

A Statewide Prescription Monitoring Program Affects Emergency Department Prescribing Behaviors

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Study objective: Ohio recently instituted an online prescription monitoring program, the Ohio Automated Rx Reporting System (OARRS), to monitor controlled substance prescriptions within Ohio. This study is undertaken to identify the influence of OARRS data on clinical management of emergency department (ED) patients with painful conditions.

Methods: This prospective quasiexperimental study was conducted at the University of Toledo Medical Center Emergency Department during June to July 2008. Eligible participants included ED patients with painful conditions. Patients with acute injuries were excluded. After clinical evaluation, and again after presentation of OARRS data, providers answered a set of questions about anticipated pain prescription for the patient. Outcome measures included changes in opioid prescription and other potential factors that influenced opioid prescription.

Results: Among 179 participants, OARRS data revealed high numbers of narcotics prescriptions filled in the most recent 12 months (median 7; range 0 to 128). Numerous providers prescribed narcotics for patients (median 3 per patient; range 0 to 40). Patients had filled narcotics prescriptions at different pharmacies (mean [SD] 3.5 [4.4]). Eighteen providers are represented in the study. Four providers treated 63% (N=114) of the patients in the study. After review of the OARRS data, providers changed the clinical management in 41% (N=74) of cases. In cases of altered management, the majority (61%; N=45) resulted in fewer or no opioid medications prescribed than originally planned, whereas 39% (N=29) resulted in more opioid medication than previously planned.

Conclusion: The use of data from a statewide narcotic registry frequently altered prescribing behavior for management of ED patients with complaints of nontraumatic pain. [Ann Emerg Med. 2010;56:19-23.]

See page 20 for the Editor's Capsule Summary for this article.

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INTRODUCTION

Pain is the one of the most common chief complaints among emergency department (ED) patients.¹ Appropriate pain management is a fundamental part of the art and the science of the practice of emergency medicine. The Joint Commission established pain assessment and management as essential aspects of health care.^{2,3} The American Pain Society has also affirmed the importance of prompt recognition and treatment of pain and quality improvement programs.⁴ Despite the current emphasis on adequate pain control, numerous studies have demonstrated inadequate pain management for ED patients.⁵⁻¹¹ Although there is general agreement that appropriate pain management is important, for the practicing clinician this is tempered by the significant problems of drug dependence and diversion in the United States.¹²

This increase in the abuse of prescription drugs far overshadows the increases in abuse of illicit substances, including marijuana, cocaine, and heroin. It has been reported that approximately 6.4 million Americans use prescription psychotherapeutic drugs nonmedically. Seventy-three percent of those drugs are pain relievers. Nonmedical use of prescription drugs among young adults was estimated at 6.3% in 2005.¹³⁻¹⁶ One example cited in frequent use among younger patients is the agent OxyContin (oxycodone hydrochloride), which has been associated with street transactions and obtaining drugs from multiple sources.¹⁷ During the period of 1999 and 2005, the number of US deaths due to poisoning nearly doubled, largely attributable to overdose deaths involving prescription opioid agents.¹⁸ Thus, it is not surprising that a subset of ED patients with complaints of pain are opioid dependent.

Diversion of these medications to illicit channels (street sale, trading, or personal distribution) is a significant public health

Editor's Capsule Summary

What is already known on this topic

Many states have monitoring programs for scheduled medications that can be accessed by emergency physicians.

What question this study addressed

Does knowledge of past prescriptions for scheduled medications filled by emergency department patients with nontraumatic pain change emergency physician prescribing behavior?

What this study adds to our knowledge

The 18 clinicians in this study changed their opiate prescription plan for 41% (74/179) of patients after reviewing the patients' prescription history. Among patients whose prescription was changed, 61% received fewer and 39% received more opiates than originally planned.

How this might change clinical practice

The routine use of such databases may change how scheduled medications are prescribed, though the effect of such changes on patient outcomes is unknown.

and law enforcement problem.^{19,20} Physicians believe the 3 main sources of obtaining medications for diversion to be "physician shopping" (when patients obtain controlled substances from multiple physicians), patient deception/manipulation of physicians, and forged or altered prescriptions.¹⁴ To limit prescription fraud and abuse, many states have created prescription monitoring programs. As of November 2008, 38 states had enacted legislation that required prescription monitoring programs. Of these programs that track prescriptions for controlled substances, 32 are currently operating and 6 are in the start-up phase.²¹⁻²³

In October 2006, Ohio initiated a statewide prescription monitoring program titled the Ohio Automated Rx Reporting System (OARRS). The registry tracks prescription drugs in schedules II, III, IV, and V, carisoprodol products, and tramadol products. The system is operated by the Ohio State Board of Pharmacy. Prescription information is collected from pharmacies and distributors twice a month, and this information is available to pharmacists, law enforcement, and prescribers who have registered with the Board of Pharmacy. Data on more than 18 million prescriptions from 2,846 dispensers are collected annually.²⁴ Reports obtained from a secure Web site contain patient-specific prescription data and are transmitted through an encrypted channel as a portable document format in real time during the patient encounter. The report includes the following information: previous controlled

substance prescriptions in the specified period (defined by the health care provider making the query), substance prescribed, amount and date dispensed, names of prescribers, names of pharmacies used, and different addresses used by the patient.

