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INSIDE

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Case Managers Cannot Ignore the Disease of Chronic Pain

Researchers advise multifaceted approach

About one in five Americans suffers from chronic pain, and one in 12 experiences high-impact chronic pain. For the older, sicker, and frailer populations seen by case managers, those percentages likely are even higher. Yet the United States medical community continues to struggle with finding ways to solve this major health issue — and the problem worsened in the past decade because of the opioid epidemic.[1,2]

In addition to being linked to opioid dependence, chronic pain leads to restrictions in mobility and daily activities, anxiety and depression, and reduced quality of life.[1]

Plus, people see their doctors for chronic pain more than three times as often as they see doctors for other chronic illnesses, such as diabetes, heart disease, and cancer. *(More information is available at: http://bit.ly/2AmEsXX.)*

> THE GOALS ARE TO MANAGE UNDERLYING DISEASES AND PAIN AND TO TEACH PATIENTS PAIN MANAGEMENT SKILLS THAT THEY CAN INTEGRATE INTO THEIR DAILY LIVES.

Pain management researchers and clinicians say a multifaceted approach is best. Patients can benefit from education, learning self-care strategies, and receiving psychosocial care.

The National Pain Strategy of 2016 creates a roadmap for transforming pain care in America, so it is a good place to start, says **Robert D. Kerns**, PhD, professor of psychiatry, neurology, and psychology at Yale University in New Haven, CT. Kerns also is director of

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mentoring and career development at the Pain Research, Informatics, Multimorbidities, and Education (PRIME) Center at VA Connecticut Healthcare System in West Haven.

"The National Pain Strategy emphasizes this concept of pain self-management," Kerns says. *(For more information, see National Pain Strategy story, page 135.)*

"It reinforces the idea that pain can be conceptualized as a problem to be solved," he adds. "And it encourages people to have self-efficacy or self-empowerment to use what they already know to be true of strategies to help manage their pain."

The goals are to manage underlying diseases and pain and to teach patients pain management skills that they can integrate into their daily lives.

Insurance companies and employers increasingly are turning to pain specialists to help patients with chronic pain. This is a return to where healthcare was 30 years ago.

"Many of us who trained in the 1970s did a lot of this work in pain management, and it was very popular, as research came out in support of it in the 1970s and 1980s," says **Michael Coupland**, CPsych, RPsych, CRC, network medical director for Integrated Medical Case Solutions (IMCS) Group in West Palm Beach, FL. IMCS has 750 psychologists across the country, working in pain management for workers' compensation organizations and others.

"Then, managed care came along and decimated these programs," Coupland says. "The tool in the provider's toolbox was to give medications; drug companies were saying, 'You got to control pain as indicated by Medicare and guidelines, and here's a safe way to do it.'"

Only, it was not safe. As the medical community learned in the past decade, opioid prescriptions led to many people becoming addicted and resulted in an epidemic of drug overdoses.

"Now it's turning around, putting emphasis back on non-opioid interventions, and these are interventions with 40 years of evidence supporting them," Coupland says.

The federal government is promoting non-opioid pain management, including a webpage

EXECUTIVE SUMMARY

Chronic pain is epidemic in the United States, and the medical community struggles with finding solutions that do not involve the use of opioids. Case management strategies can help by teaching patients to self-manage their pain.

- The National Pain Strategy of 2016 offers suggestions for how to treat chronic pain.
- Pain psychologists help patients learn to cope with their chronic pain, and teams that include case managers can reinforce exercise, meditation, and other stress reduction strategies.
- Patients with chronic pain sometimes catastrophize, which ramps up the pain response. Case managers can teach patients how to stop this destructive cycle.

by the Substance Abuse and Mental Health Services Administration – Health Resources & Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions. *(http://bit.ly/2yPL5Qy)*

The Center for Integrated Health Solutions promotes primary care providers collaborating with psychologists, addiction counselors, and pharmacists in managing pain. The webpage links to a checklist for prescribing opioids for chronic pain, noting that the benefits of long-term opioid therapy for chronic pain are not well-supported by evidence. The checklist also supports non-opioid medications, physical treatments such as exercise and weight loss, behavioral treatment, and procedures including intra-articular corticosteroids. *(http://bit.ly/2EzKisR)*

Psychologists help patients learn to cope with their chronic pain by teaching them techniques to stop catastrophizing and to change negative thoughts to affirmations, Coupland says. *(See strategies for pain self-management, page 136.)*

"Case managers can learn some reframing skills like how to take someone who is catastrophizing and settling down the catastrophizing," he says. "Teach them positive affirmations: 'I can cope with this pain.'"

