PMP Data Quality and Pharmacy Compliance

HAROLD ROGERS PDMPS AND COAP GRANTEES NATIONAL MEETING

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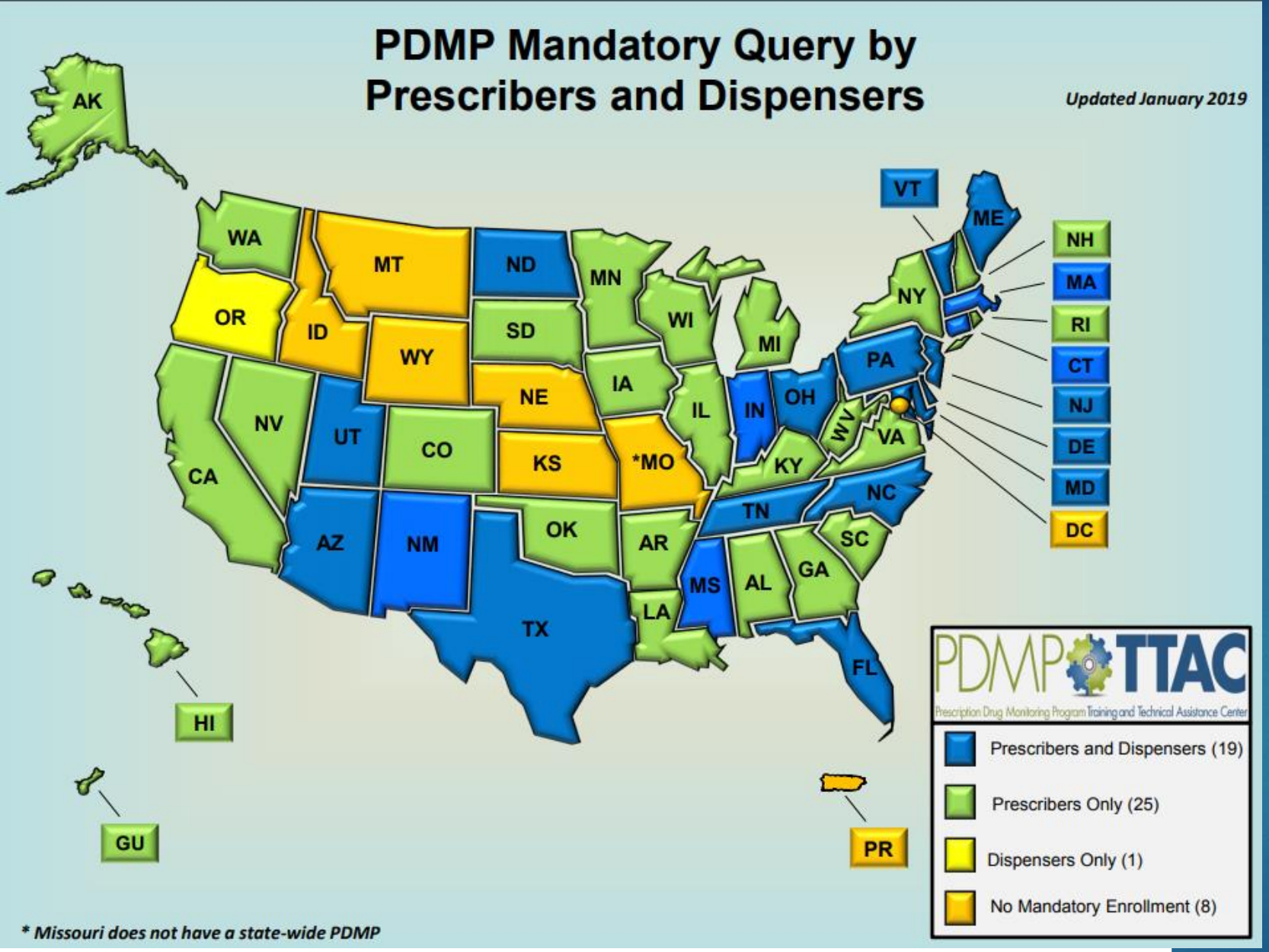

Mandatory PMP Query

- 44 states – mandatory query by prescribers
- 19 states- mandatory query by dispensers

Prescription Drug Monitoring Program Training and Technical Assistance Center. PDMP Mandatory Query by Prescribers and Dispensers. Accessed June 6, 2019. Available at: https://www.pdmpassist.org/pdf/Mandatory_Query_20190115.pdf

Possible Sources of Error

- Omission (pharmacy data submission non-compliance)
- Pharmacy data entry error
- Transmission software error

