Project Lazarus Tool Kit:

Primary Care Provider

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Introduction

Community Care of North Carolina (CCNC), in conjunction with non-profit organization Project Lazarus, is responding to some of the highest drug overdose death rates in the country. In the past decade, there are increasing indicators that the misuse and abuse of prescription opioid analgesics by patients contributes to this epidemic. This Primary Care Physician Toolkit is one of three resource documents created through this collaboration to assist medical care providers throughout North Carolina in managing patients with chronic pain. Similar Toolkits have been created for CCNC Care Managers and hospital Emergency Departments.

While Project Lazarus is initially targeting Medicaid patients, the recommended tools and strategies are useful for any patient struggling with pain issues. Medical care providers are encouraged to adopt the practices and policies in this Toolkit for all patients, regardless of payment source.

While doctors and nurses play a major role in treating chronic pain and preventing overdose deaths, the responsibility for action goes beyond the clinic. Project Lazarus is working to engage the entire community in preventing overdoses. This public health model is centered on community coalitions tailored to each locality. The model uses data from state health surveillance systems to get a clearer understanding of the nature of the overdose problem and engages doctors and nurses in both prevention of opioid abuse and optimal treatment of chronic pain. This public health model has been proven to produce results in North Carolina, including both dramatic and sustained decreases in prescription opioid overdose, and improved access to appropriate opioid pain treatment.

The goals of Project Lazarus are to reduce opioid-related overdoses, optimize treatment of chronic pain and manage substance abuse issues associated with opioid misuse. Many people who have problems with opioid use also have legitimate needs for adequate pain control. Education around safe prescribing and appropriate use of opioids in our health care system and communities will enhance pain control and prevent unnecessary injury and death for our citizens in North Carolina. Some notes on specific sections of this Toolkit:

- **Opioids in the Management of Chronic Pain**: This five-page overview provides a concise review of chronic pain issues and regulations and outlines key tools for managing the care of patients with chronic pain patients.
- **Assessment and Management Algorithms**: These flowcharts summarize the optimal processes for assessing and managing chronic pain.
- **Pain (opioid) Management Agreement**: This agreement is helpful in clarifying patient guidelines and protecting the provider from prescribing to drug-seeking patients. CCNC recommends its use with patients for whom opioids are prescribed.
- **Chronic Pain Progress Note**: This form provides a convenient record of the pain visits and a helpful reminder of questions to ask regarding risk factors for opioid misuse.

- **Medication Flowsheet:** This flowsheet is intended to serve as a comprehensive record of a patient's opioid medication history. By briefly checking this form, providers can quickly determine how many chronic pain medicines the patient has been prescribed, as well as trends in dosage.

About Community Care

CCNC is a community-based, public-private partnership that takes a population management approach to improving health care and containing costs for North Carolina's most vulnerable populations. Through its 14 local network partners, CCNC creates "medical homes" for Medicaid beneficiaries, individuals eligible for both Medicare and Medicaid, privately-insured employees and uninsured people in all 100 counties.

About Project Lazarus

Project Lazarus was established in 2006 in response to extremely high rates of unintentional drug poisoning deaths ("overdoses") in Wilkes County, NC. Project Lazarus empowers communities to prevent drug overdoses and meet the needs of those living with chronic pain by harnessing public health data and connecting community groups to state and national resources.

Opioids in the Management of Chronic Pain: An Overview

Policy for the use of controlled substances for the treatment of pain

Created: Sep 26, 1996**,** Modified: Redone July 2005 based on the Federation of State Medical Board's "Model Policy for the Use of Controlled Substances for the Treatment of Pain," as amended by the FSMB in 2004. Amended September 2008

Appropriate treatment of chronic pain may include both pharmacologic and non-pharmacologic modalities. The Board realizes that controlled substances, including opioid analgesics, may be an essential part of the treatment regimen. All prescribing of controlled substances must comply with applicable state and federal law.

Guidelines for treatment include: (a) complete patient evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate.

Deviation from these guidelines will be considered on an individual basis for appropriateness.

The Board is concerned about the three-fold rise in overdose deaths over the past decade in the State of North Carolina as a result of both prescription and non-prescription drugs. The Board has reviewed, and is encouraged by, the efforts of Project Lazarus, a pilot program in Wilkes County that is attempting to reduce the number of drug overdoses by making the drug naloxone* and an educational program on its use available to those persons at risk of suffering a drug overdose.

The prevention of drug overdoses is consistent with the Board's statutory mission to protect the people of North Carolina. The Board therefore encourages its licensees to cooperate with programs like Project Lazarus in their efforts to make naloxone available to persons at risk of suffering opioid drug overdose.

* Naloxone is the antidote used in emergency medical settings to reverse respiratory depression due to opioid toxicity.

NC Medical Board

Chronic pain is recognized to be a complicated medical condition, requiring a substantial amount of knowledge and skill for appropriate evaluation, assessment and management. Diagnostic expertise is required to rule out certain malignant conditions, while management may require consultation within an interdisciplinary team of professionals. Patients may need any of a number of different classes of medication to manage their pain, including opioid analgesics.

As outlined by the NC Medical Board above, proper steps must be taken when dealing with the difficult issue of opioid use for chronic pain. This informational toolkit explores different issues in the management of chronic pain, especially in the use of opioids. Please review and implement these recommendations as appropriate to ensure the highest standard of safety and quality of care for your patients.

Evaluation of the Patient Presenting with Chronic Pain

Opioids should not be prescribed without first performing a comprehensive assessment of the patient. The patient's history should document, among other things, an adequate trial of non-opioid therapy.

The history should also be used to screen for psychosocial factors, e.g. history of substance abuse, depression or other psychopathology that may affect the perception of pain. A biopsychosocial assessment should be performed, which includes information not only about the history of the pain, but also about the patient's quality of life and ability to perform daily functions. This information can be used to assess progress in areas other than intensity of pain. The patient may be encouraged to find out that his or her function is improving, even when there does not seem to be any improvement in pain.

When performing labs, consider the use of a urine drug screen or other tests to identify the presence of illegal drugs, unreported prescribed medication (indicating that the patient may be seeing more than one provider), or unreported alcohol use.

Management Issues

A holistic plan for managing chronic pain should address five major elements: personal goals, improving sleep, increasing physical activity, managing stress, and decreasing pain. The Personal Care Plan for Chronic Pain created by the Institute for Clinical Systems Improvement, ICSI is a good tool to help address these issues.

When considering pharmacological treatment for chronic pain, the physician should consider non-opioid medications and interventions as appropriate. If the pain is determined to be neuropathic in origin, classes such as tri-cyclic antidepressants (e.g. amytriptyline), other anti-depressants (e.g. venlafaxine, bupropion), anticonvulsants (e.g. gabapentin) or corticosteroids may be effective. Other classes of drugs to consider for the treatment of certain subtypes of chronic pain include muscle relaxants, anti-spasmodics, anxiolytics, and drugs for insomnia. [ICSI]

Cognitive Behavioral Strategies to Assist Pain Management

There are a number of cognitive-behavioral strategies that primary care providers can utilize to help their patients manage chronic pain.

Explain that pain is complex

- Tell the patient that chronic pain is a complicated problem and for successful rehabilitation, a team of health care providers is needed. Chronic pain can affect sleep, mood, levels of strength and fitness, ability to work, family members, and many other aspects of a person's life. Treatment often includes components of stress management, physical exercise, relaxation therapy and more to help patients regain function and improve the quality of their lives.

Confirm pain is real

- Let the patient know you believe that the pain is real and is not in his/her head. Let the patient know that the focus of your work together will be the management of his/her pain. ICSI Patient Focus Group feedback revealed patient concerns that their providers did not believe them/their child when they reported pain.

Engage the patient

- Ask the patient to take an active role in the management of his/her pain. Research shows that patients who take an active role in their treatment experience less pain-related disability (French, 2000 [D]).
- Tell patients to "not let pain be their guide," whether it is stopping activity because of pain or taking medications or rest in response to pain.

Don't put pain in charge

- Prescribe time-contingent pain medications, not pain medications "as needed." Time-contingent medications allow a disruption in the associations between pain behavior and pain medication. The powerfully reinforcing properties of pain medicines are then not contingent upon high levels of pain and pain behavior.
- Schedule return visits on a regular schedule and don't let the appointments be driven by increasing levels of pain. Physicians are powerful reinforcers.

Think holistically

- Reinforce wellness behaviors such as increased activity or participation in an exercise program.
- Enlist the family and other supports to reinforce gains made toward improved functioning, too.

Ease return to regular function

- Assist the patient in returning to work. Do this in a stepwise fashion that is not dependent on level of pain.
- Fear of movement or fear of pain due to movement is a significant concern for many patients with chronic pain. Inactivity or avoidance of movement leads to physical

deconditioning and disability. Try not to rely on sedative or hypnotic medications to treat the fear many chronic patients show of activity or fear of increased pain. When patients with chronic pain expose themselves to the activities that they fear, which simply means when they do the things they have been afraid of and avoiding, significant reductions are observed in fear, anxiety and even pain level (Vlaeyen, 2002 [A]). If patient's fears are excessive, relaxation strategies may be helpful or referral for more formal and intensive cognitive-behavioral therapy may be necessary.

– *ICSI Assessment and Management of Chronic Pain*

The Use of a Pain Contract/Treatment Agreement

Opioids are not benign drugs. Every effort should be made to emphasize the importance of the patient's responsibilities to manage his or her pain safely. A pain contract, or treatment agreement, addresses these issues, while proposing strict rules and penalties if the patient does not abide by these rules. This approach had been found to be effective in engaging the patient in their plan of treatment. A sample Pain Contract may be found in Section III

This written agreement may include:

- Goals of therapy--partial relief and improvement in physical, emotional, and/or social functioning
- The requirement for a single provider or treatment team
- The limitation on dose and number of prescribed medications and the proscription against changing dosage without permission; discuss the use of "pill counts"
- A prohibition on use with alcohol, other sedating medications, or illegal medications without discussing with provider
- Agreement not to drive or operate heavy machinery until medication-related drowsiness is cleared
- Responsibility to keep medication safe and secure
- Prohibition of selling, lending, sharing, or giving any medication to others
- Limitation on refills: only by appointment, in person, and no extra refills for running out early
- Compliance with all components of overall treatment plan (including consultation and referrals)
- The role of urine drug screening, alcohol testing
- Acknowledgement of adverse effects and safety issues such as the risk of dependence and addictive behaviors
- The option of sharing information with family members and other providers, as necessary
- Need for periodic re-evaluation of treatment

- Consequences of non-adherence

– *VA/DoD Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain*

Contraindications to Initiation of Opioid Therapy

Certain elements of the assessment should raise warning flags concerning the initiation of opioid therapy. Care must be taken when any of the following risk factors are present:

- Acute psychiatric instability or high suicide risk
- History of intolerance, serious adverse effects, or lack of efficacy of opioid therapy
- History of or current substance use disorder
- Inability to manage opioid therapy responsibly (e.g., cognitively impaired)
- Unwillingness or inability to comply with treatment plan
- Unwillingness to adjust at-risk activities resulting in serious re-injury
- Social instability
- Patient with sleep apnea not on CPAP
- Elderly patient
- COPD patients

– *VA/DOD Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain*

The Importance of Follow-Up

During the titration phase, a lack of response, despite increasing doses of opioids, may indicate that the patient has non-opioid responsive pain and opioids should be discontinued.

During the management phase, the opioid dose may continue to increase gradually if the patient becomes tolerant to the medication. If the physician becomes uncomfortable with the level of opioids required to manage the patient's pain, he or she is encouraged to refer the patient to any physician who has more expertise in chronic pain management. Consultation should also be requested when the patient's pain and functional status have not improved substantially after three months of opioid therapy.

Patients taking opioids for chronic pain need to be periodically reassessed every 1-6 months. The frequency of follow-up will vary according to the patient characteristics, co-morbidities, status of pain control, and type and dose of opioids used.

The follow-up visit should be used to assess the patient's progress, not only in pain control, but also quality of life and functional status. Consistent administration of questionnaires such as the

Functional Ability Questionnaire[1] created by ICSI can document any progress in these categories. This information can also be used to make concrete plans and goals with the patient.

During follow-up, the physician should also assess and document adherence to the medication. Consider using random pill counts or urine drug screens to assess adherence. Also, use this time to assess patients for behaviors that are predictive of addiction or misuse. Patients with behaviors characteristic of compulsive drug use should be referred to a substance use disorder specialist. If the patient appears to have significant problems with depression, anxiety or irritability, consider a psychiatric consultation.

