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2016 NCSBN Discipline Case Management Conference - Teamwork to Address Prevention and Detection of Narcotic Overprescribing

Event
2016 NCSBN Discipline Case Management Conference

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Presenter
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- [Elizabeth] I'd like to share with you Tennessee's story today. I hope that we'll be able to stimulate some ideas that you may be able to use in your jurisdiction. I want to share with you some data, and emphasize the point that with teamwork and communication, we've built trust and made some progress. To set the stage, this is Tennessee's story. Tennessee is an umbrella. Board of Nursing is located within the Department of Health. It's an umbrella agency. We're about 30 health-related boards. We have an Office of General Counsel that provides attorneys to support the various boards. There's an Investigations Division that provides us support. We're located in a central office as well as regional offices. And frankly, we've had a long history of working very autonomously. With about 54,000 prescribers among the prescribing boards, nursing represent about 20% of the prescribers. We identified prescription drug abuse as a priority, and I'll share with you some of the reasons, the red flags that lead us to that. You'll see this list of C-II or Controlled Substance Utilization by States, you'll see that Tennessee is number two. We're not the national champions. We're contenders. Alabama holds the title. And to bring that number down to a point that's more understandable with a population of 6 million Tennesseans, that utilization, those numbers of opioids that are prescribed represents 51 hydrocodone pills for each Tennessean, plus 22 Xanax, and 21 oxycodone pills. So we're close to 100 pills for every person in Tennessee per year, yes. I want to make sure that we're on the same page when I speak of Morphine Equivalents or MMEs. Different opioids, as you probably know, have different morphine equivalents, and are calculated in relationship to morphine. So one milligram of morphine equals one MME. Hydrocodone, another example, is one MME. We have to make sure that we're comparing apples to apples when we're looking at determining the morphine equivalents of any given provider is prescribing. So our team uses this conversion chart to make that identification. And you can see that with morphine, sort of our gold standard, it's one to one relationship. And you look at the top of the scale, buprenorphine is 10 times more potent than morphine. And then you look down at the bottom, tramadol or Ultram, a trade name, is one- tenth as potent as morphine. And fentanyl, which has been in the news recently is 7.2 times as strong as morphine on a milligram by milligram basis. And now again, that's the prescription strength fentanyl, not what would be found possibly on the street. Tennessee looked at its top

prescribers of Controlled Substances. Tennessee's guidelines for prescribing opioids suggest that a prescriber not prescribe over 120 morphine equivalent daily dose. However, looking at the CSMD which is our prescription drug monitoring program, we call it the Controlled Substance Monitoring Program, showed that the top prescribers were prescribing as many as 500 MEDDs, and up to 700. So let's see, what does that represent in terms of pills, something that you might be able to identify with if you've ever had a prescription for a narcotic? At the recommended maximum dose for a primary care provider to prescribe would be hydrocodone, the 10 milligram tablet could have 12 pills in a day with percocet oxy, 8 pills per day. The CSMD revealed that these top prescribers were prescribing as many as or more than 50 hydrocodone tablets for a day for a patient, or 33 percocet. And this wasn't just an isolated handful of people that were prescribing at this level. And for many of us, that dosage would represent lethal dosages, and lead us to believe that the patients were probably not ingesting those medications. Now we looked at our top 50 prescribers who were prescribing the highest MMEs and looked at them and compared them with the DEA registrants. So we found that even though only 22% of the DEA registrants were APRNs, they were prescribing 64%, or almost three times the number of...they were very overrepresented in prescribing the controlled substances. Another red flag was the in-patient hospitalizations for Neonatal Abstinence Syndrome in Tennessee in this. There was a five-fold increase in this 10-year period with almost a thousand cases in 2014, the last year that we have the figures. Drug overdose deaths were also alarming, and we had 1,263 deaths of Tennesseans and that represents more than three deaths per day. It's more than car accidents and gun in Tennessee. We like our guns. Well, these stats and of course many others is just a sampling. I got the attention of our state legislature as well as the boards. And the legislature acted to pass the Prescription Safety Act of 2012 that required registration rather than being voluntary. It mandates a query before an initial prescription of an opioid or a benzo. The dispenser, the pharmacist must identify the method of payment, because as we heard yesterday about cash payments can be suspect. And the pharmacy had to report the prescriptions within seven days, that's now a daily reporting. But at 2012, it was every seven days, and it authorized data sharing. The next act, the Addison Sharp Act of 2013 mandated that chronic treatment guidelines be developed and updated annually, and this has