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## Enhancing Safety for Patients and Family Medicine Practices

*Due Diligence in Prescribing Narcotics/Opioids and other Controlled Substances*

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*This article was written in collaboration with Rashmi Chugh, MD, MPH, Chair, Sachin Dixit, MD and Renee M. Poole, MD, members of the IAFP Public Health Committee, and Vince Keenan, MSPH, CAE, IAFP executive vice president and staff for the IAFP Public Health Committee.*

**S**ir William Osler (1849-1919) wrote "...the family doctor is the man behind the gun, who does our effective work. That his life is hard and exacting; that he is underpaid and overworked; that he has but little time for study and less for recreation—these are the blows that may give finer temper to his steel, and bring out the nobler elements in his character." Lately the family doctor is one of the clinicians considered by many to be behind the national epidemic of unintentional prescription opioid overdose deaths, now responsible for more overdose deaths than heroin and cocaine combined. A recent report authored by the Centers for Disease Control and Prevention (CDC), the University of North Carolina Chapel Hill School of Medicine and Duke University Medical Center, published in the *Journal of Clinical Psychiatry*, April 19, 2011, found that in 40% of the United States, unintentional drug overdose kills more people than motor vehicle accidents and suicide. The report blamed the primary care clinicians' and psychiatrists' failure to follow guidelines and safe prescribing procedures for opioids for the severe increase in overdose deaths. (1)

Also in April 2011, the White House, in conjunction with the Office of National Drug Control Policy, the U.S. Drug Enforcement Administration (DEA), and the U.S. Food and Drug Administration (FDA), released a national action plan to fight prescription drug abuse.(2) The plan outlines several action items:

- Amend the Federal law to require practitioners who request DEA registration to prescribe controlled substances to be trained on responsible opioid prescribing practices as a precondition of registration. The training would include assessing and addressing signs of abuse and/or dependence.
- An Opioid Risk Evaluation and Mitigation Strategy that requires manufacturers to develop effective educational materials and initiatives to train practitioners on the appropriate use of opioid pain relievers.
- Continuing medical education (CME) efforts focused on the proper prescribing and disposal of prescription drugs to be developed by all federal agencies that

*(continued on page 4)*



Family medicine's fast fish! Life member Mary Pohlmann, MD wins big at the 2011 U.S. Masters Swimming Summer National Championships at Auburn University. Learn more about her in the Member Spotlight on page 19.

## IAFP News

(Cover story, continued from page 1)

support their own health care systems.

- Requiring the curricula of medical schools and other health professional schools to include instructions on “the safe and appropriate use of opioids to treat pain while minimizing the risk of addiction and substance abuse.” Polypharmacy involving opioids and other prescription pain medications, benzodiazepines, anti-depressants, and sleep medications (sedatives and hypnotics), with their potentially harmful additive effects, have each been independently identified by many as a significant problem. Therefore, this article focusing on opioids also includes discussion of other controlled substances.

Pain is one of the most commonly encountered diagnoses in a typical family medicine practice. Research has shown estimates ranging from 4-40% for the prevalence of chronic non-cancer pain. It is well recognized that a significant number of patients with chronic pain have or will have substance abuse problems or mental illness, especially depression and various mood and anxiety disorders. Further, the abuse and diversion of controlled substances by the same individuals who suffer from pain can be a difficult problem to diagnose and manage, even by the most knowledgeable and diligent family physicians.

On the other side, there is a significant body of evidence suggesting that both acute and chronic pain continue to be under-treated. This can also become a serious public health problem adversely impacting a patient's functionality or quality of life. I am aware of a patient who committed suicide on account of

severe uncontrolled pain associated with an advanced cancer!

Some of the increased abuse of opioids may be attributable to those who truly believe that medications prescribed by physicians may be safer than the ones available on the street. On the other hand, these medications may be more easily available and accessible because they are prescribed by a physician, filled at a legitimate pharmacy, and possibly covered by insurance.

In my various roles as the chair of the Illinois State Medical Licensing Board, president of a hospital medical staff, chair of a clinical department of family medicine, a physician advisor at another hospital, president of the county and state medical society, chair of a peer review committee at a county medical society, and a Chief Medical Officer at a federally qualified community health center, I have witnessed unfortunate situations when some of our most respected and well-intentioned but unsuspecting colleagues were hit with a variety of sanctions, reprimands, expulsions from a professional membership society or a hospital medical staff, restrictions or loss of their privileges, or an outright loss of their DEA or state license to practice medicine or to prescribe controlled substances.

