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Options for Unsolicited Reporting

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Options for Unsolicited Reporting

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Options for Unsolicited Reporting

Overview

Unsolicited reporting of prescription drug monitoring program (PDMP) data to prescribers, dispensers, licensing boards, and law enforcement agencies is a recognized PDMP best practice. The Centers for Disease Control and Prevention (CDC) has recommended that PDMPs institute unsolicited reporting on “high-risk” patients and prescribers—those prescribed high doses of opioids or who meet criteria for questionable activity such as doctor shopping or reckless prescribing. A growing body of evidence suggests that the proactive dissemination of PDMP information about such individuals to appropriate end users helps to promote safe prescribing and limit diversion of controlled substances. However, for a variety of reasons, including regulatory restrictions, lack of resources, and concerns about unintended consequences, many PDMPs currently conduct only limited unsolicited reporting or none at all. Understanding the benefits and feasibility of unsolicited reporting may serve to encourage more widespread adoption of this practice by states.

This guidance document outlines the rationale and basic procedures for unsolicited reporting, including a discussion of criteria and thresholds in PDMP data used to select individuals for reporting. It then provides a menu of options for unsolicited reporting as illustrated by current PDMP practice. Unsolicited reports on patients meeting criteria for questionable activity, such as seeing multiple prescribers for the same drug, are typically sent to medical providers or law enforcement agencies, depending on a state’s policies and PDMP statutes (see “Unsolicited reporting to medical providers” and “Reports to law enforcement on doctor shopping” below). Some PDMPs also supply reports to licensing boards and law enforcement on prescribers who fall outside the norms for their type of practice (see “Reports on providers to licensing boards” and “Reports on providers to law enforcement” below). Examples of these types of unsolicited reporting, including selection and reporting mechanisms, are drawn from a sample of states (therefore, not all states conducting unsolicited reporting are mentioned below).

This guidance document also includes examples of promising practices and innovations in unsolicited reporting that may expand the options available to states (see “Promising practices and innovations” below). Some involve technological innovations in making PDMP data available to end users, some expand the range of end users receiving reports, and others expand the criteria for unsolicited reporting to include indicators of unsafe prescribing that go beyond doctor shopping alone.

Barriers to adopting unsolicited reporting are examined, as well as possible means to overcome them (see “Barriers to unsolicited reporting” below). The “Summary and conclusions” section lists some characteristics of unsolicited reporting, exemplified by current state practice, that appear to contribute to its effectiveness and efficiency. Overall, experience among states suggests that, given statutory support and adequate resources, unsolicited reporting is feasible for most PDMPs. Adopting unsolicited reporting can confer substantial benefits to states by

increasing utilization of PDMP data, helping to reduce prescription drug abuse, diversion, overdoses, and deaths.

Background

PDMPs are effective tools in mitigating prescription drug abuse and diversion, but only when they are well utilized. Virtually all PDMPs provide prescription history reports to authorized end users on request (solicited reports), but if reports are not requested, potentially useful information goes unseen and unused. A prescriber who does not conduct regular checks on his or her patients using the PDMP might fail to detect a possible doctor shopper (a patient obtaining multiple overlapping and medically unnecessary prescriptions for the same controlled substance) or possibly harmful drug interactions.

To ensure that prescription history information is more fully utilized, and to assist PDMP end users in carrying out their responsibilities, some PDMPs proactively send reports of data suggestive of questionable activity involving controlled substances, such as doctor shopping or illicit prescribing. Recipients of unsolicited reports or alerts¹ ordinarily include prescribers, pharmacists, law enforcement agencies, and licensing boards. These reports notify prescribers and pharmacists that patients may be abusing or diverting controlled substances and help practitioners make better decisions about prescribing and dispensing controlled substances, thus improving clinical care. Unsolicited reporting to law enforcement agencies and health professions licensing boards concerning questionable activity by patients, prescribers, and pharmacists can also assist in reducing drug diversion and ensuring safe, effective, and legal medical practice. Unsolicited reporting can also inform potential end users about the PDMP and its value, resulting in increased use of the data.

Unsolicited reports as a PDMP best practice

Prominent stakeholders in the fight against prescription drug abuse have concluded that unsolicited reporting constitutes a best practice for PDMPs. To receive funding under the National All Schedules Prescription Electronic Reporting (NASPER) Act, the Substance Abuse and Mental Health Services Administration (SAMHSA) established that PDMPs must provide unsolicited reports to medical practitioners (SAMHSA, 2005).² The Bureau of Justice Assistance (BJA) included adoption of unsolicited reporting as a priority consideration for states seeking funding under the Harold Rogers Prescription Drug Monitoring Program.³ The CDC recommended that “state prescription drug monitoring programs should routinely send reports to providers on patients less than 65 years old if they are being treated with opioids for more than six weeks by two or more providers or if there are signs of inappropriate use of

¹ Alerts notify the recipient that an individual meets criteria for questionable activity as identified in the PDMP database, but do not include prescription data and therefore are less likely to compromise patient confidentiality. The recipient of the alert is advised to consult the database to view the prescription history information.

² The NASPER grant program is currently unfunded but has provided support to PDMPs in earlier years.

³ See BJA's [Harold Rogers PDMP FY 2012 Competitive Grant Announcement \(www.bja.gov/Funding/12PDMPsol.pdf\)](http://www.bja.gov/Funding/12PDMPsol.pdf).

controlled substances.”⁴ In a recent briefing, the CDC also suggests that PDMPs should “provide unsolicited reports on high-risk providers and patients to the appropriate providers, regulatory boards, as well as law enforcement agencies under certain circumstances, such as an active investigation, court order or subpoena.”⁵

A growing body of evidence supports unsolicited reporting as a PDMP best practice. Nevada initiated its PDMP in 1997 by sending unsolicited reports to prescribers about possible doctor shoppers, a first for any PDMP. These reports quickly generated interest in the PDMP among prescribers, sparking further requests for data (solicited reports).⁶ Analyses of Nevada PDMP data from 1997 to 2002 indicate that individuals for whom unsolicited reports were sent exhibited declines in the average number of dosage units and numbers of pharmacies and prescribers visited subsequent to the reports. This suggests the reports may have influenced prescribing by providers treating these patients. Similarly, analyses of data from the Wyoming PDMP suggest that unsolicited reports helped to raise awareness of the PDMP, leading to greater requests for data, with a subsequent decline in numbers of individuals identified in the PDMP database who met thresholds for potential doctor shopping.⁷

