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Pennsylvania Prescription Drug Monitoring Program (PDMP)
System User and Stakeholder Training

Evidence-Based Prescribing: Tools You Can Use to Fight the Opioid Epidemic

Available online at www.doh.pa.gov/PDMP

Pennsylvania Prescription Drug Monitoring Program (PDMP) System User and Stakeholder Training

Learning Objectives for Modules 1-7

Module 1: Why Using the PDMP is Important for Achieving Optimal Health for Pennsylvania Citizens

1. The status of substance use disorder in general, opioid use disorder, and overdoses nationally and in Pennsylvania;
2. Common misconceptions about substance use disorder and opioid use disorder treatment and recovery;
3. Costs associated with prescription drug and heroin-associated opioid use disorder and overdose; and
4. How pervasive prescriber and pharmacist PDMP use can reduce population opioid use disorder and overdose.

Module 2: What is a PDMP, How to Use the PDMP to Make Clinical Decisions, How to Integrate the PDMP into the Clinical Workflow, and How to Access Pennsylvania's PDMP

1. Detail Pennsylvania's requirements and regulations regarding PDMP use;
2. Explore options and actions Pennsylvania prescribers and pharmacists can take to integrate the PDMP into clinical workflows; and
3. Discuss how to use the PDMP system to make clinical decisions.

Module 3: Using the PDMP to Optimize Pain Management

1. Learn how to use the PDMP to address pain management for various patient populations and pain types;
2. Understand the basic nature of pain for different patient populations and how to manage their pain using the PDMP as a clinical tool; and
3. Discuss different ways of treating patient pain that do not involve the immediate use of opioids.

Module 4: Opioid Prescribing Guide

1. Provide guidelines to inform all healthcare providers when prescribing opioids in the acute phase of pain;
2. Instruct healthcare providers on how to prescribe opioids in the chronic phase of pain, which includes information on how to initiate or continue opioid therapy, select the correct dose, and/or discontinue opioids;
3. Instruct healthcare providers on how to assess risks and address harms associated with opioid use;
4. Instruct healthcare providers on the legal responsibilities related to prescribing opioids; and
5. Instruct healthcare providers on how they may direct patients to dispose of unused medications.

Module 5: Referral to Treatment for Substance Use Disorder Related to Opioid Use

1. Define "warm handoffs" and how they can best occur;
2. Provide a schema for how any healthcare provider can implement "warm handoffs" in any clinical setting;
3. Demonstrate how primary care practices can conduct "warm handoffs" by preparing, using validated screening tools, and using patient-centered communication with patients;
4. Demonstrate how healthcare providers can determine the best type of treatment for their patients;
5. Present information on patient confidentiality that providers should be aware of when working with patients with substance use disorders and performing "warm handoffs"; and
6. Present relevant Pennsylvania links for treatment and other resources.

Module 6: Approaches to Addressing Substance Use Disorder with Patients Identified by the PDMP

1. Learn how to integrate the PDMP with other screening tools to help identify those who may require substance use disorder treatment or increased monitoring;
2. Define Screening, Brief Intervention, and Referral to Treatment (SBIRT), its main goals, and its main components;
3. Learn how to screen a patient for a potential substance use disorder, conduct a brief intervention, and refer a patient to treatment;
4. Learn how to discuss a substance use disorder with a patient and handle patient resistance; and
5. Learn how to incorporate SBIRT into clinical practice.

Module 7: Effective Opioid Tapering Practices

1. Discuss how to use the PDMP to determine if a provider should consider tapering his/her patient;
2. Discuss several indicators that prescribers can look for when considering tapering opioids;
3. Inform prescribers on how to discuss tapering with patients using patient-centered techniques;
4. Present a general opioid tapering protocol and how to adapt this protocol to the needs of any patient; and
5. Present information on how to manage withdrawal and how to use tools to measure withdrawal symptoms in patients.

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Pennsylvania Prescription Drug Monitoring Program (PDMP)
System User and Stakeholder Training

Why Using the PDMP is Important for Achieving Optimal Health for Pennsylvania Residents

MODULE 1

GUIDE DOCUMENT

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Introduction

The United States currently faces a public health crisis from opioid use disorder and related overdoses.[1,2] In fact, Pennsylvania has one of the highest rates of overdose in the nation, with 36.1 (4,415) deaths occurring per 100,000 people in 2018.[3]

Moreover, the increased prevalence of opioid use disorder has become one of the most significant public health crises the commonwealth has ever experienced. This crisis is associated with rising overdose rates, deadly social consequences, increased health-related risks and high economic and societal costs. In fact, opioid misuse costs each Pennsylvanian approximately $68, on average.[4] Examples of areas in which societal costs have been elevated due to the high rates of opioid use disorder include the criminal justice system, child welfare system, substance use disorder treatment, other areas of healthcare, emergency medical services and lost productivity costs.[5-7]

One of the reasons the societal costs and economic burden related to opioid use disorder and overdose is so high is that opioid addiction is associated with other health care risks. As just one example, rates of hepatitis C diagnoses are higher among individuals with opioid use disorder. One study showed that from 2006–2016, admissions for opioid dependence in the Appalachia region increased 21.1%.[8] At the same time, 1,377 new hepatitis C diagnoses were recorded.[8] Another study examining hepatitis C prevalence and opioid use during buprenorphine treatment indicated that 76% of people in treatment also had hepatitis C diagnoses.[9]

Until recently, overdose deaths were more commonly associated with prescription opioid use rather than with heroin use. Presently, synthetic opioids such as fentanyl and fentanyl-related substances (typically present in street heroin) have become a more prevalent cause of opioid-associated deaths, especially in Pennsylvania. Analyses of 2018 drug-related overdose deaths indicated that 70% of deaths resulted from fentanyl, while 35% of deaths resulted from heroin, 33% of deaths resulted from cocaine, and 28% of deaths resulted from benzodiazepines and 18% of deaths results from prescription opioids.[10] The association between prescription opioids and heroin is complex, but individuals who have developed opioid dependence to heroin frequently cite early access to prescription opioids and illicit prescription opioid use as their first exposure leading to future heroin use.[11]

Because of the role of prescription opioids in opioid use disorder and overdose, it is important that prevention, intervention and treatment efforts address prescription opioids at their source — with prescribers and pharmacists/dispensers. To combat the misuse of opioids, the Pennsylvania Department of Health has developed a series of Opioid Prescribing Guidelines in addition to developing a Prescription Drug Monitoring Program (PDMP). The Pennsylvania Department of Health administers this program and, in January 2017, registration for this program became mandatory for all prescribers and pharmacists of Schedule II-V substances.

In this module, prescribers and pharmacists will learn why the use of the PDMP is important to improving Pennsylvania's population health. This module will include information on:

1. The status of substance use disorder in general, opioid use disorder and overdoses nationally and in Pennsylvania;
2. Common misconceptions about substance use disorder and opioid use disorder treatment and recovery;
3. Costs associated with prescription drug and heroin-associated opioid use disorder and overdose; and
4. How pervasive prescriber and pharmacist PDMP use can reduce population opioid use disorder and overdose.

What Do We Know About Addiction, Opioid Use Disorder, and Overdose Nationally and in Pennsylvania?

Below are statistics about substance use disorder, opioid use disorder and overdoses nationally and specifically in Pennsylvania.

National Statistics

Substance use disorder rates are high in our nation.

- 20.3 million individuals in the United States (12 years of age and older) had a substance use disorder in 2018. An estimated 2 million people had an opioid use disorder which includes 1.7 million people with a prescription pain reliever use disorder and 526,000 people with a heroin use disorder.[12]
- Prescription pain reliever misuse was the second most common form of illicit drug use in the United States in 2018, with 3.6% of the population misusing pain relievers.[12]

Overdoses are occurring at alarmingly high rates.

- Overdose deaths have been increasing since 1999; however, in 2018, the United states saw a 4.1% decrease in overdose deaths from the previous year (67,367 and 70,237, respectfully). [13]
- In 2018, 69.5% (46,802) overdose deaths involved an opioid. Additionally, the rate of drug overdose deaths involving synthetic opioids other than methadone (including fentanyl and tramadol) increased by 10% in 2018.[13]
- In 2018, the states with the highest rates of death due to drug overdose were West Virginia, Delaware, Maryland, Pennsylvania, Ohio, and New Hampshire.[14]

Other comorbidities from the epidemic are increasing.

- Incidences of neonatal abstinence syndrome due to in utero exposure to opioids has increased by 300% from 1999 to 2013.[15,16]

Early misuse of prescription medications can indicate future opioid misuse in adolescents.

- Data from the 2009 National Survey on Drug Use and Health showed that approximately one-third of people 12 years and older who used drugs for the first time began with using a prescription drug non-medically.[1]
- Data from the 2018 National Survey on Drug Use and Health showed that 310,000 adolescents aged 12 to 17 misused pain relievers for the first time in the past year.[12]
- An estimated 0.4 percent of adolescents aged 12 to 17 had an opioid use disorder in the past year, which represents about 108,000 adolescents.[12]
- Opioid use disorder related to prescription pain medications is highest among adolescents and young adults, with 1.9 million people aged 12 to 26 with prescription pain medication-related opioid use disorder, as compared to 1.3 million people aged 26 or older.[12]
- Among people aged 12 or older who misused prescription pain relievers in the past year, the most common reason for their last misuse of a pain reliever was to relieve physical pain. Other common reasons were to feel good or get high (10.6%) and to relax or relieve tension (9.3%).[12]

Pennsylvania Statistics

Overdoses in our own state are steadily increasing.

- In 2018, 4,422 drug-related overdose deaths were reported in Pennsylvania versus 5,398 deaths in 2017.[18]
- The drug-related overdose death rate in Pennsylvania was 35 per 100,000 people in 2018. Nationally in 2018, there were 67,367 drug overdose deaths, 4.1% fewer deaths than in 2017 (70,237).[10]
- The presence of an opioid, illicit or prescription, was reported in 82% of the drug-related overdose deaths in Pennsylvania in 2018, compared to 84% of drug-related overdose deaths in 2017.[10]
- In 2018, overdose decedents were primarily white, male, and 25-34 years of age.[10]

Fentanyl and related synthetic opioids are at the forefront of the epidemic.

- Fentanyl was the most frequently identified substance in drug-related overdose deaths (70% of deaths), remaining consistent with 2017. The younger population demographic was associated with fentanyl usage, as fentanyl was present in more the 75% of drug related overdose decedents within the 15 to 24 and 25-34 age groups.[10]

Heroin, benzodiazepines, cocaine and prescription opioids are also frequently encountered in overdose deaths.

- Consistent with prior years, in 2018, detections of multiple drugs in screenings were prevalent: 87% of decedents presented two or more drugs, 46% presented four or more drugs, and 16% presented six or more drugs. [10]
- 70% of drug overdose toxicology reports from 2018 contained fentanyl. [10]
- 35% of drug overdoses in 2018 revealed the presence of heroin. [10]
- 28% of drug overdoses in 2018 contained benzodiazepines.[10]
- 33% of drug overdoses in 2018 resulted from cocaine. [10]
- 18% of drug overdoses in 2018 were prescription opioid-related.[10]

Neonatal abstinence syndrome still remains an issue.

- In 2019, a total of 2,140 babies were born with neonatal abstinence syndrome in Pennsylvania. The majority tested positive for some form of opioids.[19]

Do Patients Recover Who Receive Substance Use Disorder Treatment?

It is a common misconception and belief that substance use disorder treatment is not successful.[20]
It is true that substance use disorder is a chronic condition and relapse is a part of this process. However, the rate of relapse is similar to, or less than that of other chronic medical conditions. Studies have shown that 40-60% of patients remain completely abstinent one year after treatment discharge.[21] Furthermore, recovery rates continue to increase after the first year, and by year five stabilize at about an 86% recovery rate, similar to the recovery pattern seen in cancer patients.[22]

The National Institute on Drug Abuse has developed a list of 13 principles for effective substance use disorder treatment. These principles include:

The National Institute on Drug Abuse: 13 Principles for Effective Substance Use Disorder Treatment[23]

1. Addiction is a complex but treatable disease that affects brain function and behavior.
2. No single treatment is appropriate for everyone.
3. Treatment needs to be readily available.
4. Effective treatment attends to multiple needs of the individual, not just his/her drug misuse.
5. Remaining in treatment for an adequate period of time is critical.
6. Behavioral therapies — including individual, family or group counseling — are the most commonly used forms of drug misuse treatment.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.
9. Many drug-addicted individuals also have other mental disorders.
10. Medically-assisted detoxification is only the first stage of addiction treatment and, by itself, does little to change long-term drug misuse.
11. Treatment does not need to be voluntary to be effective.
12. Drug use during treatment must be monitored continuously, as lapses during treatment do occur.
13. Treatment programs should test patients for the presence of human immunodeficiency virus or acquired immunodeficiency syndrome, hepatitis B and C, tuberculosis and other infectious diseases, as well as provide targeted risk-reduction counseling, linking patients to treatment, if necessary.

Continued

Do Patients Recover Who Receive Substance Use Disorder Treatment? *(Continued)*

Literature by McLellan and O'Brien emphasizes that substance use disorder is a chronic disease and should be treated like a chronic disease.[20] Currently, substance use disorder is more commonly treated using the Acute Care Model rather than the Chronic Care Model.[21] A paradigm shift in the way that substance use disorder is viewed would be beneficial, given the similarities in medical compliance, other treatment compliance, and relapse rate that exist between substance use disorders and other chronic diseases *(Table 1)*.

Table 1: Treatment Compliance and Relapse Rates in Patients with Substance Use Disorders, Diabetes, Hypertension, and Asthma (% of Patients).[20,21,24,25]

Diagnosis	Medical Compliance*	Other Treatment Compliance**	Relapse
Substance Use Disorder	60 – 80%***	—	40 – 60%
Diabetes	< 60%	< 30%	30 – 50%
Hypertension	< 40%	< 30%	50 – 70%
Asthma	< 40%	< 30%	50 – 70%

* Compliance indicates the patient's likelihood to adhere to his/her medication regimen.

** Other treatment compliance includes: adherence to diet changes, foot care and other behavioral changes.

*** Based on compliance to naltrexone to treat alcohol dependence

Relapse rates among patients with diabetes, hypertension or asthma are just as high as relapse rates among those with substance use disorders: 30-50% of patients with diabetes and 50-70% of patients with hypertension or asthma experience recurrence of symptoms that require additional medical care.[21] In comparison, 40-60% of patients relapse back into substance use disorder.[24,25]

Studies have shown that 60-80% of patients with substance use disorder, less than 60% of patients with diabetes, and less than 40% of patients with hypertension and asthma adhere to their medication regimens.[21] In addition, less than 30% of patients with asthma, hypertension or diabetes adhere to prescribed diet, exercise or behavioral changes to improve health and mitigate risk factors.[21] Given its high prevalence across all age groups, association with unprecedented rates of overdose deaths, and high associated societal and healthcare costs, the availability of quality, evidence-based treatment for opioid use disorder is being emphasized within Pennsylvania and across the country.

Healthcare and Societal Costs Associated with Opioid Use Disorder

The total economic burden for substance use disorder and overdose related to prescription opioid dependence ranges from $78.5 billion to $400 billion.[4,26]

A comprehensive analysis of 2013 data by Florence and colleagues allocates these costs as follows: (1) healthcare costs based on claims data; (2) substance use disorder treatment costs; (3) criminal justice costs, which comprise police protection, legal and adjudication, correctional facility and property lost costs; and (4) lost productivity costs as a result of premature death, reduced productive hours or incarceration.[5]

Results from economic analyses indicate that healthcare costs associated with overdoses accounted for 33% of the total economic burden related to prescription opioid use disorder.[5] For non-fatal opioid use, substance use disorder treatment accounted for 4% of the total economic burden, lost productivity accounted for 26% of the economic burden and criminal justice-associated costs accounted for 10% of the total economic burden.[5] Costs related to lost productivity and healthcare associated with fatal prescription opioid-associated overdoses accounted for 27% of the total economic burden associated with opioid misuse.[5] The total economic burden of heroin use disorder is estimated to be around $51.2 billion ($50,799/user) based on a comprehensive analysis of 2015 data.[7] Lost productivity (19.3%), hepatitis C treatment (19.3%), crime (10.7%) and incarceration (12%) were the major contributors to the economic burden associated with heroin use disorder.[7]

How Can the PDMP Help Address Opioid Use Disorder and Overdoses in Pennsylvania?

Prescribers and pharmacists can use the PDMP to address opioid use disorder and reduce overdoses and costs in Pennsylvania in a number of ways:

1. **The PDMP can reduce the amount of opioids accessible in the community:**
   - A 2016 review of 24 states who implemented state-wide use of their PDMPs indicated that PDMP use was associated with a 30% reduction in the rate of Schedule II opioid prescriptions.[27]
   - An analysis of data from 10 states (Florida, Louisiana, Nebraska, New Jersey, Vermont, Georgia, Wisconsin, Maryland, New Hampshire, and Arkansas) showed that overall, the use of a PDMP was associated with reduced opioid volumes (2.36 kg/month).[28]
   - Since implementation of the Pennsylvania PDMP (August 2016):
     - The rate of multiple provider episodes decreased by 94.6% (events where individuals saw 5 or more prescribers and 5 or more dispensers).[29]
     - The rate of individuals receiving high dosages of opioids decreased by 52% (average daily MME > 90).
     - Opioid dispensations decreased by 34%.[29]
     - The number of individuals with more than 30 days overlapping opioid and benzodiazepine prescriptions decreased by 53%.[29]
2. **The PDMP can increase identification of persons with possible opioid use disorder and referral of these individuals to substance use disorder treatment or alternative pain management treatment.**
   - A survey of Rhode Island and Connecticut prescribers revealed that prescribers who conducted PDMP queries were more likely to follow-up with patients suspected of harmful prescription drug use with drug screens or referrals to treatment.[30]
   - A study of the Oklahoma PDMP found that 21% of prescribers using the PDMP referred patients to treatment, 21% referred patients to a mental health professional, and 64% referred patients to a pain management specialist.[31]
3. **Specialty treatment providers can use the PDMP to provide better quality of care and monitor patient abstinence.**
   - A specialty treatment center in the state of Washington used Washington's PDMP to identify patients currently using opioid or benzodiazepine prescriptions so that the patients could safely be treated with methadone.[32]
   - A treatment center in Delaware used Delaware's PDMP to identify undisclosed prescriptions and coordinate care with prescribers.[32]
   - A treatment center in Vermont used Vermont's PDMP to identify patients with prescriptions or undisclosed prescriptions to reduce the chances of negative interactions with medication-assisted treatment pharmacotherapy.[32]
4. **PDMPs are associated with reduced overdose deaths and lower demands for treatment:**
   - A study on Florida's PDMP and other prescription drug misuse and diversion prevention programs found a 41% decrease in oxycodone overdoses and an 18% decrease in overdoses caused by any prescription drug.[33]
   - The Pennsylvania PDMP launched in August 2016, and between 2017 and 2018, Pennsylvania had a 20% decrease in overdose deaths associated with any opioid.[29]

Sources

1) Bose J HS, Lipari RN, Park-Lee E, Porter JD, Pemberton MR. *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health.* 2016.
2) Centers for Disease Control and Prevention. Drug Overdose Death Data. 2016; https://www.cdc.gov/drugoverdose/data/statedeaths.html. Accessed April 27, 2017.
3) Centers for Disease Control and Prevention. 2018 Drug Overdose Death Rates; https://www.cdc.gov/drugoverdose/data/statedeaths/drug-overdose-death-2018.html. Accessed July 7, 2020.
4) Substance Abuse and Mental Health Services Administration, Matrix Global Adivsors L. *Health Care Costs from Opioid Abuse: A State-by-State Analysis*. 2015.
5) Florence CS, Zhou C, Luo F, L X. The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013. *Medical Care.* 2016;54(10):901-906.
6) Hansen RN, Oster G, Edelsberg J, Woody GE, SD S. Economic costs of nonmedical use of prescription opioids. *Clinical Journal of Pain.* 2011;27(3):194-202.
7) Jiang R, Lee I, Lee TA, Pickard AS. The societal cost of heroin use disorder in the United States. *PloS one.* 2017;12(5).
8) Zibbell JE, Iqbal, K., Patel, R. C., Suryaprasad, A., Sanders, K. J., Moore-Moravian, L., Serrecchia, J., Blankenship, S., Ward, J. W., Holtzman, D.,. Increases in Hepatitis C Virus Infection Related to Injection Drug Use Among Persons Aged ≤ Years- Kentucky, Tennessee, Virginia, and West Virginia, 2006-2016. *Morbidity and Mortality Weekly Report.* 2015;64(17):453-458.
9) Murphy S, Dweik D, McPherson S, Roll JR. Association between hepatitis C virus and opioid use while in buprenorphine treatment: preliminary findings. *The American Journal of Drug and Alcohol Abuse.* 2015;41(1):88-92.
10) United States Drug Enforcement Administration. *Drug-Related Overdose Deaths in Pennsylvania, 2018*. September 2019.
11) Lankenau S, Teti M, Silva K, Jackson-Bloom J, Harocopos A, Treese M. Initiation into Prescription Opioid Misuse among Young Injection Drug Users. *International Journal of Drug Policy.* 2012;23(1).
12) U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. 2018 Key Substance Use and Mental Health Indicators. August 20, 2019.
13) Hedegaard H, Miniño AM, Warner M. Drug Overdose Deaths in the United States, 1999–2018, NCHS Data Brief, no 356. Hyattsville, MD: National Center for Health Statistics. 2020.
14) Wilson N, Kariisa M, Seth P, et al. Drug and Opioid-Involved Overdose Deaths—United States, 2017-2018. MMWR Morb Mortal Wkly Rep 2020;69:290-297.
15) Ko JY, Patrick SW, Tong VT, Patel R, Lind JN. Incidence of Neonatal Abstinence Syndrome - 28 States, 1999-2013. Morbidity and Mortality Weekly Report. 2016;65(31):799-802.
16) McCarthy M. Incidence of neonatal abstinence syndrome triples in US. *British Medical Journal.* 2016;354.
17) White House. *Epidemic: Responding to America's Prescription Drug Abuse Crisis.* 2011.
18) Commonwealth of Pennsylvania. OpendataPA. https://data.pa.gov/stories/s/Pennsylvania-Opioids/9q45-nckt/. Accessed July 9, 2020.
19) Pennsylvania Department of Health, Bureau of Epidemiology. *Neonatal Abstinent Syndrome: 2018 Report*. August 2019.
20) O'Brien CP, McLellan AT. Myths about the treatment of addiction. *Lancet (London, England)*. 1996;347(8996):237-240.

Sources *(continued)*

21) McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. *Jama.* 2000;284(13):1689-1695.

22) Dennis, M.L., Foss, M.A., & Scott, C.K (2007). An eight-year perspective on the relationship between the duration of abstinence and other aspects of recovery. *Evaluation Review,* 31(6), 585-612

23) NIDA. Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition). National Institute on Drug Abuse website. https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition. December 1, 2012.

24) Vuoristo-Myllys S, Laaksonen E, Lahti J, Lipsanen J, Alho H, Kalska H. Predictors of self-Reported Adherence to Naltrexone Medication in an Outpatient Treatment for Problem Drinking. *Journal of Addiction Research & Therapy.* 2013;40(4):1-6.

25) Pettinati HM, Volpicelli JR, Pierce JD, O'Brien CP. Improving naltrexone response: an intervention for medical practitioners to enhance medication compliance in alcohol dependent patients. *Journal of Addictive Diseases.* 2000;19(1):71-83.

26) U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016.

27) Bao Y, Pan Y, Taylor A, et al. Prescription Drug Monitoring Programs Are Associated With Sustained Reductions In Opioid Prescribing By Physicians. *Health affairs (Project Hope)*. 2016;35(6):1045-1051.

28) Moyo P, Simoni-Wastila L, Griffin BA, et al. Impact of prescription drug monitoring programs (PDMPs) on opioid utilization among Medicare beneficiaries in 10 US States. *Addiction*. 2017.

29) Pennsylvania Department of Health. Interactive Data Report. May 26, 2020; https://www.health.pa.gov/topics/programs/PDMP/Pages/Data.aspx . Accessed July 9, 2020.

30) Green TC, Mann MR, Bowman SE, et al. How does use of a prescription drug monitoring program change medical practice. *Pain Medicine.* 2012;13(10):1314-1323.

31) Prescription Drug Monitoring Program Center of Excellence at Brandeis. *Briefing on PDMP Effectiveness.* Brandeis University: Bureau of Justice Assistance;2014.

32) Prescription Drug Monitoring Program Center of Excellence at Brandeis. *Use of PDMP Data by Opioid Addiction Treatment Programs*. The Heller School for Social Policy and Management. 2015.

33) Florida Department of Health. Prescription Drug Monitoring 2012-2013 Annual Report. Tallahassee, FL. 2013.

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Introduction

Effective and efficient use of the Prescription Drug Monitoring Program (PDMP) can help prescribers and pharmacists make better evidence-based clinical decisions and limit drug diversion and misuse.

Querying the PDMP each time a new controlled substance is prescribed to a patient offers an opportunity for the prescriber or pharmacist to prevent an overdose or refer an individual to treatment who might otherwise go untreated for a substance use disorder. All licensed prescribers and pharmacists are required to register for the PDMP. Prescribers and pharmacists are required to query the PDMP system in certain circumstances, for example, when prescribing opioids or benzodiazepines.

The PDMP system can influence clinical decisions in different ways. First, prescribers and pharmacists using the PDMP system can elect to not prescribe and dispense Schedule II–V medications when the PDMP indicates that unnecessary prescribing is occurring. Second, knowledge of PDMP data can help prescribers and pharmacists better coordinate care among other general and specialty treatment providers. Third, the appropriate use of the PDMP can help improve patient safety by reducing potentially harmful drug-drug interactions (e.g., benzodiazepines and opioids). Fourth, the PDMP can notify providers about which prescriptions patients are filling. Fifth, the PDMP improves communication, trust and collaboration between the prescriber and the patient by facilitating dialogue about the patients medication history. Finally, prescribers and pharmacists can use the PDMP to monitor patient opioid dosages to make sure that they are not at high levels (≥90 morphine milligram equivalent daily dose of a prescribed opioid).[1,2]

As with any new innovation, the integration of the PDMP into the clinical workflow can be challenging. However, there are options available to prescribers and dispensers to implement the PDMP in a way that improves effectiveness, usability and patient care.

In this module, prescribers and pharmacists will learn how to integrate the PDMP into his/her clinical workflow and use the PDMP to make clinical decisions based on the most recent requirements and regulations. This module includes the following objectives:

1. Detail Pennsylvania's requirements and regulations regarding PDMP use;
2. Explore options and actions Pennsylvania prescribers and pharmacists can take to integrate the PDMP into clinical workflows; and
3. Discuss how to use the PDMP system to make clinical decisions.

The Pennsylvania Law Related to the Mandated Use of the PDMP

Currently, 49 states, Washington D.C. and Guam have PDMPs. The Governor of Missouri, the only state without a PDMP, recently signed an executive order to phase in a PDMP. The requirements for registration, use and access are governed by state law. However, St. Louis County operates a PDMP in which other counties in Missouri can participate. This section details the Pennsylvania requirements for registration, use and access for both prescribers and pharmacists. In Pennsylvania, authorized users of the PDMP include prescribers and their delegates, pharmacists and their delegates, the attorney general (on behalf of law enforcement) and designated commonwealth personnel, medical examiners and coroners.

According to the Pennsylvania Department of Health, the PDMP's legislated purpose is "to be used as a tool to increase the quality of patient care by giving prescribers and pharmacists access to a patient's controlled substance prescription medication history, which will alert medical professionals to potential dangers for purposes of making treatment determinations and to aid regulatory and law enforcement agencies in the detection and prevention of fraud, drug misuse and the criminal diversion of controlled substances."[3] This section also discusses regulations for when the PDMP must be queried.

Prescribers

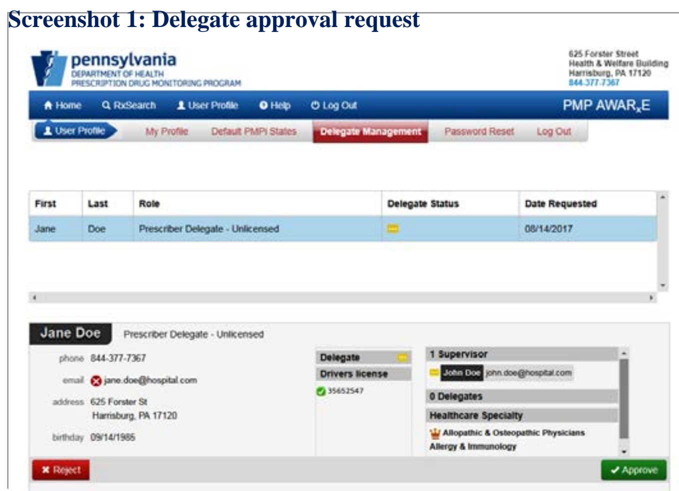
Registration and Use of Delegates

As of Jan. 1, 2017, all licensed individuals who are lawfully authorized to prescribe, distribute, dispense, or administer a controlled substance in the Commonwealth of Pennsylvania are required to register with the program. This does not include veterinarians. A Pennsylvania Professional License (i.e., license to practice granted by state accreditation boards) is needed to register for the Pennsylvania PDMP. If a prescriber has not yet registered in the Pennsylvania PDMP, they should visit the Pennsylvania Department of Health Website* to begin his/her registration. The registration process should take less than five minutes.

Prescribers can also delegate authority to individuals in their employment or under their supervision to access the PDMP, as long as delegates use their own accounts. Delegates are defined as authorized individuals who can access PDMP data on behalf of the prescriber. Delegates do not need to hold a Pennsylvania Professional License themselves, but must be authorized and overseen by individuals who do. Delegate accounts must be approved by the overseeing prescriber *(see Screenshot 1).*

Delegates can request a prescription history report for the purpose of providing medical treatment when the prescriber has a current prescriber-patient relationship with that individual (including initial office visits). The delegate is given his/her own account and password that cannot be shared. Prescribers are responsible for ensuring the security of PDMP data and patient information when their delegates are using the PDMP system. For more information on how to register delegates, please visit see the delegate registration manual**. The process for registering delegates should take less than five minutes.

Screenshot 1: Delegate approval request



* http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Pages/Register.aspx

** http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Documents/PAPDMP-DelegateRegistrationTutorial.pdf

Continued

The Pennsylvania Law Related to the Mandated Use of the PDMP *(continued)*

Prescribers *(continued)*

Requirements for Use of the PDMP

Prescribers are required to query the PDMP in three main clinical situations. First, prescribers are required to query the PDMP system for each patient the first time the patient is prescribed a controlled substance in order to establish a baseline and thorough medical record. Second, prescribers are required to query the PDMP each time the patient is prescribed an opioid or benzodiazepine medication. Finally, if a prescriber believes or has reason to believe that a patient is misusing or diverting drugs, he/she is also required to query the PDMP. These requirements apply to all inpatient and outpatient clinical settings when a new or existing patient is prescribed a controlled substance.

In an inpatient setting, the PDMP system must be queried at least once from the time of admission through discharge when a patient is prescribed a controlled substance, as required by law. Beyond the initial query, additional queries of the system are not required as long as the patient remains admitted to the licensed health care facility or remains in observation status in a licensed health care facility. However, the Department of Health recommends that healthcare professionals check the PDMP system prior to each time a controlled substance is prescribed or dispensed in any clinical setting. Please visit the general information[*] page on the Pennsylvania PDMP website for more information and frequently asked questions.

Pharmacists

Registration and Use of Delegates

Pharmacists of Schedule II-V substances must also register with the PDMP. Registration is required to access the PDMP. A Pennsylvania Professional License (i.e., license to practice as deemed by state accreditation boards) is needed to register for the Pennsylvania PDMP. If a pharmacist has not registered for the Pennsylvania PDMP, they should visit the Pennsylvania PDMP registration page[**], to begin his/her registration. The registration process will take about 10 minutes.

Pharmacists can register individually and also delegate authority to individuals in their employment or under their supervision to access the PDMP, as long as they use their own accounts. Delegates are defined as authorized individuals who can access PDMP data on behalf of the pharmacist. Delegates do not need to hold a Pennsylvania Professional License themselves, but must be authorized and overseen by individuals who do. Delegate accounts must be approved by the overseeing pharmacist entity.

Delegates of pharmacists can request a prescription history report if the request is for the current purpose of the pharmacy's practice and when the individual is a current patient of the pharmacy (including those who present a prescription to the pharmacy, although the prescription is not filled). The delegate is given his/her own account and password that cannot be shared. Pharmacists are responsible for ensuring the security of PDMP data and patient information when their delegates are using the PDMP system. For more information on how to register delegates, please see the delegate registration manual[***]. The process for registering a delegate should take less than five minutes.

* http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Pages/GeneralInfo.aspx#prescribers

** http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Pages/Register.aspx

*** http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Documents/PAPDMP-DelegateRegistrationTutorial.pdf

Continued

The Pennsylvania Law Related to the Mandated Use of the PDMP *(continued)*

Pharmacists *(continued)*

Requirements for Use of the PDMP

Dispensers must query the PDMP before dispensing an opioid or benzodiazepine when a patient: (1) is new to the pharmacist; (2) has insurance but chooses to pay for these prescriptions with cash; (3) requests an early refill; or (4) has opioid and/or benzodiazepine prescriptions from more than one prescriber.

A new patient does not include an individual going to the same pharmacy or a different physical location of that pharmacy, if the patient's record is available to the dispenser. Cash refers to any non-insurance payment, excluding copays. Early refill is defined as when the patient requests a refill prior to the date when he/she is eligible for insurance coverage for the prescription or when more than 15 percent of an earlier-dispensed medication remains when taken in compliance with the directions and quantity prescribed.

