Pharmacists' training, perceived roles, and actions associated with dispensing controlled substance prescriptions

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Abstract

Objectives: To examine situations that prompt pharmacists to access a prescription drug monitoring program (PDMP) database and management of opioid abuse/addiction; assess pharmacists' actions when abuse is suspected; and describe pharmacists' tasks when dispensing controlled substance prescriptions (CSPs) and their related continuing pharmacy education (CPE).

Design: Cross-sectional mail survey of 1,000 randomly selected pharmacists.

Setting: Texas from February 2012 to April 2012.

Participants: 1,000 Texas community pharmacists.

Intervention: Mail survey instrument.

Main outcome measures: Prompts to use a PDMP and pharmacists' views, actions, and related CPE programs

Results: The usable response rate was 26.2%. Pharmacists were more supportive of mandated PDMP use by physicians than by pharmacists (mean ± SD 4.1 ± 1.2 versus 3.2 ± 1.5; P <0.001), based on a 5-point Likert scale (1, strongly disagree, to 5, strongly agree). Most pharmacists would be prompted to use a PDMP if the prescription contains mistakes (68.1%) or the patient requests an early refill (66.3%). Bivariate statistics showed that men pharmacists, those with BSPharm degrees, and pharmacists ≥50 years of age reported a greater number of CPE hours related to prescription opioid abuse and pain management. An analysis of variance showed that pharmacy owners reported significantly more (P <0.05) CPE compared with manager and staff pharmacists.

Conclusion: Older pharmacists with a BSPharm degree may be more willing to provide counseling to patients with opioid addiction based on their work experience and additional CPE related to controlled substances. As PDMP use becomes more prevalent, pharmacists should be prepared to interact and counsel patients identified with aberrant controlled prescription drug use and properly deliver pain management care. Additionally, schools of pharmacy curricula must prepare new pharmacists to prevent abuse and diversion, as well as intervene when aberrant use is identified.

Keywords: Pharmacists, prescription drug abuse, diversion, prescription drug monitoring, opioid addiction.

J Am Pharm Assoc. 2014; 54:241–250.
doi: 10.1331/JAPhA.2014.13168

Received August 13, 2013, and in revised form December 18, 2013. Accepted for publication December 19, 2013.

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Disclosure: The authors declare no conflicts of interest or financial interests in any product or service mentioned in this article, including grants, employment, gifts, stock holdings, or honoraria.

Funding: Supported by an unrestricted educational grant from Reckitt Benckiser Pharmaceuticals, Inc.

Acknowledgments: Texas community pharmacists for their participation in the study and Patrick Knue, former Program Administrator of the Texas Department of Public Safety Prescription Program.

Previous presentation: International Society for Pharmacoeconomics and Outcomes Research International Meeting, New Orleans, LA, May 20, 2013.

The Centers for Disease Control and Prevention has determined that prescription opioid abuse remains a national epidemic.[1] The Substance Abuse and Mental Health Services Administration's Drug Abuse Warning Network reported that misuse of pharmaceuticals was associated with more than 1.3 million emergency department visits in 2010.[2]

To combat this epidemic, 47 states and the District of Columbia have implemented prescription drug monitoring programs (PDMPs) in which patients' controlled substance prescription (CSP) data can be accessed by pharmacists and prescribers.[3–6] PDMPs are state-operated electronic databases containing the records of CSPs dispensed from community pharmacies in their respective states.[3] Some states monitor other drugs with abuse potential (e.g., tramadol).[5] In many states, the PDMP database is made available to prescribers and pharmacists via an online Web portal that enables providers to view the data before prescribing or dispensing CSPs.[3,7]

In the absence of online-accessible PDMPs, community pharmacists have been faced with the challenge of determining whether to dispense CSPs based primarily on a patient's medication profile (i.e., refill history), appearance, and demeanor.[8–10] Pharmacists must also perform tasks in practice that are specific to dispensing CSPs in the community pharmacy setting. At the time of this research study, Texas was in the process of launching an online PDMP.[11]

Pharmacists have a duty to verify that CSPs are for a legitimate medical reason and must exercise "professional judgment" when there is any doubt about legitimacy.[12] Where doubt exists, pharmacists do not have to dispense CSPs. The National Center on Addiction and Substance Abuse (CASA) at Columbia University conducted a national survey of pharmacists about how often they performed tasks associated with dispensing CSPs.[13] Only about one-half reported always validating the prescriber's U.S. Drug Enforcement Administration (DEA) number (51.1%) and consulting patient records (52.1%) before dispensing. Only 57% reported always checking for contraindications, and a mere 11.7% said they ask if the patient is taking any other CSPs.

Pharmacists must be aware of the tactics used by patients seeking to divert CSPs for illicit purposes.[14] Patients have illegally altered legitimate prescriptions by changing the quantity (e.g., from 30 to 80) to obtain a larger supply. Other tactics include forging prescriptions on stolen prescription pads, calling in bogus prescriptions from what purports to be a doctor's office, and photocopying prescriptions. In the CASA survey, 62.2% of pharmacists said they were somewhat confident in their ability to recognize patient attempts at diversion.[13]

In Wisconsin, 87% of responding pharmacists reported being confident in recognizing when a patient is attempting to divert CSPs.[9] Before the availability of online-accessible PDMPs, some pharmacists reported relying on their "gut instinct" to detect diversion.[13] Additionally, in a recent survey on PDMP use among Rhode Island and Connecticut pharmacists, 78.6% of responding pharmacists reported using insurance rejection of prescription opioids to detect diversion.[15] Based on the aforementioned literature, pharmacists are faced with the challenge of providing patient care while also trying to determine the legitimacy of CSPs.

PDMPs provide pharmacists with the opportunity to detect abuse and diversion. In the past, when pharmacists' suspected abuse, most (92.8%) would call the prescribing physician.[13] However, one study showed that the majority of participating pharmacists found it somewhat difficult to communicate with physicians about patients with aberrant CSP use.[10] When pharmacists suspect that patients are abusing or diverting CSPs, the necessary actions to address the situation are not always clear. Nearly one-half (47.6%) of pharmacists in the CASA study reported contacting the police in such instances.[13] Pharmacists also sometimes tell patients that the medication is out of stock to avoid dispensing it.[15]

A lack of adequate education and training related to pain management and addiction has been reported in prior studies of pharmacists.[16,17] In one study of New Hampshire health care providers, pharmacists were least likely to feel prepared to counsel patients with pain compared with physicians and nurses.[16] Similarly, 50% of responding pharmacists in Wisconsin reported receiving only "fair" or "poor" training on opioids and pain management.[9] In the CASA survey, about one-half

At a Glance

Synopsis: This survey-based study of 1,000 randomly selected community pharmacists in Texas found age- and education-related differences in their propensity to counsel patients with prescription opioid addiction. The authors found that older pharmacists with a BSPharm degree may be more willing to provide counseling to patients with opioid addiction and attributed this to greater work experience and continuing pharmacy education related to controlled substances. This need for greater training, the authors note, is bolstered by the increasing prevalence of online databases that allow pharmacists to access patient history of prescription drug use.

Analysis: *Findings from this study—one of the first to assess the types of situations that would prompt pharmacists to access prescription drug monitoring program databases—suggest that pharmacists are confident in denying prescriptions based on patient history. More than one-third of survey participants also agreed that pharmacists should play a role in helping manage addiction, with only one-quarter feeling the need to notify law enforcement when suspecting abuse.*