Minnesota Board of Pharmacy

Report to the Legislature: Unsolicited Reporting Criteria Established and Process Review MN Prescription Monitoring Program

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Cost of Report

MN Stats. §3.197 states that a "report to the legislature must contain, at the beginning of the report, the cost of preparing the reporting, including any costs incurred by another agency or another level of government". The estimated cost of preparing this report was $9,500.

Introduction

Prescription Drug Monitoring Programs (PDMP/PMPs) have become prevalent in today's healthcare environment. Forty-nine of the fifty states have enacted legislation allowing for the creation and operation of PMPs. Evidence published by the PDMP Center of Excellence at Brandeis University suggests that PMPs are effective in reducing controlled substance misuse and diversion, supporting safe prescribing and dispensing, and addressing the prescription drug abuse epidemic. The Prescription Drug Abuse Prevention Plan, which expands on the Obama Administration's National Drug Control Strategy, calls for action in education, monitoring, proper disposal, and enforcement, in an effort to reduce prescription drug abuse.[1] The "monitoring" component includes increased utilization and enhancement of PMPs, in part, to detect and reduce "doctor shoppers" and diversion. For the purposes of this document, doctor shopping behavior is defined as the practice of obtaining controlled substance prescriptions from multiple prescribers and pharmacies without informing the providers of other care that has been received or making an effort to coordinate care.

Numerous stakeholders in the fight against prescription drug abuse, specifically, the Center for Disease Control (CDC), the Prescription Drug Monitoring Program Center of Excellence at Brandeis, and the National Alliance for Model State Drug Laws (NAMSDL), have identified several recommended practices for PMPs. One of these recommendations is the act of sending unsolicited reports based on PMP data to prescribers, dispensers, law enforcement agencies, and/or licensing boards. Unsolicited reports proactively inform the aforementioned parties of possible drug diversion, inappropriate prescribing, and doctor shopping. Unsolicited reports promote identification of individuals with high-risk behaviors, those who may be at risk of substance use disorders, and patients who may be candidates for rehabilitation or pain management programs. Additionally, unsolicited reports promote use of the PMP. A goal in sending unsolicited reports is to identify patients at high risk and to encourage early intervention so that high-risk behaviors are changed into healthy patterns.

It has been noted that unsolicited reporting is one component of a strong prescription monitoring program. NAMSDL states, "The PMP should proactively provide data to prescribers, dispensers, law enforcement, and professional licensing or certification agencies or boards regarding any individual, including a patient, prescriber, or dispenser, who meets the criteria established by an advisory committee or the PMP as exhibiting potential signs of abuse, misuse, or diversion.

[1] Office of National Drug Control Policy. (n.d.). Prescription drug abuse. Retrieved from https://www.whitehouse.gov/ondcp/prescription-drug-abuse

Ideally, such information should initially be provided to a patient's prescriber(s) and/or dispenser(s) with the goal of referring such patient to treatment, if such prescriber or dispenser deems it necessary, rather than referring the PMP information to law enforcement in the absence of clear evidence of illegal activity."[2]

The goals of the Minnesota PMP are to promote public health and welfare by detecting diversion, abuse, and misuse of controlled substances, to reduce prescription drug overdoses, and to promote safe prescribing and dispensing, all in an effort to improve patient care. Performing unsolicited reporting in Minnesota supports the goals and purpose of the PMP. It is one more tool Minnesota has in the fight against prescription drug abuse.

In July 2014, legislation was enacted to allow for the sending of unsolicited reports to prescribers and pharmacists. Per MN Statutes Section 152.126, Subd. 6(i), "The board shall review the data submitted under subdivision 4 on at least a quarterly basis and shall establish criteria, in consultation with the advisory task force, for referring information about a patient to prescribers and dispensers who prescribed or dispensed the prescriptions in question if the criteria are met…This paragraph expires August 1, 2016."

The purpose of this report is to provide an overview of the criteria established for unsolicited reporting and the review process used by PMP staff to determine the appropriateness of notifying prescribers and pharmacists of a patient of concern.

Information Gathering: Criteria Established & Notification Format

While literature supports the benefit of sending unsolicited reports and the perceived effectiveness of doing so, the data is limited in regards to the method of sending such reports. Therefore, in the fall of 2014, the PMP Pharmacist Consultant made two attempts to reach each state's PMP director to learn about their approach to unsolicited reporting. At the time of data collection, 33 of the 49 states with PMPs were legally permitted to provide unsolicited reports to prescribers and pharmacists; 5 were legally permitted to provide unsolicited reports to prescribers only.

Responses were provided by 42 states. Of the 42 states, 24 were actively providing unsolicited reports to prescribers and 12 of these states were also providing unsolicited reports to pharmacists. Six states intended to begin providing unsolicited reports to prescribers and pharmacists in the near future and an additional 2 intended to begin providing unsolicited reports to prescribers only.

