



Prescription Monitoring Program Center of Excellence

Notes from the Field

NF 2.3 Perspective from Kentucky: Using PMP Data in
Drug Diversion Investigations

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Summary

Data collected by prescription monitoring programs (PMPs) are used by law enforcement and regulatory agencies to facilitate investigations of controlled substance diversion or questionable prescribing and dispensing practices. This report highlights the work of a prescription drug diversion investigator in Kentucky in order to illustrate the value of PMP data in guiding such investigations and increasing their efficiency. The advent of Kentucky All Schedule Prescription Electronic Reporting (KASPER, Kentucky's PMP) enabled quicker identification of possible diversion cases that warranted investigation, as well as sources of evidence. This permitted work on many more cases than was possible prior to the PMP, and achieved a high rate of conviction. These convictions, plus the deterrent effect of visibly enhanced drug control, may have played a role in reducing the level of local drug diversion. However, prescription drug abuse remains at epidemic levels in Kentucky and neighboring states, due in part to out-of-state sources of illicitly obtained controlled substances.

Background

Kentucky has long had high rates of prescription drug abuse. Deaths in Kentucky from drug overdoses in 2007 were 15.1 per 100,000, second only to West Virginia among the Appalachian states, which have among the highest unintentional drug-related death rates in the nation.¹ Presently, the majority of these deaths result from prescription opioids, sometimes in combination with other controlled substances such as benzodiazepines. Recent reports suggest the problem remains at epidemic levels and may still be growing.² Due to budget limitations, state monies available for drug control in Kentucky have been sharply reduced, prompting a search for best use of remaining resources. Among these resources are prescription monitoring data provided by KASPER, which had over 7,600 authorized users in 2009, including 5311 prescribers, 1057 pharmacists and 1242 law enforcement officials.³

The observations below are based on interviews with Jon Marshall, former prescription drug diversion investigator with the Kentucky State Police, and his 2005 and 2010 presentations on KASPER at meetings hosted by the Alliance of States with Prescription Monitoring Programs. Marshall started in narcotics investigations in 1996, then in 2001

¹ Unintentional drug poisoning in the United States, July, 2010, Centers for Disease Control, at <http://www.cdc.gov/HomeandRecreationalSafety/pdf/poison-issue-brief.pdf>

² For a recent series of investigative reports on the Kentucky situation, see <http://www.courier-journal.com/section/extras15>

³ Independent Evaluation of the Kentucky All Schedule Prescription Electronic Reporting (KASPER) Program, October, 2010, Institute for Pharmaceutical Outcomes and Policy, at <http://chfs.ky.gov/NR/rdonlyres/07E92D7D-97BD-4928-A642-9FB8FA181C7F/0/KASPEREvaluationExecutiveSummary10152010.pdf>

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became special investigator for prescription drug diversion cases for all of Eastern KY, comprising 59 counties. He has also served as an educator and advocate for PMPs, giving talks to law enforcement personnel in Kentucky and elsewhere.

The role of PMP data in expediting drug diversion investigations

Typical targets of prescription drug diversion investigations include suspected doctor shoppers (patients obtaining controlled substances from multiple prescribers and pharmacies), doctors running “pill mills,” who knowingly prescribe medically unnecessary drugs for extra income, and dishonest pharmacists who take advantage of their access to controlled substances. Before the start of KASPER, drug investigators had to obtain evidence to confirm suspicion of controlled substance diversion by visiting all pharmacies in a district, a time-consuming, often hit-or-miss process. According to Kentucky investigator Jon Marshall, a single case could take 4 or 5 weeks to prepare given the number of pharmacies and doctors potentially involved. This necessarily limited the number of cases he could take on.

This changed dramatically in 1999, when KASPER began providing investigators with requested reports from its prescription monitoring database. Since reports list the controlled substance prescription purchases of a suspected doctor shopper by drug, date, pharmacy and prescriber, Marshall could see immediately whether a substantial case for diversion existed or not. If a doctor shopping case seemed worth pursuing, he visited the listed pharmacies to gather evidence – pharmacy prescription records – that the drugs were indeed picked up by the suspect (PMP reports themselves do not constitute admissible evidence). Similarly, he contacted the listed prescribers to confirm they had actually prescribed the drugs to the suspect.

PMP reports therefore accelerated the investigative process considerably, such that Marshall was able to prepare a case for prosecution in only a week to ten days, depending on how quickly prescribers responded to information requests. The increase in investigative efficiency made possible by KASPER approximately doubled the number of cases he was able to manage in a given time. And because KASPER, like all PMPs, is a statewide data base, its reports show pharmacies visited by a suspect in *all* counties, not just in the suspect’s locality. This allowed the identification of more cases and made more evidence available, increasing the likelihood of successful prosecution. According to Marshall, rates of conviction for PMP-facilitated cases are very high; those accused usually plead guilty, with only a few cases going to trial or dismissed. But it’s worth noting that PMP data can also help *disconfirm* allegations of diversion, helping to protect the innocent.

