Integrated Nationwide Prescription Drug Monitoring Program

The Committee recommends that the Association adopt the following statements:

1. APhA supports the establishment of a standardized and integrated nationwide prescription drug monitoring program (PDMP) that includes all federal, state, and territory databases for the purpose of providing health care professionals with accurate and real-time information to assist in clinical decision making when prescribing and dispensing controlled substances. [Refer to Summary of Discussion Item 2, 3, 4, 5.]

2. APhA supports pharmacist involvement in the development of uniform standards for an integrated nationwide prescription drug monitoring program (PDMP) that includes the definition of authorized registered users, documentation, reporting requirements, system response time, security of information, minimum reporting data sets, and standard transaction format. [Refer to Summary of Discussion Item 5, 6, 7.]

3. APhA supports mandatory prescription drug monitoring program (PDMP) enrollment by all health care providers who prescribe or dispense controlled substances, system query before prescribing controlled substances, and reporting by all those who dispense controlled substances. [Refer to Summary of Discussion Item 9.]

4. APhA advocates for the development of seamless workflow integration systems that would enable consistent use of a nationwide prescription drug monitoring program (PDMP) by prescribers and pharmacists to facilitate prospective drug review as a standard of practice before the prescribing and dispensing of controlled substances. [Refer to Summary of Discussion Item 10, 11.]

5. APhA advocates for continuous, sustainable federal funding sources for practitioners and system operators to utilize and maintain a standardized integrated and real-time nationwide prescription drug monitoring program (PDMP). [Refer to Summary of Discussion Item 12.]

6. APhA supports the use of interprofessional advisory boards to coordinate collaborative efforts for (1) compiling, analyzing, and using prescription drug monitoring program (PDMP) data trends related to controlled substance misuse, abuse, and/or fraud; (2) providing focused provider education and patient referral to treatment programs; and (3) supporting research activities on the impact of PDMP programs. [Refer to Summary of Discussion Item 13.]

7. APhA supports education and training for authorized users about a nationwide prescription drug monitoring program (PDMP) to ensure proper data integrity, use, and confidentiality. [Refer to Summary of Discussion Item 14.]
Summary of Discussion

1. The Committee reviewed the 1989 APhA policy related to multiple-copy prescription order programs and agreed on a need to revisit APhA’s position on this issue.

2. The Committee recognized the current lack of nationwide connectivity among state-based PDMPs. The term “nationwide” was used intentionally to describe a system that connects data rather than one system at the national level.

3. The Committee agreed that these systems should be used for clinical decision making and that part of the clinical decision-making process includes the consideration of misuse, abuse, diversion, and fraud regarding controlled substances.

4. The Committee discussed platforms, such as NABP PMP InterConnect, that connect state-based information but noted that the lack of nationwide connectivity interferes with prescribers’ and pharmacists’ ability to make sound clinical judgments related to the prescribing and dispensing of controlled substances.

5. The Committee agreed on the need to support a system that allows for interconnectivity of the data currently being collected in each state.

6. The Committee discussed the need to have uniform standards for integrated nationwide prescription drug monitoring and agreed that pharmacists must be involved in the development of such standards. Recognizing that each state currently has its own requirements related to these programs, the development of standards will be key to successful implementation of a nationwide program. The Committee agreed that funding will be a key driver in the development of nationwide standards.

7. The Committee discussed the issue of access to the information housed in PDMPs. The definition of an authorized registered user and the level of user access may vary among states and should be addressed in the creation of nationwide standards. The Committee also agreed that pharmacists’ ability to delegate access should be addressed in nationwide standards.

8. The Committee discussed the need for pharmacists to document when they refuse to fill a prescription and return it to the patient based on information found in the PDMP. Lack of documentation may pose a risk to the pharmacist if he or she is unable to explain why the database was accessed for a particular patient. The Committee felt that this concept is addressed by “documentation” in statement 2.

9. The Committee agreed that enrollment in a PDMP must be mandatory to ensure that both prescribers and pharmacists participate in the program. Optional enrollment could result in a lack of participation. Discussion centered on the need to develop systems that enable the programs to be used consistently and within the standard of practice.

10. The Committee agreed that the use of these systems should not interfere with the delivery of legitimate patient care. The seamless integration of these systems into both prescriber and pharmacist workflow is essential for the successful implementation of an integrated nationwide program.

