

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52

Title: Restrict Access to the Michigan Automated Prescription System

Introduced by: Charles J. Barone, II, MD, for the Wayne County Delegation

Original Author: Tabitha Moses

Referred to: Reference Committee B

House Action: **APPROVED**

Whereas, the Michigan Automated Prescription System (MAPS) is a prescription drug monitoring program (PDMP) that was created in 2003 to prevent iatrogenic substance use disorders and opioid overdoses from Schedule 2-5 controlled substances at patient, pharmacy, and physician level¹, and

Whereas, recent meta-analysis on PDMPs like MAPS demonstrates insufficient evidence of their efficacy in decreasing incidence of fatal or nonfatal overdoses², and

Whereas, MAPS contains protected health information (PHI) which is subject to stringent privacy standards enforced by Health Insurance Portability and Accountability Act of 1996³, and

Whereas, legislation introduced during the 2017-2018 Legislative Session, Senate Bills 1245-1247, sought to allow access to both PHI and physician identifiers within MAPS data by the Department of State Police for non-health care-related purposes⁴, and

Whereas, the Michigan Psychiatric Society, Mental Health Association in Michigan, Michigan Protection and Advocacy Services, The Arc Michigan, and Michigan Disability Rights Coalition all expressed opposition to Senate Bills 1245-1247⁵, and

Whereas, physicians may be discouraged from prescribing controlled substances due to potential police questioning regarding the validity of their medical decision-making⁶, and

Whereas, vulnerable populations, including those in low socioeconomic status areas or suffering from chronic pain and mental illness, disproportionately face discrimination related to non-abusive use of legally prescribed controlled substances⁷, and

Whereas, identification of PDMP best practices remains a priority to avoid unintended consequences such as implementation of social control by law enforcement outside the context of targeted, drug-related investigations^{6,8}, therefore be it

RESOLVED: That MSMS oppose legislation that would permit direct access by Michigan law enforcement to Michigan Automated Prescription System (MAPS) data involving patient or physician identification without probable cause; and be it further

RESOLVED: That MSMS oppose non-health care workers, who are not registered as delegate users, from receiving primary access to MAPS without following appropriate judicial proceedings.

WAYS AND MEANS COMMITTEE FISCAL NOTE: \$25,000 or more as this resolution requires legislative advocacy.

Relevant MSMS Policy:

Michigan's Prescription Drug Monitoring Program

MSMS supports education to encourage physicians and other health care providers to check the Michigan Automated Prescription System (MAPS) when prescribing controlled substances. However, MSMS opposes mandatory MAPS checking by physicians absent clinical suspicion of substance abuse or nefarious intent. (Res46-16 and Res50-16)

Addiction a Disease

MSMS consider drug intoxication and addiction as diseases. (Prior to 1990)

Pharmacy: Cooperation to Insure Patient Medication Safety

MSMS works with the Michigan Pharmacists Association to assure patient safety, confidentiality, and continuity of care. (Res88-93A)

Medicaid Substance Use Disorder Coverage

MSMS supports Medicaid payment coverage for the medical management and treatment of all substance use disorders. (Res54-17)

Relevant AMA Policy:

Prescription Drug Monitoring Program Confidentiality H-95.946

Our AMA will: (1) advocate for the placement and management of state-based prescription drug monitoring programs with a state agency whose primary purpose and mission is health care quality and safety rather than a state agency whose primary purpose is law enforcement or prosecutorial; (2) encourage all state agencies responsible for maintaining and managing a prescription drug monitoring program (PDMP) to do so in a manner that treats PDMP data as health information that is protected from release outside of the healthcare system; and (3) advocate for strong confidentiality safeguards and protections of state databases by limiting database access by non-health care individuals to only those instances in which probable cause exists that an unlawful act or breach of the standard of care may have occurred.