This study was undertaken to examine the influence of the data from a statewide prescription monitoring program on clinical management of ED patients with pain and to identify factors associated with changes in clinical management.

MATERIALS AND METHODS

Study Design and Setting

This prospective quasixperimental study was conducted at the University of Toledo Medical Center ED, an academic, suburban center with an annual census of 31,000, during June and July 2008. The study was approved by the University of Toledo Institutional Review Board.

Selection of Participants

Eligible participants included patients aged 18 years and older, with a chief complaint of painful conditions, including dental, neck, back, head, joint, or abdominal pain.

Patients were considered ineligible if symptoms were self-reported to the triage nurse as being from an acute injury, if research assistants judged patients to be acutely ill or injured, or if there was incomplete data collection.

Enrollment was based on a convenience sample, conducted in real time, when research assistants were available. The bulk of the data was collected between noon and midnight on all 7 days of the week. Research assistants, who were second-year medical students, were trained in human subject research, HIPAA, and the specific study objectives and protocol. Subjects were identified only by the research assistants who reviewed the triage information after the patients were placed in the treatment area. Neither ethnicity nor sex was a factor in selection. Patients were not aware of the study and did not provide consent. The participating providers did not provide consent.

After examination of the patient by the provider, the research assistant administered the survey to the provider about the likelihood that he or she would query the OARRS database for each patient, likelihood he or she would prescribe the patient a controlled substance (home-going medication), and if so, which drug and the quantity. Providers selected "low," "medium," or "high" likelihood or "unsure." After the 3 pre-OARRS data survey questions were answered, the OARRS data for the patient were presented to the physician. After the intervention, the research assistant again administered the survey and recorded any change in prescriptions, as reported by providers, from that which was predicted and specific information from the OARRS database that influenced the physician's decision. In addition, providers also were asked to identify other factors that influenced opioid prescriptions written, including physical examination findings, patient appearance, patient demeanor, or patient statements.

Data Collection and Processing

All data were collected and recorded by trained research assistants, including age group, ethnicity, region of residence in the greater Toledo area, occupational status, insurance status, sex, chief pain complaint (dental, neck, back, head, joint, or abdominal pain), significant medical history, chronic pain history, allergies to medications, and medications currently taken (Appendix E1, available online at <http://www.annemergmed.com>). Strict confidentiality of patient records was maintained throughout the study. No personal health information was recorded on any of the data collection sheets, and patients were assigned a sequential number. All patient identifiers, including the actual OARRS report, were placed in ED HIPAA-compliant disposal units at the end of each day.

Outcomes Measures

The primary outcome measure was change in opioid prescription writing from predicted before database use. Secondary outcome measures included reasons for change in clinical management, including information from the OARRS database (number of prescriptions, number of addresses, number of prescribing physicians), physical examination findings, patient appearance, patient demeanor, or patient statements.

Primary Data Analysis

Statistics are descriptive in nature without hypothesis testing. Binary data are presented as frequency (percentage). Count data are presented as median (mean [SD]). When the characteristics of the patients in the study are described, the unit of analysis is the patient (n=179 patients). When providers' pre-OARRS assessment and providers' change in patient management are described, data are presented both overall (combining over all providers and ignoring provider-specific dependencies) and by provider (collapsing data from patients treated by the same provider into one by-provider percentage). Data were analyzed with SAS (version 9.0; SAS Institute, Inc., Cary, NC).

RESULTS

A total of 199 patients were enrolled in the study. Twenty patients were eliminated from the study because of incomplete data collection, with 179 patients completing the study. None of the patients were acutely ill or acutely injured and none were admitted. Seventeen ED attending physicians and 1 nurse practitioner are represented in the patient data. One physician treated 30% (N=54) of the patients in the data set. This physician is the lead author, who worked the most hours during the time the research assistants were present. Three other providers each treated a significant fraction of patients (12%, N=22; 11%, N=20; and 10%, N=18). Demographic information of patients is depicted in the Table.

For each patient, the provider indicated the likelihood that he or she would query the OARRS database. In a minority of cases, providers indicated a high (47%; N=84) probability; 36%

Table. Patient demographics (N=179).

