# Prescribing Dilemmas: Case Studies from the Alabama Board of Medical Examiners Part 1

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MISSION

The Alabama Board of Medical Examiners is charged with protecting the health and safety of the citizens of the state of Alabama.

**William M. Perkins,**
**Executive Director**



## Prescribing Dilemma #1

## "The patients just came to me this way!"

## Prescribing Dilemma # 1

Presentation: Patient comes to a prescriber with a reported lengthy history of chronic conditions and multiple controlled substance prescriptions with high doses

- The patient wants the prescriber to continue the medications "just like the other doctor did it"
- The prescriber knows the dosages are too high, that the combinations are risky, but the patient is very averse to change



## Should you continue the patients on the medications or make changes?

**A) CONTINUE**

**B) MAKE CHANGES**



## Prescribing Dilemma # 1

Dilemma: Continue the patients on the medications or make changes?

- Is the prescriber aware of titration methodologies?
- Is the prescriber willing to say "No?" and mean it?

Risks to the prescriber: Patient harm, transformation of the practice into a pill mill, and Board intervention.

## Prescribing Dilemma #2

## "He prescribes the opioids. I just prescribe the benzodiazepine."



## The prescriber should remain in his or her silo.

A) TRUE

B) FALSE



## Prescribing Dilemma # 2

Presentation: A patient is being prescribed a controlled substance by one prescriber, and another prescriber is managing another condition with a controlled substance. The combination poses a risk of harm to the patient.

Dilemma: Can the prescriber remain in his or her silo? What are his/her responsibilities? What can he/she do about the risks?

## Prescribing Dilemma # 2

Review: Dr. Parran's Presentation

- Benzodiazepines are very "STICKY" drugs because short-term prescribing commonly becomes long term
- Problems with chronic (daily) benzo exposure:
  - TACHYPHYLAXIS (INSOMNIA)
  - PHYSICAL DEPENDENCE AND WITHDRAWAL (withdrawal symptoms are identical to indications for the drug)
  - LIKELY IMPAIR HELP SEEKING BEHAVIOR
  - FDA INDICATION ARE ALL FOR SHORT TERM USE
  - EFFICACY STUDIES ARE ALMOST ALL SHORT DURATION



## Prescribing Dilemma # 2

Review: Dr. Parran's Presentation

- To Taper Off the benzodiazepine
  - **Short** – switch to intermediate onset, long T1/2 agent administered **nightly** and taper.
  - **Long** – switch to intermediate onset, long T1/2 **nightly** and taper.
- Start NON-benzo TX Plan for mental health issues
- The Taper (Outpatient setting)
  - 10% / month = NON - urgent taper
  - 10% / week = Urgent taper
- Avoid PRN benzos entirely



## Prescribing Dilemma #3

**"My patient has severe pain, but she is also probably abusing/misusing the prescriptions."**

## Prescribing Dilemma # 3

Presentation: There is a legitimate diagnosis supporting the prescribing of a controlled substance, such as an opioid for chronic pain, but the prescriber has reason to believe that the patient may misuse, abuse, or divert the medication.

Dilemma: Prescribe the controlled substance or withhold it? Are there any risk mitigation measures the prescriber can take? Is there a third option?



## Prescribing Dilemma # 3

Review: Dr. Parran's Presentation

- January 2016 Annals of Intl Med: 90% of patients continued to receive prescription opioids after an accidental overdose was recorded in the chart
- March 2016 JGIM – Benzos are prescribed more frequently to patients with risk factors for benzo-related adverse events



## Prescribing Dilemma # 3

Review: Dr. Engeriser's Presentation on Buprenorphine Management

- How should I react to a positive UDS?
  - Buprenorphine is a risk reduction strategy
  - A positive drug screen in itself should not be a reason to deny/stop treatment
  - Drug screens positive for fentanyl or methadone require caution
  - Benzodiazepines, barbiturates, and alcohol can increase risk of overdose
  - Continued positive UDS on follow-up appointments may require a change in treatment strategy

# Prescribing Dilemma #4

## "What risk and abuse mitigation strategies do you want me to use?"



## Prescribing Dilemma # 4

Presentation: The Board requires the use of risk and abuse mitigation strategies tailored to the individual patient.

Dilemma: There are many strategies to choose from. Which one does the Board want me to use?



## Prescribing Dilemma # 4

Review: PDMP Presentation

- Overdose risks scores provided for all patients.
- Prescribers can search for prescriptions dispensed under his/her DEA number (MyRx).
- Quarterly Prescriber Reports.
- EHR Integration: Allows prescribers to access PDMP directly from the EHR.
- Application: How to use these reports?

## Who should utilize risk and abuse mitigation strategies?

A) COLLABORATING/SUPERVISING PHYSICIAN ONLY

B) THE PHARMACIST

C) EVERY PRACTITIONER

D) THE PRACTITIONER THAT SAW THE PATIENT FIRST



## Prescribing Dilemma #5

## "An investigator just came to my office. Am I going to lose my license?"



## Prescribing Dilemma # 5

Presentation: A Board investigator comes to your office with a subpoena or communication from the Board about your controlled substance prescribing.

Dilemma: What is going to happen next? Should I change anything I'm doing?

## Prescribing Dilemma # 5

- Self-audit questions:
  - Are my licenses in order?
  - Am I following the rules? Did the investigator just educate me on a rule?
  - Are my medical records and documentation up to date?
- Possible outcomes:
  - Nothing happens
  - Educational letter
  - Interview with the Board
  - Mandated CME
  - Discipline



## Prescribing Dilemma #6

## "What's the deal with testosterone?"



## Prescribing Dilemma # 6

Review: Dr. Koulianos on Testosterone

- Most men who need testosterone don't receive treatment, while those who don't need it, do. Low testosterone becomes increasingly common as men age.
- According to the American Urology Association, a diagnosis should rely on both blood tests and clear, persistent symptoms
- A.U.A. guideline: healthy testosterone levels in men fall between 300 and 800 nanograms per deciliter. However, testosterone can fluctuate widely. Levels are highest in the morning
- There is also a "plateau effect" with testosterone. Once a patient reaches his personal threshold, taking more of the hormone isn't going to do very much.

## Is an Advanced Practice Provider required to have a controlled substance certificate to prescribe testosterone?

**A)YES**

**B)NO**



## Resources

Board Website: www.albme.gov

- Rules page: Rules and Laws | Alabama Board of Medical Examiners & Medical Licensure Commission
- Practice Issues & Opinions | Alabama Board of Medical Examiners & Medical Licensure Commission (albme.gov)
- Investigations & Misconduct | Alabama Board of Medical Examiners & Medical Licensure Commission (albme.gov)
- Reporting | Alabama Board of Medical Examiners & Medical Licensure Commission (albme.gov)

X: Follow @AlaMedBd

- Receive alerts for new rules, agendas, newsletters, etc.
- We are also on Facebook and LinkedIn



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