arizona STATE BOARD OF NURSING
REGULATORY JOURNAL
VOL 12 • N°2
JUNE 2016

IN 2012, ENOUGH OPIOID PRESCRIPTIONS WERE SOLD TO GIVE EVERY AMERICAN ADULT A BOTTLE OF PILLS.

It's time to address the opioid epidemic.

ExperienceMagnet

WHAT MAGNET® MEANS TO US...

…it's the pride we feel because all five HonorHealth medical centers have earned Magnet recognition.

…it's the voice we have with shared governance; our Unit-Based Patient Care Councils truly allow us to drive our practice.

…it's having support to do what's best for the patient, best for each other, and best for our careers!

Nursing excellence is central to everything we do and everything we are.

HonorHealth is the only multihospital health system in Arizona to achieve elite Magnet recognition. This is an achievement shared with only 21 other multihospital health systems in the U.S.

HONORHEALTH™

WHAT YOU MEAN TO US...

You've become an expert in your area of nursing. Our vibrant RN careers give you the perfect way to apply your valuable skills. We recognize your abilities and have a team of coworkers ready to support you. We're fortunate to have nurses in top leadership roles and proud to offer you advancement opportunities at every step along the way.

We have these rewarding opportunities for skilled RN's with at least 1 yr. of experience:

- **ICU/CVICU**
- **NICU/PICU**
- **Med/Surg**
- **Home Health**
- **Pediatrics**
- **PeriOp Services**
- **Telemetry**
- **Emergency Services**

Full relocation is avalaible.

We're excited to meet you.

Our Nurse Recruiters are standing by to answer your questions and schedule a time to talk.

Email us! **Talent@HonorHealth.com**

HonorHealth is an equal opportunity employer.
We encourage qualified Minorities, Females, Protected Veterans and Individuals with Disabilities to apply and be considered for open positions.

www.HonorHealthJobs.com

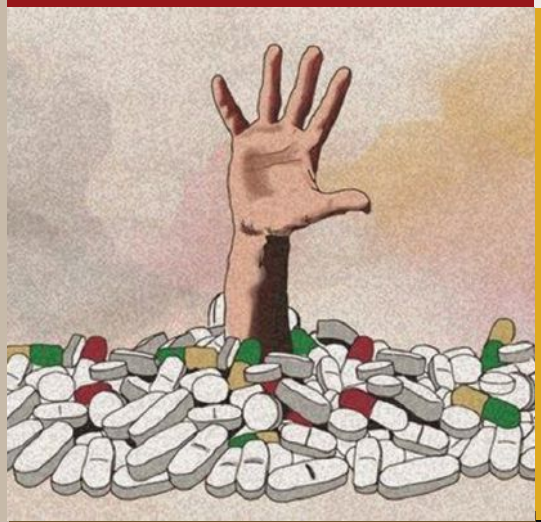
PUBLISHED BY
ARIZONA STATE BOARD OF NURSING
4747 North 7th Street, Suite 200
Phoenix, AZ 85014-3655
Phone: 602.771.7800
Main fax: 602.771.7888
CANDO fax: 602.771.7882
General e-mail: arizona@azbn.gov
Website: www.azbn.gov

VOL 12 • N°2 • JUNE 2016

EDITION 35

arizona STATE BOARD OF NURSING REGULATORY JOURNAL

78
PEOPLE A DAY DIE
from narcotic prescription overdose



pcipublishing.com

Created by Publishing Concepts, Inc.
David Brown, President • dbrown@pcipublishing.com

From the Executive Director

JOEY RIDENOUR, RN, MN, FAAN

Safe Prescribing Saves Lives

OPIOID-RELATED DEATHS:

From 2000 to 2014, nearly half a million people died from drug overdoses. According to the Centers for Disease Control and Prevention (CDC), opioid prescribing continues to fuel the epidemic. Seventy-Eight Americans die every day from an opioid overdose. Overdose deaths involving prescription opioids have quadrupled since 1999([1]) and so have sales([2]) of these prescription drugs. The majority of U.S. drug overdose deaths (more than six out of ten) involve an opioid, ([1]) and at least half of all U.S. opioid overdose deaths involve a prescription opioid. From 1999 to 2014, more than 165,000 people have died in the U.S. from overdoses related to prescription opioids. In 2014 alone, more than 14,000 people died from overdoses involving prescription opioids.

In 2014, 1,211 Arizona opioid deaths occurred, with 50% related to prescription opioids. In Arizona, approximately 600 deaths may be prevented annually with safe prescribing.

In response to the critical need for consistent and current opioid prescribing guidelines, the CDC released a new Guideline for Prescribing Opioids for Chronic Pain in May 2016. These new recommendations are found in this edition of the Arizona Journal of Nursing Regulation and focus on clinical practice and provide evidence and guidance to improve how these drugs are prescribed.

Safe Prescribing Saves Lives.

Most Commonly Overdosed Opioids

The most common drugs involved in prescription opioid overdose deaths include:

- *Methadone*
- *Oxycodone (such as OxyContin®)*
- *Hydrocodone (such as Vicodin®)([3])*

Overdose Deaths

Among those who died from prescription opioid overdose between 1999 and 2014:

- *Overdose rates were highest among people aged 25 to 54 years.*
- *Men were more likely to die from overdose, but the mortality gap between men and women is closing.([4])*

OPIOID-RELATED SUBSTANCE ABUSE:

While opioid-related deaths are increasing and alarming, opioid abuse is also at a critical level. More than 2.1 million in the US are struggling with substance abuse related to opioid pain medicine, thousands of Americans have lost their lives to prescription drug abuse, and nurses are currently participating in Board of Nursing non discipline and discipline programs related to opioid addiction.

Opioid Abuse

Overdose is not the only risk related to prescription opioids. Misuse, abuse, and opioid use disorder (addiction) are also potential dangers.

- *In 2014, almost 2 million Americans abused or were dependent on prescription opioids.*
- *As many as 1 in 4 people who receive prescription opioids long term for noncancer pain in primary care settings struggle with addiction.([5])*
- *Every day, over 1,000 people are treated in emergency departments for misusing prescription opioids.([6])*

CALL TO ACTION:

The current public health crisis also demands an educational commitment and aggressive action by nursing regulators as we all need to answer the call. The current crisis demands aggressive

Continued on page 6 >>>

Memorial
Medical Center

Nurses!
Now Earn More at MMC

Memorial Medical Center in Las Cruces has made a significant salary increase for our Nursing Team!

We are looking for nurses to work in our OR, ER, Perinatal Services, NICU, ICU, Cath Lab, Tele/Med/Surg.

Come join us in the beautiful city of Las Cruces as we continue to grow. Apply today to work where you will be honored and valued.

- On-site interview expenses
- Relocation Assistance
- Professional Development incentives for National Certifications
- Tuition Reimbursement
- Employer sponsored CEs
- Childcare Reimbursement
- Referral Bonus

Visit us at MMCLC.org and apply online.
For more information call or email our Nurse Recruiter, Ernest Perez, RN
575-635-7101 • Ernest.Perez@LPNT.net

2450 S. Telshor Blvd, Las Cruces, NM 88011 • **MMCLC.org**

action by all stakeholders in nursing, medicine, and pharmacy. The educational commitment has been made by the leading nursing organizations, including American Association of Nurse Practitioners (AANP), the American Association of Colleges of Nursing (AACN), the American Association of Nurse Anesthetists, the American College of Nurse-Midwives, the American Nurses Association, the National Association of Clinical Nurse Specialists, and the National Organization of Nurse Practitioner Faculties.

Safe Prescribing Saves Lives.

References

1. CDC. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2016. Available at http://wonder.cdc.gov.
2. Frenk SM, Porter KS, Palazzi LJ. Prescription opioid analgesic use among adults: United States, 1999–2012. NCHS data brief, no 189. Hyattsville, MD: National Center for Health Statistics. 2015.
3. Ossiander EM. Using textual cause-of-death data to study drug poisoning Islander EM Am J Epidemiology. 2014 Apr 1; 179(7):884-94. doi: 10.1093/aje/kwt333. Epub 2014 Feb 1112.)
4. Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2014 on CDC WONDER Online Database, released 2015. Data are from the Multiple Cause of Death Files, 1999-2014, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10.html.
5. Boscarino JA, Rukstalis M, Hoffman SN, et al. Risk factors for drug dependence among out-patients on opioid therapy in a large US health-care system. Addiction 2010; 105:1776–82. http://dx.doi. org/10.1111/j.1360-0443.2010.03052.x
6. Substance Abuse and Mental Health Services Administration. Highlights of the 2011 Drug Abuse Warning Network (DAWN) findings on drug-related emergency department visits. The DAWN Report. Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration; 2013. Available from URL: http://www.samhsa.gov/data/2k13/DAWN127/sr127-DAWN-highlights.htm

Janeen Dahn PhD, FNP-C
Associate Director, Complaints & Investigations

Arizona Prescribers and the **Opioid Epidemic Primer**

Since 1999, opiate overdose deaths have increased 265% among men and 400% among women (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). Opioids are substances chemically similar to alkaloids found in opium poppies that activate dopamine neurotransmitter receptors in the brain, mimicking that of a natural neurotransmitter. One of the transmitters activated by opioids is the mesolimbic (midbrain) reward system responsible for feelings of pleasure. Overstimulation of the reward system by opioids results in euphoric feelings that may lead to misuse and abuse of these drugs. Arizona prescribers can help to reduce the incidence of opioid overdose and opioid use disorder by identifying the problem of prescription abuse, the recognition of "red flags" indicating inappropriate use, and implementing universal precautions for all controlled substances.

The Problem

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) prescription drugs are misused and abused more often than any other drug, except marijuana & alcohol (2015). The Center for Disease Control and Prevention reported that approximately 15,000 people die every year from overdoses involving prescription painkillers, more than those who die from heroin and cocaine combined (2013). Opioids reduce the perception of pain but can also produce drowsiness, mental confusion, euphoria, and respiratory depression. Some people who misuse opioids do so by trying to intensify their euphoric response by snorting or injecting the substance (SAMHSA, 2015). Chronic opioid abuse may result in opioid tolerance, dependence, and addiction because of manifestations of brain changes. Prescription drug tolerance (an individual's diminished response to a drug), dependence (the need to keep taking the drug to avoid a withdrawal syndrome), and addiction (intense drug craving and compulsive use) are all indications of changes in the brain resulting from chronic drug abuse. Diagnostic codes related to substance use disorders changed in 2013. According to the Diagnostic and Statistical Manual (DSM) opioid use disorder is coded as 304.00 for opioid dependence and 305.50 for opioid abuse and the International Statistical Classification of Diseases codes opioid use disorder as F-11.20. The financial implications of substance abuse must also be considered as street prices reflect the IV-morphine-equivalence of a dose of an opioid, and thereby its "desirability" for misuse by an individual with opioid use disorder (Hosea, 2015).

