



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

**Referral to Treatment for Substance Use
Disorder Related to Opioid Use**

MODULE **5**

GUIDE DOCUMENT

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

Learning Objectives for Modules 1-7

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

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

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

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

Module 3: Using the PDMP to Optimize Pain Management

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

Module 4: Opioid Prescribing Guide

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

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

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

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

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

Module 7: Effective Opioid Tapering Practices

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

Table of Contents

Introduction	4
Defining a “Warm Handoff”	5
Guidelines for Establishing a “Warm Handoff” Protocol in Any Health care Setting	7
Conducting a “Warm Handoff” in Primary Care	8
Preparing to Conduct a “Warm Handoff” in Primary Care	8
Identifying Patients Who Might Need a “Warm Handoff”	10
Talking to Patients about Substance Use and a “Warm Handoff”	10
Conducting a “Warm Handoff” in the Emergency Medicine Site	13
How to Determine the Best Type of Treatment for the Patient Based on Assessment for Level of Care	14
Patient Confidentiality Considerations when Conducting “Warm Handoffs” and Analyzing PDMP Reports	16
Federal and State Level Confidentiality Considerations	16
PDMP Report Confidentiality Considerations	17
Links for Referral	18
Sources	20

Introduction

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

The need for early identification is high, with an estimated 21.7 million people aged 12 or older requiring substance use disorder treatment in 2015.¹ It is important to identify these individuals because early identification of substance use disorders is associated with improved treatment outcomes for patients, and early identification of individuals at an elevated risk for developing a substance use disorder has been associated with decreased chances of developing a substance use disorder.² Health care providers can use the PDMP to identify patients who may be misusing their prescription opioids or who are in the process of developing a pattern of misuse. Providers can then administer appropriate interventions to the patients and perform “warm handoffs” to specialty substance use disorder treatment providers. In order to optimize the process of early identification and ensure patient access to substance use disorder treatment when warranted, healthcare providers need to learn the proper skills to identify patients with possible substance use disorders using: (1) verified screens; (2) the appropriate communication techniques to encourage patients to pursue further assessment or treatment (when warranted); and (3) the effective methods for increasing the likelihood that the patient will access treatment services, such as conducting “warm handoffs.”

In this module, prescribers and pharmacists will learn how to determine whether a patient should be referred to substance use disorder treatment and how to conduct a “warm handoff” of that patient to specialty treatment.

This module has the following objectives:

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

Defining a “Warm Handoff”

A “warm handoff” is a collaborative effort between two members of a patient’s healthcare team for the purpose of improving the connection and reducing the gaps in services that the patient will receive. “Warm handoffs” can be conducted by prescribers, pharmacists, and behavioral health specialists.³ A general “warm handoff” consists of one team member presenting a patient face-to-face (or via telephone if necessary) to another team member for a healthcare service.⁴ Prior to the handoff, the team member who has had the most interaction with the patient discusses (using patient-centered communication strategies such as motivational interviewing principles) why the referred service is beneficial to the patient’s health. The initial or index provider should begin the “warm handoff” by connecting the patient to its practice site patient navigator.¹ The initial healthcare provider should relay to the patient the important role of the patient navigator and perform the introduction between the patient navigator and the patient.

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

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

A “Warm Handoff” Conducted via Telephone:

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

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

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Defining a “Warm Handoff” *(continued)*

In general, all patients who may require assessments for substance use disorder treatment should receive appointments at this entity within 48 hours. This is because persons who may have a substance use disorder, especially an addiction to opioids, are at risk for overdosing or other deleterious outcomes while they wait to access assessment/treatment. Thus, **all** patients who are referred to a substance use disorder treatment entity and who are suspected of having an opioid use disorder should also receive a naloxone kit, for intra-nasal administration, and instruction on how to use this kit before he/she leaves the practice site. If a naloxone kit cannot be provided to the patient, a

prescription should be written that the patient can fill at his/her pharmacy. Patients who cannot immediately access substance use disorder treatment should also be linked to recovery support services or self-help programs, such as Narcotics Anonymous, within the community. (See list of Single County Authorities below to contact for more local recovery support services.) Practices should have access to information regarding effective Alcoholics Anonymous or Narcotics Anonymous meetings in communities where their patients reside. This list of meetings can also be provided by the local Single County Authority or local substance use disorder treatment programs.