[2] National Alliance for Model State Drug Laws. (2015, July). Components of a strong prescription monitoring program. Retrieved from http://www.namsdl.org/library/8B509B0A-D51E-472E-B9F10054CE52F2F6/

Unsurprisingly, it was learned states were performing unsolicited reporting slightly differently, and no majority threshold (criteria for "doctor shopping") was identified. Some commonly used thresholds were prescriptions from 5 prescribers or more plus dispensed at 5 pharmacies or more in a 30 day period and prescriptions from 5 prescribers or more plus dispensed at 5 pharmacies or more in a 90 day period. Queries of the MN PMP database were performed in November and December of 2014 to assess the volume of individuals meeting both thresholds. Figures 1 and 2 provide an overview of the results.

Figure 1. Volume of Recipients Meeting a Threshold of 5/5/30 in MN in 2014

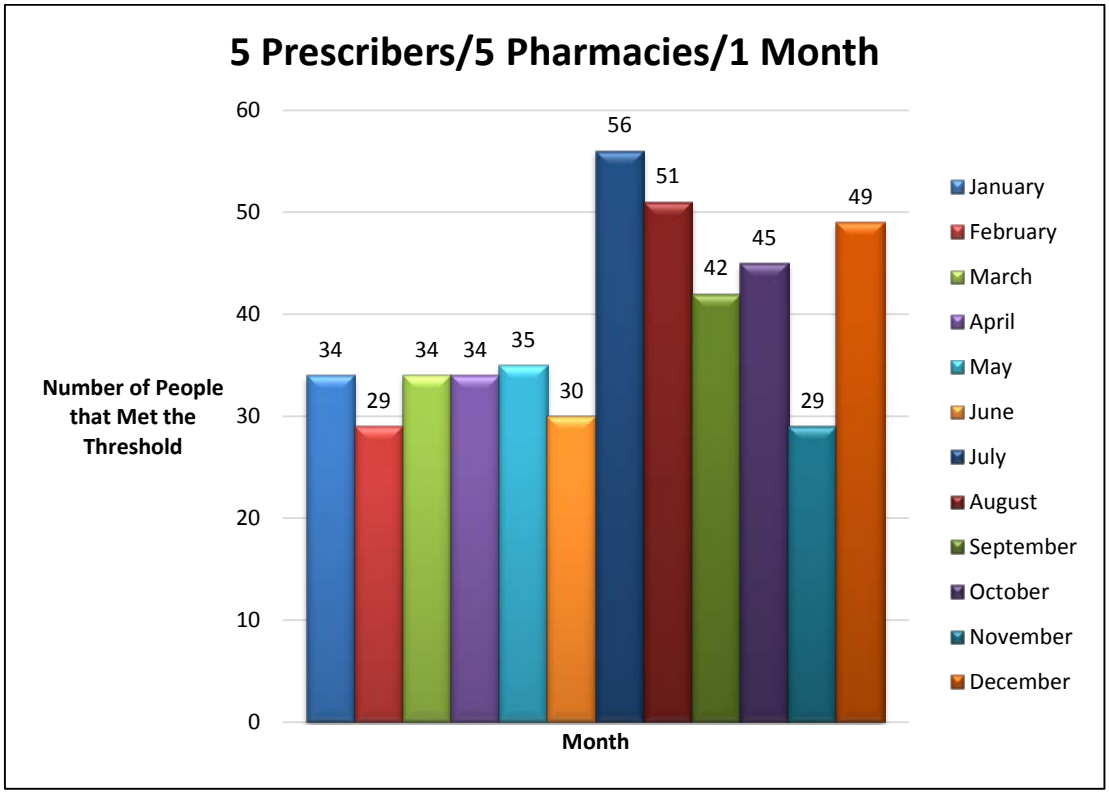
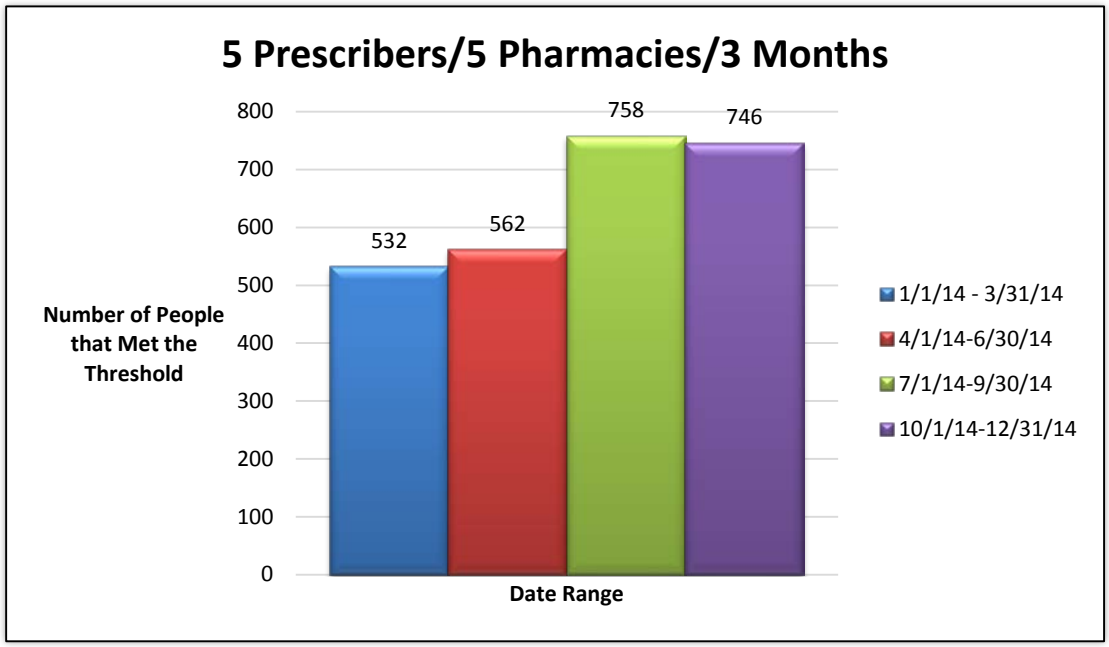


