Pharmacy Automation and Technology

Hospital Participation in Prescription Drug Monitoring Programs

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The prescription drug abuse epidemic continues to grow. This multifaceted problem requires a multifaceted solution. In this installment, we discuss prescription drug monitoring programs and their relevance to hospital pharmacies.

Over the years, there have been a several constants in the information technology (IT) world. First, devices grow increasingly smaller while increasingly more powerful. Another constant has been the convergence of functions into singular devices. Think about your smartphone, which is in reality a computer, camera, video camera, video conference unit, fax machine, voice recorder, etc. Third, competition between IT companies leads to better products for consumers. Where would we be today if Apple did not introduce the iPhone in 2007? Would we have smartphones from Samsung, Google, LG, Motorola, and a variety of other manufacturers? What would those phones look like?

There are other constants that we face in health care. Some are technical, while others are not tied to the IT tools that we use. For example, we have always appreciated the saying, “The great thing about standards in health care is that there are so many to choose from.” Certainly we are expressing our sincerest sarcasm when we use this phrase that suggests there are too many communication standards for health care information. But what are some non-IT constants in health care? First, health care is a constant struggle to deliver quality care that is accessible to all who need it at a sustainable cost. Known as the “iron triangle,” this constant summarizes the challenge in the ongoing efforts to reform health care in the United States.

Another non-IT constant in health care that hits close to home for pharmacists is the challenge of controlled substances, especially pain medications. We believe that very few individuals with formal medical training will argue the value of medications to control pain. However, the average American probably

does not understand that pain can be a chronic condition that needs treatment, much like other chronic conditions. Instead, the average American is probably more familiar with the current national epidemic of misuse and abuse of controlled substances, especially opioids.

How does this relate to IT and to your institutional pharmacy setting? Two primary scenarios immediately come to mind. The first is patients who present to ambulatory and/or outpatient pharmacies with controlled substance prescriptions and the second is patients who present to the emergency department. Note that neither of these includes the critically important issue of diversion of controlled substances from within institutions for personal use or for distribution to others. In both scenarios, however, a review of the records in the state’s prescription drug monitoring program (PDMP) database can prove valuable.

Briefly, PDMPs are state-run electronic databases that contain prescribing and dispensing records for controlled substances and, in some cases, other drugs with potential for abuse. Each PDMP is administered at the state level, which leads to substantial variation in a variety of aspects of PDMP use. Regulations differ in the requirements for who must register for and receive training in PDMPs and circumstances for mandatory access of a PDMP. State requirements about who must report and the frequency of reporting also vary. Additionally, states are not consistent in which medications must be reported to their PDMP. Although it is common for states to require Schedules II-V to be reported, some states include other medications that are not controlled but have potential for abuse. Another important distinction is that states

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vary in their sharing of data. As of this writing, authorized users in Alabama can access data from 9 states, but not from all states with which it shares a border. Fortunately, this will be changing soon.

It may seem that PDMPs are best suited for the community pharmacy setting where pharmacists face the challenges of pill mills, stolen and forged prescriptions, and other nefarious methods to obtain controlled substances. Patients can also present their prescriptions to an institution's outpatient or ambulatory clinic pharmacies that serve the public. These situations are probably a bit more obvious in terms of identifying inappropriate behavior because they match many of the "red flags" that suggest attempted abuse or misuse.¹ However, there are many models for operating these types of pharmacies. Some hospitals only serve those patients with whom they have an established relationship, but even in situations of established relationships, patients may try to inappropriately obtain controlled substances. The PDMP likely contains the information to help distinguish between appropriate and inappropriate use.

In the emergency department (ED), the focus for the use of the PDMP is to determine a patient's medication history if the patients (or their caregiver) are not able to provide a complete history. To create a history of controlled substances dispensed pursuant to a prescription, the PDMP may be the best source from which to acquire the dispensing history, regardless of the dispensing pharmacy. In the ED and any setting, there are limitations. First, the PDMP does not account for medications that are obtained illegally,

and the presence of a medication in a patient's history does not necessarily indicate that he or she took the medication. Also, the PDMP data are only as accurate as the information reported to the PDMP, and they are only as timely as required by the state. For example, some states require reporting within 24 hours of dispensing while others require weekly reporting. Even with 24-hour reporting, there is a lag time from when data is reported to when it is available to users. Despite these and other limitations, PDMPs have advanced considerably since the first one was established in 1918.

There are other scenarios in which PDMP information can be useful to hospital pharmacists. We have only highlighted 2. We recommend hospital pharmacists (1) determine their states' and institutions' requirements and expectations for PDMP use; (2) train those who are on the front lines so they can appropriately use the data; (3) provide feedback to the agency that administers the PDMP in an effort for quality improvement; and (4) recognize that some patients fit many of the criteria for misuse and abuse but are actually using controlled substances appropriately. Cancer patients are the most obvious example. We welcome your comments (Brent at foxbren@auburn.edu and Bill at felkebg@auburn.edu).

REFERENCE

1. National Association of Boards of Pharmacy. Stakeholders' challenges and red flag warning signs related to prescribing and dispensing controlled substances. <https://nabp.pharmacy/wp-content/uploads/2016/07/Red-Flags-Controlled-Substances-03-2015.pdf>. Accessed February 26, 2017. ■