been done with a interdisciplinary panel of experts. The Chronic Pain Guidelines were to be adopted as policy by the prescribing boards, and that this would be the chosen policy rather than rule. I don't know about your state, but rulemaking, we have way less flexibility in... I don't know. We'd probably be still waiting for these to be adopted. And the guidelines needed to be disseminated to the licensees through various sources such as newsletters. And in fact, we've used symposia, face to face contact with patients. And it required two CEs in controlled substance prescribing that had to include the Tennessee Chronic Pain Guidelines, which gave us a little dilemma in that there was, I guess I should say commercially available continuing education on prescribing is available, but not necessarily on the Tennessee guidelines. Another piece of legislation that we affectionately refer to is the Top 50 Act of 2013 required the department to identify the top prescribers of controlled substances. And these prescribers, another requirement was to contact by letter the prescriber, and if this prescriber was a person in a profession that was required for the prescription authority to be supervised, such as APRN, the letter would also be sent to the supervisor. And that in that letter, it would it identify the drugs that were prescribed, the MMEs, and the number of patients, so how that was calculated. And then a response was requested for an individual to provide their explanation for that pattern of prescribing. Now, of course,

there's got to be a top 50. We know that. No matter how much we reduce the controlled substances prescribed, somebody will be on the top 50 list. We just hated to see it was nurses. The Chronic Pain Guidelines Act of 2014 required that these guidelines be developed by January 1st of 2014 required two, it increased the continuing education to two hours rather than just one. And it limited the prescribing of C-II through IV to only a 30-day supply. And the Chronic Pain Guidelines had to address the prescribing of opioids, benzos, carisoprodol, and barbiturates. Now the Naloxone Act of 2015 allows a healthcare professional practitioner to prescribe naloxone to an at-risk person: a person at risk of having an opioid overdose, and prescribe that to their family member or the friend of the at-risk person. It required training in the naloxone administration, and that training was prepared by the Department of Health, placed online, and a little exam and a certificate on the website. Of course, it provided immunity for prosecution for the prescriber as well as the individual who administered the drug. So the Patient Safety Act of 2012 and these other was really the impetus for teamwork that it had to begin. The CSMD or the database itself was legislated in 2002, and this committee was set up to look at the data from the CSMD and to report any unusual patterns of prescribing and dispensing of controlled substances. And the law mandated a membership from the various prescribing boards. And in nursing, the board chose the chairman of the board to serve on this committee. Now with all of this background, we had some environmental challenges. And in the midst of all of this, our Nursing Association introduced a full practice authority bill. Well, I can tell you that this mobilized the Medical Association like no other. The APRNs found themselves in the hot seat, and this was really a position that was uncomfortable and really surprising. The APRNs...nursing, year after year is considered the most ethical profession, and then to be placed in this vulnerable position brought about a great deal of denial from our stakeholders. There was anger, there was suspicion. The CSMD data is confidential. There was suspicion about the accuracy of that data. APRNs were to be a different kind of provider. This was just not in the DNA of our APRNs to be placed in this situation, and it really was shocking. And we felt that as a nursing board too. So we realized that what we were doing was not effective, and nursing was not at the table, and you know what they say about if you're not at the table, you're probably on the menu. So we looked at how do we turn the tide of this terrible situation and contribute to solutions that would beat this epidemic? Well, first, we had to look at what do we have control over? At that point, we didn't feel like we had very much, but as our nursing team we brainstormed, and we realized, well, one thing that we do have control over is competency audits. So we immediately increased the percentage of audits that we're doing on the APRNs. We notified our stakeholders that we were going to have this increase, and almost immediately, we identified, "Oh, we've got some problems here." Just that initial return of the audits, we quickly quadrupled the percentage of records audits, and I have to give so much credit to our nursing team, because as you can imagine that this increased their workload tremendously, but we were all on board that we were going to look at anything that we could do to either prove that everybody was wrong about APRNs, or what we could do to educate and remediate. Now in Tennessee, as I said, the APRNs must practice under supervision for their prescriptive authority, and they have to submit a notice in formulary. And the notice means who's your supervising physician, and what's the person's name, and where's the practice address? And the formulary had to list the categories of drugs that were appropriate for that APRN to prescribe. And of course, current national certification is required, and at that time when we began this, the one contact hour of continuing education on the controlled substance prescribing. We quickly identified that we needed to simplify the audit