Figure 2. Volume of Recipients Meeting a Threshold of 5/5/90 in MN in 2014



While additional thresholds were reported from the participating states, the majority of the criteria used were derivations of the "X prescribers and Y pharmacies in Z days" format.

Several further aspects of sending unsolicited reports were assessed in the dialogue with the 42 PMP directors across the United States. These items included the method of sending unsolicited reports and the specific patient information disclosed in the report. It was learned that states provide unsolicited reports in several ways: United States Postal Service mail alone, email alone, or electronically, but if this is not an option, meaning the provider does not have a PMP account, the information will be provided via US mail. All of the states were asked what patient data (if any) is included in the report. The majority of PMPs do not include the patient's prescription information (or PMP report) with the unsolicited notice, only the individual's name and date of birth. It is then the responsibility of the prescriber or pharmacist to access the PMP database and generate a patient PMP report to view the controlled substance prescription history.

The frequency in which unsolicited reports are sent from state PMPs was not a focus of this research. However, it was learned that states send unsolicited reports daily, weekly, monthly, quarterly, or annually. It was also discovered that a limitation of sending unsolicited reports is the availability of resources at each PMP.

The results of the research were compiled and presented to the Minnesota PMP Advisory Task Force at the November 25th, 2014 meeting. The Task Force agreed to proceed with a pilot project using a threshold of prescriptions from five or more prescribers and dispensed by five or more pharmacies in a one month timeframe.

The Board of Pharmacy subsequently reviewed the data and supported the criteria established. The pilot project of unsolicited reporting was then titled Controlled Substance Insight Alerts (CSIAs) and launched January 1, 2015.

Review Process

The Minnesota PMP believes it is important to apply clinical judgment to PMP reports prior to sending unsolicited notices, in an effort to prevent alert fatigue and to remove the individuals identified as "false positives." A false positive is a person that has met the threshold but does not exhibit suspicious or high risk behavior and, therefore, should not have unsolicited notices provided. False positives may include patients who are receiving prescriptions from multiple prescribers within the same health care system; those who are receiving care from oncologists or hospice providers; or other traits where a lack of high risk behavior is identified. Of interest, one state discontinued sending unsolicited reports in part, due to negative feedback from prescribers, as a result of alert fatigue. This scenario highlights the importance of applying clinical judgment to PMP reports prior to providing them to health care providers, so that individuals identified as "false positives" are not included in the unsolicited notification. This scenario also highlights the importance of using a conservative threshold in which those with suspicious or high-risk behavior are most likely to be identified.

The Board considered the methods conducted by the various PMPs that were engaged in sending unsolicited reports in the Fall of 2014, and in collaboration with the MN PMP Advisory Task Force, recommended the following regarding the review process for Controlled Substance Insight Alerts (CSIAs), or unsolicited reports in Minnesota.

1. Clinical judgment will be applied to CSIAs by a licensed pharmacist, prior to the sending of unsolicited reports, so that individuals identified as false positives are not included in such notification.
2. CSIAs will be sent on a monthly basis.
3. CSIAs will be provided in a secure email, using the email address the prescriber provided in their PMP user account profile. If the prescriber does not have a PMP user account, the CSIA will be sent in the US mail. Pharmacies will receive CSIAs via US mail which will be addressed to the Pharmacist-in-Charge.
4. The prescribers and pharmacists receiving CSIAs will be encouraged to view the patient's PMP patient profile by accessing the PMP's secure database; however, there is no obligation or consequence for taking action or choosing not to do so. Prescribers and pharmacists that do not have a PMP account are encouraged to register for an account in the CSIA and instructions will be provided for how to obtain an account.

