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2016 NCSBN Discipline Case Management Conference - Using the Prescription Monitoring Program in Substance Use Disorder Cases

Event
2016 NCSBN Discipline Case Management Conference

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Presenter
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- [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.

Understanding, of course, that the PDMP does have some limitations. So why are we concerned? We know that prescription drugs are misused and abused more than any other drug in the world, except for marijuana and alcohol. We know that since 1999, there was a 265% increase among men and 400% among women -- that's a lot. Ten of the highest prescribing states for painkillers are in the South. There they are. See where you fall in there. You hear all the people from the South giggling over there. You can tell because they have like a little slang in their... Prescription drugs are the second most frequently abused drug category after marijuana. And 15,000 people die every year from overdoses involving prescription pain killers, more than those who die from heroin and cocaine combined. These are overdose deaths involving opioid analgesics, cocaine, and heroin. And you can see a 21% difference in opioid, that's your red line there. This is from 2013, for the leading cause of death. The blues...you don't have to get out your eyeglasses for this, but the blue boxes are unintentional injury, which includes overdosed deaths. You can see from the age one to 44, it is the number one killer in the United States. And for all ages, it's number four. Diversion is quite the business. If you didn't know it, here's some prices. You all are figuring out your second career now. The bad part about that, though, is that's a very short career for the most part. But very lucrative career. I'll point out the OxyContin, here, and it ranges anywhere from 50¢ to a $1 per milligram. So if you can work that out to an 80 milligram OxyContin prescription from two different providers, that's $5,000 a month. It really is another career. This is a duplicate of what Coleen showed, but I'm showing you the whole years, from 2003 to 2014, and here's 2014. I have to come up with something different so I'm going to say this is a heat index. And you'll notice the West, Southwest is a little hotter. All right, so geographically, overdose deaths in the rural areas are now higher than those in the metropolitan area. It used to be the other way around. We don't really know, why? Maybe it's because the specialists tend to be more in the cities. Then, the generalists who aren't really aware of the problems, are out in the rural areas. Or...we don't really know why. Who does the epidemic affect? Coleen brought this up as well, white men are the highest -- between the ages of 25 and 34, 45 and 54 are the highest rates. These are sales and related deaths. We can see that the rates of opioids and their intentional overdose in the addiction treatment, in that order. The sales are the green line, deaths are the red line, and treatments are the blue line. And this is by type of opioid, drug overdose involving the opioids are the solid line. And the natural and semi-synthetic opioids are the next one down. Methadone, now, is starting to be a big problem on the street -- everywhere, not just on the street -- but particularly on the street. And the biggest problem with this, methadone, is the half life of methadone. And for those of you who are not familiar with the half life of methadone, it's about 56 hours. So while you might take a Percocet in one to four hours or so it's pretty well worn off. Four to six hours, it's worn off. Well, methadone, it's about a day and a half, two days, three days sometimes before you even reach the half dose. So when somebody's taking methadone for the treatment of pain...it could be used for addiction or pain. But if they're taking it for the treatment of pain, they're thinking, "One isn't very good. So I need to take two, maybe three." Come day three, they're dead. It's a big problem. And 5,000 people, every year, die from an overdose related to methadone. And it's only getting...it's becoming a larger number because methadone is relatively cheap compared to the other drugs available. Six times as many people died from methadone than in 2009. So we see this problem escalating, and we anticipate it will escalate even more. So the PDMP, most of you know it as a PDMP, although there's different definitions depending on which state you work in. But it's essentially the state-wide electronic database that tracks the controlled substances. And depending on your

