Summary of Outcomes

Real Time Prescription Monitoring Workshops

April to June 2019



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# Background and Objectives

The Department of Health has commenced a project to enhance the existing monitoring program for Schedule 8 (controlled drugs) in Western Australia, which includes the adoption of a new electronic system capable of providing Real Time Prescription Monitoring (RTPM).

The intention of this system is to provide health professionals with online access to real time prescribing and dispensing history for controlled drugs and contribute to any national system that may be introduced.

As part of this project, the Department conducted three workshops to engage with key stakeholders and gain more information on issues relevant to the potential users of the system. A list of organisations that participated in these workshops can be found in Appendix A

The first workshop, held on 17 April 2019, focussed on additional high risk Schedule 4 medicines that should be considered for monitoring and become reportable. Topics included:

* Factors influencing the designation of Schedule 4 medicines as reportable;
* Recommendations for which Schedule 4 medicines should be reported and monitored;
* Basis for requiring authorisation to prescribe Schedule 4 reportable medicines; and
* Implications for prescribers and pharmacists.

The second workshop held on 16 May 2019 focused on issues such as whether checking a patient history should be mandatory for prescribers and pharmacists. It also considered which criteria and patterns of risk were appropriate for creating patient alerts. Topics included:

* Defining doctor shopping;
* Factors influencing RTPM patient alerts; and
* Exemptions for checking RTPM when mandated.

The third workshop held on 19 June 2019 focused on other key aspects of the system that impact on the clinical practice of the health professional, resources and support for prescribers and pharmacists and transition periods. Topics included:

* Role of Department of Health in informing prescribers, pharmacists and consumers;
* Information for consumers;
* Australian Health Practitioner Regulation Agency (AHPRA) access to RTPM data;
* Measurement of efficacy of RTPM;
* Transition periods for implementation and roll out; and
* What comes next?

# Workshop One

## Factors for reportable Schedule 4 medicines

Workshop participants were asked to rank eight identified factors that might influence the designation of a Schedule 4 medicine as a reportable item.

The results outline the factors that workshop participants considered most important when considering whether a Schedule 4 medicine should be reported and monitored to be:

* the current harm the medicine confers, e.g. morbidity and mortality;
* risk of abuse;
* risk of dependence; and
* evidence of increased abuse and misuse of the Schedule 4 medicine.

## Specific Schedule 4 medicines to be reported

Workshop participants were asked to rank types of specific Schedule 4 medicines in order of priority for inclusion in RTPM reporting and monitoring.

7th

4th

6th

5th

3rd

1st

2nd

S8 = Schedule 8 medicine

z-drugs = zolpidem, zopiclone and zaleplon

The results indicate that workshop participants considered benzodiazepines as a clear priority for monitoring, followed by tramadol, non-Schedule 8 codeine-based products, and then gabapentanoids.

Stakeholders did highlight that benzodiazepines are often co-prescribed with opiates, with evidence indicating a higher risk of mortality when these two groups of medicines are taken together.

## Authorisation to prescribe Schedule 4 reportable medicines

Workshop participants were asked to rank six possible factors, to be considered by the Department of Health, when deciding if an authorisation is required prior to prescribing a Schedule 4 reportable medicine.

S8 = Schedule 8 medicine

S4R = Schedule 4 reportable medicine

The factors identified by workshop participants as most important to determine whether authorisation should be required from the Department of Health prior to prescribing a Schedule 4 Reportable medicine was, when it was used in combination with a Schedule 8 medicine, length (duration) of treatment, and dose.

## Implications for prescribers and pharmacists

Workshop participants were asked to identify how RPTM may affect workload and workflow. Items identified included:

* even with integration into dispensing and prescribing software, there will be re-training, administrative changes, and associated costs with use of RTPM;
* Reportable Schedule 4 medicines will be channelled to the National Data Exchange (NDE), prescription records will be immediately visible, and require immediate attention of the prescriber and pharmacist;
* patients of concern could be identified early in the patient–doctor consultation process, which would enhance patient care;
* prescribers would need timely responses to applications to prescribe a Schedule 4 reportable or Schedule 8 medicine from the Department of Health;
* it will be easier for prescribers to identify over supplied and drug dependent patients, for which they may require added support and education to assist treating these patients;
* many General Practitioners are not aware of the Clinical Advisory Service offered by Next Step Drug and Alcohol Services;
* risks associated with rapid reduction or cessation of benzodiazepines and opioids, require close medical management and patient cooperation;
* oversupplied and drug dependent patients may turn to hospital emergency departments, which should be included in the RTPM system; and
* the *Medicines and Poisons Act 2014* prohibits the self-prescribing of a Schedule 4 Reportable medicine.

# Workshop Two

## Doctor shopping

Workshop participants were asked to consider the most appropriate criteria for raising an alert of potential doctor shopping patients, using the following parameters:

* Number of different prescribers visited by a patient; and
* Period of time.

Workshop participants indicated that a patient visiting four or more different doctors over a two month period should be considered indicative of potential doctor shopping behaviour.

## Patient alerts

Workshop participants were asked to rank fourteen possible factors that might be used to generate patient alerts from available RTPM data, which would assist in management of patients.

MEqD = morphine equivalents per day

DDP = Drug Dependent Person

OSP = Oversupplied Person

CPOP = Community Program for Opioid Pharmacotherapy

BZD: benzodiazepine, Rx: prescription

Workshop participants determined that the most critical factor for creating a patient alert should be when the patient has been prescribed greater than 90mg morphine equivalent per day, or the patient is an oversupplied or drug dependent person.

## Exemptions from mandatory use

Workshop participants were asked to rank ten potential situations where a prescriber might be exempted from any mandatory rules in place that require the checking for a patient history or alert supplied by the RTPM system.