Data Submission Non-Compliance

Technological

- Computer/server connection
- Dispensers unaware data not transmitting

Lack of Knowledge

- Unaware of law or regulations

Intentional Non-compliance

- Not or only partially transmitting data → may be engaged in unlawful activities (i.e., RX fraud, pill mill)
- Do not feel obligated to report
- Honor system does not work

Prescription Drug Monitoring Program Training and Technical Assistance Center, PDMP Suggested Practices to Ensure Pharmacy Compliance and Improve Data Integrity. Accessed June 6, 2019. Available at: http://www.pdmpassist.org/pdf/Pharmacy_compliance_data_quality_TAG__FINAL_20150615.pdf

Pharmacy Data Entry Errors

Type of Error	Error	Possible Causes	
Patient	Missing/incorrect/ misspelled address or phone #	-Variation in street or city name abbrev. (e.g. Avenue or Ave) -Pt has no address or phone # -Pick list (outdated info)	-Written, electronic, or telephoned RX is incomplete, inaccurate, or illegible -Transcribing errors -Procedural flaws
	Missing/incorrect DOB	-RX issued or filled date entered -Current day or future date entered	
	Misspelled name	-Variations in name spelling (e.g. Catherine, Cathy, Cat; Richard, Dick) -Hyphenated last names -First, middle, last names out of order -Alias used -Special characters in name field	
	Wrong patient	-Pick list (wrong patient selected) -Owner's rather than animal's name on veterinary RXs	

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Pharmacy Data Entry Errors

Type of Error	Error	Possible Causes	
Prescription	Incorrect days supply, incorrect quantity dispensed	-Instructions for administration or # of days unclear -Mislabeled units of measure (e.g. mg vs ml) -Wrong info in partial fill field; partial fill not indicated	-Written, electronic, or telephoned RX is incomplete, inaccurate, or illegible -Transcribing errors -Procedural flaws
	Incorrect date written or date dispensed	-DOB in wrong field -Transposing written and dispensed date -Transposing date values (e.g. MM/DD/YY or YY/MM/DD)	
	Incorrect drug name; inactive rather than active ingredient reported for a compound	-Missing NDCs for ingredients in a compounded RX -Bad NDC # -Wrong NDC #	

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Pharmacy Data Entry Errors

Type of Error	Error	Possible Causes	
Prescriber	Incorrect DEA #	-Use of incorrect DEA # for a prescriber with multiple DEA #s -Use of the "X" DEA # instead of the provider DEA #	-Written, electronic, or telephoned RX is incomplete, inaccurate, or illegible -Transcribing errors -Procedural flaws
	Wrong prescriber	-Pick list (wrong prescriber selected) -DEA # not associated with the correct prescriber	

Type of Error	Error	Possible Causes
Others	Duplicate RXs; multiple transmissions of the same data file	-Procedural flaws
	Transmission of a corrected RX mislabeled as a new RX	-Procedural flaws
	RX data transmitted even though RX not dispensed to patient	?

