MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Direct Clinics Safe Practices Guidelines: Suspecting Ongoing Substance Use or Misuse or Prescribing Clinically Indicated Controlled Substances		
Last Updated: 01/26/2022	Owner: MCCMH Chief Medical Officer	Pages: 6

I. PURPOSE:

As outpatient providers cognizant of the opioid epidemic and amplified misuse of various controlled substances in the community, it is important that as healthcare providers we follow best practices and with our expertise do our due diligence to screen and assess for the need of prompt interventions in persons served who are suspected to be at high risk for substance use or misuse.

II. DEFINITIONS:

A. Prevention
Primary prevention includes efforts to reduce the supply of opioids in the community and address conditions that create health. Secondary prevention includes interventions that assist individuals already taking prescription opioid/controlled substances and/or using illicit drugs. Tertiary prevention includes harm reduction efforts and emergency responses to opioid or other overdoses.

B. Controlled Substance
Any medication that falls under the classification by the Drug Enforcement Agency of Class II-V.

C. Opioid:
Opioids include prescription medications used to treat pain such as morphine, codeine, methadone, oxycodone, hydrocodone, fentanyl, hydromorphone, and buprenorphine, as well as illegal drugs such as heroin and illicit potent opioids such as fentanyl analogs (e.g., carfentanil). Opioids work by binding to specific receptors in the brain, spinal cord, and gastrointestinal tract. In doing so, they diminish the body's perception of pain. However, opioids can also have an impact on other systems of the body, such as altering mood, slowing breathing, and causing constipation. Opioid receptor binding causes the signs and symptoms of overdose as well as the euphoric effects or "high" with opioid use.

D. Substance Use Disorder:
A cluster of cognitive, behavioral, and psychological symptoms including that the individual continues using the substance despite significant substance-related problems. SUD diagnosis is based on a pathological pattern of behaviors related to use of the substance. Diagnosis criteria can be considered to fit within the following groupings: impaired control, social impairments, risk of use and pharmacological criteria (APA, 2013).

E. Tolerance

A state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more drug's effects over time.

F. Michigan Automated Prescription System (MAPS):

State System used to track controlled substances, schedules II-V drugs. It is a tool used by prescribers, prescriber's delegates and dispensers in the State of Michigan to assess patient risk and is also used to prevent drug abuse and diversion at the prescriber, pharmacy, and patient levels. MAPS reports provide an Overdose Risk Score (ORS) and can be completed by physician, RN or a delegate (see definition of a MAPS Requestor or delegate)

G. Overdose Risk Score (ORS)

A relative scoring system that ranges from 000-990 found in the MAPS. The scores represent the risk of unintentional overdose death. An Odds Ratio for 100-point scoring groups using 000-190 as the referent group can also be used to quantify risk.

H. MAPS Requestor or delegate

A PMP AWARXE account type that is typically used to review a patient's prescription history and who could be able to print a MAPS report. Dispensing Physician, Medical Resident, Nurse, Nurse Practitioners, Clinical Nurse Specialist, Pharmacists, Pharmacists' delegate licensed, Physician assistant, prescribed delegate licensed OR unlicensed.

I. High Risk Individual

An individual who has a history of substance use or misuse in the past; who reports or whose collaterals (per release of information) or medical records report ongoing use or misuse of any illicit substance; who is prescribed at least one controlled substance by any other medical provider; someone who is deemed by the psychiatrist/NP/PA as such; or whose MAPS shows a clinically high Overdose Risk Score (ORS) or high dosages of prescribed controlled substance and/ or multiple pharmacies/prescribers, and/or are on concurrent Benzodiazepine-Narcotic use.

III. RECOMMENDED BEST PRACTICES:

A. Physicians must complete MAPS at every visit of any person served currently being prescribed by their authority a controlled substance. Before the prescriber is considering extending a prescription for a clinically indicated controlled substance, he/she must run a MAPS to make sure this will not present a clinical risk to the person served.

