

# E•QUAL | EMERGENCY QUALITY NETWORK

Opioid Initiative Wave I  
*PDMPs and Screening*

## Presenter



**Jason Hoppe, DO**

# PDMs and Screening

Jason Hoppe, DO

Department of Emergency Medicine

University of Colorado School of Medicine

# Take away points

- Embrace your imperfect PDMP (it will get better)
- Use PDMP often as possible
- Know the high-risk indicators
  - High doses, LA/ER
  - Combination with sedatives
  - >4 providers and/or pharmacies
  - Early refills, overlapping rxs




# Why do we care?



- No end in sight for the opioid crisis
- Physicians share responsibility (Including ED)
- Improve care (patients and community)
- We lack tools to improve prescribing
  - Improve or be regulated!
  - PDMP mandates can impact our practice
    - 38 states have some mandate

# Changing physician behaviors

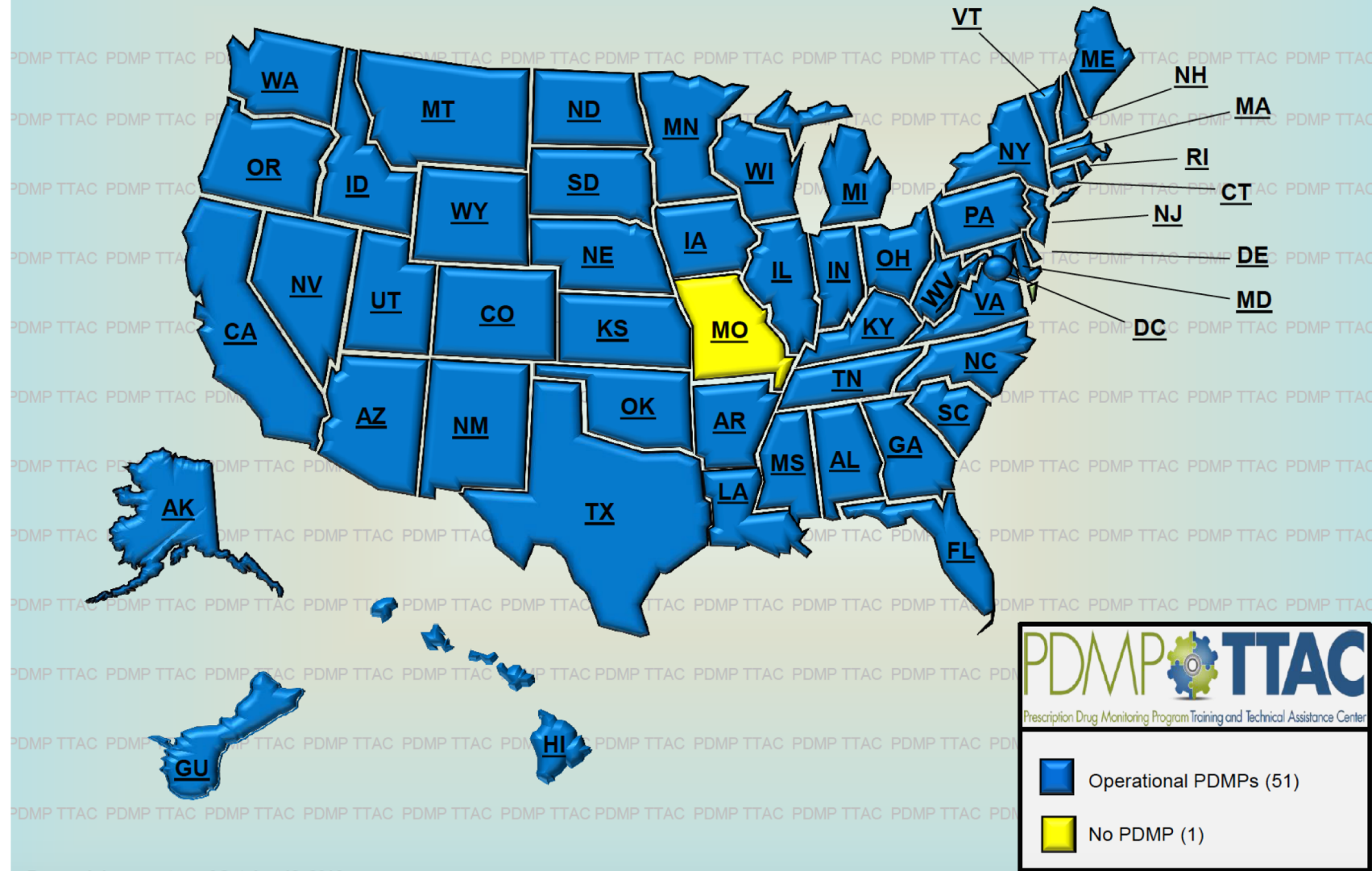
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- Education: expert opinion, consensus-based guidelines, evidence-based guidelines or decision support (PDMP)
  - Feedback: physician profiling (Unsolicited reports, Physician report cards)
  - Rationing: precertification programs (buprenorphine)
  - Penalties: licensure, capitation, withholding

