Report:

Formative Research:
Maine's Prescription Monitoring Program

Submitted to the Maine Office of Substance Abuse
by
Public Health Connections
April 25, 2011

44 Main Street, P.O. Box 783
Waterville, ME 04903-0783
Phone: 207.649.9648
E-Mail: alison@publichealthconnections.com
Web: www.publichealthconnections.com

I. Executive Summary

The Maine Office of Substance Abuse (OSA) contracted with Public Health Connections (PHC) to conduct formative research about current practices used to promote the Prescription Monitoring Program (PMP), and to develop recommendations to enhance promotion efforts through Maine's public health infrastructure to increase the use of the PMP in Maine. Specifically, OSA is interested in implementing strategies through District Coordinating Councils (DCCs) and Healthy Maine Partnerships (HMPs).

Maine's PMP promotion activities are firmly established, and ready to be increased and enhanced.

PMP promotion efforts around the country are in different stages of development. Maine's current efforts are in line with proactive efforts in other states with established PMPs.

PHC interviewed or surveyed HMP staff, individuals representing statewide associations representing health care and substance abuse treatment providers, key individuals knowledgeable about PMP in Maine, and PMP Managers in other states.

Research results indicate clearly that there is no single approach to increase registration and use of PMP in Maine, and that several interventions targeting several audiences will likely lead to the greatest possible success.

The recommendations below represent an array of suggestions that will allow OSA to support DCCs and HMPs to plan and implement a combination of activities that are appropriate to local and regional circumstances, and that are in concert with other OSA interventions to promote PMP.

Recommendations for public health interventions via HMPs and DCCs

1. Develop standardized materials about PMP for distribution statewide to identified target audiences, through DCCs and HMPs, statewide associations and other organizations.
2. Develop standardized materials on medication safety that incorporate PMP information (PMP promotes appropriate prescribing, reduces duplicate prescribing, helps prevent drug interactions; helps reduce drug diversion), in order to normalize PMP use from patient's point of view.
3. Provide opportunities through the DCCs and HMPs to educate the general public about prescription drug diversion, abuse, drug overdose, proper disposal of prescription medications and the role of PMP.
4. Provide opportunities for the DCCs and HMPs to identify target audience(s) to educate about prescription drug abuse and the role of PMP. Target audiences could include law enforcement, hospice workers, social services staff working with families (e.g. pregnant women), nursing home administrators, patients, pharmacists, parents, prescribers, users and their families/friends, etc.

5. Provide opportunities to the DCCs and HMPs to convene stakeholder task force to address prescription drug diversion, abuse, overdose and the role of PMP.

Recommendations for health care provider interventions

1. Maintain commitment of PMP Coordinator to attend statewide association meetings, make presentations, etc.
2. Broaden conversation about PMP to include discussions of opioid prescribing practices and pain management; promote conferences and educational opportunities on opioid prescribing practices and pain management. Address prescription of benzodiazepines in same way (prescribing practices and anxiety/stress management).
3. Work with pharmacists and organizations to increase their role in use of PMP, identification of prescription drug diversion and abuse.
4. Work with dentists and organizations to increase their understanding of PMP, identification of prescription drug diversion and abuse.
5. Work with health systems and hospitals to build support for PMP as the "norm" (social incentive to use PMP consistently).
6. Work with statewide associations and health systems to promote office practice protocol/procedures around consistent use of PMP.
7. Allow creation of subaccounts by non-licensed individuals.
8. Require prescribers to be trained in using PMP in order to be licensed.

Recommendations regarding technology

1. Explore option of long-term contract with vendor to avoid frequent changes in website, login process, etc.
2. Consider leveraging technology to increase registration and use, by modifying the patient search mechanism ("push" vs. "pull" mechanism, pre-populating patient information from EMR, automatic electronic reports for selected patients, etc.).
3. Work with neighboring states (and Florida) to ensure interstate sharing\
4. Consider linking PMP with EMR for ease of use

Recommendations including law enforcement

1. Include law enforcement in stakeholder groups to address local prescription drug diversion, abuse, overdose and the role of PMP.
2. Encourage law enforcement to play a role in educating prescribers about the drug diversion and abuse problem and the role of PMP in their local areas.

