amda
Dedicated To Long Term Care Medicine

American Medical Directors Association

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Mark W. Caverly
Chief, Liaison and Policy Section
Office of Diversion Control
Drug Enforcement Administration
8701 Morrissette Drive,
Springfield, VA 22152

Re: Docket No. DEA–337

Submitted electronically to dea.diversion.policy@usdoj.gov

Subject: Docket No. DEA-337N, "Dispensing of Controlled Substances to Residents at Long Term Care Facilities"

Dear Mr. Caverly,

The American Medical Directors Association (AMDA) and the undersigned organizations appreciate the opportunity to provide comments on the Drug Enforcement Administration's (DEA) June 29, 2010, *Federal Register* Notice entitled "Dispensing of Controlled Substances to Residents at Long Term Care Facilities." AMDA represents more than 8,000 medical directors, attending physicians, and others who practice in nursing homes and other venues in the long-term care continuum, including: hospitals, home health care, assisted living settings, hospice and other sites of care for disabled and elderly patients. AMDA physicians see an average of 100 nursing facility patients per month per member (approximately 8.5 million visits in 2000 or forty-two percent of the total number of nursing facility visits that year). An average of 254 prescriptions per month are written for long-term care patients by each AMDA physician. We are very pleased that the DEA is seeking information from the long-term care community in an effort to finding a solution that addresses the agency's concerns with diversion of controlled substances and our concerns with getting much-needed and appropriately prescribed medication to patients.

While we appreciate that the DEA is seeking comments to determine whether any further revisions to DEA regulations are feasible and warranted, we remain concerned about the DEA's current interpretation of policy that has led to the inability of long-term care providers to obtain lawfully prescribed controlled substances for their residents, many of whom

must wait in pain for hours, or even days, while the required paperwork is being prepared and transmitted to the dispensing pharmacy. We outlined our specific concerns in our May 5, 2009, February 6, 2010, and August 4, 2010 letters to the DEA and Department of Justice. Our primary concern is the new interpretation of policy, under which nurses are not viewed as the agents of the prescriber in long-term care settings. This interpretation has changed longstanding, previously acceptable practices.

Specifically, the DEA has taken action related to prescriptions for controlled substances transmitted orally (usually by telephone) by physicians who are temporarily off-site to nurses who are onsite at the long-term care facility. As a result, physicians are being required to confirm an order previously given to a nurse by voice or fax to the provider pharmacy. As detailed in the May 5th letter, physicians rely on nurses to submit medication orders, including those subject to controls under the Controlled Substance Act. We appreciate that the Notice has described distinctions between long-term care facilities. However, as the clinical leader, the physician works in consultation with nurses and the interdisciplinary team to determine appropriate services and programs for a nursing facility resident to ensure that these are consistent with the person's diagnoses, condition, prognosis, and wishes. This team approach to care has been in existence for approximately 30 years in the long-term care setting.

Nurses in the nursing facility do not act independently— *rather, they serve as the direct agent for the physician, providing important clinical information and responding to the physician's questions. Only then do they transcribe the physician's verbal order*. This is a critical point as the nurse is able to assess patients' pain and, in turn, can furnish the information to allow the physician—*not the nurse*—to order appropriate drugs and services. (This is no different from the way such prescribing frequently occurs at acute care hospitals all over the nation—the nurse contacts the physician, and the physician gives the order by phone.) At present, after discussing the patient with and receiving an order from the physician, the nursing facility nurse then sends a prescription to the dispensing pharmacist *on behalf* of the physician. The nurse is fulfilling an important step by providing the patient's history and helping to provide information that enables the physician to determine the most appropriate emergency treatment option. The nurse transcribes the verbal /telephone orders into the patient's facility chart exactly as ordered by the physician. The nurse then transmits the medication or treatment orders on behalf of the prescribing physician to the pharmacy to obtain the medications for the patient. This is strictly a matter of communicating the direct, individualized and carefully considered physician's order(s) and in no way constitutes a "nursing" order. The physician must also sign the telephone order in a timely fashion, as well as in many cases also sign a facsimile prescription from the dispensing pharmacy, both of which serve as checks and balances that serve to prevent diversion of medications and ensure that medications were indeed provided in accordance with the properly obtained orders. This logical and efficient chain of communication has been effective and safe for decades for all medications and treatments; it is reasonable to amend the law to make it a legal way to communicate orders for controlled substances.

