

Responding to Disruptions in Access to Opioid Prescriptions:

A GUIDE FOR STATE HEALTH DEPARTMENTS AND THEIR PARTNERS (2022)



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Introduction to Disruptions in Access to Opioid Prescriptions

Disruptions in access to opioid prescriptions can occur for several reasons, including a prescriber's death or retirement, or a federal or state law enforcement or regulatory action. These events can cause temporary or permanent disruptions and may result in complete closures of prescribers' practices. Disruptions in access to opioid prescriptions are especially dangerous for patients with physical dependency on opioids or an opioid use disorder, and they could lead to potential increases in drug-seeking behavior, drug diversion, illicit drug use, and opioid-involved injury or death among displaced patients. Risks of emotional trauma and suicide may also increase for patients with chronic pain who are being treated with, and losing access to, prescription opioids.¹ This guidebook will focus on the complexities of responding to disruptions in access to opioid prescriptions due to law enforcement actions taken against a prescriber. However, this information can be easily applied to other events that lead to disruptions in prescription supply, such as the death, retirement, or resignation of a clinician who commonly prescribes opioids for long-term pain management.

WHY DISRUPTIONS OCCUR

How are controlled substances regulated?

- Under federal law, all health professionals, including pharmacists, must be registered with the United States Drug Enforcement Administration (DEA) to dispense, administer, or prescribe federally controlled substances. As DEA registrants, these individuals must comply with regulatory requirements relating to drug security and recordkeeping.

Why might a prescriber be investigated?

- Investigations against prescribers are often aimed at those who provide prescriptions to individuals for purposes other than legitimate medical treatment or outside the scope of legitimate medical practice.

What are some common law enforcement actions that might disrupt prescription supply and impact patients?

Common law enforcement actions that can disrupt prescription supply and impact patients include:

- Search warrant executed at a facility where opioid prescribing occurs or medications for opioid use disorder (MOUD), such as buprenorphine or methadone, are provided.
- Prescriber arrest, resulting in bond conditions that temporarily or permanently suspend an individual's ability to prescribe or practice medicine.
- DEA registration immediate suspension order.
- DEA registration voluntary surrender by a prescriber.
- State controlled substance license loss (some states require a state license as well as a federal DEA license; loss of one automatically results in the loss of the other).
- Medical license suspension.²

¹ Racine M. "Chronic pain and suicide risk: A comprehensive review." *Prog Neuropsychopharmacol Biol Psychiatry*. 2018;87(Pt B):269-280. doi:10.1016/j.pnpbp.201708.020

² CDC National Center for Injury Prevention and Control Opioid Rapid Response Program.

POSSIBLE RISKS TO PATIENTS

Patients receiving opioid therapy, MOUD, or other controlled substance treatments who lose access to their prescriber may be at risk for a variety of adverse physical and mental health effects. They may experience trauma, anxiety, feelings of abandonment, fear, desperation, depression, hopelessness, and suicidal ideation. Patients who are physically dependent on their medications may experience physical pain as well as a variety of other withdrawal symptoms, depending on the medication, dosage, and length of time they have been taking the medication. Without care continuity, patients experiencing withdrawal symptoms or untreated pain may turn to the illicit drug market, where the use of counterfeit pills and other drugs such as illicitly manufactured fentanyl, put them at risk of overdose.

To mitigate risks among affected patients, patients need to quickly be notified about disruptions, obtain access to a new healthcare provider, and be provided with resources to mitigate their risk of adverse health outcomes. Due to the complexities and fragmentation of the healthcare system, risk mitigation requires coordination and layered strategies to respond to disruptions rapidly and effectively.

Common barriers states face when responding to disruptions in access to opioid prescriptions include:

1. A lack of established protocols to support state and local response to such disruptions.
2. Difficulty quickly identifying and accessing available resources to meet rapid response needs.
3. Challenges assessing patient risk due to data access restrictions.
4. Challenges identifying or contacting patients.
5. Difficulty identifying prescribers who are willing and able to accept patients taking long-term opioid therapy for chronic pain.
6. Challenges in measuring the success of the response efforts and care continuity for impacted patients.

This guidebook is intended to help states address these common challenges by assisting state health agencies and their partners in developing and enhancing state protocols for disruptions in patients' access to prescription opioids and other controlled substances.



Responding to Disruptions in Access to Opioid Prescriptions: A Guide for State Health Departments (2022) builds upon the Association of State and Territorial Health Officials' (ASTHO) 2020 document *Responding to Pain Clinic Closures: A Guide for State Health Departments*. This updated guidebook reflects the current state and federal landscape regarding disruptions, shares updated recommendations on strategies states might use to mitigate risks to patients affected by a disruption, and includes additional state examples. These updates are informed by the CDC's [Opioid Rapid Response Program](#) (ORRP) and states' coordinated responses to ORRP notifications since the program was formally established in late 2020, as well as tabletop preparedness exercises ASTHO has conducted with states.

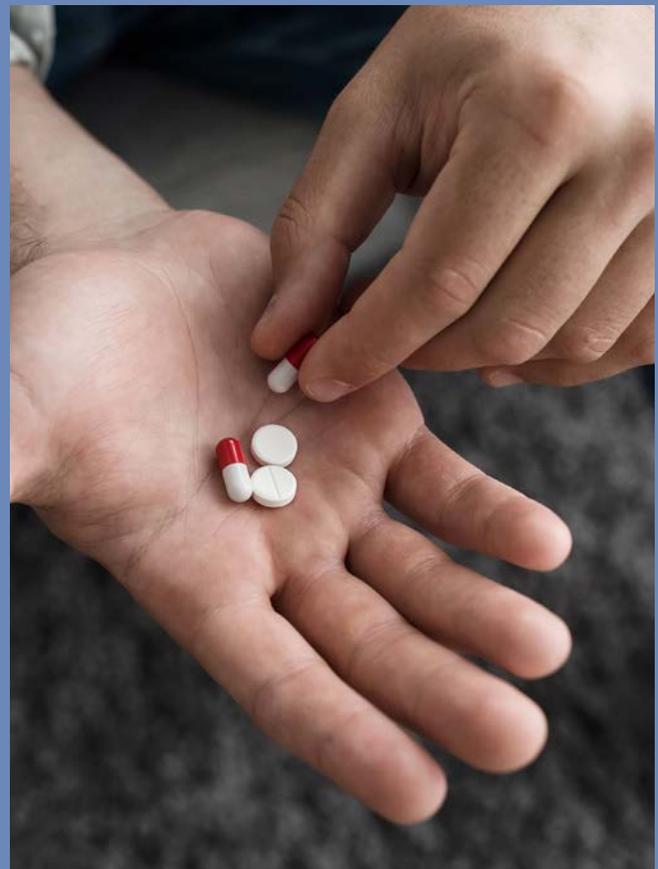
This guide is not meant to replace existing emergency protocols your state might have in place. Rather, it is intended to serve as a model to consult for augmenting or informing your current response processes.

OPIOID RAPID RESPONSE PROGRAM (ORRP)

[ORRP](#) is a coordinated interagency, federal effort designed to mitigate drug overdose risk among patients impacted by federal law enforcement actions that disrupt access to opioid prescriptions or medication-assisted treatment/medication for opioid use disorder (MAT/MOUD). The program leverages relationships across federal, state, and local agencies to increase capacity; facilitate timely communication about disruptions; and help states develop and implement rapid response protocols to facilitate care continuity, risk reduction, and other overdose prevention interventions. ORRP coordinators within CDC's Division of Overdose Prevention and the HHS' Office of the Inspector General work closely with federal law enforcement agents to ensure that sensitive information remains confidential, and that the integrity of an investigation is not compromised, while providing timely notification to trusted state health officials about potential disruptions to care. Program staff provide as-needed technical support to state health agencies throughout each response. The program also provides support for preparedness efforts and training to increase statewide capacity to respond to [ORRP](#) notifications.

Designated health officials, known as trusted contacts, may receive advanced notification of federal law enforcement actions that could disrupt a patient's access to medication. States should inform CDC of any transitions in staffing that affect their trusted contacts.

Trusted contacts may call on other state partners to help coordinate and manage a response, keeping in mind the need to withhold any confidential information as instructed by law enforcement or ORRP coordinators.



Preparing for a Disruption

Planning and preparedness activities will provide the most effective response to a disruption in access to opioid prescriptions and other controlled substances. This section includes the following preparedness steps:

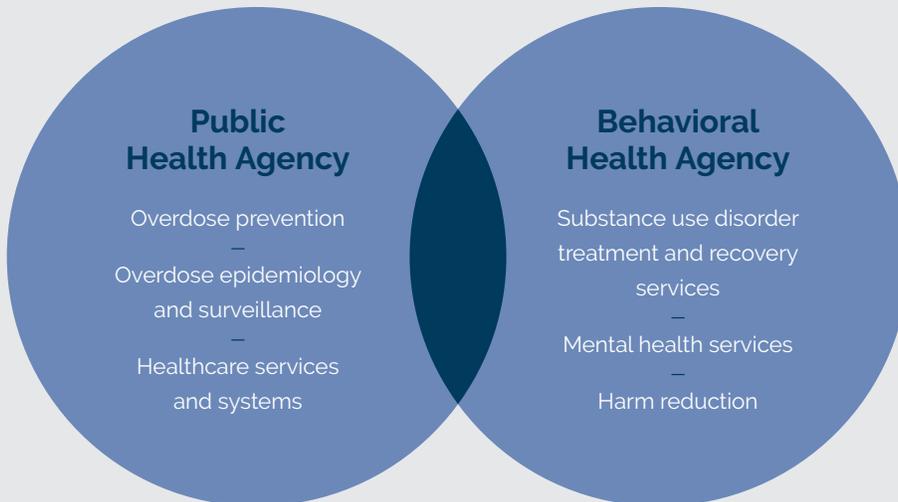
1. Structuring your response team.
2. Engaging response partners.
3. Assessing state capacity and addressing capacity needs.
4. Developing and refining a state response protocol.
5. Exercising state and local protocols.
6. Planning for coordination and communication.