Dispensation Data Reporting Requirements

Pharmacies and dispensing practitioners must submit all controlled substance (Schedules II-V) dispensation information to the PDMP no later than the close of the subsequent business day after dispensing a controlled substance. A business day is any day within the standard five-day business week beginning on Monday and ending on Friday. Dispensers are encouraged to submit every day as well as on weekends if they are open for business. For more information on data reporting requirements, please see the Data Submission Dispenser Guide*.

* http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Documents/PAPDMP_DispenserGuide_v4.pdf

Medications Targeted by the PDMP

The PDMP targets federally controlled substances, specified controlled substances regulated by the state (**Schedule II-V prescriptions**), and drugs that raise concern for potential misuse, as identified by law enforcement and addiction treatment professionals. The Drug Enforcement Administration stratifies controlled substances into the following schedule classes:[4]

Table 1: Drug Enforcement Administration Schedule I-V Definitions and Examples.

Schedule	Definitions	Example
I	Drugs with no currently accepted medical use, have high potential for misuse and are not rendered medically safe in the United States	Heroin, marijuana (cannabis), lysergic acid diethylamide (LSD), 3, 4-methylenedioxymeth-amphetamine (ecstasy), methaqualone, peyote
II	Drugs with high potential for misuse, leading to severe psychological or physical dependence	Cocaine, methamphetamine (Desoxyn), methadone, hydromorphone (Dilaudid), meperidine (Demerol), oxycodone (OxyContin, Percocet), fentanyl, amphetamine (Dexedrine, Adderall), methylphenidate (Ritalin), combination products with less than 15 mg of hydrocodone per dosage unit (Vicodin)
III	Drugs with a moderate to low potential for physical and psychological dependence, which have higher potential for misuse than Schedule IV drugs, but lower potential for misuse than Schedule I and II drugs	Drugs that contain less than 90 milligrams of codeine per dosage unit (Tylenol with codeine), ketamine, anabolic steroids, testosterone
IV	Drugs with low potential for misuse and low risk of dependence, compared to Schedule III drugs	Alprazolam (Xanax), carisoprodol (Soma), clonazepam (Klonopin), clorazepate (Tranzene), diazepam (Valium), lorazepam (Ativan), midazolam (Versed), temazepam (Restoril), triazolam (Halcion), Talwin, Ambien, Tramadol
V	Drugs with lower potential for misuse than Schedule I-IV drugs	Cough medications with less than 200 mg of codeine per 100 mg or 100 mL (Robitussin AC, Lyrica, Phenergan with Codeine)

If you would like to look up whether a specific substance is controlled, you can use the following lists:

- Drug Enforcement Administration: List of controlled substances in alphabetic order; https://www.deadiversion.usdoj.gov/schedules/orangebook/c_cs_alpha.pdf
- Centers for Disease Control and Prevention: List of controlled substances including opioids with oral morphine milligram equivalent conversion factors; or https://www.cdc.gov/drugoverdose/resources/data.html
- Pennsylvania Controlled Substance, Drug, Device and Cosmetic Act. http://www.health.pa.gov/facilities/Consumers/Health%20Facilities/Home%20Health%20Services%20and%20Hospices/DDC/Laws/DDC_Act.pdf

Actions for Pennsylvania Prescribers and Pharmacists to Integrate the PDMP into Clinical Workflows

Key informant interviews were conducted with prescribers and pharmacists across Pennsylvania to learn how they integrated PDMP use into their workflows and their recommendations for integration. Based on these interviews, and additional literature, the following actions are recommended for Pennsylvania prescribers and pharmacists to integrate the PDMP into their workflows: (1) utilize delegation; (2) submit and review data in a timely fashion; (3) integrate the PDMP into electronic health record systems; (4) review data from a broader viewpoint to see how it can be used to improve patient care; and (5) utilize bulk searches. Prescribers are encouraged to visit the Pennsylvania PDMP website* for tutorials on registering for the PDMP, registering delegates, and other sources of information on how to search for patient prescription information for activity within and outside the state of Pennsylvania.

Delegation

As noted previously, prescribers and pharmacists may authorize certain members of their healthcare teams to access the PDMP on their behalf. Delegates can save the prescriber and pharmacist time in his/her clinical workflow. Delegating access alleviates prescribers and pharmacists from diverting their attention from clinical duties, allowing them to receive information on their patients' prescriptions as needed.

During key informant interviews, a primary care practice in one of the major healthcare systems of Pennsylvania indicated that all medical and front desk staff members are delegates to each of the prescribers in the practice, making the query of the PDMP routine for each patient that comes in for a visit. To contrast, another rural healthcare system indicated that it does not use delegates and prefers to conduct patient queries during the visit while in the room with the patient. The decision of whether to use delegates or not can be determined by each individual practice. Both examples show that approaching PDMP integration differently, depending on the needs of the practice, can lead to effective PDMP use.

Using the PDMP in a Dental Office:
In a dental setting, a dental assistant or front office representative can be a delegate for the dentist. The delegate can query the PDMP for all of the patients being seen that day before the day begins using a bulk search or after a surgery when a pain relieving prescription medication is required to treat an episode of acute pain.

* www.doh.pa.gov/PDMP

Continued

Actions for Pennsylvania Prescribers and Pharmacists to Integrate the PDMP into Clinical Workflows *(continued)*

Integration into Electronic Health Record and Pharmacy Systems

Electronic health record integration allows for increased workflow efficiency by decreasing the amount of time necessary to search and analyze patient PDMP information. Several major health systems in Pennsylvania cite PDMP integration into electronic health records as a way to encourage use of the PDMP during practice. Some have even initiated integration by incorporating pop-up windows and messages reminding them to query the PDMP before prescribing medications. Other health care systems have included a link within their electronic health records, which takes the prescriber and pharmacist to the PDMP website for PDMP querying. Additionally, the Pennsylvania PDMP Integration Initiative provides healthcare entities the ability to seamlessly retrieve PDMP data on patients from within their health IT system. Healthcare entities must fill out the integration request form* on the PDMP website to participate.

Review Data

Prescribers and dispensers can also conduct a high-level review of the data obtained from the PDMP, focusing on what the data is summarizing about the patient, rather than reviewing individual dispensing. This allows the prescriber to spend less time analyzing the PDMP results and more time discussing the results with the patient.[5] For example, a prescriber can look for the calculated total morphine milligram equivalent, number of prescribers or number of pharmacies to determine whether the patient may be at an elevated risk of overdose instead of spending time reading every prescription and its dosage. While data review and patient PDMP query is required in certain situations, prescribers and pharmacists can also be flexible about when this data review occurs in his/her workflow and how they use the data to improve patient care.

One outpatient primary care practice in a major health system in Pennsylvania queries patients as part of its pre-visit planning. In doing so, patients are reminded to complete any outstanding testing/screening, so the workflow during the appointment is not interrupted as a result of missing clinical test results. Other healthcare sites query patients at each visit in order to identify aberrant behavior and to ensure that patients are being adherent with the patient-provider agreement they signed before beginning opioid therapy. *(See Module 4 for an example of a patient-provider agreement.)*

After conducting a PDMP query and reviewing the results, prescribers and pharmacists may document a query in a patient's medical records. The provider should note any potential episodes of concern such as multiple prescriptions from multiple prescribers. However, prescribers and pharmacists may also document that a patient has a PDMP report that suggests that he/she is being adherent to the patient-provider agreement.

* http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Pages/integration-request-form.aspx

Continued

Actions for Pennsylvania Prescribers and Pharmacists to Integrate the PDMP into Clinical Workflows *(continued)*

Bulk Searches

Bulk searches are mostly underutilized feature of the PDMP users that can be used to search multiple patients at one time. For instance, prescribers that see multiple patients in a day, can bulk search at the beginning of the day and can facilitate workflow throughout the work day. This can save the prescriber, pharmacist or delegate time in the clinical workflow.

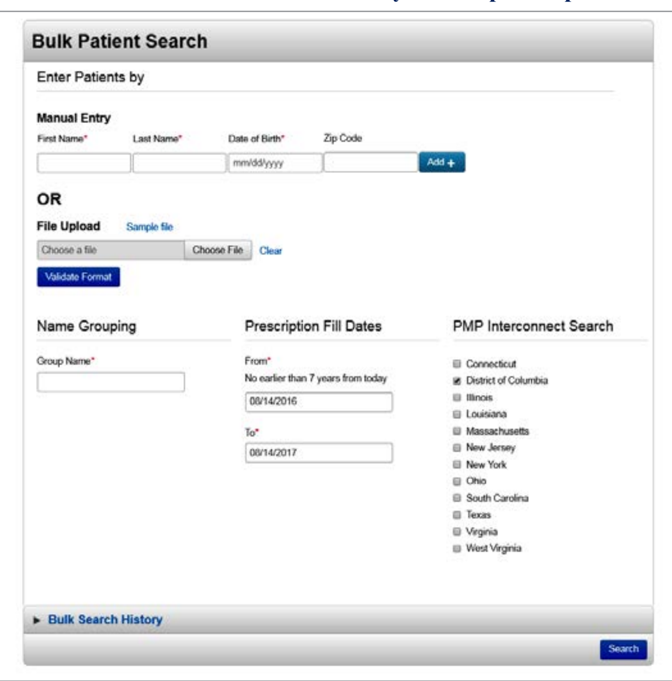
There are two ways to perform bulk searches:

1. To manually enter bulk searches, users need to enter the first name, last name and date of birth of each patient.
2. To upload a list of patients, users must first create a CSV file (using Microsoft Excel or a similar application) that contains the first name, last name, and date of birth of each patient in columns 1, 2 and 3, respectively.

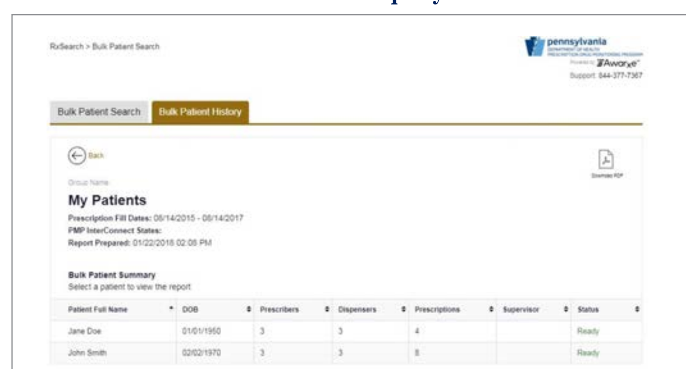
After the patient names are submitted, the group of patients should be named, and the date range for the search should be entered. Once that is complete, click search and the results will be generated.

Please note that it may take up to several minutes for the system to generate reports for a large number of patients.

Screenshot 2: Bulk search manual entry or file upload options



Screenshot 3: Results of bulk search query



Continued

Developing Clinical Decisions Using the PDMP

Patient safety is always a top priority for any healthcare professional. PDMP use can contribute to a culture of patient safety by alerting prescribers and dispensers to potential drug diversion, misuse or over-prescribing.[5] Identifying prescribing patterns or signs of misuse that put a patient at risk for adverse impacts can help prescribers and pharmacists make the best choice for the patient. For instance, the PDMP information may suggest that the prescriber should engage the patient in a discussion about treatment for substance use disorder.

PDMP Query Result

PDMP search results show that a patient is currently prescribed a high opioid dosage (morphine milligram equivalent ≥90).

Action

The patient is at an elevated risk for overdose and should be reevaluated by the prescriber for risks/benefits associated with continued opioid therapy at the current dose.

Integrating the PDMP can help facilitate clinical decision making. For instance, Geisinger Health System in Pennsylvania has seen a 50 percent reduction in controlled substance prescribing and a 6 percent ongoing monthly reduction in controlled substances since the integration of its own prescribing dashboard and then, most recently, the PDMP.

Additionally, Geisinger addresses patient safety when discrepancies are found in the PDMP by sending reports to alert the appropriate providers throughout the healthcare system.

A provider can use Screening, Brief Intervention, and Referral to Treatment (SBIRT) to address a potential substance use disorder with a patient and conduct a "warm handoff" to substance use disorder treatment. *(See Module 5 for information on conducting a "warm handoff" and Module 6 for information on SBIRT.)*

PDMP Query Result

PDMP search results show that a patient filled two opioid prescriptions from two other providers last month and did not mention the prescriptions during a follow-up appointment.

Action

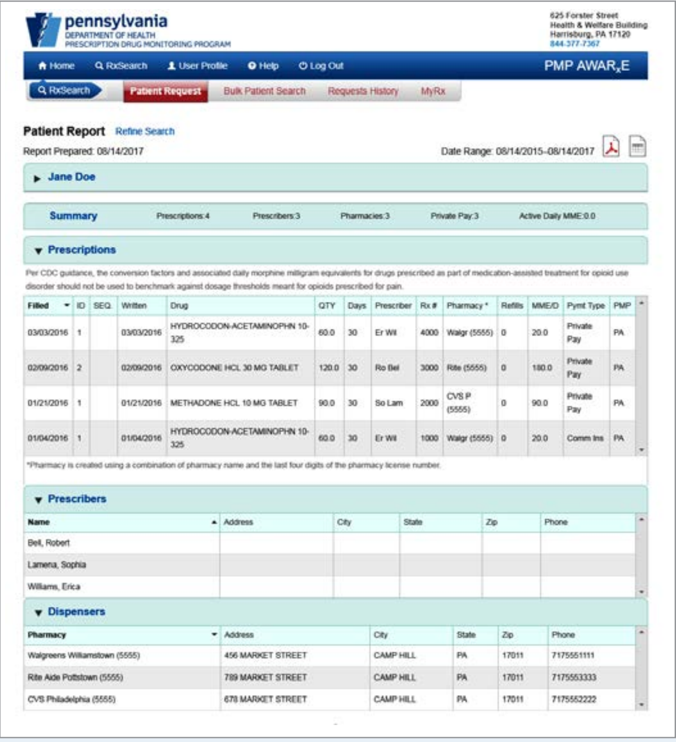
The prescriber should engage the patient in a discussion using patient-centered communication techniques about the PDMP findings. The prescriber may also consider reaching out to the other prescribers regarding treatment if they have obtained informed consent or believe that the patient is misusing his/her medication.

Continued

Developing Clinical Decisions Using the PDMP *(continued)*

By presenting PDMP information and a patient's full medical history together, providers have the ability to make more informed clinical decisions. Doing so can help providers better coordinate patient care with each other.[6] PDMP data can also be used to improve patient care coordination, greatly reducing the risk of adverse drug interactions. The PDMP can help providers who think they know their patients well avoid overlooking potential substance use problems or diversion.[7] Comprehensive screening and testing includes regularly checking the PDMP. If the urine drug screen shows no substances but the PDMP shows multiple opioid prescriptions, it could mean potential diversion or misuse of opioids.

Screenshot 4: Patient PDMP report showing multiple prescriptions, multiple providers, new pharmacies and evidence of private pay



pennsylvania
DEPARTMENT OF HEALTH
PRESCRIPTION DRUG MONITORING PROGRAM

625 Forster Street
Health & Welfare Building
Harrisburg, PA 17120
844-377-7367

Home | RxSearch | User Profile | Help | Log Out — PMP AWAR$_x$E

RxSearch | Patient Request | Bulk Patient Search | Requests History | MyRx

Patient Report Refine Search

Report Prepared: 08/14/2017 — Date Range: 08/14/2015-08/14/2017

Jane Doe

Summary — Prescriptions:4 — Prescribers:3 — Pharmacies:3 — Private Pay:3 — Active Daily MME:0.0

Prescriptions

Per CDC guidance, the conversion factors and associated daily morphine milligram equivalents for drugs prescribed as part of medication-assisted treatment for opioid use disorder should not be used to benchmark against dosage thresholds meant for opioids prescribed for pain.

Filled	ID	SEQ.	Written	Drug	QTY	Days	Prescriber	Rx #	Pharmacy *	Refills	MME/D	Pymt Type	PMP
03/03/2016	1		03/03/2016	HYDROCODON-ACETAMINOPHN 10-325	60.0	30	Er Wil	4000	Walgr (5555)	0	20.0	Private Pay	PA
02/09/2016	2		02/09/2016	OXYCODONE HCL 30 MG TABLET	120.0	30	Ro Bel	3000	Rite (5555)	0	180.0	Private Pay	PA
01/21/2016	1		01/21/2016	METHADONE HCL 10 MG TABLET	90.0	30	So Lam	2000	CVS P (5555)	0	90.0	Private Pay	PA
01/04/2016	1		01/04/2016	HYDROCODON-ACETAMINOPHN 10-325	60.0	30	Er Wil	1000	Walgr (5555)	0	20.0	Comm Ins	PA

*Pharmacy is created using a combination of pharmacy name and the last four digits of the pharmacy license number.

Prescribers

Name	Address	City	State	Zip	Phone
Bell, Robert					
Lamena, Sophia					
Williams, Erica					

Dispensers

Pharmacy	Address	City	State	Zip	Phone
Walgreens Williamstown (5555)	456 MARKET STREET	CAMP HILL	PA	17011	7175551111
Rite Aide Pottstown (5555)	789 MARKET STREET	CAMP HILL	PA	17011	7175553333
CVS Philadelphia (5555)	678 MARKET STREET	CAMP HILL	PA	17011	7175552222

PDMP Query Result

Urine drug screen results do not show opioids that were dispensed to the patient following a PDMP query for the patient.

Action

The patient may be participating in drug diversion, and the prescriber should engage the patient in a discussion about the PDMP results and consider whether he/she is being adherent to his/her medication. Prescribers should note that urine drug screens only determine the presence of drugs in the panel that is being tested. Some medications require special tests.

A rural outpatient clinic in a major healthcare system in Pennsylvania suggested checking the PDMP as part of a patient's pre-visit planning in order to quickly integrate the PDMP into the workflow. In this specific practice, this type of workflow has led to identifying patients that require further screening and has helped minimize unnecessary testing of patients. To contrast this example, a different clinic in another major Pennsylvania health system uses PDMP information coupled with urine drug screenings at each visit to indicate any potential misuse of opioids.

PDMP Query Result

A patient is requesting an increase in the dosage of his/her opioid prescription. During the PDMP query, a number of benzodiazepine prescriptions are identified that the patient did not report on his/her medical history.

Action

The patient is at an elevated risk for an adverse event given the combination of opioids and benzodiazepines and should be reevaluated by the prescriber for risks/benefits associated with continued opioid or benzodiazepine therapy. The opioid prescriber(s) should obtain permission to discuss the PDMP results with the benzodiazepine prescriber(s) to determine the best course of action.

Sources

1) Dowell D, Haegerich T, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain- United States, 2016. *Morbidity and Mortality Weekly Report.* 2016;65(1):1-49.

2) Pennsylvania Department of Health, Pennsylvania Department of Drug and Alcohol Programs, Pennsylvania Medical Society. *Pennsylvania Guideline on the Use of Opioids to Treat Chronic Noncancer Pain.* 2014.

3) Pennsylvania Department of Health. Prescription Drug Monitoring Program: About. http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Pages/home.aspx#.WckUf7KGOHs. 2017. Accessed April, 2017.

4) U.S. Department of Justice Drug Enforcement Administration. Drug Scheduling. https://www.dea.gov/druginfo/ds.shtml. Accessed April, 2017.

5) Substance Abuse and Mental Health Service Administration. *Connecting for Impact: Integrating Health IT and PDMPs to Improve Patient Care.* 2013.

6) Greenwood-Ericksen M, Weiner S, Schurr J. *Recommendations to Optimize Prescription Drug Monitoring Programs for use in Emergency Department.* Brigham and Women's Hospital; 2016.

7) Hildebran C, Cohen D, Irvine J, et al. How clinicians use prescription drug monitoring programs: a qualitative inquiry. Pain Medicine. 2014;15(7):1179-1186.

Reporting Suspected Aberrant Medication Dispensing

How to report pharmacists that have suspected aberrant dispensing practices:

As a prescriber/pharmacist, if you suspect abnormal medication dispensing of medications, illegal prescription drug sales, or suspicious internet pharmacies, you can take action through one or more of the following reporting methods, as deemed appropriate on a case-by-case basis. If suspicious activity is suspected, it is most appropriate that the individual who has the most knowledge about the situation decides how to take action. These resources can also be used for reporting any fraudulent or theft situations in addition to abnormal dispensing practices.

1. Contact the pharmacist or pharmacy and express your concerns.
2. File an online complaint to the Pennsylvania Department of State.[1]
3. Call the Pennsylvania State Board of Pharmacy to report the dispenser at **(717) 783-7156**.
4. Call the Pennsylvania Office of Attorney General Bureau of Narcotics Investigation and Drug Control of your region to report this illegal activity *(see page two for contact information)*.
5. Anonymously text the Pennsylvania Office of Attorney General to submit tips about suspicious activity by texting **PADRUGS** + **YOUR TIP** to **847411**.
6. Submit a tip to the United States Department of Justice Drug Enforcement Administration Diversion Control Division.[2]
7. Report illegal prescription drug sales or suspicious internet pharmacies by calling **877-RxAbuse** (877-792-2873). This number is a Drug Enforcement Administration tip line.
8. Submit an online report to the United States Department of Justice Drug Enforcement Administration for illegal internet drug sales.[3]

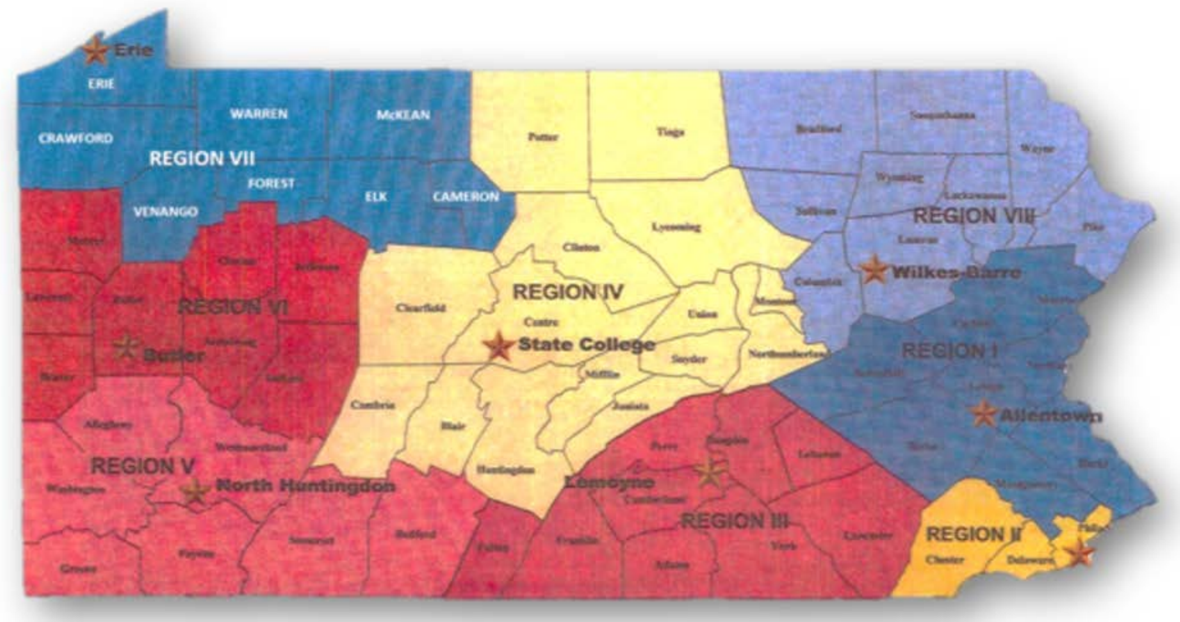
Sources

1) https://www.pals.pa.gov/#/page/filecomplaint
2) https://www.deadiversion.usdoj.gov/tips_online.htm
3) https://apps.deadiversion.usdoj.gov/webforms/jsp/umpire/umpireForm.jsp

Continued

Pennsylvania Office of Attorney General
Bureau of Narcotics Investigation and Drug Control
Regional Office Contact Information

Region	Address	Contact Information
I. Allentown	2305 28th Street, S.W. Allentown, Pennsylvania 18103	**Office:** (610) 791-6100 **Fax:** (610) 791-6103
II. Philadelphia	7801 Essington Avenue Philadelphia, Pennsylvania 19153	**Office:** (215) 937-1300 **Fax:** (215) 937-1342
III. Harrisburg	106 Lowther Street Harrisburg, Pennsylvania 17043	**Office:** (717) 712-1280 **Fax:** (717) 712-1204
IV. State College	2515 Green Tech Drive State College, Pennsylvania 16803	**Office:** (814) 863-0684 **Fax:** (814) 863-3378
V. North Huntington	10950 Route 30 North Huntington, Pennsylvania 15642	**Office:** (724) 861-3600 **Fax:** (724) 861-3690
VI. Butler	105 Independence Drive Butler, Pennsylvania 16001	**Office:** (724) 284-3400 **Fax:** (724) 284-3405
VII. Erie	4801 Atlantic Avenue Erie, Pennsylvania 16506	**Office:** (814) 836-4300 **Fax:** (814) 836-4328
VIII. Wilkes-Barre	680 Baltimore Drive Wilkes-Barre, Pennsylvania 18702	**Office:** (570) 826-2051 **Fax:** (570) 826-2447



Created On: 9/29/2017

Reporting Suspected Aberrant Medication Prescribing

MODULE 2

www.pa.gov/collections/opioid-epidemic | RA-DH-PDMP@pa.gov

How to report prescribers that have suspected aberrant prescribing practices:

As a prescriber/pharmacist, if you suspect inappropriate or over-prescribing by your colleagues or prescribers, you can take action through one or more of the reporting methods, as deemed appropriate on a case-by-case basis. If suspicious activity is suspected, it is most appropriate that the individual who has the most knowledge about the situation decides how to take action. These resources can also be used for reporting any fraudulent or theft situations in addition to abnormal prescribing or dispensing practices.

1. Contact the prescriber and talk to them about your concerns.
2. File an online complaint to the Pennsylvania Department of State.[1]
3. Call the prescriber's appropriate licensing body to report the prescriber *(see below for licensing body contact information).*
4. Call the Pennsylvania Office of Attorney General Bureau of Narcotics Investigation and Drug Control of your region to report this illegal activity *(see page two for contact information).*
5. Anonymously text the Pennsylvania Office of Attorney General to submit tips about suspicious activity by texting **PADRUGS + YOUR TIP** to **847411**.
6. Submit a tip to the United States Department of Justice Drug Enforcement Administration Diversion Control Division.[2]

Pennsylvania State Licensing Board	Contact Information
Medicine (Medical Doctors, Surgeons, Physician Assistants, Certified Nurse Midwives)	**Phone:** (717) 783-1400 **Fax:** (717) 787-7769
Osteopathic Medicine (Doctors of Osteopathic Medicine and Surgery, Physician Assistants)	**Phone:** (717) 783-4858 **Fax:** (717) 787-7769
Nursing (Advanced Practice Nurses, Certified Registered Nurse Practitioners, Certified Registered Nurse Anesthetists)	**Phone:** (717) 783-7142 **Fax:** (717) 783-0822
Dentistry (Dentists, Oral Surgeons)	**Phone:** (717) 783-7162 **Fax:** (717) 787-7769
Optometry (Optometrists) ***Note:*** These prescribers are not legally verified to prescribe Schedule II controlled substances.	**Phone:** (717) 783-7155 **Fax:** (717) 787-7769
Podiatry (Podiatrists)	**Phone:** (717) 783-4858 **Fax:** (717) 787-7769

Sources

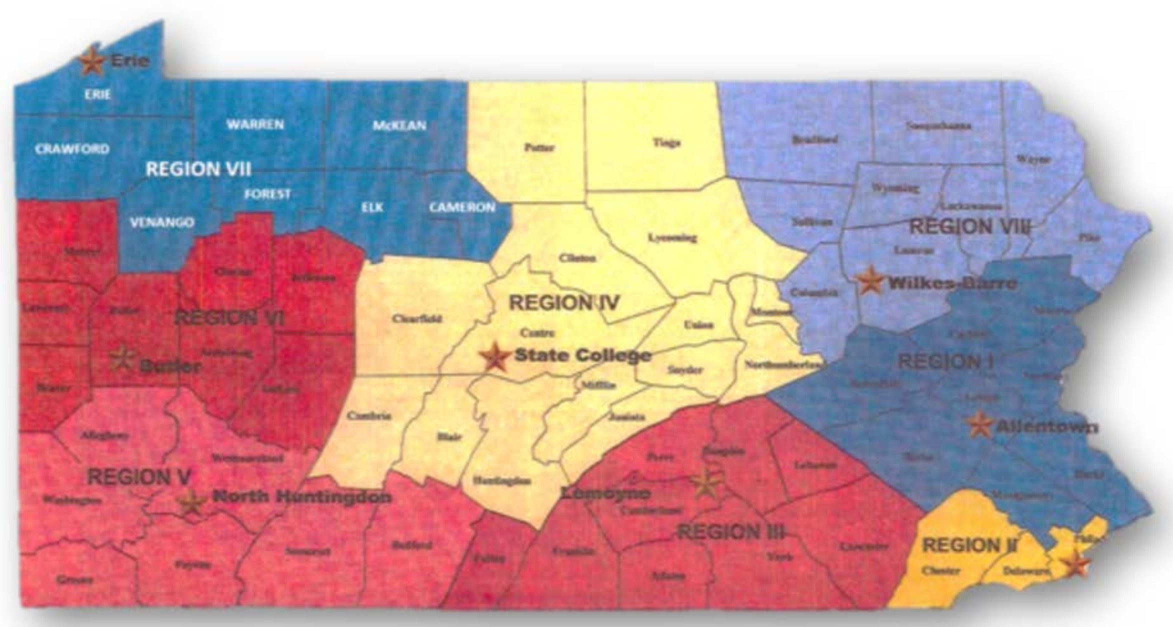
1) https://www.pals.pa.gov/#/page/filecomplaint

2) https://www.deadiversion.usdoj.gov/tips_online.htm

Continued

Pennsylvania Office of Attorney General
Bureau of Narcotics Investigation and Drug Control
Regional Office Contact Information

Region	Address	Contact Information
I. Allentown	2305 28th Street, S.W. Allentown, Pennsylvania 18103	**Office:** (610) 791-6100 **Fax:** (610) 791-6103
II. Philadelphia	7801 Essington Avenue Philadelphia, Pennsylvania 19153	**Office:** (215) 937-1300 **Fax:** (215) 937-1342
III. Harrisburg	106 Lowther Street Harrisburg, Pennsylvania 17043	**Office:** (717) 712-1280 **Fax:** (717) 712-1204
IV. State College	2515 Green Tech Drive State College, Pennsylvania 16803	**Office:** (814) 863-0684 **Fax:** (814) 863-3378
V. North Huntington	10950 Route 30 North Huntington, Pennsylvania 15642	**Office:** (724) 861-3600 **Fax:** (724) 861-3690
VI. Butler	105 Independence Drive Butler, Pennsylvania 16001	**Office:** (724) 284-3400 **Fax:** (724) 284-3405
VII. Erie	4801 Atlantic Avenue Erie, Pennsylvania 16506	**Office:** (814) 836-4300 **Fax:** (814) 836-4328
VIII. Wilkes-Barre	680 Baltimore Drive Wilkes-Barre, Pennsylvania 18702	**Office:** (570) 826-2051 **Fax:** (570) 826-2447



Pharmacist Fact Sheet

Dear Pharmacist…

Is your patient:

- ? New to your pharmacy system?
- ? Paying in cash instead of using his/her insurance?
- ? Requesting opioid medication refills early?
- ? Getting opioid and/or benzodiazepine medications from more than one prescriber?

If you answered "yes" to any of the above, you are required to query your patient in the Pennsylvania PDMP system.

Why?

- To ensure that patients are not misusing their controlled substances.
- To link patients to proper care, if needed.
- To aid law enforcement officials about illicit drug use or misuse.

Not registered for the Pennsylvania PDMP system yet?

- As of January 1, 2017, all licensed prescribers and pharmacists in Pennsylvania are required to register with the Pennsylvania PDMP.
- Please visit the Pennsylvania PDMP registration page[1] to begin your registration. Registration will take about ten minutes.
- Access to delegates can also be given, however, a separate registration is required.
- **Dispensing Practitioners:** You must also submit daily dispensation data for Schedule II-V controlled substances. For more information, please refer to the Module 2 Guide Document.
- A dispensing practitioner is a medical practitioner that stocks controlled substances and distributes the medication to patients, who then leave the facility and are responsible for administering the medication themselves.

Resources for more information:

- Registration Manual[2]
- How to Search and Identify "Red Flags"[3]
- Data Submission Dispenser Guide[4]
- Delegate Policies[5]
- Delegate Registration Manual[6]
- How to Search for your Patient Across State Lines[7]

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1 http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Pages/Register.aspx
2 http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Documents/PAPDMP-UserRegistrationTutorial.pdf
3 http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Documents/PAPDMP-PatientRecordQueryandWarningSigns.pdf
4 http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Documents/PAPDMP_DispenserGuide_v4.pdf
5 http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Documents/PAPDMP-Delegate_Policies.pdf
6 http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Documents/PAPDMP-DelegateRegistrationTutorial.pdf
7 http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Pages/interstate.aspx

Prescriber Fact Sheet

Dear Prescriber...

? Is this the first time you are prescribing a controlled substance to your patient?

? Are you prescribing an opioid or benzodiazepine medication?

? Do you suspect that your patient is abusing or diverting his/her controlled substance medication(s)?

If you answered "yes" to any of the above, you are required to query your patient in the Pennsylvania PDMP system.

Why?

- To ensure that patients are not misusing their controlled substances.
- To link patients to proper care, if needed.
- To aid law enforcement officials about illicit drug use or misuse.

Not registered for the Pennsylvania PDMP system yet?

- As of January 1, 2017, all licensed prescribers and pharmacists in Pennsylvania are required to register with the Pennsylvania PDMP.
- Please visit the Pennsylvania PDMP registration page[1] to begin your registration. Registration will take less than 5 minutes.
- **Prescribers:** You will need your personal Drug Enforcement Administration number and your Pennsylvania Professional License number. Prescribers without a Drug Enforcement Administration number must also register for the PDMP (see the Registration Manual[2] for more information).
- Access to delegates can also be given, however, a separate registration is required.

