

Prescription Drug Monitoring Program Center of Excellence at Brandeis

Use of PDMP Data by Opioid Addiction Treatment Programs

February 2015



BJA
Bureau of Justice Assistance
U.S. Department of Justice

This project was supported by Grant No. 2011-PM-BX-K002 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Use of PDMP data by opioid addiction treatment programs

- Table of Contents -

Background -----	3
Treatment program access to PDMP data-----	3
North Carolina: Update from Stepping Stone -----	4
Washington: Evergreen Treatment Services -----	5
Delaware: Brandywine Counseling and Community Services -----	6
Vermont: Chittenden Clinic -----	6
Massachusetts: Community Substance Abuse Centers-----	7
Buprenorphine treatment -----	7
Perceptions of PDMP usability -----	8
OTP non-disclosure of methadone and buprenorphine to PDMPs -----	8
Conclusion-----	10
Acknowledgements-----	10

Use of PDMP Data by Opioid Addiction Treatment Programs

Background

Longstanding abuse of illicit opioids such as heroin, along with the more recent prescription opioid abuse epidemic, has generated a pressing need for opioid addiction treatment. Opioid treatment programs (OTPs) and Office-Based Opioid Treatment Programs (OBOT) are two types of medication assisted treatment (MAT) practices that address this need. Based on individualized clinical assessments, OTPs and OBOTs provide treatment that ensures access to the most appropriate FDA-approved medications (i.e., methadone, buprenorphine, and naltrexone). In using these medications, it is critical for patient safety and MAT effectiveness for programs to monitor their patients' use of other controlled substances. Methadone in particular can be lethal when taken in unsupervised combination with other opioids, benzodiazepines, or alcohol, or when taken in excessive amounts using methadone obtained outside the OTP ("double dosing").

Data from prescription drug monitoring programs (PDMPs) are increasingly used by OTPs and OBOT providers to ensure that if patients are being prescribed controlled substances, they are medically warranted and taken as directed. Absent such data, treatment providers are left prescribing and dispensing in the dark, their patients at risk of continued addiction, overdose, and death, while some may be diverting prescription drugs. Prior to adopting the use of the PDMP as standard practice, the medical director of an OTP in North Carolina found, checking the PDMP, that 23% of patients were receiving controlled substances that weren't disclosed to staff.¹ A Washington OTP found that 28% of patients were receiving undisclosed controlled substances (see below re Evergreen Treatment Services).

This briefing describes how a convenience (non-random) sample of OTPs and OBOT providers is currently using PDMP data and the benefits and limitations of such use. Although the programs described here are not necessarily representative, similar procedures are likely followed by many of the addiction treatment providers that access their state's PDMP. The objectives, in all cases, are the same: to keep patients safe and healthy, maximize the effectiveness of addiction treatment, and curtail the diversion of controlled substances.

Treatment Program Access to PDMP Data

Since PDMPs have only recently been established in all states but Missouri, use of PDMP data by OTPs and other addiction treatment providers is an equally recent phenomenon. In 2011, Westley Clark, then director of the Center for Substance Abuse Treatment (CSAT) at the Substance Abuse and Mental Health Services Administration (SAMHSA), issued a "Dear Colleague" [letter](#) to treatment providers recommending use of prescription history data, citing a PDMP Center of Excellence case study (see note 1). Although access to a patient's PDMP

¹ See "Keeping patients safe: a case study on using PDMP data in an outpatient treatment setting," http://www.pdmpexcellence.org/sites/all/pdfs/methadone_treatment_nff_%203_2_11.pdf

Use of PDMP data by opioid addiction treatment programs

data, like other health data, is generally allowed only for medical providers who have an established relationship with the patient, some states permit addiction treatment programs such access. As of this writing, 14 PDMPs have authority to release data to treatment programs.² Moreover, some states *require* that OTPs check a patient's prescription history upon admission and at intervals thereafter.³ Given the safety and treatment effectiveness considerations mentioned above, and its increasing acceptance by programs nationwide, use of PDMP data by MAT programs and OBOT providers seems on track to become a widely adopted best practice. The American Association for Treatment of Opioid Dependence ([AATOD](#)) recommends use of PDMP data and has issued preliminary guidance on such use.⁴ The programs described here provide methadone maintenance treatment for the majority of their patients, but some also provide buprenorphine, usually in a buprenorphine/naloxone combination medication. The protocols for use of PDMP data are similar for both groups, but use of the PDMP by OTP and OBOT programs that provide buprenorphine is covered in its own section below.

