



# West Virginia Best Practice Prescribing & Drug Diversion Training

**One (1.0) Contact Hours**

**Course Expires: 04/30/2020**

First Published: 10/09/2013

Revised: 01/10/2017

Note: The West Virginia Board of Examiners for Registered Nurses requires all RNs in West Virginia to complete an initial 3 contact hour course in drug diversion training & best practice prescribing of controlled substances, as part of the current 12-hour CE requirement. Subsequent training may be shorter in length. This CE offering meets the initial CE requirement for drug diversion training.

WVBRN Provider Registration number: WV2002-0425RN.

Copyright © 2017 by RN.com.  
All Rights Reserved.

Reproduction and distribution of these materials is prohibited without an RN.com content licensing agreement.

## **Acknowledgments**

***RN.com acknowledges the valuable contributions of...  
... Suzan R Miller-Hoover, DNP, RN, CCNS, CCRN-K***

## **Conflict of Interest**

RN.com strives to present content in a fair and unbiased manner at all times, and has a full and fair disclosure policy that requires course faculty to declare any real or apparent commercial affiliation related to the content of this presentation. Note: Conflict of Interest is defined by ANCC as a situation in which an individual has an opportunity to affect educational content about products or services of a commercial interest with which he/she has a financial relationship.

The author of this course does not have any conflict of interest to declare.

The planners of the educational activity have no conflicts of interest to disclose.

There is no commercial support being used for this course.

## **Purpose & Objectives**

The purpose of this presentation is to provide healthcare professionals with information regarding the safe administration and dispensing of controlled substances to patients, and the abuse or misuse of illicit drugs in West Virginia (WV).

This presentation is divided into 2 sections: Section I covers the safe & effective prescribing, administration & dispensing of controlled substances, and section II deals with drug diversion training.

### **Objectives:**

- Explain the epidemiology of chronic pain and misuse/risks of abusing opioids.
- Describe addictive symptomatology and the use of risk evaluation and mitigation strategy in opioid safety management.
- Discuss the West Virginia Controlled Substances Monitoring Program.
- Review the development of a comprehensive patient evaluation & treatment plan.
- Identify drug diversion and drug seeking tactics and behaviors.
- Review methods to minimize drug diversion.
- Outline best practice methods for working with patients suspected of drug seeking behavior and diversion.
- Discuss best practice methods for working with colleagues suspected of drug seeking behavior and diversion.
- Describe the 5 drug diversion prevention laws in WV.

## **Section I: Introduction**

Abuse and misuse of prescription opioid medications is a major public health problem in the United States.

The National Institute on Drug Abuse (NIDA) defines prescription drug misuse as “taking a medication in a manner other than that prescribed or for a different condition than that for which the medication is prescribed.”

Prescription drug abuse is defined by the NIDA as “the intentional misuse of a medication outside of the normally accepted standards of its use”.

There has been a progressive increase in the extent of prescription drug abuse in this country, which is most likely the result of a confluence of factors, such as:

- Significant increases in the number of prescriptions
- Significant increases in drug availability
- Aggressive marketing by the pharmaceutical industry
- The proliferation of illegal Internet pharmacies that dispense these medications without proper prescriptions and surveillance
- Greater social acceptability for medicating a growing number of conditions.

(National Institute of Drug Abuse (NIDA), 2009)

## **Substance Abuse & the Law**

In 2012, Senate Bill 437 was signed into law and relates primarily to Substance Abuse in West Virginia. It is known as the Governor's Substance Abuse Law, and signifies one of the most comprehensive approaches taken in recent history to address the prescription drug diversion and substance abuse related problems in West Virginia (Jackson Kelly, 2012).

The new law contains five main areas of focus:

- Additional regulation of opioid treatment centers (Methadone Clinics).
- Establishes licensing and regulation of chronic pain clinics.
- Establishes review capabilities of the Controlled Substances Database under the Board of Pharmacy to flag abnormal or unusual usage patterns of controlled substances by patients and unusual prescribing or dispensing patterns by licensed practitioners.
- Implements a requirement for continued education for all prescribers, dispensers and persons who administer controlled substances.
- Establishes a requirement for pharmacies to utilize a Multi-State Real-Time Tracking System to track sales of pseudoephedrine, and limits the amount allowed to be legally purchased.

This law requires individualized treatment of care plans to include a recovery model that outlines steps to follow in ensuring complete physical, mental and emotional rehabilitation.

## **Test Yourself**

The Governor's Substance Abuse Law of 2012:

- A. Requires prescribers to track sales of hydromorphone hydrochloride.
- B. Enables federal tracking of individual prescriber's prescription records.
- C. Establishes licensing and regulation of chronic pain clinics.**

**Rationale: The new law contains five main areas of focus:**

- 1. Additional regulation of opioid treatment centers (Methadone Clinics).**
- 2. Establishes licensing and regulation of chronic pain clinics.**
- 3. Establishes review capabilities of the Controlled Substances Database under the Board of Pharmacy to flag abnormal or unusual usage patterns of controlled substances by patients and unusual prescribing or dispensing patterns by licensed practitioners.**
- 4. Implements a requirement for continued education for all prescribers, dispensers and persons who administer controlled substances.**
- 5. Establishes a requirement for pharmacies to utilize a Multi-State Real-Time Tracking**

**System to track sales of pseudoephedrine, and limits the amount allowed to be legally purchased.**

## **Incidence of Substance Abuse**

Data from the 2011 National Survey on Drug Use and Health (NSDUH) reports that in 2011, an estimated 22.5 million Americans aged 12 or older were current illicit drug users. This estimate represents 8.7 percent of the population aged 12 or older (Substance Abuse and Mental Health Services Administration (SAMHSA), 2013). Per the West Virginia Drug Control Update (2013), approximately 7 percent of West Virginia residents reported past-month illicit drug use; the national average is 8 percent.

Marijuana was the most commonly used illicit drug, with 18.1 million past month users in 2011, and most illicit drug users reported that their first drug was marijuana (67.5 percent) (SAMHSA, 2013).

In addition to illicit drug usage, approximately 5.2 million persons in the United States ages 12 or older were current non-medical users of prescription pain relievers. Misuse of these substances was most prevalent in young adults (ages 18–25), followed by adolescents (ages 12–17) and adults (ages 26+) (SAMHSA, 2013).

However, because prescription opioid use is so tied to chronic pain, when studying subgroups of individuals with chronic pain, opioid use has been reported to increase with age. Even though the use of prescription opioids increases as patients with chronic pain age, there are indications that risk of misuse may decline with increasing age in this group of chronic pain patients prescribed opioids (SAMHSA, 2013).

In 2011, an estimated 3.1 million persons aged 12 or older used an illicit drug for the first time within the past 12 months. More than one in five initiated with psychotherapeutics (pain relievers, tranquilizers, stimulants and sedatives).

### **Did You Know?**

**Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics (pain relievers, tranquilizers, stimulants, and sedatives) used non-medically.**

## **Definition of Pain**

Pain can be defined as “an unpleasant sensation caused by noxious stimulation of the sensory nerve endings” (Mosby’s Medical Dictionary, 2012).

It is a subjective feeling and an individual response to the cause. Pain is a cardinal symptom of inflammation and is valuable in the diagnosis of many disorders and conditions. It may be mild or severe, chronic or acute, lancinating, burning, dull or sharp, precisely or poorly localized, or referred.

"Experiencing pain is influenced by physical, mental, biochemical, psychological, physiologic, social, cultural, and emotional factors" (Mosby’s Medical Dictionary, 2012).

## **Chronic Versus Acute Pain**

Acute pain, such as occurs with trauma, often has a reversible cause and may require only transient

measures and correction of the underlying problem.

Chronic pain is different. Chronic pain persists. Pain signals keep firing in the nervous system for weeks, months or even years. There may have been an initial mishap—sprained back, serious infection, or there may be an ongoing cause of pain—arthritis, cancer, ear infection. Some people suffer chronic pain in the absence of any past injury or evidence of body damage. Many chronic pain conditions affect older adults.

Common chronic pain complaints include headache, low back pain, cancer pain, arthritis pain, neurogenic pain (pain resulting from damage to the peripheral nerves or to the central nervous system itself), psychogenic pain (pain not due to past disease or injury or any visible sign of damage inside or outside the nervous system)

Chronic pain can be defined as pain that persists after reasonable medical efforts have been made to relieve the pain or cure its cause and that has continued, either continuously or episodically, for longer than three continuous months.

For purposes of this course, “chronic pain” does not include pain associated with a terminal condition or with a progressive disease that may reasonably be expected to result in a terminal condition.

## **Epidemiology of Chronic Pain**

Millions of Americans suffer from acute or chronic pain every year and the effects of pain place a tremendous burden on our healthcare costs, services and lost worker productivity, as well as emotional and financial burdens on patients and their families (American Academy of Pain Medicine (AAPM), 2013).

Chronic pain is associated with a wide range of injury and disease, and is sometimes the disease itself. According to a recent Institute of Medicine (IOM) Report: Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research, at least 100 million adult Americans had common chronic pain conditions in 2011, which was a conservative estimate as it did not include acute pain or children. Chronic pain is a significant public health problem that costs society at least \$560-\$635 billion annually (AAPM, 2013).