Addressing Misuse

Physicians should be equipped to deal with patients who are found to be misusing opioid medication. Possible responses might include:

- Education and discussion along with restatement of the written agreement
- Review of the written opioid prescribing agreement
- Recommending or insisting on consultation with a pain and/or addiction specialist
- Discussion with others involved in the patient's care
- Administration of medications under supervision or with the assistance of others
- Change of medication or amount dispensed
- More frequent clinic contacts
- Instituting regular or random urine toxicology screens as a condition for prescription renewal

– VA/DoD Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain

Mental Health Co-Management

Chronic pain conditions result from a complex interaction among biological, psychological and social variables. Biology plays a part in the etiology of pain, but the perception of pain is shaped by psychosocial contexts. Therefore, mental health co-management should be considered for optimal improvement in the patient's functional status and psychological health. These approaches focus on the emotional, cognitive and behavioral aspects of chronic pain. General agreement exists that psychological interventions may be important adjuvant therapies in the medical management of chronic pain. [Adams et al.] These interventions, when combined with the comprehensive management plan outlined above, should improve the health of patients with chronic pain and decrease the likelihood of opioid misuse.

[1] Available online at http://www.icsi.org/pain__chronic__assessment_and_management_of_14399/pain__chronic__assessment_and_management_of__guideline_.html

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References:

North Carolina Medical Board. Policy for the Use of Controlled Substances for the Treatment of Pain, online at www.ncmedboard.org (News and Forum and Position Statements pages). Last accessed August 15, 2011.

Institute for Clinical Systems Improvement (ICSI). Assessment and management of chronic pain. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI), Fourth Edition; 2009 Nov.

Veterans Health Administration, Department of Defense. VA/DoD clinical practice guideline for the management of opioid therapy for chronic pain. Washington (DC): Veterans Health Administration, Department of Defense; 2003 Mar.

Adams N, Poole H, Richardson C. Psychological approaches to chronic pain management: part 1. *J Clin Nurs.* 2006 Mar; 15(3): 290-300.

Universal Precautions for Pain Medicine Prescribing

1. Make a careful diagnosis of the pain source. Assess co-morbid conditions, such as depression, and include them in the treatment plan. Psychiatric and substance abuse disorders must be addressed.

2. Assess the risk of substance abuse, including family history, current environment, and personal history of substance abuse. Urine drug testing may be considered, with appropriate counseling of the patient regarding illicit drug use. Some experts advocate screening everyone as part of a random process, others restrict it to problematic patients. Not infrequently, some individuals are found not to have detectable levels of the prescribed opioid, suggesting the possibility of diversion. However, no action should be taken on a single aberrant test. Patient counseling and continued monitoring should be performed.

3. Obtain informed consent. Long term opioid therapy for chronic pain carries the potential for withdrawal, and may be contentious. In addition, the consequences of opioid therapy, including constipation, reduced testosterone levels, fatigue, etc., should be disclosed.

4. A signed treatment agreement is recommended defining the obligations of the physician and patient because it is helpful in defining the parameters to guide the continuation of opioid therapy and for discontinuation. This avoids arguments and misunderstandings.

5. Document pain levels prior to and after the initiation of opioid therapy. It is essential to document an effective analgesic response to warrant continued treatment. Pain scales are not always the best measure, but other functional improvements may be useful in assessing the treatment response.

6. Initiate an appropriate trial of medication, including opioids and adjuvant analgesics.

7. Frequently reevaluate measures of efficacy. Seeking corroboration from family members and significant others can help to provide a better picture of treatment success, or of failure.

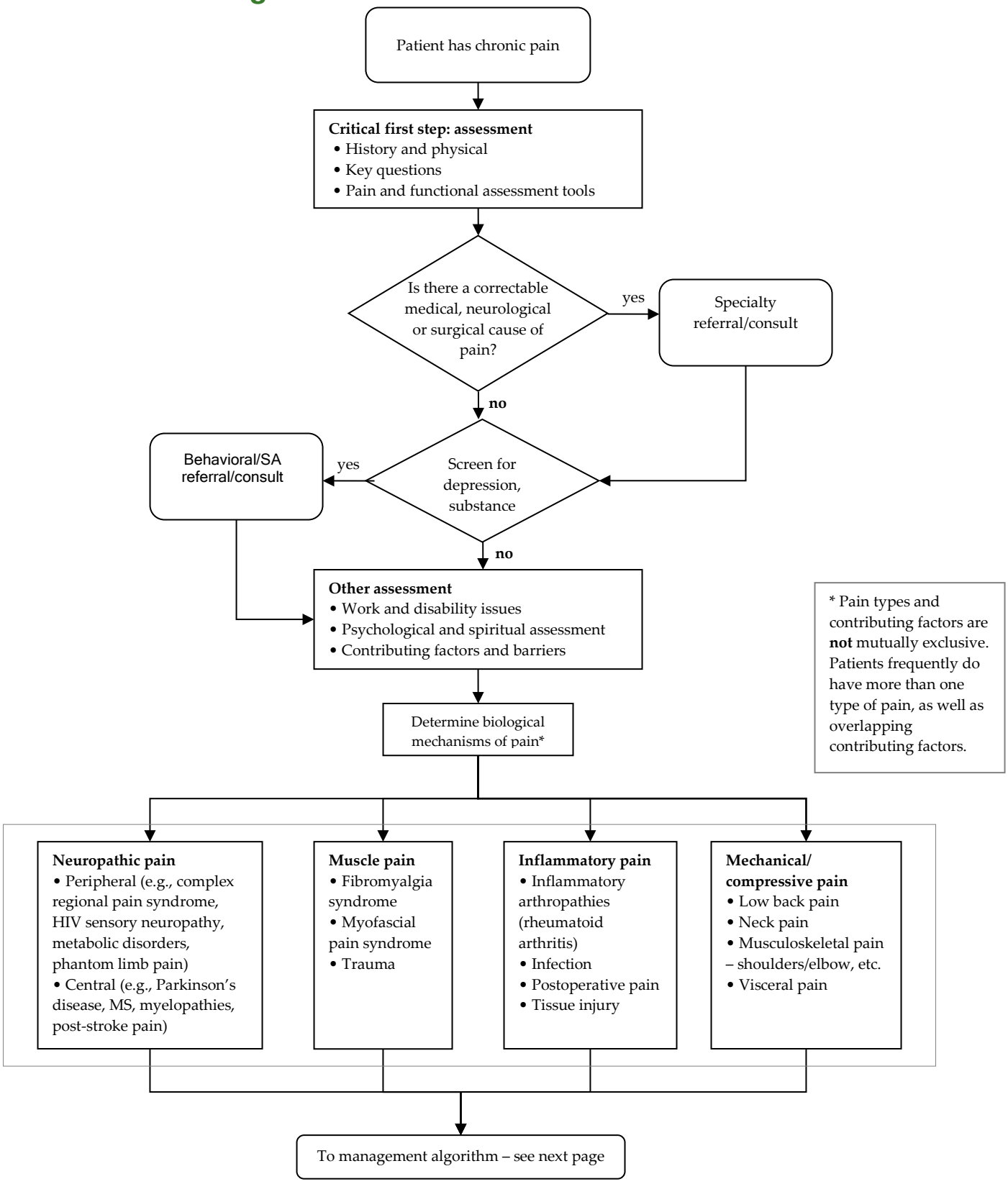
8. Regularly assess the 4 A's of pain treatment: analgesia, activity, adverse effects, and aberrant behavior.

9. Periodically reevaluate the patient's underlying condition and any co-morbid conditions.

10. Documentation! The physician and patient's best protection from legal entanglement is careful documentation of the treatment plan and monitoring efforts.

Source: Gourlay DL, Heit HA, Almahrezi A. Universal precautions in pain medicine. Pain Med 2005;6:107-12.9

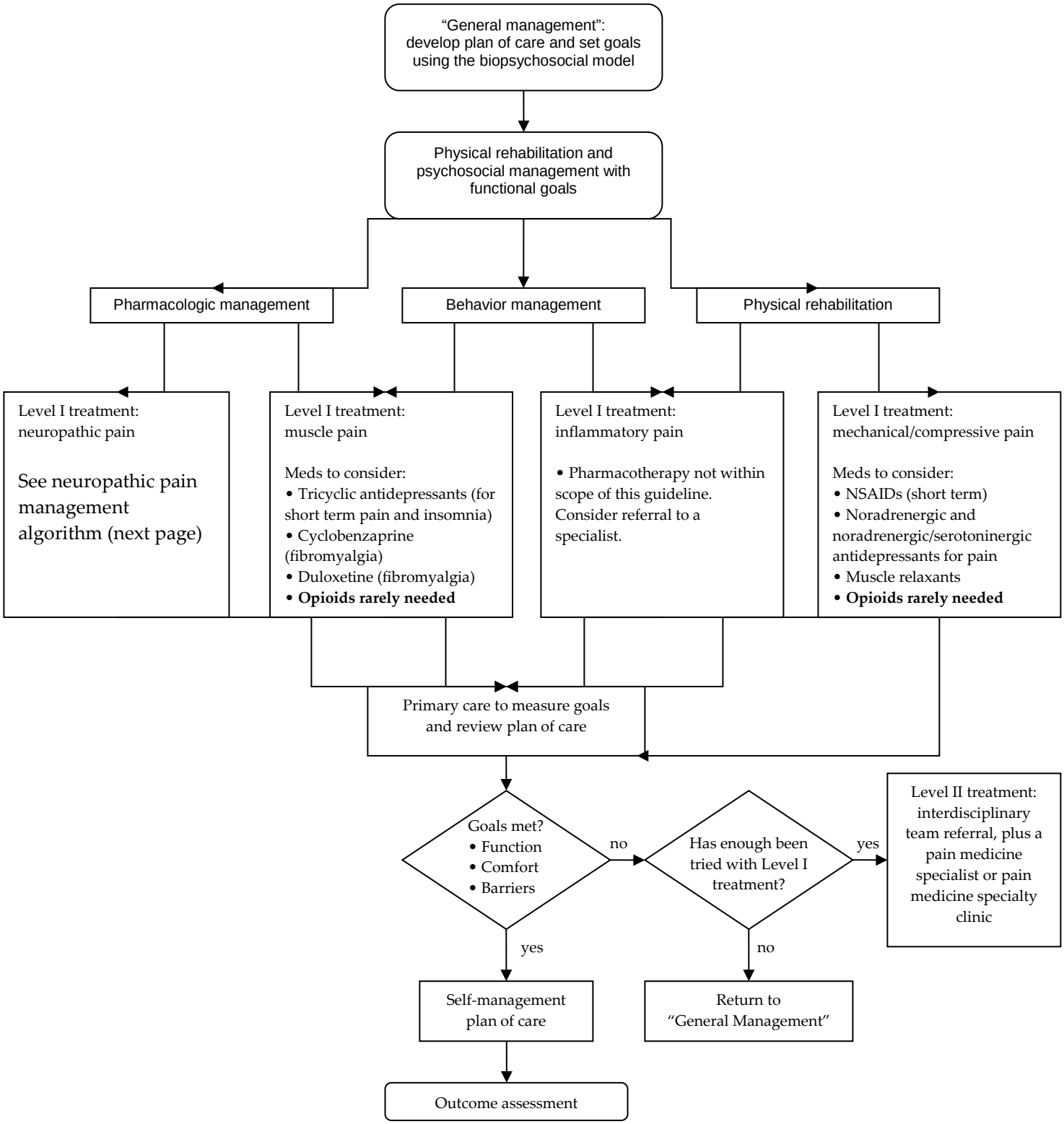
Assessment Algorithm



* Pain types and contributing factors are **not** mutually exclusive. Patients frequently do have more than one type of pain, as well as overlapping contributing factors.