# What are PDMPs?

- Electronic database to track controlled medications
- Include filled medications
- Statewide, but interstate sharing improving
- Limited access
- National push to improve utility and maximize impact

# Status of Prescription Drug Monitoring Programs (PDMPs)

*\* Click on state abbreviation to view PDMP contacts \**



Research is current as of October 18, 2016

<http://www.pdmpassist.org/pdf/PDMPProgramStatus.pdf>

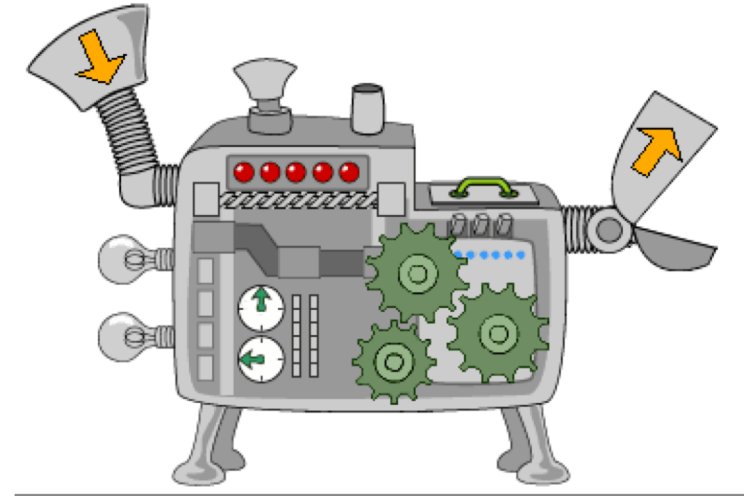


# What are PDMPs used for?

- Inform clinical practice
  - Improve prescribing/protect patients at risk
- Feedback tools to change provider behavior
  - Unsolicited reports
  - Provider report cards
- Real-time evaluations of prescribing trends for community/state
  - Target prevention efforts
  - Track emerging trends
  - Evaluation of legislative changes