Resources for more information:

- Registration Manual[2]
- How to Search and Identify "Red Flags"[3]
- Data Submission Dispenser Guide[4]
- Delegate Policies[5]
- Delegate Registration Manual[6]
- How to Search for your Patient Across State Lines[7]

[1] http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Pages/Register.aspx
[2] http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Documents/PAPDMP-UserRegistrationTutorial.pdf
[3] http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Documents/PAPDMP-PatientRecordQueryandWarningSigns.pdf
[4] http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Documents/PAPDMP_DispenserGuide_v4.pdf
[5] http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Documents/PAPDMP-Delegate_Policies.pdf
[6] http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Documents/PAPDMP-DelegateRegistrationTutorial.pdf
[7] http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Pages/interstate.aspx

Created On: 9/29/2017

www.pa.gov/collections/opioid-epidemic | RA-DH-PDMP@pa.gov

Pennsylvania Prescription Drug Monitoring Program (PDMP)
System User and Stakeholder Training

Using the PDMP to Optimize Pain Management

MODULE 3

GUIDE DOCUMENT

Pennsylvania Prescription Drug Monitoring Program (PDMP) System User and Stakeholder Training

Learning Objectives for Modules 1-7

Module 1: Why Using the PDMP is Important for Achieving Optimal Health for Pennsylvania Citizens

1. The status of substance use disorder in general, opioid use disorder and overdoses nationally and in Pennsylvania;
2. Common misconceptions about substance use disorder and opioid use disorder treatment and recovery;
3. Costs associated with prescription drug and heroin-associated opioid use disorder and overdose; and
4. How pervasive prescriber and pharmacist PDMP use can reduce population opioid use disorder and overdose.

Module 2: What is a PDMP, How to Use the PDMP to Make Clinical Decisions, How to Integrate the PDMP into the Clinical Workflow, and How to Access Pennsylvania's PDMP

1. Detail Pennsylvania's requirements and regulations regarding PDMP use;
2. Explore options and actions Pennsylvania prescribers and pharmacists can take to integrate the PDMP into clinical workflows; and
3. Discuss how to use the PDMP system to make clinical decisions.

Module 3: Using the PDMP to Optimize Pain Management

1. Learn how to use the PDMP to address pain management for various patient populations and pain types;
2. Understand the basic nature of pain for different patient populations and how to manage their pain using the PDMP as a clinical tool; and
3. Discuss different ways of treating patient pain that do not involve the immediate use of opioids.

Module 4: Opioid Prescribing Guide

1. Provide guidelines to inform all healthcare providers when prescribing opioids in the acute phase of pain;
2. Instruct healthcare providers on how to prescribe opioids in the chronic phase of pain, which includes information on how to initiate or continue opioid therapy, select the correct dose and/or discontinue opioids;
3. Instruct healthcare providers on how to assess risks and address harms associated with opioid use;
4. Instruct healthcare providers on the legal responsibilities related to prescribing opioids; and
5. Instruct healthcare providers on how they may direct patients to dispose of unused medications.

Module 5: Referral to Treatment for Substance Use Disorder Related to Opioid Use

1. Define "warm handoffs" and how they can best occur;
2. Provide a schema for how any healthcare provider can implement "warm handoffs" in any clinical setting;
3. Demonstrate how primary care practices can conduct "warm handoffs" by preparing, using validated screening tools and using patient-centered communication with patients;
4. Demonstrate how healthcare providers can determine the best type of treatment for their patients;
5. Present information on patient confidentiality that providers should be aware of when working with patients with substance use disorders and performing "warm handoffs"; and
6. Present relevant Pennsylvania links for treatment and other resources.

Module 6: Approaches to Addressing Substance Use Disorder with Patients Identified by the PDMP

1. Learn how to integrate the PDMP with other screening tools to help identify those who may require substance use disorder treatment or increased monitoring;
2. Define Screening, Brief Intervention, and Referral to Treatment (SBIRT), its main goals and its main components;
3. Learn how to screen a patient for a potential substance use disorder, conduct a brief intervention and refer a patient to treatment;
4. Learn how to discuss a substance use disorder with a patient and handle patient resistance; and
5. Learn how to incorporate SBIRT into clinical practice.

Module 7: Effective Opioid Tapering Practices

1. Discuss how to use the PDMP to determine if a provider should consider tapering his/her patient;
2. Discuss several indicators that prescribers can look for when considering tapering opioids;
3. Inform prescribers on how to discuss tapering with patients using patient-centered techniques;
4. Present a general opioid tapering protocol and how to adapt this protocol to the needs of any patient; and
5. Present information on how to manage withdrawal and how to use tools to measure withdrawal symptoms in patients.

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Introduction

This guide document discusses how prescribers and pharmacists can use the Pennsylvania Prescription Drug Monitoring Program (PDMP) to optimize a patient's pain management.

The PDMP should be used to assist in the pain management decision-making process as an important tool for assessing the appropriateness of initiation or continuation of controlled substances, including opioids, for the treatment of acute or chronic pain. The results from a patient query conducted with the PDMP provide patient prescription information that, along with other factors, can help guide prescribers and pharmacists toward strategies that will inform and help mitigate the patient's risk of opioid use disorder, misuse and overdose.[1]

In this module, prescribers and pharmacists will learn how to use the PDMP to optimize and address pain management in different patient populations. This module includes the following objectives:

1. Learn how to use the PDMP to address pain management for various patient populations and pain types;
2. Understand the basic nature of pain for different patient populations and how to manage their pain using the PDMP as a clinical tool; and
3. Discuss different ways of treating patient pain that do not involve the immediate use of opioids.

How to Use the PDMP to Address Pain Management

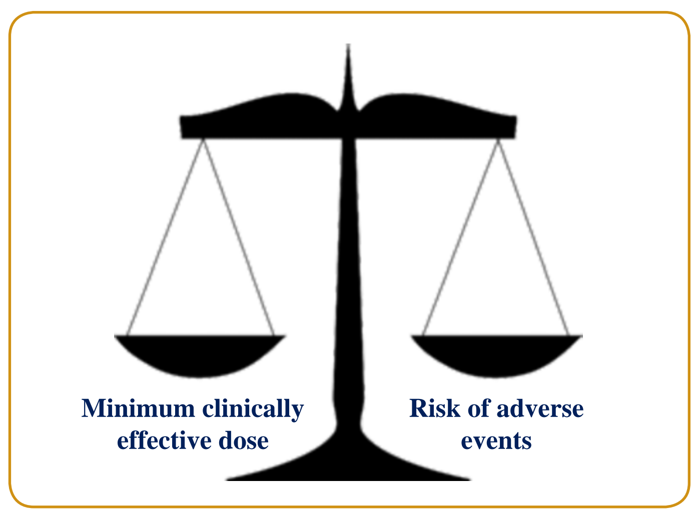
Querying the PDMP can assist in managing, improving and changing the patient's pain management strategy. A prescriber may wish to query the PDMP more often than required for some patients. These patients may be at an elevated risk for substance misuse or may be currently undergoing treatment for substance use disorder. There may also be evidence of aberrant behavior(s) or increased risk(s) when conducting a medical history and physical examination.[1,2] In Pennsylvania, some rural and urban health systems consistently use the PDMP to screen all patients who are undergoing opioid therapy for chronic non-cancer pain at every visit to assist in the management of the patient's pain, ensure patient safety, support safe prescribing and look for possible indicators of aberrant behavior. In order to best facilitate the use of the PDMP into their pain management strategies and manage their time most efficiently, prescribers and pharmacists should first integrate the PDMP into their clinical workflows (see Module 2). The PDMP data can be useful to a prescriber or a pharmacist in three major ways, including: (1) developing a medical history; (2) supporting patient safety; and (3) discussing alternative pain management strategies with patients.

Developing a Medical History

First, PDMP reports can be used when the patient's medication history is not otherwise available, such as with a new patient or a visiting patient from another prescriber. In this situation, regardless of the PDMP results, the provider is encouraged to contact the patient's previous prescriber to obtain more detailed patient information, if the patient consents. (See Module 5 for legal implications of patient consent.)[3] The PDMP allows the prescriber and pharmacist to become aware of other prescribers involved in the patient's care and become informed about unknown patient information and history.[2] The results from a PDMP search should then be used to clarify to the prescriber and pharmacist, which opioids and/or other Scheduled II-V medications have been dispensed to the patient. The list of medications should be confirmed with the patient.

Supporting Patient Safety

Second, information from the PDMP should be used to address general patient safety. Following a query, the PDMP should be used to identify duplicative drug therapy, provide evidence of misuse, highlight dangerous drug combinations and raise awareness of risk of potential accidental overdose.[2] In order to help prevent accidental overdose, it is recommended by the Centers for Disease Control and Prevention Opioid Prescribing Guidelines that prescribers and pharmacists use the PDMP results to monitor the morphine milligram equivalent of the total daily opioid dose a patient is currently being prescribed across all prescribers.[1] The PDMP provides prescribers and pharmacists a current total morphine milligram equivalent for the patient in each report. This is an advantage to using the system each time a prescription is written. Doses greater than 90 morphine milligram equivalent/day may be associated with significant risks according to the Pennsylvania and Centers for Disease Control and Prevention Opioid Prescribing Guidelines, but often the greatest increase in risk is when higher doses of opioids are co-prescribed with benzodiazepines or when the patient has other comorbidities, such as opioid use disorder, substance use disorder or serious mental illness. (See Table 1 for comparison of morphine milligram equivalents of common opioids.)



Continued

How to Use the PDMP to Address Pain Management *(continued)*

Supporting Patient Safety *(continued)*

The PDMP also supports patient safety by permitting a review of all Schedule II-V prescriptions the patient is taking and helping prescribers/pharmacists identify potentially harmful drug-drug interactions (e.g., benzodiazepines and opioids).[1] PDMP results can identify potential misuse of other scheduled drugs, not just opioids, so prescribers should pay attention to all the controlled substances present in PDMP reports. PDMP data also increases patient safety by providing important information for prescribers that will aid in their decision making around how to best manage a patient's pain with opioids, which may in some circumstances include tapering or discontinuing opioids, if the risks or adverse events outweigh any benefits. (See Module 4 for information on assessing risk and harm.)[4]

Discussing Alternative Pain Management Strategies

Third, the results can be used to discuss the role of opioids in pain management with the patient. After the prescriber or pharmacist has reviewed the patient's PDMP report, the prescriber or pharmacist should discuss the report with the patient and confirm that the patient is aware of the prescriptions. The prescriber or pharmacist should also discuss other methods of pain management and safety concerns surrounding high dosages of medications and drug-drug interactions. Concerns should be communicated to the patient's other prescribers in cases of emergency, and the prescriber should refer the patient to substance use disorder treatment if the patient has behaviors suggestive of opioid use disorder. For example, early signs of an opioid use disorder include frequent early refills for opioid prescriptions.[1] Any patient discussions should use patient-centered communication approaches involving motivational interviewing principles. Patient dismissal or steps to terminate a patient should not be taken. Patients must be referred to substance use disorder treatment programs if necessary (see Module 5).[5]

Table 1: 90 Morphine Milligram Equivalents of Common Opioids

90 mg Morphine = **90 mg Hydrocodone** = **60 mg Oxycodone** = **20 mg Methadone**

Urine Drug Testing

Urine drug testing is recommended in order to obtain a baseline assessment of the patient's opioid exposure, exposure to other controlled and prescription medication use and possible concurrent illegal drug use, if opioid medications are going to be prescribed for the management of chronic pain.[1,2,4]

Prior to conducting a urine drug test, the prescriber should discuss with the patient why the test is being ordered. The prescriber should emphasize that drug screenings are routinely conducted as part of patient visits and are not meant to be an accusation of drug misuse. However, unexpected results can be a sign of either noncompliance through diversion, deliberate misuse, illicit drug use or a failure of the patient to report other prescribed controlled substances. Urine drug testing is recommended throughout the duration of opioid therapy at random intervals, as well as immediately when a patient is exhibiting aberrant behavior. Patients who are at a higher risk of opioid misuse should be tested more frequently than those who are not. (See Module 4 for more information on assessing risk.)

The results of the urine drug test should always be compared to the results of the patient's PDMP query to ensure that all prescriptions being filled are testing positive on the urine drug test and any drugs showing up on the urine drug test are also present during the PDMP query. If there are any discrepancies between the results of the urine drug test and the PDMP query, the prescriber should discuss them with the patient.[1,2,6-8] There are differences between types of urine drug tests, such as radioimmunoassay tests and liquid chromatography-mass spectroscopy testing methods. It is important for the provider to know what can and cannot be detected by the testing method available. In addition, the prescriber should be well-versed on how to appropriately interpret urine drug test results. For example, not all opioids show up on a typical opioid urine drug test.[9] In order to learn more about urine drug testing and how to use the method effectively in practice, please refer to the American Society of Addiction Medicine Drug Testing Appropriateness Document.*

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* https://www.asam.org/

The Nature of Pain for Different Patient Populations and How to Address It

Pain can be categorized as acute or chronic. Acute pain is a type of pain associated with an acute injury, surgery or illness that resolves itself in a few weeks or months.[10] Chronic pain is categorized as pain lasting more than three months on a daily basis or pain occurring for at least six months on the majority of days during the week.[1,11]

Prescribers need to be aware of the differences between chronic and acute pain in order to effectively manage pain with and without opioids, while using the PDMP and when making clinical decisions.[1] All pain is not the same. The pain from migraines is not managed the same as the pain from fibromyalgia, for example. Acute or chronic pain can be nociceptive, neuropathic or a mixture of both. Chronic pain has physiological, social and psychological dimensions that can make it difficult and complicated to treat. These factors often act as "amplifiers" to pain sensations and perceptions of pain, resulting in more treatment-resistant pain syndromes.[12] Opioid use for acute pain and increased exposure to opioids can be associated with long-term opioid use. In other words, if the patient is prescribed opioids for any reason, there is a small, but predictable risk that he/she will continue to be prescribed opioids chronically. The long-term use of opioids may increase the risk of overdose and opioid use disorders in vulnerable populations.[13] In addition, the common patient experience of tolerance in using opioids for chronic non-cancer pain (diminished pain improvement over time) often leads to gradual dose escalations. Higher doses are associated with greater opioid complications.[14] The nature of chronic and acute pain varies across different patient populations. The following describes how pain presents in different patient populations and how it should be addressed. Table 2 (see page 10), discusses non-opioid pain management strategies to treat pain in various patient populations.

Back Pain

Back pain is the second leading symptom reported by patients to physicians and the fifth most common reason for all physician visits in the United States.[15,16] Patients with chronic low back pain also have significantly higher rates of depression or anxiety disorders than the general population.[17-19] In addition, substance use disorders in patients with chronic back pain occur at a higher rate.[16] These comorbidities can make chronic back pain and many chronic painful disorders difficult to manage.

> While opioids are commonly prescribed for chronic back pain, there is little evidence for the long-term efficacy of opioid therapy in this patient population.[1]

If a patient with chronic back pain, for example, is currently prescribed opioids for pain management or if opioid therapy is being considered, prescribers should check the PDMP at the start of prescribing and every time the medication is re-prescribed. The PDMP can be used as one tool to help determine if the patient is at risk of overdose, misusing medication or possibly involved in the diversion of a prescribed controlled substance.[1] Checking the PDMP alone is not sufficient to assess these issues. The PDMP is a supplement to clinical assessment in conjunction with urine drug testing. Pill counts are another important control that can be used, in addition to coordination with other medical prescribers. (See Module 5 for information on referrals to treatment.)[15] On occasion, a specialty drug test is ordered by the provider to determine if the specific prescription is being consumed by the patient as prescribed.

Continued

The Nature of Pain for Different Patient Populations and How to Address It *(continued)*

Osteoarthritis

During the management of osteoarthritis, prescribers should use nonpharmacological methods, such as exercise, weight loss and physical therapy to help reduce pain and improve function in those diagnosed with osteoarthritis of the knee and hip.[1] Medical procedures such as intra-articular corticosteroid injections may also be useful to relieve pain, if first-line medications are insufficient in pain relief. Opioids are not recommended to treat osteoarthritis unless all other pain management strategies fail to treat the pain.

Headache or Migraine

Opioids are not recommended for chronic headaches or migraines because of the rapid rate of tolerance in this condition and the possible worsening of headaches through the phenomena of medication overuse induced headaches. However, it is important to note that the issue of tolerance is common to all opioid use. Similar to tolerance is opioid induced hyperalgesia, a worsening of pain caused by the opioid use.[1]

Those who suffer from chronic headaches should use a multimodal approach to their pain care, maximizing non-opioid medications, diet and exercise approaches, and a focus on pain coping skills.[1]

Fibromyalgia

Nonpharmacological methods, such as exercise and other types of physical therapy, should be used to improve well-being, treat symptoms and improve physical function of individuals diagnosed with fibromyalgia. Increased activity of any kind is a primary endpoint in treating fibromyalgia. Opioids are not recommended for fibromyalgia patients, as they lead to rapid tolerance and the possible worsening of pain.[1]

Pediatrics

Chronic pain diagnosis is less frequent in pediatric populations compared to adults. How pediatric pain is managed can greatly affect long-term health outcomes. Up to 40 percent of pediatric patients report significant effects resulting from pain regarding school attendance, social engagement, appetite, sleep and health service utilization that can continue into adulthood.[20] There is also little evidence to support long-term use of opioid therapy for individuals younger than 18 years of age. Few pharmacological therapies are Food and Drug Administration-approved for chronic pediatric pain management. The only extended-release opioids approved for pediatric patients are transdermal fentanyl (for patients ages two and older) and oxycodone (ages 11 to 16).[21]

In general, opioids are rarely used or recommended in multimodal plans to manage pediatric chronic pain. In most cases, referral to specialty care is appropriate with pain of this severity. Multimodal plans that emphasize cognitive behavioral therapy, physical therapy, non-opioid pharmacological drugs (e.g., acetaminophen), and biopsychosocial models are preferred methods for this population.[20]

If opioids are going to be prescribed to anyone under the age of 18, the PDMP should be used to help determine that opioids are not being misused by the individual and that drug diversion is not taking place. Individuals under the age of 18 are at an increased risk of opioid misuse or dependence.[1] In terms of adolescents, the impulsivity of adolescence is a major risk factor of misuse, and the unknown long-term effects of opioids on the developing brain are important considerations that should be taken into consideration when managing the pain of this patient population.[22]

Continued

The Nature of Pain for Different Patient Populations and How to Address It *(continued)*

Table 2: Can I use these methods to treat acute or chronic pain?[╥]

Population	Pharmacological							Nonpharmacological		
	First-line analgesics[i]	SNRIs/ TCAs[ii]	Beta Blockers	Injections[iii]	Topical[iv]	Anti-seizure[v]	Anti-depressants[vi]	CBT/ Biopsycho-social[vii]	Weight Loss	Exercise
Back Pain[1,15]	Yes	Yes	—	Yes	—	—	—	Yes	Yes	Yes
Osteoarthritis[1]	Yes	—	—	Yes	Yes	—	—	—	Yes	Yes
Headache/ Migraine[1]	Yes	Yes	Yes	—	—	Yes	—	Yes	—	Yes
Fibromyalgia[1]	—	Yes	—	—	—	—	Yes	—	—	Depends[***]
Pediatrics[1,20]	Yes	—	—	—	—	—	—	Yes	—	Yes
Elderly[1,20,23,24]	Depends[*]	—	—	—	—	—	—	Yes	Yes	Yes
Pregnant Women[1,25,26]	Depends[**]	—	—	—	—	—	—	Yes	—	Yes

[*] Nonsteroidal anti-inflammatory drugs should be used with caution and are not recommended for long-term use in the elderly due to elevated risks of adverse effects associated with gastrointestinal, cardiovascular, and renal systems.

[**] Acetaminophen is recommended but nonsteroidal anti-inflammatory drugs are not recommended during pregnancy due to an association with birth defects.

[***] Exercise is often difficult for individuals suffering from fibromyalgia.

[╥] Always reference Pennsylvania and Centers for Disease Control and Prevention opioid prescribing guidelines.

[i] Nonsteroidal anti-inflammatory medications and acetaminophen

[ii] Serotonin and norepinephrine reuptake inhibitors and tricyclic antidepressants

[iii] Intra-articular corticosteroid injections

[iv] Topical nonsteroidal anti-inflammatory medications, lidocaine, and capsaicin cream

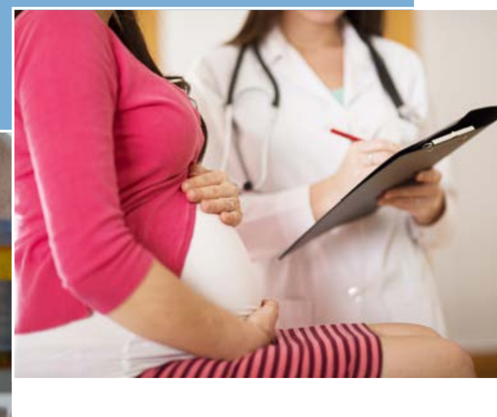
[v] Gabapentin and pregabalin

[vi] Duloxetine and milnacipran

[vii] Cognitive behavioral therapy

Continued

The Nature of Pain for Different Patient Populations and How to Address It *(continued)*



Elderly Individuals

In a nationwide survey of older adults (≥ 65 years old) conducted in 2011, 52.8 percent reported experiencing some type of bothersome pain, such as pain in the lower extremities that limits the distance an individual can walk in the previous month.[23] Caring for older adults is often more complicated than for other patient populations. Older patients are more likely to have multiple comorbidities that require a collection of different medications to treat. This situation leads to an increase in the number of drug-drug and drug-disease interactions. It can also lead to an increase in drug sensitivity, unpredictability of medication effects and potentially harmful effects.[24]

Prescribers should use increased caution and increased monitoring to minimize the risks associated with managing pain in this population.[1] When performing a query of the PDMP, prescribers and pharmacists should look for the total daily morphine milligram equivalent dose for opioids in the patient report, to ensure that the patients are not on a dosage that is associated with an elevated risk of overdose, unless absolutely necessary. They should also check for any potentially harmful drug-drug interactions given the high number of comorbidities common in this patient population. However, many common painful conditions in the elderly, such as osteoarthritis, may respond well to low-dose opioids with low rates of tolerance and misuse. Given the risks of chronic nonsteroidal anti-inflammatory drug use in this population, such as heart attack or stroke, opioids do have a role in chronic pain management in geriatric patients.[25] Table 3 *(see page 12)*, depicts non-opioid medication options to treat neuropathic and nociceptive pain in elderly patients.

Pregnant Women

Helping a woman manage pain during pregnancy can be challenging for the prescriber due to the elevated potential for reactions to analgesics and general concern for the fetus. Mothers are often concerned about taking pain medications even for chronic conditions, leading to under treatment or no treatment. Pain left untreated can lead to potentially harmful conditions, such as hypertension, anxiety and depression during the pregnancy.

While opioid use in therapeutic doses has not been linked with malformations during pregnancy, opioid misuse in pregnancy has been associated with an increased risk of negative complications to both the mother and fetus.[26,27]

Neonatal opioid abstinence syndrome occurs in some cases of women who are opioid dependent during pregnancy. The increase in neonatal abstinence syndrome over the past 10 years corresponds with the reported rise in opioid use during pregnancy. This has been attributed to a liberal use of prescribed opioids for pain control in pregnant women, illicit use of prescription and non-prescription opioids, and a large increase in medication-assisted treatment programs for the treatment of opioid addiction.[28-36]

Clinicians should: (1) weigh the risks and benefits with the patient before using medications to manage pain during a pregnancy; (2) use the lowest effective dose; and (3) carefully review the patient's medical history.[1] Prescribers should also be very cautious of the mother's withdrawal/detoxification symptoms, as well as effects of tapering, which should be done carefully for mothers who misuse opioids or for mothers who have been on opioid therapy long-term. Neonatal abstinence syndrome can be more deleterious in utero than postpartum, and miscarriage can occur as a side effect of the mother's withdrawal.[37,38]

Continued

The Nature of Pain for Different Patient Populations and How to Address It *(continued)*

Table 3: Evidence for Non-Opioid Treatment in Elderly Populations[39]

Medication	Neuropathic Pain	Nociceptive Pain
Acetaminophen	◆ (gray)	◆ (dark blue)
Nonsteroidal Anti-Inflammatory Drugs – Oral – Ibuprofen	◆ (gray)	◆ (dark blue)
Nonsteroidal Anti-Inflammatory Drugs – Oral – Naproxen	◆ (gray)	◆ (dark blue)
Nonsteroidal Anti-Inflammatory Drugs – Topical	◆ (gray)	◆ (dark blue)
Lidocaine Patch	◆ (light blue)	◆ (light blue)
Selective serotonin reuptake inhibitors	◆ (gray)	◆ (gray)
Tricyclic antidepressants – Amitriptyline	◆ (dark blue)	◆ (gray)
Tricyclic antidepressants – Nortriptyline	◆ (dark blue)	◆ (gray)
Serotonin and norepinephrine reuptake inhibitor – Duloxetine	◆ (dark blue)	◆ (light blue)
Serotonin and norepinephrine reuptake inhibitor – Venlafaxine	◆ (dark blue)	◆ (gray)
Serotonin and norepinephrine reuptake inhibitor – Milnacipran	◆ (dark blue)	◆ (gray)
Anticonvulsants – Gabapentin	◆ (dark blue)	◆ (gray)
Anticonvulsants – Pregabalin	◆ (dark blue)	◆ (gray)
Anticonvulsants – Carbamazepine	◆ (light blue)	◆ (gray)

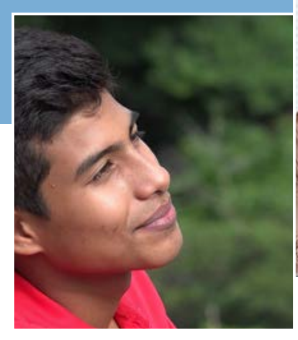
◆ (dark blue) = Data from at least one randomized controlled trial or meta-analysis of RCTs with consistent efficacy

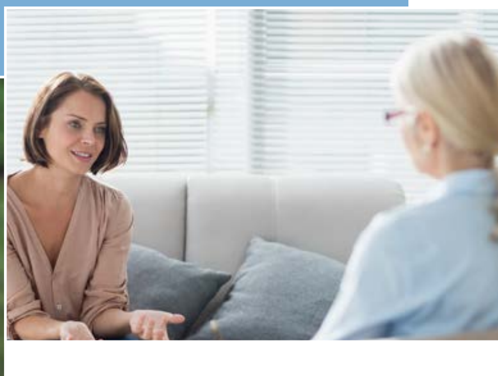
◆ (light blue) = Data from non-experimental studies or inconsistent efficacy

◆ (gray) = Inadequate or not effective

Continued

The Nature of Pain for Different Patient Populations and How to Address It *(continued)*





Persons with Other Mental Health Conditions

Psychological distress in patients with chronic pain presents a challenge to pain management and most commonly presents as co-occurring major depression, generalized anxiety disorder or difficulty in coping with pain, as indicated by high levels of pain catastrophizing. This cluster of negative affective symptoms and resulting psychiatric comorbidities can worsen chronic pain through direct effects on the processing of pain in the brain.[12] When patients with pain have comorbid depression, the pain is greater, the prognosis is worse and the number of functional disabilities is increased.[18] Moreover, patients with negative affective disorders have worse outcomes with chronic opioid therapy, such as less analgesia and higher rates of opioid misuse.

In making the decision to prescribe opioids for chronic pain, it is therefore important to assess the mental health of the patient and account for any comorbid condition(s).[40] In addition to the clinical assessment, prescribers can use validated self-report surveys such as the Generalized Anxiety Disorder 7 Questionnaire and the Patient Health Questionnaire 9 to assess for anxiety or depression symptoms.[41] Clinicians may be more cautious in prescribing opioids for those with psychiatric comorbidities or may ensure that the major depression or generalized anxiety disorder is better treated before considering opioid therapy for treatment. Opioid therapy should not be initiated during periods of acute psychiatric episodes or when suicide risk is present.[4]

Benzodiazepines and opioids can interact and increase the risk for opioid-induced respiratory depression and accidental overdose. The prescriber should use the PDMP to determine if any harmful drug-drug interactions can occur with the patient's current prescription. PDMP results should also be used to check if the patient is refilling his/her scheduled medications as prescribed.[2] When treating chronic pain in patients who are co-prescribed drugs for mental health conditions, clinicians should consider using serotonin-norepinephrine reuptake inhibitor antidepressants as a first-line agent because of their multiple actions to improve pain and treat depression or anxiety disorders. Tricyclic antidepressants are the other preferred class in this situation for the same reasons. Other antidepressants have few analgesic properties.[42] In general, prescribers should increase patient monitoring due to the elevated risk for opioid use disorder and overdose in this patient population. Clinicians should also consider consulting a behavioral health specialist before and during opioid therapy in patients with more severe mental health conditions.[1]

Substance Use Disorder

Challenges can arise when treating any phase of pain in patients diagnosed with a substance use disorder, those who have a history of substance use disorder or those who are at a high risk for developing substance use disorder. Chronic pain and substance use disorders are associated with high rates of psychiatric comorbidities.[12] Therefore, a multimodal approach using non-opioid methods of pain management for this patient population is important. An example is through active participation in a licensed psychosocial drug and alcohol treatment program. Currently available risk assessment tools have been shown to be insufficient alone when classifying a patient as high risk for misuse or illicit use.[1] Prescribers should ask patients about substance use and validate it through screening tools such as the CAGE Questions Adapted to Include Drugs Tool and the Alcohol, Smoking and Substance Involvement Screening Test.[1,43,44]

Prescribers should also use the PDMP, patient-centered communication principles and urine drug testing to assist in the screening and assessment of patients who may have a substance use disorder. (See Modules 5 and 6 for information on referral to substance use disorder treatment and Screening, Brief Intervention and Referral to Treatment (SBIRT).) Prescribers should increase the amount of monitoring and consider referral and close coordination with substance use disorder treatment specialists and/or pain management experts when treating this population.[1]

The Pennsylvania Law Related to Required Pain Management Continuing Education for Prescribers and Pharmacists

Licensing

Effective Jan. 1, 2017, licensing boards for individuals who are applying to be prescribers or pharmacists of prescription medication will require documentation of:

- At least two hours of education in pain management or identification of addiction; and
- At least two hours of education in the practice of prescribing or dispensing opioids.

The education may be part of a professional degree or continuing education program.

License renewals

Effective Jan. 1, 2017, licensing boards for individuals who are renewing their licenses will require documentation of at least two hours of continuing education in pain management, identification of addiction, or the practices of prescribing or dispensing opioids.

This requirement does not apply to a prescriber who is exempt under the Drug Enforcement Administration's requirements for a registration number and who do not use the registration number of another person or entity permitted by law to prescribe controlled substances in any manner.

(Nov. 2, 2016, P.L. 980, Act124)

Sources

1) Dowell D, Haegerich T, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain. *Jama.* 2016;315(15):1624-1645.
2) Washington State Agency Medical Directors' Group. *AMDG 2015 Interagency Guideline on Prescribing Opioids for Pain.* Olympia, WA: Washington State Agency Medical Directors' Group; 2015.
3) Moore T, Jones T, Browder J, Daffron S, Passik S. A Comparison of Common Screening Methods for Predicting Aberrant Drug-Related Behavior among Patients Receiving Opioids for Chronic Pain Management. *Pain Medicine.* 2009;10(8): 1426-1433.
4) United States Department of Veterans Affairs, United States Department of Defense. *Clinical Practice Guideline for Opioid Therapy for Chronic Pain.* 2016.
5) Elwyn G, Dehlendorf C, Epstein R, Marrin K, White J, Frosch D. Shared decision making and motivational interviewing: achieving patient-centered care across the spectrum of health care problems. *The Annals of Family Medicine.* 2014;12(3):270-275.
6) Heltsley R, Zichterman A, Black D, et al. Urine drug testing of chronic pain patients. II. Prevalence patterns of prescription opiates and metabolites. *Journal of Analytical Toxicology.* 2010;34(1):32-38.
7) Moeller K, Lee K, Kissack J. Urine drug screening: practical guide for clinicians. *Mayo Clinic Proceedings.* 2008;83(1):66-76.
8) Standridge J, Adams S, Zotos A. Urine drug screening: A valuable office procedure. *American Family Physician.* 2010;81(5):635-640.
9) Milone M. Laboratory Testing for Prescription Opioids. *Journal of Medical Toxicology*. 2012;8(4):408-416.
10) Warner E. Opioids for the treatment of chronic noncancer pain. *The American Journal of Medicine.* 2012;125(12):1155-1161.
11) Merskey H, Bond M, Bonica J, et al. Classification of chronic pain: Descriptions of chronic pain syndromes and definitions of pain terms. *Pain.* 1986.
12) Substance Abuse and Mental Health Service Administration. *TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders.* Rockville, MD. 2012.
13) Mundkur M, Gordon A, Stefan G. Will Strict Limits on Opioid Prescription Duration Prevent Addiction? Advocating for Evidence-Based Policymaking. *Substance abuse.* 2017;20(0):1547-0164.
14) Volkow N, McLellan A. Opioid abuse in chronic pain-misconceptions and mitigation strategies. *New England Journal of Medicine.* 2016;374(13):1253-1263.
15) Chou R, Qaseem A, Snow V, et al. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society. *Annals of Internal Medicine.* 2007;147(7):478-491.
16) Martell B, O'Connor P, Kerns R, et al. Systematic review: opioid treatment for chronic back pain: prevalence, efficacy, and association with addiction. *Annals of Internal Medicine.* 2007;146(2):116-127.
17) Bair M, Robinson R, Katon W, Kroenke K. Depression and pain comorbidity: a literature review. *Archives of Internal Medicine.* 2003;163(20):2433-2445.
18) Börsbo B, Peolsson M, Gerdle B. The complex interplay between pain intensity, depression, anxiety and catastrophising with respect to quality of life and disability. *Disability and Rehabilitation.* 2009;31(19):1605-1613.
19) Miller L, Cano A. Comorbid chronic pain and depression: who is at risk? *The Journal of Pain.* 2009;10(6):619-627.
20) Baumbauer K, Young E, Starkweather A, Guite J, Russell B, Manworren R. Managing Chronic Pain in Special Populations with Emphasis on Pediatric, Geriatric, and Drug Abuser Populations. *Medical Clinics of North America.* 2016;100(1):183-197.
21) US Food and Drug Administration. CDER Conversation: Pediatric pain management options. 2017.
22) Romer D. Adolescent Risk Taking, Impulsivity, and Brain Development: Implications for Prevention. *Developmental Psychobiology.* 2010;52(3):263-267.