It helps to understand how pain works: "The basic premise is that pain comes from a pain generator like a crushing injury to your fingers, which goes up your spinal cord to the brain where it is processed," Coupland explains. "The brain decides how much threat this pain really portrays and takes action from it — such as pulling fingers out of the door."

If the pain continues after the injury and tissues are inflamed, the brain sends some healing responses to that pain area. This process can be mediated by psychological factors, which is where pain psychologists can help.

"Some people filter the pain through their psychosocial factors like catastrophizing," he says. "The brain thinks this is really terrible and ramps up the pain response."

National Pain Strategy Makes Recommendations in Six Areas

The National Pain Strategy by the U.S. Department of Health and Human Services outlines the government's plan to reduce the chronic pain burden that affects millions of Americans and raises healthcare costs. *(More information is available at: http://bit.ly/2S5236e.)*

The strategy makes recommendations related to these six areas:

- population research;
- prevention and care;
- disparities;
- service delivery and payment;
- professional education and training;
- public education and communication.

The National Pain Strategy calls for the following actions:

- Healthcare organizations should develop methods and metrics to monitor and improve how pain is prevented and managed.
- Develop a system that incorporates patient-centered integrated pain management practices based on a biopsychosocial model of care that allows access to all pain treatment options.
- Medical providers should take steps to reduce barriers to pain care and to improve the quality of pain care for underserved populations, the vulnerable, and stigmatized.
- The national public health community needs to increase public awareness of pain, increasing patient knowledge of treatment options and risks, and help to develop a healthcare workforce that is better informed about pain management.

Some specific ways to accomplish these goals include the following:

- improve provider education about pain management practices and team-based care that moves away from opioid-centric treatment;
- increase patient access to quality, multidisciplinary care — especially for vulnerable populations — and improve patient self-management strategies;
- ask researchers and experts to evaluate risks and benefits of current pain treatment regimens;
- provide patients with educational tools that encourage safer use of prescription opioids;
- fund research to identify best practices in appropriate pain treatment for individual patients. ■

These response increases can result in guarding behavior in which the person freezes like a deer in headlights — not moving out of fear of the pain. This can make the underlying injury worse, causing disuse pain, he adds.

"People who previously had childhood trauma have compromised psychoneuroimmune responses, so their immune response is different from someone who didn't have a traumatic experience before," Coupland says. "For these people, their way of processing pain is counterproductive."

Several decades ago, pain researchers and experts were talking about the multidimensional nature of pain and the importance of focusing on disease contributing to pain, Kerns says.

The idea of integrated care and case managers helping patients navigate their care was novel, he says.

Studies showed some benefits of using a variety of approaches to manage pain. These included exercise, massage, acupuncture, spinal manipulation, and other strategies.

"But the science was weak, and there was a lack of financial incentives for institutions to offer these services," Kerns says. "That created a lack of availability, so those approaches were not generally available, and providers were not educated about these kinds of approaches." ■

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Case Managers Can Try Nondrug Strategies to Help Patients Cope With Pain

The proliferation of opioids and the rise of opioid addiction and deaths that surpass automobile deaths in the United States have led to an era when doctors see the risks of opioid prescriptions outweighing the benefits.

In this new reality, physicians will not prescribe opioid medication as often as in the past, which means patients who suffer from chronic pain might need nonmedication coping methods.

"Now, there is a rush to get everyone off opioids," says **Robert D. Kerns**, PhD, professor of psychiatry, neurology, and psychology at Yale University in New Haven, CT. Kerns also is director of mentoring and career development at the Pain Research, Informatics, Multimorbidities, and Education (PRIME) Center at VA Connecticut Healthcare System.

The risk is that medical care will return to the decades when it was difficult to get opioids for patients who were not at the end of life, he says.

