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A survey of physicians' perspectives on the New York State mandatory prescription monitoring program (ISTOP)

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ABSTRACT

Background: Prescription drug monitoring programs (PDMPs) have emerged as one tool to combat prescription drug misuse and diversion. New York State mandates that prescribers use its PDMP (called ISTOP) before prescribing controlled substances. We surveyed physicians to assess their experiences with mandatory PDMP use.
Methods: Electronic survey of attending physicians, from multiple clinical specialties, at one large urban academic medical center.
Results: Of 207 responding physicians, 89.4% had heard of ISTOP, and of those, 91.1% were registered users. 45.7% of respondents used the system once per week or more. There was significant negative feedback, with 40.4% of respondents describing ISTOP as "rarely" or "never helpful," and 39.4% describing it as "difficult" or "very difficult" to use. Physicians expressed frustration with the login process, the complexity of querying patients, and the lack of integration with electronic medical records. Only 83.1% knew that ISTOP use is mandated in almost all situations. A minority agreed with this mandate (44.2%); surgeons, males, and those who prescribe controlled substances at least once per week had significantly lower rates of agreement (22.6%, 36.2%, and 33.0%, respectively). The most common reasons for disagreement were: time burden, concerns about helpfulness, potential for under-treatment, and erosion of physician autonomy. Emergency physicians, who are largely exempt from the mandate, were the most likely to believe that ISTOP was helpful, yet the least likely to be registered users. 48.4% of non-emergency physicians reported perfect compliance with the mandate; surgeons and males reported significantly lower rates of perfect compliance (18.2% and 36.8%, respectively).
Conclusions: This study offers a unique window into how one academic medical faculty has experienced New York's mandatory PDMP. Many respondents believe that ISTOP is cumbersome and generally unhelpful. Furthermore, many disagree with, and don't comply with, its mandatory use.

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1. Introduction

In the United States, prescription pharmaceutical abuse has grown to epidemic proportions over the past few decades. In fact, in 2008, drug overdoses surpassed motor vehicle collisions as the leading cause of preventable death in the US (Warner, Chen, Makuc, Anderson, & Miniño, 2011). From 2000 to 2014, the rate of drug overdose death in the United States increased more than twofold, from 6.2 to 14.7 per 100,000 persons.

The epidemic of prescription drug misuse and diversion may be addressed using a multi-faceted approach that includes the use of electronic prescription drug monitoring programs (PDMPs). These state-run databases, now available in 49 states, allow prescribers to review controlled substance prescription histories in order to detect instances of aberrant use. Such aberrant use may include overuse of medications, drug diversion, and a behavior known as "doctor shopping"—i.e., a patient seeking the same prescription from multiple prescribers to attain drugs for illegitimate use.

New York State's electronic prescription monitoring program, known as the "Internet System for Tracking Over-Prescribing" (henceforth referred to as ISTOP), began in June 2013. The system is operated by the New York State Department of Health's Bureau of Narcotic Enforcement. Individual patient level ISTOP data are available to registered prescribers and pharmacists (or their registered designees) via the internet, after entering valid login credentials. Controlled substance dispensing data are submitted by pharmacies to the state in real time, and the data are available on ISTOP within 24 h (New York State Department of Health, 2014).

ISTOP has been celebrated as a success after initial studies detected a 75% drop in doctor shopping behavior[1] and a 10% drop in the overall

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[1] Doctor shopping was defined as receiving prescriptions from five or more prescribers and five or more pharmacies in a three month period.

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number of opioid prescriptions throughout the state (Prescription Drug Monitoring Center of Excellence, 2014). One hypothesis explaining New York's success is that it is one of 22 states that in some way mandate PDMP consultation prior to prescribing a controlled substance in Schedules II–IV (Prescription Drug Monitoring Center of Excellence, 2014). There are limited exceptions, such as when the drug is dispensed from an emergency department for a course of 5-days or fewer, or when the registry cannot be accessed in a timely manner.[2]

In the face of New York's promising results, the skeptical observer might ask: what is the actual process that providers engage in, using ISTOP, to produce such impressive outcomes? And how can PDMPs be improved in order to facilitate and encourage this process? Unfortunately, while many researchers have evaluated the impact of PDMPs on prescription abuse, there are only a handful of studies that shed light on physicians' perceptions of PDMP utilization. Irvine et al. (2014) surveyed a wide range of providers in Oregon, where providers are not mandated to use the PDMP, and found that many unregistered users were unaware of the system. Perrone, DeRoos, and Nelson (2012) surveyed medical toxicologists across the United States and found that while the great majority was aware of their states' PDMP, more than a quarter had never used it. In a nationwide survey of primary care providers, Rutkow, Turner, Lucas, Hwang, and Alexander (2015) found that many PCPs find the systems difficult to use, and do not access them routinely.