form and the instructions. Our instructions, I don't know if you all ever felt the same way, but people just don't know how to fill out. They don't read the instructions, so we thought if you say it more than once in a little bit different way that some person will get the idea. Well, we discounted that and just stuck to, "We'll say it once and simply." We simplified the formulary. It's a checklist instead of listing pages of categories of drugs. The categories are non-controlled substances, check, controlled substances, check two, three, four, five. And then we collected data on compliance at the initial compliance as well as the final compliance. Now there's a prescription drug abuse taskforce that's going on about this time, and that group was designed to analyze, interpret the data from the CSMD, which by the way our CSMD is under our Board of Pharmacy, and we're all located in one building. Our offices are next to each other, and collaborate on best practices, whatever, and discuss legislation, either legislation that's pending or legislation that might be helpful to address the drug epidemic. That team was composed of...and this is a staff team. We had a physician. We had no one from nursing initially, pharmacy, our legal representatives, commissioner staff were under Department of Health with the Commissioner of Health, a representative there, and the CSMD staff. So how do we get to be at the table? We weren't. Well, we know this group, they're all about data so we needed to look at what we could, what kind of contribution that we could make. We had started this audit, and we asked to be placed on the agenda of their next meeting so we could share the data from the audit. And then we also had been provided the data from the Top 50 that was handed over to us. The top 50 prescribers for three years in a row, over half of those top 50 prescribers have been APRNs. And because we had the time and the resources, we had the licensing files of those, we took that spreadsheet of those and we analyzed every factor that we could think of to look, to see if we could determine a risk profile. Who were these people? What might have led to anything that we could gather from this information that might be helpful to prevent problems? And then we found that after we had looked at every file, everything about them, whether they were compliant, previous discipline, ginger, everything that we could possibly think of, and we were ready to share that, particularly not only with the Prescription Drug Abuse Task Force, but with our board when our Office of General Counsel advised us that even this information in aggregate could be identifiable, and that we were not able to share that. Then let me back up. When we did share the data from the APRN audit, and we shared the information for that analysis that we had done on the APRNs that were in the Top 50, we were out the committee and we earned a place on the team. Then we were disappointed that we couldn't share this information. Our stakeholders again, there was not any decrease in the anger, the denial, that concern and that information being confidential just fed into that concern. So next, what could we do? We strategized again with our nursing team, and decided that we would look at the disciplinary action from our overprescribing team. So about in 2013, it was determined that we needed a team to focus on the cases that involved overprescribing. And so that team involved our legal, certain attorneys were set to be on the overprescribing team or investigators. We had the physician representative, but we didn't have an APRN on that group at that particular time. So we decided to evaluate that disciplinary action that had resulted from that team's effort. Now as an interdisciplinary team, we all agreed that education was extremely important that we know that or we believe that our prescribers don't wake up every day with the intent to overprescribe. And that if we could give them education, that we could at least change behavior of those who were open to that change. And so we agreed and we implemented face to face contact hours to meet that two-hour requirement of education on the on the CSMD registration and the Tennessee Chronic Pain

Guidelines. We stepped up email push notifications to our APRNs regarding these new requirements of just changing constantly, and people are busy. It's difficult for us to keep up with the new statutes that are changing constantly, and you can imagine the prescribers that that's not their primary focus in life. And our Medical Director of the Special Projects team provides the Board of Nursing education at every quarterly meeting. Now as a team, we endorsed the Chronic Pain Guidelines. We helped to select the interdisciplinary panel of experts to develop these that were based on the CDC guidelines. However, they were individualized for the Tennessee culture. The Vet Board released a position, had an extra position and we were able to use that position to hire an APRN who would be a member of the overprescribing team -- serves as a Board of Nursing staff member, but provides that review of the overprescribing complaints, and works with the...helping to determine the disposition of those cases as settlements. Our board has been completely supportive with continuing education and the hiring of the APRN. Now because of the APRNs were in that Top 50, and we stepped up the audits, we did audits that were not just our random audits that we normally did. We developed some