"There's such a backlash of opioids that's problematic," Kerns says.

EXECUTIVE SUMMARY

Healthcare providers are moving away from opioid-based pain management strategies to evidence-based social, behavioral, and psychological methods of helping people cope with chronic pain.

- Exercise is a first step for patients experiencing both acute and chronic pain.
- Relaxation techniques, including meditation, can work for many people.
- The National Academy of Medicine and other agencies have posted many pain management strategies online.

For the past 20 years, people in chronic pain would go to their doctors for opioids.

"Their pain was not resolving, and it might not be resolving for psychological reasons," says **Michael Coupland**, CPsych, RPsych, CRC, network medical director for Integrated Medical Case Solutions (IMCS) Group in West Palm Beach, FL.

Once these patients take opioids regularly, they become dependent on the medications, he adds.

Case managers will need to learn more about integrated strategies to helping patients cope with chronic pain.

"The importance of nonpharmacological approaches is increasingly understood," Kerns says.

Coupland and Kerns offer these suggestions for case managers:

• Help patients focus on pain management rather than a pain cure. "Our culture overemphasizes the idea that for every problem

we identify there is a cause and solution," Kerns says.

"That's not the way we think about most chronic diseases; the idea is management," he explains. "How do you manage the disease and symptoms and negative impact?"

For example, patients with arthritis might judiciously use nonsteroidal anti-inflammatory drugs, so long as they can tolerate them and do not experience problems with kidney function, Kerns says.

• Make exercise a top priority. "The number-one thing to do for pain is to keep moving and exercise, despite the pain," Kerns says.

In 1997, Australia implemented a public health initiative called "Back Pain: Don't Take It Lying Down." Its purpose was to urge people to move around and exercise when they experienced back pain, Kerns says.

"It resulted in huge government savings in terms of workers' compensation claims," he adds.

The campaign's main message was that chronic back pain patients could do a lot to help themselves. It was the first study to show that mass media could be used to reduce costs related to back pain. *(More information on the initiative is available at: http://bit.ly/2Ja2c41.)*

Case managers might remind patients to pace themselves when exercising, Coupland notes.

"Don't get into an all-or-nothing approach," he says. "People think, 'I'm having a good day, so I'll go out and garden and mow the lawn,' and then they pay for it later."

Instead, chronic pain patients should identify their limit to physical activity, take breaks during exercise, and go back to it — extending those limits at their own pace, Coupland suggests.

• Promote relaxation techniques. Any type of relaxation or distraction can help people in chronic pain, Coupland says.

"When you're in pain, you tend to tighten up muscles and recruit other muscles. Relax your body and let pain roll over you and let it go," he says. "Suggest prayer or meditation or peaceful music to patients."

• Seek telehealth and technological strategies. Talk therapy via phone or video are strategies that can help people with self-management of chronic pain.

There are web-based self-management tools, and smartphone apps are helping case managers guide patients through online and technology-driven solutions, Kerns says.

Some apps use gaming techniques to help children with headache pain and abdominal pain, he notes.

One strategy for adults involves an interactive voice response in a phone-based intervention.

"Our group at VA Connecticut developed something called COPES, which is a phone-based intervention," Kerns says. "They get a manual in the mail or online, and the manual teaches them to use a phone to report their daily personal goals or skills practice, and it follows through a set of skill-training modules."

The researchers followed patients with chronic back pain, using an interactive voice response via phone. Patients could report their symptoms, functioning, and how they coped with pain. After sending in their information, patients would receive a recorded message with feedback.[1]

Pain patients reported their daily progress on goals, using a scale of 0 to 9. After reporting their results, patients can retrieve personalized feedback from a therapist. They can see a picture and hear the therapist's voice as he or she tells the patient how they're doing on their goals.

The therapist role could be a care manager. Feedback is recorded, not live, and it works, Kerns says.

"It's not inferior to having people come to 10 weekly sessions with a psychologist," he says. "People were more adherent, meaning they did more modules on the phone. One reason could be they didn't have the burden of traveling to a site like a VA medical center, where they struggle for parking and then wait to see a doctor."