North Carolina: Update from Stepping Stone

A 2011 COE case study (see note 1), documented the adoption of PDMP reports as a clinical tool by Stepping Stone, a North Carolina OTP, among the first in the state to do so. The medical director of the program reported that it is now standard policy in the state for OTPs to review patients' prescription histories. The North Carolina OTPs have adopted a consensus statement on MAT best practices which recommends use of the PDMP at intake and at least every six months, and that the most recent PDMP report be placed in the patient's medical record. Now that patients know at admission that their prescription data will be checked, there are few instances in which such checks reveal prescriptions not disclosed to the OTP staff. This compares favorably with the first queries in 2010, in which 23% of patients were found to have undisclosed prescriptions. If undisclosed prescriptions are discovered, patients are asked to sign a release of information (ROI) form allowing their treatment status to be communicated to their prescribers; signing the ROI is requisite for remaining in treatment. The prescribers are contacted to coordinate care, ensuring that only medically necessary drugs are being used by the patient. Because discoveries of undisclosed prescriptions are now relatively rare, the medical director determined that a check of the PDMP at intake and every six months was adequate, unless reason for concern arises for a particular patient. In North Carolina OTPs, PDMP data can be accessed by non-prescribing staff as well as the medical director.

² These states include CO, DE, IL, IN, ME, MD, MS, MT, NY, ND, SC, SD, UT, and WY. Data from a 2014 survey of state PDMPs carried out by the PDMP Training and Technical Assistance Center at Brandeis.

³ States with mandates for OTPs to check the PDMP include IN, MN, MI, ND, NC, RI, TN, VT, WA, and WV. Data courtesy of NAMSDDL at <http://www.namsdl.org/library/4475CD3E-1372-636C-DD2E5186156DFB6F/>.

⁴ "AATOD believes that the PMP provides a vital source of information for the safe care of our patients and encourages all OTPs to utilize their respective state PMP databases." From AATOD's guidance on use of PDMP data by OTPs at <http://www.aatod.org/policies/policy-statements/guidance-to-otps-concerning-the-use-of-prescription-monitoring-program-pmp-databases/>

Use of PDMP data by opioid addiction treatment programs

Washington: Evergreen Treatment Services

In response to the letter from CSAT mentioned above, Seattle-based Evergreen Treatment Services (ETS) instituted use of PDMP data in 2012, starting with a [notification to patients](#) that their prescription histories would be reviewed and encouraging them to disclose all prescriptions to staff. Initial reviews found that 36% of patients (514 out of 1421) had been prescribed Schedule II-V drugs. Of these patients, 55% had been prescribed opioids and 30% benzodiazepines, the two most commonly prescribed drugs. Under agency protocols developed in consultation with state and federal regulators, staff took action regarding 404 patients (28%) who had not disclosed all their prescriptions. These patients fell into three risk categories: those with one-time prescriptions (91, low risk), those with on-going or multiple prescriptions for opioids, benzodiazepines and/or stimulants (195, intermediate risk), and those with methadone prescriptions for pain (25, highest risk since they were “double dosing”). Patients in the latter two groups were offered the chance to sign a ROI allowing ETS to coordinate care with their prescribers; if they refused to sign, those receiving methadone outside the OTP were immediately discharged, with no re-admission for a year,⁵ and those receiving other opioids or controlled substances were tapered off methadone and discharged (an “administrative taper”). Patients in the lowest risk category met with the medical provider or a counselor to discuss the need to disclose all medications to staff. In all, following the initial queries to the PDMP, 43 patients were discharged, 62 were retained in treatment contingent on a signed ROI, and 150 were reminded about their obligation to disclose prescriptions.⁶

Currently, ETS staff (medical providers and nurses) query the PDMP at admission and at least every six months during the first year of treatment, then as part of the annual medical exam; PDMP reports are placed in the patient’s file. Queries are also run when a patient is being considered for take home doses of methadone or an increase in such doses, or if the patient exhibits signs of impairment, a worrisome change in behavior, or tests positive for controlled substances not attributed to authorized prescriptions. Patients are fully informed about these procedures and understand, at admission, that their ongoing treatment is contingent upon their disclosure of medications and checks of the PDMP data.

