Nursing Homes and the DEA

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New Process In Nursing Homes In 2009

- The usual Nurse call: Can I have an order for a pain killer for your nursing home patient?
- New twist: We can’t fill that order unless you send a prescription to the nursing home pharmacy too?

The Controlled Substance Act (CSA)
Oct. 27, 1970

- Amendments:

DEA Formed in 1973 to Enforce the CSA

- last practitioner’s manual was updated in 2006
- last rule change in Dec 2007 regarding multiple prescriptions for C-2 (up to 90 day supply)
- statutory responsibilities with respect to controlled prescription drugs are two fold:
  - prevent diversion and abuse of scheduled drugs
  - Ensuring an adequate and uninterrupted supply is available to meet country’s needs

Closed System of Distribution

- The DEA is responsible for ensuring that all controlled substances transactions are done within a closed system of distribution established by congress
- All legitimate handlers (manufacturers, distributors, physicians, pharmacies, and researchers) are thus registered with the DEA and maintain strict accounting for all distributions

Missing Words in the Original Legislation

- Hospital
- Nursing home
DEA Regulations For C2-5 is Best Suited for Outpatient

- Office patient comes in for a visit and signed scripts are given. No refills allowed for C-II and No partial fill unless hospice patient
- Occasional emergency authorization to pharmacy that needs to be coupled with a written script within 7 days which the patient can pick up at the office and take to pharmacy
- Patients get their recommendations and scripts at the same visit
- Providers only write the script once, no order forms, no house pharmacy, no nothing

C3-5 at the Office

- Prescriptions can have refills (up to 5x or up to 6 months whichever comes first)
- Faxes equal original prescription
- Verbal orders to pharmacist are acceptable with no need for signature (provided the pharmacist makes out the script on his or her end)
- The office nurse can act as the agent of the provider and fax signed scripts/refills in.

DEA and Hospitals

- The DEA rules are not applied to the hospitals as they are inpatient
- Hospital pharmacies have checks and balances that address inpatient issues of diversion and tracking of scheduled drugs.
- Nursing homes have similar checks and balances but yet the DEA treats them as outpatient instead and tries to make the system work by providing them few exceptions i.e. faxed C-2 and signed orders with conditions

Pharmacy Difference Between the Hospital and Pharmacy

- The house pharmacy is located on site in hospitals and offsite in NHs, but both maintain integrated closed systems with their facilities.
- Nursing home residents have a choice of pharmacy which is rarely used and most facility patients use the default house pharmacy

What Happened in 2009?

- NO amendment to the CSA
- NO NEW DEA Rules
- Existing DEA rules were strictly enforced for the first time in nursing homes in the midwest (MI, OH, and most recently WI)
- National pharmacies like Omnicare and Pharamerica were cited for dispensing drugs without a prescription (dispensing with doctors’ orders only)

Worst Case Scenario

Waltz pharmacy in ME waited a few months then enforced the regulations beyond what the national pharmacies were doing to comply with the DEA and avoid the $10,000 per script fines

- Refusing to call providers for emergency authorization for telephone orders unless the patient is in a “true” clinical emergency. Rules do state “emergency situation”.
- Not accepting signed nursing home orders in lieu of scripts
- Requiring signed scripts for C2-5
DEA and Nursing Homes
(the Old Way)

Prior to 2009, The DEA rules were considered applicable to NHs but enforcement was non-existent because people in the know knew the inherent incompatibility between rules and setting

Some Exceptions in the rules do exist for NHs, such as:
- The ability to fax scripts
- Use signed orders as scripts provided they have the same info as a script
- Allow partial fills for nursing home patients (not assisted living) although some pharmacies like Waltz refuse to acknowledge that

Nursing Homes and C2 Orders Up to Now

All written orders are treated as scripts but pharmacy sends the facility/providers a form that includes the order in script format (continuance of therapy script) which is signed within 7 days of the order

30 day supply is sent if specified otherwise the script was valid for 7 days supply.

Renewal script form is sent to facility/office every 60 days called “continuance of therapy prescription”

DEA (New) and the Nursing Homes

Nurses can not act as the agent of the doctor in carrying out verbal/telephone orders without having a written prescription

All orders for scheduled drugs in Nursing Home charts must be coupled with signed prescriptions

A new script is needed for every change in the original order i.e. change in dosage or frequency

Hospital prescriptions can be used (provided they are not changed)

i.e. oxy 5-10 q4-6 hours can not be changed to 5 q 4h prn unless a new script is provided

The scripts are faxed to the pharmacy then the providers still get the usual pharmacy form/script to sign and claim that

E-Box Use

The customary 2 nurse sign off on any C-2 drug dispensing from the E-box

The DEA requires a signed prescription prior to such dispensing from the Emergency box

“Emergency script” before an emergency dispense

Recent charges filed against Pharamerica in Milwaukee for “dispensing without physician authorizations

The strict interpretation means a separate verbal emergency authorization in addition to existing signed scripts or previous authorization, for each time the emergency box is used.
Just When You Think You’re Done Complying

Waltz pharmacy request to one of our facilities a few weeks ago.

- Can you ask your providers to write the narcotics order on a separate order/script form?
- An increase of Oxycontin to 50mg had to be written as two scripts one for 40 and one for 10 in addition to the written and signed order in the chart. The part D insurance was confused as to which script was the latest, the 40mg or the 10mg.

