Providing Seamless Access to the Prescription Monitoring Program

- Utilizing the Health Information Exchange and Electronic Medical Records -

Produced By: The Washington State Interagency Workgroup to Prevent

Opioid Misuse, Abuse, Overdose, Morbidity, and Mortality

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Situation

In October 2011, the WA State Department of Health (DOH) started operating a repository of controlled substances dispensed from licensed pharmacies or licensed practitioners known as the Prescription Monitoring Program (PMP – also known as Prescription Review). Primary access to the program has been through a web portal developed by DOH's vendor. Clinics, hospitals, and offices where patients are treated can benefit from this PMP data by building connections to it and integrating it with their electronic medical record systems (EMRs) to provide seamless access within their workflow. This paper provides technical information, business reasons, and case examples that can assist healthcare administrators in justifying the use of resources to build these connections.

Since the PMP started, 10,700 out of 37,132 Washington prescribers have registered, which comprises only 29% of DEA registrants. On average, only 4,000 licensed practitioners access PMP data on a monthly basis. While this is a good start, we cannot realize the full value of the program or a full return on our investment in the PMP unless we reach full or near full registration and more regular use. More importantly, we are missing opportunities to better manage and prevent harm to patients.

Two remedies are available to address PMP underutilization: 1) provide education/training and encourage registration, and 2) provide more seamless access to PMP data. In-person training can be made available in addition to the online training that is already available, but incentives are needed to encourage prescribers and dispensers to take the training and use the system regularly (meaning run secure queries on their patients' prescription histories). Based on other states' experience, recruitment campaigns by themselves often fail to produce high rates of participation,[1] providing evidence for why incentives or a legal mandate may be needed.

Making data access more seamless is a more involved undertaking. State IT Policies for protected health information systems require access via two factor authentication. For the PMP this means that the device registration process must be repeated for each computer a user uses (e.g. when a provider is accessing patient information on multiple computers). In addition, providers have to log into EMR systems separately from the PMP, which may require multiple user IDs and passwords. Fortunately, WA State has established a Health Information Exchange (HIE) through the company One Health Port (OHP), where trading partners can access protected health information directly through their EMRs. If clinics and hospitals build a bridge between their IT

[1] http://www.pdmpexcellence.org/sites/all/pdfs/COE%20briefing%20on%20mandates%20revised_a.pdf

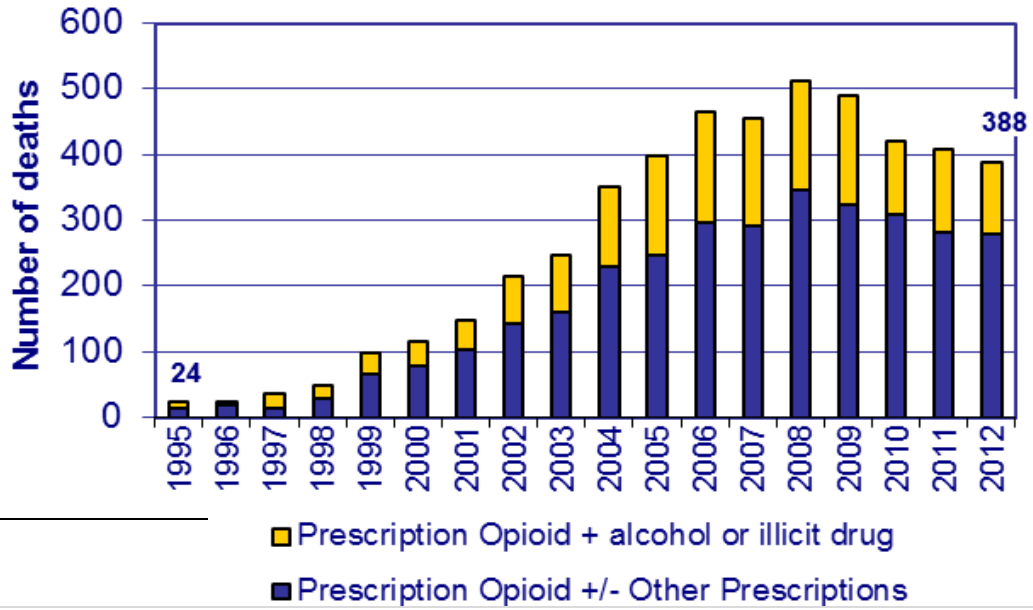
systems and the OHP, PMP data can be accessed from any device with a single log-on and authentication process. Integrating access to OHP or PMP within the EMR system is another matter but is definitely possible. Many states are already taking these steps and have experienced success.

