Physician Utilization of PMP Data

BREAKOUT
Tufts Health Care Institute
Program in Opioid Risk Management
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Breakout Session Structure

- What do “clinicians” need from the PMP?
  - Format of report
  - Other support
- What is the overall clinical approach to the patient on opioid therapy of which the PMP report is a part?
- How should clinician interpret and act on the PMP report

PMPs are for?

- Who are clinicians?
  - MDs, PAs, NPs, RPh, Enforcement
  - Others? Licensure boards
  - Quality Management (on how to use data)
- What should be covered?
  - Schedule 2-5 drugs plus-
  - Need to capture hydrocodone (C-3)
  - Tramadol, carisoprodol, are not controlled
  - Methadone and buprenorphine for opioid replacement therapy

EDUCATION-part 1

- Prescriber profiling
  - PMP Patterns
    - Don’t rush judgments
    - Opportunity to review the quality of clinician care of their patients
- Prescriber profiles relevant to peer prescribers provides valuable feedback compared to peers (protection aspect)

EDUCATION-part 2

- Education starting in school (demonstrated by competency, examination) of clinicians regarding the controlled drug laws may be key for clinicians to understand the potential for use as well as abuse of PMP data
- Important to communicate PMP data in a positive way to allay fears that law enforcement is “out to get” clinicians

What is a perfect PMP report?

- Monthly reports better than quarterly
- Prescriber specialties are available
  - Can get MD,DO, NP,DMD info from DEA numbers
- Future Interpretation: Integration of other data that could be integrated e.g. office address, lab (urine drug screen), statistically aberrant behavior, medical claims reports
- *A report that provides useful interpretation
- How much of a delay in reporting-access to data is acceptable

Interpretation of PMP Data

- PMP report is like any laboratory test:
  - Must be interpreted in light of the overall clinical picture
  - Bad data, misidentified individuals, false positives, false negatives, are always possible
  - Particular caution is needed because the “diagnostic accuracy” of any PMP cut-point is unknown

The Clinical Picture

- Medical history
  - Pain diagnosis, addiction risk factors
  - Review of medical records
- Physical exam
  - Track marks, nasal septal/palatal pathology
- Clinical benefit
  - Pain, physical function, side effects
- Aberrant behaviors
- Urine drug monitoring, pill counts, PMP report
- Opioid agreement, contracts etc

PMP Report itself: Differential Diagnosis

- Appropriate clinical care
- Administrative issues (changing insurance, moving towns)
- Poorly managed pain
- “Chemical coping”
- Abuse and addiction
- Diversion

What to do with the data? The Positive

- Facilitates better screening and evaluation
  - In ERs and Trauma may be valuable to assist
- Provide better patient outcomes
  - Build confidence among clinicians AND pharmacists to help better delineate those who legitimately need opioids from abuse, concurrent mental illnesses
  - Helps clinician avoid being victimized by patients
- Like another lab test
- Harm reduction
- Develop “Best Practices” Template

CONCERNS-the negative

- Privacy of sharing personal data
- If it's an illegal act HIPAA is not really relevant
- Misuse of data
- Not timely data
- Find a problem then what?
- Potential effect of REMS?
- Burdened by "too much information"
  - "If I don't know it I don't need to deal with it"

Suspected Abuse or Addiction: Management

- Conversation with patient
- Reinforcing or re-evaluate agreement
- SBIRT (objective behavioral assessment)
- Increased intensity of monitoring, lower supplies
- Non-opioid analgesia
- Consultation or multidisciplinary management
- Reporting suspected criminal activity
- Nevada Model-Law enforcement Interventionist
- ~~Tapering off opioid therapy for persistent~~ noncompliance

As with many other chronic, relapsing-remitting illnesses, the picture often clarifies itself with time