Practical Pointers for Prescribers, Pharmacists and Impaired Professionals in South Carolina

Presented by

Stephen R. Gardner, M.D.

Terry A. Blackmon, R.Ph.

Samuel H. McNutt, Jr., BSN, CRNA, MHSA

Dr. Gardner graduated from LSU School of Medicine in 1974 and completed a neurosurgery residence thereafter at the Medical College of Virginia. Dr. Gardner is board certified by the American Board of Neurosurgeons and is a Fellow of the American College of Surgeons. He is a member of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons. He represents the 4th Congressional District on the State Board of Medical Examiners and serves as President of the Board.

Mr. Blackmon graduated from the Medical University of SC with a BS in Pharmacy in 1980. He is the owner of the Medicine Cabinet, an independent retail pharmacy in Lake City, SC. He has faithfully served the pharmacy profession, for which he has received multiple awards, including recognition by the SC Pharmacy Association as its 2015 Pharmacist of the Year. Mr. Blackmon represents the 6th Congressional District on the State Board of Pharmacy and currently serves as Chairman.

Mr. McNutt earned his BSN from Clemson University in 1983 and obtained his Certification in Nurse Anesthesia from MUSC in 1988. He obtained his Master's of Health Services Administration from Webster University in 2005. He has served as the Chief Anesthetist at Palmetto Health Baptist since 2001. He previously worked with Critical Health Systems, Roper Hospital and the US Army Nurse Corps. He is a recipient of the Helen Arhdt and Golden Palmetto Awards. He is President of the State Board of Nursing.

Conflict of Interest Disclosure

The panelists do NOT have any relevant financial relationships with proprietary entities producing health care goods or services related to this activity.

Practical Pointers for Prescribers

2009: Publication of the SC Board of Medical Examiners (BME) first *Pain Management Guidelines*

2014: Governor Haley issues Executive Order 2014-22, forming the Governor's Prescription Drug Abuse Prevention Council (PDAP)

- Representatives from BME and Boards of Dentistry, Nursing and Pharmacy (March)

2014: BME, Dentistry, Nursing and Pharmacy publish *Joint Revised Pain Management Guidelines* (November)

Practical Pointers for Prescribers

2014: Publication of the PDAP's State Plan (December)

2014 PDAP State Plan

2016: Publication of the *CDC Guideline for Prescribing Opioids for Chronic Pain* (March)

2016 CDC Prescribing Guideline

2017: Publication of the Federation of State Medical Boards' *Guideline for the Chronic Use of Opioid Analgesics* (April)

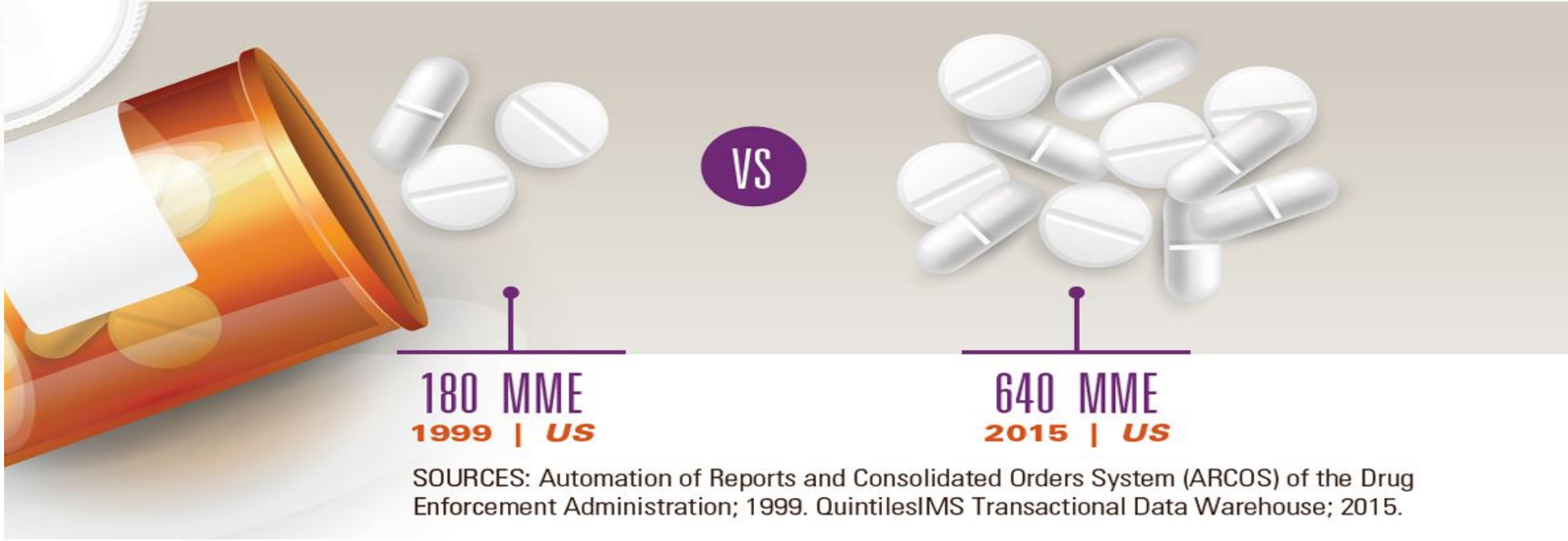
FSMB April 2017 Opioid Analgesics Guideline

