Treatment of Behavioral Health and Substance Use Disorders and Legal Concerns June 1, 2017

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Learning Objectives

- Describe common behavioral health terminology
- Identify tools for assessments of behavioral health and substance use
- Recognize legal issues related to behavioral health and substance use screening, assessment, and treatment
- Recognize how to apply the confidentiality protection for substance use treatment in an electronic health record

Learning Objectives

- Identify adverse events that may occur during opioid treatment
- Recognize the issues surrounding opioid treatment, monitoring, and controlled substance agreements
- Describe the risk factors associated with opioid use
- Apply comprehensive assessment strategies for chronic pain

Eye Opening

- **In 2014, an estimated 43.6 million Americans age 18 or older (18.1%) experienced some form of mental illness**
- **During the same year, 20.2 million adults (8.4%) had a substance use disorder. Of these, 7.9 million had both a mental disorder and a substance use disorder, also known as co-occurring mental and substance use disorders**
- **Mental disorders cost more than $200 billion a year in the United States, topping the list of the most costly conditions, according to an estimate of annual health spending for a variety of common medical conditions**

Source: Roehrig C. Mental disorders top the list of the most costly conditions in the United States: $201 billion. Health Aff 2016 Jun 1;35(6):1130-5. http://content.healthaffairs.org/content/35/6/1130.full?sid=8d428019-3a1e-42b0-815e-e0d3d48274e3; HRSA Substance Abuse and Mental Health Services Administration (SAMHSA). Behavioral health trends in the United States: results from the 2014 National Survey on Drug Use and Health. www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf

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Terminology

- **Mental illness—A medical condition impacting an individual's thinking, emotions, mood, ability to relate to others, and daily functioning, resulting in an inability to cope with life's ordinary demands and routines**

Sources: National Alliance on Mental Illness. Mental health conditions. https://www.nami.org/Learn-More/Mental-Health-Conditions; American Psychiatric Association (APA). Diagnostic and statistical manual of mental disorders (DSM-5). Arlington (VA): APA; 2013.

Terminology

- **Mental disorder—A psychological syndrome or pattern that is associated with distress (e.g., via a painful symptom), disability (impairment in one or more important areas of functioning), or increased risk of death or that causes a significant loss of autonomy**
  - However, mental disorders exclude responses such as grief from loss of a loved one as well as deviant behavior for political, religious, or societal reasons not arising from a dysfunction in the individual

Sources: National Alliance on Mental Illness. Mental health conditions. https://www.nami.org/Learn-More/Mental-Health-Conditions; American Psychiatric Association (APA). Diagnostic and statistical manual of mental disorders (DSM-5). Arlington (VA): APA; 2013.

Terminology

- **Substance use disorder—Occurs when the recurrent use of alcohol or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home**
- **Co-occurring disorders—Occur when an individual has one or more substance use disorder and one or more mental illness or mental disorder at the same time ("dual diagnosis" is an older term for "co-occurring disorders")**

Sources: HRSA Substance Abuse and Mental Health Services Administration (SAMHSA). General principles for the use of pharmacological agents to treat individuals with co-occurring mental and substance use disorders. 2012. www.samhsa.gov/sites/default/files/topics/mental_substance_disorders/pharmacologic-principles.pdf; SAMHSA-HRSA Center for Integrated Health Solutions. Glossary. www.integration.samhsa.gov/glossary

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Terminology

- **Warm handoff—Occurs when the primary care provider (PCP) initiates a face-to-face introduction between the patient and behavioral health provider during the patient's visit**

Sources: HRSA Substance Abuse and Mental Health Services Administration (SAMHSA). General principles for the use of pharmacological agents to treat individuals with co-occurring mental and substance use disorders. 2012. www.samhsa.gov/sites/default/files/topics/mental_substance_disorders/pharmacologic-principles.pdf; SAMHSA-HRSA Center for Integrated Health Solutions. Glossary. www.integration.samhsa.gov/glossary

By the Numbers: Top 10 Medical Conditions for Estimated Spending in the U.S. in 2013

1. **Mental disorders**
2. **Heart conditions**
3. **Trauma**
4. **Cancer**
5. **Pulmonary conditions**
6. **Osteoarthritis**
7. **Normal birth**
8. **Diabetes**
9. **Kidney disease**
10. **Hypertension**

Source: Roehrig C. Mental disorders top the list of the most costly conditions in the United States: $201 billion. Health Aff 2016 Jun 1;35(6):1130-5.
http://content.healthaffairs.org/content/35/6/1130.full?sid=8d428019-3a1e-42b0-815e-e0d3d48274e3