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- ⁱ A patient navigator is a member of the health care team who has been assigned the responsibility of assisting patient access to specialty treatment, such as substance use disorder treatment. Patient navigators are typically persons who have shared life experiences with the patient (i.e., sometimes they are certified recovery specialists who are also in recovery). Patient navigators may also be other members of the healthcare team who have other patient care responsibilities (i.e., nurses or social workers).
- ⁱⁱ Recovery support services are culturally and linguistically appropriate services that assist individuals and families working toward recovery from mental and/or substance use problems.
- ⁱⁱⁱ Single County Authorities are organizations that receive funding through the Pennsylvania Department of Drug and Alcohol Programs in order to manage drug and alcohol services at a social level. Each Pennsylvania Single County Authority can be found here: <http://www.pacwrc.pitt.edu/curriculum/309%20Drug%20and%20Alcohol%20Issues/Handouts/HO%2019%20Single%20County%20Authority%20List%203-29-2016.pdf>
- ^{iv} Central Intake Units serve as the points of contact for individuals in need of substance use, mental health or intellectual disabilities services. Not all Single County Authorities within Pennsylvania have Central Intake Units; instead clinical assessment and placement may be done by a substance use disorder treatment provider.

Guidelines for Establishing a “Warm Handoff” Protocol in Any Healthcare Setting

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

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

Conducting a “Warm Handoff” in Primary Care

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

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

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

i. <http://www.integration.samhsa.gov/images/res/CAGEAID.pdf>

ii. http://www.who.int/substance_abuse/activities/assist_v3_english.pdf?ua=1

iii. <http://www.mhqp.org/guidelines/perinatalpdf/ihrintegratedscreeningtool.pdf>

iv. <http://www.ceasar-boston.org/CRAFFT/>

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Conducting a “Warm Handoff” in Primary Care *(continued)*

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

Patient: I want to quit my substance use, but I just can't. I got fired from my job, and I'm getting evicted.

Provider: It can be hard to make changes when you feel like there is so much disorder around you. I think that we can work together to come up with a solution. Do you feel ready to make a change?

Patient: Yes, I do, but I'm worried about the effects of withdrawal and relapsing.

Provider: I understand why you are worried, but we can link you to services that will help your recovery and can help you manage any side effects. Can I provide you with some more information on these services?

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

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Conducting a “Warm Handoff” in Primary Care *(continued)*



Identifying Patients Who Might Need “Warm Handoffs”

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

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

Patient: Thank you.

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

Talking to Patients about Substance Use and a “Warm Handoff”

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

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

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

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

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Conducting a “Warm Handoff” in Primary Care *(continued)*

