[Please stand by for realtime realtime captions]

>> Hello and good afternoon welcome to the third opioid safety project event, we are glad you could join us. This webinar is part of the monthly series hosted by the American Medical Association, along with Telligen, with each event we have the pleasure of speakers with a focus topic around managing patients with opioids, I am senior facilitator at Telligen, I'm happy to be hosting the event.

>> Before I welcome the doctor, I have a few housekeeping items, this is an operator assistance call, this call is being recorded, it will be posted on the website with the slides in the next week or so, following the discussion today you will receive survey and we ask you to complete out for us. It should not take more than five minutes, we value your feedback.

>> As I mentioned, today's series is hosted by Telligen, the quality innovation network organization, the American Medical Association also, for those of you that are not familiar with quality improvement organizations, we improve patient Claire -- patient care.

>> The purpose of the QA program is to improve the efficiency and effectiveness and quality of service delivered to Medicare beneficiaries. The QIO provides technical assistance and learning and action no works at no cost to support improvements within your community.

>> Telligen QIO works in collaboration of a three state network in Colorado, Illinois, and Iowa.

>> We also have the American medical Association to enhance delivery of care to partner with patients to achieve better health. Now I want to introduce our first speaker, he is the president and the practice director at clinical pharmacology services in Tampa, Florida, he is on faculty at the University of South Florida College of medicine, and serves as an experienced professor across the country. He is a clinical pharmacology specialist and provides medication therapy management services. He serves as a principal investigator for phase 2 and phase 3 trials and managers a national drug information service. He provides clinical support for medical practices, health systems and plans. His practice focuses on patients taking chronic medication and provides medication therapy management services to improve health outcomes.

>> He is currently on the Board of Trustees of the American pharmacist Association and represents pharmacists on the American medical Association panel. He is serving as a medication safety fellow on the healthcare reform team.

>> He will be presenting on prescription drug monitoring program welcome.

>> Thank you. We have a lot of ground to cover today, thank you for the opportunity to present to you. This is based on the topic of a high degree of national focus on prescription drug monitoring and opiate crisis that is taking place, medication safety is key. I want to frame the discussion, medications represent the number one therapeutic tool for modality in the country, with that, adverse drug events represents the highest healthcare related harm.

>> With that comes a duty to choose and prescribe therapeutic modalities judiciously but also to understand the potential risks and harms that the medications can cause. That begins to be the foundation for the presentation today, the discussion today will cover a history and structure of state-level prescription monitoring program Scott we will go over a comparison of the legislative elements and data reporting requirements across the country, we will look at the impact that PD has made today and talk about what is the evolution that is taking place within the states at a national level at a point of care, and involving legislative activities as well.

>> They are a statewide initiative to manage controlled substance prescribing and to steer towards effective tools to reduce prescription drug abuse and diversion. Represents a user point of care driven data collection in the database so when you find common, across each of the states, it's an attempt to coalesce prescriber activity and dispensing activity into a timely and real work database, provides practitioners and facilities with prescription histories and data for use, specifically for controlled substances. We will talk about the aspirational goals as we go.

>> It's an attempt to create a system, it's been statewide up to now, mostly because of the challenges surrounding confidentiality, different state-level laws and regulations regarding documentation, and how the data can be used but it's a collection, a system for capturing prescribing data and dispensing data putting that into a database and providing an opportunity for analytics, that varies, that's one of the key issues, it varies across the states there are differences but the opportunity also for evolution and progress.

>> When you talk about data collection, and who is involved, it's taking data around the practitioner and prescriber the prescriber patient relationship, and also identifies where the medications are dispensed and as you start to look at medical claims and you compare that to pharmacy claims, you notice that until you bring those claims set together, there's a lot of elements that are difficult to connect. To be able to make an analysis. The other piece is that while most of the PDMPs around the country are focused on prescriber and pharmacy data, there remains at many states, a deficiency of facilities so being able to tie in patients accessing care at different types of healthcare facilities from clinics, outpatient acute care clinic models, hospitals, as you look at the data that is collected for many states, it needs to be improved as well.