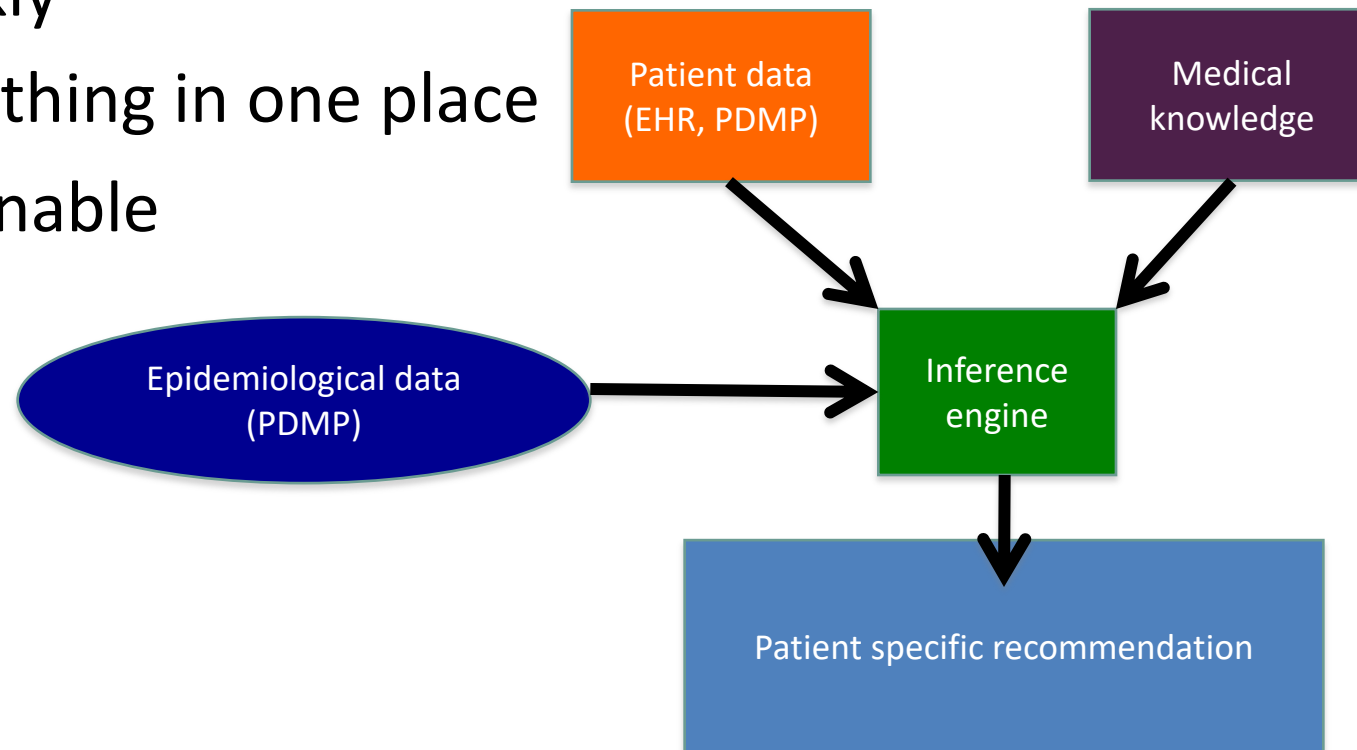
# Why PDMPs are imperfect in clinical care

- Variability in use
  - Access/usability/tech
  - Gestalt
  - Proof of success (ROI)
- Variability of interpretation
  - Lack of established decision support
  - Not optimized for end user
  - Lack of outcomes for prescribers



# Ideal PDMP as a Clinical Decision Support

- Links patient specific information within available databases to a knowledge base in order to generate case specific guidance
  - Quickly
  - Everything in one place
  - Actionable



# How to use the PDMP effectively

- Use it as often as possible
  - Gestalt important but inaccurate



- Consider other non-PDMP risks:
  - Psychiatric comorbidities
  - Substance use disorder
- Know the high-risk indicators