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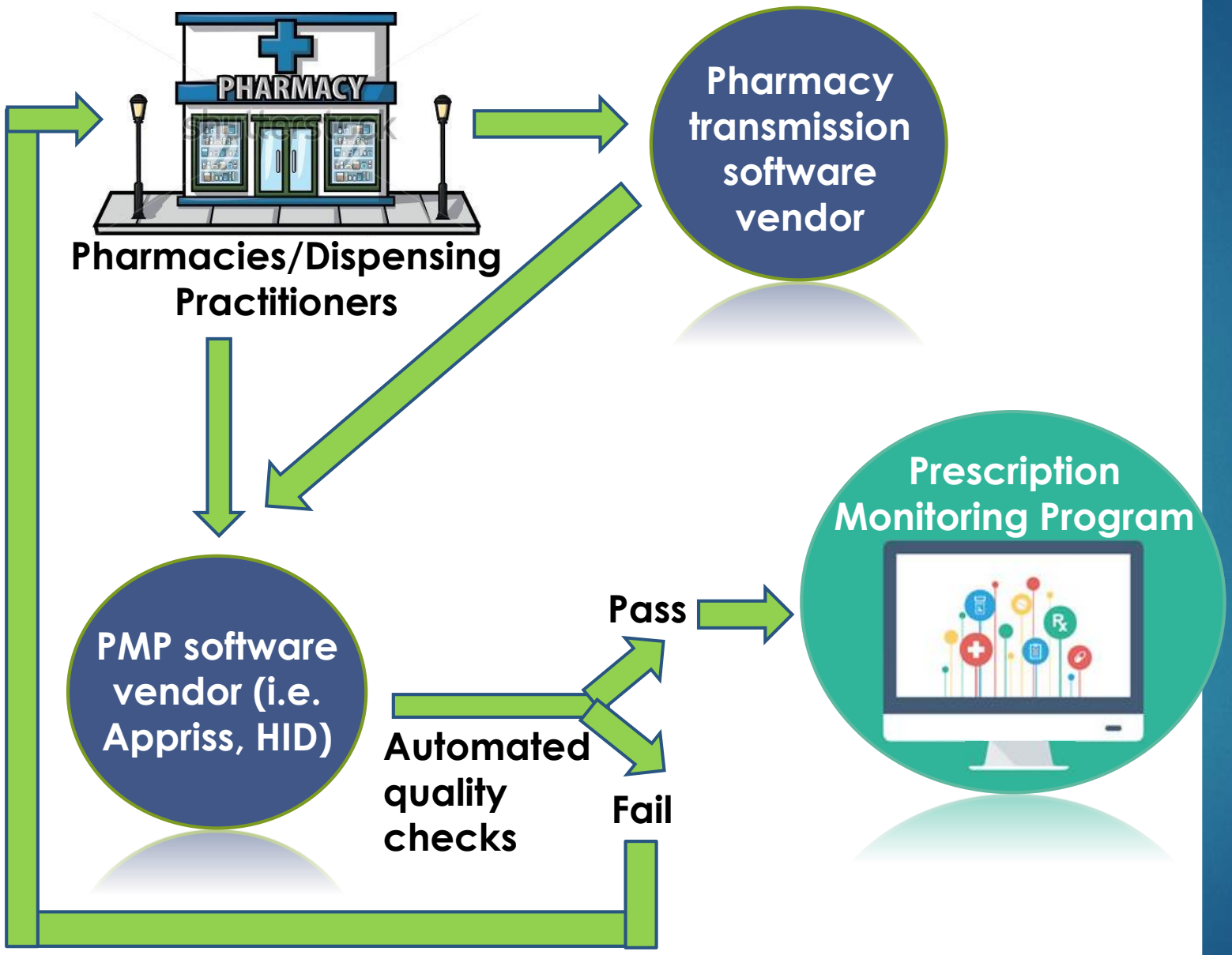


Automated Quality Checks

- RX data transmitted to the PMP undergoes automated quality checks prior to being uploaded.
- RX records that fail receive error message, are rejected, allowing dispenser to correct and re-transmit data.
- Automated quality checks can detect missing info or incorrect characters in a data field, but generally cannot detect ***incorrect info*** → erroneous data transmitted to PMP

Nevada 2017 Audit Project

- Official PMP audit project launched February 2017
  - Hired a part-time Project Analyst through Harold Rogers Grant
  - Collaboration with Roseman University of Health Sciences

- Program Goal: Determine Nevada's PMP data accuracy by:
  - Implementing a standardized process for evaluating its accuracy
  - Taking the necessary steps to correct the data if errors are identified
  - Prevent incidences of errors

Audit Methodology

- All licensed pharmacies and dispensing practitioners in Nevada undergo an annual Board of Pharmacy (BOP) inspection per regulation

PMP staff provide list of dispensers up for inspection each month → PMP dispensing history from study period pulled for each dispenser → Pre-selection of 8 RXs per dispenser → Form generated for each dispenser detailing required information for audit → Inspector collects required 10 RXs upon inspection

Audit Methodology

- 10 RXs collected from each dispenser

8 Rx's pre-selected (Rx #'s given to dispenser)

- Filled 9/1/16-10/31/16
- 4 narcotics, 2 stimulants, 2 sedatives

2 additional Rx's selected at inspection

- Filled 9/1/16-10/31/16
- Schedule II, III or IV

Error Categorization

Minor (1-2)	Major (3-4)	Severe (5-12)
1. Missing/incorrect/misspelled phone # or address of the pt 2. Incorrect days supply	3. Incorrect quantity dispensed; not indicating partial fill 4. Incorrect date issued or date dispensed	5. Missing/incorrect pt DOB 6. Misspelled pt name 7. Wrong pt 8. Wrong drug; incorrect drug name; inactive rather than active ingredient reported for a compound 9. Missing/incorrect prescriber DEA# 10. Wrong prescriber 11. RX not reported to the PMP (noncompliance, wrong ASAP file format, vendor software error) 12. MISFILL – REFER to Pharmacy Board

Data Submission Non-Compliance and Error Correction Process

**Only for "Severe" errors (types 5-12)*

Data Submission Non-Compliance/Data Error Identified by Project Analyst

1st Notification- Email
(1 week to correct)

2nd Notification- Email
(1 week to correct)

Final Notice
Certified letter from BOP

Disciplinary Action

Corrections made within time period

Case Closed: Documented in an electronic file

Error Correction

- Dispensers that have not corrected errors by the deadline given in the letter from the BOP will face possible disciplinary action by the Board.

