



ISSUES and ANSWERS

Oklahoma State Board
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Happy Hour at the Pharmacy

*By Gerald C. Zumwalt, MD
Board Secretary/Medical Advisor*

Oklahoma ranks in the top tier of all states in non-medical use of prescribed pain relievers by percentage of population (5.66% – 6.72%). The number of deaths due to drug over dosage has shown steady increase from 2000 to 2007 with a very slight drop in 2008 (last year for which statistics are complete).

The most common source for obtaining the drugs used for non-medical reasons is one single doctor/patient relationship (80.7%). By contrast the acquiring of drugs from a “drug dealer” (non physician) is 1.6%. Patients visiting several doctors represent 3.5 % of the source.

Most deaths and overdoses are the result of a combination of prescribed drug or drugs and alcohol consumption. The most common drug involved in overdose deaths in Oklahoma in 2008 was alprazolam with oxycodone a close second.

Obviously, the only cure for a one doctor-one patient relationship resulting in overdosing is a constant vigilance for medical necessity of drugs prescribed and close follow-up for effect of drug, continued medical need and frequency of refills.

For possible “doctor-shopping” there is a valuable, free, and readily available tool. Oklahoma Bureau of Narcotics (OBN) has the Prescription Monitoring Program (PMP), which can be accessed by all physicians. It lists all doctors prescribing, pharmacies filling and the amount of CDS obtained by any individual (if prescriptions are filled in Oklahoma). Directions for obtaining printouts are available from the OBN.

When you think CDS and/or Scheduled medicines, think PMP.

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Tracking addiction

by: KIM ARCHER World Staff Writer

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✈ If you or someone you know needs help with an addiction to prescription drugs, (800) 559-9503 or go to tulsaworld.com/addictionsearch

Twenty years ago, Oklahoma was the first in the nation to monitor federally controlled prescription drugs, inspiring other states to implement similar databases to track down people who are “doctor shopping,” a state narcotics official said.

It was that program that helped net former Oklahoma State University basketball coach Sean Sutton, who was arrested recently and charged Feb. 16 with four drug-related felonies, said Mark Woodward, Oklahoma Bureau of Narcotics and Dangerous Drugs Control.

Prescription drug abuse facts

- More than 35 million people used illicit drugs or abused prescription drugs in 2007.
- In 2006, people entered public drug treatment facilities more than 1 million times to end an addiction to illicit or prescription drugs.
- The federal government allocated more than \$14 billion in 2009 for drug treatment and prevention, counterdrug law enforcement, drug interdiction, and international counterdrug assistance.
- There were nearly 100,000 inmates in federal prisons in September 2008 who had been convicted and sentenced for drug offenses, representing more than 52 percent of all federal prisoners.
- Diversion of controlled prescription drugs costs insurance companies up to \$72.5 billion annually, nearly two-thirds of which is paid by public insurers.

Source: *National Drug Threat Assessment 2009*, a publication of the National Drug Intelligence Center of the U.S. Department of Justice

Although the system can be used as a law enforcement tool — as in Sutton’s case — the primary goal of the tracking system isn’t to arrest people, Woodward said.

“It’s a wonderful intervention tool,” Woodward said. “It is actually used so a doctor can recognize a problem and intervene, not so we can arrest them.”

Oklahoma’s prescription monitoring program started in 1990 and expanded to include many more drugs in 2006. It tracks prescriptions of controlled painkillers, amphetamines and anti-anxiety medications throughout the state when they are filled.

Since then, 34 states have created their own prescription drug monitoring programs. Five other states and Guam have enacted legislation to establish similar programs, but those aren’t yet fully operational, according to Drug Enforcement Administration data.

In Oklahoma, doctors and pharmacists can log into the online database and run a patient’s name through the system. It will show what drugs they are being prescribed, by whom and how much, Woodward said.

Doctors, pharmacists and law enforcement officials can identify drug-seeking behavior through their prescribing history. By running a person’s name through the database, “we get a really good picture of what the person is doing,” he said.

Epidemic

Prescription drug abuse has become a national epidemic, a silent cancer that must be exposed, said OBNDD Director Darrell Weaver

He estimated thousands of Oklahomans are struggling with an addiction to prescription painkillers, anti-anxiety medications or amphetamines. In fact, Oklahoma has seen a 76 percent increase in drug overdose deaths since 2001.

“Prescription drug abuse is not a respecter of persons. It has no social or economic boundaries and can affect anyone in Oklahoma,” Weaver said. “We must not be ashamed. We must shed our pride and seek help.”

Woodward said prescription drug abuse is growing because the drugs are readily available.

“People don’t have to go in a dark alley and participate in a dangerous drug deal,” Woodward said. “They can go to their own medicine cabinet or a relative’s cabinet. And there are so many painkillers on the market.”