Finally, AMDA supports and recognizes the importance of the DEA's mission to prevent

the sale or theft of prescription medications to drug dealers or abusers. That said, the DEA has yet to clearly establish that the diversion of controlled substances on the basis of nurses transmitting unauthorized or "counterfeit" orders is a widespread problem in long-term care facilities. Multiple safeguards assure the safe use of opioids and other controlled substances in nursing homes. To prescribe controlled substances, every physician must apply for and hold an active DEA license. The presence of a DEA license is monitored by both the nursing home and the medical director. In order to facilitate the checks and balances in long-term care facilities, AMDA officially recommends that the medical director ensures that the physician who prescribes a controlled substance has an active DEA license as part of the physician credentialing process. In addition, through medical director oversight the nursing home is made aware of physicians who do not have a DEA license; and facilities would not allow those physicians to prescribe controlled substances.

A second check currently is in place at the pharmacy dispensing level. Pharmacists are required to check that the prescribing physician holds an active DEA license before dispensing a controlled substance.

Other safeguards include use of lock boxes for opioids and other controlled substances, an inventory of narcotics at every shift change, and documentation of drug destruction. These systems are regularly reviewed as part of the federally mandated survey process.

Our General Comments focus on the immediate effect the DEA's interpretation is having on getting prescriptions to the patient. Specific comments address the Solicitation of Information the DEA requested in the Notice.

General Comments

In the past 16 months, we have received hundreds of phone calls and e-mails from our state chapters and physician members concerning the revised DEA policy that nurses are no longer viewed as an agent of the prescriber. This interpretation has adversely affected prescription practices and procedures, and the timely delivery of medications to residents. To assess the scope of the problem, AMDA conducted qualitative interviews with our state chapters. Chapters reported that there is a widespread problem in the inability of long-term care providers to obtain lawfully prescribed controlled substances for their residents, many of whom must wait in pain while the proper paperwork is being prepared and transmitted to the dispensing pharmacy, forcing physicians to send nursing home patients to an acute care hospital for pain relief. (It would be a clear breach of duty to allow a patient to suffer in that fashion, giving the physician no other choice). This is an urgent problem that needs an urgent solution. We know that patients are suffering needlessly due to the change in the DEA's interpretation of regulation. The nursing home is a place where many are at the end of life, and after a sudden turn of events are in need of pain relief and management of symptoms such as end stage shortness of breath and anxiety. Medications need to be administered within minutes to help alleviate these symptoms—yet, sometimes it is hours before these dying residents get necessary relief. This suffering is cruel and unnecessary.

Prescription Practices

Since May 2009, AMDA state chapters and physicians report that prescription practices have changed. Because it is difficult to obtain the more appropriate controlled substance, physicians are more likely to prescribe a medication that may not be of sufficient potency to alleviate a patient's pain. For example, a non-scheduled drug may be prescribed instead of a controlled substance, or a Schedule III medication may be prescribed in place of a Schedule II. Delays associated with prescribing controlled substances may leave a patient without needed medications and in severe, excruciating pain for hours or days.

Prescription Procedures

Compliance with DEA regulations has resulted in frequent delays in the dispensing and delivery of appropriately prescribed controlled substances. These delays may occur because physicians do not always have immediate access to a fax machine, have difficulties getting access to the pharmacist who can receive confirmation of the emergency verbal order, and because of possible backlog in the number of voice messages and faxes that the pharmacy has to respond to under the current process.

DEA Registrant Issue

When asked to discuss the option of registering long-term care facilities as DEA registrants similar to the status of hospitals, none of the AMDA members interviewed were aware of movement toward this process in their state. (As mentioned in our August 4, 2010 letter on the Ohio Board of Pharmacy outline, neither AMDA nor its Ohio chapter were included in the development of the Ohio Board of Pharmacy's outline.) Due to the many unanswered questions related to the newly proposed registration, facilities may be unwilling or unable to go through the process of obtaining registration and that the process will simply take too long.