Chronic pain, experienced by about a third of the population, is primarily associated with lower back pain, followed by severe headaches or migraine pain, neck pain and osteoarthritis pain. Chronic pain is related to indicators of poorer socioeconomic status. (AAPM, 2013).

***Common recurrent pain disorders are inversely related to income and education (socio-economic status).***

Healthcare professionals play an important role in increasing public awareness of chronic pain conditions and the holistic management of pain.

## **Assessment of Pain**

Pain levels should be assessed regularly and frequently. Pain is individualized and subjective; therefore, the patient’s self-report of pain is the most reliable gauge of the experience.

If a patient is unable to communicate, the family or caregiver can provide input.

Components of pain assessment include:

### **History and physical assessment:**

History of pain onset, intensity, duration & type. Examination of site of pain & examination of musculoskeletal & neurological systems.

### **Functional assessment:**

Impact of pain on daily activities & impact of pain on cognitive functioning and sleep patterns.

### **Psychosocial assessment:**

Patient's goals for pain management. Evidence of depression or alcohol/drug abuse in response to chronic pain experience.

## **Test Yourself**

Pain:

- A. Is individualized and subjective
- B. Relief should be scheduled at standardized intervals
- C. Is best assessed by observation of vital signs and clinical findings

Rationale: Pain levels should be assessed regularly and frequently. Pain is individualized and subjective; therefore, the patient's self-report of pain is the most reliable gauge of the experience. If a patient is unable to communicate, the family or caregiver can provide input.

## **Principles of Pain Management**

Pain management refers to the appropriate treatment and interventions developed in relation to pain assessment, and should be developed in collaboration with the patient and family (Mosby's, 2012).

Pain management generally benefits from a multidisciplinary approach that includes:

- Pharmacologic measures (analgesics such as narcotics, and pain modifiers such as antidepressants or anticonvulsants),
- Non-pharmacologic measures (such as interventional procedures, physical therapy and physical exercise, application of ice and/or heat)
- Psychological measures (such as biofeedback and cognitive therapy).

## **Pharmacological Therapies for Pain Management**

The use of medications to treat pain can be complex. Multiple factors must be considered including age, current medications, patient medical and substance use history, and type of pain (Maryniak, 2013).

Pharmacological treatments include:

- **Analgesics:** Acetaminophen (Tylenol®) is a common analgesic used for mild pain, or in a combination with opioids for moderate pain. There must be caution taken in the amount of excessive acetaminophen used per day, which can result in hepatic toxicity.
- **Non-steroidal anti-inflammatories (NSAIDs):** Common examples include salicylates, ibuprofen (Advil®), naproxen (Aleve®), and ketorolac (Toradol®). These are used to reduce inflammation which can decrease pain. NSAIDs can be used for mild pain, or in combination with opioids for moderate pain. Caution is needed with dosages for pediatric and elderly patients, and NSAIDs are contraindicated in patients with hepatic or renal impairment, bleeding disorders, or gastrointestinal ulcers (Maryniak, 2013).

## **Non-Pharmacological Therapies for Pain Management**

There are a variety of approaches for decreasing pain that are non-pharmacological in nature. These types of strategies are often over-looked, but can be effective for alleviating pain when used either alone or in combination with other non-pharmacological or pharmacological measures.

Non-pharmacological interventions may include:

- Heat or cold (as appropriate)
- Massage
- Therapeutic touch
- Range of motion or physical therapy
- Repositioning and/or immobilization
- Relaxation techniques and imagery or distraction
- Psychotherapy or cognitive behavioral therapy
- Use of biofeedback, music therapy, aromatherapy or acupuncture
- Transcutaneous electrical stimulus (TENS)

## **Opioid Analgesics: What Are the Risks?**

Prescription opioids are available as either immediate-release (IR) or extended-release (ER) products. Immediate-release (IR) opioid analgesics work for shorter periods of time. Extended-release (ER) opioid analgesics are designed to provide a longer period of drug release so that they can be taken less frequently. Examples of opioid analgesics formulated as IR and ER products include hydromorphone, morphine, oxycodone, oxymorphone, and tapentadol.

Long-acting (LA) opioid analgesics, such as methadone, have a longer period of action because of the inherent characteristics of the drug substance, which stays longer in the body, and not because of special design features of the finished product.

ER/LA prescription opioid analgesics can provide effective pain management when used as directed; however, there are serious risks associated with patients being prescribed these drugs who should not take them, and with improper use (whether accidental or intentional).

The amount of opioid analgesic contained in an ER tablet can be much more than the amount of opioid analgesic contained in an IR tablet because ER tablets are designed to release the opioid analgesic over a longer period. Improper use of any opioid can result in serious side effects, including overdose and death, and this risk is magnified with ER/LA opioid analgesics.

## **Addictive Symptomatology**

Addictive drug symptoms may include one or more of the following:

- Impaired control regarding the use of the drug
- Compulsive drug use
- Continued drug use despite consequences
- Unmanageable drug craving

According to the Diagnostic and Statistical Manual of Mental Disorders, substance use is considered

addictive if the person has experienced three or more of the following signs during a 12-month period:

- Tolerance is evident (The effect of a substance is diminished with continued use of the same amount of the substance).
- Withdrawal is evident (Uncomfortable symptoms occur with abstinence from the substance).
- The substance is used in greater quantities or for longer periods than intended.
- The person has a persistent desire to cut down on use of the substance, or the person's efforts to cut down on use of the substance have failed.
- Considerable time and effort are spent obtaining or using the substance or recovering from its effects.
- Important social, employment, and recreational activities are given up / reduced because of an intense preoccupation with substance use.
- Substance use is continued even though some other persistent physical or psychological problem is likely to have been caused or worsened by the substance (for example, an ulcer made worse by alcohol consumption).

Psychiatryonline (2013).

### **Risk Evaluation and Mitigation Strategy (REMS)**

In 2012, the U.S. Food and Drug Administration (FDA) approved a risk management program, known as a Risk Evaluation and Mitigation Strategy (REMS), for a class of potent pain medicines called extended-release and long-acting (ER/LA) opioid analgesics.

These new REMS will require ER/LA opioid analgesic companies to provide training for healthcare professionals (HCPs) who prescribe ER/LA opioid analgesics. The training includes proper prescribing practices and educational materials for prescribers and patients on the safe use of these powerful pain medications. REMS focused on prescriber education are intended to reduce the potential for serious adverse outcomes resulting from inappropriate prescribing, misuse, and abuse of ER/LA opioid analgesics while ensuring that patients with legitimate need for these drugs continue to have access to them.

The Food and Drug Administration Amendments Act of 2007 gave FDA the authority to require companies to develop and implement REMS when necessary to ensure that the benefits of a drug or biological product outweigh its risks.

The new ER/LA opioid analgesic REMS advances the Agency's goal of improving the safe use of ER/LA opioid analgesics while ensuring continued access to these medications for patients who need them. The new ER/LA opioid analgesics REMS is also part of the national prescription drug abuse plan announced by the Obama Administration in 2011 to combat prescription drug misuse and abuse.

(Food and drug administration (FDA), 2013)

#### **More Information**

The FDA is requiring REMS for ER/LA opioid analgesics because FDA has concluded that there is a disproportionate safety problem associated with these products that must be addressed.

### **Test Yourself**

REMS is a:



- A. Reduce Error Mitigation System developed by the CDC to manage substance abuse.
- B. Risk Evaluation and Mitigation Strategy developed by the FDA to manage opioid use.**
- C. Risk Error and Mitigation Strategy developed by the Obama Administration to limit use of morphine.

Remediation: In 2012, the U.S. Food and Drug Administration (FDA) approved a risk management program, known as a Risk Evaluation and Mitigation Strategy (REMS), for a class of potent pain medicines **called extended-release and long-acting (ER/LA) opioid analgesics.**

## REMS Commonly Asked Questions

### **What are extended-release and long-acting (ER/LA) prescription opioid analgesics?**

ER/LA prescription opioid analgesics are potent pain-relieving medicines used primarily for the management of persistent moderate pain to severe pain requiring around-the-clock opioid analgesics for an extended period.

### **What is a Risk Evaluation and Mitigation Strategy (REMS)?**

REMS are a risk management plan that goes beyond requirements in the drug prescribing information to manage serious risks associated with a drug.

### **What does this announcement mean for healthcare professionals and patients who currently prescribe or take extended-release and long-acting (ER/LA) opioid analgesics?**

This announcement will alert healthcare professionals and patients about the importance of proper prescribing and the safe and proper use of ER/LA opioid analgesic medications, and will explain the responsibility that manufacturers of these products must make educational materials available for prescribers and patients. The first continuing education activities under the REMS are available to prescribers as of March 1, 2013, with others to follow. All prescribers are encouraged to thoroughly discuss the risks and benefits of these products with their patients. A patient counseling document approved with the REMS is available to assist the prescriber in these discussions.

