ARE YOUR OPIOID PRESCRIPTIONS FOR A LEGITIMATE MEDICAL PURPOSE?

Others may not agree, including:

State or Federal Governments,
Various Licensing Agencies,
Insurance Companies, and Juries

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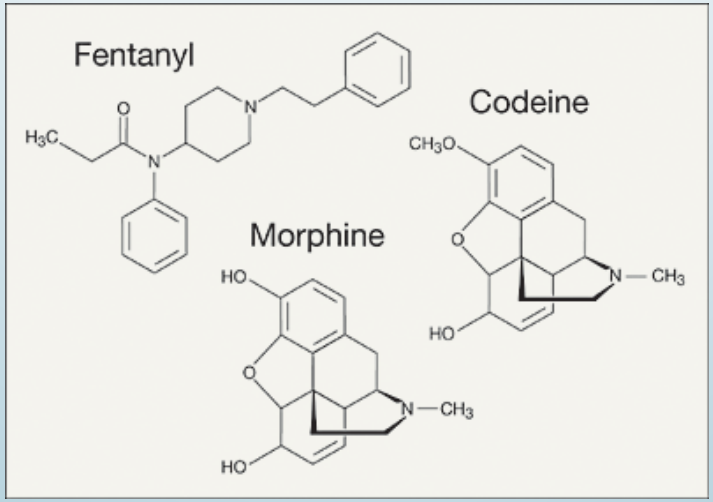
WHAT ARE OPIOIDS?

Opioid narcotics are drugs that bind to opioid receptors to block or reduce feelings of pain.

They are often prescribed for patients who have just had surgery or experienced physical trauma such as a car accident or serious sports injury.

They are also used in the treatment of many different forms of chronic pain.

These medications have turned out to be quite addictive, but why has their use increased so substantially?



THE MOST COMMONLY PRESCRIBED OPIOIDS INCLUDE:

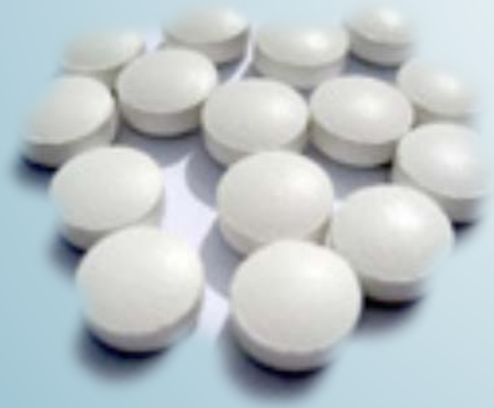
- Oxycodone (brand names: OxyContin, Roxicodone, Oxecta)
- Hydrocodone
- Methadone
- Fentanyl
- Morphine
- Codeine

The illicit street drug heroin is another form of opioid

OPIOID BACKGROUND

In 1996 the American Pain Society (APS) introduced the concept that pain was the fifth vital sign.

This initiative emphasized that pain assessment was just as important as assessing the standard four vital signs and that clinicians needed to take action when patients reported pain.



With this background, many opioid manufacturers heavily marketed their products to physicians.

CURRENT CRISIS

Fast forward to today and we are now facing a national prescription drug abuse epidemic with President Trump recently declaring the opioid crisis a public health emergency and calling opioids the “worst drug crisis in American history” with 175 people dying every day across our country from opioid overdoses.

POLITICS OCT 27 2017, 8:45 AM ET

Trump Calls Opioids ‘Worst Drug Crisis in American History’

by ALI VITALI

WASHINGTON — President Donald Trump declared the opioid crisis a public health emergency on Thursday and said the U.S. must confront "the worst drug crisis in American history."

The president said 64,000 Americans died from overdoses last year — 175 every day, seven every hour.

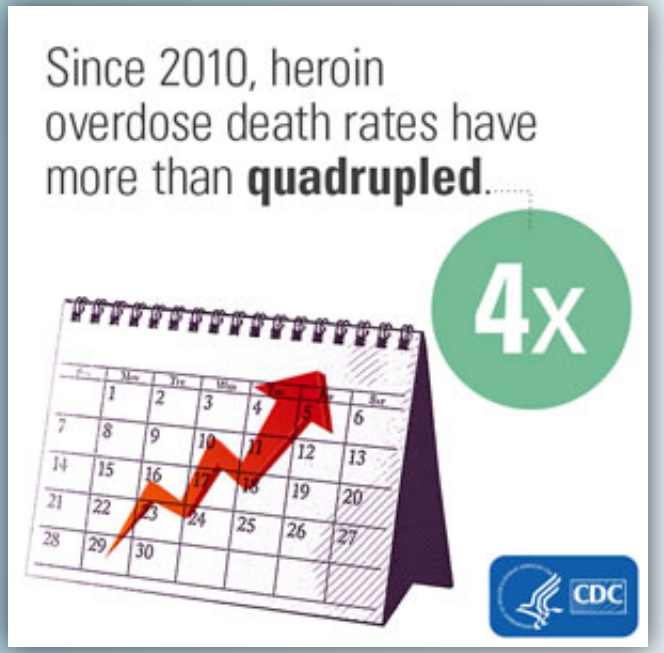
"This epidemic is a national health emergency," Trump said during an address at the White House. "Nobody has seen anything like what is going on now. As Americans, we cannot allow this to continue. It is time to liberate our communities from this scourge of drug addiction."

The president said, "We can be the generation that ends the opioid epidemic. We can do it."

Trump said he directed federal agencies to use all their resources to fight the drug crisis, including focusing on providing improved treatment for addicts.

https://www.nbcnews.com/politics/white-house/trump-declare-opioids-public-health-emergency-n814536

STARTLING STATISTICS



Researchers have found that more than one third of U.S. adults were prescribed an opioid medication in 2015 and that many of those admit to having misused the drugs.

From 1999 to 2014, the number of prescription opioids sold in America has almost quadrupled. Over the same period, prescription opioid deaths have more than quadrupled.

https://www.cdc.gov/drugoverdose/data/prescribing.html

STARTLING STATISTICS

According to the CDC, Most Commonly Overdosed Opioids
The most common drugs involved in prescription opioid overdose deaths include:

- Methadone
- Oxycodone (such as OxyContin®)
- Hydrocodone (such as Vicodin®)

Among those who died from prescription opioid overdose between 1999 and 2014:

- Overdose rates were highest among people aged 25 to 54 years.
- Overdose rates were higher among non-Hispanic whites and American Indian or Alaskan Natives, compared to non-Hispanic blacks and Hispanics.
- Men were more likely to die from overdose, but the mortality gap between men and women is closing.

https://www.cdc.gov/drugoverdose/data/overdose.html

STARTLING STATISTICS

Additional Risks

- Overdose is not the only risk related to prescription opioids. Misuse, abuse, and opioid use disorder (addiction) are also potential dangers.
- In 2014, almost 2 million Americans abused or were dependent on prescription opioids.
- As many as 1 in 4 people who receive prescription opioids long term for non-cancer pain in primary care settings struggles with addiction.
- Every day, over 1,000 people are treated in emergency departments for misusing prescription opioids.

https://www.cdc.gov/drugoverdose/data/overdose.html

STARTLING STATISTICS

West Virginia has the highest overdose death rate in the nation—**35 per every 100,000 people**. According to the Charleston Gazette-Mail, over a six-year period West Virginia was flooded with 780 million hydrocodone and oxycodone pills.

