



Recommendations to Optimize Prescription Drug Monitoring Programs for use in Emergency Department

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BACKGROUND

The United States faces an epidemic of opioid addiction, overdose, and death fueled by prescription drug abuse. This is of particular concern to those who practice emergency medicine (EM) as pain is a primary reason for emergency department (ED) visits.ⁱ One challenge is that emergency providers lack continuity of care and knowledge about the medical history of ED patients. Prescription Drug Monitoring Programs (PDMPs), searchable online patient databases of controlled substances (e.g. opioids), have been identified as a key tool in identifying at-risk patients and thereby reducing abuse, overdose, and death. PDMPs are underutilized in the ED due to regulatory limitations and PDMP design is at odds with the time pressures of patient care in the ED.ⁱⁱ It is not known how PDMPs can be optimized for use in EDs. This policy brief addresses potential ways to improve PDMPs to facilitate their use in the ED setting, summarizing findings of an expert panel.ⁱⁱⁱ

FINDINGS

Enrollment

Rates of PDMP enrollment are low; well below 50% in most states. In response, more than 20 states now mandate prescribers to enroll in their state PDMP. Supporting this policy are several observational studies associating PDMP use with decreased rates of opioid abuse.

Log-on

Providers report difficulty with navigation of the web-portal and forgotten passwords as common reasons for not using the PDMP. Integration of PDMP content into health information exchanges (HIEs) and electronic health records (EHRs) with single sign-on capabilities will remove these barriers to routine use. Push and pull are the primary types of secure data transfer; push results in automatic electronic transfer of data into the recipient's system and pull requires a query by the recipient to deliver data. Push transmission is preferred to pull - it reduces the risk of error that can occur when physicians base their use of the PDMP on personal judgment.

METHODS

We assembled an expert panel to review PDMP policies and make best practice recommendations for PDMP design and policy in the ED environment. The expert panel included key stakeholders in medicine, public health, and public policy. A systematic literature review was performed to identify best practices for PDMP design, and a policy review identified state policies of PDMPs. From this, a comprehensive list of PDMP characteristics and state policies were compiled for review by the expert panel. The panel used a consensus process with three rounds of structured conference calls in which information from experts was gathered during discussion with subsequent post-call voting to modify and rank characteristics and policies. Domains based on user-PDMP interaction were created, and the panel developed **Policy Recommendations**.

Registration

Physician assistants (PA) and nurse practitioners (NPs) now treat approximately 15% of all ED visits. A minority of states permit PDMP registration by PA and NPs, with even fewer permitting registration by resident physicians.

Mandates

States that mandate PDMP use find increased database queries and reduced opioid prescribing. State mandates are based on objective or subjective criteria for look-up prior to prescribing. There are no data to suggest that either criteria is superior, but we do know providers are imperfect at detecting at-risk patients. Objective criteria avoid this pitfall and allows states to create a reasonable minimum amount for which PDMP look-up would not be mandatory, helping to balance the work of reviewing PDMP with ED workflow concerns.

Policy Recommendations for State Prescription Drug Monitoring Programs to Facilitate Emergency Department Use

Enrollment

- PDMP enrollment should be mandatory rather than voluntary, with an automatic enrollment process to mitigate extra work. For states that prefer voluntary enrollment, we recommend automatic enrollment processes (e.g. when relicensing) to encourage participation.
- PDMP enrollment should be an automatic process (e.g. when relicensing) and we recommend against an active enrollment process to minimize workload to provider and to improve rates of enrollment.
- No requirement of notarized documents for any type of enrollment.

Registration

- Registration should be open to all prescribing providers, thus allowing PDMP use for those with partial licenses, limited licenses, and full licenses in addition to designated delegates.
- Registration should not be limited to only fully licensed providers.

Log-on

- State policy should allow PDMP integration of log-on into electronic health records as a “push” rather than a “pull” system.

Delegates

- Delegates (e.g. registration staff) should be allowed to access PDMPs in EDs to alleviate workflow burdens of PDMP access. This is of particular importance in states without PDMP integration into EHRs and states that lack access for partial/limited providers.
- Delegates’ access should be linked to an institutional account (e.g. hospital) rather than linked to individual physician accounts.

Mandates

- There should be mandatory look up for patients to whom a controlled substance is to be prescribed based on objective criteria (e.g., plan to prescribe a certain number/days of pills, validated screening tool, or morphine milligram equivalents.)

Standardization

- PDMPs should report at least the following to the ED provider: date dispensed, date prescribed, patient name/DOB/address, name/dose/number of medications prescribed, prescriber name/address.
- PDMPs should include at least schedule II-IV medications and report a minimum of 12 months of patient prescription history.

Update

- PDMPs should be updated within 48 hours of dispensing; 1 week is minimally acceptable.
- Updates longer than 1 week after dispensing are unacceptable.

Interstate Accessibility

- For states that allow interstate sharing, we recommend access to other states’ PDMP via a pull system to reduce workflow burden.
- Legislation should be enacted to enable sharing between all PDMPs.

ⁱ Todd KH et al. Pain in the emergency department. J Pain. 2007; 8:460-466.

ⁱⁱ Clark T et al. Prescription drug monitoring programs. The Prescription Drug Monitoring Program Center of Excellence, 2012. http://www.pdmpexcellence.org/sites/all/pdfs/Brandeis_PDMP_Report.pdf

ⁱⁱⁱ Greenwood-Ericksen MB et al. Best Practices for Prescription Drug Monitoring Programs in the Emergency Department Setting. Ann Emerg Med. 2015 Nov 24. [http://www.annemergmed.com/article/S0196-0644\(15\)01415-8/abstract](http://www.annemergmed.com/article/S0196-0644(15)01415-8/abstract)