Recommendations for tracking

1. OSA maintains a "scoreboard" of the number of registered healthcare providers, the number eligible to register, and the percent actually registered. If and when possible, this data should also be tracked based on the total number of eligible clinicians by specialty (e.g. emergency physicians, primary care physicians, pediatricians, etc.)

II. Introduction

The Maine Office of Substance Abuse (OSA) contracted with Public Health Connections (PHC) to conduct formative research about current practices used to promote the Prescription Monitoring Program (PMP), and to develop recommendations to enhance promotion efforts through Maine's public health infrastructure to increase the use of the PMP in Maine. Specifically, OSA is interested in implementing strategies through District Coordinating Councils (DCCs) and Healthy Maine Partnerships (HMPs). This research is timely in light of the President's recently released strategic plan, *Epidemic: Responding to America's Prescription Drug Abuse Crisis.*[1] This federal strategic plan includes recommendations regarding the use of PMPs nationwide.

PHC interviewed 13 individuals and received 32 responses via email or to an online survey (Survey Monkey) from HMP staff, statewide associations in Maine, other key individuals in Maine, and PMP Managers in other states. Results of the interviews and responses shaped the recommendations in this report. The recommendations are intended to assist OSA staff in planning PMP promotion through Maine's public health infrastructure, and in seeking additional funds for PMP work that is outside the scope of current funding.

III. Findings

PHC contacted via phone or email 28 HMPs; 14 individuals representing statewide associations; 8 other key individuals; and PMP staff from 31 states.[2] PHC succeeded in interviewing or surveying:

- 9 HMP staff directly involved in promoting PMP in their service areas;
- 8 individuals from statewide associations representing health care and substance abuse treatment providers;
- 5 key individuals knowledgeable about PMP in Maine (1 health care provider, 1 overdose prevention specialist, 2 law enforcement officers and 1 OSA staff member); and
- 23 individuals managing PMPs in other states.

A. Healthy Maine Partnerships

In general, HMP Directors, Substance Abuse Prevention Specialists and drug overdose prevention specialists educate the general public and targeted groups about prescription diversion, abuse and disposal. The role of PMP is included in some of these presentations and discussions. Some HMPs are actively engaged in educating clinicians, through articles in physician newsletters, flyers, *Diversion Alerts* and other written/electronic communication. Several HMPs noted that this approach was challenging and not always successful. HMP staff also noted that reduced funding for substance abuse prevention has significantly decreased their ability to promote PMP. Some hospitals work with HMPs to educate clinical staff about PMP through Grand Rounds presentations, direct outreach to prescribers and one-on-one technical assistance for prescribers.

HMP identified barriers to prescriber use of PMP:

1. Change in vendor/change in login process
2. Prescriber time to use PMP
3. Perception of delay of several weeks between when prescription is filled and when data appear in PMP

HMP identified facilitators to prescriber use of PMP:

1. Increased knowledge and awareness about prescription drug diversion and abuse problem in prescriber's local area
2. Hospital/health system commitment to PMP
3. Health care provider "champion" in the local area

Barriers to HMP promotion of PMP:

1. Lack of funding to promote PMP through HMPs and to provide direct technical assistance to prescribers
2. HMPs don't have access to prescribers
3. Prescribers don't listen to HMP staff about clinical issues
4. HMPs don't have access to information about which prescribers are registered and/or using PMP in their area
5. HMPs need more extensive training in how to use PMP if expectation is that HMPs will educate prescribers and/or provide technical assistance

> ***Working to promote awareness within medical practices not yet signed up, advocating for participation where it was not yet robust, and offering and responding to requests for technical assistance was a hard sell from the outside.***
> ***--HMP Staff***

HMP recommendations for increasing use of PMP:

1. Enable office staff to have subaccounts
2. Require prescribers to register for PMP

B. Statewide Associations

In general, statewide associations in the medical field have time and resources to educate their members about PMP through presentations and exhibits at annual meetings and conferences, through articles in newsletters, etc. They work closely with OSA on this. Providing CMEs for these trainings is important. Several associations have individual "champions." Statewide associations plan to continue to promote PMP in this manner.