It is not surprising then that West Virginia is also the site of dozens of lawsuits filed against physicians, pharmacists, and drug wholesalers. These lawsuits claim that doctors, drug companies, and “pill mills” exploited patients, got them hooked on pills, and cost individuals and the state millions of dollars in medical and treatment expenses.

https://www.wvgazettemail.com/news/health/drug-firms-poured-m-painkillers-into-wv-amid-rise-of/article_99026dad-8ed5-5075-90fa-adb906a36214.html

STARTLING STATISTICS

The complaints claim that by prescribing and supplying these powerfully addictive drugs, the physicians and pharmacies in question caused the plaintiffs to abuse the opioids and even engage in criminal activity to obtain them. In many cases, plaintiffs lost jobs or wages as a result of their addictions.

It is only a matter of time until these claims will be making their way to Idaho to be filed not only by Plaintiff's attorneys, but also by state and local governments looking for ways to recoup substantial medical expenses paid out to treat these addictions.

https://www.wvgazettemail.com/news/health/drug-firms-poured-m-painkillers-into-wv-amid-rise-of/article_99026dad-8ed5-5075-90fa-adb906a36214.html

STARTLING STATISTICS

The national media regularly lament the large numbers of people needlessly dying every day in America as a result of narcotic prescription drug abuse, including high profile celebrities and sports stars like Prince, Michael Jackson, Philip Seymour Hoffman, Chyna and José Fernández, to name a few.

In response to this crisis, society has demanded the government step in and take action to better protect people from these powerful and deadly drugs and those who are prescribing and profiting from them. In this regard, the pendulum has now swung back away from treating pain as the fifth vital sign. Instead, many in society now view healthcare providers as the drug dealers who are getting their patients hooked on addictive pain medication.

How do we protect our clients and help to reverse this trend?

PREFERRED FIRST LINE OF DEFENSE – PROVIDER EDUCATION

Providers must revisit the very nature of practicing medicine as it relates to the prescribing of opioids.

They are no longer able to prescribe and treat the way many providers were actually taught just a decade ago in their medical schools and residency programs.

This re-education takes time and requires the effort of all providers. There are many resources available and providers must be **proactive** or risk becoming targets.

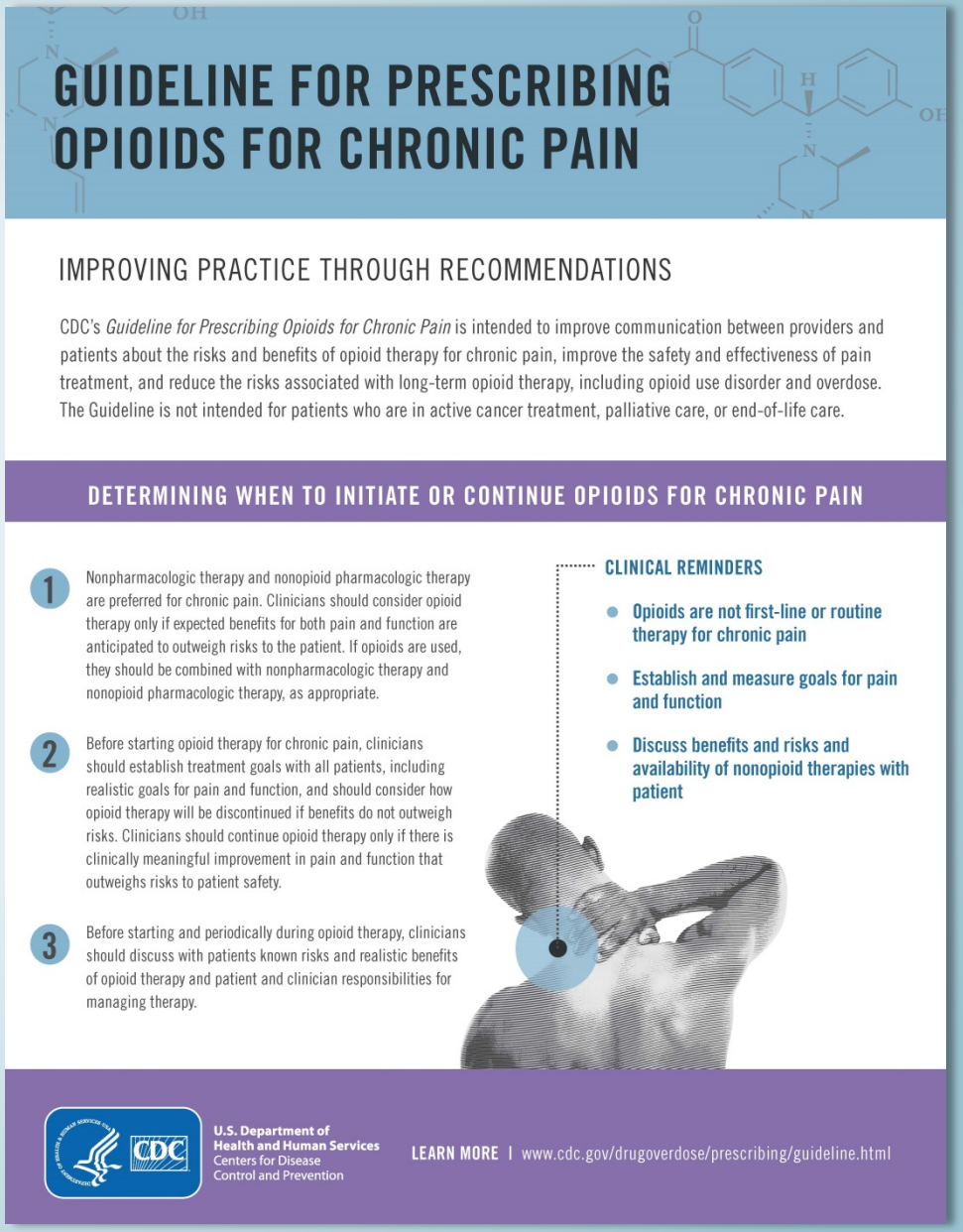
CDC GUIDELINES

The CDC Guideline addresses patient-centered clinical practices including conducting thorough assessments, considering all possible treatments, closely monitoring risks, and safely discontinuing opioids.