>> Who can access the data? The database becomes the next mechanical process and the rules vary around that.

>> The goal of the PDMP regardless of the state should be similar, too much sure access to medications, ideally we to identify those patients or inappropriately accessing and make sure the patient to need the medication, has access to different products or services, we want to improve patient safety as a result of identifying patients who are at risk, patients who are attempting diversion to avoid those, to be a preventative step in the process, target education on prescribers and patients, we collect real-world statistics and that becomes the key, rather than looking at dispensing data this is a starting platform to bring the information together and we are seeing creative efforts in the last 12, 24 months.

>> We gather the data and apply positive interventions from the data, the promotion of public health initiatives, that's taking a nationwide high priority in all practice settings and all forms whether it is through the payers or practitioners, early identification and intervention, and prevention of substance use disorder, one of the clear failures that we have across the country right now is a clear understanding for all types of healthcare professionals on where to send the patient acutely when there are individuals who are identified with early signs of substance abuse.

>> We want to route them properly into the appropriate care, facilitating timely and effective investigation, it's a piece that many people do not discuss but it is important, when you look at the volume of inappropriate prescribing activities that's taken place around the country, it's not the main focus but it is clearly a critical element as well as being able to identify outlier practices and practice settings and then identify those to look at the specific patient population and validate if it is an appropriate prescriber or if those indicators were a true indication of inappropriate prescribing.

>> When we talk about evolution of PDMPs it would surprise everyone to think this goes back as far as 1918, New York developed an early concept of tracking controlled substances, it was started around 1939 where California created the first prototype of what we have as PDMPs today with a statewide initiative. Between 1939 and 1959 there were only two different states that develop an effective model. What you see is between 60 and 69, and progressively you see it took us until 2000 to begin to see an aggressive proliferation and development, if you have seen one PDMP you have seen all PDMPs, there's a wide variety of structures , we will go through this and talk about the pressures, and how they are designed and what is done with the data, who can access the data, the last 24 months have been a high priority in recognizing the PDMPs as an initiative, they have made and demonstrated positive impact on reducing harm in the healthcare space.

>> With that, PDMPs have found their way into legislative efforts as well that reinforce to drive the momentum, there is a high percentage of states, all but one, misery is the only state currently in several territories, that do not currently have but this is showing the rate and the momentum and now we have almost all states and what we see now is progression across all the other states, have led to an increase in uniformity and standardization of what those do, so data sharing, I don't those -- a sense of community developed that shares the structure and helping to increase the rate of development, I use the term, rapid cycle development, we left it that phase, based on positive impact, and in the college of what could happen even next, has led to a greater collaboration from state to state.

>> Let's talk about the challenges, why do we not have a national PDMP in 1939 and why are even until now, there remains differences from state to state, some of those are the legislative elements that went into creating the PDMPs for each state and the challenges that they present, those who are required to enroll and the conditions for enrollment, the data submission intervals, over the years we have seen a wide variety and how frequently the data captures are taking place, it requires a one-month data submission, maybe one week, now most states you will see our one day, at the end of the day the data is submitted to a central data repository.

>> What we will see is eventually, real time so tied in with electronic medical records and pharmacy software systems, will be the ability for a direct real-time submission.

>> Rules for patient safety, and the review, who contacts the data what can be done with the data, how to structure a query how you can access the information and get an answer back from the state data set, this is a key issue. Use the staff, all these started with only the practitioner themselves, which began to create a time burden and the practice burden and that the practitioner have to stop and was the only one who could login and touch the data and we can understand that from a desire to maintain a high degree of security around the information, but like in any of the healthcare element, the protected information, there's already that same expectation on the rest of what resides in the electronic record.

>> Many states have broadened that to now allow support staff with direct accountability, to the practitioner that they are working for to be able to have access and help to assist in the efficiency of data access at the point of care. Interstate data sharing, this is something that over the last several years we have seen as border stay collaboration, so they might say I'm not prepared to share this with everybody nationwide, but we have an adjacent state that we realize if you're practicing or living on the border, those practitioners in each state should be able to see so as not to be gained on the version efforts where a patient might just cross the border.

