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The Misuse and Abuse of Prescription Medications:

Medical Regulation, Prevention and Care Initiatives in New Jersey

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Federation of STATE MEDICAL BOARDS

The Misuse and Abuse of Prescription Medications: Medical Regulation, Prevention and Care Initiatives in New Jersey

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ABSTRACT: Prescription drug abuse is considered the fastest growing drug problem in the United States. The major increase is in unintentional drug overdose from opioid analgesics, which has caused more overdose-related deaths since 2003 than cocaine and heroin combined. The misuse of prescription pills is becoming particularly prevalent among suburban and rural youth in the United States, sometimes leading to heroin addiction and putting this population at a higher risk of blood-borne pathogens where heroin is injected. New Jersey has spearheaded initiatives to address misuse of opioid analgesics. These initiatives, which are part of an overall strategy and include medical regulatory response, are consistent with the newly (2013) updated Federation of State Medical Boards (FSMB) guidelines to better educate physicians and aid in the proper diagnosis and treatment of pain. They address physician prescribing practices, consumer need for safe disposal and treatment, and educational campaigns that target providers and the general public.

Introduction

The abuse and misuse of prescription drugs has emerged as a public health crisis nationwide. The Centers for Disease Control and Prevention (CDC) identified prescription pill abuse as the fastest growing drug problem in the United States. Misuse and abuse of prescription painkillers is expensive: costing the United States an estimated $53.4 billion a year in lost productivity, and medical and criminal justice costs.[1] The major increase is in unintentional drug overdose from opioid analgesics, which have caused more overdose related deaths since 2003 than cocaine and heroin combined. The CDC reports that for every unintentional opioid analgesic death, there are:

- Four hundred sixty-one (461) reported nonmedical uses of opioid analgesics ("nonmedical use" is defined as opioid analgesic use without a prescription or a medical need to take an opioid analgesic.[2])
- One hundred sixty-one (161) reports of drug abuse or dependence.
- Thirty-five (35) emergency department visits.
- Nine (9) people admitted for substance abuse treatment.

The epidemic of prescription drug abuse has triggered a resurgence in heroin abuse by young people. Heroin is a less expensive analogue of prescription pain killers that delivers a stronger high and is currently more readily available than ever in areas with suburban and rural zip codes.[3] The relationship between the abuse of prescription medications and heroin use impacts not only addiction, but has serious consequences for the transmission of blood-borne pathogens, particularly hepatitis C and HIV, through injecting drug use.

This article provides an overview of the increase in prescription pill abuse and consequent heroin abuse epidemic nationally and in New Jersey: a situation analysis followed by theories on the etiology of this epidemic. It then describes the Federation of State Medical Boards (FSMB) policy on the use of opioid analgesics in the treatment of chronic pain and the initiatives implemented by the state of New Jersey to address this epidemic. The article summarizes the prevention, education and care-related initiatives implemented to address prescription pill misuse and abuse, positing that physicians play a key role in addressing this epidemic.

MISUSE AND ABUSE OF PRESCRIPTION PAINKILLERS IS EXPENSIVE: COSTING THE UNITED STATES AN ESTIMATED $53.4 BILLION A YEAR IN LOST PRODUCTIVITY, AND MEDICAL AND CRIMINAL JUSTICE COSTS.

Misuse vs. Abuse

According to the Food and Drug Administration (FDA), "misuse" is when a drug is taken for a purpose other than that for which it was prescribed or when one takes a drug that was not prescribed to him or her. Misuse includes taking a drug in a manner or at a dose that was not recommended by a healthcare professional. The FDA considers misuse to be "abuse" if a drug is taken to get pleasant or euphoric feelings, particularly if taken at higher doses than prescribed. Regardless of intention, both drug misuse and abuse can be harmful and even life-threatening to the individual.