Usually these investigations are triggered by charges or complaints of over-prescribing by colleagues, nurses, pharmacists, patients or their families. Patients and families frequently seek redress when there is an adverse reaction or death of a person receiving one or more controlled substances, especially with uncertain indications. The documentation in their medical records, in many of these cases, did not support initial prescription or continuation of one or more controlled substance prescriptions; yet there was a “clock-like” visit and prescription pattern every week or every month. In some records, there was no indication of the location, frequency, intensity or etiology of pain and no effort had been made to

determine the cause of a patient's pain, and nothing except a narcotic was tried to control that pain. No consultations, no monitoring, and no attempts to wean or decrease the dose were noted. However, the dose was usually escalated or another controlled substance (a narcotic, anti-depressant or a tranquilizer) added, any time the patient complained the pain was not controlled. The investigators concluded the prescriptions were being sold in return for an office visit charge, since no other service was performed! The records were mostly silent. Indefensible, is the word.

Then, there are some high profile cases of Elvis Presley, Michael Jackson and others who died as a result of their chronic prescription drug use, made possible due to actions of physicians and other caregivers who disregarded their patients' safety. Stories in the media revealed multiple prescribers, who were frequently not aware and not communicating with each other.

The Federation of State Medical Boards developed a Model Policy for the Use of Controlled Substances for the Treatment of Pain in 2004, “to clarify the board's position on pain control, particularly as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.” That model policy has been adopted by several constituent state medical boards, specialty boards and medical societies. (3). Guidelines developed and published by the American Academy of Pain Medicine in 2009 are more specific but may not be applicable to all practices. (4).

The IAFP Public Health Committee chaired by Dr. Rashmi Chugh discussed this issue at length in 2010 and appointed a subcommittee on Narcotic Policy of Drs. Arvind K. Goyal, Sachin Dixit and Renee M. Poole to propose recommendations which could help family physicians develop policies they could implement and follow in their own practices. These following recommendations on page 6 have been

approved by the IAFP Public Health Committee but not adopted by the IAFP Board or any other professional association or a regulatory body. However, they represent a reasonable balance, a template that could be modified to suit one's practice and patient population.

Another template was developed to help family physicians create a Chronic Pain Medicine, Narcotic/Opioid & Controlled Substance Agreement with their patients, popularly called a "Contract", which would serve to formalize those physician-patient discussions.

These recommendations and agreements may need to be tailored further when used for patients with cancer or other terminal illnesses, and may not be necessary in many of those cases. The IAFP Public Health Committee will be very interested in your feedback and your suggestions for improvement. You may also wish to share your written policies and agreements you already use. Email them to [iafp@iafp.com](mailto:iafp@iafp.com).

Remember, that professionalism is a social contract between the professionals and a larger society that is based on trust, and carries with it certain privileges and responsibilities, one of which is, "To establish, maintain, and apply standards of educational practice that are aimed at assuring excellence." These recommendations from your colleagues and ensuing dialogue should be a step in that direction.

#### REFERENCES:

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2. [http://www.hcplive.com/articles/Obama-Administration-Releases-Plan-to-Deal-with-Prescription-Drug-Abuse-Epidemic?utm\\_source=Listrak](http://www.hcplive.com/articles/Obama-Administration-Releases-Plan-to-Deal-with-Prescription-Drug-Abuse-Epidemic?utm_source=Listrak) (published April 19, 2011)

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4. Chou R, Fanciullo GJ, Fine PG, et al; American Pain Society-American Academy of Pain Medicine Opioid Guidelines Panel. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *J Pain*. 2009;10(2):113-130.



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**Link to the Public Health Committee's sample Chronic Pain Medicine, Narcotic/Opioid & Controlled Substance Agreement web site address:** [www.iafp.com/whatsnew/ChronicPainMedicine-Contract.pdf](http://www.iafp.com/whatsnew/ChronicPainMedicine-Contract.pdf)

#### IAFP CME Available!

[www.iafp.com/education](http://www.iafp.com/education)  
The "Pain Management with Opioid Drugs in Primary Care Practice" program will cover the Epidemiology of chronic, non-cancer pain (CNCP), help define treatment goals, and discuss pain management methods and risk management.

