



Prescription Monitoring Program Center of Excellence

Notes from the Field

2.2 Keeping Patients Safe: A Case Study on Using Prescription Monitoring Program Data in an Outpatient Addictions Treatment Setting

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Keeping patients safe: A case study on using Prescription Monitoring Program data in an outpatient addictions treatment setting

Summary

A first-person case study is presented on using prescription history data to screen and monitor patients who are opioid addicted for medically unwarranted concurrent use of controlled substances. The Medical Director of a large outpatient opioid addiction treatment program obtained prescription history data on all patients from a newly established state prescription monitoring program (PMP). The Medical Director's analysis of the data indicated that, unknown to clinic medical staff, approximately 23% of patients were being prescribed significant quantities of opiates, benzodiazepines and other controlled substances from providers outside the clinic.

These prescriptions potentially compromised treatment and put patients at risk for dangerous drug interactions, continued addiction, overdose and death. Patients in this group were advised that successful treatment and their own safety required they discontinue seeking unauthorized or duplicate prescriptions. Most patients complied and were retained in treatment, subject to continued monitoring via the state's PMP. This case study suggests that clinical use of prescription history data is a valuable adjunct in ensuring safe and effective outpatient addictions treatment.

All quotations (sections 2-9, indented in text) are taken from the Medical Director's first person written account of the events in question. Anonymity is preserved to protect doctor-patient confidentiality.

1. Background on methadone maintenance and prescription monitoring

Methadone maintenance therapy, often on an outpatient basis, remains the treatment of choice for many of those addicted to opiates, whether heroin or prescription opioid pain relievers. According to the American Association for the Treatment of Opioid Dependence, just over 1,200 methadone clinics are operating in the continental United States, with an estimated combined patient enrollment of approximately 270,000. A concern among clinicians is the illicit use or diversion of controlled substances by some methadone patients. Patients using substances such as prescription opiates and benzodiazepines beyond that indicated for clinically sound addiction treatment are at risk for dangerous drug interactions, continued addiction, overdose and death. A protocol to help reduce illicit drug use and diversion by such patients would be of great value to ensure successful treatment and increase both patient and public safety. The case study presented here suggests that clinical use of PMP data on patients' prescription histories constitutes just such a protocol.

Prescription monitoring programs, underway in the majority of US states (34) and being planned or implemented in ten others, collect data from pharmacies on prescription sales of controlled substances, recording the type of drug, quantity dispensed, customer and/or patient identifying information, prescriber, pharmacy and date of sale. In response to requests by authorized medical providers, almost all PMPs provide reports on the prescription histories of specific patients.

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Providers can, therefore, check to see whether their patients are receiving concurrent prescriptions from other prescribers, an indicator of possible prescription misuse, abuse, fraud or doctor shopping. Most PMPs have or are moving to online systems in which authorized end-users can retrieve data on a patient's prescription history from their offices. The present report suggests that quick, online (but strictly controlled) access to PMP data for medical providers can play a critical role in addictions treatment.

The Medical Director reporting data for this study was the director of a large outpatient methadone clinic. The text in sections 2-9 is drawn verbatim from his written first-person narrative, which takes us from the discovery of his state's newly implemented PMP to the consequences for treatment and patient safety of consulting prescription histories. Italics for entire sentences have been added for emphasis by the PMP Center of Excellence, whereas single words in italics or underlined were emphasized in the Medical Director's original account.

2. Discovering and using the PMP

I first learned about our state's prescription monitoring program (PMP) from an email forwarded to me by one of the administrators at the opioid treatment program (methadone clinic) where I worked. He originally received the information from a person working in the office of the state opioid treatment authority. As soon as I knew we had a functioning prescription monitoring program, I did all I needed to do to get access to this database, which was relatively simple. I had to sign a notarized statement to send to database officials, along with a copy of my driver's license. I was given an ID and a password for the database. *I consider the database one of the best tools I have to help identify and treat opioid addiction.*

Our PMP requires only a patient's first and last name and birth date to obtain database information. There's even an option if you have only an approximation of the birth date, so doctors can still find the needed information. There is a delay between the time a patient picks up a prescription and when that information is uploaded onto the site. In most cases, it takes two weeks or less. When I've had patients use these pharmacies, I've called these pharmacies to explain why it is so important to me that they participate in the PMP.

