PDMP TTAC
Prescription Drug Monitoring Program Training and Technical Assistance Center

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# Academic Detailing for PDMPs: Examples from Utah and Illinois

## May 25, 2023

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PDMP TTAC
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# Presenters

- **Connie Kitchens, Public Health Policy Manager, Utah PDMP**
- **Sarah Pointer, Clinical Director, Illinois PDMP**
- **Eric Huff, Clinical Project Manager, Illinois PDMP**

# Illinois Prescription Monitoring Program

# Academic Detailing

**Sarah Pointer, PharmD**

**Clinical Director**

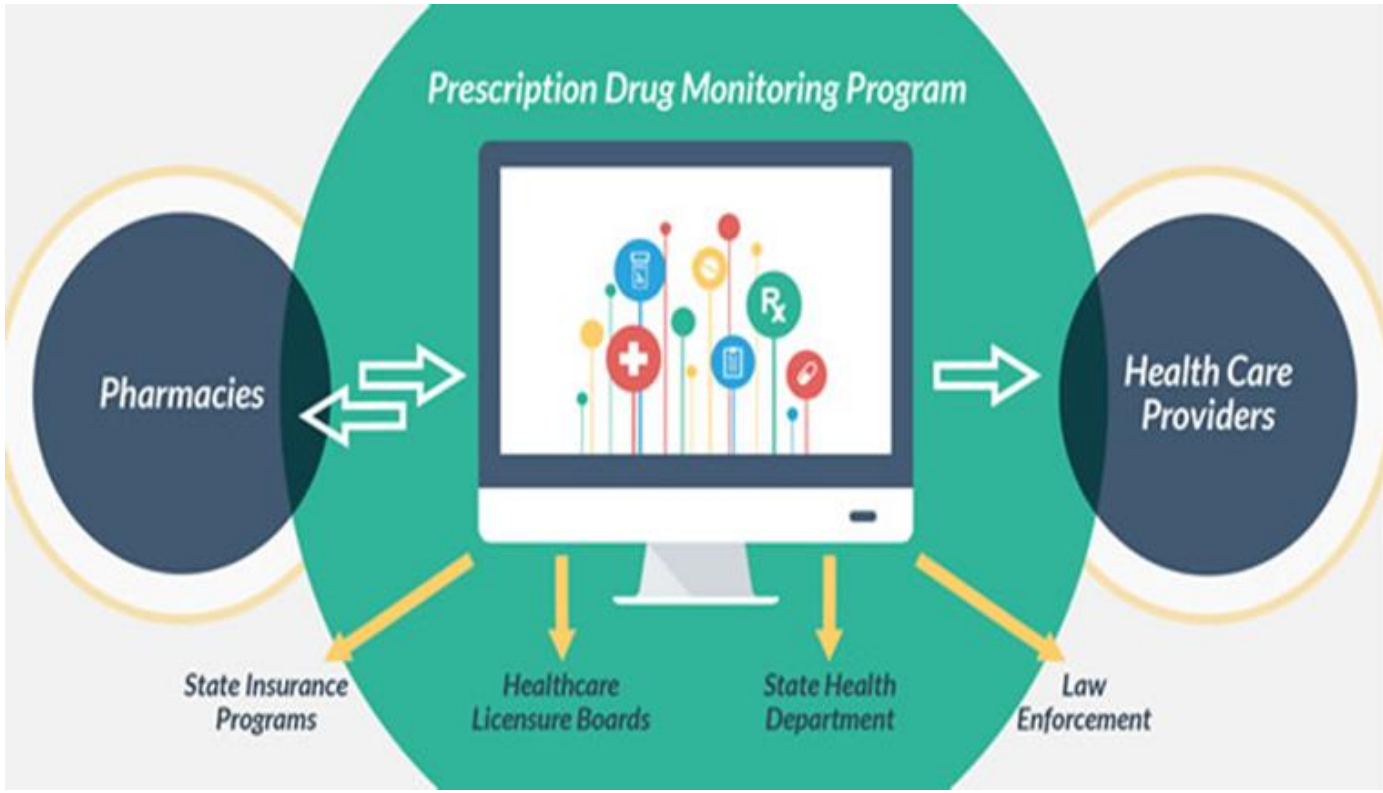
**May 25, 2023**

# Outline

- ILPMP Initiatives
- Strategies to achieve initiatives
- Initial Academic Detailing Evaluations and Outcomes
- Implications of Academic Detailing Outcomes

# Illinois PMP

- IL PMP one of oldest PMPs
- Home-grown system
- Captures data from pharmacies on all controlled substance prescriptions as well as drugs of interest



# State of Illinois Opioid Action Plan (SOAP)

# ILPMP Initiatives

Focus in four key areas:

1. Identify high risk behaviors
2. Provide education
3. Increase utilization of the PMP
4. Prevent overdose

# Strategy to Achieve Initiatives

- Academic detailing (AD) may be used as a strategy to achieve IL PMP initiatives
- AD is a method of educational outreach[1,2]
  - One-on-one, face-to-face, encounters with clinicians
- Utilizes trained academic detailers to provide current, unbiased evidence-based information
- Aims to improve prescribing behavior
- Most effective when trusting relationship between provider and detailer


1. Avorn J, Soumerai SB. Improving drug-therapy decisions through educational outreach. A randomized controlled trial of academically based "detailing". *N Engl J Med*. 1983;308(24):1457-63.
2. Soumerai SB, Avorn J. Principles of educational outreach ('academic detailing') to improve clinical decision making. *JAMA*. 1990;263(4):549-56.

# Establishing Partnerships

- Essential when developing and implementing AD programs
  - State-based prescription monitoring programs (PMP)
  - State departments of health and human services
  - Local academic institutions
  - Provider groups & healthcare systems
  - National Resource Center for Academic Detailing (NaRCAD)


# CDC Guideline Key Messages

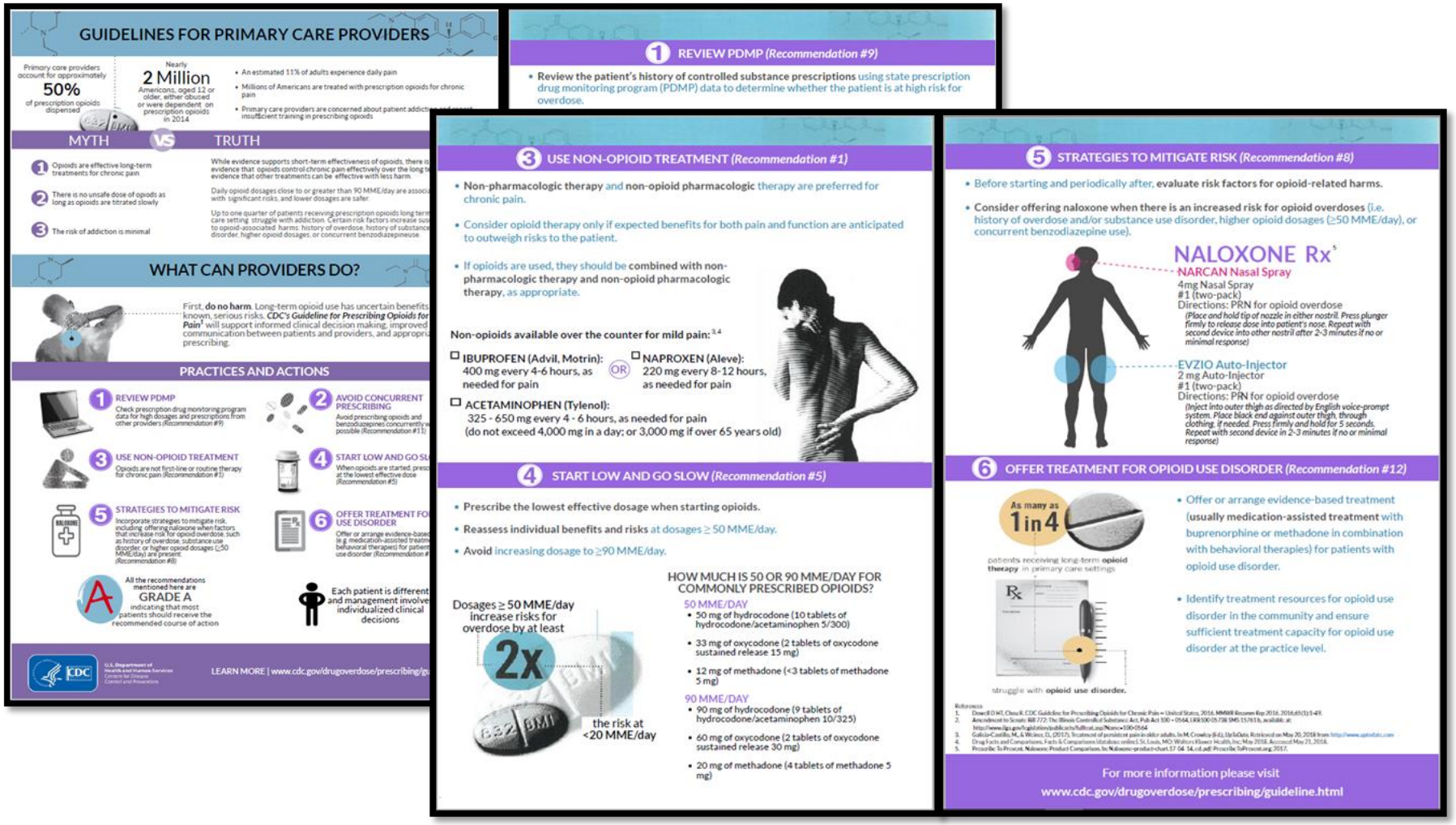
1. **Opioids are not first-line therapy**
2. Establish goals for pain and function
3. Discuss risks and benefits
4. Use immediate-release opioids when starting
5. **Use the lowest effective dose**
6. Prescribe short durations for acute pain
7. Evaluate benefits and harms frequently
8. **Use strategies to mitigate risk**
9. **Review PDMP Data**
10. Use urine drug testing
11. **Avoid opioids and benzodiazepine co-prescribing**
12. **Offer treatment for opioid use disorder**