Background

The opioid misuse and abuse epidemic has been well documented, yet still remains a problem. Washington has seen increases in the use and unintended consequences of prescription opioids. Unintentional overdose deaths from opioids surpassed deaths caused by traffic accidents in this state in 2006. The number of unintentional overdose deaths involving prescription opioids grew 21-fold from 1995 to 2008 (Exhibit 1). Between 2008 and 2012, the state experienced a 27% decline in the rate of overdose deaths involving prescription opioids, perhaps attributable to the concerted prevention efforts occurring across the state. In addition to the deaths, prescription opioid misuse, abuse, and dependence are also concerning. According to the National Survey on Drug Use and Health, Washington had the 3rd highest rate of non-medical use of prescription opioid painkillers in the nation during 2010–2011, and the 13th highest rate in 2011–2012. According to the Washington Healthy Youth Survey in 2012, 1 in 12 high school seniors and 1 in 16 10th graders used prescription opioids to get high in the previous 30 days.

Through 2013, adult admissions to publicly funded substance abuse treatment programs for prescription opioid use have remained constant at 9% of all admissions. In 2012 there were 9,370 hospitalizations for opioid dependence, 2,684 for opioid abuse, 195 for methadone poisoning, and 395 for poisoning from other prescription opioids. In the past 10 years, hospitalizations for opioid dependence and abuse have more than doubled, hospitalizations for methadone poisoning have increased fourfold, and poisoning hospitalizations from other prescription opioids have increased threefold.[2] Data indicate that Washington's prescribing in grams per 100,000 population is slightly above the national average for opioid pain relievers. Washington had the 19th highest prescribing of opioid pain relievers in 2011.[3]

Exhibit 1:
Unintentional Opioid Deaths in Washington



[2] Source: Washing
[3] Source: 2011 Dr

SAMHSA, ONC, and Other States

In 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) operationalized the Enhancing Access to PDMP through Health IT project, which the Office of the National Coordinator for Health Information Technology (ONC) managed. Pilots were conducted in six states (WA, ND, NB, MI, IN, OH) to integrate PDMP data into existing health IT systems like electronic health records and health information exchanges and provide this data to providers as part of their normal workflow. The MI pilot added PMP data to e-prescribing software so it would be included in the patient's medication history and made available to providers at the point of care. The pilots demonstrated significant value and pilot participants indicated that providing PDMP data readily as part of the workflow assisted them in their clinical decision making process. This project was scaled up to penetrate additional health IT systems within a state and also provide opportunity for expansion to other states. Pilots in 2013 were implemented in 8 states: IL, IN, KS, MI, NB, OK, TN, OH. Their goals and objectives were:

Goals	Objectives
Connect	Automate access to PDMP data for prescribers and dispensers
	Establish interstate sharing of data for prescribers & dispensers
	Maximize PDMP access through the use of intermediaries
Enable	Identify ways to insert PDMP data into prescriber and dispenser workflows
	Provide tools to evaluate PDMP data in real-time and provide analytics
Improve	Analyze tools available for methodical evaluation of PDMP data
	Identify ways to improve the data stored in PDMPDs

Again this automation and integration demonstrated value by adding "diagnostic power," improving clinical decision-making and increasing provider satisfaction. Unsolicited reports, like provider alerts when a patient exceeds a safety threshold, and patient matching algorithms, increased user confidence and resulted in more accurate diagnoses and treatment recommendations. The use of Health Information Exchanges, particularly in Indiana streamlined the sign-on process and allowed for data sharing, e.g. in emergency departments.

