PDMPs as User-Friendly Clinical Decision Support Tools

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Disclosure Statement

Christi Hildebran, LMSW, CADC III and Gillian Leichtling, BA

have disclosed no relevant, real or apparent personal or professional financial relationships with proprietary entities that produce health care goods and services.
Learning Objectives

1. Describe how prescribers currently integrate PDMP data into patient care in Oregon.
2. Advocate the use of guidelines and training to optimize prescriber use of PDMPs in patient care.
NIDA-funded Study

“Use of Prescription Monitoring Programs to Improve Patient Care and Outcomes”

Supported by the National Institutes of Health, National Institute for Drug Abuse through Grant # 1 R01 DA031208-01A1, and by the National Center for Research Resources and the National Center for Advancing Translational Sciences, through grant UL1RR024140.
Study Aims

AIM 1:
Determine the prevalence and characteristics of PDMP users and non-users

AIM 2:
Determine how providers use PDMP data; formulate recommendations for clinical guidelines

AIM 3:
Determine whether PDMP use improves patient outcomes and reduces apparent diversion and abuse
Background

• PDMPs increasingly used for public health: reduce drug abuse, improve patient safety

• Many clinicians who prescribe controlled drugs do not use PDMPs

• Little known about clinician responses to PDMP information (what is communicated to patients, what decisions are made)
Methods

• Surveyed a sample of all Oregon clinicians with DEA license (MD, DO, PA, NP, Dentists, Naturopaths; not Pharm)

• Randomly selected 650 frequent users (>1 query per month)

• Of 358 frequent users who returned a survey, 212 agreed to a follow-up interview

• Follow-up telephone interviews (n=33)
### Interview Participants

<table>
<thead>
<tr>
<th>Specialty</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care (PCP)</td>
<td>16</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>7</td>
</tr>
<tr>
<td>Procedural Specialist (dental, surgical)</td>
<td>6</td>
</tr>
<tr>
<td>Other (pain, psychiatry, addictions)</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
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Results

1. Workflow
2. Communication
3. Decision-Making
Workflow Topics

• Circumstances in which clinicians check PDMP
  – Routine versus triggered by red flag or suspicion
  – New Rx/patient versus existing patient
Results: Workflow

• Inconsistent use of routine PDMP checks
  – Some emergency and procedural specialists check routinely when controlled substance requested; others rely on red flags such as patient behavior
  – Many PCPs check routinely with new patients; for ongoing monitoring with existing patients, some rely on red flags
"If somebody immediately starts negotiating their pain medicine or telling me they’ve lost a prescription and/or they’re new to town — and usually they would say several of those things — that’s clearly a red flag. But it wouldn’t even take something that overt. If they’re hinting at...they’re low on their medication, and it’s the weekend and they haven’t been able to get in with their doctor, that’s all it usually takes to prompt me to consider or just go ahead and use the Prescription Drug Monitoring Program."

– Emergency Room Physician
Quotes: Routine vs. Triggered Checks

“I started trying to be less discriminating. If pain is the issue and if I think pain medications are going to be a question, I’ve tried to start doing it almost across the board with those people before I walk into the room. I’m not going to try to pick and choose so much, I’m going to try to do it on most if not all of the people I’m seeing.”

– Emergency Room Physician
Quotes: New vs. Existing Patients

“The new patient that's coming in asking for opiates is going to get at least checked immediately. With existing patients, it will depend on the situation. If I see them frequently wanting medications, maybe after the first or second time, I'll check them. It really depends on what they're asking for. It depends on the feel that I’m getting from the patient. I don’t have a thing I do for every patient.”

– Primary Care Clinician
Communication Topics

- Ways in which providers discuss worrisome reports with patients
- Policies or guidelines that influence checking the PDMP and/or prescribing
- Ways in which providers discuss PDMP information to assess patient medication compliance and ongoing care
Quotes: Ways Providers Discuss Worrisome Reports with Patients

• Openly discussing and sharing PDMP results with the patient

“For me, it’s a chance to be hopefully less judgmental... and an opportunity to broach the topic. And in an objective, non-judgmental way, to say, “Look at this — you’re 20 years old and I see you’ve gotten 160 Vicodin over the last month.”

– Emergency Room Physician
Quotes: Ways Providers Discuss Worrisome Reports with Patients

• Withholding PDMP results and keeping it a secret

“It’s a cat and mouse thing. I keep it secret as much as possible because it’s better used if it’s kept quiet. I can catch the patient unaware...It’s much better for me to have information and I can discover things that are happening. You have to be a bit of a detective.”

– Primary Care Physician
Quotes: Ways Providers Discuss Worrisome Reports with Patients

• Avoid discussing the PDMP results with the patient

“I never confront them with the evidence from the PDMP. I write it up in the chart, so the chart indicates 18 prescriptions for controlled substances, from six providers over the last year...I’ll flag his chart as drug seeking and that will be his number one diagnosis.”

– Primary Care Physician
Quotes: Policies or Guidelines that Influence Checking the PDMP and/or Prescribing

• Discussing PDMP as part of agency policy or guideline

“I tell them that as part of our clinic policy, I need to log in and see if they’re getting these prescriptions from another prescriber. It also helps me to tell them about the policy, the contract that we will have them sign if they start getting them long-term from us.”

