Patterns of Prescribing – The Rhode Island Prescription Monitoring Program

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ABSTRACT

Drug overdose and abuse is a growing epidemic nationally and for Rhode Island. The Rhode Island Prescription Monitoring Program (PMP) is a web-based system that collects all schedule II and III prescription information for prescriptions dispensed in or into Rhode Island. The Rhode Island Board of Pharmacy at the Rhode Island Department of Health operates this program and uses the information for investigative purposes to curb drug overdose and professional misconduct. Two case studies are presented to illustrate the use of PMP in Rhode Island.

KEYWORDS: Inappropriate Prescribing (E02.3193490), Opioid-Related Disorders (F03.900.675), Public Health (N06.850), Pharmacy (H02.646)

INTRODUCTION

The Rhode Island Prescription Monitoring program (PMP) of the Rhode Island Department of Health (HEALTH) is a perpetually updating database of all schedule II and III controlled substance prescriptions dispensed within and into the state. Rhode Island first enacted legislation authorizing HEALTH to collect and use this information in 1997, and with recent software upgrades in 2012, this information is now widely available for external use by prescribers, pharmacists, and law enforcement officials.

Matters involving narcotics or prescribing are under the jurisdiction of the Rhode Island Board of Pharmacy, the entity responsible for operating the PMP and enforcing the laws and regulations pertaining to prescription drugs. Pharmacy Board investigators have been active and engaged in the investigation of inappropriate prescribing, diversion of drugs, and misconduct involving narcotics, assisting other licensing Boards within HEALTH. Prior to the advent of PMP, Board of Pharmacy investigators were tasked with monitoring a growing prescription drug abuse epidemic with a paucity of timely prescription data. Investigators now have the capability to centralize and analyze data once scattered throughout 200 independently operating retail pharmacies into one condensed database.

Rhode Island suffers heavy costs from prescription drug abuse. About two percent of all deaths in the state (about one-fourth of all "accidental deaths") are "drug-related," and of these, more than half involve opioids, either alone or in combination with other drugs.[1] In addition, prescription drug abuse not only harms patients, but also has a devastating effect on families, neighborhoods, and the health care system. In response, investigators from the Rhode Island Board of Pharmacy are utilizing the full potential of the PMP to curb this epidemic and protect the health, safety, and welfare of the public.

Case Studies

Two recent cases illustrate the effectiveness of the PMP in an investigatory capacity.

Case 1 (Excessive Prescribing): This case began with several seemingly unrelated reports of multiple patients filling prescriptions for high dose opiates at local pharmacies. Although the patients in question initially appeared to be unrelated, based on age, address, and apparent diagnosis, investigators were able to determine that they had a common prescriber. The PMP can isolate a single prescriber and consolidate all prescriptions under that registration independent of pharmacy location, third party payer status, or drug type. Investigators subsequently developed a prescriber-specific report which revealed that the prescriber was authorizing prescriptions for 30 days of identical high dose opiates to the same patient in 10-15 day cycles. The patients frequented multiple pharmacies on a complex schedule, never visiting the same pharmacy prior to the expected due date of the prescription, and paying out of pocket for the cost of the medication. (Previous to development of the PMP, this behavior would go unnoticed, since patients and prescribers were able to circumvent the safeguards of third party payer reporting. Using the PMP, however, investigators can analyze prescribing patterns even when patients or prescribers are actively attempting to deceive the system.) Eventually, investigators were able to determine that some patients received close to 900 days worth of narcotics in a single calendar year through the issuance of identical prescriptions. Furthermore, investigators observed instances where the prescriber wrote identical prescriptions, up to 3 in a single day, resulting in hundreds of dosage units being diverted. Findings were transmitted to the prescriber's licensing board and the prescriber's license was suspended, dismantling an opiate ring, and drying up a source for illicit prescription narcotics.

Case 2 (Excessive Dispensing): Pharmacy Board investigators conducted a review of a pharmacy's dispensing history to analyze dispensing patterns over a period of time. Excessive dispensing of narcotics was found. One patient, for example, obtained refills of high dose narcotics earlier than scheduled, based on the prescription's quantity and directions, ultimately receiving over 500 days worth of narcotics in one calendar year. Problematic dispensing such as this led investigators to examine the behavior of pharmacy staff regarding drug utilization reviews and the questioning of early narcotics refills, and found them wanting, raising concerns about professional competency. As with other PMP investigations, this matter was referred to the appropriate licensing board, where responsible parties faced disciplinary sanctions and were forced to address system failures to prevent excessive narcotics dispensing in the future. Thus the PMP was used not only to prevent the diversion of narcotics, but also to enforce practice standards, leading to improved quality of care.

CONCLUSION

The PMP is a critical tool in the effort to prevent drug abuse and diversion in order to ultimately promote better health outcomes for patients and to improve professional standards in the licensing community. PMP use will be able to close the net on the pharmacy world, increasing transparency, and curbing the inappropriate distribution of prescription opiates. In concert with the overarching mission of the Department of Health, investigators will continue to the use the PMP to dry up the flood of inappropriate narcotics in our communities while concurrently promoting a higher standard of care among health care professionals.

Reference

Center for Behavioral Health Statistics and Quality, SAMHSA, Drug Abuse Warning Network, 2010; Office of Vital Statistics, Rhode Island Department of Health, 2011 death certificate data.

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