Patient Characteristic	Frequency (%), Number of Patients
Age, y	
18–40	91 (52)
41–60	73 (41)
>60	12 (7)
Male	82 (49)
Ethnicity	
White	93 (53)
Black	66 (38)
Hispanic	12 (7)
Asian	1 (<1)
Middle Eastern	0
Other	2 (1)
Occupational status	
Employed	60 (34)
Unemployed	117 (66)
Retired	0
Disabled and unemployed	1 (<1)
Insurance status	
Medicare	33 (19)
Medicaid	54 (31)
Commercial	36 (21)
Self	51 (29)
Home narcotics (including nonsteroidal antiinflammatory drugs, ketorolac, antidepressant, or antipsychotic)	36 (20)
Chronic pain	34 (19)
Chief complaint	
Dental pain	37 (21)
Neck pain	6 (3)
Back pain	46 (26)
Head pain	22 (12)
Joint pain	22 (12)
Other/none	23 (13)

(N=65) indicated a low likelihood that they would query the database. Before access to the OARRS database, providers predicted a wide range of likelihood that a controlled substance would be prescribed, including high likelihood (32%; N=57) moderate likelihood (26%; N=47), and low likelihood (36%; N=65).

OARRS data indicated high use of prescription narcotics within the most recent 12 months. The range of prescriptions per patient in a 1-year period was 0 to 128 (mean 18.9 [SD 26.6]). The range of different providers writing prescriptions in a 1-year period was 0 to 40 (mean 5.6 [SD 7.6]). The range of number of pharmacies used to fill controlled substances was 0 to 20 (mean 3.5 [SD 4.4]), and the range of number of different addresses used by patients was 0 to 14 (mean 1.8 [SD 1.9]).

After review of OARRS data, overall (combining across providers) opioid prescribing was altered for 41% (74/179) of patients. In cases of altered management, the majority (61%; n=45) resulted in fewer or no opioid medications prescribed compared with pre-OARRS assessment. Conversely, 39% were prescribed more pain relief than originally planned, after review of the OARRS data.

Overall (combining across providers), the most common reasons that the providers stated for change in management related

to OARRS data were number of previous prescriptions filled (41%, or 30 of the 74 patients for whom the physician changed management), number of physicians writing prescriptions (31%; n=23), number of pharmacies filling prescriptions (26%; n=19), and the number of addresses listed (16%; n=12). Factors that influenced management changes that were not specific to OARRS data included physical examination results (25%; n=18) and patient statement (15%; n=11). Examples of physical examination and patient statement findings that influenced management included provider assessment of pain, demeanor, truthfulness of patient statements compared with OARRS data, and patients who insisted on a specific medication.

LIMITATIONS

This study was performed at a single institution and the results may not apply to other settings. The design is not balanced; that is, the number of patients treated by each physician is not the same. The lead physician treated nearly one third of the patients in the data set, and 3 others accounted for another third. Therefore, results are influenced by the practice of a few providers. Providers and research assistants were not blinded. The study did not track pain medications given in the department. Documentation of prescriptions was by provider self-report, not by direct observation of prescription writing. Because providers were studied as they were making decisions, the study itself may have affected behavior.

Data posted to the OARRS report are delayed by 3 weeks, and the most recent opioid prescriptions may not be reflected in the report. In cities (such as Toledo) close to a bordering state, state registries may not reflect opioid prescriptions filled in the neighboring state.

DISCUSSION

In the past decade, increased emphasis has been placed on the appropriate management of pain in the ED.²⁵ Concurrently, the use and abuse of opioid drugs have grown rapidly, particularly among the teenage demographic.^{26,27} Opioid abuse occurs in 9% of patients with chronic pain, particularly those involved in motor vehicle crashes.²⁸ Among patients cared for in pain management clinics, the prevalence of opioid abuse ranges from 20% to 50%.²⁴ It has been estimated that Americans use 80% of the world's supply of opioids.²⁹

In addition to legitimate painful conditions, emergency physicians frequently encounter a subset of patients who engage in deceptive practices to obtain opiate medications. These patients may be dependent on opiate medications and may also divert these drugs for street sale.³⁰ Identification of such patients may have a significant effect on clinical management.³¹

Our study shows that a prescription monitoring program can be a useful tool for making decisions about prescribing controlled substances. It provides a pattern over time but not a measurement of today's or yesterday's activity. The physician can identify patterns of substance abuse or rule out such identifiable patterns in conjunction with the patient's physical examination results, medical history, and demeanor.

