Hello, and welcome to the Pharmacy Prescription Drug Monitoring Program Toolkit Online Course.

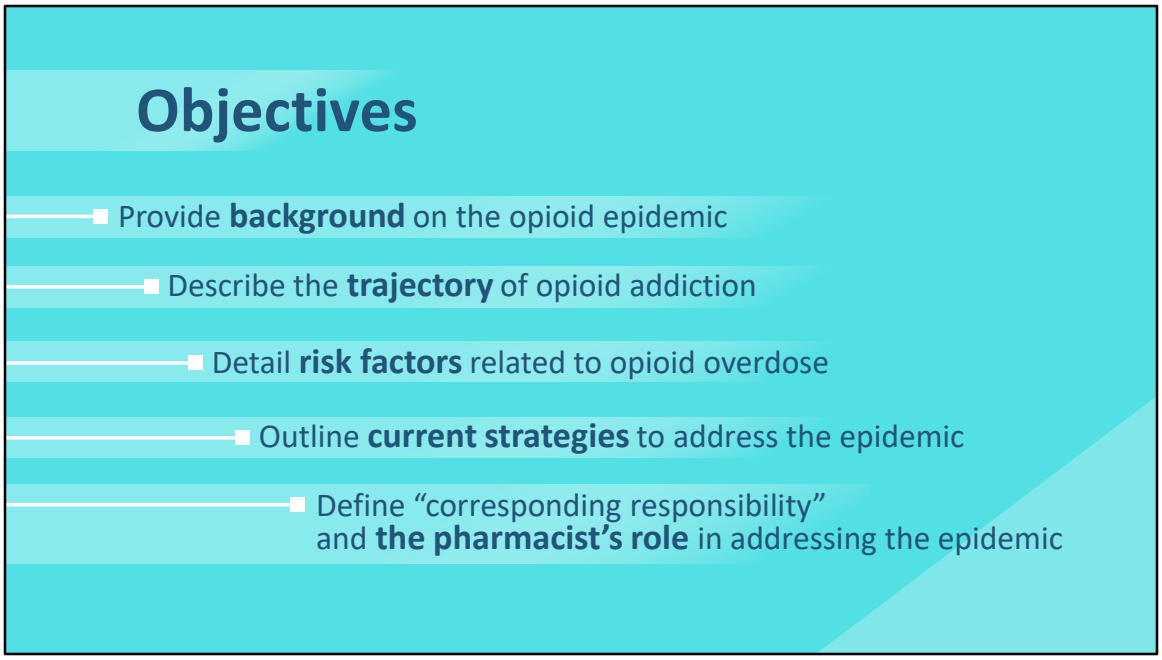
This is an interactive three part course intended to provide practicing pharmacists with education about the opioid use and abuse epidemic, the role of prescription drug monitoring programs – or PDMPs – in combating this epidemic, recommendations and guidelines for using PDMP data in practice, and approaches for talking with patients and other healthcare providers about potentially unsafe prescription opioid use.

This online module is part of a larger set of resources that have been developed by the Oregon State University College of Pharmacy and Comagine Health and funded through a grant by the Agency for Healthcare Research and Quality.

Anatomy of an Epidemic

Module 1

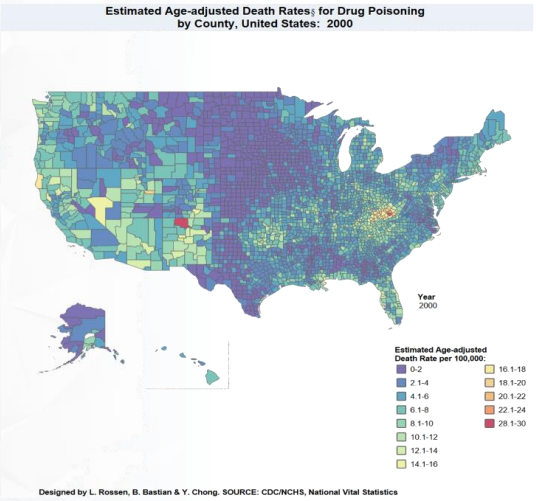
In module 1, we will provide an overview of the current opioid epidemic; its scope, magnitude, and impact; when and how it developed; and ways in which community pharmacists' can work to address it.



The objectives of this module are to:

- Provide background on the opioid epidemic
- Describe the trajectory of opioid addiction
- Detail risk factors related to opioid overdose
- Outline current public health strategies to address the epidemic
- Define "corresponding responsibility" and the pharmacist's role in addressing the epidemic

The growing epidemic

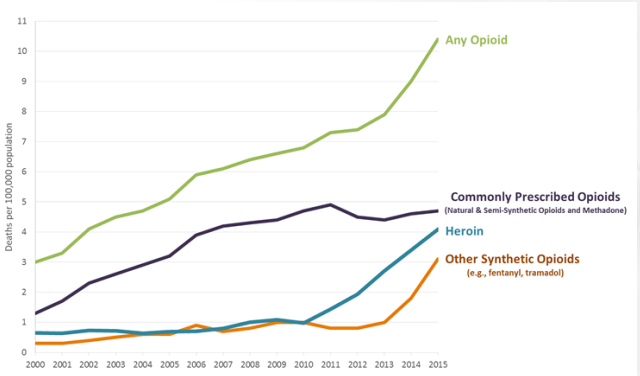


- In 2015, prescription and non-prescription opioids (including heroin) were responsible for over 33,000 deaths in the United States. To put this into context, 33,000 deaths is approximately 1-2 Boeing 747 plane crashes every week.
- The animated image shows county-level, age-adjusted drug poisoning fatalities from 2000 to 2015. Although the epicenter for this epidemic was in Appalachia, drug-related deaths have spread to nearly every region in the US in both rural and urban communities.

Introducing the **opioid epidemic**

Overdose deaths from synthetic opioids, such as fentanyl, **nearly doubled from 2013 to 2014**.

The rate of heroin overdose deaths **tripled since 2010** and **increased by 23% from 2013 to 2014**.

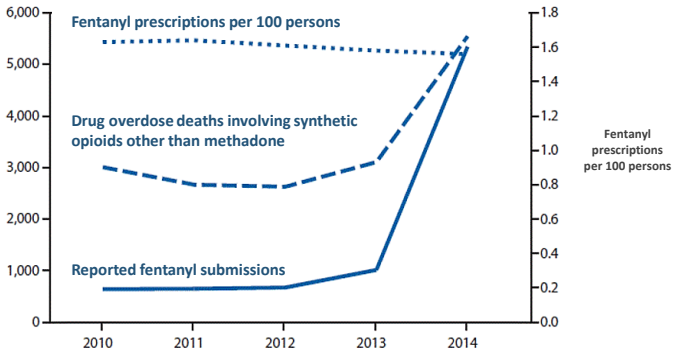


Source: CDC/NCHS, National Vital Statistics System, Mortality.

- The opioid crisis was originally driven by overprescribing and risky prescribing by healthcare providers.
- Between 2014 and 2015 there was a 2.6% increase in overdose due to commonly prescribed opioids (natural and semi-synthetic opioids), but a 20.6% rise in heroin deaths and 72.2% increase in synthetic opioids.
- Among opioid-related deaths, roughly two-thirds involve prescription opioids. This slide shows trends in age-adjusted mortality involving specific types of opioids. The largest increase involved synthetic opioids, such as fentanyl, which nearly doubled from 2013 to 2014. Rates of heroin overdose (shown in purple), has tripled since 2010, and increased by 23% from 2013 to 2014.
- While opioid prescribing rates have declined overall, they remain very high in certain areas across the country.

Illicit **opioid analogs**

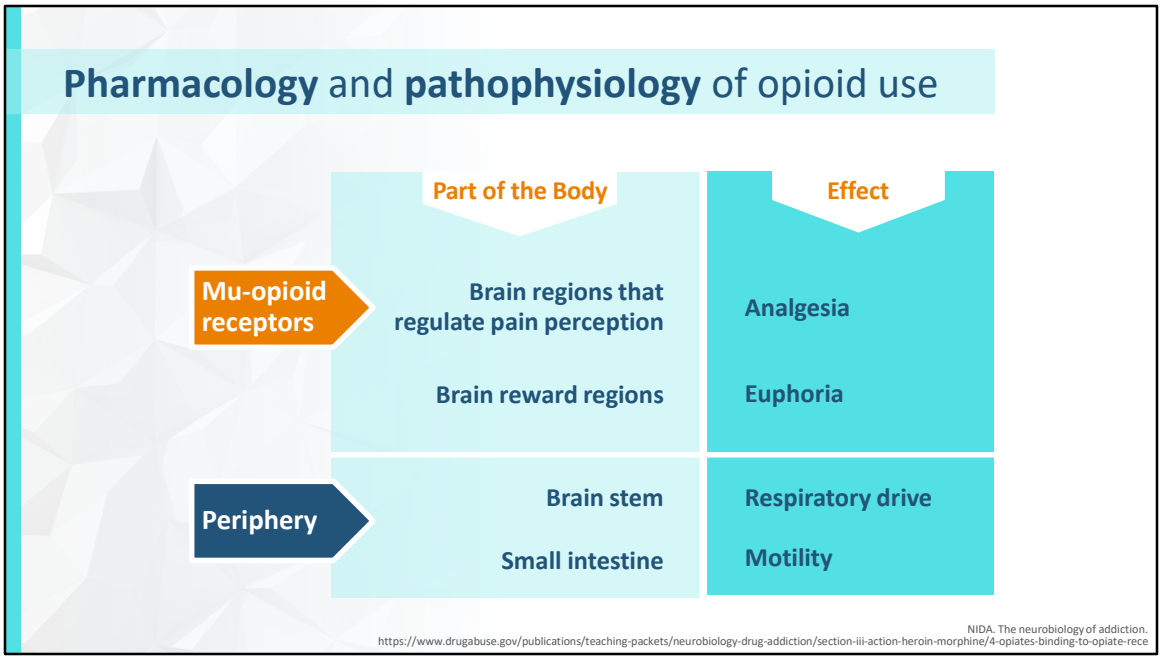
From 2013 to 2014 **fentanyl submissions** to the DEA National Forensic Laboratory **increased by 426%** and **deaths increased by 79%**, but fentanyl prescriptions remained flat.