11. The Committee discussed the fact that pharmacists have a duty to protect the public and using PDMPs in the course of patient care assists pharmacists in performing this duty.

12. The Committee recognized the costs associated with the creation and implementation of any nationwide system and agreed that sustainable funding is necessary to facilitate the
development of such a program. The Committee believes that federal funding drives implementation of nationwide standards.

13. The Committee agreed on the need to have an interprofessional advisory board to guide collaborative efforts related to PDMPs. Compiling, analyzing, and using program data will assist in providing focused provider education. In addition, analyzing data trends may help providers identify and refer patients who need addiction treatment.

14. The Committee recognized the need for ongoing education and training related to the use of a nationwide PDMP to ensure that users of the system understand how data should be maintained and utilized to ensure patient confidentiality.

Attachment

Background Paper prepared for the 2014-15 APhA Policy Committee
INTEGRATED NATIONWIDE PRESCRIPTION DRUG MONITORING PROGRAM

Background Paper Prepared for the 2014−2015 APhA Policy Committee

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Issue

The American Pharmacists Association (APhA) Board of Trustees has directed the 2014−2015 Policy Committee to recommend policy to the APhA House of Delegates concerning a National Prescription Drug Monitoring Program (NPDMP). Topics to be explored, per the direction of the APhA Board of Trustees, include components and standardization of an NPDMP, variability among controlled substance regulations between states, incorporation of drug monitoring programs into the pharmacist’s patient care process, data reporting, and financial feasibility of an NPDMP.

The abuse, misuse, and diversion of controlled medications is a nationwide problem. Between 1999 and 2010, prescription opioid sales quadrupled. The rise in opioid prescriptions was mirrored by an increase in opioid-related deaths, resulting in a mortality rate four times higher in 2008 than in 1999. In addition to a rise in opioid-related deaths, a rise in emergency department visits for opioid-related medical problems doubled between 2004 and 2007. Likewise, admissions to abuse treatment centers rose, with prescription opioids being the second leading cause of admissions. In response to the rise in opioid prescription abuse, misuse, and diversion, prescription monitoring programs were developed, first in California using resources available such as carbon copies, U.S. mail, and triplicate forms. In 2011, through national funding and the increased focus on prescription monitoring by the White House Office of National Drug Control Policy, states received additional support to create prescription drug monitoring programs (PDMPs). By 2013, 49 states passed laws enabling the creation of these programs.¹

Currently, participating states oversee their own drug monitoring programs. Despite the growth and implementation of PDMPs in each state, their inability to facilitate interstate communication limits pharmacists’ and physicians’ ability to utilize these tools to their fullest potential. The National Institutes of Health published a manuscript addressing the concerns associated with PDMPs’ inability to allow interstate communication and barriers associated with varying PDMPs.¹ Other authors attempt to study the impact that state PDMPs have on treatment referral, medication abuse, misuse, and diversion, as well as the impact on patient care, but the researchers find generalizing the data or combining PDMP data difficult due to the variations in state PDMPs.²⁻³ It seems that a national prescription drug monitoring program may be beneficial, but no organizations or groups have published reports outlining standards or recommendations for an NPDMP.
Summary of Concepts

- Medication abuse, misuse, and diversion is a national problem affecting all states.
- The use of a national prescription drug monitoring program would assist with PDMP data sharing and interstate connectivity.
- Barriers such as ineffective communication, inconsistency between state monitoring programs, insufficient funding, and lack of incorporation into the patient care process prevent efficient and optimal use of PDMPs.
- Although use of PDMPs in most states is expected, no defined regulations have been created to ensure the appropriate, consistent, efficient, and optimal use and access of PDMP data. Pharmacists, as medication experts and dispensers, have an opportunity to play a significant role in helping to curtail medication abuse, misuse, and diversion.
- PDMPs should be incorporated into health care professionals’ workflow through the study of current pilot programs and the use of health information technology (IT) to provide access to the data for all health care providers.
- A number of key aspects have been identified that allow for a successful PDMP.
- DMPs should continue to be studied to ensure their quality, efficacy, and efficiency for health care providers and patients.