Potential Solutions

Several changes in regulation have been proposed, but each is a lengthy, time-consuming solution. This is an *urgent* problem for which an *urgent* solution is long overdue. Ninety-one percent of AMDA members surveyed reported that their facility has experienced delays in obtaining controlled substance medications for residents. Seventy-one percent surveyed said that the delays apply to all schedules. Due to this inability to receive medications in a timely manner, twenty-four percent responded that their facility has had to send residents to the hospital to receive controlled substances medications.

An administrative change in DEA's interpretation of the Controlled Substances Act to better comport with its recognition of long-term care nurses as agents of the prescriber for purposes of administering controlled medications and to recognize a chart order as a valid prescription (as long as appropriate documentation for this prescription is later provided to the pharmacy) is within the DEA's regulatory capacity—indeed, this had been the apparent interpretation in widespread, nationwide practice in long-term care for at least the last decade before this new policy began. This has been the subject of multiple comment requests to the DEA from AMDA, as well as other long-term care stakeholders and other medical societies, including the American Medical Association.

The remainder of our comments focus on responding to the questions posed in the Notice. AMDA posted an online survey of questions. The answers below summarize responses from our membership.

Specific Comments

B. Scope

Question 6: For how many residents does your Long Term Care Facility (LTCF) provide care?

The most frequent response from AMDA members was that their LTCF had 100 residents. The average number of residents reported was 147.5.

Of those, what percentage require controlled substance medications?

The average percentage reported was 47 percent of residents required a controlled substance medication.

Question 7: Approximately what percentage of those residents requiring controlled substance medications receive such medications on a daily basis?

The most frequent response was that 80 percent of those residents requiring controlled substance medications receive such medications on a daily basis. The average percent reported was 71 percent.

Further, of those who receive controlled substances on a daily basis, what percentage receive Schedule II substances?

The most frequent response was that 50 percent received Schedule II substances. The average was 52 percent.

Question 8: When a person comes to a LTCF, does the person bring their own already dispensed medications?

No, a medication must be packaged by a nursing home provider pharmacy.

Question 9: What, if any, State requirements impact a person's ability to bring medication into a LTCF?

Many respondents were unsure or did not understand the question. Our members' responses varied because Board of Pharmacy regulations vary state to state as well as differing from standard federal regulations. Most who offered a response indicated that patients are not permitted to bring prescribed medications into the facility. Some mentioned that they may be allowed to bring over-the-counter medications (such as vitamins) in, however, those must be sealed in original packaging and would be kept in a locked box in the patient's room. Several stated that all prescription medications must come from the pharmacy be verified and then "sealed" packaged by that pharmacy.

Question 10: If a person arrives at the facility without any medical information, how does the facility obtain any needed medications?
Information is obtained from the patient's previous facility (i.e., hospital or other LTCF), from the patient's primary care physician, and from the patient's family.

Question 11: If a person is moving from an acute care facility to a LTCF, what factors impact the acute care practitioner's ability and willingness to provide written prescriptions to the person?
Factors that impact the practitioner's ability to provide a written prescription include the following:

- Availability of the acute care physician. It may be more difficult to provide the written prescription after hours or on weekends and/or holidays.
- Lack of awareness of DEA regulations on the acute care physicians' part, of DEA regulations. Several answers indicated that acute care practitioners might be more willing to write the script if they a) were aware that changes in DEA policy no longer recognized the long term care facility's nurse as the agent of attending physician and all that implies and that b) doing so would increase timely access to needed medications for patients they were discharging.
- Concern about diversion. Many patients going to LTCFs are not capable of going to an outside pharmacy on their own to get their prescriptions filled prior to their arrival at the LTCF (and even if they did, they would not be permitted to bring the medication into the facility for their own use in most instances). They will have the medication provided by the LTCF's dispensing pharmacy, even if there is a delay. This leaves a higher than normal risk that the hard copy prescription could be diverted and abused sometime after the patient's discharge from the acute care hospital and his/her arrival at the LTCF.