focused audits, and we don't have our data yet from the focused audits that we're looking at some of the top several hundred prescribers of MMEs. We looked at, and all of our team agree that we were going to try to educate rather than to enforce. Normally with an audit or the way we operate if a person is a non-compliant after trying in...that it would go through our enforcement division where we needed to support the... We didn't want to overwhelm our Office of General Counsel if there was something that we could do to remediate people who probably just were preoccupied or not educated in it. And then it also provided opportunities to communicate. These audits were not just paper audits. When a person was non-compliant, they were contacted by phone. You can see, it was very effective. We had less than 50% were compliant initially, but we're able to reach 100% compliance with the audited materials. And our audits weren't complete in 2015, but we expect to have 100% compliance in 2015 with those audits. Early on we surveyed our APRN Nursing Education Programs regarding the hours that they devoted to overprescribing. We didn't find any consistency. It was all over the board. Some probably hardly knew how much they were so integrated into the curriculum. And the Prescription Drug Abuse Task Force developed a DVD and provided that to the education programs. Now the prescription drug task force has evolved into a team of teams with the common goal to reduce opioid misuse. So we've expanded from just staff in our division or in our bureau to across departments for mental health and law enforcement. So take a little bit about some of the initiatives. We're focusing now on the 12- to 25-year-old in terms of improving that education. We are looking at repurposing meth-lab trailers to opioid education. And when I say that, I don't mean meth-lab trailers that were confiscated by law enforcement. No. I'm speaking of mock meth-lab trailers that law enforcement used for education purposes that we're going to repurpose for opioid education for these young people. And we're continuing our symposia. We have a face to face symposia. We go across the state. We call it our Dog and Pony show, and whenever a university, a church, school, wherever, 50 or more are gathered, we will be there and provide that education. This year, the education we're going to...after two years of reaching the larger cities, we are looking at expanding to the rural areas to the top MME counties. We are expanding and we have expanded the optimal prescribing guidelines to emergency department and pain management, and we actively support our anti-drug coalitions across the state, getting that two-way communication. Expanding efforts to reduce NAS, hired a new RN position specifically to work with this, and also to facilitate community interventions such as safe

disposal of drugs and public service announcements through social media, and again the... Now pharmacists are authorized to prescribe naloxone, and we've developed guidelines for them, collaborative agreements, and facilitated that process. Well, let's talk about results. The overprescribing team has had about 100 actions since 2013, and you'll see about half of those are our Board of Medical Examiner actions. And I believe that number will increase in the APRNs now that we've had our APRN consultant on board for a year. And I want to say that they work so collaboratively. Our APRN consultant helps out our physicians who review the complaints to the Medical Board, and really they're trying so much to be on the same page so that any discipline that's recommended would be...we would want to see that discipline appropriate and consistent, and not be in a situation where the APRN license is revoked, and the supervising physician got a reprimand. Now, we know that the APRN is certainly responsible for that prescribing, and we're not shuffling that responsibility on to the physician. However, at present, there is a physician involved in every prescription of a controlled substance, even though it is a review after the fact. Now, this slide represents a scattergram of all the APRNs who have been disciplined for overprescribing. And that represents 30 licensees. And we can see each diamond represents an APRN. And you can see that 47% or almost half violated within 20 months of becoming licensed as an APRN. And that would not have been evident without us doing this. And we're continuing to follow this. At least, this gives us a basis for developing a risk...for a risk profile, and for education. Now, in terms of morphine milliequivalents/milligram equivalents by age, you can see that we've made some progress with the younger cohort. And, I guess it is to be expected, as we're older and we have more aches and pains that we would be prescribed more opioids. That would be expected. But I think that, typically, we have thought that it would be that younger cohort who are the greatest users of opioid/prescribed opioids. But it's really the...as we've heard before, the middle-aged group. We've had reductions in our morphine, MMEs per capita -- 2012 was our peak year. That was the year the Patient Safety Act was enacted. And we're hopeful that the initiatives that we have taken have contributed to that decrease. Now, along with that we look at licenses disciplined. You can see that since 2012 we tripled the percentage of APRNs who had their license disciplined, although it represents a very, very small percentage of APRNs in a year. That analysis of the top 50, this shows the factors that we looked at, and that we did not find anything to help us with a profile. However, we