# Disruptive Practitioners/ New 2009 TJC Standards & Defending Drugs Charges and Avoiding Malprescribing

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# Disruptive Practitioners

- **OVERVIEW**
  - Disruptive physician behaviors have long been tolerated in part due to administrators worrying about antagonizing a physician who brings patients and revenue into the organization.
  - In addition, physicians were reluctant to counsel their peers particularly around issues related to behavioral compliance.
  - While poor behavior has been tolerated in the past, these behaviors by physicians or other health care staff must be curtailed according to new JCAHO standards effective January 1, 2009.
  - The new standard was developed for all JCAHO accredited providers, including hospitals, nursing homes, ambulatory surgery centers and home health agencies.

# AMA and Disruptive Practitioners

- AMA wanted TJC to delay implementation of disruptive practitioners standards
- AMA had concerns that standards were not full flushed out – hospitals/physicians were not able to adapt the standards to medical staff by-law; how do standards impact employed physicians

# How does disruptive behavior affect care?

- TJC views disruptive behavior as a serious threat to patient safety and overall quality care
- New TJC standard requires a code of conduct which defines acceptable an unacceptable behaviors
- Establishes a formal process for managing unacceptable behaviors

# TJC – LD.03.01.01

- "Effective January 1, 2009 for all accreditation programs, The Joint Commission has a new Leadership standard (LD.03.01.01) that addresses disruptive and inappropriate behaviors in two of its elements of performance:
  - EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.
  - EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors. In addition, standards in the Medical Staff chapter have been organized to follow six core competencies (see the introduction to MS.4) to be addressed in the credentialing process, including interpersonal skills and professionalism."

# TJC Suggested Actions

- TJC Suggested Actions for LD.03.01.01 –
  - **"1. Educate all team members - both physicians and non-physician staff - on appropriate professional behavior defined by the organization's code of conduct. The code and education should emphasize respect. Include training in basic business etiquette (particularly phone skills) and people skills."**
    - Issue will be compliance for these requirements – How do you get doctors/staff to the table to discuss these issues?
      - Luncheons, free meals coupled with training

# TJC Suggested Actions

- TJC Suggested Actions for LD.03.01.01(cont.) –
  - **"2. Hold all team members accountable for modeling desirable behaviors, and enforce the code consistently and equitably among all staff regardless of seniority or clinical discipline in a positive fashion through reinforcement as well as punishment."**
    - This action presents challenges with regard to non-employed physicians.
    - It will be difficult to have equitable treatment among all staff when physicians are disciplined by their peers.
    - Might require amendment of medical staff by-laws to achieve compliance with regard to enforcement/accountability

# TJC Suggested Actions

- TJC Suggested Actions for LD.03.01.01(cont.) –
  - **3. Develop and implement policies and procedures/processes appropriate for the organization that address:"**
    - **"Zero tolerance' for intimidating and/or disruptive behaviors, especially the most egregious instances of disruptive behavior such as assault and other criminal acts. Incorporate the zero tolerance policy into medical staff bylaws and employment agreements as well as administrative policies.“**
      - This concept will require a significant commitment on the part of the medical staff and will clearly turn on the definitions, which are arrived at in discussions between medical staff and hospital administration.

# TJC Suggested Actions

- TJC Suggested Actions for LD.03.01.01(cont.) –
  - **3. Develop and implement policies and procedures/processes appropriate for the organization that address:"**
    - **"Medical staff policies regarding intimidating and/or disruptive behaviors of physicians within a health care organization should be complementary and supportive of the policies that are present in the organization for non-physician staff."**

# TJC Suggested Actions

- TJC Suggested Actions for LD.03.01.01(cont.) –
  - **3. Develop and implement policies and procedures/processes appropriate for the organization that address:"**
    - **"Reducing fear of intimidation or retribution and protecting those who report or cooperate in the investigation of intimidating, disruptive and other unprofessional behavior. Non-retaliation clauses should be included in all policy statements that address disruptive behaviors."**
      - Organizations may wish to consider adding a requirement that reporting "disruptive behavior" includes a certification that the report is made in good faith and without malicious intent.

