

PMP Center of Excellence Briefing

April 2012

Best Practices for Prescription Monitoring Programs

Evidence is accumulating that prescription monitoring programs (PMPs) are effective in promoting safe prescribing and dispensing of controlled substances and in reducing their diversion and misuse.¹ However, PMPs can become more effective by adopting recognized best practices in collecting, analyzing and reporting prescription information. This briefing is intended to provide PMPs and their stakeholders with an overview of some recommended best practices, including the rationale for their adoption and their current status among PMPs. The practices described below all find support in the research literature on PMPs, PMP case studies, and/or PMP expert consensus documents.

In the Harold Rogers Prescription Drug Monitoring Program FY 2012 Competitive Grant Announcement,² the Bureau of Justice Assistance states that it will give priority consideration to PDMPs that incorporate the best practices listed here. This briefing provides information for states responding to this announcement.

Unsolicited reporting. Because many potential users of PMP data are unfamiliar with PMPs or haven't accessed prescription history information, PMPs are currently underutilized. The proactive dissemination of prescription history information via unsolicited reports and alerts helps address this problem. Unsolicited reports sent to medical providers contain the prescription history of individuals who meet criteria for questionable activity, e.g., obtaining prescriptions for the same controlled substance from 4 or more prescribers and filling prescriptions at 4 or more pharmacies in 6 months. Alerts notify providers that one or more patients meet the criteria and suggest that they access the PMP database to view prescription history information. Providing such information helps providers make better clinical decisions while simultaneously informing them of the PMP and its functions. For example, the MA PMP found in a physician survey that only 8% of respondents were "aware of all or most of other prescribers" and only 9% said "based on current knowledge, including PMP report, patient appears to have legitimate medical reason for prescriptions from multiple prescribers." Subject to proper safeguards and restrictions, unsolicited reports can also inform investigative agencies, professional licensing boards, and drug utilization and peer review systems about possible questionable activity on the part of prescribers and dispensers, as well as patients. Case studies of PMPs suggest that unsolicited reporting may reduce doctor shopping while raising awareness of and participation in PMPs.^{3 4} As of 2011, 30 PMPs were authorized to provide unsolicited reports to medical providers, but only 16 were actually doing so; 8 were providing such reports to law enforcement agencies and 7 to licensing boards.⁵ Adoption of unsolicited reporting will in some cases require states to address legislative and regulatory restrictions on this best practice.

Best Practices for Prescription Monitoring Programs

Establish interstate data sharing. Since doctor shopping and other forms of prescription drug diversion often cross state lines, PMP data from a single state are limited in their capacity to identify individuals potentially in need of intervention, whether by medical providers or investigative agencies. Combining data from neighboring states and states known to be major sources of diverted prescription drugs will help increase this capacity for all participating states. For example, a review of data in the Kentucky PMP identified that prescriptions dispensed by Kentucky pharmacies were issued by prescribers located in all 50 states, the District of Columbia and Puerto Rico, with 93.2% issued by Kentucky prescribers and an additional 5.7% issued by prescribers in adjoining states. The National PMIX architecture has been developed by the Alliance of States with Prescription Monitoring Programs (Alliance) to provide interoperability among the various interstate data solutions. The PMIX architecture allows states to choose a solution best suited for their needs, knowing it can communicate with other solutions. States will need to institute the necessary internal regulatory framework, create memoranda of understanding with data sharing partners, and implement the requisite information technology systems. Data sharing will also require uniform data fields, formats and transmission standards across states, as well as methods for reliably identifying individuals in multi-state data sets. States needing assistance in the design and development of interstate data sharing capabilities should contact the Alliance (www.pmpalliance.org) for further assistance.