Preliminary data from a Massachusetts survey of prescribers receiving unsolicited reports show that just eight percent were aware of all or most of the other prescribers listed on the reports, and only nine percent judged that the prescriptions listed were medically necessary.⁸ This indicates that unsolicited reporting of PDMP data provides new information to prescribers about possible doctor shopping. Prescribers in Maine who received automatic threshold reports on patients took a variety of clinical actions in response, suggesting that the reports helped to guide their medical practice.⁹ A cross-state evaluation of PDMPs by Simeone and Holland indicated that states with PDMPs that engaged in unsolicited reporting reduced sales of controlled substances by 10 percent compared to states without PDMPs, potentially reducing diversion and abuse.¹⁰ Preliminary findings from a Massachusetts study comparing individuals who were subjects of unsolicited reports to prescribers (cases) to a matched non-intervention comparison group (controls) show that in the year following the reports the cases exhibited greater declines than controls in the number of prescriptions, number of prescribers, number of pharmacies, average dosage units, and average days supply (how many days the supply of dispensed medication will last), with the greater decline in number of

⁴ Centers for Disease Control, Unintentional drug poisoning in the United States, <http://www.cdc.gov/homeandrecreationalsafety/pdf/poison-issue-brief.pdf>

⁵ Centers for Disease Control, “What States Can Do to Reverse the PDO Epidemic,” <http://www.sa4docs.org/wp-content/uploads/2013/07/What-States-Can-Do-to-Reverse-the-PDO-Epidemic.pdf>

⁶ Prescription Drug Monitoring Program Center of Excellence. (2011). Nevada’s proactive PDMP: the impact of unsolicited reports. NFF 2.5. Heller School, Brandeis University. Waltham, MA. http://www.pdmpexcellence.org/sites/all/pdfs/nevada_nff_10_26_11.pdf.

⁷ Prescription Drug Monitoring Program Center of Excellence. (2010). Trends in Wyoming PDMP prescription history reporting: evidence for a decrease in doctor shopping? NFF 1.1. Heller School, Brandeis University. Waltham, MA. http://www.pdmpexcellence.org/sites/all/pdfs/NFF_wyoming_rev_11_16_10.pdf

⁸ Massachusetts Department of Public Health. (2012, February). PDMP Advisory Council presentation. Public Health Advisory Council Meeting, Boston, MA.

⁹ Sorg, M., Labrie, S., & Parker, W. (2009). Analysis and evaluation of participation by prescribers and dispensers in the Maine state prescription monitoring program. Margaret Chase Smith Policy Center, University of Maine.

¹⁰ Simeone, R. & Holland, L. (2006). An evaluation of prescription drug monitoring programs. Simeone Associates, Inc. Albany, NY. www.simeoneassociates.com/simeone3.pdf

pharmacies and average days supply reaching statistical significance.¹¹ Gonzalez and Kolbasovsky report that possible doctor shoppers whose providers in a managed care organization were sent unsolicited prescription data exhibited greater reductions in opioid prescribers, pharmacies, and opioid prescriptions compared to possible doctor shoppers whose providers were not sent such information.¹² More such studies are needed to measure the impact of unsolicited reports, determine how they are best distributed and to whom, and validate the criteria of questionable activity that trigger them.¹³ However, existing research and experience of states thus far (more examples will be discussed below) support unsolicited reporting as a PDMP best practice worthy of adoption by all PDMPs.¹⁴

Current status of unsolicited reporting

The number and proportion of PDMPs conducting unsolicited reporting has been increasing. A 2006 survey of PDMPs by the BJA/IJIS Institute PMP Committee found that 25 of the 31 existing PDMPs were authorized to provide unsolicited reports to one or more categories of end users, but only 13 (42 percent) were actually doing so.¹⁵ According to surveys conducted by the PDMP Training and Technical Assistance Center in 2012, 38 of the 49 existing PDMPs were authorized to provide unsolicited reports or alerts to one or more categories of end users, and 26 (53 percent) were actually doing so. Of the PDMPs providing reports in 2012, 20 were sending them to prescribers, 10 to dispensers, 12 to law enforcement, and 13 to health professional licensing boards. In 2006, only nine were sending them to prescribers, five to dispensers, seven to law enforcement, and six to licensing boards.

Currently just three states—Delaware, Louisiana, and West Virginia—are sending unsolicited reports to all categories of recipients, and only a quarter of PDMPs (12 of 49) are submitting reports to law enforcement. However, the fact that half of the states are now engaged in at least some unsolicited reporting suggests that it is within the capacity of PDMPs, hence an attainable best practice. The benefits and feasibility of unsolicited reporting are inducements for states to amend their PDMP legislation to authorize it, or to implement it should authorization already be in place.

The remainder of this report presents examples of states conducting unsolicited reporting to various PDMP recipients under a variety of protocols, including some innovative approaches only recently adopted. They illustrate options for unsolicited reporting, one or more of which may be

¹¹ Young, Leonard, "Massachusetts Prescription Monitoring Program," presentation for the 2012 PDMP National Meeting, http://www.pdmpassist.org/pdf/PPTs/National2012/3_Young_StatePanelInnovationsMassachusetts.pdf.

¹² Gonzalez, A.M. & Kolbasovsky, A. (2012). Impact of a Managed Controlled-Opioid Prescription Monitoring Program on Care Coordination, *Am J Manag Care*. 2012;18(9):516-524.

¹³ The CDC has funded Abt Associates to conduct a randomized controlled trial of the effects of unsolicited reporting in Nevada on the medical claims of Medicaid patients. Results from this study will likely not be available for two years.

¹⁴ See PDMP Center of Excellence, 2012. Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices, pp. 31-33. http://www.pdmpexcellence.org/sites/all/pdfs/Brandeis_PDMP_Report.pdf.