### **What does the ER/LA opioid analgesics Risk Evaluation and Mitigation Strategy (REMS) include?**

The central component of the ER/LA opioid analgesics REMS is an education program for prescribers (e.g., physicians, nurse practitioners, physician assistants). Under the REMS, sponsors of ER/LA opioid analgesics are making education programs available to all DEA registered prescribers, including prescribers of ER/LA opioid analgesics.

Prescriber education includes drug information on ER/LA opioid analgesics; information on assessing patients for treatment with these drugs; initiating therapy, modifying dosing, and discontinuing use of ER/LA opioid analgesics; managing therapy and monitoring patients; and counseling patients and caregivers about the safe use of these drugs. Additionally, prescribers will learn how to recognize evidence of and potential for opioid misuse, abuse, and addiction.

The ER/LA opioid analgesics REMS also includes a patient counseling document for prescribers to give to patients, helping prescribers to properly counsel patients on their responsibilities for using these medicines safely. Patients will receive from their pharmacist an updated one-page Medication Guide along with their prescription that contains consumer-friendly information on the safe use and disposal of ER/LA opioid analgesics. Included in the guide are instructions for patients to consult their healthcare professional before changing doses, signs of potential overdose and emergency contact instructions, and advice on safe storage to prevent accidental exposure to family members (FDA,

2013).

## **Schedule of Controlled Substances**

The drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) are divided into five schedules. Substances are placed in their respective schedules based on whether they have a currently accepted medical use in treatment in the United States and their relative abuse potential and likelihood of causing dependence when abused. Some examples of the drugs in each schedule are outlined below.

All drugs listed in Schedule I have no currently accepted medical use in treatment in the United States and therefore may not be prescribed, administered, or dispensed for medical use. In contrast, drugs listed in Schedules II through V all have some accepted medical use and therefore may be prescribed, administered, or dispensed for medical use.

## **Schedule I & II Substances**

### **Schedule I Substances**

Substances in this schedule have no currently accepted medical use in treatment in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse.

Some examples of substances listed in Schedule I are: heroin; lysergic acid diethylamide (LSD); marijuana (cannabis); peyote; methaqualone; and methylene-dimethoxy-methamphetamine ("ecstasy"). Note that recently, medical marijuana has become legalized in certain states. However, West Virginia is not included.

### **Schedule II Substances**

Substances in this schedule have a high potential for abuse with severe psychological or physical dependence.

Examples of single entity Schedule II narcotics include morphine, codeine, and opium. Other Schedule II narcotic substances and their common name brand products include: hydromorphone (Dilaudid®), methadone (Dolophine®), meperidine (Demerol®), oxycodone (OxyContin®, Percocet®), and fentanyl (Sublimaze®, Duragesic®). Other Schedule II narcotics include: morphine, opium, codeine, and hydrocodone.

Examples of Schedule II stimulants include amphetamine (Dexedrine® or Adderall®), methamphetamine (Desoxyn®), and methylphenidate (Ritalin®). Other Schedule II substances include: cocaine, amobarbital, glutethimide, and pentobarbital.

### **Schedule III Substances**

Substances in this schedule have a potential for abuse less than substances in Schedules I or II.

Examples of Schedule III narcotics include products containing not more than 90 milligrams of codeine per dosage unit (Tylenol with Codeine®), and buprenorphine (Suboxone®).

Examples of Schedule III non-narcotics include benzphetamine (Didrex®), phendimetrazine, dronabinol (Marinol®), ketamine, and anabolic steroids such as oxandrolone (Oxandrin®).

### **Schedule IV Substances**

Substances in this schedule have a lower potential for abuse relative to substances in Schedule III.

Schedule IV substances include: alprazolam (Xanax®), clonazepam (Klonopin®), clorazepate (Tranxene®), diazepam (Valium®), lorazepam (Ativan®), midazolam (Versed®), temazepam (Restoril®), and triazolam (Halcion®).

### **Schedule V Substances**

Substances in this schedule have a lower potential for abuse relative to substances listed in Schedule IV and consist primarily of preparations containing limited quantities of certain narcotic and stimulant drugs. These are generally used for antitussive, antidiarrheal and analgesic purposes.

Examples include cough preparations containing not more than 200 milligrams of codeine per 100 milliliters or per 100 grams (Robitussin AC®, and Phenergan with Codeine®). Pregabalin (Lyrica®) is also a Schedule V substance.

### **Test Yourself**

Dilaudid (hydromorphone) is a Schedule:

- A. II drug
- B. III drug
- C. IV drug

Rationale: Other Schedule II narcotic substances and their common name brand products include: hydromorphone (Dilaudid®), methadone (Dolophine®), meperidine (Demerol®), oxycodone (OxyContin®, Percocet®), and fentanyl (Sublimaze®, Duragesic®). Other Schedule II narcotics include: morphine, opium, codeine and hydrocodone.

### **Reporting the Use of Scheduled Substances in WV**

All licensees who dispense Schedule II, III and IV controlled substances to residents of WV must provide the dispensing information to the West Virginia Board of Pharmacy (BOP) each 24-hour period basis.

Prescribers and pharmacists authorized to access the patient information, must certify before each search that they are seeking data solely for providing healthcare to current patients. By providing prescribers and dispensers access to controlled substance history information at the point of care it will help them make better prescribing decisions and impact prescription drug abuse in West Virginia.

Any individual who suspects that another individual or entity has accessed or disclosed patient information in violation should immediately contact the CSMP Administrator [Michael.L.Goff@wv.gov](mailto:Michael.L.Goff@wv.gov) or his clerk [Cynthia.Y.Parsons@wv.gov](mailto:Cynthia.Y.Parsons@wv.gov).

Prescribers, pharmacists and approved officers of law enforcement agencies whose primary mission involves enforcing prescription drug laws can register for a West Virginia controlled substance automated prescription program (CSAPP) account to access timely patient prescription controlled substance reports.

The role of the West Virginia Controlled Substance Automated Prescription Program (CSAPP) is to help well informed prescribers and pharmacists use their professional expertise to evaluate their patients care and assist in the help and prevention to those patients who may be abusing controlled substances (West Virginia Board of pharmacy, 2013).

### **Did You Know?**

This program also serves to identify patients who may benefit from a substance abuse referral. The state's database contains over 40 million entries of controlled substance drugs that were dispensed in West Virginia. The online C.S.A.P.P. system will make it much easier for authorized prescribers and dispensers to quickly review controlled substance information via the Patient Report to identify and deter drug abuse and diversion through accurate and rapid tracking of Schedule II, III and IV controlled substances.

### **Registration Requirements for Prescribers of Scheduled Substances**

Under the Controlled Substances Act, the term "practitioner" is defined as a physician, dentist, veterinarian, scientific investigator, pharmacy, hospital, or other person licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which the practitioner practices or performs research, to distribute, dispense, conduct research with respect to, administer, or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research.

The DEA registration grants practitioners federal authority to handle controlled substances. However, the DEA registered practitioner may only engage in those activities that are authorized under state law for the jurisdiction in which the practice is located. When federal law or regulations differ from state law or regulations, the practitioner is required to abide by the more stringent aspects of both the federal and state requirements.

In many cases, state law is more stringent than federal law, and must be complied with in addition to federal law. Practitioners should be certain they understand their state as well as DEA controlled substance regulations.

### **West Virginia Controlled Substances Monitoring Program**

The West Virginia Board of Pharmacy recently established a new Controlled Substance Monitoring Program. As part of this program, prescribers are required to create a profile in the controlled Substances Automated Prescription Program registration system before being able to access to reports and other information.

The initial registration must be made by the supervisory Physician, Pharmacist in Charge, or Organizational Head of Entities.

By registering with the Controlled Substance Monitoring Program, the clinician affirms that he or she will comply with all requirements of the West Virginia Code, maintain confidentiality of patient information as required by law, and only share information in an appropriate investigation involving the prescribing and / or dispensing of controlled substances (West Virginia Board of Pharmacy, 2013).

For more information, [click here](#)

### **Goals of Treatment**

While each individual in treatment will have specific long-term and short-term goals, all specialized substance abuse treatment programs have three similar generalized goals:

- Reducing substance abuse or achieving a substance-free life
- Maximizing multiple aspects of life functioning

- Preventing or reducing the frequency and severity of relapse (SAMHSA, 2013b).

Other goals of treatment include:

- Maximizing physical health
- Treating independent psychiatric disorders
- Improving psychological functioning
- Addressing marital or other family and relationship issues
- Resolving financial and legal problems
- Improving or developing necessary educational and vocational skills.

Programs also prepare patients to understand and guard against relapse by teaching about "triggers" for use, how to recognize cues, how to handle craving, alternative responses to stressful situations, and what to do if there is a "slip."

### Recommendations: Long-Term Opioid Use

When opioids are prescribed for the long-term use in chronic non-cancer pain management, healthcare professionals are urged to follow the recommendations from the American Pain Society/American Academy of Pain Medicine (ND) guidelines for use of opioid therapy for chronic non-cancer pain.