did refute the notion by our medical colleagues that the overprescribing APNs just had to be those APRNs who went to the initial licensure master's programs. That it couldn't possibly be the old school, for example, nurse practitioner who had many years of experience as an RN before becoming an APRN. So that was not the case. We've had about a 20% reduction in MMEs by the top 50 prescribers. So, of course, we're always going to have a top 50. They're prescribing 20% less. They're still prescribing very large amounts of opioids. Now, the registration in CSMD is mandatory. It's mandatory to query. There were 54,000 prescribers. And we have...let's see, I believe it's 48,000. Over 48,000 who are registered. I do want to say that I guess this only makes the situation that much worse for the picture, for the APRNs. When only about half of our APRNs are actually prescribing controlled substances. Many will, even though they have DEA, we looked at...probably two-thirds have a DEA. But only about one-third were actually using it to meet the registration guidelines, which is prescribing 15-days...over 15-days in a calendar year. So the Board adopted those Interdisciplinary Developed Guidelines in 2014. We had an expert panel come in, in the last month. And the guidelines have been revised and expanded. And the Board...well, the Board has adopted the guidelines, twice. So we're on a third go around. As far

as education, we said we support education. We provide free symposia across the state so that no one can say that the education is not accessible. No cost. And in fact, we provide a free meal. We do it on Thursday evenings, generally, from 6:00 to 9:00, with the meal at 5:00. Our community stakeholders have just really stepped up to the plate. And they have made these presentations. They provide the venue, they make the presentations available online -- stream -- simultaneously. They archive the content and make it available so if someone...usually, at a presentation, there may be a couple hundred, several hundred. Or, really, it could be a much smaller number. And then there's...there might be hundreds more who are listening to the presentation at home, or wherever -- online. And if a person is not able to meet that day, they can go into these archived videos, and they are able to get the...download a certificate that shows that they participated and made the requirements. We make it so easy. If they don't even get a certificate, we keep...if they registered and had their name. We'll accept their name. So to really try to be extremely flexible and not have anyone have any excuse to not getting this education. It's not just the excuse. We want them to be...we want them to have this education. Board members are educated, as I've said before. They're supportive. And NCSBN is supportive. NCSBN provides on there...have a website a resource compendium of Board of Nursing initiatives. Again, the Board, their specific actions. They endorsed the guidelines. They increased the requirement for the continuing...of the contact hours, to two hours, from one. They've increased the Board panel. I have to give so much credit to our Office of General Counsel. Because, now, our Board has an 11 member board. And the Board has been authorized to break down into panels of at least three members to hear cases. Well, this...with the increasing caseload now, we're running at our quarterly meeting three panels at a time. Of course, that's increased the workload of our Office of General Counsel, to have these hearings -- three going on, simultaneously. But we're... I think that just speaks to our commitment across the board. Now, what are we doing? What will we do in the future? We expect that we'll grow our teams. We're extending our efforts to reach educationally, to reach our RNs and LPNs. This isn't just an APRN or a physician problem. All nurses -- you know the tremendous role that our RNs and LPNs provide in questioning prescriptions, and the role that they can have to support their prescriber. And we want to reach them, to help us fight this opioid epidemic. We've extended our collaboration to our licensing, our health care facilities licensing agency. They've conducted annual training for the last couple of years. They meet with leaders of the long-term care industry. And we asked to be placed on their agenda, and we've gone across the state to speak not just on the opioid epidemic, but other...it gives us an opportunity to reach out, and communicate in another way, with a different group. A group that we've not traditionally reached. And then we're including, this, our education in every form. When we make school site visits, we are spreading the word about misuse of opioids and overprescribing just to raise awareness -- and not just with the students, not just with the faculty. We are spreading this word and we are communicating this to our administration, and our colleges, and universities. And it's been...it's resonated with that group. I think they feel that they can take ownership and that their nursing program is going to be a part of the solution. So that's been well received. We haven't been able to measure it yet. But if we can think of a way, we'll try. And student presentations -- we take the opportunity to present to students when asked. And a facility-in-services [SP] is another way that we've reached out. So that concludes the presentation. And I'll be happy to try to answer any questions that you might have. - [Alice] I'm Alice Carter [SP] from the Virginia group, here, and I'll be presenting a little bit later. But I just want to congratulate on an outstanding presentation.