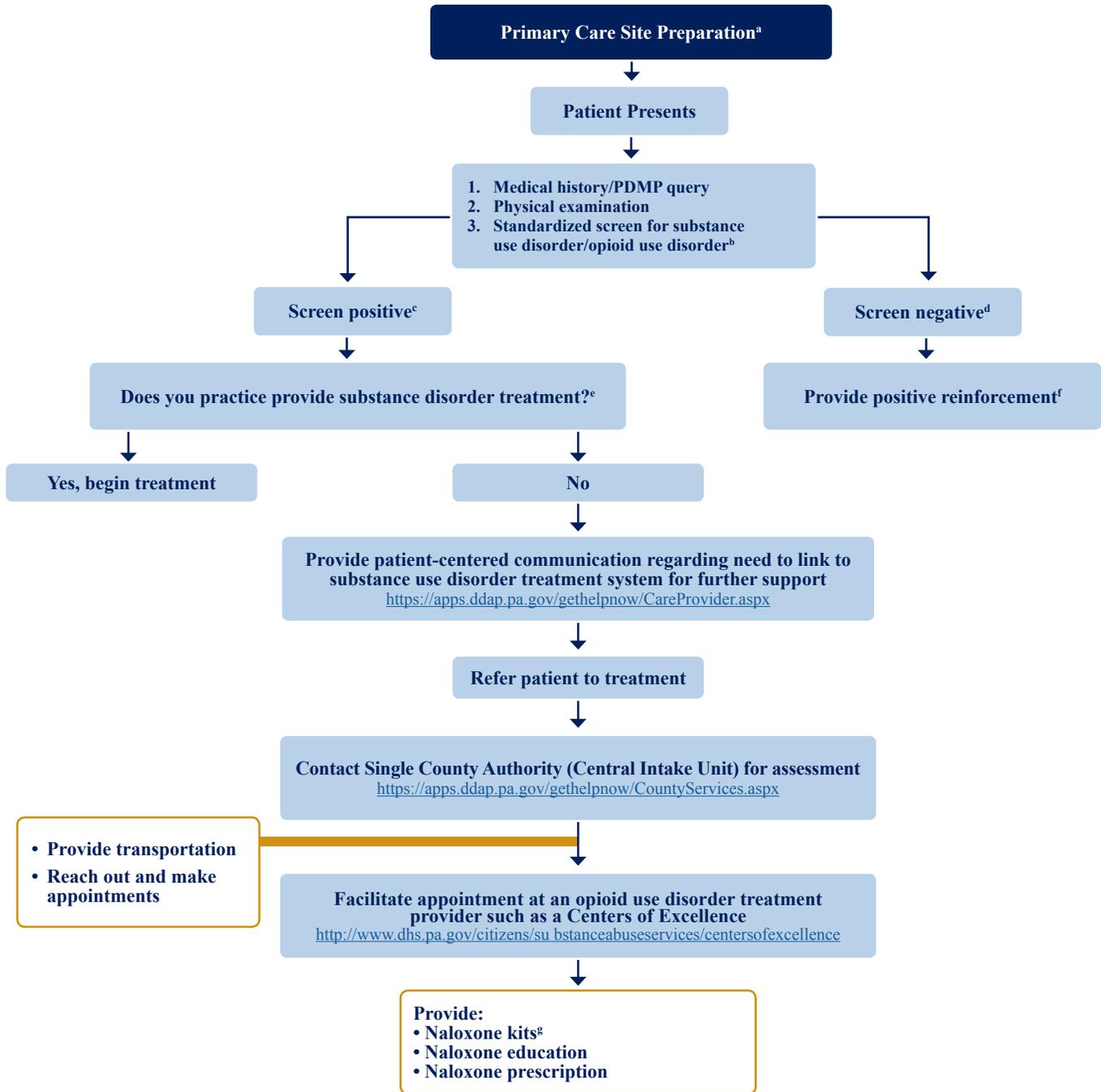


Figure 1: Example of a “Warm Handoff” in a Primary Care Site

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

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

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

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

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

^f Reinforce healthy behavior(s) through positive reinforcement.

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

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Conducting a “Warm Handoff” in Primary Care *(continued)*

