmacy [4]. The CDC had reported that opioids were accountable for 61% of all drug-related deaths in 2014 and that hospitalizations for opioid-related disorders had increased 150% [5]. This is quite possibly another unintended issue reflecting the medical communities response to reports of oligoanalgesia and the introduction of pain as the "fifth vital sign" and a society with more access to opiates than ever before [6,7]. The idea of the prescription monitoring program was to help curb this epidemic by identifying individuals at risk and to provide providers with a resource to adopt good prescribing practices regarding opioids.

The PMPs are a noble effort. They do attempt to identify individuals who may be obtaining opioids from multiple sources. They can also be useful in identifying individuals who may have a substance abuse disorder based on these trends. There is evidence that initiation of the PMPs have resulted in fewer prescriptions opioid related deaths. For example, The State of

Florida reduced deaths from oxycodone by 25% after implementation of the PMP program [8]. Other states have reported a reduction in patients receiving prescriptions from multiple providers.

There is some criticism of the PMPs as well. We don't yet know if they will be causal for reducing opioid prescriptions. They often lag in being up to date, they take time to access and they can identify individuals who need pain medication for legitimate needs or who are "pseudo-addicts" [9]. What we must be most concerned with, however, is whether we will be repeating history. While we have seen decreases in deaths from prescription drug deaths, deaths from illicit drugs such as heroin and fentanyl have increased during this same period. Using Florida again as our example, that state saw an eight-fold increase in heroin deaths and a five-fold increase in fentanyl deaths. This is a disturbing trend. The opiate epidemic, in fact, continues to surge, with opiate-related deaths now surpassing those from gun violence [10,11].

We will also need to start holding providers accountable. Those who overprescribe or who ignore the trends that can be highlighted by the PMP need to be held accountable. We need to have system in place that allows for searches by provider as well as by patient to determine if there are providers who are overprescribing. This needs to be coupled with education but in certain cases also with restrictions on licenses and prescribing privileges.

Overall, there will likely be some benefit to the PMPs. They at the very least will help raise awareness and may allow for better prescription practices. We must not lose track, however, that this reduction is related to the ongoing and rising use of illicit opioids. We do not know if prescription opioid reductions are causal for either reduction of or increases in illicit opioid related deaths. We also must not lose track of the concept that PMPs need to be coupled with provider education on identifying

addiction and how to manage it, something that is still lacking in medical and nursing education. Finally, we must use our resources wisely and invest in user-centric, evidenced based treatment for substance use disorder to truly be effective in stopping the opioid epidemic.

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