- Providers in the highest prescribing counties prescribed 6 times more opioids per person than the lowest prescribing counties in 2015.
- Half of US counties had a decrease in the amount of opioids (MME*) prescribed per person from 2010 to 2015.
- The MME prescribed per person in 2015 was about 3 times as high as in 1999.

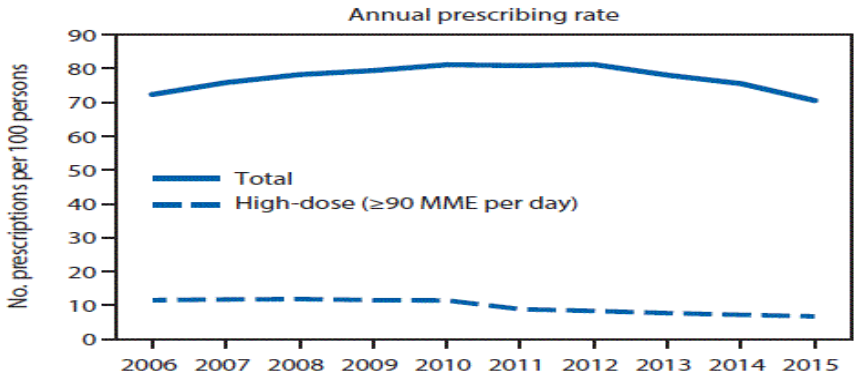
* MME, morphine milligram equivalents, is a way to calculate the total amount of opioids, accounting for differences in opioid drug type and strength.

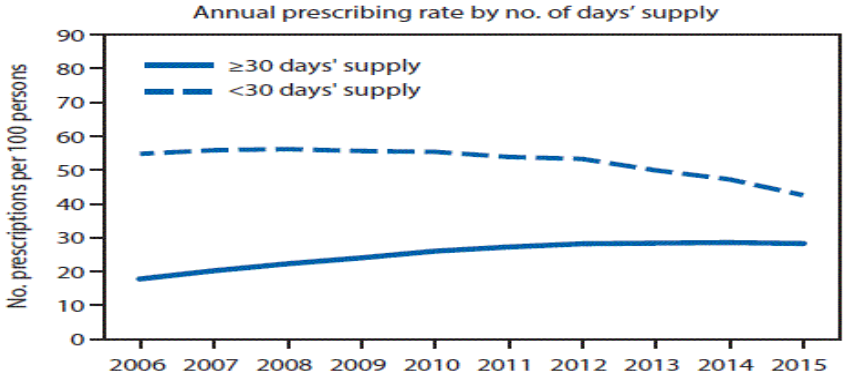
https://www.cdc.gov/vitalsigns/opioids/index.html

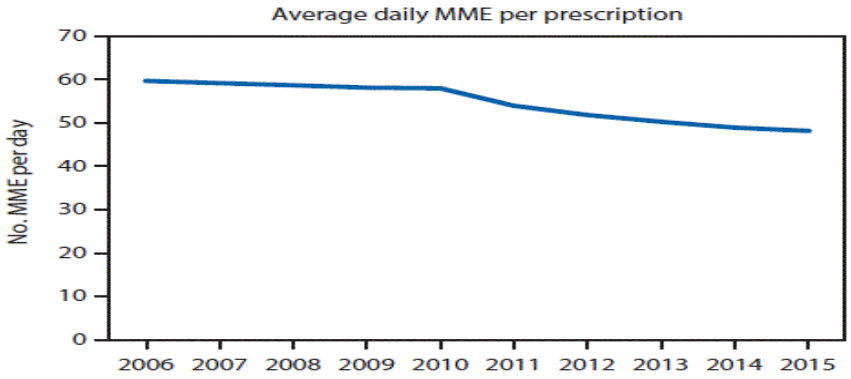
The amount of opioids prescribed per person was three times higher in 2015 than in 1999.