You covered a tremendous amount of information in a very short time. I have one big question, though. Who funds this? Does your legislature provide some means for the budget, or anything like that, in order to do this? Our Prescription Monitoring Program in Virginia is entirely funded, right now, because of a Purdue Pharma lawsuit. And the money that's left over from that is what's funding that. So I'm interested to hear if Tennessee is having a broader perspective on it? - Our CSMD is funded by the Prescribing Boards. And it's done in proportion to the...of the number of prescribers. And then, the other efforts, we've just taken on as just part of our workload. - Thank you so much. - You're welcome. Thank you. - [Woman] A very insightful presentation. Thank you. When you do your audits of APRNs, what are you using as your definition of overprescribing? - Well, we're not auditing for overprescribing. We're auditing to see that the person has dotted the I's and crossed the T's. We're auditing for, is there a notice, a current notice in formulate? We don't know where a person's practicing. So the only way that we would know that the notice...that the formulary is current is, if we ask for that in the audit. And we're asking for the...who is your supervising physician? And then, we make sure that we update that online, and for the record, and the formulary of course. We're auditing for the continuing education. If they have not done that, we offer them, "Well, where are the next symposia? Where are you? Here's our schedule. Be there, and submit that documentation, and we'll close out your audit." And then we ask for a copy of their current National Certification. So we're not auditing for the overprescribing. The overprescribing is a function of the CSMD. And as far as...we don't know. I can't tell you exactly what overprescribing would be. But we're looking at those top 50 out of 54,000 prescribers. - [Woman 2] Thank you. - [Woman 3] Hi. Thank you. I'm wondering if there was any analysis done of where the APRNs were working? In most places, APRNs do work with an underserved population, more than physicians. Do work with people with a lot of health disparities, a lot of social-economic determinants of health that are disadvantageous. So I wonder if any of that was taken into account with your top 50 list? If that could account for any of those differences? I don't know. And then, if indeed, it wouldn't account for any of those things. As an APRN from an independent state, I have to say that your supervision requirement didn't prevent any of that from happening. So I hope all of you will weigh-in on the VA. Right now, they're taking opinions on independence for APRNs. So, thanks. - Okay. Well, as far as where? We didn't... I can't tell you where they were practicing, even though we know. We certainly did. But I can say that they were not practicing in hospice, not practice in orthopedics, not practicing in any...in oncology. They were practicing in primary care and the over prescribers in the pain clinics. Of course, we consider in Tennessee, a pain clinic, as any practice, regardless of what kind it is. That, where 50% or more than 50% of the patients are prescribed opioids for chronic pain. Meaning, over a certain period of time...over 90-days, I believe...three months. So it is the primary care. Interestingly, our top prescriber for a couple years was a CRNA. Who, by the way, did not have prescribing authority. Anybody else? Well, thank you for your attention. I appreciated it. And I will be here and be happy to talk to you at the break.