When confronted with a PDMP report showing undisclosed prescriptions, which happens infrequently since patients know their prescription histories will be checked, most patients agree to discontinue any medically unnecessary prescriptions and sign an ROI allowing coordination of care with outside prescribers; a few will refuse and are discharged from the program. Prescribers contacted under these circumstances are often unaware that their patient is in addiction treatment, and usually understand the need to terminate or adjust a prescription to conform to good medical practice. If a patient is receiving prescriptions outside the OTP but does not test positive for the prescribed medications, the patient may be diverting them,

⁵ The executive director reported that the policy of immediate discharge for undisclosed methadone prescriptions is being revisited given the priority of keeping patients in treatment.

⁶ These data are included in a presentation by Ron Jackson at http://www.dpt.samhsa.gov/pdf/ETS_PMP_2012_508.pdf.

Use of PDMP data by opioid addiction treatment programs

possibly in collaboration with unscrupulous prescribers or pill mills. Failure to find the prescribed medication in the patient's urine drug screen is cause for follow-up.

The executive director described the PDMP as an invaluable tool, used daily, which has helped to improve the treatment milieu by reducing drug dealing and impairment. Transparency and trust are maintained by notifying patients at intake, and at intervals thereafter, that their prescription data will be reviewed, a key element of successful PDMP utilization.

Delaware: Brandywine Counseling and Community Services

This Wilmington, Delaware OTP began reviewing patient prescription histories in 2013, a practice that the medical director described as “eye-opening.” Some clients that appeared to be doing well in treatment were discovered, with the help of the PDMP, to be selling prescribed controlled substances or using them non-medically. Brandywine's policies on PDMP utilization are similar to those described above: clients' prescription histories are reviewed at intake, then on a random basis or periodically if there is reason for concern. PDMP data are also reviewed if a drug screen comes back positive, e.g., for benzodiazepines undisclosed to staff. Should undisclosed prescriptions be found, clients meet with the medical director or clinician and are asked to sign a ROI permitting contact with their prescribers to coordinate care. Should they refuse, clients undergo a medically supervised withdrawal and are subsequently discharged. As with other OTPs, clients are informed of these policies in advance, so they enter treatment knowing that it's likely any non-medical use or diversion of prescribed medications they obtain from providers outside the OTP will be discovered.

Currently, PDMP queries are conducted by the medical director and a physician's assistant, but newly adopted regulations in Delaware will permit nurses to access the PDMP, which Brandywine Counseling will take advantage of soon.

Vermont: Chittenden Clinic

The Chittenden Clinic in Burlington, Vermont provides methadone and buprenorphine treatment, among other services, and began accessing PDMP data in 2011, shortly after the inception of the Vermont PDMP. Vermont has recently mandated that all OTPs check their patients' prescription history at intake, at which time patients give informed consent and sign a release. State guidelines for office-based opioid treatment (OBOT) programs with over 30 patients recommend that the PDMP be checked quarterly. Checks at Chittenden are also triggered by positive drug tests or behavioral evidence of non-medical substance use. Clinical management software used by the program includes a prompt to conduct quarterly queries and record the date when they are completed. As with the programs described above, the clinic informs patients regarding its access to their PDMP data.

If prescriptions that conflict with MAT protocols are found, after receiving patient consent, Chittenden notifies the prescribers that their patients are in addiction treatment and need

Use of PDMP data by opioid addiction treatment programs

coordinated care concerning medications.⁷ The medical director emphasized the importance of tapering off benzodiazepines, or very strict monitoring of their use, given the dangers of interactions with opioids. Most patients agree to such measures as a condition of entering or remaining in treatment. Overall, queries of PDMP have been “low yield,” in that few undisclosed prescriptions have been found, due in part to the deterrent effect of knowing searches will be performed. Consequently, PDMP reports usually validate the patients’ report of their current medications. Queries are usually performed by nurses, although Vermont regulations permit clinic staff without medical licenses to perform them as well.

Massachusetts: Community Substance Abuse Centers (CSAC), Boston

CSAC is a privately owned and operated OTP with 16 locations in New England, including Boston. The medical director of the Boston site reported that CSAC has fields in its program management software for a PDMP query to be performed at intake and for the annual medical check-up. Queries are also conducted for cause, e.g., positive drug screens or behavior suggestive of non-medical substance use or diversion. They are often conducted in “real time” with the patient during a clinical assessment or check-in with the medical supervisor. Should discrepant prescriptions appear in the PDMP report, a conversation ensues about the advisability of taking the medications given the dangers of polypharmacy: over-sedation, memory loss, vulnerability to being robbed, respiratory depression, overdose and death. The patient’s prescribers outside the OTP are contacted and encouraged to increase their monitoring and to work closely with the program to ensure patient safety. Although the medical director found the PDMP data query platform cumbersome and time consuming (see below), like others interviewed for this report, he found PDMP data were of great value in monitoring patient substance use and for confirming or disconfirming self-reported use of controlled substances.

