The Impact of Prescription Drug Monitoring Programs and Prescribing Guidelines on Opioid Prescribing Behaviors: A Time for Institutional and Regulatory Changes

The rising rate of prescription opioid misuse, abuse, and opioid-related fatalities has prompted the development of a number of guidelines for prescribing opioids to patients with chronic noncancer pain, including the recently published US Centers for Disease Control and Prevention Guidelines for Prescribing Opioids for Chronic Pain [1]. These guidelines outline a number of core opioid risk mitigation strategies. These strategies include use of controlled substance agreements when initiating long-term opioid therapy, urine drug monitoring, limiting the supply and dosing of opioids, and employing state prescription drug monitoring programs (PDMP). Pomerleau and colleagues [2] conducted a multicenter, cross-sectional web-based survey of emergency department (ED) providers on opioid prescribing practices. Respondents were queried about their decisions regarding opioid prescribing and their use and knowledge of opioid prescribing guidelines and PDMPs. Results of the survey revealed that only 59% of the respondents were registered to access the PDMP in their respective states and 5% were unaware of whether their state had a PDMP. Only 40% of the study cohort used opioid prescribing guidelines; 24% did not, and 35% were not cognizant of the guidelines. Lastly, 16% of the respondents acknowledged that they prescribed an opioid to expedite discharge from the ED, and 12% prescribed an opioid to improve patient satisfaction scores.

These results are rather surprising given the present-day academic, regulatory, public, and media attention to the opioid “epidemic” and the need for a culture change in how we manage pain effectively, as exemplified by the broad recommendations in the recently published “National Pain Strategy” [3], while reducing the risk of opioid diversion, misuse, abuse, and opioid-related fatalities. The findings of Pomerleau et al., however, are not unique to ED clinicians. Leichtling et al. [4] performed a semistructured telephone interview of 33 clinicians from primary care physicians (PCPs), EDs, pain medicine, psychiatry, dentistry, and surgery settings, evaluating patterns of PDMP use and how PDMP profiles altered clinical decision-making. The use of PDMP varied from consistent use to checking the PDMP only if there was a suspicion of misuse or abuse. PCPs tended to check the PDMP less frequently with established patients than new patients, and prescribers of short-term opioid therapy were less consistent in using the PDMP. This trend in the inconsistent use of the PDMP is concerning given the evolving evidence of the potential effectiveness of PDMP in reducing risk. For example, Ali et al. [5] examined data from the National Survey of Drug Use and Health from 2004 through 2014 comparing state-level variation in the timing of implementing a PDMP and PDMP characteristics and assessed if PDMPs were associated with a reduction in prescription opioid misuse and if this reduction led to an increase in heroin use. It was discovered that implementation of PDMPs was associated with a decrease in doctor shopping without an increase in procuring opioids illegally and was not associated with an increase in use or initiation of heroin.

The studies of Pomerleau et al. [2] and Leichtling et al. [4] focused on clinicians’ prescribing behaviors and, to a certain degree, clinicians’ failure to follow the current standard of care (opioid prescribing guidelines). Pomerleau et al. [2] also found that, to a lesser degree, clinicians prescribed opioids to promote improved patient satisfaction scores and accelerate discharge. These patterns also suggest a more systemic issue of institutional and regulatory shortcomings. Clinicians are subjected to increasing demands to care for more patients, to follow multiple practice guidelines, and to document on an electronic medical record, typically while seeing the patient and thus further eroding the clinician-patient relationship. Institutional and clinician reimbursement tied to patient satisfaction can lead to increased pressure on clinicians to prescribe opioids even in cases where there is no discernable organic pathology accounting for the pain [6], although there is some evidence that opioid prescribing in the ED is not associated with patient satisfaction scores [7].

The vast majority of clinicians are committed to improving the quality of life of the patients they serve and doing no harm. Without institutional support, however, clinicians will continue to struggle with balancing the myriad of daily clinical demands (time, documentation, patient satisfaction, etc.) and providing compassionate and thoughtful care. Needed institutional and regulatory support to enact change in how clinicians care for these complex patients include: enhancing reimbursement for cognitive medicine, allowing more time for patient interaction, and performing due diligence in following established guidelines; compensated time for completing education on the basics of pain medicine, addiction, and appropriate opioid prescribing; and consistent non-punitive feedback and corrective action when standards of care are not followed. An example of a systematic
approach to this program is the Opioid Safety Initiative (OSI) of the Veterans Health System [8]. The OSI’s academic detailing approach, combining monitoring of opioid prescribing patterns with feedback and supportive education and access to integrative and psychological therapies, has demonstrated effectiveness as a model for helping change clinical practice [9].

On a larger scale, ensuring effective, multimodal pain management including opioid therapy in carefully selected patients while mitigating the risk of opioid misuse, abuse, and prescription opioid-related fatalities will require a herculean effort to face and correct the substantial and entrenched barriers to meaningful pain care [3,10,11]. This effort will include: establishing core competencies in pain and addiction medicine to medical schools, residencies, and other health professional education [10]; improving reimbursement for nonopioid therapies (physical therapy, psychological services); and bolstering access to substance abuse treatment [11].

Turning the tide on the opioid epidemic and alleviating the suffering of the countless number of individuals with pain necessitate a top to bottom reformation, starting with the top (institutions, regulators, insurance industry) and not just focusing on the end result of clinicians’ decision-making and behavior.

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References