Innovations and Challenges of Prescription Drug Monitoring Programs

Announcer:	Welcome, and thank you for listening to this recording, part of the Comprehensive Opioid Abuse Program (or "COAP") podcast series. COAP provides financial and technical assistance to states and units of local and Indian tribal governments to plan, develop, and implement comprehensive efforts to identify, respond to, treat, and support those impacted by the opioid epidemic. Since 2017, BJA has supported innovative work on these COAP sites across the nation.
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Meelee Kim:	Hello, you're listening to the Comprehensive Opioid Abuse Program podcast series on Prescription Drug Monitoring Programs. I'm your host, Meelee Kim. The topic of today's podcast is about innovations across Prescription Drug Monitoring Programs, or what you'll hear as PDMPs, and some of the challenges facing that. So just a quick recap about what are PDMPs. They're essentially a data system run by government agencies, particularly at the state level, and they contain information about controlled substance prescription drugs that are dispensed by pharmacies and dispensing practitioners. So these types of drugs are those deemed by the U.S. Food and Drug Administration and the U.S. Drug Enforcement Administration as having medical value, but at the same time, all the potential for abuse, such as opioid analgesics and stimulant drugs. Prescription Drug Monitoring Programs exist in every state in the U.S. plus the District of Columbia, Guam, and Puerto Rico.
	And while there are unique characteristics across these Prescription Drug Monitoring Programs, there are core common features. So, for example, all programs collect prescription information on schedules

2 through 4, and many more collect schedules 2 through 5. There's also a standard technical format for obtaining this prescription information from pharmacies called the ASAP standards. And that stands for American Society for Automation and Pharmacy. They also all serve to function as a public health and public safety tool. And the primary end users of these systems are physicians and other health care providers. So, during this podcast, you'll hear from some PDMP administrators talk about their thoughts on what PDMPs are or should be doing to be more effective. And in particular, we'll hear what they have to say about making the PDMP more user friendly for health care providers and what are some of the challenges to making them more effective. So here's Dave Hopkins from the Kentucky Prescription Drug Monitoring Program, called KASPER, on his thoughts when I asked about where PDMPs are heading and molded to be more effective in addressing prescription drug abuse and related overdoses.

Dave Hopkins: Well, Meelee, as we move into the new arena, if you will, where more and more states are requiring mandatory registration with a PDMP and more and more situations, they are actually requiring prescribers and possibly pharmacists to query the PDMP before they prescribe or dispense controlled substances in some situations. The use of the PDMPs now, and the time it takes for those practitioners and pharmacists to access the PDMP and review it, is becoming more and more important.

And so the integration with the electronic health record systems, pharmacy management systems, and the state Prescription Drug Monitoring Programs is becoming more and more important. The reason for that being that what we need to do is simplify the process and integrate it into this typical workflow for the practitioner or the pharmacist, so that they don't. . . as in many cases as they have to do today, go outside of their normal workflow, log into the PDMP, obtain the patient data or report, and then review it and take any appropriate actions. Instead, if they're already in their electronic health record system or pharmacy management system, the goal would be that they don't have to go outside of that workflow—that they can simply, from within their system, request that PDMP information.

Meelee: That was Dave Hopkins from the Kentucky PDMP. And as I mentioned before, the primary users of PDMP systems are health care practitioners, which makes sense when you think about who are the gatekeepers of these prescription drugs. So one of the current evolutionary phases of PDMPs is to function as a clinical decision support tool. Most, if not all, PDMP administrators are aware of the challenges for clinicians trying to get access to the PDMP information, and it's certainly supported by multiple studies conducted over the past several years that found that there were relatively low utilization rates.

However, at the same time, studies also found that clinicians believe that PDMP information are valuable to support their decision making about their patients' treatment involving controlled substances. As Dave alluded to from the Kentucky PDMP, making the information easy to access is the main reason behind the lower-than-expected utilization notes, even when there are state requirements to register or check the PDMP. And currently, most states have some level of integrating PDMP information with electronic health records or EHR systems, but that doesn't mean that these states have all addressed the workflow interruption or eased the access completely. And next, we have Rodd Kelly from the Massachusetts Prescription Drug Monitoring Program, talking about what's happening with EHR integration there in Massachusetts and why it's needed.