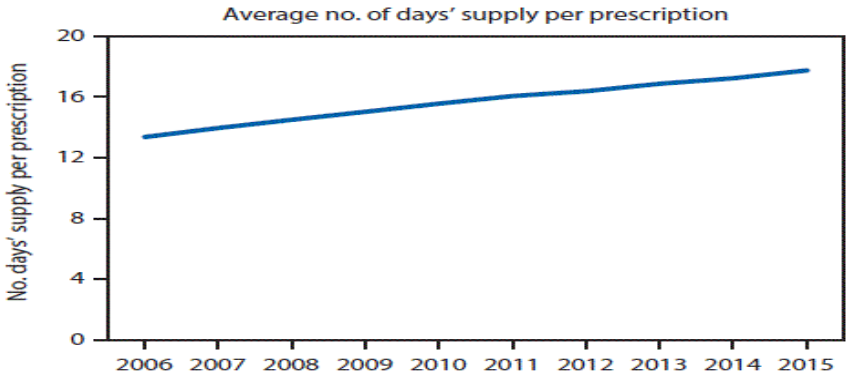


SOURCES: Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration; 1999. QuintilesIMS Transactional Data Warehouse; 2015.









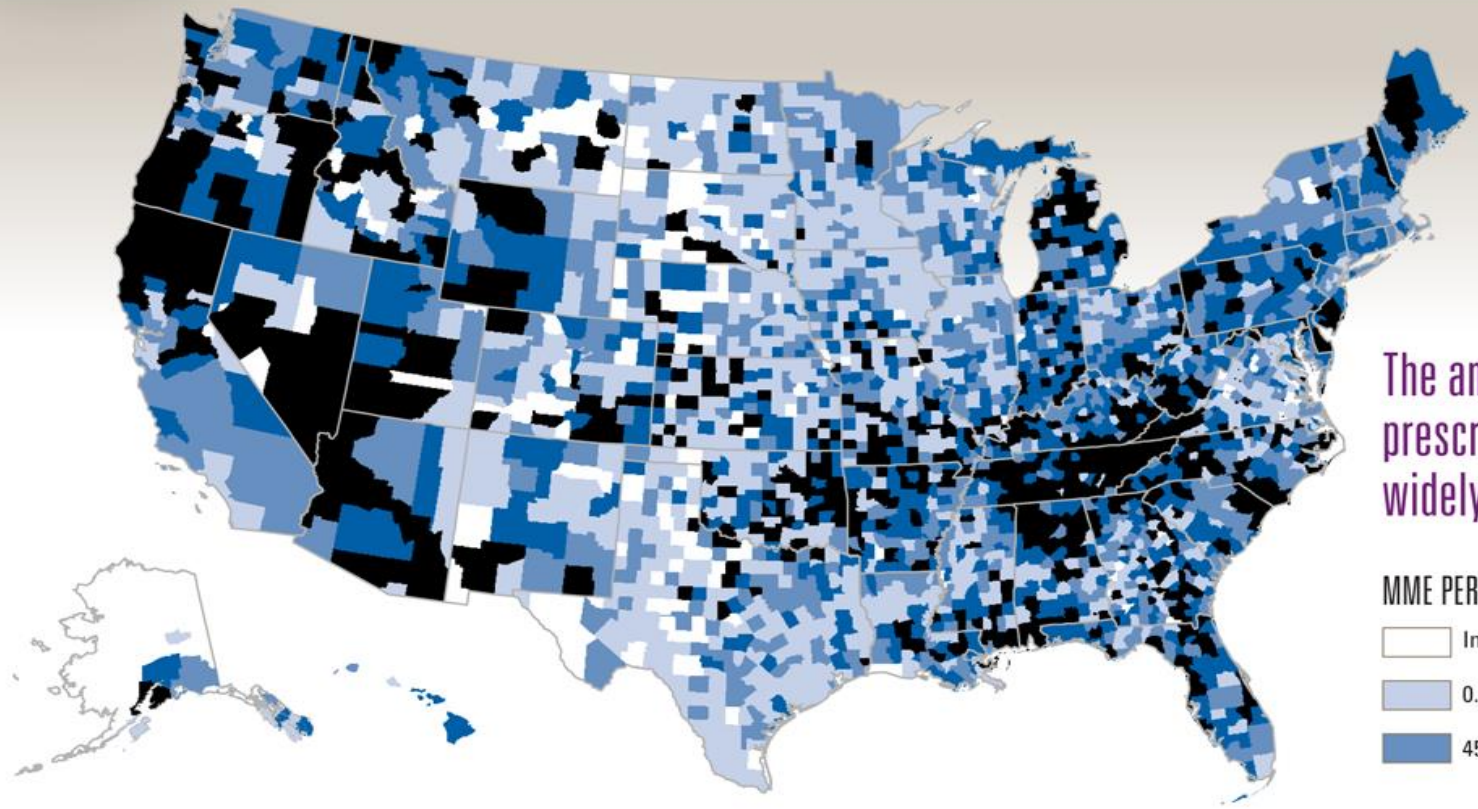
Guy GP Jr., Zhang K, Bohm MK, et al. Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:697–704. DOI: http://dx.doi.org/10.15585/mmwr.mm6626a4

What Leads to Higher Opioid Prescribing?