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Primary Care Usage: Selected Mental Health and Substance Use Conditions in Health Centers

		FTEs (a)	Clinic visits (b)	No. of patients (c)
20a	Psychiatrists	590.94	1,458,241	
20a1	Licensed clinical psychologists	707.52	733,872	
20a2	Licensed clinical social workers	2,623.22	2,334,711	
20b	Other licensed mental healthcare providers	1,889.73	1,774,940	
20c	Other mental health staff	1,969.35	949,731	
20	Total mental health services (sum lines 20a-20c)	7,780.76	7,251,495	1,491,926
21	Substance abuse services	959.63	1,038,230	117,043
22	Other professional services	1,301.24	1,643,717	584,902

Source: Bureau of Primary Health Care. 2015 health center data. https://bphc.hrsa.gov/uds/datacenter.aspx
FTE = full-time equivalent

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Integrating Treatment for Behavioral Health and Substance Use Disorders into Primary Care

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What Is Behavioral Health Integration?

Behavioral health integration is the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Source: Peek CJ, National Integration Academy Council. Lexicon for behavioral health and primary care integration: concepts and definitions developed by expert consensus. AHRQ publication no.13-ip001-ef. Rockville (MD): Agency for Healthcare Research and Quality; 2013. http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf

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Behavioral Health Services Integrated in Primary Care

- **A fully integrated behavioral health model includes resources for a number of services required by those with mental health conditions:**
  - Universal screening for behavioral health issues (including substance and alcohol use disorders, depression, and other mental health conditions)
  - Self-management support and brief interventions by a behaviorist
  - Treatment of the behavioral health condition by the care team
  - Appropriate referral for treatment to a psychologist or psychiatrist, as warranted

Source: HRSA Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Integrated Health Solutions. The business case for behavioral health care. 2013. www.integration.samhsa.gov/integrated-care-models/The_Business_Case_for_Behavioral_Health_Care_Monograph.pdf

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AHRQ Playbook for Integration: Key Components

- **Plan for integration**
  - Define vision and game plan
- **Implement plan**
  - Establish operating systems
  - Secure financial support
  - Collect and use data
- **Educate patients and families**
  - Obtain expertise
  - Establish protocols
- **Track and monitor patients and outcomes**
- **Review observations from exemplary sites**
  - A Guidebook of Professional Practice for Behavioral Health and Primary Care Integration

Source: AHRQ. Integration playbook. http://integrationacademy.ahrq.gov/playbook/about-playbook

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Rationale for Integrating Behavioral Health and Substance Use Services into Primary Health Care

1. Reduced stigma for people with behavioral health/substance use disorders and their families
2. Improved access to care
3. Reduced comorbidities
4. Improved prevention and detection of substance use disorders
5. Better treatment and follow-up with specialists
6. Better physical accessibility
7. Better financial accessibility
8. Better acceptability
9. Improved social integration
10. Better health outcomes for people treated in primary health care
11. Improved human resource capacity for mental health

Source: World Health Organization (WHO). The WHO MIND Project: Mental Health in Development. Integrating mental health services into primary health care. http://www.who.int/mental_health/policy/services/3_MHintoPHC_Infosheet.pdf

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Group Discussion: Integrating Behavioral Health

- Is treatment for behavioral health or substance use disorders in your health center's current scope of services?
- What does integrating behavioral health and substance use services into primary care (for new or expanded services) mean for patients and providers?
- What are the barriers to integration?
- How do you know if you've succeeded?

Source: AHRQ. Integration playbook. http://integrationacademy.ahrq.gov/playbook/about-playbook

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Clinical Management of Behavioral Health and Substance Use Issues

Behavioral Health Providers: Key Strategies

What can behavioral health providers do to protect themselves and thereby protect their patients?

- Use informed consent procedures to make patients aware of the limitations of confidentiality
- Keep up to date on education and professional development activities related to suicide, crisis intervention, and ethical/legal issues in counseling

Source: Laux JM. A primer on suicidology: implications for counselors. J Couns Dev 2002;80(3):380-3.

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What Is Informed Consent?