Sources *(continued)*

23) Patel K, Guralnik J, Dansie E, Turk D. Prevalence and impact of pain among older adults in the United States: Findings from the 2011 National Health and Aging Trends Study. *Pain.* 2013;154(12):2649-2657.

24) van Ojik A, Jansen P, Brouwers J, van Roon E. Treatment of chronic pain in older people: evidence-based choice of strong-acting opioids. *Drugs & aging.* 2012;29(8):615-625.

25) Naple J, Gellad W, Hanlon J. Managing Pain in older Adults: The Role of Opioid Analgesics. *Clinical Geriatric Medicine*. 2016;32(4):725-735.

26) ACOG Committee on Health Care for Underserved Women, American Society of Addiction Medicine. ACOG Committee Opinion No. 524: Opioid abuse, dependence, and addiction in pregnancy. *Obstetrics and Gynecology.* 2012;119(5):1070-1076.

27) Babb M, Koren, G., & Einarson, A.,. Treating pain during pregnancy. *Canadian Family Physician.* 2010;56(1):25-27.

28) Ailes EC, Dawson AL, Lind JN, et al. Opioid Prescription Claims Among Women of Reproductive Age- United States, 2008-2012. *Morbidity and Mortality Weekly Report.* 2015;64(02):37-41.

29) Cicero TJ, Ellis MS, Harney J. Shifting patterns of prescription opioid and heroin abuse in the United States. *New England Journal of Medicine.* 2015;373:1789-1790.

30) Epstein RA, Bobo WV, Martin PR, et al. Increasing pregnancy-related use of prescribed opioid analgesics. *Annals of Epidemiology.* 2013;23(8):498-503.

31) Gomes T, Juurlink DN. Opioid use and overdose: what we've learned in Ontario. H*ealthcare Quarterly.* 2016;18(4):8-11.

32) Jansson LM, Velez M. Neonatal abstinence syndrome. *Current Opinion in Pediatrics.* 2012;24(2):252-258.

33) Krans EE, Cochran G, Bogden DL. Caring for Opioid-dependent Pregnant Women: Prenatal and Postpartum Care Considerations. *Clinical Obstetrics and Gynecology.* 2015;58(2):370-379.

34) Stover MW, Davis JM. Opioids in pregnancy and neonatal abstinence syndrome. *Seminars in perinatology.* 2015;39(7):561-565.

35) Warren MD, Miller AM, Traylor J, Bauer A, Patrick SW. Implementation of a Statewide Surveillance System for Neonatal Abstinence Syndrome - Tennessee, 2013. *Morbidity and Mortality Weekly Report.* 2015;64(05):125-128.

36) Yazdy MM, Desai RJ, Brogly SB. Prescription Opioids in Pregnancy and Birth Outcomes: A Review of the Literature. *Journal of Pediatric Genetics.* 2015;4(2):56-70.

37) Behnke M, Smith V. Prenatal Substance Abuse: Short- and Long-Term Effects on the Exposed Fetus. *American Academy of Pediatrics.* 2013;131(3).

38) Jones H, Martin S, Stine S, et al. Treatment of Opioid Dependent Pregnant Women: Clinical and Research Issues. *Journal of Substance Abuse Treatment.* 2008;35(3):245-259.

39) Makris UE AR, Gurland B, Reid MC,. Management of persistent pain in the older patient: a clinical review. *Jama.* 2014;312(8):825-836.

40) Wasan A, Michna E, Edwards R, et al. Psychiatric Comorbidity Is Associated Prospectively with Diminished Opioid Analgesia and Increased Opioid Misuse in Patients with Chronic Low Back Pain. *Anesthesiology.* 2015;123(4):861-872.

41) Kroenke K, Spitzer R, Williams J, Lowe B. The Patient Health Questionnaire Somatic, Anxiety, and Depressive Symptom Scales: a systematic review. *General Hospital Psychiatry.* 2010;32(4):345-359.

42) Verdu B, Decosterd I, Buclin T, Stiefel F, Berney A. Antidepressants for the treatment of chronic pain. *Drugs.* 2008;68(8):2611-2632.

43) Basu D, Ghosh A, Hazari N, Parakh P. Use of Family CAGE-AID questionnaire to screen the family members for diagnosis of substance dependence. *The Indian journal of medical research.* 2016 Jun;143(6):722.

44) Organization WH. *The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST).* 2010.

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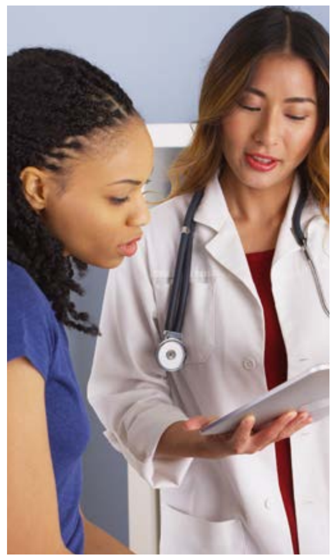

Pennsylvania Prescription Drug Monitoring Program (PDMP)
System User and Stakeholder Training

Opioid Prescribing Guide

MODULE 4 | GUIDE DOCUMENT

Pennsylvania Prescription Drug Monitoring Program (PDMP) System User and Stakeholder Training

Learning Objectives for Modules 1-7

Module 1: Why Using the PDMP is Important for Achieving Optimal Health for Pennsylvania Citizens

1. The status of substance use disorder in general, opioid use disorder, and overdoses nationally and in Pennsylvania;
2. Common misconceptions about substance use disorder and opioid use disorder treatment and recovery;
3. Costs associated with prescription drug and heroin-associated opioid use disorder and overdose; and
4. How pervasive prescriber and pharmacist PDMP use can reduce population opioid use disorder and overdose.

Module 2: What is a PDMP, How to Use the PDMP to Make Clinical Decisions, How to Integrate the PDMP into the Clinical Workflow, and How to Access Pennsylvania's PDMP

1. Detail Pennsylvania's requirements and regulations regarding PDMP use;
2. Explore options and actions Pennsylvania prescribers and pharmacists can take to integrate the PDMP into clinical workflows; and
3. Discuss how to use the PDMP system to make clinical decisions.

Module 3: Using the PDMP to Optimize Pain Management

1. Learn how to use the PDMP to address pain management for various patient populations and pain types;
2. Understand the basic nature of pain for different patient populations and how to manage their pain using the PDMP as a clinical tool; and
3. Discuss different ways of treating patient pain that do not involve the immediate use of opioids.

Module 4: Opioid Prescribing Guide

1. Provide guidelines to inform all healthcare providers when prescribing opioids in the acute phase of pain;
2. Instruct healthcare providers on how to prescribe opioids in the chronic phase of pain, which includes information on how to initiate or continue opioid therapy, select the correct dose, and/or discontinue opioids;
3. Instruct healthcare providers on how to assess risks and address harms associated with opioid use;
4. Instruct healthcare providers on the legal responsibilities related to prescribing opioids; and
5. Instruct healthcare providers on how they may direct patients to dispose of unused medications.

Module 5: Referral to Treatment for Substance Use Disorder Related to Opioid Use

1. Define "warm handoffs" and how they can best occur;
2. Provide a schema for how any healthcare provider can implement "warm handoffs" in any clinical setting;
3. Demonstrate how primary care practices can conduct "warm handoffs" by preparing, using validated screening tools, and using patient-centered communication with patients;
4. Demonstrate how healthcare providers can determine the best type of treatment for their patients;
5. Present information on patient confidentiality that providers should be aware of when working with patients with substance use disorders and performing "warm handoffs"; and
6. Present relevant Pennsylvania links for treatment and other resources.

Module 6: Approaches to Addressing Substance Use Disorder with Patients Identified by the PDMP

1. Learn how to integrate the PDMP with other screening tools to help identify those who may require substance use disorder treatment or increased monitoring;
2. Define Screening, Brief Intervention, and Referral to Treatment (SBIRT), its main goals, and its main components;
3. Learn how to screen a patient for a potential substance use disorder, conduct a brief intervention, and refer a patient to treatment;
4. Learn how to discuss a substance use disorder with a patient and handle patient resistance; and
5. Learn how to incorporate SBIRT into clinical practice.

Module 7: Effective Opioid Tapering Practices

1. Discuss how to use the PDMP to determine if a provider should consider tapering his/her patient;
2. Discuss several indicators that prescribers can look for when considering tapering opioids;
3. Inform prescribers on how to discuss tapering with patients using patient-centered techniques;
4. Present a general opioid tapering protocol and how to adapt this protocol to the needs of any patient; and
5. Present information on how to manage withdrawal and how to use tools to measure withdrawal symptoms in patients.

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Introduction

This summary document for prescribers and pharmacists/dispensers discusses opioid prescribing guidelines published by the Pennsylvania Department of Health for acute and chronic pain management in healthcare settings as well as information published by the Centers for Disease Control and Prevention for chronic and acute pain management in all medical practices.[1-4]

It also discusses how the Prescription Drug Monitoring Program (PDMP) should be incorporated into patients' pain management and risk assessments when opioids are being used to manage pain. The PDMP should be used before and throughout therapy as a tool to help assess patient risk, monitor morphine milligram equivalent dose levels, screen for potentially harmful drug-drug interactions, and check for opioid misuse.[4] It should be incorporated into the guidelines of all prescribers when prescribing opioids for acute and chronic pain in any healthcare setting.

In this module, prescribers will learn how to safely and accurately prescribe opioids throughout the different phases of pain for all patient populations. This module is meant to guide practitioners in healthcare settings and has the following objectives:

1. Provide guidelines to inform all healthcare providers when prescribing opioids in the acute phase of pain;
2. Instruct healthcare providers on how to prescribe opioids in the chronic phase of pain, which includes information on how to initiate or continue opioid therapy, select the correct dose, and/or discontinue opioids;
3. Instruct healthcare providers on how to assess risks and address harms associated with opioid use;
4. Instruct healthcare providers on the legal responsibilities related to prescribing opioids; and
5. Instruct healthcare providers on how they may direct patients to dispose of unused medications.

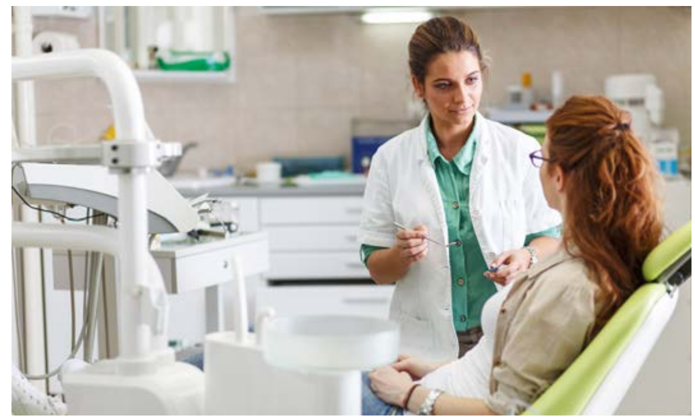
Prescribing Opioids in the Acute Phase of Pain

The acute phase of pain is considered to be the period of time that immediately follows the episode of pain until six weeks post-episode. The prescriber should reserve opioids for the treatment of acute pain that results from severe injuries or medical conditions, surgical procedures, or when non-opioid alternatives are ineffective at relieving the patient's pain. Prescribers who are concerned with perioperative settings are referred to the American Society of Anesthesiologists' guidelines for acute pain management in perioperative settings.[5]

Clinical Recommendations for Healthcare Providers

These recommendations for prescribing opioids for acute pain are based on the Centers for Disease Control and Prevention guidelines for prescribing opioids:[4]

1. The prescriber should optimize non-opioid pharmacological and nonpharmacological pain management methods before considering opioids *(see Module 3 for information on non-opioid pain management strategies)*.
2. If opioids are going to be prescribed, query the PDMP and determine whether the patient is currently prescribed any medications, including opioids or benzodiazepines.
3. For initial prescriptions, prescribe immediate-release opioids instead of extended-release opioids at the lowest effective dose and only for the expected duration of the pain.
4. In most cases of acute pain not related to surgery or trauma, a supply less than or equal to three days is usually sufficient to effectively manage the patient's pain. However, a supply range less than or equal to a seven-day range may also be appropriate on a patient-by-patient basis. If opioids are considered for acute pain for longer than seven-days, a reassessment is suggested prior to another seven-day prescription.
5. Prescribers should re-evaluate a patient who is experiencing severe acute pain that is lasting longer than the expected duration before refilling an opioid prescription. For further recommendations and information related to acute and subacute pain management, prescribers are referred to the Washington Agency Medical Directors' Group Interagency Guidelines on Prescribing Opioids for Pain, Part II: Prescribing Opioids in the Acute and Subacute Phase.[6]



Clinical Recommendations for Dental Prescribers

Dental prescribers often provide acute pain treatment in cases of dental emergencies or as part of routine dental care. If properly trained, dental prescribers may also be involved in the treatment of chronic facial and neuromuscular pain that may require more potent opioids.[3] The following are clinical recommendations for prescribing opioids for acute dental pain.[3,7-9] These recommendations are based on the Pennsylvania guidelines.

1. Before beginning opioid treatment:
   a. Conduct and document a medical and dental history that includes an update of all current medications, a PDMP query, and a physical examination;
   b. Talk to all other prescribers, as appropriate, for the patient;
   c. Conduct the appropriate diagnostic and imaging tests for the patient; and
   d. Formulate at least a preliminary diagnosis for why the patient is having pain.

Continued

Prescribing Opioids in the Acute Phase of Pain *(continued)*

2. Clinicians should administer nonsteroidal anti-inflammatory drugs before administering opioids (unless there are absolute contraindications to nonsteroidal anti-inflammatory drugs), as most cases of dental pain include an inflammatory component. Nonsteroidal anti-inflammatory drugs have been demonstrated to be highly effective in the treatment of dental pain and are often more effective than opioids. Clinicians should consider beginning nonsteroidal anti-inflammatory drugs immediately before dental treatment and continue a scheduled dosage following the procedure.
   a. Discuss and check the patient's medical history to determine if the patient is currently prescribed any anticoagulants, as nonsteroidal anti-inflammatory drugs can significantly increase the risk of bleeding when combined.
   b. Use caution if the patient has a history of hepatic or renal impairment or has previously reported reactions to nonsteroidal anti-inflammatory drugs.
   c. Use optimal dosages of non-opioid medications:
      i. *Ibuprofen 400-800 mg, acetaminophen 1,000 mg, or a combination;*[8]
      ii. *Acetaminophen has been shown to be synergistic with nonsteroidal anti-inflammatory drugs, and when combined, have the same efficacy as low-dose opioids.*
3. To avoid the use of opioids to treat acute pain following a procedure, clinicians should consider administering local anesthetics or regional nerve blocks to assist in pain management.
4. If an opioid is to be administered, the prescriber should ensure that the dose and duration of therapy only last for a short period of time.
   a. Access the PDMP database before prescribing opioids and act in accordance with the current Pennsylvania state laws.
   b. Document the patient's psychiatric status, substance use history, and assess opioid misuse risk and harm.
   c. Choose the lowest potency opioid necessary to treat the patient's pain, as long-acting or extended-release opioids are not suggested for acute pain.
   d. Check medical history and obtain a list of current medications, in order to determine any potential interactions with other prescriptions and assess the risks involved. Some of the risks include:
      i. *Individuals taking benzodiazepines which interfere with the metabolism of some prescription opioids and increase the risk of adverse events or even death; and*
      ii. *Individuals with obstructive sleep apnea are at an increased risk for adverse events from opioid-induced respiratory depression.*
   e. Monitor the patient's total daily dose of acetaminophen in order to ensure that it does not exceed 3,000 mg/day across all current prescription medications.[3]
   f. Give specific opioid care instructions to the patient, including proper safekeeping and disposal.
5. Do not prescribe extended-release opioids unless the clinician has training and experience in treating chronic facial or neuromuscular pain.
6. Coordinate pain therapy with other clinicians before treatment if:
   a. The patient is receiving chronic opioids as shown on his/her PDMP report;
   b. The patient has a history of substance use disorder; or
   c. The patient is at a high risk for aberrant drug-related behavior *(see Assessing Risks and Addressing Harms of Opioid Use on page 9).*
7. In general, it is not proper to prescribe opioids without a face-to-face encounter and evaluation with the patient.
   a. If pain is more severe or lasts longer than expected, reassess the patient before prescribing additional opioids.
   b. Patients who report unexpected or prolonged pain and do not show ongoing pathology should not be prescribed opioids. The prescriber should consider a specialist referral.
   c. Proceed with caution if the patient requests opioids, especially if he/she is a new patient.
   d. Prescribers should refer patients to substance use disorder treatment if there are reasons for concern.

Continued

Prescribing Opioids in the Acute Phase of Pain *(continued)*

Clinical Recommendations for Emergency Department Prescribers

Prescribers should obtain a medical history, physical examination, and order appropriate diagnostic testing, as necessary. The American College of Emergency Physicians recommends always checking the PDMP before prescribing or dispensing a controlled substance and stresses how useful the protocol is in the emergency department. The American College of Emergency Physicians also recommends that other guidelines for chronic and acute pain management be followed by physicians and other emergency department prescribers.[10] The following are recommendations for prescribing opioids in the emergency department for healthcare providers.[1,10-12]

These recommendations are based on the Pennsylvania guidelines.

1. Prescribers should consider non-opioid alternatives for pain management before prescribing opioids, such as nonsteroidal anti-inflammatory drugs, acetaminophen, and topical diclofenac, lidocaine, and capsaicin.
2. Prescribers should search the PDMP database before writing a prescription for opioids and benzodiazepines in accordance with Pennsylvania state laws.
3. Prescribers should only discharge patients with an appropriate amount of opioids, limited to how much is needed until their follow-up appointments, which are usually within seven days.
4. Prescribers should prescribe or dispense the lowest potency opioid necessary to relieve the patient's pain, such as codeine or tramadol.
5. Prescribers should only dispense enough medication for the patient's pain until he/she is able to access a pharmacy. Under Act 122, physicians in hospital emergency departments and urgent care facilities may not prescribe opioids in excess of a seven-day supply. ***Exception:*** If opioids will be prescribed in an excess of seven days to treat acute pain or pain associated with a cancer diagnosis or palliative care, the physician should document in the patient's medical records that a non-opioid alternative was not appropriate under the circumstances.
6. Prescribers should only prescribe short-acting or immediate-release opioids and avoid prescribing extended-release opioids unless discussed with the patient's outpatient prescriber.

7. Prescribers in the emergency department should not replace lost or stolen prescriptions for controlled substances.
8. Emergency department prescribers should not refill prescriptions for patients who run out of pain medications. Any refills should go through the patients' primary or specialty prescriber.
9. Prescribers should encourage the patient whose behavior raises addiction concerns to seek treatment. Emergency department staff should have referral information on hand to distribute to the patient. The law requires that physicians, nurse practitioners, physician assistants, and urgent care facilities refer individuals to treatment if they are believed to be at risk for a substance use disorder.
10. When a patient is assessed to likely require substance use disorder treatment for opioids, emergency department prescribers should initiate a "warm handoff" to substance use disorder providers, in order to increase the chance the patient will access substance use disorder treatment. For example, an emergency department prescriber could facilitate an introduction between the patient and a behavioral health specialist during discharge.

Prescribing Opioids in the Chronic Phase of Pain

The chronic phase of pain is defined as having pain on a daily basis for more than three months or pain on more days of the week than not for at least six months. These guidelines address adult (≥ 18 years old) pain management using prescription opioids in outpatient settings, or outside of active cancer treatment, palliative care, and end-of-life care.[2,4,9,13-15] These recommendations are based on the Pennsylvania Medical Society and Centers for Disease Control and Prevention guidelines.

Initiation or Continuation of Opioid Therapy

1. Clinicians should only consider opioid therapy if the expected benefits outweigh the risks. Nonpharmacological and non-opioid therapies are preferred for chronic pain and should be combined with opioids whenever they are prescribed.
2. Before beginning opioid therapy, establish treatment goals with the patient regarding pain and function. Discuss how therapy will be discontinued if benefits do not outweigh risks and if the therapy is not related to a clinically meaningful improvement in pain or function.
   a. Conduct a thorough medical history and physical examination and obtain a list of the patient's current medications.
   b. Come to an agreement with the patient on what problem is being treated and the initial diagnosis for the pain complaint.
   c. Identify the patient's treatment goals using specific and measurable descriptors, ideally in the patient's own words.
   d. Present the opioids (or any other treatment for pain) as a trial. If opioids do not help achieve the specified goals, they will be discontinued so that other treatments can be implemented.
   e. Review the risks associated with using opioids in pain management with the patient.
   f. Acquire a signed patient agreement form *(Appendix I)* with informed consent and a plan of care that is written in a language that the patient can understand.
   g. Review and potentially implement monitoring practices, such as urine drug tests, prescription refill policies, and the PDMP.
   h. For the initial prescription, schedule a follow-up visit within two to four weeks to assess the effects of the pain medication.
3. Before and during therapy, clinicians should continue discussing the known risks of opioids and remain a responsible prescriber.

Opioid Selection, Dosage, Duration, Follow-up, and Discontinuation

1. When beginning therapy, prescribe immediate-release opioids instead of extended-release/long-acting opioids. The prescriber should also prescribe the lowest effective dose of the opioid.
   a. The Centers for Disease Control and Prevention recommends that prescribers should reassess evidence of the benefits to the individual when increasing dosage to ≥ 50 morphine milligram equivalent/day (e.g., ≥ 50 mg hydrocodone; ≥ 33 mg oxycodone) and avoid increasing to ≥ 90 morphine milligram equivalent/day (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone) when possible due to an increased risk of complications.
   b. Refer to the PDMP to determine current morphine milligram equivalent levels in patients.
   c. For current information on drug-drug interactions and other product-specific information, visit the National Institutes of Health website.*
2. Evaluate benefits and harms of opioid therapy for chronic pain management within one to four weeks or before increasing the dosage.
   a. Repeat the same evaluation every three months.
   b. Optimize other therapies or consider tapering to lower dosages or discontinuing the opioids if benefits do not outweigh the harms.

* https://dailymed.nlm.nih.gov/dailymed/

Continued

Prescribing Opioids in the Chronic Phase of Pain *(continued)*

Assessing Risks and Addressing Harms of Opioid Use

1. Review the patient's medical history and query the PDMP when starting opioid treatment and throughout therapy whenever a new prescription for an opioid or benzodiazepine is prescribed to the patient.
2. Communicate with the patient's previous prescriber, if the patient is new.
3. Evaluate risk factors periodically and before beginning opioid therapy. Reassess the patient at return visits or as often as necessary.
   a. Known risk factors for opioid misuse:[16-19]
      i. *Adults younger than 45 years old;*
      ii. *Personal history of any substance use disorder: illicit or prescription drugs, alcohol, or nicotine;*
      iii. *Family history of substance use disorders;*
      iv. *Criminal or legal history;*
      v. *Psychiatric disorders; and*
      vi. *History of sexual abuse.*
   b. Incorporate strategies to mitigate risk for the patient. Consider offering naloxone, if the patient has a history of overdose, severe opioid use disorder, higher opioid dosages (≥ 90 morphine milligram equivalent/day), or concurrently uses benzodiazepines. For more information on prescribing naloxone, prescribers are referred to the Pennsylvania Department of Drug and Alcohol Programs and Pennsylvania Department of Health's Provider Guide to Prescribing Naloxone to Patients Who Use Opioids.*
   c. Use the three-item Pain, Enjoyment, and General Activity *(Appendix II)* validated scale to assess and reassess pain levels and/or by asking patients if they have had progress toward meaningful and functional goals. This scale is used to develop baseline levels of pain in order to measure a patient's response to a new regimen of medications or the addition of a nonpharmacological therapy. However, the prescriber cannot use the scale to compare two separate patients, as pain levels are subjective. A patient's Pain, Enjoyment, and General Activity score may decrease over time after therapy has begun. Keep in mind that if activity levels increase because of improved pain control, the overall rating of chronic pain by the patient may remain the same. The patient's score in each of the three categories should be averaged together. A 30% improvement from baseline is considered to be clinically meaningful, with the caveat noted above.
4. Administer a urine drug test before prescribing opioids and continue at least annually to assess potential drug misuse or diversion, as well as currently prescribed medication. Urine drug tests may need to be administered more often in cases of at-risk individuals or those who show signs of aberrant behavior.
5. If deemed necessary, consider pill counts to confirm adherence and minimize diversion of the prescription medication. As a suggestion, prescribe a 28-day supply (rather than 30-day), so that the patient has residual medication at appointments. Ask the patient to bring medications at each visit for identified risks or concerns. The prescriber can request random call-backs for immediate counts. Prescribers should also recommend that medications be kept in a locked container for medication safety.
6. Avoid concurrent benzodiazepine and opioid prescriptions, given the high risk of adverse drug-drug interactions, specifically respiratory depression and death. For current information on drug-drug interactions and other product-specific information, visit the National Institutes of Health website.**
7. Offer or arrange evidence-based treatment for patients with moderate or severe opioid use disorders, such as buprenorphine or methadone in combination with behavioral therapies.

* http://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Documents/SN%20-%20Naloxone%20for%20Opioid%20Safety%20-%20A%20Provider%27s%20Guide%20to%20Prescribing%20to%20Patients%20Who%20Use%20Opioids.pdf

** https://dailymed.nlm.nih.gov/dailymed/

Legal Responsibilities Related to Prescribing Opioids in Other Situations

Prescribing Opioid Drug Products to Patients in an Emergency Department, Urgent Care Center, or Who Are in Observational Status in a Hospital

Effective January 1, 2017, opioid drug products can only be prescribed for up to seven days to a patient seeking treatment in an emergency department, urgent care facility, or who is in observation status in a hospital for up to seven days. If more opioid drugs are needed to treat a patient's acute condition, cancer diagnosis, or palliative care, he/she can be prescribed; however, the condition triggering the extension and an indication that a non-opioid treatment is not appropriate must be documented in the patient's medical record.

Prescribers in these facilities cannot refill a patient's opioid prescription regardless of the amount prescribed.

If a patient appears to be at risk for a substance use disorder, the practitioner must refer the patient to treatment.

Checking the PDMP is not required for any medication provided to a patient in the course of treatment while undergoing care in an emergency department. This exception does not apply to patients undergoing care in urgent care centers or when in observation status in a healthcare facility. If a medication prescription is issued during discharge, then the PDMP system must be queried. As part of good clinical practice, the Department of Health recommends that healthcare professionals check the system every time before a controlled substance(s) is prescribed or dispensed in any clinical setting *(refer to the Pennsylvania Guidelines on Emergency Department Pain Treatment for additional information).*

(Nov. 2, 2016, P.L. 976, Act 122)

Prescribing Opioid Drug Products to Minors

A minor can only be prescribed a controlled substance containing an opioid with the written consent of his/her parent or guardian for up to seven days. If consent is given by a minor's authorized adult (i.e., an adult who has a valid healthcare proxy to consent to the minor's medical treatment), the prescription is limited to a single 72-hour supply. "Minor" does not include an individual under 18 years of age who is emancipated:

- By marriage;
- By entering the United States armed forces;
- By being employed and self-sustaining; or
- Is otherwise independent from the care of a parent, guardian, or custodian.

The seven-day limitation does not apply to prescriptions associated with a medical emergency or if the limitation would be detrimental to the minor's health. These exceptions must be noted in the minor's medical health record. Additional exceptions can be made when the prescription is for the management of pain associated with cancer, other chronic pain, or used in palliative or hospice care.

Before prescribing to a minor, the prescriber must:

1. Assess whether the minor has taken or is taking prescription medication for a substance use disorder by checking the PDMP system.
2. Discuss the following topics with the minor and his/her parent, guardian, or authorized adult:
   a. The risks of addiction and overdose;
   b. The increase risk of addiction for individuals suffering from a mental disorder; and
   c. The dangers of taking a controlled substance containing an opioid with benzodiazepines, alcohol, or central nervous system depressants.
3. Obtain written consent from the minor's parent, guardian, or authorized adult before a controlled substance containing an opioid is prescribed. A consent form example is available at on the Pennsylvania Bulletin website.*

The procedures do not apply if the minor's treatment is associated with a medical emergency or compliance with the procedures would be detrimental to the minor's health or safety. Exceptions must be documented in the minor's health record.

(Nov. 2, 2016, P.L. 983, Act 125)

* http://www.pabulletin.com/secure/data/vol47/47-5/191.html

Continued

Legal Responsibilities Related to Prescribing Opioids in Other Situations *(continued)*

A Patient's Voluntary Non-Opioid Directive Form

Practitioners and their patients can execute a voluntary non-opioid directive form developed by the Pennsylvania Department of Health. Before signing, a practitioner can assess the patient's personal and family history of alcohol or drug misuse and evaluate the risks for medication misuse. The practitioner must access the PDMP to see if there is an unusual or suspect pattern for prescribing opioids. The form can be revoked at any time, either in writing or orally.

Sharing data relative to the voluntary non-opioid directive form must comply with all federal and state confidentiality laws.

(Nov. 2, 2016, P.L. 987, Act 126)

David's Law (Good Samaritan Law): Opioid Overdose Reversal Act

Act 139 expands access to naloxone by allowing naloxone dispensing to individuals without a prescription. It also allows first responders, family members, and friends to administer naloxone to individuals experiencing an overdose, and it provides immunity to individuals who prescribe, dispense, and administer naloxone. Additionally, individuals who report drug overdoses and do possess drug paraphernalia and small amounts of drugs are protected under the law.

(Sep. 20, 2014, P.L. 2487, Act 139)

Disposal Guidelines for Opioids and Other Medications

Prescribers should instruct their patients on how to properly dispose of unused medications *(see below).* Some medications are more harmful than others and rarely include specific disposal instructions on their labeling, including flushing down the sink or toilet. While most medications are not recommended to be disposed of by flushing, a regularly updated list of medicines recommended for disposal by flushing is available from the Food and Drug Administration.*

The following are guidelines for proper drug disposal.[20]

1. Instruct patients to be aware of community prescription drug take-back programs that offer a central location for people to dispose of their unused medications. The Department of Drug and Alcohol Programs has a list of drug take-back boxes at: Drug Take-Back Box Locator**
2. Follow any specific disposal instructions presented on the label or in the patient materials that accompany the medication. Do not flush medications down the sink or drain unless instructed.
3. Dispose of drugs in the trash by removing the medication from the original container and placing it in a sealed bag with undesirable substances to make it less appealing to others, if there are no instructions or community take-back programs available. For example, place the medications in a sealed plastic bag filled with coffee grounds and then dispose in a waste canister.
4. Scratch off all identifying information from the prescription label before disposing of a bottle or taking it to a drug take-back program in order to keep medical history and identity private.

* https://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm576167.htm

** https://apps.ddap.pa.gov/gethelpnow/PillDrop.aspx

Sources

1) Pennsylvania Department of Health, Pennsylvania Department of Drug and Alcohol Programs, Pennsylvania Medical Society, American College of Emergency Physicians. *Pennsylvania Guidelines Emergency Department (ED) Pain Treatment Guidelines.* 2017.

2) Pennsylvania Department of Health, Pennsylvania Department of Drug and Alcohol Programs, Pennsylvania Medical Society. *Pennsylvania Guideline on the Use of Opioids to Treat Chronic Noncancer Pain.* 2014.

3) Pennsylvania Department of Health, Pennsylvania Department of Drug and Alcohol Programs, Pennsylvania Dental Association. *Pennsylvania Guidelines on the Use of Opioids in Dental Practice.* 2015.

4) Dowell D, Haegerich, TM, & Chou, R. CDC Guideline for Prescribing Opioids for Chronic Pain. *JAMA*. 2016;315(15):1624-1645.

5) American Society of Anesthesiologists Task Force on Acute Pain Management. Practice guidelines for acute pain management in the perioperative setting: an updated report by the American Society of Anesthesiologists Task Force on Acute Pain Management. *The Journal of the American Society of Anesthesiologists.* 2012;116:248-273.

6) Washington State Agency Medical Directors' Group. *AMDG 2015 Interagency Guideline on Prescribing Opioids for Pain.* Olympia, WA: Washington State Agency Medical Directors' Group; 2015.

7) Becker DE. Drug Therapy in Dental Practice: General Principles: Part 2- Pharmacodynamic Considerations. *Anesthesia Progress.* 2007;54(1):19-24.

8) Becker DE. Pain Management: Part 1: Managing Acute and Postoperative Dental Pain. *American Dental Society of Anesthesiology.* 2010;57(2):67-79.

9) Chou R, Fanciullo G, Fine P, Adler J, Ballantyne J, Davies P. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *The Journal of Pain.* 2009;10(2):113-130.

10) Cantrill S, Brown M, Carlisle R, et al. Clinical policy: critical issues in the prescribing of opioids for adult patients in the emergency department. *Annals of Emergency Medicine.* 2012;60(4):499-525.

11) Lewis V, Colla C, Tierney K, Van Citters A, Fisher E, Meara E. Few ACOs pursue innovative models that integrate care for mental illness and substance abuse with primary care. *Health Affairs.* 2014;33(10):1808-1816.

12) Allegheny County Medical Society. *Pennsylvania's New Opioid Laws and How They Impact Physicians.* 2016.

13) Chou R, Ballantyne J, Fanciullo G, Fine P, Miaskowski C. Research gaps on use of opioids for chronic noncancer pain: findings from a review of the evidence for an American Pain Society and American Academy of Pain Medicine clinical practice guideline. *The Journal of Pain.* 2009;10(2):147-159.