>> That is really, that is where the greatest progress is happening right now, it's in the concept of data collaboration. And the data evaluation, for the most part it was the profile to see what is there and close that, now we start to see a higher degree of analytics and creativity on how to design the access to the data and manipulate that to be able to help with care coordination and drive medical decision-making.

>> There are differences, let's look at the different comparison features, 24 PDMPs capture identification so they are not all direct on the patient information, 46 capture method of payment, 50 collect data less than seven days, a much greater tightening of the window to improve the utility of the information for the prescriber and the dispenser. 11 have health information exchange integrations, the number you will see transition may be trouble, quadruple this year alone, 46 allow unsolicited reports and alerts, 28 have mandatory enrollment of varying types, who has to participate or engage or access the PDMP, 32 have mandatory utilization, in some states you have to be able to access but you are not required to access and utilize the information, a lot of standardization starts to take place, all in the name of trying to make the time, the effort, and the data collected a greater utility for patient safety.

>> 47 allow delegate access, someone in the support staff to be able to access with the practitioner, 37 engage in interstate data sharing, that is what is changing, I will call the exponential change, and what's about to take change -- take place.

>> The problems and challenges, will focus on what types of data, who is required, if you're the individual who is in charge of managing or developing and you are accountable to manage the PDMP the state they have other challenges, there is the diversity of how those PDMPs are funded, this is a tremendous amount of IT infrastructure commitment, staffing, legal and regulatory support, these are not a basic function to develop, they are not the entire EHR but there's a tremendous amount that goes into ensuring the privacy and the protection of the data and it is used properly.

>> And how that funding comes to be his different across each day, -- is patient -- is different across each state.

>> You may spend three months on the project and live in a completely different region of the country, variations in data reporting and application, EMR integration, we have said that's a great progress area, until you realize that each EMR and EHR will have different standards, that the government has developed but that doesn't mean everyone has refined the data exchange process or interoperability.

>> It still presents a challenge for the PDMPs over are holding a critical data set that others need to make sure have access to EMR's.

>> HIPPA and litigation, I wish I could tell you that have been no problems, with data security, that there have been no challenges or no legal cases that involve inappropriate use but they have happened, they have been few but they been strong examples on the importance for anyone who has authority to access the data, to do that properly and there is ramifications if they do not maintain that respect and security. And the accuracy, the data accuracy and liability is another piece, we are looking at this collectively as something that improve patient care but if the data that is in the PDMP is not accurate, many practitioners have expressed concerns on how the data could be used incorrectly in terms of scoring or making judgments about the care that is provided.

>> This goes back to that it takes a community to help manage this and all voices should be heard in the process.

>> When you look at primary funding sources, I recommend that you go to this PDMP site, there's a lot of great information, there is tracking that takes place of different critical elements, what is displayed here is nine states use general state funds, the state has made the commitment to fund that and you can see those listed in dark blue. You can see other creative portals or baskets of funding some states have used an element of the healthcare practitioners licensing fees as the funding pool, it comes out of that as opposed to state general funds and others control substance registration fees, regulatory board funds, other state funding, federal grants There's a wide variety. You will see as the standardization takes place, across the country, and we have a more national perspective taking place, you will see more standardization of how the states fund their individual initiatives.

>> Who has the authority over the PDMPs? This will illustrate in 20 PDMPs they are managed by that states Board of pharmacy, 16 are managed by the states Department of Health, five would be by law enforcement, six professional licensing agencies, and substance abuse and consumer protection, only one state.

>> You can see a variety of who is assigned with the responsibility and accountability for designing an ongoing management of the PDMP.

>> When you say PDMP, you say controlled substance tracking, the assessment and the collection of prescription data, it varies, 35 of the states include tracking schedules, 16 of the states track schedules, one of the things will start to see over time is all become uniform and Allstate PDMPs track all

controlled substances. There's even a discussion of the possibility of tracking or prescription medication. That's a broader discussion but when you begin to think of the ability to assess the patient safety and risk factors, there is merit further discussion.