The three main focus areas in the Guideline include:

1. Determining when to initiate or continue opioids for chronic pain

- Selection of non-pharmacologic therapy, non-opioid pharmacologic therapy, opioid therapy
- Establishment of treatment goals
- Discussion of risks and benefits of therapy with patients



GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

CDC GUIDELINES

2.Opioid selection, dosage, duration, follow-up, and discontinuation

- Selection of immediate-release or extended-release and long-acting opioids
- Dosage considerations
- Duration of treatment
- Considerations for follow-up and discontinuation of opioid therapy

3. Assessing risk and addressing harms of opioid use

- Evaluation of risk factors for opioid-related harms and ways to mitigate patient risk
- Review of prescription drug monitoring program (PDMP) data
- Use of urine drug testing
- Considerations for co-prescribing benzodiazepines
- Arrangement of treatment for opioid use disorder

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4 When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5 When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6 Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7 Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9 Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12 Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

SECOND LINE OF DEFENSE – PROSECUTION OF PROVIDERS

Administrative Remedies - State Licensing Agencies

- Idaho Board of Medicine
  - Board Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain.

Providers prescribing over 150 narcotic pain pills per month to any of your patients, the federal government may already be monitoring your practice via your state's pharmacy profile. Many providers do not appreciate that the state is constantly monitoring providers all over Idaho to see how much they are prescribing. If the Boards of Pharmacy or Medicine gets suspicious, they will often send records requests and begin an investigation. If the provider's records do not measure up, some measure of professional discipline is likely to follow. This can result in loss of prescribing practices, agreements not to treat chronic pain, license suspension, re-education requirements, payment of administrative costs, required use of a proctor, etc.

SECOND LINE OF DEFENSE – PROSECUTION OF PROVIDERS

- Idaho Board of Pharmacy
  - State prescription drug monitoring program - records information including who prescribed, what prescribed, when filled, where filled and for what quantity – pharmacies have a legal obligation to ensure the validity of a prescription for an opioid before it is filled and if they question it, often they will forward it to the DEA in order to comply with federal law.

- Idaho Department of Health and Welfare
  - Medicaid Audits and Fraud Investigations – adverse findings often result in recoupment actions by the state and/or criminal charges by the Idaho Attorney General's office. These cases can result from over prescribing, improper coding, deficient recordkeeping, fraud, etc. This is a funding source for the state and federal government by seeking recoupment of hundreds of thousands of dollars in many instances.

SECOND LINE OF DEFENSE – PROSECUTION OF PROVIDERS

Criminal Remedies - Role of Federal Agencies

- Drug Enforcement Agency – drug trafficking
- U.S. Attorney's Office – federal criminal violations
- Department of Health and Human Services - Medicare Audits and Fraud Investigations

While issues concerning overprescribing often lead to administrative investigations of physicians by state boards of medicine, physicians are increasingly becoming the targets of devastating criminal prosecutions by the federal government.

Many health care providers do not appreciate the fact that under the federal Controlled Substances Act (CSA), it is illegal for "any person" knowingly or intentionally to distribute or dispense a controlled substance. 21 U.S.C. § 841(a).

SECOND LINE OF DEFENSE – PROSECUTION OF PROVIDERS

The CSA makes exceptions to this prohibition for certain individuals who are registered “practitioners” under the Act, such as physicians and pharmacists. See 21 U.S.C. §§ 821-23.

However, the Supreme Court has held that medical practitioners are still subject to criminal prosecution “when their activities fall outside the usual course of professional practice.” United States v. Moore, 423 U.S. 122, 124 (1975); see also 21 C.F.R. § 1306.04 (providing that a practitioner “shall be subject to the penalties ... relating to controlled substances” unless the prescriptions he or she writes are “issued for a legitimate medical purpose ... [and he or she is] acting in the usual course of his or her professional practice”).

The question becomes who decides whether a provider’s prescription is for a legitimate medical purpose.

WHEN IS AN OPIOID ISSUED FOR A LEGITIMATE MEDICAL PURPOSE?

Physicians remain criminally liable and will be treated essentially as a drug dealer if he or she ceases to distribute or dispense controlled substances as a medical professional should in the eyes of the federal government.

Given the opioid drug crisis, the field of pain management has generated controversy because of its reliance on opiate-based narcotic pain medications. Due to the ongoing prescription drug epidemic, the federal government has become more aggressive in prosecuting doctors and other prescribing providers who distribute opioids and other prescription drugs under the guise of legitimate medical practice.

WHEN IS AN OPIOID ISSUED FOR A LEGITIMATE MEDICAL PURPOSE?

Unfortunately, many health care providers still do not appreciate the fact that if an opioid prescription is deemed to have been issued without a legitimate medical purpose or outside the usual course of professional practice, that the person knowingly filling such a purported prescription (the pharmacy), as well as the person issuing it (the provider), is subject to the criminal penalties of 21 U.S.C. § 841.

These penalties include having your personal assets seized by the federal government and the loss of your license to practice medicine anywhere in the country.

21 U.S.C §841 VIOLATION PENALITIES

21 U.S.C §841 makes it a crime for a person to unlawfully dispense or distribute a Schedule II controlled substance (opioids) and provides for a maximum sentence of 20 years of imprisonment.

It also provides a minimum prison sentence of 20 years and an enhanced maximum prison sentence of life if "death or serious bodily injury results from the use of such substance."

Courts have held that a patient's hospitalization for withdrawal from opioids is sufficient to qualify as a "serious bodily injury" and therefore justified a life sentence enhancement for the offending medical provider.

NEW YORK DOCTOR INDICTED

NEWS AMERICA'S HEROIN EPIDEMIC NOV 8 2017, 8:02 PM ET

New York Doctor Eugene Gosy Accused in Six Opioid Deaths

by TOM WINTER and TRACY CONNOR

A globe-trotting New York doctor whose clinic prescribed more pain pills than any hospital in the state has been charged in the deaths of six people who overdosed on opioids.

Dr. Eugene Gosy of Williamsville, near Buffalo, was indicted last year on federal narcotics and fraud charges by prosecutors who said he turned patients of his pain management clinic into drug addicts for profit.

Seven months later, a grand jury has handed up a superseding indictment that says his alleged pill-pushing "caused the death of at least six individuals, and contributed to the deaths of others."

The 166-count indictment made public Wednesday also alleges that Gosy signed death certificates, without an autopsy, for patients taking controlled substances.

Dr. Eugene Gosy in a mug shot obtained by NBC News.

"Today's charges cannot bring back the lives of those who died, but is a message to traffickers and rogue doctors that their actions have irrevocable consequences," said Drug Enforcement Administration Special Agent-in-Charge James Hunt.

A DEA official said that to tie deaths to a doctor, investigators have to gather evidence to show that the drug ingested before they overdosed came from the defendant. That can include witnesses who saw the victim take pills from a bottle with the doctor's name and toxicology reports showing the concentration of the drug in the victims system lines up with the dosage of pills missing from the bottle, the official said.