- **Informed consent is the process by which the treating health care provider discloses appropriate information to a competent patient, so that the patient may make a voluntary choice to accept or refuse treatment**

Source: Appelbaum PS. Assessment of patients' competence to consent to treatment. N Engl J Med 2007;357(18):1834-40. http://www.nejm.org/doi/full/10.1056/NEJMcp074045 PubMed: https://www.ncbi.nlm.nih.gov/pubmed/17978292

Clinical Suggestions for Management of Behavioral Health Issues

- Be aware of signs and symptoms of behavioral health problems and conduct a thorough assessment
- Use assessment and screening tools for drug and alcohol use disorders/withdrawal, depression, and suicide
- Use medication protocols for substance use or psychiatric diagnoses
- Conduct warm handoffs and provide a thorough review of the patient's history to other treatment providers
- Consider telepsychiatry for behavioral health consults
- Maintain access to substance use health professionals (University of California, San Francisco): http://www.nccc.ucsf.edu/clinician-consultation/substance-use-management/

Patient Suicide Risk

- Be aware of risk factors for suicide, assessment procedures, and guidelines for intervention
- Appropriately document identified risk factors, assessment procedures, and interventions implemented
- Consult with other behavioral health professionals when assessing for suicide risk and determining appropriate interventions—it is important to reach a consensus and solicit advice when making decisions

Sources: Brems C. Dealing with challenges in psychotherapy and counseling. Belmont (CA): Brooks/Cole; 2000. Remley TP Jr, Herlihy B. Ethical, legal, and professional issues in counseling. Upper Saddle River (NJ): Prentice Hall; 2001.

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Suicide Risk: To Tell or Not to Tell?

- **Best interest of patient or best practice?**
- **When a patient is suicidal or has suicidal thinking and tells you so, at what point does your risk increase?**

Treating Substance Use Disorders

Question:

- **What risks and liabilities are associated with treatment for substance use disorders in the primary care setting?**

Treating Substance Use Disorders

Answer:

- **Over- or undertreatment of pain**
- **Suicide**
- **Overdose**
- **Misuse**

SBIRT (Screening, Brief Intervention, Referral to Treatment)

- Screening—Quickly assesses the severity of substance use and identifies the appropriate level of treatment
- Brief intervention—Focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change
- Referral to treatment—Provides those identified as needing more extensive treatment with access to specialty care
- Primary care centers, hospital emergency departments, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur

Source: HRSA Substance Abuse and Mental Health Services Administration (SAMHSA). About SBIRT 2015 Jun 4. https://www.samhsa.gov/sbirt/about

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Medication-Assisted Treatment (MAT)

- **MAT is the use of medications in conjunction with counseling and behavioral therapies to treat substance use disorders and prevent opioid overdose**
  - Methadone, buprenorphine, and naltrexone are used to treat opioid dependence
  - Naloxone prevents an opioid overdose
  - Disulfiram, acamprosate, and naltrexone are the drugs most commonly used to treat alcohol use disorder

- **Patients must receive medical, counseling, vocational, educational, and other assessment and treatment services, in addition to prescribed medication**

Resources for MAT

- For information on buprenorphine treatment, contact the SAMHSA Center for Substance Abuse Treatment (CSAT) at 866-BUP-CSAT (866-287-2728) or infobuprenorphine@samhsa.hhs.gov
- For information about other types of MAT or the certification of opioid treatment programs (OTPs), contact the SAMHSA Division of Pharmacologic Therapies at 240-276-2700 or otp-extranet@opioid.samhsa.gov
- Contact SAMHSA's regional OTP compliance officers at https://www.samhsa.gov/medication-assisted-treatment/opioid-treatment-programs/compliance-officers to determine whether an OTP is qualified to provide treatment for substance use disorders
- Medication for the Treatment of Alcohol Use Disorder: A Brief Guide. http://store.samhsa.gov/shin/content/SMA15-4907/SMA15-4907.pdf

Confidentiality Regulations

- The U.S. Department of Health and Human Services finalized changes to the Confidentiality of Alcohol and Drug Abuse Patient Records regulations (42 CFR part 2)
- Changes facilitate health integration and information exchange within new health care models while continuing to protect the privacy and confidentiality of patients seeking treatment for substance use disorders

❖See *Federal Register,* January 18, 2017; effective February 17, 2017
https://www.federalregister.gov/documents/2017/01/18/2017-00719/confidentiality-of-substance-use-disorder-patient-records

Resources for Behavioral Health Screening/Assessment in Primary Care

- Depression screening tool: www.aafp.org/afp/2008/0715/p244.html
- Resources for assessing and treating patients at risk for suicide: http://www.sprc.org/comprehensive-approach/identify-assist
- Substance use screening tools for adolescent patients: www.ncbi.nlm.nih.gov/pmc/articles/PMC3623552/
- Single-question screening test for alcohol use disorder: www.ncbi.nlm.nih.gov/pmc/articles/PMC2695521
- Behavioral health screening at well child visits: www.ncbi.nlm.nih.gov/pubmed/24247911