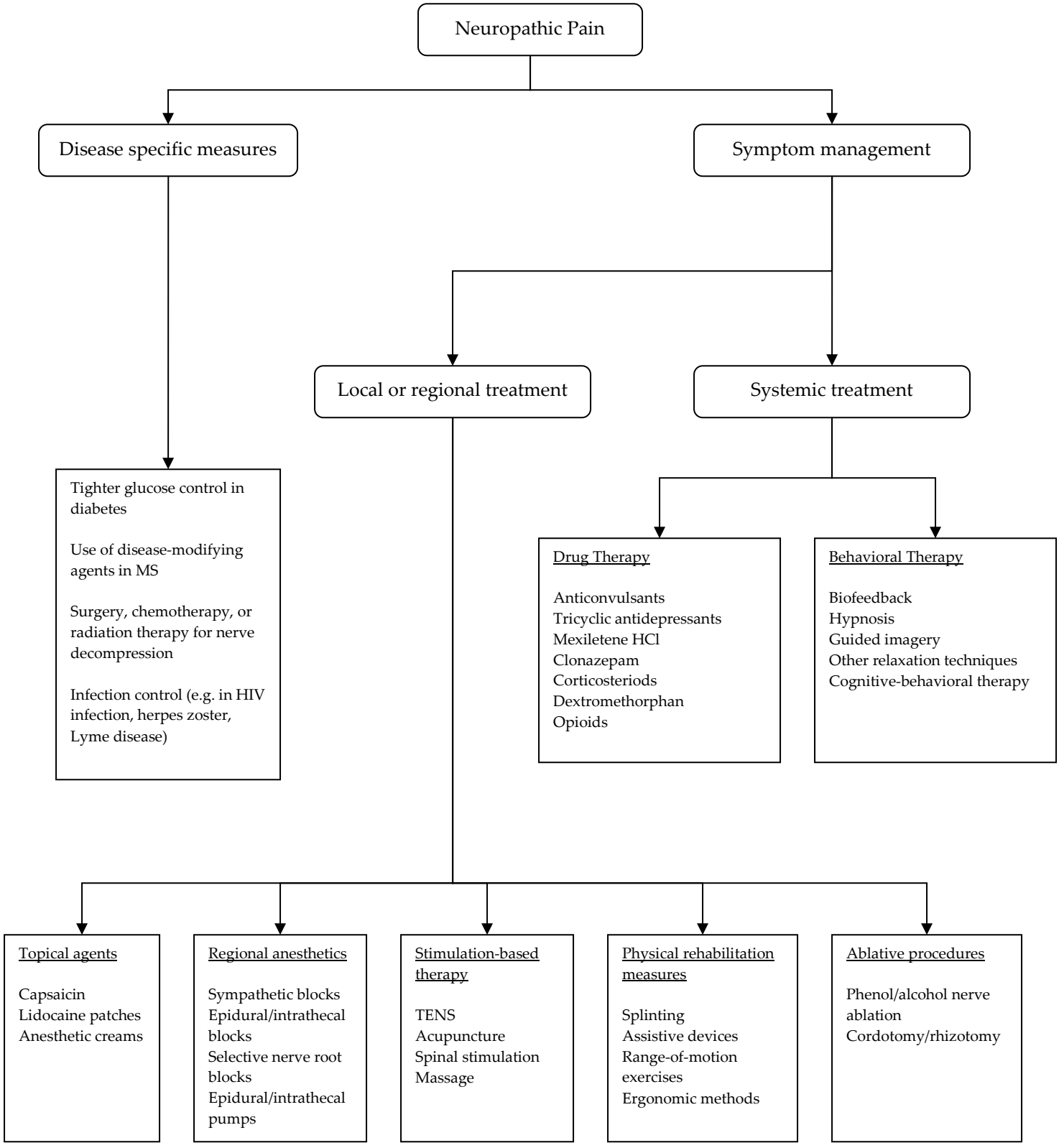
Modified from ICSI Assessment Algorithm, available at: http://www.icsi.org

Management Algorithm



Modified from ICSI Management Algorithm, available at: www.icsi.org.

Management Algorithm – Neuropathic Pain



Source: Belgrade, MJ. Following the clues to neuropathic pain. PostGraduate Medicine, 106(6), November 1999.

Pain Management Agreement

I understand that Dr. _____ is prescribing opioid medication to help me manage chronic pain that has not responded to other treatments. The goal of this medication is to lead to partial relief from pain, so that my physical, emotional, and social function will improve. If my activity level or general function gets worse, the opioid may be stopped or changed to something else. The risks, side effects and benefits of opioid treatment have been explained to me and I agree to the following instructions. Failure to follow these instructions may result in stopping the medication.

1. I will participate in any **other treatments** recommended by my provider**.** I will be ready to decrease or stop the opioid medication when other effective treatments become available.
2. I will take my medications **exactly as prescribed** and will not change the medication schedule or dosage without advance approval from my provider. I will provide my medication for pill counts at the provider's request. I will not request early refills.
3. I will keep **regular appointments** with my provider.
4. All opioid and other controlled drugs for pain must be prescribed **only** by Dr. _____.
5. I will inform my provider within **a week of discharge** if I am **hospitalized** for any reason, or if I have another condition that requires the prescription of a **controlled drug** (like narcotics, tranquilizers, barbiturates, or stimulants).
6. I will choose **one pharmacy** where all of my prescriptions will be filled.

   Pharmacy Name: _____
   Phone Number: _____
   Fax Number: _____
   Address: _____
   _____

7. I understand that lost or stolen prescriptions will **not be replaced**, so I will keep my prescription and medication in a safe place. I will not under any circumstances sell, lend, or give my medication to others.

8. I agree to **avoid all illegal and recreational drugs (including alcohol)** and will provide urine or blood specimens at the doctor's request to monitor my compliance.

9. I agree to follow my doctor's recommendations regarding the operation of **motor vehicles or heavy machinery** while taking this medication.

10. Refills will be made only during regular office hours, which are _____. Refills will not be made at night, on weekends or during holidays. I am responsible for keeping track of my remaining medication, so that I can **call for refills in advance**. This way, I will not run out of medication.

Patient Name (print): _____

Patient Signature:_____ Date:_____

Provider Signature: _____ Date:_____

Witness (optional): _____ Date:_____

Source: Adapted from ICSI Assessment and Management of Chronic Pain, Second Edition, March 2007

Chronic Pain Management Progress Note

Patient Name:_____ Date of Visit:_____
DOB:_____ Chart Number:_____

ANALGESIA

Scale of 0-10 (0 = no pain; 10 = worst pain imaginable) rank:

1. What was your pain level on average during the past week? _____
2. What was your pain level at its worst during the past week? _____
3. Compare your average pain during the past week with the average pain you had before you were treated with your current pain relievers. What percentage of your pain has been relieved? _____
4. Is the amount of pain relief you are now obtaining from your current pain relievers enough to make a real difference in your life?
Yes_____ No_____

ACTIVITIES OF DAILY LIVING

Physician observation comparing usual functioning during the past month with usual functioning before being treated with current pain reliever(s):

B = Better S = Same W = Worse

Physical functioning: _____

Family relationships: _____

Social relationships:_____

Sleep patterns:_____

ADVERSE EVENTS

Is patient able to tolerate current pain relievers?
Yes_____ No_____

Is patient experiencing any side effects from current pain relievers? (i.e. constipation, itching, mental clouding, other)
Yes_____ No_____

Detail:

POTENTIALLY ABERRANT DRUG-RELATED BEHAVIOR

Using EtOH?	Yes	No
Using illicit drugs?	Yes	No
Requests frequent early renewals	Yes	No
Increased dose without authorization	Yes	No
Reports lost or stolen prescriptions	Yes	No
Attempts to obtain prescriptions from other doctors	Yes	No
Changes route of administration	Yes	No

INTERIM HISTORY	**ASSESSMENT/PLAN**
Employment:	
	□ FAQ performed □ Screened for depression
	□ Care Plan reviewed/updated
Social Support:	□ Urine drug screen performed
	Result:
Mental Health:	□ Continue regimen
	□ Changes made:
	_____
Physical Activity:	_____
	_____
	_____
Social Activity:	
	Next visit:_____

Source: Modified from: "Expert Guide to Pain Management", edited by Bill McCarberg and Steven D. Passik.

Chronic Pain Medication Flowsheet

Patient Name:_____
Treatment Agreement in Place? Yes ___ No ___
Patient DOB:_____
Pharmacy Home: _____
Chart No:_____

Date	Medicine	Dose	Instructions	Refills	Drug Testing Performed?	Medicine Count?	CSRS* Checked?

*CSRS—Controlled Substances Reporting System

How to Prevent an Opioid Overdose

MEDICAL CARE PROVIDERS: Providers can help reduce the likelihood of an opioid overdose by identifying patients who are at increased risk of opioid-induced respiratory depression *prior* to initiating or renewing a prescription for an opioid(s) to treat pain or substance abuse. This can be done through patient history review, brief interventions or referral for specialized pain management or substance abuse treatment (e.g., SBIRT and the CSRS). Prior to prescribing an opioid, determine if a patient has any of the following risk factors. Then establish a treatment plan to minimize the risk of opioid-induced respiratory depression by balancing the risks and the benefits of prescribing opioid-based interventions vs. only recommending alternative methods that are not supported by narcotic analgesics to treat chronic pain or substance abuse.

RISK FACTORS for opioid-induced respiratory depression

1. Recent emergency medical care for opioid poisoning/intoxication/overdose
2. Suspected history of heroin or nonmedical opioid use (e.g., DAST-10)
3. High dose opioid prescription (e.g., >100 mg. morphine equivalence/day)
4. Any methadone prescription to opioid naïve patient
5. Recent release from incarceration/prison/jail
6. Recent discharge from opioid detox or abstinence-based program
7. In methadone or buprenorphine detox/maintenance for addiction or pain
8. Request from patient or family member
9. May have difficulty accessing EMS (distance, remoteness, etc.)

Any opioid prescription AND …

10. Respiratory diagnoses: Smoking/COPD/emphysema/asthma/sleep apnea/ other.
11. Renal dysfunction or hepatic disease.
12. Known or suspected concurrent alcohol use (e.g., AUDIT).
13. Concurrent benzodiazepine prescription or nonmedical use (e.g., CSRS).
14. Concurrent SSRI or TCA anti-depressant prescription (e.g., CSRS).

In August 2008, the N.C. Medical Board determined that “the goals of Project Lazarus are consistent with the Board’s statutory mission to protect the people of North Carolina. The Board therefore encourages its licensees to abide by the protocols employed by Project Lazarus and to cooperate with the program’s efforts to make naloxone available to persons at risk of suffering drug overdose.”

PATIENTS, FAMILY AND PEERS: Patients and their families need to be reminded that all medications, especially prescription pain relievers, need to be taken only as directed. Opioids that are not taken as prescribed can cause death.

- If pain is not controlled, patients should call and make a return appointment with their medical care provider.
- All patients who use prescription pain medication need to make an overdose plan.
- Patients need to find a person they trust to be their Rescue Peer. They need to teach that person the signs and symptoms of an opioid overdose, what to do for an overdose, what not to do, and where they keep their naloxone, if they have it.
- In addition, there are four simple rules for all patients who are being treated with pain medication to follow:

(1) TAKE CORRECTLY

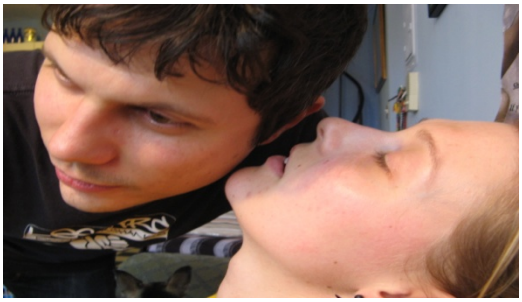
(2) STORE SECURELY

(3) DISPOSE PROPERLY

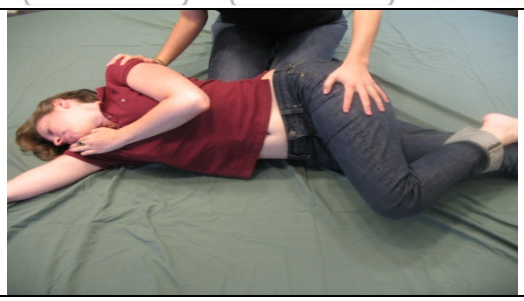
(4) NEVER SHARE

How to Recognize and Reverse an Opioid Overdose[2]

All patients who are using opioids need to make an overdose plan. Part of the plan is to teach their families and peers how to recognize the signs and symptoms of an opioid overdose and what to do to reverse the overdose.

Steps	What to Do	Illustrations
1. Check for signs of an overdose.	Awake but cannot speak; slow or shallow breathing; abnormal snoring or gurgling; slow heartbeat or pulse; sweating or flushing of the skin; blue skin, lips or finger/toe nails; not responding to being shaken or called; eyes rolled back.	
2. Call out the person's name	Speak in a loud voice.	
3. Rub the sternum or upper lip.	Using your knuckles, rub hard up and down the middle of the person's chest (the sternum) or across the top lip. If the person wakes up, keep the person awake and stay with him or her for at least 2 hours. If in doubt, CALL 911.	
4. Check breathing	Watch the person's chest to see if it is moving up and down; place your ear next to the mouth to see if you can hear or feel a breath. If there are no breath sounds, or you don't think the person is breathing, CALL 911.	
5. Call 911.	Tell the operator that the person is not breathing and won't wake up. Give the person's exact location – the full address and the room. You do NOT have to say that you think the person is overdosing. Tell the operator you are going to begin rescue breathing and cannot stay on the phone, but you will keep the phone on and near you.	