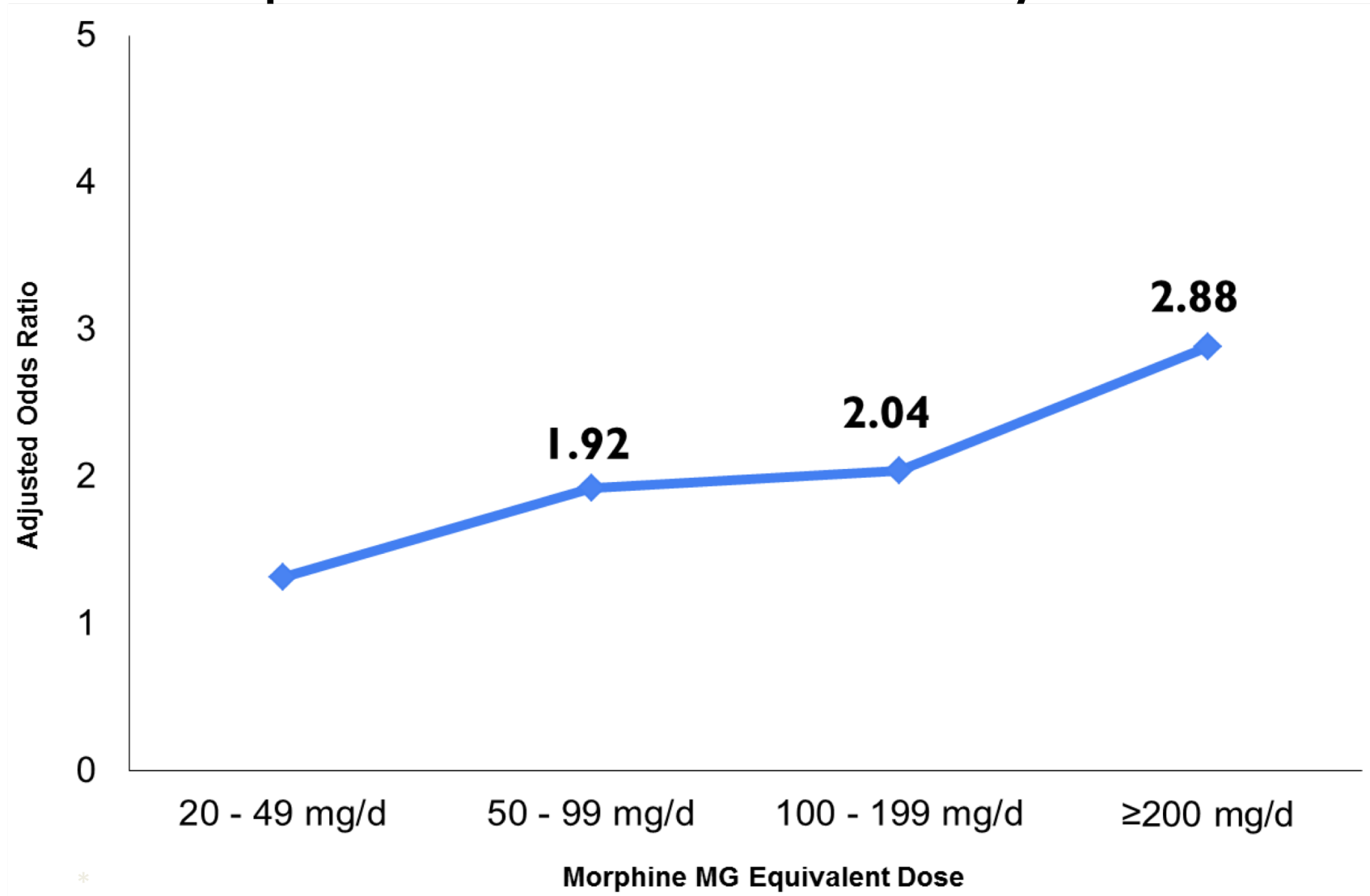
# Lower risk by PDMP

- **Nobody is zero risk**
- $\leq 3$  prescriptions in past year
- No early refills
- No active sedative use (inc. benzodiazepine)
- No self pay

# Moderate risk by PDMP

- 40-90 MME per day
  - Six 5 mg oxycodone = 45 MME!
- Opioids and Benzodiazepines together
  - Always use caution!
- More than 4 providers in 12 months
- More than 4 pharmacies in 12 months
- Early refills/overlapping prescriptions
- Self pay

# Opioid Dose and Mortality Risk



# Highest risk by PDMP

- High dose: More than 90-100 MMEs per day
- Long acting/Extended release opioids
  - Methadone, Oxycontin, MS-Contin, Fentanyl patches, etc.