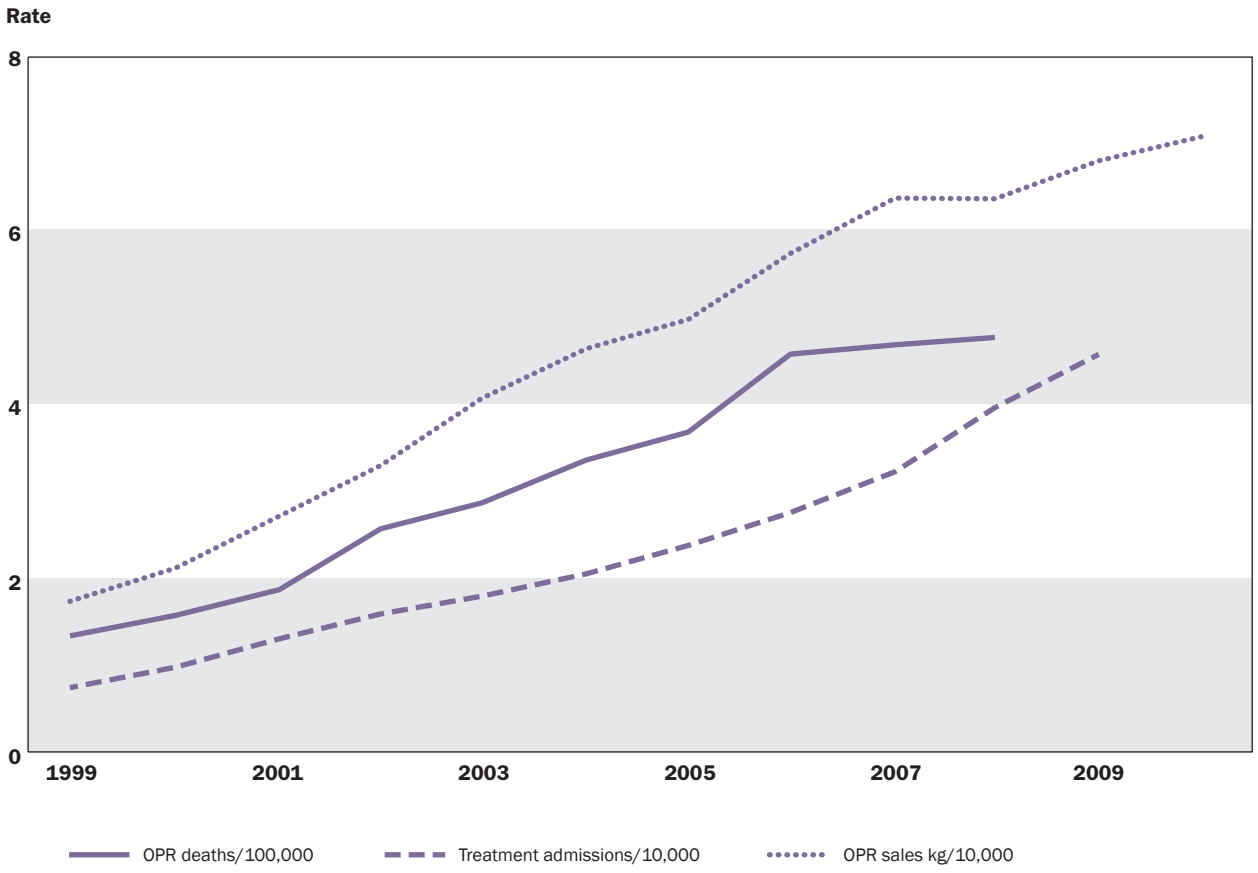
IN 2010, THE NUMBER OF OVERDOSE DEATHS FROM PRESCRIPTION PAINKILLERS WAS GREATER THAN THOSE FROM HEROIN AND COCAINE COMBINED.

Nonmedical Use of Prescription Painkillers: National Trends

In November 2011, the CDC reported deaths from prescription painkillers had reached epidemic levels.[4] In 2010, the number of overdose deaths from prescription painkillers was greater than those from heroin and cocaine combined. According to the CDC, in 2010, about 12 million Americans (age 12 or older) reported nonmedical use of prescription painkillers in the past year. According to CDC, in 2010:

- Nearly 15,000 people died of an overdose involving prescription painkillers.
- 1 in 20 people in the United States (age 12 or older) reported using prescription painkillers for nonmedical reasons.

Figure 1
Rates of Opioid Pain Reliever (OPR) Overdose Death, OPR Treatment Admissions, and Kilograms of OPR Sold, United States, 1999–2010



Source: CDC, MMWR. "Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999—2008" November 4, 2011 / 60(43);1487-1492. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm?s_cid=mm6043a4_w#fig2

- Enough prescription painkillers were prescribed to medicate every American adult around-the-clock for a month.

Drug Overdoses: an Example from New Jersey

Mirroring the trends across the nation, suburban opioid use — both injected and non-injected — in adults less than 26 years of age has become a major public health concern in New Jersey. Prescription drug abuse related mortality increased by 51% in New Jersey from 6.5/100,000 population in 1999 to 9.8/100,000 population in 2010.[5] Drug overdose is now the leading cause of accidental death in New Jersey: in 2009, 752[6] people died from drug overdoses compared to 583[7] who died from motor vehicle-related causes. Deaths are just the tip of the iceberg: while non-fatal overdoses have been described anecdotally, specific statistics on these events are not currently available.