Gosy's attorney, Joel Daniels, did not immediately respond to a request for comment. But in the past, Gosy has said he committed no wrongdoing and portrayed himself as an advocate for people struggling with pain.

https://www.nbcnews.com/storyline/americas-heroin-epidemic/new-york-doctor-eugene-gosy-accused-six-opioid-deaths-n818456 1/2

Headlines - Indicted on federal narcotics and fraud charges.

Indictment for death of at least six individuals

His clinic prescribed more pain pills than any hospital in the state of New York.

Faces up to life in prison.

For the moment, he is still practicing medicine but cannot write prescriptions for controlled substances

https://www.nbcnews.com/storyline/americas-heroin-epidemic/new-york-doctor-eugene-gosy-accused-six-opioid-deaths-n818456

WHEN IS AN OPIOID ISSUED FOR A LEGITIMATE MEDICAL PURPOSE?

Many providers summarily dismiss concerns over this issue under the mistaken belief that all of the opioid prescriptions they issue are reasonable and necessary in their mind and should therefore be considered legitimate.

However, what the government contends looking back over a provider's records qualifies as a legitimate medical purpose within the usual course of professional practice for that specific provider may surprise you.

In this regard, what is happening to this New York doctor is virtually identical to what happened last year to two different Idaho family practice providers. These cases should serve as strong warnings. This is where we as attorneys can and should help to educate healthcare providers.

IDAHO'S LOCALITY RULES WERE DEEMED INAPPLICABLE

Those of you who practice medical malpractice law in Idaho are aware that we have provider friendly statutes. To prove a claim for medical malpractice requires a showing that the physician deviated from the local community standard of practice for that specialty at that time per Idaho Code §6-1012.

Unfortunately, when prosecuting these criminal drug cases under 21 U.S.C §841 against medical providers in Idaho, the federal government was allowed to use a completely different standard that your clients need to be made aware of.

FEDERAL COURT DEFERRAL TO IDAHO BOARD OF MEDICINE OPIOID POLICY

In 2016, two Idaho family practice physicians were separately convicted of violating 21 U.S.C. § 841. Both providers were sentenced to 96 months or longer in federal prison, fined hundreds of thousands of dollars, had their assets seized, lost their medical practices and lost their licenses to practice medicine.

In both cases the federal government argued that a determination of whether the provider had issued a prescription for a legitimate medical purpose or acted within the usual course of professional practice required the jury to consider whether the provider conformed with the Idaho Board of Medicine Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain found on the Board's website.

IDAHO BOARD OF MEDICINE OPIOID POLICY

Idaho Board of Medicine Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain

Section I: Preamble

The Idaho Board of Medicine is obligated under the laws of the State of Idaho to protect the public health and safety. The Idaho Board of Medicine recognizes that principles of high-quality medical practice dictate that the people of the State of Idaho have access to appropriate, safe and effective pain management. The application of up-to-date knowledge and treatment modalities can help to restore function and thus improve the quality of life of patients who suffer from pain, particularly chronic pain [4,8,26].

This policy has been developed to articulate the Board's position on the use of controlled substances for pain, particularly the use of opioid analgesics and with special attention to the management of chronic pain. The policy thus is intended to encourage physicians to be knowledgeable about best clinical practices as regards the prescribing of opioids and be aware of associated risks. For the purposes of this policy, inappropriate treatment of pain includes non-treatment, inadequate treatment, overtreatment, and continued use of ineffective treatments.

The Board recognizes that opioid analgesics are useful and can be essential in the treatment of acute pain that results from trauma or surgery, as well as in the management of certain types of chronic pain, whether due to cancer or non-cancer causes [20,26,28]. The Board will refer to current clinical practice guidelines and expert reviews in approaching allegations of possible mismanagement of pain [8,10,12,14,26-41, 80].

Responsibility for Appropriate Pain Management: All physicians and other providers should be knowledgeable about assessing patients' pain and function, and familiar with methods of managing pain [4,16]. Physicians also need to understand and comply with federal and state requirements for prescribing opioid analgesics [3,12,19]. Whenever federal laws and regulations differ from those of a particular state, the more stringent rule is the one that should be followed [42].

Physicians should not fear disciplinary action from the Board for ordering, prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the course of professional practice, when current best clinical practices are met.

The Board will consider the use of opioids for pain management to be for a legitimate medical purpose if it is based on sound clinical judgment and current best clinical practices, is appropriately documented, and is of demonstrable benefit to the patient. To be within the usual course of professional practice, a legitimate physician-patient relationship must exist and the prescribing or administration of medications should be appropriate to the identified diagnosis, should be accompanied by careful follow-up monitoring of the patient's response to treatment as well as his or her safe use of the prescribed medication, and should demonstrate that the therapy has been adjusted as needed [7,38,43]. There should be documentation of appropriate referrals as necessary [36-37].

The medical management of pain should reflect current knowledge of evidence-based or best clinical practices for the use of pharmacologic and nonpharmacologic modalities, including the use of opioid analgesics and non-opioid therapies [14,16,27]. Such prescribing must be based on careful assessment of the patient and his or her pain (see the discussion on risk stratification, below) [33].

the dispensing pharmacy to a state agency, which collates and analyzes the information [3,24].

After analyzing the efficacy of PDMPs, the GAO concluded that such programs have the potential to help law enforcement and regulatory agencies rapidly identify and investigate activities that may involve illegal prescribing, dispensing or consumption of controlled substances. Where real-time data are available, PDMPs also can help to prevent prescription drug misuse and diversion by allowing physicians to determine whether a patient is receiving prescriptions for controlled substances from other physicians, as well as whether the patient has filled or refilled an order for an opioid the physician has prescribed [24,78-79].

Tolerance: Tolerance is a state of physiologic adaptation in which exposure to a drug induces changes that result in diminution of one or more of the drug's effects over time. Tolerance is common in opioid treatment, has been demonstrated following a single dose of opioids, and is not the same as addiction [28].

Trial Period: A period of time during which the efficacy of an opioid for treatment of an individual's pain is tested to determine whether the treatment goals can be met in terms of reduction of pain and restoration of function. If the goals are not met, the opioid dose may be adjusted, a different opioid substituted, an adjunctive therapy added, or use of opioids discontinued and an alternative approach to pain management selected [36].

Universal Precautions: The concept of *universal precautions* is borrowed from an infectious disease model of the same name to underscore its comparability to practices in other areas of medicine. The concept recognizes that all patients have a level of risk that can only be estimated initially, with the estimate modified over time as more information is obtained. The 10 essential steps of universal precautions can be summarized as follows [38]:

1. Make a diagnosis with an appropriate differential.
2. Conduct a patient assessment, including risk for substance use disorders.
3. Discuss the proposed treatment plan with the patient and obtain informed consent.
4. Have a written treatment agreement that sets forth the expectations and obligations of both the patient and the treating physician.
5. Initiate an appropriate trial of opioid therapy, with or without adjunctive medications.
6. Perform regular assessments of pain and function.
7. Reassess the patient's pain score and level of function.
8. Regularly evaluate the patient in terms of the "5 A's": Analgesia, Activity, Adverse effects, Aberrant behaviors, and Affect.
9. Periodically review the pain diagnosis and any comorbid conditions, including substance use disorders, and adjust the treatment regimen accordingly.
10. Keep careful and complete records of the initial evaluation and each follow-up visit.