Effectiveness

In regards to measuring the effectiveness of unsolicited reporting, the majority of states have not conducted any scientific studies. However, the majority of those that have assessed effectiveness have noticed a downward trend in the number of unsolicited reports being generated over time. One PMP administrator commented that a handful of individuals will repeatedly meet the threshold. However, after unsolicited reports have been provided for a while, they tend to see an improvement in the number of providers seen and eventually, the individuals stop meeting the threshold.

The CSIA pilot project was conducted from January 1st 2015 to June 30th 2015. During this timeframe, CSIAs were provided monthly following the above recommendations. Effectiveness of unsolicited reporting during this pilot was measured in several ways:

1. The trends of individuals meeting the threshold were compared on day 1, when they initially met the threshold, and then again 90 days after the CSIAs were provided to prescribers and pharmacists-in-charge.
2. The number of new prescriber PMP accounts were assessed within 3 weeks of providing CSIAs.
3. The occurrence or likelihood of providers viewing their patients' PMP report after receiving a CSIA was assessed.
4. The medical specialty of the prescriber receiving the report was documented to determine if there was a trend in prescriber location and reports sent.
5. Prescribers and pharmacists were surveyed after 6 months of unsolicited reporting to assess the perceived effectiveness and impact of CSIAs.

Trend Analysis

During the 6 month pilot project, 1,652 CSIA notifications were sent regarding 137 unique individuals. Of the 137 unique individuals, 945 CSIAs were provided to prescribers and 707 were provided to pharmacists-in-charge (some of which were sent to the same prescriber or pharmacy if the individual repeatedly met the threshold). Figure 3 below, shows the monthly overview of CSIAs distributed based on top prescriber discipline. Those that have received CSIAs consist of Medical Doctors (MD), Advance Practice Registered Nurses (APRN), Dentists (DDS/DMD), Physician Assistants (PA), Doctors of Osteopathy (DO), and Doctors of Podiatric Medicine (DPM). If only a handful of prescribers of a particular discipline received a CSIA they are not included in Figure 3. Medical doctors represent the largest discipline of prescribers to receive CSIAs.

Using specialty information derived from the MN Board of Medical Practice's website (which includes self-reporting as well as information obtained from the American Board of Medical Specialties or the American Board of Osteopathic Medical Specialties), the majority of MDs that received CSIAs during the pilot, specialized in Family Practice (179), then Emergency Medicine (131), and Internal Medicine (57).

Figure 3. CSIA Distribution Based on Top Prescriber Discipline from Jan to Jun 2015

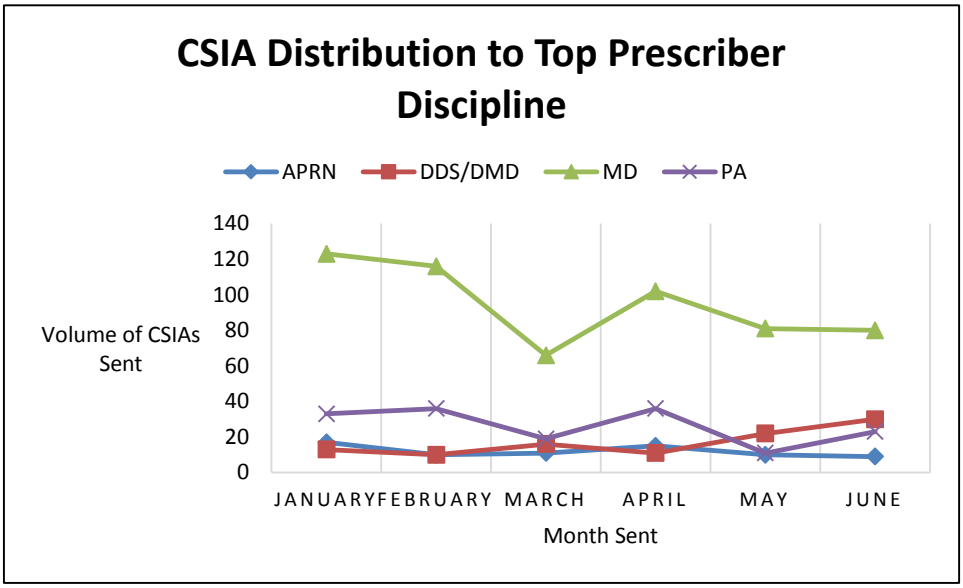
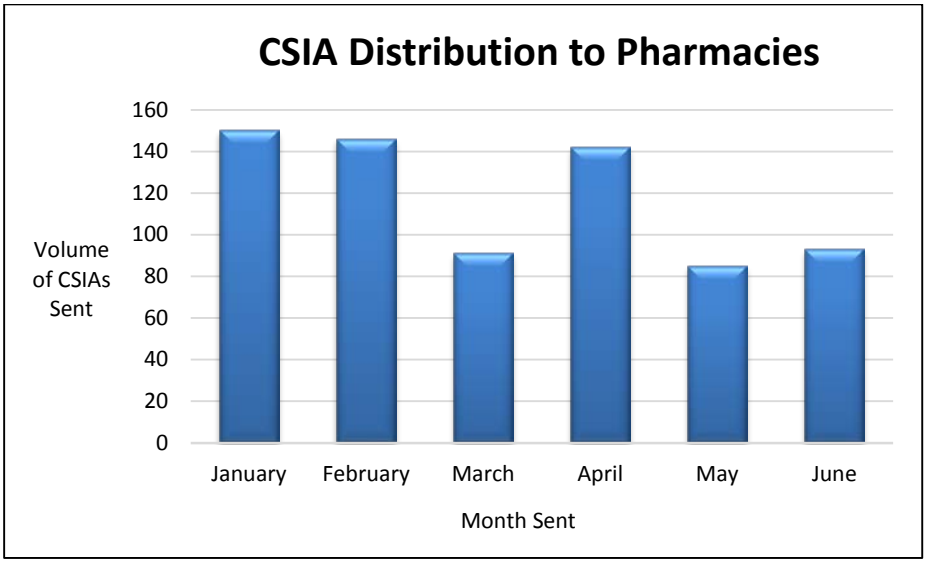