[2] *Pictures used with permission from the Open Society Institute. Text excerpted and adapted from the Harm Reduction Field Guide: Overdose Prevention and Response. By Curtis M. and Guteman L., 2009. A Guide for People Who Use Drugs and Harm Reduction Staff in Eastern Europe and Central Asia.*

6. Clear the mouth	Check the person's mouth and remove any objects, like food or chewing gum or tobacco.	
7. Perform rescue breathing	Put the person on his or her back. Tilt head back and chin up. Pinch nose shut with your fingers. Place your mouth over the person's mouth, making a tight seal with your lips. Gently exhale into the person's mouth two times in a row. Then breathe every 5 seconds, and repeat at least 5 times. Check to see if person is breathing. Continue to do rescue breathing until the person starts breathing or until help comes. Don't waste time doing anything else. A person who can't breathe needs oxygen to live. Don't give up. Keep breathing until help comes. **RESCUE BREATHING IS THE MOST IMPORTANT THING YOU CAN DO!**	
8. Administer Naloxone, if available.	Assemble the syringe, naloxone and nasal adaptor: insert white cone into nostril; give a short vigorous push to spray naloxone into the nose: one half of capsule into each nostril.	
9. Put person in recovery position	Once person starts breathing, or if you have to leave, place person in the recovery position so the person cannot roll over onto the back or stomach. This will help prevent the person from getting vomit in the lungs. Place person on the floor on the left side. Rest the head on the left arm and pull the left leg straight. Place the right so it rests on the floor. Bend the right leg up so that the knee and the foot are on the floor.	
10. Stay with person until help comes	If the person wakes up, keep the person awake and have someone stay for at least 2 hours. Tell the person he or she overdosed, but will feel better in a little while. Talk the person out of taking more drugs. Keep the person awake and talking. Encourage the person to go to the emergency room now and to consider getting help for substance abuse soon, if appropriate.	

How to Make an Overdose Plan

1. Start a conversation about needing a rescue peer
   - Mistakes can happen when using pain medication.
     - I need someone to help me stay safe and out of pain.
     - This person can be a family member or friend.
     - We call this person a rescue peer.
   - Too many pain pills or mixing with other drugs or alcohol can make me stop breathing.
   - I am now a member of CCNC. They have given me a naloxone rescue kit.
   - The kit has a DVD that describes what an overdose looks like and what to do.
   - The kit also has the medicine, Naloxone, you will use to start me breathing again.
   - The kit location is written on the Project Lazarus magnet that's on the 'fridge door.

2. Who is your rescue peer? _____

3. What your rescue peer needs to do.

   - Watch the Project Lazarus DVD.

     -- Learn signs and symptoms of an overdose and how to rescue.
   - Review naloxone rescue kit contents.
   - Know location of rescue kit.
   - Call Project Lazarus (336-667-8100) for questions about responding to an overdose.

4. If your prescription is not working, call your doctor.
   - Don't self medicate.

5. What to do if you are taking pain pills not prescribed for you or not following your doctor's advice.
   - Don't mix your pills with other drugs or alcohol.
   - Call your peer and ask this person to check on you hourly.
   - Make sure someone can get to you if needed.

6. What your peer should NOT do in case of an overdose.
   - Put me in a bathtub for a cold shower. I could drown.
   - Give me stimulants, like coffee. They don't work.
   - Put ice on my body to wake me up. It wastes time and doesn't work.

IF A RESCUE IS NEEDED, BE SURE TO CALL 911.

Project Lazarus P.O. Box 261 Moravia Falls, NC 28654
Phone: 336-667-8100 – Fax: 866-400-9915 – www.projectlazarus.org

Chronic Pain Overview

What is chronic pain?

There are 2 types of pain: acute and chronic. Acute pain doesn't last long and usually goes away as your body heals. Chronic pain lasts at least 6 months after your body has healed. Sometimes, people who have chronic pain don't know what is causing it. Along with discomfort, chronic pain can cause low self-esteem, depression and anger. It can also interfere with your daily activities.

How is chronic pain treated?

Treatment of chronic pain usually involves medicines and therapy. Medicines used for chronic pain include pain relievers, antidepressants and anticonvulsants. Different types of medicines help people who have different types of pain. You usually use long-acting medicines for constant pain. Short-acting medicines treat pain that comes and goes.

Several types of therapy can help ease your pain. Physical therapy (such as stretching and strengthening activities) and low-impact exercise (such as walking, swimming or biking) can help reduce the pain. However, exercising too much or not at all can hurt chronic pain patients. Occupational therapy teaches you how to pace yourself and how to do ordinary tasks differently so you won't hurt yourself. Behavioral therapy can reduce your pain through methods that help you relax, such as meditation and yoga. It can also help decrease stress.

Lifestyle changes are an important part of treatment for chronic pain. Getting regular sleep at night and not taking daytime naps should help. Stopping smoking also helps because the nicotine in cigarettes can make some medicines less effective. Smokers also tend to have more pain than nonsmokers.

Most pain treatments will not take away all of your pain. Instead, treatment should reduce how much pain you have and how often it occurs. Talk to your doctor to learn how to best control your pain.

What should I tell my doctor about my pain?

Telling your doctor about your pain will help him or her find the right treatment for you. Tell your doctor where the pain is, how bad it is and how often your pain occurs. Also talk about what makes the pain better or worse.

Your doctor may review other health problems you may have (such as arthritis, breathing problems and heart conditions) because these may keep you from doing some types of therapy. Your doctor may also ask if you have had any problems with sleep, mood or anxiety.

More Information

Pain Disorders

- Chronic Fatigue Syndrome
- Arthritis

- Giant Cell Arteritis and Polymyalgia Rheumatica
- Complex Regional Pain Syndrome
- Lumbar Spinal Canal Stenosis
- Piriformis Syndrome
- Patellofemoral Pain Syndrome
- Somatoform Disorders
- Low Back Pain

Other Organizations

- American Council for Headache Education
- American Pain Society
- American Pain Foundation
- American Chronic Pain Association

Source: Written by familydoctor.org editorial staff. Treatment of Nonmalignant Chronic Pain by DA Marcus, M.D. (American Family Physician March 1, 2000 http://www.aafp.org/afp/20000301/1331.html) Copyright © 2000-2011 American Academy of Family Physicians; used with permission.

Resource Links

Community Care of North Carolina (CCNC)
http://www.communitycarenc.org

Governor's Institute on Substance Abuse
http://www.governorsinstitute.org

North Carolina Controlled Substances Reporting System
http://www.ncdhhs.gov/MHDDSAS/controlledsubstance/

Medical Associations
North Carolina Medical Society
http://www.ncmedsoc.org

North Carolina Nurses Association
http://www.ncnurses.org

North Carolina Dental Society
http://www.ncdental.org

Medical Professional Boards

North Carolina Medical Board
http://www.ncmedboard.org

- Prescribing controlled substances responsibly
  http://www.ncmedboard.org/articles/detail/prescribing_controlled_substances_responsibly/
- Position Statement, NC Medical Board
  http://www.ncmedboard.org/images/uploads/other_pdfs/PS_May2011.pdf

North Carolina Board of Nursing
http://www.ncbon.com/

North Carolina State Board of Dental Examiners
http://www.ncdentalboard.org

North Carolina Board of Pharmacy
http://www.ncbop.org

North Carolina Veterinary Medical Board
http://www.ncvmb.org

Federation of State Medical Boards
http://www.fsmb.org/

Government

Injury and Violence Prevention Branch, NC Division of Public Health
http://www.injuryfreenc.ncdhhs.gov/

Substance Abuse Services, NC Division of Mental Health, Developmental Disabilities and Substance Abuse
http://www.ncdhhs.gov/mhddsas/

Statistical Services Unit, N.C. State Center for Health Statistics
http://www.epi.state.nc.us/SCHS/about/statserv.html

National Institute on Drug Abuse
Prescription Drug Abuse
http://teens.drugabuse.gov/facts/facts_rx1.php#most_common

Facts on Prescriptions and Over-the-Counter Drugs
http://teens.drugabuse.gov/peerx/pdf/PEERx_Toolkit_FactSheets_RxDrugs.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA)
http://www.samhsa.gov/publicAwareness/

Office of National Drug Control Policy (ONDCP)
http://www.whitehouse.gov/ondcp

Other Agencies

NC Poison Control Center
http://www.ncpoisoncenter.org

Alcohol Drug Council of North Carolina (ADCNC)
www.alcoholdrughelp.org

Center for Lawful Access and Abuse (CLAAD)
http://www.claad.org

American Academy of Pain Medicine
http://www.painmed.org

American Society of Addiction Medicine (ASAM)
http://www.asam.org

U.S. Pain Foundation
http://www.uspainfoundation.org

American Chronic Pain Association (ACPA)
http://www.theacpa.org

American Pain Foundation (APA)
http://www.painfoundation.org

American Pharmacists Association (APhA)
http://www.pharmacist.com

Pain Treatment Topics
http://www.pain-topics.org

Industry

RX Safety Matters
The Importance of Providing Relief While Preventing Abuse
http://RxSafetyMatters.org

CARES Alliance (Collaborating and Acting Responsibly to Improve Safety)
Improving Patient Safety in Pain Management
http://CARESAlliance.org

Books/Journals

- Responsible Opioid Prescribing, A Physicians Guide -- Scott M. Fishman, MD
- Opioid Prescribing Toolkit -- Nathaniel Katz
- Pain Medicine
    - Project Lazarus: Community-Based Overdose Prevention in Rural North Carolina
      http://onlinelibrary.wiley.com/doi/10.1111/j.1526-4637.2011.01128.x/abstract
    - Current issue of *Pain Magazine*
      http://onlinelibrary.wiley.com/doi/10.1111/pme.2011.12.issue-6/issuetoc

SBIRT Annual Screening Questionnaires (English & Spanish)

Annual Questionnaire

Once a year, all our patients are asked to complete this form because drug use, alcohol use, and mood can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below.

Are you currently in recovery for alcohol or substance abuse? ☐ Yes ☐ No

Alcohol: One drink = 

12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	○	○

Mood:	No	Yes
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○

*Any answer other than "none" constitutes a positive screen. Follow up with the AUDIT and/or DAST-10 as appropriate.

Cuestionario anual

Una vez al año, pedimos a todos nuestros pacientes que completen este formulario, ya que el consumo de drogas y alcohol y el estado de ánimo pueden afectar su salud y los medicamentos que toma. Ayúdenos a brindarle la mejor atención médica al responder las preguntas que aparecen a continuación.

¿Está actualmente en rehabilitación por abuso de alcohol o sustancias? Sí No

Alcohol: Una bebida = 

12 oz cerveza  5 oz vino  1.5 oz licor (un trago)

	Ninguno	1 o más
HOMBRES: ¿cuántas veces durante el último año ha bebido 5 o más bebidas en un día?	○	○
MUJERES: ¿cuántas veces durante el último año ha bebido 4 o más bebidas en un día?	○	○

Drogas: las drogas recreativas incluyen metanfetaminas (velocidad, cristal), cannabis (marihuana, tiesto), solventes (solvente de pintura, aerosol, pegamento), tranquilizantes (Valium), barbitúricos, cocaína, éxtasis, alucinógenos (LSD, hongos) o narcóticos (heroína).

	Ninguno	1 o más
¿Cuántas veces durante el último año ha consumido una droga o utilizado un medicamento recetado para fines que no son médicos?	○	○

Estado de ánimo:	No	Sí
Durante las últimas dos semanas, ¿se ha sentido molesto con poco interés o placer en hacer las cosas?	○	○
Durante las últimas dos semanas, ¿se ha sentido molesto porque se siente deprimido, decaído o sin consuelo?	○	○

SBIRT AUDIT Forms (English and Spanish)

Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	Zero to two	Three or four	Five or six	Seven to nine	Ten or more
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

I	II	III	IV
0	8	16	20

AUDIT cuestionario de prueba de detección de alcohol

Debido que ingerir alcohol puede afectar su salud e interferir con ciertos medicamentos y tratamientos, es importante que le hagamos algunas preguntas sobre su uso del alcohol. Si se siente incómodo al llenar este formulario, hágaselo saber a su proveedor de atención médica.