These recommendations include:

Topic Area	Recommendations
<p><b>Patient selection and risk stratification</b></p>	<ul style="list-style-type: none"> <li>• Prior to initiating chronic opioid therapy, clinicians should conduct a history, physical examination and appropriate testing, including an assessment of risk of substance abuse, misuse, or addiction.</li> <li>• A benefit-to-harm evaluation including a history, physical examination, and appropriate diagnostic testing, should be performed and documented on an ongoing basis during chronic opioid therapy.</li> </ul>
<p><b>Informed Consent &amp; Opioid Management Plans</b></p>	<ul style="list-style-type: none"> <li>• When starting chronic opioid therapy, informed consent should be obtained. A continuing discussion with the patient regarding chronic opioid therapy should include goals, expectations, potential risks, and alternatives to chronic opioid therapy.</li> <li>• Clinicians may consider using a written chronic opioid therapy management plan to document patient and clinician responsibilities and expectations and assist in ongoing patient education.</li> </ul>
<p><b>Initiation and titration of chronic opioid therapy</b></p>	<ul style="list-style-type: none"> <li>• Clinicians and patients should regard initial treatment with opioids as a therapeutic trial to determine whether chronic opioid therapy is</li> </ul>

	<p>appropriate.</p> <ul style="list-style-type: none"> <li>• Opioid selection, initial dosing, and titration should be individualized per the patient's health status, previous exposure to opioids, attainment of therapeutic goals, and predicted or observed harms. There is insufficient evidence to recommend short-acting versus long-acting opioids, or as needed versus around-the-clock dosing of opioids.</li> </ul>
<b>Methadone</b>	<ul style="list-style-type: none"> <li>• Methadone is characterized by complicated and variable pharmacokinetics and pharmacodynamics and should be initiated and titrated cautiously, by clinicians familiar with its use and risks.</li> </ul>
<b>Monitoring</b>	<ul style="list-style-type: none"> <li>• Clinicians should reassess patients on chronic opioid therapy periodically and as warranted by changing circumstances. Monitoring should include documentation of pain intensity and level of functioning, assessments of progress towards achieving therapeutic goals, presence of adverse events, and adherence to prescribed therapies.</li> <li>• Clinicians should periodically obtain urine drug screens or other information from patients on chronic opioid therapy to confirm adherence to the chronic opioid therapy plan of care.</li> </ul>
<b>High-risk patients</b>	<ul style="list-style-type: none"> <li>• Clinicians may consider chronic opioid therapy for patients with chronic non-cancer pain and history of drug abuse, psychiatric issues, or serious aberrant drug-related behaviors only if they can implement more frequent and stringent monitoring parameters.</li> </ul>
<b>Dose escalations and high-dose therapy</b>	<ul style="list-style-type: none"> <li>• When repeated dose escalations occur in patients on chronic opioid therapy, clinicians should evaluate potential causes and re-assess benefits relative to harms.</li> <li>• In patients who require relatively high doses of chronic opioid therapy clinicians should evaluate for unique opioid-related adverse effects, changes in health status, and adherence to the chronic opioid therapy treatment plan on an ongoing basis, and consider more frequent follow-up visits.</li> </ul>

Table modified from Chou, R (2009)

## Termination of Therapy

Termination of therapy is an intentional process that occurs when a client has achieved most of the goals of treatment, and/or when therapy must end for other reasons (Deardorff, 2012). Ideally, clinician and patient agree about when to terminate the relationship.

Appropriate termination of the therapeutic relationship helps to avoid the betrayal of trust and abuse of power, prevents harm, and conveys caring which is critical to treatment (Deardorff, 2012).

The termination of therapy should be part of the treatment plan from the very beginning. It is recommended that the therapist discuss termination at three stages of treatment:

- The intake
- During treatment
- When ending the intervention

### Did You Know?

The HCP should aim to address termination strategies as part of the therapeutic relationship to allow the patient to view termination of therapy as a positive occurrence, that symbolizes independence and reflects the positive gains achieved in therapy.

## Termination Strategies for Ending the Therapeutic Relationship

To successfully terminate the therapeutic relationship, the HCP must ensure that certain components are in place.

Components of a successful termination strategy include:

- Informed consent in which the patient is “informed” and understands the treatment plan proposed, how it will be implemented, the anticipated course of treatment, the therapist and client’s responsibility in the professional relationship, management of unanticipated issues, and the termination of the relationship.
- Appropriate and realistic treatment goals must be set at the beginning of therapy so that the patient understands when termination of therapy can be expected to occur.
- Objective monitoring of the patient’s response to treatment using appropriate objective measures, to gauge a patient’s response to treatment.
- Avoidance of termination of the relationship when a patient is in crisis. This is consistent with quality and ethical care. If a patient is terminated while in crisis, it might reasonably be considered abandonment.
- Provision of resources to the patient. As part of the termination preparation process, the patient should be given information about other available resources. This might include community clinics, community resources and support groups, etc. Document that these resources have been provided.

(Deardorff, 2012)

## Section II: What Is Drug Diversion?

The National Association of Drug Diversion Investigators (NADDI) defines drug diversion as "Any criminal act involving a prescription drug." (The National Association of Drug Diversion Investigators (NADDI), 2013)

According to the United States Drug Enforcement Administration, diversion is the use of prescription drugs for recreational or illicit purposes. The term comes from the "diverting" of the drugs from their original purposes. The Drug Enforcement Administration employs Diversion Investigators to address these problems.

Drug diversion may also refer to programs available to first time drug law offenders, which "divert" offenders from the criminal justice system to a program of education and rehabilitation (NADDI, 2013).

## **Drug Diversion: How Large Is the Problem?**

While drug diversion is not a new phenomenon, there is a significant increase in the problem in the United States (Centers for Medicare and Medicaid Services (CMS), 2012).

In fact, per the 2010 National Drug Threat Assessment report, the threat posed by the diversion and abuse of controlled prescription drugs (CPDs), primarily pain relievers, is increasing (CMS, 2012).

### **More Information**

This report highlights opioid pain relievers as the most commonly diverted CPDs, because of the euphoria they induce.

## **What Types of Drugs Are Involved?**

Opioid pain relievers include:

- Codeine
- Fentanyl (Duragesic, Actiq)
- Hydromorphone (Dilaudid)
- Meperidine (Demerol, which is prescribed less often because of its side effects)
- Morphine (MS Contin)
- Oxycodone (OxyContin)
- Pentazocine (Talwin)
- Methadone (Dolophine)
- Hydrocodone combinations (Vicodin, Lortab, and Lorcet)

(CMS, 2012)

In addition to opioids, it has been reported that significant diversion is occurring with high cost antipsychotic and mental health drugs, such as aripiprazole (Abilify), ziprasidone (Geodon), risperidone (Risperdal), quetiapine (Seroquel), and olanzapine (Zyprexa), as well as benzodiazepines such as alprazolam (Xanax), clonazepam (Klonopin) and lorazepam (Ativan) (CMS, 2012).

## **Impact of Drug Diversion**

The impact of drug diversion is huge and affects the entire healthcare system, as well as the individuals involved. Drug diversion impacts medical costs including costs associated with doctor's visits, emergency department (ED) treatment, rehabilitation centers, and other healthcare needs, not to mention the human toll.

In 2008, the Drug Abuse Warning Network (DAWN), operated by the Substance Abuse and Mental Health Services Administration (SAMHSA), estimated that prescription or over-the-counter drugs



used non-medically were involved in 1.0 million ED visit (SAMHSA, 2013).

### **More Information**

Among the legal drugs, the most common drug categories involved were drugs acting on the central nervous system, especially opioid painkillers and psychotherapeutic drugs (especially sedatives and antidepressants) (CMS, 2012).

## **Methods to Minimize Drug Diversion**

One of the first lines of prevention in drug diversion is the ability to identify and screen high risk providers that may facilitate drug diversion.

The Affordable Care Act gives States significant new authority to fight fraud and abuse in drug diversion, including the ability to:

- Establish enhanced oversight for new providers.
- Establish periods of enrollment moratoria or other limits on providers identified as being high risk for fraud and abuse.
- Establish enhanced provider screening.
- Require States to suspend payment when there is a credible allegation of fraud which may include evidence of overprescribing by doctors, overutilization by recipients, or questionable medical necessity.

Other methods that can be used to minimize drug diversion practices in WV include:

- Implementing a prescription drug monitoring program (PDMP).
- Monitoring pain management clinics for evidence of overprescribing opioids.
- Encouraging beneficiary participation in the national prescription drug "Take-Back" campaign that offers more than 4,000 sites around the nation where the public can drop off expired, unused and unwanted prescription drugs. Unused medications in the household may contribute to growing rates of prescription drug abuse among Americans. The first ever National Prescription Drug Take Back Day on Saturday, September 25, 2010, collected 121 tons of pills.
- Patient Education.

## **Implementing a Prescription Drug Monitoring Program (PDMP)**

The Prescription Drug Monitoring Program was created by the 2002 U.S. Department of Justice Appropriations Act (Public Law 107-77). Under this new legislation, Congress appropriated funding to the U.S. Department of Justice to support the Prescription Drug Monitoring Program (PDMP).