Share data with researchers for prevention, surveillance and early warning systems. PMP data are useful not only for identifying individuals in possible need of intervention, but for describing trends in prescribing and questionable behavior for use in drug abuse surveillance and prevention efforts. PMPs can therefore increase their impact and effectiveness by making data available for analysis by public health epidemiologists and other researchers. For instance, geo-spatial analyses of doctor shopping rates for community prevention coalitions in Massachusetts indicate that communities with the highest rates of probable doctor shoppers also tend to have the highest concentrations of opioid overdoses and deaths; such information can be used to target prevention efforts.⁶ De-identified data from states neighboring Georgia identified zip codes within Georgia in which Georgia prescribers were issuing unusually large numbers of controlled substances prescriptions, suggestive of pill mill operations.⁷ Recent PMP data analyses from South Carolina and Wyoming suggest that opioid use and perhaps doctor shopping may be increasing among younger age groups. If they are not already doing so, PMPs can partner with state and government agencies, universities and research organizations to facilitate such analyses; the Alliance and the PMP Center of Excellence (www.pmpexcellence.org) can provide assistance in arranging such partnerships.

Collect and report prescription data for Schedule II-V controlled substances. Almost two-thirds of PMPs collect and report prescription history information on all classes of controlled substances (Schedules II-V).⁸ Collecting data on all schedules permits more accurate estimates of questionable behavior using PMP data, and enables prescribers and pharmacists to examine the full spectrum of controlled substance prescriptions when making clinical decisions. Drugs in all schedules are potentially subject to abuse; for example, by 2009 there were nearly as many admissions to emergency departments for benzodiazepine overdoses (373,200) as for opioid overdoses (393,200).⁹ Expanding data collection to include all schedules may require regulatory or legislative reform, but the strong rationale and ample precedent for this best practice will help PMPs advocate for the necessary changes.

Collect data using the most recent ASAP standard. Standards for pharmacy data fields and formats, including those reported to PMPs, are set by the American Society for Automation in Pharmacy (ASAP). All PMPs employ ASAP standards, but differ in the version used. Use of the most recent ASAP standard (4.2) by all states would increase PMP effectiveness by facilitating cross-state data sharing, multi-state data analyses, and collaborations with other organizations making use of prescription history data. More recent standards also make available more data fields, simplify data correction, and permit additional data reporting functionalities. The Alliance/PMP Training and Technical Assistance Center (www.pmpalliance.org/content/training-and-technical-assistance-center-ttac) can assist states in updating their ASAP standard.

Expand access to PMP data. PMPs differ in their data access policies, sometimes limiting or barring use of PMP data by certain categories of potential users. PMPs can therefore increase their impact and effectiveness by seeking to widen access to their data by all legitimate users, making sure sufficient safeguards are in place to prevent misuse of patient and prescriber information. In particular, local, state, federal and tribal law enforcement agencies and investigators could be given case-appropriate access to PMP data. Such access can assist in drug diversion investigations¹⁰ and may help decrease death rates from unintentional opioid overdoses, as suggested by experience in California and Texas, which have long provided both unsolicited and solicited reports to law enforcement agencies.^{11 12} Some PMPs have made their data available to medical examiners, drug treatment programs, criminal justice diversion programs, drug courts, and drug prevention initiatives; outcomes of such use seem promising.¹³ Others provide PMP data to licensing boards and peer review committees, helping to maintain professional standards and good clinical practice. Further examples of users allowed by some PMPs include Medicaid agencies, workers compensation boards, researchers (using de-identified data), and drug counselors. Expanding access to all legitimate PMP users often requires amending PMP enabling legislation and regulations governing their operation; the benefits of expanding access can be cited when seeking legislative and regulatory reform.

Confidentiality, security, and privacy provisions regarding the collected data. Data collected by PMPs from pharmacies include sensitive personal health information that requires protection. From the initiation of PMPs in 1939 until the present, confidentiality protection has been a high priority for all states and their PMPs. In addition to general state laws and regulations governing the protection of personal health information, most states specifically identify protections for the data collected by PMPs, its storage and its use. Among such protections are the specifications of types of users to whom PMP data may be provided and circumstances under which the data may be provided. Distribution of PMP reports to unauthorized users is prohibited by PMP enabling legislation; violations usually carry significant penalties and may result in revocation of professional licenses. States permitting law enforcement to request PMP data typically require reports be issued only related to existing investigations and only to authorized, registered investigators. Similarly, states which permit access by other types of users, for example medical examiners, substance abuse treatment programs, and drug courts, require safeguards against, and penalties for, any unauthorized dissemination of prescription history information. States implementing PMPs or expanding data access to law enforcement and other users can draw on legislation and regulations developed by existing PMPs which specifically address data protection. The Alliance of States with Prescription Monitoring Programs (www.pmpalliance.org) can provide assistance in directing states to appropriate resources.