Admissions to drug addiction treatment centers is likely to mirror drug abuse trends in the community. In New Jersey, the number of admissions to drug addiction treatment centers for opioid pill addictions tripled from 2006 to 2011, with more than 8,600 admissions in 2011. Nearly half of these patients were age 25 or younger.[3] Addiction treatment admissions for opiates other than heroin for New Jersey's youth and young adults represented nearly half (46%, 3,304 admissions) of all other opiate use admissions in 2010, and increased a staggering 1,145 admissions from 2009. These admissions are for non-prescription use of methadone, codeine, morphine, oxycodone, hydromorphone, meperidine, opium, and other drugs with morphine-like effects.[8]

Many sources, both published and anecdotal,[9 10] have shown that the use and misuse of prescription pills can lead to heroin addiction. The transition from pills to heroin "happens when the medicine cabinet runs dry and they can no longer afford, on the black market, to use the pill form and transition on to cheap bags of heroin," said John Hulick, head of Governor Chris Christie's Council on Alcohol and Drug Abuse (GCADA). Goldberg and Queally summarized the supply and subsequent transition from pills to heroin quite eloquently: "The [heroin] market was flooded, the price has dropped, and with a generation of young, tech-savvy opiate addicts running low on cash and [prescription] pills, the demand [for heroin] has exploded. There were so many painkillers out there in people's medicine cabinet that it just created a massive wave of heroin users. When the pills became too scarce or too expensive, addicts still needed to get high and so they switched to heroin."

IN NEW JERSEY, THE NUMBER OF ADMISSIONS TO DRUG ADDICTION TREATMENT CENTERS FOR OPIOID PILL ADDICTIONS TRIPLED FROM 2006 TO 2011, WITH MORE THAN 8,600 ADMISSIONS IN 2011.

As a result, heroin addiction treatment admissions for this age group climbed to 5,815 in 2010, more than 1,100 more than in 2005 — despite the fact that heroin admissions for all age groups declined slightly from 2005 to 2010, from 23,377 to 21,942 annually. Heroin remains the primary drug of choice at admission, representing 31.6% of total admissions in 2010.[11]

The demographic profile of these new heroin users is interesting, even surprising: a report by CDC[12] found that admissions for treatment of heroin use decreased among *urban* residents from 2,018 in 1993 to 1,076 in 1999 and increased among suburban/rural area residents from 691 to 1,817. During this period, the number of young heroin users who reported injecting as their usual method of drug use increased substantially among suburban/

Table 1
2009 overdose deaths in New Jersey

Cause	Number of deaths
Prescription opioid overdose	180
Heroin overdose	110
Cocaine overdose	80
Combination of prescription opioids, heroin and cocaine	50
Prescription opioids and heroin	109
Prescription opioids and cocaine	55
Combination of heroin and cocaine	65
Other drugs	103
Total drug overdoses	752

Drug Policy Alliance. New Jersey Overdose Statistics. Available at: http://www.drugpolicy.org/sites/default/files/Overdose%20Prevention%20Campaign%20OD%20Stats%20NJ_0.pdf

rural residents from 232 in 1993 to 920 in 1999; the number of injectors remained approximately the same among urban residents.

Risk of Blood-Borne Pathogen Infection

Injection drug use brings with it risks other than addiction and overdose, if re-using injecting equipment, the user is at risk of acquiring blood-borne infection. The U.S. Department of Health and Human Services described[13] an emerging epidemic of hepatitis C infection among young IDUs in rural and suburban settings. Evidence came from surveillance data shared by Massachusetts in 2010 showing an increase of hepatitis C among persons aged 15–24 between 2002 and 2009. The young people being reported were from all over the state, almost all outside of metropolitan Boston, primarily white, and equally male and female. In-depth interviews with a number of these hepatitis C positive young people uncovered that most were IDUs who had started opioid use by first misusing oral oxycodone around 1–1.5 years before transitioning to injecting heroin.[14]

Injecting drug use can also put the user at risk of HIV infection. The editorial note that followed the Massachusetts study stated: "Although similar increases in human immunodeficiency virus (HIV) infection were not identified for this age group, increases in reports of hepatitis C infection among injection drug users might be a harbinger of increases in IDU-associated HIV."[15]

Unlike Massachusetts, New Jersey has not yet witnessed the acute hepatitis C epidemic[16,17] seen in some other states. Even though acute hepatitis C case reports went up in 2011 and 2012, the overall trend since 2006 has been downward. The

AMONG NONMEDICAL USERS, 76% TAKE MEDICATION PRESCRIBED FOR SOMEONE ELSE AND ONLY 20% INDICATE THEY RECEIVED THE MEDICATION THROUGH A PRESCRIPTION FROM THEIR PHYSICIAN.

drop in the number of hepatitis C case reports is likely due to the same reasons HIV case reports in IDUs are falling: state-wide program efforts to increase users' access to clean syringes through syringe access programs (SAPs) and pharmacies; efforts to promote safer injection practices; and possible changes in risk networks and other social mixing patterns that vary from place to place. Falls in HIV rates have also been due to the effects of antiretroviral therapies on infectivity of IDUs;[18] with the advent of the highly effective anti-Hepatitis C drugs that have become available over the past year, there is optimism that hepatitis C transmission rates will also further fall in coming years.