**Red** = Key messages covered

# AD Program Summary

- Complete 2 visits with primary care providers (MD, DO, NP, PA)
  - Visit length between 15 and 30 minutes
  - 2 visits separated by 6 to 8 weeks
- Content development
  - Focused on CDC prescribing guidelines
  - Tailored to needs of providers
  - Prescriber-specific data
- Detailer training
  - NaRCAD train-the-trainer model
  - Quality assurance and troubleshooting
- Evaluation
  - Effect of the AD
  - Development of AD tools

# Educational Toolkits



# Provider-specific Information

- Audit and feedback is a widely used strategy to motivate behavior change
- Feedback on provider clinical performance was provided via opioid prescribing information
- Provider-specific opioid prescribing information was obtained from the IL PMP
- Detailers shared this information with providers at each visit

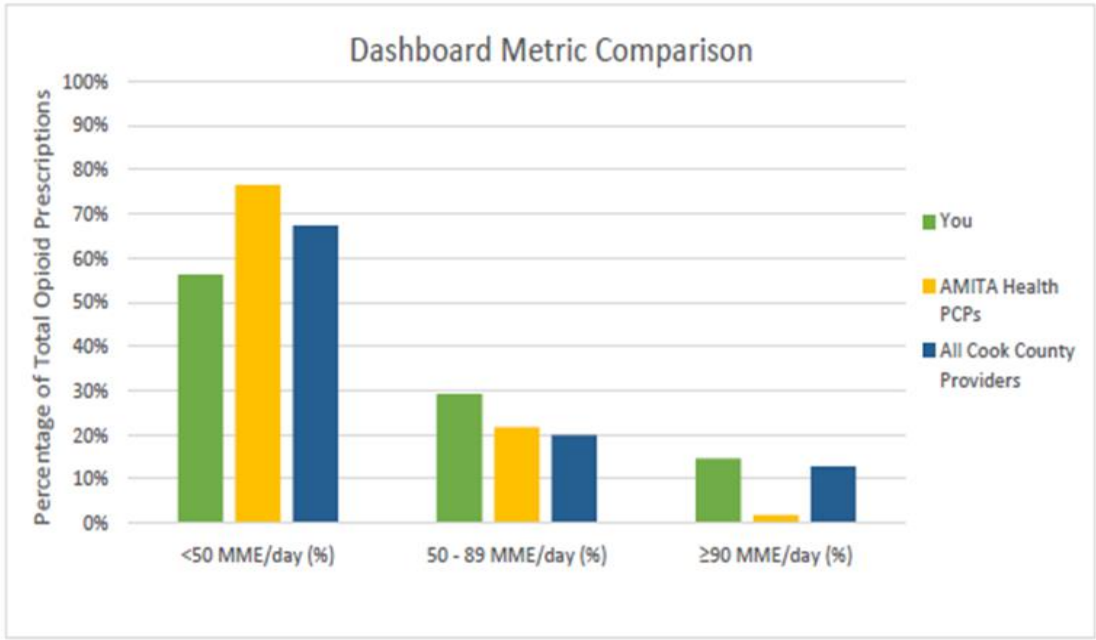
# AD Program Summary

## Illinois Prescription Monitoring Program Dashboard Metrics

Below is a 6-month comparison (Nov 2017-Apr 2018) of your number of opioid prescriptions
morphine milligram equivalents (MME) per day, average number of monthly opioid prescripti
number of monthly PMP queries along with the average for all AMITA Health primary care pr
providers from Cook County.

| | You | | AMITA Health PCPs | |
|---|---|---|---|---|
| <50 MME/day (%)[1a] | 27 | (56%) | 12,903 | (76%) |
| 50 - 89 MME/day (%) | 14 | (29%) | 3,668 | (22%) |
| ≥90 MME/day (%) | 7 | (15%) | 312 | (2%) |
| Average number of monthly opioid prescriptions | 8.0 | | 13.5 | |
| Average number of monthly PMP queries | 0.0 | | 3.6 | |

1. % = proportion of total opioid prescriptions over the 6-month period
   a. i.e. Your MME/day <50 = 10%, meaning 10% of your total opioid prescriptions over 6 months w




Email: info@ilpmp.org | Website: www.ilpmp.org

# Provider Satisfaction Measure Results

| Item* | Urban | Rural |
|---|---|---|
| This is an important topic | 97% | 100% |
| The detailer was knowledgeable | 93% | 100% |
| The detailer was an effective communicator | 96% | 100% |
| The key messages are feasible to implement in my practice | 89% | 94% |
| My practice is likely to change as a result of this visit | 49% | 69% |
| I would be receptive to future visits | 78% | 94% |

*Response options: “not at all”, “slightly”, “moderately”, “very”, or “extremely”. The results reported are for “very” or “extremely” responses

# Evaluation

- Change in mean monthly number of:
  - Total opioid prescriptions
  - High dose opioid prescriptions (>90 MME/day)
  - Patients co-prescribed opioids and benzodiazepines
- Outcomes measured at six months post-AD program implementation
- Comparison groups: Academic detailing vs. No academic detailing
- Used Difference-in-Difference approach to compare two groups before and after AD visits

# Outcomes

| Table 2. Difference-in- Difference Estimates for Mean Monthly Total Opioid Prescriptions per Provider | | | | | |
|---|---|---|---|---|---|
| | Pre-AD Mean | Post-AD Mean | D-I-D Estimator | 95% CI | P-value |
| AD-exposed | 15.22 | 15.51 | -0.85 | (-1.36, -0.33) | 0.001 |
| AD-unexposed | 13.86 | 15.00 | | | |

**Interpretation:**

- On average, nearly 1 less opioid prescription per month per provider were dispensed among AD-exposed providers relative to AD-unexposed providers

- This translates to ~1,500 fewer opioid prescriptions dispensed annually (Ex: -0.85 opioid prescriptions x 151 AD-exposed providers x 12 months = ~1,500 fewer opioid prescriptions)

# Outcomes (Cont'd)

| Table 3. Difference-in- Difference Estimates for Mean Monthly High-dose Opioid Prescriptions per Provider | | | | | |
|---|---|---|---|---|---|
| | Pre-AD Mean | Post-AD Mean | D-I-D Estimator | 95% CI | P-value |
| AD-exposed | 0.86 | 0.55 | -0.11 | (-0.24, 0.01) | 0.08 |
| AD-unexposed | 1.10 | 0.90 | | | |

**Interpretation:**

- On average, 0.11 fewer high-dose opioid prescriptions per month per provider were dispensed among AD-exposed providers relative to AD-unexposed providers

- This translates to ~200 fewer high-dose opioid prescriptions dispensed annually (Ex: -0.11 opioid prescriptions x 151 AD-exposed providers x 12 months = ~ 200 fewer high-dose opioid prescriptions)

# Outcomes (Cont'd)

| Table 4. Difference-in- Difference Estimates for Mean Monthly Patients Co-Prescribed Opioids and Benzodiazepines | | | | | |
|---|---|---|---|---|---|
| | Pre-AD Mean | Post-AD Mean | D-I-D Estimator | 95% CI | P-value |
| AD-exposed | 3.68 | 3.36 | -0.22 | (-0.41, -0.04) | 0.02 |
| AD-unexposed | 3.31 | 3.21 | | | |

**Interpretation:**

- On average, 0.22 fewer patients were co-prescribed benzodiazepines and opioids per month per provider among AD-exposed providers relative to AD-unexposed providers

- This translates to ~400 fewer patients co-prescribed benzodiazepines and opioids annually (Ex: -0.22 patients co-prescribed benzodiazepines and opioids x 151 AD-exposed providers x 12 months = ~ 400 fewer patients co-prescribed benzodiazepines and opioids)

# Implications

- **Establishing partnerships are crucial** for implementation of strategies to achieve initiatives that address the opioid epidemic

- AD was effective at reducing **the number of opioid prescriptions and patients co-prescribed benzodiazepines and opioids** among AD-exposed providers relative to AD-unexposed providers

- Next steps included **expansion of opioid-related AD programs** for delivery to other relevant providers across the state

# Expansion

- **Public Act 101-0278**
  - Establish an evidence-based, non-commercial education program for Medicaid prescribers consisting of web-based curriculum and academic educator outreach
- OD2A shift to Pharmacist Detailing
- Progression of Academic Detailing Efforts