Education and outreach to stakeholders on how to access and utilize prescription history reports. Even in states with long-standing PMPs with broad data access policies, many medical providers, licensing boards and investigative agencies do not make use of PMP databases. To expand PMP utilization, potential users need to be made aware of their value and functions, and need education in how to access and apply PMP data. Awareness campaigns undertaken by states have been both broad-based, for instance including information about PMPs when providers are asked to renew licenses to prescribe or dispense controlled substances, and targeted, such as recruiting the most active prescribers as identified in PMP databases. Educational approaches typically include in-person presentations to prospective user groups, online short courses and webinars, and paper-based and web-page materials, for instance prescriber “toolkits” on how to use PMP data and links to Screening, Brief Intervention, and Referral to Treatment (SBIRT) resources. In planning outreach and educational initiatives, PMPs may wish to consult with the Alliance (www.pmpalliance.org), which facilitates the sharing of PMP expertise and resources among states, including educational strategies and materials. The Alliance has developed guidelines for PMP Administrators on a curriculum and training for prescribers and dispensers about access to and utilization of PMP reports. It is also developing a similar curriculum for law enforcement agencies which will be published in late fall of 2012.

Notes

¹ PMP Center of Excellence. Briefing on PMP Effectiveness. PMPs: An Effective Tool in Curbing the Prescription Drug Abuse Epidemic. February, 2011.

http://www.pmpexcellence.org/sites/all/pdfs/pmp_effectiveness_brief_final.pdf.

² The announcement is available at <https://www.bja.gov/Funding/12PDMPsol.pdf>.

³ PMP Center of Excellence. Notes from the Field 1.1. Trends in Wyoming PMP Prescription History Reporting: Evidence for a Decrease in Doctor Shopping? September, 2010.

http://www.pmpexcellence.org/sites/all/pdfs/NFF_wyoming_rev_11_16_10.pdf.

⁴ PMP Center of Excellence. Notes from the Field 2.5. Nevada’s Proactive PMP: The Impact of Unsolicited Reports. October, 2011.

http://www.pmpexcellence.org/sites/all/pdfs/nevada_nff_10_26_11.pdf.

⁵ PMP Center of Excellence survey of PMPs. November, 2011.

⁶ Carnevale & Associates and PMP Center of Excellence. Prescription monitoring and prevention: recommendations for increased collaboration. Working paper produced for the Substance Abuse and Mental Health Services Administration. December 3, 2010.

⁷ Ibid.

⁸ Data from <http://pmpalliance.org/content/drug-schedules-monitored>.

⁹ Substance Abuse and Mental Health Services Administration, Drug Abuse Warning Network. Highlights of the 2009 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits. The DAWN Report. December, 2010.

¹⁰ PMP Center of Excellence. Notes from the Field 2.3. Perspective from Kentucky: Using PMP Data in Drug Diversion Investigations. May, 2011.

http://www.pmpexcellence.org/sites/all/pdfs/NFF_kentucky_5_17_11_c.pdf.

¹¹ Eadie, J. Toward the next generation of PMPs: Enhancing prescription monitoring programs’ ability to address the prescription drug abuse epidemic - testimony for the U.S. Senate Sub-Committee on Crime and Terrorism. May, 2011.

http://www.pmpexcellence.org/sites/all/pdfs/next_generation_pmps_6_2_11.pdf.

¹² Paulozzi LJ, Stier DD. Prescription drug laws, drug overdoses, and drug sales in New York and Pennsylvania. J Public Health Policy. 2010 Dec; 31(4):422-32.

¹³ PMP Center of Excellence. Notes from the Field. <http://www.pmpexcellence.org/content/notes-field-0>.