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 benzos. One of the commonly used combinations that you'll see is what we call the "trio, " which is a combination of alprazolam, or typically known as Xanax, or any benzodiazepine; hydrocodone, also known as Vicodin, Lortab; and Soma -- so a muscle relaxer, a benzodiazepine, and an opioid. But if we add oxycodone to the mix, then it becomes the Holy Trinity. And this is what name is on the street. So if you hear those names, that's not talking about religion...or maybe their religion. So, hopefully, the PDMP is going to help us... You have to determine whether it's the II to IV depending on what your state is...and that should be IV or V. If there's abuse patterns, it will help us to identify that. It'll help us identify over-prescribing. It'll help us to know if there's the overuse of controlled substances if there's multiple prescribers. And if there's early refills. Those are the common uses of this. We can see on the report how many pharmacies there are. We want to see if the prescriptions are consistent with the medical records that are actually supplied, or subpoenaed. And if the urine drug screen is consistent with what's on the actual report. Sometimes you'll find other drugs in the urine drug screen, sometimes you won't find the drugs that are being prescribed on the drug screen. If a substance is prescribed for a legitimate purpose, that's going to be hard to prove in some cases. Are they taking cocktails, known cocktails like the trio? And are they compliance or in compliance or in abstinence in monitoring programs? One thing to remember when you are requesting the PDMP that there has to be a nexus to the case. We can't just order them across the board on anybody that comes through. You know, "They're acting funny." Well, we need a little bit more than that. So there's got to be the nexus before we can actually order that, or request that. We also have to ensure confidentiality, like we would any other investigative report. That becomes a part of the investigation and is considered confidential. And that data must also be secured. Any aspect of the investigation report are considered confidential and that includes the data collection, the storage, the transmission of the request and any dissemination of the reports. We cannot share that information without the proper documentation in place. So let's take a look at what a case study might look like when you're investigating the prescriber. So in some case...in some states, your nurse practitioner is able to prescribe, in some states, the CNS. You wouldn't necessarily see this for CRNAs because they order. They don't typically prescribe. So majority of this is going to be on your CNSs and NPs. So this is what a typical report looks like, and this is out of the state of Arizona. Although, they all pretty much look similar. We call them the CSPMP -- Controlled Substance

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 have a prescriber that's prescribing refills way too often you might want to look at it from that regard. And, certainly, as a patient, if they're filling their refills too soon? That's also a concern. Keep in mind that you cannot write refills on Schedule II drugs, those have to be new and written every time. But the IIIs, IVs, and Vs can all have refills up to six months. All right, so this is a list of prescribers and list of pharmacies. On the top here, these are all the different prescribers in that five year frame for this particular patient. And on the bottom is the pharmacies. This is pretty typical. If you think about, how many times you go to a different pharmacy? How many different providers you would see in a typical year? This is, again, five years. This is something that would be pretty normal. But what we're looking at when we're looking at these things is, if the patient has stayed in the same home, the same address, or the same area? When we look at pharmacies and when we look at prescribers, are they in the generally the same area as well? So I don't know anything about Virginia, but we'll just say East and West. If someone is living in the West and they get prescriptions filled on the East, that should raise a flag for you. Just looking at the area, does it make sense where they're going? And it may, because maybe they have family members there. But it's still something to look at. So for this particular patient, we had a prescriber...this is what we would actually write in the investigative report. So we would identify that this is a five year report, or almost five years from 2010 to 2015. Review of the prescription profile for Patient C indicated that [inaudible 00:18:41] was the primary prescriber, with two exceptions. That from, in, or around 2014 to 2015, Patient C received six early refills of alprazolam 2 mg. From June to July respondent prescribed Xanax 2 milligrams totaling 300 tablets in around 60 days, averaging 5 tablets or 10 milligrams of Xanax daily. That might be how you would write that in your investigative report. And then, of course, you would have to have a statement below that identifying what the standard of care would be. So let's look at a case study with a nurse who has substance use disorder. In this particular one, we're going to look at all of these addresses that the patient reports. This is the same timeframe -- 2010 to 2015. But how many different addresses do we have there? All the same person. In this particular case, the birth dates are all the same, however, that's another common thing that they'll do. Is, they'll change their date by one or two. So we have three different addresses that tend to repeat theirselves. But, pretty much, all the other ones are the same. Here, we're looking at multiple prescribers. In the purple, in the orange, here, these are different prescribers. And we can tell that by their DEA number. By the way, when you're looking at a DEA number...and this is true any state you work. The first