



Prescription Drug Monitoring Program

Mandatory Enrollment And Use of PDMPs

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Background

Full utilization of prescription drug monitoring programs (PDMPs) can help maximize their potential in addressing prescription drug misuse and diversion and in improving patient care. As more and more PDMPs became operational, health care professionals' enrollment in the PDMP was discretionary, as was viewing a patient's prescription history when prescribing or dispensing controlled substances. To induce health care professionals to enroll and use the program, PDMPs began promotional and marketing campaigns focused on the merits and value of PDMPs within a clinical setting. As these campaigns took hold, PDMPs began to realize that these resource-intensive promotional efforts often failed to produce high rates of participation. In fact, most, if not all, PDMPs had an average of only 20 percent of their health care professionals enrolled or using the program. To increase the use of the program, some PDMPs began to adopt a statutory mandate for prescribers to enroll in the program. However, requiring enrollment could not guarantee that the prescribers or dispensers would actually make use of PDMP data. Another option to increase prescriber and dispenser utilization that gained acceptance was a statutory mandate for prescribers and dispensers to query the PDMPs under certain circumstances.

The PDMP Training and Technical Assistance Center (TTAC) and its sister organization, the PDMP Center of Excellence (COE), began examining state mandates in 2013, when it published its first briefing focusing on the experience of Kentucky when the mandates were implemented by the state. The COE issued an update of the briefing in October 2014 and again in 2016. The previous updates focused on the experience of four states: Kentucky, New York, Ohio, and Tennessee. The briefings described some of the challenges faced by these states as they began implementing the mandatory enrollment and use laws. Because of the profound changes brought about by the mandates on the respective PDMPs, it is worth repeating the impact the new laws had on enrollment and use of the PDMPs, prescribing and dispensing, and multiple prescriber episodes (MPEs). Highlights from the briefings are summarized below.

A. Enrollment and Use

In Kentucky, enrollment in the PDMP increased rapidly, from 7,911 registered prescriber and pharmacist users in April 2012 to 25,409 by the end of July 2013, more than a three-fold increase. The total number of the PDMPs' prescription history reports requested by users rose from 811,000 in 2011 to 2,691,000 in 2012—an increase of more than 230 percent—then rose to 4,586,500 reports in 2013, up 70 percent. Tennessee enrollment in its program increased from 15,323 providers in 2011 to 34,802 by the end of 2013, more than 125 percent; in 2015, enrollment had reached 42,835. The number of prescription history reports requested rose sharply as a result, from an average of 123,911 reports per month in 2011 to an average of 374,984 reports per month for 2013, then 537,092 per month in 2015. New York's earlier online PDMP had only 5,087 users, who requested 465,639 reports over 3½ years, averaging approximately 11,000 reports per month. As of February 17, 2014, six months after the mandate began, the number of active users reached 67,779. Between August 27, 2013, and February 17, 2014, these users requested more than 7.3 million reports on more than 3.5 million unique patients. In Ohio, after rules were adopted, the utilization of its PDMP increased dramatically,

from 911,000 reports requested in 2010 to 1.8 million in 2011, 5.4 million in 2012, 7.3 million in 2013, and more than 2 million in the first quarter of 2014.

B. Prescribing and Dispensing

Kentucky experienced an overall decline in the dispensing of controlled substances after the mandate was in place, from 7.39 million doses in the one-year period from August 2011 to July 2012 to 6.76 million doses from August 2012 to July 2013, a drop of 8.5 percent. Doses dispensed declined for hydrocodone (10.3 percent), oxycodone (11.6 percent), oxymorphone (35 percent) and alprazolam (13.4 percent) but increased for methylphenidate (7.5 percent) and amphetamines (9.2 percent). Tennessee saw the number of opioid prescriptions reported to the PDMP fall from 8,778,561 in 2012 to 8,580,375 in 2013, then to 8,084,981 in 2015—down nearly 8 percent from 2012—while the total morphine milligram equivalents (MMEs) of opioids dispensed dropped more than 8 percent during the same period. In New York, the number of prescriptions for all opioids, as well as the number of individuals with a prescription for an opioid, decreased by 9.5 percent. The largest decreases in prescriptions were seen in hydrocodone (-20.4 percent) and codeine (-33.2 percent). There were slight increases in the number of prescriptions for oxycodone (0.72 percent) and individuals with an oxycodone prescription (1.55 percent) but decreases in the total number of practitioners issuing these prescriptions (-8.5 percent) and the total doses of oxycodone dispensed (-2.5 percent). From 2012 to 2013, Ohio also experienced a drop in the number of doses and prescriptions of its two most prescribed drugs, hydrocodone and oxycodone. Hydrocodone doses dropped by 3.5 percent and prescriptions by 11.1 percent; oxycodone doses dropped 1.7 percent and prescriptions by 8.7 percent. The MME per opioid prescription also fell approximately 12 percent from 2010 to 2013.