Some characteristics of counties with higher opioid prescribing:

- Small cities or large towns
- Higher percent of white residents
- More dentists and primary care physicians
- More people who are uninsured or unemployed
- More people who have diabetes, arthritis, or disability

https://www.cdc.gov/vitalsigns/opioids/index.html



The amount of opioids prescribed per person varied widely among counties in 2015.

MME PER PERSON

- Insufficient data
- 0.1 - 453
- 454 - 676
- 677 - 958
- 959 - 5,543

Higher opioid prescribing puts patients at risk for addiction and overdose. The wide variation among counties suggests a lack of consistency among providers when prescribing opioids. The CDC Guideline for Prescribing Opioids for Chronic Pain offers recommendations that may help to improve prescribing practices and ensure all patients receive safer, more effective pain treatment.
SOURCE: CDC Vital Signs, July 2017

Promising actions for safer opioid prescribing.

Problem: High prescribing
Solution: Safer prescribing practices

Problem: Too many prescriptions

In 2015, the amount of opioids prescribed was enough for every American to be medicated **around the clock for 3 weeks.**

(640 MME per person, which equals 5 mg of hydrocodone every 4 hours)

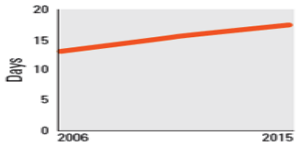
Solution: Fewer prescriptions

Use opioids **only** when benefits are likely to outweigh risks. Options other than opioids include:

- Pain medicines like acetaminophen, ibuprofen, and naproxen
- Physical therapy and exercise
- Cognitive behavioral therapy

Therapies that don't involve opioids may work better and have fewer risks and side effects.

Problem: Too many days



Even at low doses, taking an opioid for more than 3 months increases the risk of addiction by **15 times.**

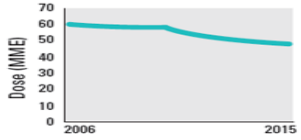
Average days supply per prescription increased from 2006 to 2015.

Solution: Fewer days

For acute pain, prescriptions should only be for the expected duration of pain severe enough to need opioids. **Three days or less** is often enough; more than seven days is rarely needed.

If continuing opioids, ask whether benefits continue to outweigh risks. If not, use other treatments and taper opioids gradually.

Problem: Too high a dose



A dose of 50 MME or more per day **doubles** the risk of opioid overdose death, compared to 20 MME or less per day. At 90 MME or more, the risk increases **10 times.**

Average daily MME per prescription declined both nationwide and in most counties, but it is still too high.

Solution: Lower doses

Use the lowest effective dose of immediate-release opioids when starting, and reassess benefits and risks when considering dose increases.

Avoid a daily dose of 90 MME or more. If already taking high doses, offer the opportunity to gradually taper to safer doses.

For more recommendations when considering opioids for chronic pain outside of end-of-life care, see the ***CDC Guideline for Prescribing Opioids for Chronic Pain.*** The *Guideline* can also be used to inform health systems, states, and insurers to ensure appropriate prescribing and improve care for all people.

www.cdc.gov/drugoverdose/prescribing/guideline.html

SOURCE: CDC Vital Signs, July 2017

South Carolina's Response in 2017

The South Carolina State Boards of Dentistry, Medical Examiners, Nursing and Pharmacy recently approved updated Joint Guidelines to assist practitioners with their prescribing decisions. These Joint Guidelines integrate the principles espoused in the national dialogue with current South Carolina law. The CDC Guideline's 12 Recommendations, with deference to South Carolina statutory requirements, establish the standard of care for prescribers of controlled substances in our state.

Chronic pain shall not be treated by the use of controlled substances through telemedicine. Physicians who establish the physician-patient relationship exclusively via telemedicine must obtain express authorization from the BME to prescribe CIII or CII before prescribing.

12 Recommendations for Prescribers

The recommendations set forth below are divided into three categories:

(1) determining when to initiate or continue opioids for chronic pain;

(2) opioid selection, dosage, duration, follow-up, and discontinuation; and

(3) assessing risk and addressing harms of opioid use.