Una bebida estándar equivale a:

- 1.5 oz de licor (por ejemplo, un trago de whisky)
- 12 oz cerveza
- 5 oz de vino

Bebida mixta o cóctel cerveza vino

Preguntas	0	1	2	3	4
1. ¿Con qué frecuencia toma una bebida que contenga alcohol?	Nunca	Mensualmente o menos	2 a 4 veces al mes	2 a 3 veces a la semana	4 o más veces a la semana
2. ¿Cuántas bebidas que contengan alcohol toma en un día normal cuando bebe?	1 ó 2	3 ó 4	5 ó 6	7 a 9	10 o más
3. ¿Con qué frecuencia toma seis o más tragos en una ocasión?	Nunca	Menos que mensualmente	Mensualmente	Semanalmente	Diariamente o casi diariamente
4. ¿Con qué frecuencia durante el último año se dio cuenta que no podía parar de beber una vez que comenzaba?	Nunca	Menos que mensualmente	Mensualmente	Semanalmente	Diariamente o casi diariamente
5. ¿Con qué frecuencia durante el último año no pudo hacer lo que se esperaba normalmente de usted debido a estar bebiendo?	Nunca	Menos que mensualmente	Mensualmente	Semanalmente	Diariamente o casi diariamente
6. ¿Con qué frecuencia durante el último año ha necesitado de un primer trago en la mañana para iniciar una actividad después de una fuerte sesión de bebidas?	Nunca	Menos que mensualmente	Mensualmente	Semanalmente	Diariamente o casi diariamente
7. ¿Con qué frecuencia durante el último año ha tenido un sentimiento de culpa o remordimiento después de beber?	Nunca	Menos que mensualmente	Mensualmente	Semanalmente	Diariamente o casi diariamente
8. ¿Con qué frecuencia durante el último año no ha podido recordar lo que sucedió la noche anterior debido a que estuvo bebiendo?	Nunca	Menos que mensualmente	Mensualmente	Semanalmente	Diariamente o casi diariamente
9. ¿Usted o alguien más han sido lastimados debido a que usted estuviera bebiendo?	No		Sí, pero no en el último año		Sí, durante el último año
10. ¿Algún familiar, amigo, médico u otro trabajador de atención médica ha estado preocupado con el hecho que usted beba o le ha sugerido que lo deje?	No		Sí, pero no en el último año		Sí, durante el último año

I	II	III	IV
0	8	16	20

SBIRT DAST-10 Forms (English and Spanish)

Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Which recreational drugs you have used in the past year?

- ☐methamphetamines (speed, crystal)
- ☐cocaine
- ☐cannabis (marijuana, pot)
- ☐narcotics (heroin, oxycodone, methadone, etc.)
- ☐inhalants (paint thinner, aerosol, glue)
- ☐hallucinogens (LSD, mushrooms)
- ☐tranquilizers (valium)
- ☐other _____

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes
	0	1

0	1	3	6
I	II	III	IV

For clinician:

Clinician Name:_____ **Date:** _____ **DAST Zone:** _____

Brief intervention: ☐ Raised subject ☐ Provided feedback ☐ Enhanced motivation ☐ Negotiated plan

☐ Not done

☐ Referral recommended (consider using Oregon referral line: 1 (800) 923-4357)

Cuestionario de prueba de detección de drogas (DAST, por sus siglas en inglés)

Debido a que el uso de drogas puede afectar su salud, necesitamos hacerle algunas preguntas sobre su uso de las drogas. Si se siente incómodo al completar este formulario, hágaselo saber a su proveedor de salud.

En los siguientes enunciados, "abuso de drogas" se refiere a:

1. Usar medicamentos con receta médica o de venta libre excediéndose de las instrucciones, y
2. Cualquier uso de drogas que no sea uso médico.

Las distintas clases de drogas pueden incluir metanfetaminas (velocidad), cannabis (marihuana, tiesto), solventes (solvente de pintura), tranquilizantes (Valium), barbitúricos, cocaína, estimulantes (velocidad), alucinógenos (LSD) o narcóticos (heroína). Recuerde que las preguntas *no* incluyen bebidas alcohólicas.

Marque con un "Sí" o "No" las siguientes preguntas:	0	1
1. ¿Ha utilizado drogas que no sean las que se requieren por razones médicas?	No	Sí
2. ¿Abusa de más de una droga a la vez?	No	Sí
3. ¿No puede dejar de usar drogas cuando quiere?	No	Sí
4. ¿Alguna vez ha tenido desvanecimientos o escenas retrospectivas como resultado del uso de drogas?	No	Sí
5. ¿Alguna vez se siente mal o culpable por usar drogas?	No	Sí
6. ¿Su cónyuge (o padres) se queja alguna vez por su participación con las drogas?	No	Sí
7. ¿Ha abandonado a su familia por su uso de las drogas?	No	Sí
8. ¿Ha participado en actividades ilegales para obtener drogas?	No	Sí
9. ¿Alguna vez ha experimentado síntomas de retraimiento (se ha sentido enfermo) cuando dejó de tomar drogas?	No	Sí
10. ¿Ha tenido problemas médicos como resultado de su uso de las drogas (por ejemplo, pérdida de memoria, hepatitis, convulsiones, sangrado)?	No	Sí

I	II	III	IV
0	1	3	6

For clinician:

Clinician Name:_____ **Date:** _____ **DAST Zone:** _____

Brief intervention:
- ☐ Raised subject
- ☐ Provided feedback
- ☐ Enhanced motivation
- ☐ Negotiated plan

☐ Not done

☐ Referral recommended
(consider using Oregon referral line: 1 (800) 923-4357)

Template for Scoring the SBIRT-AUDIT Form/ DAST-10

Score: _____

Scores for questions 1 through 8 are –

1st response = 0
2nd response = 1
3rd response = 2
4th response = 3
5th response = 4

Scores for questions 9 and 10 are –

1st response = 0
2nd response = 2
3rd response = 4

Score	Degree of problem related to alcohol consumption	Suggested Action
0	No problems reported.	No action at this time.
1-7	Low level.	Monitor, reassess at a later time.
8-12, female 8-14, male	Moderate level. Associated w/ harmful or hazardous drinking.	Further investigation. Consider for Project Lazarus.
>= 13, female	Substantial to severe level. Likely to indicate alcohol dependence.	Intensive assessment. Consider for Project Lazarus.
>= 15, male	Substantial to severe level. Likely to indicate alcohol dependence.	Intensive assessment. Consider for Project Lazarus.

Adapted from Saunders JB, Aasland OG, Babor TF *et al*. Development of the alcohol use disorders identification test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption —II. *Addiction* 1993, **88: 791–803.

TEMPLATE FOR SCORING THE DAST-10©

Score:_____

Score 1 point for each question answered "yes," except for question 3 for which a "no" receives 1 point.

DAST-10 Interpretation

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported.	None at this time.
1-2	Low level.	Monitor, reassess at a later date.
3-5	Moderate level.	Further investigation. Consider for Project Lazarus.
6-8	Substantial level.	Intensive assessment. Consider for Project Lazarus.
9-10	Severe level.	Intensive assessment. Consider for Project Lazarus.

Developed on 07/15/2008. For more information, go to www.coloradoguidelines.org or call (720) 297-1681.

The CRAFFT Screening Interview

Screening Date: _____

Age 13-18 **Completed By:** _____

Part A: During the PAST 12 MONTHS, did you:

Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	☐ Yes	☐ No
Smoke any marijuana or hashish?	☐ Yes	☐ No
Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	☐ Yes	☐ No

Part B:

Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐ Yes	☐ No
Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	☐ Yes	☐ No
Do you ever use alcohol or drugs while you are by yourself, or ALONE?	☐ Yes	☐ No
Do you ever FORGET things you did while using alcohol or drugs?	☐ Yes	☐ No
Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐ Yes	☐ No
Have you ever gotten into TROUBLE while you were using alcohol or drugs?	☐ Yes	☐ No

Calculating DIRE Score

D.I.R.E. Score: Patient Selection for Chronic Opioid Analgesia

For each factor, rate the patient's score from 1-3 based on the explanations in the right hand column.

Score	Factor	Explanation
	Diagnosis	1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, nonspecific back pain. 2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain. 3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis.
	Intractability	1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process. 2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness). 3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response.
	Risk	(R = Total of P + C + R + S below)
	Psychological:	1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues. 2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder. 3 = Good communication with clinic. No significant personality dysfunction or mental illness.
	Chemical Health:	1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse. 2 = Chemical coper (uses medications to cope with stress) or history of CD in remission. 3 = No CD history. Not drug-focused or chemically reliant.
	Reliability:	1 = History of numerous problems: medication misuse, missed appointments, rarely follows through. 2 = Occasional difficulties with compliance, but generally reliable. 3 = Highly reliable patient with meds, appointments & treatment.
	Social Support:	1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles. 2 = Reduction in some relationships and life roles. 3 = Supportive family/close relationships. Involved in work or school and no social isolation.
	Efficacy score	1 = Poor function or minimal pain relief despite moderate to high doses. 2 = Moderate benefit with function improved in a number of ways (or insufficient info – hasn't tried opioid yet or very low doses or too short of a trial). 3 = Good improvement in pain and function and quality of life with stable doses over time.

___ Total score = D + I + R + E

Score 7-13: Not a suitable candidate for long-term opioid analgesia
Score 14-21: May be a candidate for long-term opioid analgesia

Narcotics Utilization Report/Explanation

The *Narcotics Utilization and CPI Priority Flag Report by Practice* allows users to generate a parameterized data set around the use of narcotics, benzodiazepines, and sedative/hypnotics. This report initially returns all enrollees within your practice who have at least one opioid prescription fill in the previous 365 days. Those who meet criteria for the CCNC Chronic Pain Initiative (CPI) Priority Indicator as defined below, will have that flag noted in the "CPI Priority" column. The user may choose to reset the parameters regarding ED visits, opioid prescriptions in the past year, or CPI priority as defined below to return a specific defined sample for the practice.
Inclusion criteria may be set for the practice, number of narcotic prescriptions in the most recent 12 months, the number of pharmacies visited, and the number of emergency department visits in the most recent 12 months. Data is reported by practice and includes patient specific information (name, DOB, MID, county, DMA narcotic lock-in status, distinct category number and aggregate number of opioids/ benzodiazepines/ sedative-hypnotics prescribed in the last 12 months, number of pharmacies visited, number of practices visited, and number of emergency department visits in the last year.

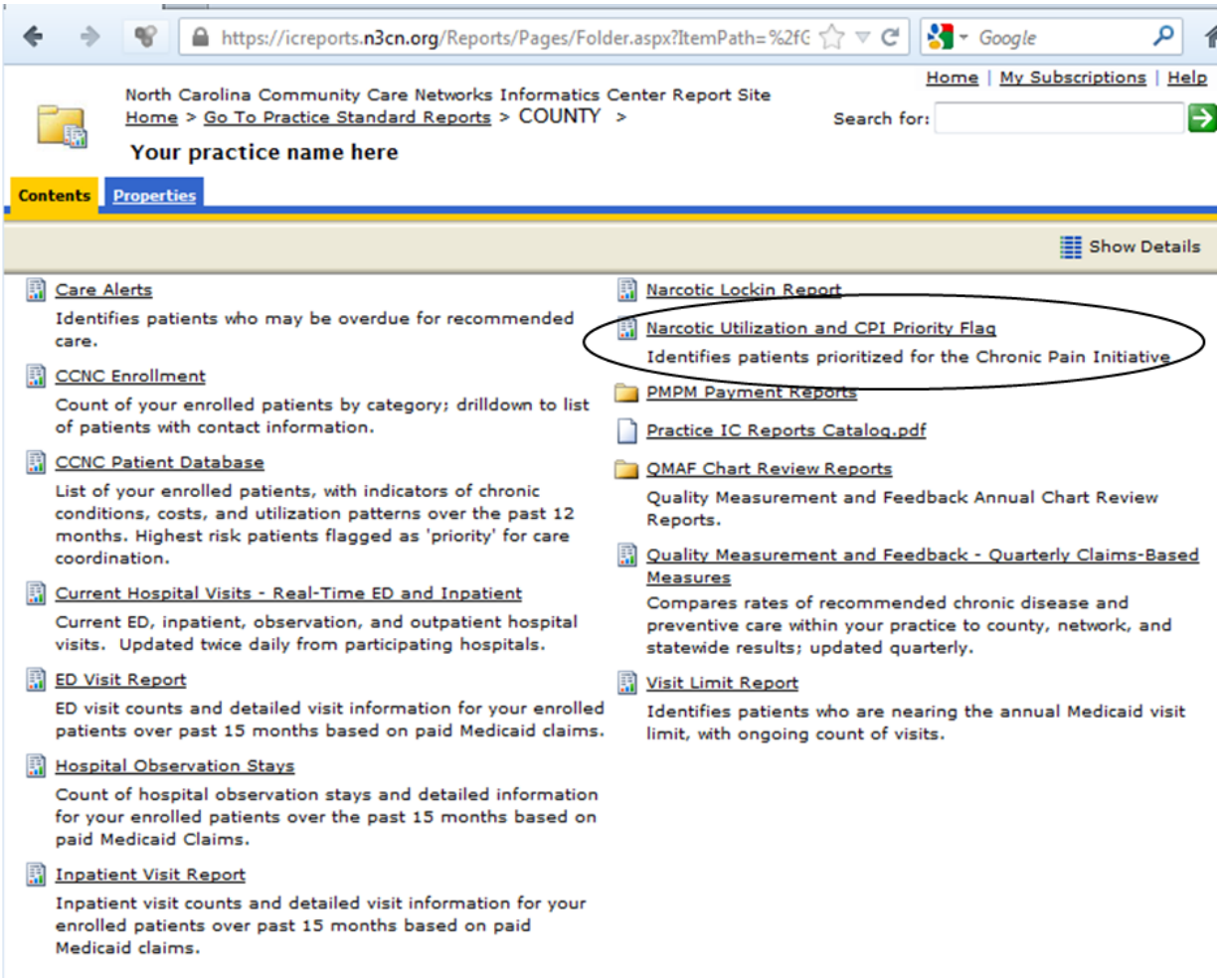
Users may find helpful to sort on higher frequency of narcotic use and ED use together to identify at risk cases. The use of a lower fill rate would give a more inclusive potential at-risk population. By setting the number of pharmacies visited at 0, the report gives a broader representation of patients included (similar to setting the narcotics fill lower) versus setting the level higher. For patients listed, there is a link to the portal medication history report for additional information. The report may be found in the CCNC IC Portal Reports Center at:

North Carolina Community Care Networks Informatics Center Report Site
Home > Go To Practice Standard Reports > YOUR COUNTY > YOUR PRACTICE >
Narcotic Utilization and CPI Priority Flag

Report definitions are outlined below:

- CPI Priority = "YES" if person has had >12 narcotic Rx fills AND >= 10 ED visits in the last 12 months and no cancer diagnosis in recent claims history
- of Opioid fills in past year: The total number of prescriptions fills for a opioid-containing product (GC3 = "H3A") in the previous 365 days (does not include Ultram/tramadol)
- # of Benzo fills in past year: The total number of prescriptions fills for a benzodiazepine-containing product (GC3 = "H2F") in the previous 365 days

- # of Hypnotic fills in past year: The total number of prescriptions fills for a hypnotic-containing product (GC3 = “H2E”) in the previous 365 days
- Patients with > 3 fills for all 3 classes: Patients are "YES" if they have had > 3 fills for Opioids AND Benzodiazepines AND Sedative Hypnotics in the previous 365 days
- # of Total Prescriptions fills (Opioids, Benzos, Hypnotics): The total number of fills for drugs in all three classes (Opioids + Benzos + Hypnotics)
- # of Distinct Meds (Opioids, Benzos, Hypnotics): The number of unique drug products (drug, strength or form) that are opioids (H3A) or benzo (H2F) or hypnotics (H2E) filled in the previous 365 days.
- # of Pharmacies : The total number of unique pharmacies with ANY prescription fill used by the patient in the previous 365 days
- # of Practices visited: Count of different provider numbers billing for outpatient CPT codes (excludes inpatient & emergency E&M codes)
- # Ed Visits in Past year: The total number of ED visits by the patient in the prior year
- Narcotic Lockin =” YES” if person appears in narcotic lock-in table



Interpreting Urine Toxicology Screens

General Information			**Toxicology Laboratory:** 966-6338 *or* 966-2361
	• Before ordering a urine toxicology screen, review the patient's medication record to ensure it is accurate and up-to-date • Sensitivities, cross-sensitivities, false positives, and false negatives may vary based on assay; contact the laboratory for specific information • False positives and negatives are possible on initial urine screens but can be ruled out on confirmation screens • Contact the laboratory if results of urine toxicology screen are abnormal, or not as expected • Currently, assays are unable to determine a reliable relationship between dose and urine concentration		
Included in Standard Urine Toxicology Screen	**Substance** ***(compound targeted by assay)***	**Window of Detection**	**Notes & Clinical Pearls**
	Amphetamines *(d-amphetamine, d-methamphetamine)*	3 – 72 hours	• Cross reactivity possible with many prescription (e.g., pantoprazole (Protonix)) or over-the-counter products (e.g., pseudoephedrine); contact lab for details • Must specify with laboratory if testing for ecstasy (metabolites are present for < 24 hours) or ephedra
	Barbiturates *(Secobarbital)*	1 – 21 days	
	Benzodiazepines *(Nor-diazepam)*	72 hours	• Assay unable to distinguish between specific benzodiazepines; contact toxicology laboratory if screening for a specific agent • Windows of detection depend on specific agents; shorter-acting benzodiazepines (e.g., alprazolam, lorazepam) have shorter windows of detection while longer-acting agents (e.g., diazepam) are present for longer • Temazepam and oxazepam are hepatic metabolites of diazepam and may be positive in confirmation screens for diazepam
	Cannabinoids *(THC metabolites)*	0 – 21 days	• Window of detection generally depends on duration of use; single uses are generally detectable for 2 to 4 days; moderate use for one week or more; chronic use may last up to several weeks • After discontinuing marijuana, cannabinoids distribute from the tissue and may result in positive screens for over days to weeks; results may also be affected by underlying fluid status (i.e., dehydration vs. fluid overload) • A positive result cannot be explained by passive smoke inhalation; also unlikely with hemp ingestion
	Cocaine *(Benzoyl ecgonine)*	12 – 72 hours	• Positive result can occur due to topical anesthetic use
	Methadone	72 hours	• Can measure chronic use with the urine concentration of the methadone metabolite, EDDP (ethylene dimethyl diphenyl pyrrolidine)
	Opiates *(Codeine, Morphine)*	2 – 5 days	**Specific medications and interpretation of results** *(Confirmation Screens)* • **Codeine**: expect codeine and morphine on urine screen. Codeine alone is possible if patient is deficient in CYP2D6 pathway. Small amounts of hydrocodone may also be present. Morphine alone generally indicates heroin use • **Morphine**: expect morphine on urine screen; high doses may result in small amounts of hydromorphone (< 5%) due to an alternate metabolic pathway. • **Hydrocodone**: expect hydrocodone on urine screen; may also produce small quantities of hydromorphone, the primary metabolite of hydrocodone. • **Hydromorphone**: expect **only** hydromorphone on urine screen • **Oxycodone**: may not be detected on initial urine drug screen (i.e., about 75% sensitivity), so confirmation may be necessary; other opioids should not be seen on urine screen • **Oxymorphone**: Sold as Opana, but it is also a metabolite of oxycodone, and is seen with chronic oxycodone use • Synthetic and semi-synthetic opioids (e.g., fentanyl, oxycodone, buprenorphine) may not be reliably detected on urine screen; must specifically order test for detection of fentanyl
	Propoxyphene	2 – 7 days	• No longer prescribed in the United States
Specific	Fentanyl		• Not included in opiate screening; must be specifically requested
	Phencyclidine (PCP)	5 – 7 days	
	LSD		Not used if collected after ≥ 8 hours, due to rapid metabolism

Controlled Substance Reporting System

Registering for the CSRS:

- MDs, DOs, PAs, and Medical Residents can register using the following methods:

    1. Register through the NC Medical Board website: www.ncmedboard.org.
    2. Register using the paper-based method.

- Pharmacists can register using the following methods:

    1. Register through the Board of Pharmacy's website: www.ncbop.org
    2. Register using the paper-based method.

- Advanced Practice Registered Nurses with prescriptive authority (Certified Registered Nurse Anesthetists, Certified Nurse Midwives, Clinical Nurse Specialists, or Nurse Practitioners) can register using the following methods:

    1. Register through the NC Nursing Board website: www.ncbon.com
    2. Register using the paper-based method.

- Dentists can register using the following methods:

    1. Register using the paper-based method.

Directions for registering for access as a provider to the NC CSRS Online:

Dr.'s, DO's, and ML's can now register for the NC Controlled Substances Reporting System through the NC Medical Board's website (www.ncmedboard.org) at any time!

Directions:

1. Go to the medical board website and look under the "Quick Links" menu and click on the second option, "Update Licensee Info Page".

2. Scroll down to the bottom of this page and sign in using your File ID# and DOB. If you have forgotten your File ID#, just click the box that says "Recover File ID" to retrieve this information. All you need to retrieve is the last 4 digits of your social security number and your DOB.

3. Once you have successfully logged into the licensee page you will look for the menu option "Training and CSRS". Once you click this option scroll down to the section on the CSRS. There will be a blue "Click Here" button to register for the NC CSRS.

4. Fill out the required information and submit. The password must be exactly 8 characters with one capital letter and one number. Do NOT use any symbols.

Your application should be processed within 2 weeks, and you will receive an email confirmation from Health Information Designs once you have access to the database. Please make sure to check your spam folder as well. If you do not receive an email after two weeks please contact the CSRS office at 919-733-1765.

To register online for access to the NC CSRS through the NC BON website, complete the following:

Go to the NC BON website: http://www.ncbon.com/

1) Hold mouse over tab “Licensure/Listing”

2) Go to section headed “Advanced Practice Registered Nurse”

3) Click “Controlled Substance Reporting System”

4) Follow instructions to sign up online

5) *Note that the CSRS registration is accessed within the **NCBON Nurse Gateway** and you will first be directed there from the CSRS registration link.

Direct Link: http://www.ncbon.com/dcp/i/licensurelisting-advanced-practice-registered-nurse-controlled-substances-reporting-system

Your application should be processed within 2 weeks, and you will receive an email confirmation from Health Information Designs once you have access to the database. Please make sure to check your spam folder as well. If you do not receive an email after two weeks please contact the CSRS office at 919-733-1765.

To register online for access to the NC CSRS through the NC BOP website, complete the following:

Go to the NC BOP login website: http://www.ncbop.org/

1) On left-hand side click “Pharmacist” link

2) Go to section under it labeled “Pharmacy login”

3) Enter information to log in

4) You will be asked “Are you currently employed in a Pharmacy?”
Click “Yes” and you will see a pre-populated CSRS Application

5) Fill out empty fields and thoroughly read the Privacy Statement

6) Click “Submit”

Direct Link:
https://www.ncbop1.org/NCBOPCE/login.aspx?ReturnUrl=%2fNCBOPCE

Your application should be processed within 2 weeks, and you will receive an email confirmation from Health Information Designs once you have access to the database. Please make sure to check your spam folder as well. If you do not receive an email after two weeks please contact the CSRS office at 919-733-1765.

Instructions for completing the Prescriber / Dispenser Database Access Request:

1. Information on the form must be legible

2. Fill in **ALL** fields

3. Propose a password:
   - Passwords must be at least 8 characters in length
   - Passwords must contain at least one (1) capital letter and one (1) lowercase letter and one (1) number
   - Passwords **CANNOT** contain symbols

4. After completing the access request form, have it notarized and mail **ALL of the following documents** to the address listed on the application:
   1. access request
   2. signed privacy statement
   3. copy of your current driver's license

*Health Information Designs, Inc. will notify you by e-mail with your confirmation login information. Please be sure to check your spam folder frequently if using a highly secure website.

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Controlled Substances Reporting System
Mail Service Center 3008
Raleigh, NC 27699-3008
Phone: (919) 733-1765
Fax: (919) 508-0983

Prescriber / Dispenser Database Access

☐ New ☐ Update ☐ Terminate

Name (First, MI, Last, Suffix (Jr., Sr., III))	
Professional Title	State Board License Number
Facility Name	DEA Number (Hospital Residents add DEA extension #)
Facility Address	City, State, Zip Code
Area Code & Telephone Number	Area Code & Fax Number
Email Address *Note: Please add nccsrs-info@hidinc.com to your email contacts or acceptance list to prevent your notification emails from being rejected or sent to your spam folder.	Proposed Password
Signature	Date

Subscribed and sworn to me, a notary public in and for the State of North Carolina, on this _____ day of _____, _____. My commission expires on the _____ day of _____, _____.

_____
Notary Signature

Pursuant to N.C.G.S. 90-113.75 a person who intentionally, knowingly, or negligently releases, obtains, or attempts to obtain information from the system in violation of a provision of this section or a rule adopted pursuant to this section shall be assessed a civil penalty not to exceed ten thousand dollars ($10,000) per violation.

Mail the following items to the Controlled Substances Reporting System:
- **Notarized Database Access Form**
- **Signed Copy of Privacy Statement**
- **Copy of Current Driver's License**

DEPARTMENT USE ONLY			
Date received	☐ Approved ☐ Disapproved	Signature	Date of Action

Prescriber / Dispenser Database Access Application January 2014

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Controlled Substances Reporting System
Mail Service Center 3008
Raleigh, NC 27699-3008
Phone: (919) 733-1765
Fax: (919) 508-0983

Privacy Statement

Statutory Authority:
Article 5E, 90-113.70 the North Carolina Controlled Substances Reporting System Act, requires the Department of Health and Human Services to establish and maintain a controlled substances prescription reporting system of dispensed prescriptions for all Schedule II-V controlled substances. The purpose of this legislation is to improve the State's ability to identify controlled substances abusers or misusers and refer them for treatment, and to identify and stop diversion of prescription drugs in an efficient and cost effective manner that will not impede the appropriate medical utilization of licit controlled substances.

