



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

Using the PDMP to Optimize Pain Management

MODULE 3

GUIDE DOCUMENT

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

Learning Objectives for Modules 1-7

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

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

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

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

Module 3: Using the PDMP to Optimize Pain Management

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

Module 4: Opioid Prescribing Guide

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

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

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

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

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

Module 7: Effective Opioid Tapering Practices

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

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Introduction

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

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

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

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

How to Use the PDMP to Address Pain Management

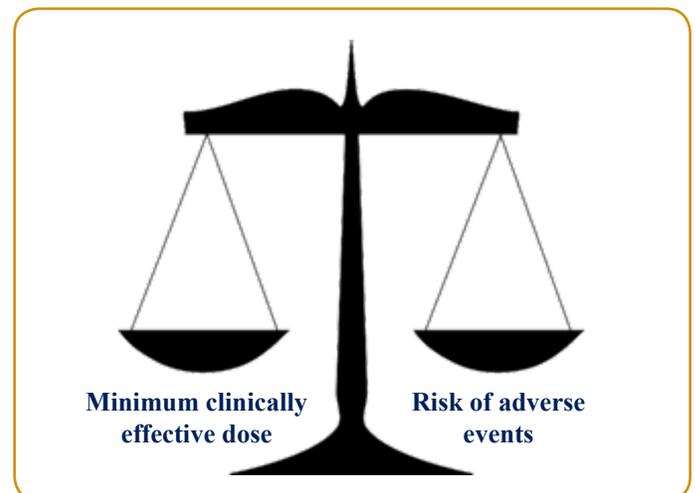
Querying the PDMP can assist in managing, improving and changing the patient's pain management strategy. A prescriber may wish to query the PDMP more often than required for some patients. These patients may be at an elevated risk for substance misuse or may be currently undergoing treatment for substance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

Developing a Medical History

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

Supporting Patient Safety

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



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

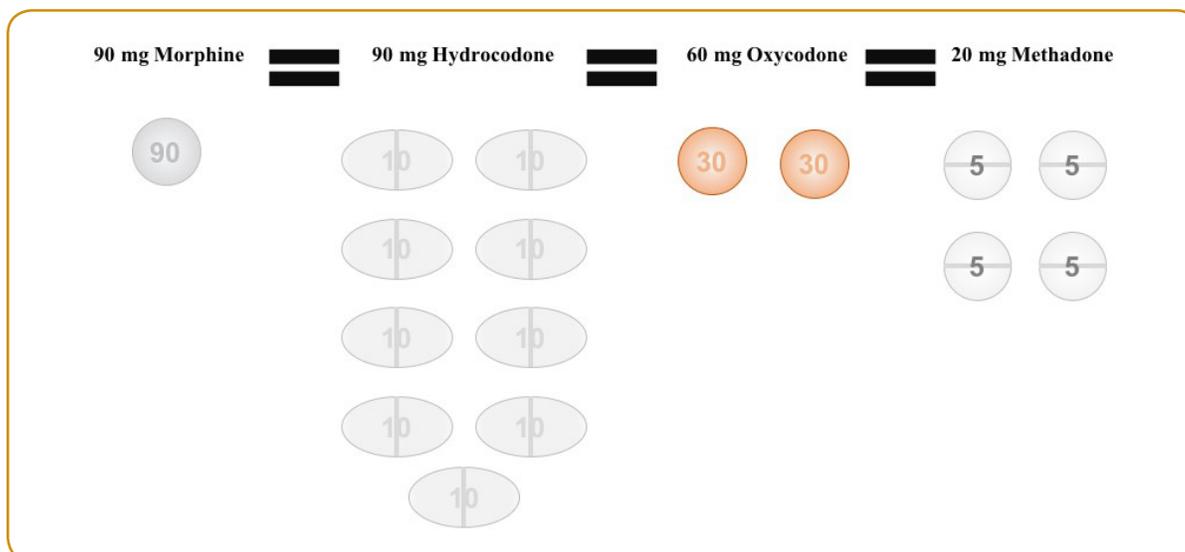
Supporting Patient Safety *(continued)*

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

Discussing Alternative Pain Management Strategies

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

Table 1: 90 Morphine Milligram Equivalents of Common Opioids



Urine Drug Testing

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

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

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



* <https://www.asam.org/>

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

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

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

Back Pain

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

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

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

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

Osteoarthritis

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

Headache or Migraine

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

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

Fibromyalgia

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

Pediatrics

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

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

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

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

Table 2: Can I use these methods to treat acute or chronic pain?†

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

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

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

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

† Always reference Pennsylvania and Centers for Disease Control and Prevention opioid prescribing guidelines.

i Nonsteroidal anti-inflammatory medications and acetaminophen

ii Serotonin and norepinephrine reuptake inhibitors and tricyclic antidepressants

iii Intra-articular corticosteroid injections

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

v Gabapentin and pregabalin

vi Duloxetine and milnacipran

vii Cognitive behavioral therapy

Continued ►

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

Elderly Individuals

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

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



Pregnant Women

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

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

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

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

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

Table 3: Evidence for Non-Opioid Treatment in Elderly Populations³⁹

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

- ◆ = Data from at least one randomized controlled trial or meta-analysis of RCTs with consistent efficacy
- ◆ = Data from non-experimental studies or inconsistent efficacy
- ◆ = Inadequate or not effective

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

Persons with Other Mental Health Conditions

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

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

Benzodiazepines and opioids can interact and increase the risk for opioid-induced respiratory depression and accidental overdose. The prescriber should use the PDMP to determine if any harmful drug-drug interactions can occur with the patient's current prescription. PDMP results should also be used to check if the patient is refilling his/her scheduled medications as prescribed.² When treating chronic pain in patients who are co-prescribed drugs for mental health conditions, clinicians should consider using serotonin-norepinephrine reuptake inhibitor antidepressants as a first-line agent because of their multiple actions to improve pain and treat depression or anxiety disorders. Tricyclic



antidepressants are the other preferred class in this situation for the same reasons. Other antidepressants have few analgesic properties.⁴² In general, prescribers should increase patient monitoring due to the elevated risk for opioid use disorder and overdose in this patient population. Clinicians should also consider consulting a behavioral health specialist before and during opioid therapy in patients with more severe mental health conditions.¹

Substance Use Disorder

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

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

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

Licensing

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

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

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

License renewals

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

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

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

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