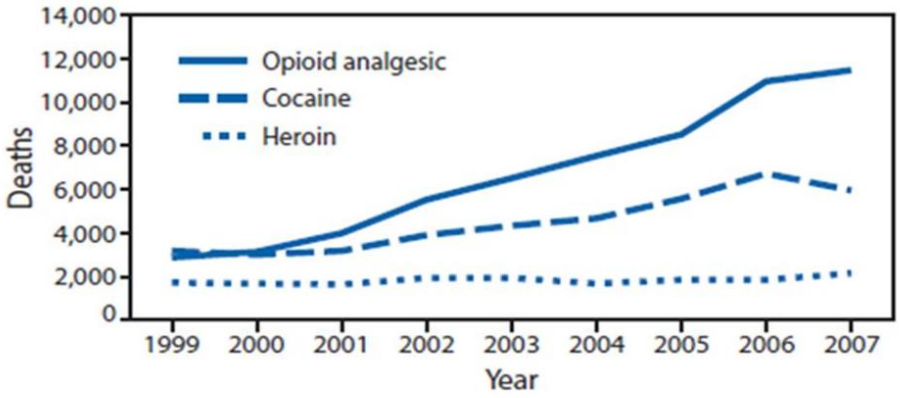
Utilization of Texas Prescription Monitoring Program: A Texas Pain Society White Paper
By Texas Pain Society

Background:
The United States currently has a prescription drug abuse epidemic (1). The unintentional lethal prescription overdoses (OD) has increased in proportion to opioid prescribing patterns (2). Opioids are the primary drug resulting in these preventable deaths. For each unintentional lethal prescription OD, 9 people are admitted for substance abuse treatment, 35 visit the emergency department, 161 people report drug abuse or dependency, and 461 individuals report non-medical use of opioid analgesics (1). Among the victims of lethal prescription OD, the rural and more impoverished counties, Medicaid populations, and mental illness are overrepresented (1, 2). Deaths from opioid prescriptions now exceeds deaths from cocaine and heroin combined (fig 1).

20% of the OD deaths were from a single practitioner prescribing low doses of opioids. While 40% of the OD deaths were from a single practitioner prescribing high doses of opioids (defined as greater than or equal to 100 mg of morphine equivalents). Another 40% of lethal OD occurred from persons obtaining prescriptions from multiple clinicians (1). Obtaining prescriptions from multiple clinicians is known as "doctor shopping" which is a felony in Texas. The CDC has suggested, based on this data, prevention strategies should focus on the high dose prescribing physicians and identifying doctor shopping persons (1).

Figure1 **Number of unintentional drug overdose deaths involving opioid analgesics, cocaine, and heroin — United States, 1999–2007**



Source: National Vital Statistics System. Multiple cause of death dataset. Available at http://www.cdc.gov/nchs/nvss.htm.

Chronic opioid therapy (COT) is an increasingly controversial treatment strategy as long term data with objective outcome metrics justifying this treatment do not exist (3). However, there is significant data that adverse events related to COT are occurring at an alarming rate. Principles of responsible COT prescribing should include exhausting all reasonable and conservative treatment options prior to starting COT and ensuring that an objective and clinically meaningful

therapeutic benefit is obtained once COT is initiated. If a therapeutic benefit is not obtained after a reasonable titration, then the medical necessity to continue COT has not been achieved. There is no reason to expect that a higher dose is necessary if a therapeutic benefit has not been achieved at low to moderate doses. The higher doses are known risk factors for adverse events including unintentional lethal OD. Early use of COT after occupational injuries has been associated with decreased function and increased disability rates (4, 5).

Ensuring that reasonable alternative treatment options are explored prior to initiating COT and ensuring that an objective and clinically meaningful therapeutic outcome is achieved once COT is started should reduce the problem of deaths related to COT from single practitioner is using high dose COT. Empirical observations by pain management physicians suggest that COT in well selected individuals is an effective treatment. However, "well selected" is the key concept.

With respect to doctor shoppers, historically physicians had few tools to identify this problem. When it was identified it was usual very late after the event had occurred.

Texas has had the Texas Prescription Program (TPP) to monitor CIIs since 1982 and in 2008 started monitoring CIII-V, but today physicians have easier accessibility to the monitoring program through Prescription Access in Texas II (PAT II), where they can login to the TPP via a secure website. In September 2011 a company, Optimum, received the contract for hosting and collecting the data for the TPP. Previously the hosting, development and data collection was done internally by Department of Public Safety (DPS). DPS had developed a website accessible version of the TPP (referred to as PAT I – Prescription Access in Texas) which went through several rounds of beta testing that began in August of 2011. The traditional fax request method is still in place.

August 2012 PAT II was rolled out in stages and is now available for registrants. To register for the system, registrants need to go to: https://www.texaspatx.com/Login.aspx. There is a FAQ section and a tutorial available that registrants should read before using the site. TPS heavily cautions all members to use due diligence when reading and interpreting data results. The information in this database is received directly from pharmacy reports are subject to error. The automated error checks the system performs are not an endorsement of the accuracy of the information, but a check that all fields are filled in.

The use of Texas PAT II is a valuable tool to reduce the incidence of doctor shoppers which is estimated to have an incidence of 10% of individuals prescribed opioids (1). However, the SOC regarding how to use the PAT II has not been established. Some state agencies have expressed to the Texas Pain Society (TPS) that they expect clinicians to use PAT II on each patient encounter. Mandating that the physician queries the data base on every patient is not necessary, as there is no current evidence that this would decrease the risk of diversion or abuse. Furthermore, it is not practical and would be an unfunded mandate on clinicians at a time in which numerous regulatory and economic factors impair the delivery of quality care. Therefore, this white paper will establish minimum suggestions for PMP utilization. It is hoped that in the near future, software automation will mine the database and automatically alert prescribing clinicians via email or similar modalities of suspicious prescription profiles that may represent doctor shopping behaviors so that the clinician may further investigate at the next office visit.

The TPS, in response to membership concern, authored a urine drug testing (UDT) article regarding best practices and applications for UDT (6). In an effort to avoid repeating subject matter, readers are encouraged to review the TPS UDT article which discusses in detail risk factors for non-therapeutic use of opioids, UDT, and how to perform a risk assessment for potential abuse of controlled substances in the future.

The Texas Medical Board rule 170 requires a risk assessment for potential future abuse of controlled substances prior to initiating treatment. The TPS currently recommends the SOAPP-R for risk assessments related to COT. The SOAPP-R divides individuals into three groups- low, moderate, and high risk for aberrant drug taking behavior.

Recommendations:
These recommendations are intended for clinicians who are prescribing controlled substances, but the program is available to any DPS approved registrant.
The TPS recommends that low risk patients on COT have a random UDT performed 1 to 2 times per year. Moderate risk individuals should be tested 2 to 4 times year. High risk individuals should be tested 4 times a year to every scheduled visit. Therefore, it seems reasonable to use the same strategy for PAT II utilization.

Baseline:	PAT II check prior to starting COT
Low risk:	PAT II checked 1-2 times per year.
Moderate risk:	PAT II checked 2-4 times per year
High risk:	PAT II checked 4 times per year to every visit

Of course, achieving this strategy will become obsolete if a reliable and automated alert system comes online for the PAT II. These recommendations are minimum suggestions. The clinician may use the PAT II more frequently especially if any clinically observed behavior or aberrant UDT raises concern.

References:

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