¹⁵ PMP Committee Phase II PMIX Pilot Project Survey of State Prescription Monitoring Programs at: http://www.kms.ijis.org/db/share/public/PMIX/ijis_pmix_survey_ta_report_20070204.pdf, and Appendix E: Survey Tabulation Worksheets—available upon request from IJIS Institute or PDMP Center of Excellence at Brandeis University: www.pdmpexcellence.org.

currently feasible for a state, though they might require regulatory changes and/or development of the necessary capacity. It is important to note that some PDMPs not mentioned in this guidance document are conducting unsolicited reporting to various end users in ways that may be similar to the selected examples.

Options for unsolicited reporting

Procedures for unsolicited reporting to prescribers and dispensers

Criteria for questionable activity. The process of unsolicited reporting to prescribers and dispensers begins with analyses of PDMP data to flag patients meeting criteria or thresholds for questionable activity, such as doctor shopping, or for receiving possibly dangerous quantities and/or combinations of controlled substances. Criteria ordinarily include receiving prescriptions for the same drug type from multiple prescribers and pharmacies in a relatively short time period, resulting in overlapping prescriptions, or being prescribed more than a certain average daily dose of opioids (e.g., above 100 morphine milligram equivalents).^{16,17} Individuals who meet these thresholds may be doctor shopping or be at risk of abuse, medical complications, overdose, or death; this justifies unsolicited reporting as a public health and safety intervention. Although a particular threshold for doctor shopping or unsafe prescribing or dispensing may produce false positives, prescribers and dispensers following up on a PDMP report make the final determination on whether a patient's controlled substance behavior warrants intervention. Unsolicited reporting can, therefore, err somewhat on the side of greater sensitivity, identifying all or most questionable activity, without compromising good medical care. However, too many false positives might produce "alert fatigue" among recipients and undermine the credibility of the PDMP, so a reasonable degree of specificity is needed. Research on criteria for questionable activity as identified in PDMP and other data is ongoing and will serve to inform and improve best practices in unsolicited reporting.¹⁸ Optimal criteria for unsolicited reporting may vary by state.

¹⁶ Dunn, K.M., Saunders, K.W., Rutter, C.M., Banta-Green, C.J., Merrill, J.O., Sullivan, M.D., Weisner, C.M., Silverberg, M.J., Campbell, C.I., Psaty, B.M., & Von Korff, M. (2010). Opioid prescriptions for chronic pain and overdose. *Annals of Internal Medicine*, 152(2), 85--93.

¹⁷ Maine's PDMP statute specifies criteria for its unsolicited reporting: "The Office shall review prescription monitoring information related to individual patients to determine which patients have surpassed threshold levels of controlled substances. These threshold levels may include any of the following:

- high number of prescribers in a short time period, as determined by the Office [of Substance Abuse];
- high number of doses during a short time period, as determined by the Office;
- days supply of prescriptions for the same drug overlapping by more than a few days;
- unhealthy combinations of controlled substances, as determined by the Office;
- more than one method of payment within a short time period;
- more than one out of state prescriber for the same patient, during a short time period, as determined by the Office;
- more than one pharmacy on the same day;
- more than one pharmacy in different public health districts within one month; AND/OR
- dangerous levels of specific drugs, as determined by the Office."

¹⁸ See PDMP Center of Excellence, 2011, "Identifying probable doctor shopping and other questionable activity using prescription monitoring data: some preliminary findings," http://www.pdmpexcellence.org/sites/all/pdfs/COE_rpt_dr_shopping_6.pdf and PDMP Center of Excellence, 2012. Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices, pp. 21-24, http://www.pdmpexcellence.org/sites/all/pdfs/Brandeis_PDMP_Report.pdf.

Setting a threshold. A given threshold for questionable activity—for example, being prescribed opioids by four prescribers and being dispensed those prescriptions from four pharmacies in a three-month period—will flag a certain number of individuals for reporting. Depending on the threshold and the population of the state, individuals flagged can number in the thousands. To make unsolicited reporting manageable, states can set an initial threshold commensurate with their capacity to send reports or alerts. That capacity will, of course, depend on the reporting mechanism itself, which may be conducted via mailed paper reports, fax, email, or automated flags in an electronic medical record. As a state increases its capacity and as the number of individuals meeting a particular threshold declines,¹⁹ the threshold can be lowered as appropriate.

Unsolicited reporting to medical providers

Paper-based reporting in Maine. Since 2005, Maine has sent prescribers quarterly threshold notification reports via U.S. mail. Reports are sent to prescribers when a patient 1) has exceeded a certain number of prescribers and pharmacies in a three-month period; 2) has exceeded a specified average daily dose of acetaminophen coming from prescriptions of opioid-acetaminophen combination drugs (e.g., Vicodin, Percocet); or 3) is prescribed buprenorphine (a partial opioid agonist used in treating opioid dependence in office-based settings) and another opioid in a 30-day period. (For further details on Maine's unsolicited reporting criteria, see note 16 above.) Reports list the other providers who have prescribed to the patient, the pharmacies that dispensed to the patient, and details of prescriptions dispensed for the past three months. Reports are sent both to prescribers who are enrolled and to those not enrolled in the PDMP. The automated data analyses, report production, and mailing are currently handled by Maine's PDMP vendor. The fee for reporting is built into the vendor contract, not charged on a per-report basis. A 2009 survey of prescribers who received threshold reports found that substantial proportions of respondents took action in response, including looking up the patient's prescription history in the PDMP, calling other prescribers, talking to the patient, and conducting a substance abuse screening and brief intervention.²⁰ Recent numbers of reports, determined by the number of individuals meeting the questionable activity threshold, have ranged from 1,686 for the third quarter of 2011, to 778 for the third quarter of 2012, to 1,139 for the fourth quarter of 2012. The threshold has remained constant, so the number of likely doctor shoppers as measured by this criterion (those meeting the threshold) declined 32 percent from the third quarter of 2011 to the fourth quarter of 2012.

Faxed alerts in Arizona. Since 2009, the Arizona PDMP has been alerting prescribers every month about possible doctor shopping via faxed letters on patients meeting a relatively high threshold, one unlikely to generate false positives. The letters contain the patient's name and date of birth, and the prescriber is encouraged to access the PDMP to review that patient's

¹⁹ The number of individuals meeting a threshold can decline in response to use of PDMP, including both unsolicited and solicited reports. See PDMP Center of Excellence, NFF 1.1, http://www.pdmpexcellence.org/sites/all/pdfs/NFF_wyoming_rev_11_16_10.pdf.