14) Chou R, Fanciullo G, Fine P, Miaskowski C, Passik S, Portenoy R. Opioids for chronic noncancer pain: prediction and identification of aberrant drug-related behaviors: a review of the evidence for an American Pain Society and American Academy of Pain Medicine clinical practice guideline. *The Journal of Pain.* 2009;10(2):131-146.

15) National Institute on Drug Abuse. Sample Patient Agreement Forms. 2017.

16) Ives T, Chelminski P, Hammett-Stabler C, et al. Predictors of opioid misuse in patients with chronic pain: a prospective cohort study. *BMC health Services Research.* 2006; 6(46).

17) Liebschutz J, Saitz R, Weiss R, et al. Clinical factors associated with prescription drug use disorder in urban primary care patients with chronic pain. *The Journal of Pain.* 2010;11(11):1047-1055.

18) Michna E, Ross E, Hynes W, et al. Predicting aberrant drug behavior in patients treated for chronic pain: importance of abuse history. *Journal of Pain and Symptom Management.* 2004;28(3):250-258.

19) Reid M, Engles-Horton L, Weber M, Kerns R, Rogers E, O'Connor P. Use of opioid medications for chronic noncancer pain syndromes in primary care. *Journal of General Internal Medicine.* 2002;17(3):173-179.

20) United States Food & Drug Administration. Disposal of Unused Medicines: What You Should Know. 2016.

Appendix I: Sample Opioid Medication Patient Agreement

Source: University of Denver – Anschutz Medical Campus.
http://www.ucdenver.edu/Search/Results.aspx?k=sample%20patient%20agreement&s=All%20Sites

This is an agreement between (the patient) and (the doctor) concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of a chronic pain problem. The medication will probably not completely eliminate my pain, but is expected to reduce it enough that I may become more functional and improve my quality of life.

1. I understand that opioid analgesics are strong medications for pain relief and have been informed of the risks and side effects involved with taking them.
2. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable, but not a life-threatening condition.
3. I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids and withdrawal can be life-threatening for a baby.
4. Overdose on this medication may cause death by stopping my breathing; this can be reversed by emergency medical personnel if they know I have taken narcotic pain-killers. It is suggested that I wear a medical alert bracelet or necklace that contains this information.
5. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.
6. I understand it is my responsibility to inform the doctor of any and all side effects I have from this medication.
7. I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. Running out early, needing early refills, escalating doses without permission, and losing prescriptions may be signs of misuse of the medication and may be reasons for the doctor to discontinue prescribing to me.
8. I agree that the opioids will be prescribed by only one doctor and I agree to fill my prescriptions at only one pharmacy. I agree not to take any pain medication or physician without first discussing it with the above-named doctor. I give permission for the doctor to verify that I am not seeing other doctors for opioid medication or going to other pharmacies.
9. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced.
10. I agree not to sell, lend, or in any way give my medication to any other person.
11. I agree not to drink alcohol or take other mood-altering drugs while I am taking opioid analgesic medication. I agree to submit a urine specimen at any time that my doctor requests and give my permission for it to be tested for alcohol and drugs.
12. I agree that I will attend all required follow-up visits with the doctor to monitor this medication and I understand that failure to do so will result in discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities recommended by my doctor.
13. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.

I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the doctor may discontinue this form of treatment.

Patient signature:

Doctor signature:

Date:

Appendix I: Sample Opioid Medication Patient Agreement

(continued)

Addendum:

[Sample statement that could be in this agreement or included in chart at each visit]

I understand that the medication is prescribed as follows:

Type of medication: ______________________________

Number of pills and frequency: ______________________________

Total number of pills: ______________________________

Next Refill Due: ______________________________

____
Patient signature:

____
Doctor signature:

____
Date:

This could avoid confusion if you are out of the office, if the patient is calling in for early refill, or if the patient says that you told them something different.

Appendix II: Pain, Enjoyment, and General Activity Scale

1. What number best describes your pain on average in the past week?

1	2	3	4	5	6	7	8	9	10
No Pain									Pain as Bad as You Can Imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

1	2	3	4	5	6	7	8	9	10
Does Not Interfere									Completely Interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

1	2	3	4	5	6	7	8	9	10
Does Not Interfere									Completely Interferes

Created On: 9/29/2017

Opioid Prescribing Guidelines for Chronic Pain Checklist

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Before Initiation of Opioid Therapy

- ☐ Determine whether non-opioid options for pain management have been attempted and optimized.
- ☐ Conduct a thorough medical history, including obtaining a comprehensive list of current medications and conducting a thorough physical examination of the patient.
- ☐ Establish treatment goals regarding expected improvements in pain or function and obtain baseline data using standardized instruments, such as the Pain, Enjoyment, and General Activity scale *(see Appendix II)*.
- ☐ Evaluate the patient for risks or harms of opioid therapy by reviewing PDMP data, conducting urine drug screenings, and discussing risk factors.
- ☐ Use increased caution and more frequent monitoring when beginning opioid therapy if the patient screens positive for risk factors *(see table on right)* or is part of an at-risk patient population (e.g., elderly, pediatrics, or pregnant women).
- ☐ Present the opioid treatment to the patient as a test that will be discontinued if the treatment does not help the patient reach the desired treatment goals.
- ☐ Acquire a signed patient-provider agreement that the patient fully understands and promises to abide by throughout treatment. This includes providing the patient with informed consent of the relevant risks associated with opioid therapy. The patient should understand that if conditions within the patient-provider agreement are broken, opioid therapy may be discontinued *(see Appendix I)*.
- ☐ Schedule initial reassessment within two to four weeks of treatment initiation to determine whether opioids are an effective method of pain management for the patient. Explain to the patient that opioids will be discontinued if he/she is not improving in pain and function and that he/she can try other strategies.
- ☐ Prescribe immediate-release opioids at the lowest effective dosage instead of extended-release opioids. Match prescription dose duration to the date of the reassessment appointment.
- ☐ Always use patient-centered communication strategies *(see Module 6)* when discussing patient pain management strategies.

Evaluating Risk of Opioid Harm or Misuse

- **Adults younger than 45 years**
- **Personal history of any substance use disorder**
- **Family history of substance use disorders**
- **Criminal or legal history**
- **Psychiatric disorders**
- **Sexual abuse**
- **Concurrent benzodiazepine use**
- **Sleep disordered breathing**

Continued

Opioid Prescribing Guidelines for Chronic Pain Checklist

Reassessing the Patient at Return Visit(s)

- ☐ Review medical history and PDMP data.
- ☐ Confirm clinically meaningful improvements in pain and function using an instrument like the Pain, Enjoyment, and General Activity Scale by comparing the current score to baseline or the most recent assessment screen scores.
- ☐ Evaluate the patient for risks or harms of opioid therapy by reviewing PDMP data, conducting urine drug screenings, conducting pill counts/reconciliations, and discussing risk factors *(see list of risk factors on page 1)*.
- ☐ If there are signs of opioid use disorder, potential overdose risk, or over-sedation in the patient, refer him/her to specialty substance use disorder treatment or discontinue or taper the patient from opioids immediately *(see Module 5)*.
- ☐ Continue to optimize non-opioid therapies throughout opioid treatment in order to maximize benefits of the therapy.
- ☐ Monitor the patient's opioid morphine milligram equivalent using the PDMP and medical history data throughout treatment.
- ☐ Schedule reassessment at regular intervals (≤ three months) if the patient will be continuing opioid therapy.

Sources

1) Dowell D, Haegerich T, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain. *JAMA*. 2016;315(15):1624-1645.

2) Pennsylvania Medical Society, PA Department of Health. Pennsylvania Guidelines on the Use of Opioids to Treat Chronic Noncancer Pain. 2014. http://www.health.pa.gov/My%20Health/Diseases%20and%20Conditions/M-P/opioids/Documents/PAGuidelinesonOpioids.pdf. Accessed May 8, 2017.

3) Checklist for Prescribing Opioids for Chronic Pain. https://www.cdc.gov/drugoverdose/pdf/pdo_checklist-a.pdf. Accessed May 8, 2017.

4) Pain, Enjoyment, General Activity Scale. http://mytopcare.org/wp-content/uploads/2013/06/PEG-pain-screening-tool.pdf. Accessed May 8, 2017.

5) National Institute on Drug Abuse. Sample Patient Agree Forms. https://www.drugabuse.gov/sites/default/files/files/SamplePatientAgreementForms.pdf. Accessed May 18, 2017

6) Washington State Agency Medical Directors Group. http://www.agencymeddirectors.wa.gov/opioiddosing.asp. Accessed May 18, 2017.

7) Elwyn G, Dehlendorf C, Epstein R, Marrin K, White J, Frosch D. Shared decision making and motivational interviewing: achieving patient-centered care across the spectrum of health care problems. *The Annals of Family Medicine*. 2014;12(3):270-275.

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Summary of Opioid Prescribing Guidelines for Noncancer Chronic Pain

MODULE 4

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1. Prescribers should exhaust all options of non-opioid pain management strategies. Non-opioid therapies should be the preferred methods of chronic pain management or be co-prescribed with opioid therapy in order to maximize the effects of the opioid therapy on the patient *(see Module 3 for alternative pain management methods).*
2. Before beginning opioid therapy, establish treatment goals with the patient regarding pain and function. Determine baseline information using the Pain, Enjoyment, and General Activity Scale, which can be used to assess progress throughout opioid therapy. A 30% increase in pain and function is considered clinically meaningful. Reassess the benefits of continued opioid therapy if there is no clinically meaningful improvement in pain or function.
3. Before and during therapy, discuss how therapy will be discontinued if the benefits do not outweigh the risks. The patient should be aware of all the risks associated with long-term opioid therapy and sign a patient-provider agreement that discusses controlled substance policies, medication management practices, and the adverse health effects attributed to opioid therapy.

Non-Opioid Pain Management Methods

- **Medicinal:** Nonsteroidal anti-inflammatory drugs and acetaminophen as the first-line of defense
- **Physical:** Exercise and weight loss
- **Behavioral:** Cognitive behavioral therapy
- **Procedural:** Intra-articular corticosteroids

4. Patient risk and harm should be addressed before and during opioid therapy using urine drug tests, the Prescription Drug Monitoring Program (PDMP), pill counts, and ongoing discussions with the patient regarding opioid risk factors.
5. Prescribe immediate-release opioids at the lowest effective dosage instead of extended-release. The dose duration should be matched to the date of the reassessment appointment made within two to four weeks of the prescription start date.
6. Avoid co-prescribing benzodiazepines with opioids, when possible, given the dangerous drug-drug interactions that can occur between the two substances.

Continued

Summary of Opioid Prescribing Guidelines for Noncancer Chronic Pain

7. Refer to the PDMP for current patient morphine milligram equivalent dosage information. Reassess evidence of the benefits of continued opioid therapy when increasing dosage to ≥ 50 morphine milligram equivalent/day when possible, due to an increased risk of complications.
8. The prescriber should continue to reassess the patient for potential benefits and harms of opioid therapy at least every three months during long-term opioid therapy.
9. If the benefits of therapy no longer outweigh the harms at any point during treatment, the provider should discontinue or begin to taper the patient off of the opioid regimen using a taper protocol individualized to the patient *(see Module 7 for information on tapering to a lower dosage or to discontinuation).*
10. The provider should refer a patient to substance use disorder or opioid use disorder treatment using a "warm handoff" whenever he/she believes a patient is at risk of harm or overdose *(see Modules 5 and 6 for information on "warm handoffs" and Screening, Brief Intervention, and Referral to Treatment).*

Opioid Formulations

Immediate-Release/Short-Acting

Generic	*Brand Name**
Morphine	Morphine
Codeine	Codeine
Hydrocodone	Vicodin
Hydromorphone	Dilaudid
Oxycodone	Percocet
Oxymorphone	Opana
Tramadol	Ultracet

Extended-Release/Long-Acting

Generic	*Brand Name**
Morphine	Avinza
Hydrocodone	Zohydro
Hydromorphone	Exalgo
Oxycodone	OxyContin
Oxymorphone	Opana
Methadone	Dolophine
Fentanyl transdermal	Duragesic
Tramadol	Ultram ER

**Brand names are select brand names for generic opioids.*

Sources

1) Dowell D, Haegerich T, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain. *JAMA*. 2016;315(15):1624-1645.

2) Pennsylvania Medical Society, PA Department of Health. Pennsylvania Guidelines on the Use of Opioids to Treat Chronic Noncancer Pain. 2014. http://www.health.pa.gov/My%20Health/Diseases%20and%20Conditions/M-P/opioids/Documents/PAGuidelinesonOpioids.pdf

3) Checklist for Prescribing Opioids For Chronic Pain. https://www.cdc.gov/drugoverdose/pdf/pdo_checklist-a.pdf

4) List of Extended-Release and Long-Acting Opioid Products Requied to Have an Opioid REMS. https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm251735.htm. Accessed May 15, 2017.

Commonwealth of Pennsylvania Laws Surrounding Controlled Substances

What laws of the Commonwealth of Pennsylvania affect opioid prescribing?

ACT 122 of 2016: Safe Emergency Prescribing Act

Effective Jan. 1, 2017

Explains opioid prescription practices for prescribers in emergency department, urgent care, and hospital observation settings.

- **Seven-day Supply Limit:** Up to a seven-day supply of opioid drug products can be prescribed to a patient seeking treatment in an emergency department, urgent care facility or in observation status in a hospital.

  Exceptions: If additional opioid drugs are needed to treat a patient's acute condition, cancer diagnosis or palliative care, they can be prescribed; however, the condition triggering the extension and an indication that a non-opioid treatment is not appropriate must be documented in the patient's medical record.

- **No Refills:** Prescribers in emergency departments, urgent care centers or caring for patients under observation status in hospitals may not refill prescriptions for opioid and opioid-like products.

- **Substance Use Disorder Referrals to Treatment:** Individuals seeking treatment at emergency departments, urgent care centers or during hospital observation who are "at risk" for substance use disorder must be referred to treatment.

- **Prescription Drug Monitoring Program (PDMP)** Checking the PDMP is not required for any medication provided to a patient in the course of treatment while undergoing care in an emergency department. This exception does not apply to patients undergoing care in urgent care centers or when in observation status in a healthcare facility. If a medication prescription is issued during discharge, then the PDMP system must be queried. As part of good clinical practice, the Department of Health recommends that healthcare professionals check the system every time before a controlled substance(s) is prescribed or dispensed in any clinical setting. *(See Act 191 of 2014 (as amended by Act 124 of 2016).)*

- **Penalties:** Noncompliance with this act may result in review and disciplinary action.

Continued

ACT 191 of 2014 (as amended by Act 124 of 2016): Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP)

Effective Jan. 1, 2017

Act 191 of 2014 (as amended by Act 124 of 2016) is intended to increase the quality of patient care by giving prescribers and dispensers access to a patient's prescription medication history. In general, prescribers and dispensers are required to submit information and query the PDMP system for Schedule II through V controlled substances.

Prescriber Query Information

- **Prescriber:** A prescriber is defined as a person who is licensed, registered, or otherwise lawfully authorized to distribute, dispense, or administer a controlled substance, other drug or device in the course of professional practice or research in Pennsylvania. Veterinarians are excluded from this definition.
- **Prescribers are required to query the PDMP:**
  1. Each time a patient is prescribed an opioid or benzodiazepine drug product;
  2. Before the first time a patient is prescribed a controlled substance for the establishment of a baseline and thorough medical record; or
  3. When the prescriber believes that the patient is misusing or diverting drugs.
- **Prescribers must document PDMP results into the patient's medical record when:**
  1. The individual is a new patient; or
  2. The prescriber determines a drug should not be prescribed to a patient based upon the information from the PDMP.

The PDMP system must be queried at least once from the time of admission through discharge when a patient is prescribed a controlled substance, as required by law. Beyond the initial query, additional queries of the system are not required as long as the patient remains admitted to the licensed health care facility or remains in observation status in a licensed health care facility.

Please note that as of 2/22/2018, due to a subsequent amendment to Act 191, prescribers will no longer be required to query the PDMP when prescribing a non-narcotic Schedule V controlled substance for the treatment of epilepsy or a seizure disorder. This exception does not apply to the prescribing of other controlled substances, regardless of treatment purpose.

Dispenser Query Information

- **Dispenser:** A dispenser is defined as a person who is lawfully authorized to dispense medication in Pennsylvania, including internet and mail-order dispensing.
- **Dispensers are required to query the PDMP system:**
  1. When an individual is a new patient to the pharmacy (i.e., the dispenser has no previous or updated medical record of the patient): a "new patient" does not include an individual going to the same pharmacy or a different physical location of that pharmacy if the patient's record is otherwise available to the dispenser;
  2. When the patient pays cash for his/her prescription when he/she has insurance: "cash" refers to any non-insurance payment, excluding copayments;
  3. If the patient requests refills early: an "early refill" is defined as when the patient requests a refill before the date upon which they are eligible for insurance coverage for the prescription or when more than 15 percent of an earlier-dispensed medication would remain when taken in compliance with the directions and quantity prescribed; or
  4. When the patient is obtaining opioid or benzodiazepine prescriptions from more than one prescriber.

* http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Pages/GeneralInfo.aspx#.WZ3J8IqQyuq

Continued

ACT 191 of 2014 (as amended by Act 124 of 2016): Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP)

Effective Jan.1, 2017

(continued)

- A dispenser or pharmacy must submit dispensing information to the PDMP database no later than the close of the next business day after dispensing.

For more information visit the Pennsylvania Department of Health Prescription Drug Monitoring Program Question & Answer Site.*

Licensing Board Requirements:

- **Initial licenses:** Effective Jan. 1, 2017, licensing boards for individuals who are applying to be prescribers or dispensers will require documentation of:
  - At least two hours of education in pain management or identification of addiction; and
  - At least two hours of education in the practice of prescribing or dispensing opioids.

The education may be part of a professional degree or continuing education program.

- **License renewals:** Effective Jan. 1, 2017, licensing boards for individuals who are renewing their licenses will require documentation of at least two hours of continuing education in pain management, identification of addiction, or the practices of prescribing or dispensing of opioids.

This requirement does not apply to a prescriber who is exempt under the Drug Enforcement Administration's requirements for a registration number and who do not use the registration number of another person or entity permitted by law to prescribe controlled substances in any manner.

ACT 125 of 2016: Prescribing Opioids to Minors

Effective Feb. 4, 2017

A minor can be prescribed a controlled substance containing an opioid (for up to seven days) with the written consent of his/her parent or guardian. If consent is given by a minor's authorized adult (i.e., an adult who is a validated health care proxy to consent to the minor's medical treatment), the prescription is limited to a single 72-hour supply. "Minor" does not include an individual under 18 years of age who is emancipated:

- By marriage;
- By entering the United States armed forces;
- By being employed and self-sustaining; or
- By being otherwise independent from the care of a parent, guardian or custodian.

Before prescribing opioids to a minor, prescribers must:

1. Assess whether the minor has taken or is taking prescription medications for a substance use disorder by checking the PDMP system.
2. Discuss the following topics with the minor and his/her parent, guardian or authorized adult:
   - The risks of addiction and overdose;
   - The increased risk of addiction for individuals suffering from a mental disorder; and
   - The dangers of taking a controlled substance containing an opioid with benzodiazepines, alcohol, or central nervous system depressants.

Obtain written consent from the minor's parent, guardian or authorized adult before a controlled substance containing an opioid is prescribed. A consent form is available online.*

Prescribers may NOT:

- Prescribe an opioid-containing substance to a minor unless:
  - The treatment is for an incident or medical emergency, which is clearly documented in the minor's record; or
  - If, in the prescriber's professional judgement, not using opioids would be detrimental to the minor's health or safety.
- Prescribe more than a **seven-day supply** of opioids unless:
  - The individual's treatment is associated with a documented medical emergency; or
  - Therapy is associated with cancer, palliative care or management of chronic pain not associated with cancer.
- Reasons for using opioids instead of another therapy must be documented.

Other limitations:

If the individual is an authorized adult, prescribers may not prescribe more than a single 72-hour supply, and prescribers should indicate on the prescription the amount that should be dispensed.

Penalties:

Violations can result in licensing board sanctions.

* http://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Documents/Act%20125-Consent%20to%20Prescribe%20Opioid%20Medication%20to%20Minor%2020170123.pdf

ACT 126 of 2016: Safe Opioid Prescription, Patient Voluntary Non-Opioid Directive, and Imposing Powers and Duties

Effective Aug. 1, 2017.

Practitioners and their patients can execute a voluntary non-opioid directive form developed by the Pennsylvania Department of Health. Before signing, a practitioner can assess the patient's personal and family history of alcohol or drug misuse and evaluate the risks for medication misuse. The practitioner must access the PDMP to see if there is an unusual or suspect pattern for prescribing opioids. The form can be revoked at any time, either in writing or orally.

Sharing data relative to the voluntary non-opioid directive form must comply with all federal and state confidentiality laws.

ACT 139 of 2014: David's Law – Opioid Overdose Reversal Act

Effective Nov. 28, 2014

Act 139 of 2014 expands access to naloxone to emergency services personnel including law enforcement, firefighter and emergency medical service workers. It also allows medical professionals to dispense and prescribe naloxone, either directly or through a standing order, to individuals who may be at risk of overdose. Pursuant to this authority, Pennsylvania's Physician General, in 2015, issued a standing order to allow access to naloxone to individuals who are in the position to help a person at risk of experiencing an opioid-related overdose.

Created On: 9/29/2017

www.pa.gov/collections/opioid-epidemic | RA-DH-PDMP@pa.gov

Pennsylvania Prescription Drug Monitoring Program (PDMP)
System User and Stakeholder Training

Referral to Treatment for Substance Use Disorder Related to Opioid Use

MODULE 5

GUIDE DOCUMENT

Pennsylvania Prescription Drug Monitoring Program (PDMP) System User and Stakeholder Training

Learning Objectives for Modules 1-7

Module 1: Why Using the PDMP is Important for Achieving Optimal Health for Pennsylvania Citizens

1. The status of substance use disorder in general, opioid use disorder, and overdoses nationally and in Pennsylvania;
2. Common misconceptions about substance use disorder and opioid use disorder treatment and recovery;
3. Costs associated with prescription drug and heroin-associated opioid use disorder and overdose; and
4. How pervasive prescriber and pharmacist PDMP use can reduce population opioid use disorder and overdose.

Module 2: What is a PDMP, How to Use the PDMP to Make Clinical Decisions, How to Integrate the PDMP into the Clinical Workflow, and How to Access Pennsylvania's PDMP

1. Detail Pennsylvania's requirements and regulations regarding PDMP use;
2. Explore options and actions Pennsylvania prescribers and pharmacists can take to integrate the PDMP into clinical workflows; and
3. Discuss how to use the PDMP system to make clinical decisions.

Module 3: Using the PDMP to Optimize Pain Management

1. Learn how to use the PDMP to address pain management for various patient populations and pain types;
2. Understand the basic nature of pain for different patient populations and how to manage their pain using the PDMP as a clinical tool; and
3. Discuss different ways of treating patient pain that do not involve the immediate use of opioids.

Module 4: Opioid Prescribing Guide

1. Provide guidelines to inform all health care providers when prescribing opioids in the acute phase of pain;
2. Instruct healthcare providers on how to prescribe opioids in the chronic phase of pain, which includes information on how to initiate or continue opioid therapy, select the correct dose and/or discontinue opioids;
3. Instruct healthcare providers on how to assess risks and address harms associated with opioid use;
4. Instruct healthcare providers on the legal responsibilities related to prescribing opioids; and
5. Instruct healthcare providers on how they may direct patients to dispose of unused medications.

Module 5: Referral to Treatment for Substance Use Disorder Related to Opioid Use

1. Define "warm handoffs" and how they can best occur;
2. Provide a schema for how any healthcare provider can implement "warm handoffs" in any clinical setting;
3. Demonstrate how primary care practices can conduct "warm handoffs" by preparing, using validated screening tools and using patient-centered communication with patients;
4. Demonstrate how healthcare providers can determine the best type of treatment for their patients;
5. Present information on patient confidentiality that providers should be aware of when working with patients with substance use disorders and performing "warm handoffs"; and
6. Present relevant Pennsylvania links for treatment and other resources.

Module 6: Approaches to Addressing Substance Use Disorder with Patients Identified by the PDMP

1. Learn how to integrate the PDMP with other screening tools to help identify those who may require substance use disorder treatment or increased monitoring;
2. Define Screening, Brief Intervention, and Referral to Treatment (SBIRT), its main goals and its main components;
3. Learn how to screen a patient for a potential substance use disorder, conduct a brief intervention and refer a patient to treatment;
4. Learn how to discuss a substance use disorder with a patient and handle patient resistance; and
5. Learn how to incorporate SBIRT into clinical practice.

Module 7: Effective Opioid Tapering Practices

1. Discuss how to use the PDMP to determine if a provider should consider tapering his/her patient;
2. Discuss several indicators that prescribers can look for when considering tapering opioids;
3. Inform prescribers on how to discuss tapering with patients using patient-centered techniques;
4. Present a general opioid tapering protocol and how to adapt this protocol to the needs of any patient; and
5. Present information on how to manage withdrawal and how to use tools to measure withdrawal symptoms in patients.

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Introduction

The Prescription Drug Monitoring Program (PDMP) can aid in the early identification of patients with substance use disorders or help identify those who are at an elevated risk for developing a substance use disorder.

The need for early identification is high, with an estimated 21.7 million people aged 12 or older requiring substance use disorder treatment in 2015.[1] It is important to identify these individuals because early identification of substance use disorders is associated with improved treatment outcomes for patients, and early identification of individuals at an elevated risk for developing a substance use disorder has been associated with decreased chances of developing a substance use disorder.[2] Health care providers can use the PDMP to identify patients who may be misusing their prescription opioids or who are in the process of developing a pattern of misuse. Providers can then administer appropriate interventions to the patients and perform "warm handoffs" to specialty substance use disorder treatment providers. In order to optimize the process of early identification and ensure patient access to substance use disorder treatment when warranted, healthcare providers need to learn the proper skills to identify patients with possible substance use disorders using: (1) verified screens; (2) the appropriate communication techniques to encourage patients to pursue further assessment or treatment (when warranted); and (3) the effective methods for increasing the likelihood that the patient will access treatment services, such as conducting "warm handoffs."

In this module, prescribers and pharmacists will learn how to determine whether a patient should be referred to substance use disorder treatment and how to conduct a "warm handoff" of that patient to specialty treatment. This module has the following objectives:

1. Define "warm handoffs" and how they can best occur;
2. Provide a schema for how any healthcare provider can implement "warm handoffs" in any clinical setting;
3. Demonstrate how primary care practices can conduct "warm handoffs" by preparing, using validated screening tools, and using patient-centered communication with patients;
4. Demonstrate how healthcare providers can determine the best type of treatment for their patients;
5. Present information on patient confidentiality that providers should be aware of when working with patients with substance use disorders and performing "warm handoffs"; and
6. Present relevant Pennsylvania links for treatment and other resources.

Defining a "Warm Handoff"

A "warm handoff" is a collaborative effort between two members of a patient's healthcare team for the purpose of improving the connection and reducing the gaps in services that the patient will receive. "Warm handoffs" can be conducted by prescribers, pharmacists, and behavioral health specialists.[3] A general "warm handoff" consists of one team member presenting a patient face-to-face (or via telephone if necessary) to another team member for a healthcare service.[4] Prior to the handoff, the team member who has had the most interaction with the patient discusses (using patient-centered communication strategies such as motivational interviewing principles) why the referred service is beneficial to the patient's health. The initial or index provider should begin the "warm handoff" by connecting the patient to its practice site patient navigator.[i] The initial healthcare provider should relay to the patient the important role of the patient navigator and perform the introduction between the patient navigator and the patient.

Patient navigators, coordinators or care managers will typically assist patients in reducing barriers to accessing substance use disorder treatment. The most common barrier to gaining access to available substance use disorder assessment or treatment is the patient's lack of appropriate transportation. Patient navigators can mitigate this by helping patients find appropriate ways of transportation to the services they need. The patient navigator may be a hospital staff member, a treatment provider staff member, a Single County Authority staff member or a volunteer. The navigator will vary across institutions and practices. There may be a larger or smaller number of patient navigators depending on the needs of the institution. However, it is recommended that all medical programs designate one or more individuals who will be a patient navigator and make the initial contact for the patient either through a telephone call or through an in-person introduction. The key role of the patient navigator is to foster a relationship between the patient and the treatment provider, making it easier for the patient to seek treatment and improve the continuity of care.

If a face-to-face introduction is not feasible due to constraints, the patient navigator should call the substance use disorder treatment entity, a recovery support service or aid[ii] and make an appointment for the patient to receive a clinical assessment at either the Single County Authority[iii], Central Intake Unit[iv] or substance use disorder treatment facility. These assessments are necessary in Pennsylvania to determine the level of substance use disorder treatment that the patient requires. The type of entity to which the patient should be connected will vary from county to county. The practice is urged to determine which entity should be used to obtain a patient appointment by contacting the Single County Authority for the county in which the practice is located.

A "Warm Handoff" Conducted via Telephone:

Initial Provider: "Ms. Jones I am going to put you on the phone with Ms. Smith, who is a Care Manager with the Clarion County Single County Authority. Ms. Smith will help you get the help you need by introducing you to the right people. She will go over all of your needs and help you with any childcare or transportation requirements."

Patient Navigator: "Hello Ms. Jones, I will be with you every step of the way to make sure that you get the help you need. I am going to send a car over to pick you up from your doctor's office now so that you can come over to the Single County Authority for an assessment."

Continued

Defining a "Warm Handoff" *(continued)*

In general, all patients who may require assessments for substance use disorder treatment should receive appointments at this entity within 48 hours. This is because persons who may have a substance use disorder, especially an addiction to opioids, are at risk for overdosing or other deleterious outcomes while they wait to access assessment/ treatment. Thus, ***all*** patients who are referred to a substance use disorder treatment entity and who are suspected of having an opioid use disorder should also receive a naloxone kit, for intra-nasal administration, and instruction on how to use this kit before he/she leaves the practice site. If a naloxone kit cannot be provided to the patient, a prescription should be written that the patient can fill at his/her pharmacy. Patients who cannot immediately access substance use disorder treatment should also be linked to recovery support services or self-help programs, such as Narcotics Anonymous, within the community. (See list of Single County Authorities below to contact for more local recovery support services.) Practices should have access to information regarding effective Alcoholics Anonymous or Narcotics Anonymous meetings in communities where their patients reside. This list of meetings can also be provided by the local Single County Authority or local substance use disorder treatment programs.

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[i] A patient navigator is a member of the health care team who has been assigned the responsibility of assisting patient access to specialty treatment, such as substance use disorder treatment. Patient navigators are typically persons who have shared life experiences with the patient (i.e., sometimes they are certified recovery specialists who are also in recovery). Patient navigators may also be other members of the healthcare team who have other patient care responsibilities (i.e., nurses or social workers).

[ii] Recovery support services are culturally and linguistically appropriate services that assist individuals and families working toward recovery from mental and/or substance use problems.

[iii] Single County Authorities are organizations that receive funding through the Pennsylvania Department of Drug and Alcohol Programs in order to manage drug and alcohol services at a social level. Each Pennsylvania Single County Authority can be found here: http://www.pacwrc.pitt.edu/curriculum/309%20Drug%20and%20Alcohol%20Issues/Handouts/HO%2019%20Single%20County%20Authority%20List%203-29-2016.pdf

[iv] Central Intake Units serve as the points of contact for individuals in need of substance use, mental health or intellectual disabilities services. Not all Single County Authorities within Pennsylvania have Central Intake Units; instead clinical assessment and placement may be done by a substance use disorder treatment provider.

Guidelines for Establishing a "Warm Handoff" Protocol in Any Healthcare Setting

In order for a "warm handoff" to be effective at connecting patients to substance use disorder assessment/treatment, healthcare providers should work together to develop a protocol that is appropriate for their particular workflow. The Agency for Healthcare Research and Quality recommends a general five-step process for implementing a "warm handoff" office protocol in any healthcare setting:[3,4]

1. **Identify** all potential points at which a handoff could take place during a normal patient visit.
2. **Understand** each stakeholder in the handoff process. Determine which internal staff members and outside providers will be involved in the handoff and their roles in the process.
3. **Prioritize "warm handoffs"** (i.e., the face-to-face introduction of the patient to a navigator and the next provider in the referral chain) and determine where they are most necessary in the clinical workflow.
4. **Analyze** current workflow protocols and determine each staff member's level of engagement.
5. **Design** a new workflow by:
    a. Identifying an implementation leader and engaging staff members;
    b. Working with staff members to determine how the workflow can be adapted to accommodate "warm handoffs";
    c. Training team members on how to properly carry out "warm handoffs";
    d. Explaining to patients and their families what "warm handoffs" are and how they improve a patient's link to treatment; and
    e. Evaluating the "warm handoff" protocol periodically to determine how it can be made more effective.

Conducting a "Warm Handoff" in Primary Care

It is recommended that the following protocol be used to prepare for identifying a patient with a substance use disorder and conducting a "warm handoff" to treatment in primary care settings.