Buprenorphine treatment

Most of the programs mentioned above provide both methadone and buprenorphine, the latter usually in combination with naloxone, for pharmacotherapy treatment. Patients receiving buprenorphine, like those on methadone, are screened using the PDMP as part of the intake process, and informed that their prescription history data will be reviewed regularly. Although buprenorphine taken with other drugs (e.g., other opioids, benzodiazepines, barbiturates, alcohol, cocaine) does not present the same risk for overdose as methadone, it is still important to minimize non-medical substance use by buprenorphine clients to help ensure their safety and the efficacy of treatment. Viewing PDMP data is an essential component of minimizing such use. Vermont requires that office-based buprenorphine providers check the PDMP at least three times a year.

⁷ The medical director reported that two clinics in northern Vermont, as part of their standard practice, obtain patient consent to notify a patient’s providers *and local emergency departments* that the patient is in MAT.

Use of PDMP data by opioid addiction treatment programs

Unlike methadone and buprenorphine dispensed by OTPs, buprenorphine prescribed by office-based addiction treatment providers is reported to state PDMPs when written prescriptions are filled at pharmacies. Queries to the PDMP can, therefore, reveal whether the patient is receiving buprenorphine or other controlled substances from any other providers – information crucial for safe and effective treatment. Queries can also show the date a buprenorphine prescription is filled, helping to monitor for overlapping prescriptions which can be an indication of possible diversion or misuse. As with methadone patients, those receiving buprenorphine are subject to initial and periodic queries to the PDMP. Should discrepant medications be found, patients are counseled on the need to coordinate care to ensure that only medically necessary drugs are being prescribed to them. Agreement by the patient on this score is generally a condition for continued treatment using buprenorphine.

Perceptions of PDMP usability

Some medical directors commented on the usability of their state's PDMP. Several found the data query platforms to be slow (“clunky”, “a lot of effort to check”) and non-intuitive; lack of integration with electronic health records and other health databases was seen as problematic. Time spent inputting patient names and downloading PDMP data was time that could be better spent with patients. In addition to integrating PDMPs with health IT systems, medical directors suggested creating an easy-to-use batch look-up function that support staff could access in advance of the next day's appointments, and maintaining a patient registry for prescribers to expedite data access. Vermont allows for batch checking which greatly reduces the time spent accessing PDMP data, according to the medical director at Chittenden.

Medical directors and OTP staff in states which have not yet authorized delegates were eager to expand access to PDMP data to non-prescribers such as nurse managers, a step which would save time for clinicians and greatly increase the chances a PDMP query would be carried out. Two short-comings pointed out by one respondent were that PDMP data don't necessarily include a patient's most recent prescriptions, depending on whether data are collected bi-weekly, weekly, daily, or in real time at point of sale (only Oklahoma has this last capability); and that at least in his state, prescription history reports are not time stamped, so it may not be clear when reports placed in a patient's file were retrieved.

One correspondent praised pharmacist use of the PDMP in assisting buprenorphine (or OBOT) providers. Dispensers will sometimes alert a provider should they discover prescriptions for controlled substances coming from multiple prescribers, or that might be contraindicated given a patient's status in MAT.

OTP non-disclosure of methadone and buprenorphine to PDMPs

The executive and medical directors interviewed for this report were invited to comment on federal 42 CFR Part 2 regulations. These prohibit OTPs from reporting dispensed methadone or buprenorphine to PDMPs in order to maintain confidentiality about their patients' status in chemical dependency treatment. Given concerns about the stigma attached to addiction,

Use of PDMP data by opioid addiction treatment programs

patients may choose to conceal their treatment status from providers outside the OTP. This means, however, that outside providers might prescribe doses of opioids, benzodiazepines, barbiturates and stimulants which they otherwise might not had they known their patients were receiving methadone or buprenorphine, given the risks of drug interactions, abuse, and overdose.