Prescription drug addicts go to “great lengths” and will drive many miles to get multiple prescriptions for a controlled dangerous substance, he said.

A case in point: OBNDD agents arrested an individual in December who had gone to 195 medical professionals and 105 pharmacies.

“This is somebody who’s going to multiple doctors to feed an addiction,” Woodward said.

Eighty-six percent of Oklahoma drug overdose deaths in 2008 were due to prescription drugs, he said.

“I think it just shocks the conscience a little bit. It’s a snapshot of the problem, and I think it’s very telling,” he said. “I believe it is an intervention tool. We aren’t going to be able to arrest our way out of this problem.”

Of course, if public safety is in jeopardy, people will be arrested, Weaver said.

“These people are driving our highways. So we will protect the public,” he said.

Currently, about 60 percent of the state’s medical professionals use the database, a number Weaver is hoping will grow quickly.

“We want to err on the side of caution. We don’t want anyone in pain in Oklahoma,” he said. “But we also know this goes way beyond pain.”

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Most commonly abused prescription drugs

- Painkillers such as Oxycontin and Lortab;
- Sedatives such as Xanax and Valium;
- Stimulants such as Ritalin and Adderall

Office of the Chief Medical Examiner Certification of death

When it has been determined that the death of a patient does not meet the criteria for the Medical Examiner to take jurisdiction and therefore certify death, completion of the death certificate becomes the responsibility of the attending physician. Since the death certificate is a legal and not a scientific document, the physician is not required to establish a specific anatomical reason responsible for death. For that requirement, anatomical dissection or additional postmortem studies would be necessary in all deaths, which is clearly unmanageable and beyond the resources of the Medical Examiner and the medical community. The requirement for certification is a statement of the general disease process or condition most likely responsible for death.

We have encountered difficulties with physicians who state that they are uncertain why a patient died although they have been treating the patient for a stable, although not necessarily life threatening condition, for example, a hypertensive patient, quite well controlled, who drops dead suddenly and in view of witnesses. The physician may feel that the death is unexplained and requires an autopsy for specific anatomical diagnosis. However, this death would be viewed as outside the Medical Examiner’s jurisdiction, since medical history provides adequate information for a reasonable cause of death, i.e. hypertensive heart disease and should be so certified.

A second example may be useful. A patient with diagnosed, long standing cirrhosis may die suddenly with no suspicion surrounding death. The anatomical reason may be ruptured esophageal varices or pneumonia or pulmonary embolus. However, the certification requirement is simply cirrhosis with the awareness that the terminal condition may not be established.

It is acceptable to use “probable” to identify a suspected final event, e.g., probable rupture of esophageal varices due to or as a consequence of cirrhosis of the liver. If a specific anatomic cause of death is desired, the physician is free and encouraged to seek autopsy permission from the family after clearing the death with the Medical Examiner. Mechanisms of death frequently encountered on death certificates include atherosclerotic cardiovascular disease, acute coronary syndrome, etc. If a physician has difficulty in completing the certificate, the physician should consult with the Medical Examiner’s Office. If an accident or any type of violence such as a fracture due to a fall causes or contributes to the death, the death is within the jurisdiction of the Medical Examiner. Physicians in Oklahoma should only certify deaths which the manner is “natural” and all other deaths should be certified by the Medical Examiner.

Electronic Death Registration

*Mikeal Murray, Training Coordinator
Center for Health Statistics, OSDH*

The arrival of electronic death registration is close at hand! **ROVER (Registering Oklahoma Vital Event Records)** is on the horizon and soon to be in production statewide. We are in the final stages of development and trials to make sure the system works as it should. As of mid-September, Vital Records staff have entered every death certificate we have received into ROVER and the experience has been very positive. **Our target date for making ROVER widely available to the industry is January 3rd, 2011.**

It has taken us some time to implement this system. As you may know, the death registration process can be very complex depending on circumstances. A record can travel back and forth between the funeral home, the medical certifier, the Medical Examiner's Office and the State. Funeral homes and/or medical certifiers can change; all sorts of things can happen. We want to make sure that ROVER can handle all of these contingencies before we make it available to the industry.

Our rollout process for ROVER will be controlled and gradual between January 2011 and July 2012. In an effort to make sure there are no major "bugs" in the system, we will begin ROVER implementation with the Medical Examiner followed shortly thereafter by those funeral directors located in the Oklahoma City Metro area. Once we are comfortable with ROVER's performance, we'll roll it out to the other metropolitan areas beginning with Tulsa, followed by areas such as Lawton, McAlester, and Enid. As we go, we will try to include as many of the offices from the surrounding areas, as possible. We will finish the implementation process by picking up those groups we missed the first time around. Finally, once we have a large number of funeral homes on ROVER, we will begin bringing on physicians starting with those who sign the largest number of certificates in the state and will work our way out from there with hospital systems and nursing homes.