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

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



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

Conducting a “Warm Handoff” in the Emergency Medicine Site

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

Emergency Department “Warm Handoff”: For Opioid Use Disorder

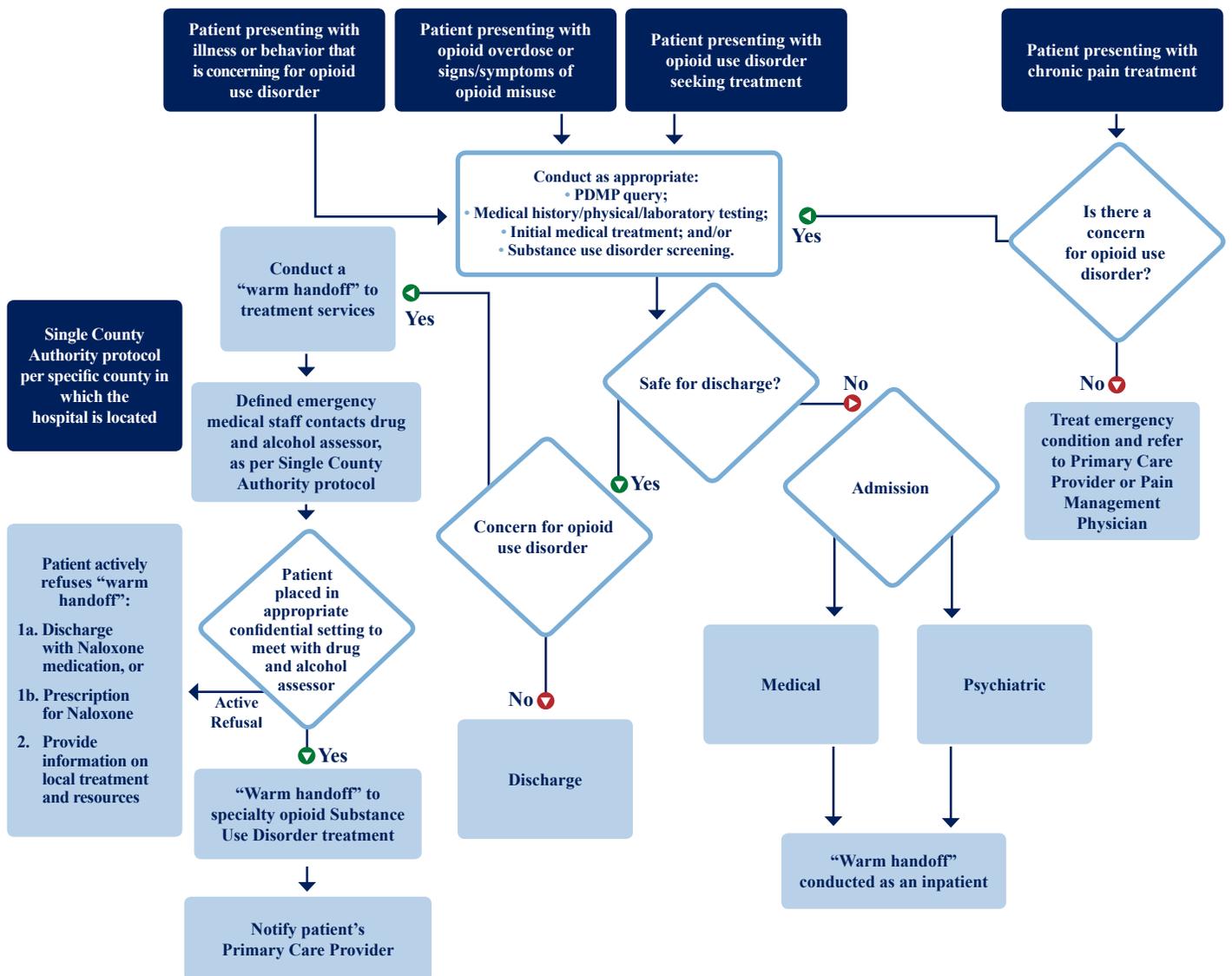


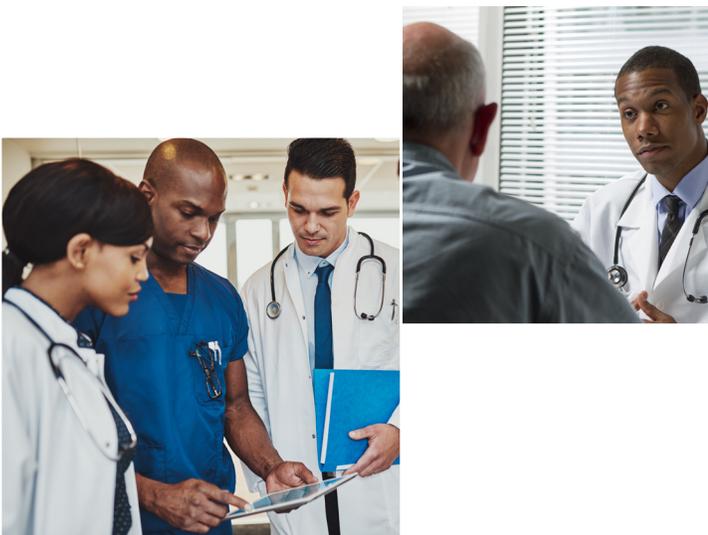
Figure 2: Example of Substance Use Disorder Referral to Treatment in the Emergency Medical Site
Image adapted with permission from the Pennsylvania Department of Drug and Alcohol and Programs.