- If data errors are discovered which caused harm to a patient, potential harm to patient, or issues for a prescriber the PMP team members will directly refer this matter to the BOP through the BOP complaint process.

Nevada Regulations

- Nevada regulation (NAC 639.926) require pharmacies/dispensers to transmit controlled substance RX (II-V) info to the PMP
- Failure to transmit the info can result in a fine of $100 for each day of the violation up to a fine of $10,000

Audit Project Timelines

- Year 1 (February 2017 – January 2018)
- January 2018 Newsletter – education provided to dispensers on initial audit results
- Year 2 (July 2018 - June 2019)

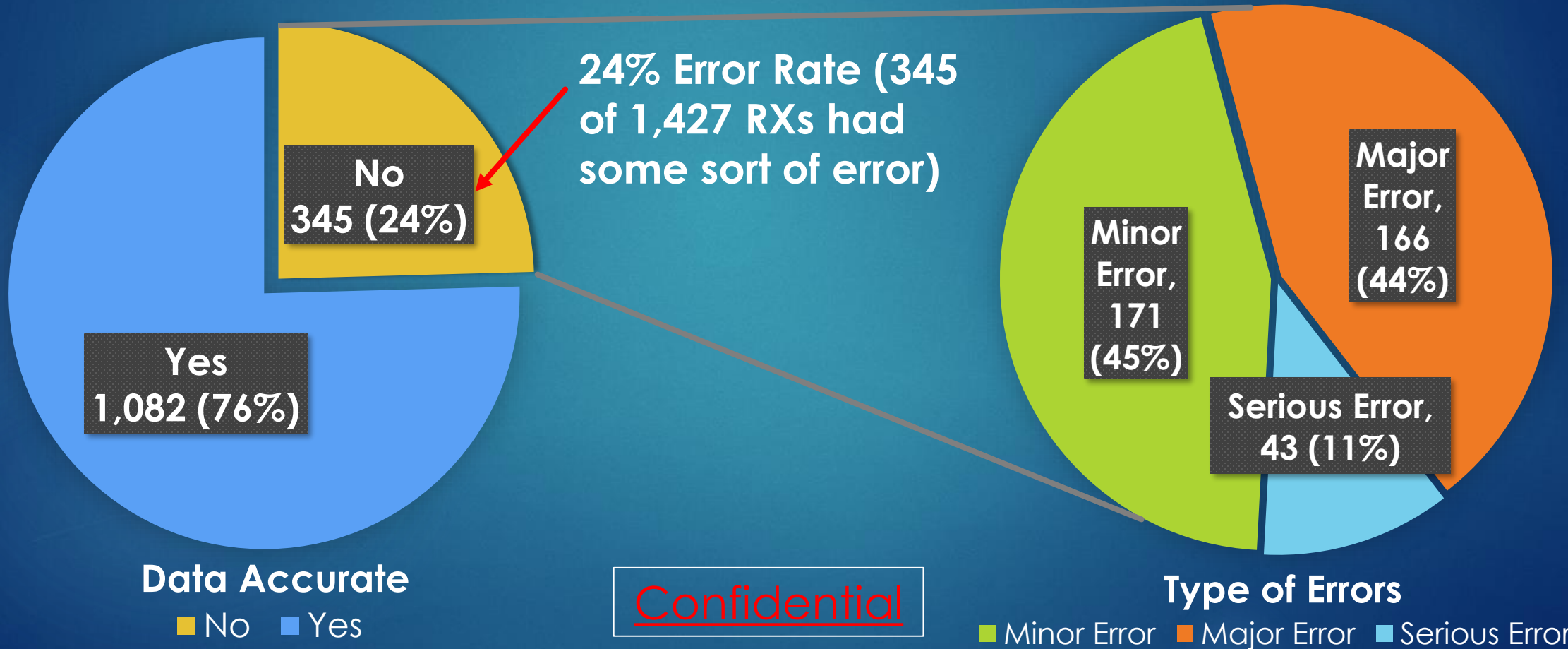
Legislation Changes

- Assembly Bill (AB) 474 Effective January 1, 2018
  - Requires practitioners to clearly indicate their DEA number and all controlled substance prescriptions
  - Days supply to be provided by the practitioner