Background

Definitions

For the purposes of this discussion paper, the following definitions will be used:

**Prescription Drug Monitoring Program (PDMP)**

According to the National Alliance for Model State Drug Laws (NAMSDL), a PDMP is a statewide electronic database that collects designated data on substances dispensed in the state. The PDMP is housed by a specified statewide regulatory, administrative, or law enforcement agency. The housing agency distributes data from the database to individuals who are authorized under state law to receive the information for purposes of their profession.4

**Controlled Substances**

A controlled substance is a drug or chemical whose manufacture, possession, or use is regulated by a government and whose general availability is restricted. Controlled substances are subject to government control. They may include prescription medications and drugs or other substances that are strictly regulated or outlawed because of their potential for abuse or addiction.4

**White House Office of National Drug Control Policy (ONDCP)**

ONDCP was created by the Anti-Drug Abuse Act of 1988. ONDCP advises the President on drug-control issues, coordinates drug-control activities and related funding across the federal government, and produces the annual National Drug Control Strategy, which outlines administration efforts to reduce illicit drug use, manufacturing and trafficking, drug-related crime and violence, and drug-related health consequences.5
**National Drug Control Strategy**
The ONDCP’s National Drug Control Strategy outlines innovative policies and programs and recognizes that substance use is not only a criminal justice issue but also a major public health concern.⁶

**2014 Reform Drug Policy**
This policy focuses on prevention, expansion, reform, and support. Prevention strategies will use education to prevent drug use before it begins. Expansion will increase patient access to treatment centers. Reform will change the legal system to break the cycle of drug use, crime, and incarceration while maintaining the safety of the public. Support will focus on working to eliminate or reduce the stigma associated with substance abuse or disorders to provide greater support for Americans struggling with substance abuse.⁷

**Benefits of PDMPs**
The overview provided by NAMSDL clearly identifies the benefits of a PDMP as a tool used by states to address prescription drug abuse, addiction, and diversion. It may serve several purposes:

1. Support access to legitimate medical use of controlled substances
2. Either prevent or identify and deter drug abuse and diversion
3. Facilitate and encourage the identification of persons potentially involved in medication abuse, misuse, or diversion
4. Inform public health initiatives through outlining medication use and abuse trends
5. Educate individuals about PDMPs and the use, abuse, diversion of, and addiction to prescription drugs⁴

**PDMP facts**
As of June 2014, 49 states and the District of Columbia (DC) have enacted PDMP legislation, and 48 of the 49 states currently have operational PDMP programs; only DC and New Hampshire do not have operational programs. The majority of the states’ programs require submission of prescription data within 1 week of collection, with a few processing the information within 1 to 3 days. Oklahoma is the only state that processes the information in real time. The majority of states’ PDMP information is housed in health departments, single state authorities, or the board of pharmacy, but the PDMPs of five states are regulated by law enforcement agencies. For example, Georgia’s PDMP is regulated by the Narcotic and Drug Agency under the direction and oversight of the Board of Pharmacy. Although each state’s program regulations vary concerning who can access the PDMP information, the majority allow access by the following entities: licensing and regulatory boards; practitioners; authorized agents; law enforcement officials (pursuant to an active investigation); judicial and prosecutorial officials; Medicare, Medicaid, and State Health Insurance Programs; patients; parents (either with or without a consent form); prescribers; and dispensers. In addition, approximately 50% of the states provide immunity to prescribers and dispensers, meaning the data collected through PDMPs cannot be used to accuse prescribers or dispensers of illegal or unethical activity.
Finally, the majority of states have some regulation in place to deter users of PDMP services from disclosing or obtaining information unethically.  

**Components of a Strong Prescription Drug Monitoring Program as identified by the National Alliance for Modern State Drug Laws**

1. **Drugs Monitored:** The medications monitored should be those having high abuse potential, including controlled substances, but also medications that have a history of abuse but are not classified as a C-II through C-V medication.

2. **Disclosure:** PDMPs should proactively provide information to prescribers, dispensers, law enforcement, and occupational licensing individuals.

3. **De-identified Information:** De-identified information should be allowed for release to individuals, groups, or organizations using the information for any of the following purposes: statistical analysis, public research, public policy, or educational purposes. Information that should be removed must include anything that could identify or reasonably identify the patient, prescriber, dispenser, or other person who is the subject of the information.

4. **Authorized Users:** Authorized persons include dispensers, prescribers, law enforcement officials (pursuant to an active investigation), prosecutorial officials, health licensing agencies, boards for prescribers or dispensers, and patients. In addition, other authorized users who may be considered are those who will use this information to enhance patient care or patient safety, for example, medical examiners, coroners, and representatives of drug and alcohol abuse treatment centers.