The purpose of the Prescription Drug Monitoring Program is to enhance the capacity of regulatory and law enforcement agencies to collect and analyze controlled substance prescription data. The program focuses on providing help for states that want to establish a prescription drug monitoring program. Resources are also available to states that wish to expand their existing programs (U.S. Department of Justice, BJA2013).

Prescription monitoring programs help prevent and detect the diversion and abuse of pharmaceutical controlled substances, particularly at the retail level where no other automated information collection system exists. States that have implemented prescription monitoring programs have the capability to collect and analyze prescription data much more efficiently than states without such programs, where the collection of prescription information requires the manual review of pharmacy files, a time-

consuming and invasive process (Bureau of Justice Assistance [BJA], 2013).

Program objectives include:

- Building a data collection and analysis system at the state level.
- Enhancing existing programs' ability to analyze and use collected data.
- Facilitating the exchange of collected prescription data among states.
- Assessing the efficiency and effectiveness of the programs funded under this initiative.

(BJA, 2013).

### **Please note!**

The PDMP in WV monitors Schedule II, III & IV Drugs (BJA, 2013).

## **Test Yourself**

A Prescription Drug Monitoring Program (PDMP):

- A. Helps prevent and detect the diversion and abuse of pharmaceutical controlled substances.
- B. Allows states to collect and analyze prescription data much more efficiently and provides assistance for states that want to establish a prescription drug monitoring program.
- C. **Both of the above.**

Rationale: The purpose of the Prescription Drug Monitoring Program is to enhance the capacity of regulatory and law enforcement agencies to collect and analyze controlled substance prescription data.

Prescription monitoring programs help prevent and detect the diversion and abuse of pharmaceutical controlled substances, particularly at the retail level where no other automated information collection system exists. States that have implemented prescription monitoring programs have the capability to collect and analyze prescription data much more efficiently than states without such programs, where the collection of prescription information requires the manual review of pharmacy files, a time-consuming and invasive process (Bureau of Justice Assistance [BJA], 2013).

## **Monitoring Pain Management Clinics**

Pain management clinics are often at the center of significant drug diversion activities and are unregulated in some states. In WV, the Boards of Medicine is required to collaborate with the Secretary of the Department of Health and Human Services in developing rules for the licensure of pain management clinics to ensure adequate care, treatment, health, safety, welfare and comfort of patients. The rules must include the following:

- Regulation of the qualifications and supervision of licensed and non-licensed personnel at pain management clinics, including regulation of written plans of care; management, operations, staffing and equipping the clinic; and medical and business records.
- Identification of drugs that may be used to treat chronic pain including, at a minimum, tramadol and carisoprodol.
- Inspection of data collection methods and reporting requirements.

In addition, monitoring programs should not only review opioids dispensed at pharmacies, but also those opioids that might be dispensed by the provider in the pain management clinic. State regulation of pain management clinics can also deter drug diversion activities, especially if penalties are issued

for non-compliance.

Pain management clinics can take several additional steps to reduce the risk of drug diversion. These steps may include:

- Tighter control over availability and monitoring / documentation of scheduled drugs.
- Increased patient education programs to address the negative physical and psychological effects of prescription drug abuse.
- Strict Policies and procedures for disposal of expired prescription drugs.
- Improved documentation and staff training.
- Implementing patient urine screens prior to prescribing scheduled drugs.

## **Encouraging Participating in Drug Take-Back Programs**

Unused medications in the household may contribute to growing rates of prescription drug abuse in the U.S. today. Many Americans are not aware that medicines that languish in home cabinets are highly susceptible to diversion, misuse, and abuse (Drug Enforcement Administration [DEA], 2013). By controlling the amount and availability of unused medications in the home, possible drug diversion activities may be deterred.

In addition, many Americans do not know how to properly dispose of their unused medicine, often flushing them down the toilet or throwing them away – both potential safety and health hazards. Healthcare professionals can encourage beneficiary participation in the national prescription drug "Take-Back" campaign. Participation in the program can significantly reduce drug diversion activities.

Government, community, public health and law enforcement partners are collecting potentially dangerous expired, unused, and unwanted prescription drugs for destruction at many sites across the US. The service is free and anonymous, and no questions are asked. Collection sites in every local community can be found by going to [www.dea.gov](http://www.dea.gov) . This site is continuously updated with new take-back locations.

The national prescription drug "Take-Back" campaign offers more than 4,000 sites around the nation where the public can drop off expired, unused and unwanted prescription drugs (CMS, 2012).

Additionally, US Food and Drug Administration has posted guidelines for consumers on how to properly dispose of unused medications at:

<http://www.fda.gov/forconsumers/consumerupdates/ucm101653.htm>

### **Did You Know?**

Other participants in this initiative include the White House Office of National Drug Control Policy; the Partnership for a Drug-Free America; the International Association of Chiefs of Police; the National Association of Attorneys General; the National Association of Boards of Pharmacy; the Federation of State Medical Boards; and the National District Attorneys Association

## **Patient Education**

The drug overdose rate in the United States has been increasing rapidly since the early 1990s and is now considered an epidemic. Prescription drugs have been the primary contributor to the increase in drug overdose death rates (CDC, 2013).

Patient education is a vitally important prevention tool. Healthcare professionals can educate patient

about the dangers of prescription drug abuse and increase the public's awareness of the dangers of drug diversion.

Healthcare providers can:

- Discuss pain treatment options more fully with patients, including ones that do not involve prescription drugs.
- Discuss the risks and benefits of taking prescription painkillers. This includes when painkillers are taken for chronic conditions.
- Follow guidelines for responsible painkiller prescribing, including:
  - Screening and monitoring for substance abuse and mental health problems.
  - Prescribing only the quantity needed based on appropriate pain diagnosis.
  - Using patient-provider agreements combined with urine drug tests for people using prescription painkillers long term.
  - Teaching patients how to safely use, store, and dispose of drugs.
  - Avoiding combinations of prescription analgesics and benzodiazepines (such as alprazolam and diazepam) unless there is a specific medical indication.
- Talk with patients who are dependent on prescription narcotics about treatment options, such as opioid agonist therapy or refer them to qualified addictions medicine specialists and chemical dependency treatment and recovery centers.
- Use prescription drug monitoring programs (PDMPs) to identify patients who may be improperly using prescription painkillers and other drugs.

(CDC, 2013b)

## **Additional Safeguards**

In addition to the previously discussed methods of minimizing drug diversion, HCPs can take several precautions to avoid being taken advantage of by drug-seeking patients.

Recommended clinical practices include:

- Protecting access to prescription pads
- Adhering to strict refill policies
- Adhering to prescribing principles for opioids and other controlled substances
- Thorough documentation of prescribed narcotics
- Rapid reporting of lost or stolen controlled substances through the Prescription Drug Monitoring Program (PDMP) to law enforcement agencies, licensing officials and other appropriate authorities.

## **Working with Substance Abuse Clients**

If a healthcare professional (HCP) suspects a patient of substance abuse, appropriate screening and assessment must take place prior to beginning any intervention. The type and sequence of activities undertaken in response to screening results will depend on several factors, including the severity of any positive findings, the specialized assessment and treatment resources available, and the primary care clinician's expertise in the substance abuse field (SAMHSA, 2013b).

Patients with positive findings from the screening will need follow-up, which will depend on how much

time and effort the HCP is willing to commit and how much training and experience he or she has in addiction medicine.

If mild to moderate substance abuse problems are apparent and the patient appears to be at risk for experiencing negative consequences because of current substance abuse patterns, or if co-existing illnesses may be exacerbated by continued substance abuse, the clinician can initiate a brief, office-based, therapeutic intervention.

The flow chart on the left (Courtesy of the National Institute on Alcohol Abuse & Consumption) can guide HCPs in determining patient flow through screening and referral.

To enlarge image, [click here!](#)

## **Screening for Substance Abuse & Drug Diversion**

All HCPs should be trained to recognize dysfunction caused by substance abuse as early as possible by:

- Taking a history of alcohol and drug use in any health examination and screening for symptoms that suggest drug abuse
- Initiating a brief intervention (if trained to do so)
- Matching patient needs for ongoing assessment and treatment with available resources
- Making a referral for appropriate medical care

(SAMHSA, 2013b).

### ***Taking A History***

The goal of history taking is to identify individuals who have or are at risk for developing substance abuse problems, and to identify patients who need further assessment to diagnose their substance use disorders and develop plans to treat them.

When taking a history, questions should cover the severity of the suspected abuse, the types and frequency of problems connected with the patient's use, and other special medical and psychiatric considerations. If the patient's responses suggest a diagnosis of a substance abuse or dependence disorder per criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IVTR) (Psychiatryonline, 2013), the clinician should initiate a referral for an in-depth assessment.