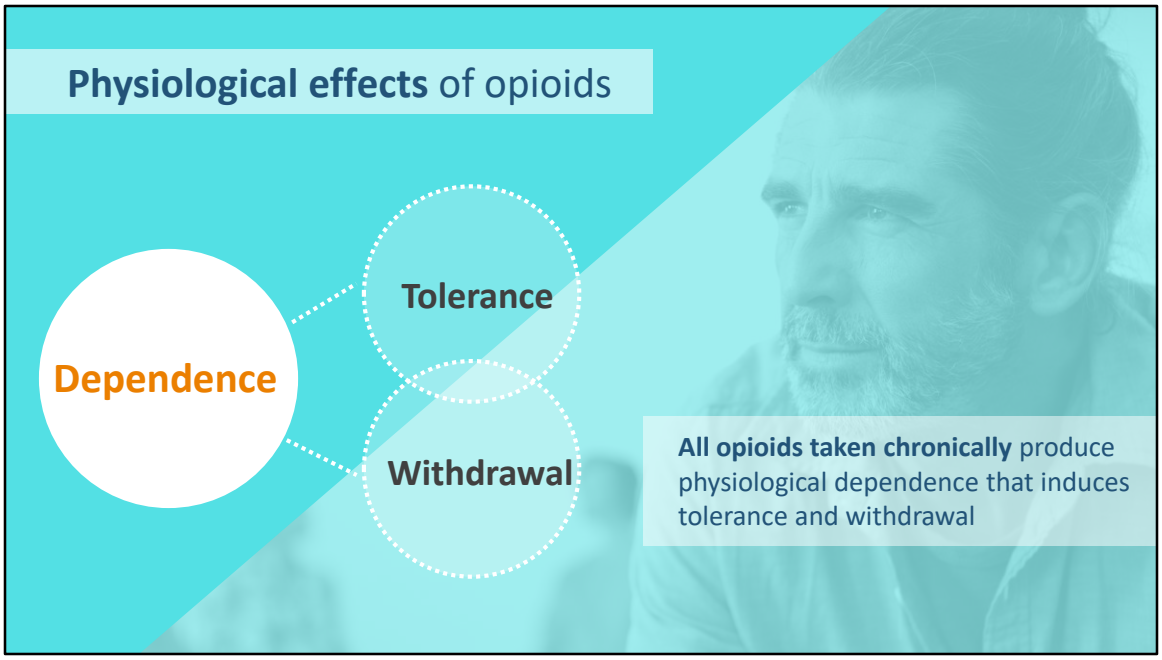
Gladden RM, Martinez P, Seth P. Fentanyl Law Enforcement Submissions and Increases in Synthetic Opioid–Involved Overdose Deaths — 27 States, 2013–2014. MMWR Morb Mortal Wkly Rep 2016;65:837–843.

- Illicitly produced fentanyl and fentanyl analogs such as carfentanil, are many times more potent than morphine and often mixed or sold as heroin, or pressed into counterfeit pills—not through prescription fentanyl. The photos on the right show a real and counterfeit Xanax obtained on the street.
- From 2013 to 2014 fentanyl submissions to the DEA National Forensic Laboratory increased 426% and deaths increased 79%, but fentanyl prescriptions remained flat.
- Efforts to stem the tide of death attributable to fentanyl-related compounds include:
    - Raising awareness among stakeholders and the public about the emergence of these very lethal counterfeit products
    - Increased screening and surveillance by state and local health departments and law enforcement
- Recognition that reversing overdose due to these potent drugs may require multiple doses of naloxone.

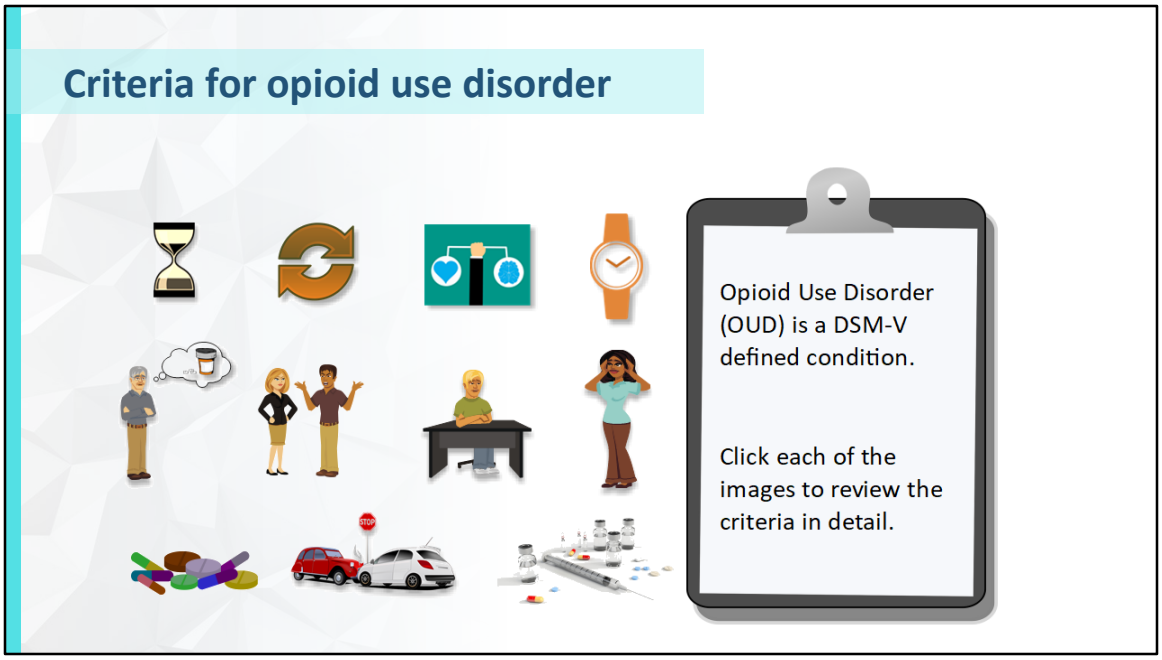
- While these statistics primarily reflect overdose deaths, there are many other issues associated with the opioid epidemic that warrant attention and prevention efforts.
- For every one opioid overdose we see, there are 15 substance use disorder treatment admissions, 26 opioid-related emergency department visits, 115 patients meeting criteria for opioid use disorder, and 733 patients using opioids for non-medical reasons.



Analgesic effects of opioids are derived from mu-opioid receptors in the brain that regulate pain perception. Mu receptors are also found in areas that regulate emotional responses and reward regions, explaining perceptions of euphoria. Mu receptors found in the brain stem and periphery underlie adverse opioid-related effects such as respiratory depression and decreased bowel motility.



- Chronic opioid use will result in physiological dependence that induces tolerance and withdrawal. This is true for all patients.
- Tolerance is characterized by the inability of the mu receptor to continue to propagate a signal after opioid binding due to receptor desensitization in the presence of persistent exogenous opioid stimulation. Tolerance is identified by the need to increase dosage over time to achieve the same therapeutic effect.
- This physiologic adaption underlies the phenomena of physical dependence and is distinct from addiction.
- Withdrawal symptoms from opioids can occur 8-12 hours after opioid discontinuation. Symptoms can include tachycardia, elevated blood pressure, restlessness, agitation, tremor, goosebumps, sweating, pupil dilation, and runny eyes and nose.
- Physical dependence to opioids means that the body relies on an external source of opioids to prevent withdrawal. Physical dependence is predictable, easily managed with medication, and is ultimately resolved with a slow taper off of the opioid. Conversely, addiction is abnormal and classified as a disease. Uncontrollable cravings are the single greatest indicator of addiction.



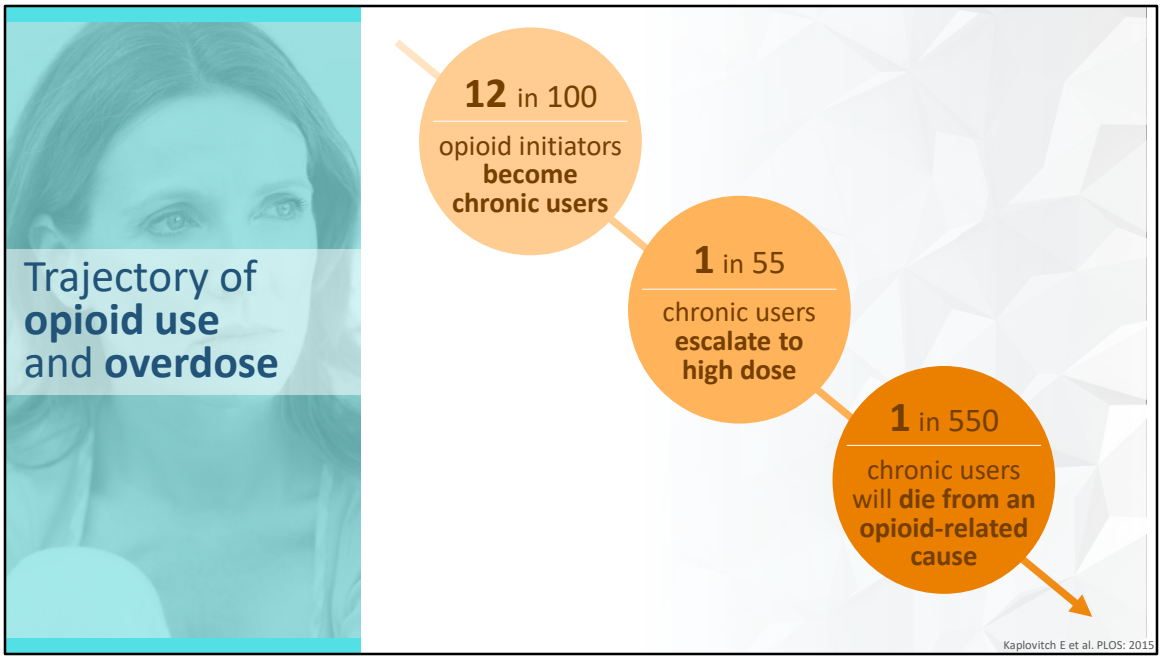
Opioid use disorder is a DSM-V defined condition that involves misuse or diversion of prescription or illicit opioids that leads to clinically significant impairment or distress, as manifested by at least two of the following criteria, occurring within a 12-month period. To review the criteria in detail, click through each of the following images.

