Helping patients by using prescription drug monitoring programs

JUL 10, 2016

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Prescription drug monitoring programs (PDMP) can be an effective clinical tool to assist physicians in making prescribing decisions. Effective PDMPs can help identify red flags in prescription use, and provide information when assessing and making treatment decisions. Learn how one physician in New York uses his PDMP to inform treatment options and discuss safety issues with patients.

What a PDMP can do for patients and physicians

“The bottom line is that New York’s PDMP is a good tool to use to get some information for your assessment and discussion with your patient,” said Frank Dowling, MD, clinical associate professor of psychiatry at SUNY at Stony Brook and medical director at Long Island Behavioral Medicine. “It’s like blood sugar or hemoglobin A1c [data]. They give you certain information about your diabetic patient—how they’re doing over time and what’s going on and the PDMP can be used similarly regarding controlled medications.”

The New York PDMP is fully funded, can be integrated into practice work flow and contains the relevant and timely information that physicians need. It is a tool to see exactly what prescriptions for controlled substances are being filled for individual patients, Dr. Dowling said. “So many patients in pain management are afraid to tell me as their psychiatrist that they’re taking [opioid analgesics]. And then if I’m giving an anxiety drug, for example, they’re afraid to tell the pain specialist that they’re on a tranquilizer because … they know there’s a stigma, and they feel kind of like they’re stuck between a rock and a hard place.”

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When a patient is being treated with controlled medications, it’s important to be careful about quantity and interactions with other medications, he said. Medications aside, the medical conditions themselves may increase risk for some patients, so the information from the PDMP can be useful during the discussion with a patient.

“I actually print up the PDMP report,” Dr. Dowling said. “We could just pull it up on the screen and eyeball it, but we print it up. And if there’s no major discussion, I write a line in the chart, and we shred it. But if there’s a [need for] discussion, I show the patient.”

When the PDMP report shows, for example, that the patient has been prescribed controlled medications from two different physicians, it provides an opportunity for physicians to have a conversation about how to better coordinate that patient’s care.

In New York, the PDMP report identifies all prescribers, prescriptions and amounts that were dispensed. It also shows which pharmacy the patient used and how the prescription was paid for. “[Payment information] comes up either public, private, self-pay or cash because those are additional red flags that can help you to intentify a possible problem,” Dr. Dowling said.

“It’s a conversation and further assessment,” Dr. Dowling said. “I love to show them what the PDMP shows. Just like if I do a toxicology screen, and it shows something aberrant or something different than what I expect or hope to see.”

“I try to be open and come across as nonjudgmental as I can,” he said. “If it’s high doses of a few different [drugs], I have to say I’m a little worried. Sometimes this is appropriate, but sometimes it could be a risky situation, and we need to talk and work it out together. It’s still about the patient and about the situation that’s unsafe, not that the patient did a bad thing—this is for their own safety.”

In Dr. Dowling’s practice, every patient’s PDMP report is examined, whether or not he is prescribing a medication because it’s useful information for assessment and decision-making, he said.

“When we first started using the PDMP, we looked up about 400 people over the first few months,” Dr. Dowling said. “It stirred up about 40 or 50 conversations,” some of which were about how a pain medication could interact with a psychiatric medication and required his practice to follow more closely, “due to the risk of sedation and accidental overdose,” he said.

“Sometimes they’re just people who get in over their head with pain medications, and they’re just looking for some help,” he said. “And you can talk with them. You can give them a pathway … prescribe buprenorphine … connect them to therapy and meetings, detox or rehab if needed.”

Speaking on a panel at the 2016 AMA Annual Meeting last month, Dr. Dowling offered one of three things every physician should do when treating pain, including information on how to use a

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PDMP.

Focusing on the individual patient

Dr. Dowling detailed one case in which the PDMP helped him identify a patient who was in need of help. The PDMP report showed that the patient was receiving multiple prescriptions from multiple physicians, and he was using different pharmacies as well.

The patient was prescribed buprenorphine for opioid use disorder. “He’d had a problem with heroin in his teens,” Dr. Dowling said. But the patient had been off of opioids for several decades and was a high-level executive. But then he experienced a physical injury to his shoulder, for which an opioid medication was prescribed.

There were 23 scripts in a short period of time, and the patient was taking about 12 tablets a day when three or four is usually the daily maximum, Dr. Dowling said.

“I was very worried about him, and I called him,” Dr. Dowling said. “I started to talk with him on the phone, and I said, ‘Is there anyone in your family with the same name?’”

The patient sounded nervous but relieved, Dr. Dowling said. The patient then said, “Why do you ask?”

Dr. Dowling told him that the PDMP report showed that he was receiving more than one medication from more than one prescriber and that he was worried. The patient replied that he was glad that Dr. Dowling called because he had gotten himself in troubleand he didn't know how to deal with it.

“He told me everything,” Dr. Dowling said. “He said, ‘I’m seeing these two other docs, and I got myself in over my head. I’m terrified that none of you will work with me, and I don’t know what to do.’”

Dr. Dowling then told him, “That’s why I’m calling, so come on in.”

“I set up a visit the next day, and we talked and cleared the air,” Dr. Dowling said. “I told him that what’s important here is you have an addiction problem and we’ve got to get a handle on it. [You need] one prescriber, and you should let me talk to the other docs. If you’re comfortable with one of the other docs, that’s fine, and we’ll do a smooth handoff. If you’re comfortable with me, that’s fine too; you can let them know, and we’ll consolidate with me.”

“He decided to stick with me,” Dr. Dowling said. “This particular patient, to his credit, is active in 12-step meetings, and he said, ‘You know, doc, I owe these other two doctors an amends. Can you give me a couple of days to call them so they hear it from me first?’”

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“That was great—that’s the perfect, ideal thing,” Dr. Dowling said. “We tapered him down by one dose every two days in the outpatient setting without a problem. And since then there’s been no aberration with the PDMP or toxicology screens.” The patient only takes buprenorphine as prescribed and has been functioning well for several years.

One of the recommendations of the AMA Task Force to Reduce Prescription Opioid Abuse is to register for and use your state PDMP to check prescription history. Check out all five recommendations for physicians to take action and prevent opioid abuse.

For more on physician efforts to end the opioid overdose epidemic

- How to talk about substance use disorders with your patients
- Physicians team up to treat addiction in rural areas
- 3 steps for talking with patients about substance use disorder
- Entire state gets one naloxone prescription
- How naloxone can be a way to start the broader conversation about risk

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