5. **Authorized Users Training and Education:** All authorized users who may access the information should prove they have the education and training to use the PDMP data appropriately.

6. **Standards of Procedure for Access and Use of PDMP Data:** Providing standards of use should stand to decrease abuse and misuse of the system. In addition, standards of procedure will allow the PDMP to be utilized to its full capacity to improve patient care and safety.

7. **Linkage to Addiction Treatment Professionals:** Allowing linkage to addiction treatment professionals may enhance the PDMP’s ability to identify patients who qualify for addiction treatment centers.

8. **Interstate Sharing of PDMP Data:** Recipients of PDMP data from other states may include prescribers, dispensers, law enforcement representatives, PDMP officials, or other specified authorities.

9. **Confidentiality Protections:** The confidentiality protections should not only outline regulations but also provide information concerning penalties for nonessential disclosure of the confidential information. To prevent improper disclosure, the PDMP managing body should maintain procedures to protect the privacy and confidentiality of patients and to ensure that data collected, recorded, transmitted, and maintained pursuant to the PDMP law are not disclosed or used except as authorized by the law.

10. **Evaluation Component:** The evaluation component of the PDMP is necessary to determine the cost benefit of the program and identify the impacts of the use of PDMP data on authorized users’ practices. It will also provide a means to identify potential operational improvements. It is suggested that the evaluation component consist of an advisory committee.
Discussion

Due to the rise in prescription drug abuse, misuse, and diversion in the United States, the government provided national funding through the White House ONDCP to support the development of prescription monitoring programs for each state. By condensing prescription dispensing information into one database, PDMPs provide health care providers with the opportunity to review a patient’s medication history and assist them with decisions concerning their medication regimen. For example, PDMPs allow physicians to identify patients who may benefit from substance abuse counseling, prevent prescribing that may result in overdose, help coordinate patient care, and perhaps identify patients and practitioners who abuse or divert prescription drugs. It is for these reasons that the Centers for Disease Control and Prevention (CDC) as well as the President support the use of PDMPs.²

Despite national support of the development of state-based drug monitoring programs, the creation of these programs has been controversial. Prescription monitoring programs were originally designed to assist with law enforcement and decrease opioid abuse and diversion; however, they have secondarily facilitated addressing public health concerns by allowing monitoring of physician prescribing and identifying opportunities for addiction services. This secondary role has left some physicians feeling scrutinized, which may affect their opioid prescribing. This situation in turn may lead to over- or under-prescribing of opioids resulting in inappropriate or inadequate pain management. In addition, concerns are raised about privacy and the inadvertent release of private information. In conjunction with privacy concerns are concerns about who should have access to data collected by drug monitoring programs and how often. Finally, the impact of prescription monitoring programs on patient care is also under question. It is yet to be determined whether PDMPs improve or worsen patient care. No evidence exists to support the notion that PDMPs have significantly assisted with situations mentioned above or helped regulatory agencies identify illegal activities. Lack of significant data could be due to an inconsistency among different state programs, including variations and frequent changes in PDMP laws.

In addition to being unable to identify whether PDMPs affect patient care and the control of illegal and unethical activities, PDMPs are also limited by their individual state-to-state use. Because each state has its own program with different regulations and collection guidelines, the information is not readily shared across state lines, making the monitoring of individuals who have moved or travel frequently difficult. With the increase in travel across state lines and the inability to study the impact of PDMPs and their cost benefit, it has been suggested that the creation of a National Prescription Drug Monitoring Program (NPDMP) may be beneficial.⁷ An NPDMP would provide a means to use data from different states when a person travels or moves. However, the NPDMP opportunity does not come without barriers. To create, establish, and execute an NPDMP, legislative action, including funding, will need to commence; then standards and regulations must be created by the appropriate federal agency.
Potential Approach to a National Prescription Drug Monitoring Program