The virtual feedback is scripted and doesn't respond to patients' complaints. Patients rate the relationship with the virtual therapist as highly as they rate their relationship with the in-person therapist, he adds.

• Check out evidence-based websites on chronic pain. In June 2011, the National Academy of Medicine (formerly the Institute of Medicine) issued a report that is cited often as a blueprint for how the healthcare industry can change the way it deals with chronic pain. Titled "Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research," the report addresses pain as a national challenge that affects 100 million Americans and costs more than $600 billion each year in medical treatment and lost productivity. *(The report is available at: http://bit.ly/2S8nJOF.)*

The following are some other government and professional resources about chronic pain:

• The Substance Abuse and Mental Health Services Administration – Health Resources & Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions has a section on pain management, with links to an opioid prescription checklist, a National Pain Strategy,

the PainEDU website, a cognitive therapy paper, and guidelines on how to manage chronic pain in adults with or in recovery from substance use disorders, available at: *http://bit.ly/2yPL5Qy.*

• Project ECHO is a lifelong learning and guided practice model that provides pain experts via videoconferencing, available at: *https://echo.unm.edu/*.

• The PAINS project of the Academy of Integrative Pain Management integrates biopsychosocial pain care with patient-centered medical homes and accountable care organizations, available at: *http://bit.ly/2PMPCdM*.

• The Comprehensive Pain Rehabilitation Center of the Mayo Clinic, founded in 1974, provides rehabilitation services to people with chronic noncancer pain. The three-week outpatient program helps patients learn what they can control about their pain when a cure is not possible. It stresses minimization of pain behaviors, relaxation, eliminating use of pain drugs, daily exercise, stress management techniques, and emotional coping techniques. More information can be found at: *https://mayocl.in/2Amsrlk*. ■

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New Report Looks at Strategies for Treating Substance Abuse

Changing 42 CFR Part 2 could help

An estimated 12% of adult Medicaid beneficiaries suffer from substance abuse disorder, according to 2011 government data. People with this disorder also often experience physical health problems that include liver disease, pancreatitis, and chronic pain. *(View the report at: http://bit.ly/2PKPN9b.)*

About one out of every eight people who visit an ED present with substance abuse or mental health needs. These data suggest the need for care coordination initiatives. *(For more information, visit: http://bit.ly/2S5D8zv.)*

Case management for substance abuse patients can help coordinate their health and social services, according to a new report by The Association for Community Affiliated Plans (ACAP). Four ACAP-member Safety Net Health Plans are building case management strategies for fighting addiction.

The association has focused on the opioid epidemic for about five years, says **Margaret A. Murray**, MPA, chief executive officer of ACAP in Washington, DC. ACAP, a trade association of 63 Safety Net Health Plans, serves more than 21 million people in 29 states.

The association promotes a change in federal rules protecting confidentiality of substance abuse records, 42 CFR Part 2, because these are more stringent than rules under the HIPAA Privacy Rule and they hinder coordinated care for patients with substance abuse disorder.

"Substance abuse providers are subject to higher rules about privacy than people on the physical health side," Murray says. "This limits communication between substance abuse providers and physical health providers."

Because of 42 CFR Part 2, a patient's doctor might not know about the patient's treatment for substance abuse. Advocates for a change thought an opioid bill, called the SUPPORT for Patients and Communities Act, signed by President Trump on Oct. 24, would change this requirement. It could have made it easier for providers to communicate about patients' substance abuse treatment, but the bill's final version did not change privacy requirements. *(The text of the bill is available at: http://bit.ly/2Pkb2lw.)*

"We felt like this should have been changed in the opioid bill, but it wasn't," Murray notes. "Many of us think privacy rules related to substance abuse should be similar to those about mental health, similar to HIPAA rules."

ACAP's work also includes helping healthcare professionals to be mindful with prescribing pain medication and assisting patients with substance abuse disorder.

"We have done a couple of reports where we're talking about how the plans work with providers to change their prescribing patterns," she says. "All of these changes have to be supported by an improvement in care management, an understanding of what people are facing."

The reports also include strategies for prescribing medication-assisted therapy and supporting case management.

For instance, one plan involves embedding case managers in clinics to provide substance abuse assistance, Murray says.