Rodd Kelly: The Massachusetts does have for the online platform, integration is now really taking hold. We have some pilot facilities that we're going through and kind of vamping up that piece. And again, that goes back to the ease of access. The prescribers have been asking for that for a long time that, "If there's a patient within my office, I already have a profile, why do I need to log in to an entirely separate system? Why can't I just pull information from the online system?" And that's coming, and we'll see a bump in increase in user activity and hopefully even compliance to our regulations once that really takes hold.

Meelee: And Massachusetts is just one of multiple states making tremendous efforts to integrate PDMPs with existing EHR systems. I think one example to highlight is the Washington State Emergency Department Information Exchange, or what they call EDIE. And we

have Chris Baumgartner from the Washington State Department of Health, that houses their PDMP. Tell us a little bit about that.

Chris Baumgartner: EDIE is the Emergency Department Information Exchange, and I believe Washington State was the first to stand up this type of system, but Oregon, I believe, has adopted it and others are considering it as well. And the best way I like to explain it is, it's basically a PDMP for emergency department data. So it's a way that emergency departments can share their information so that if someone is frequently going to a lot of emergency rooms, the other hospitals can be aware of that as they're treating those patients and try to direct them to more appropriate care, because there has been overutilization and misuse of emergency departments in our country, and it costs a lot of money when people are going to the emergency department for nonemergent reasons. And obviously, a lot of that overutilization and misuse of ERs has been driven by people seeking opioid medication.

And so in our state, we were able to pass legislation that allow the Emergency Department Information Exchange on behalf of those EDs to request PMP data and provide that in that same workflow that the providers are already used to seeing that emergency department data in—which has been a great step forward for them to see that controlled substance information alongside their emergency department visitation history, basically.

And actually, one of our big innovations, where we're looking at doing this year to build on top of that, is because the EDIE system knows when a patient has experienced a fatal or nonfatal overdose on opioids, because it collects again the admission and discharge information from the emergency department, and our PMP knows who's prescribed to those patients. We're trying to use those data in concert to then provide a feedback notice to emergency departments as well health care providers who have been treating those patients, because we really feel like in most cases, especially primary care, is likely not made aware of when their patient has experienced a nonfatal opioid overdose and has been treated at an emergency department for that. And so we're really excited about that potential and are looking forward to kicking that off this year.

Meelee: There are many other types of innovations going on with PDMPs across the country. Just to mention a few, there's the Nebraska PDMP that is fully integrated through their statewide health information exchange. And so this program is able to provide a comprehensive view of all prescription drugs to their health care practitioners. So it's not just the controlled substance drugs, it's all prescriptions drugs. There are also many states that provide prescriber feedback reports that basically tells the practitioner whether or not he or she is prescribing certain prescription drugs within a range compared to their medical peers. There are also many states that provide educational opportunities and materials to practitioners by joining forces, if you will, with other stakeholder agencies, such as the medical licensing boards, professional organizations, and such. And again, if you'd like to learn more about some of those program innovations going on, please visit the coapresources.org website.

Next, we'll talk a little bit about the challenges facing PDMPs. Here's Meghna Patel, from the Pennsylvania Department of Health, talking about one fundamental challenge and some of her other thoughts.

Meghna Patel: First important is the quality of the data. So I think it's important to collect better data that helps identify an accurate patient, an accurate prescriber, an accurate dispenser or pharmacy. So given an example of an accurate patient, sometimes John Doe in Virginia with the same date of birth could be a different John Doe in Pennsylvania with the same date of birth, and PDMPs need to do. . . or I would say that we need to collect better data from patients in order to keep them different John Does and not combine them as one John Doe. We've done a good job in sharing data between states, but I think we could improve a lot in terms of sharing with all the other states as well, but that is only helpful when we can fix the accurate patient identification.