letter of the DEA number is, for a nurse practitioner, will be an "M," or a CNS for that matter. And that stands for mid-level. Nurse practitioners don't like that name, so don't call them that in the public. But that's what it stands for. And then physicians have different letters, "Bs" is one of the more common ones, but there's other initials that they'll use. So first letter is an M, and then the second letter is the first letter of their last name, just so you can help identify who the prescribers are. So here, we have four different prescribers. And then you'll note over here, in the fill dates...in the fill dates, here, we have the same prescribers filling two different drugs. And the same drug, here. So we got 40 and we got 10 milligrams of oxycodone. Now, sometimes, that's because intentional, they wanted a 50 milligrams dose. So you're really looking at patterns of these types of behaviors. What was interesting on this one, you have the 40 milligrams here, in February, by this one provider. But when you come up here, same milligram, oxycodone 40. You've got a different prescriber. So then you have

multiple prescribers. So these are the patterns that you're trying to identify. Again, this is on the second page, here. We have a boat load of different prescribers all the way down the line. And then, over here was the pay column -- ones and fours. Fours are the ones that are receiving it by insurance, payment by insurance. And all the ones are cash pay. And you'll see that the one's that are being filled early happen to be cash pay. The story goes together. Okay, so in this particular case, our written report might look something like, "From April to December of 2010, respondent received controlled substances from a minimum of eight different providers, receiving monthly refills for the same prescription, oxycodone and OxyContin. Respondent filled prescriptions early on 17 occasions and paid cash at four different pharmacies with dosages and quantities progressively increasing." It's very helpful for board members, if you can summarize what you have in the data because you're not going to be putting it...not necessarily, I guess it depends on your board. But you're not really going to be putting the report, the data report, with your investigative report. You're going to summarize that information for the most part. In our next study here, we'll talk about how you might want to put that in a table format to put in your report. Very important that when you are making a summary of what your findings are, that you put the format of your report to best help identify what the problem is. So if you're trying to show that the nurse is improving and using less controlled substances, you may just want to use the total quantities. Versus, if you're trying to show that they moved from one drug to another, you may want to present that a little bit differently. So it depends on how you diagram, or use a figure, or a chart to present your information. And that's a whole other lecture. So here's what one might look like on the written report. This is specifically for March through July of 2012. We wanted to show that there were 12 days from the last refill there, 8 days from the last refill, 8 days, 10 days, 21 days. So you can see how putting this one in a chart actually helps to show that the problem here is the early refills. In the next column over it says how many days is this early? Twenty-two, 37, 20, 24 days early. So it really helps to depict how we have...in this particular case, we have a problem with benzodiazepines. And we can see that they're getting 90 tablets, 60 tablets, 90 tablets throughout. So this written report we might say that, "From around 2010 to 2012, respondent had a history of receiving escalating doses of oxycodone with multiple providers and early refills. For example, February 2011, respondent received 104 tablets of oxycodone from two different providers. And in March of 2011, she received 270 tablets of oxycodone from three different providers. From a period of 2010 to 2011, respondent had received only two prescriptions for a benzodiazepine, totaling 40 tablets. So again, summarizing what you have in the chart just to make it more simple. And I think most of the board members do have a mix of public members in different levels of nursing. And we really don't expect the public members, the ALJs, or law judges that are hearing this to understand the medication. So we have to do a very good job of speaking to the lowest level of education when we're writing these reports. So some of the reminders when we're looking at the PDMP. Make sure that you've identified your nexus. Again, we don't want to start doing something that will end us up losing the ability to do that. The PDMP is a really good tool at identifying problems early on. So we want to make sure that we're requesting the information when it's appropriate to do so. So when would it be appropriate? If you have someone that we know has a positive drug screen in their workplace. That would definitely be a known cause...a reason. If we have someone who has behaviors that are indicative of impairment on the job, we would definitely want to consider that. If we know that maybe someone was arrested for a DUI, but they have a blood...they did a blood draw and it showed that there were drugs in the system at that point,

