An Evaluation of the Care Provided to Patients Prescribed Controlled Substances for Chronic Nonmalignant Pain at an Academic Family Medicine Center

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Background and Objectives: Prescribing medications for chronic nonmalignant pain (CNMP) can be challenging for physicians for many reasons. In 1999, the state of Oregon implemented new guidelines governing the prescription of medications for CNMP. This study assessed the quality of care provided to CNMP patients, including the extent of compliance with the new state requirements 2 years after they were implemented. Methods: We used telephone records to identify patients who had called for prescription refills between mid 2001 and mid 2002. We then reviewed medical records of those patients to identify those who received refills for opioids or benzodiazepines for treatment of chronic pain. Medical records were evaluated to measure the percentage of records exhibiting documentation of compliance with state prescribing laws and other features indicative of a high standard of care. Results: Ninety-seven percent of records included documentation of the diagnosis for which chronic therapy was indicated. Required Material Risk Notification Forms were absent from 100% of charts. Seventy-five percent of records documented consultation with a pain specialist or other physician with specialty pertinent to the patient’s source of pain. Medication contracts were only present in 39% of records, and documentation of a pain evaluation and functional evaluation was present in 67% and 54% of records, respectively. Conclusions: Review of medical records in our clinic documented less-than-optimal compliance with state laws regulating prescribing for CNMP and the need for improvement in assessment and care of these patients.

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Chronic pain is one of the most common reasons for which patients see primary care physicians. There are an estimated 60–75 million patient visits for chronic pain annually in the United States. A recent systematic review of mostly European studies reported a prevalence of chronic pain ranging from 10% to 55% of the adult population, with a higher prevalence among females. Given the high prevalence of chronic pain, knowledge and skills in the treatment of chronic pain are essential for primary care physicians.

While guidelines have been developed for treatment of patients who have acute pain and cancer pain, perhaps the most difficult challenge for office-based physicians is treatment of patients with chronic nonmalignant pain (CNMP). The complexity of this clinical issue relates to the subjective nature of pain symptoms, the accessibility and diversity of treatment guidelines about which physicians may be unaware, the many concomitant medical, psychiatric, and substance abuse disorders seen in patients with chronic pain, and frequent changes in health plan formularies that require alterations in treatment regimens based on the patient’s ability to obtain a specific medication. Perhaps because of these factors, CNMP is often undertreated.

In 1999, the state of Oregon developed requirements for the prescription of controlled substances for chronic therapy of nonmalignant pain. These guidelines have since been amended, but at the time of the study, patients receiving ongoing controlled substance treatment must (1) undergo evaluation either by a pain specialist or by a consulting physician experienced in an area of practice pertaining to the likely source of the patient’s pain and (2) sign a Material Risk Notification Form that informs patients about the risk of long-term therapy with controlled substances.

In recognition of the difficulties involved in treating CNMP and of the new regulatory guidelines, we undertook a quality improvement project to examine the care of CNMP patients. The study’s specific objective
was to assess the quality of care provided to CNMP patients, including the extent to which physicians in our clinic were in accordance with the new state guidelines.

Methods

We conducted a retrospective review of the medical records of patients receiving opioids, benzodiazepines, and promethazine with concomitant methadone therapy for 60 days or longer for the treatment of CNMP. This was a clinical quality improvement project that did not require institutional review board approval.

Setting

The study was conducted at a university-affiliated family medicine residency clinic. The clinic is a training site for 12 family medicine residents. Seven full- and part-time faculty members also provide patient care and supervise residents at the site.

Subject Selection

A written list of all patients who contacted the clinic via telephone for prescription refills was obtained for the period of time from July 1, 2001, to May 31, 2002. Medical records of these patients were reviewed to identify those who received prescriptions for opioids, benzodiazepines, or promethazine with methadone. Patients were excluded from the study if they were deceased or had been discharged from clinic during the study period, if their medical record was unavailable for review, or if their care had been initiated during the last 60 days of the study period. Patients were also excluded if they had a diagnosis of malignant disease or if the medications were being prescribed for conditions other than CNMP.

The number of patients before exclusions was 560. The exclusion criteria eliminated 247 patients, leaving a final study population of 313 patients.

Data Collection

The clinic maintains both a paper-based medical record unique to the clinic site and the Lifetime Clinical Record (LCR), which is an electronic medical record for the entire hospital system. For all 313 patients, we reviewed the progress notes and problem lists in the paper and LCR records to assess for compliance with the state regulations, which include: (1) presence or absence of an evaluation performed by a consulting physician specializing in an area of practice thought to be the source of the intractable pain or by a pain specialist, was documented in 75% of the medical records. Material Risk Notification forms were absent from 100% of the charts audited.

Medication contracts were present in 39% of patient charts reviewed, absent from 57% of charts, and an additional 4% of charts contained a reference to a contract in the notes although no physical contract was found to be present. Documentation of a pain evaluation was absent in 33% of the medical records. A brief pain evaluation was present in 48%, and a thorough evaluation was present in 19% of the records. Documentation of functional assessment was absent in 46% of charts. A brief functional evaluation was present in 41%, and a thorough functional evaluation was present in 13%. These findings are outlined in Table 1.

Discussion

At the time of the study (mid 2001 to mid 2002), none of the 313 charts reviewed were in compliance with the 1999 Oregon Intractable Pain Law. All lacked required Material Risk Notification forms, and 25% lacked a specialist consultation required by state statutes. Additionally, most charts lacked medication contracts. Most patients had pain and function assessed, but this was often not thoroughly documented. Overall, our study results indicate that care of chronic pain patients at our clinic needs improvement.

While lack of documentation in the medical record is not proof of substandard care, it is documentation of failure to comply with state laws. Due to high physician turnover, residency clinics may be at particular risk for not complying with documentation requirements of prescribing laws. Such clinics should be diligent in establishing systems that ensure that residents and faculty have access to appropriate education about CNMP
and also to information and documents that are required to facilitate compliance with pertinent legal standards. Since the completion of our study, we have implemented changes to assure compliance with prescribing laws, including routine use of Material Risk Notification forms in patient charts and training sessions for physicians. The use of medication contracts is also increasing, enabling physicians and patients to adhere to an agreed-upon treatment plan.

Limitations

Our study has several limitations that should be considered when interpreting the results. First, as noted, lack of documentation in the medical record does not always indicate that a specific intervention did not take place. For example, patients may have been referred for consultation with a pain specialist or other specialist despite lack of documentation of such consultation in the medical record.

Second, this study was conducted in a single residency program in one state. The findings may not be applicable to residency programs or physicians in other geographic areas. Indeed, the implementation of a CNMP prescribing law in Oregon may have focused a degree of attention on prescribing for CNMP that may not be present in other states.

Third, our method of subject selection relied on telephone records about patients calling for prescription refills. These records may not have been complete, and the effect of such incomplete records on our study results is unknown.

Conclusions

We found that 2 years after our state implemented new regulations governing prescriptions of CNMP, the physicians in our residency program were not in full compliance with regulations. This finding, as well as our assessment of quality of care parameters, indicates need for improvement in the prescribing and documentation practices at our clinic. To the extent that our clinic is representative of other residency clinics, there may be widespread need to improve prescribing practices.

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REFERENCES


Editor’s Note: This paper was acknowledged at the 2003 American Academy of Family Physicians Scientific Assembly as an award-winning paper in the category of research by a medical student (Wasmann and Watkins).