According to the United States Department of Health and Human Services (2013), an estimated 24.6 million Americans, aged 12 or older, used illicit drugs in the past 30 days prior to the survey interview (Figure 1). The estimate represents 9.4% of the population aged 12 or older.

In Arizona, approximately 10 million Class II-IV prescriptions were written and 524 million pills are dispensed each year and account for over half of the drugs dispensed in the state (Arizona Department of Health Services [ADHS], 2014). Opioid overdoses

Continued on page 11 >>>

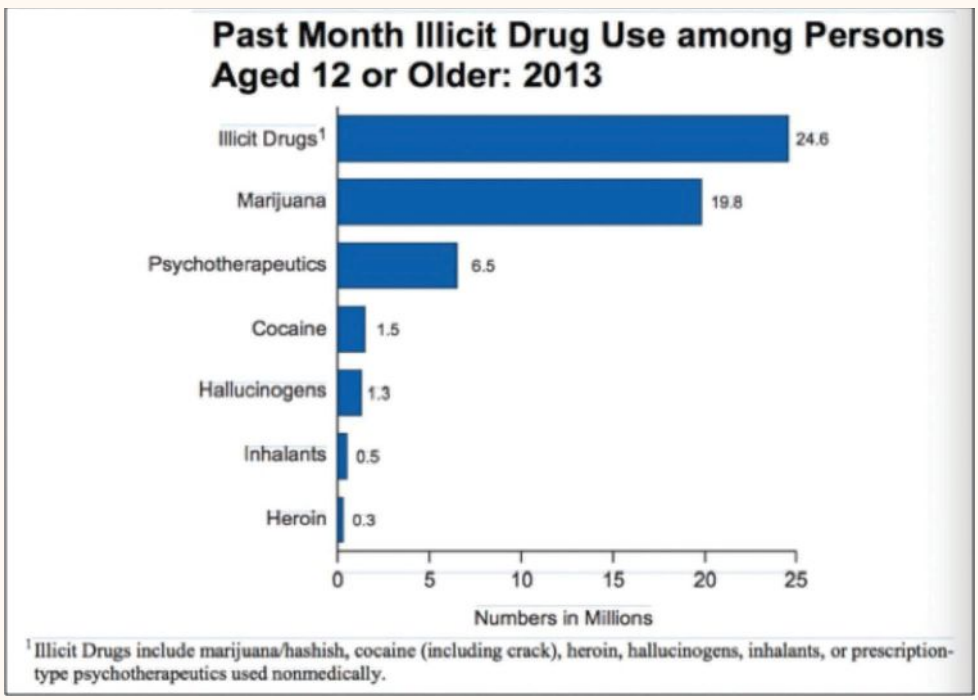


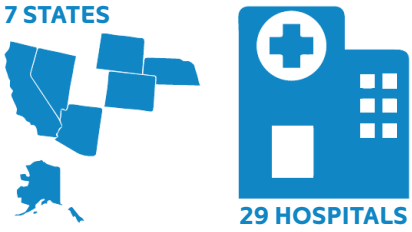
Figure 1. Past Month Illicit Drug Use among Persons aged 12 or Older in 2013 (U.S. Department of Health Services, 2013).

Banner Health®

Your next healthcare journey starts here.

CHOOSE YOUR PATH.

EXCEPTIONAL CAREERS THROUGHOUT THE WEST



Our growing health system, one of the nation's largest, features 29 hospitals in 7 western states and employs over 47,000 people.

FULL SPECTRUM OF HOSPITAL SETTINGS

We feature every practice setting imaginable - from rural community hospitals to metropolitan teaching and research medical centers. Our locations also offer an unequaled variety of lifestyle options.

NURSING EXCELLENCE

Nurses are the heartbeat of a hospital, and we do our best to keep them beating happily and well. Part of this is the breadth of career options for RNs at Banner Health. We have opportunities for nurses of any skill set.

AWARD-WINNING CARE

We are one of the most respected health systems in the nation, receiving accolades from *Becker's Hosptial Review, Truven Health Analytics, U.S. News & World Report* and more - as a system, for individual locations and leadership.

CAREERS FOR NURSES ON THE MOVE

Banner Staffing Services has excellent travel and registry opportunities throughout our system, offering your career a welcome change of place.

Help define the future of healthcare. Learn more at

http://tinyurl.com/h4v8vfj

EEO/AA. We support a tobacco-free and drug-free workplace.

STAFF DIRECTORY

ADMINISTRATION

Joey Ridenour, MN, RN, FAAN
Executive Director
602.771.7801
jridenour@azbn.gov

Janeen Dahn, PhD, RN, FNP-C
Associate Director Complaints & Investigations
602.771.7814
jdahn@azbn.gov

Judy Bontrager, MN, RN
Associate Director, Operations & Licensing
602.771.7802
jbontrager@azbn.gov

Pamela Randolph, MS, RN, FRE
Associate Director Education & Evidenced Based Regulation
602.771.7803
prandolph@azbn.gov

Valerie Smith, MS, RN, FRE
Associate Director Hearings
602.771.7804
vsmith@azbn.gov

Dolores Hurtado,
Senior Investigator to the Associate Director of Complaints/Investigations - Intake Triage Coordinator
602.771.7845
dhurtado@azbn.gov

Susie Flores
Administrative Assistant to the Executive Director
602.771.7806
sflores@azbn.gov

Becky Melton
Administrative Assistant to Associate Director Operations/RN-LPN Exams
602.771.7805
bmelton@azbn.gov

Lila Wiemann
Administrative Assistant
602.771.7890
lwiemann@azbn.gov

CANDO

Janet (Jan) Kerrigan, BSN, RN
Nurse Practice Consultant
602.771.7864
jkerrigan@azbn.gov

Olga Zuniga
Administrative Secretary
602.771.7865
ozuniga@azbn.gov

COMPLAINTS-INTAKE

Dolores Hurtado,
Senior Investigator
Complaints-Intake Triage Coordinator
602.771.7845
dhurtado@azbn.gov

Lynette Drafton
Senior Investigator
Applicant Triage
602.771.7827
ldrafton@azbn.gov

EDUCATION

Ronda Doolen, MSN, BSN, RN
Education Program Administrator
602.771.7877
rdoolen@azbn.gov

Cindy George, BSN, RN
Nurse Practice Consultant
602.771.7857
cgeorge@azbn.gov

Lyn Ledbetter
Administrative Assistant
602.771.7856
lledbetter@azbn.gov

FISCAL SERVICES

Tracy Kreck
Fiscal Services Manager
602.771.7809
tkreck@azbn.gov

Traci O'Connor
Accounting Tech
602.771.7810
toconnor@azbn.gov

HEARINGS

Trina Smith
Legal Assistant
602.771.7852
tsmith@azbn.gov

INVESTIGATIONS

Kristi Hunter, MSN, FNP-C
Advanced Practice Nurse Consultant
602.771.7854
khunter@azbn.gov

Kathleen Harrington, BA, ADN, RN
Nurse Practice Consultant
602.771.7811
kharrington@azbn.gov

Cindy Mand, MSN, RN
Nurse Practice Consultant
602.771.7815
cmand@azbn.gov

Michael Pilder, MSN, PHCNS-BN APHN-BC
Nurse Practice Consultant
602.771.7816
mpilder@azbn.gov

Ruth Kish, MN, RN
Nurse Practice Consultant
602.771.7823
rkish@azbn.gov

Stephanie Chambers, MN, RN
Nurse Practice Consultant
602.771.7818
schambers@azbn.gov

SENIOR INVESTIGATORS

Bonnie Richter, MSW
Senior Investigator
602.771.7828
brichter@azbn.gov

Daniel Phelan, M. Adm., B.S.
Senior Investigator
602.771.7813
dphelan@azbn.gov

David Elson, III
Senior Investigator
602.771.7851
delson@azbn.gov

Frank Curatola
Senior Investigator
602.771.7822
fcuratola@azbn.gov

Jennifer Ingram
Senior Investigator
602.771.7835
jingram@azbn.gov

Katrina Alberty
Senior Investigator
602.771.7817
kalberty@azbn.gov

Kirk Olson
Senior Investigator
602.771.7824
kolson@azbn.gov

Linda Monas
Senior Investigator
602.771.7826
lmonas@azbn.gov

Max Barker
Senior Investigator
602.771.7812
mbarker@azbn.gov

Michelle Morton
Senior Investigator
602.771.7850
mmorton@azbn.gov

Susan Bushong, B.A.
Senior Investigator
602.771.7821
sbushong@azbn.gov

LEGAL SECRETARIES

Lynette Drafton
Senior Investigator
602.772.7827
ldrafton@azbn.gov

Gari Carrol
Legal Secretary
602.771.7841
gcarrol@azbn.gov

Richard Carr
Legal Secretary
602.771.7852
rcarr@azbn.gov

INFORMATION TECHNOLOGY

Adam Henriksen
602.771.7807
ahenriksen@azbn.gov

Cory Davitt
602.771.7808
cdavitt@azbn.gov

LICENSING

Claudia Deines
Verifications
602.771.7833
cdeines@azbn.gov

Donna Frye
RN/LPN Renewals/Advance Practice Certifications
dfrye@azbn.gov

Gail Maloney
LPN/RN & CNA Renewals
602.771.7836
gmaloney@azbn.gov

Helen Tay
CNA Exam/Endorsements
602.771.7832
htay@azbn.gov

Idalyne Eskava
RN/LPN Endorsements
602.771.7840
ieskava@azbn.gov

Monica Ortiz
RN/LPN Endorsements
602.771.7831
mortiz@azbn.gov

Naira Kutnerian
Administrative Assistant to Associate Director of Operations & Licensing/Advance Practice Certifications
602.771.7834
nkutnerian@azbn.gov

MAILROOM

Karen Johnson
602.771.7876
kjohnson@azbn.gov

MONITORING

Tamara Greabell, MA, BSN, RN
Nurse Practice Consultant
602.771.7862
tgreabell@azbn.gov

Brent Sutter
Legal Assistant
602.771.7860
bsutter@azbn.gov

RECEPTIONISTS

Jamie Fivecoat
602.771.7871
jfivecoat@azbn.gov

Nancy Davis
602.771.7872
ndavis@azbn.gov

Susan Kingsland
602.771.7873
skingsland@azbn.gov

RECORDS

Anne Parlin
602.771.7875
aparlin@azbn.gov

involve both men and women of all ages, ethnicities, demographic and economic characteristics, and involves both illicit opioids such as heroin and, prescription opioid analgesics such as oxycodone, hydrocodone, fentanyl, and methadone (Painkillers fuel growth in drug addiction, 2011). In 2010, Arizona ranked 6th highest in the nation for drug overdose deaths and 5th highest opioid prescribing rate in the U.S. (ADHS, 2014).