Figure 4 depicts the volume of CSIAs that were provided to pharmacies, and addressed to the pharmacist-in-charge. The decline in CSIAs sent in the month of March, may be attributed, in part, to the short month of February.

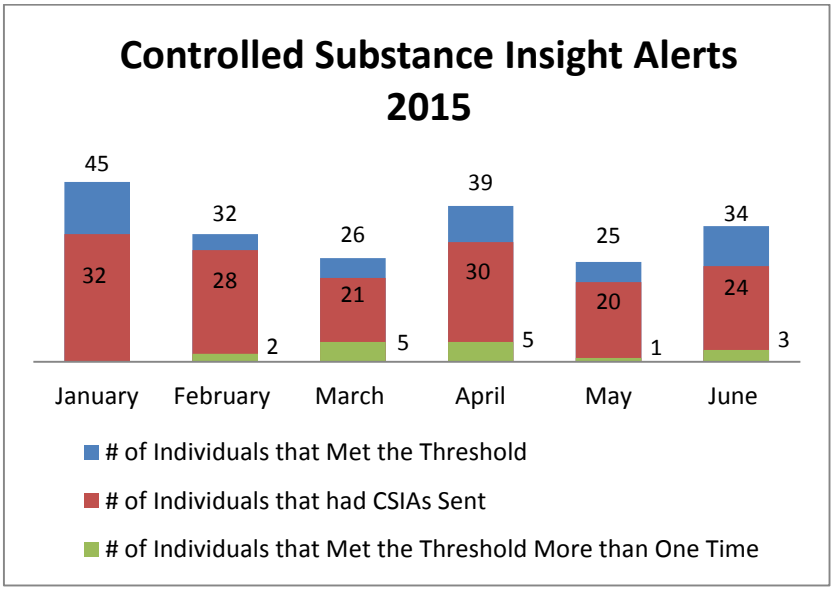
Figure 4. CSIA Distribution to Pharmacies from Jan to Jun 2015



Prior to sending CSIAs each month, clinical judgment was applied to the PMP report. During the first six months of sending CSIAs, 27 individuals met the threshold but were identified as false positives, meaning doctor shopping or suspicious behavior was not identified, and therefore, CSIAs were not provided. An example of an individual being identified as a false positive is if he/she saw multiple prescribers within the same healthcare system. An additional 20 individuals met the threshold, but it was unclear if the prescription activity was indicative of high-risk behavior. These individuals were assessed for 90 days. During this timeframe, if the prescription activity stayed the same or lessened, they were considered a false positive and CSIAs were not sent. If the prescription activity became indicative of high-risk behavior (multiple prescribers or pharmacies were identified), then CSIAs were provided, and the patient, prescriber, and pharmacy information is counted in Figures 3, 4, and 5 based on the month in which CSIAs were actually provided.

Figure 5 shows the monthly overview of the number of individuals that met the threshold during the first six months of sending unsolicited reports. The blue portion of the column indicates the number of individuals that met the threshold each month prior to the application of clinical judgment. The red portion of the column indicates the number of individuals for which CSIAs were actually sent. These numbers include those that had CSIAs sent to both prescribers and pharmacies, as well as those that had CSIAs sent to prescribers alone. Occasionally, there would be an individual whose PMP report looked moderately suspicious, but also could have been legitimate. As opposed to alerting everyone, the MN PMP erred on the side of caution and sent CSIAs to prescribers only to review, in these instances.