Structuring Your Response Team

RESPONSE COORDINATION TEAM ROLES

Prescription Drug Monitoring Program



Emergency Preparedness and Response

Staffing a state response coordination team can begin with your state's designated ORRP "trusted contacts." Due to the confidential nature of information about ongoing law enforcement investigations, ORRP establishes "trusted contacts" within each state and Washington, D.C. Trusted contacts typically include one individual from the state health department who oversees overdose prevention activities and one individual from the state's mental health and addiction services agency. These individuals (three people at most) typically serve as the response coordination

team because they are often the first to know about a disruption and were selected as trusted contacts because of their knowledge of state overdose prevention, response, recovery, and treatment resources. There are times when trusted contacts are not permitted to share specific information about an upcoming disruption with anyone else in their agencies until closer to or immediately after the disruption occurs. For this reason, their ability to access relevant information about a healthcare provider or patient population can help them anticipate risks as well as needed interventions.

QUESTIONS TO CONSIDER

- Do your trusted contacts have direct access to prescription drug monitoring program data (PDMP) data? If not, should your PDMP administrator become a trusted contact?
- Do your trusted contacts have access to lists of addiction treatment resources throughout the state? If not, should your state opioid treatment authority also become a trusted contact?
- Besides your state's trusted contacts, who should be part of a broader response coordination team when more information can be shared about an impending or immediate disruption?

Examples:

PDMP Administrator

PDMP access is critical during the risk assessment phase of a response to a disruption in access to opioid prescriptions and can provide valuable insights about affected patients, including where they are located, the composition and doses of their prescriptions, and their insurance coverage. However, access to PDMP data varies by state, and depends on the laws and regulations that govern how PDMPs operate in that state. Because of these considerations, including your PDMP administrator as part of the response coordination team may be helpful.

Overdose Response Strategy Public Health Analyst

[The Overdose Response Strategy](#) (ORS) is implemented by teams made up of drug intelligence officers and public health analysts who work together on drug overdose issues within and across sectors, states, and territories. By sharing information across sectors, the ORS is growing the body of evidence related to overdose early warning signs and prevention strategies. The ORS public health analyst in your state can help guide and support your preparedness and response efforts, especially those related to communicating with and leveraging public safety partners.

Emergency Preparedness and Response

State and local emergency preparedness and response departments help communities prepare for, respond to, and recover from naturally occurring and man-made public health emergencies using specialized knowledge, skills, techniques and organizing principles. Given this expertise, emergency preparedness and response staff are excellent partners to include in the response coordination team and can share how best to make use of a state's resources and surge capacity.

Incident Command Systems

One system commonly utilized by state emergency preparedness offices to manage response efforts is the Incident Command System (ICS). FEMA defines ICS as a system to organize the assets to respond to an incident and the processes to manage the response through its successive stages. ICS is built in a modular fashion based on incident size and complexity, but always includes an incident commander who has overall responsibility for the incident and sets objectives. ICS also generally includes operations, planning, logistics, and finance and administration leads who report to the incident commander. ICS enables a coordinated response among various jurisdictions and agencies and allows for the integration of resources (e.g., facilities, equipment, and personnel) within common organizational structures. When preparing for a disruption to opioid prescriptions, ICS can be a helpful tool for communication and coordination. The benefits of an ICS include:

- [Clarifying chain of command and responsibilities to improve accountability.](#)

↑ [Click to see Appendix A: Job Action Sheets for Partners](#)

- Leveraging interoperable communications systems and plain language to improve communications.
- Providing an orderly, systematic planning process.
- Implementing a common, flexible, predesigned management structure.
- Fostering cooperation between diverse disciplines and agencies.
- When developing a protocol for disruptions in access to opioid prescriptions, states should consider whether an ICS structure would benefit state response efforts. Each state is different, so not all states may choose to utilize an ICS in these responses.

ROLES AND RESPONSIBILITIES

Response Coordination Team Roles: During a Response

- Receive notification directly from CDC's ORRP and engage in an initial call with ORRP staff ([see ORRP Trusted Contacts FAQ's](#)).
- Conduct an initial risk assessment based on known facts surrounding the disruption (see Assessing Patient Risk Section). **See page 16.**
- Determine an initial list of partners that will need to be notified and engaged in response efforts.
- Identify available state and local resources to aid in the response (see State Capacity Assessment).
- Obtain additional information that could inform risk assessment (e.g., PDMP data, or Medicaid claims data).
- Develop task lists and assign roles and responsibilities.
- Document and monitor response activity to inform an after-action debrief and facilitate continuous improvement.

Response Coordination Team Roles: Prior to or Between Responses

- Conduct a state response capacity assessment (see State Capacity Assessment) **on page 10.**
- Develop, exercise, and refine the state's rapid response protocol.
- Develop a phone tree and contact list.
- Strengthen relationships and connections with partners who need to be involved, consulted, or informed of a disruption in prescription supply.

STATE-LED ACTIONS

Unlike those actions in which federal law enforcement agencies are involved and CDC coordinates communication about the action with state trusted contacts, state-led law enforcement or licensing actions would typically require direct coordination between state health officials and the agencies taking actions that could lead to a disruption in patients' access to controlled substances. After your state has an established response protocol to mitigate risks among patients, you might want to engage with the following state agencies to implement a notification process for state-led actions that impact patients:

- Bureau of Narcotics Enforcement
- State Attorney General's office
- State medical boards (or other licensing agencies)



ENGAGING RESPONSE PARTNERS

The response coordination team will work with many state and local partners to form a response team. Response partners may vary depending on the nature of the disruption, the location of the patients, and their needs. Preparedness activities should include as many potential partners as possible to help ensure rapid response capability if and when they are called upon to assist with a response. When thinking about potential response partners, it helps to consider who can assist with the following:

- Assess substance use disorder treatment capacity throughout the state (e.g., State Opioid Treatment Authority, and Substance Abuse and Mental Health Services Administration regional administrator).
- Assess other healthcare resource availability, including hospital and mental health service capacity.
- Identify and communicate directly with affected patients (e.g., state Medicaid office, private payers, and PDMP administrators).
- Increase naloxone distribution.
- Alert harm reduction organizations.
- Identify which health systems (e.g., community health centers, university-based health systems, public hospitals) can absorb displaced patients.
- [Provide clinical support to healthcare providers inheriting displaced patients.](#)

↑ **Click to see Appendix C:
Communicating with Healthcare Providers**

- Provide patient triaging and care coordination.
- Share effective messaging.
- Monitor for overdoses and other adverse health effects among affected patients.

Potential State Response Partners

- State hospital association
- State medical licensing board
- State office of emergency preparedness and response
- State Opioid Treatment Authority
- State health agency's communications office
- Health systems
- Regional health officers
- [Prescription drug monitoring program](#)
- ↑ **Click to see Appendix B:
Communicating with PDMP**
- State board of pharmacy
- State Medicaid office
- Behavioral health contractors
- Overdose response strategy teams (public health analysts and drug intelligence officers)
- Private insurers/managed care organizations

Potential Local and Community Response Partners

- Emergency medical services
- Hospital systems and emergency departments
- Primary and ambulatory care clinics
- Federally qualified health centers (FQHCs) and look-alike community health centers
- Harm reduction service organizations
- Peer recovery services

STATE CAPACITY ASSESSMENT

With help from key partners, the state health department should assess state capacity to address a disruption in access to opioid prescriptions. Consider the following:

Healthcare capacity:

- Assess the number of prescribers and FQHCs in the state and their capacities to (1) accept new patients who are taking opioids for chronic pain (2) treat patients with substance use disorder.
- If possible, verify the number of buprenorphine-waivered prescribers and assess their experience prescribing MOUD.
- Review the locations of waived prescribers; if there is a deficit, encourage healthcare providers to apply for a waiver and consider models of telehealth across the state.
- Consider developing a list of clinics or healthcare providers willing to accept patients being treated for chronic pain.
- Understand the capacity of local hospitals. Rural and urban hospitals function differently. Differences may include management and programs, reimbursement models, volunteer versus paid, EMS and staff experience.
- Create lists of available opioid treatment programs and buprenorphine-waivered prescribers in specified areas. If possible, consider creating a geographic information system (GIS) map of primary care practices linked to Medicaid claims data and the PDMP.
- Consider the availability of certified addiction specialists and peer support specialists to connect affected patients with continuity of care.
- Assess state helpline staff's ability to address diverse patient needs, particularly for patients who may not have or self-identify as having a substance use disorder but who need preventive health assessments.

Relevant legislation:

- Consider state legislation and try to predict what legal challenges may arise.
- Understand state data-sharing laws, including what types of PDMP data can be accessed or shared with state health agencies working on the response (e.g., patient lists, aggregate counts, direct outreach to effected patients).

Resource availability:

- Assess the infrastructure of the area, including transportation challenges, especially in rural areas.
- Assess ability to build and obtain needed resources to fill gaps identified by state capacity assessment.
- Assess availability of mobile units and healthcare staff.
- Ensure availability and distribution of naloxone to key areas.



ADDRESSING CAPACITY NEEDS

To address any identified capacity needs, ensure that training opportunities, and other resources are shared with key partners. This includes requesting federal resources, such as technical assistance from ORRP, or requesting support through the [Emergency Management Assistance Compact](#).

Partners:	Suggested Training Topics:
Prescribing Professionals	<ul style="list-style-type: none"> • Naloxone administration • Ensure capacity to provide training around tapering opioids and benzodiazepines • Applying for a DATA-waiver • Handling patients with co-morbidities • Screening for substance use disorders and mental health disorders • Implicit bias and anti-stigma training • Telehealth • Standing orders • CDC's Opioid Response Training for Prescribers
Law Enforcement and First Responders	<ul style="list-style-type: none"> • Naloxone administration • Mental health crisis training • Good Samaritan laws • Compassion fatigue and available resources • Safety training, including: <ul style="list-style-type: none"> – Investigation and evidence handling – Searching subjects – Special operations and decontamination – Personal protective equipment
Local Health Districts	<ul style="list-style-type: none"> • Naloxone administration • Public communication strategies
Community Members	<ul style="list-style-type: none"> • Naloxone administration • Awareness of resources, including the hotline, safe stations, and where to look for information during an incident
State Health Agency Staff	<ul style="list-style-type: none"> • CDC's Opioid Response Training—General Public • FEMA 100, 200, and 700

DEVELOPING AND REFINING A STATE RESPONSE PROTOCOL

If the state does not have a response protocol in place, the response coordination team should work to develop one. A protocol can help states prepare and plan for a response by outlining key steps and strategies for communication and coordination with partners, patient risk assessment, patient risk mitigation and monitoring and evaluation. See the Responding to a Disruption section for information on what to consider while developing your response protocol. Response protocols should be reviewed and updated based on after-action debriefs; lessons learned from preparedness tabletop exercises; and resource, policy, or capacity changes.