Recognizing Signs of Misuse and Abuse - Red Flags

Since 2006, death rates for the top leading causes of death such as heart disease and cancer have decreased substantially, while the death rate associated with opioid pain medication has increased markedly. Opioid painkillers like OxyContin, Percocet, and Vicodin have become the most widely prescribed drugs in the country, with sales of nearly $2 billion a year (Upp Technology, 2015). Opioids are abused or misused for a variety of reasons but healthcare providers can reduce the incidence by recognizing the red flags that are signs of aberrant behavior. While not all users of opioids are seeking a prescription with an intention to misuse or abuse the drug, several behaviors are common in those who do.

Prescriber Shopping

Prescriber shopping, also known as "doctor shopping," is characterized by an individual seeking out providers who will prescribe the requested medications without adhering to the safety guidelines. Individuals who use opioids illicitly will seek out prescribers who are known to not check the Controlled Substance Prescription Monitoring Program CSPMP, or who will prescribe without valid documentation or objective information supporting a complaint of pain. The CSPMP is a program developed to promote the public health and welfare by detecting diversion, abuse, and misuse of prescription medications classified as controlled substances under the Arizona Uniform Controlled Substances Act (Arizona State Board of Pharmacy, 2016). Drug monitoring programs collect, monitor, and analyze electronically transmitted controlled drug prescribing and dispensing data submitted by pharmacies and dispensing practitioners.

This pattern is evidenced by multiple providers noted on the CSPMP, often in different geographical regions, and sometimes across state lines. Individuals with substance use disorders may state they are unable to provide past medical records because the provider is no longer in business, or the office burned down, had a computer failure, or a variety of other reasons. Instead of relying on patient reports of previous care provided,

Continued on next page >>>

prescribers should consider starting from the beginning in the treatment plan by obtaining the appropriate test, examinations, and supportive evidence for the need of opioid treatment. Standard of care frequently recommends patients participate in physical therapy for many acute and chronic pain conditions and evidence of this therapy should be obtained from the treatment facility, not from patient report.

Multiple Pharmacies

Drug seeking individuals may also have prescriptions filled at multiple pharmacies in different locations, ranging from corporate pharmacies such as Wal-Mart®, Walgreen®, or CVS®, to the smaller privately owned establishments and typically, the locations are several miles apart. Individuals who obtain prescriptions from multiple providers tend to pay cash for the prescriptions in an attempt to circumvent the insurance company from tracking the use of controlled substances, to persuade the small business owner from asking questions, or because of lack of coverage.

Frequent Visits, Escalating Dosages, and High Quantities

When an individual has frequent office visits and consistently asks for higher dosages and larger quantities of pain medication, a mental red flag should be raised in the prescriber's mind, to evaluate the appropriateness of the drug, dose, and quantity prescribed. The prescriber should determine if the opioid is absolutely necessary and if the dose and quantity are appropriate given the objective supportive information available. For example, "back pain," or lumbago is a symptom, not a pain generator. The clinician must first determine what is causing the pain using objective information such as a comprehensive musculoskeletal examination, diagnostic imaging, review of previous medical records, etc. Once a diagnosis is determined, the clinician should choose the best treatment, pharmacological and/or nonpharmacological, for the individual patient. Clinicians may see frequent canceled appointments for diagnostic imaging for a number of reasons. For example, patients may cite financial stressors, family emergencies, work schedules, out of state commitments, personal crises, etc. as reasons for not obtaining the imaging. Additionally, those individuals with substance use disorders, or those who are diverting medications commonly refuse diagnostic imaging and are not interested in a diagnosis or alternative treatments.

Morphine Equivalency Dosing (MED)

The Morphine Equivalency Dosing (MED) number is provided on the CSPMP when opioids are reported to the databank. The MED number was developed by the Center for Disease Control, and is a conversion chart designed to equate different opiates and strengths into a standard morphine equivalent value. Each active opioid prescription (those that the patient is currently taking based on how the prescription is written) will have a MED value on the conversion chart, and then combined into one daily MED value. It is important to note that the MED value is a snapshot of the day that the report is run and may have up to a two-week lag time for prescriptions not yet entered. The MED value is intended to trigger the prescriber to pause and take into account a number of clinical considerations (Dahn, 2015). A study published in the Journal of the American Medical Association identifies an increased incidence of accidental overdose in patients taking opioids at doses greater than 100mg of morphine equivalents each day.

Early Refills, Lost or Stolen Prescriptions

Requests for early refills are common in

individuals who have an active opioid use disorder.. A few days early every month quickly adds up to a full prescription in a short period of time and often a variety of excuses are provided for why an early refill is necessary. If an early refill is provided, prescribers should consider a lesser quantity on the next refill to reduce the incidence of over prescribing. Lost or stolen prescriptions are another common tactic for those with aberrant behaviors. A police report is only evidence that a report was filed, not that the individual actually had a prescription or that it was stolen, it is merely a record of a report.

Abnormal Drug Screen/Test

Drug screens conducted in the office or tests in the lab are another method for monitoring compliance with a medication plan. An unexpected test result may be a red flag that the individual is not taking the medication (as evidenced by a negative test), or that the individual is taking medications not prescribed or illicit drugs. Unexpected lab results should always raise a flag of aberrant behavior.

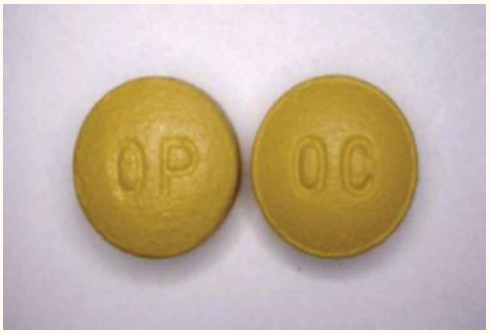


Figure 2. New and Old OxyContin Pills. 80-milligram tablets of the current OxyContin OROS REMS abuse prevention formula (left) and the previous OxyContin formula (right).

Social Issues and Street Value

Another common red flag are individuals who do not have a job or legitimate source of income but frequently pay cash for office visits or prescription drugs. According to the National Association of Drug Diversion Investigators (2007) and StreetRx (2015), oxycodone in any formulation cost about $1.00 a milligram almost anywhere in the United States. A 30mg instant release oxycodone tablet has a street value as much as $60.00. The higher doses of 80mg extended release formula, sold as OxyContin, with Osmotic Controlled-Release Oral Delivery System (OROS) Risk Evaluation and Mitigation Strategies (REMS) "abuse" prevention cost only $50 as it turns into a gel when crushed and consequently not easily converted into an intravenous formulation (Figure 2 and 3).

Clinicians should be aware that Percocet 10/325, written for a quantity of 90 tablets may only cost a $10 copay at the pharmacy, but sell for $900, or more, on "the street." Patterns of behaviors relating to missed appointments, termination by other providers and reports of deterioration of work/social function or disability are all signs of possible substance use disorder.

Combined Controlled Substances Cocktail

The "Trio" or "Trinity" is a popular drug regimen that contains hydrocodone, a benzodiazepine, and carisoprodol (Soma). When hydrocodone is replaced by oxycodone, the popular name is the "Holy Trinity" (Figure 4 and 5). Opioids, benzodiazepines, and carisoprodol have some side effects that include drowsiness, respiratory depression, confusion, tremor, and seizures risk. In combination, these three drugs are synergistic in causing respiratory depression and may consequently result in death (Fudin, 2014).

Sharing of Medications and Fraudulent Demographics

Other potential red flags include patients whose family members are taking the same type of opioid. Sharing of medications is common among persons with substance use disorders and frequently found in those whose intention it is to sell the prescription drug as

Continued on next page >>>

Figure 3. New Verses Old OxyContin. The newer formula OROS REMS abuse prevention formula is more difficult to break up (right) while the pre-2010 OxyContin pill crushes into grains (left).

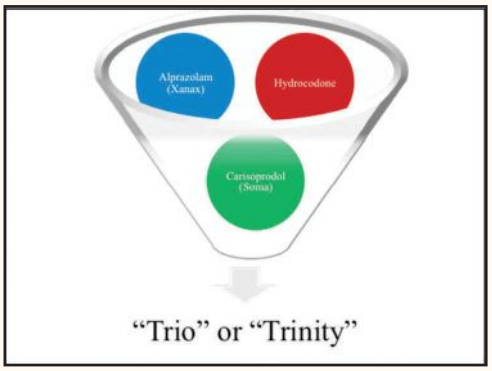


Figure 4. Trio or Trinity. Benzodiazepine, Muscle Relaxant, and Hydrocodone.

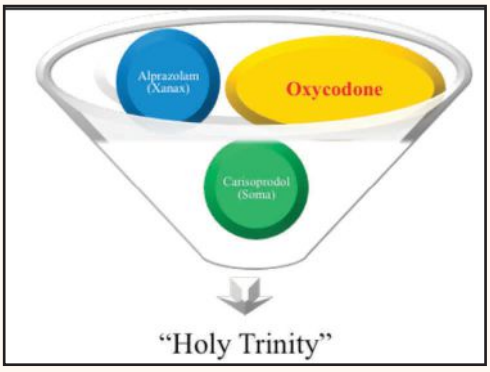


Figure 5. Holy Trinity. Benzodiazepine, Muscle Relaxant, and Oxycodone.

multiple sources are of value when trying to pass "pill counts" (counting of pills as a strategy to determine if patients are taking pills as prescribed). Patients at risk for opioid addiction may use the strategy of providing multiple addresses or similar birthdates in an attempt to divert identity on the CSPMP. According to the National Institute on Drug Abuse, as of 2014, prescription drug misuse or abuse is increasing among young men and women in their 20s and people in their 50s.

Universal Precautions

Universal precautions are strategies intended to minimize the risk of opioid misuse and abuse while maintaining compassionate care. The term ""universal precautions," in terms of infectious diseases, evolved out of the realization that it was impossible for providers to reliably assess risk of infectivity during an initial assessment of a patient and therefore, all patients were considered potentially infected to which a reasonable approach was to apply a minimum level of precaution to all patients reducing the risk of infection. Opioid precautions in pain management began in the mid 2000's with the rise in opioid abuse. The application of "universal precautions" in the initial assessment and treatment of a patient may reduce the risk of accidental overdose, abuse, and misuse. Gourlay and Heit (2005) identified 10 recommended steps in universal precautions for all pain patients.

10 Recommended Steps in Universal Precautions

Step 1. Diagnosis. Identify the pathophysiology for the pain. Identify the pain generator through appropriate diagnostic imaging and other testing.

Step 2. Psychological assessment. Psychological screening including risk of addictive disorders, depression, and anxiety; positive findings may require referral to specialist.

Step 3. Informed consent. Discuss the risks and benefits of opiate therapy, including side effects and risk of addiction.