The primary care site should begin by preparing for managing patients with a suspected substance use disorder:

1. **Know the Single County Authority of the county of practice and know how it supports patient access to substance use disorder treatment.** The patient should contact the Single County Authority where the patient will learn where the assessment for substance use disorder is completed. The assessment will either be completed at the Single County Authority by a specialty intake provider or at another treatment provider.
2. **Raise site members' awareness of substance use disorder treatment resources available in the community.** The Single County Authority will guide the patient to the provider who will complete the clinical intake assessment.
3. **Build rapport with the recovery support services in the community and be aware of the services that they can provide for patients.** (See page 18 for referral links.) Depending on the specific recovery support service, some will come to the primary care site and accompany the patient to the location where treatment will take place. Others will work with patients through community outreach, keeping in contact with patients and helping them access self-help meetings and other treatment services that would support their recovery.
4. **Increase your site's proficiency in using validated screens** to determine whether a patient may have a substance use disorder or require some form of medically assisted detoxification or overdose prevention. Below, there are four recommended screening tools for adult, pregnant and adolescent patients. These screening tools are not required but are recommended for use in these patient populations. (See Module 6 for information on screening individuals for substance use disorder.)
   - **Adult patients:**
     - The CAGE Questions Adapted to Include Drugs Tool screens for alcohol and drug misuse. CAGE is derived from the four questions of the tool: Cut down, Annoyed, Guilty and Eye-opener.[i]
     - The Alcohol, Smoking, and Substance Involvement Screening Test is used to screen adult patients for drug, alcohol and tobacco use.[ii]
   - **Pregnant patients:**
     - The Institute for Health and Recovery Integrated Screening Tool also named the 5P's screening tool, is a screening tool designed for women. It screens for emotional problems, alcohol, tobacco, other drug use, and domestic violence. The 5P's are derived from Parents, Peers, Partner, Past, and Present.[iii]
   - **Adolescent patients:**
     - The CRAFFT screening tool is a behavioral health screening tool for use with children under the age of 21. It can be used to screen adolescents at high risk for alcohol and other substance use disorders simultaneously. CRAFFT is derived from Car, Relax, Alone, Forget, Friends and Trouble.[iv]

i. http://www.integration.samhsa.gov/images/res/CAGEAID.pdf
ii. http://www.who.int/substance_abuse/activities/assist_v3_english.pdf?ua=1
iii. http://www.mhqp.org/guidelines/perinatalpdf/ihrintegratedscreeningtool.pdf
iv. http://www.ceasar-boston.org/CRAFFT/

Continued

Conducting a "Warm Handoff" in Primary Care *(continued)*

5. **Learn how to use patient-centered communication techniques,** such as motivational interviewing, to discuss substance use and related issues with patients to improve the outcome of conversations. (See Module 6 for information on addressing substance use with patients.)

> **Patient:** I want to quit my substance use, but I just can't. I got fired from my job, and I'm getting evicted.
>
> **Provider:** It can be hard to make changes when you feel like there is so much disorder around you. I think that we can work together to come up with a solution. Do you feel ready to make a change?
>
> **Patient:** Yes, I do, but I'm worried about the effects of withdrawal and relapsing.
>
> **Provider:** I understand why you are worried, but we can link you to services that will help your recovery and can help you manage any side effects. Can I provide you with some more information on these services?

6. **Increase the effectiveness and efficiency of screenings, patient interventions and "warm handoffs"** to treatment by integrating them into the office workflow and electronic health record.
7. **Assemble patient educational materials** that are relevant to substance use disorder treatment services and have them readily available to be disseminated to patients when necessary.
8. **Determine the patient's need for social services** in order for him/her to be successfully linked to treatment. Examples of necessary social services are transportation, child care and financial aid to cover treatment costs.
9. **Provide a safe location at the practice site or within the community** for the patient to connect with his/her transportation to substance use disorder assessment/treatment or to be introduced to his/her patient navigator, care manager or recovery support specialist.
10. **Obtain a sufficient number of naloxone patient kits and naloxone educational materials** to provide to patients who require naloxone to prevent overdose.

Continued

Conducting a "Warm Handoff" in Primary Care *(continued)*

Identifying Patients Who Might Need "Warm Handoffs"

After preparing with the necessary knowledge and materials to conduct a "warm handoff", screen and assess the patient. Assess the patient's medical history, conduct a physical examination and perform standardized screening for substance use disorder using validated assessment tools (see Module 6). Then, assess the results of the standardized screening. If the screen is negative for substance use disorder, use positive reinforcement strategies to encourage continued positive patient behavior:

Provider: It's really great that you're using your prescription medications correctly and drinking at low-risk levels.

Patient: Thank you.

Provider*:* These actions will greatly reduce your risk for developing substance use disorders or other healthcare complications.

Talking to Patients about Substance Use and a "Warm Handoff"

If the screen is positive for a possible substance use disorder, discuss the results of the screen with the patient and assess the patient's need for immediate detoxification services. When immediate detoxification is necessary, conduct a "warm handoff" to a medically monitored non-hospital detox program. If there are substantial medical complications, a "warm handoff" to an emergency medical center for inpatient treatment can be completed. If immediate detoxification is not necessary, use patient-centered communication techniques and a "warm handoff" to link the patient to the substance use disorder treatment system for further support. A recovery support services specialist may be able to come to the primary care site and accompany the patient to the Single County Authority or substance use disorder treatment provider.

In some cases, the Single County Authority, treatment provider, or other substance use disorder professional such as a certified recovery specialist, will come to the primary care site. The representative from the treatment center may then perform the assessment at the primary care site and wait for transportation to a substance use disorder treatment location with the patient. However, this representative will not necessarily accompany the patient to treatment in every case.

Follow up with the patient and offer assistance regarding treatment referral when necessary (see page 18 for referral links). Figure 1 (page 11) depicts the entire "warm handoff" process and can be used by primary care sites for workflow integration.

Not all positive screens will indicate the need for a "warm handoff." Some positive screens may just indicate a moderate risk for substance use disorder. In these instances, a referral may not be necessary, but primary care site staff should still use patient-centered communication strategies to discuss with the patient the risk of his/her behaviors and the options and actions for reducing risk. Primary care sites will want to continue to monitor, screen and assess the patient to determine if the behaviors worsen and a referral to substance use disorder treatment is needed.

Continued

Conducting a "Warm Handoff" in Primary Care *(continued)*

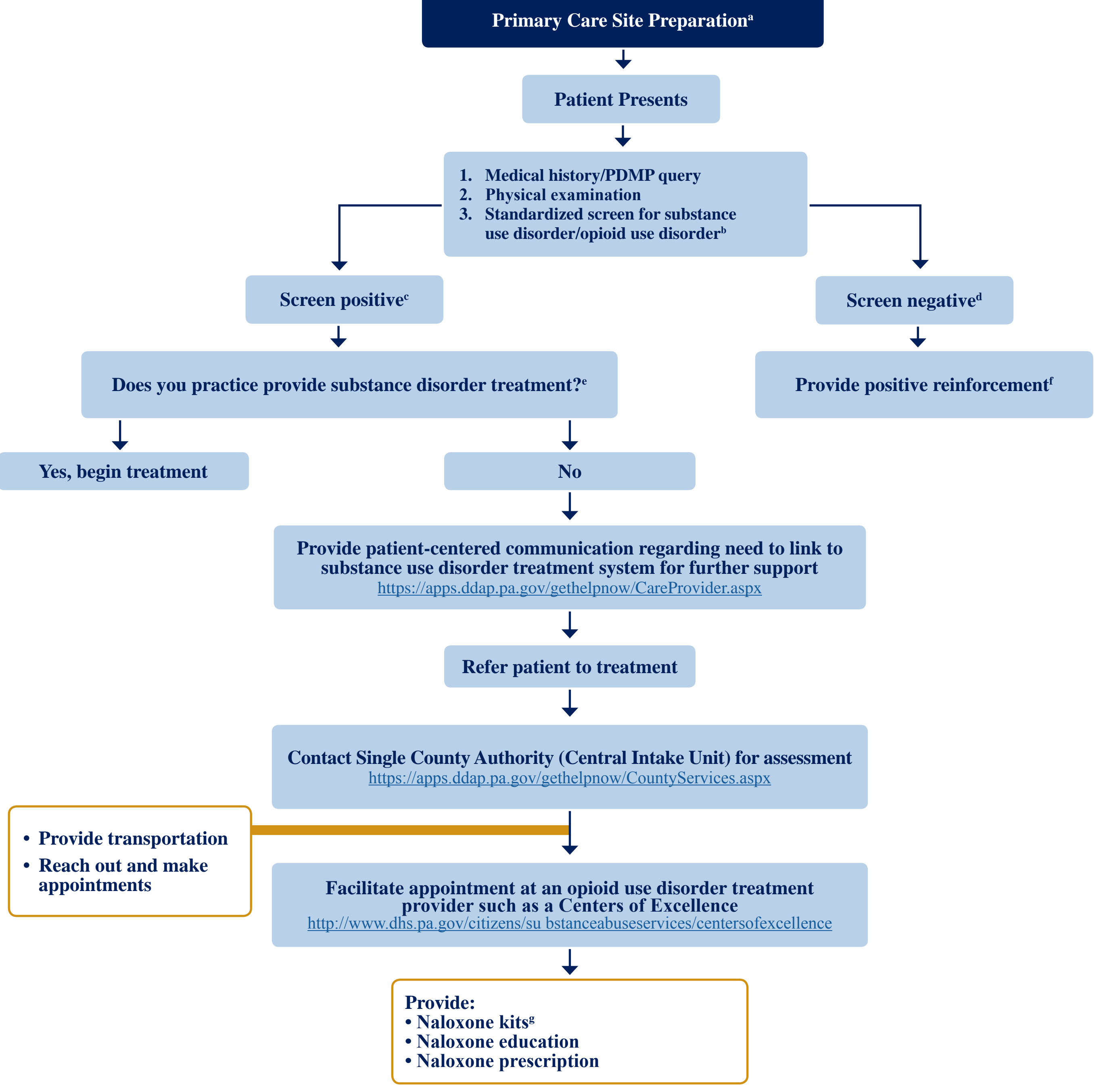


Figure 1: Example of a "Warm Handoff" in a Primary Care Site

[a] Prepare for managing patients with substance use or opioid use disorder *(see steps 1–10 on pages 8-9).*

[b] Assess risk for possible substance use disorder using recommended screening tools and conduct laboratory testing (if necessary): liver function/enzyme test; multi-panel blood test; and urine, saliva or hair drug test.

[c] Positive screen: patient is showing signs of substance use disorder after a PDMP query (i.e., multiple provider episodes), physical examination (i.e., exhibiting symptoms of withdrawal) or standardized screening (i.e., positive results of questionnaire). If the patient presents with one or more of these criteria during screening, then a brief intervention should be conducted to determine appropriate subsequent care services. (Refer to Module 6 on Screening, Brief Intervention and Referral to Treatment.)

[d] Negative screen: patient shows no signs of substance use disorder during assessment

[e] Assess need for detoxification: consider results of substance use disorder screening tools, consider results of laboratory testing, and conduct withdrawal screening using the Clinical Opiate Withdrawal Scale or the Subjective Opiate Withdrawal Scale. (See Module 7 for more information on withdrawal scales.)

[f] Reinforce healthy behavior(s) through positive reinforcement.

[g] If naloxone kits are not available, patients should be provided with a naloxone prescription and should also be informed that the naloxone standing order allows the patient to obtain naloxone without a prescription if needed.

Continued

Conducting a "Warm Handoff" in Primary Care *(continued)*

The Pennsylvania Department of Drug and Alcohol Programs has published a document that suggests the use of the permission, open-ended questions, listening reflectively, affirmation, rolling with ambivalence and summarizing plans (POLAR*S) model for practicing patient-centered communication.[5,6]

Healthcare providers should follow this protocol to discuss treatment and "warm handoffs" with patients:

1. **Permission:** Respecting the patient's autonomy by asking permission to talk about the health care issue.
2. **Open-ended Questions:** Using open-ended questions to allow the patient to openly discuss his/her background and to allow the clinician to actively listen and take in information.
3. **Listen Reflectively:** Listening and reiterating the patient's statements to make the patient feel like the prescriber or pharmacist is engaged and willing to help the patient throughout the treatment process.
4. **Affirmation:** Affirming the patient, acknowledging strengths and weaknesses, and being sincere in statements.
5. **Roll with Ambivalence:** Recognizing where the patient is willing and not willing to make changes and eliciting important and confident acknowledgments from the patient about this ambivalence.
6. **Summarize Plans:** Restating the conversation can make the patient more aware of the conversation and build rapport.

Conducting a "Warm Handoff" in the Emergency Medicine Site

"Warm handoffs" can be conducted in any health care setting. Patients with substance use disorder can be found in emergency medicine settings and can present with symptoms other than those related to their substance use disorder. In fact, a much higher prevalence of emergency medicine patients will present with a concurrent substance use disorder compared to patients who present at a primary care setting.[7,8] The same process of preparation for "warm handoffs" can be followed as was described for primary care practices. In order to provide these patients with appropriate care, the Pennsylvania Department of Drug and Alcohol Programs recommends combining the POLAR*S model with the following workflow in order to achieve optimal substance use care for patients. ***Figure 2*** shows the process for conducting a "warm handoff" in an emergency medical setting for opioid use disorder.

Emergency Department "Warm Handoff": For Opioid Use Disorder

Patient presenting with illness or behavior that is concerning for opioid use disorder

Patient presenting with opioid overdose or signs/symptoms of opioid misuse

Patient presenting with opioid use disorder seeking treatment

Patient presenting with chronic pain treatment

Conduct as appropriate:
- PDMP query;
- Medical history/physical/laboratory testing;
- Initial medical treatment; and/or
- Substance use disorder screening.

Is there a concern for opioid use disorder?

Yes

No

Treat emergency condition and refer to Primary Care Provider or Pain Management Physician

Safe for discharge?

No

Admission

Medical

Psychiatric

"Warm handoff" conducted as an inpatient

Yes

Concern for opioid use disorder

No

Discharge

Yes

Conduct a "warm handoff" to treatment services

Single County Authority protocol per specific county in which the hospital is located

Defined emergency medical staff contacts drug and alcohol assessor, as per Single County Authority protocol

Patient placed in appropriate confidential setting to meet with drug and alcohol assessor

Active Refusal

Patient actively refuses "warm handoff":

1a. Discharge with Naloxone medication, or

1b. Prescription for Naloxone

2. Provide information on local treatment and resources

Yes

"Warm handoff" to specialty opioid Substance Use Disorder treatment

Notify patient's Primary Care Provider

Figure 2: Example of Substance Use Disorder Referral to Treatment in the Emergency Medical Site

Image adapted with permission from the Pennsylvania Department of Drug and Alcohol and Programs.

How to Determine the Best Type of Treatment for the Patient Based on Assessment for Level of Care

The provider should screen for and address any substance use during all patient interactions within any healthcare setting in order to optimize the management of each patient's health. Patients suffering from a substance use disorder often do not seek treatment that is specific to their substance use disorder. Instead, they seek treatment for other healthcare issues. The provider should evaluate the patient for risk of substance misuse using validated screening tools and the PDMP (see Module 6).[9] The results can describe how necessary a referral to treatment is for the patient. For example, some patients (e.g., patients who are in active withdrawal from sedatives) may require immediate detoxification services. Detoxification services are not considered "treatment" but are an important part of medical stabilization in the continuum of care and are a vital element in connecting the patient for subsequent treatment access.

When a patient is referred to a detoxification or substance use disorder treatment program, he/she receives a more detailed clinical assessment from a licensed assessor to determine the severity of his/her condition. The assessment also determines the social, physical and psychological issues associated with the patient's substance use disorder.[9] The results of this initial clinical assessment are then applied to a standardized patient placement criteria system (e.g., the Pennsylvania Client Placement Criteria or American Society of Addiction Medicine Placement Criteria) to determine the best care possible for the patient. There are six clinical dimensions in the Pennsylvania Client Placement Criteria that are considered when determining the appropriate level of substance use disorder treatment for a patient:[10]

1. Acute intoxication and withdrawal should be considered to determine an individual's level of functioning, the degree to which his/her functioning is hindered and his/her risk for severe withdrawal.
2. Biomedical conditions and complications should be used to identify any medical problems that may be complicated by substance use or that need to be monitored in a medical setting.
3. Emotional/behavioral conditions and complications should be considered to assess mental status, emotional stability, danger to self or others, and whether psychiatric disorders are present that need to be treated simultaneously. Comorbid psychiatric disorders and substance use disorders must be addressed together to achieve a higher likelihood of treatment success and lower likelihood of relapse.
4. Willingness to participate in treatment should be determined.
5. Potential for relapse should be considered.
6. Whether the patient's environment may facilitate or hinder recovery should be considered.

Continued

How to Determine the Best Type of Treatment for the Patient Based on Assessment for Level of Care *(continued)*

There are four main types of treatment services that a healthcare provider can refer a patient to for substance use disorder treatment, depending on the state of his/her health condition. Medication assisted treatment may occur at any of the levels. The Pennsylvania Client Placement Criteria suggests the following four patient care levels and nine service types:[9]

Level 1: Outpatient and Intensive Outpatient Treatment

- **Outpatient treatment:** No more than five hours of treatment per week
- **Intensive outpatient treatment:** At least five but less than 10 hours per week

Level 2: Partial Hospitalization and Recovery Residence

- **Partial hospitalization:** At least three days per week, with a minimum of 10 hours per week
- **Recovery residence:** Live-in/work-out treatment that typically lasts three to six months

Level 3: Medically-Monitored Inpatient Treatment

- **Medically-monitored detoxification:** 24-hour observation, monitoring, and medication; full resources of acute care, general hospital are not necessary
- **Medically-monitored short-term residential:** 24-hour treatment for patients with moderate impairment in functioning in which rehabilitation is the goal
- **Medically-monitored long-term residential:** 24-hour treatment for clients with severe impairment and chronic deficits in functioning in which habilitation is the goal

Level 4: Medically-Managed Inpatient Treatment

- **Medically-managed inpatient detoxification:** 24-hour medically-directed detoxification in an acute care setting; medical services and full hospital resources are available
- **Medically-managed inpatient residential:** 24-hour medically-directed treatment for patients with coexisting biomedical, psychiatric or behavioral conditions, who require frequent care, at least 24-hour nursing care, access to specialized and intensive medical care and access to physician care

Patient Confidentiality Considerations when Conducting "Warm Handoffs" and Analyzing PDMP Reports

Patients with a substance use disorder receive confidentiality protections different from other patient populations. These confidentiality protections are in place to protect individuals who experience substance use disorder from the potentiality detrimental results of personal medical information being used in a manner that is not beneficial to the individual's health and welfare. The unintended release or mishandling of confidential medical information could lead to a potential loss of employment, loss of license, imprisonment and/or other negative personal and familial consequences to the individual in question. Fear of such consequences can prevent an individual from seeking the help they need. It is therefore important that medical providers are aware of what confidential medical information they can legally obtain or distribute to other medical providers about their patients.

Federal and State Level Confidentiality Considerations

Providers should be aware that all patient information relating to identity, treatment or substance use diagnosis is confidential. If conducting a "warm handoff" to substance use disorder treatment, there are important considerations of which the medical providers should be aware of to ensure that they are appropriately handling patient medical records and information related to substance use.

Medical Information: In order to share or distribute medical information to another medical provider, the provider is required to obtain informed consent and a medical release of information from the patient prior to releasing or discussing any medical information. This is most commonly completed during patient intake in most medical facilities as required by Health Insurance Portability and Accountability Act (HIPAA). Acquiring informed consent from the patient will enhance the continuity of care. This will also allow for the substance use disorder treatment provider to follow up with the medical provider to relay any important information about the patient's health and vice versa.

Substance Use Information: Federal Confidentiality Regulations (42 CFR) relate to the handling of substance use related information and place restrictions on what can legally be discussed between individuals. In the event that the medical or substance use disorder provider works within a facility that is a 42 CFR covered program, the provider cannot share substance use disorder related information that would identify the patient as having a substance use disorder. 42 CFR covered programs are commonly but not explicitly assisted by federal funds and involve substance use education, treatment, or prevention.

There are nine exceptions to the 42 CFR Part 2 general confidentiality rule. The most common is through the use of a 42 CFR Part 2 compliant release of information specific to substance use disorder. This information may also be shared in the case of a medical emergency. There is no state or federal limit on the content of what may be shared between treatment providers except that it is limited to information for the purpose identified in the release of information. It is recommended that medical and SUD providers that work in facilities that deal with substance use disorder, consult with counsel to determine if they are a 42 CFR covered program.

A medical provider who wishes to receive information about a client should use one of the exceptions to 42 CFR such as a release of information or medical emergency exception. Anyone that receives information from a 42 CFR covered program may not redisclose the information that is received.

There are also state, drug and alcohol confidentiality legalities that apply to private practitioners and hospitals that are not 42 CFR covered programs. The Confidentiality Section of the Pennsylvania Drug and Alcohol Abuse Control Act (Section 1609.108(c) found at 71 P.S. § 1609.108(c)) states that all patient records relating to drug and alcohol misuse prepared or obtained by private practitioners, hospitals or clinics should remain

Continued

Patient Confidentiality Considerations when Conducting "Warm Handoffs" and Analyzing PDMP Reports *(continued)*

confidential. Providers should know that medical records can only be disclosed in two situations. First, when the patient gives consent that his/her medical records may be released to other medical providers for the sole purpose of diagnosis and treatment. Second, to government or other officials exclusively for the purpose of obtaining benefits due to the drug or alcohol misuse and/or dependence. However, similarly to 42 CFR covered programs, if the patient's safety is in danger, records can be released without prior consent to medical providers solely for the purpose of providing medical treatment.

The information discussed above is meant only as an introduction to patient confidentiality in relation to substance use disorder. There are other exceptions and requirements related to patient confidentiality that are not mentioned within this document. It is recommended that medical providers refer to a confidentiality training program for more information on patient confidentiality, such as one of the free training programs sponsored by the Pennsylvania Department of Drug and Alcohol Programs.* Medical providers are also referred to Pennsylvania Chapter §255, which expands the scope of what may be provided to certain entities such as insurers and criminal justice professionals, as well as 42 CFR Part 2, which defines the general confidentiality standard, to obtain additional information.

PDMP Report Confidentiality Considerations

Medical providers should also obtain informed consent and HIPAA compliance release of information before discussing a patient's PDMP report with another medical provider listed on the PDMP report. This information could pertain to the current list of medications listed on the PDMP report. If a medical provider has obtained informed consent, they should contact the other prescribers on the PDMP report if they deem it appropriate or necessary. (See Module 2 for more information on making clinical decisions based on PDMP reports.) However, a medical provider may contact other prescribers on a PDMP report without obtaining informed consent if communication is necessary to prevent fraud or misuse of prescription medication. For example, if a medical provider believes the patient is filling prescriptions by multiple prescribers in an illegal manner, they should contact the other prescribers on the patient's PDMP. This is also true in the context of patient safety. For example, if a medical provider notices a potentially harmful drug-drug interaction on a patient's PDMP report, they should contact and inform the patient's other prescriber to increase patient safety.

* https://apps.ddap.pa.gov/tms/PortalCourseSearch.aspx?cti=2

Links for Referral

The Pennsylvania Department of Health outlines the following protocol for how healthcare providers can refer a patient to treatment:

1. Talk to the patient about the results of his/her PDMP query.
2. If the patient screens positive for a potential substance use disorder, the provider can use motivational interviewing principles and the POLAR*S Model to ask the patient if he/she is willing to engage in treatment.
3. If the patient agrees to accessing substance use disorder treatment, the following resources can be used for treatment referral:

    a. **Single County Authorities:**
    This link includes referral information for the Single County Authorities across Pennsylvania. Depending on the Single County Authority, it may service more than one county.[9] Each county will have a designated protocol for a "warm handoff," which is approved by the Pennsylvania Department of Drug and Alcohol Programs. As discussed above, these procedures vary based on local needs. For example, procedures in an urban area may be different than in a rural area. https://apps.ddap.pa.gov/gethelpnow/CountyServices.aspx

    b. **Pennsylvania Get Help Now: 1-800-662-HELP (4357)**
    This 24/7 toll-free hotline serves to help those with substance use problems by finding immediate help through one phone call, thus facilitating the connection into substance use disorder treatment.

    c. **Care providers:**
    This link includes substance use disorder treatment providers for each county in Pennsylvania. It can be searched by zip code or by county name. It also provides links for contacts who can help identify treatment providers and patient access to treatment.[9] https://apps.ddap.pa.gov/gethelpnow/CareProvider.aspx

    d. **Centers of Excellence:**
    The Centers of Excellence throughout Pennsylvania provide resources to support and coordinate the patient's recovery from opioid-related substance use disorder. They also ensure that patients on Medicaid with opioid-related substance use disorder adhere to their treatment. The following link outlines the locations and goals of these centers:
    http://www.dhs.pa.gov/citizens/substanceabuseservices/centersofexcellence/.

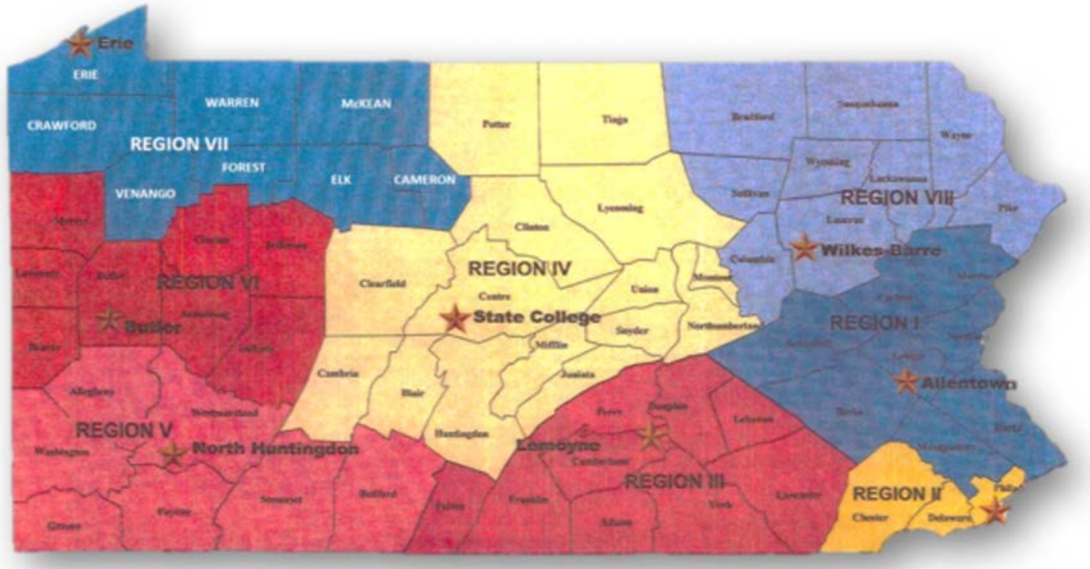
Continued

Links for Referral *(continued)*

4. If fraudulent or illegal activity (i.e., stolen prescription pads or altered prescriptions) is suspected, contact the Bureau of Narcotics Investigation or the Drug Control Regional Office. The phone number and location of offices across Pennsylvania are listed below in **Table 1**.

Table 1. Pennsylvania Office of Attorney General Bureau of Narcotics Investigation and Drug Control Regional Office Contact Information

Region	Address	Contact Information
I. Allentown	2305 28th Street, S.W. Allentown, Pennsylvania 18103	**Office:** 610-791-6100 **Fax:** 610-791-6103
II. Philadelphia	7801 Essington Avenue Philadelphia, Pennsylvania 19153	**Office:** 215-937-1300 **Fax:** 215-937-1342
III. Harrisburg	106 Lowther Street Harrisburg, Pennsylvania 17043	**Office:** 717-712-1280 **Fax:** 717-712-1204
IV. State College	2515 Green Tech Drive State College, Pennsylvania 16803	**Office:** 814-863-0684 **Fax:** 814-863-3378
V. North Huntington	10950 Route 30 North Huntington, Pennsylvania 15642	**Office:** 724-861-3600 **Fax:** 724-861-3690
VI. Butler	105 Independence Drive Butler, Pennsylvania 16001	**Office:** 724-284-3400 **Fax:** 724-284-3405
VII. Erie	4801 Atlantic Avenue Erie, Pennsylvania 16506	**Office:** 814-836-4300 **Fax:** 814-836-4328
VIII. Wilkes-Barre	680 Baltimore Drive Wilkes-Barre, Pennsylvania 18702	**Office:** 570-826-2051 **Fax:** 570-826-2447



Sources

1) Bose JH, S. L., Lipari, R. N., Park-Lee, E., Porter, J. D., Pemberton, M. R. . K*ey substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health.* 2016.

2) Samet JH, Friedmann, P., Saitz, R.,. Benefits of Linking Primary Medical Care and Substance Abuse Services. *The Journal of the American Medical Association.* 2001; 161(1):85-91.

3) Agency for Healthcare Research and Quality. *Design Guide for Implementing Warm Handoffs.*

4) Agency for Healthcare Research and Quality. *Implementation Quick Start Guide Warm Handoff*

5) Pennsylvania Department of Drug and Alcohol Programs. *Emergency Department Warm Handoff: For Opioid Use Disorder.* 2017.

6) M Miller W, Rollnick S. *Motivational interviewing: helping people change.* New York, NY: Guilford Press; 2013.

7) Coffey R, Houchens R, Chu B, et al. *Emergency Department Use for Mental and Substance Use Disorders.* Agency for Healthcare Research and Quality (AHRQ); 2010.

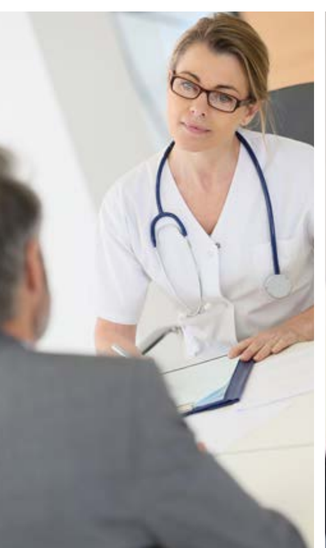
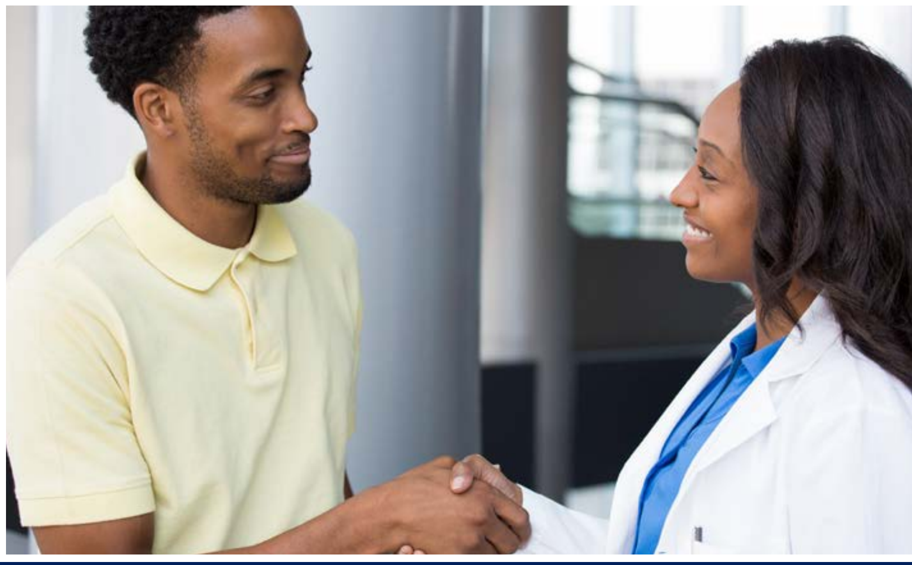
8) Florida Alcohol and Drug Abuse Association. *Impact of Substance Use Disorders on Health Care.* Florida.

9) SMaRT Policy Working Group. *Guidelines for Medical Health and Substance Treatment Systems.* 2010.

10) Commonwealth of Pennsylvania Department of Drug and Alcohol Programs. *Pennsylvania's Client Placement Criteria For Adults.* 2014.

Created On: 9/29/2017

www.pa.gov/collections/opioid-epidemic | RA-DH-PDMP@pa.gov

Pennsylvania Prescription Drug Monitoring Program (PDMP)
System User and Stakeholder Training

Approaches to Addressing Substance Use Disorder with Patients Identified by the PDMP

MODULE 6

GUIDE DOCUMENT

Pennsylvania Prescription Drug Monitoring Program (PDMP) System User and Stakeholder Training

Learning Objectives for Modules 1-7

Module 1: Why Using the PDMP is Important for Achieving Optimal Health for Pennsylvania Citizens

1. The status of substance use disorder in general, opioid use disorder and overdoses nationally and in Pennsylvania;
2. Common misconceptions about substance use disorder and opioid use disorder treatment and recovery;
3. Costs associated with prescription drug and heroin-associated opioid use disorder and overdose; and
4. How pervasive prescriber and pharmacist PDMP use can reduce population opioid use disorder and overdose.

Module 2: What is a PDMP, How to Use the PDMP to Make Clinical Decisions, How to Integrate the PDMP into the Clinical Workflow, and How to Access Pennsylvania's PDMP

1. Detail Pennsylvania's requirements and regulations regarding PDMP use;
2. Explore options and actions Pennsylvania prescribers and pharmacists can take to integrate the PDMP into clinical workflows; and
3. Discuss how to use the PDMP system to make clinical decisions.

Module 3: Using the PDMP to Optimize Pain Management

1. Learn how to use the PDMP to address pain management for various patient populations and pain types;
2. Understand the basic nature of pain for different patient populations and how to manage their pain using the PDMP as a clinical tool; and
3. Discuss different ways of treating patient pain that do not involve the immediate use of opioids.

Module 4: Opioid Prescribing Guide

1. Provide guidelines to inform all healthcare providers when prescribing opioids in the acute phase of pain;
2. Instruct healthcare providers on how to prescribe opioids in the chronic phase of pain, which includes information on how to initiate or continue opioid therapy, select the correct dose and/or discontinue opioids;
3. Instruct healthcare providers on how to assess risks and address harms associated with opioid use;
4. Instruct healthcare providers on the legal responsibilities related to prescribing opioids; and
5. Instruct healthcare providers on how they may direct patients to dispose of unused medications.

Module 5: Referral to Treatment for Substance Use Disorder Related to Opioid Use

1. Define "warm handoffs" and how they can best occur;
2. Provide a schema for how any health care provider can implement "warm handoffs" in any clinical setting;
3. Demonstrate how primary care practices can conduct "warm handoffs" by preparing, using validated screening tools and using patient-centered communication with patients;
4. Demonstrate how healthcare providers can determine the best type of treatment for their patients;
5. Present information on patient confidentiality that providers should be aware of when working with patients with substance use disorders and performing "warm handoffs"; and
6. Present relevant Pennsylvania links for treatment and other resources.