AFTER-ACTION DEBRIEFS

After a response to a disruption has concluded, bring partners together to discuss successes, opportunities for improvement, unmet needs, and viable solutions for addressing gaps. After-action debriefs should focus on sharing perspectives and what can be learned to inform the next response effort. Try to debrief one to two months after a response so that there is time for disrupted patients to find care and for response members to reflect on challenges and successes from the response. Consider requesting assistance from a trained facilitator to ensure that the discussion is productive. ASTHO and ORRP can assist with this.

EXERCISING STATE AND LOCAL PROTOCOLS

ASTHO assists states in conducting preparedness tabletop exercises to help build knowledge about disruptions in access to opioid prescriptions, facilitate important planning discussions amongst key state and local agencies and organizations, and provide a structure for developing and/or refining a written response protocol. Exercises are critical for effective emergency preparedness as they can help assess your state's level of preparedness and identify gaps that need to be addressed through training, modified plans, or additional resources.

ASTHO tailors exercises based on state and local structure and capacity. States are offered a menu of exercise options based on (1) whether there is already a response protocol in place, and (2) the degree to which this protocol has been exercised or used in practice. While most exercises occur at the state level, local jurisdictions are often involved and may have unique needs, prompting the necessity to exercise a variety of different scenarios in different locations throughout the state.

Types of Exercises:

WITH STATE PARTNERS

Workshop

The workshop is designed for states without a statewide response protocol. This exercise involves a partnership-building component and walks participants through a mock scenario using the four phases of a response to develop a state's protocol.

Seminar Tabletop

The seminar tabletop is for states with a draft statewide response protocol. This option is for states interested in reviewing their state response protocol with partners as well as walking through a mock scenario using the four phases of a response to enhance their state's protocol.

Full Tabletop

The full tabletop is designed for states with a robust statewide protocol that has been exercised with partners or used in cases of a disruption in access to opioid prescriptions. This exercise is for states interested in assessing their statewide protocol in accordance with FEMA's Homeland Security Exercise and Evaluation Program guidelines.

Facilitated Hotwash

The facilitated hotwash is an exercise option for states that recently experienced a disruption in access to opioid prescriptions due to a law enforcement action taken against a prescriber. States will engage in an after-action discussion to evaluate their performance to the recent disruption and identify areas of strength and improvement to enhance future response efforts. This option is part of a longer-term planning process for a tabletop exercise (workshop, seminar tabletop, and full tabletop).

Tabletop in a Box

The Tabletop in a Box is a toolkit that houses all the materials a state needs to conduct a tabletop exercise to test their opioid preparedness protocols. Materials include facilitation guides, participant lists, mock scenarios, and template Homeland Security Exercise and Evaluation Program materials. This draft tool is in pilot phase, and states engaged in this exercise format will provide critically important feedback on the usability of the tool.

WITH LOCAL JURISDICTIONS

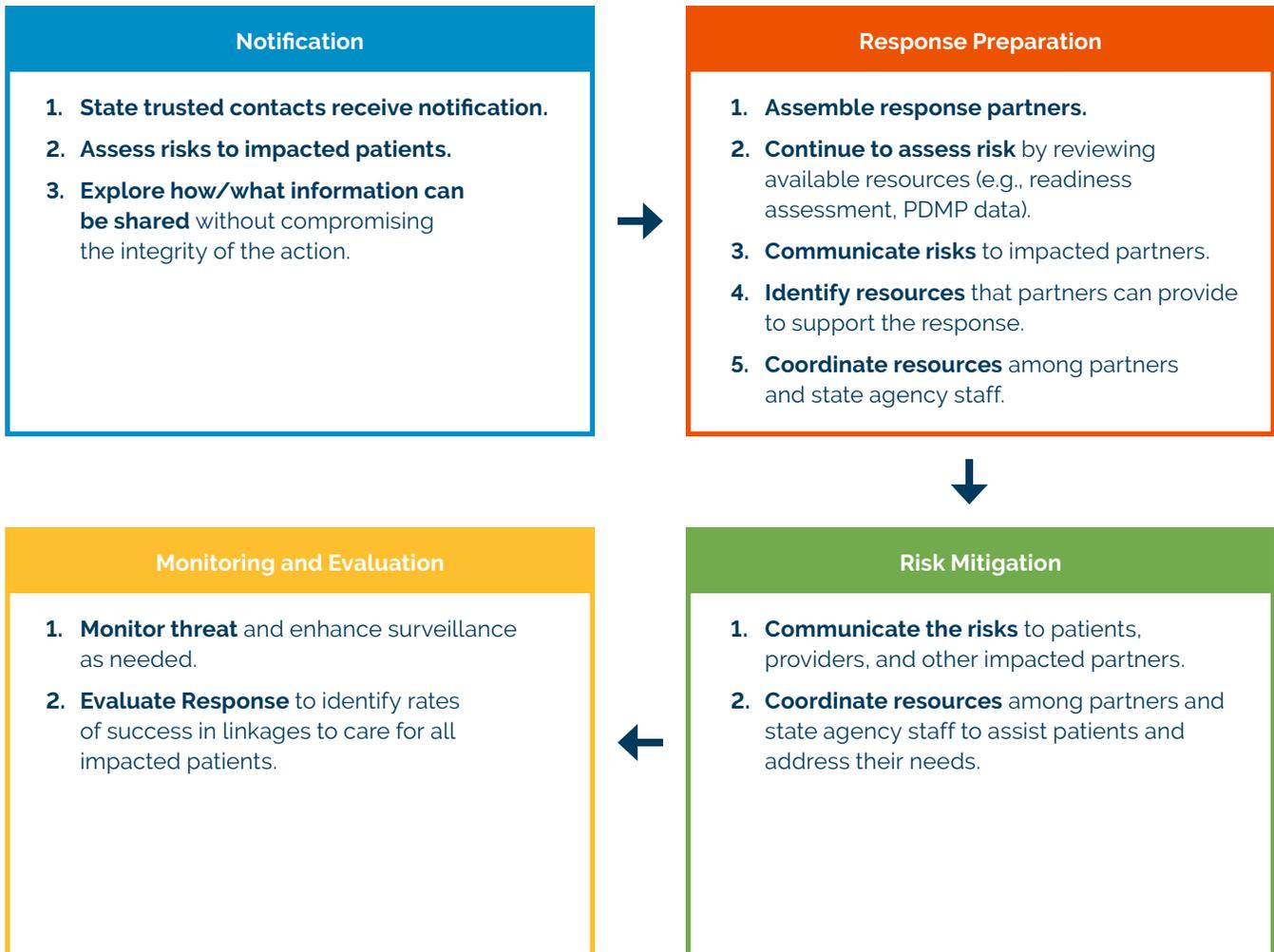
Tabletop Exercise with One Local Jurisdiction

A tabletop exercise with one local jurisdiction is led by the state where partners from one local jurisdiction come together to test a response protocol. It can be used when a local jurisdiction has either experienced a disruption in access to opioid prescriptions or believes they are at heightened risk for this event to happen in the future. This type of exercise provides an opportunity for the state to focus on the response protocols of one local jurisdiction.

Tabletop Exercise with Multiple Local Jurisdictions

A tabletop exercise with multiple local jurisdictions is led by the state where partners from multiple local jurisdictions come together to test a response protocol. During the exercise, local jurisdictions break out into small groups discussions after a scenario is presented. This provides an opportunity for the local jurisdictions to learn from each other and update their local response protocols as necessary.

Responding to a Disruption



→ = **COMMUNICATION AND COORDINATION** (Cross-Cutting for the Duration of the Response)

NOTIFICATION OF A DISRUPTION

Responding to a disruption in access to opioid prescriptions will generally begin with a notification from ORRP advising the state's trusted contacts of the situation and requesting a meeting to discuss details of the action. Once notified of an impending disruption, the state will need to move quickly to mobilize information and resources to ensure continuity of care and access to needed services for displaced patients. During a response effort, there are four primary considerations: **communication and coordination, assessing patient risk, mitigating patient risk, and monitoring and evaluation.**

COMMUNICATION AND COORDINATION

Having a well thought-out and targeted communication and coordination plan is essential at every stage of the response process. Planning must include both internal interagency communication and external communication with partners and the community. As the needs of states and localities vary, it is important to keep the plan flexible and include information on how and when to communicate with a diverse group of partners. Establishing and maintaining situational awareness among partners is key to ensuring a response can be tailored to meet specific needs.

Communication and Coordination Key Considerations:

- Plan for how the response coordination team will meet to discuss sensitive information prior to the launch of broader response efforts.
- Once information can be shared more broadly, form a daily or weekly (depending on the urgency and pace of the response) check-in with response coordination team members and response partners to discuss the response and walk through the talking points for consistent messaging.
- Consider having the state health official issue a "Dear Colleague" letter to healthcare providers in the affected area notifying them of an expected surge in patients from the closure.
- Reach out to healthcare providers in the affected area to notify them of an expected increase in patients due to the closure.
- Establish a hotline for patients with referral information for continuity of care.
- Issue a public service announcement.
- Reassess communication messages, delivery mechanisms, and placements, and update if necessary.

STATE SPOTLIGHT: SITUATIONAL AWARENESS IN PENNSYLVANIA

To communicate and coordinate with partners during their response efforts, Pennsylvania's Patient Advocacy Program invites partners to a virtual meeting, shares details of what occurred, and invites each partner to briefly share their observations of what might be needed (e.g., patient intakes, signs on the doctor's office). The patient advocacy program shares unified talking points for consistent messaging at the state and local level and among all partners. They then send email status updates until the formal response is deactivated.