Criteria:

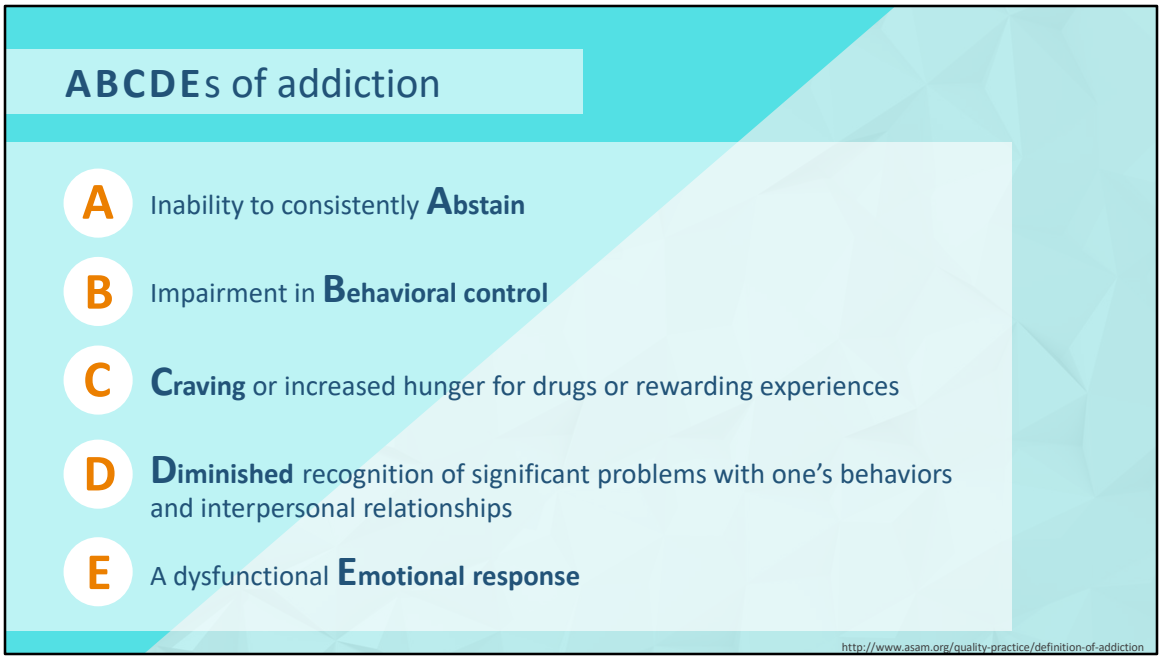
- Duration—taking opioids in larger amounts or for longer periods of time than intended.
- Desire—there is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- Time—a great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- Craving—craving or a strong desire/urge to use opioids.
- Recurrent use—recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
- Recurrent social or interpersonal problems—continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- Social isolation—important social, occupational, or recreational activities are given

up because of opioid use.

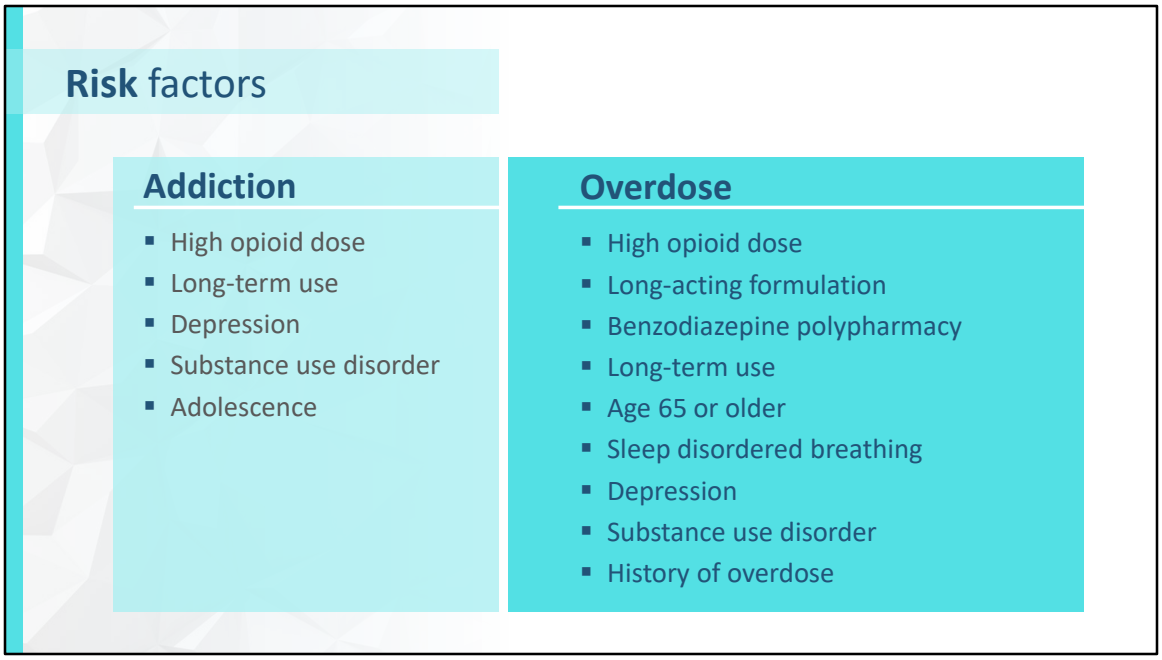
- Hazardous situations—recurrent opioid use in situations in which it is physically hazardous.
- Recurrent physical or psychological problem—continued opioid use despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- Tolerance—tolerance, as defined by either of the following:
    - A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
    - A markedly diminished effect with continued use of the same amount of an opioid.
- Withdrawal—withdrawal manifested by either of the following:
    - The characteristic opioid withdrawal syndrome
    - Opioids (or a closely related substance) are taken to relieve withdrawal symptoms



- While we know that certain characteristics increase the risk for addiction and overdose, patients can develop an opioid use disorder without pre-disposing conditions.
- Population level studies suggest that of every 100 individuals initiating an opioid, 12 will eventually become a chronic opioid user defined as 3 months of use. Of these chronic users, 1 of 55 will escalate to a high dose and 1 in 550 will die of an opioid-related cause in a median of 2.6 years.



- Addiction is a primary chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations; which is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.
- While the symptoms of tolerance and physical dependence will dissipate within days or months, addiction is a chronic condition that persists for months to years.
- The American Society of Addiction Medicine characterizes the ABCDEs of addiction as:
    - Inability to consistently Abstain;
    - Impairment in Behavioral control;
    - Craving; or increased "hunger" for drugs or rewarding experiences;
    - Diminished recognition of significant problems with one's behaviors and interpersonal relationships; and
- A dysfunctional Emotional response.



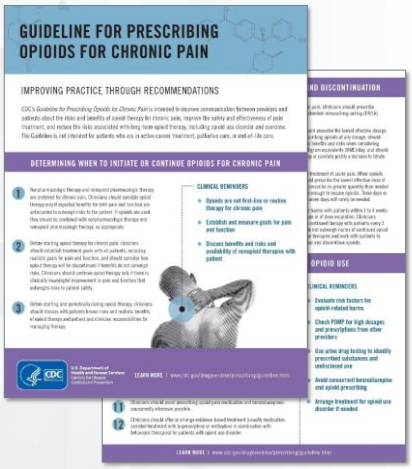
- Because the rising number of opioid-related deaths, a significant amount of epidemiologic work has been conducted to identify risk factors for both overdose and addiction.
- Commonly cited risk factors for overdose include: opioid daily dosage over 90-100 MME per day, the use of long-acting formulations such as methadone or fentanyl patch, co-prescription with benzodiazepines which also cause CNS and respiratory depression, chronic use generally defined as greater than 3 months of use, age over 65, pre-existing breathing conditions such as sleep apnea, depression, substance use disorders or history of previous overdose.

Opioid addiction is not rare

The following video, created by our partners at Oregon Pain Guidance, will provide more context for the history and reality of the opioid epidemic in the United States, including additional information on pain management and addiction.

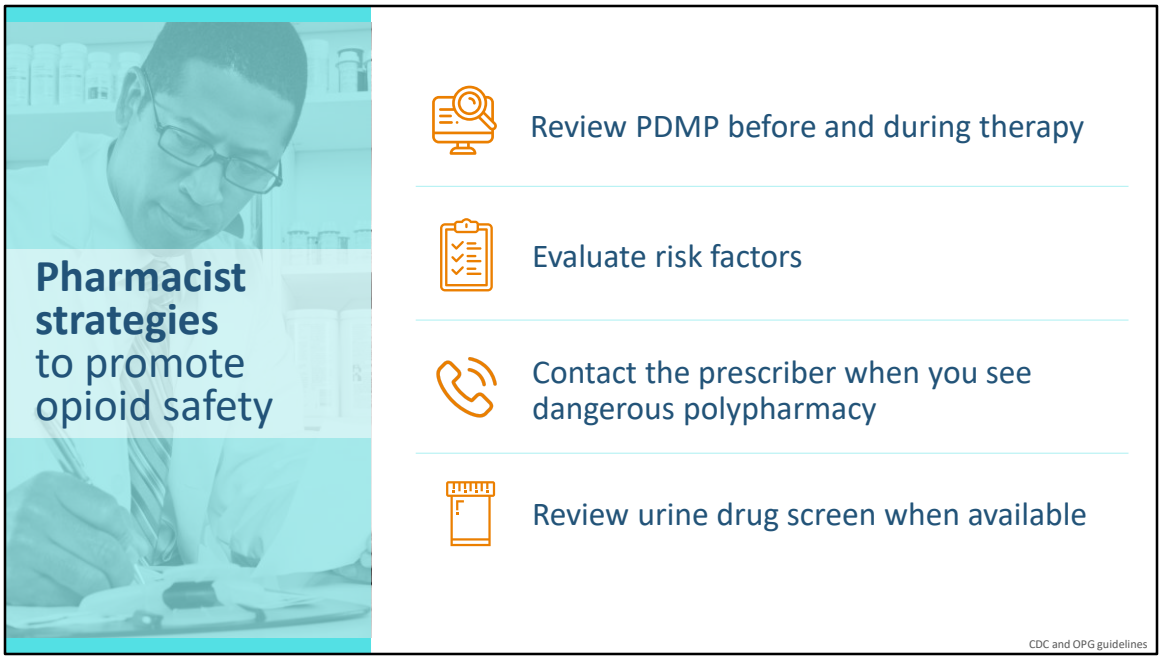
- Historically, issues of drug abuse, both prescription and illegal, have primarily elicited responses from a criminal justice perspective. Because much the current opioid epidemic has its origins in the legitimate practice of medicine, the response in recent years has involved a larger public health component.
- Specifically, federal and state governments, healthcare systems, and payers have responded in a number of ways. Approaches include improving access for screening and treatment of opioid use disorders, development and promotion of abuse deterrent medication formulations, greater and easier public access to medication disposal venues, education on appropriate and safe prescribing, increased distribution of naloxone to reverse opioid overdose, and promotion and enhancement of state PDMPs.