Dishonest doctors and dispensers

As described above, PMP data can reliably identify plausible suspicion of doctor shopping by seeing which patients in its database meet or exceed a certain threshold, for instance obtaining controlled substance prescriptions from five or more prescribers and buying drugs from five or more pharmacies in a 3 month period. KASPER and other

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PMPs can also help identify doctors running pill mills – “pill doctors” – by screening data for unusual amounts and types of controlled substances prescribed by a single practitioner. Operators of pill mills typically prescribe certain types of drugs at very high rates compared to those engaged in legitimate practice, especially drugs used to make so-called “drug cocktails,” such as the popular combination of hydrocodone (an opioid), Xanax (a benzodiazepine) and Soma (a muscle relaxant).⁴ Another sign of a pill mill discernable in PMP data is a large geographic separation between patients and prescriber as indicated by zip code. Pill mill customers will often travel long distances, sometimes hundreds of miles both in and out of state, to visit a doctor willing to prescribe psychoactive drugs without medical justification.

The Drug Enforcement and Professional Practices Branch (DEPPB) that operates KASPER would analyze the KASPER data and investigate potential pill mill operators. In cases where inappropriate prescribing practices or pill mill operations were indicated, DEPPB alerted Marshall so he could investigate by running his own KASPER report on the doctor(s) in question. Subsequent steps in investigations would often be conducted in collaboration with federal law enforcement agencies (FBI, DEA), with many cases tried in federal court. Marshall and his co-investigators succeeded in shutting down pill mills both in Kentucky and in neighboring states, such as Ohio, but he acknowledged that pill mills remain a significant source of illicit controlled substances for Kentucky residents. In particular, Florida’s “Oxy express” (or “Flamingo express”) continues to be a major supplier of diverted medications.⁵

Marshall also used KASPER data for investigations of pharmacists suspected of illicit dispensing. Initial leads in one such case included phone calls from concerned citizens and (honest) pharmacists about a pharmacy that accepted cash payments only, not insurance or co-payments. A KASPER report on the pharmacy helped to show it was dispensing certain controlled substances (e.g., opioid pain relievers, tranquilizers and stimulants) as 90% of its business, compared with a typical pharmacy’s 20-25%. Subsequent investigation found that the pharmacist was forging prescriptions from non-existent doctors to provide cover for illicit sales. Moreover, he was collaborating with physicians running pill mill clinics in another state. Patients by the van load would travel first to the clinics to get prescriptions, then to the pharmacy, then back home, a round trip of well over a 100 miles. As this case illustrates, KASPER and other PMPs lay the groundwork for successful investigations by revealing patterns of prescribing, dispensing and patient travel that strongly suggest diversion of prescription drugs.

⁴ Note that legitimate medical practice, e.g., oncology and pain medicine, may involve prescribing above average quantities of controlled substances. Inferences from PMP data must be carefully validated before investigative action is taken.

⁵ About recent developments regarding Florida’s drug diversion problem, see <http://www.pmpexcellence.org/content/rogers-applauds-florida-governor-and-state-officials-implementing-prescription-drug-monitori>

Safeguards in the investigative process

According to Kentucky law, and those of most other states with PMPs, requests for PMP data by law enforcement and drug control agencies can only be made for individuals reasonably suspected of violating controlled substance regulations. Justifiable cause for requesting a KASPER report includes witness statements, pill discoveries (for instance during a traffic stop, street sales of diverted drugs, or home visit by a nurse or social worker), and testing positive for controlled substances in a blood or urine drug screen. This protects legitimate patients from investigation and harassment and ensures that PMP data are not used indiscriminately or on behalf of a personal agenda. However, analyses of PMP data by PMP staff can reveal prescribing patterns suggesting criminal diversion that may warrant investigation by law enforcement. As in the pill mill investigations discussed above, the Drug Enforcement and Professional Practices Branch would occasionally alert Marshall about possible diversion cases found in analyses of PMP data.⁶

KASPER reports are not public records, and stringent safeguards are in place to maintain confidentiality of patients, prescribers and pharmacies. As mentioned above, PMP data themselves do not constitute evidence admissible in court, and are not kept in case files. Printed KASPER reports are shredded once an investigation is complete. However, the identical report (each one is assigned a unique tracking number) can be re-run should that prove necessary in an investigation. To monitor use of KASPER by law enforcement, investigator requests are reviewed and tracked by their supervisors, and electronic copies of the reports are automatically available for supervisor review.