RESPONSE PREPARATION

When a disruption happens, the risks to patients depend on the types of medications being taken, potential withdrawal symptoms, the health conditions of the patients, and patients' ability to quickly find alternative quality healthcare. Response teams may not have all the information they need to assess patient risk. Nevertheless, it may be helpful to consider the following:

- Are there patients being treated for a substance use disorder?
- Are there patients being treated for chronic pain?
- Are there patients receiving palliative care?
- Are there patients being treated for psychiatric conditions, such as anxiety or depression?
- Is there a chance the patients will experience withdrawal symptoms if they cannot receive their prescriptions? (Note: severe withdrawal symptoms may be experienced among patients taking opioids, including MOUD, or benzodiazepines.)
- Are there other healthcare providers who are willing and able to absorb the patients and care for them effectively?
 - If so, what barriers might the patients face (e.g., stigma, clinic policies, transportation, cost/insurance)?
- Are patients diverting medications, meaning selling them or trading them illicitly? If so, consider risks to the end users (e.g., drug supply disruption and counterfeit pills containing fentanyl).



Relevant Data to Inform Risk Assessment

The quality and amount of information you have about the prescriber under investigation and patient population will determine how accurately you can assess potential patient risk. Useful data sources include:

- Information obtained by law enforcement investigators (often shared with state health officials through ORRP coordinators)
- Prescription drug monitoring program (PDMP) data
- Medical claims data

For federal actions, ORRP coordinators can help obtain some information about the prescribing patterns of the healthcare provider and certain patient characteristics that could impact risk. Because investigations can take a long time, the PDMP data obtained as part of the investigation might be outdated or it might represent only a sample of patients. Therefore, access to PDMP data by state health officials is critical to obtaining a clear and complete picture of possible patient risks and appropriate risk mitigation strategies.



RESPONSE PREPARATION

QUESTIONS TO HELP ASSESS PATIENT RISK

What type of healthcare provider is involved?

- Doctor of medicine (MD)
- Doctor of osteopathic medicine (DO)
- Nurse practitioner (NP)
- Advanced practice registered nurses (APRN)
- Physician assistant (PA)
- Pharmacist

What type of practice is it?

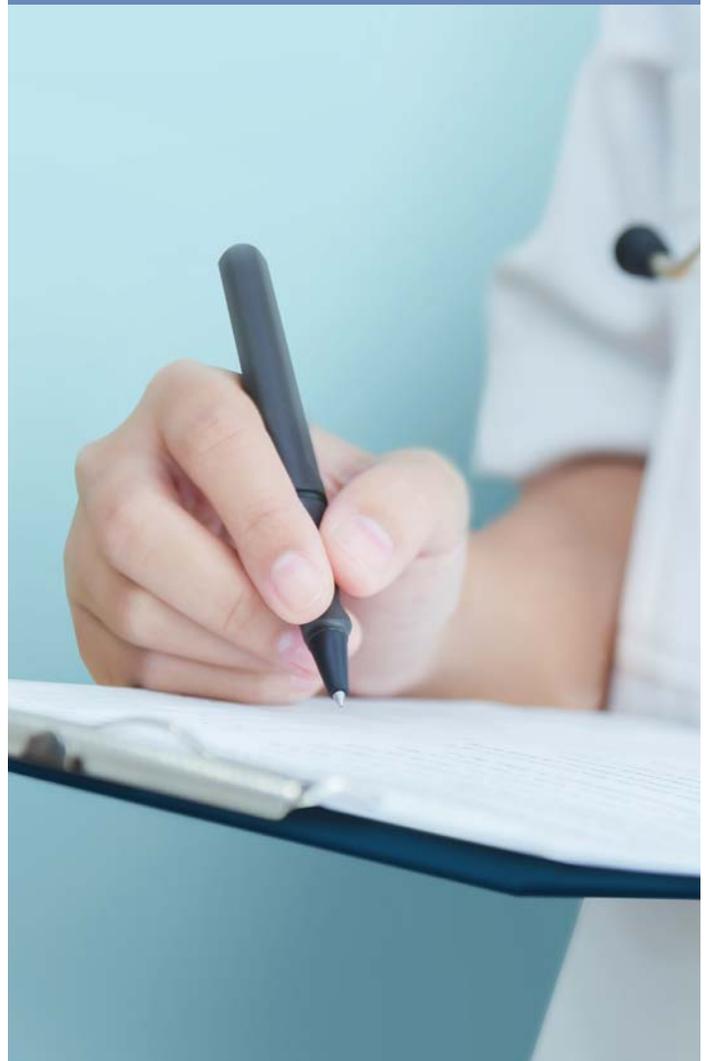
- Primary care/family practice/internal medicine
- Pain management
- Psychiatry
- Other _____

Which of the following are commonly prescribed by the healthcare provider?

- Opioids
- Benzodiazepines
- Muscle relaxants
- Stimulants
- Buprenorphine
- Methadone
- Other _____

Know Your State's Laws and Regulations

PA and NP prescribing authority regulations vary by state (www.aapa.org and www.ama-assn.org). In the event a healthcare provider is no longer able to prescribe, depending on the state, a PA or NP might be able to assist with care continuity, including bridge prescribing until the patient can obtain a new healthcare provider. However, it is important to note that in some cases, NPs are required to complete a number of years or hours of practice under a "mentorship" or "collaborative agreement" with a physician or another APRN. Licensing authorities can assist in determining prescribing authority for specific healthcare providers.



Risk of Withdrawal Symptoms Onset

Depending on the medications being prescribed, risks of withdrawal can begin within hours. Consider the specific timing onset and symptoms of withdrawal from the medications and dosages being prescribed. Withdrawal onset and severity depends on a variety of factors, including the type of medication and the length of time a person has been taking the medication.

How many patients are currently prescribed controlled substances by the healthcare provider?

- Total number of patients?
- Number of patients receiving opioids?
- Number of patients receiving benzodiazepines?
- Number of patients receiving buprenorphine?
- Number of patients receiving methadone?
- Number of patients receiving opioids and benzodiazepines?

Are any medications dispensed or administered in the clinic?

If so, which medications and how are they typically administered (e.g., pill, injection)? (Assume more immediate care continuity needs if patients are routinely administered medication onsite, such as at a treatment facility.)

How much diversion by patients is suspected? (E.g., most, some, few, unknown amount)?

How many patients receiving the above medications are:

- Medicaid beneficiaries?
- Medicare beneficiaries?
- Private insurance beneficiaries?
- Paying cash for services or prescriptions?

Is the healthcare provider buprenorphine-waivered (able to treat patients for substance use disorder with buprenorphine)?

Are there other healthcare providers who work in the same office who are not under investigation?

- If yes, do they have independent prescribing authority?
- If yes, are any of them DATA-waivered?

What is the expected status of the healthcare provider's prescribing ability?

- Possible suspension (e.g., in cases of search warrants, arrests and bond hearings, and court orders).
- Definite suspension (e.g., in cases of known voluntary DEA surrender, immediate suspension order of a controlled substance registration, or medical license revocation).

What is the expected status of the healthcare provider's professional practicing ability?

- Medical license retained
- Suspended medical license

PATIENTS WITH UNIQUE NEEDS

Unless the disruption is occurring at a substance use disorder treatment facility or with an addiction treatment specialist, many of the patients might not qualify as having a substance use disorder (SUD), even though they might have physical dependency on a medication. Many also might not self-identify as having substance use disorder and could feel their pain is well controlled on their current medications. It is important to meet patients where they are and not to presume or prejudge patients' health status, diagnoses, or health risks.

SPECIAL CONSIDERATIONS FOR TREATMENT FACILITIES

Actions resulting in disruptions or abrupt closures of treatment facilities pose unique risks to patients, particularly if any patients are in the early stages of detoxification at the time of the disruption, as these patients are in a particularly vulnerable state. For actions impacting a treatment facility, law enforcement personnel should coordinate carefully with state treatment authorities whenever possible and take special precautions, such as having emergency medical personnel or addiction treatment specialists onsite and assigning personnel to monitor patients in the early stages of detoxification as part of the operations plan.

Questions to Inform Geographic Scope and Strategies to Reach Affected Patients

1. Is the healthcare provider providing services via telehealth? (e.g., all, most, some, few, none)
2. Do patients physically come to the office for appointments or to receive prescriptions?
3. What counties do most patients live in?
4. Are patients crossing state lines to see the healthcare provider?
5. If yes, which states and how many patients?
6. Are any pharmacies commonly used to fill the healthcare provider's prescriptions?



RISK MITIGATION

The main types of risk mitigation strategies involve:

- Providing on-site support to patients in need of bridge prescriptions and referrals to healthcare providers.
- Leveraging resources to help notify patients about the disruption and link patients to appropriate healthcare providers, which may include primary care physicians, pain specialists, pharmacists, first responders, community-based organizations, and substance use disorder treatment providers.
- Notifying and supporting the healthcare workforce and other service providers, including emergency department personnel and first responders.

RISK MITIGATION ELEMENTS, GOALS, AND OUTCOMES



On-Site Health Support

In some cases, law enforcement may request on-site health support to address patients' questions and immediate needs on the day of action. This provision can help law enforcement focus on their operational tasks while ensuring that patients have a designated trained professional to help address their immediate needs. Patients arriving onsite for a doctor's appointment might need prescriptions, health assessments, harm reduction services or supplies, risk communication, and/or psychosocial support. At a minimum, health professionals can answer patients' questions about what is happening, hand out informational flyers with resources, and communicate care and concern for their well-being.

Mobile care units can be dispatched to locations where the disruption is occurring and revisit the area to intercept patients coming to the office for appointments in the event they were not notified about the closure.