An example of a patient who demonstrated a history of prescription opioid abuse is a man who gave an address from a southern state and claimed to be in town on business. The OARRS report for this patient showed 16 prescriptions from 15 physicians, filled in Ohio at 12 pharmacies, and listed 8 Ohio addresses.

Equally important is the possible finding that a patient has no documented recent history of narcotic use. As demonstration of this point, this study showed that when there was a change in treatment, 39% of those resulted in providing more pain relief than initially planned.

Some EDs have attempted to address the problem of frequent opioid prescription abuse by keeping patient logs or notebooks.³² This practice has come under criticism because of possible HIPAA violations or undue bias against patients who may have a legitimate need for pain control. A readily available prescription monitoring program eliminates the need for departments to keep such records. The OARRS reports are usually available to the physician within 15 seconds of request.

Although a prescription monitoring program is useful in identifying patterns of behavior that can be construed as inappropriate, such programs are less useful in determining the management of patients with chronic noncancer pain. For a variety of reasons, including cultural, sex, fear by physicians of inducing addiction, and suspicion by physicians of the motives of the patient, pain is undertreated in the emergency setting.³³ Patients with chronically undertreated pain, also called pseudoaddiction, can be more difficult to identify. Such patients may have a long list of medications filled, but perhaps use only one address and one physician. Like a laboratory test, a prescription monitoring program should be used as an adjunct to all the information gained in the clinical encounter. This information should be used judiciously before a decision is made about pain control.

Because not all states have a prescription monitoring program, there is a problem with patients shifting their illegal activity to border states. The Integrated Justice Information Systems Institute, in conjunction with the Bureau of Justice Assistance, is currently working with the Ohio Board of Pharmacy to create a centralized system for exchange of information between states.

The use of data from a statewide narcotic registry frequently altered providers' prescribing behaviors for patients with nontraumatic pain complaints. In addition to information from the registry, information from the physical examination results and statements by the patients also altered management in some cases.

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CORRECTION NOTICE

In the April 2010 issue, in the article by Kanwar et al ("Confusion About Epinephrine Dosing Leading to Iatrogenic Overdose: A Life-Threatening Problem With a Potential Solution,"; pages 341-344), the caption for Figure 1 is incorrect. The IM dosage should have said, "0.3 mg of 1:1000 concentration IM dose."

Appendix E1. Clinical Applications of the Ohio Automated Rx Reporting System (OARRS) in the Emergency Department.

Patient # _____ Doctor # _____ Research assistant # _____

Patient Demographics

Age category (circle one)

Gender: M F

18-25 26-30 31-35 36-40 41-45 46-50 51-55

56-60 61-65 66-70 71-75 76-80 81-85 Over 85

Ethnicity: Cauc AfrAm Hisp Asian MidEast Other

Region of Residence: N S E W Central Suburban Other

Occupational status: Employed Unemployed Retired Disabled

Insurance status: Medicare Medicaid Commercial Self

Pain complaint: Dental Neck Back Head Joint

Other _____

Sig. PMH: Sickle cell Fibromyalgia Depression Arthritis

Alcoholism Other addiction Smoker Chronic pain _____

Other _____

Allergies: NSAID Ketorolac Tramadol APAP Any opiate

Medications: Hydrocodone Oxycodone Codeine Propoxyphene

NSAID Ketorolac Tramadol Fentanyl Oxycontin Methadone

Antidepressant Antipsychotic

Other _____

Pre-OARRS Physician Assessment:

What is the likelihood that you would query the OARRS database for this patient?

Low moderate high unsure

What is the likelihood that you will prescribe a controlled substance to this patient?

Low moderate high unsure

What controlled substance do you believe you will prescribe, and quantity?

Drug: None Hydrocodone Oxycodone Codeine Propoxyphene

Other _____

Amount: _____

OARRS Data (12 months)

Rx _____ # Doctors _____ # Pharmacies _____ # Addresses _____

Physician Management (post OARRS data review)

Drug(s) prescribed: Hydrocodone Oxycodone Codeine Propoxyphene

NSAID Ketorolac Tramadol Fentanyl Oxycontin

Other _____

Quantity: (draw line to drug) _____ _____

If management changed based on the OARRS data, name the most important factors?
(Circle all that apply)

Rx # Doctors # Pharmacies # Addresses

If management changed, what other factors affected your decision change?
(Circle all that apply)

Physical exam Pt appearance Pt demeanor Pt statement

Clinical Applications of the Ohio Automated Rx Reporting System (OARRS) in the Emergency Department

Zip Code Categories

North: 43611, 43612, 43613, 43623

South: 43607, 43609, 43614

East: 43605, 43616, 43619

West: 43606, 43615, 43617, 43628

Central: 43602, 43604, 43608, 43610,

Suburban: 43460, 43537, 43560