Is The DEA Criminalizing Routine Care In Nursing Homes (In The News)?

“Nursing homes, drug firm questioned on dispensing of drugs”

- By John Diedrich of the Journal Sentinel
- Posted: Sept. 6, 2009
- Milwaukee, WI

1st Paragraph of the article (Milwaukee)

“Several nursing homes in Wisconsin may have been providing powerful prescription drugs such as Fentanyl and OxyContin to patients without a doctor’s authorization, in violation of federal rules, according to documents filed in federal court.”

This is in reference to E-box emergency dispense based on doctors’ written or verbal orders (but no signed script provided for each e-box access). Two nurses co-signed each time the e-box is used based on orders.

Assisted Livings

Not recognized as facilities at all

- Patients are essentially living at home and should be seeing the doctors at an office setting
- No faxed scripts from the facility for any scheduled drugs is acceptable
- All orders in the charts for scheduled drugs need a hard script sent to the pharmacy

Are they really braking the law intended to limit abuse and diversions?
Impact of DEA Rules On Pain Control Initiatives

- Less aggressive pain management in NHs is expected as the bureaucratic and logistical burden associated with the use of narcotics multiplies.
- Any change of order have the same requirements as new narcotic orders if we follow the letter of the law. This may result in less changes even if pain is not controlled.
- Hospital discharge scripts are left unchanged even if the drug or the dosage/interval is undesirable.

DEA Rules Impact On DEA Goals Of Abuse Prevention

- The application of the standard outpatient rules in nursing home setting:
  - Distracts from focusing on drug diversion which is the major abuse issue in nursing homes.
  - Creates a new way of abuse through theft of the hard scripts filed in charts that cannot be tracked properly.

Impact on Geriatrics

- Makes recruiting geriatricians to nursing home practices even harder.
- Increasing redundancy in paperwork and with over-the-phone authorizations there is an increased chance of med errors if records are not readily available.
- Increased liability with our scripts and DEA numbers all over the charts.

Impact on Drug Wasting

- Providers are incentivized to write for larger scripts of narcotics each time so that they won't have to give new scripts over and over again.
- No partial fill is allowed except for hospice patients.
- Excess narcotics can not be returned and so they are all destroyed in the facility (by a pharmacist and nurse).
- If you write 30 day supply for an OXY 5mg q3h PRN the facility will get 240 tablets.
- Skilled patients average stay is 2 weeks, you do the math.
Interim Solutions For Nursing Home Providers

- Consider modifying your physician order forms to include the information available on your prescriptions and use them in lieu of scripts.
- Ask the pharmacy to send all the computer generated scripts (based on your orders) to the facility on the same day they receive new orders.

Modified Order Form

New Order Script From Pharmacy

Emergency Authorization After Verbal Orders

- When not on site in the NH and not at the office, instead of calling the pharmacist to initiate an emergency authorization, the pharmacist should be encouraged to call or page the providers.
- This minimizes error rate as the pharmacist has the info and the provider is offsite with limited or no access to the nursing home chart.
- Wait time for providers and need to provide demographic info is minimized

Emergency Authorization Pharmacy Prescription

Two Steps Forward One Step Back
Follow The Leaders But Make Sure They’re Right

Interim Solution (cont.)
- Instead of following verbal orders with a script:
  - Ask the pharmacy to fax to the facility the pharmacy generated script based on your orders.
  - The facility can ensure that those scripts are signed within 7 days and sent back to the pharmacy.

Continuance of Therapy Prescription

Interim Solutions (cont.)
- Consider limiting the use of your tamper proof hard scripts in nursing homes as they are valid if taken to any outside pharmacy by a family member or a staff member. All they have to do is demonstrate that they are care givers for an elderly person and provide an ID.
- Giving hard scripts doesn’t stop the flow of the pharmacy generated scripts that you are asked to sign. Hard scripts become a triple redundancy here.

Last But Not Least

Consider asking the pharmacy to send a continuation of therapy scripts every 30 days instead of every 60 days. The state of Maine requires renewal of narcotics orders every 30 days.

Remember to ask for the continuation of therapy scripts when the pharmacy/nursing homes asks you to write a renewal “script”. The pharmacies did this for years and they can keep doing it. NO DEA VIOLATION there.

When no continuation of therapy scripts are not provided yet the pharmacy is calling the facility for the renewal script raise that in QI meetings.
Need for Long Term Intervention?

- Can pharmacies comply with DEA rules and still meet the needs of nursing home residents and their providers?
  - the illusive answer is “NO”
- Why?
  - Good system, wrong setting

Long Term Solutions

Sign the petition to stop the DEA from criminalizing routine care in nursing homes

Convince congress to intervene to:

- Stop the DEA from applying the rules designed for outpatient setting to nursing homes
- Advise the DEA to treat nursing homes just like hospitals and inpatient rehab facilities
- The DEA to recognize nurses as the agent of providers in nursing home and assisted living setting able to take verbal orders and implement them.

Long Term Solutions (cont.)

- Simplify rules about partial fill for narcotics in nursing homes and assisted living facilities to limit waste and potential abuse when a month or two month supply is sent to the facilities.

If all fails think what else you can do

Other than Geriatric Medicine