# TJC Suggested Actions

- TJC Suggested Actions for LD.03.01.01(cont.) –
  - **3. Develop and implement policies and procedures/processes appropriate for the organization that address:“**
    - **“Responding to patients and/or their families who are involved in or witness intimidating and/or disruptive behaviors. The response should include hearing and empathizing with their concerns, thanking them for sharing those concerns, and apologizing."**
      - If an apology is to be given, it should be carefully worded and it is best for you to consult legal counsel before making them. Many states (e.g., Arizona, California, Colorado, Connecticut, Delaware, Georgia, Idaho, Illinois, and Louisiana as well as others) have laws providing some form of protection to such certain types of apologies, often as an evidentiary privilege in subsequent judicial or administrative proceedings.  Louisiana’s “I’m Sorry Law” is found at LSA-R.S. 13:3715.5.

# TJC Suggested Actions

- TJC Suggested Actions for LD.03.01.01(cont.) –
  - **3. Develop and implement policies and procedures/processes appropriate for the organization that address:“**
    - **"How and when to begin disciplinary actions (such as suspension, termination, loss of clinical privileges, reports to professional licensure bodies)."**
    - Decisions on the process for instituting disciplinary actions will obviously vary between individuals who are employees of a healthcare facility and individuals who are on the medical staff, but in private practice.
    - Some healthcare facilities may have a progressive discipline policy already in place or may have a grievance policy in place which would need to be supplemented with regard to disruptive behaviors.
    - Issues concerning loss of clinical privileges would need to be addressed in medical staff bylaws and the process for such disciplinary action would be as set forth in the bylaws.
    - You will need to consult your states statutes to determine when you would be required to report loss of privilege/suspension issues to the Board

# TJC Suggested Actions

- TJC Suggested Actions for LD.03.01.01(cont.) –
  - **"4. Develop an organizational process for addressing intimidating and disruptive behaviors (LD.3.10 EP 5) that solicits and integrates substantial input from an inter-professional team including representation of medical and nursing staff, administrators and other employees."**
    - Input from the medical staff or nursing staff on this topic may be more easily achieved through separate meetings with nursing and medicine or through a formal/informal poll of these individuals.

# TJC Suggested Actions

- TJC Suggested Actions for LD.03.01.01(cont.) –
  - **"5. Provide skills-based training and coaching for all leaders and managers in relationship-building and collaborative practice, including skills for giving feedback on unprofessional behavior, and conflict resolution. Cultural assessment tools can also be used to measure whether or not attitudes change over time."**
  - **"6. Develop and implement a system for assessing staff perceptions of the seriousness and extent of instances of unprofessional behaviors and the risk of harm to patients."**

# TJC Suggested Actions

- TJC Suggested Actions for LD.03.01.01(cont.) –
  - **"7. Develop and implement a reporting/surveillance system (possibly anonymous) for detecting unprofessional behavior. Include ombuds services and patient advocates, both of which provide important feedback from patients and families who may experience intimidating or disruptive behavior from health professionals. Monitor system effectiveness through regular surveys, focus groups, peer and team member evaluations, or other methods. Have multiple and specific strategies to learn whether intimidating or disruptive behaviors exist or recur, such as through direct inquiries at routine intervals with staff, supervisors, and peers."**
  - **"8. Support surveillance with tiered, non-confrontational interventional strategies, starting with informal 'cup of coffee' conversations directly addressing the problem and moving toward detailed action plans and progressive discipline, if patterns persist. These interventions should initially be non-adversarial in nature, with the focus on building trust, placing accountability on and rehabilitating the offending individual, and protecting patient safety. Make use of mediators and conflict coaches when professional dispute resolution skills are needed."**

# TJC Suggested Actions

- TJC Suggested Actions for LD.03.01.01(cont.) –
  - **"9. Conduct all interventions within the context of an organizational commitment to the health and wellbeing of all staff, with adequate resources to support individuals whose behavior is caused or influenced by physical or mental health pathologies.“**
    - ADA may be implicated in this provision – regarding definition of "disability" – if triggered an organization might have limited action to address disruptive behavior

# TJC Suggested Actions

- TJC Suggested Actions for LD.03.01.01(cont.) –
  - **"10. Encourage inter-professional dialogues across a variety of forums as a proactive way of addressing ongoing conflicts, overcoming them, and moving forward through improved collaboration and communication."**
  - **"11. Document all attempts to address intimidating and disruptive behaviors."**

# What is “Disruptive Behavior?”

- **Sample language from a hospital perspective (broad language)**:

- Sample No. 1: "***Disruptive and Inappropriate Behavior***. Disruptive and inappropriate behavior is interaction among hospital personnel, patients, family members or others that interferes or may interfere with patient care or hospital operations. Such behavior includes, but is not limited to, verbal abuse, loud or obscene comments, offensive comments based upon an individual=s gender, race, ethnicity, religion, disability or sexual orientation, misuse of operating room instruments or equipment, or inappropriate or unprofessional physical contact or gestures."