A National Prescription Drug Monitoring Program concept has been mentioned and supported by some health care providers, the Bureau of Justice Assistance, and the National Institutes of Health as a means to enhance the fight against prescription drug abuse, misuse, and diversion; identify patients for abuse treatment programs; provide a database for states not currently using a PDMP; and provide uniform expectations for prescribers, dispensers, and consumers.\(^1,8\) However, the federal government and CDC do not support a National Prescription Drug Monitoring Program. This lack of support may be due to a lack of awareness of the deficiencies in having individual PDMPs operated in each state. These deficiencies include the inability to adequately study the effects a PDMP has on patient care and safety, the difficulty involved in interstate communication, and a low level of understanding of the issues associated with the lack of standardization or consistency among state PDMPs. The lack of standardization prevents the linkage of state programs. Therefore, the Council of State Governments, Congressman Hal Rogers of Kentucky, and the National Association of Boards of Pharmacy have discussed interoperability standards to facilitate interstate communication.\(^1\) In addition, standardization would prevent the abuse of some controlled substances from going unidentified. For instance, a patient’s abuse or misuse may continue unidentified due to substitution with a medication that is not on the PDMPs list of medications required to be monitored.

Recommendations include both standardizing the medications to be monitored, and standardizing the way in which access is granted. Web-based PDMPs seem to provide the most benefit, by allowing immediate access to data versus waiting on information via fax, telephone, or mail. Another recommendation is to standardize the length of time prescribers and pharmacists are given to report information to the database. Because daily or real-time reporting may be burdensome and monthly reporting may be suboptimal, it may be most appropriate for pharmacies to report information to the PDMP every week. Determining a standard reporting time would need to be agreed upon nationally and would most likely require further evaluation. Finally, all states should be required to ensure the accuracy of data, determine the impact of the program, and evaluate responses to program changes through an evaluation process.

A key consideration in the discussion of a drug monitoring program is the type of program to be implemented. Studies have shown that proactive programs with periodic unsolicited audits perform better than those that do not require these audits.\(^1,9\) Standard reviews would provide more data and information pertaining to drug abuse and misuse such as geographical areas of high incidences, patients filling prescriptions from five or more prescribers within a 6-month period, patients who submit prescriptions in an overlapping period, and identification of at-risk co-prescriptions.

Implementing education and training requirements to ensure program awareness as well as an understanding of the protocols and procedures regulating the program may be necessary. One barrier to using the NPDMP may be an inability to incorporate it into clinical workflow. To make the data provided by the NPDMP more accessible, an increase in authorized users of the PDMP may be necessary. Allowing for better incorporation of PDMP data into workflow is supported by the Substance Abuse and Mental Health Services Administration, which
recommends allowing physicians to access the information via medical records and allowing unsolicited alerts inside the medical record to highlight potential abuse or misuse situations.9

Currently, states’ PDMPs are funded individually by general state revenues, licensing board fees, state controlled substance registration fees, health insurers’ fees, and state and federal grants, but a national PDMP would require more extensive funding and might result in better consistency and efficiencies among states. The annual cost of a state PDMP is $125,000 to $1 million.10 A potential revenue source would be the National All Schedules Prescription Electronic Reporting program, which would require Congress to restore funding for the program. It may also be beneficial to consider funding from pharmaceutical companies that have a significant stake in appropriate use of controlled substances. Selling points for industry buy-in are that the NPDP may reduce prescription drug abuse and overuse and thereby decrease the likelihood of more restrictive regulations on controlled substances. In addition, complications from abuse, misuse, and overdose place a high cost burden on pharmaceutical companies, and the successful implementation of a national PDMP could potentially alleviate some of this strain.1

The Bureau of Justice Assistance (BJA) is also focused on improving interoperability and has made this initiative a priority. The BJA has facilitated the creation of a national Prescription Drug Monitoring Information Exchange (PMIX) architecture. PMIX enables nationwide information sharing while allowing states to maintain their current technology. PMIX does not require adoption of a particular system. The primary concern, or barrier, for a national program involves standards, but PMIX standards are free, open, and community-based. Users of PMIX are allowed access to the nationally built standards at no cost. By keeping the standards open and free, PMIX preserves states’ choices to build, buy, or reuse software according to a commonly understood and accepted framework that will facilitate PDMP system interoperability. The second barrier for a national PDMP is common formatting of shared data. PMIX addresses this issue by using the National Information Exchange Model (NIEM). NIEM establishes common data vocabulary and format for interstate information sharing, thereby allowing states to continue managing their information as they currently do, while enabling them to share information across state boundaries. PMIX protects personally identifiable information and protected health information by requiring end-to-end data security and encryption of data. This form of protection ensures that information reaches its intended destination. The security technology used allows incorporation into numerous types of systems, including non-PDMPs and other systems that are consistent with Health Insurance Portability and Accountability Act standards.11

