

Preventing Prescription Drug Abuse

A Physicians's Perspective

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Personal Background

- Board certified and practicing emergency physician
 - Special interest in chemical dependency identification and treatment
- Former member of the California Medical Board
 - President of Division of Medical Quality
 - Vice-President of the Board
 - Member of the Pain Management Task Force
- Former police officer
 - Court recognized expert on drug and alcohol enforcement

Drug-Seeking Patient vs. Physician



Sample Clinical Case

- 28 y/o Armenian male with history of “Familial Mediterranean Fever” came to the emergency department by ambulance with severe abdominal pain.
- The patient was afebrile, but diaphoretic, tachycardic and rolling around the gurney in pain. He had a bag of emesis at his side.
- The patient requested Dilaudid by name citing an allergy to Toradol and Morphine.

Sample Clinical Case

- The patient was in the fetal position and refused examination until he received pain medication.
- The patient received 2mg of Dilaudid, IV fluids, anti-emetics. Labs and a CT scan of the abdomen were ordered.
- The patients mother was at the bedside asking that the patient receive more pain medication
- Each time lab draw or CT were to be performed, the patient refused asking for more pain medication.

Sample Clinical Case

- I became suspicious and began spying on the patient through an opening in the mini-blinds covering the window to the patient's room.
- The patient was observed looking around while moaning, putting a finger down his throat, and even getting out of the bed and doing pushups.
- The patient and his mother were summarily evicted from the emergency department.