we may want to do it then. But we wouldn't do it routinely for someone who had a DUI. See, we don't really have a nexus, there. A DUI doesn't mean someone is abusing drugs. So, again, make sure we have a solid nexus before you order it. And remember, again, that the CSPMP is just a tool. It too has its limitations. If you're ever questioning what's on the PMP you want to make sure that you actually get that prescription from the pharmacist -- the actual prescription. Preferably, you're going to ask them for a prescription with the provider's signature on it. The number one abused drug up until last year, for a scheduled drug, does anybody know? Number one abused drug? Vicodin/hydrocodone/Lortab. And that's because it could be called in. It was a Schedule III drug and, Schedule II, now. So it has to be written, but that's the reason why. Is, they would call it in. And so there was no record of that prescription. So now, if you're concerned about that prescription, you're going to want to pull that prescription from the pharmacy. Look at the actual prescript...the signature on the prescription. Particularly if you're looking at the prescriber. And you also want to look at the prescription to see if it's been adulterated. One of the things we teach the MPs is to make sure...or any prescriber for that matter, to make sure you write out the number of pills that they're prescribing. Because what we'll see sometimes, when we pull these prescriptions for nurses who are abusing. Is, if they were prescribed 24 tablets. The nurse, themselves, added zero on the end. So it'd be 240 tablets. That's very common. So we would look to see that the prescription wasn't adulterated as well. You're going to identify patterns. You're going look at the...you're going to consider the use or the street value of the drug. Something that should alert, if someone's coming and asking for a prescription of oxycodone, and Soma, and Xanax -- ding, ding, ding, ding, ding, ding. That's a pretty valuable cash in there. And, hopefully, you're not getting a kickback, so you're not going to give it to them. But you want to identify some of these things before it becomes a problem. Anytime someone requests a specific drug it should be a red flag. Anytime someone asks you for increasing dosages every time, it should be a little red flag. And you will see this as you're reviewing the PDMP, you'll see that the dosages and the numbers are increasing over time. Not saying that that's wrong/that you can't do that. That may very well be warranted. It should just be a red flag that's raised. So how do we use it? Well, first thing. We want to make sure we verify the recipient because there's a lot of John Doe's out there. And when patients are paying cash-pay-only, there's even more Joe Doe's out there. So you want to make sure that you're verifying the recipient as best as you can. You want to verify the quantities. Verify that the prescription was actually picked up. Remember, if it's on that list, it only means that that's when it was filled. The pharmacies are supposed to return it in two weeks. And then go back, and essentially, give a credit to the PDMP. But, sometimes, they don't do that. So before you want to use this information, make sure that the information is correct. Request the medical records to go with your PDMP. And, again, you're looking at, does the medical record match the PDMP? So do you see where the prescriber is actually prescribing that nurse 90 tablets of the oxycodone every month. Or, are they prescribing 15 or 30 and it turns into 90? Whatever the case may be, you're matching it. You want to request the prescription profiles from the pharmacy as well, and maybe even from insurance. Because sometimes you may be requesting medications from the PDMP, but...or you're seeing them from the PDMP. But if you do it through the insurance profile, you might get a different picture because maybe they're going across the lines, the state lines. So your insurance company will have that information. Or your pharmacies, if they're out-of-state, may have that information if they cross...like Walgreens' and CVS' will share that information on their profile -- the pharmacy profile -- but not on the PDMP. Because some states don't cross lines. On your

interview, we want to ask the patients' what medications have been prescribed long before they even know you have a PDMP. Ask the nurse ahead of time: what medications are you taking? Include all herbals, or anything that goes in your mouth. What kinds of medications are you taking? And ask them: How often? How many providers are you seeing? What's the medication for? Get the whole story. And then, look at the PDMP and determine whether or not that actually fits. Does the story make sense? Usually, when it doesn't make sense there's a problem. And, again, just remember that the PDMP is a tool. So what are the limitations? Well, human error. This, right now, unfortunately, we are still human and we do make mistakes. And I'm sure that there's a root cause analysis out there somewhere, working on it. The humans actually input the information into the databank. And you know, as well as I do, when you look at a prescription you have absolutely no idea who signed that at the bottom. And you've got five providers listed on the top. Guess