Although acute hepatitis C reports are still relatively low (71 in 2012), it is important to note that 70% of New Jersey's cases in 2012 were attributed to injecting drug use. This emphasizes the warning that an increase in the rate of injecting drug use could be a harbinger of another HIV epidemic in this population if effective prevention initiatives are not in place.

'WHEN THE PILLS BECAME TOO SCARCE OR TOO EXPENSIVE, ADDICTS STILL NEEDED TO GET HIGH AND SO THEY SWITCHED TO HEROIN.'

Prescribing and Abuse

Given the morbidity and mortality related to prescription opioid misuse and abuse and the consequent abuse of heroin, it is important to discuss some of the factors behind this epidemic as a key to the development of effective strategies to address this crisis. Starting with the role of the physician, it has been speculated that prescribing practices play a central role in opioid analgesic abuse:

- The overwhelming majority, 80%, of patients on these medications receive low dose (<100 mg morphine equivalent dose per day) prescriptions from a single healthcare provider.[19, 20] These patients account for 20% of the overdoses.
- 10% of patients receive prescriptions for high doses (≥100 mg morphine equivalent dose per day) from a single prescriber. These patients are involved in 40% of the opioid overdoses.[21,22]
- The remaining 10% of patients get high daily dose prescriptions from multiple prescribers and account for 40% of the opioid overdoses and are likely diverting these medications to people who use them without a prescription.[23]

- Among nonmedical users, 76% take medication prescribed for someone else and only 20% indicate they received the medication through a prescription from their physician.[24]

What happened?

Since 1999, sales of prescription painkillers in the United States have quadrupled.[25] There are many reasons for this increase, both legitimate and illegitimate. The "modern" field of pain medicine is very new, having developed only in the past two to three decades. Prior to this time, treatments for pain were limited and standardized tools for pain assessment were non-existent. It is now recognized that pain has been both significantly under-treated and under-recognized. Based on this new assessment, the medical community sought to improve the care of patients by ensuring their pain was recognized and treated.[26]

Campaigns to change the former to the current perspective led and sustained the trend to prescribe more painkillers. One that has received inadequate attention is the "Pain as the 5th Vital Sign" campaign that the Veterans Health Administration launched in 1999, and the Joint Commission pain awareness campaign launched in 1996. The

SOME QUESTION...WHETHER PAIN MANAGEMENT HAD BEEN IMPROVED BY REDEFINING IT AS THE 5TH VITAL SIGN.

Joint Commission's website states, "On January 1, 2001, pain management standards went into effect for Joint Commission accredited ambulatory care facilities, behavioral health care organizations, critical access hospitals, home care providers, hospitals, office-based surgery practices, and long term care providers. The pain management standards address the assessment and management of pain. The standards require organizations to: recognize the right of patients to appropriate assessment and management of pain; screen patients for pain during their initial assessment; and, when clinically required, during ongoing, periodic re-assessments educate patients suffering from pain and their families about pain management."[27] Some question, however, whether pain management had been improved by redefining it as the 5th vital sign.[28]

A second issue in the prescription drug abuse debate is the increasing emphasis on patient satisfaction, a poorly described concept that has nonetheless become a common metric when

A SECOND ISSUE IN THE PRESCRIPTION DRUG ABUSE DEBATE IS THE INCREASING EMPHASIS ON PATIENT SATISFACTION, A POORLY DESCRIBED CONCEPT THAT HAS NONETHELESS BECOME A COMMON METRIC.

discussing health care quality.[29] Doctors complain that trying to improve patient satisfaction often results in pressure to do things that may not be in the best interest of the patient's health. This was underscored by a study that showed improved patient satisfaction correlated with increased mortality.[30] The current consumer model of health care combined with the above factors has certainly contributed to the increased use of pain medications that may be addictive and contribute to the problem.

