2016 NCSBN Discipline Case Management Conference

- [Janeen] I wanted to start off with...actually, just a little bit of a story. Some of you may know one of the national speakers, Zig Ziglar. Some of you are familiar with his work. He used to tell a story about a young couple who was fixing, it happened to be Easter dinner. And they were making a ham. And the wife was...the wife was cooking, happened to cut off the ends of the ham. And the husband asked, "Why did you do that?" She goes, "Oh, I don't know. It's just something we do. And it probably has something to do with the way the ham is cooking, or the heat, or something and... I don't know. Let me call mom." So she gets on the phone and she calls her mom and her mom says, "Yeah, you cut off the ends of the ham. It has something to do with the airflow and the oven, and the way it makes the flavor more juicy or something like that. But I'm not sure that that's it. My mom always did it that way." So, her mom was still alive, she's in a nursing home. So they picked up the phone and they called her mom. And by the time her mom got to the phone she forget her question, but they eventually got around to it. And said that the daughter asked mom, "Why do we do that? Your granddaughter called today and wanted to know. And, I think it's because of the flavoring and how it cooks and that kind of thing. And so I'm curious, why do we do that?" And she says, "Well, I don't know why you did it, but I had to cut off the ends to fit in my pan." So the whole purpose of that story is, sometimes we need to look at things differently. If we continue to do things the way that we've always done them, progress is impossible. So, hopefully, with this opioid epidemic that we know we have...and Coleen stole my thunder a little bit, wherever she went. So I'll have to make up something when I come to those slides. But hopefully we can look at things a little bit differently than we have 10-20 years ago, and see that opioids have their own problems. And we need to look at how we're treating patients, and patients being our nurses as well. And how we can help them? How can we identify them, and how can we help them? So our objectives of today's talk, because I'm going to give you a few of the statistics that are concerning opioids. And I'm only going to speak about opioids as opposed to all of the other millions of drugs that we could get involved with. This talk will only be involved with opioids. Describe the role of the Regulatory Board and the opioid epidemic, and how the PDMP plays a role in there. And then we're going to talk about how you would document those findings in your investigative reports.

database, it may only track Schedule IIs, or it may track all the way through Schedule V. And for those non-nursing people in the room, Schedule II are the most addictive drugs, Schedule V are the least addictive drugs. What's the role of the Regulatory Board? We use the PDMP to investigate healthcare professionals who prescribe, who dispense it, and who abuse prescription controlled substances. That's the purpose for what we're looking for. Hopefully, we can help reduce prescription drug misuse, abuse, and diversion. And we can request the data as evidence for an existing investigation. Typically, this will need a subpoena for the information or some sort of authority requesting that information. Right now, this is where the licensing boards...these are the licensing boards that are able to request the PDMP. You'll see that the yellow, the bright yellow there, Nebraska and Minnesota do not have access to reports, not yet. So we use this PDMP as a tool. It's strictly a tool, and that's something we do need to keep in mind anytime we're looking at these data reports that we're getting. The tool will help us to identify individuals who are obtaining medications/controlled substances from multiple providers. It helps us to calculate the total amount of opioids being used per day. It helps us to identify individuals who are being prescribed other substances that might increase the risks of opioids, such as the benzpstD.20 One pf the commpnly used combinatipns that lypu' see is what we call the "trip, " which is a combinatipn pf alprazplam, pr typically knpwn as Xanax, or any benzpdiazepine; hydrocodpne, also knpwn as Vicodin, Lortab; and Soma -- so a muscle relaxer, a benzdiazepine, and an opipid. But if we add pxycod one to the mix, then it becomes the Holy Trinity. And this is what name is on the street. So if ypu hear thpse names,

Prescription Monitoring Program. And what we're looking at here is, you have on the top, the patients' names and addresses right there. And this report was ran, you can see up here, from 2010 and 2015. It'll tell you the date that you run it. Typically, they default to one year. So if you want to change that, you can request to change in date, you just need to do that. And then down below, it gives you the medications, who prescribed it. I don't expect you to read that, but that's what the information is that's down there. I blew this up a little bit so you all didn't have to put your glasses on, but this particular drug is for Alprazolam. And we're looking on this particular form on, how often this particular nurse practitioner prescribed the drug? So we're looking over here, at the fill date. And one thing I want to point out over here, on the field date is, this is not when the prescription was written. This is when the patient actually...when the pharmacist actually put the drug into the bottle. Not when the patient picked it up, not when the prescription was written, but when the pharmacist put it in the bottle. So if there's a concern about that date, you really need to call the pharmacist and get a more clear answer. Over here, however, is when the prescription was written. So from the prescribing perspective, this is really the number you're looking at to see were they prescribing it appropriately? Compared to when the drug was actually filled. Sometimes people will hold on to their prescriptions. And so when it looks like it's an early refill, it really isn't. This is what the form looks like in its totality. This one is nice and clean because you can see the Alprazolam is all the way down the board and that's about a month or so apart. One of the things we're also looking at as we're looking at these is, how do they pay for the prescription? And we don't want to put too much bias on this report. But, typically, those who are abusing controlled substances usually pay private pay, usually, not always. Sometimes when you're getting more than one a month, the insurance won't pay for it and so that's why you'll see maybe once in a while they'll get an insurance to pay for it. But it's also a tactic to use for those who are abusing it, so that they don't...the insurance company doesn't tip off the provider. Because insurance companies are now starting to follow this and they'll say, "Hey, did you know your patient was getting prescriptions from another provider, and they're getting them about every two weeks?" So they don't want to do that. So if they do private pay, they're less likely to be caught. We also know that if they're doing private pay, particularly the smaller companies don't tend to question as much. The other part is the MED, which is the morphine equivalent dosing...and there it is right there. And this is something that the CDC came up with as a chart to help us determine, how much, if we put all this together and we made it all a morphine-type drug, how much is that person actually getting? This came out a couple years ago. And the important thing to remember about this is it's only a snapshot of what drugs are supposed to be in effect, right now. So if somebody wrote a prescription for 10 days' worth, if you're looking 11 days out, it won't show up in this. And we know sometimes people have medications left over. They don't take it as prescribed and so, you may have extras here and there. So something to keep in mind when you're looking at this, this is only a snapshot of what, if taken as prescribed, this is what would be in the system. And we're looking at numbers that would concern us. Anything over 100 is supposed to cause the prescriber to...they call it a pause. To step back and look at it and determine, "Does this person really need this medication?" It's not saying, "Don't prescribe after 100." It's not saying that over 100, it's dangerous that's...well, it is dangerous. But, exceptionally, so that you're not going to give them that medication -- that's not what that means. It's strictly a pause. And what that should do for you, as the regulator, is determine: Is my patient on 100? My patient, being my nurse, on 100 or above? Do I need to be concerned about their ability to function under these types of medications? You wouldn't necessarily only

do that at 100. You may do that at 50, depending on the type of complaint that you got. But it's certainly something to consider as part of your investigation. And then the other part is that is it a new prescription or a refill? And if you hav