Data quality and compliance

The usefulness of PMP reports depends on the completeness and accuracy of the information reported by pharmacies to the PMP. According to Marshall, compliance with KASPER reporting requirements improved over time as pharmacies became familiar with the necessary data gathering procedures. There were understandable omissions and inaccuracies in reporting, given the multiple demands on pharmacists' time. But there were also some instances of "selective reporting" in which pharmacies under-reported to the PMP controlled substances they dispensed, perhaps to conceal illicit sales made by dishonest pharmacists or prescriptions provided by pill doctors. Suspicions of selective reporting can be investigated by means of comparing prescriber and pharmacy records, and Marshall described this as a "labor-intensive process." Electronic prescribing of controlled substances, now being explored by some states, would help curb such diversion, as would comparing net quantities of controlled substances delivered to a pharmacy to net quantities reportedly dispensed, a policy

⁶ Policies regarding unsolicited PMP reports to law enforcement vary by state, and are a matter of ongoing discussion among PMP stakeholders seeking to formulate best practices in the use of PMP data.

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adopted recently by the state of New York. Maintaining and improving data reporting compliance by pharmacies will continue to play a central role in increasing PMP effectiveness.

Opportunities for improvement

Marshall noted several other respects in which PMPs could be improved and their impact maximized. The timeliness of PMP data is crucial for investigations since any delay in learning of possible diversion is a window of opportunity for those engaged in prescription fraud. The utility of KASPER reports went up as pharmacies moved from uploading data every month to every 7 days. But even a day between a prescription sale and its reporting to the PMP leaves time for further diversion activity, especially with public access to online pharmacies. For investigators, the obvious next step is for real-time, point-of-sale data uploading, so that a suspect's most recent purchasing, dispensing, or prescribing behavior is captured immediately and displayed in a PMP report.

Another PMP improvement on Marshall's wish list is interstate data-sharing. As noted above, doctor shoppers routinely cross state lines when visiting multiple prescribers and pharmacies, looking for new sources of controlled substances. Although Marshall became an authorized user of the Ohio and West Virginia PMPs, and could check their databases during investigations, a simpler and quicker alternative would be for data requests to simultaneously query other cooperating states. Just as KASPER made available in a single report the prescription history of an individual for the entire state of Kentucky, so would interstate data-sharing among PMPs make it available for an entire region, or between specific states (e.g., Kentucky and Florida, Kentucky and Georgia). This would increase the possibility of detecting doctor shoppers whose doctor visits and prescription purchases within a state might not reach its threshold for possible questionable activity.

Marshall also suggested that more could be done to increase law enforcement use of the PMP, in particular by officers who discover pills while conducting road stops. Were officers authorized and able to remotely query PMP data via onboard computers,⁷ this would enable them to quickly take a critical first step in the evidence-gathering process. In support of this suggestion, Marshall noted that an increasing number of instances of "driving under the influence" involve use of prescription drugs.⁸

Lastly, he suggested more could be done to educate investigators and other law enforcement personnel about the use and value of KASPER data. At a time when prescription drugs have become the nation's second leading cause of unintentional

⁷ But only when strictly warranted, see the section "Safeguards in the investigative process."

⁸ See the Office of National Drug Control Policy press release on drugged driving at <http://www.whitehousedrugpolicy.gov/news/press10/113010.html>

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death after automobile accidents, those working in law enforcement should at least be made aware of their state's PMP and, when appropriate, trained in its use.

Local versus out of state diversion

As mentioned in the introduction, overdoses and deaths from non-medical use of controlled substances are epidemic in Kentucky, its neighboring states, and the country as a whole. Diversion of prescription drugs remains Kentucky's number one drug problem, despite the best efforts of drug investigators, even as assisted by KASPER. A significant factor exacerbating Kentucky's situation mentioned by Marshall is out-of-state prescribing for and dispensing to its residents. Buses, planes, vans and family vehicles carry residents to pill mills in Florida, and bring back thousands, even millions, of doses of drugs that will be used non-medically. Such interstate trafficking is perhaps an order of magnitude greater than locally generated diversion, especially since with the help of KASPER many in-state sources of illicit prescribing have been discovered and curtailed.

This suggests that the positive impact of KASPER in controlling diversion originating in Kentucky is being overshadowed by a problem that can only be solved by drug control measures taken by other states, for instance in establishing effective PMPs and eradicating pill mills (both are now underway in Florida, Georgia and other states). Cross-state collaboration in sharing PMP data to track illicit prescribing and doctor shopping are also necessary elements in any successful strategy to bring the prescription drug epidemic under control. Kentucky's epidemic is not just of its own making, but the entire country's. Were effective PMPs operating in all states, and talking to one another, local drug investigators in Kentucky and elsewhere would have an even more powerful resource at their command.

Note: For inquiries concerning this report, please contact the PMP Center of Excellence at Brandeis at www.pmpexcellence.org or call 781-736-3909.