**NABP PMP InterConnect® Platform**

In addition to the approaches described above, the National Association of Boards of Pharmacy launched InterConnect® in July 2011, a platform that facilitates the transfer of PDMP data across state lines to authorized users. It allows participating state PDMPs across the United States to be linked, providing a more effective means of combating drug diversion and drug abuse nationwide. Information about this program is provided as a supplement to this background paper (Appendix A).
Role of Pharmacists in the National Prescription Drug Monitoring Program

Pharmacists using prescription monitoring programs can assist in detecting and then intervening to decrease the abuse, misuse, and diversion of controlled substances state- and nationwide. They can also help determine whether patients are being inadequately controlled for pain. Through identification of patients with inadequate or inappropriate pain control, they can refer the patient to an appropriate resource such as a pain management physician or abuse treatment center. However, pharmacists are limited in their ability to assist with drug diversion without systems that communicate effectively. Development of a user-friendly database providing the means for interstate communication would greatly increase pharmacists’ ability to assist in this situation. Such a database would apportion the responsibility of managing and addressing drug diversion, enable pharmacists to assist prescribers with medication-related decisions, and help them avoid facilitating diversion. Because prescription abuse continues to be a national concern for health care providers, creation of an NPDMP would allow for better transparency of patient history and better patient care assessments by the pharmacist concerning the dispensing and use of controlled substances.

Benefits of a National Prescription Drug Monitoring Program

Creation of a National Prescription Drug Monitoring Program would require states to agree on national standards to regulate their PDMPs to decrease abuse, misuse, and diversion of controlled substances. The use of a national PDMP may be sensible because the problem of abuse, misuse, and diversion exists nationwide; therefore, it should be monitored and regulated with a nationwide program. For patients who do not remain in one state and travel or move from state to state, a national program would allow for continued observation and maintenance of prescription use data. A national program may be created by unification of the current state-regulated PDMPs and therefore decrease the cost burden associated with building a NPDMP. Moreover, a national drug monitoring program could extend beyond communication of information about controlled substances and commonly abused medications; it could also communicate information concerning drug shortages and drug importation. In addition, creation of a national drug monitoring program would increase pharmacists’ ability to assist with pain management, drug diversion, abuse, and misuse and thereby increase their role and involvement in the health care system. Finally, a national program with scheduled reviews could highlight patients who are “doctor shopping,” prescribers who are unethically or illegally prescribing medications, and/or pharmacists who are unethically or illegally dispensing medications.

Barriers to Implementation of a National Prescription Drug Monitoring Program

Funding

Although the government has funded some of the state-level prescription monitoring programs and the BJA has supported the creation of the PMIX, there is currently no identified funding for a national prescription drug monitoring program. While states have the opportunity to take advantage of federal grants, these opportunities are limited. Private, nonfederal grants, such as those from the National Association of State Controlled Substances Authorities, a nonprofit educational program, provide smaller amounts of funding for educating stakeholders, but these
funds would not be sufficient for a national program. The majority of states fund their PDMPs through revenue funds, using state taxes, sales taxes, income taxes, and property taxes. While taxes would be an option for funding a national program, doing so might not receive positive feedback and approval from the public. Other revenue sources for PDMPs include licensing boards, controlled substances registration fees, and other local fees, which would not be appropriate for funding a national prescription drug monitoring program. Due to current state-to-state techniques and strategies for funding PDMPs, finding a financially feasible funding source for a NPDMP may prove difficult.12, 13 To develop a successful NPDMP, national funding must be identified to ensure an effective and beneficial national program.

Incorporation into the patient care process

For an NPDMP to be financially beneficial, all states’ health care practitioners must take advantage of the program and use it to its fullest potential. Currently, however, studies have shown that only five states require prescribers to access PDMPs and those requirements apply only to a specific set of physicians in limited situations. With a national PDMP, access to PDMPs by health care professionals must be mandated and incorporated into the patient care process in a seamless manner. Based on white papers published by the Department of Health and Human Services Office of the National Coordinator for Health Information Technology (ONC), successful incorporation of the PDMP system into physician workflow changes prescribing habits.14 The Indiana Direct Messaging white paper reports that sending unsolicited secure electronic messages improves prescriber awareness.14 These messages provide alerts to physicians on a weekly basis identifying persons of interest (POIs) based on a defined “at-risk” threshold. Other projects have incorporated PDMPs into e-prescribing to improve usability and access and have provided direct links inside electronic health records (EHRs) to connect physicians to PDMPs. Projects that combine incorporation into EHRs and identifying POIs increase physicians’ access to and use of PDMPs.14 However, the use of PDMPs must be incorporated into both physician and pharmacy workflow. A white paper by the ONC identified the possibility of using health IT to implement the current process for identifying patient insurance eligibility to access patients’ prescription use information. This step would eliminate pharmacists’ need to access the information manually and would result in a substantial increase in access to PDMP data.13, 14

