Assessing the Utilization and Value of the Prescription Drug Monitoring Program Prescriber Report, Rhode Island

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BACKGROUND

The Rhode Island Prescription Drug Monitoring Program (RI PDMP) collects data for controlled substance prescriptions (Schedule II – V) and opioid antagonists into a centralized database.[1] These data can then be used by prescribers and pharmacists in the active treatment of their patients. The RI PDMP's primary functions are to identify high-risk prescribing patterns such as overprescribing, dangerous drug combinations, and controlled substance prescription dispensations from multiple pharmacies and providers, to name a few.

In January 2022, the RI PDMP introduced an individualized electronic prescriber report. This report is provided quarterly to each prescriber in the state who has an active PDMP account, a defined role and specialty, and has written at least one opioid, sedative, or stimulant prescription in the designated lookback period (typically six months). This enhanced, personalized report provides prescribers a snapshot of their prescribing history and includes helpful metrics such as prescribing patterns for opioids, buprenorphine, sedatives, and stimulants, as well as how these values compare to those of their peers. The report also presents information on patients at potentially elevated risk of overdose due to overlapping therapies, patients with multiple providers, high morphine milligram equivalent (MME) thresholds, and patient search activity, including searches performed by authorized delegate(s) on the prescriber's behalf.

The primary intent of the prescriber report is to provide prescribers with insight into their own prescribing patterns in relation to their peers, serving as a supportive tool in clinical decision-making rather than a form of administrative oversight. In January 2025, the RI PDMP conducted a survey to both examine prescriber utilization of the report and to assess changes in prescribing practices in response to the report.

METHODS

This analysis used data from a survey sent out in January 2025 to all prescribers in Rhode Island that are registered with the Rhode Island Prescription Drug Monitoring Program (PDMP). The survey was constructed and tested by members of the PDMP team at the Rhode Island Department of Health (RIDOH) before dissemination. The survey was sent out to 4,588 prescriber emails via a REDCap participation list and was available to participants for one month.

Data regarding respondent demographics, such as sex at birth, years of practice, specialty type, etc., were reported, as well as responses to questions assessing respondents understanding, perception, and utilization of the prescriber report. Respondents who reported being unfamiliar with the prescriber report were excluded from the analysis. Results were stratified by respondent workplace. Using thematic analysis for open response questions, answers were sorted into appropriate categories and were reviewed by two PDMP team members for accuracy. Categories with counts fewer than five were suppressed to protect the confidentiality of individual identities per the RIDOH Small Numbers Policy.[2]

RESULTS

In total, 184 prescribers responded to the survey. From this sample, 139 (75.5%) reported that they were familiar with the report (e.g., knew what the report was, had heard about the report, etc.). Of these 139 respondents included in the analysis, 86 (61.9%) had 15+ years of experience in their field [**Table 1**]. Just over half (n=75, 54.0%) of respondents worked in an outpatient setting (e.g., primary care, telehealth, community center), 46 (33.1%) worked in an inpatient setting (e.g., hospitals, skilled nursing facilities), and 18 (12.9%) worked in other settings (e.g., academic medical centers, director and consultant positions). Physicians made up 62.6% (N=87) of respondents, and 43 (30.9%) respondents specialized in primary care [**Table 1**].

Nearly 80% (N=111) of respondents included in the analysis stated that they have viewed the prescriber report. A higher proportion of inpatient respondents reported viewing compared to outpatient respondents (84.7% vs 78.7%, respectively; **Table 2**). When asked about frequency of access, 23% of all respondents stated that they "Never/Rarely" view the report, 33.1% of all respondents reported "Sometimes" viewing the report, and 21.6% reported they "Often/Always" view the report. These responses did not significantly differ by work setting. Respondents that stated they check the report, but answered "Never/Rarely" when asked about frequency may have viewed the report once or twice but do not regularly check the report. When asked about barriers that might prevent a respondent from viewing the report, 10.1% reported time constraints, 5% reported workload, and 8.6% reported that the prescriber

Table 1. Respondent Demographics

Demographic	N (%)
Years of Experience	
<5	12 (8.63%)
5 to <10	16 (11.5%)
10 to <15	25 (18.0%)
15+	86 (61.9%)
Place of work	
Inpatient	46 (33.1%)
Outpatient	75 (54.0%)
Other	18 (12.9%)
Prescriber Type	
Physician	87 (62.6%)
Nurse Practitioner/Clinical Nurse Specialist	46 (33.1%)
Other	6 (4.32%)
Prescriber Specialty	
Emergency Medicine/Urgent Care	10 (7.91%)
Primary Care	43 (30.9%)
High Prescribing Physicians[a]	8 (5.76%)
Pediatrics	11 (7.91%)
Psychiatry	22 (16.6%)
Surgical/Wound Care	6 (4.32%)
Other	25 (18.0%)
Missing	12 (8.63%)

[a] High Prescribing Clinicians include prescribers specializing in oncology, hospice, palliative care, and pain management.

report does not feel relevant to their practice [**Table 2**].