- Sample No. 2: "***Policy:*** All reported incidents of physician/staff disruptive behavior will be referred to the Medical Staff for either information or action.

# What is "Disruptive Behavior?"

- **Sample language from a hospital perspective (broad language)**:
- ***Criteria:*** In an attempt to define physician/staff disruptive behavior, the following are offered as criteria in determining appropriate incidents to be reported:
  - A. Verbal or physical attacks leveled at other appointees to the hospital which are personal and irrelevant, or go beyond the bounds of professional conduct;
  - B. Non-constructive criticism addressed to the recipient in such a way as to intimidate, undermine confidence, belittle or imply stupidity, bad motives, or impugn the competency of the individual;
  - C. Impertinent and inappropriate written comments in the medical record impugning the quality of care of the hospital, or attacking particular physicians, hospital staff or hospital policy;
  - D. Imposing unnecessary demands on hospital staff which have nothing to do with better patient care, but serve only to burden the hospital staff with special techniques and procedures;
  - E. Rude or abusive conduct to other care givers;
  - F. Intentional abuse of hospital property and equipment;
  - G. Rude or abusive behavior to patients or visitors;
  - H. Derogatory comments about physicians, hospital staff, or treatment being given the patient, or about the operation of the hospital; and/or
  - I. Threats and/or physical assaults on physicians, hospital staff, or any others in the hospital."

# What is "Disruptive Behavior?"

- **Sample language from a physician perspective (specific language):**
  - "'Disruptive Behavior' shall mean personal conduct within the facility of HOSPITAL X that is, or is reasonably likely to be:
    - (i) detrimental to patient safety or to the delivery of quality or efficient patient care in HOSPITAL X;
    - (ii) disruptive to hospital operations such that the quality or efficiency of patient care is, or is likely to be, materially and adversely affected;
    - (iii) physical, written, or verbal abuse of others involved with providing patient care or patients;

# What is "Disruptive Behavior?"

- **Sample language from a physician perspective (specific language):**
  - (iv) sexual harassment (defined as unwelcome sexual advances, requests for sexual favors, or verbal or physical activity through which submission to sexual advances is made an explicit or implicit condition of employment or future employment-related decisions; unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with the employee's work performance or which creates an offensive, intimidating or otherwise hostile work environment);
  - (v) unethical under the applicable code of ethics of the STATE LICENSINGBOARD or the STATE MEDICAL SOCIETY;
  - (vi) a felony or a misdemeanor involving moral turpitude; or
  - (vii) contrary to the Medical Staff Bylaws or any rules, policies, standards, or regulations of conduct of HOSPITAL X or the Medical Staff."

# What is "Disruptive Behavior?"

- **Sample language from the American Medical Association (see AMA Ethics Policy**
  - E-9.045(1)): "Personal conduct, whether Verbal or physical, that affects or that potentially may affect patient care negatively constitutes disruptive behavior. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.) However, criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior."

# HOSPITAL'S PERSPECTIVE ON NEW JOINT COMMISSION STANDARDS

## Disruptive Physician Behavior- Hospital Issues

- Hospital Personnel Manuals
  - Disruptive behavior creates a hostile work environment - needs to be examined in light of existing employment manual
  - EEOC Monitor can be point person
  - Hospitals must establish a team approach among all staff at all levels
  - Consider "whistle blower" protection as part of surveillance system (non-retaliation clauses) for "good faith" reporting
- - Medical Staff Bylaws
  - Disruptive and inappropriate behaviors should be grounds for discipline
  - Require certain amount of education hours on this topic to be re-credentialed
  - Incorporate a zero tolerance policy into bylaws
  - Include non-retaliation clause - physicians should not retaliate against hospital personnel who report them in good faith

# HOSPITAL'S PERSPECTIVE ON NEW JOINT COMMISSION STANDARDS

## Disruptive Physician Behavior- Hospital Issues

- Medical Staff Credentialing
  - Interpersonal and communication skills and professionalism should be included in the standards to receive hospital privileges
- - Code of Conduct
  - Hospitals need to have a code of conduct that defines acceptable, disruptive and inappropriate behaviors
- - Risk Management/ Quality Assurance
  - Hospital must regularly evaluate the culture of safety and quality using valid and reliable tools
  - Provide opportunities for all individuals who work in the hospital to participate in safety and quality initiatives
  - Provide education that focuses on safety and quality for all individuals
  - Make literature and advisories relevant to patient safety available to all individuals who work in the hospital
  - Develop processes and policies regarding patient complaints of unprofessional or disruptive behavior
- - Reports to Board of Medicine may be impacted by new guidelines.