Step 4. Treatment agreement. This agreement details the conditions under which the opioid will be continued or discontinued. Both the provider and patient should agree on the contents prior to entering into a long-term opioid treatment plan.

Step 5. Pre and post intervention assessment of pain level and function. Pain scores and level of functionality should be recorded in the medical record to support continuation of therapy.

Step 6. Appropriate trial of opioid therapy with or without adjunctive medication. If no improvement, the treatment should be titrated down and discontinued.

Step 7. Reassessment of pain score and level of function. Reassessment should be completed at each visit and support the need for continued treatment.

Step 8. Regularly assess the "A's" of pain medicine. Routine assessment of analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors support the need for continued therapy. "Adherence" (urine toxicology) and "affect" (observed mood) might also be added.

Step 9. Periodically review pain diagnosis and comorbid conditions, including addictive disorders. Refer to specialist if underlying addiction disorder or aberrant behaviors are present.

Step 10. Documentation. Complete and accurate documentation of the initial and each follow up visit. Documentation of a physical assessment should be completed with each dosage adjustment.

State and National Guidelines

Other strategies identified as universal precautions are evident in state and national guidelines. In 2004, the Arizona State Board of Nursing developed an advisory opinion addressing The Use of Controlled Substances for the Treatment of Chronic Pain that was later revised in 2009, 2012 and is in the process of updating in 2016. In 2014, the Arizona Department of Health Services published a voluntary consensus set of guidelines that promotes promising practices for prescribing opioids for acute and chronic pain. Additionally, in March of 2016, the Centers for Disease Control and Prevention released CDC Guideline for Prescribing Opioids for Chronic Pain in an effort to improve the way opioids

are prescribed. Common themes found in state and national guidelines include:

- A comprehensive medical and pain related evaluation determining if opioids are appropriate or if other non-opioid pharmacological or nonpharmacological therapies are preferred. If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate. Clinicians treating patients with opioids for chronic pain should obtain and review past records or communicate with former treatment providers. Caution should be used when patients provide their own medical record instead of obtaining of records directly from the provider.
- A goal directed trial of opioid therapy and the establishment of treatment goals. Opioids should only be continued if there is meaningful clinical improvement.
- Before starting and periodically during opioid therapy, the clinician should assess for risk of misuse, addiction, or adverse effects, and perform a risk stratification before initiating opioid treatment and discuss patient and clinician responsibilities for managing therapy in an "Opioid Agreement" signed by both the clinician and patient. In patients with a history of substance abuse, strong consideration should be given for a referral to an addictionologist or a physician with specialty training in this area.
- When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release (IR) opioids instead of extended-release/long-acting (ER/LA) opioids. Clinical evidence reveals a higher risk for overdose among patients initiating treatment with ER/LA opioids than among those initiating treatment with immediate-release opioids (Miller, Barber, Leatherman, 2015).
- When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and no greater quantity than needed for the expected duration of pain severe enough to require opioids. Opioid related adverse events increase with doses >50 -100 mg of morphine equivalent dose per day (MED) and reaching these doses should trigger a re-evaluation of therapy.
- Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms.
- Review of the CSPMP to determine whether the patient is receiving opioid dosages or dangerous combinations that put the individual at high risk for overdose.
- Drug testing and Pill counts. Drug testing before starting opioid therapy and periodically thereafter (at least annually). Drug testing should access for the presence of prescribed drugs, as well as other drugs, to ensure the patient is taking the drugs prescribed and not taking illicit or other substances. A common strategy in practicing universal precautions is a random system determining who will submit to a pill count or drug test during medical visits. The use of a "testing die" (small throwable object with multiple resting positions, used for generating a random number) and a predetermined number for the day. For example, anyone rolling a four (4) that day will submit to a pill count or drug test. Consistent with universal precautions, this practice should be applied to all patients receiving controlled substances. Drug testing or pill counts should also be performed when the healthcare provider suspects aberrant behaviors.
- Avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible as this practice significantly increases the incidence of overdose and respiratory depression.
- Refer for treatment in patients with opioid use disorder. Clinicians should consider consultation for patients with complex pain conditions, serious co-morbidities including mental illness, a history or evidence of current drug addiction or abuse, patients who are pregnant or breastfeeding, or when the provider would benefit from help managing the patient.
- Adherence to clinical guidelines are one strategy to optimize care and improve patient safety based on evidence-based practice and for improving prescribing practices and health outcomes in Arizona, as well as reverse the cycle of opioid pain medication misuse that contributes to the opioid overdose epidemic.
  State and national guidelines provide recommendations that are based on the best available evidence that is interpreted and informed by expert opinion.
- The CSPMP has emerged as a key strategy nationally for addressing the misuse of prescription opioids and thus preventing opioid overdoses and deaths. Twenty-nine (29) states have mandatory access provisions mandating, by statute, rule, or board that a prescriber query the prescription monitoring program for information regarding a patient when prescribing controlled substances. Universal precautions recommend accessing the CSPMP whenever prescribing any opioid substance to any patient.
- Know the risks and establish treatment goals: If the benefits of opioids do not outweigh the risks of the drug, clinicians should consider discontinuing the opioid.
- Prescribe in terms of duration: Prescribing the lowest effective dose of immediate-release medications over long-term release medications. Avoid prescribing immediate-release opioids in combination with long-acting opioids.
- Review Patient History: Clinicians should

Continued on next page >>>

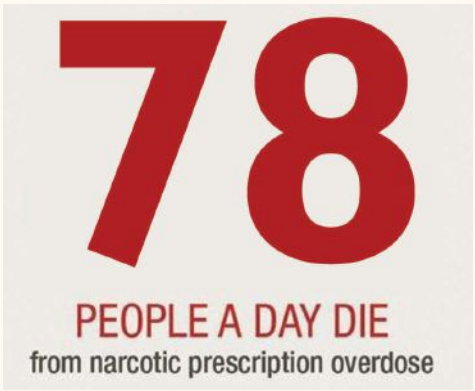
check for a history of controlled substance abuse or if a patient may be taking another drug that could have a negative interaction with the prescribed opioid. (ADHS, 2014, Arizona State Board of Nursing, 2012, Center for Disease control and Prevention, 2016, Upp Technology, 2016).

Arizona Legislation Enacted in 2015 & 2016

Arizona Revised Statute (A.R.S.) 36-2606. A.R.S. 36-2606, effective December 31, 2015, requires every Arizona medical practitioner, including Nurse Practitioners & Nurse Midwives who intend to obtain a Drug Enforcement Administration (DEA) number or who hold one or more DEA registration number to also hold a Controlled Substances Prescription Monitoring Program (CSPMP) registration issued by the Arizona State Board of Pharmacy.

Senate Bill 1283. Governor Ducey signed Senate Bill (SB) 1283 into law on May 12, 2016. The mandate would become effective October 1, 2017, and 60 days after the Arizona Health-e Connection has integrated the PDMP data into the state health information exchange, states that a medical practitioner, before prescribing an opioid analgesic or benzodiazepine controlled substance shall obtain a patient utilization report (CSPMP) regarding the patient for the preceding 12 months from the CSPMP central database tracking system at the beginning of each new course of treatment and at least quarterly while that prescription remains a part of the treatment. Prescribers would not be required to check the CSPMP if any of the following apply (please refer to the statute for a full description of the exceptions):

- Patient is receiving hospice or palliative care serious or chronic illnesses.
- Patient is receiving care for cancer or a cancer-related illness or dialysis treatment.
- Prescriber is administering the controlled substance.
- The patient is receiving the controlled substance during the course of inpatient or residential treatment in a hospital, nursing care facility, assisted living facility, mental health facility or a correctional facility.
- Prescriber is prescribing the controlled substance to the patient for no more than ten days for invasive medical procedure or medical procedure, which results in severe acute pain to the patient.
- Prescriber is prescribing the controlled substance to the patient for no more than a ten-day period for an invasive medical or dental procedure or a medical or dental procedure that results in acute pain to the patient.
- Prescriber is prescribing no more than a five-day prescription and has reviewed the CSPMP patient data within the last thirty days and no other medical practitioner has prescribed to the patient in the preceding 30-day period.
- The prescription is a substitute for an initial prescription to which the patient had an adverse reaction.
- If the CSPMP is not operational or available in a timely manner or the medical practitioner is experiencing equipment or technological problems (date and time must be documented).



Conclusion

With an increasing number of opioid overdose deaths, Arizona can participate in combating the epidemic of opioid overdoses by changing the current practices of prescribing opioids for acute and chronic pain. Before starting opioid therapy, clinicians should be mindful of red flags that may indicate abuse or misuse. Clinicians should follow state and national guidelines for the treatment of acute and chronic pain. Additionally, prescribers should adopt universal precautions by treating every patient who receives opioids with the same precaution. Every patient should be screened for appropriateness of the drug and clinicians should be mindful of aberrant behaviors. Every patient should have established treatment goals, including realistic goals for pain and function. Prescribers should consider how opioid therapy will be discontinued if benefits do not outweigh risks and should continue opioid therapy only if there is meaningful clinical improvement in pain and function that outweighs risks to patient safety. The risk of opioid overdose can be minimized through adherence to universal precautions whenever prescribing any opioid substance to any patient. Opioid medication have a clear role in the treatment of acute and chronic pain, but by applying these strategies into practice the risk of opioid use and abuse is significantly lessened.