Rx = prescription

S8 = Schedule 8 medicine

The workshop participants indicated that the prescriber might be exempted from checking a patient history or alert in the following situations:

* acute emergency service;
* patient is in palliative care;
* the system is unavailable;
* prescriber or pharmacist is under duress; and
* the patient is in a residential care facility.

Workshop participants also indicated that where a RTPM alert had been reviewed by the prescriber and a considered decision made to prescribe, that it should be incumbent on the prescriber to advise the pharmacist as part of the prescription, that a specific decision had been made.

# **Workshop 3**

## **Role of the Department of Health**

Workshop participants were asked to identify areas of RTPM use that will require further supports and resources for health professionals and patients.

Workshop participants indicated that the following areas should be considered as requiring attention and support when implementing RPTM:

* an increased demand for referral to drug and alcohol services;
* clear and simple pathways for prescribers to refer into drug and alcohol services;
* education of prescribers and pharmacists around the role of, and services provided by drug and alcohol services in Western Australia;
* difficulties experienced by country patients in accessing drug and alcohol services;
* education of prescribers and pharmacists to communicate effectively and empathetically with patients who may have dependence issues; and
* strategies for pharmacists presented with high-risk prescriptions, when the prescriber or Department of Health are not contactable for assistance.

Workshop participants were also asked about relevant considerations when designing education tools for the successful implementation and use of RTPM by practitioners. Responses included that:

* a wide range of different tools is needed;
* the changes to codeine scheduling were identified as a good example of using engaged stakeholders and networks;
* faxes and letters were still an effective way to reach prescribers and pharmacists;
* online learning modules for prescribers and pharmacists needed to contribute towards continuing professional development points;
* there should be appropriate leverage of existing resources such as:
	+ National Strategic Plan for Pain Management;
	+ Next Step Drug and Alcohol Services; and
* pharmacists at the “front line” require additional supports to be properly equipped to manage problematic prescription medicine use.

Workshop participants were asked for their opinions on consumer education and awareness in relation to RPTM. They identified important concerns as including:

* that monitoring is about saving lives and is not punitive;
* the medical risks of high dose opioid use needs to be emphasized;
* RTPM only provides prescribers and pharmacists with data;
* not all prescribers might have the required skills to manage problematic prescription medicine use; and
* best pain management may not always involve “jumping straight to a prescription”.

## Access to RTPM data by other regulators

Workshop participants were asked if bodies such as AHPRA should have access to RTPM data, where this may have a bearing on the competent practice by prescribers or pharmacists. Based on existing data requests; participants were asked regarding the relevance of access to:

* a prescribers pattern of Schedule 8 and Schedule 4 Reportable prescriptions;
* correspondence from the Department of Health regarding authorisation of prescribing; or
* no access.

DoH = Department of Health

S8 = Schedule 8 medicine

S4R = Schedule 4 reportable medicine

Currently AHPRA can compel provision of records as part of an investigation. This would include the prescribing history of Schedule 8 medicines.

Workshop participants indicated that AHPRA was believed to have a remit that did not extend to constructive feedback on prescribing habits.

Participants indicated that unrestricted access to prescribing history for this regulator may help identity a small number of prescribers with questionable prescribing habits, but would create unnecessary complications for the larger cohort of compliant prescribers.

## **Monitoring efficacy of RTPM**

Workshop participants were asked to rank four identified factors as valuable to evaluate the efficacy of RTPM.

S8: Schedule 8 medicine, S4R: Schedule 4 “reportable” medicine.

Workshop participants strongly agreed that a reduction in deaths from prescription opiate use would be the primary indicator of efficacy of RTPM.

## Transition period

Workshop participants were asked to choose between options for a transition period in the introduction of RTPM before prescribers and pharmacists will be mandated to check and use the system. Options proposed included:

* 6 months;
* 12 months; or
* 18 months.

Workshop participants strongly supported a 12 month transition period.

## Timing of alerts

Workshop participants indicated that a patient alert should be visible on their system as early as possible in the normal patient consultation process.

## Next Steps

The next steps to implement RTPM in Western Australia were outlined to participants:

* the existing Department of Health database for monitoring Schedule 8 medicines;
* the new database will interface with the Commonwealth’s NDE;
* access to the NDE will be opened to prescribers and pharmacists;
* a transition period is anticipated to occur prior before mandatory use (if any) of RPTM is imposed; and
* other States and Territories connect to the NDE and interjurisdictional data sharing occurs to form a national RTPM system.

# Appendix A: Organisations that participated in the Workshops

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| --- |
| * Alcohol and Drug Foundation
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| * Alcohol and Other Drug Consumer and Community Coalition
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| * Australian and New Zealand College of Anaesthetists: Faculty of Pain Medicine
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| * Australian College for Emergency Medicine
 |
| * Australian Health Practitioner Regulation Agency
 |
| * Chief Pharmacist Forum
 |
| * Fiona Stanley Hospital, Pain Management Clinic
 |
| * Health Consumer Council
 |
| * Mental Health Commission
 |
| * West Australian Department of Health, Public and Aboriginal Health Division
 |
| * Next Step Alcohol and Drug Services
 |
| * Pharmacy Guild of Australia
 |
| * Pharmaceutical Society of Australia
 |
| * Royal Australian and New Zealand College of Psychiatrists
 |
| * Royal Australasian College of Physicians: Chapter of Addiction Medicine
 |
| * Royal Perth Hospital, Pain Medicine Centre
 |
| * The Royal Australian College of General Practitioners
 |
| * The Society of Hospital Pharmacists of Australia
 |
| * West Australian Primary Health Alliance
 |
| * Western Australian Network of Alcohol and other Drug Agencies
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