B. Nursing staff and/or Licensed prescriber must complete medications reconciliation at every encounter to remain aware of any changes in the person's served medications. Updates should be reflected in the appropriate section of the EMR.

C. Urine Toxicology screening should be ordered at initiation of treatment with any person served who falls under the definition of high risk or when considering starting someone on any controlled substance. Licensed Provider reserves the right to order a Urine Toxicology and/or Blood Alcohol Level when and as often as clinically appropriate. In

the event the individual declines it, this must be documented. In the event the individual's refusal in addition to other findings raises a genuine clinical concern for potential ongoing use/misuse of illicit substances, this must be discussed with the person served. Appropriate staff should provide further substance use disorder assessment and co-occurring services. It is ultimately to the person served and his/her guardian to decide on pursuing treatment. CMH treatment team should provide services matched to Pre-contemplation Stage of Change. If person served continuously refused the above interventions, education on the matter and encouragement should be provided at every visit in efforts to give the person served support and the opportunity to reconsider their decision.

1. In the event an RN or Case Manager/Therapist notices this has not followed as stated above, it is the responsibility of these disciplines to notify the licensed provider so the appropriate laboratory screening orders can be provided and be completed no later than during the next visit or sooner.

2. Licensed Provider may consider ordering other laboratory tests such as Hepatitis Panel, CBC, Comprehensive Metabolic Panel, Liver Function, Blood Alcohol Level/s, etc. at the provider's discretion based on the clinical relevance of these as it pertains to the impact of certain illicit drugs or controlled substances to body organ function, their risk for communicable diseases because of certain routes of drug usage, and the potential for unsafe drug to drug interactions. It is the expectation that all providers follow appropriate standards of practice when monitoring for these other important markers and that provide appropriate referrals when medically necessary. Nursing staff must actively assist these individuals by providing patient education on the issues identified and an active coordination of care.

D. It is the due diligence of the treatment team, to confirm that the individual is not using/misusing other substances including sedatives (benzodiazepines) or alcohol. The licensed provider with the assistance of his/her clinic teams must make efforts to obtain collateral information to corroborate with other sources the individual's reports. When accessing collaterals (i.e relatives, friends, etc.) for information of the person served it is important there is always and appropriate release of information signed first.

E. Physician/NP/PA are to always consider any controlled substance as third line treatment and when other non-controlled- class-drug options have been exhausted. The licensed provider must always apply best clinical judgment when prescribing any controlled substance. The prescriber is responsible for evaluating the risk factors for controlled substance-related harms and using their best judgment in determining absolute clinical need for its/their use, this rationale must be clearly documented in the EMR. If controlled substances are deemed to be clinically indicated, it is recommended the licensed provider extends prescriptions with small quantities at the time rather than full 30-day refills.

F. Prescribers must always attempt to treat with the lowest but most effective clinical dose to mitigate risk and monitor for any increased tolerance signs the person served may present with at each encounter.

G. At a clinic visit, when suspecting undisclosed substance use or misuse, the clinician is to provide education and for those in pre-contemplation stage and via the use of appropriate motivational interviewing techniques provide encouragement to reconsider their choices. As the person served expresses wish to reconsider or open to disclose, revise treatment plan and crisis plan accordingly with new goals or steps and provide support by adjusting the frequency of counseling & assessments until the individual; is lined with the appropriate substance referral resource of their choice (i.e., inpatient detox, dual diagnosis clinic, etc.).

H. In the event this initial disclosure is to an RN or licensed provider, these disciplines must notify the clinician/social worker on the case of the individual's disclosure so that appropriate referrals and revisions of the crisis plan, and PCP can occur without delays. It is the responsibility of the team member/discipline who is first to hear of this disclosure to communicate to the other treatment team members (RN/Psychiatrist/NP/therapist/CM, etc.) so that all disciplines are aware of the need to further explore the appropriate treatment options with the individual promptly and do their due diligence, as it pertains to their specific professional disciplines, i.e., revising the PCP, crisis plan, etc.