Using a team approach, case managers work to get patients what they need and help clinicians understand the implications of substance abuse disorder from a behavioral health perspective, she explains.

"Some plans provide staff training to increase the number of providers who provide medication-assisted therapy," Murray says.

Medication-assisted therapy reduces cravings and side effects — but, like methadone, does not give them a high. Patients can live on it the rest of their lives, Murray says.

"It is an effective way to treat substance abuse," she says. "For a lot of people, the opioid addiction is too strong. This is a way to allow them to not have the behaviors of drug-seeking, but it reduces cravings, and they can live a normal life."

Some providers are not comfortable with this approach, so it's not available to everyone who would benefit from it, she says.

The following are some of the other benefits ACAP offers patients with substance abuse disorders:

Case managers help patients with nonmedical-covered benefits, such as offering them transportation to see their doctors. "A couple of our plans have bus passes or agreements with ride-sharing services," Murray says.

"Our plans provide acupuncture and try to find pain management alternatives to opioids," she says. "The care manager is involved in making sure people know what their alternatives are, including therapeutic massage, acupuncture, and behavioral therapies to deal with pain."

These strategies can work for people who suffer from opioid addiction and for those who do not, she notes.

"We hope the report will be read widely so plans and care managers can learn what's working, what they can improve to serve their beneficiaries better," Murray says. ■

Employee Health Programs Stepping Up on Drug Diversion

If you look for drug diversion, you probably will find it

Ten thousand pain pills. That is what authorities estimated were once contained in the stacks of blister packs found at the residence of a 33-year-old nurse recently arrested in Spring Hill, FL.

The nurse is charged with diverting opioids such as hydrocodone, morphine, and hydromorphone from a health and rehabilitation center where she worked. She reported "battling an extensive drug addiction for many years, after suffering an injury," the Hernando County Sheriff's office said in statement.[1]

It was not clear if the injury was occupational, but nurses in all types of healthcare settings certainly run that risk. Nurses face a confluence of risk factors for addiction, including long hours, risk of injury, and access to powerful medications, says **Indra Cidambi**, MD, an addiction specialist and medical director for Center for Network Therapy treatment centers in Middlesex, NJ.

"Nurses are hands-on, and it could be that lifting a patient could cause them to have a herniated disc or some kind of other injury," she says. Minor injuries can become aggravated, as nurses may not have time off due to lack of coverage by other staff, and must adhere to a schedule that requires long hours, she says.

"They may just pull a muscle, but they have to go back to work and deliver patient care," she says. "It becomes a chronic issue. They are working with slight pain, and eventually it becomes a chronic injury. They end up taking pain medication."

Eventually, if their primary care provider will no longer prescribe opioids — which is becoming more likely under stricter guidelines — nurses may be tempted to divert.

"There is an assumption that nurses wouldn't have drug problems and commit diversion, but the literature shows that their problems with addiction are the same as the general population — about 10%," says **Linda Good**, PhD, RN, COHN-S, manager of occupational health services at Scripps Health in La Jolla, CA. "Nurses have opportunities to self-medicate — they are in contact

with pharmaceutical-grade drugs on a frequent basis."

Once the downward spiral of addiction starts, nurses and other healthcare workers may become overconfident in their ability to handle opioids, notes **Kimberly New**, JD, BSN, RN, executive director of the International Health Facility Diversion Association.

Nurses and other clinicians can become "desensitized" to the danger of the drugs, she said recently in Minneapolis at the annual conference of the Association for Professionals in Infection Control and Epidemiology.

"I see a lot of nurses who are actually diverting an opioid and something like naloxone — a rescue drug," she said. "They feel they are so in control that they can inject themselves with the opioid and then rescue themselves."

They are not always successful, as some diversion investigations begin with the overdose death of a healthcare worker, she added. Another impact beyond patients is that addicted healthcare workers are driving.

"These people come to work impaired and leave impaired," New said. "I'm aware of one case in Florida where an entire family was killed by an impaired provider driving home."

Threat to Patients

Of course, patients are the primary risk group. Drug diversion by addicted healthcare workers has resulted in recurrent outbreaks of hepatitis and resulted in tens of thousands of patients being advised to seek testing for bloodborne pathogens. For example, a hospital in Puyallup, WA, recently contacted some 2,800 patients and advised them to be tested for hepatitis C virus (HCV).