# Illinois Prescription Monitoring Program

# Academic Detailing

**Eric N. Huff, PharmD**

**Clinical Project Manager**

**May 25, 2023**

# Objectives

- ILPMP academic detailing partnership (contract funded)
- Pharmacist academic detailing efforts
- Prescriber academic detailing
- State of Illinois Opioid Action Plan (SOAP) Priority 6
- Illinois Advance Medicaid provider detailing
- Plans moving forward

# Academic Detailing Partnership

- University of Illinois at Chicago (UIC) Department of Pharmacy Systems Outcomes and Policy
- Funded through CDC Overdose Data to Action Grant
- Develop educational material
- Schedule and conduct academic detailing visits
- Two distinct phases
  - Phase 1: Pharmacy education
  - Phase 2: Prescriber education

PHARMACY SYSTEMS OUTCOMES AND POLICY
COLLEGE OF PHARMACY
UIC

# Phase 1: Pharmacist Academic Detailing

Naloxone Education Outreach to Community Pharmacies across the Chicago Metropolitan and Surrounding Areas

- Two-year program
- Identify barriers and educate community pharmacies on naloxone dispensing
- Increase utilization of Illinois' naloxone standing order
- Obtaining and use of fentanyl test strips

# Pharmacy Identification and Contact

- 1,000 pharmacies in Illinois identified for contact via mail
  - Counties with higher non-fatal opioid overdoses and lower naloxone dispensing
- Two postcards sent four weeks apart
- "Dear Pharmacists" letter sent ~6 months later
- Academic detailing visits conducted in northern Illinois

# Detailer Assessment of Visit Effectiveness (DAVE)

Six item measure completed by detailer after visit*

- This visit was informative/useful to the provider
- The provider is willing to implement the key points
- It is feasible for the provider to implement the key points
- The key messages were relevant to their practice
- The conversation went smoothly
- The provider is willing to change his/her/their practices as a result of this visit

*Development of an Instrument to Assess the Perceived Effectiveness of Academic Detailing - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8051138/

# Pharmacy Detailing Materials

- Naloxone standing order
- Naloxone dispensing information to identify and counsel patients
- General naloxone education on purpose and how to obtain
- Handout to receive/purchase, and use fentanyl test strips
- Information on discussing naloxone with patients

Naloxone Handouts


# Save a life! Dispense Naloxone!

States adopting naloxone access laws granting direct authority to pharmacists experienced significant reductions in fatal opioid-related overdoses[1]

## Identify Those at Risk

Consider offering naloxone to:

- Patients who are on **benzodiazepine and opioid** concomitant therapy
- Patients on opioid prescriptions with
  - **high dosages** (≥ 50 morphine milligram equivalents/ day),
  - with a **recent increase** in dosage, or
  - that are **long-acting formulations**
- Patients with **history** of overdose or substance use disorder
- **Anyone** voluntarily asking for it

## Tips on Counseling

**Ask permission** to discuss ("Would you mind if I talk to you about naloxone?")

**Avoid stigmatizing words** like "abuse/abuser", "addict", "opioid use disorder", "overdose"

**Ask open-ended** questions to **encourage a discussion** between you and the patient

Use an **analogy**:
*"Naloxone is for opioid medications like a fire extinguisher in case of a fire accident. Hopefully you wont need it but it is important to have on hand just in case there is a bad reaction."*

## Costs $$

**Run the claim** before the patient picks up their opioid prescription - you never know!

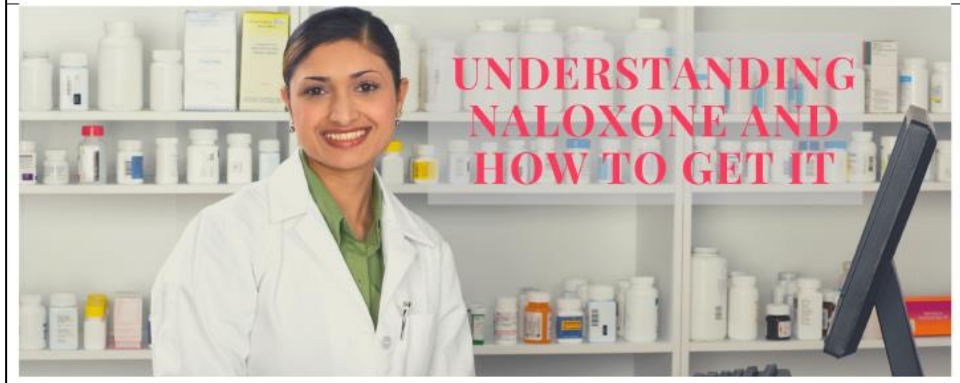
Medicaid / Medicare part D often cover naloxone with no copay to the patient

Visit the **Illinois Overdose Education and Naloxone Distribution sites (OEND)** website to identify other city-specific locations to obtain naloxone by visiting: https://idph.illinois.gov/OpioidDataDashboard/ or by scanning the QR code.

## Report your naloxone dispensing to the Illinois Prescription Monitoring Program

The state wants to capture naloxone dispensing as an important indicator for combating the opioid epidemic.

Sources:
1) Abouk R, Pacula RL, Powell D. Association Between State Laws Facilitating Pharmacy Distribution of Naloxone and Risk of Fatal Overdose. JAMA Intern Med. 2019;179(6):805-811. doi:10.1001/jamainternmed.2019.0272
2) https://www.dph.illinois.gov/naloxone
3) https://www.in.gov/isdh/files/75_Pharmacists%20and%20Naloxone.pdf



# UNDERSTANDING NALOXONE AND HOW TO GET IT

## WHAT IS NALOXONE?

Naloxone is a drug used to reverse opioid overdose. It works by blocking the effects of opioid drugs like heroin, morphine, fentanyl, Vicodin, Norco, and OxyContin.

It's available at many access sites and pharmacies as an easy-to-use nasal spray, or as an injection.

## WHO SHOULD GET NALOXONE?

**Anyone** at risk of having an opioid overdose or caring for someone at risk of an overdose.

Signs/Symptoms of opioid overdose include:

- **Slow/shallow breath,**
- **Pale/blue fingertips or lips,**
- **Vomiting, gurgling,**
- **Inability to speak or wake up, and/or**
- **A slow/stopped pulse**

**Scan the QR codes below to learn more about naloxone and where to get it, or visit:**
https://dph.illinois.gov/topics-services/opioids/naloxone.html
https://www.dhs.state.il.us/page.aspx?item=137653

## GET NALOXONE AT YOUR LOCAL PHARMACY OR AT AN ILLINOIS OEND SITE

**Community safety centers (Opioids Education and Naloxone Distribution (OEND) sites)** are another way to obtain naloxone **free of charge**.

How to use naloxone?

When to use naloxone?

IL Site Lookup tool

UIC PHARMACY
Pharmacy Systems Outcomes and Policy

# Fentanyl Test Strip Handout

September 2022

# FENTANYL TEST STRIPS

***Inspect BEFORE You Ingest***

FTS are an **inexpensive, easy-to-use, rapid** harm reduction technology developed to detect fentanyl **and its analogs.**

## FENTANYL FACTS

- Associated with 71,238 deaths in 2021
- 50x more potent than heroin
- You can't see it, smell it, or taste it
- Frequently found in cocaine, MDMA, and pills

In June 2022, Illinois passed legislation under House Bill 4556, expanding access for pharmacists to distribute FTS and legally protecting customers who receive FTS through the initiative.

FTS can prevent overdose if used alongside other risk reduction practices

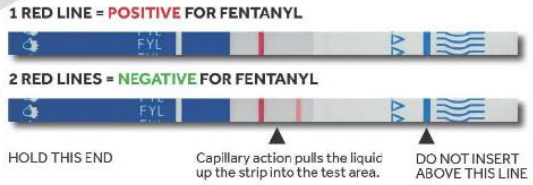
FTS users are **more** likely to...

- **Avoid** drug use completely
- Use **less** of a drug
- **Go slow**; using test shots
- Use drugs **with other people**
- Use with **naloxone** on hand

Research found FTS are **96-100% sensitive** and **90-98% specific** for fentanyl

## HOW TO USE

**Step 1:** Dissolve small amount of drug supply in water
**Step 2:** Hold strip and dip into 15 mL water for ~15s
**Step 3:** Set strip on flat surface until results appear
**Step 4:** Read results (see image)




FTS test if drugs contain **fentanyl** and some **analogs**, but not **how much** or its **potency**

## RESOURCES

Organizations in Chicago can provide FTS upon request

- Chicago Department of Public Health | Contact: osu.cdph@cityofchicago.org to order
- Chicago Recovery Alliance | anypositivechange.org/van-timetable
- Live4Lali (delivery) | live4lali.org/harmreductionoutreach/

