Clinical contracts

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Why?

- Ameliorates power imbalance
- States a goal for the agreed upon activity
- Allows for contingency management to keep behaviour within safe and acceptable limits
  - Prevents acceleration of medication use
  - Allows monitoring and describes its use
- Provides documentation that safe limits have been established

Types of contracts

- Prescribing agreements
  - Weaning agreements
- Monitoring agreements

Prescribing agreements

- Mandatory if narcotics prescribed
  - Should include any long term narcotic prescriptions, including T#3's
  - Discuss OTC narcotics as well
- Strongly advised for benzodiazepines, Z drugs, stimulants
  - Modify the narcotics agreement
  - Other medications if a Hx of substance use is present (gabapentin, cyclobenzaprine, bupropion)
- Not necessary for acute pain relief, unless Hx of substance use

Weaning agreements

- Very difficult to enforce, with frequent bargaining due to the intrusion of adverse life events
  - Easy to become derailed
  - Therefore the initial detailed discussion of weaning schedule and agreement of this is critical and allows the schedule to remain on track (e.g. 10 % reduction in benzodiazepine dosage per month is the standard)
  - exceeding this rate in a hurried response to escape a situation will result in bargaining and pressure to modify the agreement

Monitoring agreements

- PharmaNet – have every patient sign on first encounter and include all names of clinic physicians on each contract
  - Advise that a pharmanet search will precede every prescription of a potentially addictive medication
- Requests for random UDS, pill callbacks are usually embedded in prescribing agreements

Initiating the agreement

Review the goal (e.g. improved function, not pain relief with narcotics) and review the time line of the agreement (esp for weaning agreements)

Do not be in a hurry

- Outline a schedule of appointments, prescribing elements and contingency consequences and frequency of monitoring
  - Outline the significant clauses and have patient initial them – may wish to have patient repeat clause in their own words

Initiating continued

- Have client choose one drug store and create working relationship with pharmacist
  - Advise patient that pharmacist reports will be believed and acted upon
- Notify other prescribers (notify again if duplicate prescribing continues)

Give patient a copy of the agreement

Have agreement readily available in chart

Ensuring adherence

Step 1

- Track one's own prescribing
  - Avoid prn doses – change to regular dosing
  - Calculate the amounts prescribed in weeks (months and 100 day amounts are too vague to follow accurately)
  - Document start date and end date (remember that a week's prescription which starts on Wednesday will end on a Tuesday)
  - Also document dispensing schedule on prescription
  - Advise patient to make a return appointment before they leave the office (avoids the crisis of not being able to get an appointment on the day that the pills are finished)

Step 2 – the levers available

- Prescribing in the first place (not ethical to refuse patient care in other matters due to a voided prescribing contract)
- Appointment frequency (missed appointment is a contract violation) and length of prescription
- Dispensing frequency
  - Colleagues expected to impose DWI/daily dispensing if bridge dosing
- Dose
- Monitoring frequency

Step 3

- At each contract violation, a new response is necessary
  - Temporary action is preferred if violations are infrequent, minor and the patient appears teachable
  - Consequences may have to be longer/permanent if repeated violations, loss of trust or threat to patient safety
  - Ensure pharmacy is aware of your policy re: violations
  - Consequences need to be permanent if monitoring unable to detect the problem

The Art of Enforcing contracts

- Base response on safety, patient understanding and regard for spirit of contract
- Inappropriate severe consequences can be as unsafe as having no boundaries on prescribing (precipitated withdrawal, use of illegal substances, IDU, loss of physician-patient relationship)
- A modulated approach to consequences will be easier for the physician to enforce and will be more palatable to the patient
  - Caveat is safety – if there is a substantial risk, then greater measures must be taken immediately
- But every contract violation needs a response

When resistance occurs

- Roll with it and don’t push back
- Frame re: safety
- Ally with patient against problem
- Speak in the theoretical

Before the appointment with client

- Know the prescribing boundaries
- State the boundary immediately and then have discussion
- Practice enforcement phrases or responses
- Avoid fatigue
- If a pattern of inappropriate prescribing already exists, schedule extra time and state the new conditions – do not let time considerations force you into an expedient decision

Monitoring

- PharmaNet check before writing any prescription for narcotics, sedatives, stimulants or any other medication suspected of abuse
  - E.g. gabapentin, buprenorphine, cyclobenzaprine, quetiapine, trazodone, etc.
- If inappropriate third party prescribing occurs, notify prescriber and warn patient
- If continues, then wean or terminate prescribing

Monitoring - UDS

- Point of care UDS – both at appointments and random call backs
  - Allow 2 days – can sit in fridge over W/E
  - Laboratory collections are stricter and often unsettling (patients treated differently when submitting UDS)
  - r/o forced UDS – creat > 20, SG > 1.002, no adulterants, temperature > 34
  - Need to see prescribed substance and no other substance
  - If unclear, send to laboratory for LC/MS confirmation

POC UDS

- Financially viable – 15040 ($12.40)
- Interpretation can be complex
  - False positives common for amphetamines
  - Only chlordiazepoxide, diazepam, oxazepam, temazepam expected on BZP screen
  - Only codeine, morphine and heroin seen on opiate screen
  - + ve for 2-3 days after occl use and +ve for 30 days after continuous use

Monitoring

- Random pill call back counts
  - Be able to recognize tablet – know which store patient uses and have store send a photo of the tablet/capsule dispensed
- Appointment adherence – often a marker to adherence in other areas
  - Have a policy for called in appointments written into contract

Both for random UDS and pill count callbacks, it is the patient's responsibility to keep contact information and drugstore information up to date – inability to contact cannot be used as an excuse to avoid contingency consequences

Special situations

- Hospitalization – s/w hospitalist/MRP
- Travel
  - Sent script to destination drug store
  - If out of province, ask to see travel documents

Things change over time