"We believe that a healthcare worker was taking part of doses of pain medications that were meant to be given to patients," the hospital said in a statement on its website.[2]

The hospital said that six patients tested positive for HCV that was genetically matched to two initial cases that triggered the investigation. A nurse was initially arrested but was released, and the case remains under investigation.

Too often in these cases a fired healthcare worker may end up in another facility, as healthcare employers fearing negative publicity may simply terminate the worker rather than reporting him or her to health officials.

Because of these continuing incidents and outbreaks, many hospitals are setting up drug diversion programs to detect and prevent theft of narcotics. "You need to make sure employees are not under the influence of anything that could jeopardize themselves and the patients," Cidambi says.

It is critical to develop a proactive diversion prevention program, and many employee health professionals are playing key roles in these efforts.

Seek and Find

As experts have emphasized, if you look for drug diversion, you probably will find it.

In ramping up a prevention program and hiring a full-time diversion specialist, a monthly audit of the frequency of medication use on hospital units picked up suspicious activity, says **JoAnn Shea**, ARNP, MS, COHN-S, director of employee health and wellness at Tampa General Hospital. Shea also co-chairs the hospital's Controlled Substance Diversion Prevention Committee.

"We look at who is taking the most drugs out," she says. "When we see outliers, the diversion specialist does some chart audits. We saw some issues of [a nurse] giving drugs too close together, or she would sign them out and not administer them."

When the nurse declined testing, the health department was contacted, and somewhat surprisingly, public health officials asked to see the minutes of the hospital's diversion prevention committee meetings.

"We have never been asked that before," says Shea, who was told by the health department that "'the district attorney really wants us to make sure hospitals have these programs in place now.' That was interesting, because there are still a lot of healthcare organizations that don't have these committees."

While healthcare drug diversion is a longstanding problem, these latest incidents are occurring amid a national opioid epidemic. The CDC recently reported that synthetic opioids like fentanyl drove a record 72,000 overdose deaths estimated for 2017.[3]

The opioid epidemic has resulted in public health and regulatory actions that have reduced the availability of the drugs. For example, hydrocodone has been reclassified as a Schedule II opioid, and many states have tightened requirements for physician review of prescription drug monitoring programs. The crackdown has led to shortages of common opioids like morphine, hydromorphone, and fentanyl.

The efforts to stem the flow of these opioids is in sharp contrast to

years past when the focus was on relieving patient pain, Good says.

"In my opinion, it has swung far in the other direction," she says. "I think there are people with chronic pain problems who are having more difficulty accessing medication because their doctors are under pressure to prescribe less opiates."

Shea concurred, saying, "I think sometimes, yes, doctors overordered a long time ago, but that was because we were told we weren't relieving pain adequately," she says. "People were not being relieved. Now [the message] is people are getting addicted because of the pain meds."

Fewer Drugs, More Diversion?

Ironically, the shortage of drugs could contribute to drug diversion incidents by healthcare workers, as scarcity leads to hoarding of vials. Unfamiliar products also make tampering less detectable, New reports.

"Be aware that the opioid shortage may be changing the [diversion] landscape," she said. "Many facilities are having a lot of trouble now getting the opioids that they need. One facility I worked with in Florida said we will be out of hydromorphone in the next two months if something doesn't change. Many facilities have gone now from a 2 mm morphine syringe to a 10 mm."

That can raise the temptation to preserve drugs that would normally be wasted, creating pockets of opioids for drug diverters.

"Multidosing — we are seeing people holding on to stuff as they conserve," New said. "People delay drug wasting. They try to hold on to it just in case something comes up and they may need to use a little more. People are carrying around opioids for extended periods of time."

While this is being done to ensure pain medication is available for patients, these breaks in normal practice may create the temptation to divert drugs.

IRONICALLY, THE SHORTAGE OF DRUGS COULD CONTRIBUTE TO DRUG DIVERSION INCIDENTS BY HEALTHCARE WORKERS, AS SCARCITY LEADS TO HOARDING OF VIALS.

For example, if such hoarding and scavenging become accepted practice on a given unit, workers found with opioids could claim they were saving them for patients, Good says.