The following capabilities may be helpful for those providing on-site support:

- Individuals who can express care and concern for patients' well-being.
- Healthcare providers who can provide health assessments, and have prescribing ability to provide bridge prescriptions, and/or are DATA-waivered for buprenorphine initiation.
- Healthcare providers who practice harm reduction, recognizing that substance use disorder treatment referrals might not be appropriate for all patients.
- Behavioral healthcare capabilities.
- Recovery coaching experience.
- An on-site healthcare provider who can access the PDMP to be able to see what medications a patient has been recently prescribed.

Signs and resource one-pagers to post on facility's door and be distributed onsite can include:

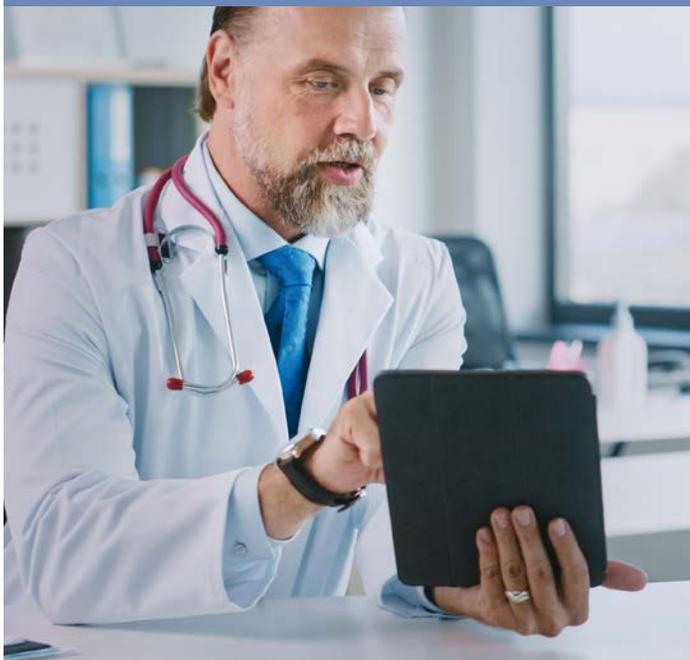
- A patient referral phone number for prescriber services.
- Treatment and recovery services information.
- Harm reduction information.

Additional supplies to have onsite include:

- Naloxone kits and fentanyl test strips.
- Information about avoiding illicit drug supply or medication obtained from non-medical persons. Let patients know that there are dangers associated with medications that are not from a healthcare professional, and they may encounter illicit manufactured fentanyl or other dangerous substances that could lead to adverse health effects.

**STATE SPOTLIGHT:
MOBILE SERVICES IN CONNECTICUT**

During a response to a disruption, the Connecticut Department of Mental Health and Addiction Services (DMHAS) arranged to have a mobile van onsite at the time of the law enforcement action. The mobile van was operated by a community behavioral health provider and staffed with a behavioral health professional and a substance use recovery support professional. The mobile van was able to provide support for impacted patients around the state and had the following resources available: printed materials on local resources, assistance with referrals to clinicians and treatment and recovery support, harm reduction materials such as naloxone and fentanyl test strips, and bridge prescriptions for a limited supply of medication. The strategy of the onsite team was to engage patients arriving for scheduled appointments to mitigate self-referral to emergency departments or illicit drug purchases.



**Communication and Coordination
for Risk Mitigation**

Notifying Patients

Patients need immediate notification if their healthcare provider can no longer prescribe controlled substances. It is important to consider not only patients seeking services on the day of the law enforcement action, but also the patients whose prescription might end 30 days and beyond. In most cases, states will need to leverage partners to notify patients about the disruption and assist them with finding a new healthcare provider.

This important messaging should include:

- A brief statement explaining that the healthcare provider may not be able to prescribe their medication.
- Who the patient can contact for help finding a new healthcare provider.
- Who the patient can contact if they need substance use disorder treatment, with a listing of nearby treatment facilities.
- Where to access naloxone and other harm reduction services.
- Information about crisis hotlines, patient advocacy programs, mental health treatment programs, and other clinics in the area.

Useful strategies for communicating with patients when you do not have a means to conduct direct patient outreach include:

- Posting flyers and notices on the clinic door.
- Issuing a health department press release.
- Issuing local public health alerts to hospitals, healthcare providers, pharmacists, and community partner organizations and providing resources for them to share with impacted patients they might encounter.

Insurers can contact members to help facilitate care continuity. Encourage Medicaid and private payer partners to use their data to identify potentially affected members, provide those members with appropriate notification, and facilitate care coordination to mitigate possible negative health impacts.

Alerting Healthcare and First Responder Communities

Reach out to prescribers in the affected area to notify them of an expected increase in patients seeking services.

- Consider having the state health official issue a "Dear Colleague" letter to prescribers in the affected area, notifying them of an expected surge in displaced patients and encouraging them to accept patients and provide patient-centered care. Communicate the following to healthcare providers:
 - Continue opioid therapy for patients in transition.
 - Develop a patient-centered, individualized care plan.
 - Use caution when tapering opioid therapy.
 - Document patient care decisions.
 - Prescribe buprenorphine when appropriate.

Notify emergency departments within affected jurisdictions with health alerts or advisories and ensure they have appropriate resource information and treatment protocols for displaced patients who have been taking opioids, benzodiazepines, or other controlled substances. Patients are more likely to turn up in the emergency departments because they have difficulty finding new healthcare providers. Education and communication for emergency departments personnel may be needed. Designate a response team partner to serve as a point of contact to provide clinical advice for hospital emergency departments and to share and receive status updates.

Utilize your [Overdose Response Strategy](#) (ORS) team. ORS is a public health-public safety partnership between the High Intensity Drug Trafficking Area program and CDC with a mission to help communities reduce fatal and nonfatal overdoses. The ORS team includes a public health analyst and drug intelligence officer who can help issue information and communication between public health and public safety agencies. This includes working with fusion centers that can disseminate information quickly to thousands of first responders, allowing them to be aware of a disruption on the prescription side and be on the lookout for possible increases in overdose.

Notify Harm Reduction, Treatment, and Recovery Support Partners

Engage with harm reduction service organizations about disruptions because the situation could require increased naloxone distribution or increased risk communication about illicit drug supply, including counterfeit pills.

Note that for some patients, treatment referrals might be appropriate, so response partners need to rapidly identify:

- Outpatient treatment programs
- DATA-waivered providers in the area who have experience prescribing buprenorphine
- Inpatient treatment facilities with availability and recovery coaches

MONITORING RESPONSE PROCESS AND OUTCOMES

To continuously improve response capability, performance monitoring is essential. The response coordination team will need to rely on response partners to track response activities, processes, and outcomes. Determining specific information that can be easily tracked over a specific duration of time by each response partner, can help set expectations and access response data without overburdening partners during or after a response. To the extent possible, monitor both processes and outcomes of your response, based on your response strategies and goals. Relevant process and outcome measures might include:

- The number of patients sent information by (1) mail, (2) phone, (3) email, and (4) electronic health record portal.
- The number of patient encounters, both on-site or via mobile clinic.
- The number of patient calls to helplines.
- The number of patients who are (1) assigned a case manager, (2) assisted in re-establishing care, (3) provided referrals to MOUD, (4) provided referrals to pain clinics, and (5) provided referrals to a primary care provider.
- The number of commercial plans and managed care organizations with impacted patients, including:
 - Number of patients screened for SUD.
 - The total number of patients assisted.
 - The number of patients screened for substance use disorder.
 - The number of patients who have found another healthcare provider or had their benefit terminated.
 - The number of emergency department visits and nonfatal overdoses among affected patients.
 - The number of fatal overdoses among affected patients.
 - The number of affected patients receiving a new substance use disorder diagnosis.
 - Information about medication regimen continuity for 30, 60, and 90 days following a disruption for affected patients.
 - The number of patients starting MOUD.

Communication and Coordination for Improved Monitoring and Evaluation

- Re-assess communications activities (E.g., the need to continue the hotline) and restructure your plan, if needed.
- If the information is available, follow up with affected patients to ensure they are connected to the appropriate level of care.
- Conduct additional follow-up with the response team as needed.



Health agencies preparing for or responding to a disruption may request technical assistance from the Opioid Rapid Response Program at CDC by emailing ORRP@cdc.gov. Note: CDC does not participate in active law enforcement investigations taken by federal or state agencies, nor does CDC deploy health professionals to states in response to disruptions in patient care. CDC staff cannot provide direct services to patients, including referrals to specific healthcare providers. Patients seeking assistance in referrals to healthcare providers may consult with their local or state health department or their healthcare insurance provider.

Appendix A:

JOB-ACTION SHEETS FOR PARTNERS



RESPONSE TEAM MEMBER JOB-ACTION SHEET

Behavioral Health Specialist

1. Member Title: Behavioral Health Specialist

2. Incident Type: OD Cluster or Pain Center Closure

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Assist in coordination of on-scene behavioral health responders, if requested by local incident management personnel
- Consult with staff, patients, clients, and family members on appropriate behavioral health services needed
- Assist patients, clients, and family members in location of and connection to available behavioral health services
- Observe Strike Team members for signs of stress or emotional difficulty; refer for support or substitution if needed
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Assist with position-specific team member replacements as needed
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- Specific Behavioral Health Training, including Professional/Clinical Services Training
- Cultural Competency Training (specific to the incident location)

RESPONSE TEAM MEMBER JOB-ACTION SHEET

Clinical Care Specialist

1. Member Title: Clinical Care Specialist

2. Incident Type: OD Cluster or Pain Center Closure

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Assess current clinical/healthcare resources for needs
- Provide consultation to clinic managers (Pain Center Closure), hospitals, health departments (OD Cluster) as needed
- Assure that appropriate client or patient referral practices are engaged
- Support Epidemiology Specialist team member in acquisition of needed medical records and other incident-specific information needed for field investigation or surveillance processes
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Assist with position-specific team member replacements as needed
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- Healthcare Management Training
- Clinical Care Training (RN, MD, etc. not required, but recommended)
- Cultural Competency Training (specific to the incident location)

RESPONSE TEAM MEMBER JOB-ACTION SHEET

Emergency Medical Services (EMS) Specialist

1. Member Title: EMS Specialist**2. Incident Type: OD Cluster****3. Member Roles—Immediate (Mobilization through first 24 hours)**