References

Arizona Department of Health Services [ADHS]. (2014). Arizona opioid prescribing guidelines. Retrieved from http://azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/az-opiod-prescribing-guidelines.pdf

Arizona State Board of Pharmacy. (2016). Latest News. Retrieved from https://pharmacypmp.az.gov/

Center for Disease control and Prevention. (2016). CDC guideline for prescribing opioids for chronic pain – United States, 2016. Retrieved from http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

Center for Disease Control and Prevention. (2013). Prescription Painkiller Overdoses in

the U.S. Retrieved from http://www.cdc.gov/Features/VitalSigns/PainkillerOverdoses/index.html

Dahn, J. (2015). Controlled substance prescription monitoring program. Retrieved from http://www.digitaleditionsonline.com/article/Controlled+Substance+Prescription+Monitoring+Program/2261463/271503/article.html

Fudin, J. (2014). The perfect storm: Opioid risk and 'The Holy Trinity'. Retrieved from http://www.pharmacytimes.com/contributor/jeffrey-fudin/2014/09/the-perfect-storm-opioid-risks-and-the-holy-trinity

Gourlay D., Heit H. (2005). Universal precautions in pain medicine: the treatment of chronic pain with or without the disease of addiction. Medscape Neurol Neurosurg. 7(1). Retrieved from http://www.medscape.org/viewarticle/503596

Miller M., Barber C.W., Leatherman S., Fonda, J., Hermos, J.A., Cho, K, Gagnon, D.R. (2015). Prescription opioid duration of action and the risk of unintentional overdose among patients receiving opioid therapy. JAMA Intern Med 175:608–15 Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/25686208

National Association of Drug Diversion Investigators. (2007). Street prices. Retrieved from: http://www.naddi.org/aws/NADDI/asset_manager/get_file/3145

National Alliance for Model State Drug Laws. (2015). 2015 annual review of prescription monitoring programs. Retrieved from: http://www.namsdl.org/library/1810E284-A0D7-D440-C3A9A0560A1115D7/

Painkillers fuel growth in drug addiction. (2011). Harvard Health Publications. *The Harvard Mental Health Letter*, Retrieved from http://search.proquest.com/docview/1370198247?accountid=35812

ResearchGate. (2015). What is the predictive value of STREET PRICES in determining potential for misuse of substances? Retrieved from https://www.researchgate.net/post/What_is_the_predictive_value_of_STREET_PRICES_in_determining_potential_for_misuse_of_substances

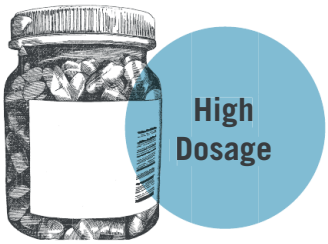
Substance Abuse and Mental Health Services Administration [SAMHSA]. (2015). Substance Use Disorders. Retrieved from http://www.samhsa.gov/disorders/substance-use

StreetRx (2015). Latest prices. Retrieved from: http://streetrx.com/index.php

Upp Technology. (2015). America's opioid Epidemic. Retrieved from: http://www.upp.com/news/special_report_america%E2%80%99s_opioid_epidemic

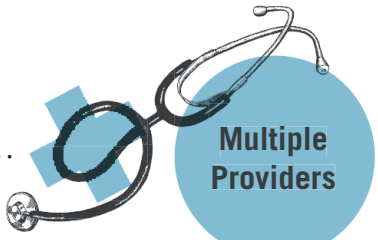
Upp Technology. (2016). CDC releases new painkiller prescriptions guidelines. Retrieved from http://www.smarthealthclaims.com/blog_post/cdc_releases_new_painkiller_prescriptions_guidelines

WHAT SHOULD I CONSIDER WHEN PRESCRIBING OPIOIDS?



High Dosage

Talk to your patient about the risks for respiratory depression and overdose. Consider offering to taper opioids as well as prescribing naloxone for patients taking 50 MME/day or more.



Multiple Providers

Counsel your patient and coordinate care with their other prescribers to improve safety and discuss the need to obtain opioids from a single provider. Check the PDMP regularly and consider tapering or discontinuation of opioids if pattern continues.

Drug Interactions

Whenever possible, avoid prescribing opioids and benzodiazepines concurrently. Communicate with other prescribers to prioritize patient goals and weigh risks of concurrent opioid and benzodiazepine use.

WHAT SHOULD I DO IF I FIND INFORMATION ABOUT A PATIENT IN THE PDMP THAT CONCERNS ME?

Patients should not be dismissed from care based on PDMP information. Use the opportunity to provide potentially life-saving information and interventions.

1. **Confirm that the information in the PDMP is correct.**
   Check for potential data entry errors, use of a nickname or maiden name, or possible identity theft to obtain prescriptions.

2. **Assess for possible misuse or abuse.**
   Offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients who meet criteria for opioid use disorder. If you suspect diversion, urine drug testing can assist in determining whether opioids can be discontinued without causing withdrawal.

3. **Discuss any areas of concern with your patient and emphasize your interest in their safety.**

HOW CAN I REGISTER AND USE THE PDMP IN MY STATE?

Processes for registering and using PDMPs vary from state to state.

For information on your state's requirements, check The National Alliance for Model State Drug Laws online:

www.namsdl.org/prescription-monitoring-programs.cfm

Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- ☐ Check that return visit is scheduled ≤3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - – If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - – If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (**PDMP**): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores
(30% improvement from baseline is clinically meaningful)

Q1: *What number from 0–10 best describes your **pain** in the past week?*
0="no pain", 10="worst you can imagine"

Q2: *What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*
0="not at all", 10="complete interference"

Q3: *What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?*
0="not at all", 10="complete interference"

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

TO LEARN MORE
www.cdc.gov/drugoverdose/prescribing/guideline.html

March 2016

Valerie Smith MS, RN, FRE
Associate Director Hearing Department

Substance Use Disorders

Recognizing and Speaking Up Can Save Lives

Addiction, also referred to as substance use disorder, is a chronic and complex disease with physical, cognitive, emotional, spiritual, financial and legal consequences not uncommon. It is a brain disease that causes compulsive drug seeking and use despite harmful consequences to the individual and to those around him or her.

The course of the disease follows a predictable and progressive course and may result in death if left untreated. Substance use disorder is characterized by a maladaptive pattern of substance use manifested by at least two of the following:

- Persistent desire or unsuccessful attempts to "cut down" or control one's use
- Using the substance(s) in a larger amount or longer than intended
- Excessive time spent seeking and/or using alcohol and/or drugs
- Reduction of important activities as the substance use becomes more pervasive
- Changes in tolerance
- Continued use despite adverse consequences or high potential for adverse consequences
- Withdrawal

While individuals may have initially chosen to use or misuse substances, the disease of addiction is not intentional. Individuals who struggle with a substance use disorder do not set out to destroy themselves, everyone and everything in their path. These disastrous and often deadly consequences are the result of the vicious cycle of a defined medical condition.

Second to alcohol, the most commonly used and abused drug by the general population is marijuana. However, the abuse of opioids, prescribed and illicit, is on the rise. Other common drugs of abuse include cocaine, inhalants, LSD (acid), MDMA (ecstasy), methamphetamine, phencyclidine (PCP), steroids (anabolic), and other prescription and non-prescription drugs.

Opioid Crisis

In recent years, the opioid crisis and the resulting devastation in the United States has drawn the attention of healthcare providers, legislators, communities, families and the media. Opioids are a class of controlled drugs that include oxycodone, hydrocodone, codeine, morphine, fentanyl, heroin and others. The U.S. consumes more legal and illegal opioids than any other country. According to the Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, of the 21.5 million Americans 12 or older that had a substance use disorder in 2014, 1.9 million had a substance use disorder involving prescription pain relievers and 586,000 had a substance use disorder involving heroin. Unintentional drug overdoses are the leading cause of accidental death in the U.S., with 47,055 lethal drug overdoses in 2014. In 2014, 18,893 overdose deaths were related to prescription pain relievers, and 10,574 overdose deaths were related to heroin.

Heroin use has been on the rise. Four in five new heroin users started out misusing prescription opioids. It is less expensive to obtain than prescription opioids and readily available for purchase on the streets. In more recent years, other potent and deadly drugs have joined heroin as being cheaper and readily available from the illicit market. In March 2015, the Drug Enforcement Agency (DEA) issued a nationwide alert on fentanyl as a threat to health and public safety after identifying an alarming rate of drug incidents and overdoses related to fentanyl. Fentanyl is a schedule II narcotic used as an anesthetic and analgesic. It is the most potent opioid available for use in medical treatment and is 50 to 100 times more potent than morphine and 30 to 50 times more potent than heroin. According to the DEA, illicit fentanyl is being produced in clandestine labs and is being trafficked into the U.S. for sale and distribution. While it is often laced in heroin resulting in unpredictable but higher potency dose, fentanyl and fentanyl analogues are also being used by individuals unaware of the potency and lethal consequences, even when used at a low dose. In the media are multiple reports of many deaths due to unintentional fentanyl overdoses. While there is a common cause of death, the deaths span age, gender, ethnic and socioeconomic groups.

Local Impact: Opioid Crisis

Arizona has the tenth highest overdose rate in the nation. Information available from the Arizona Department of Health Services indicates that 1,052 people required emergency room treatment for prescription drug overdoses in 2014, up from 1,018 in the previous year. Approximately one Arizona resident dies per day due to prescription opiate poisoning. Heroin overdoses increased from 521 in 2013 to 605 in 2014 and the number of heroin related deaths has doubled between 2010 and 2014 with 180 deaths in 2014. More recently, media articles and reports describe the increasing availability and prevalence of illicit fentanyl being cut into heroin and other drugs, or being used independently, resulting in unintended fatal overdoses. Many of these overdoses and deaths impact our youth.

Substance Use Disorders In Nursing

Substance use disorders in nursing is not a modern day phenomenon and many experts believe the risk of prescription drug misuse is higher among nurses than the general population. Factors associated with nurses having a higher risk of misuse and abuse include the easy access of medications/drugs, belief that medications/drugs can and will alleviate unwanted feelings and the belief that with the nurse's knowledge of pharmacology, they can control their use. Although the actual rate of addiction in nurses is unknown, estimates range from 6% to 20% of all nurses suffer from a substance use disorder. What is known is that allegations of substance misuse, abuse, dependence and including drug diversion from patients is one of the most common complaints received by boards of nursing and resulting licensure disciplinary action.

Profile Of The Nurse With A Substance Use Disorder

Despite the prevalence of substance use disorders both within society and the nursing profession and despite increased media attention, many co-workers, supervisors, employers and others have difficulty recognizing or assisting a nurse colleague with an obvious substance use disorder. This is disturbing considering the inherent responsibilities nurses have for patient care and safety and the fatal nature of the disease if left untreated.

Nurses and other healthcare professionals take great effort to protect their professional reputation, identity and nursing license. It is not uncommon that the nurse with a substance use disorder continues to be perceived by colleagues and themselves as high functioning well into their disease. Thus, signs and symptoms of the disease in the workplace usually indicates a late stage disease process and is characteristic of the inability to control one's use and the continued use despite potential for negative consequences including compromised patient care, patient harm, loss of job and licensure sanctions. Even late into their disease process, many nurses

will continue to rationalize their use and want to believe they can control their substance use. Their denial, intense shame and fear of consequences should others learn of their "secret" prevents them from proactively seeking treatment. Managers and co-workers may unintentionally enable the disease to progress by ignoring or excusing poor performance, incomplete work, attendance issues and other symptoms of a substance use disorder. Another way in which the disease is enabled is when an employer recognizes symptoms consistent with a possible substance use disorder and opts to allow the nurse to resign or terminates the nurse without addressing the possible substance use disorder and/or reporting the nurse to the Board. When this happens, the nurse is allowed to continue with a potentially fatal disease and patient care with the next employer is potentially negatively impacted.