Module 6: Approaches to Addressing Substance Use Disorder with Patients Identified by the PDMP

1. Learn how to integrate the PDMP with other screening tools to help identify those who may require substance use disorder treatment or increased monitoring;
2. Define Screening, Brief Intervention and Referral to Treatment (SBIRT), its main goals and its main components;
3. Learn how to screen a patient for a potential substance use disorder, conduct a brief intervention and refer a patient to treatment;
4. Learn how to discuss a substance use disorder with a patient and handle patient resistance; and
5. Learn how to incorporate SBIRT into clinical practice.

Module 7: Effective Opioid Tapering Practices

1. Discuss how to use the PDMP to determine if a provider should consider tapering his/her patient;
2. Discuss several indicators that prescribers can look for when considering tapering opioids;
3. Inform prescribers on how to discuss tapering with patients using patient-centered techniques;
4. Present a general opioid tapering protocol and how to adapt this protocol to the needs of any patient; and
5. Present information on how to manage withdrawal and how to use tools to measure withdrawal symptoms in patients.

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Introduction

When using data queried from the Prescription Drug Monitoring Program (PDMP), prescribers and pharmacists are often faced with the challenge of discussing substance use with their patients.

It is important to know how to effectively discuss substance use with a patient based upon PDMP queries for various reasons. First, prescribers, as a result of a PDMP query, may have to change a patient's pain management approach. Knowing how to have effective conversations with patients regarding the need for tapering and/or discontinuing opioid therapy is of vital importance. Additionally, as a result of a PDMP query, prescribers may need to explore with the patient whether his/her substance use is linked to or causing other physical, emotional, or social healthcare problems. Finally, the PDMP query may raise concern that the patient is misusing substances or using other substances illicitly. The practitioner would therefore need to be equipped with the knowledge of how to accurately identify patients who have potential substance use disorders and possess the skill to effectively talk to them using patient-centered communication techniques aimed at motivating the patient to change his/her behaviors, such as reducing substance use or accessing substance use disorder treatment. A proven methodology, Screening, Brief Intervention and Referral to Treatment (SBIRT), can be used by all provider types for each of these scenarios linked to PDMP queries. SBIRT can be used to screen for potential substance use disorder and discuss the results with the patient in a manner that motivates him/her to change his/her substance use behavior or agree to treatment changes (e.g., tapering or discontinuation of pain medications). Then, the provider can refer the patient to substance use disorder treatment specialists for further evaluation, if needed.

SBIRT is promoted by the Substance Abuse and Mental Health Services Administration. It is an evidence-based approach for the delivery of early intervention and facilitated referral to substance use disorder treatment services for patients whose substance use puts them at risk for psychosocial and other health care-related problems, up to and including dependence. The main goal of SBIRT is to improve community health through the reduction of adverse consequences of substance misuse and substance use disorders. The flexibility of SBIRT has allowed it to be adapted for use in a variety of healthcare settings, including emergency departments, primary care offices, oral healthcare settings and other settings. This makes it a powerful tool to screen, intervene and refer patients to substance use disorder treatment.[1]

In this module, prescribers will learn how to integrate a PDMP query into SBIRT for their clinical practice and workflow. The module includes the following objectives:

1. Learn how to integrate the PDMP with other screening tools to help identify those who may require substance use disorder treatment or increased monitoring;
2. Define SBIRT, its main goals and its main components;
3. Learn how to screen a patient for a potential substance use disorder, conduct a brief intervention and refer a patient to treatment;
4. Learn how to discuss a substance use disorder with a patient and handle patient resistance; and
5. Learn how to incorporate SBIRT into clinical practice.

Using the PDMP when Screening for a Substance Use Disorder

PDMP data can be used to facilitate SBIRT use by all types of prescribers and pharmacists. Prescribers and pharmacists can use PDMP data to identify patients who are at risk of developing substance use disorders with PDMP data that suggests the patient: (a) is filling multiple opioid prescriptions or is going to multiple prescribers to obtain his/her opioid or other interacting medications (e.g., benzodiazepines); (b) is using sedatives in addition to opioids; and/or (c) has been steadily increasing his/her use of relevant medications.

PDMP data can be coupled with other screening methods such as urine drug tests and standardized screening tools (obtained via self-report) to aid in the development of interventions. (See the SAMHSA website* for a list of and links to these screening tools.) These interventions are typically brief conversations aimed at motivating patients to improve their health such as decreasing the misuse of relevant medications. The interventions help patients to be more receptive to receiving additional services that will help them reduce or eliminate their opioid use.[2]

Knowledge of PDMP data can be brought into an intervention and shared with the patient whenever the prescriber is helping the patient realize his/her risk for a substance use disorder. Therefore, the PDMP report is an effective way of broaching the subject of substance use with a patient.[3,4] However, it should not be used as undeniable proof that a patient has a substance use disorder or be used as a reason to dismiss a patient from medical care. When a prescriber suspects that a patient has a substance use disorder following a PDMP query, the prescriber should discuss the PDMP results with the patient in conjunction with the results from other screenings.[5,6] The prescriber should allow for the patient to explain him or herself for any potential irregularity in the report or sign of substance misuse. Afterwards, if the conversation indicates treatment may be necessary, the prescriber should recommend all potential treatment options and conduct a "warm handoff" to treatment when necessary (See Module 5 for how to conduct a "warm handoff.") The SBIRT techniques discussed throughout this module can be used to guide prescribers when working with patients, if a screen suggests a potential substance use disorder.

Provider: "Your PDMP results show that you received another opioid prescription from a dentist across town. Your patient-provider agreement that you signed with me states that I would be the only person allowed to prescribe you opioids. Could you please tell me more about your dental visit?"

* http://www.integration.samhsa.gov/

The Value, Goal, and Definition of SBIRT

Substance misuse by patients is commonly encountered by healthcare providers in a variety of settings. However, evidence-based practices, such as SBIRT, have been shown to be effective in reducing the negative healthcare consequences of substance misuse and its associated costs.[7,8] In a recent evaluation of two Substance Abuse and Mental Health Services Administration SBIRT implementation cohorts of more than one million screened patients, both brief intervention and referral to treatment were associated with positive outcomes.[9] When properly integrated, SBIRT can yield great benefits for the patient and allow for more efficient and cost-effective patient-provider episodes. SBIRT skills are especially helpful for prescribers and pharmacists to use with patients who are particularly resistant to making changes that would support better health or deny any misuse of medications despite objective evidence.

Despite SBIRT's demonstrated success, early identification, assessment and referral to specialty care can be challenging for even experienced healthcare providers if they do not have proper training and support with a process such as SBIRT.[10,11]

SBIRT is a comprehensive and integrated approach to the delivery of early intervention and treatment services through universal screening processes that identify individuals at risk of a substance use disorder and those currently with a substance use disorder.[12]

"**Screening**" is the process of identifying patients whose substance use puts them at increased risk for psychosocial and other health care-related problems.

The "**Brief Intervention**" component consists of a brief dialogue with patients to provide feedback on risks associated with substance use and explore consequences of use with the intent to strengthen patients' own motivation and commitment to positive behavior changes.

"**Referral to Treatment**" consists of actively linking patients in need of specialty services to appropriate substance use disorder treatment and recovery support services.

SBIRT: How to Proceed when Encountering a Patient with a Suspected Substance Use Disorder

SBIRT can be used by prescribers and pharmacists as a methodology to use when encountering a patient with a suspected substance use disorder. If the PDMP displays any potential "red flags", screening can be used as a next step to help provide further evidence of any substance misuse. If it becomes evident that the patient may be dealing with an issue related to substance misuse, a brief intervention can be conducted using the principles of motivational interviewing to discuss the results of the screening and the PDMP query. The prescriber can perform a "warm handoff" to substance use disorder treatment or continue to follow-up with the patient on a regular basis regarding his/her drug and/or alcohol use. The description of the key components of SBIRT that follows should assist prescribers with conducting SBIRT in various healthcare settings.

Screening

SBIRT screening employs the use of validated screening instruments with documented sensitivity and specificity. The instruments identify a screening score and associated risk level to guide an appropriate clinical intervention. Universal screening procedures for all patients increase the ease and speed of the data collection from the patient. Incorporating PDMP data into the clinical workflow supplements SBIRT screening by identifying patients who may have a substance use disorder. The PDMP can be incorporated using several different methods. For example, delegates for a prescriber associated with the PDMP make it easy to combine the treatment tools during an appointment. (See Module 2 for more information on clinical and workflow incorporation.)

Routine screening makes substance use conversations commonplace and reduces a patient's hesitancy in discussing his/her substance use. Validated screening tools promote documentation of identified substance use issues and supports related billing, continued follow-up and interprofessional communication. The type of screening tool used should vary based on the type of substance use that is suspected, the amount of time that is available for the screen, and the ability to conduct the screen in a written and/or oral fashion. There are four recommended screening tools depending on the patient population. These tools are not required but are recommended for use in adolescent, adult and pregnant patient populations.

Screening Tools for Adults Patients

The Alcohol, Smoking and Substance Involvement Screening Test can be used to screen patients for drug, alcohol, and tobacco-related problems in a primary care setting. It has eight questions that cover a total of 10 different substances total: tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants, inhalants, sedatives, hallucinogens, opioids and "other drugs". The screen takes approximately 15 minutes to complete.[13,14]

The CAGE Questions Adapted to Include Drugs Tool is a screen for alcohol and drug misuse. CAGE is derived from the four questions of the tool: Cut down, Annoyed, Guilty and Eye-opener. The four item screening tool takes approximately one minute to administer and score.[15]

Screening Tool for Pregnant Patients

The Institute for Health and Recovery Integrated Screening Tool: 5 P's Screening Tool is a screening tool designed for women. It screens for emotional problems, alcohol, tobacco, other drug use, and domestic violence. The 5 P's are derived from Parents, Peers, Partner, Past and Present. It is a quick, easy, non-threatening and effective tool that asks pregnant woman about their substance use in a nonjudgmental manner. It also asks about emotional health and domestic violence.[16]

Screening Tool for Adolescents

The CRAFFT Screening Tool is a behavioral health screening tool for use with individuals under the age of 21. It can be used to screen adolescents for high-risk alcohol and other substance use disorders simultaneously. CRAFFT is derived from Car, Relax, Alone, Forget, Friends and Trouble. It is a quick screen that consists of a series of six questions meant to determine whether a longer conversation about the context of use, frequency, and other risks and consequences of alcohol and other drug use is necessary.[17]

Continued

SBIRT: How to Proceed when Encountering a Patient with a Suspected Substance Use Disorder *(continued)*

Brief Intervention

A brief intervention is a structured clinical process with a beginning, a middle and an end. It can be used to discuss a patient's substance use following a substance use screen or results from the PDMP which indicate potential substance misuse. Even if results do indicate potential substance misuse, prescribers should never refer to patients as "drug seeking" or use the term "doctor shopping." This type of language can be very stigmatizing. It can also lead to a patient's actual pain or other health issue to be left untreated. Prescribers should also not focus on whether or not they believe patients. Engaging in that type of negative process often leads to a less constructive and negative clinical interaction. The provider should therefore be focusing on helping the patient out of pain and not be casting judgement upon him/her.

The skills used to carry out a brief intervention are broadly applicable to the management of many chronic conditions. The underpinnings of an effective brief intervention draw from the fundamental principles of motivational interviewing.[12] Spirit, skills and strategy, the basic components of motivational interviewing, are described below. However, this module does not presume to provide comprehensive training in the practice of motivational interviewing. The prescriber should be aware that these components make up the basis for the brief intervention component of SBIRT and can be used when discussing a multitude of different health-related issues with patients.

Three Basic Components of Motivational Interviewing

1. **Spirit:** Collaboration, acceptance, evocation, compassion
2. **Skills:** Open-ended questions, affirmations, reflections, summaries
3. **Strategy:** Engaging, focusing, evoking, planning

The brief negotiated interview is a brief intervention model based on motivational interviewing that is a proven evidence-based practice and can be completed in five to 15 minutes. (See Key Components of Motivational Interviewing for more information on motivational interviewing principles.) The model was originally developed in 1996 and refined in the early 2000s.[18-20] The brief negotiated interview acknowledges the time constraints on patient-provider interactions while still seeking to capitalize on opportunities to increase patient motivation to make a positive behavior change. It is an effective method for discussing a patient's substance use and screening results. The four steps outlined below discuss how to effectively conduct a brief negotiated interview in medical or oral healthcare settings.

Continued

SBIRT: How to Proceed when Encountering a Patient with a Suspected Substance Use Disorder *(continued)*

1. **Build Rapport and Raise the Subject:** Begin by raising the subject and building rapport through general conversation. Ask the patient permission to discuss his/her drug use. Use open-ended questions to allow the patient to reflect on the pros and cons of his/her drug use.

   "Thank you for answering these screening questions. Can we discuss them together?"

   "Describe a typical day in your life. How does your drug use fit into your routine?"

   "What are some of the things you enjoy about your drug use? What are some of the things that you do not enjoy about your drug use?"

2. **Provide Feedback:** Provide feedback to enhance motivation and readiness to change. Ask the patient permission to relay information on drugs and alcohol, as well as to discuss the results of the screening. Discuss the connections between substance use behaviors and known consequences to those behaviors.

   "In order to prevent new health problems from forming or prevent current problems from getting worse, I recommend that all of my patients drink less than the low-risk limits and abstain from using drugs."

   "Many patients who score this highly are at an elevated risk of social or legal problems, as well as illness and injury. Can I talk to you about some of these risks?"

   "There are many different reasons you could be feeling this way. Can I ask you some questions so we can try to figure this out?"

3. **Build Readiness to Change:** The use of a readiness ruler (Figure 1) can support the brief intervention. It can help patients identify behavior changes they are ready to make, increase the importance of the behavior change, and build their confidence in changing the behavior. It asks patients on a scale of 0-10 how ready they are to change a behavior.

   Figure 1: Readiness Ruler

0	1	2	3	4	5	6	7	8	9	10
Not at all										Extremely

   "On a scale of 0-10, with 0 being not ready at all and 10 being extremely ready, how ready and confident are you that you can change your behavior?"

   "It's okay if you do not feel ready to make this change. Would you like to discuss some other options?"

   "So you feel you are at a 6 in terms of readiness to address your use of prescription opioid medications. Can you tell me your thoughts behind that answer? Why didn't you choose a lower number?"

4. **Negotiate a Plan for Change:** Complete the brief negotiated interview by negotiating and advising a plan for change. The negotiation should include a plan for reducing use to low-risk levels and an agreement to follow up with specialty treatment services. Attached is a list of demonstration videos. The videos are from SBIRT Oregon and demonstrate the application of the brief negotiated interview.

   "What steps do you think you can take that will help you reach your goal of reducing your drug use to low-risk levels?"

   "Those are great ideas! Can we write down your plan so that you can refer to it in the future?"

   "Can we schedule a follow-up appointment to see how you are doing?"

   "It's really great that you came in and talked to me about this. Let's review what we discussed."

Continued

SBIRT: How to Proceed When Encountering a Patient with a Suspected Substance Use Disorder *(continued)*

Referral to Treatment

Referral to treatment is the process of actively linking patients to specialty substance use disorder treatment and recovery support services. The process of making a "warm handoff" to treatment involves directly contacting a substance use disorder treatment provider and solidifying a related appointment while the patient is present. This method will increase the likelihood that patients will engage in substance use disorder treatment, as opposed to providing patients with treatment contact information to navigate on their own. (See Module 5 for more information on referral to substance use disorder treatment.) If a patient resists treatment completely, the prescriber should follow-up with the patient regularly and make future referral attempts whenever possible. The provider should also maintain a positive, non-confrontational tone. This should remain a positive and respectful exchange so that when the patient changes his/her mind later (even minutes later) the patient can feel safe to re-engage with this provider or another provider. Providers should offer materials that the patient can look at later, including contact information for substance use disorder assessment.

How to Address Patient Resistance

Prescribers should expect to encounter resistance from some patients when raising the subject of substance use or misuse. Prescribers should be prepared to handle the situation in order to manage the patient's health and connect the patient with substance use disorder treatment when necessary. Motivational interviewing is a proven method to help address patient resistance. Its principles should be used to help avoid this type of patient-provider situation and make the patient feel more comfortable discussing his/her substance use. Integrating a "warm handoff" protocol into your health care setting can also help to avoid this scenario by diminishing barriers related to access of care and providing patient support throughout the referral process (see Module 5). Below are several examples of patient resistance, or a mismatch between patient and provider goals, with corresponding examples of how a clinician could respond from the National Institute on Drug Abuse:[21]

Table 1: How to Handle Differences in Provider and Patient Goal Scenarios and Clinician Responses

Patient Resistance Scenario	Clinician Response
Patient answers "no" to any drug use, without any thoughtful consideration.	• Gently probe with a question, such as "Not even when you were in school?" • Encourage discussion by saying "go on" or "tell me more".
Patient is uncomfortable disclosing personal substance use on a form.	• Tell the patient your plan to follow-up in person about the screening. • Reinforce confidentiality when possible. • If the patient is still uncomfortable, skip the screening and reiterate the harms associated with drug use.
Patient appears ashamed or embarrassed about recommendations to change substance use behaviors.	• State that the recommendation is related to his/her overall health and that as his/her provider, it's your role to share test results with your patients. • Remind the patient that it is not meant as a judgement.
An at-risk patient seems to have mixed feelings regarding changing his/her substance use behavior.	• Acknowledge the patient's current set of feelings and express your concern. • Explain how the behavior may poorly affect the patient's health or personal life.
Patient becomes upset, angry and/or argumentative.	• Refrain from arguing with the patient and allow the patient to have time to make a decision unless the condition is life-threatening. • Discuss and reflect on the patient's concerns and convey that you understand how the patient feels.

Continued

How to Address Patient Resistance *(continued)*

Patient Resistance Scenario	Clinician Response
Patient declines referral for additional assessment and/or treatment.	• Explore the patient's concerns regarding the assessment to determine why he/she is resisting. • Emphasize that a referral to treatment means many different things and does not always equate to substance use disorder treatment.
Patient cites barriers to attending the substance use disorder treatment or other treatment referral appointments.	• Discuss the barriers and offer support, such as follow-up calls, transportation assistance, child care, and other methods to improve access to care. • Contact the local Single County Authority or substance use disorder treatment center and see if they can offer any assistance.
Patient declines the idea of going into formal substance use disorder treatment.	• Reiterate to the patient that you are not insisting on formal treatment. • Explain that treatment is often easier than quitting without any outside assistance and stopping certain drugs without any medical supervision can be dangerous to his/her health.
In follow-up visits, patient shows no progress with change efforts.	• Reiterate that change is difficult. • Repeat the brief intervention and discuss alternative methods that may help the patient be more successful in the future. • Make additional referrals for any patients who may have missed a previous appointment.

Establishing SBIRT in Practice

In a similar fashion to implementing a "warm handoff" protocol or the PDMP into an office workflow, prescribers should work to establish SBIRT into their daily practices. Workflow integration of SBIRT allows for the provider to spend his/her time efficiently and make as positive an impact as possible on the patient. The Centers for Disease Control and Prevention have a guide for implementing screening and brief intervention into clinical practice in primary care settings. It discusses a step-by-step protocol that can be used by practitioners.[22] The following is a modified version of this guide. The steps do not necessarily need to be enacted in order and can be completed concurrently in many cases.

Preparing for SBIRT

1. Understand the importance of SBIRT.
2. Obtain commitment from your organization regarding the implementation of a new clinical and workflow protocol.
3. Become familiar with SBIRT coding for reimbursement. Visit the Substance Abuse and Mental Health Services Administration website for more information on billing codes.[*]

Adapting SBIRT

4. Complete a "**screening**" plan.
   a. When will you screen the patient?
   b. Which patients will you screen?
   c. How often will the patient be screened?
   d. Which screening tools will you use in which patient situations?
   e. Where will the screening take place?
   f. How will the screening results be shared and stored?
5. Complete a "**brief intervention**" plan for your brief negotiated interview.
   a. Who will conduct the brief interventions in your organization?
   b. Where will the brief negotiated interview take place?
6. Determine how "**referral to treatment**" will proceed.
   a. How will you refer patients who screen positive to treatment?
   b. Where will referral information be located?
   c. Who will distribute the referral information?
   d. Please see Module 5 for more information on referral to substance use disorder treatment ("warm handoff").

[*] https://www.samhsa.gov/sbirt/coding-reimbursement

Continued

Establishing SBIRT in Practice *(continued)*

Implementing SBIRT

7. Provide orientation and training to any staff involved.
    a. Visit http://www.SBIRT.pitt.edu for further information on training programs.
    b. Select the training programs that best meet your needs.
8. Pilot test your protocols to evaluate them and enhance them, as needed.
9. Once the pilot test has been perfected and the staff have been properly trained, implement the program as part of the regular office workflow protocol.

Example Protocol: SBIRT in the Emergency Department

1. The patient arrives at the emergency department.
2. The patient is escorted to the exam room.
3. A PDMP query is conducted for the patient if the patient is presenting with pain symptoms.
4. A physician, nurse, or specially trained health professional completes a screening by asking initial screening questions and using a validated screening tool as indicated.
5. Based on the screening results, a provider determines whether a brief negotiated interview should be conducted.
6. The provider conducts a brief negotiated interview.
7. If a referral to substance use disorder treatment is necessary, a "warm handoff" to substance use disorder treatment is carried out per the site-specific protocol.
8. Appropriate follow-up is carried out to ensure the patient engages in substance use disorder treatment.

Refining and Promoting

10. Protocols should be periodically evaluated and updated according to how successful or unsuccessful the plans are in screening and referring individuals to treatment. Make any necessary changes to increase the efficacy of the program.
11. Disseminate your patient success to other practitioners to improve their implementation protocols and increase the success of SBIRT throughout Pennsylvania.

Sources

1) Agerwala S, McCance-Katz E. Integrating screening, brief intervention, and referral to treatment (SBIRT) into clinical practice settings: a brief review. *Journal of Psychoactive Drugs.* 2012;44(4):307-317.
2) Padwa H, Urada D, Antonini V, Ober A, Crevecoeur-MacPhail D, Raweson R. Integrating Substance Use Disorder Services with Primary Care: The Experience in California. *Journal of Psychoactive Drugs.* 2012;44(4):299-306.
3) Hildebran C, Cohen D, Irvine J, et al. How clinicians use prescription drug monitoring programs: a qualitative inquiry. *Pain Medicine.* 2014;15(7):1179-1186.
4) Irvine J, Hallvik S, Hildebran C, Marino M, Beran T, Deyo R. Who uses a prescription drug monitoring program and how? Insights from a statewide survey of Oregon clinicians. *The Journal of Pain*. 2014;15(7):747-755.
5) Dowell D, Haegerich T, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain. *JAMA.* 2016;315(15):1624-1645.
6) Washington State Agency Medical Directors' Group. *AMDG 2015 Interagency Guideline on Prescribing Opioids for Pain.* Olympia, WA: Washington State Agency Medical Directors' Group; 2015.
7) Fleming MF, Mundt, M.P, French, M.T., Manwell, L.B., Stauffacher, E.A., & Barry, K.L. Benefit-cost analysis of brief physician advice with problem drinkers in primary care settings. *Medical Care.* 2000;38(1):7-18.
8) Solberg LI MM, Maciosek MV, Edwards NM. Primary care intervention to reduce alcohol misuse: ranking its health impact and cost effectiveness. *American Journal of Preventative Medicine.* 2008;34(2):143-152.
9) Babor TF, Del Boca F, Bray JW. Screening, Brief Intervention, and Referral to Treatment: Implications of SAMHSA's SBIRT initiative for substance abuse policy and practice. *Addiction.* 2017;112(2):110-117
10) Bernstein S.L. HJS. Public health, prevention, and emergency medicine: a critical juxtaposition. *Academic Emergency Medicine.* 2008;15(2):190-193.
11) Van Hook S, Harris, S. K., et al. The "Six T's": barriers to screening teens for substance abuse in primary care. *Journal of Adolescent Health.* 2007;40(5):456-461.
12) Miller WR, & Rollnick, S. *Motivational interviewing: helping people change.* New York, NY: Guilford Press; 2013.
13) WHO ASSIST Working Group. The alcohol, smoking and substance involvement screening test (ASSIST): development, reliability and feasibility. *Addiction.* 2002;97(9):1183-1194.
14) Humeniuk R, Ali R, Babor T, et al. Validation of the alcohol, smoking and substance involvement screening test (ASSIST). *Addiction.* 2008;103(6):1039-1047.
15) Basu D, Ghosh A, Hazari N, Parakh P. Use of Family CAGE-AID questionnaire to screen the family members for diagnosis of substance dependence. *The Indian journal of medical research.* 2016 June;143(6):722.
16) Institute for Health and Recovery Integrated Screening Tool. http://www.mhqp.org/guidelines/perinatalpdf/ihrintegratedscreeningtool.pdf. Accessed August 18, 2017.
17) The Center for Adolescent Substance Abuse Research. http://www.ceasar-boston.org/CRAFFT/pdf/CRAFFT_English.pdf. Accessed August 18, 2017.
18) Bernstein E, Bernstein J, Levenson S. Project ASSERT: An ED-based intervention to increase access to primary care, preventive services, and the substance abuse treatment system. *Annals of Emergency Medicine.* 1996;30:181-189.
19) D'Onofrio G, Bernstein E, Rollnick S. Motivating patients for change: a brief strategy for negotiation. *Case studies in emergency medicine and the health of the public.* Boston, MA, 1996.
20) D'Onofrio G, Pantalon MV, Degutis LC, Fiellin DA, O'Connor PG. Development and implementation of an emergency practitioner-performed brief intervention for hazardous and harmful drinkers in the emergency department. *Academic Emergency Medicine.* 2005;12(3):249-256.
21) National Institute on Drug Abuse. How Do You Address Patient Resistance? 2017.
22) Higgins-Biddle JC, Hungerford DW, Baker SD, et al. *Planning and Implementing Screening and Brief Intervention for Risky Alcohol Use: A Step-by-Step Guide for Primary Care Practices.* Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilites; 2014.

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Key Components of Motivational Interviewing

MODULE 6

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Motivational interviewing is **"a collaborative conversation style for strengthening a person's own motivation and commitment to change."**

Spirit

Collaboration is a partnership between the provider and the client. Motivational interviewing is done "for" and "with" the individual being interviewed not "to" or "on." This builds rapport and facilitates trust between the provider and patient.

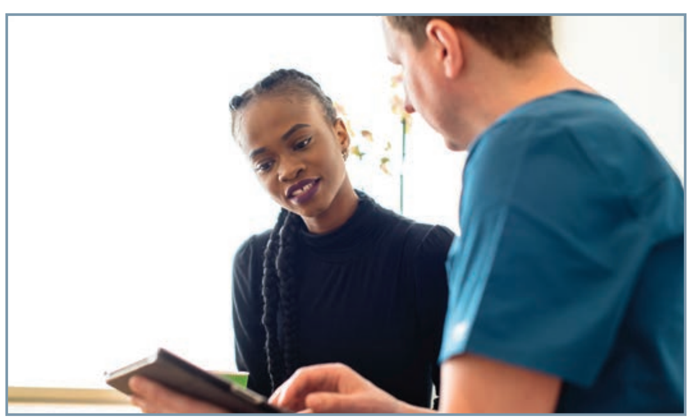
Acceptance of what the client brings is also a key component of motivational interviewing. The provider is not accepting or approving of the patients actions. The provider's acceptance should consist of absolute worth, affirmation, autonomy and accurate empathy. This means that you accept who the client is as a person, try to understand him/her, honor his/her will to go in a certain direction and seek and acknowledge the person's strengths and efforts.

Evocation is the drawing out of an individual's own thoughts and ideas rather than probing for deficits. People already have what is needed for change within them. The provider's job is to bring it forward to elicit the behavior change.

Compassion is an active commitment to pursuing and promoting the patient's welfare by giving priority to his/her needs.

Three Basic Components of Motivational Interviewing

1. **Spirit:** Collaboration, acceptance, evocation, compassion
2. **Skills:** Open-ended questions, affirmations, reflections, summaries
3. **Strategy:** Engaging, focusing, evoking, planning



Skills

Open-Ended Questions invite the person to answer in his/her own words. These questions evoke motivation and increase the odds of planning a course that involves change.

"How have things been going since we last met?"

"What are some reasons you might want to change?"

Affirmations recognize a client's particular strengths, abilities, good intentions, and efforts. These statements should be positive and genuine instead of cheerleading.

Reflections allow for the client to hear his/her own thoughts and feelings that he/she is expressing in order to increase his/her own considerations. Use statements such as:

"Sounds like..."

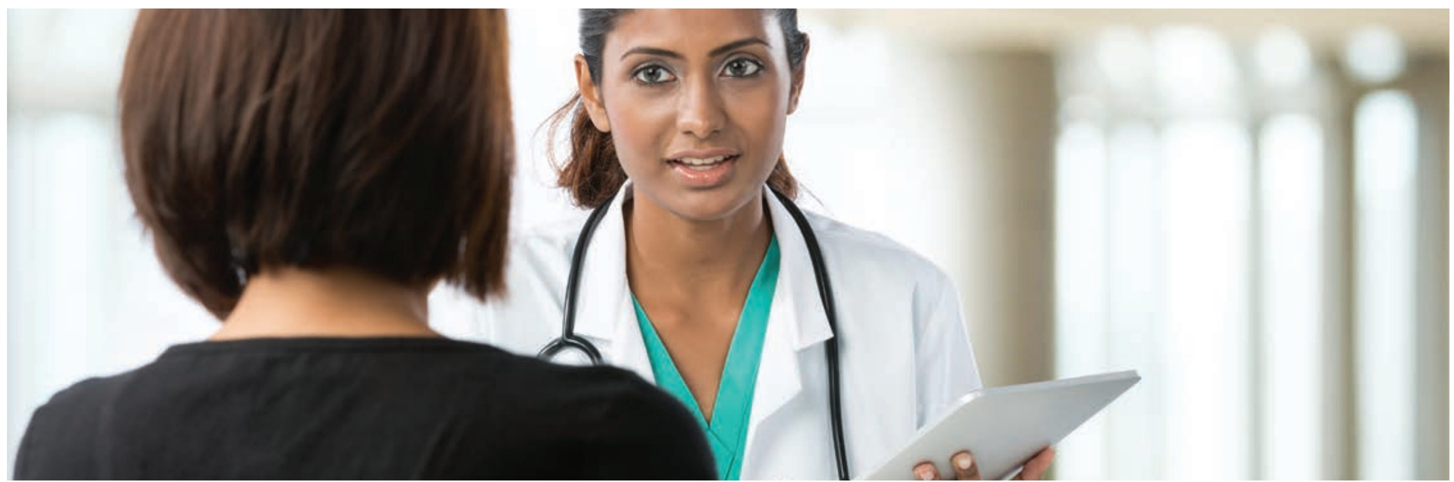
"Seems like..."

"You feel..."

Summaries pull together what the client has been explaining throughout the interview and provide a reflection that promotes understanding. They demonstrate that you have been listening carefully and valuing the patient's comments.

Continued

Key Components of Motivational Interviewing



Strategy

I. Engaging is the process through which the client and provider build and establish a helpful connection and a working relationship. Therapeutic engagement is the building block of the relationship necessary for successful motivational interviewing.

II. Focusing is the process by which the provider develops and maintains a specific direction throughout the conversation regarding one or more change goals. It is the focus on what the client came to talk about.

III. Evoking is the elicitation of the client's own motivations or desires for change. It occurs when there is a focus on a particular change and the provider elicits the patient's own ideas and feelings about how the patient will complete the change.

IV. Planning occurs after an individual's level of motivation allows him/her to begin to think and plan about how the change will occur and less about whether or why it may not.

Sources

1) Miller W, Rollnick, S. *Motivational interviewing: helping people change.* New York, NY: Guilford Press; 2013.

Frequently Asked Questions
SBIRT Training and Implementation

Issue Raised	Literature or Resource	How the Resource Addresses the Issue
SBIRT use is not related to the effective use of the PDMP.	Irvine, et al., 2014 Hildebran, et al., 2014	The PDMP can help facilitate communication with patients regarding substance misuse and identify those who may require SBIRT.
I don't have room to incorporate the SBIRT training into my practice.	Maciosek, et al., 2006 O'Connor, et al., 2011 Solberg, et al., 2008	SBIRT is ranked high among all preventative interventions in effectiveness and is increasingly used by health professionals.
I'm not convinced SBIRT is effective in reducing patient/client alcohol and drug use.	Madras, et al., 2009 Agerwala & McCance-Katz, 2012 Cherpitel, et al., 2010	SBIRT is effective in preventing substance use disorders, especially alcohol use disorder.
I don't think SBIRT is relevant to my profession.	Osborne & Benner, 2012 *(Social Work)* Bray, et al., 2014 *(Pediatrics)* Désy, et al., 2010 *(Nursing)* Cuevas & Chi, 2016 *(Dentistry)*	SBIRT is effective when applied to healthcare disciplines, such as medicine, social work, nursing, dentistry, pediatrics, etc.
I don't think that people in healthcare who we train to use SBIRT will find it useful.	Bernstein, et al., 2007 Mitchell, et al., 2013 Tanner, et al., 2012	The majority of SBIRT trainees find the program to be useful.
I don't think people recover from substance use disorder anyway.	McLellan, et al., 2000 O'Connor, 2013	Patients with substance use disorder are more likely to develop recovery than patients with other chronic medical conditions, such as patients with hypertension, asthma, and diabetes.
I think people would get offended when asked about their alcohol and drug use.	Miller, et al., 2006 Bonds, et al., 2007	Most patients will not be offended and will volunteer honest answers about their substance use when asked by a health professional.
I'm not sure SBIRT is cost-effective.	Barbosa, et al., 2015 Solberg, et al., 2008	SBIRT has reduced downstream healthcare costs and hospital readmissions.

