Introduction

The Illinois Prescription Monitoring Program (IL PMP) is a state program that collects controlled substance prescription records from pharmacies and then provides the data to authorized end-users for:

- Clinical care;
- Regulation of professional practice;
- Research and evaluation;
- Law enforcement.

Schedule II, III, IV and V controlled substance prescriptions are currently transmitted on a daily basis by all licensed pharmacies dispensing in Illinois to the PMP database. In addition to dispensers, authorized prescribers and their designees are allowed access to query their current or prospective patients.

Until very recently, prescribers could only access the PMP database by logging in with a username/password combination. Today, DHS has the ability to assist health care facilities to permit an automated connection that integrates the service directly into a hospital’s Electronic Health Record System. This seamless upgrade offers many advantages including opportunity to improve medication stewardship and reconciliation, increased time efficiencies, and enhanced care coordination.

GENERAL INFORMATION

- **How does an organization obtain initial information about participating in the DHS Pilot?**
  - An overview of the collaborative pilot is available as a Power Point on the Illinois Health and Hospital Association web portal. Click [here](#) to view and download a copy.
  - Organizations should explore this project with a team-centered approach. Interested facilities are encouraged to share and discuss the information internally with staff leads from medical staff, pharmacy, nursing, information technology and quality.
  - Hospitals may contact IHA at [ihainstitute@team-iha.org](mailto:ihainstitute@team-iha.org) to arrange a preliminary fact-finding call with your organizational team.

- **What is anticipated timeline to upgrade access to the PMP?**
On average it takes a couple of weeks to program and implement the automated EHR access to the Illinois PMP. Access is contingent on multiple factors (A) Information Technology; (B) Organizational Readiness, including Leadership Approval; (C) Availability of DHS Staff; (D) Staff Preparation and Education; (E) Other. The following addresses concerns with each.

(A) Information Technology

What are the overall IT needs?

There are no fees imposed by DHS to implement the upgrade. Last year, the Centers for Disease Control and Prevention (CDC) awarded the state a four year grant worth $3.6M, with some of that funding directed to support enhancing the PMP. The pilot centers on programming and implementing web-based software that is supplied by DHS through a third party contract, an activity that averages an estimated 40 hours, requiring related staff time from the organization. The time relates primarily to a programmer’s availability and in depth knowledge of the hospital’s EMR system.

- What assistance and anticipated costs may be needed from a hospital’s EMR Vendor?

Organizations should notify their EMR vendor early in your considerations to determine any specific needs or concerns. There may some expense from your EMR vendor depending on what they may need to do for your hospital. For example, one hospital had to pay their vendor $1200 to open a port on the system.

- What may a hospital have to address internally to align PMP query information with other pharmacy related fields?

The IL PMP database does not use federal National Council for Prescription Drug Programs standards (NCPDP). Yet, most hospital pharmacy information exists in IT formats that reflect those federal standards. In order to enhance alignment of the PMP data with the organization’s format, additional program mapping is likely needed. DHS’s third party vendor that supplies the automated query software will assist with this additional effort. The estimated programming time remains variable contingent on hospital system and testing requirements.

- What are considerations if EMR already employs Allscripts or SureScripts connection?

An organization’s familiarity with connecting to and using Allscripts or similar product should ease the implementation process for the automated connection to the PMP. Commercial connections typically reflect subsets of insurance payers and/or pharmacy plan beneficiaries. Therefore health care facilities using the automated link to the PMP will likely expand their understanding of additional patient populations with ability to capture
“others” that are currently not in their Allscripts or SureScripts, i.e. Medicaid, cash users, and any commercial entity that is not in the organization’s commercial database cohort.

- **Does this enhancement meet Stage Two of Meaningful Use?**

  Yes.


  OR


- **Is DHS available for discussions with our hospital’s EMR Vendor?**

  Yes. Please work through IHA staff to coordinate specific dates and times.

(B) **Organizational Readiness**

*What internally should my hospital address to be in best position for initiating the programming upgrade to DHS software?*

The following outlines activities that each hospital may address prior to engaging in programming revisions:

- Consensus-based approach should be adopted by administrative champion, clinical and quality improvement team, and information technology;
- Identify your project coordinator and information technology lead to coordinate effort with DHS and IHA;
- Secure existing declaration of HIPPA compliance;
- Determine preferred schedule for programming time and initial system testing that complements organizational priorities and staff availability;
- Finalize programming expectations with DHS and IHA;
- Coordinate programming phase with staff education and quality improvement plan.
  - Determine how this initiative aligns with your organization’s efforts for enhancing medication stewardship, including medication reconciliation, safe prescribing of controlled substances, and avoidable adverse events.
  - Discuss training that addresses prescribing providers versus training for other point of care staff.
  - Consider how to use robust access to improve related patient teaching and discharge planning.
  - Integrate considerations into avoidable readmissions work.
Plan how to integrate this effort into strengthening communication to community-based providers, e.g. patient’s primary care & specialty physicians, home health.