12 Recommendations for Prescribers

1. **Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.**

12 Recommendations for Prescribers

2. **Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.**

12 Recommendations for Prescribers

3. **Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.**
4. **When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.**

12 Recommendations for Prescribers

5. **When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.**

12 Recommendations for Prescribers

6. **Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.**

12 Recommendations for Prescribers

7. **Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.**

12 Recommendations for Prescribers

8. **Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.**

12 Recommendations for Prescribers

9. **Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.**

Mandatory SCRIPTS for Prescribers

H. 3824, which became effective on May 19, 2017, mandates registration and utilization of SCRIPTS prior to prescribing Schedule II narcotics, with limited exceptions. SC Code Section 44-53-1645(B) exempts the following:

(1) a practitioner issuing a prescription for a Schedule II controlled substance to treat a hospice certified patient;

(2) a practitioner issuing a prescription for a Schedule II controlled substance that does not exceed a five day supply for a patient;

(3) a practitioner prescribing a Schedule II controlled substance for a patient with whom the practitioner has an established relationship for the treatment of a chronic condition; however, the practitioner must review the patient's controlled substance history maintained in the prescription monitoring program at least every three months;

(4) a practitioner approving the administration of a Schedule II controlled substance by a health care provider licensed in South Carolina;

(5) a practitioner prescribing a Schedule II controlled substance for a patient in a skilled nursing facility, nursing home, community residential care facility, or an assisted living facility and the patient's medications are stored, given, and monitored by staff; or

(6) a practitioner who is temporarily unable to access the prescription monitoring program due to exigent circumstances; however, the exigent circumstances and the potential adverse impact to the patient if the prescription is not issued timely must be documented in the patient's medical record.

H. 3824 (2017)

12 Recommendations for Prescribers

10. **When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.**
11. **Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.**

12 Recommendations for Prescribers

12. **Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.**

IT IS YOUR PRESCRIPTION PAD. . .

Prescribing guidelines are simply guidelines.

The decision whether to prescribe controlled substances , specifically opioids, the dosage and duration of prescription is within the prescriber's clinical judgment and discretion.

A complete medical record is your best defense.

Practical Pointers for Pharmacists

The History of Opioids

"The first recorded use of opium, a mixture of alkaloids from the opium poppy (Papaver somniferum) seed, was during the third millennium BC. Opium was later described in the Ebers Papayrus (around 1500 BC.). Paracelsus discovered that opium alkaloids are soluble in alcohol during the 16th century and popularized the use of his preparation, laudanum, for pain and insomnia. Descriptions of opium dependence first began to emerge in the early 18th century. Around the turn of the 19th century, Sertürner isolated the first opiate, morphine, which was used to treat pain and opium addiction. About 7 decades later, heroin was synthesized from morphine and was marketed by Bayer for cough and respiratory illnesses. (Tuberculosis and pneumonia were major health issues at the time.) Heroin was initially claimed to be a nonaddictive alternative to morphine and codeine."

Pharmacists Have Key Role in Combatting Opioid Abuse - Medscape - Apr 07, 2016.

The current epidemic is the result of increased prescriptions of opioids in response to the designation of pain as the “fifth vital sign” in the 1990s and misinformation regarding the addictive risks associated with opioids.

Pharmacists can help reduce the likelihood of opioid misuse, abuse, and diversion while minimizing the impact on legitimate pain management efforts.

- ❖Assess prescriptions that are presented for opioid medications
- ❖Manage patients receiving opioids
- ❖Dispense Naloxone without a prescription, where appropriate
- ❖ Follow-up when misuse, abuse, or diversion has been identified
- ❖Report suspicious prescriptions and/or prescribing behavior

OVERDOSE DEATHS

involving prescription opioids have quadrupled since 1999

As many as 1 in 4 PATIENTS

receiving long-term opioid therapy in a primary care setting struggles with addiction.

Pharmacists are an essential part of the health care team. On the front lines of dispensing opioid pain medications and providing medication-related services, pharmacists can serve as a first line of defense by engaging in prevention and treatment efforts of opioid use disorder and overdose.

Tips for Communicating with Patients

- Ask open-ended questions
- Be empathetic
- Use active listening
- Use clear explanations—avoid jargon
- Include verbal and written materials

SIMPLE WAYS TO START CONVERSATION

- ☑ What medications are you taking?
- ☑ What medications have you taken to manage pain and how did you respond?
- ☑ Describe how you normally take your medications.
- ☑ How well is your medication controlling your pain?
- ☑ Are you experiencing any side effects from your pain medications?
- ☑ In addition to medications, what other ways are you managing your pain?
- ☑ Do you know which medications you should avoid while taking opioids?
- ☑ What questions do you have about your medications?