The Problem

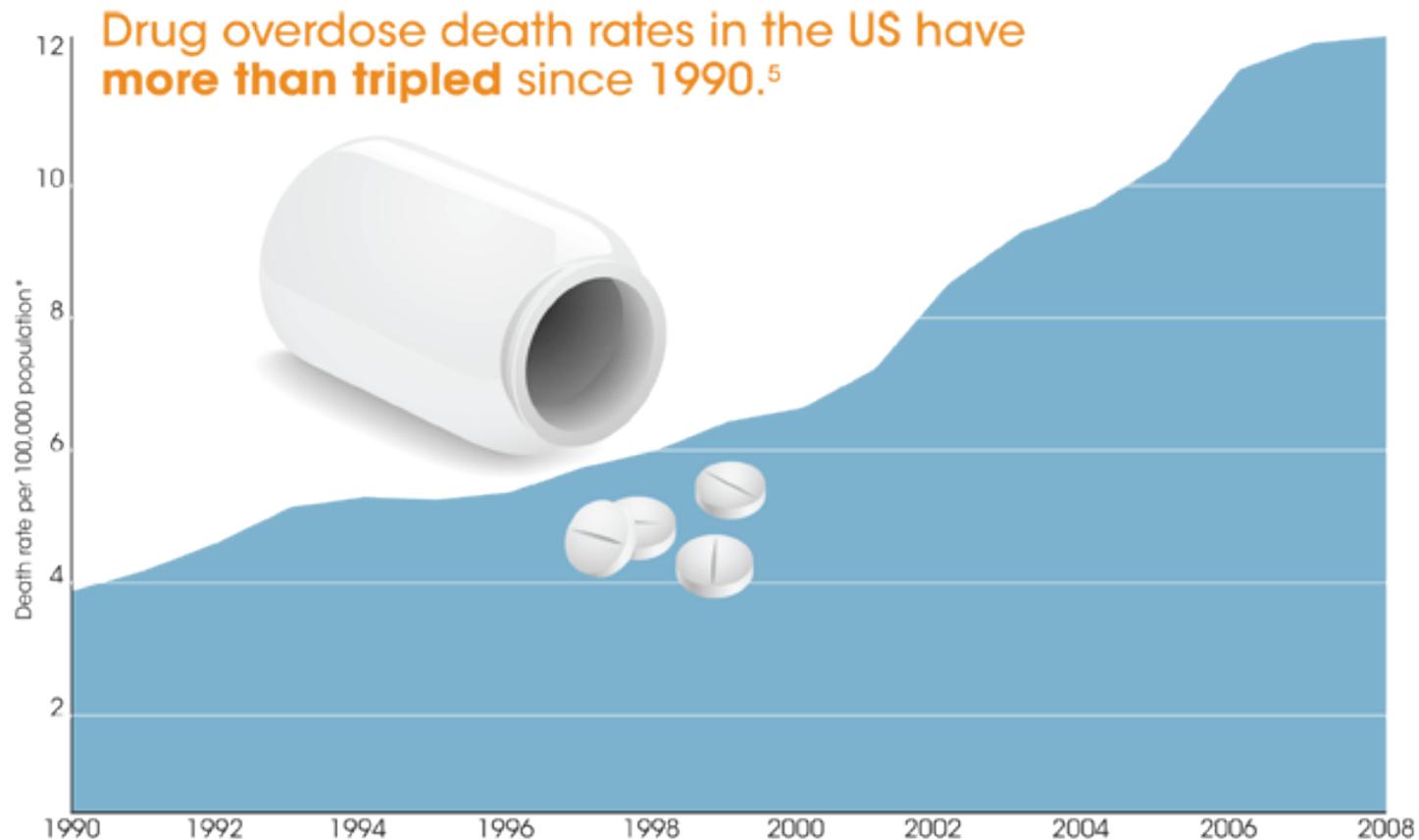


The Problem

- The United States makes up only 4.6 percent of the world's population, but consumes 80 percent of its opioids -- and 99 percent of the world's hydrocodone, the opiate in Vicodin.
- Gil Kerlikowske, the national drug czar, says the current culture of writing narcotic prescriptions for moderate pain, which began about a decade ago, needs to be changed and doctors need to be retrained.

Source: ABC News, April 20, 2011

The Problem – CDC Data



*Deaths are those for which poisoning by drugs (illicit, prescription, and over-the-counter) was the underlying cause.

The Problem – CDC Data

For every **1** death there are...



10 treatment admissions for abuse⁹

32 emergency dept visits for misuse or abuse⁶

130 people who abuse or are dependent⁷

825 nonmedical users⁷

The Problem – CDC Data

Who is most at risk:

- People who obtain multiple controlled substance prescriptions from multiple providers—a practice known as “doctor shopping.”
- People who take high daily dosages of prescription painkillers and those who misuse multiple abuse-prone prescription drugs.
- Low-income people and those living in rural areas.
- People on Medicaid are prescribed painkillers at twice the rate of non-Medicaid patients and are at six times the risk of prescription painkillers overdose. A Washington State study found that 45% of people who died from prescription painkiller overdoses were Medicaid enrollees.
- People with mental illness and those with a history of substance abuse.

The Problem – CDC Data

- Almost all overdose deaths come from physician prescriptions.
- Once they are prescribed and dispensed, prescription drugs are frequently diverted to people using them without prescriptions.
- More than three out of four people who misuse prescription painkillers use drugs prescribed to someone else.

The Rest of the World

- Pain is treated very differently in the rest of the world:
 - NSAIDS
 - Paracetamol / acetaminophen
 - Tramadol
 - Physical therapy
 - Traditional, herbal and/or supportive management
- In many countries narcotics only dispensed by a few government operated pharmacies
- Inpatient pain management is rarely dependent on narcotics

The Need for Dialogue



Not all Pain is the Same

- Acute
 - Fractures, dislocations, appendicitis, kidney stones, gallstones, etc.
- Chronic
 - Low back pain, arthritis, sickle cell disease, lupus, migraine headache, etc.
- Acute on chronic

Challenges

- Chronic pain that is poorly diagnosed and managed
- Over prescribing of narcotic pain medications, anxiolytics, barbiturates and antibiotics
- High dependence on opiates for initial treatment for pain
- Poor access to primary care
- Poor access to pain management specialists
- Poor access to drug treatment programs

Challenges

- Conflicting role of physicians as gate keepers, healers and licensed professionals
- Hospital and health plan focus on patient satisfaction
- Physician personalities that seek to avoid conflict
- U.S. recreational drug culture
- Mixed messages about drugs, i.e. “medical marijuana”

Challenges

- Societal conflict in the classification of addictions as a disease or a crime
- Poor communications between law enforcement, physicians, regulators and lawmakers.
- Boundary violations between physicians and patients
- Physicians criminally prescribing are a small percentage of the problem

Recommendations



Recommendations

- Physicians do not need additional pain management training; however, the Board's *Guidelines for Prescribing Controlled Substances for Pain* probably require an update (last updated in 2004)
- We must recognize and be comfortable with the notion that not all pain is the same, and not all pain treatment requires narcotics. The *Guidelines for Prescribing Controlled Substances for Pain* should emphasize the use of non-narcotic strategies.
- We must send a clear message that physicians, clinics, urgent care centers and E.R.'s can, and should, refuse to prescribe or deliver narcotics, anxiolytics, barbiturates and antibiotics when not medically indicated.