FTS may also be purchased online for delivery at

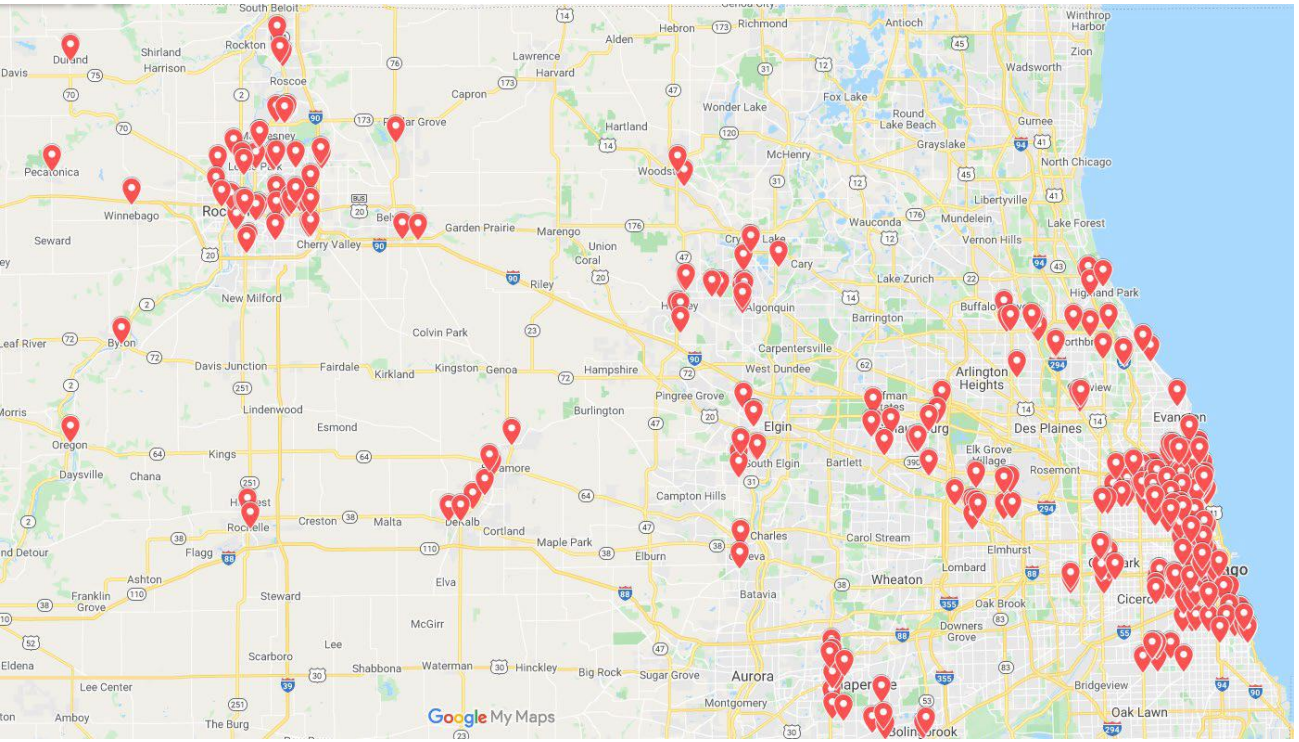
- dancesafe.org/shop
- dosetest.com/product/fentanyl-test-strips
- bunkpolice.com/product/fentkit

ILPMP Illinois Prescription Monitoring Program

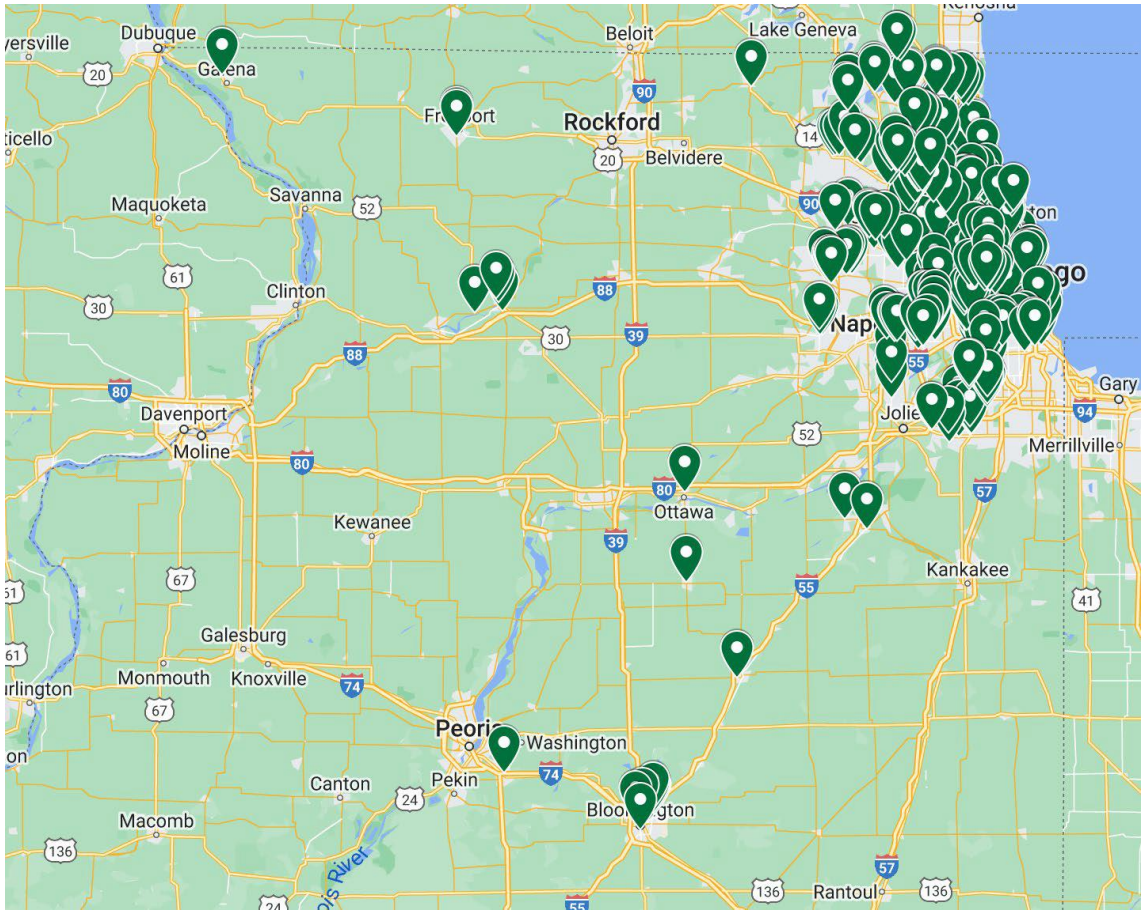
PHARMACY SYSTEMS OUTCOMES AND POLICY COLLEGE OF PHARMACY

# Pharmacy Education Visit Locations

## 2021 Pharmacy Visits = 333




## 2022 Pharmacy Visits = 303



# Barriers/Pain Points for Pharmacist AD

- COVID-19 restrictions
- Difficulty in conducting virtual visits
- Travel and time constraints for in-person visits
- Pharmacist availability

# Phase 2: Prescriber Academic Detailing

- Education component required by Illinois Controlled Substances Act
- "High-risk" prescribers identified by Peer Review Committee (PRC) process
- Tailored approach based on prescribing habits
- Primarily focused on previous prescribing and CDC guidelines
- DAVE and PSAD scoring (Provider Satisfaction with Academic Detailing)

# Peer Review Committee (PRC)

- Review and identify prescribers or dispensers operating outside of accepted standards and practices of their profession
- 3 Physicians, 3 Pharmacists, 1 Dentist, 1 Advance Practice Nurse, 1 Physician Assistant, 1 Optometrist
- Meet twice yearly
- Make recommendations to provide Academic Detailing

Note: ILPMP only involved to facilitate the review process and communication with prescribers, as well as analyze prescribing data to identify prescribers

*720 ILCS 570/320 available at https://ilga.gov/legislation/ilcs/ilcs5.asp?ActID=1941&ChapterID=53

# Prescribers Identified

- Co-prescribing thresholds set based on capabilities for review and education for prescribers
- Co-prescribing opioids & benzodiazepines to ≥10 PT x 3 consecutive months of prior 6mo (July-Dec)
- 2 rounds of prescriber reviews per year
- Target range of 35-40 prescribers

# Request for Information Letter (RFI)

- Required by Illinois Controlled Substances Act
- Up to 3 letters sent to respond for request for information
- 30 days to respond to each letter
- 5 questions for tailored academic detailing
- Failure to respond requires referral to state licensing body

*720 ILCS 570/320 available at https://ilga.gov/legislation/ilcs/ilcs5.asp?ActID=1941&ChapterID=53

# Request for Information (RFI) Questions

1. Provide a general clinical rationale for your current opioid-benzodiazepine co-prescribing patterns
2. What risk mitigation strategies do you employ and how frequently?
3. Are you board certified in a specialty or sub-specialty?
4. How do you and your staff currently utilize the ILPMP?
5. Confirm your contact and taxonomy information for your ILPMP account, or note the correction needed

*Approved by Peer Review Committee

# Request for Information (RFI) Letters to Prescribers

March 29, 2023 3rd Request

Dr. [redacted]

As clinical members of the Illinois Prescription Monitoring Program Peer Review Committee, we have been charged under 720 ILCS 570/320 to identify those prescribers who may be prescribing outside the currently accepted standards of practice for their profession.