CDC guidelines for prescribers



- Use immediate-release, short-acting opioids when starting opioid therapy
- Use the lowest effective dose: less than 50 Morphine Milligram Equivalents (MME) per day to start and avoid prescribing greater than 90 MME
- Prescribe short durations of immediate-release formulations for acute pain: 3 days or less is recommended (avoid prescribing more than 7 days worth)

The US CDC has issued important new guidelines for prescribers, to encourage safer opioid prescribing. If you notice that a patient's prescription diverges from these guidelines, consider contacting the prescriber to follow up.



- Prior to deciding to begin opioid therapy the CDC emphasizes that providers should evaluate risk factors for both addiction and overdose.
- This includes periodically reviewing the PDMP before and during therapy to check for purposeful or inadvertent safety issues.
- Providers may want to consider controlled substance agreements or urine drug screening to ensure patients are using opioids appropriately.
- Finally, it is recommended that providers avoid potentially dangerous polypharmacy with drugs like benzodiazepines, muscle relaxants, and sleeping medications such as Zolpidem.

Pharmacists' role in appropriate prescribing and dispensing of controlled substances is codified in the Code of Federal Regulations stating: "The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription." Pharmacists have a responsibility to determine the legitimacy of a controlled substance prescription if one is suspect. Moreover, pharmacists who deliberately ignore questionable prescriptions issued for non-medical purposes can be prosecuted for a felony offense.

- Pharmacists also have a larger and more important role in assuring the safe use of medications, including opioid pain relievers. Specifically, it is important for the pharmacist to review each opioid prescription thoroughly considering available information from the prescribers' recommendation, patient demographics and comorbidities, and details provided during your patient interactions.
- If you have concerns about the safety of an opioid prescription based on any of these criteria, query the PDMP for patients' medication history. Practice effective communication with opioid patients, and maintain good relationships with providers in your area. Strategies for this will be provided in Module 3.
- And remember… first, do no harm. If you are concerned about the safety of a patient, consider providing naloxone education and obtaining a naloxone prescription for them. Make sure you know where the nearest drug disposal unit is relative to your pharmacy, and refer patients there who have unused medications in their household.

- This concludes your Module 1 training.
- The next two modules will cover more detail about your role as a pharmacist in addressing the opioid epidemic while providing high quality, safe, and compassionate care for patients.
- Module 2 will focus exclusively on using the PDMP and Module 3 will provide patient and provider communication strategies. Thank you!

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In Module 2, we will provide an overview of the history of prescription drug monitoring programs, describe the current status of PDMPs, discuss the evidence of effectiveness, and provide recommendations for workflow integration.
In preparing this training program, our researchers conducted confidential online focus groups with community pharmacists in Oregon to gain insight into how the PDMP affects daily practice. You will see and hear quotes from these pharmacists throughout the training.

Objectives

- Explain the history and present use of Prescription Drug Monitoring Programs (PDMP)
- Outline the benefits of PDMP use in community pharmacy settings
- Review recommendations for pharmacist use of the PDMP as part of a safe medication screening process
- Describe PDMP rights and liability considerations

Pharmacist insights

> The PDMP is very helpful in terms of **finding patterns of patient use**. It restores my faith in people's honesty most of the time. **And I can get a real drug utilization review going, with all doctors and pharmacies involved.**
>
> —Oregon Community Pharmacist, 2016

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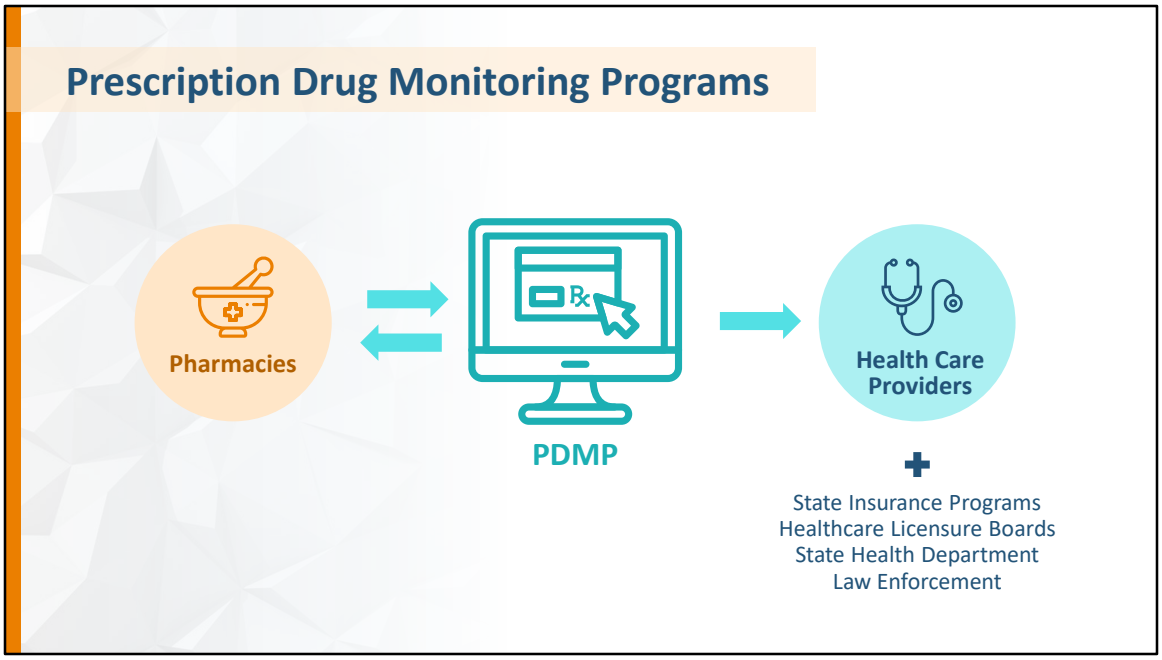

- PDMPs are statewide electronic databases that gather information from pharmacies on dispensed prescriptions for controlled substances. However, PDMP practices and policies are not consistent between states. Pharmacy data include: date dispensed, patient, prescriber, drug, and dosage.
- Most PDMPs provide secure online access to this information for a select group of authorized recipients such as prescribers, pharmacists, delegates, and nurses.
- In some states, practitioner licensing boards, law enforcement officials, drug control agencies, medical examiners, drug court officials, and addiction programs may also access the PDMP. Some states may also generate unsolicited reports describing controlled substance prescriptions.

The **national landscape** of PDMPs

- The national landscape regarding PDMPs is constantly evolving. Enhanced functions, such as maps, summary reports, and MME calculators are being integrated into multiple states' programs at the discretion of the states' respective PDMP vendor.
- Check with your local PDMP administrator to learn more about your states' PDMP vendor, registration and recommendations, and any potential forthcoming enhancements.

Improving PDMP effectiveness

- Better **data timeliness**
- Encourage **research using PDMP**
- Expand **proactive reporting**
- Increased **sharing**
- Broader **access**

Decision support for **safety monitoring**

Despite wide variation in pharmacy policies across the country regarding when to check the PDMP, there is some consistency in the types of triggers pharmacists typically rely on for knowing when to submit a query.

The most common triggers or “red flags” relating to general safety considerations are:

- If the patient presenting the opioid prescription is new to the pharmacy.
- If the prescription contains an opioid dose that seems inappropriate. For example, if an opioid naïve patient’s first dose seems higher than necessary, or if a chronic opioid user’s dose suddenly and significantly increases for no known reason.
- If the prescription contains a risky combination of medications, such as an opioid and a benzodiazepine or muscle relaxant, that seems unsafe.
- If the patient seems to be filling opioid prescriptions too frequently.

Potential safety triggers for checking PDMP

Step 1

Initial Screening

Drug Utilization Review

The Prescription

- Has **missing or unreadable info**
- **Appears altered** or irregular
- Is from an **unfamiliar prescriber**
- Is from **outside surrounding area**
- Is **denied coverage** by patient's insurance company

The Patient

- Is **new to the pharmacy**
- **Refuses to show identification**
- Is picking up R_xs for **multiple people**
- Is **paying cash**

Step 2

Safety Trigger Review

PDMP

- Opioid dosage **significantly higher than necessary** for a new or chronic user
- **Combination** of medications poses risk
  - ! Opioid with benzodiazepine and/or muscle relaxant
  - ! Long-acting and short-acting dosage forms
- Combination of **contradicting medications**
- Prescriptions have been **filled too frequently**
- Patient is seeing **multiple prescribers and/or pharmacies**

for various issues, and that their providers are knowledgeable about the situation.

- Sometimes, an effective way to maximize time and manage workflow in the pharmacy is to delegate the responsibility of PDMP investigations to someone other than the pharmacist.
- A delegate is a member of the pharmacy staff who is authorized by the pharmacist to access the PDMP system on his or her behalf. Some states allow pharmacy technicians and interns to act as delegates.
- Check with your local PDMP administrator and pharmacy director to learn more about delegate use, recommendations, and any restrictions that may affect your practice.

Pharmacist insights

I now see myself as **part of a healthcare team**, even if I am only working one shift at one pharmacy one day. I can still use my training to look at patient histories and the PDMP and phone prescribers with concerns or suggestions, and also leave documentation for the regular pharmacists at that pharmacy.