Statewide association identified barriers to prescriber use of PMP:

1. Prescriber time to access and use PMP
2. Change in vendor/change in login process
3. Print-out is too large for 8x11 paper
4. Hard to use

Statewide association identified facilitators to prescriber use of PMP:

1. Peer-to-peer discussions

2. Peer expectations
3. Office practice identifies and implements most efficient way to organize workflow to incorporate PMP

Statewide association identified barriers to promoting PMP:

1. None identified

Statewide association recommendations for increasing use of PMP:

1. Education/mentoring/expectations by peers
2. Enable office staff to have subaccounts
3. Legislative mandate that prescribers and dispensers be enrolled in PMP to attain/maintain Maine licensure
4. Underscore criminal sanctions for inappropriate use when trainings occur

> ***Now we understand how PMP works in Maine. There has been no "chilling effect," so we can begin to give greater access.***
> ***Practicing psychiatrist***

C. Key Individuals in Maine

Key individuals interviewed were law enforcement officers, a health care provider, an overdose prevention specialist, and Maine's PMP Coordinator. For law enforcement, there is an interest in educating law enforcement officers and the general public more about PMP ("it will have a deterrent effect"), and also to have a role in educating prescribers about the drug diversion and abuse problem in their local areas. All individuals interviewed agreed that patients and the general public are undereducated about prescription drug diversion, abuse and disposal and could be allies in decreasing diversion and abuse.

> ***If you want to increase use of PMP, you have to increase access.***
> ***Maine PMP Coordinator***

Key individuals' identified barriers to prescriber use of PMP:

1. Prescriber time to access and use PMP
2. Change in vendor/change in login process
3. Lack of internet access
4. Lack of knowledge about the program

Key individuals' identified facilitators to prescriber use of PMP:

1. Office practice protocol for PMP
2. Increased awareness of prescription drug abuse/diversion/overdose problem in local areas

Key individuals' identified barriers to promoting PMP:

1. Continued change in vendor creates lack of receptivity on part of prescribers

Key individuals' recommendations for increasing use of PMP:

1. Enable office staff to have subaccounts

2. Create legislative mandate that prescribers and dispensers be enrolled in PMP to attain/maintain Maine licensure
3. Work toward interstate data sharing
4. Make learning about PMP an educational requirement of all nurses and prescribers
5. Develop physician practice protocol for use of PMP in office workflow
6. Require hospital systems to require policies and procedures for use of PMP
7. Educate patients, so they know PMP is accepted practice (not just for drug users)
8. Encourage greater use by pharmacists; educate pharmacists about their role (dispensing, linking with health care providers, counseling patients re prescriptions and interactions)
9. Convene a community group locally to start talking about the prescription drug problem
10. Prepare set of materials for use statewide with consistent message about prescription drug abuse and diversion
11. Maintain a long-term contract with the vendor
12. Limit number of pills prescribed at one time
13. Target education and technical assistance for PMP to internists and family practitioners because they prescribe large amounts of controlled substances for chronic pain
14. Eliminate 90 day prescribing practices for controlled substances

D. Other States

In general, PMP Managers and staff promote PMP in other states in the same way that state level staff promote PMP in Maine: working with statewide associations to promote PMP through conference exhibits and presentations; working with Licensing Boards to educate prescribers; patient threshold reports; Grand Rounds presentations; word of mouth; newsletter articles in professional publications; and brochures for prescribers.