Some reports blame the black market supply of prescription painkillers on unscrupulous, yet licensed physicians who practice "improper prescribing of pain medication." Florida, in particular has become the haven of black marketers because of its inadequate tracking and monitoring of prescription pain relieving medications.[31] But it happens in many other states as well. According to a report from the State of New Jersey Commission on Investigation "Some medical management companies with names that incorporate benign terms like "pain management" and "wellness" have transformed street-corner drug-dealing into an orderly and seemingly ordinary business endeavor, except for the hidden financial backing from individuals linked to organized crime, the multiple bank accounts for money-laundering, the expert help of corrupt physicians and the shady characters who recruit and deliver customers and provide security."[3]

FSMB Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain

The Federation of State Medical Boards (FSMB) has long been concerned with the appropriate diagnosis and treatment of chronic pain. In 1997, in order to better educate physicians and aid in proper diagnosis and treatment of pain, the FSMB

developed guidelines to encourage state medical boards to adopt policies encouraging safe and effective use of opioids. The FSMB updated its guidelines in 2004 and again in 2013; the most recent update emphasized inadequate treatment and the inappropriate use of opioids.[32]

The policy emphasizes the professional and ethical responsibility of physicians to appropriately assess and manage patients' pain, assess the relative level of risk for misuse and abuse, monitor for aberrant behaviors and intervene as appropriate. Under-treatment of pain is recognized as a serious public health problem. The following factors contribute to the difficulty of chronic pain management:

PATIENTS SHARE WITH PHYSICIANS A RESPONSIBILITY FOR APPROPRIATE USE OF THEIR PAIN MEDICATION. THIS RESPONSIBILITY INCLUDES PROVIDING THE PHYSICIAN WITH TRUE INFORMATION AND COMPLYING WITH THE MEDICAL INSTRUCTIONS.

- Physicians' lack of knowledge, including a limited experience in working with savvy drug users.
- Conflicting clinical guidelines.
- Concerns of scrutiny by regulatory authorities.
- Fear of causing addiction or being deceived by a patient who seeks drugs for purposes of misuse.[33]

Patients share with physicians a responsibility for appropriate use of their pain medication. This responsibility includes providing the physician with true information and complying with the medical instructions and contract guidelines. The *Model Policy* also provides the state medical boards with guidelines for physicians to follow to adhere to the accepted best clinical practices.[34]

Physicians are held liable to determine if opioids are clinically indicated and to discuss possible risks and benefits of therapy. The decision to begin opioids should be a shared decision of the physician and patient after such a discussion. Given the possibility of addiction, the physician must monitor for signs of potential abuse, and when appropriate, make dose reductions or wean off the opioid. The dose should be as low as possible and continue only if beneficial effects and pain relief are achieved. The state prescription drug monitoring program should be checked in advance of prescribing opioids and should be monitored throughout the course of management.[35]

The FSMB *Model Policy* defines the usual course of professional medical practice:

- A legitimate physician-patient relationship must exist.
- The medical management of pain should reflect current knowledge of evidence-based or best clinical practices for the use of pharmacologic and nonpharmacologic modalities, including the use of opioid analgesics and nonopioid therapies.
- Prescribing needs to be based on careful assessment of the patient and their pain through a history, physical examination, and diagnostic work-up.
- Medication prescribing or administration should be appropriate for the diagnosis, and should include careful follow-up monitoring of the patient's response to treatment as well as his or her safe use of the prescribed medication, and should demonstrate that the therapy has been adjusted as needed. This should be documented as should appropriate referrals as necessary.
- The choice of treatment modalities (including the quantity and frequency of medication doses) should be adjusted according to the nature of the pain, the patient's response to treatment, and the patient's risk of potential misuse or abuse.[36]

As of March 2012, 57 of 70 state medical boards had policy, rules, regulations or statutes reflecting the FSMB's *Model Policy for the Use of Controlled Substances for the Treatment of Pain*.[37] It is important to understand the extent to which FSMB policies have been implemented and a state-by-state comparison of the effectiveness of these programs; however such an analysis is beyond the scope of this article.

THE MOST RECENT TRUST FOR AMERICA'S HEALTH REPORT RANKS NEW JERSEY AS HAVING THE 11TH LOWEST DRUG OVERDOSE DEATH RATE IN THE UNITED STATES.

New Jersey's Response

The most recent Trust for America's Health report ranks New Jersey as having the 11th lowest drug overdose death rate in the United States. The report ranked states according to their proactive and effective strategies for addressing prescription drug abuse. New Jersey received seven on a scale of 10 possible points, ranking it 18th in the country. Initiatives to address the misuse and abuse of drugs have had a great deal of support in both New Jersey's public and private sectors. New Jersey's approach to addressing the prescription pill, heroin and other opioid drug abuse epidemics has been a collaboration between the New Jersey Board of Medical Examiners (BME), Department of Health, GCADA, the Division of Consumer Affairs, Department of Human Services, Department of Public Safety,

INITIATIVES TO ADDRESS THE MISUSE AND ABUSE OF DRUGS HAVE HAD A GREAT DEAL OF SUPPORT IN BOTH NEW JERSEY'S PUBLIC AND PRIVATE SECTORS.