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

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

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

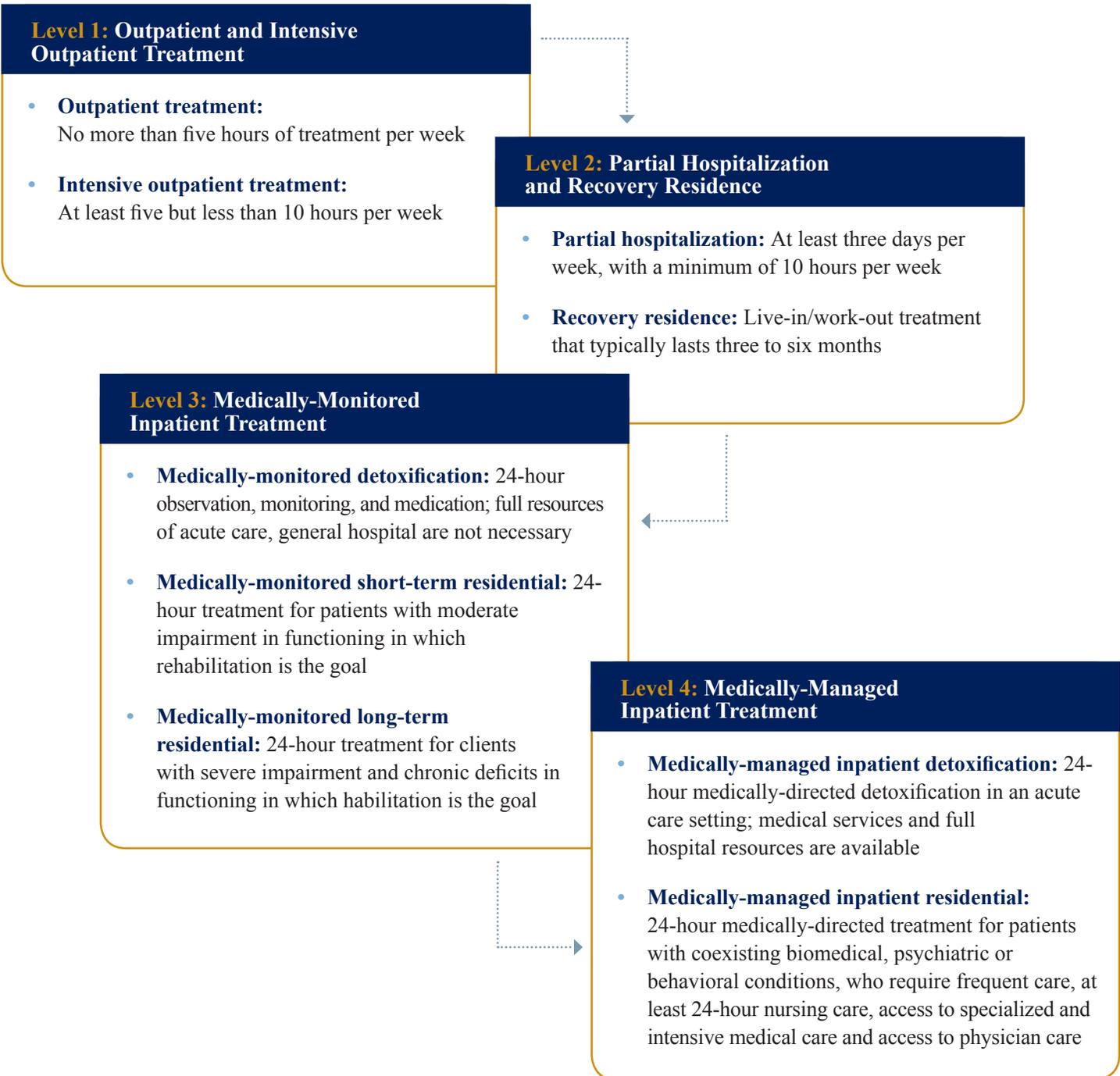
1. Acute intoxication and withdrawal should be considered to determine an individual's level of functioning, the degree to which his/her functioning is hindered and his/her risk for severe withdrawal.
2. Biomedical conditions and complications should be used to identify any medical problems that may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



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

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



Patient Confidentiality Considerations when Conducting “Warm Handoffs” and Analyzing PDMP Reports

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

Federal and State Level Confidentiality Considerations

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

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

Substance Use Information: Federal Confidentiality Regulations (42 CFR) relate to the handling of substance use related information and place restrictions on what can legally be discussed between individuals. In the event that the medical or substance use disorder provider works within a facility that is a 42 CFR covered program, the provider cannot share substance use disorder related information

that would identify the patient as having a substance use disorder. 42 CFR covered programs are commonly but not explicitly assisted by federal funds and involve substance use education, treatment, or prevention.