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A Screening, Brief Intervention, and Referral to Treatment Primer

MODULE 6

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Overall SBIRT

Unhealthy substance use by patients, which encompasses the full spectrum of hazardous use to the development of severe substance use disorders, is commonly encountered by healthcare providers in a variety of health care settings. The Pittsburgh Screening, Brief Intervention and Referral to Treatment (PGH SBIRT) [pronunciation: es-bert] curriculum is designed to aid health professionals in significantly increasing their knowledge and skills needed to address substance use with their patients.

1. The goal is to put healthier patients at lower risk for substance use disorders.
2. SBIRT is cost-effective and cost-beneficial.
3. Fidelity and documentation are necessary for reimbursement.
4. Health impairment begins with substance use below the diagnostic level of dependence; it begins with use that puts a patient at a greater risk for harm (hazardous and harmful use).

Screening Tools

Screening is a strategy for early identification and assessment of individuals with unhealthy substance use through interview or self-assessment.

1. Many screening tools are available for diverse patient populations and substances used.
2. Effective use of screening instruments requires proper study of the instrument; become familiar with the instrument you will be using as a provider.
3. Recommended instruments for adult patients include the Alcohol, Smoking, and Substance Involvement Screening Test and the CAGE Questions Adapted to Include Drugs Tool.

The Prescription Drug Monitoring Program (PDMP) can be combined with these screening tools to determine if a patient is at an elevated risk for a substance use disorder. It provides additional patient prescription information that can indicate if a patient is filling multiple opioid prescriptions, is going to multiple providers to obtain his/her prescription(s), and/or has been steadily increasing his/her use of medications to levels that would support elevated risk of development of substance use disorder.

Continued

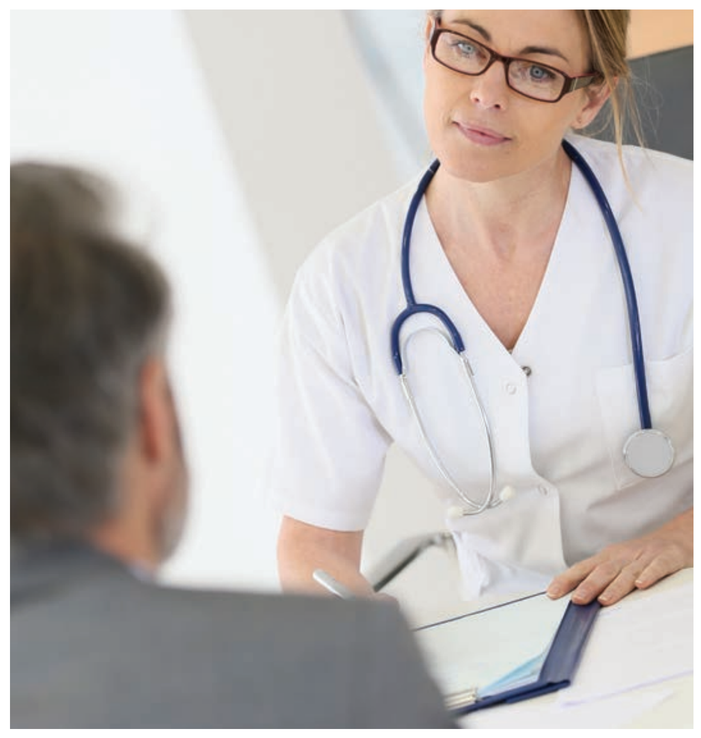
Brief Negotiated Interview

The brief negotiated interview is defined as a brief intervention model, based on motivational interviewing principles, and is a proven evidence-based practice that can be completed in five to 15 minutes. The following four steps address how to carry out a brief negotiated interview in clinical settings:

1. **Raise the subject and build rapport:** Begin by building a rapport through general conversation. Ask the patient permission to talk about drugs. Use open-ended questions for the patient to reflect on the pros/cons of his/her drug use. Allow reflection.
2. **Provide feedback:** Ask the patient for permission to relay information on drugs and to discuss the results of the screening. Discuss the findings and link findings to substance use behaviors and any known consequences. Use this feedback to enhance motivation and readiness to change.
3. **Build readiness to change:** Use the readiness to change scale, 0 being not at all ready to change and 10 being extremely ready to change, to support the patient in identifying and increasing the importance of making a behavior change. This can also be used to facilitate his/her confidence levels and readiness to make a change.

Not at all	0	1	2	3	4	5	6	7	8	9	10	Extremely

4. **Negotiate a plan for change:** Complete the brief negotiated interview by negotiating and advising a plan for change. The negotiation should include a plan for reducing use to low-risk levels and an agreement to follow-up with specialty treatment services.



Referral to Treatment

This is described as a proactive process that facilitates access to specialty substance use disorder treatment, including pharmacotherapies, for individuals with substance use disorders.

1. Understand that patients are more lost than the provider in trying to find their way around treatment services.
2. Become familiar with types of treatments and services and get to know local resources.
3. Abide by restrictive confidentiality and privacy rules; plan to maintain contact. (See Module 5 for more information on confidentiality considerations.)

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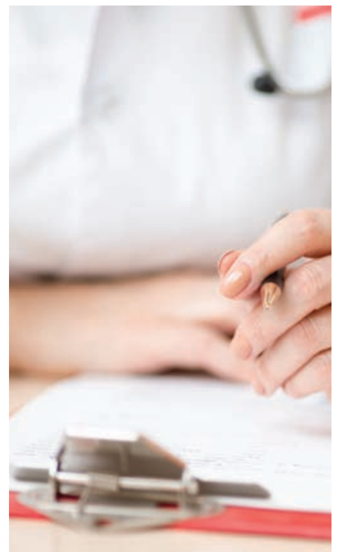

Pennsylvania Prescription Drug Monitoring Program (PDMP) System User and Stakeholder Training

Effective Opioid Tapering Practices

MODULE 7

GUIDE DOCUMENT

Pennsylvania Prescription Drug Monitoring Program (PDMP) System User and Stakeholder Training

Learning Objectives for Modules 1-7

Module 1: Why Using the PDMP is Important for Achieving Optimal Health for Pennsylvania Citizens

1. The status of substance use disorder in general, opioid use disorder and overdoses nationally and in Pennsylvania;
2. Common misconceptions about substance use disorder and opioid use disorder treatment and recovery;
3. Costs associated with prescription drug and heroin-associated opioid use disorder and overdose; and
4. How pervasive prescriber and pharmacist PDMP use can reduce population opioid use disorder and overdose.

Module 2: What is a PDMP, How to Use the PDMP to Make Clinical Decisions, How to Integrate the PDMP into the Clinical Workflow, and How to Access Pennsylvania's PDMP

1. Detail Pennsylvania's requirements and regulations regarding PDMP use;
2. Explore options and actions Pennsylvania prescribers and pharmacists can take to integrate the PDMP into clinical workflows; and
3. Discuss how to use the PDMP system to make clinical decisions.

Module 3: Using the PDMP to Optimize Pain Management

1. Learn how to use the PDMP to address pain management for various patient populations and pain types;
2. Understand the basic nature of pain for different patient populations and how to manage their pain using the PDMP as a clinical tool; and
3. Discuss different ways of treating patient pain that do not involve the immediate use of opioids.

Module 4: Opioid Prescribing Guide

1. Provide guidelines to inform all health care providers when prescribing opioids in the acute phase of pain;
2. Instruct healthcare providers on how to prescribe opioids in the chronic phase of pain, which includes information on how to initiate or continue opioid therapy, select the correct dose, and/or discontinue opioids;
3. Instruct healthcare providers on how to assess risks and address harms associated with opioid use;
4. Instruct healthcare providers on the legal responsibilities related to prescribing opioids; and
5. Instruct healthcare providers on how they may direct patients to dispose of unused medications.

Module 5: Referral to Treatment for Substance Use Disorder Related to Opioid Use

1. Define "warm handoffs" and how they can best occur;
2. Provide a schema for how any healthcare provider can implement "warm handoffs" in any clinical setting;
3. Demonstrate how primary care practices can conduct "warm handoffs" by preparing, using validated screening tools, and using patient-centered communication with patients;
4. Demonstrate how healthcare providers can determine the best type of treatment for their patients;
5. Present information on patient confidentiality that providers should be aware of when working with patients with substance use disorders and performing "warm handoffs"; and
6. Present relevant Pennsylvania links for treatment and other resources.

Module 6: Approaches to Addressing Substance Use Disorder with Patients Identified by the PDMP

1. Learn how to integrate the PDMP with other screening tools to help identify those who may require substance use disorder treatment or increased monitoring;
2. Define Screening, Brief Intervention, and Referral to Treatment (SBIRT), its main goals and its main components;
3. Learn how to screen a patient for a potential substance use disorder, conduct a brief intervention and refer a patient to treatment;
4. Learn how to discuss a substance use disorder with a patient and handle patient resistance; and
5. Learn how to incorporate SBIRT into clinical practice.

Module 7: Effective Opioid Tapering Practices

1. Discuss how to use the PDMP to determine if a provider should consider tapering his/her patient;
2. Discuss several indicators that prescribers can look for when considering tapering opioids;
3. Inform prescribers on how to discuss tapering with patients using patient-centered techniques;
4. Present a general opioid tapering protocol and how to adapt this protocol to the needs of any patient; and
5. Present information on how to manage withdrawal and how to use tools to measure withdrawal symptoms in patients.

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Introduction

This guide document discusses different opioid tapering strategies for prescribers who need to either taper a patient to a lower daily dosage or to discontinuation of opioid therapy.

Tapering opioids can be challenging for patients who have spent extended amounts of time on high dosages of opioid medications due to psychological and physiological dependence. The key goal is to taper slowly, which can mean just a slight incremental reduction in a daily dose per month if someone has been on higher doses of opioids chronically.[1] However, if the taper must be done more quickly, due to adverse effects or misuse, it can be performed over a two- to four-week period with the assistance and coordination of a substance use disorder health provider, if needed.[2]

The clinical decision-making process regarding tapering should be made on an individual basis, given that patients will present with varying responses to opioids and corresponding dosages. Involuntary tapers have the potential to harm patients and destabilize an otherwise stable patient.[3] If the provider believes that the risks of opioids (or opioids at a certain dose) are greater than the benefits, this concern should be discussed with the patient. Optimally, in this case, both provider and patient agree to reduce or eliminate opioids from the patient's pain regimen. Thus, the patient should be intimately involved in the tapering decision and process.[1,3] It may be that once a taper is initiated, the provider and/or the patient decide that tapering is causing more harm than good; reassessment of the goal of tapering should occur throughout the tapering process. Prescribers can use a Prescription Drug Monitoring Program (PDMP) query to assist in determining when a patient could or should be tapered to a lower opioid dosage or to discontinuation of opioid therapy.[1] Recommendations contained in this guide document are meant to guide practitioners and should be adjusted accordingly based on the patient's individual circumstances.

In this module, prescribers will learn how to effectively and safely taper any patient from opioid therapy. The module has the following objectives:

1. Discuss how to use the PDMP to determine if a provider should consider tapering his/her patient;
2. Discuss several indicators that prescribers can look for when considering tapering opioids;
3. Inform prescribers on how to discuss tapering with patients using patient-centered techniques;
4. Present a general opioid tapering protocol and how to adapt this protocol to the needs of any patient; and
5. Present information on how to manage withdrawal and how to use tools to measure withdrawal symptoms in patients.

Using the PDMP to Assess a Patient for Tapering

The PDMP can be a useful tool to help in the tapering process or when deciding whether or not to taper a patient.

For example, the PDMP can be used to engage the patient in a discussion about opioid dosage or to check for any concurrent interacting prescriptions, such as benzodiazepines, that can increase the risk of adverse opioid-related events. These PDMP checks can inform decisions about whether an opioid dose should be tapered or discontinued.[1,2]

The PDMP can also be used to provide evidence of several different types of opioid misuse by the patient. Aberrant behaviors such as obtaining opioid prescriptions from other prescribers and other behaviors that violate the patient-provider agreement can all be signs of potential opioid misuse or non-medical use of prescription opioids.[4,5] A PDMP query can also call attention to potential drug diversion by comparing the results of a urine drug test to the results of a PDMP query. If the prescribed drug(s) are not present in the urine drug test, and the test is appropriately interpreted, the prescriber should consider why - did the patient run out early, stopped taking the medication altogether or is he/she diverting the opioids? It is important to avoid assumptions based on PDMP data alone.[1,5] If necessary, the prescriber should use the results of the PDMP to talk to the patient about his/her opioid use. If the patient is assessed as having an opioid use disorder, the patient should be referred to appropriate substance use disorder treatment specialists.[1]

Indications for Tapering

In general, the most frequent indication for opioid tapering is lack of effectiveness of therapy, in which patients are not experiencing sustained improvements in pain and functioning.

It is important when initiating prescription opioids for chronic pain that appropriate expectations are instilled in the patient. For example, the provider should explain that opioids may not be effective in the long run and may need to be discontinued in the future. When tapering a patient to a lower dose or to discontinuation of opioid therapy, there is no validated, standardized approach, but there are best practices. These recommendations for when to begin an opioid taper are based on the Centers for Disease Control and Prevention opioid prescribing guidelines.[1]

Criteria for Identifying Patients Who Should Discontinue or Taper Opioid Treatment to a Lower Dosage[1,2,3,6,7]

1. There is a lack of clinically meaningful improvement in pain or function. The patient is demonstrating functional impairment or an inability to achieve or maintain the anticipated pain relief, even as the dose of opioids is increased. (See Module 4 for information on how to assess and reassess pain levels using the Pain, Enjoyment and General Activity Scale.)
2. The adverse effects brought on by opioid therapy are intolerable at the minimum dosage that relieves pain. (See Appendix for Clinical and Subjective Opiate Withdrawal Scales.)
3. The patient breaks aspects of the patient-provider agreement he/she signed before beginning treatment and affirmed during the course of treatment.
4. There are concerns about opioid use disorder or opioid misuse.
5. Physical and emotional deterioration can be attributed to opioid therapy.
6. The patient is no longer in pain or the issue that caused the original pain episode requiring opioids has resolved itself.

How to Discuss Tapering with Patients

In general, patient-centered techniques, such as motivational interviewing, should be used to regularly discuss the patient's opioid taper to decrease the risk that the patient will discontinue the taper.[2,5,8]

As noted, setting appropriate expectations at the beginning of opioid treatment is critical. Tapering can create a patient-provider relationship that is difficult to manage, since patients may report worsening pain and blame the provider for causing them to suffer. Patients may even become hostile toward the provider due to a physiological or psychological need or want to continue opioid therapy. Therefore, the discussion regarding tapering is vital to its success and can provide information regarding a potential need for referral to substance use disorder treatment. (See Module 5 for information on patient-centered communication techniques and referral to treatment.)[1]

The conversation should begin by discussing the rationale for why the patient is at risk for opioid-related harm. The provider should help the patient understand that opioids are not the only method to treat the patient's pain and the complexities of chronic pain.[5] If it is clear that opioids need to be discontinued for any given reason, such as known illegal activity by the patient, the prescriber should focus the conversation on helping the patient manage without opioids. The prescriber should also safely taper the patient off the current opioids and consider non-opioid options or medication assisted treatment options if indicated. Due to the fact that motivational conversations are usually part of an ongoing relationship, it is important to remember that they should not be accusatory or judgmental, but rather supportive and clinically oriented. These conversations should begin early, as concerns develop, rather than waiting until there is a concern that a full substance use disorder has emerged.

When the indication to taper or discontinue opioids is based on clinical judgement, the prescriber should consider saying:

"It is my medical opinion, as your physician (or health care provider), that the risks of prescribing opioids are greater than the benefits you are receiving with them. I would like to talk to you about this opinion, and get your thoughts and feedback. You have to understand that I am trying to provide you the best care possible. Here are the reasons why I think we should taper your opioids: **(list reasons)**.

In reaching this conclusion, I also considered your condition and these factors: **(list any PDMP findings, lab results, etc.)** I know this is a lot to consider; however, I would like your opinion on this so that we can come to a mutually agreeable plan of action."

(Obtain patient opinion.)

"You should be aware that if we do agree to taper, I will not abandon you, and during any tapering process, we will constantly reassess the decision to taper your opioids."

Continued

How to Discuss Tapering with Patients *(continued)*

During the conversation, the prescriber may need to "agree to disagree" with the patient. Always emphasize the difference between discontinuing opioid therapy and abandoning the patient. The patient may still require medical attention, even if he/she needs to be tapered or discontinued off of opioids, so the provider should not make the patient feel as though he/she will go medically untreated. Several objections should be expected when discussing opioid tapering or discontinuation with the patient:[9]

"I really need the opioids, doc."

"Don't you trust me?"

"I thought we had a good relationship!"

"I thought you cared about me."

"If you don't prescribe opioids to me,
I will do drugs, drink, or hurt myself."

"Can you just give me enough until I can
find a new doctor?"

These objections should be met with an empathetic review of the benefits and risks associated with opioid therapy to effectively manage the situation. If necessary, the prescriber should contact a pain specialist to assist with the taper.[1,3] Conversations with the patient about tapering can be difficult, and providers all want their patients to be pleased with the care provided. It is very reasonable for providers to feel uncomfortable in these situations, and it may help to let the patient know this, by saying:

"I understand that this medication has been an important tool for your pain management. As part of tapering, we are going to increase the use of other pain management techniques to help offset any change in pain levels."

"I wish that I did not have to taper you, and I don't want you to be unhappy, but it really is the best thing to do for the management of your chronic pain. I will continue to take care of your health in the best way I can."

Providers may want to broaden the discussion as well. For example, if the patient is claiming that he/she has not been responding to continued opioids, sometimes the cause is the development of tolerance or opioid induced hyperalgesia (an intensifying of pain caused by the use of opioids). For these reasons, reduction of opioids can actually reduce the experience of pain.

Opioid Tapering Protocol

The prescriber should carefully monitor and individualize the tapering protocol used for each patient to minimize increases in pain symptoms and signs of withdrawal.[1] If the tapering process is doing more harm than good, the entire tapering plan should be re-examined. The speed of the taper depends on: (1) how long the patient has been prescribed opioids; (2) his/her current dosage level; (3) the type of opioid formulation; and (4) the patient's medical history, including any present psychiatric conditions or substance use disorders.[1,2]

The Department of Veterans Affairs opioid prescribing guidelines recommend slowly reducing the original weekly dosage of opioid prescriptions by 5-20 percent every four weeks over months or even years when tapering.[2] Gradual tapers that allow for neurobiological, psychological and behavioral adaptations to take place are generally more tolerable for the patient.[2] Patients should receive psychosocial support from the prescriber or be referred to a mental health provider, as well as alternative pain treatments, when necessary. (See Module 3 for more details on alternative pain treatments.) If the prescriber is not familiar with tapering, the patient requires a more rapid taper, or if the patient has failed a previous taper, the prescriber should consider consulting a pain specialist or an appropriate substance use disorder treatment expert to reduce the possibility of adverse events.[1,2] However, it is unlikely that the opioid prescriber will find another provider to do the tapering, and thus it behooves the opioid prescriber to have the skills for tapering.

In some circumstances, a more rapid taper or abrupt discontinuation of opioid therapy may be justified. If there is evidence of diversion or if a patient exhibits extreme aberrant behaviors (e.g., threatening behaviors), the prescriber may consider an abrupt discontinuation of opioid therapy. In these situations, the prescriber should immediately provide an emergent psychiatric referral and medical care to manage the symptoms of opioid withdrawal. Non-opioid methods of pain management should be applied to the patient's treatment plan with careful documentation in the patient's medical records as to why discontinuation was necessary.[2]

The following general approach can be used when either tapering a patient to discontinuation or to a lower opioid dosage. In the absence of validated protocols, these recommendations are based on the Centers for Disease Control and Prevention, Department of Veterans Affairs and Washington State Interagency evidence-based opioid prescribing guidelines, as well as the most recently published literature on tapering opioids. They should be used as a guide and adjusted on a patient-by-patient basis.[1,2,3,5,6,10]

Before the Taper

Educate and assess the patient for related risk(s).

1. Discuss the patient's opioid use with proven patient-centered techniques, such as motivational interviewing.
2. Conduct a biopsychosocial assessment to evaluate patients. Assess patients for risks and benefits associated with continued opioid therapy versus tapering to a lower dose or to discontinuation.
3. Communicate with patients regularly throughout the tapering process to ensure that they do not feel abandoned and that non-opioid methods of pain management will be continuously added to the patient's pain management plan.
4. Educate patients and their families on the taper process and provide them with both written and verbal instructions of the taper protocol. Discuss the possibility of the formation of symptoms of withdrawal during the taper and provide patients with strategies to manage those symptoms.
5. Educate patients about overdose and offer naloxone to patients who are at risk for overdose, including those who are already in the process of tapering. The Department of Veterans Affairs guidelines recommend that prescribers strongly caution patients to abide by the taper plan by making patients aware that it takes as little as a week to lose tolerance to their prior dose and that they are at risk of overdose if they resume the prior dose at some point before the completion of the taper.[2]

Continued

Tapering Protocol *(continued)*

Begin the Taper Process

Calculate and determine the rate and speed of the taper.

6. Find a balance for each patient and adjust the speed of the taper accordingly, depending on the level of concern. The rate of the taper will depend on the opioid dose, duration of therapy, type of opioid formulation, and any psychiatric, medical or substance use disorder comorbidities.
7. Use the PDMP to determine the patient's current dosage of instant-release and/or extended-release opioids. Use an online morphine milligram equivalent calculator that can assist in the calculation of morphine milligram equivalent values. Also, the PDMP system calculates the average active daily MME as part of the patient report summary. If the patient is currently on both formulations of an opioid (instant-release and extended-release), the prescriber should consider which formulation to taper first on an individual basis. Consider tapering both simultaneously after assessing the risks and benefits related to the patient
8. Slow the pace of the taper during periods of intense stress or if withdrawal symptoms appear. Pauses for weeks or even months allow patients time to acquire new pain management skills and/or learn how to manage their emotions. This can also allow time for neurobiological equilibration that limits symptoms of withdrawal. Managing the taper this way can keep the patient on track and make him/her less likely to drop out of the taper.

Reassess the Patient

Follow up with patient and reassess him/her for related risk(s).

Symptoms of opioid use disorder may present themselves in the patient that were not present before the taper. Constantly be aware of signs of any substance use disorder throughout the taper and refer to treatment, if necessary. Patients on long-term opioid therapy with a diagnosed substance use disorder may require a medically-assisted taper with methadone or buprenorphine/naloxone. A primary or specialty care office can complete a medically-assisted taper if properly equipped with the necessary resources and provider education. Physicians are referred to the Substance Abuse and Mental Health Services Administration website[**] for more information on buprenorphine and medically assisted treatment. Slowing the taper may be considered until a "warm handoff" to substance use disorder treatment can be completed. (See Module 5 for information of "warm handoffs" and referral to treatment.)

9. Reevaluate the risks and benefits of the taper periodically and conduct further biopsychosocial assessments during follow-up appointments. The frequency of follow-up appointments should be individualized on a patient-by-patient basis, depending on the risk assessment performed by the health care team. Generally, follow-up should occur one week to one month after any opioid dosage change and should be used as an opportunity to further educate the patient on the risks associated with opioid therapy. At follow-up visits, continue to check the PDMP to ensure patients are not receiving opioids from another source and/or check for evidence that may suggest aberrant behavior.
10. Treat withdrawal symptoms accordingly using alpha-adrenergic agonists, such as clonidine 0.1-0.2 mg two or three times daily, and monitor the patient for significant hypertension and anticholinergic side effects.
11. Increase use of alternative pain treatment methods for the increased pain caused by short-term withdrawal symptoms. Acetaminophen and nonsteroidal anti-inflammatory drugs are often a part of taper protocols. Other multimodal pain management methods should be used throughout the taper, such as cognitive behavioral therapy, exercise and interdisciplinary physical therapy. Underlying mental health conditions may be exacerbated by the taper process and mental health professionals should become involved in the taper when deemed appropriate by the prescriber. (See Module 5 for information on referrals.)
12. Monitor special patient populations, such as pregnant women, individuals with substance use or mental health disorders and individuals concurrently prescribed other medications more carefully.

Meet the Goal of the Taper

Taper the patient to a lower dose or discontinuation.

13. Consider a taper successful if the patient is making progress and decreasing from the original dosage. The opioid can be discontinued when taken less than once a day or continued when the goal decreased daily dosage has been reached.
14. Following discontinuation of opioids, consider continuing risk mitigation strategies, since tapering may expose a substance use disorder. If the patient was tapered to a lower dosage, continue assessing the patient for risks and benefits of continued opioid therapy.

[*] https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

[**] https://www.samhsa.gov/

Managing Physical Withdrawal

Symptoms of withdrawal usually present themselves two to three half-lives after the last dose of an opioid. Symptoms include anxiety, restlessness, tremor, diaphoresis, mydriasis, piloerection, hypertension, tachycardia, nausea, diarrhea, abdominal cramping, anorexia, dizziness, hot flashes, shivering, myalgia or arthralgia, rhinorrhea, dysphoria and insomnia.[3,11]

Withdrawal symptoms will commonly make a patient more reluctant to continue the taper. Symptoms can be treated using alpha-adrenergic agonists, such as clonidine and tizanidine, which reduce the sympathetic activity stimulated by the decreased sympathetic antagonism from the opioids, and therapy to address gastrointestinal symptoms, including diarrhea (e.g., small doses of loperamide).[3,12] Other medications that can be used to treat withdrawal include lomotil, Motrin, trazadone and combined buprenorphine/naloxone therapy. For more information on medications used for withdrawal management, see Washington State Interagency Guidelines on Prescribing Opioids for Pain[*].

Prescribers should use tools to measure withdrawal symptoms in their patients, such as the Subjective Opiate Withdrawal Scale (see Appendix I) or the Clinical Opiate Withdrawal Scale (see Appendix II) to assist in the risk/benefit determination process.[3,13,14] Additionally, there are often significant psychological withdrawal symptoms, such as craving, anxiety and dysphoria, that typically occur prior to any physical withdrawal symptoms. These symptoms may be evidence of psychological dependence on opioids that may not have been evident beforehand. Prescribers should closely monitor patients for signs of anxiety, psychiatric disorders like depression, and opioid use disorder that can be brought on by the taper.[1,3] Prescribers should work with pain specialists to assist with the patient's pain management and refer the patient to psychological, psychiatric and substance use disorder treatment experts, if necessary.[15] Prescribers should note that a successful taper is also one that minimizes the symptoms of withdrawal.

[*] http://www.agencymeddirectors.wa.gov/guidelines.asp

Sources

1) Dowell D, Haegerich T, Chou R. CDC guideline for prescribing opioids for chronic pain. *JAMA*. 2016;315(15):1624-1645.

2) Department of Veterans Affairs, Department of Defense. *Clinical Practice Guideline for Opioid Therapy for Chronic Pain.* 2016.

3) Berna C, Kulich R, Rathmell J. Tapering Long-term Opioid Therapy in Chronic Noncancer Pain: Evidence and Recommendations for Everyday Practice. *Mayo Clinic Proceedings.* 2015;90(6):828-842.

4) Cochran GL, Klepser DG, Morien M, Lander L. Health Information Exchange to Support a Prescription Drug Monitoring Program. *Innovations in Pharmacy.* 2015;6(1).

5) Washington State Agency Medical Directors' Group. *AMDG 2015 Intergency Guideline on Prescribing Opioids for Pain.* Olympia, WA: Washington State Agency Medical Directors' Group;2015.

6) Kral L, Jackson K, Uritsky T. A practical guide to tapering opioids. *Mental Health Clinician.* 2015;5(3):102-108.

7) Substance Abuse and Mental Health Service Administration. *TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders.* Rockville, MD,2012.

8) Elwyn G, Dehlendorf C, Epstein R, Marrin K, White J, Frosch D. Shared decision making and motivational interviewing: achieving patient-centered care across the spectrum of health care problems. *The Annals of Family Medicine,.* 2014;12(3):270-275.

9) Boston Medical Center- General Internal Medicine. How to Discuss Stopping Opioid Therapy with the Patient. 2017.

10) Fishbain D, Rosomoff H, Cutler R, Rosomoff R. Opiate detoxification protocols: a clinical manual. *Annals of Clinical Psychiatry.* 1993;5(1):53-65.

11) Farrell M. Opiate withdrawal. *Addiction.* 1994;89(11):1471-1475.

12) Gowing L, Farrell M, Ali R, White J. Alpha2-adrenergic agonists for the management of opioid withdrawal. *Cochrane Database of Systematic Reviews.* 2009;15(2).

13) Handelsman L, Cochrane K, Aronson M, Ness R, Rubinstein K, Kanof P. Two new rating scales for opiate withdrawal. *American Journal of Drug and Alcohol Abuse.* 1987;13(3):293-308.

14) Wesson D, Ling W. The clinical opiate withdrawal scale (COWS). *Journal of Psychoactive Drugs.* 2003;35(2):293-308.

15) Pennsylvania Medical Society, Pennsylvania Department of Health. *Pennsylvania Guidelines on the Use of Opioids to Treat Chronic Noncancer Pain.* 2014.

Appendix I: Subjective Opiate Withdrawal Scale

Subjective Opiate Withdrawal Scale. Reprinted from *J Drug Alcohol Abuse*[13]

Score: 4-22=mild; 23-44=moderate; 45-64=high

Subjective Opiate Withdrawal Scale (SOWS)							
In the column below, write today's date and time, and in the column underneath, write in a number from 0-4 corresponding to how you feel about each symptom: RIGHT NOW. Scale: 0 = Not at all; 1 = A little; 2 = Moderately; 3 = Quite a bit; 4 = Extremely							
Date							
Time							
	Symptom	**Score**	**Score**	**Score**	**Score**	**Score**	**Score**
1	I feel anxious.						
2	I feel like yawning.						
3	I am perspiring.						
4	My eyes are teary.						
5	My nose is running.						
6	I have goosebumps.						
7	I am shaking.						
8	I have hot flushes.						
9	I have cold flushes.						
10	My bones and muscles.						
11	I feel restless.						
12	I feel nauseous.						
13	I feel like vomiting.						
14	My muscles twitch.						
15	I have stomach cramps.						
16	I feel like using now.						
	TOTAL						

Appendix II: Clinical Opiate Withdrawal Scale

Clinical Opiate Withdrawal Scale. Reprinted from *J Psychoactive Drugs*[14]

Score: 5-12=mild; 13-24=moderate; 25-36=moderately severe; more than 36=severe withdrawal

Clinical Opiate Withdrawal Scale (COWS)	
For each item, circle the number that best describes the patient's signs or symptoms. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase in pulse rate would not add to the score.	
Patient's Name: ___________________ Date and Time: ____/____ /_____	
Reason for this assessment:____	
Resting Pulse Rate:_________beats/minute *Measured after patient is sitting or lying for one minute.* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**Gastrointestinal Upset:** *Over last ½ hour.* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *Over past ½ hour not accounted for by room temperature or by activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor:** *Observation of outstretched hands.* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness: *Observation during assessment.* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment.* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil Size: 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint Aches: *If patient was having pain previously, only the additional component attributed to opiate withdrawal is scored:* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit	**Gooseflesh Skin (piloerection)** 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection
Runny nose or tearing: *Not accounted for by cold symptoms or allergies.* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	**Total Score** _________ The total score is the sum of all 11 items Initials of person completing assessment: ______________

Opioid Tapering

MODULE **7**

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BEFORE

- Consider opioid tapering if the risks of continuing opioid therapy outweigh the benefits, there is physical or emotional deterioration, the patient breaks the patient-provider agreement, there is a lack of clinically meaningful improvement in pain and function, intolerable adverse effects exist, or the patient is no longer in pain.
- Check the Prescription Drug Monitoring Program (PDMP) to determine if there are any potentially dangerous drug-drug interactions (e.g., opioids and benzodiazepines) present or signs of aberrant behavior (e.g., filling multiple prescriptions by multiple providers) to inform decisions about potential tapering.

1

- Discuss the patient's opioid use with proven patient-centered communication techniques, such as motivational interviewing.
- Help the patient understand the risks and harms associated with long-term opioid use.
- Review the risks and benefits of alternate pain management methods, such as those noted below.

2

- **Start slow:** Decrease dosage at an appropriate speed for the patient, as determined by your risk assessment.
- The rate of the taper will depend on the opioid dose, duration of therapy, type of opioid formulation and any psychiatric, medical or substance use disorder comorbidities.
- Tapering of the opioid medication may take months.

3

- Conduct continual patient risk assessments until the goal of the taper is reached.
- Tapering should be individualized to the patient. It can be slowed or paused if necessary, but not reversed.

4

- Treat withdrawal symptoms by prescribing alpha-adrenergic agonists, such as clonidine or tizanidine, two or three times daily to control withdrawal symptoms and other medications like small doses of loperamide to treat diarrhea.
- Use alternative pain methods to help the patient cope with the symptoms of withdrawal and manage the change in opiates, such as acetaminophen, nonsteroidal anti-inflammatory drugs, topical therapies like diclofenac gel or lidocaine patches, and non-pharmacologic therapy.

5

- The taper is considered successful as long as the patient is making progress and decreasing from the original dosage.
- The opioid may be discontinued when taken less frequently than once a day.

Sources

1) Dowell, D., Haegerich, T. M., & Chou, R. (2016). CDC guideline for prescribing opioids for chronic pain. *JAMA*. 2016. 315(15), 1624-1645.
2) Berna, C., Kulich, R., & Rathmell, J. (2015). Tapering Long-term Opioid Therapy in Chronic Noncancer Pain: Evidence and Recommendations for Everyday Practice. *Mayo Clinic Proceedings*. 2015. 90(6), 828-842.
3) CDC. Fact Sheet: Calculating Total Daily Dose of Opioids for Safer Dosage. https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf. Accessed April 28, 2017.
4) Substance Abuse and Mental Health Services Administration. Enhancing Motivation for Change in Substance Abuse Treatment. https://www.ncbi.nlm.nih.gov/books/NBK64967/