# HOSPITAL'S PERSPECTIVE ON NEW JOINT COMMISSION STANDARDS

## Disruptive Physician Behavior- Physician Perspective

- ISSUES RAISED BY THE NEW STANDARDS
  - *Definitions*:
    - How will the Medical Staff define "acceptable and disruptive and inappropriate behaviors"?
    - Will these definitions be the same as those used in hospital personnel policies? (The new standards expand the focus of behavior beyond the Medical Staff.)
    - If a physician is operating under an employment or service agreement (i.e., independent contractor basis) with the hospital that addresses such behaviors, should these definitions be the same?
    - What documents will control if these definitions are not uniform?
    - JCAHO suggests "informal 'cup of coffee' conversations directly addressing the problem and moving toward detailed action plans and progressive discipline"; however, would such informal conversations be excluded from the legal protection of peer review immunity and confidentiality?

# HOSPITAL'S PERSPECTIVE ON NEW JOINT COMMISSION STANDARDS

## Disruptive Physician Behavior- Physician Perspective

- <u>ISSUES RAISED BY THE NEW STANDARDS</u>
  - *Other Effects:* Will these new standards cause a flood of complaints and reports by disgruntled non-physician staff?
  - Should there be a mechanism of accountability when making certain complaints and reports (i.e., whether abusing the reporting system, such as fraudulent reports and reports made in bad faith, should be subject to discipline)?
  - In addition to disciplinary procedures for such behaviors, should there be a mediation-type of process to handle repeated complaints between the same persons? How will a mediation process be woven into a peer review activity and whether such a process would be afforded the same legal protection of peer review immunity and confidentiality?

- Without such a process or controls, there could be ongoing "turf battles" between physicians and non-physician staff.

# **Scenarios -** "Dr. Studly" and Dr. Uptight in the Operating Room

- **Scenario 1 -** Dr. Stuart DaLeigh is a renowned neurosurgeon, who has developed a series of patented medical equipment and devices which he and only a handful of other neurosurgeons are qualified to operate and to implant. General St. Hospital, where Dr. DaLeigh now serves as chief of the medical staff, has invested almost $500,000 and other resources in Dr. DaLeigh and his clinical research. The hospital's investment is beginning to pay dividends. Since Dr. DaLeigh's addition to the medical staff and the public announcements of his patent awards and other medical breakthroughs, the hospital's patient census has had double digit annual increases, research grants are numerous and easily attainable, and highly desired medical subspecialists are now applying by the handfuls for employment positions and for medical staff privileges.

  Not only is Dr. DaLeigh a successful and cutting edge neurosurgeon, he is charismatic and strikingly handsome. In fact, most of the females of the Medical Staff and of the nursing staff have nicknamed him "Dr. Studly" and address him by his nickname whenever patients are not present. At General St. Hospital, the operating room culture is one of sexual jokes, innuendo and flirting. Because of Dr. DaLeigh's "movie star" looks, Dr. DaLeigh has found himself the frequent and aggressive target of such sexual comments. While he has been attracted to many of the females who flirt with him, Dr. DaLeigh has always remained faithful to his girlfriend.

# **Scenarios -** "Dr. Studly" and Dr. Uptight in the Operating Room

Dr. Sally Uptight, a gifted anesthesiologist, joins the surgery team after her grandfather, who is on the board of directors, convinces her that General St. Hospital is a wholesome place for God to work. Unlike the other females in the operating room, Dr. Uptight grew up in a very conservative and religious household. She is unmarried and never had a boyfriend. She is uncomfortable with the sexual nature of the small talk and gestures in the operating room. The physicians and staff in the operating room believe she is a kill joy and tease her that she was the basis for "The 40-Year Old Virgin" movie.

Because Dr. DaLeigh's of nickname, his striking good looks and the sexual comments consistently being directed toward him, Dr. Uptight concludes that Dr. DaLeigh is the ringleader and should be sanctioned. She files a complaint that Dr. DaLeigh has engaged in unprofessional conduct that is disruptive to the safety of patients.