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Assist local incident management in assessing need for additional (external) jurisdiction EMS assets
- Assist responding EMS agencies with replacement of depleted Naloxone and other prehospital care supplies, if needed
- Assist responding EMS agencies with pertinent information for reporting, after action review, etc.
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Assist with position-specific team member replacements as needed
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- EMS Technical Training (EMT/Paramedic) optional but recommended
- Cultural Competency Training (specific to the incident location)

RESPONSE TEAM MEMBER JOB-ACTION SHEET

Epidemiology Specialist

1. Member Title: Epidemiology Specialist

2. Incident Type: OD Cluster or Pain Center Closure

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Initiate field investigation and surveillance processes, including case definition, incident rate, population health assessment, clinical picture, etc.
- Assist Clinical Care Specialist team member with consultation and key epidemiology information to support client/patient care
- Develop appropriate public health interventions
- Provide consultation services to healthcare services and public health leadership
- Document and report findings
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Assist with position-specific team member replacements as needed
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- Epidemiology and Surveillance-Specific Training
- Cultural Competency Training (specific to the incident location)

RESPONSE TEAM MEMBER JOB-ACTION SHEET

Fatality Management Specialist

1. Member Title: Fatality Management Specialist

2. Incident Type: OD Cluster

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Assist local jurisdictions in identification, appropriate movement, and storage of remains
- Assist with additional storage solutions (e.g., state medical examiner facility) for fatality surge
- Develop report with fatality numbers, information, location, etc. as needed and allowed by law
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Assist with position-specific team member replacements as needed
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- Coroner, Medical Examiner, Pathology Training not required, but recommended
- Cultural Competency Training (specific to the incident location)

RESPONSE TEAM MEMBER JOB-ACTION SHEET

Human Services Specialist

1. Member Title: Human Services Specialist

2. Incident Type: OD Cluster or Pain Center Closure

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Assist clients, patients, and families with Medicare, Medicaid, and other related state or community social services
- Engage Children's or Adult Protective Services as needed (OD cluster)
- Assist clients in transitioning to other clinical centers (pain center closure)
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Assist with position-specific team member replacements as needed
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- Specific, job-related training for human services type employment
- Cultural Competency Training (specific to the incident location)

RESPONSE TEAM MEMBER JOB-ACTION SHEET

Incident Management Specialist

1. Member Title: Incident Management Specialist

2. Incident Type: OD Cluster or Pain Center Closure

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Assure communication/liaison with Strike Team's jurisdiction Public Health incident management system
- Assure communication/liaison with Emergency Management or on-scene command post
- Assist Team Leader in ensuring that all Strike Team activity remains within the mission assignment provided by the jurisdictional incident management system
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Monitor for safety issues related to Strike Team members and report accordingly
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Monitor team members for fatigue, family concerns, etc.
- Consider team member replacements and ensure smooth transition of members
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- ICS 300 Course
- Cultural Competency Training (specific to the incident location)
- Training for competency of communication/technology resources to be used

RESPONSE TEAM MEMBER JOB-ACTION SHEET

Information Management Specialist

1. Member Title: Information Management Specialist

2. Incident Type: Pain Center Closure

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Investigate/develop access routes for sharing of critical information among team members, incident management personnel, and other responders as needed
- Determine key information on client population (e.g., patients who will require immediate access to medical treatment, prescriptions)
- Work with Epidemiology and Clinical Care Specialists to identify and alert other healthcare organizations of potential surge of patients needing continued care
- Provide consultation services to healthcare services and public health leadership
- Focus on protection of sensitive medical data of center patients
- Document and report findings
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Continue to provide patient information to external healthcare facilities to ensure continuity of care for former pain center patients
- Assist with position-specific team member replacements as needed
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)

RESPONSE TEAM MEMBER JOB-ACTION SHEET

Laboratory Services Specialist

1. Member Title: Laboratory Services Specialist

2. Incident Type: OD Cluster

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Assist jurisdictional response agencies with specimen sample collection, as needed
- Communicate with clinical, commercial, and state-level labs to coordinate analysis and identification of specimen samples
- Assist with additional support coverage by various labs in a surge incident
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Assist with position-specific team member replacements as needed
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- Position-specific training—microbiology, toxicology, lab procedures, etc. (not required but recommended)
- Cultural Competency Training (specific to the incident location)

RESPONSE TEAM MEMBER JOB-ACTION SHEET

Law Enforcement Specialist

1. Member Title: Law Enforcement Specialist

2. Incident Type: OD Cluster or Pain Center Closure

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Connect and provide information to local law enforcement personnel to aid in their investigation
- Manage scene safety for team members
- Aid in scene control in support of local law enforcement, if necessary
- Assist scene responders and Laboratory Services Specialist with sample acquisition, as needed (chain of evidence protocol, etc.)
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Assist with position-specific team member replacements as needed
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- Law Enforcement-Specific Training, with accompanying certification
- Cultural Competency Training (specific to the incident location)

RESPONSE TEAM MEMBER JOB-ACTION SHEET

Pharmacy Specialist

1. Member Title: Pharmacy Specialist

2. Incident Type: Pain Center Closure

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Support local clinic staff with RX management/transfer, including documentation
- Provide consultation to clients/family members on impacted dispensing/administration process, locating other pharmacies, etc., as needed
- Communicate as needed with State Board of Pharmacy regarding pharmacy service closure, referrals, records, etc.
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Assist with position-specific team member replacements as needed
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- Pharmacist-Level Training and Education
- Pharmacy Management Training
- Cultural Competency Training (specific to the incident location)

RESPONSE TEAM MEMBER JOB-ACTION SHEET

Team Leader

1. Member Title: Team Leader

2. Incident Type: OD Cluster or Pain Center Closure

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Incident Command Operational Briefing
- Receive tactical assignment for Strike Team
- Confirm internal and external communication systems between team and Incident Command
- Muster team and prepare for deployment if indicated
- Review assignments with team members and assign tasks
- Monitor work processes and adjust as necessary
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Establish communication channel with jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Monitor team members for fatigue, family concerns, etc.
- Consider team member replacements and ensure smooth transition of members
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Direct demobilization procedures as directed
- Direct team hotwash and prepared for after action review

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- ICS 300 Course
- Cultural Competency Training (specific to the incident location)
- Training for competency of communication/technology resources

Appendix B:

COMMUNICATING WITH PRESCRIPTION DRUG MONITORING PROGRAMS



During Disruptions in Access to Opioid Prescriptions

Role of Prescription Drug Monitoring Programs

Prescription Drug Monitoring Programs (PDMPs) track dispensed controlled substance prescriptions. They provide health authorities with timely information about prescribing and patient behavior and can help prevent opioid misuse, opioid use disorder, and overdose. They also allow clinicians who prescribe or dispense prescription opioids to see patients' prescription histories, which can help inform care.

PDMP access is critical during the risk assessment phase of a response to a disruption in access to prescription opioids and can provide valuable insights about the number of patients potentially affected, where they are located, the composition and doses of their prescriptions, and their insurance coverage. However, access to and use of PDMP data varies by state, depending on the laws and regulations that govern how PDMPs operate in that state. PDMPs are often housed within the state public health, regulatory, or enforcement agency.

A memorandum of understanding (MOU) or data use agreement (DUA) may be necessary if the PDMP is housed in an agency or division separate from the authority who wishes to access it. In most cases, only aggregate data reports may be sharable with select response coordinators; this information may be critical in helping to scale and direct risk mitigation resources and activities. Some policies fully restrict PDMP data from being shared outside of the program. It is important to understand the landscape in your state and what data the PDMP might be able to share during a response.

Messaging Considerations

- PDMPs can provide valuable insights during a response.
- PDMPs house sensitive information on all patients of clinicians who prescribe or dispense prescription opioids.
- The sharing and accessing of individual-level information in PDMPs can be legislatively and/or logistically difficult.
- Aggregate data reports without patient-identifiable information can be useful to the response.
- If states cannot gain access to PDMP data following a disruption in access to opioid prescriptions, it may lead to a less effective response or higher incidence of opioid overdose spikes.
- The ability to access and share PDMP data is vital in keeping patients connected to the care that they need.

Relevant Policies

Kentucky

In March 2020, Kentucky passed a law permitting the use of PDMP data to identify and notify to patients of clinicians who have prescribed or dispensed opioids following the closure of an office or clinic. The law will allow public health officials to use PDMP data to inform patients in a timely manner, thereby preventing disruptions to medical treatment and promoting continuity of care.

Pennsylvania

Pennsylvania changed an existing law in February 2020 to allow public health departments to access identified PDMP data. Pennsylvania plans to use the identified data for activities such as targeting educational programs, increasing public health interventions, and analyzing prescribing trends. Through a data sharing agreement approved by the Department of Health's legal office, some local health departments also plan to use identified PDMP data to analyze prescribing and dispensing, provide data to overdose fatality review panels, and for academic detailing.

Examples of Effective Collaboration

Pennsylvania

In Pennsylvania, PDMP data resides within the Department of Health and access includes data at both the individual and aggregate levels. The Department of Health utilizes identified PDMP data to connect to patients of clinicians who have prescribed or dispensed opioids with appropriate medical services if a clinician is unable to continue to prescribe controlled substances due to regulatory or law enforcement action. In the event of disruptions in access to opioid prescriptions, controlled substance dispensation data from the PDMP helps create clinician profiles to assess impacted patient populations. If the number of patients affected is low, the Department of Health does not take further action. However if it is high, the Department of Health activates its coordinated response protocol.

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- https://www.cdc.gov/drugoverdose/pdf/PDMP_Factsheet-a.pdf
- <https://www.cdc.gov/drugoverdose/pdmp/index.html>
- <https://www.cdc.gov/drugoverdose/pdf/Leveraging-PDMPs-508.pdf>
- <https://apps.legislature.ky.gov/recorddocuments/bill/20RS/hb344/bill.pdf>
- <https://www.legis.state.pa.us/cfdocs/legis/LI/uconsCheck.cfm?txtType=HTM&yr=2014&sessInd=0&smthLwInd=0&act=191&chpt=0&sctn=9&subsctn=0>
- <https://code.wvlegislature.gov/60A-9-4/>

Appendix C:

COMMUNICATING WITH HEALTHCARE PROVIDERS



During a Disruption in Access to Opioid Prescriptions

Role of Healthcare Providers

During a disruption in access to opioid prescriptions, individual healthcare providers can serve to connect displaced patients with the care, prescriptions, and support they need.