#### AAFP opposes White House proposal of mandatory CME for providers

AAFP president Roland Goertz, MD recently addressed AAFP's opposition to provisions in the White House strategy to address prescription drug abuse in the August 25 issue of AAFP News Now.

"The White House recently announced a multifaceted strategy to curb what it is calling an "epidemic" of prescription drug abuse. Although there are portions of the White House plan (e.g., enhanced monitoring, surveillance and enforcement efforts) that deserve our support, there is one aspect that we cannot accept: the call for mandatory CME for health care professionals who prescribe controlled substances...

...In March, Sen. Jay Rockefeller, D-W. Va., introduced a bill that would amend the Controlled Substances Act and that calls for prescribers to complete 16 hours of mandatory CME related to opioids and pain management every three years.

According to the Obama administration, if this legislation becomes law, physicians would be required to complete the CME to receive or renew their DEA registration, regardless of whether they write prescriptions for long-acting opioids. This approach not only places an undue burden on physicians, it does not address the real and rapidly growing problem of drug diversion."

Link to Goertz's entire column at <http://www.aafp.org/online/en/home/publications/news/news-now/opinion/20110824opioidvoices.html?cmpid=10036-em-1>

## Recommendations for a Model Controlled Substance Policy for Family Practice

*Submitted by the IAFP Public Health Committee, September 2011*

- a. Family Physicians should adopt a reasonable Chronic Pain Medicine, Narcotic/Opioid and Controlled Substance Policy which fits their practice and patient population and follow it every day, for every patient and at each encounter.
- b. The policy need not be applied to prescriptions written for less than two weeks at a time, renewable only once (total of 28 days) for treatment of acute pain and other symptoms.
- c. Confirm the identity of all patients at registration. All patients should be checked for some form of legal identity at the time of check in process. Patient should be screened for different names/namesakes as well, if feasible.
- d. With few exceptions, post-surgical pain management should be continued by the surgeon who performed a given surgical procedure. For each exception, there should be a written consult, a letter or documentation of a phone conversation in the patient's medical record specifying the exception.
- e. For prescriptions beyond a total of 28 days, it is recommended that the medical record documentation include:
  - (a) Completion of appropriate evaluation including history and physical exam, nature and intensity of the pain, current and past treatments for pain, sleep, and depression, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, past history of substance abuse and investigation of the cause of symptoms.
  - (b) The presence of one or more recognized medical indications and relative contraindications for the use of the prescribed medicine/s.
  - (c) Recommendation and arrangement for consultation with appropriate specialists specializing in pain management, psychiatry, rehabilitation medicine, musculoskeletal disorders and nerve disorders, etc. A written consult report or documentation of a phone conversation with the consultant should be available in the patient's medical record.
  - (d) Consideration and discussion with the patient regarding alternatives to requested or intended prescriptions for chronic pain medicine/s, narcotics/opioids and controlled substances including non-pharmacological and oral and topical non-opioid therapies.
  - (e) Illinois Prescription Information Library accession by prescribing physician or designated staff initially or every 90 days ([www.ilpmp.org](http://www.ilpmp.org)) and documentation in the patient's medical record.
  - (f) Discussion with the patient of the indications and common potential side effects and risks of prescribed medicine/s, need to avoid alcohol and all illegal drugs, limit of no more than 28 day supply at a time with no possibility of replacement if lost or stolen, non-availability of phone prescription refills therefore requiring a face to face office/clinic visit and documentation of progress by the physician or clinician at least once every 28 days, safe keeping of all medicine/s for personal use only, agreement to not get narcotics/opioids and controlled substances prescriptions from any other physician, clinician or ER, agreement to use only one pharmacy, and availability for random urine and serum drug screen without advance notice. Alternatively, a "Narcotic Contract" or agreement developed to cover above expectations signed by the patient and witnessed preferably by a family member of the patient and placed or scanned in the patient's medical record will be acceptable.
  - (g) Statement of a plan to try and wean off/taper the prescribed medicine/s.
  - (h) Report of a standard Urine Drug Screen initially and every 90 days as a minimum. Additionally, Urine test for Oxycodone and a Serum Drug Screen test may be ordered based on the judgment by the prescribing physician.
  - (i) Documentation and appropriate action in case of a positive drug screen for an unprescribed medicine, a negative drug screen for a prescribed medicine, missed scheduled appointments, violent or threatened behavior, hospitalization, alcohol intoxication, intervening acute or new illness, or other instances of non-compliance with agreement and recommendations.
  - (j) Physicians should not avoid the prescribing of controlled substances in appropriate patients within the framework of such a policy.
  - (k) Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Objective evidence of improved or diminished function should be monitored and information from family members or other caregivers should be considered in determining the patient's response to treatment. Attempts to wean off or discontinue the medicine/s should match the documented progress in patient's medical record.
  - (l) If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities or referral to an appropriate consultant or rehabilitation facility for further care.