# Overview

- How do DEA investigations of Docs get started?
- Legal Framework
  - Illegal distributions/dispensing CS outside usual course of professional practice (21 USC 841 (a)(1))
  - Internet trafficking (21 USC 841 (h)(1))
- Drugs and chemicals of concern
  - DEA Hit List
- Criminal Schemes
  - Methods of Diversion
  - Doctor Shopping
  - Internet Diversion
  - Prescription Fraud
- Strategies

# New Orleans Crime Scene News
# Doctor pleads guilty to distribution!

## Former doctor pleads guilty in drug case

**by West Bank bureau, The Times-Picayune**

**Friday July 24, 2009, 5:30 AM**

A Plaquemines Parish woman pleaded guilty Thursday to illegally dispensing controlled substances, U.S. Attorney Jim Letten's office said.

Jacqueline Cleggett, 46, faces up to 20 years in prison and up to $1 million in fines after pleading guilty to conspiracy to dispense and distribute controlled substances, including Oxycodone, Alprazolam and Hydrocodone. Sentencing is set for Nov. 4.

Authorities said that from 1999 until early 2002, Cleggett, who was a doctor, ran a pain management clinic on Chef Menteur Highway in New Orleans. Her medical license was later revoked. The clinic operated at unusual hours, from the late afternoon until 2 a.m. or later, authorities said, adding that there was always a large number of patients at her office regardless of the time of day, according to the press release.

In addition, a large number of the cars had Mississippi or Florida license plates, and all payments for visits were on a "cash only" basis, the press release said.

In addition, authorities learned through a joint investigation conducted by the U.S. Drug Enforcement Administration and the Tri-County Narcotics Task Force in Jackson, Miss., that Cleggett had supplied prescriptions for Oxycontin to a group of people who redistributed the drugs throughout Mississippi. Seventeen people eventually were arrested, the press release said.

The case was investigated by the Drug Diversion Unit of the Drug Enforcement Administration. The prosecution is being handled by Assistant United States Attorney Theodore Carter.

# How do DEA investigations of Docs get started?

- Someone is upset with the doctor and/or is concerned about his/her practices
  - Colleagues/competitors
  - Employees
  - Pharmacists
  - Payors
  - Patients
  - Persons harmed by patients
- Confidential Informants (CI)

# Legal Framework: Controlled Substances Act of 1970

- Established a "closed system" of distribution
- Five "schedules" of controlled substances
- Created the Compliance Program (1971) to monitor the legitimate manufacture and distribution of controlled substances
- Clearly differentiated controlled substances from other drugs handled under the FDCA
- Authorized DEA to register dispensers, practitioners and pharmacies
- CSA/Regulations address creation, signature and retention of prescriptions/records

# Legal Framework

- 21 USC 841(a)(1) – dispensing controlled dangerous substances "outside" the usual course of professional practice.
  - What is "outside" the usual course of practice?
    - No physical exam or cursory exam of patient
    - Inordinately large quantities of controlled substances
    - Inordinately large quantities of prescriptions
    - Large numbers of "young" patients with chronic pain
    - Prescription intervals inconsistent with legitimate treatment
    - Physician/Staff using "street" slang
    - No logical connection between the drug and diagnosis/condition

# Legal Framework

- 21 USC 841(a)(1) – What is "outside" the usual course of practice (cont.)?
  - Patients receive same drugs, or combination, regardless of Dx/condition.
  - Physician writes scripts in third party patient names
  - Patients travel long distances to see physician
  - Large amounts of "cash" patients
  - Large amount of narcotic prescribing by Non-pain specialists

# Legal Framework:

## Prescription Requirements

| | Schedule II | Schedule III | Schedule IV | Schedule V |
|---|---|---|---|---|
| Written | Yes | Yes | Yes | Yes |
| Oral | Emergency Only* | Yes | Yes | Yes |
| Fax | Yes** | Yes | Yes | Yes |
| Refills | No | Yes# | Yes# | Yes# |
| Partial Fills | Yes*** | Yes | Yes | Yes |

*Must be reduced in writing, and followed by signed, hard copy of the prescription.