RESOURCES AND EDUCATION

American Pharmacists Association: www.pharmacist.com/

CDC Injury Prevention and Control Opioid Overdose: www.cdc.gov/drugoverdose/

CDC What Patients Need to Know factsheet: www.cdc.gov/drugoverdose/pdf/aha-patient-opioid-factsheet-a.pdf

Substance Abuse and Mental Health Services Administration: www.samhsa.gov

PDMP Resource: www.namsdl.org/prescription-monitoring-programs.cfm

Drug Enforcement Administration: www.dea.gov/index.shtml

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

www.cdc.gov/drugoverdose

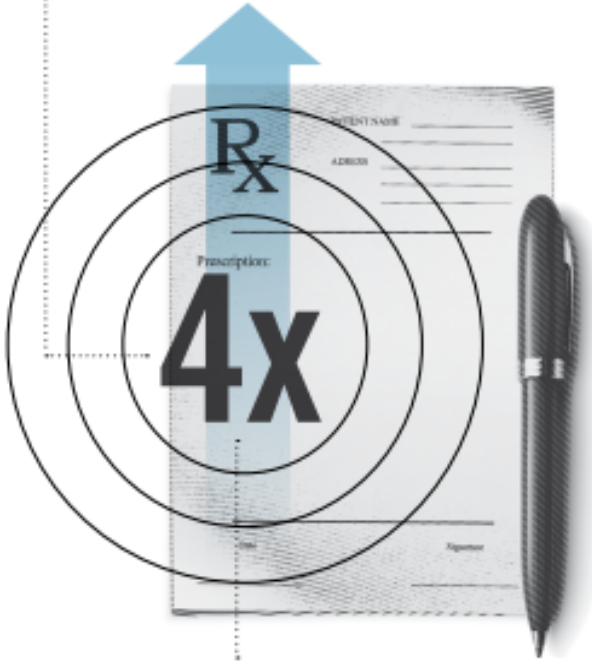
PHARMACISTS: ON THE FRONT LINES

Addressing Prescription Opioid Abuse and Overdose

Sales of prescription opioids in the U.S. nearly

QUADRUPLED

from 1999 to 2014,



but the amount of pain Americans reported remained

UNCHANGED

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

*Recommendations focus on pain lasting longer than 3 months or past the time of normal tissue healing, outside of active cancer treatment, palliative care, and end-of-life care.

In 2014, Nearly

2M

Americans

aged 12 or older, either abused or were dependent on opioids.

BALANCING ROLES

Pharmacists have multiple and complex roles— including evaluating new prescription orders with concurrent treatments, determining whether medication is improperly prescribed, and assessing prescription orders for forgery/alteration. Often faced with limited time and information, pharmacists work to:

- **Assess.** Look for "red flags" that patients might be struggling with opioid use disorder or diverting medications, such as:
  - Forged prescriptions (e.g. lack of common abbreviations or overly legible handwriting)
  - Prescriptions originating from outside the immediate geographic area
  - Altered prescriptions (e.g. multiple ink colors or handwriting styles)
  - Cash payments
  - Inconsistent or early fills
  - Multiple prescribers

The DEA mandates pharmacists assess whether controlled substance prescriptions are written for a legitimate medical purpose in the usual course of professional practice.

- **Verify.** Validate prescriber DEA registration and patient identification.
- **Consult.** If available, check prescription drug monitoring program (PDMP) as well as patient records.
- **Communicate.** Contact the prescriber with questions or concerns, talk to the patient, and submit information to the PDMP, if available.

PARTNERING WITH PRESCRIBERS

Pharmacists and prescribers share a common goal of ensuring safe and effective treatment for patients. The *CDC Guideline for Prescribing Opioids for Chronic Pain* emphasizes patient safety and encourages prescribers and pharmacists to collaborate in integrated pain management and team-based practice models.

Pharmacists and prescribers should apply the guideline and work collaboratively to optimize pain management while preventing opioid use disorder and overdose. Establishing and maintaining collaborative working relationships improves patient outcomes.