C. Multiple Prescriber Episodes (MPEs)

Even though the definition of MPEs may differ from state to state, the number of MPEs declined in the states studied. In Tennessee, the number of individuals meeting the threshold for MPEs declined from 9,230 in 2011 to 4,602 in 2015, down 50 percent. In New York, the number of individuals meeting the state's threshold for MPEs decreased by 74.8 percent from the fourth quarter of 2012 to the fourth quarter of 2013. By the fourth quarter of 2014, individuals involved in MPEs had decreased by 82 percent. In Ohio, the rate of those meeting its MPE threshold declined from 25 per 100,000 residents in the first quarter of 2010 to just more than 10 per 100,000 in the last quarter of 2013.

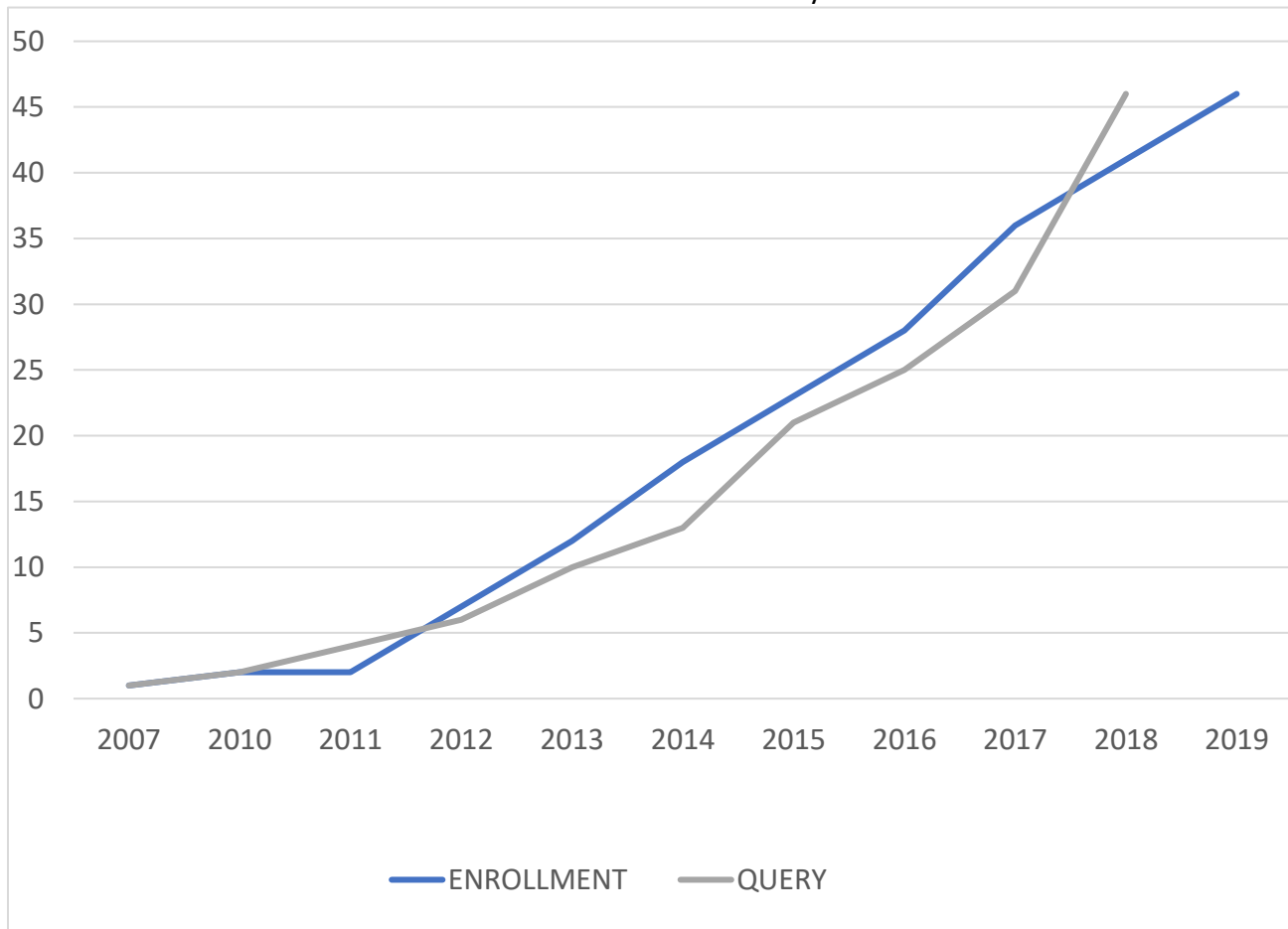
History of Prescriber Use Mandates

Arizona, in 2007, was the first state to require prescribers to register with the PDMP. That same year, Nevada became the first state to require use of the PDMP by prescribers for certain circumstances. The law required use when practitioners had a reasonable belief that patients may be seeking their controlled substances, in whole or in part, for reasons other than the treatment of an existing medical condition. In 2010, Oklahoma adopted a limited, single substance mandate, requiring that a practitioner check the PDMP only when prescribing,

dispensing, or administering methadone. Both Nevada and Oklahoma expanded their mandates in 2015.

Prior to 2012, only four states had passed either an enrollment or use mandate law (Alabama, Arizona, Nevada, and Oklahoma). However, from 2012 to 2015, 21 states had enrollment mandates and 19 states had use mandates. The graph below illustrates the accelerating trend in mandating enrollment and use that took place starting in 2012. Several states began with an enrollment mandate but, in later years, passed a use mandate law as well. Kentucky, for example, implemented an enrollment mandate in 2012 and passed a use mandate law in 2015. TTAC's research found at least 14 other states that followed the same path as Kentucky.

PDMP Enrollment and Use Mandates by Year Enacted



Currently, 46 states and the territory of Guam have adopted a prescriber use mandate, although some apply to only certain classes of practitioners (e.g., clinicians in opioid treatment programs) and/or prescriptions (e.g., opioids). Currently, 20 states require dispensers such as pharmacies and pharmacists to enroll with the program and 19 states require dispensers to query PDMPs prior to dispensing controlled substance prescriptions. Finally, 16 states require both prescribers and dispensers to enroll and query PDMPs.