²⁰ Sorg et al., 2009, op cit., p. 34.

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prescription history. The alerts thus serve as an inducement to use the database (Arizona currently mandates that prescribers enroll with the PDMP, but not that they use it). In 2009, over 40 individuals met the threshold in one month, requiring alerts to over 200 prescribers; since then, the number meeting the threshold has declined, plateauing in the mid-teens, which still generates over 100 letters to prescribers each month. The decline in the number of possible doctor shoppers since 2009 suggests that the alerts, by encouraging use of the PDMP, may prompt providers to take action to curtail medically unnecessary or dangerous prescribing. The generation and faxing of letters takes approximately three days per month, so the PDMP is considering ways to streamline the process—for instance, via emailed alerts (see the examples below regarding Massachusetts and Louisiana electronic alerts). In consultation with its advisory committee, Arizona is also considering moving to a lower threshold, in particular for its rural areas. This would flag more likely doctor shoppers, but would require additional resources to disseminate the additional alerts.

At the recent request of Arizona's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), the PDMP now reviews the prescription histories of all those meeting the threshold to see if any individuals have obtained controlled substances via Medicaid. If they have, their prescription information is forwarded to AHCCCS, which then undertakes its own reviews. The PDMP data assist in these reviews since they contain an individual's entire prescription history, including information not usually visible in Medicare claims data, such as prescriptions paid for in cash and by other insurers. Thus far, approximately one to three patients per month have been referred to AHCCCS.

Electronic alerts in Massachusetts. From January 2010 to December 2012, the Massachusetts Prescription Monitoring Program (MA PMP) sent paper-based unsolicited reports on over 100 individuals exceeding thresholds for doctor and pharmacy shopping. A total of 2,087 unsolicited reports were sent to the prescribers associated with these individuals' prescriptions, with some prescribers receiving reports on two or more individuals. As noted above in the section "Unsolicited reports as a PDMP best practice," a large majority of prescribers responding to a survey reported being unaware of all the other providers prescribing to these patients, indicating that the reports functioned to notify them about possible clinically inappropriate use of controlled substances.

The MA PMP has discontinued paper-based unsolicited reports to prescribers and now issues electronic notifications (alerts); the first alerts were sent out in July 2013. The PDMP system identifies individuals meeting a threshold based on experience with the database, peer-reviewed literature, and recommendations from the MA PMP's Medical Review Group (MRG). (The MRG, composed of physicians, dentists, and pharmacists, is charged with assisting the Massachusetts Department of Public Health in the evaluation of prescription information.) Alerts for each flagged individual are generated and emailed automatically to all the prescribers registered with the PDMP who issued prescriptions to those individuals. The system is designed to allow the PDMP to set the repeat interval for when a prescriber would receive another email alert concerning the same patient (to avoid "alert fatigue"). Costs associated with the system were primarily generated during the design,

testing, and implementation phases; operating costs are anticipated to be minimal. Once alerts are fully operational, the MA PMP plans to assess its impact by monitoring recipients' queries to the database and via a web-based survey of prescribers.

Electronic and mailed alerts in Louisiana. Louisiana's PDMP has conducted unsolicited reporting to both prescribers and dispensers since January 2010. As in Massachusetts' electronic system described above, patients meeting a threshold for questionable activity are flagged via an automated search of the PDMP database. A prescription history profile for each patient is generated and made available for download in the relevant provider's PDMP account. If a prescriber is enrolled in the PDMP, an alert is sent via email to the prescriber informing them that the profile is available for viewing, along with the profile's query number and the patient's name and date of birth. If a prescriber is *not* enrolled, they receive a hard-copy letter notifying them about the patient and suggesting they enroll in the PDMP so they can view the profile.²¹ Dispensers only receive hard-copy letters, addressed to the pharmacist-in-charge. As in Massachusetts, no prescription data are transmitted in any alerts; this serves to protect patient confidentiality and incentivize enrollment and system use. Before alerts are released, each patient's prescription history is reviewed by the PDMP administrator to ensure that it is truly indicative of questionable activity, helping to prevent false positives. The design and implementation costs for the unsolicited reporting system were estimated at approximately \$40,000.

When alerts were first sent in 2012, the alert threshold flagged 1,106 patients, which would have resulted in 5,817 alerts to prescribers and 5,784 to dispensers. However, after review, enough reports were judged false positives (patients for whom alerts were *not* sent after their prescription histories were reviewed) that the decision was taken to raise the threshold. Fewer individuals are automatically flagged at this higher threshold, but their prescription histories are more likely to merit alerts, thus reducing the administrator's time spent weeding out likely false positives. Recently, the Louisiana Medical Board requested a list of prescribers not enrolled in the PDMP that received the most alert letters—that is, those that had the most possible doctor shoppers in their practice. The Medical Board then contacted those physicians to encourage enrollment, after which they registered with the PDMP and began requesting patient profiles. Only the PDMP's proactive identification of possible doctor shoppers in these practices enabled the Medical Board to take such action.

Unsolicited reporting to law enforcement and licensing boards

Reports to law enforcement on doctor shopping

Some states either require or permit unsolicited reporting of possible doctor shoppers to law enforcement. Here are four examples:

²¹ A presentation on Louisiana's unsolicited reporting that includes the text of the letter can be viewed at <http://www.pdmassist.org/pdf/PPTs/South2012/UnsolicitedReportingLA.pdf>.

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North Carolina. The North Carolina PDMP statute requires that “unusual patterns” of patient behavior be reported to the Attorney General. The North Carolina PDMP flags patients who meet a threshold of prescribers and pharmacies suggestive of doctor shopping and controlled substance diversion. Before forwarding prescription history reports on these patients to the Attorney General, the information is carefully reviewed to rule out explanations other than doctor shopping and to find any recent indications of behavior change, such as prescriptions for buprenorphine used in office-based opioid addiction treatment. Over the past three years, approximately 100 such reports have been forwarded. The threshold used and the careful review in North Carolina’s unsolicited reporting to the Attorney General help to focus law enforcement attention on the most serious cases of possible doctor shopping and drug diversion detectable in PDMP data.