### **More Information**

To screen for prescription drug use, a clinician can ask questions such as:

- "Do you see more than one healthcare provider regularly? Why? Have you switched doctors recently? Why?"
- "What prescription drugs are you taking? Are you having any problems with them?"
- "Where do you get your prescriptions filled? Do you go to more than one pharmacy?"
- "Do you use any other nonprescription medications? If so, what, why, how much, how often, and how long have you been taking them? "

It is recommended that all patients be routinely and periodically assessed for substance use disorders. Deciding to screen some patients and not others opens the door for cultural, racial, gender, and age biases that result in missed opportunities to intervene with or prevent the development of drug-related problems (SAMHSA, 2013b).

Although screening for drug use in the primary care setting can make patients and clinicians uncomfortable, asking about illicit drug use is as important as asking about other personal practices (such as sexual practices that put patients at higher risk for sexually transmitted diseases) that can affect a patient's health.

Using a screening tool is often the best way to capture pertinent information. In the primary care setting, substance abuse screening can be done using brief written, oral, or computerized questionnaires. Several factors must be considered in determining the suitability of a screening instrument for this setting. These include sensitivity and specificity, cost, ease of administration, and patient acceptance.

## **Factors to Consider in Selecting a Screening Tool**

### **Sensitivity:**

Sensitivity is a screening instrument's capacity to identify true cases of the target condition in each population. The closer to 100 percent of those with substance abuse problems that a screen identifies as positive for that condition, the more sensitive the test.

### **Specificity:**

Specificity refers to an instrument's ability to identify people who do not have the disorder. False positives (identifying people who do not have the disorder as having it) tend to increase as sensitivity increases, and false negatives (missed cases) tend to increase as specificity increases. Because screening instruments are imperfect, balancing sensitivity against specificity is a situation-specific issue. Generally, for screening in primary care, sensitivity should be emphasized over specificity- that is, it is more important not to miss true cases than it is to assess further some patients who ultimately turn out not to have a substance use disorder. A positive screen can usually be confirmed or refuted with further history taking or, if necessary, evaluation by a substance abuse specialist.

Two popular screening instruments for substance abuse detection are the four-question CAGE questionnaire and the Alcohol Use Disorders Identification Test (AUDIT) (SAMHSA, 2013b).

### **Cost:**

Costs of administering a screen depend on who does the screening (e.g., physician, nurse, nurse practitioner, or physician assistant), how long it takes, and what special training (if any) is required; whether the instrument can be self-administered by the patient via pencil and paper or computer; and how long it takes to score the instrument.

### **Ease of Administration:**

The written questionnaire format is self-explanatory; the interview format consists of a HCP asking the patient a set of predetermined questions. Computerized versions of validated paper questionnaires such as the CAGE are growing in popularity.

Computerized testing can reduce the time needed for manual scoring and keep track of who has been screened and when.

### **Patient Acceptance:**

Simply raising the subject of substance abuse with patients can be useful. Evidence indicates that asking questions about alcohol or other drugs "primes" patients to disclose information and results in a two to threefold increase in their stated intention to discuss substance abuse problems with their healthcare provider in the future (Skinner et al., 1985 in SAMHSA, 2013b).

While opinions vary about whether to integrate substance abuse screening into a standard history, asking potentially sensitive questions about substance abuse in the context of other behavioral and lifestyle questions appears to be less threatening to patients. Placing the questions within the larger context of preventive healthcare can help both patient and clinician feel more comfortable, reduce any perceived stigma or bias about the questions, and decrease anxiety in the patient (SAMHSA, 2013b).

## Test Yourself

Factors to consider in selecting a screening tool are:

- A. Cost, availability, ease of administration, and preference of HCP.
- B. Sensitivity and accuracy, availability, cost and time to administer.
- C. **Sensitivity and specificity, cost, ease of administration and patient acceptance.**

Rationale: Several factors must be considered in determining the suitability of a screening instrument for this setting. These include sensitivity and specificity, cost, ease of administration, and patient acceptance.

## Brief Intervention

Brief intervention is a pre-treatment tool or secondary prevention technique that clinicians (MDs, Physician Assistants & APRNs) can easily incorporate into their care delivery. Once screening results are obtained, the clinician should explain the results, provide information about the dangers of substance abuse and provide advice about changing. An intervention includes assessing the patient's readiness to change, negotiating goals and strategies for change, and arranging for compliance monitoring.

The goal of intervention is to get patients to reduce or eliminate substance abuse and thereby minimize associated problems, whether through the technique itself or through subsequent referral. The specific goal varies depending on the patient's current status and previous treatment attempts. For a patient who does not realize there is a problem, the goal may be to get the individual to start thinking about the issue and come back for another visit.

A brief intervention could also be an appropriate primary prevention tool for the alcohol or drug user who is at risk for problem development because of a hazardous consumption pattern but has not yet experienced harmful consequences (e.g., the college student who is experimenting with drugs in a fraternity setting).

For patients who are ready for and capable of change, the goal will be to reduce or eliminate substance abuse through specified steps. If the problem is more serious, and if initial attempts to change fail, the goal of brief intervention is to convince a patient to accept a referral for more specialized assessment and treatment services.

(SAMHSA, 2013b)

## Matching Patients with Available Resources

The HCP is instrumental in linking patients to available community resources and local support groups. Become familiar with your community resources, so that you are well prepared to match clients to available and appropriate resources.

Two national resources are:

### **The National Clearinghouse for Alcohol and Drug Information**

(800) 729-6686

(301) 468-6433 fax

### **The National Council on Alcoholism and Drug Dependence, Inc. (NCADD)**

12 West 21st Street

New York, NY 10010

(212) 206-6770

(212) 645-1690 fax

Hope Line: (800) NCA-CALL

For drug-specific information: (800) 729-6686

<http://www.ncadd.org/>

### **Making Referrals for Appropriate Care**

Making referrals and providing information about community resources is an important component of care and a major responsibility of the HCP.

Some information and referral services for substance abuse in West Virginia include:

- **2-1-1** is an easy to remember telephone number that connects people with important community services, disaster information and volunteer opportunities. 2-1-1 brings together existing information and referral providers and crisis services into one coordinated system. Families can dial 211 or view an online resource directory [here](#).
- **BeeHive** is a database that makes it easy for patients to find the best available tools and information to help manage the challenges of everyday life.  
<http://wv.thebeehive.org/>  
Families can search [this webpage](#) for resources.
- **West Virginia Secretary of State Customer Service Center**  
<http://www.wvsos.com/service/referralhelpline.htm>  
Or call: 304-558-0900 or go to: [wvsos@wvsos.com](mailto:wvsos@wvsos.com)
- **Free Clinics (Health Rights)**  
<http://www.wvochs.org/dpc/freeclinics.aspx>  
Free Clinics (Health Rights) provide basic primary care, specialty services, and pharmacy to uninsured people who meet low income guidelines. For more information, families can go to: [http://www.wvochs.org/shared/content/primarycare/pcsites/primary%20care%20clinics\\_webuse.pdf](http://www.wvochs.org/shared/content/primarycare/pcsites/primary%20care%20clinics_webuse.pdf) or call 304-558-4007
- **WV Primary Care Association** provides high-quality, affordable healthcare services to all West Virginians; regardless of economic, social, or income statuses.  
<http://www.wvpca.org/>  
For more information, families can visit <http://asoft157.securesites.net/secure/wvpca/index.php?src=gendocs&ref=Interactive%20Map> or call 304-346-0032



- **Narcotics Anonymous** is an international, community-based association of recovering drug addicts with membership open to all drug addicts, regardless of the drug or combination.  
[www.na.org](http://www.na.org)  
For more information, families can call 1-800-766-4442 or 304-344-4442
- **WV Primary Care Association** provides high-quality, affordable healthcare services to all West Virginians; regardless of economic, social, or income statuses.  
[www.wvpca.org](http://www.wvpca.org)  
For more information, families can visit  
<http://asoft157.securesites.net/secure/wvpca/index.php?src=gendocs&ref=Interactive%20Map> or call 304-346-0032

## Working with Colleagues Who Abuse or Divert Drugs

Healthcare professionals are as likely as anyone else to abuse drugs, and may in fact be more likely to abuse drugs if working under severely stressful conditions, with easy access to controlled substances. Even though the clear majority of registered practitioners comply with the controlled substances law and regulations in a responsible and law abiding manner, you should know drug impaired health professionals are one source of controlled substances diversion.

The ANA estimates approximately 6% to 8% of nurses are practicing while impaired. This prevalence parallels the prevalence of substance abuse in the general population (Tanga, 2011).

Many nurses have easy access to controlled substance medications; and some will divert and abuse these drugs for reasons such as relief from stress, self-medication, or to improve work performance and alertness (Drug Enforcement Administration [DEA], 2013b).

## What are Your Responsibilities?

You have a legal and ethical responsibility to uphold the law and to help protect society from drug abuse. You have a professional responsibility to prescribe and dispense controlled substances appropriately, guarding against abuse while ensuring that patients have medication available when they need it. You have a personal responsibility to protect all patients. You must become aware of the potential situations where drug diversion can occur and safeguards that can be enacted to prevent this diversion (DEA, 2013b).

### More Information

Nurses who are chemically dependent may be successful at disguising dependency issues because they are often stellar employees, popular, respected, and bright (Tanga, 2011).