Resources for Substance Use Screening Tools

- SAMHSA (Substance Abuse and Mental Health Services Administration). SBIRT (Screening, Brief Intervention, and Referral to Treatment). www.integration.samhsa.gov/clinical-practice/sbirt
- National Institute on Drug Abuse. Chart of evidence-based screening tools for adults and adolescents. www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/screening-assessment-drug-testing-resources/chart-evidence-based-screening-tools-adults
- American Society of Addiction Medicine (ASAM). Screening tools. www.asam.org/for-the-public/screening-and-assessment

Prescribing Opioids

Prescribing Opioids for Chronic Pain

Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose from these drugs

Centers for Disease Control and Prevention. Guideline for prescribing opioids for chronic pain. 2017 Mar 15. https://www.cdc.gov/drugoverdose/prescribing/guideline.html

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Prescription Opioid Misuse

- **From 1999 to 2015, the number of opioid prescriptions sold in the U.S. quadrupled (CDC)**
- **Annual health-care-related costs for prescription opioid abuse exceed $72 billion (Florence et al.)**
- **Emergency department visits related to opioid use rose more than 99% over a 9-year period (AHRQ)**
  - 89.1 per 100,000 people in 2005 to 177.7 per 100,000 people in 2014
- **Hospital admissions related to opioid use rose 64% (AHRQ)**
  - 137 per 100,000 people in 2005 to 225 per 100,000 people in 2014

Sources: Weiss et al. Opioid-related inpatient stays and emergency department visits by state, 2009-2014. AHRQ Healthcare Cost and Utilization Project. Statistical brief #219. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb219-Opioid-Hospital-Stays-ED-Visits-by-State.jsp; CDC. Wide-ranging online data for epidemiologic research (WONDER). Atlanta (GA): CDC, National Center for Health Statistics; 2016. http://wonder.cdc.gov; Florence et al. The economic burden of prescription opioid overdose, abuse, and dependence in the United States, 2013. Medical Care 2016 Oct;54(10):901-6.

Fatalities Associated with Opioid Pain Relievers

- **Persons in the United States consume opioid pain relievers (OPRs) at a greater rate than any other nation**
- **Overprescribing of OPRs can result in multiple adverse health outcomes, including fatal overdoses**
- **In 2014, opioids (including heroin) were implicated in more than 28,000 overdose deaths**
  - More than half of these deaths involved prescription opioids
- **Thousands of Americans are also dying from the lethal combination of opioids and benzodiazepines**

Source: Rudd et al. Increases in drug and opioid overdose deaths—United States, 2000–2014. MMWR Morb Mortal Wkly Rep 2016 Jan 1;64(50):1378-82. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm?s_cid=mm6450a3_w PubMed: https://www.ncbi.nlm.nih.gov/pubmed/26720857

Opioids Are High-Alert Medications

Opioids are known as high-alert medications, which can cause significant harm or death to a patient if they are used incorrectly

Prescription Drug Monitoring Programs (PDMPs)

- **PDMPs are state-run electronic databases used to track the prescribing and dispensing of controlled prescription drugs to patients**
- **They provide information regarding a patient's controlled substance prescription history and identify patients at high risk of abuse who would benefit from early interventions**
- **PDMPs are state-specific**
  - See a state-by-state breakdown of CDC's drug monitoring program website at https://www.cdc.gov/drugoverdose/pdmp/

Example: Pennsylvania PDMP

- Per Act 191 of 2014, lawfully authorized prescribers are required to query the PDMP for an existing patient when the following clinical situations apply:

1. For each patient, the first time the patient is prescribed a controlled substance by the prescriber for purposes of establishing a baseline and a thorough medical record; or
2. If a prescriber believes or has reason to believe, using sound clinical judgment, that a patient may be abusing or diverting drugs; or
3. Each time a patient is prescribed an opioid drug product or benzodiazepine by the prescriber

- These requirements apply (1) to inpatient or outpatient settings; to acute or anticipated chronic controlled substance(s) prescriptions; to new or established patients; and in situations where the prescriber is seeing his or her own patient or is covering for a colleague. Writing a controlled substance(s) prescription for the first time to a patient is the basis for checking the PDMP in (1) above
- However, as part of good clinical practice, the Department of Health recommends that health care professionals check the system every time before a controlled substance(s) is prescribed or dispensed in any clinical setting