Question 12: If a person arrives at a facility without medication and without prescriptions, what steps does the facility take to assess the person's medication needs?
In cases where the physician or practitioner is not onsite at the time of LTCF admission, the nursing facility nurse calls the physician or practitioner, reviews the information that is available (such as hospital discharge transfer orders, medication administration records from the previous care setting, medication lists from the patient or family members, etc.), and obtains new prescription orders for the necessary medications from the prescriber. The new attending physician or his/her practitioner does an admission history and physical (H&P), reviews available documentation from the institution previously caring for and referring the individual, and, if possible, interviews the patient's family. Often, information available from the transferring facility lacks a current prescription, causing a delay between the time of admission and the time at which the admitted patient's prescription is dispensed. Physicians at hospitals are often unfamiliar with federal regulations on nursing homes, and do not send a prescription, or refuse to do so for fear that a prescription with their DEA number would be floating around unprotected. Physicians at hospitals also may believe—appropriately in most cases—that the physician assuming care at the LTCF will ensure that the patient receives the necessary medications to the best of his/her ability. However, the hospital physician in most cases does not

understand that in the case of controlled substances, there are impediments that will cause a long delay for the transferred patient to obtain that much needed medication.

Question 13: What are the current practices for obtaining controlled substance prescriptions for residents at a LTCF?
Currently, with the recent DEA enforcement, a physician with a valid DEA license must write a prescription on a hard copy prescription blank, and fax it into the pharmacy. The required elements of the hard copy script are as follows:

- Date of issue;
- Patient's name and address (A nursing facility is the address for the resident);
- Practitioner's name, address, and DEA registration number;
- Drug name;
- Drug strength;
- Dosage form;
- Quantity prescribed;
- Directions for use;
- Number of refills (if any) authorized; and
- Manual signature of prescriber.

Alternatively, the physician must call and speak to a pharmacist (emergency situation only) for a limited supply of the needed drug, until they can get a hard copy script to the pharmacy (but must arrive within 7 days of the verbal order). In either case, according to the DEA's new interpretation of the regulations, the nurse may no longer communicate the practitioner's order to the pharmacy.

How do these practices differ between Schedule II controlled substances and Schedule III-V practices?
At this time, most pharmacies are accepting nursing facility chart orders for CIII-V. However, we have heard that the DEA will be asking that practitioners provide a written prescription for CIII-V. This order may be written in the chart and faxed to the pharmacy as long as it has all of the elements of a hard copy script as above for CII, including the quantity and number of authorized refills to be used within six months of date of issue and complete addresses and the DEA number. The practitioner or the agent of the practitioner may phone a CIII-V prescription directly to the pharmacist and with no hard copy to follow required. In some areas, if the prescriber gives a telephone order to the nurse for CIII-V medications, the pharmacist is requiring a separate oral verification directly from the prescriber.

How do these practices differ between an emergency situation and a nonemergency situation?
If the facility has an "emergency kit," the nurse may access the medication (if it is available in the kit) and administer it to the resident for whom it was ordered, but can only do so once the physician has given a verbal order to the pharmacist and the pharmacist has communicated with the nursing facility (confirmation of order) that the order for a controlled substance has been received. However, responses indicated great difficulties in connecting all necessary parties (physician, pharmacy, pharmacist, nursing home) in communication during emergency situations. Some physicians stated that if

they are unable to get the prescription to their patient in severe pain during an emergency, they will advise that the patient should be transferred to the hospital for pain control, causing unnecessary pain, the trauma of ambulance rides and emergency room visits, additional delays in receiving necessary medication, and other potential negative outcomes, and incurred costs (both to the patient and the health care system at large). In some instances, these situations that could easily have been managed within the LTCF with appropriate, timely administration of prescribed medication, but instead, have resulted in unnecessary rehospitalizations.

Question 14: What types of emergency situations arise at a LTCF that would necessitate the use of controlled substances?
An example of an emergency situation is when a resident arrives from an acute care facility having been treated for pain in the hospital several hours earlier, but arrives at the nursing facility with no hard copy prescription for pain medications and requires immediate pain management. Another example is a patient with an unanticipated acute exacerbation of a chronic illness who needs immediate pain medication but for whom no existing order for a controlled substance exists. Another situation is when a patient who is actively dying suddenly needs more pain medication than previously anticipated, and the need exceeds current availability or requires new medication.