Access to Information:
NCGS 90-113.74. (c) (1) authorizes DHHS to release data from the Controlled Substances Reporting System to persons authorized to prescribe or dispense controlled substances for the purpose of providing medical or pharmaceutical care for their patients.

NCGS 90-113.74. (c) (3) authorizes DHHS to release data from the Controlled Substances Reporting System to Special agents of the North Carolina State Bureau of Investigation who are assigned to the Diversion & Environmental Crimes Unit and whose primary duties involve the investigation of diversion and illegal use of prescription medication and who are engaged in a bona fide specific investigation related to enforcement of laws governing licit drugs. The SBI shall notify the Office of the Attorney General of North Carolina of each request for inspection of records.

Unlawful Disclosure:
Prescription information in the Controlled Substances Reporting System is privileged and confidential, is not a public record pursuant to G.S. 132-1, is not subject to subpoena or discovery or any other use in civil proceedings, and except as otherwise provided in Article 5E, may only be used for investigative or evidentiary purposes related to violations of State or federal law and regulatory activities. Except as otherwise provided in Article 5E, prescription information shall not be disclosed or disseminated to any person or entity by any person or entity authorized to review prescription information.

As per 90-113.75., a person who intentionally, knowingly, or negligently releases, obtains, or attempts to obtain information from the system in violation of a provision of this section or a rule adopted pursuant to this section shall be assessed a civil penalty not to exceed ten thousand dollars ($10,000) per violation. The clear proceeds of penalties assessed under this section shall be deposited to the Civil Penalty and Forfeiture Fund in accordance with Article 31A of Chapter 115C of the General Statutes.

Account Agreement:
By signing this agreement I understand that inappropriate access or disclosure of this information is a violation of North Carolina law. I hereby agree to follow the security and password policies of the NC Controlled Substances Reporting System. I agree that user account additions, deletions, and changes will be submitted in writing. I agree that I will not share my account information, login name, or password with anyone, even if they are authorized users of the program.

Signature: _____ Date: _____

Print Name: _____

FACTS ABOUT CONTROLLED SUBSTANCES

Approximately 18.5 million prescriptions for controlled substances are dispensed by North Carolina pharmacies each year.

Approximately 2.5 million North Carolina residents (26% of total population) receive a controlled substance prescription in a 6 month period of time.

There are currently over 112 million prescriptions in the database.

The number of accidental poisoning deaths in North Carolina from prescription controlled substances were:

January – December 2008	798
January – December 2009	826
January – December 2010	810
January – December 2011	878

Number of Dispensers and Practitioners registered to use the system is over 17,000.

* Data is as of September 2013

QUESTIONS?

Contact the Drug Control Unit

919-733-1765

John Womble

johnny.womble@dhhs.nc.gov
nccontrolsubstance.reporting@dhhs.nc.gov

www.nccsrs.org

WHO MAY RECEIVE INFORMATION FROM THE SYSTEM?

- Prescribers authorized to prescribe controlled substances for the purpose of providing care for their patients (web access).
- Dispensers of controlled substances for the purpose of providing care (web access).
- NC Controlled Substance Authorities (DHHS) (web access).
- State Medical Examiners for the purpose of determining cause of death (upon written request).
- SBI Diversion Crime Unit investigators pursuant to a bona fide investigation with notification to the Attorney General's Office (upon written request).
- Licensing Boards with jurisdiction over healthcare professionals as a part of an investigation (upon written request).
- DMA for the purpose of administering the State Medicaid program (upon request, with limited web access).
- Other state Controlled Substance Monitoring Authorities (upon request).
- To law enforcement upon court order as part of a bona fide specific investigation.
- To a patient upon written request to the program (notarized request).

A Project of the Governor's Institute on Substance Abuse

Funded wholly or in part by the federal Substance Abuse Prevention and Treatment Block Grant Fund (CFDA #93.959) as a project of the NC Division of Mental Health, Developmental Disabilities & Substance Abuse Services.
State of North Carolina - Pat McCrory, Governor
Department of Health and Human Services
Aldona Zofia Wos, Secretary
Division of Mental Health, Developmental Disabilities and Substance Abuse Services
www.ncdhhs.gov/mhddsas/

09/13 - 3000 of this document were printed at $0.24 each. [Fourth Printing]

NORTH CAROLINA CONTROLLED SUBSTANCES REPORTING SYSTEM

NORTH CAROLINA DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

CONTROLLED SUBSTANCES REPORTING SYSTEM

WHAT IS THE CSRS?

Established by State law, the CSRS is a prescription reporting system that allows registered dispensers and practitioners to review a patient's controlled substances prescription history on the web. It is intended to assist practitioners in monitoring patients by identifying and referring patients for substance abuse treatment or specialized pain management.

HOW DOES THE SYSTEM WORK?

All prescriptions for controlled substances, schedule II through V, dispensed in North Carolina are reported into the CSRS database. Pharmacists transmit the data every 72 hours (starting Jan 2014). Prescribers and pharmacists register and are given a password to access the online system to look up a patient's controlled substances prescription history. Information in the system dates back 6 years. Prescribers may legally query the system for their patients only.

WHAT CAN I DO WITH THE INFORMATION?

Sit down with the patient and discuss any findings of concern. A referral to a substance abuse specialist and/or pain specialist may be appropriate. Prescribers may document findings in their records and may discuss with other prescribers. Behavioral Health practitioners need to continue to follow other applicable consent laws. Pharmacists should review the patient profile and contact the prescriber(s) to discuss or alert the practitioner of troublesome patterns or drug combinations.

FOR MORE INFORMATION VISIT
NCCSRS.ORG

DOS & DON'TS

DO

- Check the database prior to prescribing or dispensing a controlled substance.
- Notify your patients that you use the system.
- Discuss findings of concern with your patients.
- Listen to your patients when they say the system is in error and contact us for further assistance.
- Use treatment agreements when appropriate.
- Report forgeries to law enforcement.
- Inform us of non-reporting pharmacies.
- Educate your colleagues about the value of the system.
- Invite CSRS staff to make a presentation at a meeting to educate your peers.
- Educate patients about safe storage of controlled substances.

DON'T

- Use the CSRS to screen out-patients.
- Allow office personnel to check the CSRS for you unless they are registered as a delegate. (Anticipated start date of Spring 2014)
- Assume all CSRS data is the absolute truth.
- Discharge patients misusing controlled substances without intervening and attempting to refer for substance abuse treatment or pain management.
- Refer suspected "doctor shoppers" to police unless there is evidence from sources other than the CSRS.
- Give CSRS information to law enforcement unless there is evidence of forgery.
- Give patients a copy of CSRS data.

INSTRUCTIONS FOR CSRS ACCESS

1	**Read Instructions and Complete Access Application**
2	**Sign Privacy Statement**
3	**Photocopy Driver's License**
4	**Notarize the Application**
5	**Mail a hard copy of the items above to:** **NC CSRS** **3008 Mail Service Center** **Raleigh, NC 27699-3008**
6	**Health Information Designs, Inc. will notify you by email when your request has been approved***

Online registration is now available through the following Licensing Boards:

- NC Medical Board
- NC Board of Pharmacy
- NC Board of Nursing

Simply go to your licensing boards website, log into your account, and complete the online application. Our vendor, Health Information Designs, Inc. will notify you by email when your request has been approved.*

http://bit.ly/csrs-application (Application for prescriber access)

* If you do not receive an email from Health Information Designs, Inc. in 2 weeks please contact the Drug Control Unit at 919-733-1765

Do's and Don'ts for Prescribers and Dispensers Using the NC Controlled Substances Reporting System

DO

- Check the database prior to prescribing or dispensing a controlled substance.
- Discuss any findings of concern directly with your patients.
- Listen to your patients when they say the system is in error - contact NC CSRS staff to help address questions and verify information.
- Learn about SBIRT (Screening, Brief Intervention and Referral for Treatment www.sbirtnc.org) and use with your patients.
- Use behavioral contracts with patients when appropriate.
- Report forgeries to law enforcement.
- Inform us of non-reporting pharmacies.

DO NOT

- Use the CSRS to exclude patients from practices or services.
- Discharge patients without intervening and attempting to refer for substance abuse treatment or pain management.
- Use CSRS prescription information to make a referral to law enforcement when it's your only source of information.

For Information or Questions please contact the North Carolina Controlled Substances Reporting System staff at 919.733.1765 or NCControlSubstance.Reporting@dhhs.nc.gov

December 2013 NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Senate Bill 222 Highlights and Timelines

1. Reduces the time interval for Dispensers to report to the CSRS from 7 days to 3 business days after the drug is dispensed and encourages daily reporting.
    - *Effective 1/1/14*

2. Requires method of payment be reported to the CSRS.
    - *Effective 1/1/14*

3. Allows DHHS to notify practitioners that a patient may have obtained prescriptions for controlled substances in a manner that may represent abuse, diversion, or an increased risk of harm to the patient (referred to as "unsolicited alerts").

4. Allows DHHS to alert licensing and regulatory bodies responsible for healthcare practitioners to patterns of concern.

5. Allows practitioners or dispensers authorized to delegate the authority to receive data from CSRS to others provided DHHS approves of the delegation (referred to as "Delegate Accounts").
    - *Available Spring/Summer 2014 at the earliest*

6. Allows SBI Diversion and Environmental Crimes Unit to provide information they receive from CSRS to other SBI agents involved in drug investigation.
    - *Effective 1/1/14*

7. Gives the Attorney General the option of referring an unusual pattern of prescribing reported by DHHS to the appropriate Sheriff, as well as the SBI, for further investigation.
    - *Effective 1/1/14*

8. Increases the civil penalty from a maximum of $5,000 to a maximum of $10,000 for improper disclosure of CSRS information
    - *Effective 1/1/14*

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2013

SESSION LAW 2013-152
SENATE BILL 222

AN ACT TO REVISE THE NORTH CAROLINA CONTROLLED SUBSTANCES REPORTING SYSTEM ACT, AS RECOMMENDED BY THE CHILD FATALITY TASK FORCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-113.72 reads as rewritten:

"**§ 90-113.72. Definitions.**

The following definitions apply in this Article:

(1) "Commission" means the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services established under Part 4 of Article 3 of Chapter 143B of the General Statutes.

(2) "Controlled substance" means a controlled substance as defined in G.S. 90-87(5).

(3) "Department" means the Department of Health and Human Services.

(4) "Dispenser" means a person who delivers a Schedule II through V controlled substance to an ultimate user in North Carolina, but does not include any of the following:

a. A licensed hospital or long-term care pharmacy that dispenses such substances for the purpose of inpatient administration.

~~b. A person authorized to administer such a substance pursuant to Chapter 90 of the General Statutes.~~

c. A wholesale distributor of a Schedule II through V controlled substance.

d. A person licensed to practice veterinary medicine pursuant to Article 11 of Chapter 90 of the General Statutes.

(5) "Ultimate user" means a person who has lawfully obtained, and who possesses, a Schedule II through V controlled substance for the person's own use, for the use of a member of the person's household, or for the use of an animal owned or controlled by the person or by a member of the person's household."

SECTION 2. G.S. 90-113.73 reads as rewritten:

"**§ 90-113.73. Requirements for controlled substances reporting system.**

(a) The Department shall establish and maintain a reporting system of prescriptions for all Schedule II through V controlled substances. Each dispenser shall submit the information in accordance with transmission methods and frequency established by rule by the Commission. The Department may issue a waiver to a dispenser ~~that~~ who is unable to submit prescription information by electronic means. The waiver may permit the dispenser to submit prescription information by paper form or other means, provided all information required of electronically submitted data is submitted. The dispenser shall report the information required under this section ~~on a monthly basis for the first 12 months of the Controlled Substances Reporting~~

~~System's operation, and twice monthly thereafter, until January 2, 2010, at which time dispensers shall report no later than seven days~~ no later than the close of business three business days after the day when the prescription ~~is dispensed~~ was delivered, beginning the next day after the delivery date; however, dispensers are encouraged to report the information no later than 24 hours after the prescription was delivered. The information shall be submitted in a format as determined annually by the Department based on the format used in the majority of the states operating a controlled substances reporting system.