SAMHSA is continuing to assist states with maximizing the use of PMP data by offering grants to states that are willing to build these capabilities. Interested healthcare administrators should contact the DOH PMP as there may be grant funding available to assist with building the connections.

Compelling Reasons to Integrate the PMP into EMRs via a Connection to One Health Port

1. Patient Safety

- The primary goal for using the PMP is patient safety, which supports the goal of providing the highest quality of care and reducing harm. The PMP informs the provider of a patient's controlled substance prescription history, which helps prevent drug-drug interactions that may lead to an adverse outcome, therapeutic duplication, and alerts the provider to length of time a patient has taken prescription opioids, and understanding of undertreated pain.

- The PMP can send provider auto-alerts about patients receiving opioids, benzodiazepines, and other drugs that can potentiate an adverse outcome at the same time.
- The PMP can send provider auto alerts for any patients on > 120mg Morphine Equivalent Dose (MED) opioids.

2. State Laws and Meaningful Use

- Washington State's opioid prescribing rules suggest that providers should use PMP data: "providers *shall* take a health history when evaluating a patient for chronic non-cancer pain, which *should* include review of any available PMP data" (WAC 246-919-853) and "PMP data *should* be reviewed when patient seeks episodic care e.g. urgent care" (WAC 246-919-859).
- Washington State's workers' compensation program requires prescribers to use the PMP. According to WAC 296-20-03035: "Providers must check the prescription monitoring program data base... and document before prescribing opioids in the sub-acute phase and repeat during chronic opioid therapy at intervals according to the worker's risk category as described in the agency medical directors' group's guideline. Any provider performing a preoperative evaluation for elective surgery in workers on chronic opioid therapy should also check the prescription monitoring program data base and document as part of a treatment plan for post-surgical pain management."
- WA DOH has obtained approval to list the PMP as an official "other specialized registry" in compliance with stage 2 meaningful use, which can bring in revenue.
- Once connected to the HIE, healthcare organizations can also connect to other data systems and trading partners. DOH for example also provides connections to immunizations, laboratory reporting, syndromic surveillance, and cancer registry in addition to the PMP.
- Using the PMP has become mandatory in Tennessee, Kentucky, and New York. States are increasingly sharing prescription data to improve care for patients who seek medication in multiple states. While it is not mandatory currently in WA State it is important to be forward thinking around these issues.

3. Preventing Fraud and Abuse

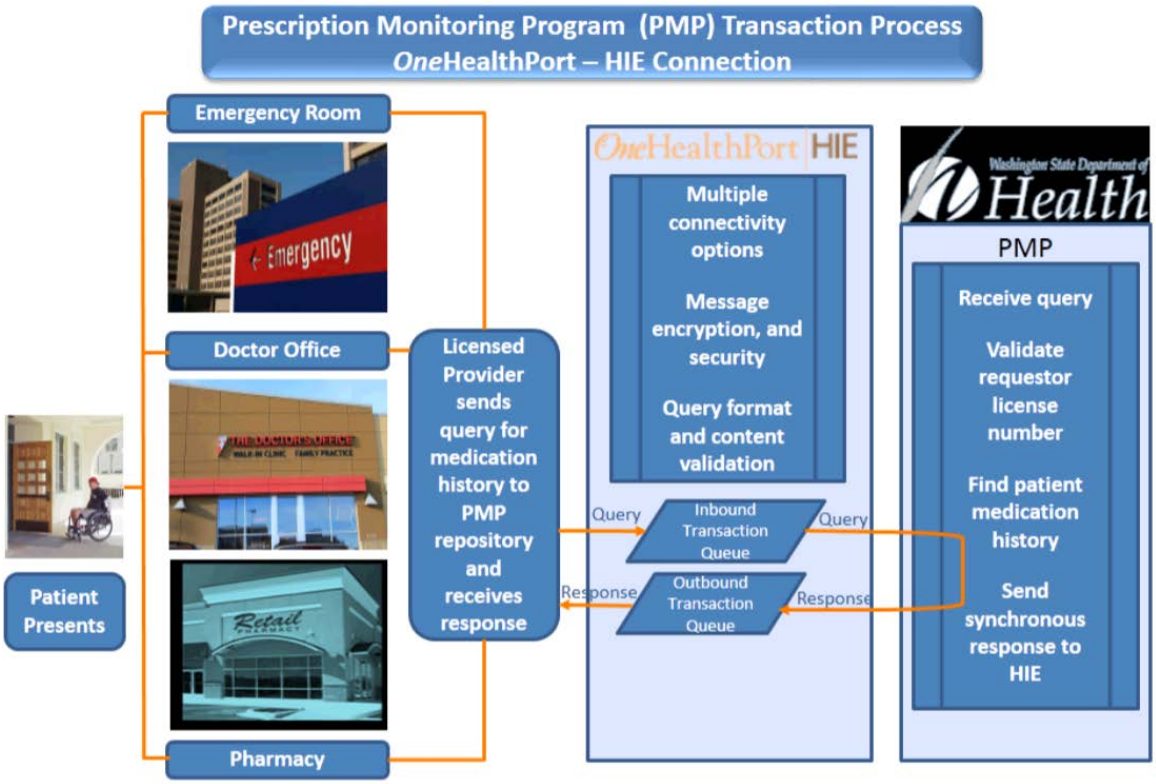
- The PMP allows prescribers to view their prescribing history to watch for fraudulent scripts
- The PMP allows prescribers and dispensers to check for possible Rx misuse, multiple prescribers, adverse drug interactions, undertreated pain, and fraudulent scripts.
- The PMP can flag individuals that have potential abuse patterns such as having seen 5 or more opioid prescribers and dispensers.