The Illinois Prescription Monitoring Program data shows that you have been co-prescribing benzodiazepines and opioids to 15 or more patients for three consecutive months during a 6-month period of July-December 2022. This data suggests some of your prescribing practices may be outside of the recommendations provided by the *Center for Disease Control and Prevention (CDC) Clinical Practice Guideline for Prescribing Opioids for Pain* which states "*Clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants.*"

The data available to the ILPMP is limited, so we are reaching out to you for additional contextual clarification regarding your prescribing practices. We understand there may be clinical circumstances warranting co-prescribing opioids and benzodiazepines that cannot be determined from the data available to us. Also, the ILPMP does not guarantee the complete accuracy of the information provided as it is reported by pharmacies and other state departments.

**Within the next 30 days,** please log in to ILPMP.org and click "MyPMP" to review to verify the accuracy of the data, and the contact and taxonomy information in your profile. Click on the "Request for information" tab, and respond to the following questions, **in detail**:

1. Provide a general clinical rationale for your current opioid-benzodiazepine co-prescribing patterns.
2. What risk mitigation strategies do you employ and how frequently?
3. Are you board certified in a specialty or sub-specialty?
4. How do you and your staff currently utilize the ILPMP?
5. Confirm your contact and taxonomy information for your ILPMP account, or note the correction needed.

It is not the committee's intention to impede your practice, but to aid in patient care. Education or academic detailing on risk mitigation strategies may be recommended following the review of your answers. Our partners at The University of Illinois Chicago College of Pharmacy provide this educational outreach on behalf of the ILPMP's Peer Review Committee and may contact you to set up an academic detailing meeting.

**Failure to respond to this request for information may result in a referral to IDFPR per the statutory authority provided under** 720 ILCS 570/320. If you have any questions or need any help with this request, please email us at dhs.pmp@illinois.gov. Thank you for your time and attention to this very important matter.

Sincerely,
***Peer Review Committee***

# Detailer Website View

3 tables separate the prescribers identified to receive RFI letters

- Responded and recommended for AD visit
- Responded and NOT recommended for AD visit
- Not responded to RFI

The prescribers in the table below have been identified by the Peer Review Committee as needing Academic Detailing services. Click the Unique ID to view the subject's response, contact information, and the committee's feedback.

| Unique Id | Name | County | Taxonomy | Date Responded |
|---|---|---|---|---|

The prescribers in the table below have responded to the request for information letter but have not been recommended by the committee for Academic Detailing.

| Unique Id | Name | County | Taxonomy | Date Responded |
|---|---|---|---|---|

The prescribers in the table below have not responded to the request for additional information on their prescribing practices.

| Unique Id | Name | County | Taxonomy |
|---|---|---|---|

# Detailing Process

- UIC Contact prescriber to set up virtual or F2F visit
- Two visits planned
    1. Prescribing history and best practices for co-prescribing opioid + benzodiazepine
    2. Focus on CDC guideline updates and tapering

- Within ~24 hours of each visit:
    - Detailer completes DAVE (Detailer Assessment of Visit Effectiveness)
    - Prescriber is sent PSAD (Provider Satisfaction of Academic Detailing)

PSAD Instrument

## Provider Satisfaction with Academic Detailing (PSAD)

Directions: Please mark the box indicating your response below for each of the following questions after your academic detailing session.

Years of practice: _____

| Satisfaction with academic detailing visit | Response Options | | | | |
|---|---|---|---|---|---|
| | Not at all | Slightly | Moderately | Very | Extremely |
| 1. The detailer was knowledgeable | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. The detailer was an effective communicator | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Academic detailing is an effective way to get updated on important topic(s) | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. The printed/electronic detailing material was useful[1] | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. I would be receptive to future visits | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. This topic was relevant to my practice | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. This is an important topic | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. The key messages are feasible to implement in my practice | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9. The key messages were consistent with my practice | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. My practice is likely to change as a result of this visit[2] | ☐ | ☐ | ☐ | ☐ | ☐ |

# Contacting RFI Prescriber

- 5-week communication cycle, 1 contact per week
- Initial email
  - *"The goal of this initial session will be to further understand your patient population, the current strategies you use in determining which of your patients are appropriately prescribed a benzodiazepine and opioid concurrently, your attempts at opioid- or benzo-tapering, and how you mitigate risks of overdose and death in these patients."*
- Two follow-up emails
- Two phone calls
- Final follow-up email after phone calls

# Prescriber Responses and Contact Information

- Detailers select unique ID for each recommended prescriber
- Phone and e-mail information displayed for UIC to contact
- Prescriber responses to RFI letter displayed
- Individual prescribing history can be viewed

# Detailing Content/Materials

- Opioid-BZD co-prescribing flyer
- Fentanyl Test Strip flyer
- CDC Guideline PowerPoint slides

- CDC risk mitigation toolkits shared
  - Use of the PMP
  - Naloxone
  - Toxicology testing

Opioid-BZD Co-Prescribing Flyer

# OPIOIDS + BENZODIAZEPINES: FALLING OUT OF FAVOR

The Centers for Disease Control and Prevention (CDC) Clinical Practice Guideline for Prescribing Opioids for Pain recommends that clinicians use caution and consider risks versus benefits when prescribing opioids and benzodiazepines (BZDs) concurrently.[1]

## FAST FACTS

- In 2020, 16% of overdose deaths involving opioids also involved BZDs.[2]
- The overdose death rate among patients receiving opioid + BZD has been shown to be 10x higher than those receiving opioids alone.[3]
- Patients on opioids and BZDs have worse health outcomes, greater utilization of healthcare resources, and higher mental health comorbidities.[4]

## BENZODIAZEPINES ARE OVERPRESCRIBED

During 2014-2016, BZDs were prescribed at 27 annual visits for every 100 adults who visited an office-based doctor.[5]

BZDs can be useful for the short-term treatment of anxiety and insomnia; however, many patients continue to be prescribed BZDs for inappropriate conditions and duration.[6,7]

## BENZODIAZEPINE TAPERING CONSIDERATIONS

- Opioid withdrawal can be stressful, but is rarely a medical emergency, while BZD withdrawal symptoms can be life-threatening.[8]
- BZDs should be tapered gradually (over 3-6 months) to mitigate potentially significant risks of withdrawal.[9]
- Alternatively, substituting with longer-acting BZD then tapering can be an effective approach.[9]

## OPIOID TAPERING CONSIDERATIONS[9]

Tapering opioids after years of use can be challenging due to dependence. It is more likely to succeed when patients and providers collaborate to develop an individualized tapering plan.

- Discuss patient perceptions of benefits, risks, and adverse effects of continued opioid therapy.
- Include patients in decision making such as which medication will be decreased first, and how quickly tapering will occur.
- For patients struggling to tolerate a taper, maximize non-opioid treatments for pain and address behavioral distress.

- Evidence to support specific tapering rates is limited.
- Tapering rates should be based on the patient's clinical situation and duration of opioid therapy.

**The following strategies may be better tolerated and increase the likelihood of minimizing withdrawal symptoms:**

- Longer durations (≥1 year):
  - Tapering dose ≤ 10% per month or slower.
- Shorter durations (weeks to months):
  - Original dose decreases of ~10% per week to 30% of the original dose. Followed by weekly decreases of ~10% of the remaining dose.

## GENERAL CONSIDERATIONS

- Stop co-prescribing opioids and BZDs.
- Consider non-opioid approaches to managing pain.
- Taper opioids and BZDs slowly.
  - Establish clear treatment goals for pain and function
  - If tapering is not possible, titrate doses to a minimum effective dose
  - Titrate opioid medications to a realistic level of function, not a pain-free state
  - Do not escalate dosage to accommodate opioid tolerance


References:

1. Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022. MMWR Recomm Rep. 2022;71(3):1-95.
2. CDC Wonder. Multiple Causes of Death 1999-2020. . Centers for Disease Control and Prevention, National Center on Health Statistics; Released December 2021.
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4. Nielsen S, Lintzeris N, Bruno R, et al. Benzodiazepine use among chronic pain patients prescribed opioids: associations with pain, physical and mental health, and health service utilization. Pain Med. 2015;16(2):356-366.
5. Santo L, Rui P, Ashman JJ. Physician Office Visits at Which Benzodiazepines Were Prescribed: Findings From 2014-2016 National Ambulatory Medical Care Survey. Natl Health Stat Report. 2020(137):1-16.
6. Lembke A, Papac J, Humphreys K. Our Other Prescription Drug Problem. N Engl J Med. 2018;378(8):693-695.
7. Olfson M, King M, Schoenbaum M. Benzodiazepine use in the United States. JAMA Psychiatry. 2015;72(2):136-142.
8. Gupta M, Gokarakonda SB, Attia FN. Withdrawal Syndromes. In: StatPearls. Treasure Island (FL): StatPearls Publishing Copyright © 2022, StatPearls Publishing LLC.; 2022.
9. Office of Quality and Performance and the Veterans Affairs and Department of Defense Development Work Group. Management of Substance Use Disorders. Veterans Health Administration, Department of Veterans Affairs; 2015.

Risk Mitigation Toolkits

# RISK MITIGATION TOOLKIT
## Using the ILPMP

Recommendation #9 from the 2022 CDC Guideline for Prescribing Opioids for Pain states, "When prescribing initial opioid therapy for acute, subacute, or chronic pain, and periodically during opioid therapy for chronic pain, clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose".