who gets to go in? The first provider at the top that gets listed. So particularly on prescribers, you need to make sure that it is the right prescriber. A true case. Over the Arizona Board of Nursing, we had somebody in Monitoring who was a prescriber, and had their prescribing rights taken away from them. They were suspended. And, it showed up that she was prescribing all of these controlled substances. Well, it turns out that there's two people with the same name in the state. And the pharmacy didn't know any different. We noticed the difference because one started with an M, and the other one started with a doctor's initial B, in this case. So we were able to determine that the information on this PDMP was incorrect. But had we not really looked at that, it looked like a nurse practitioner was in fact prescribing when she was suspended. So human error -- make sure you verify the information on there. The date filled may differ. Again, we talked about is that, it's actually the time that goes into the bottle, not necessarily the time that they pick it up. And that you can access these drugs across the borders. So you may call-in a prescription here, in Arizona, and ask for it to be filled over at Walgreens. But then you go over to a different state, in the Walgreens in a different state. It's a legitimate prescription, but now you can get it early, probably. Pay cash for it, and it's not going to show up on you're PDMP. Remember that there is a maximum of a two-week log in most states, anyway. A two week lag, not log...in data entry. So that if you do get a prescription today, it could take as long as two weeks to show up on that Prescription Monitoring Program. Most of the time it's within a few days. Most of the states require it within a week. But just know that in some states it can be up to two weeks. So people that do not contribute, or entities that don't contribute. The VA, they're doing better, but not all the VAs. And, of course, that's one of our highest offenders, is the VA. We have a lot of people in the VA system that require controlled substances. And so it's one of the most prescribed drugs in the VAs. And, yet, not everybody participates. Any of the federal facilities, not just the VA, Department of Defense, and then the Indian Health Services also does not participate in-full, with this. Here's the map. You can see who's participating right now. The green ones are some of the VA pharmacies reporting. And the blue is supposed to be all of the VA pharmacies reporting. I can tell you that's not really true. Sharing the PMP information -- so what do you do when you get that? So states can share this information, if you have the proper documentation in place. So if you have a valid MOU, or Memorandum of Understanding, you may gain access to other interstate's data. You can log directly into the system. Sometimes it requires some sweet talking. And, generally that works. You just need to know who to talk to, and use your legal statutes in that state. And most places you can, with a letter, request that information. But I'm telling you, the easiest way to do it at least through a compact [SP] state, is to ask your compact state people to get it for you -- much quicker that way. Several

additional states intend to begin sharing. Right now, we have a few that are sharing. You can see the green ones, the dark green are the ones that are sharing. And Nebraska is still not catching up, there. - [Woman] [inaudible 00:34:53] - Well, it is Nebraska. So one of the things about the PMP, it's a great tool, but it is only that. It is only a tool. And so when you're using the information to identify problems you want to make sure that you verify the information, number one. And that you give your respondent, whether it's a prescriber or the nurse, the ability to provide any information that they have to contradict [SP] that. And many times, they do. We hate to jump to conclusions before you actually have all your ducks in a row. All right I have 10 minutes left for questions. Make them easy, please. - I have two questions. How often, when you're doing an investigation, that you're able to verify that somebody's not using the meds but...because we have some people that take a whole lot, not appropriately, but they take a whole lot. Versus selling, and what the trend might be with that in a little cottage industry? And, also, how much are you finding...because this will not reflect, necessarily, medication sold online. And what is the online factor, in terms of people getting their drugs that way? And, yeah, that would probably be it. Thanks. - Now I forgot the first question. All right. So one of the concerns when you don't know if someone's taking the medication. Are they selling it, or are they taking it? Sometimes you can get that information by looking at the medical records, and hopefully your provider's done some drug screens. But remember that a drug screen is done in the office, and it's looking for cutoff levels. Whereas a drug test is looking for metabolites, and that's actually done in a lab. So look at what type of testing you're getting. Because if the drug screen comes back negative, it doesn't necessarily mean they weren't taking it. So that's one of the best ways to do it. Is, look at that medical record to determine: Are the prescriptions being