>> Participation, which professionals got 28 require pharmacist to submit data, 25 require pharmacist and physicians, the uniformity and standardization is important as well and we will begin to see where both will be required in all's -- in all the states.

>> We talked about practitioners, there's also others who have requested or have access as well they are provisional access, who has authorized provisional access, law enforcement, the definition and the process varies from state to state as what can trigger a law enforcement request and report.

>> Licensing and regulatory boards, they can also do that, they can access the data set for investigations, Medicaid programs for provider reviews, medical examiners, you can have a broader sense of what the patient had access to in terms of prescription medication, and population health research, that is not uniform but we have seen an increase in that as well.

>> This looks at the release of PDMPs for research whether it is epidemiologic or educational, 24 states allow authorized release of identify data for research, and 21 allows authorized release only not just for the research but authorized release. And if you do not.

>> We will begin to see that to be standardized as well.

>> One of the changes that has taken place in the last 12, 24 months as many of the PDMPs have updated from a seven, 14 day data submission interval down to every business day, a 24 hour interval. Eventually there are real-time examples, we will see the utility of the entire process is underscored when real-time data access becomes uniform.

>> Interesting survey physician survey out of Maryland, they look at the attitudes and experiences with PDMPs and they saw interesting results, 74% found the PDMPs data was useful, 70% increase the comfort when prescribing opioids when they had the capacity to know what else the patient was having access to, but 20% reported difficulty with accessing the data.

>> It's mostly because the influence were concerns around the efficiency in a given practice setting, when we have more limited access as we have greater support staff, and delegation within the practice, that helps to reduce the concern.

>> When we talk about what success has, one of the things that's been used in many states, while not a perfect metric, and one that needs to have the caveats and the exceptions ensure to meet patient's needs, it's a term we use, that is when we look at comparing opiates within healthcare and pharmacy analysis, and what we see are three states demonstrating some dramatic results. Florida demonstrated an 80% reduction in opioid prescribing, Ohio 85%, Kentucky was 62% reduction, there is a significant impact and it's one thing to say, that's just the basic count, does it make a difference in terms of health care?

>> This helps to illustrate that You can see an example, this comes from a particular report done in Florida but it shows as the prescription counts for oxycodone prescriptions, were rising from 2006, until 2008, and continues to rise until 2010, we also saw with a corresponding reduction of oxycodone prescriptions we also saw a significant reduction in prescriptions between 2010 and 2012, but a 52% reduction in deaths during that same time Period so there's correlation between the efforts of a PDMP and the utilization of the data , it impacts prescribing and it impacts reducing patient harm.

>> If we start to look at the evolution, that's a lot of progress and a lot of consternation that's taken place just getting states to work together to collaborate, to share structures, successes, challenges, what lies ahead? Exponentially, if you think it's been a fast and wild ride up to this point, what's the next three, five years, it is showing positive impact. And because we have heightened crisis at a national level to a high priority, let's look at what someone does -- let's look at the evolution of PDMPs.

>> These are the aspirational goals. Increased efficiency, is a high degree of focus on knowing that they make a positive impact, how to ensure that they are reducing practice burden and improving utility, all schedule medications, when we look at medication safety, opioids are only one factor. When we look at drug interactions, complications from other medications, many of those are falling outside of the opioid class so if we're building the system for the data capture, both prescription and dispensing, it brought into all medications it will create a much richer data set to improve patient safety.

>> Standardizing the collection in metrics, that will go miles for helping the process, real-time data collection, clearly when it went from seven days and 14 days down to daily, there was dramatic improvements when we can go to real-time, the ability to capture the facilities or looking at different windows of time, will be narrowed significantly. Increasing data capture, we need to make sure for all points of access weather is outpatient, inpatient, that we are capturing all those settings, and integrating the data into an EMR, for real-time utility.

>> All practitioners and staffing support, we have to get that standardized across the states, to help efficiency and one I do not see yet but I think will be a natural evolution is a single national data repository. This already discussion on the medication safety and management side and electronic prescribing, to create such a portal or platform, so I think it's a natural fit with the discussion and the momentum that is happening within PDMPs as well.