Recognizing Workplace Indicators Of Substance Use Disorder

As the substance use disorder progresses, signs and symptoms of the disease begin to manifest in the workplace. Workplace indicators of a substance use disorder may include and is not limited to the following:

Attendance: As the disease progresses, the individual's world get smaller as they select activities providing access and opportunity to use. If the substance of abuse is obtained outside of the workplace (alcohol, illegal drugs) the individual may begin to demonstrate progressive absences from work, difficulty adhering to their work schedule, unusual or implausible reasons for absences. When at work, they may also demonstrate on the job absences such as unexplained frequent or prolonged absences from the unit. When the workplace has become a source of supply of the drug and drugs are being diverted, it is not uncommon for the nurse to seek employment opportunities that provide access to the drug. This may be through work setting, patient selection, additional work hours including overtime and they may have unexplained presence in the workplace during scheduled times off.

Interpersonal: Indicators of a substance use disorder may include complaints from co-workers, patients or others; increased isolation from others; unpredictability; changes in mood and/or energy level (alert to appearing sedated); increased conflict with others; legal problems; family or social problems.

Job Performance: Substance use disorder indicators may include difficulty in organizing and prioritizing duties and responsibilities; difficulty meeting deadlines; deterioration in quality of work; poor judgment; forgetfulness; below standard of practice in care of patients; odor of alcohol; inappropriate, inadequate or missing documentation; discrepancies with controlled drugs or the amount removed as compared to co-workers without a corresponding change in the patient condition that would explain the need for additional medications; high volume of controlled drug "waste", discrepancies in the accounting for controlled medications signed out; unauthorized removal of controlled substances or other medications of abuse; missing medications; selecting patients or assignments that provide them with access to drugs; altered provider orders for controlled substances and prescription fraud. Just as we are seeing with the general public, when controlled drugs are involved, the drugs are most commonly opioids and the nurse may also be obtaining from other non-work related sources.

What Not To Do

Whether it is a member of your family, a friend, or colleague, do not ignore your observations and intuitive concerns. Often by

Continued on next page >>>

the time an individual begins to consider the possibility that their family member, friend, patient or colleague has a substance use disorder, there is merit to the concerns. Speaking up and proactively addressing your concerns can save lives.

If it is a nurse colleague, do not allow the nurse who is demonstrating active signs and symptoms of impairment to continue to provide patient care or make decisions impacting patient care until further expert assessment can be completed and evidence of ability to safely practice is determined. Do not encourage the nurse to resign or be terminated without addressing identified concerns, providing resources for further evaluation and treatment and without notifying or causing the Board to be notified. Do not encourage the nurse to hide information from the Board. At times, and perhaps well meaning friends, colleagues, and others advising the nurse have encouraged the nurse to not disclose their substance use history or substance use disorder with the Board. Not disclosing can put patients at risk and can have deadly consequences for the nurse. It is a barrier to the nurse obtaining appropriate intervention and treatment. Addiction is a chronic progressive disease that may and often does result in death if left untreated.

What To Do

One of the first steps is to increase everyone's knowledge and understanding of substance use disorder. It is an equal opportunity disease that is often misunderstood by those with or impacted by the disease, and frequently misunderstood by family members, healthcare providers, employers and colleagues.

In caring for patients, nurses are in an important position to provide patient education related to safe medication use, including use while driving or engaged in other safety sensitive activities; appropriate disposal once the medication is no longer needed; and dangers of sharing medications with others, including family members. An unsafe but not uncommon practice is for individuals to save and later use or share their unused pain medications with others. According the Center for Disease Control, most adolescents who misuse prescription opioids were initially given them by a friend or relative or took them from the family medicine cabinet. Education is critical to combating the current opioid crisis. If you suspect a patient you are providing care to has an underlying substance use disorder, speak up and advocate for the patient to receive appropriate referrals, assessments and treatment. Recognizing and speaking up saves lives.

Nurses with an active substance use disorder have potential to not only harm patients but also cause harm or death to themselves. Colleagues who work closely with a nurse struggling with a substance use disorder often recognize that something is wrong before the manager, who may not have as frequent encounters with the nurse, recognize the indicators. Do not assume the manager is aware and openly address the concerns with the manager. Understand that simply asking the nurse whether or not they have a substance use disorder will not likely result in an admission. The barriers for those with a substance use disorder being truthful results from their intense shame and fear. Be prepared to present objective information and ask questions until you understand what did or did not happen. Do not accept implausible answers. Anytime that there is reasonable concern that a nurse, for whatever reason, is currently unable to safely practice, they should immediately be removed from patient care until further assessment can be completed. If employer policies permit, and there is reasonable suspicion that the nurse may be under the influence of a substance, a drug test should be obtained and the panel of drugs tested should include the drug(s) that are suspected. A nurse with a suspected substance use disorder should be referred for further evaluation for possible treatment and a report submitted to the Board for further review and investigation by the Board to determine safeness to practice. If the nurse acknowledges a substance use disorder, they may be eligible for CANDO, the Board's non-public and non-disciplinary monitoring program for nurses with substance use disorders. Information about CANDO can be found on the Board's website at www.azbn.gov. Although the Board's mission is patient protection, patient protection can often be accomplished by nurses who have a recent or active substance use disorder entering into CANDO or entering into a Consent Agreement with the Board that mandates treatment, abstaining from unauthorized substance use, practice limitations and practice supervision.

Summary

As nurses, we have shared responsibilities for patient safety. When we recognize that one of our patients may be struggling with a substance use disorder, we have a responsibility to do the right thing and bring it to the attention of someone who can intervene on behalf of the patient. Likewise, when we recognize that one of our colleagues may be struggling with a substance use disorder, we have a responsibility to do the right thing and bring it to the attention of someone who can intervene on behalf of both the nurse and patients under their care.

While there remains much to learn about substance use disorders, the evidence shows that a combination of treatment and involvement in 12-step meetings can have a positive impact on facilitating remission and preventing deaths. We need to see this disease and the current opioid crisis with eyes wide open. The increasing death rates are staggering and profoundly impacting families, communities and others. To be effective in identifying and appropriately responding to individuals with possible substance use disorders we need to shed the stereotype view of what a person with an addiction looks or acts like and timely respond with compassion, understanding, firmness and at times, persistence. It is not if but rather when you suspect a family member, friend, patient or colleague has a substance use disorder, dare to do the right thing and share your concerns. By speaking up and making your concerns known to those who have the ability to further assess and intervene if needed, lives can be saved.

EFFECTIVE DATE	NAME	CERTIFICATE	DISCIPLINE
12/30/2015	Alchesay, Lauren G.	CNA1000022650	Revoked
12/14/2015	Alvey, Judah D.	CNA Applicant	Certificate Denied
2/8/2016	Arroyo, Jessica A.	CNA999995403	Voluntary Surrender
3/24/2016	Battle, Sherrod T.	CNA Applicant	Certificate Denied
12/21/2015	Begay, Linda C.	CNA480118353	Decree of Censure
3/10/2016	Bennett, Brett S.	CNA1000041932	Revoked
2/1/2016	Bernot, Anthony J.	CNA Applicant	Certificate Denied
3/9/2016	Berryhill, Brittany A.	CNA Applicant	Certificate Denied
3/7/2016	Boarder, Carrie L.	CNA1000007537	Voluntary Surrender
2/22/2016	Botta, Aleshia S.	CNA1000026576	Voluntary Surrender
1/14/2016	Bouchard, Channel C.	CNA1000037612	Revoked
3/9/2016	Bowers, Wesley J.	CNA999998005	Revoked
1/21/2016	Carasco, Ghislaine	CNA999996010	Stayed Revocation with Suspension
12/8/2015	Casey, Monica E.	CNA999995295	Decree of Censure
2/24/2016	Chandler, Paul E.	CNA1000043924	Voluntary Surrender
3/7/2016	Chavez, Angelica M.	CNA Applicant	Certificate Denied
3/7/2016	Chavez, Sabrina N.	CNA Applicant	Certificate Denied
12/14/2015	Chillis, Lashunda D.	CNA Applicant	Certificate Denied
1/29/2016	Clah, Christine R.	CNA1000014051	Stayed Revocation
2/4/2016	Clements, Mariah	CNA Applicant	Certificate Denied
12/3/2015	Comer, Keith E.	CNA Applicant	Certificate Denied
12/16/2015	Davis, Kristy A.	CNA Applicant	Certificate Denied
12/30/2015	Davis, Natanya R.	CNA Applicant	Certificate Denied
3/9/2016	Dayway, Tina R.	CNA1000014883	Revoked
12/24/2015	Delgado, Jose M.	CNA Applicant	Certificate Denied
3/23/2016	Dixon, Caroline L.	CNA Applicant	Certificate Denied
3/9/2016	Dow, Cheriena K.	CNA1000024739	Revoked
2/10/2016	Downing, Tammy K.	CNA Applicant	Certificate Denied
12/30/2015	Driver, Crystal A.	CNA1000028604	Revoked
3/15/2016	Durazo, Maria L.	CNA Applicant	Certificate Denied
12/28/2015	Dursma, Jennifer R.	CNA1000045326	Revoked
3/29/2016	Ellsworth, Amanda M.	CNA1000031012	Voluntary Surrender
12/30/2015	Esquer, Cynthia	CNA457283333	Decree of Censure
3/24/2016	Fadok, Daniel S.	CNA Applicant	Certificate Denied
2/4/2016	Foos, Melissa A.	CNA Applicant	Certificate Denied
12/1/2015	Fraga, Jonelle L.	CNA1000036629	Probation
3/28/2016	Giamei, Desiree R.	CNA Applicant	Certificate Denied
3/2/2016	Gomez, Julissa A.	CNA1000022127	Decree of Censure
12/14/2015	Graham, Keith A.	CNA1000049082	Civil Penalty
12/14/2015	Greer, John A.	CNA Applicant	Certificate Denied