** A signed, hard copy of the prescription must be presented before the medication is dispensed.

*** 72 hour time limitation

# With medical authorizations, up to 5 in 6 months.

# Legal Framework: New Felony Offense Internet Trafficking

21 USC 841(h)(1) – It shall be unlawful for any person to knowingly or intentionally:

- (A) deliver, distribute, or dispense a controlled substance by means of the internet, except as authorized by this title; or
- (B) aid or abet any violation in (A)

# Drugs and Chemicals of Concern

## Drugs and Chemicals of Concern

- **2,5-Dimethoxy-4-(n)-propylthiophenethylamine (2C-T-7)**
  (Street Names: Blue Mystic, T7, Beautiful, Tripstay, Tweety-Bird Mescaline)
- **3,4-Methylenedioxymethamphetamine**
  (Street Names: MDMA, XTC, X, Ecstasy)
- **4-Bromo-2,5dimethoxyphenethylamine**
  (Street Names: 2C-B, Nexus, 2's, Toonies, Bromo, Spectrum, Venus)
- **4-Iodo-2,5-Dimethoxyphenethylamine**
  (Street Names: 2C-I, i)
- **5-Methoxy-N,N-diisopropyltryptamine (5-MeO-DIPT)**
  (Street Names: Foxy, or Foxy Methoxy)
- **Alpha-methyltryptamine**
  (Street Name: Spirals)
- **ANABOLIC STEROIDS**
  (Street Names: Arnolds, Gym Candy, Pumpers, Roids, Stackers, Weight Trainers, Gear, and Juice)
- **Benzodiazepines**
  (Street Names: Benzos, Downers, Nerve Pills, Tranks)
- **N-Benzylpiperazine**
  (Street Names: BZP, A2, Legal E or Legal X)
- **Buprenorphine**
  (Trade Names: Buprenex®, Suboxone®, Subutex®)
- **Carisoprodol**
  (Trade name: Soma®)
- **Clenbuterol**
  (Street Names: Clen)
- **Cocaine**
  (Street Names: Coke, Snow, Crack, Rock)
- **Cyclobenzaprine**
  (Trade Name: Flexeril®)
- **Dextromethorphan**
  (Street Names: DXM, DM, CCC, Triple C, Candy, Robo, Velvet, Rojo)

# Drugs and Chemicals of Concern

- **N,N-DIMETHYLTRYPTAMINE**
  (DMT)
- **d-Lysergic Acid Diethylamide**
  (Street Names: LSD, Acid, Blotter Acid, Window Pane)
- **Fentanyl**
  (Trade names: Actiq®, Duragesic®)
- **Gamma Hydroxybutyric Acid**
  (Street Name: GHB, Liquid Ecstasy, Liquid X, Goop, Georgia Home Boy, Easy Lay)
- **Human Growth Hormone**
  (Trade Names: Genotropin®, Humatrope®, Norditropin®, Nutropin®, Saizen®, Serostim®)
- **Hydrocodone**
  (Trade Names: Vicodin®, Lortab®)
- **Hydromorphone**
  (Trade Names: Dilaudid, Palladone™)
- **Ketamine**
  (Street Names: Special K, "K", Kit Kat, Cat Valium)
- **Kava**
  (Other Names: Ava, Intoxicating Pepper, Kawa Kawa, Kew, Sakau, Tonga, Yangona)
- **KHAT**
  (Street Names- Khat, Qat, Kat, Chat, Miraa, Quaadka)
- **KRATOM (Mitragyna specious Korth)**
- **Methamphetamine**
  (Trade Name- Desoxyn®; Street Names- Meth, Speed, Crystal, Glass, Ice, Crank, Yaba)
- **Methadone**
- **Methylphenidate**
  (Trade Names: Ritalin- (IR, LA, and SR), Concerta, Metadate- (CD and ER), Methylin- (IR and ER) and Focalin- (IR and ER))
- **Nalbuphine Hydrochloride**
  (Trade Name: Nubain®)
- **Oxycodone**
  (Trade Names: Tylox®, Percodan®, OxyContin®)
- **Phencyclidine**
  (Street Names: PCP, Angel Dust, Supergrass, Boat, Tic Tac, Zoom, Shermans)
- **Salvia Divinorum**
  (Street Names: Maria Pastora, Salvia)
- **Spice Cannabinoid**
  - CP 47,497 and homologues
  - HU-210,
  - HU-211,
  - JWH-018,