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Our field staff will show you how to access ROVER, and then you and your staff will be trained on how to enter new records. We will provide you with a fingerprint reader which the physician will use to sign the certificate. ROVER will spell check your cause-of-death statements, as well as guide you through completion of the medical information. **Cause-of-death statements and items left blank are responsible for a majority of errors we see; therefore we expect to see a big decrease in the number of amendments that are submitted in the future.**

We're pleased with the potential that ROVER will bring to death registration including speed, accuracy, and efficiency. If all of the players necessary to complete a death certificate are available on the system at the same time, a death certificate could literally be completed in its entirety and registered with the state in minutes without ever leaving your office! At the very least, the three-day time limit mandated by state law should not be a problem anymore. OSDH will be able to monitor the entire process and can begin proactively contacting those who are contributing to outstanding delays. Families of decedents should receive their certified copies of death certificates faster and with fewer errors. This will allow them to take care of important final affairs and secure the needed resources to move forward with their lives. That's the greatest service any of us can provide during such a difficult time.

For further information regarding the ROVER program, contact:

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Program cuts red tape for volunteer health professionals

Using new national website before a disaster saves time when every minute counts

To make volunteering in an emergency easier for health professionals, the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Preparedness and Response launched a national website today for the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP). [www.phe.gov/esarvhp]

ESAR-VHP is a national network of state-based programs that verifies the identity, licenses, and credentials of health professionals before an emergency happens. The HHS national ESAR-VHP website provides a single point of entry for potential volunteers, connecting them with each state's ESAR-VHP program, so health professionals can volunteer quickly without losing time waiting to have their credentials verified.

"ESAR-VHP saves time so we can make the most of volunteers' specialized medical skills when hours, even minutes, really matter," explained Dr. Nicole Lurie, HHS' assistant secretary for preparedness and response. "Volunteering to help those in need during a disaster is an incredible act of compassion, and ESAR-VHP helps us get volunteers in place when they can make the biggest impact. It puts those who want to volunteer in the best position to be able to do so."

All health professionals are encouraged to visit the ESAR-VHP website, and follow the steps to register with their state system. Health professionals include doctors, nurses, dentists, veterinarians, medical technologists, clinical social workers, medical records technicians, and mental health counselors.

Registering with ESAR-VHP does not mean that health professionals are obligated to serve. Once registered, participants can opt in or out when contacted for volunteer service.

With 49 state programs in place, ESAR-VHP already counts almost 150,000 volunteers in its ranks. Yet with the number of volunteers who could be needed in a disaster is unknown, state coordinators are eager to add to the number of volunteers willing and ready to serve.

"Everybody volunteers for different reasons," says Matthew McCoy, an emergency medical technician from Oklahoma City whose ESAR-VHP registration enabled him to volunteer for three hurricane responses, including Hurricane Katrina. "There's a part of everybody that really wants to help, and when you volunteer with ESAR-VHP, that happens. No matter what you do, you've helped somebody."

ESAR-VHP helps communities, states, and the nation become prepared for disasters. For more information on ESAR-VHP, visit www.phe.gov/esarvhp.

New Rules Effective

A new definition of Physician/Patient relationship has been adopted by the Board and became effective earlier this spring. A related change to the rules of unprofessional conduct was adopted concurrently.

435:10-1-4. Definitions

"Physician/patient relationship" means a relationship established when a physician agrees by direct or indirect contact with a patient to diagnose or treat any condition, illness or disability presented by a patient to that physician, whether or not such a presenting complaint is considered a disease by the general medical community. **The physician/patient relationship shall include a medically appropriate, timely-scheduled, actual face-to-face encounter with the patient, subject to any supervisory responsibilities established elsewhere in these rules.** The act of scheduling an appointment, whether by a physician or by a physician's agent, for a future evaluation will not in and of itself be considered to establish a physician/patient relationship.

435:10-7-4. Unprofessional conduct

(49) Failure to establish a physician/patient relationship prior to providing patient-specific medical services, care or treatment, except in a clearly emergent, life threatening situation.

SIGN UP FOR the OKMRC

The **Oklahoma Medical Reserve Corps** provides medical and public health professionals, as well as dedicated citizens, an organized system for volunteering during a large-scale emergency such as a pandemic, chemical spill, or act of terrorism. In addition, OKMRC volunteers work to improve the overall health and well-being of their communities by engaging in public health initiatives throughout the year. Benefits of membership include:

- Serve your family, friends, neighbors and loved ones in your town and beyond
- Be part of a team trained to provide medical, public, and mental health support during an emergency
- Network with other medical and public health professionals, as part of a critically important and specialized team
- Participate in initiatives that enhance and strengthen public health such as vaccination and health education programs
- An MRC trained volunteer could be part of a team mobilized during a national emergency such as Hurricane Katrina

Visit www.okmrc.org to join!

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