**All prescribers with an Illinois controlled substance license must register with ILPMP regardless of practice type. It is mandatory to search ILPMP when prescribing schedule II narcotics with limited exemptions.**

# RISK MITIGATION TOOLKIT
## Prescribing Naloxone

Recommendation #8 from the 2022 CDC Guideline for Prescribing Opioids for Pain states, "Before starting and periodically during continuation of opioid therapy, clinicians should evaluate the risk for opioid-related harms and discuss risk with patients. Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone".

### When to Prescribe Naloxone

Prescribers should offer naloxone to patients at increased risk for opioid overdose, including patients with a history of overdose, patients with a history of a substance use disorder, patients with sleep-disordered breathing, patients taking higher dosages of prescription opioids (e.g., ≥50 MME/day), patients taking benzodiazepines with opioids, patients taking illicit opioids, and patients at risk for returning to a high dose to which they have lost tolerance

# RISK MITIGATION TOOLKIT
## Toxicology Testing

Recommendation #10 from the 2022 CDC Guideline for Prescribing Opioids for Pain states, "When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances."

### When to Conduct Toxicology Testing

Before starting opioids, when taking over opioid therapy, and periodically (at least annually) during opioid therapy, prescribers should consider the benefits and risks of toxicology testing to assess for prescribed opioids and other prescription and nonprescription substances that increase the risk for overdose when combined with opioids, including nonprescribed and illicit opioids and benzodiazepines. Before ordering toxicology testing, have a plan for responding to unexpected results.

### Speaking with Patients about Toxicology Testing and Results

# Detailer Partner Reporting to ILPMP

- Weekly update sent to ILPMP on status of prescriber contact and detailing
- Detailer visit comments entered to ILPMP website
  - Will be visible by Peer Review Committee
- Partners summarize visit information to present to Peer Review Committee

# Academic Detailing Barriers/Pain Points

- Completely new process for ILPMP in 2023
- Website display & access for Academic Detailers
- RFI responses from high-risk prescribers
- Prescriber contact and coordination with detailing partner
- Concerns that academic detailing may be punitive in nature

# State of Illinois Opioid Action Plan (SOAP)

SOAP Strategy #6: Address high-risk prescribing and dispensing through peer-to-peer academic detailing

- Provide peer-to-peer AD and/or technical assistance to prescribers and dispensers
  - Supplement knowledge of chronic pain management, OUD/SUD, and opioid prescribing
  - Specifically including racial and ethnic minority providers and associations

- Work with project partners to develop process for identifying high-risk prescribers and dispensers

Metrics (summarized)

- Roster of trained peer educators
- Number of peer education sessions (AD visits)
- Number of prescribers & dispensers participating
- Process for identifying high-risk prescribers

# Illinois Advance at UIC

**A**cademic **D**etailing **V**isits **A**nd **N**ew Evidence **CE**nter

- Illinois Public Act 101-0278 required evidence-based, non-commercial education program for Medicaid prescribers
- Separate from ILPMP directed academic detailing
- Multiple disease states and topics covered, including opioid prescribing & management, asthma, diabetes, and sexually transmitted infections
- ACCME accredited continuing education offered on many topics
- Any healthcare provider can request education/information from Illinois Advance

https://illinoisadvance.com/

# Moving Forward

- Pharmacist Review Process
  - Similar to Peer Review Committee prescriber RFI process
  - Currently establishing criteria to identify pharmacies
  - PIC (Pharmacist in Charge) will be point of contact for each pharmacy
- Continuing Peer Review Committee high-risk prescriber process
- Expansion of prescriber AD
  - Increase prescribers beyond PRC process
  - Lower threshold for second tier of "high-risk" prescribing

Questions?

**ILPMP.org**
**Contact information:**

**Fax: (217) 557-7975**
dhs.pmp@illinois.gov
Eric.huff@illinois.gov
Sarah.pointer@illinois.gov

ILPMP
Illinois Prescription Monitoring Program

UTAH | COMMERCE

Division of Professional Licensing

# Utah's Controlled Substance Database

# Controlled Substance Database

Utah's Prescription Drug Monitoring Program

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Public Health Consultant

**Ellen Maxfield**
Public Health Consultant

# CSD Utilization

## Three Primary Users:

1-Law Enforcement/Courts

2-The Utah Department of Health

3-Division of Professional Licensing

# Controlled Substance Database

- WELCOME
- PRESCRIBER TRAINING EXAM
- SUBMISSION OF DATA
- DATA ACCESS
- ACADEMIC DETAILING
- LAWS & RULES
- FREQUENTLY ASKED QUESTIONS
- FORMS
- TOOLS AND RESOURCES
- CONTACT US

## Welcome!

Log Into the CSD

Utahs Controlled Substance Database Program (CSD) is a resource that assists prescribing practitioners and pharmacists in providing efficient care for their patients and customers usage of controlled substances.

The Utah Controlled Substance Database Program was legislatively created and put into effect on July 1, 1995. The CSD collects data on the dispensing of Schedule II-V drugs from all retail, institutional, and outpatient hospital pharmacies, and in-state/out-of-state mail order pharmacies. The data is disseminated to authorized individuals and used to identify potential cases of drug over-utilization, misuse, and over-prescribing of controlled substances throughout the state.

Click for information regarding approved Controlled Substance Continuing Education Courses.

# Controlled Substance Database

# When is it Required to Check the CSD?

1-“A prescriber shall check the database for information about a patient before the **first time** the prescriber gives a prescription to a patient for a **Schedule II opioid or a Schedule III opioid**”

2-“If a prescriber is repeatedly prescribing a **Schedule II opioid or a Schedule III opioid** to a patient, the prescriber shall **periodically review** information about the patient in the database or other similar records of controlled substances the patient has filled”

3- In 2022 session, 58-37-6 (11), effective 5/4/2022: “A practitioner who issues a **high risk prescription** to a patient shall, before issuing the high risk prescription to the patient, **verify in the database** that the patient does not have a high risk prescription from a **different practitioner** that is currently active.”

High Risk Prescription = Rx for opiate or benzodiazepine for longer than 30 consecutive days

4- Must **consult** other practitioner, **document** the contact and why the pt. needs multiple high risk prescriptions from different providers

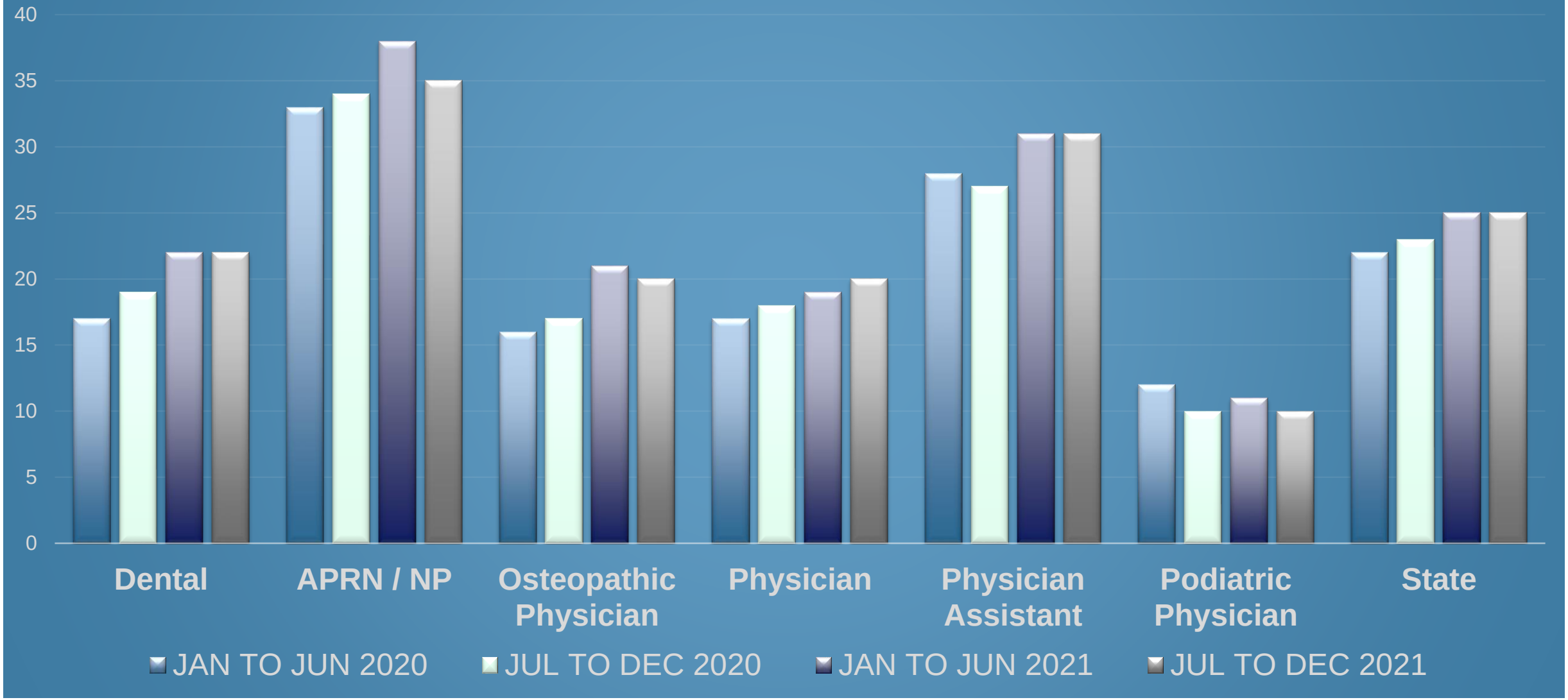
# Utah House Bill 186

**Amendment to the CSD Act Passed in Utah**
**2019 GENERAL SESSION**

Section 58-37f-702: **Reporting prescribed controlled substance poisoning or overdose to a practitioner.**