—Oregon Community Pharmacist, 2016

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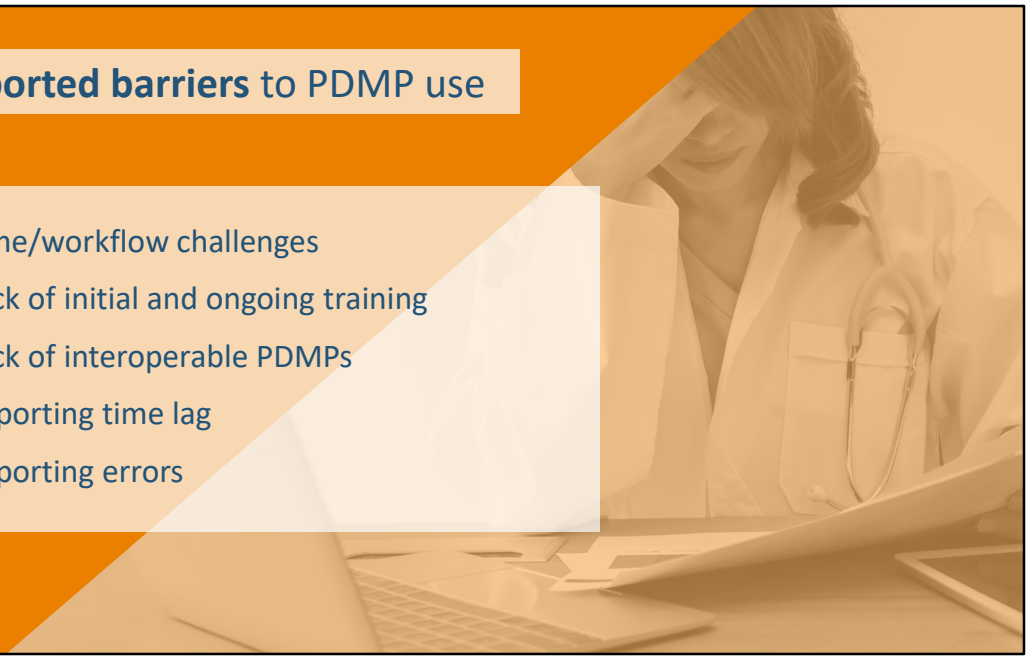
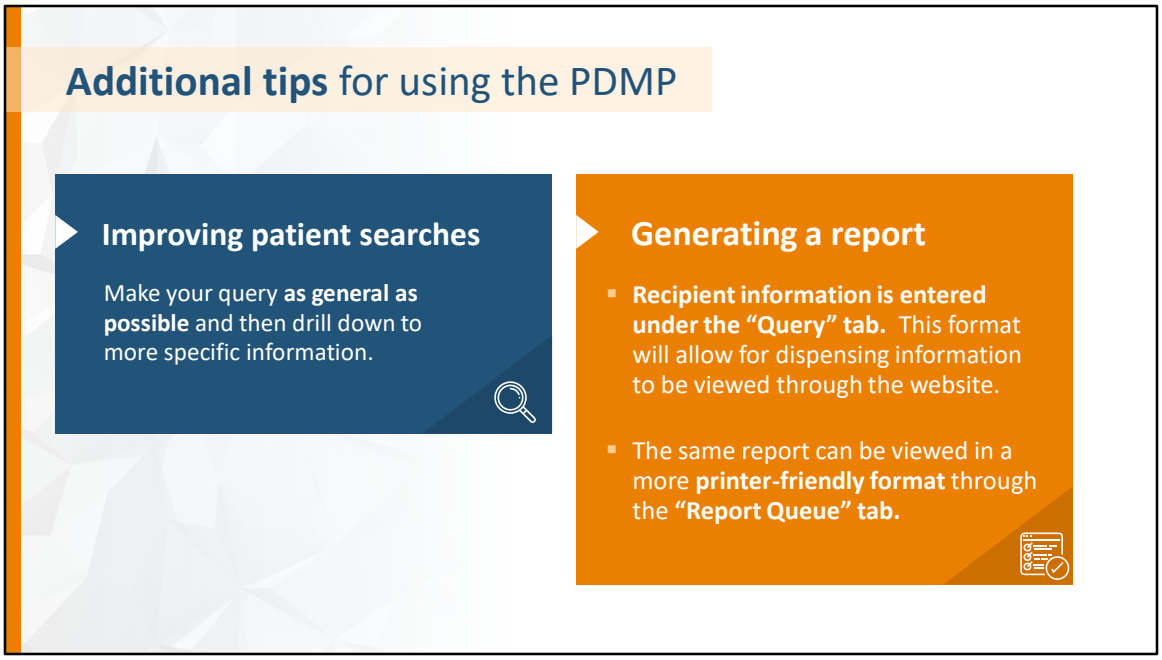
Reported barriers to PDMP use

- Time/workflow challenges
- Lack of initial and ongoing training
- Lack of interoperable PDMPs
- Reporting time lag
- Reporting errors





There are a couple of other tips to help users navigate the PDMP that are worth highlighting.

- When starting a query, it is recommended to start as general as possible and then drill down to more specific information once you have identified the correct person.
- For example, you can enter a patient's last name, first letter of the first name, and birth date. This will display preliminary results on the screen from which you can select the person of interest.
- If your state PDMP has a map function or summary report, you can use these tools to see from whom patients are receiving prescriptions and filling their medications. This objective information is useful for enhancing your communication with the patients' prescribers if you feel a current prescription may put them at risk and you would like to learn more about their medical history.

Pharmacist Liability

Private Data

Patients' PDMP data is confidential under HIPPAA

Security Breaches

Must be reported as soon as possible (refer to state administrator for specific timelines for reporting)

Penalties

Unauthorized access/disclosure may result in criminal, civil and/or administrative sanctions

- Suspected breaches of the PDMP system or evidence of unauthorized access must be reported as soon as possible. The window for required reporting varies by state.
- PDMP data should be treated as private, confidential, and secure.
- Inappropriate access or disclosure of patients' PDMP information may result in criminal, civil, or administrative sanctions including disciplinary action by your licensing board and/or employer.
- Check with your local PDMP administrator to learn more about your states' reporting requirements.

- This concludes your Module 2 training.
- The next module will cover more detail about your role as a pharmacist in addressing the opioid epidemic while providing high quality, safe, and compassionate care for patients.
- Thank you!

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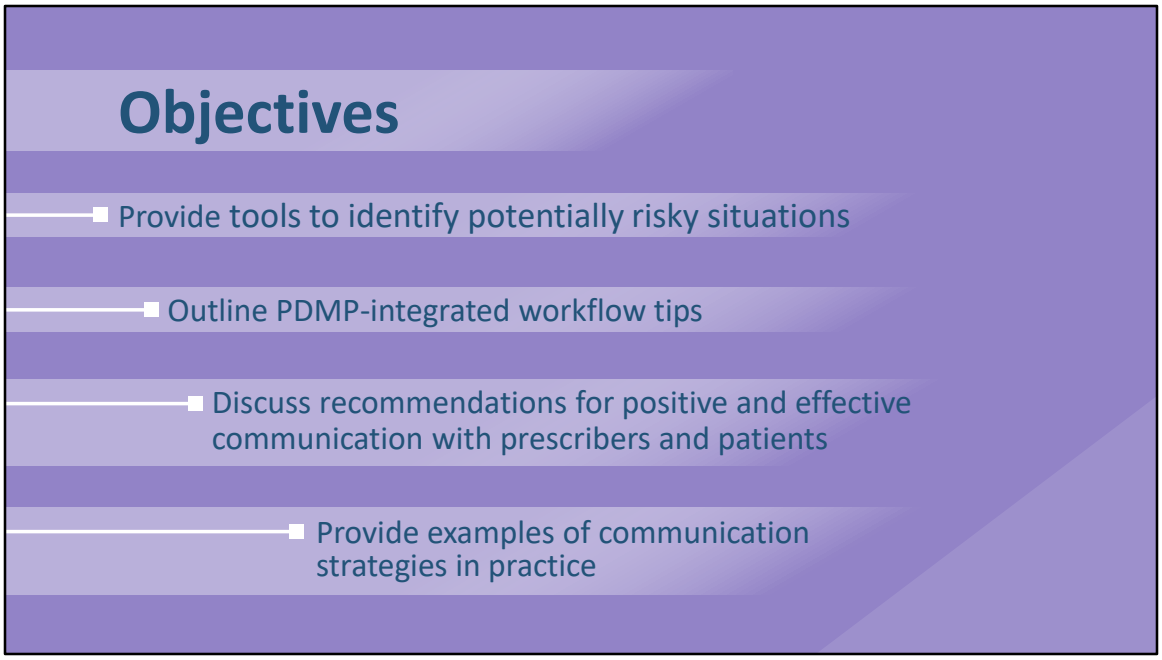
In module 3, we will provide information on how and when to screen patients with the PDMP and contact prescribers, as well as outline effective strategies for navigating potentially difficult conversations with patients.
In preparing this training program, our researchers conducted confidential online focus groups with community pharmacists in Oregon to gain insight into how the PDMP affects your daily practice. You will see and hear quotes from these pharmacists throughout the training.