Commission of Investigation, the Attorney General's Office, county prosecutors, the public and press.[38] New Jersey's comprehensive state-wide approach includes medical regulation as well as the following:

- **Education:** The New Jersey Division of Consumer Affairs has taken the lead on education targeted to the public and to prescribers as well as continuing medical education initiatives. These initiatives include enduring materials (such as the Department of Health's biannual publication "New Jersey AIDSLine"), regional symposia (e.g., "Do No Harm"), lectures and hospital grand rounds.
- **Prevention:** New Jersey has implemented public education initiatives such as "Project Medicine Drop," "American Medicine Chest Challenge," "National Prescription Drug Take-Back Day," and a database that guides prescribers in determining if a patient is potentially drug seeking (prescription monitoring program), all of which are described below.
- **Treatment access:** New Jersey has expanded Medicaid to increase the availability of addictions treatment services. The Overdose Prevention Act makes available the drug naloxone to reverse an overdose after it has occurred and provides legal protection for those who call 911 in an overdose situation. Both are described below.

1. ***Medical Regulation:*** New Jersey has not adopted the FSMB *Model Policy* in its entirety; however many aspects of the policy have been incorporated into New Jersey's comprehensive response. The BME controlled and dangerous substances (CDS) prescribing requirements follow the *Model Policy* emphasis on the professional and ethical responsibility on physicians to diagnose, assess and appropriately treat pain as well as to minimize the risk of the misuse and abuse of prescription drugs.

   Consistent with the FSMB's policy, the BME requires physicians to have a bona fide doctor-patient relationship with persons to whom they prescribe CDS. This includes a thorough initial assessment, with a complete history, physical examination, assessment and plan, as well as proper medical record documentation. New Jersey also requires prescribers to have a CDS registration in addition to their U.S. Drug Enforcement Administration (DEA) registration to prescribe CDS. The BME expects appropriate monitoring of patients on opioids to reduce risk of abuse. The BME encourages prescribers to use the prescription monitoring program to make sure that patients are not getting opioids from other prescribers. Deviations from the standard of care, if necessary, can be addressed through disciplinary action. The BME is actively involved in prescriber education related to the proper use of opioids. The BME holds physicians accountable for their quality of care, including CDS prescribing through its investigatory and disciplinary process.

2. ***Prescription Monitoring Program:*** Nationally, prescription monitoring programs were created through funding from Congress through the Fiscal Year 2002 United States, Department of Justice Appropriations Act (Public Law 107-77). Their purpose is to help prevent and detect the diversion and abuse of pharmaceutical controlled substances by enhancing the ability of regulatory and law enforcement agencies to collect and analyze controlled substance prescription data. Prescription monitoring programs focus on the retail level, where prescribed medications are purchased.[39]

The New Jersey Prescription Monitoring Program (NJPMP), established by New Jersey law (N.J.S.A. 45:1-45 et. seq.), is a statewide database for the collection data for prescriptions filled by the pharmacy for CDS and human growth hormone (HGH) dispensed in outpatient settings in New Jersey and by out-of-state pharmacies dispensing into New Jersey. Pharmacies are required to submit this data at least every two weeks, but physician participation as legislatively required is voluntary.[40] Mandatory physician participation would require a legislative change in New Jersey.

NJPMP access is granted to prescribers and pharmacists who are licensed by the state of New Jersey and in good standing with their respective licensing boards. Prior to prescribing or dispensing a medication, qualified prescribers and pharmacists registered to use the NJPMP are able to access the website and request the CDS and HGH prescription history of the patient. Users must *certify before each search* that they are seeking data solely for the purpose of providing healthcare to a specific, current patient. Authorized users agree that they will not provide access to the NJPMP to any other individuals, including members of their staff. The patient information is strictly confidential, in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules.[41]

Unauthorized access of the New Jersey PMP is prohibited by N.J.S.A. 45:1-49. Prescribers or pharmacists who access or disclose NJPMP information for any purpose other than to provide healthcare to a current patient or to verify the record of prescriptions issued by the prescriber are subject to civil penalties of up to $10,000 for each offense and disciplinary action by the prescriber's or pharmacist's professional licensing board. The same penalties apply if a prescriber or pharmacist allows another individual to access the NJPMP using his/her access codes.[42] Any individual concerned that confidential information may have been accessed for an unauthorized purpose can contact the New Jersey Division of Consumer Affairs.

THE NJPMP INFORMATION CAN BE USED BY INDIVIDUAL REGISTRANTS TO DO A SELF LOOKUP TO ASSESS THEIR PRESCRIBING PRACTICES AND TO DETERMINE IF PRESCRIPTIONS HAVE BEEN FILLED THAT HAVE NOT BEEN WRITTEN BY THEM...

