PDMP CENTER OF EXCELLENCE Brandeis University The Heller School FOR SOCIAL POLICY AND MANAGEMENT

Prescription Drug Monitoring Program Center of Excellence at Brandeis

COE Briefing

PDMP Delegate Account Systems

May 2015

This project was supported by Grant No. 2011-PM-BX-K002 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

PDMP Delegate Account Systems

Although prescription drug monitoring programs (PDMPs) are effective tools in efforts to promote safe prescribing and detect prescription drug misuse,[1] they are often underutilized by prescribers, dispensers and others given statutory authority to access PDMP data. Steps to promote greater utilization include adoption by states of prescriber mandates to query the PDMP, issuing unsolicited prescription history reports, and integration of PDMP data with health information systems.[2]

As identified in a recent survey, a significant barrier to prescriber use of PDMPs is the time consumed in retrieving prescription information.[3] To address this problem, many states allow primary or master PDMP account holders (e.g., prescribers, dispensers) to designate non-prescribing employees in their practices to access the database via delegate accounts, sometimes called sub-accounts. This saves the master account holder the time of inputting patient names and downloading PDMP data. The number of states authorizing delegate accounts has increased rapidly, from one state (Utah) in 2010, to 12 in 2012, to 36 in 2014.[4] The addition of delegate accounts has been identified as a PDMP best practice.[5]

To assist states in setting up their own delegate accounts, this briefing describes well-established delegate account systems in Maine, Washington and Kentucky.[6] These systems have shared characteristics as described in the following section.

Characteristics of Delegate Accounts in Maine, Washington and Kentucky

Although delegate users of the PDMPs described below are sometimes required to be licensed health care professionals, they are not prescribers or dispensers, so do not have controlled substance numbers assigned by the DEA. Delegates log into their accounts with their own user name, password and other required authentication; they do not access the PDMP via the primary account for which they are conducting a query. This means that information available to a prescriber about her own prescribing history – a "self-lookup" of prescribed controlled substances linked to her DEA number in the PDMP – is not available to delegates. Delegates only see the prescription histories of *patients,* those served by the primary account holder. This information includes all the prescribers who have prescribed controlled substances to the

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[1] See the COE Briefing on PDMP Effectiveness, http://www.pdmpexcellence.org/sites/all/pdfs/Briefing%20on%20PDMP%20Effectiveness%203rd%20revision.pdf.
[2] See for example "Providing Seamless Access to the Prescription Monitoring Program - Utilizing the Health Information Exchange and Electronic Medical Records," Washington State Interagency Workgroup, http://www.pdmpassist.org/pdf/PMP%20White%20Paper%20HCO%20Final%2020141103.pdf.
[3] Rutkow, L. et al., Many primary care physicians are aware of prescription drug monitoring programs, but many find the data difficult to access. *Health Affairs* 34, No. 3 (2015): 484-492. Available at http://content.healthaffairs.org/content/34/3/484.abstract.
[4] According to the Brandeis PDMP Training and Technical Assistance Center, in 2014, of the 36 states with the authority to have delegate accounts; 28 states had implemented them.
[5] See "Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices," PDMP Center of Excellence, 2012, p. 47, http://www.pdmpexcellence.org/sites/all/pdfs/Brandeis_PDMP_Report.pdf.
[6] Note that these three states constitute a convenience sample for illustrative purposes only. Their delegate account systems may not be representative of all states' systems.

patient in a designated period, the names of the drugs, amounts, date dispensed, and the dispensing pharmacies, among other data.

Like other personal medical information, PDMP data are held confidential according to each state's statutes and regulations. Delegates thus have a responsibility not to share PDMP reports with others not directly involved in the patient's care, or who are not authorized to access the data. However, to help ensure proper data access, prescribers, dispensers and other primary account holders are held responsible for their delegates' use of the system. The availability of delegate accounts helps to improve data security by avoiding the temptation of a primary account holder to share his or her account access, including user names and passwords, with other clinical staff. Having distinct delegate and primary accounts also allows more accurate auditing of what type of staff (prescriber, dispenser, or delegate) is querying the database.

Maine, Washington and Kentucky, like all states with PDMPs, have penalties for misuse of PDMP data which apply to delegates as well as primary account holders. Penalties range from a class C felony (Maine), to a class B misdemeanor for a first offense and class A misdemeanor for subsequent offenses (Kentucky). Those interviewed for this briefing reported extremely low risk of abuse of their systems, with misuse rates at or below the rate for licensed prescribers. This suggests that delegate access to PDMPs is consistent with maintaining confidentiality of controlled substance prescription information.

No formal training specifically tailored to delegates is required in Maine, Washington or Kentucky, but delegates typically familiarize themselves with the system using online and printed educational materials, or attend standard trainings on how to use the PDMP. Primary account holders are responsible for deactivating sub-accounts when delegates leave their practice.

Delegate access to PDMP data ordinarily requires specific legislative and/or regulatory authorization in statutes enabling the PDMP. Therefore, states wishing to add delegate accounts will likely have to revise any applicable language.

Maine

As of December 2014, there were 2,584 PDMP delegate accounts registered in Maine, compared to 6,347 prescriber accounts and 777 pharmacist accounts (the latter two being primary accounts). Originally, delegates were required to be licensed health care workers, but this requirement was lifted since it was judged to be a barrier to using delegates. Now that delegates need not be licensed, their accounts are being added at an increasing rate. Primary account holders can add as many delegates as they wish, and a delegate can conduct queries for more than one primary account holder.