PHARMACISTS: PART OF THE TEAM

Managing Pain. The guideline recommends prescribing the lowest effective dose and using caution at any dosage. As medication experts, pharmacists can:

- Educate patients on risks of opioids and ways to manage those risks
- Review and monitor patients' medications in collaboration with prescribers
- Assist in implementing treatment plans with other health care team members
- Provide drug information and recommendations to the health care team

Preventing Abuse. When opioids are prescribed, increase follow-up and frequently assess risks and benefits. Pharmacists can:

- Monitor for signs of aberrant behavior, abuse and diversion
- Use PDMPs to identify patients at increased risk of overdose, such as those taking high dosages or obtaining opioids from multiple prescribers
- Communicate with prescribers about any concerns or unusual behavior observed in patients
- Monitor for risk of overdose, dispense naloxone per authority, and counsel on how to use.

COMMUNICATING WITH PATIENTS

In addition to increasing communication with prescribers, pharmacists talk to patients about the safe use of opioids. Pharmacists can educate patients about:

1. **Proper use:** Discuss how to take medication(s) exactly as prescribed and the risks of using medication inappropriately.
2. **Side effects:** Review most common side effects and stress the importance of reporting them to their prescriber or pharmacist for effective management.
3. **Medication fills:** Discuss and manage expectations regarding refill requirements and the importance of using one pharmacy for all medications.
4. **Stockpiling medication:** Counsel patients about the dangers of saving unused medication.
5. **Safe storage and disposal:** Explain how to safely store and dispose of unused medications to prevent diversion or misuse. Refer to the DEA website www.deadiversion.usdoj.gov/drug_disposal/ for fact sheets and details regarding drug disposal.

New Continuing Education Requirement

In 2015, the S.C. Legislature first required physicians to obtain2 hours of continuing education per the biennial renewal cycle relating to the monitoring and prescribing of controlled substances.

The S.C. Legislature recognized the impact pharmacists can make in combating the opioid epidemic with the passage of H. 3824 in 2017, which imposed a **1 hour per year** continuing education requirement regarding the procedures for monitoring of controlled substances to pharmacists. This legislation also extended continuing education requirements to dentists, optometrists, physician assistants, and podiatrists.

Dispensing Naloxone Without a Prescription

What Is Naloxone?

Naloxone is a medication approved by the Food and Drug Administration (FDA) to prevent overdose by opioids such as heroin, morphine, and oxycodone. It blocks opioid receptor sites, reversing the toxic effects of the overdose. Naloxone is administered when a patient is showing signs of opioid overdose. The medication can be given by intranasal spray, intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection.

Dispensing Naloxone Without a Prescription

- On June 3, 2015, the South Carolina Overdose Prevention Act was enacted, authorizing first responders, such as law enforcement, fireman, and EMS personnel, to carry Naloxone and administer it to a person whom the first responder believed in good faith was experiencing an opioid overdose. Otherwise, Naloxone could only be dispensed by a pharmacist pursuant to a written prescription or a standing order from a licensed prescriber.

South Carolina Overdose Prevention Act

- A year later, on June 5, 2016, in an effort to further reduce opioid-related deaths, an amendment to the Act, Bill H5193, became effective, allowing a person at risk of experiencing an overdose or a caregiver for such person to obtain Naloxone from a pharmacy without a prescription.

South Carolina's Amendment to Allow Naloxone Without a Prescription

The Joint Naloxone Protocol

The Joint Protocol issued by the BME and BOP broadly defines who is "at risk" of experiencing an opioid-related overdose to include the following:

- Current illicit users or non-medical opioid users or persons with a history of such use
- Persons with a history of opioid intoxication or overdose and/or emergency medical care for acute opioid poisoning
- Persons with an opioid prescription
- Persons from an opioid detoxification and mandatory abstinence program
- Persons entering methadone maintenance treatment programs (for addiction or pain)
- Persons who may have difficulty accessing emergency medical services

The Joint Naloxone Protocol

Naloxone saves lives by blocking the opioid's effects. Not only is Naloxone safe but also easy to use. The Joint Protocol permits a pharmacist to dispense Naloxone as either a nasal spray, the preferred method, or in liquid form that can be injected into the shoulder or thigh, without a prescription.

The South Carolina Board of Medical Examiners and the South Carolina Board of Pharmacy's Joint Protocol to Initiate Dispensing of Naloxone HCI Without a Prescription

NaloxoneSavesSC.org

A website has been created to provide information regarding Naloxone and support to pharmacists and the public who may need to obtain Naloxone without a prescription.

NaloxoneSavesSC.org

Features of the website include:

- Resources for Dispensers, including Patient Education Materials and FAQS for Pharmacists
- Information about where to get Naloxone (for consumers)
- General information
- The Joint Protocol
- Naloxone Dispensing Form, by which pharmacists may report dispensing
- Naloxone Dispensing Participation Form
  - Pharmacists may notify the Board of Pharmacy of their voluntary participation by executing this online form
- Naloxone Reversal Survey
  - Naloxone users may anonymously and voluntarily report their use of Naloxone online
- Overdose FAQs
- Resources

A Few Reminders for Pharmacists

- Prescribers who establish the physician-patient relationship exclusively via telemedicine may **not** prescribe CII or CIII substances without express permission from the BME before prescribing.
- Pharmacists should notify law enforcement, SC DHEC Bureau of Drug Control and LLR whenever fraud or improper prescribing is identified.
- Pharmacists should communicate with prescribers regarding any concerns before dispensing.