Kansas. Kansas recently passed legislation²² creating a PDMP Advisory Committee empowered to “identify patterns and activity of concern” using PDMP data. A volunteer panel of six prescribers and pharmacists drawn from the advisory committee—the Peer Review Committee—reviews PDMP reports (“patient profiles”) suggestive of possible doctor shopping sent to them by PDMP staff. The Peer Review Committee determines whether further action is warranted (the decision must be unanimous) and, if so, sends the reports to medical providers or law enforcement, depending on the level of prescription activity. Over the past year, it has sent unsolicited reports to law enforcement on just four individuals, those with the highest numbers of prescribers and pharmacies according to analyses of PDMP data. As judged by the committee, this level of activity was indicative of organized diversion for which criminal investigation would be appropriate.

Wyoming. Wyoming’s PDMP will sometimes notify local law enforcement officials about individuals in their area who exhibit patterns of suspicious behavior that show up in PDMP data, such as traveling out of state to obtain prescriptions while simultaneously using local providers. Such individuals may or may not meet a standard threshold for questionable activity used for sending out unsolicited reports to medical providers. The decision to report to law enforcement is based upon the accumulated experience and discretion of PDMP staff in deciding which prescription histories indicate likely instances of diversion that merit criminal investigation, as opposed to instances of possible addiction or abuse best brought to the attention of medical providers.

Texas. The Texas PDMP routinely conducts data analyses to identify possible doctor shoppers for law enforcement investigation. For further details, see “Reports on providers to law enforcement” below.

²² http://www.kslegislature.org/li_2012/b2011_12/measures/documents/summary_sb_134_2012.pdf

Unsolicited reporting on medical providers

Unsolicited reporting is applicable concerning medical providers who, whether intentionally or not, may be engaging in risky or illegal prescribing or dispensing. The CDC recommends that PDMPs focus on “prescribers who clearly deviate from accepted medical practice in terms of prescription painkiller dosage, numbers of prescriptions for controlled substances, and proportion of doctor shoppers among their patients.”²³ Alerts concerning questionable activity by providers may be appropriately addressed to licensing boards, peer review committees, third-party payers, Medicare and state Medicaid, and other bodies charged with monitoring medical practitioners. When analysis of PDMP data identifies probable criminal activity, such as prescribing and/or dispensing by pill mills, referral to law enforcement agencies is appropriate.

Indicators of possible problematic *prescribing* detectable in PDMP data might include, for example, opioid prescriptions and/or doses in excess of accepted norms for the type of practice (e.g., a dentist routinely prescribing and renewing a month’s supply of 80 mg oxycodone); primarily prescribing combinations of drugs known to be “drug cocktails” (e.g., the combination of hydrocodone or oxycodone, alprazolam, and carisoprodol); having many patients in a practice that meet criteria for doctor shopping; and prescribing for many out-of-state or geographically distant patients. Data on deaths, overdoses, and other adverse health outcomes associated with prescription drug abuse among a prescriber’s patients would also be relevant. Signs of possible problematic *dispensing* by pharmacists and physicians include high proportions of cash payments for prescriptions dispensed, especially for prescriptions that duplicate those covered by Medicaid, filling what are obviously forged prescriptions, and filling duplicate or excessive prescriptions without seeking confirmation from prescribers. Reliable criteria in PDMP and other data of questionable activity by providers need further research and validation.²⁴

As PDMPs review provider prescription records that might trigger unsolicited reports, they should consider possible legitimate reasons for what might appear to be problematic prescribing or dispensing, such as pain management specialists practicing in a hospital-based pain clinic. Even after such review, it is important to note that unsolicited reports on providers are only preliminary, possible indicators of a problem. Determining whether a problem exists and any further investigation is appropriate is a matter for further consideration by the body receiving the report (e.g., licensing board, peer review committee, or law enforcement agency). Such investigations can involve coordination among some or all of those bodies charged with maintaining good medical practice and ensuring public safety.

²³ CDC, Policy Impact: Prescription Painkiller Overdoses, at <http://www.cdc.gov/homeandrecreationalsafety/rxbrief/>.

²⁴ See, for instance, DuBose, P., Bender, A., & Markman, J.W. (2011, June). Rank-ordering physicians by opioid abuse and diversion risk. Poster presented at the International Narcotics Research Conference, Hollywood, FL.

Reports on providers to licensing boards

Even if possible problematic prescribing or dispensing does not reach a level or type meriting law enforcement investigation, it may nevertheless be appropriate for reporting to medical and pharmacy licensing boards. Here are two instances of such reporting:

Kentucky. As part of its recent legislative mandate for proactive use of PDMP data, Kentucky's PDMP—the Kentucky All Schedule Prescription Electronic Reporting system (KASPER)—conducts unsolicited reporting on prescribers in coordination with the Drug Enforcement and Professional Practices branch of the Office of the Inspector General (OIG). Reporting is based upon criteria established by the Governor's KASPER Advisory Council, which is composed of representatives from Kentucky licensing boards, professional associations, law enforcement, and other key stakeholders. Prescription history reports on the top prescribers of the most commonly abused and diverted controlled substances are sent to OIG investigators, who evaluate the reports to see if further investigation of potentially inappropriate or illegal prescribing is warranted. Initial prescriber reviews were conducted based on KASPER Advisory Council criteria specifying the top two percent of prescribers issuing prescriptions for oxycodone, hydrocodone, oxymorphone, methadone, alprazolam, and the drug “cocktail” (see “Unsolicited reporting on medical providers” above). The OIG investigators are registered pharmacists and certified peace officers in Kentucky who review the provider's prescribing history, the type of practice, prior record of disciplinary action, and several other factors. If the review indicates a substantial likelihood of problematic prescribing, the information is forwarded to the appropriate licensing board for further review. A second set of prescriber reviews is underway based upon revised criteria provided by the KASPER Advisory Council after evaluating the results of the initial reviews.

If a report forwarded to a licensing board results in a prescriber investigation, the licensing board notifies authorized personnel in the OIG, Attorney General's office, and Kentucky State Police Drug Enforcement/Special Investigations unit. Such notifications assist in case coordination and de-confliction (such as identifying when an investigation of the same provider is underway by a sister agency). Since unsolicited reporting began in July 2012, KASPER reports have triggered over 80 licensing board investigations of prescribers. These have resulted in retirements, agreed orders setting out sanctions and terms to be imposed upon the prescriber, and controlled substance license revocations, with the result that some problematic prescribers have modified their practices or have been removed from the system. Without proactive analysis of KASPER data and reporting to boards, these prescribers would likely have gone undetected.