By acknowledging the fact that there are no signs that invariably point to substance use disorder [41], the universal precautions encourage a consistent and respectful approach to the assessment and management of pain patients, thereby minimizing stigma, improving patient care, and reducing overall risk [38].

Policy adopted by the Idaho Board of Medicine September 6, 2013

http://bom.idaho.gov/BOMPortal/BOM/PDF%20FORMS/ModelPolicyUseofOpioidAnalgesicsinTreatmentofChronicPain.pdf

IDAHO BOARD OF MEDICINE OPIOID POLICY

Many providers in Idaho are totally unaware this Idaho Board of Medicine Opioid Policy even exists. Without question this policy was never intended by the Idaho Board of Medicine to be used to determine whether a provider was committing a federal drug crime, but yet this is how our providers are being judged.

The potential implications of this strategy by the federal government are profound. It basically creates a strict liability situation for providers. If you have clients prescribing narcotics to any patient, I strongly urge you to have them visit the above link and carefully read and implement the Board's opioid policy into their practice.

IDAHO BOARD OF MEDICINE OPIOID POLICY

This policy was adopted by the Idaho Board of Medicine in September 2013 and is modeled after similar policies which have been adopted by administrative boards of medicine in other states nationwide.

The Idaho policy states within the preamble that “physicians should not fear disciplinary action from the Board” for prescribing controlled substances provided they are for a “legitimate medical purpose and in the course of professional practice, when current best practices are met.”

IDAHO BOARD OF MEDICINE OPIOID POLICY

In prosecuting these two Idaho family practice providers, however, the federal government was allowed to instruct the jury that if they concluded the Board's opioid policy had not been complied with, that such a failure was proof of a criminal violation under 21 U.S.C. § 841.

This was allowed despite the complete absence of any evidence that such a policy had been adopted in Idaho by any state statute or administrative regulation and was therefore nothing more than a recommendation by the Idaho Board of Medicine. Furthermore, the federal prosecutors called a board certified pain specialist as an expert witness against the family practice providers and advocated for holding the defendants to a higher level of competency than would exist in a medical malpractice case under Idaho law.

PROTECT YOUR CLIENTS BY HAVING THEM USE "BEST CLINICAL PRACTICES"

For those who have not reviewed it, the IBOM's opioid policy is extensive and includes the following issues which must be addressed in order to comply with what the Board has determined to be the best clinical practice for chronic pain management:

1) Documentation

- Compliance with the Board's policy will be judged on the basis of available documentation. Document a legitimate basis for prescribing medication including complete system review, medical history, diagnosis, level of pain, the degree of relief after receiving the pain medication and the plan for follow up.

- Carefully structure a treatment plan that reflects the particular benefits and risks of opioid use for each individual patient, including documenting improvement in any pain associated symptoms.

- Whenever possible initiate treatment with a non-narcotic pain medication first and include the use of nonpharmacological treatment therapies.

- Document appropriate referrals and diagnostic testing to support the working diagnosis. Include in your initial work up a social and vocational assessment including any histories of drug, alcohol, sexual and physical abuse, depression and other mental health disorders as they are risk factors for potential misuse.

PROTECT YOURSELF WITH BEST CLINICAL PRACTICES

2) Ensuring adequate communication with other providers.

- Document communication between providers to ensure who is managing a patient's pain medication needs.
- This would include requesting records from prior providers before agreeing to prescribe any narcotic pain medication without exceptions.
- Document that these records have been reviewed.

PROTECT YOURSELF WITH BEST CLINICAL PRACTICES

3) Ensuring use of existing safeguards in addition to using clinical judgment. This would include:

- Not prescribing in excess of your diagnosis;
- Documenting the results of having regularly checked the state prescription drug monitoring program to verify whether the patient had been receiving medication prescriptions from other providers;
- Obtaining periodic drug testing of the patient to monitor adherence to the treatment plan and to confirm that no other legal or illegal substances were also being taken.

Pill counting and patient self-reporting cannot be relied upon to ensure compliance in the treatment of chronic pain patients in this day and age regardless of the patient. North Idaho example.

PROTECT YOURSELF WITH BEST CLINICAL PRACTICES

4) Pain contracts/treatment agreements.

- Do not let the patient dictate the care;

- When prescribing narcotics beyond an acute injury use signed agreements to clarify expectations with the patient including the fact that they should not be getting pain medication from any other provider or taking anyone else's medications, that you check state pharmacy profiles from your state and surrounding states before issuing prescriptions and that you employ the use of periodic random drug tests to ensure compliance.

- Document the intended goals of the treatment such as restoring daily functioning as well as documenting the responsibility of the patient to use the medications only as prescribed.
- A signed treatment agreement/informed consent must be in the patient chart.

PROTECT YOURSELF WITH BEST CLINICAL PRACTICES

5) Documenting informed consent.

- Document a detailed discussion regarding the risks of abuse, addiction, dependence, side effects, prescribing policies and expectation such as rules for early refills, inability to replace stolen medications, etc. should all be addressed and documented.

- Include the risks of addiction, constipation, impaired cognitive function, motor skills and over sedation.

- Consider getting input from an addiction specialist and/or psychiatrist or other mental health provider regarding the use of narcotic pain medication in patients with histories of drug, alcohol, sexual and/or physical abuse.

- For patients with a history of substance abuse these consultations should occur before opioid therapy is initiated.

PROTECT YOURSELF WITH BEST CLINICAL PRACTICES

6) Consultation and Referral.

- Patients who are stable on mid to high level doses of narcotic pain medication should undergo routine efforts to reduce the dose to minimize addiction and/or dependence issues.

- Employ use of the 5A's of chronic pain management:
  - determination of whether the patient is experiencing a reduction in pain (Analgesia);
  - have they demonstrated an improvement in level of function (Activity);
  - have there been any (Adverse) effects;
  - is there any evidence of (Aberrant) substance related behavior;
  - and consider the mood of the individual (Affect).

- In addition to seeking appropriate consultation and referrals, also consider whether to discontinue opioid therapy and initiate and document a plan for dosage reduction and/or referral to a pain specialist.

- For physically dependent patients, a safely structured tapering regimen must be initiated and/or referral made to an addiction specialist.

PROTECT YOURSELF WITH BEST CLINICAL PRACTICES

7) Verify your internal controls.

- Protect your prescription pads, do not allow anyone authority to give prescriptions to patients you have not seen and do not have signed prescriptions prepared ahead of time.
- Do not ignore drug seeking behavior.
- Document and report drug diversion and prescription forgery and terminate such patients.
- Take note of, and respond to, patients with obvious impairment, accidental overdoses, etc.
- At least annually obtain a state pharmacy profile on yourself and have your staff ensure that the only people listed to be getting prescriptions from your office are actually your patients.
- Your medical record must contain all prescription orders for opioid analgesics and other controlled substances whether written or telephoned as well as documenting written instructions given for those medications.