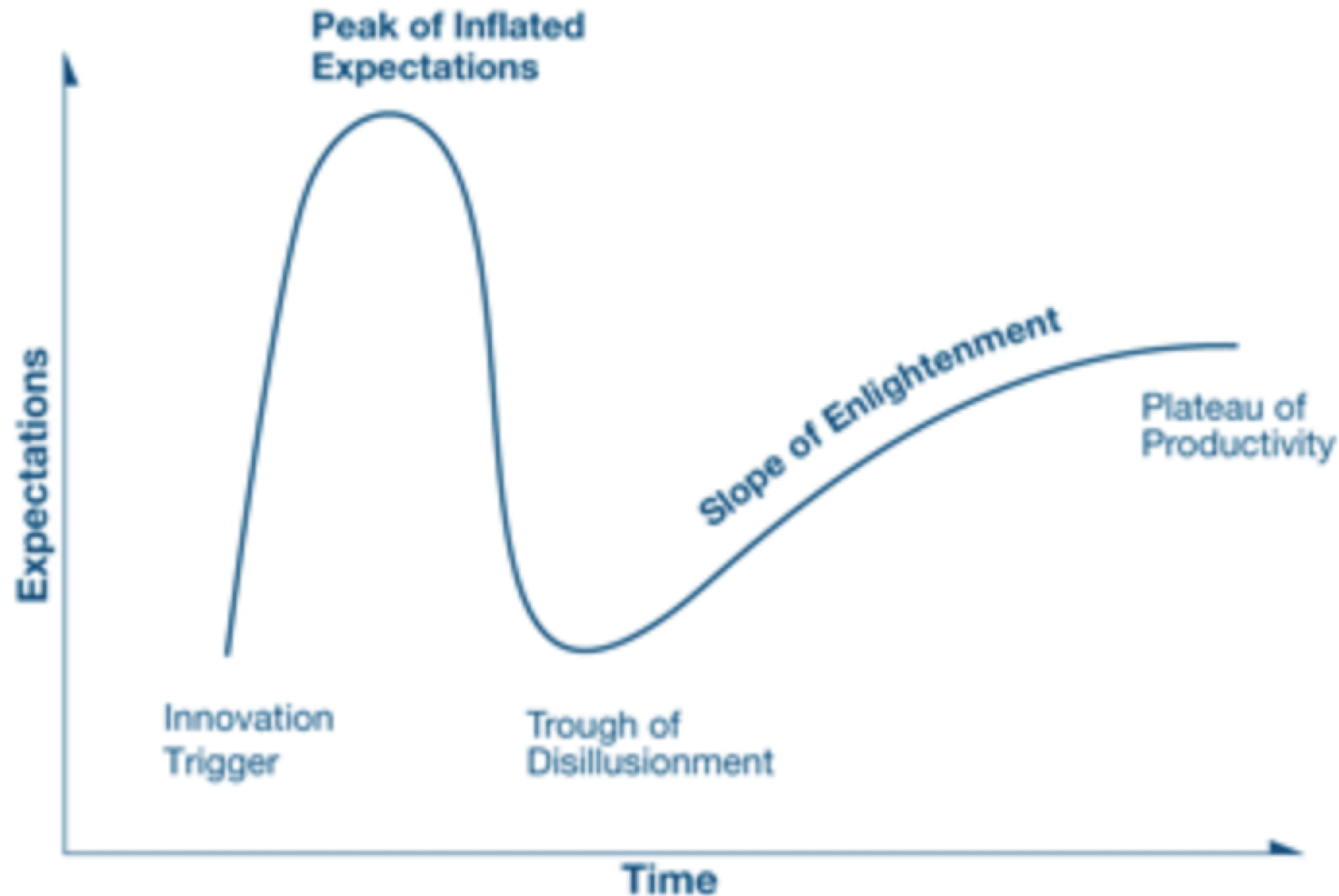
# Take back to your institution/state: PDMP integration

- Everyone benefits!
  - Clinicians: improve adoption of best practices, improve gains in performance
  - Admin: Improve patient care, easily enact legislative changes, system reports
  - General public: Safe treatment of pain and improved functionality



# Where are PDMPs in the tech lifecycle?

- Gartner Hype Cycle: interpreting tech hype



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# References

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## For More Information

- E-QUAL Website
  - ▶ [www.acep.org/equal](http://www.acep.org/equal)
  - ▶ [equal@acep.org](mailto:equal@acep.org)
- Contacts:
  - ▶ Nalani Tarrant: (Senior Project Manager)  
[ntarrant@acep.org](mailto:ntarrant@acep.org)
  - ▶ Dhruv Sharma: (Project Manager)  
[dsharma@acep.org](mailto:dsharma@acep.org)



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