Tennessee. The Tennessee PDMP currently provides data to licensing board investigators on the most frequent prescribers, both for numbers of prescriptions and total dosage units of certain controlled substances. The PDMP is in the process of incorporating refinements to these criteria, such as data on how a provider's prescribing compares to norms for a particular type of practice (e.g., general medicine or orthopedics) and how practices vary in the types and dosages of prescribed controlled substances. The PDMP has added staff with analytical and epidemiological expertise to develop these measures using PDMP data. At the

time of this report, no data were available on outcomes of unsolicited reporting of prescribers to Tennessee licensing boards.

Reports on providers to law enforcement

Some states conduct unsolicited reporting on medical providers to law enforcement, usually in coordination with licensing boards so that cases are referred to the most appropriate agency. Here are three examples:

Texas. The Texas PDMP, the Texas Prescription Program²⁵ housed in the Department of Public Safety (DPS), conducts frequent analyses of its database to detect possible problematic prescribing and dispensing, as well as doctor shopping. Automated algorithms generate reports on providers meeting pre-defined criteria suggestive of diversion, such as being among the most frequent prescribers or dispensers of certain controlled substances. Prescription data are reviewed to help rule out legitimate reasons for what seems to be diversionary prescribing or dispensing, as well as to scan for indicators warranting further exploratory or targeted data analyses. When a provider or a possible doctor shopper is identified as reportable to law enforcement, staff decides whether to refer the case to investigators within the DPS or to another law enforcement agency—federal, state, county, or local. Investigators receive a complete prescription history report; in some cases, copies of prescriptions are included. Cases on medical providers not deemed appropriate for law enforcement investigation are referred to licensing boards. Care is taken to coordinate with other agencies in order not to compromise investigations already underway (de-confliction) and to supply PDMP data relevant to those investigations. The Texas PDMP has produced an average of 20-25 prescription drug cases a month for law enforcement investigation, making it among the most active PDMPs for this type of unsolicited reporting. Recently, several doctor shopping cases have been initiated and successfully prosecuted with the help of PDMP data.

New Jersey. The New Jersey statute enabling the PDMP, which started in September 2011, permits unsolicited reporting of medical providers to law enforcement. Quarterly analyses are conducted to look for concerning patterns of prescribing and dispensing, such as identifying the state's top prescribers and pharmacies for controlled substances commonly encountered in cases of illegal prescribing. Database searches are conducted using drug therapeutic codes and dosage types (e.g., 30 mg Roxicodone) and payment type. If suspicious departures from normal prescribing practice are detected, the appropriate law enforcement agency (or licensing board, depending on the level and type of activity) is contacted. Recent analyses related to possible diversion have focused on top prescribers of oxycodone where payments for prescriptions are made in cash. The PDMP also runs ad hoc analyses to further explore patterns identified in quarterly reviews or investigate developments reported to the PDMP by other agencies. For example, law enforcement agencies may report that

²⁵ http://www.txdps.state.tx.us/RegulatoryServices/prescription_program/

promethazine with codeine syrup is turning up on the street, so analyses are run for promethazine. The PDMP hopes to add more regular analyses using preset criteria as resources permit.

Louisiana. In addition to its unsolicited reporting of doctor shoppers (see “Unsolicited reporting to medical providers” above), the Louisiana PDMP occasionally notifies law enforcement (e.g., narcotics investigators) about individual prescribers engaging in suspected diversionary prescribing, such as operating a pill mill.

Promising practices and innovations

Besides the types of unsolicited reporting surveyed above, some PDMPs have explored novel approaches to proactive dissemination of data that expand the range of analyses, end users receiving reports, and means of dissemination. Although the efficacy and general applicability of these approaches are yet to be determined, they are worth noting as examples of how states develop and test innovative applications of PDMP data.

North Carolina alerts to pharmacies and physicians on suspect prescriptions. In collaboration with pharmacies and prescribers, the North Carolina PDMP is developing and validating analyses to detect possible prescription forgeries. For example, if an individual fills a number of prescriptions of a controlled substance from a single doctor at different pharmacies in a week’s time, this may suggest passing forged prescriptions, especially if there is no prior history of being prescribed controlled substances. The North Carolina PDMP staff will contact the pharmacies that dispensed the suspect prescriptions to see if they were verified with the prescriber and, if not, suggest they do so. If the prescription cannot be verified with the prescriber, this alerts both the pharmacy and prescriber that forgery may have occurred. These unusual prescription pattern cases are referred to the Office of the Attorney General for review to determine the appropriate course of action.

Massachusetts outreach to at-risk prescribers. As a strategy to increase provider enrollment in the MA Online PMP, Massachusetts’ Drug Control Program, identified so-called “at-risk” prescribers: those with significant numbers of patients meeting criteria for possible doctor and pharmacy shopping. In 2012, the PDMP sent an outreach letter to 150 at-risk prescribers who were not yet enrolled to use the online PDMP. The letter informed the provider that MA PMP data showed that their practice had a high proportion (relative to the state average) of doctor and pharmacy shoppers and suggested they enroll in the MA Online PMP. As of April 2013, approximately 40 percent of these prescribers had registered with the PDMP. To assess the impact of PDMP enrollment of at-risk prescribers on doctor shopping, analyses of PDMP data were conducted comparing a group of at-risk prescribers enrolled in the PDMP for at least one year (N=20) to a non-enrolled group of at-risk prescribers (N=70). From 2009 to 2012, prescribers who eventually enrolled had a 65 percent decrease in the number of patients who met criteria for doctor and pharmacy shopping, while prescribers who did not

enroll had a 35 percent decline.²⁶ These findings suggest that use of the PDMP by at-risk prescribers can help reduce the prevalence of doctor and pharmacy shopping.²⁷

Mississippi unsolicited reporting to patients. In a 2011 pilot project,²⁸ the Mississippi PDMP sent letters to 40 individuals who had used more than one pharmacy, visited more than 10 practitioners, and received more than 24 controlled substance prescriptions in a 180-day period. The letter notified recipients that it was “a good faith effort to prevent you from circumventing state and federal laws in obtaining prescription drugs and assist you if you need medical help.” It included a toll-free number for the Mississippi Department of Mental Health’s helpline on drug prevention and treatment resources. Prior to notification, these individuals on average were receiving eight prescriptions and 278 dosage units per month. Dosage units for these patients in the month prior to sending the letters totaled 11,435. Three months after the letters were sent, this total dropped to 7,295, a 36 percent decline. Follow up on these individuals showed that in May 2013, 10 had no PDMP prescription activity, while the 30 who did have activity averaged two prescribers, two pharmacies, and four prescriptions in that month. These data suggest that the letters may have had an effect on these individuals’ access to controlled substances, at least as measured by PDMP data (there were no data gathered in this study on comparable individuals who were not sent letters).