Currently, sub-accounts are requested using a registration form that specifies which prescriber or dispenser primary account they will be linked to. Should a delegate leave a practice, the provider informs the PDMP so that the account can be de-activated. In a new system slated to start in mid-2015, all delegates must electronically re-register their accounts. Using a drop-down menu of delegate names, primary account holders will then select those that they wish to

access the PDMP on their behalf. Primary account holders will be able to monitor their delegates' PDMP queries, helping to maintain oversight and ensure appropriate access. When a delegate leaves a practice, the primary account holder will simply de-activate the delegate using the drop-down menu.

Eventually, the Maine PDMP will have the audit capability of distinguishing delegate queries from those of primary account holders. This will permit compiling data on the contribution of delegate accounts to the total utilization of the PDMP.

Washington

The provision for delegate accounts was included in the original design of the Washington PDMP, which became operational in 2011. By regulation, only prescribers can establish delegate accounts,[7] and delegates must be licensed Washington health care providers who don't have federal controlled substance prescribing privileges, e.g., licensed practical nurses, registered nurses, and medical, nursing and dental assistants.

These licensed providers can register for delegate accounts online; once approved, they become eligible for selection by prescribers with master accounts. Only when selected by at least one prescriber can a delegate begin conducting queries to the PDMP. As in Maine, Washington enables a many-to-many relationship between primary and delegate account holders: prescribers can select more than one delegate and a delegate can be linked from multiple master accounts (for example, those of prescribers in a group practice or prescribers in different practices). Delegates must specify the account for which they are conducting a query; the Washington PDMP audit trail shows the prescriber for whom a delegate was accessing the database, should they need verification. Should a delegate leave a clinic or practice, the prescriber(s) are instructed to de-select that delegate, preventing the delegate from conducting further queries on their behalf. Delegate accounts remain active even if no master account holder is linked to them, saving the time and trouble of re-applying for an account. Should a delegate lose his or her license, the delegate account will be de-activated when comparing the Washington health licensure database with the delegate account database, which is done periodically.

Delegate accounts in Washington currently number nearly 1,500, compared with approximately 11,600 prescriber master accounts and 4,300 pharmacist master accounts. Queries by delegates nearly doubled from 2012 to 2013, from 32,330 to 61,752. Although this represents a relatively small proportion of queries compared to those by prescribers (319,050 in 2012 and 362,705 in 2013) the rate of increase is noteworthy.

[7] As of 2014, of the 36 states allowing delegate accounts, 27 allowed both prescriber *and* pharmacist delegate accounts.

Kentucky

Kentucky's PDMP, the Kentucky All Schedule Prescription Electronic Reporting system (KASPER), underwent a major technological upgrade in 2005 (to the "eKASPER" online system), that provided the ability to utilize delegate accounts. In 2012, the delegate account registration process was streamlined to allow primary account holders to add delegates either electronically or via paper application (see here for instructions). As in Maine and Washington, there can be a many-to-many relationship between delegate and master account holders. Delegates in Kentucky need not be licensed health care providers. Master account holders are responsible for de-activating a delegate from their account should the delegate leave the practice.

By the end of 2014, KASPER had 10,062 delegates associated with the 15,531 in-state prescriber master accounts and 179 delegates associated with the 4,540 in-state pharmacist master accounts. KASPER's out-of-state users are also eligible to designate delegates; by December 2014 there were 950 delegates for the 5,346 out-of-state prescriber KASPER account holders and 34 delegates for the 1,071 out-of-state pharmacist account holders. KASPER also has 36 master accounts held by judges in state; currently there are nine delegate accounts associated with these judge master accounts.

Recent data from KASPER indicate that delegate users, especially those associated with prescribers, are contributing substantially to its utilization. During the fourth quarter of 2014, 1,240,400 reports were requested by prescribers (both in and out-of-state). Of those, 742,127 or 59.8% were requested by prescriber delegates. In the same time period, 33,406 reports were requested by in-state and out-of-state pharmacists. Of those, 1,679 or 5% were requested by pharmacist delegates.

Conclusion

Delegate accounts, properly supervised and maintained as illustrated above, are a secure and effective means to increase PDMP utilization. Until such time as prescribers and dispensers have PDMP data integrated into their online patient records (still in very early stages in most states, but see note 2), allowing delegate access to the PDMP is an important step states can take to ensure that prescription histories are routinely considered in patient care. Especially as increasing numbers of states mandate that prescribers (and in some cases pharmacists) view a patient's prescription history prior to prescribing or dispensing controlled substances, allowing delegate accounts will reduce the administrative burden on medical providers, thus facilitating their compliance with mandates.

Since a single delegate may be able to conduct queries for more than one primary account holder, depending on the system, the number of delegate account holders alone is not a clear indicator of how much delegates are contributing to PDMP utilization. A better measure, as used in Washington and Kentucky, is the actual number of queries conducted by delegates. Calculating this measure requires having the necessary audit capability and allocating staff time

to analyze utilization data. However, being able to show the impact of delegate accounts on increasing utilization will help support it as good PDMP policy.

As with other enhancements to PDMPs, the implementation of delegate accounts may require additional IT and staff resources, as well as legislative and/or regulatory changes. Since greater utilization of PDMP data helps to improve prescribing and reduce controlled substance misuse and its associated costs, a good case can be made that implementing delegate accounts constitutes a wise public health investment.

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Acknowledgements

The COE wishes to acknowledge PDMP administrators John Lipovsky (Maine), Chris Baumgartner (Washington), and Dave Hopkins (Kentucky) for their expertise and editorial assistance in producing this report.