In addition to the incorporation of patient information into the PDMP, pharmacists are concerned about their ability to manage the information obtained from the system when encountering a potential abuser and protecting their and their staff’s safety. In August 2014, the Joint Commission of Pharmacy Practitioners (JCPP) adopted a statement and principles on pharmacists’ role in addressing prescription medication misuse and abuse. Included within this document were the following points of discussion:

- **Prescription Drug Monitoring Programs**: Prescription drug monitoring programs are useful clinical tools to identify, prevent, and manage prescription medication abuse and misuse. JCPP supports pharmacist access to and use of prescription monitoring programs and dispensing systems that provide timely, bi-directional, and seamless data collection tools to help identify potential abuse and misuse of prescription medications and support access to current relevant
medical information that will allow pharmacists to make appropriate decisions regarding medication therapy.

• **Patient referral mechanisms:** Recognizing that alcohol, chemical, and substance abuse is a disease, health care professionals and law enforcement agencies should have referral and treatment resources available to recommend to patients, family members, and caregivers, and individuals identified with a problem should be encouraged to seek treatment.

• **Need for provider protection:** Systems should be in place to allow providers to anonymously report (1) practitioners who may be abusing prescribing authority and (2) patients who are abusing or misusing prescription medications. Employers and public safety officials must respond to pharmacist and other health care professional calls for assistance, personal security, and legal protections to ensure professional and physical safety related to the reporting and management of situations in which abuse and misuse of prescription pain medications is suspected.

• **Education of providers:** Health care professionals and students who will ultimately prescribe and/or dispense prescription medications with the potential for abuse should have access to continuing education programs and institutes that address the various aspects of addiction, substance abuse, treatment, and recovery, including discussion of prevention, appropriate and safe use, proper storage and proper disposal of medications, patient education, and other related topics.

• **Cost of abuse-prevention systems:** To ensure the sustainability of prescription medication abuse and misuse monitoring and reporting systems, adequate financial and human resources must be available to providers and government agencies.

**Conclusion**

Because prescription abuse, misuse, and diversion is a nationwide issue, it is vital that states work together to share PDMP data and provide a national solution to prescription abuse issues. During the development of solutions to PDMP data access and information exchange, it is important to define standards for monitored drugs, identify persons who will have access, determine funding options, and make other determinations to ensure that a national prescription drug monitoring program meets the needs of all states and is successful in deterring abuse and identifying persons who can benefit from abuse treatment centers.

Pharmacists are well-positioned to provide valuable information for PDMPs and also to identify and recommend patients to abuse treatment centers. As medication experts and dispensers of prescription medications, pharmacists can provide counseling and support to assist with drug abuse and misuse awareness. As standardized methods for incorporating prescription monitoring data become available, it is important for pharmacists to continue to play an active role in prescription use monitoring. Providers should be supplied with proper education on the way in which to incorporate PDMPs into the workflow process, and they should be given additional resources to support their use of the PDMP data.
References


14. The Office of the National Coordinator for Health Information Technology. Use of Health Information Technology to Optimize Provider Access and Use of Prescription Drug Monitoring Information.

Related APhA Policies

1989 Multiple Copy, Prescription Order Programs
1. APhA opposes federally mandated, multiple copy, prescription order programs.
2. APhA supports the right of individual states to develop programs to prevent drug abuse and drug diversion.

2002 National Framework for Practice Regulation
1. APhA supports state-based systems to regulate pharmacy and pharmacist practice.
2. APhA encourages states to provide pharmacy boards with the following: (a) adequate resources; (b) independent authority, including autonomy from other agencies; and (c) assistance in meeting their mission to protect the public health and safety of consumers.
3. APhA supports efforts of state boards of pharmacy to adopt uniform standards and definitions of pharmacy and pharmacist practice.
4. APhA encourages state boards of pharmacy to recognize and facilitate innovations in pharmacy and pharmacist practice.