I'm not particularly computer savvy, but it didn't take long to become proficient in searching the online database. I've become very efficient at this website and can check a patient in about 20 seconds, though much more time is required if I find any prescriptions.

3. The importance of PMP screening: dangers of concurrent substance use during methadone treatment

I feel that it's my obligation to use the PMP to screen all of the patients being admitted to methadone maintenance treatment. Since most people seeking treatment for opioid addiction in our state are addicted to prescription opioids, and not heroin, checking the PMP database was, and is, a goldmine of information. Many of the patients who were opioid addicted got at least part of their opioids by prescription from their doctors, and often were prescribed other

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controlled substances that they used non-medically, or sold. These people often didn't seem to realize how addictive and dangerous prescription medications can be, and mistakenly thought prescription pills were safer than what they considered "hard" drugs.

Methadone is a strong opioid, and can be fatal when mixed with other drugs or medications. Benzodiazepines, combined with methadone or other opioids, have caused many overdose deaths in our state. Many opioid-addicted patients seeking treatment at opioid treatment programs are also addicted to benzodiazepines. By addicted, I mean they use them inappropriately and non-medically, whether they get them by prescription or off the street. Opioids can cause overdose deaths even if not mixed with other drugs. *For this reason, it's critical to make sure we know whether or not the patient is getting another opioid in addition to the methadone we are prescribing.*

4. Findings from PMP data: concurrent prescription use by some methadone patients

When I became the Medical Director of the opioid treatment center I checked all patients' PMP data myself. One of the regulations of our PMP website is that the physician can't delegate this task to anyone else. I was overwhelmed and dismayed about what I found the first time I checked our patients on this database. *Approximately 23% were getting significant prescriptions about which we had no prior information.*

It didn't take me long to decide that, at least for the time being, I would ignore patients getting occasional prescriptions for 20 or 30 hydrocodone pills. As a matter of triage I had to focus on the more serious cases: those getting prescriptions for methadone, Oxycontin, fentanyl, or relatively large amounts of benzodiazepines (e.g., prescriptions for 2 milligrams of Xanax taken twice a day), or combinations of these. Most worrisome were the patients filling prescriptions for methadone, besides dosing with the methadone we prescribed at the clinic. I can recall at least eight or nine doing this. About half of them said they were selling or giving the methadone pills prescribed by community doctors to friends or family. The other half claimed to be taking the extra methadone themselves, with no good explanation about why they hadn't asked for dose increases at our treatment program.

Benzodiazepines were mostly alprazolam, diazepam, or clonazepam. Some patients said they had been taking these prescriptions, and found methods to avoid detection on observed urine drug screens (a fascinating topic of its own), some said they were giving them to friends or family members, and some admitted selling them. None of their community-based physicians knew they were being treated at an opioid addiction treatment program. *No one at our treatment center knew they were seeing another doctor, or what they were being prescribed, prior to access to this data via the prescription monitoring program.* These patients, like all treated by our program, were asked at intake about what medications they were being prescribed, but obviously did not disclose these prescriptions to our staff.

5. Clinical interventions and patient responses

There were too many patients for me to meet individually with all of them to discuss results of the database, though I saw many of them. Because of the large number of patients involved, program managers and patient counselors had to help me.

My approach with a patient would be to say, “Look, we have this new way of checking for other powerful prescriptions and this is what I found for you. Can you explain to me what’s going on?” There were several common ways patients responded.

The majority of patients said something like, “Yeah, I’m getting them. I know I’m not supposed to, but I didn’t think you’d find out.” Most patients agreed to sign release of information (ROI) forms allowing me to call the other doctor, or multiple doctors in many cases, to tell them the patient was being treated with methadone for an addiction and consult about the best course of treatment.