Indiana user-led unsolicited reports. In Indiana, a practitioner who has retrieved PDMP data suggestive of a patient’s questionable activity has the option to email alerts to prescribers and dispensers mutually treating the patient. The alerts contain a hyperlink to the patient’s prescription history report that registered users can use to view the report. If an alert recipient is *not* registered with the PDMP, they must register before the link enables them to view the report. The alerts thus function to encourage enrollment in the program as well as to notify those already enrolled that a patient may be involved in medically unnecessary prescription drug use or controlled substance diversion. In May 2012, 140 practitioners sent 2,284 alerts on 214 unique patients; recipients of alerts included 770 registered PDMP users and 1,690 unregistered users.²⁹ By enabling providers to send alerts as part of their medical practice, Indiana increases the proactive dissemination of PDMP data at virtually no cost to the program.

Automated delivery of prescription data: Kansas/Via Christi and NarxCheck™. In a pilot project funded by a SAMHSA 2012 PDMP Electronic Health Record Integration and Interoperability grant,³⁰ the Kansas PDMP is collaborating with Via Christi Health System (the state’s largest health care services provider) to make PDMP data continuously available to its six Kansas

²⁶ The fact that non-enrolled prescribers also exhibited a decline, albeit not as great, in the percentage of doctor and pharmacy shoppers in their practices indicates that there are likely other factors involved in these downward trends. Further research is necessary to identify these factors and determine the relative contribution to changes in doctor shopping measures. Unsolicited reports on patients were also being sent to some prescribers during this time.

²⁷ A presentation on this study can be viewed at: <http://www.slideshare.net/OPUNITE/new-focuses-forpdmpseffortsfinal> (see slides 47-66).

²⁸ A presentation on this program can be viewed at: <http://www.pdmpassist.org/pdf/PPTs/South2012/UnsolicitedReportingMS.pdf>.

²⁹ A presentation on this initiative can be viewed at http://www.pdmpassist.org/pdf/PPTs/National2012/2_Allain_StatePanelInnovationsIndiana.pdf.

³⁰ <http://www.samhsa.gov/grants/2012/TI-12-011.pdf>

hospital emergency departments (EDs). A revised summary screen of patient information for ED admissions will add a cell for each patient containing a snapshot of his or her PDMP data, including recent numbers of prescriptions and providers and a link to the patient's complete prescription history. The cell will also include an alert system, with a red flag indicating that the patient meets a threshold for questionable activity as set by Via Christi practitioners (the same threshold will be used by all six Via Christi EDs). The system is due for testing with live patient data in the summer of 2013. The pilot project was undertaken partially in response to concerns from ED practitioners that threshold letters (unsolicited reports) coming from the Kansas PDMP were not timely enough to inform their prescribing.

A similar approach, now available in Indiana and Ohio, is offered by the NarxCheck™ system, which automatically provides summary prescription history information to prescribers as they view a patient's electronic health record. Utilizing PDMP data and proprietary algorithms to detect possible doctor/pharmacy shopping, the system displays risk scores for patients on three categories of drugs: narcotics, sedatives, and stimulants. The patient's full prescription history is accessible in both graphical and tabular formats.³¹

It should be noted that prescription information integrated with electronic health records, whether in EDs or other facilities, will only be seen by a prescriber when retrieving those records. This prescriber-initiated mode of access to PDMP data is therefore not equivalent to proactively delivered alerts, which notify medical providers about a possible problem independently of patient visits. Efforts to increase provider use of PDMP information by integrating it into electronic health records and medical workflow will be the focus of a separate PDMP Center of Excellence report.

Other criteria for unsolicited reporting in Maine. As noted above in "Unsolicited reporting to medical providers," the Maine PDMP sends unsolicited reports not only for patients who meet a threshold for doctor shopping, but for those exceeding a certain average daily dose of acetaminophen from prescribed controlled substances that would put them at risk of liver failure and death. It also reports on patients prescribed buprenorphine and any other opioid, which could compromise addiction treatment or indicate diversion. This suggests that PDMPs can improve prescribing by searching for and reporting instances of possibly harmful drug combinations, such as overlapping prescriptions for opioid and benzodiazepines, or for simultaneous prescriptions of drugs in the same therapeutic class that if taken as directed might result in an overdose. PDMPs can, therefore, contribute to good medical practice by proactively reporting potentially unsafe prescribing that may not be directly related to suspected doctor shopping.

Arizona unsolicited reporting to Medicaid. As described above in "Unsolicited reporting to medical providers," Arizona's PDMP forwards prescription history reports to the state's Medicaid agency for individuals meeting criteria for questionable activity who have purchased prescriptions via Medicaid. Public and private third-party payers can benefit from such

³¹ A presentation on Narxcheck™ is available at <http://www.pdmpassist.org/pdf/PPTs/National2013/25-6-A%20Allain.pdf>.

unsolicited reporting in monitoring patient and prescriber behavior because PDMP data capture the full range of non-hospital dispensed prescriptions, including those paid for in cash.³²

Barriers to unsolicited reporting

As noted above in “Current status of unsolicited reporting,” many states do not conduct unsolicited reporting despite the fact that it is considered a PDMP best practice. There are a variety of barriers to adopting unsolicited reporting that need to be addressed, including:

Legislative restrictions. Some states either expressly forbid unsolicited reporting to one or more types of end users in their PDMP-enabling legislation or do not specifically provide for it in legislative or regulatory language. Amending legislation and/or regulations to permit such reporting requires building support for such a change among stakeholders and finding legislators and policy makers who understand the issue and will support the needed changes. (North Carolina recently enacted changes to its legislation to permit unsolicited reporting to medical providers and licensing boards.) The evidence in favor of the efficacy and positive impact of unsolicited reporting, some of which is mentioned above, can help build such support. Washington State’s 2007 enabling legislation³³ was farsighted in its inclusion of specific language permitting the PDMP to provide data to a wide range of end users, including medical providers, law enforcement, licensing boards, Medicaid, workers’ compensation, and the Department of Corrections. States considering legislation bearing on unsolicited reporting may wish to consult the PMP Model Act 2010 revision Section 7 on providing prescription monitoring information.³⁴

Resource limitations. Even if their legislation permits unsolicited reporting, many PDMPs are under-resourced, whether in staff, funding, or analytical and reporting capacities, so they cannot undertake new initiatives. For a PDMP to adopt unsolicited reporting as a best practice, among other PDMP best practices, it may be necessary to secure additional resources. Again, marshaling evidence for the effectiveness of unsolicited reporting can help a PDMP make the case for the requisite staffing or operational capacity. There is also a range of approaches to unsolicited reporting, some described above, which involve relatively little ongoing expense once the necessary systems and software are in place. States embarking on unsolicited reporting can learn from other PDMPs’ experience and perhaps improve on original designs and find ways to reduce costs.

Concerns about unintended consequences. Use of PDMPs to monitor possible questionable activity by patients and practitioners, including sending unsolicited reports, sometimes sparks concerns about unintended consequences. For example, some have suggested that practitioners might worry about becoming a target of a licensing board or law enforcement

³² For other examples of PDMP data sharing with third-party payers, see PDMP Center of Excellence, 2013, “Using PDMPs to improve medical care: Washington state’s data sharing initiative with Medicaid and worker’s compensation,” http://www.pdmpexcellence.org/sites/all/pdfs/washington_nff_final.pdf.

³³ See <http://apps.leg.wa.gov/RCW/default.aspx?cite=70.225.040>.

³⁴ See <http://www.pdmpassist.org/pdf/PMPModelActFinal20100628.pdf>.

investigation triggered by a PDMP report and thus could choose to cease prescribing controlled substances altogether; or patients whose prescriber misinterpreted a PDMP report and wrongly accused them of doctor shopping could be fired by their doctors, leaving them without access to needed pain medications. Examining the validity of such concerns is beyond the scope of this report, but it should be noted that PDMPs, cognizant of the downsides of false positives, are generally conservative in setting thresholds for detecting questionable activity among patients, using higher rather than lower numbers of providers and pharmacies. In reporting possible questionable activity by medical providers, PDMPs consult with licensing boards, peer review and advisory committees, and law enforcement agencies to ensure that the criteria for reporting only flag cases meriting their attention. Moreover, unsolicited reports (and PDMP data in general) are themselves never conclusive evidence of aberrant behavior, but simply one piece of information considered by their recipients in determining whether an investigation or intervention should be initiated. PDMPs are careful to note the limitations of their data when providing them to end users. Such considerations may help allay fears among providers and patients that PDMPs are overzealous in unsolicited reporting and thus inadvertently discouraging legitimate medical practice. However, if instances of such outcomes resulting from unsolicited reporting or other PDMP activity occur, they should be examined and taken into appropriate account in setting PDMP policy.

Summary and conclusions

The examples of unsolicited reporting surveyed here provide a menu of options for states wishing to adopt this PDMP best practice.³⁵ They illustrate the feasibility of unsolicited reporting and its benefits in helping to improve medical care and reduce aberrant prescribing and dispensing. Given sufficient funding, one or more of the approaches to unsolicited reporting described above, involving mail, fax, and email notifications, are within the capabilities of most PDMPs and will help them maximize the utilization of their data for public health and safety. Elements of effective unsolicited reporting by PDMPs include:

- Choosing a threshold for questionable activity commensurate with PDMP capacity to issue unsolicited reports or alerts.
- Carefully and periodically reviewing criteria for unsolicited reporting and the reports themselves to ensure that false positives are minimized but that most questionable activity is reported.
- Educating and training recipients of reports to ensure they understand the meaning, uses, and limitations of prescription history data.
- Regularly communicating with recipients of unsolicited reports to help validate their criteria and assess their utility, so that reporting can be improved.

³⁵ Note that other PDMPs unmentioned in this guidance document also conduct unsolicited reporting in ways similar to the selected examples.

Options for Unsolicited Reporting

- Consulting with practitioner groups and law enforcement agencies to determine the level and types of possible questionable activity suitable for criminal investigation instead of a medical or pre-criminal intervention.
- Facilitating cross-agency communication on unsolicited reports concerning practitioners to ensure that cases of possible aberrant prescribing or dispensing are referred to the appropriate agency (e.g., licensing board vs. drug control) and that existing or planned investigations are not compromised.
- Tracking the outcomes and impact of unsolicited reporting—for instance, on PDMP utilization, doctor shopping, and aberrant prescribing—using PDMP and other data sources.

Although unsolicited reporting is a recognized PDMP best practice, promising and innovative approaches to unsolicited reporting being explored by states still need to be evaluated for efficiency and effectiveness. As new information technologies become available and PDMP information is better integrated into health care systems, more cost-effective means to alert end users of questionable controlled substance activity will likely be developed (e.g., see *Electronic alerts in Massachusetts* in “Unsolicited reports to medical providers” and *Automated delivery of prescription data: Kansas/Via Christi and NarxCheck™* in “Promising practices and innovations”). The menu of options for unsolicited reporting will likely expand to incorporate newly proven approaches, and the range of standard criteria for triggering reports may expand as well to include, for example, acetaminophen dose thresholds, dangerous drug combinations, and simultaneous prescriptions for drugs in the same therapeutic class.

Universal adoption of unsolicited reporting and its identified best practices will require overcoming legislative, regulatory, and resource barriers and addressing possible concerns about unintended consequences. The experience of states engaged in unsolicited reporting, some of which is summarized above, can provide direction for PDMPs seeking to become more proactive in disseminating prescription history information to help mitigate the prescription drug abuse epidemic.

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