Treatment Agreements
“Clinical Contracts”

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Prescribers Course, Vancouver, BC, Canada
October 13, 2017

Faculty/presenter disclosure

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Relationships with commercial interests:

- Grants/research support: Alberta Labour
- Speakers bureau/honoraria: None
- Consulting fees: None

Opinions are my own!

We see what we want to see

Need for universal precautions and good boundaries

Behavioural contracts?

Include contracts for managing:

- “difficult patients”
- suicide prevention contract
- healthy living contracts
- “opioid contracts” e.g.
  - “Opioid Treatment Agreement”
  - “Safe Prescribing Agreement”

Contracts/agreements/consents

Purpose:

- Educational and informational, articulating rationale and risks of treatment
- Clarifies prescribing standards
- Articulates monitoring (PharmaNet, UDT, pill counts, etc.) and
- Action plans for aberrant medication taking behaviour
- Takes “pressure” off provider to make individual decisions (“Our clinic policy is…”)

Fishman SM, Kreis PG. Clin J Pain 2002; Arnold RM et al. Am J of Medicine 2006

Before I start?

- Patient selection and risk stratification
- Informed consent (opioid-related adverse effects)
- Initiation and titration of chronic opioid therapy
- Dose escalations, opioid rotation, and indications for discontinuation of therapy
- Breakthrough pain
- Regular visits and random call-ins
- Office opioid policies – single pharmacy
- Explain monitoring – UDT, pill (patch) counts, PharmaNet
- Use of e.g. methadone
- Driving and work safety
- Many sample agreements

Initiating the agreement

- Review goal of “TRIAL” (e.g. improved function, not pain relief with narcotics) and review the timeline of the agreement (especially for weaning agreements)
- Do not be in a hurry
  - Outline a schedule of appointments, prescribing elements and frequency of monitoring and contingency consequences
  - Outline the significant clauses and have patient initial them – may wish to have patient repeat clause in their own words

Initiating the agreement

- Have patient choose one drug store and create working relationship with pharmacist
  - Advise patient that pharmacist reports will be trusted and acted upon
- Notify other prescribers (notify again if duplicate prescribing continues)
- Give patient a copy of signed agreement
- Have agreement readily available in chart

“Prescribing” component

- Should include any long term narcotic prescriptions, including T#3’s
- Strongly advised for benzodiazepines, Z-drugs, stimulants
- Other medications if a history of substance use is present (gabapentin, cyclobenzaprine, bupropion)
- Not necessary for acute pain relief, unless history of substance use
- Importance of prescription monitoring program

“Monitoring” component

- 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
- Request for regular but random UDS is usually embedded in prescribing agreements
- Random visits for pill (patch) count
- Other monitoring agreements beyond the scope of this presentation

Biological drug testing is more than “pee-testing”

- Collection (supervised vs. witnessed)
- Transportation (chain of custody paperwork)
- Testing techniques (“screening” vs. “confirmatory”)
- Interpretation of test results
- Verification by certified medical review officer
- Reporting*

Analytic techniques

- **“Screening” (POCS):**
  - Series of initial tests designed to distinguish negatives from presumptive positive samples
  - Enzyme multiplied i**mmunoassay** technique (EMIT)

- **“Confirmatory” (lab):**
  - Second test used to positively identify a drug or drug metabolite
  - Gas chromatography/mass spectrometry (**GCMS or LC/MS/MS**)

Monitoring: urine drug testing

- Implementation considerations
  - Know limitations of your test and your lab
  - Be careful of false negatives and positives
  - Good question: “If I check your urine right now what will I find in it?”
  - ? Random versus scheduled
  - ? Supervised, temperature strips, check creatinine and specific gravity
  - ? Chain-of-custody procedures

Gourlay DL, Heit HA, Caplan YH. Urine drug testing in primary care. Dispelling myths and designing strategies monograph (www.familydocs.org/files/UDTmonograph.pdf)

Source of opiates or opioids

Natural (from opium)	Semisynthetic (derived from opium)	Synthetic (man-made)
Codeine	Hydrocodone	Meperidine
Morphine	Oxycodone	Fentanyl
	Hydromorphone	Propoxyphene
	Oxymorphone	Methadone
	Buprenorphine	

POC UDS

- Financially viable – 15040
- 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
  - Positive for two to three days after occasional use and positive for longer after continuous use

Ethyl glucuronide(EtG)

- Metabolite of alcohol
- Offers extended window for detection
- Can be detected three to five days following consumption
- Not detectable unless alcohol consumed
- Unintentional alcohol consumption?
- Unintentional alcohol exposure?

Urine Drug Testing

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

Monitoring

- Universal PharmaNet before every prescription
- Random pill/patch callback 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 drug store information up to date – inability to contact cannot be used as an excuse to avoid contingency consequences

Monitoring: urine drug tests

Purpose:

- Evidence of therapeutic adherence
- Evidence of non-use of illicit drugs

		Behaviour Issues		
		YES	NO	TOTAL
Urine Tox	POSITIVE	10 (8%)	26 (21%)	36 (29%)
	NEGATIVE	17 (14%)	69 (57%)	86 (71%)
	TOTAL	27 (22%)	95 (78%)	122

26/122 (21%) of patients had no aberrant behavioural issues
BUT had abnormal drug screen

Katz NP et al. Clinical J of Pain 2002

Self-audit/monitoring

- Track one's own prescribing
  - Avoid prn scheduling – change to **regular** dosing
  - Calculate prescribed amounts 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 they run out of pills)

Accountability

Contingency behavioural management (CBM)

- CBM is evidence-based
- Consequences/rewards for behaviour
- Couples benefits (ongoing prescribing, disability insurance, employment) with attempted adherence to recommendations
- Physicians, dentists, nurses, pilots, drug courts, driver diversion programs
- Support with accountability
- CBM is opposite to “enabling”

Leverage

- Emphasize focus and 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, accidental OD, 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, safety, safety – if there is a substantial risk, then greater measures must be taken immediately
- But every contract violation needs a response

Leverage available

- 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

Further thoughts

- 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
  - Consequences need to be permanent if monitoring unable to detect the problem
- Train the patient to acceptable behaviour
  - Each consequence, if graded, is easier to impose and will not result in a loss of the physician-patient relationship

Resistance

- Roll with resistance
- Frame re: safety, safety, safety
- Ally with patient against problem

- 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

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)
  - exceeding this rate in a hurried response to escape a situation will result in bargaining and pressure to modify the agreement

Recruit

- Significant other – if disagrees with your approach, need at least to know how many are not on side!
- 12-step programs, Smart Recovery, LifeRing – provide with central contact numbers
- Alcohol and drug counselling and treatment centres
- Take-home naloxone kit – “Toward the Heart” – free via BC Centre for Disease Control
  - Drug store will charge

Special situations

- Hospitalization – s/w hospitalist/mrp
- Other colleagues' inappropriate prescribing – send notice
  - Specialists
  - WICs
- Travel
  - Sent script to destination drug store
  - If out of province, ask to see travel documents

How to get yourself into trouble

- Forget that boundaries protect the physician as well as the patient
- Don’t design and adhere to a system of “universal precautions”
- Don’t utilize a safe prescribing agreement
- Don’t obtain informed consent
- Don’t use PharmaNet
- Don’t do random urine drug testing (supervised collection, etc.)
- Blame the patient or the drug for bad outcome
- Violate the prescribing agreement or ignore breach of compliance
- Don’t **document, document, document**

Thank you

- Questions?
- www.cpsbc.ca

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