"I haven't experienced this, but I also could see healthcare workers who, in the past, have had legitimate prescriptions for opioids but are no longer getting them in the amount they feel they need and may be more desperate to meet their need in illegitimate ways, including diversion," Good says.

While another department performs pre-employment drug testing, employee health becomes involved if a healthcare worker is tested based on a for-cause incident at her facility, she says.

"Our process is that if someone's behavior indicated that they may be under the influence or diverting, the manager would contact HR," Good says. "HR contacts us to do the collection with the chain-of-custody form and send it out, and then the results go to HR."

Having researched drug diversion as part of her academic training, Good says some of the common warning signs of addicted healthcare workers include rapid mood swings, suspicious behavior around controlled substances, volunteering to give meds for others, a lot of wasted medications, and uneven fluid levels in vials or predrawn syringes.

Once they have gone down this road, diverters rarely turn back until their activities are detected or unsafe use of needles and vials results in a patient outbreak. New is wary of moments of temptation created by the current drug shortage.

"At one facility I worked with, the nurses are required to walk down to the pharmacy to get a morphine syringe, and then they carry it back up," New said. "That is a lot of time to be unsupervised with an injectable. A lot of things could happen in that time."

As various manufacturers try to meet the opioid demand, new products are coming into clinical settings, she added. Healthcare workers may be unfamiliar with the tamper protections, which were removed by a nurse in one facility New investigated.

"A new syringe from a new manufacturer was given to a particular unit because they couldn't get them from their regular manufacturer," she said.

The new syringes had a tamper-evident feature, but nobody knew beforehand because they had not worked with the product. "A charge nurse made sure she was right there

when they were stocking it, and she pulled the tamper-evident feature off every one of them," New said.

Diverters seem to favor tampering to outright theft, refilling syringes with water or saline after injecting the opioid. "Tampering is happening at an alarming rate," New said. "It continues to increase. I am seeing cases every single week — just right and left. Many times these cases are not handled appropriately."

For example, healthcare workers seeing something different about a syringe may assume it was a manufacturing defect and discard it without reporting suspected tampering. Although tampering can be done with sufficient skill to pass for the original medication, it is also a "desperate activity" where safeguards will often be bypassed, New said.

"Often they are doing this in a staff bathroom, trying to tamper quickly before anybody becomes suspicious," New said. "One nurse who confessed to tampering actually had open lesions on her arms from injecting."

The diverter may take the drugs home for use, filling empty syringes with water or saline and replacing them the following day.

Despite all the publicity drug diversion has received with high-profile arrests and outbreaks in recent years, it too often remains the unspoken "elephant in the room" at many facilities, she said. Having looked for diversion and consistently found it for years in all manner of settings, New still is often told that it is not a priority because the organization has never had any incidents.

"That couldn't be further from the truth," she said. "If you have controlled substances in your facility — it doesn't matter where you are or whether it is an outpatient or inpatient setting — you will have drug diversion. It is a fact." ■

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Key Components of a Drug Diversion Program

Diversion risk points include preparation, administration, and waste

Although drug diversion may be considered a rare event, investigations reveal that the practice could be going undetected in facilities that do not have a proactive prevention program, warns **Kimberly New**, JD, BSN, RN, executive director of the International Health Facility Diversion Association.

"Having a formal program is essential. If you are treating this as a one-off, you are going to be inconsistent and have an incomplete response," she said recently in Minneapolis at the annual conference of the Association for Professionals in Infection Control and Epidemiology.

In the most basic terms, the program should increase transparency and develop a culture of accountability. "If you are not open within the organization about drug diversion, then people are not going to believe it's a risk," she said. "Make sure you have a good auditing surveillance program in place. Risk rounding is essential to prevention."

Essential Elements of a Diversion Program

Employee health professionals looking to establish or improve a drug diversion program at their facilities may want to consider some of the measures taken by **JoAnn Shea**, ARNP, MS, COHN-S, director of employee health and wellness at Tampa General Hospital.