All those interviewed endorsed the privacy rationale for the current policy, and several thought that, at least in their locations, it was critical that providers not learn of their patients' treatment status, given prevailing attitudes about addiction. For some, perhaps many, patients, disclosure of that status would be a strong disincentive for them to enter treatment in the first place, so patients are usually reassured that the OTP does not submit any information to the PDMP (see for example the [notification to patients](#) issued by Evergreen Treatment Services). Nor do queries of the PDMP by the OTP on their patients reveal their status to outside providers. To varying degrees, however, the medical directors also acknowledged the downsides of not reporting MAT methadone and buprenorphine to the PDMP: the risk of sub-optimal (given treatment goals) and perhaps even dangerous prescribing due to ignorance of a patient's use of methadone or buprenorphine.

One respondent suggested that the OTP itself is in a position to detect medically inappropriate drug use by means of PDMP queries and drug screens, so that non-OTP prescriber awareness of methadone isn't necessary for patient safety. But, as another suggested, reliable detection of questionable prescribing for all clients would mean frequent checks of the PDMP, not the quarterly or once or twice annual checks that most OTPs carry out (North Dakota requires monthly checks for patients in its OTPs). Increasing the capacity of OTPs to conduct queries, obtain ROIs, and follow up with outside providers would help close the gap in awareness created by current regulations, and so presents an interim solution. But the ideal solution, according to most respondents, would be to permit OTP reporting of MAT pharmacotherapies like methadone and buprenorphine to the PDMP, were stigma concerning addiction to lessen sufficiently. Several suggested that increased public and medical education was needed to change prejudicial attitudes towards those in recovery before such reporting would be feasible. Since these attitudes vary regionally, and are liberalizing in some jurisdictions, permitting states to regulate reporting of OTP-dispensed methadone and buprenorphine to PDMPs, as opposed to the current federal ban on such reporting, would allow them to adopt policies congruent with the prevailing beliefs about addiction.

Because office-based (as opposed to OTP) buprenorphine prescriptions *are*, in some cases, reported to PDMPs, a subset of those in addiction treatment is in effect communicating their status to outside providers.⁸ Examining to what extent these patients are stigmatized by outside providers, and how outside provider knowledge of their status might contribute to de-stigmatizing addiction, may help inform MAT privacy policy.

⁸ In many cases, both the OBOT prescriber and the patient are unaware that this information is being submitted to the PDMP.

Use of PDMP data by opioid addiction treatment programs

Conclusion

The programs described above have roughly similar policies and procedures for accessing PDMP data to help monitor their clients' use of prescribed controlled substances. All those interviewed agreed that such access plays an important role in reducing medically unwarranted and possibly dangerous substance use, coordinating and improving patient care, increasing the chances of recovery, and reducing the diversion of prescribed medications. Informing patients in advance that their prescription histories will be reviewed helps to deter non-medical prescription drug use while maintaining transparency, trust and accountability in the therapeutic relationship.

Although the percent of OTPs and OBOT providers who access PDMPs is unknown, access has increased as more PDMPs have come online and as awareness has grown of their role in improving patient care. MAT programs and other addiction treatment programs that don't consult their state's PDMP are missing important data bearing on their patients' status. As noted above, some states therefore mandate that OTPs query the PDMP at intake and regularly thereafter.

It seems likely that use of PDMP data in substance abuse treatment is a best practice worthy of universal adoption. However, comments by the medical directors interviewed for this report suggest that much could be done to improve PDMP access and thus encourage use, including allowing delegates and integrating access with electronic health records. Optimizing the PDMP experience for drug treatment staff will make requirements to use it that much less onerous. Determining the appropriate frequency and triggers for PDMP queries, and appropriate policies for patients found to have undisclosed prescriptions, are also open questions which further experience by OTPs and OBOT providers will help to clarify. Guidelines on these and other aspects of PDMP utilization by substance abuse treatment programs are under development, according to CSAT. A published set of best operational practices and policies for the use of PDMP data by drug abuse treatment programs will encourage such use, helping to ensure patient safety and improve the chances of recovery.

Acknowledgments

The COE wishes to acknowledge the generous cooperation, expertise and editorial assistance of the following individuals in the preparation of this briefing:

John Brooklyn - Chittenden Clinic, Burlington, VT

Jana Burson - Stepping Stone, Boone, NC

Molly Carney - Evergreen Treatment Services, Seattle, WA

Michael Krafchick - Brandywine Counseling & Community Services, Wilmington, DE

Colleen Labelle - Office-based Opioid Treatment with Buprenorphine, Boston Medical Center

Jinhee Lee - Division of Pharmacologic Therapies, CSAT/SAMHSA

Alex Walley - Community Substance Abuse Centers, Boston, MA