"When the division receives a report from the medical examiner under Section 26-4-10.5 regarding a **death caused by poisoning or overdose involving a prescribed controlled substance**, for each practitioner identified by the medical examiner under Subsection 26-4-10.5 (1)(c), the division: (i) shall, **within five business days** after the day on which the division receives the report, provide the practitioner with a copy of the report; and **(ii) may offer the practitioner an educational visit to review the report. (b) A practitioner may decline an educational visit described in Subsection (2)(a)(ii).** (c) The division may not use, in a licensing investigation or action by the division: (i) information from an educational visit described in Subsection (2)(a)(ii); or (ii) a practitioner's decision to decline an educational visit described in Subsection (2)(a)(ii)"

# AVERAGE % USAGE OF THE CSD BY PROFESSION of the Registered CSD users (No EHR)



# Public Health Consultations

Interactive educational outreach to medical practitioners with the goal of improving patient care.

We provide unbiased, noncommercial, evidence-based information.

We provide technical assistance on Controlled Substance Database utilization before prescribing Schedule II or III opioids.

# How to we get Practitioners to meet?

# Opioid Ratio Report (ORR)

A report is generated and compiled each month to list the practitioners that have a dispensed opioid attributed to their DEA and the providers that have used the CSD directly.

- Number of zero searches with scripts attributed

PRESCRIBER LIST of ACTIVE CSD USERS FROM THE OPIOID RATIO REPORT (ORR)
0
***IMPORTANT PLEASE READ*** 3 of 5
Source ID: 101814193
Report Date: 7/19/2022

Prescriber by Dispensing Count with Zero Search Count

| ORDER | DEA | NAME | DC | SC | DC/SC |
|---|---|---|---|---|---|
| 1 | Provider #1 | Provider Name #1 | 480 | 0 | 480 |
| | Provider #1 X | Provider Name #1 | 3 | 0 | 3 |
| 2 | Provider #2 | Provider Name #2 | 165 | 0 | 165 |
| 3 | Provider #3 | Provider Name #3 | 126 | 0 | 126 |
| 4 | Provider #4 | Provider Name #4 | 117 | 0 | 117 |
| 5 | Provider #5 | Provider Name #5 | 113 | 0 | 113 |
| | Provider #5 X | Provider Name #5 | 1 | 0 | 1 |
| 6 | Provider #6 | Provider Name #6 | 111 | 0 | 111 |
| 7 | Provider #7 | Provider Name #7 | 104 | 0 | 104 |
| 8 | Provider #8 | Provider Name #8 | 98 | 0 | 98 |
| 9 | Provider #9 | Provider Name #9 | 93 | 0 | 93 |
| | Provider #9 X | Provider Name #9 | 30 | 0 | 30 |
| 10 | Provider #10 | Provider Name #10 | 91 | 0 | 91 |
| 11 | Provider #11 | Provider Name #11 | 91 | 0 | 91 |

# Stimulant Ratio Report (SRR)

A report is generated and compiled each month to list the practitioners that have a dispensed stimulants attributed to their DEA.

- Number of zero searches with scripts attributed

# Office of the Medical Examiner


- Practitioner is  emailed  a letter
  - Offer of education to provider
  - They can respond through an online form

# Future

- Those with new DEA licenses in Utah
- DEA
- Adult Probation & Parole Officers
- Expand Searching reports for other users
  - High prescribers with few searches, etc

UTAH DEPARTMENT OF COMMERCE
Division of Professional Licensing

# Controlled Substance Database Consultation

Please fill out the information to help us set up an appointment for consultation on using Utah's Controlled Substance Database (CSD). This will be a brief 15-20 minute visit.

Your completion of the form signifies your willingness to participate in this consultation. Attempts will be made to maintain your confidentiality as any information reported from this form will be shared only in aggregate data. Your participation is optional and voluntary.

.

ckitchens@utah.gov Switch account

Not shared

* Indicates required question

**First and last name** *

Your answer

**Email address** *

Your answer

**Cell phone number** *

Your answer

**Preferred method of contact:** *

Choose

**Preferred method for meeting:**

Choose

**Which method of contact did you receive from DOPL/CSD?**

- ○ I received an email about one of my patients regarding the Office of Medical Examiners report
- ○ I received a certified letter from the Division of Professional Licensing (DOPL)
- ○ I received an email offering me training on using the CSD
- ○ I wasn't contacted by DOPL/CSD
- ○ Other:

**Consultation topic preferences: (Check all that apply)**

- [ ] Reset UTAH ID passwords, update Multifactor Authentication and/or general help with logging in
- [ ] Proxies/Delegates – adding or deleting a proxy
- [ ] Navigating the Dashboards (Patient and Provider)
- [ ] Explore Database features including searching tips
- [ ] Calculating the Morphine Milligram Equivalent (MME)
- [ ] Controlled Substance Database (CSD) Laws & Rules
- [ ] Utah Clinical Guidelines for Prescribing Opioids & The CDC Clinical Practice Guideline for Prescribing Opioids for Pain (2022 Clinical Practice Guideline)
- [ ] Other: _____

**Pre-consultation review**

This section will help us understand your use of the Controlled Substance Database (CSD)

How familiar are you with the following CSD laws?

| | Very familiar | Familiar | Somewhat |
|---|---|---|---|
| Requirement of when to check the CSD | ○ | ○ | ○ |
| Medication combinations considered high risk (opioid/benzo) | ○ | ○ | ○ |
| Co-prescribing Naloxone with opioids (law is active 1/1/24) | ○ | ○ | ○ |
| Third-party notification | ○ | ○ | ○ |

How helpful is the CSD as a clinical tool to inform you when:

| | Helpful | Not helpful | Neutral/Unsure |
|---|---|---|---|
| Patient has high risk medication combinations? | ○ | ○ | ○ |
| Patient is seeing multiple providers? | ○ | ○ | ○ |
| Patient has drug related records (justice system, hospital overdose or medical cannibas card)? | ○ | ○ | ○ |
| Checking your DEA # for fraudulent use | ○ | ○ | ○ |

These are challenges you face when using the CSD

| | Agree | Disagree | Neutral/Unsure |
|---|---|---|---|
| Takes too much time | ○ | ○ | ○ |
| The CSD is difficult to navigate | ○ | ○ | ○ |
| Difficulty accessing/logging in | ○ | ○ | ○ |
| The CSD is not embedded in my EHR | ○ | ○ | ○ |
| I do not consider the data up-to-date | ○ | ○ | ○ |
| Out of state patient searching is difficult | ○ | ○ | ○ |
| I do not consider the data reliable | ○ | ○ | ○ |

# CSD Patient Dashboard Navigation

# What is the CSD Patient Dashboard?

Live: November 2017

## Electronic Clinical Decision-Making Tool within the CSD

- The patient dashboard contains data regarding:
  - Prescriptions for dispensed CS(S)
  - Poisoning or overdose
  - Certain violation of Utah Controlled Substance Act

## Four Metrics

- Total Active Daily Morphine Milligram Equivalents
- Number of Prescribers in 6 Months
- Number of Pharmacies in 6 Months
- Active Benzo Opioid Combo