Use Mandate Requirements

Recent and past experiences in states with use mandates indicate that mandates can rapidly increase utilization of PDMPs. As rates of PDMP participation have increased in states, measures of MPEs, which is an indicator of possible inappropriate use of controlled substances and prescribing of certain drugs, have declined. This suggests that PDMP utilization helps promote medically warranted prescribing and dispensing and can assist in detecting possible controlled substance misuse and diversion.

Although no two states' prescriber use mandates are exactly alike, mandates can be classified according to the conditions under which prescribers are required to view a patient's prescription history.

Most mandates currently in place require that all prescribers query PDMPs when initially prescribing any opioid, regardless if it is a Schedule II or III controlled substance or benzodiazepine. Some states require prescribers to query PDMPs every time a controlled substance is prescribed, while other states require a query only for the initial prescription. Subsequent checks of PDMPs also vary from every time a prescription is issued to specific intervals (e.g., every 90 days, twice a year, annually) should prescribing continue.

Some mandates have categorical requirements; e.g., a query must be made if the prescription is for greater than a three-day or seven-day supply or if a certain prescribed level of MME is exceeded.

Other states' mandates are based on subjective criteria; e.g., a prescriber's judgment of possible inappropriate use or the discretion of the prescriber as to whether to query the PDMP. Finally, some states mandate that only prescribers in opioid treatment programs, workers' compensation programs, or pain clinics must query PDMPs.

- A listing of the mandate criteria is available on the TTAC website in the PDMP Policies and Procedures section: <https://www.pdmpassist.org/Policies/Maps>.
- A compilation of each state's laws and regulations on mandates also is available on the website: <https://www.pdmpassist.org/Policies/Legislative>.

Conclusion

States with use mandate laws quickly increase utilization of PDMPs with subsequent decreases in patient risk measures and prescribing of commonly misused controlled substances, as well as reduced morbidity and mortality related to prescription drug misuse. Mandates are consequently seen as best practices that states have adopted in efforts to promote consistent use of PDMPs by prescribers and to realize the benefits associated with such use.