Question 15: What are the standard operating procedures to address emergencies?
The physician must call the prescription in to the pharmacy and speak to a pharmacist him/herself or send a fax. Compliance with DEA regulations has resulted in frequent delays in dispensing and delivery of appropriately prescribed controlled substances. These delays are occurring for several reasons: Physicians do not always have immediate access to a fax machine; they are often traveling between settings (in rural areas, this travel may be extensive.). Often, physicians have difficulty getting access to the pharmacy because the pharmacies that serve LTCFs are not set up like retail pharmacies; there may be hundreds of calls coming in but only a few pharmacists available to answer the calls. As a result, there may be a backlog in the number of voice messages and faxes that the pharmacy has to respond to under the current process, or a prolonged delay for the physician to get to speak directly with the pharmacist.

What are the procedures in a LTCF for obtaining controlled substance medications for residents in an emergency situation? Is the process different for Schedule II as opposed to Schedule III–V controlled substances?
If an e-kit is available, it can be accessed once the prescription process is followed and the order "dispensed." However, the e-kit also can be used in a nonemergency situation. Again, there is no difference between an "emergency" situation and a nonemergency situation. This creates a particularly frustrating situation for attending physicians as the medications are onsite and available, but cannot be dispensed until the time consuming prescription process is followed and the medications are authorized to be dispensed. (It should be noted that other medications such as antibiotics, antiemetics, etc., are also kept on the e-kit and can be used in a variety of situations, both emergent and non-emergent.)

Question 16: Has your facility experienced delays in obtaining controlled substance medications for residents?
Ninety-one percent of respondents answered "yes."

If so, why have these delays occurred?
The following responses were mentioned as reasons contributing to delays:

- Physicians may not be in a position to send a fax or call a pharmacy directly (e.g., after hours, on vacation, stuck in traffic).
- There may be delays between the time a physician sends a fax or calls a pharmacy and when the pharmacy is able to respond to the fax or return the call.
- Medications can no longer be kept and dispensed from e-kits without approval from the pharmacy. (Note, even if a controlled substance is available in an e-kit, it still may not be dispensed until the practitioners has communicated to the pharmacist and the pharmacist has communicated to the nurse at the facility that the order was received and the details of the order.)
- Discharging physicians at hospitals usually have not issued prescriptions to patients being transferred to nursing homes.

At what steps in the prescribing process have the delays occurred? (Please specify whether the delay was with a Schedule II or a Schedule III-V controlled substance.)
Seventy-one percent of respondents said that the delays apply to all schedules. Twenty-one percent reported delays only for Schedule II, while the remainder reported delays for all schedules, but noted that the problem is worse for Schedule II controlled substances. The most common responses indicated that the point of admission and the point of renewal are the most problematic, many indicating that there are delays in all situations and at all points in the prescription process. There is widespread consensus that the delays are exacerbated during after hours.

Question 17: Have any residents at your facility experienced problems caused by delays in obtaining prescriptions for controlled substances?
Ninety-three percent of respondents answered "yes." Many respondents reported that they have had patients who experienced uncontrolled pain (at the time of death in many instances) and anxiety while waiting for medications as a result of prescription delays.

If so, what was the reason for the delay?
Most respondents reiterated or simply referred to their responses in prior questions, citing the need for the physician to fax a prescription or contact the pharmacy directly as the cause for delays. The delays happen when the facility has difficulty contacting the physician, when the physician is not in a position to send a fax or call the pharmacy, and when the pharmacy has a backlog of faxes and calls to return. Again, the problem is exacerbated during after hours, on weekends, holidays, or when the attending physician is on vacation.

One member provided us with the following anecdote: "Between calling the nursing home back, obtaining the information, and then calling the pharmacy, and then waiting to speak to a pharmacist, my patients were left waiting in exam rooms feeling neglected and

the waiting room was backed up for hours. If I could have just spoken to the nurse in the nursing home, I could have gone right back in the exam room instead of taking significant time away from my office patients and backing everyone's schedules up. So many patients are being affected by this, not just the ones in nursing homes. This just wasn't fair."