> ***There is not a single method that is most effective [to increase prescriber registrations to PMP].***
> ***PMP Manager***
> ***Connecticut***

Some additional promotional methods include:

1. Use DVD that promotes use and demonstrates how to register and use PMP
2. Link with statewide initiative on safer opioid prescribing practices
3. Link with statewide chronic pain initiatives
4. Link with Project Lazarus
5. Distribute PMP note pads and post cards

Barriers to prescriber use of PMP in other states:

1. Physician time
2. Password resets/log-in procedures

3. Lack of internet access in the office
4. Lack of computer skills
5. Can't have delegate accounts (subaccounts)
6. Bias that prescribers feel they can "recognize" doctor shoppers by looking at them (without using PMP)

Facilitators to prescriber use of PMP in other states:

1. PMP is free; available 24/7; mobile web use is available
2. Technical assistance available during business hours by phone, email and instant message
3. Patient reports available to the requester in 11 seconds (on average)
4. Ability to have delegates (subaccounts)
5. Simple registration, simple interface
6. "One click" service

Recommendations from other state PMP Managers for increasing use of PMP:

1. Keep promoting it, including through professional associations
2. Promote the PMP through licensing agency, so that every time practitioners renew their licenses, they receive information about PMP. (This could prevent some promotion problems when budget reductions make it difficult for PMP staff to do promotion activities.)
3. Consider pain management legislation/rulemaking like Washington State passed in 2010[3]
4. Change law to require registration
5. Mandate use via licensing entities
6. Utilize pharmaceutical company representatives to promote PMP

> ***Even after 8-9 years, [we are] still making presentations every month.***
> ***PMP Manager***
> ***Michigan***

IV. Recommendations

Research results indicate clearly that there is no single approach to increase registration and use of PMP in Maine. Several interventions targeting several audiences will likely lead to the greatest possible success. The recommendations listed below are provided so that OSA can support DCCs and HMPs to plan and implement a combination of activities appropriate to local and regional circumstances. For example, where health systems have strong commitments to PMP, the DCC and HMPs may be able to convene a stakeholder group to pursue development of office practice or emergency room protocol for use of PMP. In other areas, where law enforcement is particularly engaged in prescription drug issues, the DCC and HMPs may opt for extensive education and awareness raising about prescription drug abuse and the role of PMP that includes law enforcement to implement outreach activities.

OSA may wish to target funds to areas with the greatest need (e.g. highest overdose death rate, lowest prescriber registrations per capita, lowest patient

reports requested per capita).

Many of the recommended activities below are underway in Maine and elsewhere; and many were suggested by more than one group interviewed. Several of the recommendations are included in the President's strategic plan to address prescription drug abuse. These overlaps underscore the fact that PMPs are a fairly new tool in the fight against prescription drug diversion, abuse and addiction, and that there are many opportunities to improve use of them.

Nearly all individuals that PHC contacted in Maine recommended that non-licensed individuals such as medical assistants be permitted access to PMP as subaccount users. As of the date of this report, emergency legislation has been referred to the Joint Standing Committee on Health and Human Services to make this change to Maine's PMP.[4]

Recommendations for public health interventions via HMPs and DCCs

6. Develop standardized materials about PMP for distribution statewide to identified target audiences (see below), through DCCs and HMPs, statewide associations and other organizations.
7. Develop standardized materials on medication safety that incorporate PMP information (PMP promotes appropriate prescribing, reduces duplicate prescribing, helps prevent drug interactions; helps reduce drug diversion), in order to normalize PMP use from patient's point of view.
8. Provide opportunities through the DCCs and HMPs to educate the general public about prescription drug diversion, abuse, drug overdose, proper disposal of prescription medications and the role of PMP. (The President's strategic plan includes a recommendation to increase public awareness and provide education on new methods of safe drug return and disposal).
9. Provide opportunities for the DCCs and HMPs to identify target audience(s) to educate about prescription drug abuse and the role of PMP. Target audiences could include law enforcement, hospice workers, social services staff working with families (e.g. pregnant women), nursing home administrators, patients, pharmacists, parents, prescribers, users and their families/friends, etc.
10. Provide opportunities to the DCCs and HMPs to convene stakeholder task force to address prescription drug diversion, abuse, overdose and the role of PMP.