MID-LEVEL PROVIDERS RISK EXPOSURE WITH OPIOID PRESCRIBING

If your clients are using physician assistants ensure they are working within an appropriate and documented scope of practice.

Your physician provider is liable for that midlevel so they need to verify training, review patient records and engage in regular record review.

Ensure your midlevel providers are engaging in appropriate and timely collaboration and consultation with assigned supervisors.

The supervision of a midlevel must be meaningful and not just in name only.

EXAMPLES OF PROPER DOCUMENTATION AND WAYS TO TERMINATE A PATIENT FOR NONCOMPLIANCE AND AVOID ABANDONMENT CLAIMS.

Family Medicine & Urgent Care

Dear_____

The providers at _____ Family Medicine have strived to provide effective and safe care for patients suffering from long-term conditions and disease processes by following prescribing guidelines while working to assist patients to better achieve health outcomes. On March 15, 2016, the CDC released its position regarding the use of narcotics to treat chronic pain by stating that patients should not be prescribed dosages that exceed 50 mcg of any Morphine Equivalent (MEQ). Strict recommendations regarding prescribing policy for Anxiety and Depression have also been issued by the CDC recently. Recommendations pertaining the use of medication for sleep disorders was previously issued and our policies have changed to reflect the most current and safest methods by which to treat these conditions. Our new prescribing guidelines effective 4/1/16 are listed below to help you understand how we are working to provide the safest and most beneficial way to treat your symptoms.

Chronic Pain

Because our prescribing policies follow the CDC and other governing bodies,_____ approach will closely mirror these recommendations. Our goal is to assist patients to achieve relief of pain while taking the lowest possible dosage of medication. This approach will require patients to attempt other, non-narcotic methods of achieving relief such as Physical Therapy, Exercise and Weight Management. All patients receiving controlled substances must have current medical documentation to support the need for narcotics as a means of pain management. This means, patients must have advanced imaging such as MRI within the last five years. Patients currently receiving narcotics with an MEQ exceeding 80mcg per day must be evaluated annually by a pain specialist (ie. Dr. _____). Treatment plan recommendations included in this evaluation *will be followed*, with an emphasis on options that do not utilize narcotics as the single means of treatment.

Fibromyalgia

Per the CDC's recommendations, patients diagnosed with Fibromyalgia do not qualify for narcotic treatment for their symptoms. Because our prescribing policy follows the CDC and other governing bodies, SFM's approach will closely mirror these recommendations. Patients currently receiving narcotics for this diagnosis may choose to be referred to a Pain Specialist or Rheumatologist for continuation of pain management.

Anxiety and Depression

In addition to guidelines regarding narcotics, the CDC issued recommendations for the treatment of Anxiety and Depression. Treatment for these conditions in conjunction with chronic pain management will not include the use of Benzodiazepines and narcotics as prescribed together. In order to adhere to these published guidelines, patients being treated with Benzodiapines (ie. Xanax) will begin a tapering regimen to reduce any amounts currently prescribed. Patients who feel their current dosage(s) must remain unchanged will be referred to Dr. _____ for evaluation.

Sleep Disorders

Recommendations from the National Sleep Association and the FDA state that sleeping pills shouldn't be taken every night of the week. Dosing recommendations also should not exceed 20 nights per month. Women and men over 70 years of age should not be prescribed Ambien to exceed 5 mg per day while men under 70 years of age are not to exceed 10 mg of Ambien. Strict adherence to these guidelines is the result of studies indicating that the use of sleep medications for prolonged periods can cause patients to experience amnesia. Our providers are committed to following FDA guidelines and will work with you to find a solution to your sleep issues. Because new FDA guidelines show high overall risks associated with Soma, we've decided to take a firm approach and completely discontinue the use of Soma in our practice. Other medications are available and we encourage you to meet with your provider to determine which alternative to Soma is best for you.

Electronically signed by _____ **Date: 07/14/2016**

Family Medicine & Urgent Care

Chronic Pain Medication Contract

Patient: _____ DOB: _____ Pharmacy: _____

Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment.

I, _____ understand that compliance with the following guidelines is important in continuing care with this office.

- I understand that I have the following responsibilities:
  1. I will take medications only at the dose and frequency prescribed.
  2. I will not increase or change medications without the approval of this office.
  3. I will actively participate in any program designed to improve function (including social, physical, psychological and daily or work activities.
  4. I will not request opioids or any other pain medicines from physicians other than from this office. This office will approve and prescribe any other mind or mood altering drugs.
  5. I will obtain all medications from one pharmacy, when possible known to this office with full consent to talk with the pharmacist given by signing this agreement.
  6. I will protect my prescriptions and medications. Lost prescriptions or medications will not be replaced.
  7. I agree to participate in psychiatric or psychological assessment, if necessary.
  8. If I have an addiction problem, I will not use illegal or street drugs or alcohol. This office may ask me to follow through with a program to address this issue. Such programs may include the following:
     - 12-step program and securing a sponsor
     - Individual counseling
     - Inpatient or outpatient treatment
     - Other:
  9. I will inform all other physicians and/or dentists that I am on a pain contract with this office.
- I understand that in the event of an emergency, this office should be contacted and the problem will be discussed with the emergency room or other treating physician. No more than 3 days of medications may be prescribed by the emergency room or other physician without this office's approval. My medical records may be obtained from or released to any other medical provider.
- I understand that I will consent to random drug or alcohol screening. A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking. I will be responsible for the payment of a drug screen that is requested by my physician.
- I will schedule my follow-up appointments for 3 days prior to my medications being out. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment time.
- I understand that this office may stop prescribing opioids or change the treatment plan if:
  1. I do not show any improvement in pain from opioids or my physical activity has not improved
  2. My behavior is inconsistent with responsibilities outlined in #1 above.
  3. I give, sell or misuse the opioid medication.
  4. I obtain opioids from anyone other then this office.
  5. I refuse to cooperate when asked to get a drug screen
  6. If an addiction problem is identified as a result of prescribed treatment or any other addictive substances.
  7. If I am unable to keep follow-up appointments.
  8. If I am non-compliant with this contract.
  9. If I am found to be using any addictive drugs, alcohol or non-prescribed street drugs, including marijuana.
- I will only use the pharmacy stated above to fill any pain medications.

Electronically signed by _____ Date: 04/29/2015

Electronically signed by _____ Date: 04/29/2015

EXAMPLES OF PROPER DOCUMENTATION AND WAYS TO TERMINATE A PATIENT FOR NONCOMPLIANCE AND AVOID ABANDONMENT CLAIMS.