If we could address data quality issues, and here's what I would jump on and say, we can think about electronic prescribing. There's a better way to ensure that data is not entered by a human and collected electronic. It's submitted electronic and it's seen electronic. There's all these other areas that we will kind of avoid and that would even solve the problem of diversion. There are the nontechnical barriers, I would say, where their data's not quite much talked about, but when physicians look into the patient's

PDMP report and sometimes when they identify red flags, they don't necessarily know how to taper the opioids down. They don't necessarily know how to refer the patient to a treatment program. And I think there needs to be solutions such as education and outreach in terms of educating prescribers on opioid tapering, how to conduct a warm handoff, and what sort of other statewide resources are available so they can at least have the patient do a treatment or recovery program.

We have to think outside of PDMP. So you have to look into this data and see where. . .or understand, I would say, where is the substance use sort of a patient outgoing? So if there's a way to include other data into PDMP, such as any overdose events, or if there's any pain management contracts or agreements with the patient, those kinds of data, sort of inclusion of that data, would really help as a user, as a prescriber and dispenser, to see what else do I need to talk to my patient about, or whether I need to prescribe more or prescribe less. And do I have to taper down the opioids or other controlled substances?

Meelee: Again, that was Meghna Patel from the Pennsylvania Department of Health. We're going to hear next from Chris Baumgartner again on his thoughts about another fundamental issue that PDMPs in general are facing today, which is about sustainable funding for these programs.

Chris: Sure. I think some of the issues we're facing today are. . .one is, I think, just funding. There's some programs that are in better situations than others, but there's increasingly a lot of great ideas and best practices that a lot of different stakeholders and partners want to see prescription monitoring programs do. And that is fantastic. And that's the great thing about a PMP. They have so much potential for helping in a lot of different ways, but we don't always get the funding that we need to carry out those different things. For example, one of the biggest new areas, I think, is using PMP as a public health surveillance tool, and that's a great goal, and the PMP can be very helpful for that. But when you collect millions of records a year, having the software, hardware, and the analytic team to do that kind of work isn't something every PMP has available.

Meelee: And on that note, I asked Michelle Ricco-Jonas from the New Hampshire Board of Pharmacy that houses their PDMP about what she thought is the next phase for PDMPs, and here's what she had to say.

Michelle Ricco-Jonas: So I think my wishful thinking is making sure that we're getting our data out there in combination with other data to show that this database has more information than just that of the opioids. And two, and I think that's been brought out in a most recent conference, which was our stimulants are on the rise and the combination that that has with potentially the cocaine deaths that we're starting to see. And then the other thing, I think the PDMP can be an integrated tool across the continuum, and that's kind of been my mantra. So there's the SBIRT, which is the Screening Brief Intervention Referral and Treatment tool that has been, I think—is still working on it—but still pretty integrated across primary care, community health centers, and whatnot, and why not combine the PDMP within that tool, because it can be used across the continuum. It is a screening tool, in essence.

As in the very beginning, it can be used to continue to look at somebody when they're receiving treatment and beyond. So it's another piece of the puzzle, so to speak. And so in New Hampshire, where we're actually looking at working with public health in an application that we just submitted for dentists who are going to be trained in SBIRT, but integrating the PDMP within that model. So hopefully, we'll look at it, we'll see, and then show some success with it and then maybe get some legs underneath it. And then we can pitch it out to the other folks who are also using SBIRT that this is a tool that you can—it's not just for the opioids that you're writing for the treatment of your pain, but across anything that you're using it for. I think people need to understand that when PDMPs are understaffed, they're not used to their full potential. It can be just a tool for providers and pharmacists, or it can be more, but it's got to be given the capacities to be more.

Meelee: To end on a positive note, I will say that federal agencies, including the Bureau of Justice Assistance and the Centers for Disease Control and Prevention, have been expanding their funding opportunities to states, territories, and local communities that are all looking to enhance the utilization of PDMPs as well as build up their capacity. Well, I hope you walk away knowing that Prescription Drug

Monitoring Programs continue to evolve in ways to help prevent and address the current opioid abuse and overdose crisis, despite the multiple challenges. To learn more about these programs, please visit our website at www.pdmpassist.org or www.coapresources.org. That completes this episode of our podcast on Prescription Drug Monitoring Programs. Thanks for listening. This podcast is brought to you by Brandeis University, the Prescription Drug Monitoring Program Training and Technical Assistance Center, and the Institute for Intergovernmental Research, funded by the Bureau of Justice Assistance.

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