Recommendations for health care provider interventions

9. Maintain commitment of PMP Coordinator to attend statewide association meetings, make presentations, etc. Continue to use case studies (positive consequences of using PMP, negative consequences of not using PMP) and peer-to-peer teaching moments in trainings.
10. Broaden conversation about PMP to include discussions of opioid prescribing practices and pain management; promote conferences and educational opportunities on opioid prescribing practices and pain management. Address

prescription of benzodiazepines in same way (prescribing practices and anxiety/stress management).

11. Work with pharmacists and organizations to increase their role in use of PMP, identification of prescription drug diversion and abuse.
12. Work with dentists and organizations to increase their understanding of PMP, identification of prescription drug diversion and abuse.
13. Work with health systems and hospitals to build support for PMP as the "norm" (social incentive to use PMP consistently).
14. Work with statewide associations and health systems to promote office practice protocol/procedures around consistent use of PMP.
15. Allow creation of subaccounts by non-licensed individuals (e.g. medical assistants).
16. Require prescribers to be trained in using PMP in order to be licensed. (This recommendation is included in the President's strategic plan.)

Recommendations regarding technology

5. Explore option of long-term contract with vendor to avoid frequent changes in website, log-n process, etc.
6. Consider leveraging technology to increase registration and use, by modifying the patient search mechanism ("push" vs. "pull" mechanism, pre-populating patient information from EMR, automatic electronic reports for selected patients, etc.).
7. Work with neighboring states (and Florida) to ensure interstate sharing. (A similar recommendation is included in the President's strategic plan.)
8. Consider linking PMP with EMR for ease of use. (A similar recommendation is included in the President's strategic plan.)

Recommendations including law enforcement

3. Include law enforcement in stakeholder groups to address local prescription drug diversion, abuse, overdose and the role of PMP.
4. Encourage law enforcement to play a role in educating prescribers about the drug diversion and abuse problem and the role of PMP in their local areas.

Recommendations for tracking

2. OSA maintains a "scoreboard" of the number of registered healthcare providers, the number eligible to register, and the percent actually registered. This is the benchmark against which progress should be measured. If and when possible, this data should also be tracked based on the total number of eligible clinicians by specialty (e.g. emergency physicians, primary care physicians, pediatricians, etc.)

Endnotes

[1] Office of National Drug Control Policy, *Epidemic: Responding to America's Prescription Drug Abuse Crisis*. April 2011.

[2] 43 states have legislation creating PMPs; however not all PMPs are currently operational. PHC solicited information from the 35 states with functioning PMPs.

[3] The 2010 legislature in Washington passed Engrossed Substitute House Bill 2876 in response to concerns about the consequences and risks of managing chronic, long-term pain. The bill requires five boards and commissions to adopt rules related to pain management by June 30, 2011. These boards and commissions have separate disciplining and rulemaking authority. The legislation does not require one set of rules for all professions. It does require separate rules for each of the following professions: medical physicians and medical physician assistants, advanced registered nurse practitioners, osteopathic physicians and osteopathic physician assistants, dentists, and podiatrists. Washington State department of Health website. http://www.doh.wa.gov/hsqa/professions/painmanagement/FAQ.htm Accessed April 24, 2011.

[4] LD 332 (HP 265) "Resolve, Regarding Legislative Review of Portions of Chapter 11: Rules Governing the Controlled Substances Prescription Monitoring Program, a Major Substantive Rule of the Department of Health and Human Services" (Emergency). Maine State Legislature website. http://www.mainelegislature.org/LawMakerWeb/summary.asp?ID=280039409 Accessed April 25, 2011.