PRELIMINARY* Findings

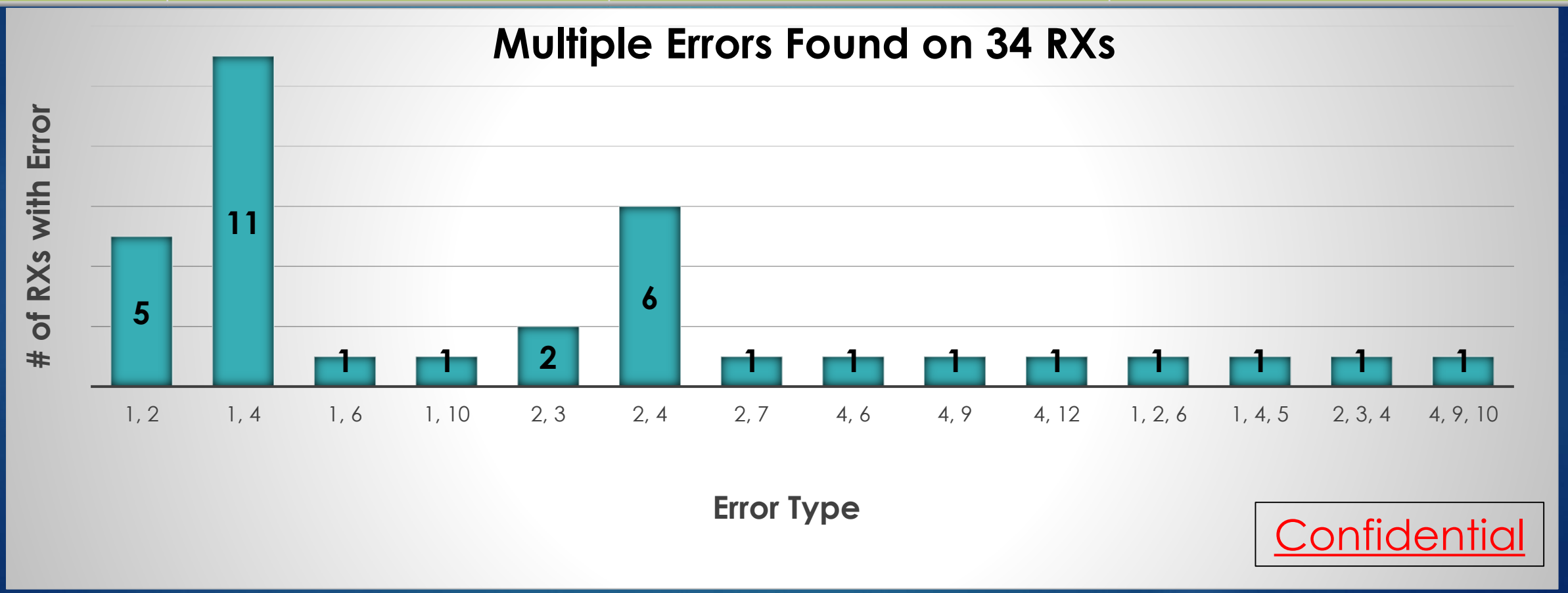
Feb 1st, 2017 – Feb 1st, 2018

1,427 RXs audited (a few *pharmacies did not have all 10 RXs)*



* The information above is from preliminary research and may not reflect the actual numbers.

Error Key			
Minor: 1-2 **Serious: 3-4** **Fatal: 5-12**	**1. Missing/incorrect/misspelled phone # or address of pt** **2. Incorrect days supply** 3. Incorrect quantity dispensed; not indicating partial fill **4. Incorrect date issued or date dispensed**	5. Missing/ Incorrect pt DOB 6. Misspelled pt name 7. Wrong pt 8. Wrong drug; incorrect drug name; inactive rather than active ingredient reported for a compound	9. Missing/incorrect prescriber DEA# 10. Wrong Prescriber 11. RX not reported to the PMP (noncompliance, wrong ASAP file format, vendor software error) 12. MISFILL – Refer to Pharmacy Board



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Confidential

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Challenges

- Informing pharmacies of new inspection process
- Time consuming
  - Pharmacy inspectors
  - Pharmacy personnel
  - Shear number of errors – error correction process

Challenges

- Pharmacies have different processes or use different vendors to transmit PMP data → difficult to provide guidance to pharmacies who need to correct/address PMP data errors

- Dispensers' miscommunication and frustration with their data transmission software vendor and with PMP software vendor

Questions?

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