Messaging Considerations

- Healthcare providers may be hesitant to enroll new patients—especially patients with a history of substance use disorder or who have been undergoing long-term opioid therapy.
- Advanced discussions with health system leadership, your state's primary care association, community health center associations, and others to describe the impact of disruptions and link them to available clinician support can be invaluable.
- Healthcare providers who inherit patients undergoing long-term opioid therapy might be fearful of increased scrutiny from federal or state law enforcement or regulators. This concern can be alleviated by encouraging clinicians to document their interactions with patients in medical records and provide individualized patient-centered care. In addition, when there is a disruption, health departments can communicate with agencies in their states who monitor prescribing patterns to explain why there may be a sudden increase in opioid prescribing by a clinician who has inherited many patients taking long-term opioid therapy.
- Providing specific resources related to caring for patients taking long-term opioid therapy, experiencing chronic pain, or at risk of substance use disorders can be helpful in overcoming stigma and other barriers to patients' access to care.
- A disruption in access to care can be a traumatic experience for some patients and a trauma-informed approach may be needed.
- Clinical prescribing guidelines, including avoiding rapid or forced tapering of opioids and benzodiazepines, can help guide clinical decision-making and practice. Please refer to the resources listed below and consider the following best practices:
 - Continue opioid therapy for patients experiencing transitions in care.
 - Develop a patient-centered, individualized care plan.
 - Use caution when tapering opioid or benzodiazepine therapy.
 - Document patient care decisions.
 - Prescribe buprenorphine when appropriate.
 - Co-prescribe naloxone.
- Licensing, scope of practice, and waiver requirements can vary by jurisdiction or change over time. It is important to understand the laws and regulations of the jurisdiction where the disruption occurs.
- Healthcare providers can work in various settings, including but not limited to private practices, hospitals, healthcare systems, and federally qualified healthcare centers. It is important to understand that there may be different communication channels to utilize when identifying providers to support a displaced patient population.

Relevant Policies

- Title 21, Code of Federal Regulations, Section 1300.01, defines controlled substances.
- Each state has different prescribing rules for mid-level providers. Mid-level providers are healthcare providers who are not "physicians, dentists, veterinarians, or podiatrists" who are licensed, registered, or permitted to dispense controlled substances. For more details about your specific jurisdiction please refer to DEA's Mid-Level Practitioners Authorization by State.

Resources

- [A Webinar for Providers: What Do I Do With Inherited Patients on Opioids?](#)
- [HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics](#)
- [Module 6: Dosing and Titration of Opioids: How Much, how Long, and How and When to Stop?](#)
- [Inherited Patients Taking Opioids for Chronic Pain — Considerations for Primary Care](#)



State of California—Health and Human Services Agency
California Department of Public Health



September 7, 2021

Dear Provider,

Health care providers continue to be essential partners in addressing the opioid epidemic in California. Working together, we want to ensure that providers have access to resources and support to help improve patient pain management.

Alert: The abrupt closure of 29 California pain management centers in May 2021 resulted in over 20,000 patients without referrals, medical records, or treatment plans, and created potentially dangerous disruptions in care for patients receiving treatment with opioids therapy. This was a striking example of a common problem: many patients with long-term opioid use find themselves suddenly stranded, without a doctor, whether due to clinician retirement, state or federal action, or other cause.

Action: Given the national shortage in pain management providers, we anticipate many patients dependent on opioids may have difficulty finding a new pain management provider. Subsequently, primary care providers may inherit these patients.

On behalf of the [Statewide Overdose Safety \(SOS\) Workgroup](#) and partners, please consider these best practices:

- Continue opioid therapy for patients in transition.
- Develop a patient-centered, individualized care plan.
- Use caution when tapering opioid therapy.
- Document patient care decisions.
- Prescribe buprenorphine when appropriate.

Continue Opioid Therapy for Patients in Transition: Following clinical guidelines for safe opioid prescribing, providers are encouraged to consider providing opioids to patients during transitions to avoid dangerous disruptions in care. While many providers may not have chosen to start opioids for a given chronic pain condition, stopping opioid therapy is different due to the physiological changes brought on by long-term opioid therapy. Stopping opioid therapy has been

CDPH Substance and Addiction Prevention Branch, MS 8701, P.O. Box 997377,
Sacramento, CA 95899-7377
(916) 449-5211
[California Department of Public Health](#)



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shown to increase illicit opioid use, emergency medical care utilization, mental health crises, medically-attended overdose events, and death from overdose and suicide. It may be necessary and medically appropriate to continue opioid therapy, particularly if a patient will have a prolonged wait to see a pain management specialist. Whenever possible, discuss the patient's history with their former provider, complete baseline assessments of pain, review expectations for opioid prescribing, and start discussing treatment for opioid use disorder (OUD) if appropriate. If you are unable to treat the patient, provide a warm hand-off to another provider to avoid the experience or perception of abandonment.

Develop a Patient-Centered, Individualized Care Plan: Develop an individualized plan in collaboration with the patient for continuing opioid therapy, tapering down or off of opioid therapy, or transitioning to buprenorphine. Engage the patient and include discussions around social issues and support, mental health services, alternative pain management strategies, and overdose risk. Consider the patient's perceived risks and benefits of opioid therapy.

Use Caution when Tapering Opioid Therapy: Providers should not abruptly discontinue or rapidly taper opioids in a patient who is physically dependent on opioid therapies. Safe tapers may take months to years to accomplish. Ensure patients understand the risks and benefits of dose maintenance versus dose tapering. Work with the patient to identify which medications to taper and how fast.

Document Patient Care Decisions: The majority of investigations of providers around opioid prescribing that have resulted in a complaint or disciplinary action against a license contained violations of insufficient documentation. Document the rationale for continuing or modifying a patient's opioid therapy. Include descriptions of pain conditions, previous and current therapy, assessment of risk and evidence of OUD, and opioid stewardship measures. Comprehensive documentation benefits both the patient and the provider.

Prescribe Buprenorphine when Appropriate: Buprenorphine has been shown to be a highly safe and effective treatment for pain management and OUD, and is FDA-approved for both conditions. Buprenorphine reduces craving, withdrawal, and overdose risk, has low potential for misuse and diversion, and increases

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retention in care. Buprenorphine for pain has proven to be an effective and safe alternative for patients dependent on long-term opioid agonists. Buprenorphine for OUD can be prescribed by any provider with an X number (X-waiver), in-person or via telehealth, to new and existing patients with OUD. As of April 28, 2021, providers may now request an X-waiver to treat up to 30 patients with buprenorphine without having to complete training or to certify that they can provide counseling or other ancillary services. To prescribe buprenorphine to more than 30 patients, however, training and meeting certain conditions are required. [Sign-up for an X-waiver](#). Note: Prescribing buprenorphine for pain does not require an X-waiver.

Support and Resources: The [Center for Innovation in Academic Detailing on Opioids](#) (CIAO) of the San Francisco Department of Public Health, in collaboration with the California Department of Public Health recorded a webinar in June 2021 to support providers inheriting patients on opioids. The presentation focuses on sharing information and clinical tools about inheriting patients on opioid therapy, ensuring continuity of care, and utilizing buprenorphine: [A Webinar for Providers: What Do I Do With Inherited Patients on Opioids?](#)

The National Clinician Consultation Center offers free guidance and support to providers treating patients with OUD through these telephone services:

1. [California Substance Use Line](#): (844) 326-2626. Clinically-supported advice on substance use management for health care providers, staffed 24/7 in collaboration with addiction experts at the University of California, San Francisco Clinicians Consultation Center and California Poison Control.
2. [Substance Use Warmline](#): (855) 300-3595. Confidential clinician-to-clinician telephone consultation from addiction medicine-certified physicians, clinical pharmacists, and nurses with special expertise in pharmacotherapy options for opioid use, available Monday through Friday, between 6 a.m. and 5 p.m. PST. Voicemail is available 24/7.

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Thank you for continuing to provide quality medical care to your patients.

Sincerely,

Tomás J. Aragón, MD, DrPH
Director and State Public Health Officer
California Department of Public Health

Kimberly Kirchmeyer
Director
Department of Consumer Affairs

William Prastika,
Executive Director
Medical Board of California

Michelle Baass
Director
California Department of Health Care Services

Appendix D:

ADDITIONAL EXAMPLES



WHERE TO SEEK CARE | You are not alone.



This resource provides an overview of options for patients who are prescribed a controlled substance medication and have lost access to their healthcare provider. Some resources promoted below may not be applicable to all patients.

Patients Prescribed Opioids (e.g., oxycodone) or Benzodiazepines (e.g., alprazolam)

If you have a primary care provider, contact them to discuss next steps in care.

If you do not have a primary care provider or if they are unable to provide care, find a provider by calling the number on the back of your health insurance card or check your insurer’s website for in-network providers.

If you do not have insurance, you may find a community healthcare provider at a health center near you. Visit findahealthcenter.hrsa.gov.

Please note, a new provider may recommend a new treatment plan.

Patient Advocacy Program

The Patient Advocacy Program is available to help patients decide on next steps and may make referrals.

Email ra-dh-advocacy@pa.gov or call 844.377.7367 (option 3), Monday through Friday 8:00 AM- 4:00 PM.



Find more resources online. Scan the code to the left with your phone camera or visit bit.ly/patientadvocacyPA.

Patients Prescribed Buprenorphine (Suboxone or Subutex)

If you have health insurance, you may call the number on the back of your health insurance card or check your insurer’s website for in-network providers.



Or, search online for providers who may prescribe buprenorphine. Scan the code to the left with your phone camera or visit findtreatment.gov/results.

Patients who are prescribed buprenorphine as part of the treatment for opioid use disorder may also visit ddap.pa.gov for more resources and information.

Get Help Now

24/7 help is always available for anyone who is battling a substance use disorder.