# Criminal Schemes

- Methods of Diversion
  - Practitioners/Pharmacists
    - Illegal distribution
    - Self Abuse
    - Trading drugs for sex
  - Employee pilferage
    - Hospitals
    - Practitioners' offices
    - Nursing homes
    - Retail pharmacies
    - Manufacturing/distribution facilities
  - Pharmacy/Other Theft
    - Armed Robbery
    - Burglary (Night Break-ins)
    - In Transit Loss (Hijacking)
    - Smurfing
  - Patients
    - Drug rings
    - Doctor-shopping
    - Forged/fraudulent/altered prescriptions
    - The medicine cabinet
  - The Internet

# Criminal Schemes

## The plans that set the process in motion

- Doctor Shopping - Docs are in the "crosshairs"
  - NDIC definition
    - A practice whereby persons who may or may not have legitimate medical conditions visit numerous physicians to obtain drugs in excess of what should be legitimately prescribed
  - Targets for individual patients
    - Physicians – Obtaining prescriptions from multiple physicians. Physicians willing to prescribe controlled substances over an extended period of time with little or no follow up.

# Criminal Schemes

## The plans that set the process in motion

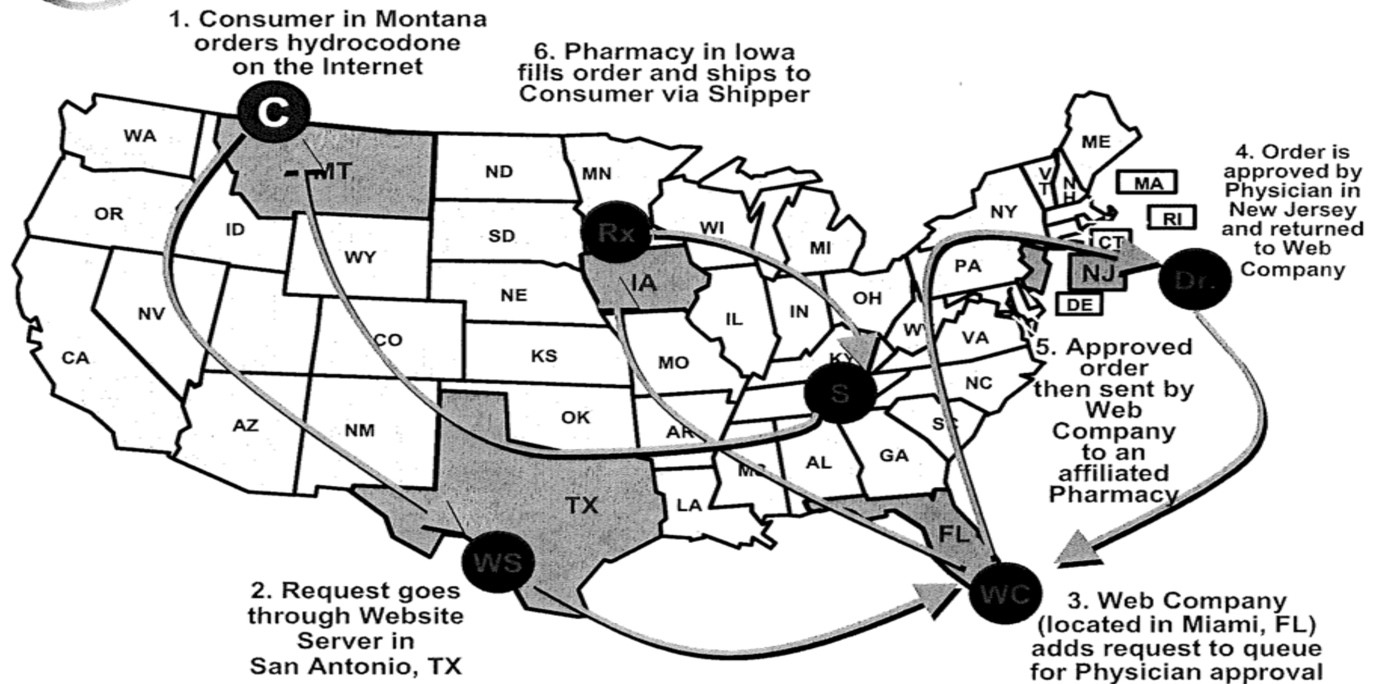
- Doctor Shopping (cont.)
  - Targets for individual patients (cont.)
    - Pharmacies
      - Utilize multiple pharmacies to fill orders to avoid suspicion
      - Use pharmacies known to dispense controlled substances without asking questions
  - Targets for Drug Trafficking Organizations
    - Physicians
      - Known to prescribe with little or no F/U
      - Sympathetic to patients' medical situation
      - Commonly long distance from patient's residence