The Opioid Epidemic and Impaired Professionals in South Carolina

Healthcare Workers Are Not Immune

South Carolina Department of
Labor, Licensing and Regulation

Number of Licensees by Profession*

- **Dentists: 3,198**
- **Nurses: 81,254**
  - **APRN: 6,614**
  - **RN: 62,325**
  - **LPN: 12,315**
- **Pharmacists: 8,472**
- **Pharmacy Technicians: 9,553**
- **Physicians: 19,807**
- **Physician Assistants: 1,742**

TOTAL: 124, 026

* Data provided by LLR and current on September 5, 2017

Drugs of Choice of Impaired Dentists, Nurses Pharmacists, and Physicians Enrolled in RPP (2015-2017)

Professional Board	Number Enrolled (2015-2017)	Year Enrolled	Drugs of Choice
Dentistry	9	2015 (5) 2016 (3) 2017 (1)	Alcohol, Fentanyl, Hydrocodone, Hydromorphone , Oxycodone
Medical	57	2015 (29) 2016 (16) 2017 (12)	Alcohol, Amphetamine, Cocaine, Fentanyl, Hydrocodone, and Marijuana,
Nursing	411	2015 (145) 2016 (160) 2017 (106)	Alcohol, Alprazolam, Amphetamine, Buprenorphine, Butalbital, Clonazapam, Cocaine, Diazepam, Fentanyl, Heroin, Hydrocodone, Hydromorphone, Ketamine, Lorazepam, Marijuana, MDMA, Meperidine, Methamphetamine, Methylphenidate, Midazolam, Morphine, Oxycodone, Phentermine, Pseudoephedrine, Tramadol, and Zolpidern
Pharmacy	49	2015 (21) 2016 (16) 2017 (12)	Alcohol, Alprazolam, Amphetamine, Butalbital, Cocaine, Hydrocodone, Lorazepam, Marijuana, Oxycodone, and Tramadol
Total Enrolled (2015-2017):	526		

Data provided by South Carolina Recovering Professionals Program through September 1, 2017.

Trends Observed with Impaired Dentists, Nurses, Pharmacists and Physicians (2015-2017)

- Impaired professionals are presenting with more than one drug of choice.
  - For example, we are now seeing abuse of benzodiazepines and alcohol, with or without an opiate.
- Impaired professionals are mixing prescription and illicit drugs, such as cocaine and heroin.
- Impaired professionals are accessing RPP voluntarily via self-referral and pursuant to disciplinary action.

Trends Observed with Impaired Dentists, Nurses, Pharmacists and Physicians (2015-2017)

- Impaired professionals often have a mental health diagnosis in addition to Substance Use Disorder, such as:
  - ADHD/ADD
  - Anxiety
  - Bipolar Disorder
  - Borderline Personality Disorder
  - Depression
  - Disruptive Behavior Disorder
  - Narcissistic Personality Disorder

Trends Observed with Impaired Dentists, Nurses, Pharmacists and Physicians (2015-2017)

- Impaired professionals are sometimes involved with other adjudicatory processes:
  - Criminal charges
    - Relating to prescription drugs, illicit drugs, domestic violence, firearms, traffic offenses (DUI), fraudulent billing
  - Civil charges
    - Family Court (Divorce and/or Custody Proceedings; Restraining Order)
    - Medical Malpractice/ Abandonment/ Abuse
    - Traffic Accident Claims Arising from Impaired Operation of a Vehicle
    - Trespass
    - Tax Evasion
    - Fraud

Who Reports Impaired Professionals?

- Co-workers
- Employers
- Family Members
- Former Spouses
- Law Enforcement/DHEC Bureau of Drug Control
- Patients
- Pharmacists

SC Recovering Professionals Program

If you are an impaired healthcare worker or know someone who is, please seek professional care.

You may contact SC Recovering Professionals Program:

- 440 Knox Abbott Drive
  Suite 220
  Cayce, SC 29033
  Office Phone: (803) 896-5700
  Fax: (803) 896-5710

  https://scrpp.org/
- Members of the RPP staff are available 24 hours a day, 365 days a year at **1-877-349-2094.**

QUESTIONS?