Family Medicine & Urgent Care

Chronic Pain Prescription Agreement
Responsibilities in Opioid Therapy of Chronic Pain

Patient: _____

Your provider's responsibility include. Listening carefully to your concerns, treating you with care with due respect, and making clinical decisions based on what he/she believes is in your best interest.

Your responsibilities: In order to maximize the potential benefits of opioid medications and t minimize the potential risks, it is important that you accept the following responsibilities. In signing this agreement, you agree to:

1. **Use your opioid medication** as prescribed for the purpose of relieving pain.
2. **Keep your medication** locked up to avoid intentional or un intentional use or diversion by others. **Discard** all unused medication.
3. **Be honest** with your providers about your medication or other drug use.
4. **Use no illegal drugs and not abuse alcohol** while being prescribed opioids.
5. **Not share, sell, trade, or in any way provide your medication to others.**
6. **Receive opioid medication from only this practice.** If opioids are prescribed unexpectedly by another office (for example due to an accident), inform this office within 24 hours.
7. **Fill your opioid medication at only one pharmacy.**
8. **Have urine drug tests on a random basis and as requested by your provider even on days not scheduled for appointment.** Opioids may be discontinued if illicit drugs found or medication not present when it should be.
9. **Bring your opioid medication.** If requested by the practice at any time.
10. **Participate in other treatment ordered by your provider. Keep all appointments** scheduled for your care.
11. **Permit this practice to communicate with other care providers and/or your significant other** as needed to assure opioids are being used appropriately and are beneficial to your health and well-being.

Your medication may be continued if they improve if they improve your pain, help you engage in valued activities, and/or enhance your quality of life and if you adhere to the above responsibilities. They may be discontinued if your goats for treatment are not met, if you experience negative effects from using them, or if you do not adhere to this agreement.

If you develop complications of opioid use, such as addiction, we will assist you in finding treatment. Please be aware, however, that our practice cooperates fully with law enforcement, the US Drug Enforcement Agency and other agencies in the investigation of opioid related crimes including sharing, selling, trading, or other potential harmful use of those powerful medications.

I have read and signed the Consent to treatment form and agreement to my responsibilities as outlined above. I have reviewed this document and been given the opportunity to have any questions answered. I understand the possible benefits and risks of opioid medication and I accept the responsibilities described above.

Patient: Electronically Signed by _____ Date 07/14/2016

Family Medicine & Urgent Care

INFORMED CONSENT FOR OPIOID TREATMENT FOR CHRONIC PAIN
Family Medicine & Urgent Care

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your health care provider comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

I have agreed to use opioids (morphine-like drugs) as part of my treatment for chronic pain. I understand that these drugs can be very useful, but have a high potential for misuse and are therefore closely controlled by the local, state, and federal government. Because my health care provider is prescribing such medication to help manage my pain, I agree to the following conditions:

1. I am responsible for my pain medications. I agree to take the medication only as prescribed.
   a. I understand that increasing my dose without the close supervision of my physician could lead to drug overdose causing severe sedation and respiratory depression and death.
   b. I understand that decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal. **Withdrawal symptoms** can include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh", abdominal cramps, and diarrhea. These symptoms can occur 24-48 hours after the last dose and can last up to 3 weeks.
2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my health care provider at _____ Family Medicine.
3. There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing).

   It is my responsibility to notify my health care provider for any side effects that continue or are severe (i.e., sedation, confusion). I am also responsible for notifying my pain physician immediately if I need to visit another physician or need to visit an emergency room due to pain, or if I become pregnant.
4. I understand that the opioid medication is strictly for my own use. The opioid should never be given or sold to others because it may endanger that person's health and is **against the law.**
5. I should inform my physician of all medications I am taking, including herbal remedies. Medications like Valium or Ativan; sedatives such as Soma, Xanax, Fiorinal; antihistamines like Benadryl; herbal remedies, alcohol, and cough syrup containing alcohol, codeine, or hydrocodone can interact with opioids and produce serious side effects.
6. During the time that my dose is being adjusted, I will be expected to return to the clinic as instructed. After I have been placed on a stable dose, I will return to the office monthly for a medical evaluation and refill of my medication.
7. I understand that opioid prescriptions **will not be mailed.** If I am unable to obtain my prescriptions monthly, I will be responsible for finding a local physician who can take over the writing of my prescriptions.
8. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.
9. I will communicate fully with my health care provider to the best of my ability at the initial and all follow-up visits my pain level and functional activity along with any side effects of the medications.
10. You should not use any illicit substances, such as cocaine, marijuana, etc. while taking these medications. This will result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship.
11. The use of alcohol together with opioid medications is contraindicated.

EXAMPLES OF PROPER DOCUMENTATION AND WAYS TO TERMINATE A PATIENT FOR NONCOMPLIANCE AND AVOID ABANDONMENT CLAIMS.

Family Medicine & Urgent Care

12. I am responsible for my opioid prescriptions. I understand that:
    a. Prescriptions can be written for a maximum of one month supply and will be filled at **the same pharmacy.**
    b. **It is my responsibility to schedule appointments for the next opioid refill before I leave the clinic or within 3 days of the last clinic visit.** I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. I will then report the stolen medication to my physician. If my medications are lost, misplaced, or stolen my physician may choose not to replace the medications or to taper and discontinue the medications.
    d. Refills will not be made as an "emergency", such as when you suddenly realize I will "run out tomorrow".
    e. Refills can only be filled by a pharmacy in the State of Idaho, even if I am a resident of another state.
    f. Prescriptions for pain medicine or any other prescriptions will be done only during an office visit or during regular office hours. **No** refills of any medications will be done during the evening or on weekends.
    g. **You must bring back all opioid medications and adjunctive medications prescribed by your physician in the original containers/bottles at every visit.**
    h. Prescriptions will not be written in advance due to vacations, meetings, or other commitments.
    i. If an appointment for a prescription refill is *missed*, another appointment will be made as soon as possible. *Immediate* or *emergency* appointments will not be granted.
    j. No "walk-in" appointments for opioid refills will be granted.

13. While physical dependence is to be expected after long-term use of opioids, **signs of addiction, abuse, or misuse shall prompt the need for substance dependence treatment as well as weaning and detoxification from the opioids.**

    a. **Physical dependence** is common to many drugs such as blood pressure medications, anti-seizure medications, and opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal response. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.

    b. **Addiction** is a primary, chronic neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life. If the patient exhibits such behavior, the drug will be tapered and such a patient is not a candidate for an opioid trial. He/she will be referred to an addiction medicine specialist.

    c. **Tolerance** means a state of adaptation in which exposure to the drug induces changes that result in a lessening of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a *realistic* decrease of the patient's pain.

14. If it appears to the health care provider that there is no improvement in my daily function or quality of life from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed by the physician.

15. If I have a history of alcohol or drug misuse/addiction, I must notify the physician of such history since the treatment with opioids for pain **may** increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery **is a necessity.**

16. I will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment, and sometimes two to three days extra if the prescription ends on a weekend or holiday. This extra medication is **not** to be used without the explicit permission of the prescribing physician unless an emergency requires your appointment to be deferred one or two days.