EFFECTIVE DATE	NAME	CERTIFICATE	DISCIPLINE
12/30/2015	Greybull, Anita L.	CNA1000019636	Revoked
12/30/2015	Gronewold, Holly A.	CNA1000035109	Revoked
3/16/2016	Guerrero, Marlayna A.	CNA Applicant	Certificate Denied
3/23/2016	Gullett, Lance C.	CNA Applicant	Certificate Denied
3/25/2016	Hall, Jeffrey J.	CNA1000035855	Stayed Revocation
3/23/2016	Harris, Ivey H.	CNA1000035493	Voluntary Surrender
3/28/2016	Hewitt, Jeremy	CNA Applicant	Certificate Denied
1/6/2016	Hillo Contreras, Vania N.	CNA1000007351	Decree of Censure
12/18/2015	Hinton, Colette E.	CNA Applicant	Certificate Denied
2/29/2016	Hunter, Gregory E.	CNA Applicant	Certificate Denied
2/10/2016	Jhinnu, Erica A.	CNA1000049456	Suspension
9/10/2015*	Johnson, Debra J.	CNA Applicant	Certificate Denied
3/24/2016	Johnson, Justin I.	CNA Applicant	Certificate Denied
3/7/2016	Johnson, Yolanda	CNA Applicant	Certificate Denied
1/15/2016	Jorstad, Jeri A.	CNA Applicant	Certificate Denied
3/9/2016	Kaylor, Wendy M.	CNA873294641	Revoked
3/22/2016	Kelley, Ashley A.	CNA Applicant	Certificate Denied
2/11/2016	King, Louise E.	CNA919401093	Decree of Censure
2/1/2016	Lapizco, Javier A.	CNA Applicant	Certificate Denied
1/29/2016	Leon, Vanessa M.	CNA1000038133	Stayed Revocation
3/18/2016	Leon, Vanessa M.	CNA1000038133	Revoked
2/10/2016	Lewis, Keishawna R.	CNA Applicant	Certificate Denied
3/29/2016	Loudermilk, Lasheika D.	CNA Applicant	Certificate Denied
3/2/2016	Loustaunau, Samuel D.	CNA Applicant	Certificate Denied
12/24/2015	Luna, Krystal M.	CNA1000001930	Renewal Denied
12/2/2015	Lupkin, Elizabeth	CNA643386803	Decree of Censure
12/30/2015	Maloney, Stella	CNA854036803	Revoked
3/23/2016	Martin, Sheila	CNA Applicant	Certificate Denied
3/9/2016	Mattson, Carl W.	CNA231441106	Revoked
12/30/2015	Mccollam, Lyle G.	CNA1000009153	Revoked
12/30/2015	Mendoza, Elizabeth A.	CNA1000022954	Revoked
3/8/2016	Merkle, Jessi D.	CNA999993874	Decree of Censure
3/28/2016	Miller, Alexandria R.	CNA Applicant	Certificate Denied
2/10/2016	Miller, Stephenie C.	CNA Applicant	Certificate Denied
3/17/2016	Mims, Tamara L.	CNA Applicant	Certificate Denied
3/9/2016	Monterroso, Lucrecia M.	CNA1000038279	Revoked
3/8/2016	Moreno, Christopher E.	CNA999994803	Decree of Censure
3/3/2016	Morren, Nicole R.	CNA1000028218	Decree of Censure
3/9/2016	Morris, Mellonee L.	CNA174139237	Certificate Denied
1/4/2016	Munhall, Kadee R.	CNA Applicant	Certificate Denied

*Not reported in previous Journal

EFFECTIVE DATE	NAME	CERTIFICATE	DISCIPLINE
3/16/2016	Nachu, Sasha T.	CNA Applicant	Certificate Denied
12/2/2015	Nelson, Gail M.	CNA1000048914	Decree of Censure
12/30/2015	Partridge, Pamila A.	CNA999951646	Revoked
2/12/2016	Peters, Sharon L.	CNA Applicant	Certificate Denied
12/24/2015	Phelps, Andrea L.	CNA1000021611	Civil Penalty
2/10/2016	Pleasant, Tony	CNA Applicant	Certificate Denied
3/1/2016	Ramierz Olvera, Amador	CNA999992750	Voluntary Surrender
12/30/2015	Roberts Rodriquez, Enrique B.	CNA1000035858	Decree of Censure
2/3/2016	Rojas Flores, Jaravith	CNA999950975	Civil Penalty
12/29/2015	Rubio, Rachel A.	CNA Applicant	Certificate Denied
12/15/2015	Russell, Cheyenne B.	CNA Applicant	Certificate Denied
12/30/2015	Sailer, Galen B.	CNA1000021612	Revoked
2/29/2016	Salcido, Catherine E.	CNA Applicant	Certificate Denied
3/8/2016	Sanchez, Alexis N.	CNA1000024984	Decree of Censure
3/9/2016	Santillan, Michael S.	CNA1000039987	Revoked
12/29/2015	Schwind, Michele M.	CNA Applicant	Certificate Denied
3/10/2016	Sharpe, Chaunci L.	CNA1000030803	Revoked
3/16/2016	Sheridan, Gerard A.	CNA Applicant	Certificate Denied
12/29/2015	Skinner, Catherin M.	CNA595830103	Renewal Denied
3/16/2016	Snodgrass, Michael A.	CNA Applicant	Certificate Denied
11/20/2015*	Spangler, Pamela J.	CNA1000000543	Stayed Revocation
3/24/2016	Springer, Pena C.	CNA Applicant	Certificate Denied
3/10/2016	Sturges, Angela M.	CNA999999851	Revoked
3/8/2016	Tavara, Karen L.	CNA1000032237	Decree of Censure
3/16/2016	Taylor, Sequone L.	CNA Applicant	Certificate Denied
3/25/2016	Thomas, Wilma T.	CNA704099803	Revoked
3/24/2016	Van Kirk, Patricia D.	CNA Applicant	Certificate Denied
12/24/2015	Villalba, Jessica M.	CNA1000021398	Decree of Censure
12/29/2015	Ward, Roxie M.	CNA Applicant	Certificate Denied
2/10/2016	Washington, Lasheena M.	CNA Applicant	Certificate Denied
2/11/2016	Weaver, Stephanie A.	CNA Applicant	Certificate Denied
3/15/2016	Wells, Tiffany L.	CNA Applicant	Certificate Denied
3/24/2016	Wersonick, Brittney M.	CNA Applicant	Certificate Denied
2/10/2016	Wienskovich, Rachel A.	CNA Applicant	Certificate Denied
2/10/2016	Willie, Karen	CNA Applicant	Certificate Denied
3/16/2016	Wilson, Justin R.	CNA Applicant	Certificate Denied
12/31/2015	Wise, Pamela E.	CNA Applicant	Certificate Denied
3/24/2016	Wright, Keosha Q.	CNA Applicant	Certificate Denied
2/10/2016	Zay Zay, Henry L.	CNA Applicant	Certificate Denied
3/16/2016	Zbasnik, Becky A.	CNA Applicant	Certificate Denied