The objectives of this module are to:

- Provide tools to identify potentially risky situations
- Outline PDMP-integrated workflow tips
- Detail recommendations for positive, effective communication with prescribers and patients, and
- Provide examples of communication strategies in practice

PDMP potential workflow

- Now let's integrate use of the PDMP into the potential workflow of a community pharmacy. A patient comes in with a prescription for a controlled substance. What might be the steps?
- <u>Step 1: Collect Information</u>
    - Similar to all prescriptions, information will need to be collected to allow the pharmacist to complete a drug utilization review (DUR). Board of Pharmacy regulations state that the pharmacists shall make a reasonable effort to obtain, record, and maintain the following information:
        - Full name of the patient for whom the drug is prescribed
        - Address and telephone number of the patient
        - Patient's gender, age, or date of birth
        - Chronic medical conditions and disease states for the patient
        - A list of all drugs or devices the patient is currently obtaining at the pharmacy including the name, strength, quantity with date received, and prescribing practitioner
        - Known allergies, adverse drug reactions, and drug idiosyncrasies
        - Comments relevant to the individual's drug therapy and any additional information that may relate to the DUR or for the monitoring of the patient as appropriate

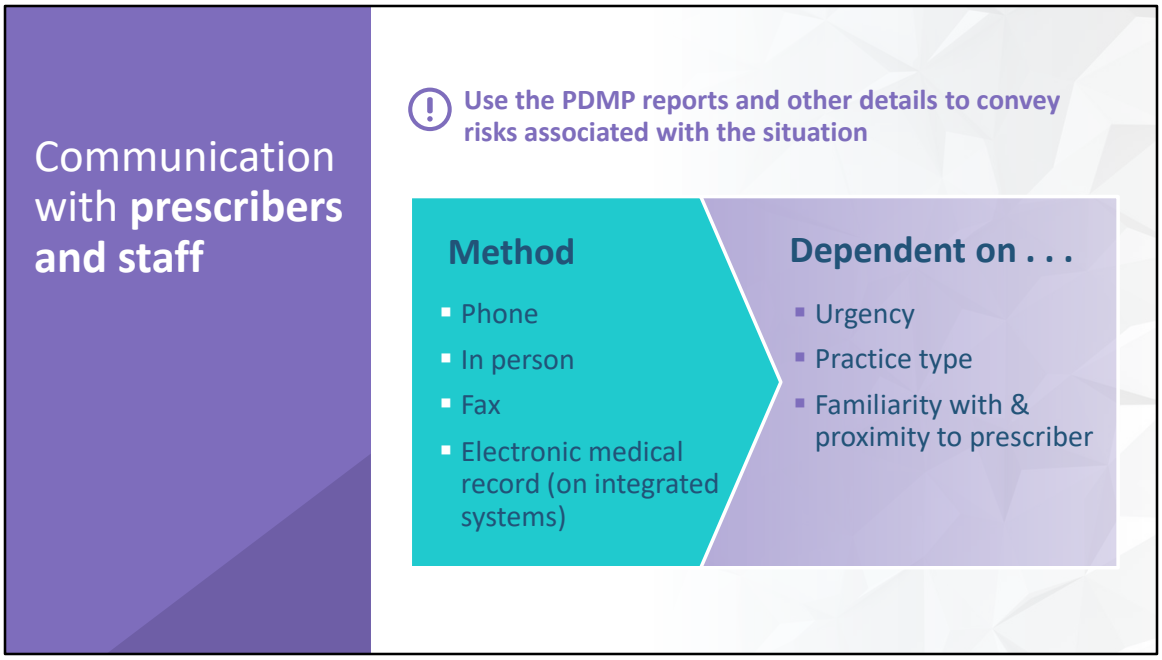
    - As a result, these requirements require collection of information that may help identify patients where a review of the PDMP would be appropriate. Additionally, collecting this information allows for a patient interaction that may assist in identifying “red flag” or “yellow flag” behaviors.
- Step 2: Flag Prescriptions for PDMP Review Prior to Dispensing
    - Each pharmacy will need to develop an individualized process, but consider developing specific recommendations for when the PDMP should be reviewed prior to dispensing based on patient and/or prescription characteristics. The “red” and “yellow” flag behaviors presented earlier in the module are a good place to begin development of the recommendations.
- Step 3: Access the PDMP & Run Report
    - Similarly, each pharmacy will need to develop an individualized process; however, consider developing a separate workflow for prescriptions needing a review of the PDMP prior to dispensing.
    - As a reminder, this activity does not need to be performed by the pharmacists and can be delegated to another pharmacy staff member.
- Step 4: Using a PDMP Report
    - After the report is created, it will need to be reviewed by a pharmacist.
        - If no issues are identified, then the prescription can go into the queue to be processed and dispensed as other controlled medications .If concerns are identified, then the order should not go into the queue and pharmacist will need to address the situation.
- Step 5: Handling Concerns
    - If concerns are identified, then the pharmacist will need to address the situation. This includes everything from talking to the patient or provider to refusing to fill the prescription.
    - Patient and prescriber conversations can be challenging.

"How do we transfer that responsibility back to patients and doctors? We all play a role, starting with the prescriber."

Decision support for **prescriber contact**

- The decision to involve the prescriber may be determined by store-level policies and/or pharmacist professional judgment. However, in many instances, the decision making process is similar to that for querying the PDMP because the prescription itself is determined to be high risk. This could be because of the combination of medications, conflicting pharmacology, high opioid dose in an opioid naïve patient, or a variety of other reasons as outlined previously.
- Involving the prescriber may also be due to troubling patterns identified during the PDMP query such as overlapping prescriptions for similar medications, use of multiple pharmacies, or a dramatic increase in opioid use in a short timeframe.

- Contacting prescribers about an opioid prescription can be intimidating. However, it is important to view the prescriber and their support staff as teammates in combating substance abuse.
- As possible, based on the setting and number of prescribers in the area, take the time to understand what issues or concerns they would want communicated and their preferred method of communication. It may be valuable to establish a "point person" for these types of concerns.
- It is important to be proactive and confident in your decision to contact the medical office, but also recognize that the PDMP is one piece of a larger picture. There may be things that you don't know about situation. If you disagree, then be professional.



- Common routes of communication include phone and fax; however, it is becoming more common in integrated systems for communication to occur through the electronic medical record.
- Getting in contact with a provider can often be challenging, but choosing the appropriate route of communication can make things easier. The mode of communication will often depend on the details of the situation such as the urgency of the request, practice type, and familiarity with the prescriber.
- Regardless of the method, it is important to use the PDMP report and other details collected to communicate the risk associated with a situation.

Provider Communication

Discussing concerns with a patient

Safety

Inform the patient that you are concerned about their safety, first and foremost.

Use nonjudgmental, supportive language.

History

Inform them that you have reviewed their prescription history using the PDMP. They have a legal right to know that you have reviewed their report and to see a copy of the printed report.

Next Steps

Inform them of next steps, and be sure to include an expected timeline (e.g., 24 hours).

Pharmacist insights

I feel as though we are expected to police usage when we really don't know the circumstances of the patient's condition. We are stuck between sticking our nose into something that both the providers and the patients view as 'none of our business,' and the 'powers that be,' demanding that we do so.

—Oregon Community Pharmacist, 2016

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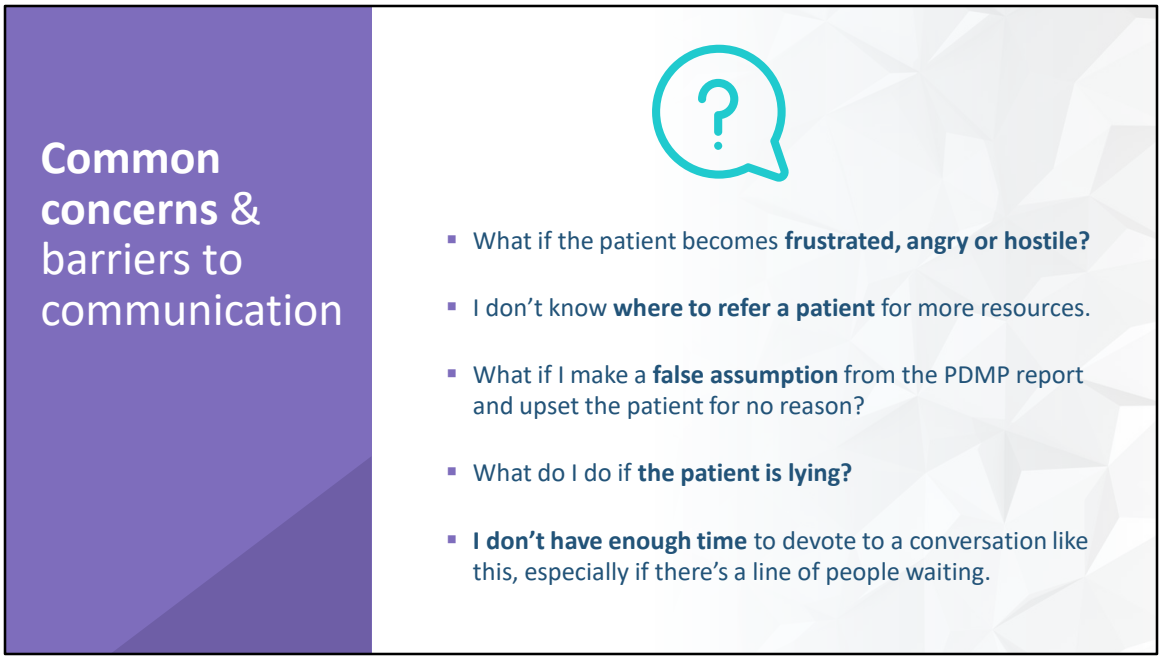
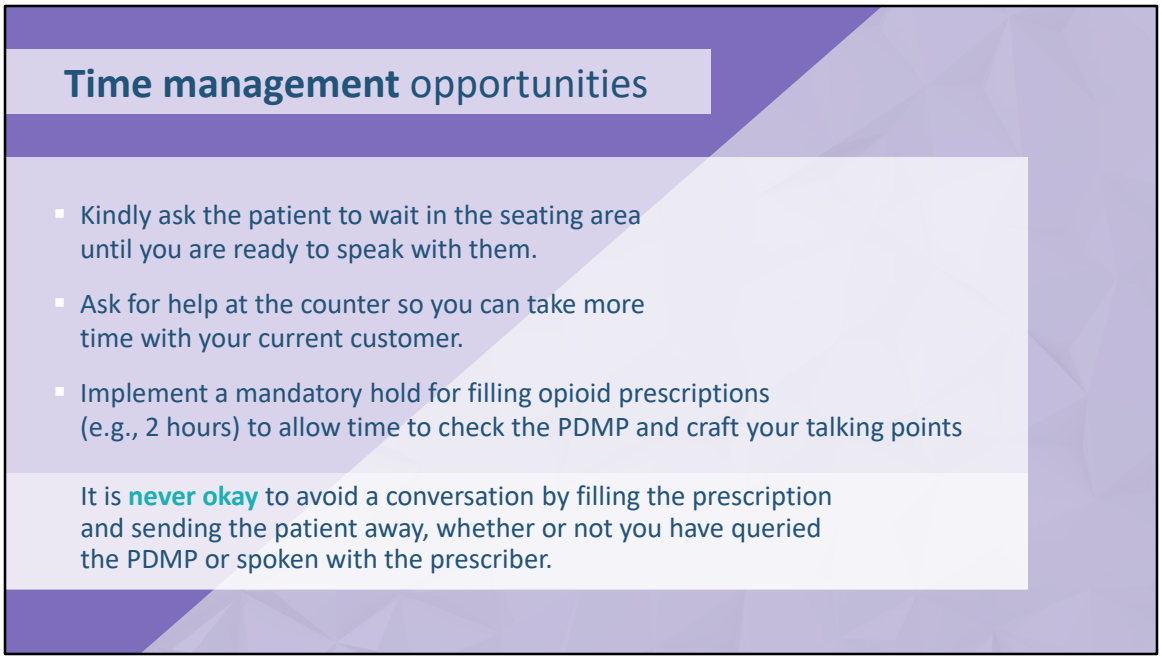
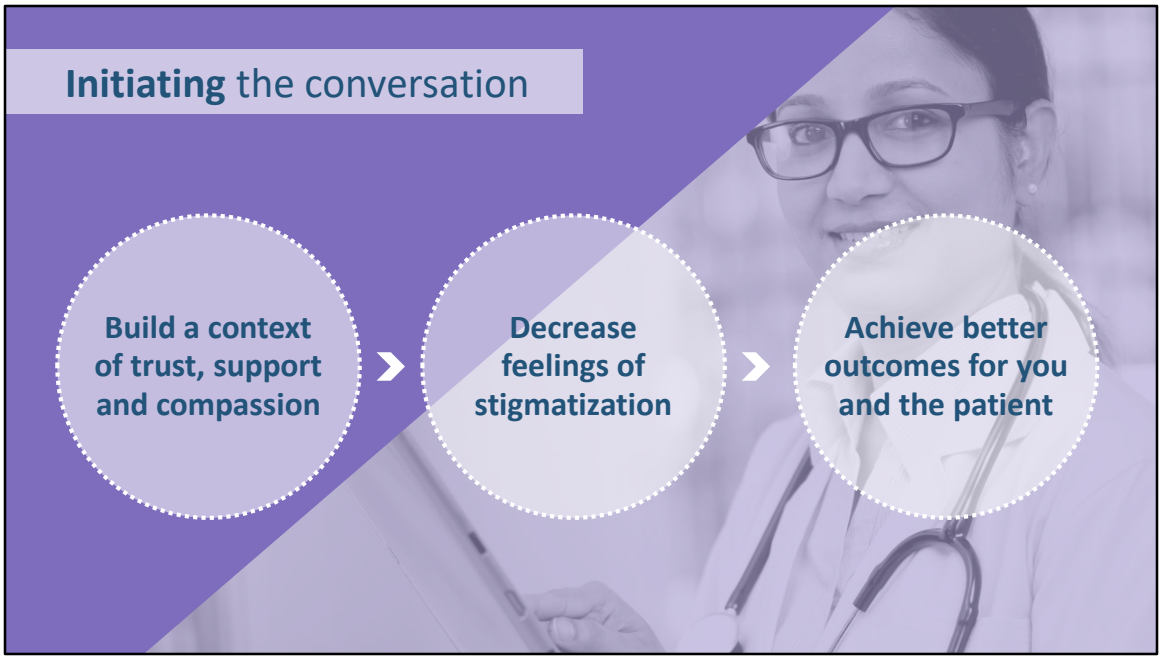