## Drug seeking - a lesson in creativity

By Jim Cunnar, MD  
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After 14 years of private practice, I think I've seen my fair share of the unbelievable. This week, I saw something new. A patient misspelled their name when they registered with our office. On purpose. You'll understand the importance of this in a minute.

In April, Karla, my physician assistant, saw a new patient who came in for a visit. He had moved to Illinois from out of state, and based on his medication list, we knew this patient was going to need careful monitoring. He was on a significant amount of narcotics and anxiety drugs. Karla came to me for guidance, and we decided that based on the sheer amount of narcotic he was taking (80+ milligrams a day), he would need to get his prescriptions through a pain management physician. So, we gave him some names, asked him to let us know when he secured an appointment with the pain specialist, and sent him on his way.

He called two weeks later, saying he was going out of state and was afraid of running out of medicines. He said he had an appointment with the pain management doctor for when he returned. So, I refilled his medicines, but just one time, and made it clear to the patient I wouldn't refill them again.

This past week, we received a fax from a local big-box pharmacy, with a list of prescriptions filled by the above patient, from 5 different physicians in the last 12 weeks. Narcotics, anxiety drugs, sleep medicines. And there was my name, scattered amongst the other physicians who were prescribing for him. The pharmacy was notifying us they wouldn't fill any further prescriptions

for the patient, because he was getting the same medicine from multiple prescribers.

The list which was faxed to us is from the Illinois Prescription Monitoring Program (IPMP). Controlled medicines, like narcotics, are reported by pharmacies to the state, which then posts the information on a website for prescribers and pharmacists. It's a fantastic resource, and 34 states have a monitoring program like this, [but Florida does not](#).

We checked this database the moment the patient left our office. The database didn't show any controlled substance prescriptions for him, because he misspelled his last name on his registration forms. ON PURPOSE. He knew we were going to check the database. The fax from the pharmacy listed the patient's birth date and name, but his last name was spelled differently. We actually addressed the spelling issue when he checked in, because his wife's insurance card had a different spelling on it. In addition, the patient conveniently had forgotten his driver's license, so we couldn't double-check his information against a legitimate form of ID.

We got a call from the pain management physician on Friday that the patient failed to show up for his appointment. I will be discharging the patient from our practice next week.

Chronic pain is a problem for millions of people. Narcotics are a mainstay of managing their pain. The difference between compliant patients and the addict I describe above is that compliant patients are exactly that. They keep appointments. They allow the doctors to count their medicines. They sign narcotic contracts. They don't take advantage of the physician.

Two or three times a year we get new

patients like this. A few years ago, we had no way to check if we were being played by patients seeking inappropriate prescriptions. The IPMP has changed the game. Physicians can remain compassionate, without thinking every patient requesting a strong pain medicine is a drug seeker. If we are suspicious, we can easily check to see if they are listed, and if their name doesn't come up, we can take care of them without concern.

Prescription monitoring programs should be in place in all 50 states. There is no reason why physicians and pharmacies shouldn't have the ability to check for patients who abuse medicines. The problem is, we aren't utilizing these resources like we should. If we checked these databases on each and every patient, it would be a significant deterrent to stop this type of behavior. If we could make it harder for them to get their fix, then maybe, with the grace of God, we could help them climb out of the hole of addiction.

*This blog post originally appeared June 6, 2011. Reprinted with permission from Dr. Cunnar. Follow his blog at <http://oncall24seven.blogspot.com>*

**Connect to the  
Illinois Prescription  
Monitoring program  
database at  
[www.ilpmp.org](http://www.ilpmp.org)**