How often have such problems occurred?
Fifty-seven percent answered that the problems happen at least weekly. Of those, half reported that the problems occur daily. Of the remaining 43 percent, respondents reported that problems occurred "frequently," "often," "very frequently," or some variation thereof.

Did the delays occur with Schedule II or with Schedule III-V substances?
Almost half of those responding reported that delays happen with all schedules. Sixteen percent answered that the problems are worse for Schedule II, but occur for all substances. Twenty-two percent said the delays occur only for Schedule II drugs. Four percent said the delays occurred primarily for Schedule III-V drugs.

Question 18: Does your facility send residents to the hospital to receive controlled substance medications because they were unable to receive the medications at your facility in a timely manner?
Twenty-four percent responded that their facility has had to send residents to the hospital to receive controlled substances medications because they were unable to receive the medications at their facility in a timely manner.

C. Communication
Question 19: How often are practitioners contacted by LTCFs regarding requests for changes in residents' medications generally?
Almost half of respondents answered that they were contacted by LTCFs at least daily, with many saying this happens many times throughout the day. Another 18 percent answered at least weekly. Eighteen percent also answered "frequently," "regularly," "often," or some variation thereof. The remaining respondents said they were contacted at least monthly or were unsure.

How often does this occur for controlled substance prescriptions specifically?
Most respondents answered that they were contacted at least daily or weekly about requests for controlled substances.

Question 20: How does communication currently occur among the practitioner, the LTCF and the pharmacy, *e.g.* phone, fax, other?
The physician either calls the pharmacy directly, or sends a signed fax. Nurses are not allowed to communicate the order on behalf of the prescribing physician. Often, physicians are required to leave a voice message with the pharmacy. Delays result when the pharmacy takes time to return the physician's call (which can take many hours, and at that point, the physician may be tied up seeing patients and may have to try to return the

call, causing a miscommunication loop.). Also, our members report delays in pharmacy responses to faxed prescriptions. There also report delays resulting from faxes that get lost, requiring the process to be restarted. In the past, when the physician could communicate the prescription to a nurse directly, such delays were less common, if not nonexistent.

Do you expect the new DEA regulations providing the option of electronic prescriptions will be used by practitioners and pharmacies in your LTCF?
While respondents were hopeful that this might be a future fix, they all reported that the systems and technology are not currently available and will not address the current situation, which requires urgent attention.

If so, do you anticipate that the use of electronic prescriptions will alleviate delays you may have experienced in providing controlled substances to residents?
Similar to the responses for the previous question, respondents are concerned that the systems and technology are not yet available to allow the use of electronic prescriptions.

Question 21: Does the LTCF or practitioner communicate other information to the pharmacy, such as changes in the resident's practitioner or the change in status of a resident?
Normally, the facility communicates this information to the pharmacy (change of practitioner, discharge status, room change, medication changes, etc.).

Question 22: Would practitioners have any interest in designating certain persons at LTCFs as their agents solely for the purpose of communicating controlled substance prescription information to the pharmacy, understanding that the agent would be working under the prescriber's DEA registration and that the prescriber would be responsible for the agent's actions, which must be consistent with the CSA?
Yes. AMDA believes the DEA should recognize nursing staff, especially the licensed nurse, as agents of the prescriber/physician in long-term care facilities.

E. Chart Orders
Question 25: In current practice, when must a practitioner acknowledge a chart order by signing it?
There is no standard practice. It is dependent upon the nature of the order. A non-emergent verbal order, such as a change in diet, may be signed on the next visit. Often, the facility medical director will set the parameters of when he/she will want the attending practitioners to sign orders. Orders may be faxed to a practitioner, then signed and faxed back for placement in the chart as well. However, in AMDA's survey, on average a practitioner will acknowledge a chart order within 48 hours to within 7 days.

Do State laws/regulations, HHS regulations, or other standards (e.g. Joint Commission) define the time period within which the practitioner must sign the chart order for any care setting (hospital, clinic, or LTCF)?
Federal licensure regulations do not stipulate time frames to sign orders. State licensure regulations vary. Hospitals have time frames consistent with the presence of daily physician presence. The Joint Commission acknowledges following each facility's state requirements or facility policy.