If one or more opioid prescriptions were being filled, I had to ask the patient if they were taking these themselves. Many were. These patients needed methadone dose *increases*, since they were still able to feel euphoria from other opioids. This meant their methadone dose wasn’t high enough for opioid blockade. *As long as the patient agreed to stop getting other opioids, they could stay in treatment with us, and the patient was better off. Many such patients later said they were glad this had happened. They said it burned the bridge of access to drugs they often misused.*

Other patients acknowledged *filling* the prescriptions, but denied *taking* the medications themselves. I really didn’t need to know what they were doing with them (selling or giving them to others), so long as they signed a ROI and stopped getting them. Most did stop. I re-checked these patients a month or so later, to make certain. If I found they were still getting prescription medications even after our talk, and if they refused to sign the ROI, I decided they weren’t appropriate for treatment at our program. In these cases, prior to discharge I slowly (e.g., over weeks or months) tapered their methadone to low levels, while advising them of other treatment options, for instance detox or a non medication-assisted program.

Some patients denied they were getting these medications at all. Since pharmacies can make errors when they upload data, I was careful to double-check names, birthdates, and the home addresses, to make sure they matched. If they did, I told the patient that it is possible this was a case of medical identity theft, and I would investigate. Only one time, out of about a hundred of such cases, was there actual medical identity theft. In all the rest of the cases, our patients were lying when they said they had not filled the prescription in question.

Surprisingly, more than a few patients were belligerent and angry. Many declared that their other medications weren’t any of my business. I claimed that as long as they were asking me to prescribe methadone for them, it certainly was my business. This is particularly true if they’re still filling prescriptions for the very medications to which they were addicted, and for which they had sought treatment.

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6. Patient safety the paramount concern

The issue of patient safety for me was the first consideration. I wanted to keep patients in treatment if it was reasonably safe to do so, and deciding what was “safe” and what wasn’t was a judgment call. I talked to the other doctors at our clinic, but as Medical Director, the decision ultimately fell to me. If it had been more than three weeks since the patient last filled the prescription in question, I made sure the patient wouldn’t be prescribed that medication again, by talking with her other doctor, and we continued to dose the patient. All take home doses were stopped, of course, and the patient had to come to the clinic every day.

I constantly asked myself if I was handling situations as I should. I felt anger towards these patients, that they weren’t taking their recovery seriously, and I worried the anger would color my judgment about the best course of action. I was angrier with long-term patients who were supposedly doing well. Thirty or forty patients on take-home level five or six (meaning they only came to the clinic to be dosed once every week or once every two weeks) were found to be furtively obtaining methadone or Oxycontin or fentanyl, and I felt their deception was greater. I felt they treated our efforts to help them recover from a potentially fatal illness, opioid addiction, with disdain.

My anger cooled after many months of repeatedly checking the PMP database for new patients and old patients. I began to realize this furtive activity of still getting pills was part of the old lifestyle of addiction, and its grasp doesn’t release quickly. It doesn’t release at all for some people. *Plus, it’s still important for me to remember that the majority of methadone patients didn’t get prescriptions after entering treatment with us, and did do well in this form of treatment.*

7. Improvements in treatment and public safety: patient and staff perceptions

Many patients voiced appreciation of our efforts. They said after we checked the prescription database, there was much less drug dealing in the parking lot. The majority of patients were dedicated to their recovery and found the drug dealing to be a temptation and a vexation. Much of the parking lot violence was related to this dealing.

Most of the counselors and nurses, who had direct contact with patients, were supportive, and glad to have this new tool to use. *Over and over, counselors said patients who stopped getting covert prescriptions did better in treatment afterward. Many of the patients also thanked us for addressing the issue.* Some felt they were in better recovery, and others enjoyed a safer parking lot.

I’ve worked in the field of addiction for nine years. *The prescription monitoring database is the best tool I’ve been given.* I know these databases have saved lives, prevented overdoses, and brought people into treatment. I know there’s less drug dealing when the databases are used. This decreased drug dealing was an unexpected but pleasant unintended consequence of using the database.

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8. Ongoing prescription history screening as a clinical tool

I now check patients entering the opioid treatment program on our prescription monitoring database when they are admitted, and several times per year. It's much better to let patients know from the start that we check the database, so it doesn't turn into a kind of "gotcha" situation like it did on the first go-round. I can have an honest conversation about all prescription medications. I can explain why continuing old addictive habits will hurt their recovery. Most patients respond in a positive way. A few decide they don't want to stop getting prescribed opioids, even though they misuse them, run out early, then go into withdrawal. I tell them that if they change their mind, they're welcome back, leaving the door to treatment open.