Call 1.800.662.4357.



Or, text 717.216.0905.

If you are feeling overwhelmed or are having trouble coping, call the National Suicide Prevention Lifeline at 1.800.273.8255.

If someone takes drugs and becomes unresponsive, call 911.





JB Pritzker, Governor

Grace B. Hou, Secretary

This handout provides resources for patients who are prescribed controlled substance medication and have lost access to their healthcare provider. Some resources may not be applicable to all patients. This information may be helpful now, or in the future, as you identify and navigate your healthcare needs.

Where can I go for pain management services? If you are seeking pain management services and would like a new provider, then please call your insurance carrier for physicians who practice pain management.

Where can I go for primary care services? If you are seeking primary care services and would like a new provider, then please call your insurance carrier. You may also be interested in low cost primary care services available from Federally Qualified Health Centers (FQHCs). Please see the following website to find an FQHC near you:
<https://data.hrsa.gov/data/reports/datagrid?gridName=FQHCs>

Where can I go for treatment or intervention services? The Illinois Helpline for Opioids and Other Substances helps individuals in need of treatment and intervention services. To learn more about substance use disorder treatment and recovery home services from the Helpline, you can connect in three ways: Helpline website - <https://helplineil.org/>, 800 phone number - 833-234-6343 and text - "HELP" to 833234.

Where can I obtain naloxone (a.k.a., Narcan)? If you or someone you know is worried about overdosing, please contact the Overdose Education and Naloxone Distribution (OEND) sites across the state who distribute naloxone free of charge. To find an organization distributing naloxone, visit:
https://hub.helplineil.org/spa_result/incident_id/fd5b0ddb-b8c0-493a-8608-ac9adaa873ce

You can also get naloxone at pharmacies. Most chain pharmacies can provide naloxone without a prescription through a "standing order." Ask for a naloxone kit. If you prefer, you can request a prescription for naloxone from your doctor and bring it to the pharmacy to be filled. Many insurance providers, including Medicaid, cover some or all costs of naloxone.

Where can I find recovery support services? You may be interested in connecting with a person who can provide support to you. To explore recovery support services, please contact a recovery-oriented systems of care (ROSC) council. To identify the ROSC council in your area, please visit: <https://www.dhs.state.il.us/page.aspx?item=117096>

The Samaritans 24/7 Crisis Services provides 24/7 emergency emotional support, you can get help from a trained volunteer offering non-judgmental support through phone, text, or online chat. All services are free, confidential, and anonymous: call - 877-870-4673 (toll-free) or visit - <https://samaritanshope.org/our-services/247-crisis-services/>

National Suicide Prevention Lifeline: No matter what problems you're dealing with, whether or not you're thinking about suicide, if you need someone to lean on for emotional support, call the Lifeline. The Lifeline provides 24/7, free and confidential support for people in distress, prevention and crisis resources for you from anywhere in the United States. To find resources visit: <https://suicidepreventionlifeline.org/>

For immediate assistance call the hotline: 1-800-273-8255

Maryland Prescriber-Enforcement Action Protocol

I. Purpose

Law enforcement actions focused on reduction of inappropriate prescription practices are an essential component of Maryland’s opioid response strategy. When enforcement actions take place, effective communication between law enforcement and public health is necessary to address urgent medical concerns and reduce the impact on Maryland’s health systems.

II. Scope

The PRESCRIBER-ENFORCEMENT ACTION Protocol identifies communication and coordination procedures in the event of a law enforcement action against a prescriber or medical facility stemming from the alleged inappropriate prescribing of controlled medications. The Protocol identifies information needs, information sharing channels, and public health response priorities.

III. Information Sharing

DESIGNATED HEALTH POINT OF CONTACT

(TO BE CONFIDENTIALLY NOTIFIED PRIOR TO OR IMMEDIATELY FOLLOWING A PRESCRIBER-ENFORCEMENT ACTION)

Fran Phillips RN, MHA

Deputy Secretary of Public Health Services
Maryland Department of Health

Cell: (410) 999-7400

Email: fran.phillips@maryland.gov

IMPORTANT INFORMATION ELEMENTS

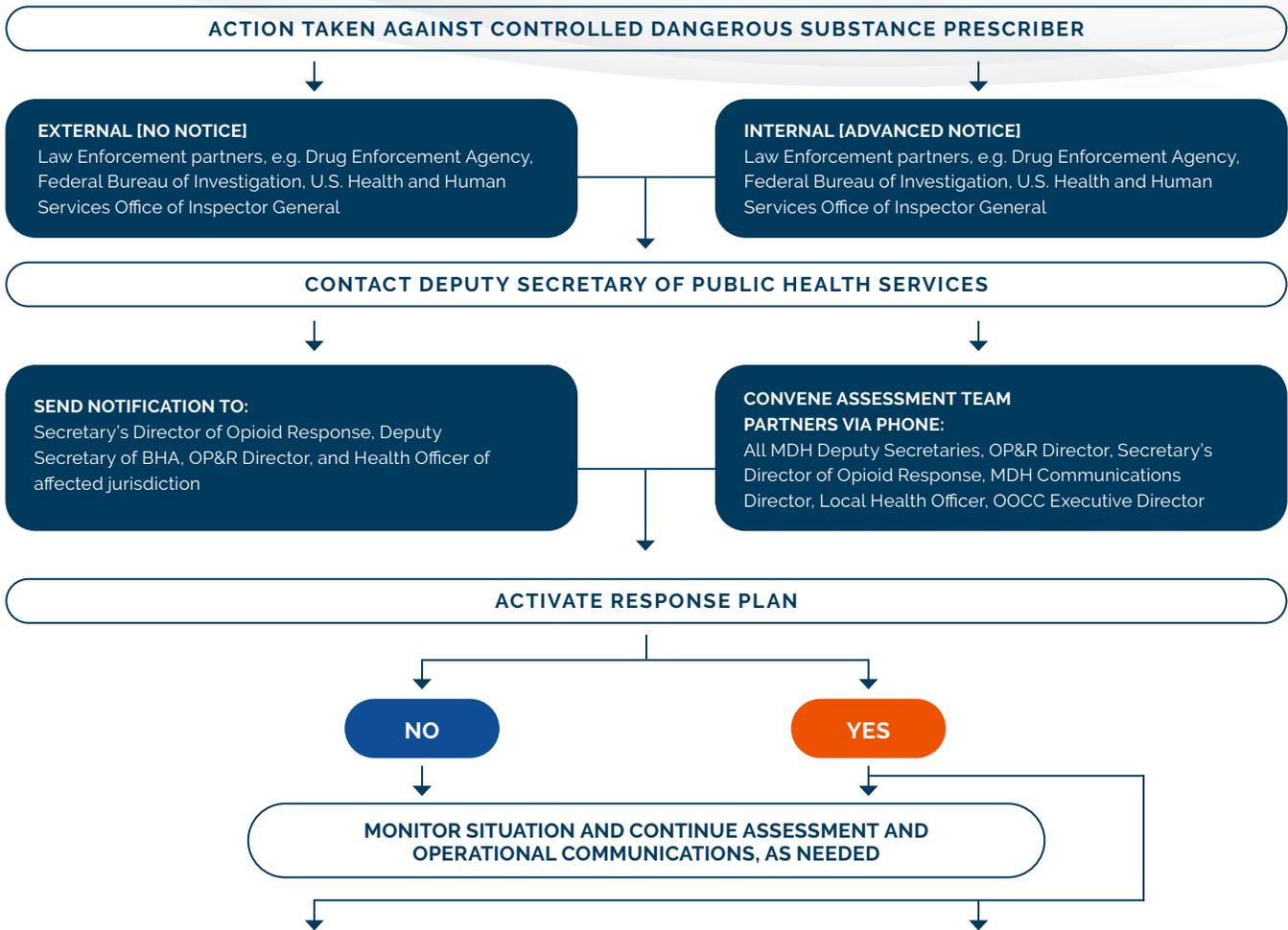
When possible, a notification from law enforcement to Dept. of Health should include:

- Type of law enforcement action
 - Record seizure
 - Removal or surrender of DEA registration or controlled substance license
- Facility closure
- Arrest of prescribers
- Timing, location, and duration of the action
- Ability to share clinical information
- Law enforcement point of contact for any follow-up communication about the enforcement action

INFORMATION SHARING PARAMETERS

When possible, a notification should specify the parameters for re-sharing any information that is shared between law enforcement and Dept. of Health:

- **Sensitive**
Approved for re-sharing with directly-impacted health authorities only
- **For Official Use Only**
Approved for re-sharing with official partners only (gov’t response partners, medical providers, pharmacists, etc.). Should not be shared with the public
- **Approved for Public Release**



- PHS / BHA / MEDICAID RESPONSE ACTIVITIES**
- Mobilize resources [pre-scripted messaging, county emergency hotline, collate / map provider resources by specialty area]
 - Develop list of resources for continuity of care [BHA]
 - Distribute partner notifications / situational awareness / guidance documents and situation reports to key points of contact for further distribution, as approved [OP&R]
 - Distribute initial list of PDMP data and locations of patients by insurance type to assessment team [OP&R and BHA]
 - MCOs / Beacon / Mobile support coordination [Medicaid and commercial insurers]
 - Implement legal authorities, as needed
 - Update MDH Office of Communications

- LOCAL HEALTH DEPARTMENT RESPONSE ACTIVITIES**
- Collect PDMP provider consent
 - Post LHD contact number for patients
 - Establish call center as needed
 - Notify pharmacies, EMS, and care providers
 - Provide coordination for continuity care
 - Utilize health data to support local response, as available
 - Provide situation reports to assessment team for distribution
 - Coordinate public information in county

- KEY ELEMENTS FOR CONTINUITY OF CARE**
- Determine level of urgency [CDS license status, facility status, patient population]
 - Obtain list of patients and current medications from provider, PDMP, or OCSA
 - Establish communications with patients [by phone, call-in number, or direct patient contact]
 - Provide patients with resource guidance and lists [primary care, pain management clinics, MAT programs]
 - Alert pharmacies to incident and urgency to provide prescription continuity