Figure 5. Volume of Individuals Meeting Threshold from January to June 2015



These numbers cannot be added through time to yield the number of unique individuals for which CSIAs were sent due to the individuals that met the threshold more than one time in various months that were inevitably counted each month he/she met the threshold in the above diagram. The same applies for the green portion of the column above (individuals that met the threshold more than one time are not necessarily unique individuals each month).

The green portion of the column in Figure 5 indicates the number of individuals that met the threshold more than one time in previous month(s). The individuals that met the threshold more than once may be the same person, or a different individual depending on the month. Likewise, the individual may have received prescriptions from the same prescriber and pharmacy or a different prescriber and pharmacy, depending on the month. Regardless, if the individual met the threshold again in a subsequent month and was demonstrating high-risk prescription behavior, prescribers and pharmacies were notified, in some instances, more than one time.
The results of the data analysis reveal that after CSIAs were provided to prescribers and pharmacists-in-charge regarding the 137 unique individuals, 92% of the individuals did not meet the threshold again.

Trends in the individuals' controlled substance prescription history were analyzed 3 months after CSIAs were provided to prescribers and pharmacists-in-charge. Individuals that met the threshold more than one time were included in the analysis based on the first month they met the threshold only (and in which CSIAs were sent). In the analysis of the 137 individuals, several potentially favorable outcomes were noted that may suggest prescriber or pharmacist intervention. Overall, three months after CSIAs were provided, there was a 64% reduction in the number of prescriptions filled. Of the 137 individuals, 93% had a reduction in the number of prescriptions dispensed. There was a 53% reduction in the total quantity dispensed (quantity refers to dosage units of a prescription such as tablets, capsules, or milliliters). Of the 137 individuals, 88% had a reduction in the total quantity dispensed of prescriptions from when the individuals met the threshold, compared to 90 days after CSIAs were provided. Additionally, there was a 70% reduction in the number of prescribers writing prescriptions for controlled substances and a 71% reduction in the number of pharmacies dispensing prescriptions. Of the 137 individuals, 98% filled prescriptions from fewer prescribers than when they had initially met the threshold and 99% were filling them at fewer pharmacies. Table 1 provides an overview of the 90 day trends.

Table 1. Assessment of Patient Trends 90 Days after Sending CSIAs

Patient Trends in the Number of Prescriptions Dispensed		
Reduction	Increase	No Change
127	7	3
Patient Trends in the Total Quantity (Metric Units) Dispensed		
Reduction	Increase	No Change
120	16	1
Patient Trends in the Number of Prescribers Prescribing Prescriptions		
Reduction	Increase	No Change
134	2	1
Patient Trends in the Number of Pharmacies Dispensing Prescriptions		
Reduction	Increase	No Change
135	2	0

Data suggests that several individuals have what appear to be additional interventions conducted by a prescriber or pharmacist after CSIAs were provided. Specifically, three months after CSIAs were provided, 17% had only one prescriber and one pharmacy providing controlled substance prescriptions to them, which may be suggestive of a pain management agreement (or pain contract). An additional intervention suggested by the data consists of individuals receiving buprenorphine-naloxone or buprenorphine, a medication commonly used to treat opioid dependence, during the 90 day window after CSIAs were sent. Of the 7% of individuals receiving buprenorphine-containing products, some of the prescribers received CSIAs and then prescriptions for buprenorphine were identified within the 90 days that followed. One prescriber had been prescribing buprenorphine during the time when the individual met the threshold; however, in the 90 days after the CSIAs were provided, the multiple prescribers prescribing opioids were no longer doing so. Of note, if an individual was referred to an Opioid Treatment Program or facility, their prescriptions for treatment of opioid dependence will not appear in the PMP database due to federal regulations regarding patient privacy.

Assessment on Utilization of the PMP Database

During the first six months of sending unsolicited reports, 28 of the prescribers who had received a CSIA created a new PMP user account within three weeks of receipt of the CSIA. This equates to 8% of prescribers that did not have a PMP user account at the time CSIAs were sent, applying for an account. If the prescriber applied for and was granted access to the PMP in the 4th week or greater after the CSIAs were sent, they were not captured in the assessment window. Of the 945 CSIAs that were sent to prescribers (not necessarily unique prescribers if the individual met the threshold more than one time and prescriptions were from the same prescriber), 54% of the prescribers had an active PMP account, 35% did not have an account, and 11% had an inactive account. An account may go into “inactive” status if the account holder does not sign into the database during a window of time in which he/she is required to review and update their contact information. Unfortunately, the MN PMP staff are unable to easily assess when an account becomes inactive so no correlation to CSIAs was able to be determined for inactive status accounts. Additionally, the PMP staff were unable to measure new pharmacist accounts as the CSIAs were sent to the current Pharmacist-in-Charge, which may not have been the same person who originally dispensed the medication.