Recommendations

- We should renew our commitment to addressing substance dependence as a disease.
- Patients with chronic pain must be managed by their primary care physician, or pain management specialist. They should all have a contract that outlines strategies for managing break-through pain, and discouraging doctor shopping or E.R. visits.
- For patients with chronic conditions, the CURES database should be able to provide a diagnosis, the PMD contact info, and a copy of the pain contract.

Recommendations

- We must find ways to eliminate traditional paper prescriptions.
- Consider using barcodes on printed prescriptions to protect physician license and DEA numbers.
- Consider assigning a PIN to each DEA number so that unapproved prescriptions cannot be phoned in.
- EMR's can and should transmit electronic prescriptions to a single pharmacy, designated by the patient.

Recommendations

- Care must be taken when handling complaints resulting from patients that have been denied medications because there was no medical necessity for such.
- Programs such as MediCal, Medicare and private insurance must establish systems for monitoring prescription drug abuse, tied to additional medical evaluation, counseling, treatment, and/or legal action.
- Pharmacies, the Pharmacy Board and DOJ should be allowed greater flexibility in implementing prescription drug monitoring programs, which identify and report inappropriate prescribing and prescription drug abuse.

Recommendations

- We must improve communications between law enforcement and physicians, including the Medical Board and the medical societies
- DOJ needs a system for capturing patients that abuse injectable narcotics through frequent E.R. visits, but never appear in CURES because they do not fill prescriptions
- Physicians need the ability to store and share data on prescription abusing patients, both locally and amongst acute care facilities and EMS, without HIPAA concerns
- Physicians need a clear and simple way to report prescription abusing patients

Recommendations

- Prescription drug monitoring programs should be allowed to link with hospital and physician EMR's.
- Lawmakers should consider enhancement of criminal penalties for illegal prescribing, drug diversion, prescription forgery, and/or sale of prescription drugs not medically prescribed to the end user.

Recommendations

- I would encourage all interested media, regulators and lawmakers to spend a day with a physician at their local emergency department. The California Chapter of the American College of Emergency Physicians can assist in coordinating such visits.

San Diego County Perspective

Dr. Paul Negocian, MD

Safe Pain Medicine Prescribing in the Emergency Department

We are about you. We are committed to treating you safely and in the right way. Pain relief treatment can be complicated. Mistakes or abuse of pain medicine can cause serious health problems and death. Our emergency department will only provide pain relief options that are safe and correct.

For your SAFETY, we follow these rules when helping you with your pain.

1. We look for and treat emergencies. We use our best judgment when treating pain. These recommendations follow legal and ethical advice.
2. You should have only ONE provider and ONE pharmacy helping you with pain. We do not usually prescribe pain medication if you already receive pain medicine from another health care provider.
3. If pain prescriptions are needed for pain, we can only give you a small amount.
4. We do not refill stolen prescriptions. We do not refill lost prescriptions. If your prescription is stolen, please contact the police.
5. We do not prescribe long acting pain medicines: OxyContin, MSContin, Dilaudid, Fentanyl (Duragesic), Methadone, Opana ER, Exalgo, and others.
6. We do not provide missing doses of Subutex, Suvoxone, or Methadone.
7. We do not usually give shots for flare ups of chronic pain. Medicines taken by mouth may be offered instead.
8. Health care laws, including HIPAA, allow us to ask for your medical records. These laws allow us to share information with other health providers who are treating you.
9. We may ask you to show a photo ID when you receive a prescription for pain medicines.
10. We use the California Prescription Drug Monitoring Program called CURES. This statewide computer system tracks narcotic and other controlled substance prescriptions.

If you need help with substance abuse or addiction, please call 1-888-724-7240 for confidential referral and treatment.



Questions?



Thank You!



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