I also prescribe buprenorphine (better known by its brand name Suboxone) in a private office, treating opioid addiction. The majority of my patients were addicted to pain pills prescribed by doctors. I check each patient on the prescription database the night before I see them, for every visit. *It's a delight to look at the database and see multiple opioid prescriptions from multiple doctors before starting treatment, and after starting treatment, the only opioid they fill is buprenorphine.* Since I check the database before every visit, if the patient has relapsed, the prescriptions don't continue very long before I talk with them about their commitment to their recovery, and what they want to do about their problem.

9. Barriers to PMP participation, recommendations for improvements

The main obstacles to physician use of the databases that I see are avoidance, time restraints, and apathy. Most doctors feel uncomfortable talking to patients about alcohol and drug use. There still is a value judgment attached to this disease. Some doctors think addicts are bad people, not sick people. They have a hard time believing that their "nice" patients could have an addiction. Plus, doctors have to do more and more, in less time per visit. Where would they find time to check the prescription database for everyone they see? And some docs just don't care. If the patient's addicted...so what. Let them take their dirty little habit elsewhere to be cured.

I suggest these improvements: link all states on one database. We had a Suboxone patient who occasionally traveled to a neighboring state. Something seemed off about him. I got permission from two adjoining states to access their databases. He was being prescribed very large amounts of methadone, filled in both of these states. I know for sure he can't be taking both Suboxone and methadone, as he would be in withdrawal, so he must have been selling one of them. This could have been detected months to years earlier if all states' databases were linked.

Make cross-state access relatively easy for physicians. Our office is close to another state, but no physician is permitted access to that state's database unless they have a license to practice medicine in that state. Some states seem to have made it difficult to even find their database online. I searched for over an hour, using search engines, to locate a state's site, to see what their requirements were.

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And advertise the benefits to doctors. I think our state has an excellent program, and the administrators that run the program are top-notch. They have published information in a physician organization's newsletter, increasing the numbers of physicians who use the PMP system.

10. Conclusion

The Medical Director's first person narrative bears powerful witness to the dangers of medically unwarranted prescription drug use among methadone patients, as well as the value of PMP data for safe and effective addictions treatment. Before the establishment of the state's PMP and the Medical Director's use of it, this methadone clinic's staff was unaware that some patients were using or diverting controlled substances prescribed by providers outside the clinic.

Knowledge of patients' prescription histories derived from the PMP database allowed staff to intervene appropriately to reduce medically unwarranted drug use, revisit patients' commitment to treatment, and in some cases adjust methadone dosing to more appropriate levels. According to the Medical Director, most patients confronted with evidence of illicit prescription drug use were retained in treatment, and some expressed appreciation for the interventions.

Use of PMP data became an indispensable clinical tool in monitoring patient compliance with treatment protocols. Besides keeping patients safe and improving the prospects for successful treatment outcomes, interventions made possible by these data helped reduce the diversion and illicit sale of controlled substances, according to the Medical Director, clinic staff and patients themselves.

This case study strongly suggests that initial and ongoing monitoring of a patient's prescription history using PMP data can play an important role in safe and effective addictions treatment. State substance abuse service agencies might profitably consider making PMP data available to Medical Directors and clinicians involved in patient care.

This study also highlights the importance of proper safeguards when using PMP data in addiction treatment settings. These include maintaining patient confidentiality and notifying patients in advance, with their consent, that the PMP will be consulted as an aid to effective clinical practice. Such protocols respect patients' dignity and autonomy while helping to ensure they are retained in the recovery process. For further information and resources on patients' confidentiality, consent, and proactive engagement in treatment, we refer readers to the American Association for the Treatment of Opioid Dependence (<http://www.aatod.org/>), the Substance Abuse and Mental Health Services Administration (<http://www.samhsa.gov/>), and to each state's single state agency for substance abuse services, listed at <http://www.samhsa.gov/grants/ssadirectory.pdf>.