Development and Promotion of Single National Prescription Drug Monitoring Program H-95.939

Our American Medical Association (1) supports the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically appropriate; (2) encourages states to implement modernized PDMPs that are seamlessly integrated into the physician's normal workflow, and provide clinically relevant, reliable information at the point of care; (3) supports the ability of physicians to designate a delegate to perform a check of the PDMP, where allowed by state law; (4) encourage states to foster increased PDMP use through a seamless registration process; (5) encourages all states to determine how to use a PDMP to enhance treatment for substance use disorder and pain management; (6) encourages states to share access to PDMP data across state lines, within the safeguards applicable to protected health information; and (7) encourages state PDMPs to adopt uniform data standards to facilitate the sharing of information across state lines.

Prescription Drug Diversion, Misuse and Addiction H-95.945

Our AMA: (1) supports permanent authorization of and adequate funding for the National All Schedules Prescription Electronic Reporting (NASPER) program so that every state, district and territory of the US can have an operational Prescription Drug Monitoring Program (PDMP) for use of clinicians in all jurisdictions; (2) considers PDMP data to be protected health information, and thus protected from release outside the healthcare system unless there is a HIPAA exception or specific authorization from the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information; (3) recommends that PDMP's be designed such that data is immediately available when clinicians query the database and are considering a decision to prescribe a controlled substance; (4) recommends that individual PDMP databases be designed with connectivity among each other so that clinicians can have access to PDMP controlled substances dispensing data across state boundaries; and (5) will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths.

Drug Abuse Related to Prescribing Practices H-95.990

1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices: A. Institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students. B. Placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.
2. Our AMA: A. promotes physician training and competence on the proper use of controlled substances; B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients; C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and D. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances.
3. The Council on Science and Public Health will report at the 2012 Annual Meeting on the effectiveness of current drug policies, ways to prevent fraudulent prescriptions, and additional reporting requirements for state-based prescription drug monitoring programs for veterinarians, hospitals, opioid treatment programs, and Department of Veterans Affairs facilities.
4. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances.

¹ US Drug Enforcement Agency. Michigan Automated Prescription System: 2012 statistics, DEA analysis, and Board of Pharmacy updates 2013. https://www.deadiversion.usdoj.gov/mtgs/pharm_awareness/conf_2013/may_2013/maps.pdf. Accessed January 18, 2019.

² Fink, DS, Schleimer, JP, Sarvet, A, et al. Association Between Prescription Drug Monitoring Programs and Nonfatal and Fatal Drug Overdoses. *Annals of Internal Medicine*. 2018;168,783-790. doi:10.7326/M17-3074.

³ US Health and Human Services. Summary of the HIPAA Privacy Rule 2003. <https://www.hhs.gov/sites/default/files/privacysummary.pdf>. Accessed January 18, 2019.

⁴ Michigan Senate Fiscal Agency. SB 1245-1247: Summary of bill reported from committee 2018. <http://www.legislature.mi.gov/documents/2017-2018/billanalysis/Senate/pdf/2017-SFA-1245-F.pdf>. Accessed January 18, 2019.

⁵ United States, Congress, Shirkey, Mike. "Legislative Analysis: Law Enforcement Access to Michigan Automated Prescription System Data Act," 2018. 1245-1247. <http://www.legislature.mi.gov/documents/2017-2018/billanalysis/House/pdf/2017-HLA-1245-3891CA53.pdf>. Accessed January 20 2018.

⁶ American Civil Liberties Union of Rhode Island. Your medications are under investigation 2016. <http://www.riaclu.org/blog/post/your-medications-are-under-investigation>. Accessed January 18, 2019.

⁷ American Psychiatric Association. Ethnic and racial minorities & socioeconomic status 2016.

<https://www.apa.org/pi/ses/resources/publications/factsheet-erm.pdf>. Accessed January 18, 2019.

⁸ Beletsky, L. Deploying prescription drug monitoring to address the overdose crisis: Ideology meets reality. *Indiana Health Law Review*. 2018;15(2),139-185. doi:10.18060/3911.0046.