While these studies provide insight into providers' experiences in specific specialties or states, no studies were specifically conducted in a population of providers who are subject to a mandate. We suspect that support for, and compliance with, New York's mandate will be mixed, due to two major opposing forces. On one hand, as suggested by a recent expert panel, there may be some consensus that PDMP registration and use mandates are best practices (Greenwood-Ericksen, Poon, Nelson, Weiner, & Schuur, 2015). On the other hand, providers may find PDMP use complicated and/or difficult to comply with, and these difficulties may be intensified under a mandate (Haffajee, Anupam, & Weiner, 2015).

In this survey measuring physicians' experiences with ISTOP, we suspect to find differences in PDMP use and mandate opinion among various specialties, due to variation in frequency of, and indication for, controlled substance prescription. Mandate agreement and compliance are likely to be lower among groups of physicians that are required to use an onerous system more frequently, or when patient characteristics are such that the indication for a controlled substance would not be significantly altered by the patient's prescription history.

2. Methods

2.1. Survey design

After validating a pilot survey instrument with a focus group of providers, a three part survey was crafted to measured physicians' patterns of ISTOP use, attitudes toward the program, and demographic characteristics (Table 1). Part one assessed controlled substance prescription frequency, ISTOP familiarity and registration rates, and history of ISTOP use. ISTOP users were asked to report their approximate frequency of ISTOP use, rate of doctor shopping detection, rate of ISTOP use when prescribing controlled substances (i.e., mandate compliance), time per ISTOP query, and ease of using ISTOP. Non-users were asked to report their reason for non-use. Users who reported that ISTOP was difficult to use were asked to explain why. Part two of the survey assessed all respondents for their perception ISTOP's helpfulness, awareness of the ISTOP mandate, agreement with ISTOP mandate, and if applicable, reason for disagreement with the mandate. Part three evaluated demographics including primary specialty, sex, and years of clinical experience.

2.2. Setting

The study was conducted at NYU Langone Medical Center (NYULMC), a large, academic medical center located in New York City. NYULMC offers comprehensive inpatient and outpatient clinical services and trains new physicians at the New York University School of Medicine. In addition to its private hospitals (Tisch Hospital, the Rusk Institute of Rehabilitative Medicine, and the Hospital for Joint Diseases) the School of Medicine maintains affiliations with New York's flagship public hospital, Bellevue Hospital Center, and with the Manhattan Campus of the New York Harbor VA Medical Center, which both serve as clinical sites for its faculty, residents, and medical students. The study was reviewed by the IRB and deemed to be exempt from IRB review.

2.3. Survey distribution and data collection

An attempt was made to survey the entire full-time clinical faculty at NYULMC, consisting of approximately 1000 physicians. Participants were eligible only if they were attending physicians at NYULMC. The following providers were excluded: residents, fellows, non-physicians, and physicians who reported "never" prescribing controlled substances. In order to remain blinded to participants' identities, an email containing a link to the survey was distributed on our behalf by administrators from each clinical department. At the time of distribution, all participants were notified that their participation would be completely voluntary and anonymous. Prior to taking the survey, respondents were presented with a short statement describing ISTOP and its goals. Approximately one month after the initial invitation, a single repeat invitation email was sent to the Departments of Medicine, Obstetrics and Gynecology, Pediatrics, Emergency Medicine, and Surgery, in order to seek additional responses from a diverse group of practitioners. The survey was available from September 25th, 2014 through December 20th, 2014, on the Qualtrics survey platform (Qualtrics LLC, Provo, UT), where all responses were securely recorded and stored throughout the collection period. No compensation was provided for participation.

2.4. Data analysis

Raw data from Qualtrics were exported into Microsoft Excel. Basic descriptive statistics were calculated for baseline participant characteristics, and all outcome variables. A mean and standard deviation were calculated for our one continuous variable (years of clinical experience), while frequencies and percentages were calculated for the categorical variables. The population was sorted by each of the following criteria: specialty, sex, years of clinical experience, frequency of controlled substance prescribing, past ISTOP use status, and ISTOP use frequency. The chi-square test and Fisher's exact test of independence were used, as appropriate, to compare rates among categorical variables; Student's t-test was used to determine differences in mean years of clinical experience for physicians falling into different categories. Statistical significance was defined as a p-value ≤ 0.05 by any of these tests.

3. Results

3.1. Respondent characteristics

A total of 1023 email links to surveys were distributed in an attempt to capture the vast majority of the clinical faculty of NYU Langone Medical Center. Of these, 303 surveys were started, and 261 were completed and returned (25.5% response rate) (see Fig. 1). Of these, 26 responses (10.0%) were excluded due to the respondent identifying as other than "attending physician," and 28 (10.7%) were excluded due to the respondent identifying as "never prescribing" controlled substances, for a

[2] For a complete list of exceptions to the mandate, see https://www.health.ny.gov/professionals/narcotic/prescription_monitoring/docs/pmp_registry_faq.pdf

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