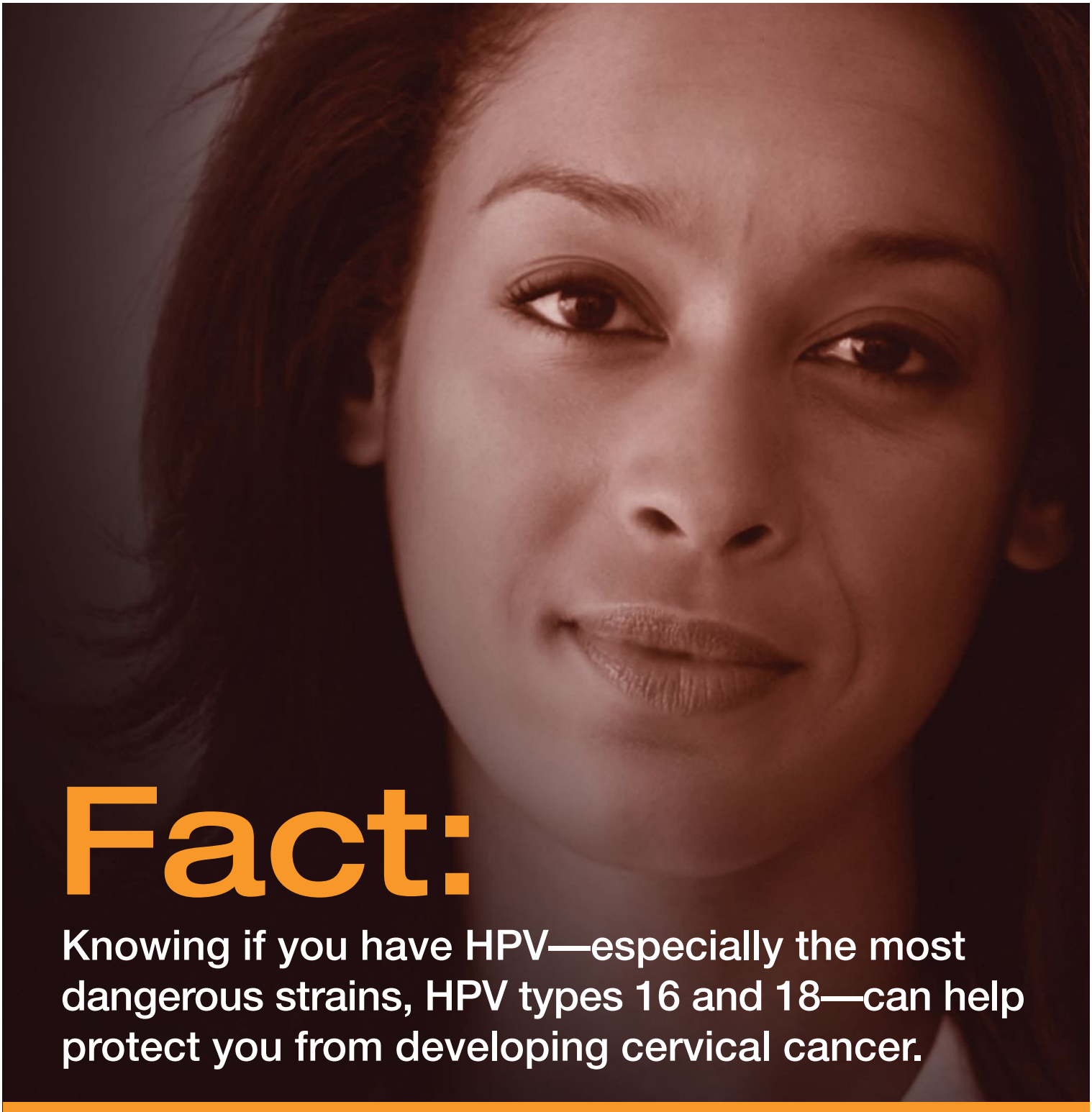
*Not reported in previous Journal

EFFECTIVE DATE	NAME	CERTIFICATE	DISCIPLINE
3/21/2016	Absalon, Michelle L.	RN134359	Voluntary Surrender
1/29/2016	Anako, Imo J.	RN107716	Probation
2/18/2016	Arguelles, Carmen	RN082051/CRNA0354	Voluntary Surrender
1/28/2016	Atha IV, Frank P.	LP047602	Decree of Censure
3/23/2016	Bader, Sarah A.	LPN Endorsement	License Denied
2/1/2016	Balka, Eric A.	RN Endorsement	License Denied
3/9/2016	Ballhorst, Chelsie R.	RN162043/LP044594	Revocation
1/13/2016	Bays, Nichole L.	RN137178	Voluntary Surrender
3/4/2016	Biggs, Jamey L.	Compact, MO RN2003024481	Revocation of Nurse Multi-State Licensure Privilege`
2/29/2016	Bolton, Cecilia D.	RN097867	Decree of Censure
2/1/2016	Borkowski, Annie C.	RN Endorsement	License Denied
2/22/2016	Botta, Aleshia S.	RN196179	Voluntary Surrender
2/3/2016	Bowditch, Allison D.	RN146622	Revocation
1/5/2016	Boyle, Dale R.	RN167405	Voluntary Surrender
12/21/2015	Bresil, Lorie	RN170756	Suspension
2/2/2016	Bush, Jeremy F.	RN191903	Voluntary Surrender
3/23/2016	Bustillos, Ryan E.	LPN Reissuance	Reissuance Denied
12/9/2015	Butler, Jeremy S.	RN140180/AP8337	Civil Penalty
3/14/2016	Calabro, Elizabeth J.	RN078191	Voluntary Surrender
12/8/2015	Callaghan, Kristina D.	RN113300	Voluntary Surrender
1/4/2016	Coleman, Samuel L.	RN135736	Revocation
2/12/2016	Davison, Sarah K.	RN134577	Stayed Revocation with Suspension
3/10/2016	Devillier, Jamie P.	RN168377	Voluntary Surrender
12/3/2015	Diaz, Richard M.	RN138054	Civil Penalty
3/21/2016	Downey, Jeffrey L.	LP026343	Decree of Censure
3/16/2016	Droit, Jennifer C.	RN162108	Decree of Censure
1/29/2016	Du Bois, Marsha B.	RN116207	Decree of Censure
12/30/2015	Dudenhoefer Jr, Paul A.	RN000099612	Revocation
1/29/2016	Eagley, Melissa L.	RN166358	Voluntary Surrender
12/3/2015	Erickson, Melissa M.	RN182599	Voluntary Surrender
12/30/2015	Farley, Kerry L.	RN154627	Revocation
1/28/2016	Finkle, Jennifer E.	RN164378/LP045004	Decree of Censure
3/25/2016	Fisher, Nicholas A.	RN198642	Probation
12/1/2015	Fraga, Jonelle L.	RN196132	Probation
1/29/2016	Freytag, Alan L.	RN133378	Voluntary Surrender
1/4/2016	Gallardo, Carolyn A.	RN163381	Probation
12/30/2015	Gomez, Melissa S.	LP039414	Revocation
12/14/2015	Graves, Jessica E.	RN Endorsement	License Denied
12/2/2015	Griffin, Mary E.	LP011505	Voluntary Surrender
2/24/2016	Gubbels, Ann Lisa D.	RN114152	Voluntary Surrender
3/3/2016	Hamm, Kristi D.	RN175526	Decree of Censure
3/3/2016	Harney, Jamie L.	LP049562	Probation
12/16/2015	Hector, Erik R.	RN Exam	License Denied
1/14/2016	Henely, Richard J.	RN046579	Stayed Revocation with Suspension
3/15/2016	Hickbottom, Lytonya F.	LP050532	Probation
1/29/2016	Hochman, Susan D.	RN189864	Voluntary Surrender

*Not reported in previous Journal

EFFECTIVE DATE	NAME	CERTIFICATE	DISCIPLINE
1/29/2016	Hoffend, Mary A.	RN073837	Summary Suspension
12/2/2015	Hopper, Lauren S.	RN Endorsement	License Denied
12/14/2015	Howard, Cynthia L.	RN Endorsement	License Denied
12/30/2015	Hubbard, Peter C.	RN155275	Suspension
3/4/2016	Hunsaker, Vickie L.	LP031936	Probation
12/17/2015	Hyder, Jean A.	RN032556	Voluntary Surrender
12/17/2015	Irwin, Kathryn M.	RN137937/AP5452	Voluntary Surrender
12/23/2015	Iwunze, Eunice C.	LP032436	Reissuance with Stayed Revocation Probation
12/30/2015	Jeffers, Sara N.	RN064730	Revocation
12/18/2015	Jessup, Mark D.	RN Reissuance	Reissuance Denied
3/9/2016	Joaquin, Mary A.	LP019500	Revocation
3/21/2016	Johnson, Dennis P.	RN170254	Probation
2/11/2016	Johnson, Margene A.	RN Reissuance	Reissuance Denied
3/9/2016	Johnson, Sherrie A.	LP035774	Revocation
2/1/2016	Johnson-Copney, Brittanie A.	LP049380	Decree of Censure
12/30/2015	Kalinowski, Patricia A.	RN153782	Revocation
1/22/2016	Kern, Jason A.	RN124000/LP036078	Voluntary Surrender
12/30/2015	Kinkead, Lauren R.	LP048640	Revocation
12/30/2015	Koppen, Deborah K.	RN171730	Revocation
3/3/2016	Kwofie, Agatha J.	LP047430	Decree of Censure
2/24/2016	Lamb, Carolyn A.	RN093325	Decree of Censure
3/25/2016	Langrock, Sheila J.	RN095006	Civil Penalty
3/28/2016	Lavin, Luann B.	AP8594	Probation
12/28/2015	Lee, Kelley L.	LP043218	Probation
12/14/2015	Leeper, Ashley L.	LPN Endorsement	License Denied
3/25/2016	Liu, Qing	RN178970	Suspension
2/25/2016	Locke, Julie S.	RN158299	Decree of Censure
3/25/2016	Long, Sandra K.	RN079849/AP2928	Stayed Revocation with Probation
12/24/2015	Lynn, Diana M.	RN045486	Probation
1/5/2016	Martinez, Michelle A.	RN086968	Decree of Censure
12/24/2015	Mason, Priscilla	RN085502/LP027667	Stayed Suspension with Probation
1/29/2016	Mbithi, Cyrus M.	RN173726	Summary Suspension
12/28/2015	McAvoy Jr, James A.	RN124750/AP3968	Revocation
12/17/2015	McKinley, Allison C.	RN190340	Decree of Censure
3/9/2016	Merritt, Richard V.	RN Reissuance	Reissuance Denied
1/29/2016	Minch, Alice J.	RN079946/LP026129	Summary Suspension
3/16/2016	Muchoki, Paul Abdallah K.	LP043837	Decree of Censure
1/29/2016	Mueller, Brita L.	RN171349	Summary Suspension
1/19/2016	Murphy, Robert A.	RN102316	Voluntary Surrender
3/25/2016	Nissl, Donna L.	LP041769	Summary Suspension
3/17/2016	Nuuyoma, Aina	LP033276	Decree of Censure
12/2/2015	Owens, Anne M.	RN115007	Revocation
12/18/2015	Padgett, Stacey M.	RN131412	Voluntary Surrender
12/30/2015	Payne, Kelly J.	LP035029	Voluntary Surrender
12/25/2015	Penkey, Alicia M.	LPN Endorsement	License Denied
3/9/2016	Perkins, Lynne A.	LP038649	Revocation

EFFECTIVE DATE	NAME	CERTIFICATE	DISCIPLINE
1/13/2016	Quintana, Amy M.	LP048140	Voluntary Surrender
12/30/2015	Quintero, Kathleen E.	RN102714/LP031407	Revocation
2/16/2016	Raleigh, Cherise C.	RN098313	Decree of Censure
1/28/2016	Ramirez, Gerardo	RN134500	Suspension
12/21/2015	Ramsey, Prudence A.	RN169503	Suspension
1/6/2016	Reagan, Bridget M.	RN161514	Voluntary Surrender
12/21/2015	Reagan, Bridget M.	RN161514/SN1045	Stayed Revocation with Suspension
3/23/2016	Recinos, Myrna B.	RN195701	Voluntary Surrender
1/13/2016	Reichle, Lynn L.	RN168901/AP4106	Revocation
12/14/2015	Rendon, Rebecca C.	LP027665	Civil Penalty
2/11/2016	Reynolds, Mathew J.	RN156969	Revocation
3/2/2016	Risner, Todd J.	RN181729	Probation
12/3/2015	Santiago, Mario A.	RN148573	Stayed Revocation with Suspension
2/22/2016	Scala, Kay M.	RN049048/AP3431	Voluntary Surrender
3/23/2016	Scarfone, Helen M.	LP042905	Voluntary Surrender
12/23/2015	Schatz, Paul R.	RN Reissuance	Reissuance Denied
12/21/2015	Schucker, Lynn A.	RN045450	Probation
1/11/2016	Schumacher, Nancy A.	RN048435	Voluntary Surrender
3/1/2016	Self, Cheryl L.	RN063054	Reissuance with Stayed Revocation Probation
2/29/2016	Sinotte, Doris M.	RN181095	Decree of Censure
3/24/2016	Smith, Beth K.	RN Endorsement	License Denied
12/3/2015	Spender, Neale M.	RN196222/AP8338/Compact, CO RN	Civil Penalty
12/9/2015	Stanley, Nancy L.	RN095529	Decree of Censure
2/22/2016	Starkey, Alana M.	RN175676	Decree of Censure
12/30/2015	Steigert, Andrew D.	RN160712	Revocation
2/25/2016	Swanson, Renee L.	RN174057	Voluntary Surrender
12/8/2015	Sykes, David A.	RN171580	Voluntary Surrender
3/24/2016	Tarango, Luz M.	LP008527	Civil Penalty
12/4/2015	Tremble-Webster, Crystal	RN196177/LP037627	Decree of Censure
1/15/2016	Ude, Lillian J.	LP037683	Decree of Censure
2/26/2016	Ussery, Vivian M.	LP034864	Probation
3/8/2016	Velovich, Tamara V.	LP046656	Revocation
1/29/2016	Vinyard, Laura C.	RN182725	Voluntary Surrender
12/2/2015	Wakefield, Jenny A.	RN196188	Probation
12/17/2015	Watson, Karen	LP036032	Stayed Revocation with Suspension
3/21/2016	Watson, Patricia D.	RN181734	Voluntary Surrender
3/14/2016	Weyant, Jennifer	RN195344	Voluntary Surrender
3/23/2016	Wheeler, Carissa M.	LPN Endorsement	License Denied
3/25/2016	Williams-Tate, Nikki R.	LP047258	Summary Suspension
12/16/2015	Wilmont, Korissa N.	LP039253	Probation
1/13/2016	Wright, Lisa M.	RN132858	Voluntary Surrender
3/24/2016	Ybarra, Cheryl J.	LPN Endorsement	License Denied
3/8/2016	Yeaman, Howard P.	RN193789	Revocation
12/30/2015	Yonan, Alan I.	LP040734	Revocation
3/22/2016	Zarate, Georgieanna P.	RN Reissuance	Reissuance Denied
12/28/2015	Zuniga, Brianna M.	RN169195	Decree of Censure



Fact:

Knowing if you have HPV—especially the most dangerous strains, HPV types 16 and 18—can help protect you from developing cervical cancer.

If you are 30 or older, ask your health care provider about getting an HPV test with your Pap test. Learn more at www.healthywomen.org/hpv.

This resource was created with support from Roche Diagnostics Corporation.

healthy women
informed. empowered.
www.healthywomen.org

ARIZONA STATE BOARD OF NURSING
4747 North 7th Street, Suite 200
Phoenix, AZ 85014-3655

PRESORTED
STANDARD
U.S. POSTAGE PAID
LITTLE ROCK, AR
PERMIT NO. 1884