Question 26: Currently, are chart orders (in hospitals or in LTCFs for non-controlled substances) required to have an ''expiration'' date, at which time they must be either reauthorized or closed? LTCFs differ from hospitals in that residents in LTCFs by definition stay for a longer period. Because of this, should chart orders in LTCFs ''expire'' at some time after issuance? If so, what time period would be appropriate?
No. This is an unnecessary burden because orders must be reviewed and signed every 30-60 days depending on the type of order. At that time, the physician has the option to renew or discontinue each prescription. Further, federal guidelines require monthly consultant pharmacist review, and unused medications are identified by that mechanism.

Question 27: If certain persons at the LTCF were designated to act as agents of individual practitioners (to the extent authorized by the CSA) to communicate controlled substance information from the individual practitioner to the pharmacy, how would this change current practices at your facility for obtaining controlled substance medications for residents? What safeguards should be required?
Patients would receive medications in a timelier manner because the medication could be dispensed as soon as the order is given. A policy should require that verbal/telephonic orders be signed within forty-eight (48) hours, similar to the process followed for other verbal/telephonic orders, to ensure that a review process is in place.

H. Staff
Question 37: Does the Medical Director of your facility also serve as Medical Director for other locations or facilities? If so, for how many? AMDA data collected through a survey of our membership showed that the average number of long-term care facilities served by AMDA medical directors is one to two.

Question 38: Is the Medical Director of your facility also an attending physician?
AMDA data collected through a survey of our membership showed that approximately 88 percent of AMDA members also serve as attending physicians in the long-term care facility.

Question 39: Is your Medical Director registered with the DEA as a practitioner?
Ninety six percent of respondents stated that the medical director is registered with the DEA.

Question 40: If your LTCF is a Medicare or Medicaid approved facility, what barriers, if any, has your facility faced in assuring the provision of physician services 24 hours a day in case of an emergency?
Most respondents answered that there have been no barriers, with many saying that the responsibility falls to the Medical Director in cases where another physician might not be available.

Question 41: As a LTCF, does your facility have a physician onsite during regular business hours?
Nine percent of respondents answered that they have a physician onsite during regular business hours. The remainder answered that there are physicians onsite part of the time, when making either medically necessary visits or federally mandated scheduled visits.

Question 42: How does your facility communicate with a resident's practitioner?
Respondents stated that the nurse was usually the person who contacted them and that they typically were contacted via phone or fax. Other communication methods included pages, texts, voice mail, and emails.

Question 43: How frequently is a physician onsite at your facility?
Respondents indicated that the answer to this question depends on the physician and on the medical condition of the patients in the facility. In a LTCF, aside from the federally mandated visit schedule, visits are made on a "medical necessity" basis. That is, visits are dependent on the resident's medical and psychological needs.

Do most physicians treat multiple residents at a single facility?
Almost all respondents indicated that physicians treat multiple residents at a single facility. Only one person indicated that they treated one patient at a single facility.

The survey responses and data validate AMDA concerns about recent DEA policy on controlled substance prescribing. Members repeatedly relate experiences regarding patients suffering needlessly in pain because of unnecessary requirements. Since this issue first emerged in Ohio in March 2009, no substantiated evidence of diversion on the basis of falsified prescriptions called in by rogue nurses has emerged. For decades, providers of long term care in nursing facilities have worked in cooperation to ensure that safeguards are fully implemented in this setting and the interdisciplinary team concept of care has been the standard of long-term care for decades. In particular, the nurse, as agent of the physician, has worked hand-in-hand with the physician to ensure that both legal compliance of pharmaceutical distribution and timely patient care are addressed. There is no reason to continue to make these frail, vulnerable patients suffer.

Please do not hesitate to contact AMDA Director of Government Affairs Kathleen Wilson, PhD, with any questions at (410) 740-9743.

Sincerely,

Paul Katz, MD, CMD
AMDA President

California Association of Long Term Care Medicine

Florida Medical Directors Association

Georgia Medical Directors Association

Kentucky Medical Directors Association

Maine Medical Directors Association

Maryland Medical Directors Association

Missouri Association of Long Term Care Physicians

Ohio Medical Directors Association

Texas Medical Directors Association

Wisconsin Association of Medical Directors