Continuing Medical Education

The Role of Continuing Medical Education in Increasing Enrollment in Prescription Drug Monitoring Programs

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ABSTRACT

Purpose: Opioid diversion, misuse, and abuse are rapidly growing problems in the United States; >60% of all drug overdose deaths involve an opioid. At least 49 states now have fully operational prescription drug monitoring programs (PDMPs) to support legitimate medical use of controlled substances; however, there is considerable underutilization of such programs.

Methods: To increase awareness of PDMPs and their use, a continuing medical education program including 2 webcasts and a series of newsletters was offered to health care providers.

Findings: Four hundred and sixty-five clinicians participated in 1 of 2 webcasts. Of those, 207 clinicians responded to a pre-survey and 64 responded to a post-survey. Slightly more than half of clinicians were registered for their state's PDMP program before the educational intervention, and although significantly more clinicians reported increased likelihood to access their state PDMP after participation, the number that actually registered only trended toward a statistically significant increase to 74% after the education ($P = 0.06$). Immediate post-activity evaluation also indicated that the education significantly improved clinician knowledge of the characteristics of addiction, findings in a PDMP that would suggest diversion or abuse, and strategies to complement the use of a PDMP ($P < 0.001$).

Implications: Continuing medical education is effective for improving clinician knowledge and confidence related to opioid misuse, abuse, and diversion and effective use of a PDMP; however, the education did not result in a significant increase in enrollment in state PDMPs. (*Clin Ther.* 2017;39:1896–1902) © 2017 Elsevier HS Journals, Inc. All rights reserved.

Key words: addiction, continuing medical education, dependence, diversion, opioids, prescription drug monitoring programs.

INTRODUCTION

The nonmedical use of drugs with addiction potential and its impact are substantial. The number of Americans aged ≥12 years who reported current nonmedical use of controlled substances reached 6.5 million in 2014, of whom two thirds specifically reported nonmedical use of pain relievers.[1] Each year, an additional 1.9 million Americans initiate nonmedical use of pain relievers,[2] making opioid misuse and abuse a significant problem in the United States. According to the Centers for Disease Control and Prevention, >60% of all drug overdose deaths involve an opioid.[3] Because most prescription drugs involved in overdoses are originally prescribed by a health care provider, there is hope that widespread use of a prescription drug monitoring program (PDMP) may reduce diversion, misuse, and abuse.[4]

PDMPs were developed as a law enforcement tool, but 49 states now have operational PDMPs to support legitimate medical use of controlled substances.[4]

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Numerous studies indicate that, when used, PDMPs are effective. The foundational research on the effectiveness of PDMPs included data from all 50 states and concluded that the presence of a PDMP reduced the supply and abuse of Schedule II opioids.[5] A study in Ohio evaluated the prescribing behaviors of emergency department physicians before and after they viewed PDMP data of 179 patients and found that, on the basis of the PDMP data, prescribing was altered in 41% of the cases, and 60% of those cases resulted in fewer or no controlled pain medications being prescribed.[6] A review of 2 drug abuse surveillance databases found significantly fewer opioid intentional exposures ($P = 0.036$) and a trend toward fewer opioid treatment admissions ($P = 0.058$) in states with a PDMP.[7]

Despite their effectiveness, there is ample evidence indicating that PDMPs are underutilized. One study found that 68% of physicians believed that PDMPs were useful for monitoring patients and would decrease doctor shopping, but only 11% reported past utilization of a PDMP.[8] Another study reported that only 59% of physicians who were aware of the PDMP had actually used it.[9] Nurse practitioners reported that PDMP data were useful for providing improved patient care; however, only 58% of the respondents were registered for the PDMP and, of those, only 56% reported past use.[10] Overall, approximately 35% of clinicians who prescribe at least 1 controlled substance are registered; however, that number does not necessarily reflect utilization.[11] The main reasons for underutilization are 2-fold: systems barriers and clinician awareness. There is variability from state to state in terms of the type of information and the timeliness with which information can be obtained. In most states, PDMPs are reactive in that data are accessed only if a provider queries the PDMP. Additionally, PDMP participation is rarely mandatory; currently only 30 states require at least certain clinicians to access the state PDMP when prescribing a controlled substance.[12] On the other hand, major barriers to use are simple lack of awareness that PDMPs exist and of the kind of information they can provide.

Continuing medical education (CME) activities can be effective at changing clinician behavior and improving performance.[13] This educational initiative aimed to improve awareness and increase the number of prescriber registrants in PDMPs in those states that have operational programs. While registration does not guarantee either active use of the PDMP or a reduction in opioid diversion and doctor shopping, the authors believe that an increase in PDMP registration is a necessary prerequisite and a reliable surrogate measure for these activities.

METHODS

To increase awareness of PDMPs and their use, a CME initiative, "Prescription Drug Monitoring Programs: An Important Tool to Decrease Diversion and Abuse of Opioids," was offered to providers, including physicians (MD and DO), nurse practitioners, and physician assistants. Participants in the educational program were recruited from readers of Elsevier publications relevant to the target audience. A control group was established from a random sample of opted-in subscribers to these same publications. Hosted online at courses.elsevier.com/pmp/homepage, the education included 2 enduring, learner-driven, interactive, CME-certified webcasts. In the first 30-minute webcast, "Prescription Drug Monitoring Programs: Guarding Against Drug Diversion," participants were informed of the existence, use, monitoring capabilities, and benefits of PDMPs. This initial course was designed to increase clinician knowledge of PDMPs and to increase enrollment in and utilization of PDMPs. Enrollees in webcast 1 completed the program between December 2014 and December 2015. The second webcast, "Prescription Drug Monitoring Programs: Valuable Clinical Tools in Treating Pain and Substance Use Disorder," included case examples that illustrated probable misuse, diversion, and abuse of prescription drugs. The content was intended to increase clinicians' competence, confidence, and performance related to using a PDMP with other clinical tools and identifying the differences among addiction, misuse, and physical dependence and tolerance. Enrollees in webcast 2 completed this program between June 2015 and October 2015. After participation, learners received monthly newsletters via e-mail for 3 months. These newsletters were intended as reinforcement of the educational content and encouragement for participants to engage with their state PDMP.

Figure 1 illustrates the education design and survey deployment. A survey of questions on demographic characteristic; yes or no questions related to current use of PDMPs; multiple-choice, knowledge assessment

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