- If you have decided or been told not to dispense a pain medication, you are likely preparing to have a difficult and unpredictable conversation with a patient.
- Community pharmacists like yourself have provided multiple common barriers to engaging in such conversations.
- See if any of these feel familiar to you.
    - Concern that the patient might become frustrated, angry, or hostile.
    - Feeling like you have a lack of information on the appropriate resources to refer a patient to, or inadequate knowledge about medication risks.
    - Fearing the risk of making an assumption from the PDMP report that is false, and upsetting the patient for no reason.
    - Concern that the patient may lie and you'll have no good way to handle it.
    - Feeling like you have a lack of time to devote to a conversation with one patient, especially when you have a line waiting.



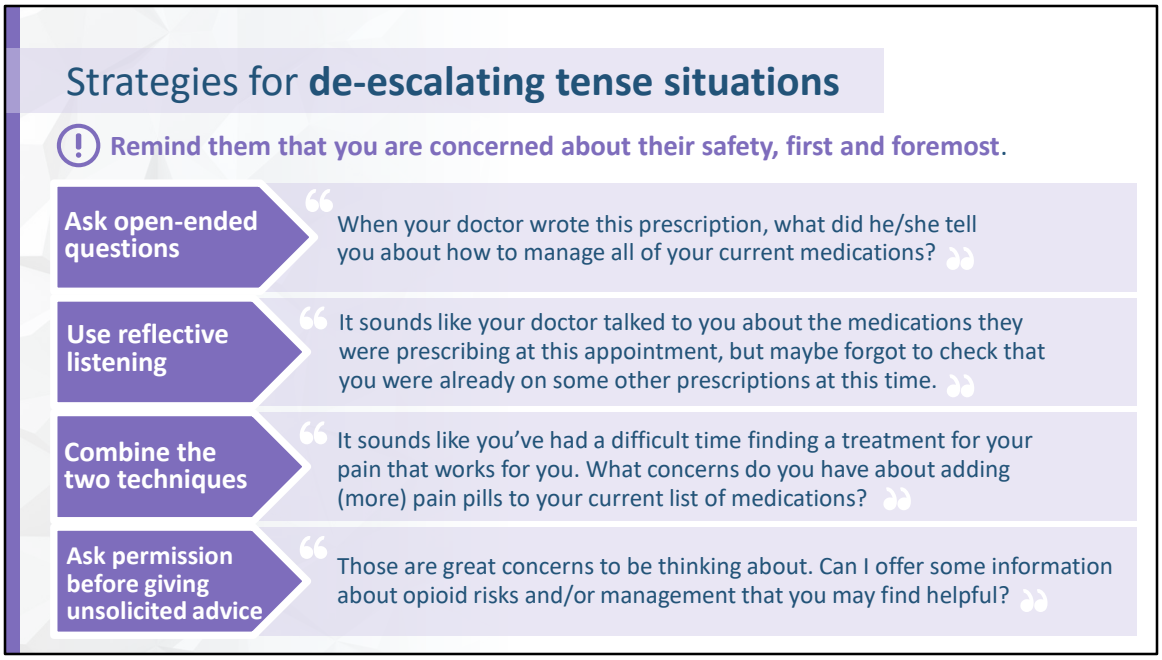
- One of the most commonly-stated barriers to discussing a PDMP report with a patient is *lack of time* for the conversation.
- It is never okay to avoid a conversation by filling the prescription and sending them away, whether or not you have queried the PDMP or spoken with the prescriber.
- However, there are options…
    - You can kindly ask the patient to wait in the seating area until you are ready to speak with them, or…
    - Ask for help at the counter so you can take more time with your current customer.
    - You and your staff can also implement a mandatory hold – for example, two hours - before filling opioid prescriptions, to allow time to check the PDMP and craft your talking points.


Initiating the conversation
Build a context of trust, support and compassion
Decrease feelings of stigmatization
Achieve better outcomes for you and the patient

Pharmacist insights

When handling awkward conversations, **I try to just stick to the facts** and if the patient starts getting emotional or angry, **try to stress that the reason we're concerned is for their safety**. I've noticed that when approached from the safety standpoint, patients have a hard time remaining angry or hostile - I mean, who doesn't want their provider concerned about their safety?

—Oregon Community Pharmacist, 2016



- Start by talking to patients about their current prescriptions, and specifically their use of opioids. Sometimes patients *will* become frustrated, angry, or hostile when you question their prescription history, but there are ways to avoid or diminish this…
- **Remind them that you are concerned about their <u>safety</u>, first and foremost**
- **Ask open-ended questions**
    - Yes/No questions can create awkward pauses and walls in conversations.
    - Focus on questions starting with "what, how, and why"
- **Use reflective listening**
    - Listen to the patient's story, and repeat it back to them as best you can while adding important pieces they may have left out.
    - Reflective listening lets them know they are being heard, and also provides them a mirror to understand how they are really impacted by a topic.
    - Begin your statement with a soft phrase, such as "It sounds like…" , "I get the sense that…", or "What I hear you saying is…".
- **Combine the two techniques**
    - Oftentimes, patients will respond to a 'reflective listening' prompt as if it were a question. They will want to clarify your understanding, or add some new insight you've opened their minds to.

    - Sometimes, though, they may need an additional follow-up. It is best to return to a direct open-ended question when you can.
- **Resist giving information or advice until asked or until it becomes necessary**
    - People are inherently resistant to advice if they have not specifically asked for it. Offering unsolicited information may, in itself, anger some patients.
    - If you reach a point in the conversation where education is needed and the patient has not asked for it yet, one great workaround is to **ask permission** to offer information.

Strategies for **motivating positive steps**

Normalizing

"What I hear you saying is that you recognize you are juggling some difficult prescriptions and you may be worried about addiction. This is something a lot of people are struggling with right now."

Supporting Self-Efficacy

"It sounds like you've been trying to work in a few alternative ways to manage your pain. That is great! How have you been able to do that?"