17. I agree and understand that my physician reserves the right to perform random or unannounced urine drug testing. If requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my doctor may change my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the doctor/patient relationship. The presence of a non-prescribed drug (s) or illicit drug (s) in the urine can be grounds for termination of the doctor/patient relationship. Urine drug testing is not forensic testing, but is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.

18. I agree to allow my health care provider to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions *if the physician feels it is necessary.*

19. I agree to a family conference or a conference with a close friend or significant other *if the physician feels it is necessary.*

20. I understand that non-compliance with the above conditions may result in a re-evaluation of my treatment plan and discontinuation of opioid therapy. I may be gradually taken off these medications, or even discharged from the clinic.

I, have read the above information or it has been read to me and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy & acknowledge receipt of this document.

Patient: Electronically signed by _____ Date 07/14/2016

Family Medicine & Urgent Care

Safety Risks, Side Effects, Recommendations, Personal Care Plan and Treatment Plan Patient:

Your Safety Risks While Working Under The Influence of Opioids:

You should be aware of potential side effects of opioids such as decreased reaction times, clouded judgement, drowsiness and medication tolerance. Also, you should know about the possible danger associated with the use of opioids while operating heavy equipment and driving.

Side Effects of Opioids:

- Confusion or other changes in thinking abilities, sleepiness or drowsiness
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or vehicles.
- Nausea, constipation or vomiting.
- Breathing too slowly, overdose can stop your breathing and lead to death.
- Aggravation of depression
- Dry mouth

Risks:

- Physical dependence. This means that abrupt stopping of the drug may lead to withdrawal symptoms.
- Psychological dependence. This means it is possible that stopping the drug will cause you to miss or crave it.
- Tolerance. This means you may need more and more drug to get the same effect.
- Addiction. A small percent of patients may develop addiction problems based on genetic other factors.
- Problems with Pregnancy. If you are pregnant or contemplating pregnancy, discuss with your physician.

Recommendations To Manage Medications:

- Keep a diary of the pain medication. Dose, Time, Effectiveness, Side Effects.
- Use of a medication box.
- Take along only the amount of medication you need when leaving home.

Personal Care Plan:

- Improve Functional Ability.
- Improve Sleep Pattern.
- Attend Physical Therapy or Complete Daily Exercise and Stretching at home.
- Manage Stress, practicing daily relaxation techniques at home or formal intervention (ie. Counseling)
- Decrease Pain Level with Non-medication Treatment, Ice/heat, and Chronic Pain Medication.

Treatment Plan:

Our Treatment Plan involves finding a dose of medication which relieves enough pain to return the patient to a functional state, not necessarily entire or complete relief of pain. It may include adjunctive items such as epidural steroids, TENS units, physical therapy, biofeedback and/or other mechanisms for pain relief.

I have read the document, understand and have had all my questions answered satisfactorily.
Electronically Signed by _____ Date 07/14/2016

EXAMPLES OF PROPER DOCUMENTATION AND WAYS TO TERMINATE A PATIENT FOR NONCOMPLIANCE AND AVOID ABANDONMENT CLAIMS.

Family Medicine & Urgent Care

Patient Name: _____
DOB: _____

Apr 14, 2017

Dear _____,
_____ Family Medicine will no longer write narcotic medications for you. We were informed that you are dispensing your narcotic medication and this is against the pain contract you signed. We do not tolerate this behavior in our clinic. _____ FNP has agreed to continue seeing you for your other health care needs but will not write any narcotic medications. If you feel that our office is no longer a good fit for you, we will make your medical records available upon request.

Sincerely yours,

Electronically Signed by: _____ Date:

Family Medicine & Urgent Care

May 11, 2017

_____
_____
_____

Dear _____:

I find it necessary to inform you that as of May 11, 2017, we are withdrawing from further professional attendance upon you.We feel that our practice is no longer a good fit for your medical needs. We suggest that you place yourself under the care of another physician. Should a medical emergency arise in the next 30 days, you may contact our office for treatment. We suggest that you contact _____.

We shall make our records of your care available to the physician of your choice. Since your records are confidential, I shall require your written authorization to make them available.

We are sorry that we cannot continue as your physician. I extend to you my best wishes for your future health and happiness.

Very truly yours,

_____

MEDICAL PROVIDERS BEWARE

Complete and timely medical records are crucial to establish that the prescriptions at issue were provided were for a legitimate medical purpose and in the course of professional practice.

It is a troubling development for the U.S. District Court to have allowed the Board's opioid policy to be used by a jury to determine whether a physician had illegally prescribed a controlled substance under federal drug trafficking laws.

MEDICAL PROVIDERS BEWARE

With the prescription drug abuse epidemic at an all-time high in the United States and people demanding that state and federal governments do more, the government has elected to target health care providers as a primary source for legal drugs which wind up getting diverted into the wrong hands and/or being abused by patients often through no fault of the health care providers.

Attorneys need to warn and educate their medical provider clients so they are aware this is the new reality we are seeing today. Jurors are more accepting the argument that the physicians must be proactive, stop prescribing and maintain tight controls using low doses. Patients are no longer accountable and providers must prove themselves innocent.

GONE ARE THE GOOD OLD DAYS

The physician/patient relationship is grounded in trust and honesty, however, providers can no longer rely on this time-honored expectation when prescribing narcotic medications that are so prone to abuse by patients and having such a high value on the street of over a dollar per milligram.

Keep in mind that oftentimes patients arrested for diverting or selling their narcotic medications have been offered plea deals in exchange for turning in the physicians who were innocently and unknowingly providing medication for what they thought was a legitimate medical purpose.

PARTING SHOT – CAN YOU TRUST YOUR PATIENT?

In both cases involving the family practice physicians convicted in Idaho last year, both had undercover officers (wearing audio and video recording devices) coming into their offices and posing as fake patients who were able to obtain narcotic pain prescriptions. These undercover officers were coached on how to act and gave compelling stories to the providers who reasonably believed them, provided opioid prescriptions and then found themselves being charged criminally with separate counts for every prescription written.

These two Idaho doctors were forced to defend themselves, not because they were necessarily bad doctors, but because they were soft hearted with their patients, overly trusting, somewhat lazy, but most of all they simply did not comply with the dictates of the Board's opioid policy.

Both are now facing years of prison time, they have lost their families, their medical licenses and their medical practices they worked decades to build, they are financially destitute having had their assets seized and they have significant fines waiting to be paid when they are ultimately released from prison.

Please take these recommendations to heart and advise your clients accordingly to prevent them from becoming another casualty in our government's latest war on drugs. Tell them to make sure their prescriptions of opioids are for a legitimate medical purpose!

QUESTIONS?

Resources

Idaho Board of Medicine Policy on Opioid Use

Adobe Acrobat Document

Example Opioid Policy Forms

Adobe Acrobat Document