Of the respondents, 83 (59.7%) found the prescriber report to be useful to their practice. A slightly higher proportion of inpatient respondents found the report to be useful compared to outpatient respondents (60.8% and 54.7%, respectively; **Table 3**). Respondents found that the average number of opioids, stimulants, and benzodiazepines dispensed per

Table 2. Assessing respondents' capacity to view the report.

	Type of work setting			Total
	Outpatient (N=75)	Inpatient (N=46)	Other (N=18)	
Do participants view the prescriber report?				
Yes	59 (78.7%)	39 (84.7%)	13 (72.2%)	111 (79.9%)
Frequency of viewing report				
Never/Rarely	15 (20.0%)	12 (26.0%)	5 (27.8%)	32 (23.0%)
Sometimes	24 (32.0%)	16 (34.7%)	6 (33.3%)	46 (33.1%)
Often/Always	18 (24.0%)	10 (25.6%)	<5	30 (21.6%)
Barriers to viewing the report?[a]				
Time constraints	6 (8.0%)	<5	<5	14 (10.1%)
Workload	5 (6.67%)	<5	<5	7 (5.04%)
Not Relevant	6 (8.0%)	<5	<5	12 (8.63%)
Participants felt confident in their understanding of the report				
Yes	55 (73.3%)	33 (71.7%)	12 (66.6%)	100 (71.9)

[a] Categories are not mutually exclusive.

Table 3. Assessing the value of the report in respondents' practice

	Type of work setting			Total
	Outpatient (N=75)	Inpatient (N=46)	Other (N=18)	
Do participants find the report useful?				
Yes	41 (54.7%)	28 (60.8%)	14 (77.8%)	83 (59.7%)
What reporting metrics are most useful?[a]				
Avg number of opioid RXs dispensed per patient	23 (16.5%)	11 (7.91%)	5 (3.59%)	39 (28.1%)
Number of patient report requests	6 (4.31%)	10 (7.19%)	<5	19 (13.7%)
Avg daily MME for opioids dispensed per patient	18 (12.9%)	5 (3.59%)	<5	25 (18.0%)
Avg number of stimulant RXs dispensed per patient	21 (15.1%)	8 (5.75%)	7 (5.03%)	36 (26.9%)
Avg number of benzodiazepine RXs dispensed per patient	21 (15.1%)	9 (6.47%)	6 (4.31%)	36 (25.9%)
Dangerous medication combinations	22 (15.8%)	17 (12.2%)	6 (4.31%)	45 (32.4%)
Patients exceeding multiple provider thresholds	23 (16.5%)	14 (10.1%)	5 (3.59%)	42 (30.2%)
Number of unique patients	8 (5.75%)	5 (3.59%)	<5	14 (10.1%)
Avg number of controlled substances dispensed per patient	15 (10.8%)	9 (6.47%)	3 (2.15%)	27 (19.4%)
Avg days' supply of controlled substances dispensed per patient	10 (7.19%)	7 (5.03%)	<5	18 (13.0%)
Top medications prescribed	14 (10.1%)	8 (5.75%)	<5	26 (18.7%)
Did participants change their prescribing practices after viewing the report?				
Yes	11 (14.7%)	7 (15.2%)	<5	20 (14.4%)

[a] Categories are not mutually exclusive.

patient, as well as tallies of dangerous medication combinations and the number of patients exceeding multiple provider thresholds to be the most useful metrics reported. This differed by work setting, as less than 7% of inpatient respondents found the average number of stimulant and benzodiazepine prescriptions dispensed per patient to be as useful to their practice, compared to just over 15% of outpatient respondents [**Table 3**]. On top of this, nearly 13% of outpatient respondents found the average daily MME for opioids dispensed per patient to be a useful metric, compared to only approximately 4% of inpatient respondents. Nearly 15% (N=20) of all respondents reported changing their prescribing practice after viewing the prescriber report. This did not differ by work setting [**Table 3**].