Affirmations & Next Steps

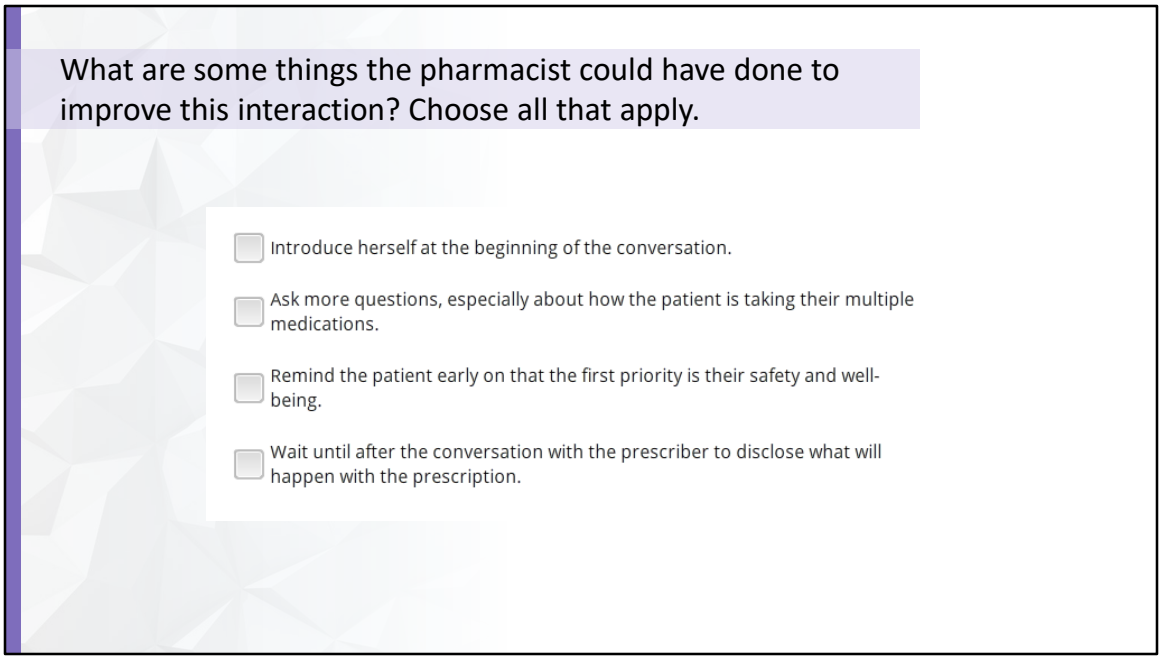
"Your commitment to your health really shows through your efforts to use alternative therapies and willingness to coordinate a better prescription plan with your doctors. This all sounds really great! We're going to hold off on filling your prescription at this time, and I am going to talk with your provider today to recommend they review your prescription history and consider an alternative to the pain medicine they have requested for you. I hope to see you back in here soon and learn about how things are improving for you!"

future.

- Ending on an affirmation is a great way to leave the conversation on a positive note, despite having to refer the patient back to their provider and/or deny their prescription. Actually, in the best of scenarios, at this point you may be “offering” to refer them back to the provider as opposed to “denying” them treatment.
- Affirmations are simple, positive statements about the patient’s self-efficacy, commitment to their own health, and/or likelihood of behavior change.

Video: Pharmacist interaction

[placeholder for video]



What are some things the pharmacist could have done to improve this interaction? Choose all that apply.

Let's review the opportunities for improving this interaction with the patient.

No information was given about the PDMP. The patient has the right to know the PDMP exists and to see a copy of their report if they want to.

No questions were asked. The patient was *told* a lot of information about their history and current status, but they were not asked any questions at all. In this situation, the pharmacist could have asked, "What do you mean it was a mistake? Can you tell me more about that?" Asking questions is a simple way to help someone feel included in the conversation.

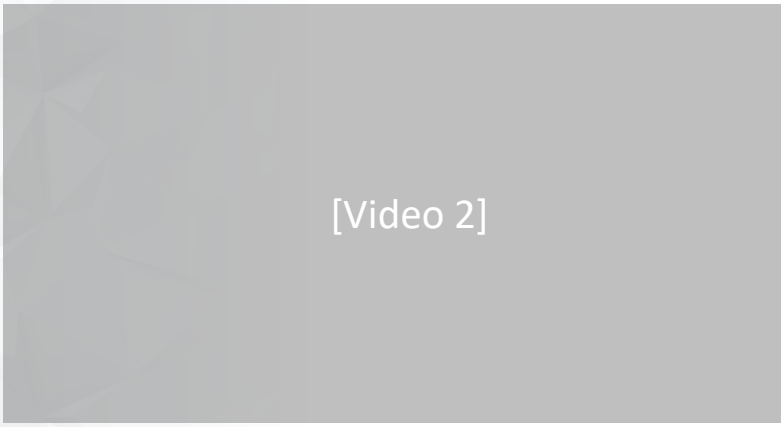
Decisions were made without the patient. Having more background information from the patient may have helped the pharmacist investigate possible discrepancies within the PDMP report *before* contacting the provider and having the prescription cancelled.

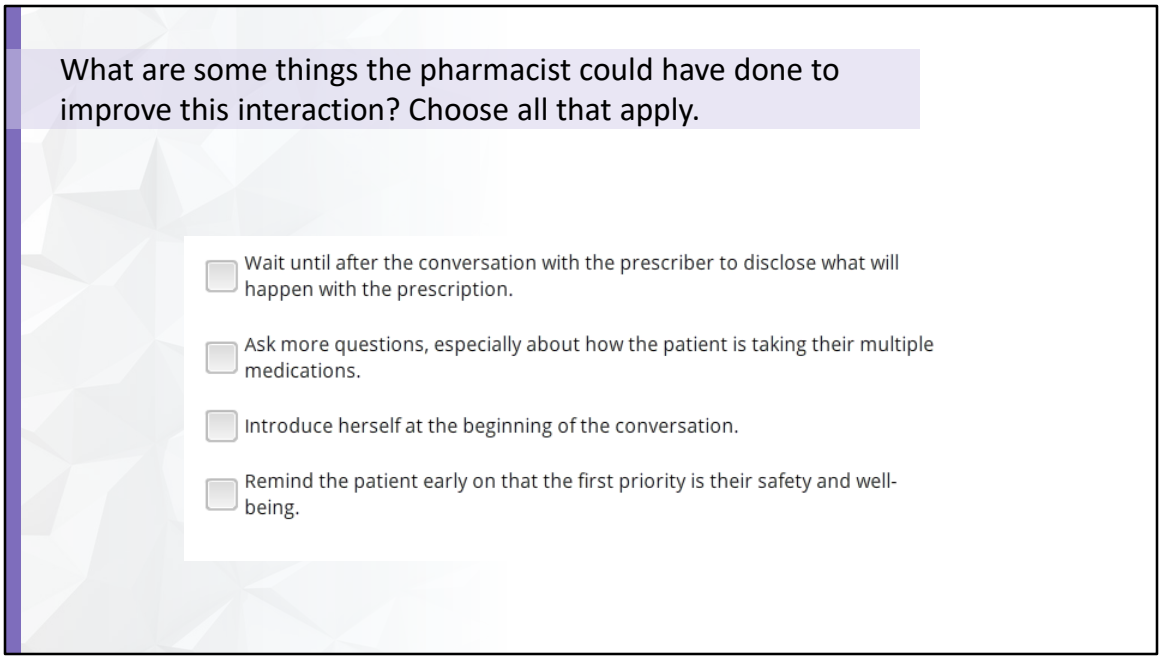
The tone was formal and unsupportive. The patient made comments that he may be feeling unfairly stigmatized for his age and diagnosis. His body language and gestures could have been a red flag to a pharmacist, but the lack of supportive tone and

language likely escalated his anxiety and feelings of stigmatization instead of diminishing them.

So, let's try again.

Video: Pharmacist interaction





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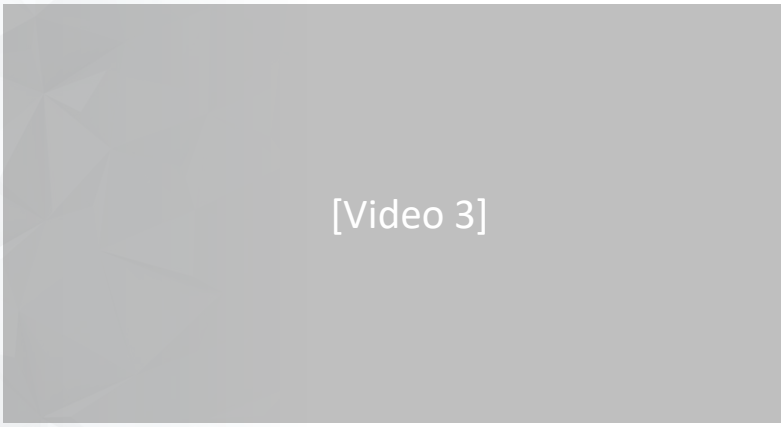
Video: Pharmacist interaction



This conversation was successful in many of the ways we discussed earlier, but not all real-world interactions will go this smoothly. When facing highly emotional situations, consider what may be underlying the strong emotional expression. Underneath a heightened emotion such as anger, there is often shame, fear, grief, panic, sadness, and possibly a belief that living without prescription opioids is impossible. Communication that demonstrates empathy, compassion, and strong boundary setting will lead to more positive clinical outcomes. With the right mindset and tools, difficult conversations can become medicine that is safe, effective, and satisfying for patients, families, and the healthcare team. Here are some important things to keep in mind when interacting with patients who are prescribed opioids:

- Most patients receiving opioids have legitimate pain or worry that they will be in pain soon.
- Most prescriptions are legitimate. The patient may be advocating for themselves at the counter, but someone else wrote that prescription for them. If a patient presents with a risky prescription, you can now advocate for their safety on their behalf with the prescribing provider.
- Most patients have done a lot of work before even entering the pharmacy. Odds are they are tired, scared, or frustrated, and although it may affect how they act toward you, it is not actually about you.

- Once you've begun a conversation with an individual, show a willingness to feel uncomfortable instead of rushing the interaction. Notice your own automatic physical reactions, like jaw clenching or shallow breathing, and work to relax your muscles. Modeling calm behavior while avoiding defensiveness helps keep the other person calm, too.
- Offer reflection, validation, and support. You don't have to agree with the patient or condone their behavior to validate their experience.
- Keep your expectations realistic. A patient may get angry or they may walk away from the interaction feeling upset, but that doesn't mean that the conversation was a failure. If your actions are guided by the patient's best interest and you conveyed your concerns in a supportive and compassionate way, then the interaction should be considered a success.
- Your job is to advocate for their safety and to do no harm. Period. How you articulate this to them will have a lot to do with how the conversation unfolds.

Changing and improving your communication habits is an ongoing process that takes time, practice, and committed effort. It may be helpful to incorporate one or two of the tools mentioned in this module into your daily conversations until they become habit. For more resources related to clinician-patient communication, visit the Oregon Pain Guidance website.

This concludes your Module 3 training. You have now fully finished the RESPOND Toolkit online course.

Thank you!