New queries of the PMP database, regarding the 137 unique individuals, were assessed in the one month timeframe prior to the individual meeting the threshold and then again within the three week window after the CSIAs were provided. Based on the variability in which prescribers or pharmacists perform queries in the database, it is difficult to capture all queries performed regarding any given individual. As a result, the following numbers are indicative of prescribers and pharmacists performing patient queries around the time in which CSIAs were provided. During the first six months of sending CSIAs, 365 prescriber queries of the PMP database were readily identifiable by PMP staff in the one month timeframe prior to the individual meeting the

threshold. Of the 365 prescriber queries, 30% of the prescribers wrote a prescription during the timeframe when the individual met the threshold. The prescriber query could have occurred prior to writing the prescription or after the prescription was written. This means 70% of the prescriber queries did not result in a prescription being written and dispensed during the month when the individuals met the threshold.

In the three week window after CSIAs were provided, 371 prescriber queries were readily identifiable by PMP staff. The queries may have occurred as a result of new prescribers considering prescribing controlled substances, other applicable reasons (such as emergency medical treatment), or due to the prescriber having received a CSIA. Of the 371 prescriber queries, 99 were attributed to prescribers that had received CSIAs. Again, this is likely not a complete picture of all queries performed based on the nature in which users perform queries. Additionally, queries performed beyond the three week window were not captured in the assessment period.

Pharmacist queries were also assessed in the one month window before the individuals met the threshold and then again within the three week window after CSIAs were provided. Unfortunately, there is no way to confirm where the pharmacist worked when the query was performed or which pharmacist dispensed the medication based on PMP information. The following numbers will include all pharmacist queries, which may include those pharmacists considering dispensing a controlled substance or those who have received a CSIA. In the one month before the individuals met the threshold, 252 pharmacist queries were readily identifiable. In the three weeks after CSIAs were distributed, 260 pharmacist queries were readily identifiable.

Even though it is impossible to know the exact reason a prescriber or pharmacist queried the PMP, it can be inferred that some of the queries identified were in response to having received a CSIA. A measurement of effectiveness was to assess the occurrence of providers viewing their patients' PMP report after receiving CSIAs. The aforementioned numbers indicate that prescribers and pharmacists are in fact, performing patient queries around the time of sending CSIAs.

Much of the unsolicited feedback the PMP staff have received in response to CSIAs has been positive. The prescribers and pharmacists that have reached out, have thanked the PMP staff for the information and said it is very helpful that the alerts are being provided. Some pharmacists have commented that they did not query the individual once they received a CSIA, but rather, made a note to run a query the next time the individual is wanting to fill controlled substance prescriptions. As a reminder, pharmacists and prescribers are not obligated to query individuals in response to receiving CSIAs. In fact, they are not required to take any action. However, based

on the feedback, queries, new PMP accounts, and patient trends after CSIAs were sent, it can be deduced that prescribers and pharmacists are taking the notifications seriously.

PMP Survey Results

In July 2015, the PMP staff administered a survey to its users, in part, to identify the perceived effectiveness and impact of CSIAs. The survey invitations were emailed to 7,684 prescribers and 4,819 pharmacists with PMP user accounts, with a response rate of 23% for prescribers and 19% for pharmacists. Prescribers and pharmacists were asked if being notified about patients that have unusual or suspicious prescription activity (i.e. multiple prescribers and pharmacies in a given period of time) would be helpful in their practice. 93% of prescribers that answered thought this would be beneficial and 94% thought that such notifications would help to reduce doctor shopping behaviors in Minnesota. Of the pharmacists that answered, 90% thought such notifications would be helpful and 94% thought the information would help reduce doctor shopping behaviors in the state.

Prescribers and pharmacists were then asked if they had ever received a CSIA from the Minnesota Prescription Monitoring Program; 216 prescribers and 124 pharmacists responded that they had received a CSIA at some point in the past six months. Just under 70% of the prescribers and pharmacists reported learning new information regarding their patient's prescription activity as a result of the CSIA. Items reported as learned include the number of overlapping prescriptions, the number of prescribers visited, the number of pharmacies visited, the volume of drug(s) prescribed over a short period of time, and the number of early refills the patient had obtained.

Prescribers and pharmacists that received CSIAs were asked what actions occurred as a result of the CSIA. Table 2 outlines responses from prescribers and pharmacists (211 prescribers and 119 pharmacists responded). The question was posed in which multiple selections could be made as more than one action may occur after receiving a CSIA. The table is listed in order of frequency of response; however, some questions were unique to prescribers, while other questions were unique to pharmacists. The notation "n/a" is listed if the question was prescriber or pharmacist specific, or when it is appropriate, the pharmacist version of the question is listed in parentheses next to the given action that occurred.