The NJPMP information can be used by individual registrants to do a self lookup to assess their prescribing practices and to determine if prescriptions have been filled that have not been written by them, for example, through prescription blank theft. Prescription blank theft needs to be reported to the police, DEA, NJPMP and the BME. There are anecdotal instances in which prescriber self lookup has identified prescription blank theft through this mechanism, appropriately reported it, and the NJPMP was able to alert pharmacies about the theft. Prescribers can also use the NJPMP to confirm the patient's drug history, document therapeutic regimen compliance and detect if their patient is also getting CDS prescriptions from other prescribers. Registered prescribers currently complete over 120,000 patient lookups monthly.

ALTHOUGH PRESCRIPTION MONITORING PROGRAMS, SUCH AS NJPMP, ARE STATE-BASED, INFORMATION SHARING AMONG STATES IS A NATIONAL PRIORITY.

As with all prescription monitoring programs, patient information in the NJPMP is intended to supplement an evaluation of a patient, confirm a patient's prescription history, or document compliance with a therapeutic regimen. When prescribers or pharmacists identify a patient as potentially having an issue of concern regarding drug use, they are encouraged to help the patient locate assistance and take any other action deemed appropriate.[43] For persons for whom drug treatment is appropriate, New Jersey increased access to drug treatment through expanded Medicaid and a list of licensed drug treatment sites is readily available on the New Jersey Department of Human Services web site.

Although prescription monitoring programs, such as NJPMP, are state-based, information sharing among states is a national priority. The Bureau of

Justice Assistance has developed policy and technology to enable interstate sharing of the information in this program.[44] New Jersey has a formal agreement with other states, such as Connecticut, for data sharing. Additional data sharing agreements are in process.

3. ***Project Medicine Drop:*** New Jersey also provides consumers with a way to dispose of unused medications and to keep medications safe within their homes. Project Medicine Drop allows consumers to dispose of unused and expired medications anonymously, seven days a week, 365 days a year, at "prescription drug drop boxes" located within the headquarters of participating police departments in each of the 21 counties in New Jersey. The participating police agencies maintain custody of the deposited drugs, and dispose of them according to their normal procedures for the custody and destruction of controlled dangerous substances. One-day events are also available statewide through the U.S. Drug Enforcement Administration's National Take-Back Initiative and the American Medicine Chest Challenge, which is sponsored in New Jersey by the DEA, Partnership for a Drug Free New Jersey, and Sheriffs' Association of New Jersey. Both Project Medicine Drop and the American Medicine Chest Challenge (described below) provide single-day opportunities to drop off unused medications at pre-identified, secure locations.[45]

4. ***The American Medicine Chest Challenge:*** The American Medicine Chest Challenge raises awareness about the adverse consequences of prescription drugs. It includes an annual nationwide day of disposal, the second Saturday of November, when unused, unwanted and expired medicine can be taken to a collection site or collected from the home for proper disposal. It is a partnership between community based public health organizations with law enforcement.[46]

5. ***The National Prescription Drug Take-Back Day:*** The National Prescription Drug Take-Back Day is an annual event that provides a safe, convenient, and responsible means of disposing of prescription drugs. Like the American Medical Chest Challenge, it also provides education on the dangers and potential abuse of prescription drug use.[47]

6. ***Education campaigns:*** Education is an important component of the New Jersey response. "The Right Prescription for New Jersey," is an educational campaign for the public during which the State of New Jersey Commission on Investigation, along with the DEA, the Partnership for a Drug-Free New Jersey and other entities, produced multi-media advertisements, including a radio message from a New Jersey woman who lost her son to a prescription-pill overdose.[3] A medical education campaign has also been implemented with presentations at medical organizations, continuing medical education (CME) enduring materials, and CME presentations to prescribers. This is consistent with the FSMB approach to education as outlined in "Responsible Opioid Prescribing: A Clinician's Guide," a CME enduring material to teach clinicians how to decrease abuse, addiction and diversion when prescribing opioids to treat pain.[48]

7. ***Overdose Prevention Act:*** On May 2, 2013, Governor Christie signed into law the Overdose Prevention Act (P.L. 2013, c. 46, N.J.S.A. 24:6J-1 et seq.), also referred to as the Good Samaritan Law. New Jersey is now the 12th state to enact protections for "Good Samaritans" in drug overdose cases. The Overdose Prevention Act allows people to call 911 when a friend or neighbor is overdosing and they will not be liable for drug use or possession charges for calling the police. In addition, the statute expressly recognizes that greater availability and accessibility of the drug naloxone hydrochloride, an opioid antidote (Narcan), would "reduce the number of opioid overdose deaths and be in the best interests of the citizens of this State." The legislation specifically endorses distribution of naloxone to those who themselves are at-risk for an opioid overdose and to "members of their families or peers and persons in a position to assist."[49]

PROJECT MEDICINE DROP ALLOWS CONSUMERS TO DISPOSE OF UNUSED AND EXPIRED MEDICATIONS ANONYMOUSLY, SEVEN DAYS A WEEK, 365 DAYS A YEAR, AT 'PRESCRIPTION DRUG DROP BOXES.'