# Criminal Schemes

## The plans that set the process in motion

- Internet Diversion
  - Players in the game
    - Web Broker/Facilitator
    - Practitioner
    - Pharmacy
    - Source of Supply

# See Map for Internet Scheme



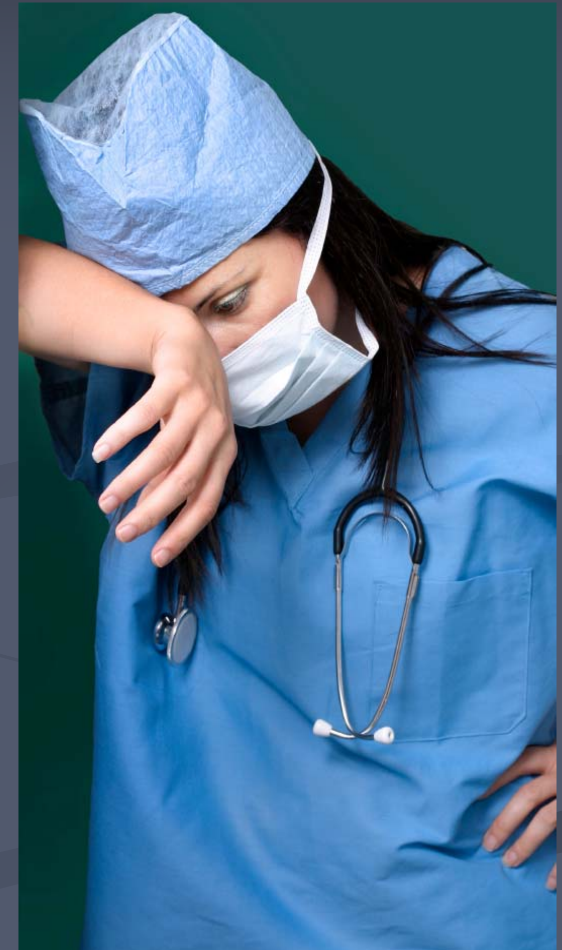
# Criminal Schemes

## The plans that set the process in motion

- Prescription Fraud
  - Fake prescriptions
  - Stolen prescriptions

# Strategies
# How to address issues

- Before a criminal investigation (Preventative Measures)
- During a criminal investigation (what to do and not to do)
- After a criminal investigation (charges brought by prosecutor – federal or state)



# Strategies
# How to address issues

- Prevention is the key to avoid criminal prosecution
  - Reducing Activity
    - Utilize pain management guidelines regarding analgesic prescribing published by professional organizations and state medical boards
    - Refer patients with chronic pain issues to pain management specialists (MDs Board Cert in Anesthesia, Physical Rehab, Psych, Neurology)

# Strategies
# How to address issues

- Prevention is the key to avoid criminal prosecution (cont.)
  - Comply with the Law
    - Comply with all Federal and State laws and regulations governing prescribing-have and follow a compliance/risk management program
      - Program should comply with local and federal laws
      - Program should be updated on a regular basis
  - Keep current with and comply with DEA policy statements (www.deadiversion.usdoj.gov)
  - Comply with State Board of Medical Licensure Policies, Guidelines, and Newsletters, especially guidelines for use of controlled substances in pain treatment

# Strategies
# How to address issues

- Prevention is the key to avoid criminal prosecution (cont.)
  - Keep up with your documentation
    - Especially treatment plans for patients
    - Adopt, use and update forms such as "Controlled Substances Agreements" (CSA)
      - CSAs explain the risks associated with consumption of controlled substances
  - Have plans for handling patients suspected of drug abuse and diversion

# Strategies
# How to address issues

- After you become aware of a criminal investigation
  - Retain experienced criminal defense counsel immediately
  - Do not destroy any records – files, email messages, etc.
  - Do not speak with law enforcement officers without counsel present
  - Do not speak to anyone on the phone/in person about investigation

# Strategies
# How to address issues

- After the criminal investigation – charges filed
  - Rely on the advice of your defense attorney

# Bibliography

The Role of DEA in Controlling Drug Abuse, U.S. Drug Enforcement Administration, June 30, 2009

Defending Drug Charges (Drug Abuse and Malprescribing), Erin Brisbay McMahon

# DISCLAIMER

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