I. A thorough substance history, at time of intake or any other initial encounter, must be fully documented for those individuals at risk such as those who as per the definition present with past history of substance use, recent history of intoxication episodes, admit to recent ongoing experimentation with illicit/controlled substances, have an ongoing alcohol use or misuse, deny use but their denial is conflicting with information provided by collaterals/MAPS report, or instances in which facts shared in the recent or previous documented history are substantial to raise high suspicion for risk. An initial Urine Toxicology should always be ordered, and results reviewed. Team members should involve RNs and/or licensed provider so that appropriate orders are in place to carry out the collection of the necessary laboratory tests. If the person served declines, this should be documented along with the efforts and education provided as rationale for the need of the test.

J. When in doubt, clinicians should provide the person served with the information on available services for co-occurring disorders within the clinic and available higher level of referrals as clinically appropriate, including opioid medication assisted treatment services in the event the individual was to reconsider later. Make sure accurate documentation of those efforts and the individual's refusal when applicable is documented in the record at time of occurrence.

K. Licensed providers, when identifying risk for relapse, ongoing misuse, or when the use of illicit substances presents a high risk for a detrimental interaction with medications being currently prescribed, reserve the right to request the individual for pill count of controlled

substances the provider may be prescribing via the Controlled Substance Monitoring Process (Appendix A). RNs and other team members involved in the person's served treatment, in the application of their clinical judgment, may also make a recommendation for such to the licensed provider so that Controlled Substance Monitoring Process can be implemented following the licensed provider order (Appendix A).

L. When concerned about use of misuse of controlled substances prescribed by other providers, the licensed provider/RN must do their due diligence in relaying this information to the person's served existing PCP on his/her findings via the appropriate HIPPA compliant coordination of care process, doctor-to-doctor or RN to doctor.

M. Pregnancy test for women of childbearing age:
  - ✓ If pregnancy test is positive, assist patient engagement with an appropriate obstetric provider. The individual's licensed professional (i.e., Psychiatrist/NP/PA) should be notified to make recommendations on the risks vs benefits from continuation or discontinuation of person's served medications.
  - ✓ Licensed provider should guarantee an appropriate coordination of care occurs with an Obstetric provider while remaining mindful that various Controlled Substances are contraindicated in pregnancy.

N. In the event staff comes across a person's served who shows the following signs: Unconsciousness or inability to awaken, slow or shallow breathing or breathing difficulty such as choking sounds or a gurgling/snoring noise from a person who cannot be awakened, fingernails or lips turning blue/purple an opioid overdose may be suspected. In this case notify RN staff and 911 immediately and licensed provider if available on-site. While waiting for them stimulate the person: Call the person's name, if this does not work, vigorously grind knuckles into the sternum (the breastbone in middle of chest) or rub knuckles on the person's upper lip, administer Narcan if available following first aid/CPR training instructions. If the person responds, assess whether he or she can maintain responsiveness and breathing. Continue to monitor the person, including breathing and alertness, and try to keep the person awake and alert. Follow the licensed provider instructions if he/she is on site to assist.

IV. TRAINING:

All Direct Clinic staff will be required to take the designated MCCMH training in efforts to assist MCCMH staff on gaining insight on the subject and the importance of following these guidelines.

V. MONITORING:

The Chief Medical Office, Quality Division and CRMC will monitor for compliance with this practice.

VI. EXHIBITS:

Appendix A: MCCMH Direct Clinics Controlled Substance Monitoring Process

VII. REFERENCES:

A. https://www.aha.org/system/files/media/file/2020/07/HIIN-opioid-guide-0520.pdf
B. https://store.samhsa.gov/sites/default/files/d7/priv/sma18-4742.pdf
C. https://www.michigan.gov/documents/lara/2b-Michigan_PMP_AWARxE_Requestor_User_Support_Manual_556541_7.pdf
D. https://www.cdc.gov/opioids/providers/prescribing/guideline.html

Annual Review Attestation / Revision History:

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1	01/26/2022	Development of Guidelines	Dr. Serpa