PERFORMANCE AUDIT

Report Highlights

Office of the Washington State Auditor
Pat McCarthy

Prescription Monitoring Program: Evaluating system processes and program oversight

When prescription medications are misused or overprescribed, they can contribute to dangerous drug interactions, substance use disorder, overdoses and deaths. Prescription monitoring program (PMP) databases offer medical professionals a tool to help them reduce overprescribing of opioids and other controlled substances. By accessing their state's PMP system, medical professionals can review medications their patients received in the past before prescribing or dispensing new or additional medicines.

Washington's PMP began operating in 2011 and is administered by the Department of Health (DOH). State law requires pharmacies to submit to the PMP system all Schedule II-V controlled-substance prescriptions that have been given to a patient. In addition, most medical professionals must check the PMP before prescribing controlled substances. The Washington State Hospital Association and the Washington State Medical Association jointly oversee the Better Prescribing, Better Treatment Collaborative, which uses PMP system data from DOH to create opioid prescribing reports. The Collaborative distributes these reports to educate medical professionals about their prescribing practices and how they compare to their peers.

DOH needs a more comprehensive process to ensure PMP data is sufficiently complete and timely to meet the needs of prescribers who are making decisions about patient care

To ensure medical professionals have complete information when prescribing, it is important to monitor whether pharmacies have promptly submitted prescription records. DOH does not monitor PMP data to see if pharmacies submit prescription records within one day of distributing a prescription. Until recently, DOH did not contact pharmacies that failed to correct records with errors that the PMP system automatically blocked from uploading. And because DOH does not ensure that pharmacies correct records with errors, prescribers may not have access to complete PMP data. In addition, DOH lacks a process to determine whether pharmacies have submitted all required prescriptions to the PMP system. Overall, DOH has not prioritized monitoring pharmacy compliance with PMP reporting rules.

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Improving and expanding opioid prescribing reports to more medical professionals could help provide better patient care

Opioid prescribing reports help some of Washington's medical professionals understand their own prescribing activity and how it compares to their peers. Since 2019, the Collaborative has used PMP data to send opioid prescribing reports to medical professionals. Further enhancements to the reports could increase their usefulness to prescribers. Expanding the prescribing reports to other health care professions would require engagement with their associations and additional resources. As the lead state health agency, DOH can bring together stakeholders to help the Better Prescribing, Better Treatment Collaborative improve the reports and expand their reach.

State law does not allow DOH to share PMP identifiable data for the purpose of independent oversight of the program

State law restricts access to PMP data to protect patients, prescribers and pharmacies. The restrictions curtail independent oversight that might identify opportunities for improvement. Auditors in other states used PMP data to identify prescribing and dispensing patterns of concern, which we could not replicate due to the data restrictions. In addition, our ability to examine certain system processes was limited. These restrictions in state law inhibited our ability to complete this planned audit work. Furthermore, neither DOH nor the regulatory licensing boards and commissions analyze PMP data in search of those concerning patterns.

State Auditor's Conclusions

More than 9,000 Washington residents have died from opioid prescription drug overdoses over the last two decades, according to Department of Health data. Many more have had their lives affected by opioid-use disorders. In 2020, more than a quarter of opioid-related deaths in Washington involved commonly prescribed opioids, according to the Addictions, Drug and Alcohol Institute at the University of Washington. The Department of Health's Prescription Monitoring Program began operating more than 10 years ago to improve patient care, reduce the abuse of controlled substances and help medical professionals reduce overprescribing. Through this independent, in-depth performance audit, our Office has identified detailed steps that will help the relatively small program – it currently has a staff of seven – improve the effectiveness of this system.

Checks to ensure compliance with the program should be improved, such as confirming available prescription information is complete and checking the appropriateness of waivers granted to non-participating pharmacies. Importantly, select independent oversight agencies should be allowed to access prescription data. One goal of this audit was to identify problematic prescribing and dispensing patterns, but we could not perform that analysis due to legal restrictions on program data. State and legislative auditors in other states, such as Colorado, Louisiana and Oregon, have used their access to this type of data to identify instances of doctor and pharmacy shopping by patients, severe cases of overprescribing by health care providers, and prescriptions involving dangerous drug combinations. That level of accountability is needed in Washington, to help prevent drug misuse, overdose and tragedy.

Recommendations

We recommended DOH perform additional compliance activities and update its administrative rules in the WAC to help ensure pharmacies submit all required prescriptions records in a timely manner. We recommended DOH participate in a workgroup with the Better Prescribing, Better Treatment Collaborative to help improve and expand opioid prescribing reports to more medical professionals. We also recommended the Pharmacy Commission make some additions to pharmacy inspection processes that will help ensure completeness of PMP data. Finally, we made a recommendation to the Legislature to amend state law so that independent auditors can have the authority to access identifiable PMP data.