(C) Availability of DHS Staff

- What support does DHS staff provide before and during the programming phase?
  DHS staff are essential partners available throughout the project to address programming needs and other concerns.

(D) Staff Preparation and Education Plan

- How do authorized prescribers identify designees to access the PMP on their behalf?
  The passage of Public Act 99-480 that went into effect in September 2015 amended Illinois Controlled Substance Act to allow registered PMP prescribers or dispensers the option of authorizing a designee to make inquiries on the provider’s behalf into the state’s PMP provided the delegation meets the following mandated criteria: (1) the designee is employed by the same hospital or health care systems; is employed by the same professional practice; or is under contract with such practice, hospital or health care systems; (2) the prescriber or dispenser takes reasonable steps to ensure that such designee is sufficiently competent in the use of the inquiry system; (3) the prescriber or dispenser remains responsible for ensuring that access to the inquiry system by the designees is limited to authorized purposes and occurs in a manner that protects the confidentiality of the information from the PMP, and remains responsible for any breach of confidentiality; and understands that (4) the ultimate decision as to whether or not to prescribe or dispense a controlled substance remains with the prescriber or dispenser.

While the law states that the PMP will send to registered designees information regarding the inquiry system, including how to log onto the system, activated pilot sites will not require this step as authorized users ‘log in to an organization’s EHR functionally serves as access to the PMP.

- Should “Go Live” implementation be phased in across an organization?
  While the automated access is programmable to meet the organizational capacity all at once, the hospital may choose phase in point of care implementation by unit, service lines and/or progressively across care sites that best complements their plans for staff training and education.

(E) Other End User Concerns

- What are the current limits of Illinois PMP program?
Presently, the PMP database only contains controlled substance information. Any other patient prescription information is not searchable via the PMP database. However, DHS has developed a database containing all the prescription activity for Illinois 1262 long term care facilities and plans are in place to integrate the long term care information with the PMP, which should ideally enhance timely medication reconciliation and care coordination across these key care venues. Additionally, specific interests are working on other means to connect medication information so that e-sourcing is more robust and complete.

PMP queries may result in more than one patient with same first and last name and date of birth as the existing identifiers are presently limited to those fields. Therefore, hospitals have to provide additional means to guide staff for matching right medication record with right person. Suggestions include evaluating prescriber, pharmacy and street address information.

ADDITIONAL OPERATIONAL MATTERS

- **Is the PMP Automated Connection available for inpatient and outpatient access?**
  
  Yes.

- **Is the PMP Automated Connection available from prescriber’s mobile devices?**
  
  If your authorized prescribers are able to currently access your organization’s EMR and individual patient medical records from their devices as supported by organizational policy and technology, then yes, they will be able to access the PMP via hospital’s EMR.

- **Should the organization pursue a “view” screen approach or incorporate the PMP patient-specific information into the hospital’s medical record?**
  
  It is possible to directly integrate the PMP data into each patient’s EHR record or provide an alternative viewing pathway to the person’s specific PMP information. For example, one hospital stores the data in a PDF for each patient. When the patient profile is pulled up in the EMR software, a clickable link is shown. Whenever the prescriber or authorized designee clicks the link, the patient data is displayed in the PDF.

- **How long will the PMP data be viewable on my organization’s EMR System?**
  
  This decision is determined by each organization respective EHR policies.

- **What information does the PMP need for the connection?**
  
  The data is transferred to the PMP in XML form. The search criteria submitted from the hospital will need to include the patient’s first name, last name and date of birth.

- **How secure is the connection?**
The connection travels over a secure https web connection. In addition, the request and response also has end to end encryption and is locked down by username and IP address. This makes it more secure than a standard IL PMP web search.

- **When should the web service run?**

  There are a variety of scenarios:

  ✓  In the Emergency Department where time is of the essence and some patients are walking in for services, the recommendation it to run the access on a continuous basis from the start of initiating care services. That way, when a physician conducts his/her examination and evaluates the individual, their patient-specific PMP data is readily available.

  OR

  ✓  In a physician’s office where a visit is scheduled in advance, a report generated the previous night or morning of the appointment can be used.

  OR

  ✓  In a pediatrician’s office where patient medication abuse is apt to be much less frequent, a request is unlikely needed for each patient. A button may be placed on that physician’s EMR portal to accommodate as needed access.

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