written? And are they doing the drug tests that match? Another thing you can do as regulatory board is, you can certainly request a drug screen, right? Or, most of you can, anyway. A drug screen, you can do it by hair or nail, which will look up to six months, right? So if they don't have any drug in their system for six months but they've been getting it every week or every month for six months, guess what they've been doing with that? And I'm sure they paid the provider cash. So that's one way to look at it. Otherwise, it's really hard to tell. You can get serum levels as well. Those are a little bit more controversial. But you can get serum levels of drug. But probably, I would say, the most commonly used is the hair test, to determine. And it'll tell you the level that's used, as well. - And I also asked about online, to being able to track online. I'm looking from...thinking about mysterious sources. Other words, online or people...we've got a lot of people in Louisiana who work in Louisiana but live in Mississippi, trying to...just because our PMR comes up blank. That doesn't mean that they're not still getting drugs. - Right. And it is relatively easy to get these medications. You can do a Google search and figure out where to get them. It's amazing where you can get them. You can bring stuff over from Canada. You can bring it up from Mexico. They don't really look unless you're bringing big baskets full, of course. Then you're on the news. But you do get them. And sometimes they'll even tell you where they got them. They'll even tell you that they got their benzodiazepine down in...well, I'll use Arizona just because we're close -- in Mexico. And they'll tell you that so that when they pop positive for their urine, you'll know where they got it from. Well, of course, the problem when you're getting medications outside the United States is, you don't really know what's in that drug. So heroin is heroin is heroin. Fentanyl is fentanyl is fentanyl, we saw that that's not necessarily the case either. So you can get these medications on the internet, across the lines, from the neighbor next door. Preferably the child who's 12-years-old, who probably has the best access -- sadly.

But, yeah, there are many, many sources. You just cannot rely on the fact that you're going to see it on the PDMP, unfortunately. And that's when the hair test or nail test will come in handy. To verify that if they had any of these substances in the last 12 months, or six months, rather. And one thing to keep in mind about the hair test or the nail test is, you want to make sure whatever test you're ordering, whether it's a urine test or not, that the drug you're looking for is actually in the panel. Something to keep in mind. And know that the urine test, when you're checking for fentanyl...because that's now the new drug. Fentanyl doesn't really come out in the urine very often. Because it has such a short window. So if you don't get them within five-hours or so, it's not going to show. You're going to need to go to the hair test for that. Any other questions? - Just a comment. I've used the PDMP sometimes, to verify what nurses are telling me about their prescribing. Whether they've had treatment and so on. And I wasn't automatically doing it but I've started, because I realized that every once in a while I'll see the doctor's name. And it's not just a primary care physician. But it turns out that they're seeing pain management or somebody who's an addictionologist, and not telling me that they were in treatment. So I've made it a habit to look up every physician/every provider on the PDMP, to see what you're being treated for. In another case, where a nurse was telling me that she was no longer taking opiate medication. And I look at PDMP, and sure enough in July, the Vicodin prescription stopped. Well, that also happened to be around that time that the diversion may have started. And when I got the physician records, it's not that she weaned herself off, or they weaned her off. It was that they cut her off because she was having issues that were showing up, there. So there are a lot of ways to use it, to identify things that the nurses aren't being truthful about. - You mentioned looking up the doctors, to find out who's prescribing. That actually is a good point. Because you want to make sure you'll look up the doctors that are on the PDMP. Because many times, they're in the same organization or the same agency. And so you don't want to say that they're necessarily doctor shopping because all five people were in the same Cigna clinic and that's just who they got that day. So those are the kinds of information you don't want to jump to conclusions with. You want to make sure you gather all your information. And one thing, just a little bit more about the trio, or Holy Trinity in this case. That is really a big red flag. That should always...because we know that when you're dealing with any type of opioid and any type of benzo, you're just enhancing, you're increasing the chance of the respiratory depression. We know that from all the media stuff. But that should be a big red flag to anybody who sees that behavior. So when you're looking at these PDMPs, look for those three drugs. And if you're seeing that, you need to start asking some question. Anything else? All right. Thank you.