– Primary Care Clinician
Quotes: PDMP Information
Communicated as a Tool to Assess Patient Medication Usage

• Discusses PDMP results routinely as part of the visit

“I communicate much of the time that, ‘It looks like you’ve been filling your Ambien about two weeks late, so it looks like you haven’t been using it every night. What have you been doing to help yourself sleep on the nights that you don’t take it?’”

– Psychiatrist
Decision-Making Topics

• Prescribing decisions in light of worrisome PDMP profile
  – New/episodic patients
  – Existing patients

• Referrals
  – Emergency/procedural specialist referral to PCP
  – Referrals to behavioral health provider

• Discharge from care
Results: Prescribing and New Patients

• Clinicians generally won’t prescribe for new patient with worrisome profile
  – Some PCPs/clinics had policies against prescribing at first visit or until specific conditions met

• Clinicians will prescribe for verifiable acute condition (e.g., broken bone) regardless
  – Emergency and procedural specialists generally won’t prescribe for chronic pain conditions unless authorized by PCP
“I just say, ‘I see you’ve gotten multiple scripts filled from multiple providers. I just need to look into this some more, and I’ll see you back in X amount of time, hopefully when I’ve gotten the records, and we can figure out what else we’re going to do for your anxiety or pain management.”

– Primary Care Clinician
“I’ll bring the PDMP report back with me and I’ll say, ‘I want to get clear on the information we discussed. You told me you take a Vicodin once in a while, but I have access to your prescription history and when I looked it up, I see you’re getting a regular prescription for this many from Dr. So-and-So, and that’s more than once in a while. So I want you to know before we do treatment, I will not be able to prescribe you any narcotics in addition to what you're already getting.’”

– Dentist
Results: Prescribing and Existing Patients

• Some clinicians discontinue ongoing Rx automatically at worrisome profile
  – Violation of medication agreement

• For some, depends on patient circumstances
  – If continue Rx: revisit medication agreement, more frequent monitoring, shorten refill/visit schedule, behavioral health visit

• If discontinue Rx: some taper, others do not
Quotes: Existing Patients

“If they’ve gone to other prescribers, I’ve found it’s most commonly dentists and they don’t think of it as the same thing...I am aware of the kind of mistakes that people make, but when somebody has been to an ER three times in the last month and hasn’t told me, and got prescriptions every time, I simply say, ‘That’s a violation and I can no longer prescribe for you.’”

– Primary Care Clinician
“It depends on their history and the risk of addiction and abuse. We do a risk evaluation when they first come in, so they’re either a mild, moderate, or high-risk patient. If they’re a high-risk patient and something happens, then it’s a lot more severe what I do. If they’re a moderate or low-risk patient, chances are I might not be as controlling. I might just say ‘Okay, you did this — now we’re reiterating that this is our policy. You can’t do this again.’ Then I’ll watch their drug monitoring program a lot closer and maybe do urine drug screens more frequently.”

– Primary Care Clinician
Results: Referral and Discharge

• Some emergency and procedural specialists refer patient to primary prescriber/PCP, or may contact PCP to ask about prescribing

• PCPs and clinicians who provide ongoing prescribing had varied responses
  – Some may discharge if worrisome report; others will not
  – Most offer referrals and/or alternatives
“If I feel like they have a legitimate reason for wanting more, sometimes I will call their medical doctor or whoever’s been prescribing all the other pain medicine, and talk to them to see if they feel comfortable with me giving the patient more, or ask them if the patient has a legitimate reason for being out.”

– Dentist
“We are not going to manage medications, narcotics at least, for long periods of time. So when I get into situations like that, I would rather refer them to somebody that is better suited to handle a longer-term situation. Or if I think that they’re going to be a problem, somebody that needs to be monitored a little more closely with urine drug screens and things like that.”

– *Surgical Specialist*
Quotes: Discharge

“Usually the people I choose to discharge from my clinic are the ones who have been getting narcotics multiple other places and haven’t been honest with me.”
– Primary Care Clinician

“You have to be a really bad person to get discharged from our practice...I think as clinicians, a lot of times we hide behind the Hippocratic Oath or behind this side that we don't want to hurt anybody. Well, we already got all those patients on these medications. It's best that you work with them to turn the ship.”
– Primary Care Clinician
Conclusions: Workflow

• Routine use of PDMP vs. triggered by red flags
  – Some emergency and procedural specialists not checking routinely
  – Some PCPs checking routinely only with new patients; for ongoing monitoring rely on red flags

• Need for guidance:
  – What policies or guidelines support optimal use of PDMP?
Conclusions: Communication

• Some discuss PDMP results openly; others hold back PDMP results to unearth patient dishonesty

• Need for guidance:
  – What works best in engaging patient?
  – What should be the role of episodic providers in discussing concerns with patient?
Conclusions: Decision-Making

• Clinicians likely not to prescribe for new patients with worrisome profile
• Decisions related to existing patients varied
• Need for guidance:
  – For existing patients, when to taper, discontinue, or continue prescription?
  – What is the optimal care related to discharge in response to a worrisome profile?
Next Steps

• Understand when it is optimal to access PDMP
• Understand how the various ways of communicating PDMP results may affect provider-patient relationship and ongoing patient engagement
• Understand how clinic policies or guidelines may affect provider actions
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Project Funding:
National Institute on Drug Abuse, 1R01DA031208-01A1

For more information, please visit:
http://www.acumentra.org/PDMP/