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

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

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

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

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

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

PDMP Report Confidentiality Considerations

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

^{*} <https://apps.ddap.pa.gov/tms/PortalCourseSearch.aspx?cti=2>

Links for Referral

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

1. Talk to the patient about the results of his/her PDMP query.
2. If the patient screens positive for a potential substance use disorder, the provider can use motivational interviewing principles and the POLAR*S Model to ask the patient if he/she is willing to engage in treatment.
3. If the patient agrees to accessing substance use disorder treatment, the following resources can be used for treatment referral:
 - a. **Single County Authorities:**
This link includes referral information for the Single County Authorities across Pennsylvania. Depending on the Single County Authority, it may service more than one county.⁹ Each county will have a designated protocol for a “warm handoff,” which is approved by the Pennsylvania Department of Drug and Alcohol Programs. As discussed above, these procedures vary based on local needs. For example, procedures in an urban area may be different than in a rural area. <https://apps.ddap.pa.gov/gethelpnow/CountyServices.aspx>
 - b. **Pennsylvania Get Help Now: 1-800-662-HELP (4357)**
This 24/7 toll-free hotline serves to help those with substance use problems by finding immediate help through one phone call, thus facilitating the connection into substance use disorder treatment.
 - c. **Care providers:**
This link includes substance use disorder treatment providers for each county in Pennsylvania. It can be searched by zip code or by county name. It also provides links for contacts who can help identify treatment providers and patient access to treatment.⁹ <https://apps.ddap.pa.gov/gethelpnow/CareProvider.aspx>
 - d. **Centers of Excellence:**
The Centers of Excellence throughout Pennsylvania provide resources to support and coordinate the patient’s recovery from opioid-related substance use disorder. They also ensure that patients on Medicaid with opioid-related substance use disorder adhere to their treatment. The following link outlines the locations and goals of these centers:
<http://www.dhs.pa.gov/citizens/substanceabuseservices/centersofexcellence/>.

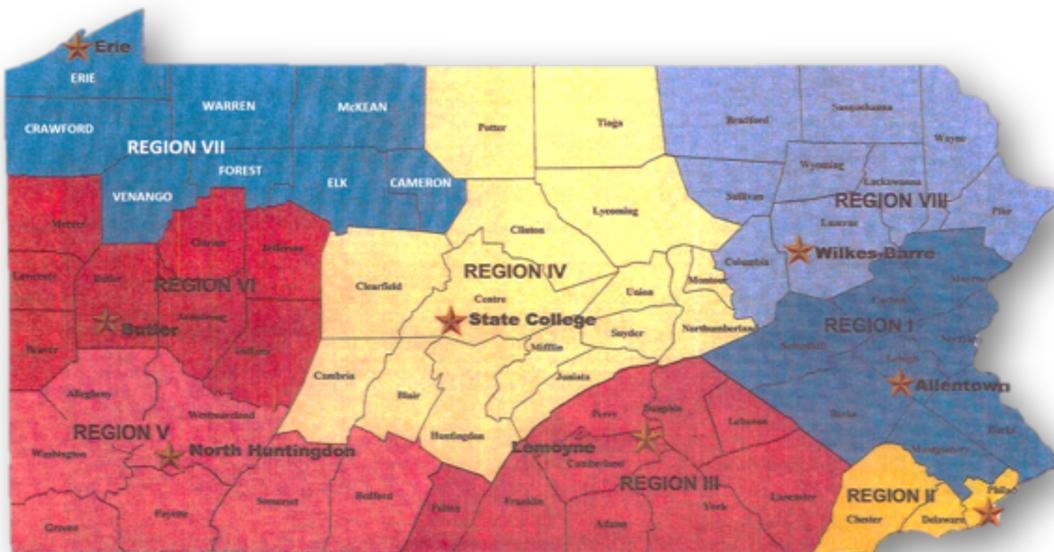
Continued ►

Links for Referral *(continued)*

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

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

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



Sources

- 1) Bose JH, S. L., Lipari, R. N., Park-Lee, E., Porter, J. D., Pemberton, M. R. . *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health*. 2016.
- 2) Samet JH, Friedmann, P., Saitz, R.,. Benefits of Linking Primary Medical Care and Substance Abuse Services. *The Journal of the American Medical Association*. 2001; 161(1):85-91.
- 3) Agency for Healthcare Research and Quality. *Design Guide for Implementing Warm Handoffs*.
- 4) Agency for Healthcare Research and Quality. *Implementation Quick Start Guide Warm Handoff*
- 5) Pennsylvania Department of Drug and Alcohol Programs. *Emergency Department Warm Handoff: For Opioid Use Disorder*. 2017.
- 6) M Miller W, Rollnick S. *Motivational interviewing: helping people change*. New York, NY: Guilford Press; 2013.
- 7) Coffey R, Houchens R, Chu B, et al. *Emergency Department Use for Mental and Substance Use Disorders*. Agency for Healthcare Research and Quality (AHRQ); 2010.
- 8) Florida Alcohol and Drug Abuse Association. *Impact of Substance Use Disorders on Health Care*. Florida.
- 9) SMaRT Policy Working Group. *Guidelines for Medical Health and Substance Treatment Systems*. 2010.
- 10) Commonwealth of Pennsylvania Department of Drug and Alcohol Programs. *Pennsylvania's Client Placement Criteria For Adults*. 2014.