The Act, under certain circumstances, provides immunity from civil and criminal liability for non-healthcare professionals who administer naloxone or any similar acting FDA approved medication, to someone whom they believe is having an opioid overdose. The Act also provides civil, criminal, and professional disciplinary immunity for health-care professionals and pharmacists involved in prescribing or dispensing the opioid antidote.[50]

In March 2014 the BME approved a rule proposal to ensure that physicians understand that they are relieved of certain obligations when prescribing naloxone to first responders or to the family and friends of a person at-risk. Under the Act, the prescription may be issued in the name of a person who is not the intended end-user of the medication. Accordingly, there is no need for an examination before or follow-up after the issuance of the prescription, as required by existing BME rules. In addition, while awaiting the adoption of this rule relaxation, on April 9, 2014, the BME issued a Certificate of Waiver to all physicians licensed by the BME, waiving enforcement of these rules as to prescriptions to those not intended to be the end-user of the medication, in order to facilitate the implementation of the Overdose Prevention Act.[51] The Certificate of Waiver expires on April 9, 2015 or upon adoption of revised BME regulations.[52]

CONSISTENT WITH THE OVERDOSE PREVENTION ACT, NEW JERSEY IMPLEMENTED A PILOT PROJECT TO ALLOW POLICE AND EMERGENCY MEDICAL TECHNICIANS (EMTS) TO PROVIDE NALOXONE FOR OVERDOSES.

8. ***Drug treatment expansion and Medicaid lock in program:*** New Jersey is also addressing prescription drug abuse from the treatment perspective. The Department of Human Services has lead the Medicaid expansion will provide expanded access to substance abuse treatment and services. Medicaid also has a lock in program in which recipients suspected of misusing CDS are locked into using a single pharmacy and a prescriber. Physicians are required to have a bona fide doctor-patient relationship with persons to whom the CDS is prescribed. This includes a history, physical examination, assessment and plan.[2]
9. ***Patient responsibility:*** Patients are prohibited from withholding information about other prescription medications they take from the prescriber.[2]

New Jersey Pilot Project on Naloxone Use: A Case Study

Consistent with the Overdose Prevention Act, New Jersey implemented a pilot project to allow police and emergency medical technicians (EMTs) to provide naloxone for overdoses. This required collaboration between the New Jersey Department of Law and Public Safety, Division of Consumer Affairs, the New Jersey Department of Health, county prosecutors, and local police. The NJ BME certificate of waiver provided the regulatory ability for physicians to prescribe naloxone to be used by police and EMTs. The Department of Health developed a waiver to allow EMTs to give naloxone. The Division of Consumer Affairs provided training to EMTs and police in all of Ocean County's municipalities; they were taught to identify the symptoms of a drug overdose, how to administer the intranasal naloxone spray, and where to refer drug abusing individuals for care.

The pilot project started in April 2014 in Ocean County, the County with the most overdose related deaths in 2013 (112 in 2013[53]). During the first 7 weeks alone, there were 40[54] successful reversals in Ocean County. Based on the success of the pilot project, Naloxone administration by police and EMTs is being expanded to all 21 counties in New Jersey.

PREVENTION REQUIRES A COMBINED APPROACH BY PATIENTS AND THEIR FAMILIES, HEALTHCARE PROVIDERS, MEDICAL REGULATION, PUBLIC HEALTH, AND LAW ENFORCEMENT TO ADDRESS THIS BURGEONING EPIDEMIC.

Conclusions

Prescription drug abuse is an increasing public health problem. The prevention of prescription drug abuse is primary prevention for the adverse outcomes of addiction, blood-borne pathogen transmission,

transition to illicit drug use, and overdose. Prevention requires a combined approach by patients and their families, healthcare providers, medical regulation, public health, and law enforcement to address this burgeoning epidemic.

Collaboration between medical licensing boards and other governmental agencies can impact this epidemic through the use of naloxone for overdose death prevention, providing tools such as the NJPMP to assist with proper prescribing, providing education, and providing access to treatment. The goal is to prevent more people from becoming addicted, to properly treat those who are addicted and to save lives through first responder naloxone administration.

AREAS FOR FUTURE RESEARCH INCLUDE THE EXTENT OF IMPLEMENTATION OF FSMB POLICY AND ITS IMPACT, ALONG WITH A COMPARISON OF STATE PROGRAMS IN ADDRESSING USE AND ABUSE OF PRESCRIPTION DRUGS.

New Jersey has been publicly recognized for its proactive approach in addressing the misuse and abuse of prescription medications.

Areas for future research include the extent of implementation of FSMB policy and its impact along with a comparison of state programs in addressing use and abuse of prescription drugs. ■

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