(b) The Commission shall adopt rules requiring dispensers to report the following information. The Commission may modify these requirements as necessary to carry out the purposes of this Article. The dispenser shall report:

(1) The dispenser's DEA number.
(2) The name of the patient for whom the controlled substance is being dispensed, and the patient's:
    a. Full address, including city, state, and zip code,
    b. Telephone number, and
    c. Date of birth.
(3) The date the prescription was written.
(4) The date the prescription was filled.
(5) The prescription number.
(6) Whether the prescription is new or a refill.
(7) Metric quantity of the dispensed drug.
(8) Estimated days of supply of dispensed drug, if provided to the dispenser.
(9) National Drug Code of dispensed drug.
(10) Prescriber's DEA number.
(11) Method of payment for the prescription.

(c) A dispenser shall not be required to report instances in which a controlled substance is provided directly to the ultimate user and the quantity provided does not exceed a 48-hour supply."

SECTION 3. G.S. 90-113.74 reads as rewritten:

"§ 90-113.74. Confidentiality.

(a) Prescription information submitted to the Department is privileged and confidential, is not a public record pursuant to G.S. 132-1, is not subject to subpoena or discovery or any other use in civil proceedings, and except as otherwise provided below may only be used for investigative or evidentiary purposes related to violations of State or federal law and regulatory activities. Except as otherwise provided by this section, prescription information shall not be disclosed or disseminated to any person or entity by any person or entity authorized to review prescription information.

(b) The Department may use prescription information data in the controlled substances reporting system only for purposes of implementing this Article in accordance with its provisions.

(b1) The Department may review the prescription information data in the controlled substances reporting system and upon review may:

(1) Notify practitioners that a patient may have obtained prescriptions for controlled substances in a manner that may represent abuse, diversion of controlled substances, or an increased risk of harm to the patient.

(2) Report information regarding the prescribing practices of a practitioner to the agency responsible for licensing, registering, or certifying the practitioner pursuant to rules adopted by the agency as set forth below in subsection (b2) of this section.

(b2) In order to receive a report pursuant to subdivision (2) of subsection (b1) of this section, an agency responsible for licensing, registering, or certifying a practitioner with prescriptive or dispensing authority shall adopt rules setting the criteria by which the Department may report the information to the agency. The criteria for reporting established by rule shall not establish the standard of care for prescribing or dispensing, and it shall not be a basis for disciplinary action by an agency that the Department reported a practitioner to an agency based on the criteria.

(c) The Department shall release data in the controlled substances reporting system to the following persons only:

(1) Persons authorized to prescribe or dispense controlled substances for the purpose of providing medical or pharmaceutical care for their patients. A person authorized to receive data pursuant to this paragraph may delegate the authority to receive the data to other persons working under his or her direction and supervision, provided the Department approves the delegation.

(2) An individual who requests the individual's own controlled substances reporting system information.

(3) Special agents of the North Carolina State Bureau of Investigation who are assigned to the Diversion & Environmental Crimes Unit and whose primary duties involve the investigation of diversion and illegal use of prescription ~~medication and~~ medication. SBI agents assigned to the Diversion & Environmental Crimes Unit may then provide this information to other SBI agents who are engaged in a bona fide specific investigation related to enforcement of laws governing licit drugs. The SBI shall notify the Office of the Attorney General of North Carolina of each request for inspection of records maintained by the Department.

(4) Primary monitoring authorities for other states pursuant to a specific ongoing investigation involving a designated person, if information concerns the dispensing of a Schedule II through V controlled substance to an ultimate user who resides in the other state or the dispensing of a Schedule II through V controlled substance prescribed by a licensed health care practitioner whose principal place of business is located in the other state.

(5) To a ~~court~~ sheriff or designated deputy sheriff or a police chief or a designated police investigator who is assigned to investigate the diversion and illegal use of prescription medication or pharmaceutical products identified in Article 5 of this Chapter of the General Statutes as Schedule II through V controlled substances and who is engaged in a bona fide specific investigation related to the enforcement of laws governing licit drugs pursuant to a lawful court order ~~in a criminal action.~~ specifically issued for that purpose.

(6) The Division of Medical Assistance for purposes of administering the State Medical Assistance Plan.

(7) Licensing boards with jurisdiction over health care disciplines pursuant to an ongoing investigation by the licensing board of a specific individual licensed by the board.

(8) Any county medical examiner appointed by the Chief Medical Examiner pursuant to G.S. 130A-382 and the Chief Medical Examiner, for the purpose of investigating the death of an individual.

(d) The Department may provide data to public or private entities for statistical, research, or educational purposes only after removing information that could be used to identify individual patients who received prescription medications from dispensers.

(e) In the event that the Department finds patterns of prescribing medications that are unusual, the Department shall inform the Attorney General's Office of its findings. The Office of the Attorney General shall review the Department's findings to determine if the findings should be reported to the SBI and the appropriate sheriff for investigation of possible violations of State or federal law relating to controlled substances.

(f) The Department shall purge from the controlled substances reporting system database all information more than six years old.

(g) Nothing in this Article shall prohibit a person authorized to prescribe or dispense controlled substances pursuant to Article 1 of Chapter 90 of the General Statutes from disclosing or disseminating data regarding a particular patient obtained under subsection (c) of this section to another person (i) authorized to prescribe or dispense controlled substances pursuant to Article 1 of Chapter 90 of the General Statutes and (ii) authorized to receive the same data from the Department under subsection (c) of this section.

(h) Nothing in this Article shall prevent persons licensed or approved to practice medicine or perform medical acts, tasks, and functions pursuant to Article 1 of Chapter 90 of the General Statutes from retaining data received pursuant to subsection (c) of this section in a patient's confidential health care record."

SECTION 4. G.S. 90-113.75 reads as rewritten:

"§ 90-113.75. Civil penalties; other remedies; immunity from liability.

(a) A person who intentionally, knowingly, or negligently releases, obtains, or attempts to obtain information from the system in violation of a provision of this ~~section~~ Article or a rule adopted pursuant to this ~~section~~ Article shall be assessed a civil penalty by the Department not to exceed ~~five thousand dollars ($5,000)~~ ten thousand dollars ($10,000) per violation. The clear proceeds of penalties assessed under this section shall be deposited to the Civil Penalty and Forfeiture Fund in accordance with Article 31A of Chapter 115C of the General Statutes. The Commission shall adopt rules establishing the factors to be considered in determining the amount of the penalty to be assessed.

(b) In addition to any other remedies available at law, an individual whose prescription information has been disclosed in violation of this ~~section~~ Article or a rule adopted pursuant to this Article may bring an action against any person or entity who has intentionally, knowingly, or negligently released confidential information or records concerning the individual for either or both of the following:

(1) Nominal damages of one thousand dollars ($1,000). In order to recover damages under this subdivision, it shall not be necessary that the plaintiff suffered or was threatened with actual damages.

(2) The amount of actual damages, if any, sustained by the individual.

(c) ~~A health care provider licensed, or an~~ An entity permitted access to data under this ~~Chapter~~ Article that, in good faith, makes a report or transmits data required or allowed by this Article is immune from civil or criminal liability that might otherwise be incurred or imposed as a result of making the report or transmitting the data."

SECTION 5. G.S. 90-5.2 is amended by adding a new subsection to read:

"(a1) The Board shall make e-mail addresses and facsimile numbers reported pursuant to G.S. 90-5.2(a)(7) available to the Department of Health and Human Services for use in the North Carolina Controlled Substance Reporting System established by Article 5E of this Chapter."

SECTION 6. Sections 1 and 2 of this act become effective on January 1, 2014, and apply to prescriptions delivered on or after that date. The remainder of this act is effective when it becomes law.

In the General Assembly read three times and ratified this the 13th day of June, 2013.

s/ Daniel J. Forest President of the Senate

s/ Thom Tillis
Speaker of the House of Representatives

s/ Pat McCrory Governor

Approved 4:26 p.m. this 19th day of June, 2013

DMA Lock-in Program

Update on Narcotic and Benzodiazepine Management Lock-In Program -- 10.27.2011

N.C. Medicaid has implemented a recipient management lock-in program to control recipient overutilization of Medicaid benefits. Recipients identified for the lock-in program are restricted to a single prescriber and pharmacy in order to obtain opioid analgesics, benzodiazepines, and certain anxiolytics covered through the Medicaid Outpatient Pharmacy Program.

Who does this apply to?

History of filling more than 6 six new prescriptions or refills in two consecutive months for either opioids or benzodiazepines,receive prescriptions for opioids and benzodiazepines from more than three providers in two consecutive months, or are referred by a provider who feels the patient should be enrolled in the program.

Recipients who meet the criteria are notified by letter from DMA. In this letter, recipients are asked to choose a prescriber and a pharmacy (all three will then receive a confirmation letter). If no patient choice is made, DMA uses algorithmic guidelines to determine an assigned provider and/or pharmacy. The recipient must obtain all prescriptions for these medications from their lock-in prescriber and lock-in pharmacy in order for the claim to be paid.

The lock-in program went live on October 11, 2010, with a plan for 200 additional patients to be enrolled monthly.

Important Facts Regarding the Lock-In Program:

- **Prescriber's NPI is required on the pharmacy claim;** submitting the prescriber's DEA results in claim being denied.

- Claims submitted by a prescriber or filled at a pharmacy other than the one listed on the lock-in file will be denied; patient cash payment may be utilized to bypass the lock-in system.

- Recipients may not change their lock-in prescriber or pharmacy without authorization from DMA. *For situations in which 2 providers are being utilized (e.g. psychiatrist prescribes benzodiazepine and pain management provider prescribes narcotic), DMA may be requested to allow for up to 2 providers for a*

single patient. The patient may make this request of DMA or the pharmacist may contact DMA. If the pharmacist makes the request of DMA, a brief claims review may be useful to substantiate the request. Patients may make one call to change their lock-in status per lock-in period, then subsequent contacts for provider changes must be in writing. At this time, a provider or their designee (office staff, network pharmacist) may contact/call DMA to request to change a patient's provider lock-in status. DMA will validate the authenticity of the caller and make the provider change.

- Lock-in period is for one year. After one year, the patient is removed from the program if they no longer meet criteria. Recipients who continue to meet the criteria will be locked in for an additional year.

- Medicaid Provider Referrals: Patients may be referred to DMA for consideration for the lock-in program. If the referee does not meet lock-in criteria, there must be clinical grounds/basis for the lock-in referral.

- **Emergency Measures**

    - In response to an emergent situation, N.C. Medicaid will reimburse an enrolled pharmacy for a four-day supply of a prescription dispensed to a recipient locked into a different pharmacy and prescriber. A "3" in the level of service field should be utilized to indicate that the transaction is an emergency fill.

    - The recipient will be responsible for the appropriate copayment; paid quantities for more than a four day supply are subject to recoupment.

    - Only one emergency occurrence will be reimbursed per lock-in period.

    - Records of dispensing of emergency supply meds are subject to review by DMA Program Integrity.

- **Other Issues**
    - The definition of medications included in the lock-in calculation includes "certain anxiolytics." This category includes the benzodiazepine anxiolytics and meprobamate/Miltown which has a GC3 of H2F. As meprobamate is not a benzodiazepine, but is an anxiolytic, this language was crafted to cover this issue. The anxiolytics buspirone and hydroxyzine are not lock-in medications.

- Medicare Part D beneficiaries are affected by this program for the number of benzodiazepine prescriptions and the number of prescribers for benzodiazepines.

- When a patient is discharged from their lock-in provider and is having trouble identifying another provider, DMA will handle the situation on a case by case basis. DMA is NOT taking recipients out of the program—although that is often the patient request. The patient is reminded to get the list from the local DSS and call for a provider. DMA has also made contact with the network pharmacists asking for their help by forwarding the recipient's phone number and information. Additionally, the recipient can use their emergency override.

Additional Assistance:

- For additional information, you may contact:
  - Krista Kness, RPh, North Carolina DMA at Krista.kness@dhhs.nc.gov or phone 919-855-4303
  - Jerry McKee, Pharm.D., M.S., BCPP at jmckee@n3cn.org or phone 919-745-2387

- Or refer to the North Carolina DMA website at: http://www.ncdhhs.gov/dma/pharmacy

Lock-in Referral Form

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
PHARMACY LOCK-IN REFERRAL FORM

This form is used for referring North Carolina Medicaid recipients with possible medication overutilization to the Recipient Management Lock-in Program to evaluate the need for possible lock-in to one prescriber and one pharmacy. Please fax this form along with any supporting documentation to 919-715-1255. For questions regarding the use of this form, call 919-855-4300. Please note this completed form contains Protected Health Information (PHI) and should be handled in accordance with HIPAA regulations.

Referral Information

Referral Source:
[ ] Medicaid Provider
[ ] CCNC Network Employee

Referral Name: _____
Referral Phone : _____
Date of Referral: _____
Please include contact information for appeals support.

Recipient Information

Recipient Name: _____
Recipient Medicaid ID: _____
Recipient DOB: _____