>> Going back to the earlier point, the more standardized the data collection the easier it is to have a national repository that is built and structured for common data across each PDMP.

>> Enhanced use of data, this can almost be its own lecture, just on the slide, beginning to capture the intent, which then begins to help with the clinical assessments around the medication not just the one that any other controlled substance is that is being prescribed, that will increase the utility. The validation of the patient and family based on the ID that in many states the patient to pick up the controlled substance but so can someone else, the ability to truly track who picked up and the relationship to the patient, that will tighten up the drug diversion significantly.

>> The prior arrest data, emergency room visits, the frequency dates, substance use disorder, overdose data, there is a program right now that is expanding utility significantly, it brings together an enhanced level of data analysis, think of the care management platform, but with the capacity to securely access per authorized user whether that is the prescriber or the pharmacy, you pull the data and bring that through so for mature management perspective, you can have more timely information brought into your electronic record to help with medical decision-making and can be an early identifier.

>> The frequency and use, or prescription data would be a significant enhanced use, and point-of-care report cards, the ability for a healthcare home being able to provide practitioners with timely data surrounding opiate use.

>> One of the sources I will drive you to, it's important to go look at is the national Association of boards of pharmacy, is an individual -- there is an individual who is the liaison for the organization, and has been providing a series of recent updates helping to illustrate the progress of a program called interconnect, this is the solution attempt at a national level, they deal with information across all the states they have developed this program.

>> It is helping to broaden -- we have 41 states engaged in the data sharing but not all of those are nationwide, a smaller set have implemented interstate data sharing, 41 have started the process, six more are following but interconnect as a program speaks to being able to share that nationwide.

>> So PDMP interconnect gives an individual one click access to information and the number of states that are embracing this are going up rapidly. We will see all the states in a short period of time based on the success of the program, they will share the data.

>> When we talk about the progress we have seen, some of the aspirational goals, are people putting money in the right places? Are they putting effort in the right places? If you look at the national level, we see this is no longer just the state driven issue but a national issue, several pieces of legislation are addressing this, the prescription drug monitoring act, is specifically requiring national PDMP sharing, the opioid crisis response, that is also encouraging nationwide data utilization of PDMPs, you're probably all heard of the controlled substance act in 2016, the second version, is also expanding access to recovery services, but also underscoring improved PDMP utilization and the opioid pace is a program that is encouraging increased education for prescribers and pharmacists involved with pain management.

>> This is reinforcing PDMP access as part of the solution so a lot of national activity is looking at improving the use, the design or the funding of PDMPs.

>> If you look at the Outlook as well, these agencies, they are both prioritizing and placing activity at a high priority as well NIH is dedicated $1.1 billion in 2018 and the goal of preventing addiction and improve the treatment, that includes PDMP focus and for the FDA, they are taking a greater focus on health care as opposed to simply a regulatory process for assuring safe medication use, they are focusing on health care outcomes and you can see efforts to reduce consumer advertising, to reduce community supplies a prescription medication, so more judicious dispensing monitoring is taking place.

>> At this point We are set to be able to take questions. I appreciate your attendance today and I encourage you that you closely track this based on what is happening in your own state and at the national level.

>> It's very important that everybody had their voice heard to make sure the programs evolve with the appropriate components and caveats that patients who need the care, get access to the medications they need but we all work together to identify patterns or potential areas for harm for patients or abuse and diversion as well. Any questions?

>> Thank you. At this time, we will take questions over the phone.

>> In order to ask a question press *1.

>> Thank you for the presentation. One state did not have the PDMP, can you speak to why you think they are resistant.?

>> Can you talk about something that I'm hearing about, the complexity and the burden it creates for them, are you hearing that from other people? Are there workflow issues that we can assist with?

>> When you look at the momentum, we show the decades of time, we got to the point now where we have 49 states. I am perplexed, in anticipation of the question, I've gone back and tried to -- look at what we can find that was the focal point of the dialogue around why they do not have one.