DISCUSSION

Overall, the majority of the respondents had viewed the report, which aligns with one of the main goals of the survey. Specifically, 80% of the respondents reported viewing the report and over half of respondents reported viewing the report sometimes/often/always and found the report to be useful to their practice.

While greater than 50% of respondents found the prescriber report to be useful to their practice, the usefulness of specific metrics varied by workplace setting. A higher proportion of outpatient respondents found the average number of opioids, stimulants and benzodiazepines dispensed per patient, dangerous medication combination metric, and average daily MME for opioid patients metric more useful in their practice compared to inpatient respondents. Outpatient providers are most likely to see patients on a continuous basis and therefore dispense these medications regularly, while inpatient prescribers typically prescribe on an acute basis.

Several barriers to viewing the report were identified, with time constraints emerging as a significant barrier particularly among prescribers in outpatient settings. Of note, outpatient prescribers who identified community health centers as their primary work setting cited workload and time limitations as primary obstacles of engaging with the report (Results not shown due to RIDOH's Small Numbers Policy).

Relevance to practice was another commonly mentioned barrier. Prescribers who listed their specialty as emergency medicine noted that the nature of their practice is characterized by unique circumstances such as trauma/injury, and unpredictable patient populations made it difficult to effectively assess their prescribing patterns. Due to the acute and varied nature of their patient cases, they found it challenging to compare their prescribing habits with those of their peers. Similarly, providers who specialize in treating specific patient populations such as end of life/palliative care indicated that they did not find any significant value in the report. This is because their patients often require medications for symptom management such as pain and anxiety that typically involve controlled substances. As a result, these providers noted that the reports may not offer meaningful insights, since their prescribing practices are driven by the need to provide symptomatic relief for a specific patient population (Results stratified by prescriber specialty not shown due to RIDOH's Small Numbers Policy). The prescriber report is available to providers who prescribed a controlled substance within the previous six months. Providers that rarely prescribe controlled substances may not find value in this report.

While it is promising that many respondents have viewed the report, about 20% of respondents still have not or have not regularly viewed the report. Due to the frequency that the report is sent out, it is unlikely that a prescriber will view the report every quarter, and a prescriber may not have to view the report for them to determine if it is useful or meaningful in their practice. This is especially true among the inpatient respondents, as they are likely not seeing the same patient population over multiple visits, and trends in their prescribing may not be as relevant to them as it would be to outpatient respondents.

Though a small proportion of respondents reported changing their prescribing habits after viewing the report, this does not directly speak to the usefulness of the report. The prescriber report is designed to be a tool to increase provider awareness of their prescribing habits and gauge where these patterns are in relation to their peers. If a provider feels confident with their prescribing habits, a change in practice after viewing the report may not be necessary.

Though the responses from respondents that were unfamiliar with the report were not included in this analysis, the majority of excluded responses were largely from emergency medicine/urgent care prescribers. In addition to this, excluded respondents report "lack of knowledge of report", "difficulty finding report", and "technical difficulties" as barriers to viewing the report (Results not shown due to due to RIDOH's Small Numbers Policy and exclusion from analysis). This highlights the need for increased communication and training around the utilization of the prescriber report.

A limitation of this analysis is that the results from this survey are not generalizable, as they pertain to the experiences of prescribers practicing in RI and using the specific PDMP system procured by the state. Due to the voluntary nature of the survey, prescribers were not required to respond to any or all questions, which lead to a low response rate (~4%). A low response rate, however, is expected for this survey as it was presented to professionals without a direct incentive. Time constraint was reported as a barrier to viewing the prescriber report and may have been a barrier for professionals to complete the survey. In addition, as with many survey results, response bias might influence a respondent's answers and lead to flawed conclusions. We were also

unable to stratify by meaningful groups, such as prescriber specialty, due to low response counts in some categories.

Future work will focus on further evaluating the usefulness of the prescriber report and ensuring that utilization and general communication regarding the report is improved to allow all interested providers an opportunity to easily access it and understand its purpose as a tool. In addition to this, efforts will increase future survey completion as responses to these surveys will be used to make the prescriber report more valuable to RI prescribers.

References

1. Rhode Island Department of Health. Prescription Drug Monitoring Program (PDMP) [Online]. https://health.ri.gov/medicine-and-drugs/prescription-drug-monitoring-program-pdmp
2. Rhode Island Department of Health. Rhode Island Small Numbers Reporting Policy [Online]. https://health.ri.gov/sites/g/files/xkgbur1006/files/2025-02/SmallNumbersReporting.pdf

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Disclosures

None

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