## Collaborative Effort

Utah Department of Commerce
Division of Professional Licensing

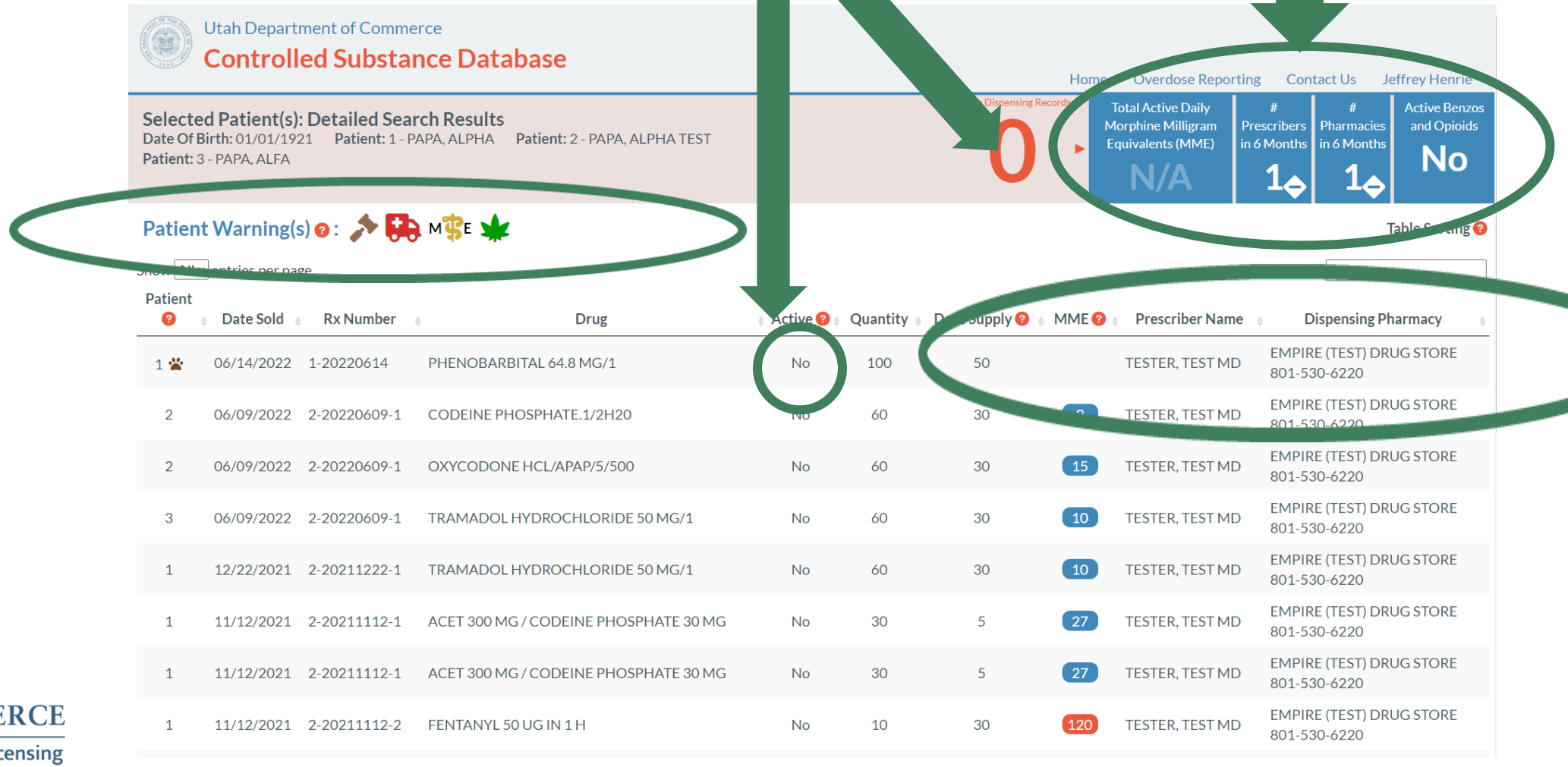
utah govops

Utah Department of Health & Human Services

# Dashboard Patient Metrics Example

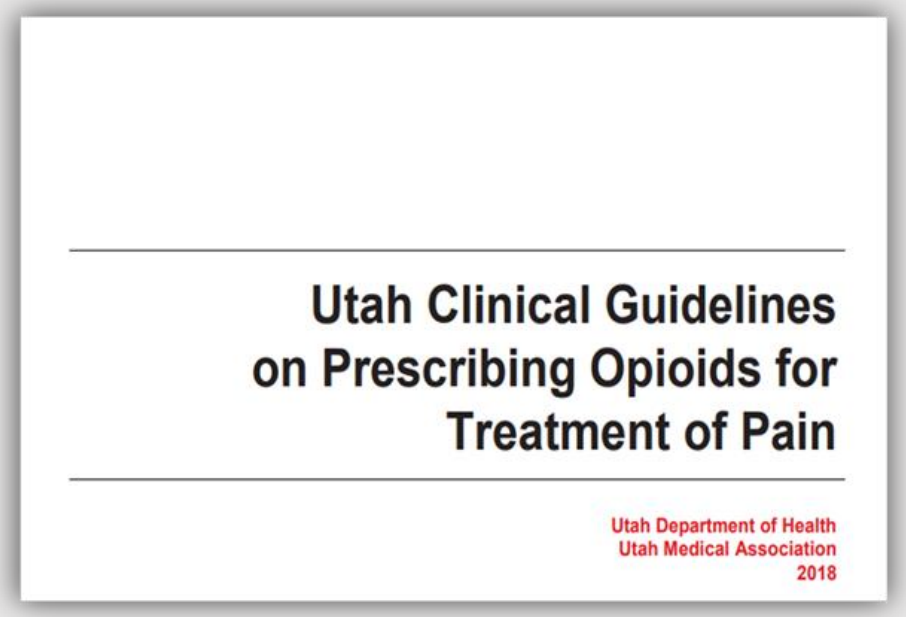
**Zero Active Dispensing Records**

**Click on any Four Metrics to "Learn More"**



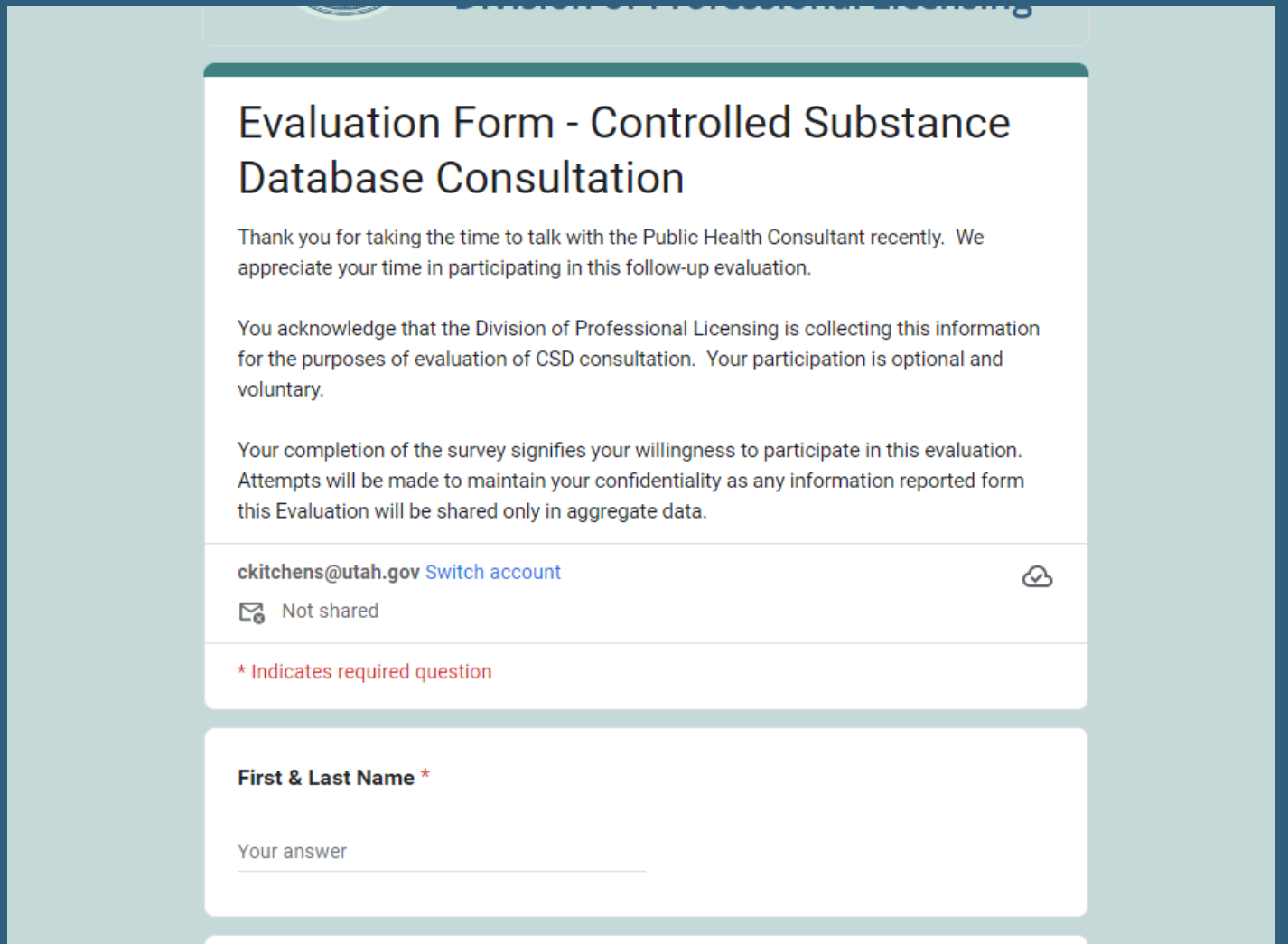
# Best Practices Prescribing Opioids


Provides recommendations to prescribers regarding best practices in the prescribing of opioids



# Evaluation

2 Instruments just created



## Evaluation Form - Controlled Substance Database Consultation

Thank you for taking the time to talk with the Public Health Consultant recently. We appreciate your time in participating in this follow-up evaluation.

You acknowledge that the Division of Professional Licensing is collecting this information for the purposes of evaluation of CSD consultation. Your participation is optional and voluntary.

Your completion of the survey signifies your willingness to participate in this evaluation. Attempts will be made to maintain your confidentiality as any information reported form this Evaluation will be shared only in aggregate data.

ckitchens@utah.gov Switch account

Not shared

* Indicates required question

**First & Last Name** *

Your answer

# Questions?

# CSD Contact Information

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# Thank you!

PDMP TTAC

Prescription Drug Monitoring Program Training and Technical Assistance Center

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**Telephone: 850/481-PDMP (7367)**

**Website: www.pdmpassist.org**