## Test Yourself

The prevalence of substance abuse among nurses:

- Is higher than 10%
- Parallels that of the general population**
- Is greater than in any other healthcare profession

Rationale: The ANA estimates approximately 6% to 8% of nurses are practicing while impaired. This prevalence parallels the prevalence of substance abuse in the general population (Tanga, 2011).

## **Working with Colleagues Who Abuse or Divert Drugs**

### ***How Do I Recognize a Drug Impaired Co-Worker?***

Drug abusers often exhibit similar aberrant behavior. Certain signs and symptoms may indicate a drug addiction problem in a healthcare professional. Have you observed some of the following signs?

- Work absenteeism –absences without notification and an excessive number of sick days used;
- Frequent disappearances from the work site, having long unexplained absences, making improbable excuses and taking frequent or long trips to the bathroom or to the stockroom where drugs are kept;
- Excessive amounts of time spent near a drug supply. They volunteer for overtime and are at work when not scheduled to be there;
- Unreliability in keeping appointments and meeting deadlines;
- Work performance which alternates between periods of high and low productivity and may suffer from mistakes made due to inattention, poor judgment and bad decisions;
- Confusion, memory loss, and difficulty concentrating or recalling details and instructions. Ordinary tasks require greater effort and consume more time;
- Interpersonal relations with colleagues, staff and patients suffer. Rarely admits errors or accepts blame for errors or oversights;
- Heavy "wastage" of drugs;
- Sloppy recordkeeping, suspect ledger entries and drug shortages;
- Inappropriate prescriptions for large narcotic doses;
- Insistence on personal administration of injected narcotics to patients;
- Progressive deterioration in personal appearance and hygiene;
- Uncharacteristic deterioration of handwriting and charting;
- Wearing long sleeves when inappropriate;
- Personality change - mood swings, anxiety, depression, lack of impulse control, suicidal thoughts or gestures;
- Patient and staff complaints about healthcare provider's changing attitude/behavior;
- Increasing personal and professional isolation.

(CDC, 2013b)

### ***Should I Become Involved?***

Healthcare professionals often avoid dealing with drug impairment in their colleagues. There is a natural reluctance to approach a co-worker suspected of drug addiction. There is the fear that speaking out could anger the co-worker, resulting in retribution, or could result in a colleague's loss of professional practice. Many employers or co-workers end up being "enablers" of healthcare practitioners whose professional competence has been impaired by drug abuse. Addicted colleagues are often given lighter work schedules, and excuses are made for their poor job performance. Excessive absences from the work site are often overlooked. Drug impaired co-workers are protected from the consequences of their behavior. This allows them to rationalize their addictive behavior or continue their denial that a problem even exists (CDC, 2013b).

If you recognize the aforementioned signs or symptoms in a co-worker, it's time to demonstrate concern. You may jeopardize a person's future if you cover up or don't report your concerns. Many well-educated, highly trained, and experienced healthcare practitioners lose their families, careers, and futures to substance abuse. Tragically, some healthcare workers have even lost their lives to

their drug addiction because the people who saw the signs and symptoms of their drug use refused to get involved. By becoming involved, you cannot only help someone who may be doing something illegal, but more importantly, your action could affect the safety and welfare of your addicted employee or coworker and those patients or the public who may encounter him or her.

### ***What If I Know That Drugs Are Being Sold or Stolen?***

Drug abuse and drug dealing are serious problems that should be handled by qualified professionals. If you suspect that a drug deal is in progress, do not intervene on your own. Contact security or notify the police. If you are a DEA registrant and become aware of a theft or significant loss involving controlled substances, you must immediately report the theft or loss to the nearest DEA office as well as your local police department.

### ***What Can I Do to Help?***

For some employees, the mere fact that their supervisor talks to them about their poor work performance is enough to help them change. For others, the problem may require more drastic measures. The threat of losing a job may have some influence on modifying behavior. Drug addicts can recover, and help is available. Encourage your co-worker to seek drug treatment assistance.

Additional information on DEA's Diversion Control Program is available at:

[www.deadiversion.usdoj.gov](http://www.deadiversion.usdoj.gov)

## **Test Yourself Case Study**

Nurse X is your colleague on the labor and delivery unit that you work on. She is one of the most highly respected, clinically competent nurses in your unit and is always helpful, compassionate and easy to work with. However, lately you have noticed that she is frequently late for her shift and often disappears from the unit without explanation. Lately, her personal appearance has deteriorated and she seems distracted and inattentive.

Some of her patients have been complaining about ineffective pain management in early labor and there have been some inaccurate narcotic counts in the past month on the unit that has all the staff concerned.

You suspect that she may be diverting drugs. What should your next course of action be? (Scenario adapted from Tanga, 2011).

### **Answer:**

Nurse X's behavior is consistent with that of an individual who may be diverting drugs. As a professional, you have an ethical and moral duty to protect your patients, colleagues, the nursing profession, and the community. Patients' safety should be the most important priority. Your suspicions should be reported confidentially to the Nurse Manager, who then has an ethical and legal responsibility to investigate the situation further.

Failure to report the situation would be negligent and potentially subject the nurse and her patients to further harm. It is in the best interest of Nurse X to get the help she needs through nurse peer assistance programs that are available nationwide.

Nurses should know drug diversion is a symptom of the disease of addiction and that addiction is a treatable disease (Tanga, 2011). Nurse diversion programs ensure that nurses can obtain treatment, and a safe return to the workplace can be facilitated. (Scenario modified from Tanga, 2011).

## **Drug Diversion Prevention Laws in WV**

There are five specific prescription drug overdose state laws in West Virginia, designed to address and control drug diversion activity in the state of West Virginia. These five laws include:

- Laws Requiring a Physical Examination before Prescribing
- Laws Requiring Tamper-Resistant Prescription Forms
- Laws Setting Prescription Drug Limits
- Laws Prohibiting “Doctor Shopping”/Fraud
- Laws Requiring Patient Identification before Dispensing

## **Laws Requiring a Physical Examination before Prescribing**

### ***What are Physical Exam Laws?***

States with Physical Exam Laws require that a physical examination of a patient is conducted by a healthcare provider prior to prescribing. This law is intended, in part, to prevent inappropriate prescribing of controlled substances.

In West Virginia, this examination is required prior to the prescribing of all prescription drugs and all controlled substances. In some states (LA, NM, OH, TN & TX), a physical examination is only required prior to prescribing drugs used only for pain management. It is important to note that there must be a valid practitioner-patient relationship established prior to the prescribing of drugs in West Virginia. In this state, a pharmacist has the right to refuse to dispense a prescribed drug if he or she has reason to believe that there is no practitioner-patient relationship. WV also has explicit provisions dealing with prescribing based solely on patient questionnaire (or internet pharmacy).

The Physical Exam Law was enacted as of August 31, 2010, and has been implemented in 42 states at the time of this publication.

To view the 42 states that have enacted this law, [click here](#).

## **Laws Requiring Tamper-Resistant Forms**

Laws mandating the use of tamper-resistant forms are intended to prevent the use of fraudulent prescriptions to obtain controlled substances.

Medicaid-related laws require the use of special tamper-resistant (TR) prescription forms for prescriptions covered by the Medicaid program.

The Centers for Medicare and Medicaid Services issued guidance specifying requirements that a tamper-proof prescription pad must have. To be considered TR, a prescription pad must contain industry-recognized features that prevent the following forms of prescription tampering:

- Copying of a completed or blank prescription form, such as a void pantograph, white area on the prescription, or special paper containing watermarking.
- Erasing or modifying any of the information written on the prescription by the prescriber, such as quantity check boxes, refill indicators, or chemically reactive paper.
- The use of counterfeit prescription forms, such as serial numbers or logos printed on the prescription form.

### **Please note!**

A law does not have to require all these features to be included.

In WV, tamper-resistant prescriptions are required for all prescriptions or all controlled substance prescriptions, unless specific exemptions apply (for direct administration, emergencies, institutional settings, etc.).

The law also provides specific deadlines for practitioners to begin using TR forms, and mandates one or more security features that prescription pads must contain.

The law mandating the use of TR forms has been implemented in 26 states at the time of this publication. To view the 26 states that have enacted this law, [click here](#).

## **Prescription Drug Limit Laws**

### ***What are Prescription Drug Limit Laws?***

These are laws setting prescribing or dispensing limits for controlled substances. These laws limit:

- The number of days after a prescription is issued during which a pharmacist can fill a prescription.
- The quantity prescribed and/or dispensed of a controlled substance for no more than a specified days' supply (including laws limiting the quantity prescribed and/or dispensed during an emergency period).
- The number of days' supply for an individual practitioner prescribing multiple controlled substance medications.
- The quantity or days supplied in refills for a controlled substance medication.
- The number of days that a benefit plan will pay for (e.g., states where Medicaid will not pay for a new prescription until 85% of the days' supply has elapsed).
- The quantity or days' supply of controlled substances prescribed orally (including medications prescribed during an emergency period).
- The quantity or days' supply of controlled substances prescribed by healthcare practitioners other than a physician (physician assistants, nurse practitioners, etc.).