Source: Pennsylvania Department of Health. Prescription Drug Monitoring Program. http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Pages/PDMP-Portal.aspx#.WQdGxOLD9jQ

Case Study

- 48-year-old woman with major depression, two suicide attempts several years ago, followed by a psychiatrist
- On lorazepam (Ativan), citalopram (Celexa)
- New complaint of insomnia and “legs jumping”
- Psychiatrist added 3 mg of Ativan at bedtime for daily total of 12 mg
- Psychiatrist referred to PCP to assess “legs jumping”
- PCP ordered sleep studies and evaluation for restless legs syndrome (RLS)
- Diagnoses: sleep apnea and RLS

Case Study *(cont'd)*

- Ordered bilevel positive-airway-pressure treatment and pramipexole (Mirapex) (for RLS)
- Psychiatrist and PCP communicate weekly via e-mail to assess the effectiveness of treatment
- Patient develops severe muscle and joint pain; no relief from Mirapex
- PCP orders oxycodone (OxyContin), 60 (5-mg) tablets for pain
- Six weeks later, PCP orders another 200 (5-mg) tablets of OxyContin; new prescription is noted in the record, but no other comments
- Three weeks later, patient is found dead in apartment
- Autopsy indicates suicide by overdose of OxyContin and Ativan

What Went Wrong?

1. How many is too many?
2. Are benzodiazepines and opioids safe together?
3. What communication should happen between providers?
4. What follow-up is appropriate?

Case Study: Lessons Learned

- Risk assessments when altering treatment plans
- Drug maximum doses
- Drug combinations
- Drug side effects
- Benzodiazepines
- Refills of opiates
- Documentation of symptoms
- Consulting over e-mail

Barriers to Safe Use of Opioids

- Lack of knowledge about potency differences among opioids
- Improper prescribing
- Administration of multiple opioids
- Multiple modalities of opioid administration (oral, parenteral, and transdermal patches)
- Inadequate monitoring of patients on opioids

Source: Joint Commission. Sentinel Event Alert 49: safe use of opioids in hospitals. 2012 Aug 8. https://www.jointcommission.org/sea_issue_49/

Opioid FDA Alert

The U.S. Food and Drug Administration (FDA) announces safety labeling changes for extended-release and long-acting (ER/LA) opioids:

- ER/LA opioids are indicated for management of pain severe enough to require daily, around-the-clock, long-term opioid treatment, and for which alternative treatment options are ineffective
- New boxed warning to include neonatal opioid withdrawal syndrome

Source: U.S. FDA. New safety measures announced for extended-release and long-acting opioids. 2016 Feb 4. https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm363722.htm

Opioid FDA Alert

FDA provides a list of ER/LA opioids:

- Avinza (morphine sulfate)
- Dolophine (methadone hydrochloride)
- Duragesic patch (fentanyl transdermal)
- Embeda (morphine sulfate and naltrexone hydrochloride)
- MS Contin (morphine sulfate)
- Nucynta ER (tapentadol)
- Opana ER (oxymorphone hydrochloride)
- OxyContin (oxycodone hydrochloride)

Source: U.S. Food and Drug Administration. Risk evaluation and mitigation strategy (REMS) for extended-release and long-acting opioid analgesics. 2017 Apr 26. http://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm163647.htm

Factors to Consider Before Prescribing

- Pain condition
- General medical history
- Psychosocial history
- Functional status
- Sleeping patterns
- Psychological evaluation
- Substance use history
- Addiction risk screening
- Prescription drug monitoring program
- Urine drug screening

Source: Manchikanti L, Abdi S, Atluri S, et al. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: part 1–evidence assessment. Pain Physician 2012;15:S1-S66. http://painphysicianjournal.com/2012/july/2012;15;S1-S66.pdf

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Educate the Patient to Make Informed Decisions

Discuss the risks and benefits of opioid therapy prior to initiating treatment:

1. Opioids reduce pain and improve ability to be active when appropriate criteria are met
2. Opioids may help on a short-term basis but there are risks
3. Consider potential challenges with tolerance, dependency, addiction, and hyperalgesia

Source: Manchikanti L, Abdi S, Atluri S, et al. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: part 1 – evidence assessment. Pain Physician 2012;15:S1-S66. http://painphysicianjournal.com/2012/july/2012;15;S1-S66.pdf

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Informed Decision Making

Additional considerations before initiating opioid therapy:

Side effects:

- Common: nausea, constipation, drowsiness, itching, vomiting
- Serious: respiratory depression, addiction, hormonal deficiency, fatigue