>> The majority always comes back to the security and the restriction parameters the access of the data, the level of collaboration and sharing and success stories, the incidence of abuse have been few, I cannot attempt to gauge the amount of harm that one would have as you look at those examples, they vary in what was said or done.

>> The penalties have been harsh so I think as in any other healthcare data, and protecting information, we spend a lot of time as a country in dealing with that, most states seem to deal with that.

>> I cannot tell you other than a recurring statement of concern over privacy and access, that is the recurring theme so one would hope that the national surrounding pressure would help them find the best practice across other states and I can tell you, there appears to be no restricted access, everyone seems to be open to sharing, they are not secretive, one of the things that is happening right now and in the fast manner is a lot of standardization and modeling across each other of what the successful measures are and how to make more -- how to make it more efficient. They all improve. It has to be soon for that. On your issue regarding complexity, I don't think the complexity will get less quickly but the access allowing access to support staff, to expand the practitioners flexibility whether that is a nurse with a pharmacy technician, it has increased the utility and the frequency, not every state requires you have to touch and use the data, the increased use of support staff is increasing the amount and the frequency of the data.

>> When we look at programs, we have tools that can be used and the platform they use is PDMP gateway to pull the data from, it begins to apply algorithms for improving pain management.

>> If you want to ask a question *1.

>> For EHR systems that do not have functionality to query the PDMP, do you think having a simple checkbox would be acceptable?

>> Yes. I am not aware of any particular state that requires a particular form within the PDMP, they can see that on an audit of who touched, how long you are they are, -- how long you are there. That's a point of transition, if you can start and eventually identify additional points that you think help to acknowledge that you checked and there was a problem, if there was a category, many states require that if you identify problems you're supposed to document what you did to try to resolve them.

>> It's a great addition to an EMR even though it is a manual point for record-keeping and would encourage -- there's another product, another checklist, it gives you a point of care capacity to check off what concerns you have in each category and whether you had a concern. There are some creative tool to augment that if you work EHR does not currently import the data.

>> What are your thoughts about incorrect day supply entered by pharmacies affecting accurate data?

>> That's a huge issue. When you look at prescription data alone, you miss a lot of critical information. If you look at quality metrics, around medicine and pharmacy, you will see a lot of confusion around -- days covered, around the possession time, and how to interpret that, the problem is as a prescription comes in, it's not always clear as to how many days based on its use, the minute the day is covered, part of that is how the information is entered into a fixed field and whether there is sufficient data and how that information is used to interpret it, it should be acknowledged at the point of evaluation.

>> Any other questions?

>> There are no questions at this time.

>> How do you access the slide?

>> We will distribute them. We will send that out following the presentation.

>> Can you comment on whether individuals outside the health care system should have access to PDMP information ? Should it be available to law enforcement officers?

>> Yes. Like every perspective, there should be caveats. The information should only be able to be used for appropriate purposes, and should require that the law enforcement non-healthcare professional has assistance in determining before making judgments, interpreting clinical appropriateness and/or the caveats surrounding the therapy.

>> I think that's an area for improvement in many states, that's when we talk about the use of the data, and how it's evaluated, law enforcement should always have the responsibility to understand the data points and not make -- decisions were presumptions without understanding the data.

>> It plays a role in the investigation, it should just be used with healthcare professional input.

>> What are your opinions for the national alert system?

>> I'm not sure what you are referring to.

>> This ties to the emergency alerts, and whether or not PDMPs are properly reflected in emergency situations. I'm not sure I can fully answer the question.

>> Thank you for answering all the questions. I want to talk about what organizations can do to address the crisis, as you can see on your slides, we participate in the initiative, is the national action for improving management, CMS is focused on improving health outcomes, reducing unnecessary utilization and generating cost savings. We encourage you to demonstrate your commitment to this issue by signing this pledge to educate yourselves and your team. If you need assistance completing the pledge, please feel free to contact us. We want to thank you for your commitment to this issue.

>> Please join us again for the upcoming opioid safety project series in October, November, December.

>> Any other questions? Thank you for Brad -- thank you for providing us with this wonderful information. Have a great day.

>> [Event concluded]