4. Increased Efficiency

- Providers can delegate authority to other licensed clinical support persons (e.g. MA, LPN, RN) to query the PMP for their patient's prescription history making workflows efficient.
- The WA state public health officer, DOH, and many state agencies and health care facilities jointly collaborate to reduce morbidity and mortality related to the unintentional use, misuse, and abuse of opioids. One of their key strategies is to facilitate clinical service sites, building the connection to One Health Port for more seamless access to PMP data.

Technical Requirements

The schema for connecting to One Health Port is illustrated below. The connection between the HIE and the PMP is already built. Healthcare organizations would need to build the connection on the left side of the diagram from their EMR to the HIE.



The response provided from the PMP database via the HIE is:

- A real-time transaction based on the authentication of the requestor's license (pre-registration of the user in the online PMP system)
- A match of the patient record requested
- Utilizes the NCPDP Script Standard for medication history. OHP HIE is utilizing the NCPDP 2013.12 standard.

This would enable providers to log into the EMR, click on a PMP icon (for example), and have immediate access to PMP data for each patient. Requests can also be triggered automatically by the EMR when a patient is admitted to a hospital. A similar connection has been done in several other states and One Health Port has a technology guide for how to accomplish this[4]. The PMP query uses a standard medication history already in place in certified clinical systems that query repositories such as Surescripts for medication history. The estimated cost figures for this range from $45,750 to $102,000 depending on the extent of integration desired e.g. hospital/ER department, physician, pharmacy, or a combination.

[4] http://www.onehealthport.com/sites/default/files/hie/CanonicalGuide_PMP.pdf

Recommendations

1. Approach medical, administrative, and technical leadership regarding this opportunity. Include a discussion on the ability of the PMP to help meet Meaningful Use requirements.
2. Contact the WA Department of Health if there is interest in using the PMP to meet Meaningful Use requirements. To register (www.doh.wa.gov/healthit).
3. Contact OneHealthPort (OHP) to begin the onboarding process which involves a trading partner agreement (if your organization is not signed up yet) and getting the technical specifications (https://www.onehealthport.com/hie).
4. Work with OHP to build and test your connection for the PMP transaction.
5. Ensure all providers in your organization are registered for PMP use (www.wapmp.org).
6. Consider creating PMP champions who can train users on how to query and use the report from the connection that have been built. Take advantage of the PMP training videos online or contact DOH PMP staff for in-person training or via webinar (www.doh.wa.gov/pmp).
7. Consider creating standard protocols and prioritizing which situations warrant a PMP query on a patient (example: new patient visit) and how patient care is handled depending on the results of the query.