Abrupt discontinuation/stoppage could result in withdrawal

Medication should be safely secured and should never be shared

Source: Manchikanti L, Abdi S, Atluri S, et al. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: part 1–evidence assessment. Pain Physician 2012;15:S1-S66. http://painphysicianjournal.com/2012/july/2012;15;S1-S66.pdf

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Initiation of Therapy

- **Start with a low-dose, short-acting opioid**
- **Titrate over an 8- to 12-week period**
- **In general, patients who do not respond to a low or medium dose of opioids will not respond to higher doses**

Source: Manchikanti L, Abdi S, Aluri S, et al. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: part 1 – evidence assessment. Pain Physician 2012;15:S1-S66. http://painphysicianjournal.com/2012/july/2012;15;S1-S66.pdf

Controlled Substance Agreement

- A strong agreement, followed by all parties, is essential in the initiation and maintenance of opioid therapy
- Agreements may reduce overuse, misuse, abuse, and diversion
- Multiple sample agreements/contracts are available
- Agreements address risks and benefits of opioid therapy
- Specifies the need for one prescribing doctor and one designated pharmacy
- Makes provision for urine/serum drug screening when requested
- Prohibits early refills and calling medications in to the pharmacy
- May require a police report prior to issuing new prescriptions if medications are lost or stolen

Source: Manchikanti L, Abdi S, Atluri S, et al. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: part 1–evidence assessment. Pain Physician 2012;15:S1-S66. http://painphysicianjournal.com/2012/july/2012;15;S1-S66.pdf

Resources: Patient Agreements

- National Institute on Drug Abuse. Sample patient agreement forms: http://www.drugabuse.gov/sites/default/files/files/SamplePatientAgreementForms.pdf
- Community Care of North Carolina. Chronic Pain Initiative tool kit: http://www.p4communitycare.org/media/related-downloads/cpi-toolkit-pcps.pdf
- State of Indiana. First do no harm: the Indiana healthcare providers guide to the safe, effective management of chronic non-terminal pain. http://www.in.gov/bitterpill/toolkit.html

Discontinuation of Opioids

- Avoid abrupt discontinuation of ER/LA opioids (unless an adverse reaction has occurred)
- Use a gradual downward titration of the dose to prevent signs and symptoms of withdrawal in the physically dependent patient

Opioid Withdrawal

- **Opioid withdrawal symptoms**
  - Central nervous system, cardiac (nervousness, restlessness, irritability, tachycardia)
  - Respiratory, metabolic, vasomotor (sweating, goose bumps, body aches, fever, runny nose, sneezing, yawning)
  - Gastrointestinal (nausea, vomiting, diarrhea)
- **Neonatal opioid withdrawal syndrome (NOWS)**
  - Convulsions, excessive crying, hyperactive reflexes

Summary of Key Risk Management Considerations for Opioids

- **Remember that opioids are high-alert medications**
- **Conduct a comprehensive assessment**
- **Initiate therapy prudently:**
  - Start with a low-dose, short-acting opioid
  - Titrate over an 8- to 12-week period
- **Use evidenced-based guidelines for opioid treatment**
- **Educate patient to assist with informed consent**
- **Obtain a controlled substance agreement**
- **Monitor for sedation and respiratory depression**
- **Order laboratory studies according to guidelines**

ECRI Institute Clinical Risk Management Resources

- Get safe: Assessing patients for risk of self-harm
  www.ecri.org/components/HRSA/Pages/GetSafe_112812.aspx
- Get safe: Managing the behavioral health patient in primary care
  https://www.ecri.org/components/HRSA/Pages/GetSafe_032814.aspx
- Get safe: Supporting substance use disorder capacity
  www.ecri.org/components/HRSA/Pages/GetSafe_033016.aspx
- Get safe: Using warm handoffs to improve behavioral health referrals
  www.ecri.org/components/HRSA/Pages/GetSafe_112213.aspx
- Patient suicide risk: assessment and evaluation
  www.ecri.org/components/HRSA/Pages/STPol8.aspx
- Practice alert: Comprehensive behavioral health screening in primary care
  www.ecri.org/components/HRSA/Pages/PracticeAlert120613.aspx
- Quality in action: Increasing access to comprehensive behavioral healthcare
  www.ecri.org/components/HRSA/Pages/QualityinAction_012615.aspx

Thank You

Additional Questions?

BPHC Helpdesk:

1-877-974-BPHC (2742)

https://www.hrsa.gov/about/contact/bphc.aspx

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