Table 2. Most Common Actions that Occurred After Prescribers and Pharmacists Received CSIAs

Actions that Occurred	Prescriber Responses	Pharmacist Responses
Performed a query in the MN PMP regarding the individual	46%	68%
Identified a patient that was misusing, abusing, or diverting controlled substance prescriptions	55%	42%
Contacted a prescriber listed on the PMP report	12%	40%
Had a conversation with my patient about their PMP report in regards to misuse, abuse, or diversion of controlled substance prescriptions	33%	18%
Began using the MN PMP more frequently for my patients	26%	16%
Confirmed that my patient is not misusing controlled substance prescriptions	25%	20%
Contacted a pharmacy listed as a dispenser on the report	11%	23%
Changed my prescribing routine for future patients	21%	n/a
Tapered my patient down or off of a controlled substance medication (For pharmacists: recommended or assisted a prescriber with a taper down or off of the medication)	18%	6%
Changed my dispensing or verification routine for future patients	n/a	12%
Required my patient to sign a Pain Management Agreement (For pharmacists: recommended to the prescriber that a Pain Management Agreement be utilized)	9%	5%
Discharged the patient from my practice	7%	8%
Conducted a screening, brief intervention, and referral to treatment (The referral to treatment may not have occurred if the need was ruled out.) (For pharmacists: recommended to the prescriber to conduct a screening, brief intervention, and/or referral to treatment if appropriate)	5%	8%
Made a referral to treatment or began prescribing a medication for opioid addiction or dependence (For pharmacists: recommended to the prescriber that a referral to treatment or prescription for opioid addiction or dependence be prescribed)	7%	3%
None of the above	11%	11%

As previously mentioned, pharmacists and prescribers are not obligated to take any action as a result of the CSIA; however, the results of Table 2 indicate that various actions have occurred. With the threshold of 5 prescribers or more plus 5 pharmacies or more in a one month timeframe, it is unsurprising that 55% of prescribers and 42% of pharmacists identified a patient that was misusing, abusing, or diverting controlled substance prescriptions after receiving the CSIA. In addition, it also does not come as a surprise to learn that 25% of prescribers and 20% of pharmacists identified individuals that were not misusing controlled substances after viewing the PMP report.

As mentioned above, upon meeting the threshold, if the PMP report appeared moderately suspicious yet there may have been a medical need for the number of prescribers and pharmacies visited, the PMP has erred on the side of caution and provided CSIAs to prescribers only, or to prescribers and pharmacists-in-charge, for review.

One item worth mentioning is that “discharged the patient from my practice” may have been interpreted differently amongst those taking the survey. For example, a prescriber may have interpreted this question to mean they no longer prescribed controlled substances to the individual but continued to provide care for him/her. In any future surveys, a more descriptive option should be offered. It is not a goal in sending CSIAs for individuals to be discharged from prescriber’s offices or pharmacies, but rather, that individuals may be provided the care they need, as healthcare providers deem appropriate.

Prescribers and pharmacists were asked if, overall, the information provided by the CSIA was useful; over 90% of prescribers and pharmacists that responded felt the information was useful.

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Conclusion

Data suggests that alerting prescribers and pharmacists in regards to individuals with high-risk behavior improves patient care. Three months after notifications were sent to prescribers and pharmacists 98% of individuals identified filled prescriptions from fewer prescribers and 99% filled them at fewer pharmacies. Additionally, after CSIAs were provided, 92% of the individuals identified did not meet the threshold again. Regardless of if they had received a CSIA to date, the large majority of prescribers and pharmacists with PMP accounts that were surveyed felt notifications regarding patients with unusual or suspicious prescription activity (i.e. multiple prescribers and pharmacies in a given period of time) would be helpful to their practice and that such notifications would help to reduce doctor shopping behaviors in Minnesota.

After the first six months of sending unsolicited reports to prescribers and pharmacists and measuring the impact it has had on potential doctor shopping behaviors, staff of the Minnesota PMP continue to send CSIAs. Healthcare providers continue to register for PMP accounts and run patient queries upon receipt of CSIAs. Unsolicited feedback from healthcare providers remains positive and appreciative of such notifications. There is reason to believe that prescriber and pharmacist intervention will continue to occur when warranted. CSIAs may be the crucial piece of information that leads to a patient receiving care for a substance use disorder.

The Board of Pharmacy strongly recommends that the practice of sending unsolicited reports continue indefinitely with the continuance of measuring the impact on doctor shopping as well as other identifiable changes in patient behavior. The Board of Pharmacy's Minnesota Prescription Monitoring Program will continue to look to other states, the Centers for Disease Control, Prescription Drug Monitoring Programs Center of Excellence, the National Alliance for Model State Drug Laws, and the PMP Advisory Task Force for guidance regarding its efforts with unsolicited reporting.