The Prescription Drug Limit Laws have been implemented in 35 states at the time of this publication. To view the 35 states that have enacted this law, [click here](#).

### **Please note!**

The prescription limit law limits the number of days' supply of drugs for specific schedules of drugs in WV.

## **Doctor Shopping Laws**

### ***What are Doctor Shopping Laws?***

The term "doctor shopping" has traditionally referred to a patient obtaining controlled substances from multiple healthcare practitioners without the prescribers' knowledge of the other prescriptions (CDC, 2013).

Almost all states have a "general" fraud statute that adopts verbatim or with slight alteration the provision in the Uniform Narcotic Drug Act of 1932 or the Uniform Controlled Substances Act of 1970. These statutes prohibit obtaining drugs, including through "doctor shopping," by any or all the following means: fraud, deceit, misrepresentation, subterfuge, or concealment of material fact (CDC,

2013).

This resource distinguishes between general statutes and laws categorized as “specific” doctor shopping laws. Specific doctor shopping laws prohibit patients from withholding from any healthcare practitioner that they have received either any controlled substance or prescription order from another practitioner, or the same controlled substance or one of similar therapeutic use within a specified time interval or at any time previously.

The Doctor Shopping Laws have been implemented in all 50 states to varying degrees. In 34 states, there is only a “general” doctor shopping law. In one state (Florida), there is a “specific” doctor shopping law, and in 15 other states there are both “specific” and “general” doctor shopping laws (Including WV).

To view these states, [click here](#).

## **Laws Requiring Patient Identification before Dispensing**

### ***What are Identification Requirement Laws?***

Laws that require patients to provide identification prior to filling a controlled substance are designed to prevent prescription fraud and diversion by ensuring persons obtaining a prescription are who they claim to be.

These laws require a person to identify himself or herself or requires or permits a pharmacist to request identification prior to dispensing a controlled substance. This might occur at the discretion of the pharmacist or in certain circumstances, e.g., the person has similar prescriptions from multiple practitioners or the prescription was written in another state, or the prescription was not covered at least in part by a health plan (CDC, 2013).

Among the laws requiring identification prior to dispensing, the CDC identified a subset requiring that a pharmacy submit a patient’s “identification number” to the state prescription drug monitoring program. An “identification number” is defined as the unique number contained in the state-issued valid driver’s license of the recipient and/or the person for whom the drug is intended, a valid military identification card, a valid identification card issued by the bureau of motor vehicles, or an assigned unique identification number that could be linked to other personal identifiers (CDC, 2013).

The Prescription Drug Limit Laws have been implemented in 22 states at the time of this publication. To view the 22 states that have enacted this law, [click here](#).

## **Conclusion**

Best practice prescribing of controlled substances training includes information for HCP's about the safe and effective prescribing, administration and dispensing of controlled substances in patient care.

Drug diversion training includes knowledge and understanding of prescription drug abuse and misuse; the epidemiology of chronic pain and misuse of opioids; initiation and management of chronic pain with opioid-based therapies, monitoring and periodic review; patient education, documentation and identification of diversion and drug seeking tactics in patients and colleagues.

By adhering to the principles of best practice prescribing and having an awareness of drug diversion practices, the HCP can ensure a safe environment of care for the patient. This will ensure that patients in chronic pain will be able to legitimately obtain the pain relief they require, and diversion of drugs into the illegal market will be controlled. HCP's have an ethical and legal responsibility to prevent drug diversion and to comply with current legal requirements, without compromising patient



care.

## REFERENCES

American Academy of Pain Medicine (AAPM), (2013). AAPM Facts and Figures on Pain. Retrieved from: [http://www.painmed.org/patientcenter/facts\\_on\\_pain.aspx](http://www.painmed.org/patientcenter/facts_on_pain.aspx)

American Pain Society. (2009). Pain: Current understanding of assessment, management, and treatments. Glenview, IL: American Pain Society. Retrieved from:

<http://www.americanpainsociety.org/uploads/pdfs/npc/npc.pdf>

American Pain Society. (ND). Guideline for the use of chronic opioid therapy in chronic noncancer pain: evidence review. Retrieved from:

<http://americanpainsociety.org/uploads/education/guidelines/chronic-opioid-therapy-cnccp.pdf>

Centers for Disease Control & Prevention [CDC], (2013). Prescription Drug Overdose: State Laws: Selected State Legislative Strategies Governing Prescription Drug Abuse and Diversion in the US. Retrieved from: <http://www.cdc.gov/homeandrecreationalafety/Poisoning/laws/index.html>

Centers for Disease Control & Prevention [CDC], (2013b). CDC Vital Signs: Prescription Painkiller Overdoses. Retrieved from: <http://www.cdc.gov/vitalsigns/PrescriptionPainkillerOverdoses/index.html>

Centers for Medicare & Medicaid Services [CMS], (2012). Drug Diversion in the Medicaid Program: State Strategies for Reducing Prescription Drug Diversion in Medicaid. Retrieved from:

<http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/downloads/drugdiversion.pdf>

Chou, R. (2009). 2009 Clinical Guidelines from the American Pain Society and the American Academy of Pain Medicine on the use of chronic opioid therapy in chronic noncancer pain. What are the key messages for clinical practice? Retrieved from:

<http://www.anthem.com/painmanagement/documents/ClinicalGuidelines2009.pdf>

Deardorff, W. (2012). Reducing Premature Termination in Psychotherapy. Retrieved from:

<http://www.behavioralhealthce.com/index.php/component/courses/?task=view&cid=99>

Drug Enforcement Administration [DEA], (2013). Over 3,400 sites join DEA Nationwide Effort to Take-Back Prescription Drugs on Sept.25. News Release. Retrieved from:

<http://www.justice.gov/dea/pubs/pressrel/pr091510.html>

Drug Enforcement Administration [DEA], (2013b). Drug Addiction in Health Care Professionals. Retrieved from:

[http://www.dea.gov/pubs/brochures/drug\\_hc.htm](http://www.dea.gov/pubs/brochures/drug_hc.htm)

Food and Drug Administration (FDA), (2013). Questions and Answers: FDA approves a Risk Evaluation and Mitigation Strategy (REMS) for Extended-Release and Long-Acting (ER/LA) Opioid Analgesics. Retrieved from:

<http://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm309742.htm#Q1>

Jackson Kelly, LLC. (2012). Health Law Monitor. West Virginia Legislature Enacts Comprehensive Substance Abuse Laws. Retrieved from: <http://healthlawmonitor.jacksonkelly.com/2012/04/west-virginia-legislature-enacts-comprehensive-substance-abuse-laws.html>

Maryniak, K. (2013). Pain Assessment & Management. RN.com. Retrieved from:

[http://www.rn.com/getpdf.php/1975.pdf?Main\\_Session=c10e4a4c9a3ea43cef4e31289fea4874](http://www.rn.com/getpdf.php/1975.pdf?Main_Session=c10e4a4c9a3ea43cef4e31289fea4874)

Mosby's Dictionary of Medicine, Nursing & Health Professions, 9th ed. (2012). St. Louis: Mosby Elsevier.

National Institute of Drug Abuse (NIDA). (2009). Mind Over Matter: Prescription Drug Abuse. Retrieved from: <http://www.drugabuse.gov/publications/mind-over-matter/prescription-drug-abuse>

Psychiatryonline (2013). DSM-IV-TR Diagnostic and Statistical Manual of Mental Disorders: Chapter 4, Substance-Related Disorders.

Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Behavioral Health Statistics and Quality (2013). 2011 National Survey Results on Drug Use and Health (NSDUH): Summary of National Findings. Retrieved from: <http://www.samhsa.gov/data/NSDUH/2k11Results/NSDUHresults2011.pdf>

Substance Abuse and Mental Health Services Administration (SAMHSA), (2013b). A Guide to Substance Abuse Services for Primary Care Clinicians, Center for Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 1997. (Treatment Improvement Protocol (TIP) Series, No. 24.) Chapter 3—Brief Intervention. Retrieved from: <http://www.ncbi.nlm.nih.gov/books/NBK64821/>

Tanga, H. (2011). Nurse Drug Diversion and Nursing Leaders' Responsibilities Legal, Regulatory, Ethical, Humanistic, and Practical Considerations JONA'S Healthcare Law, Ethics, and Regulation, 13 (1) January–March 2011.

The National Association of Drug Diversion Investigators [NADDI], (2013). Drug Diversion. Retrieved August 7, 2013 from: [http://www.naddi.org/aws/NADDI/pt/sp/home\\_page](http://www.naddi.org/aws/NADDI/pt/sp/home_page)

U.S. Department of Justice (2013). Office of Diversion Control. Information & Legal Resources. Retrieved from: <http://www.deadiversion.usdoj.gov/Resources.html>

West Virginia Board of Pharmacy (2013). CS Monitoring Program. Retrieved from: [http://www.wvbop.com/index.php?option=com\\_content&view=article&id=99&Itemid=117](http://www.wvbop.com/index.php?option=com_content&view=article&id=99&Itemid=117)