Shea and colleagues are following Guidelines on Preventing Diversion of Controlled Substances, issued last year by the American Society of Health-System Pharmacists (ASHP).[1]

The ASHP recommends forming a drug diversion committee that should include members from employee health, pharmacy, nursing, risk management, security, and other departments. Another key step is hiring a diversion specialist who can dedicate his or her time to detecting and preventing drug theft and tampering.

All of the Tampa General specialist's time is devoted to identifying diversion, Shea says.

The ASHP recommends that the diversion officer should have a license and a college degree in pharmacy or nursing, with at least

five years of healthcare experience. At Tampa General, a pharmacy nurse specialist has been hired as the drug diversion point person.

"We actually created that position for her," says Shea, who co-chairs the hospital's Controlled Substance Diversion Prevention Committee. "She reports to me and to the pharmacy director. It's kind of a 'dotted-line' relationship."

Duties include education, diversion identification, audits, and conducting a gap analysis based on ASHP best practices. The diversion committee meets quarterly and is currently conducting a gap analysis of drug use and controls throughout the facility. The hospital IT team developed software that can show graphs and detailed drug use by unit.

"It is an internal database that we can look at to review diversion issues," Shea says.

Focus on Education and Training

The diversion specialist and members of the team also are creating a controlled substance workflow checklist to be used in unit audits. In reviewing drug use practices, Shea says she is seeing medication overrides granted too routinely.

"That is not really a best practice, but once it is accepted it becomes the norm," she says. "We have had some diversion issues with discrepancies. One of the nurses will go to the charge nurse and say, 'I miscounted — the count's off.' And instead of doing a look-back [investigation], the nurse signs off."

The committee decided to ramp up education and training on diversion and drug-wasting, which prior to that had been a 30-minute program for new hires.

"We realized there is a lot of training and education involved," she says. "We needed education on diversion, discrepancies, and waste."

During an audit, the diversion specialist may pull charts and documentation to see if, for example, any leftover drug was wasted within 30 minutes of administration.

"Did they administer the drug within 30 minutes or an hour of signing it out?" Shea adds. "Those are the kinds of things we are looking at."

The audit checklist is a work in progress, with Shea and colleagues still identifying components to be assessed. Those may include establishing some benchmark for the number of discrepancies a given unit should have.

"Why does this unit have 100 discrepancies and every other one has 10?" she says. "We are still building that part of the program. We based our gap analysis on what the ASHP recommended — their [guidelines] are very well put together."

Given the diverse challenges of a large hospital system and a single diversion specialist, interventions will have to be prioritized.

"We can't do everything at once with one person," Shea says. "We have to look at our inpatient pharmacy and our flow of drugs between our ambulatory facilities and inpatients. We have a freestanding ER and a surgery center. We want to make sure the chain of custody is being followed when we are moving controlled substances to the hospital."

Risk Points

The ASHP warns that there are multiple risk points for drug diversion as controlled substances move through healthcare systems. These include the following at various phases:

- procurement;
- preparation and dispensing;
- prescribing;
- administration;
- waste and removal. ■

REFERENCE

1. Brummond PW, David F. Chen DF, Churchill WW, et al. ASHP Guidelines on Preventing Diversion of Controlled Substances. American Journal of Health-System Pharmacy 2017, ajhp160919; DOI: https://doi.org/10.2146/ajhp160919.

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CE QUESTIONS

1. **Health officials estimate that which proportion of Americans experience chronic pain?**

   a. One in 12
   b. One in 7
   c. One in 5
   d. Half of Americans

2. **The National Pain Strategy by the U.S. Department of Health and Human Services outlines the government's plan to reduce Americans' chronic pain burden. The strategy makes recommendations related to which of these areas?**

   a. Population research
   b. Prevention and care
   c. Disparities
   d. All of the above

3. **An Australian public health initiative related to exercise for chronic pain called "Back Pain: Don't Take It Lying Down," showed what result?**

   a. It saved money on workers compensation claims.
   b. It reduced back pain surgeries.
   c. It increased media ad spending.
   d. None of the above

4. **Approximately what percentage of adult Medicaid beneficiaries experiences a substance abuse disorder?**

   a. 12%
   b. 16%
   c. 21%
   d. 28%

CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how the clinical, legal, legislative, regulatory, financial, and social issues relevant to case management affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities.