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Facilitating Overdose Risk Mitigation Among Patients Following a Clinician Office Closure: A Connecticut Case Study of the Opioid Rapid Response Program

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ABSTRACT

The Opioid Rapid Response Program (ORRP) is a federal program designed to support states in mitigating risks to patients who lose access to a prescriber of opioids or other controlled substances. Displaced patients might face risks of withdrawal, overdose, or other harms. Rapid response efforts to mitigate risks require coordination across multiple parts of the health care system. This case study describes an ORRP-coordinated event, including notification from law enforcement, information sharing with state health officials, state-coordinated response efforts, key observations, and lessons learned. Timely risk mitigation and care continuity required coordination between law enforcement and public health in advance of the disruption and throughout the state-led response. Patients' acute and prolonged health care needs were complex and highlight the importance of investing time and resources in coordinated, multisector state and local preparedness for these types of disruptions.

KEY WORDS: law enforcement, opioids, overdose prevention, prescription, risk mitigation, state and local public health

Context for the Case Study

The overdose crisis in the United States has been characterized by 3 waves.[1] The first wave began in the 1990s and was driven by widespread prescribing of opioids to treat acute and chronic pain. In 2010, the United States entered the second wave and began experiencing increases in overdose deaths involving heroin, driven by increased demand for lower-cost opioids supplied by the illicit market.[2] Overdoses continued to increase, and by 2013, the United States was in its third wave, with increases in overdose deaths involving more potent synthetic opioids, particularly illicitly manufactured fentanyl, which can be up to 50 times stronger than heroin. As the second and third waves of overdoses tracked upward, new evidence of the dangers associated with chronic or long-term use of opioid therapy led to changes in clinician education and guidance[3] as well as regulations and laws intended to reduce dangerous prescribing patterns.[4] Since opioid prescribing in the United States peaked in 2012, prescribing rates have declined steadily nationally, though rates vary by state and county,[5] and complaints of health care fraud and dangerous prescribing of opioids and other controlled substances continue.[6,7]

In 2018, federal and state law enforcement agencies were particularly focused on a US region experiencing the highest rates of opioid prescribing as well as overdose deaths.[8] Federal authorities established the Appalachian Regional Prescription Opioid Strike Force (ARPO), a group of prosecutors and law enforcement agents from multiple federal agencies focused on health care fraud schemes related to illegal prescribing of opioids. This group partnered

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with public health experts at the Centers for Disease Control and Prevention (CDC) to try to mitigate risks among patients needing care continuity or treatment for opioid use disorder (OUD) following a clinician's arrest or forced clinic closure. These cases affected a mix of patients, including those taking long-term opioid therapy for pain management, with or without OUD, and patients prescribed excessive amounts of opioids, benzodiazepines, or combinations of both. Some patients were prescribed opioids that were medically unnecessary, and some patients were found to be diverting their medications (ie, selling or trading the medications illicitly). According to the CDC's 2016 Guidelines for Prescribing Opioids for Chronic Pain, when opioids are reduced or discontinued, a taper slow enough to minimize symptoms and signs of opioid withdrawal should be used, and tapering plans may be individualized on the basis of patient goals and concerns.[3] Additional US Department of Health & Human Services guidance was provided in 2019 stating, "Opioids should not be tapered rapidly or discontinued suddenly due to the risks of significant opioid withdrawal."[9] When disrupted access occurs, patients often need a pain specialist or a primary care physician willing to accept them and provide individualized, patient-centered care.[10] Unfortunately, research studies have demonstrated reduced access to primary health care for patients receiving prescription opioids.[11,12] Physicians' time, reimbursement, clinic-specific policies, and lack of resources were cited as possible reasons for refusing to accept patients taking prescription opioids.[11,12]

Building on the lessons learned from the ARPO collaboration, the Opioid Rapid Response Program (ORRP) was established as a national program in 2020. The federal program is managed by the CDC, in partnership with the US Department of Health & Human Services Office of the Inspector General (HHS OIG), with oversight by the Office of the US Assistant Secretary for Health (OASH). Through ORRP, the CDC established "trusted contacts" within each state's public health and behavioral health agencies; these individuals were selected specifically for their ability to maintain confidentiality as well as identify, coordinate, and mobilize appropriate overdose prevention and substance use disorder (SUD) treatment resources throughout their state. Diversion investigators and agents from either the Drug Enforcement Administration (DEA) or the HHS OIG contact ORRP coordinators about law enforcement or regulatory actions that might disrupt patients' access to opioids and other controlled substances. The ORRP coordinators then work with the agents to discuss possible patient risks and determine what information can be shared with the state's trusted contacts before and immediately after the action occurs. The goal is to disclose only enough information to inform state-led response strategies while not compromising the investigation or law enforcement operations. The ORRP staff then offer remote technical assistance to state and local health officials throughout their response. In addition to response coordination, the ORRP supports state capacity building through various preparedness, workforce development, and training activities for clinicians and nonclinicians who may be involved in either a rapid response or sustained risk mitigation for displaced patients.

The purpose of this case study is to describe an ORRP-coordinated event, including notification from law enforcement, brokerage of information with state health officials, and the response activities carried out by the state to mitigate risks among patients.

Data Informing the Case Study

This case study is informed by observations and meeting notes. All notes taken before and during the response were documented by ORRP staff at the CDC and at the lead state agencies involved in the response. Notes from a facilitated debrief session, conducted 4 weeks after the law enforcement action, were recorded by meeting participants using the digital whiteboard application, Google Jamboard.

ORRP Event Notification and Coordination

Identification of disruptive event

Two weeks before a search warrant was to be executed by HHS OIG agents in Connecticut, a criminal investigator at HHS OIG notified their in-house ORRP coordinator about the upcoming action. A call was immediately scheduled so that the ORRP coordinators could ask the investigator a series of questions about the planned action and determine whether the action was likely to disrupt patients' access to care. The ORRP team obtained the following information: the subject of the investigation was a licensed physician with an estimated 500 patients. Prescribing patterns included mostly opioids and benzodiazepines (2 contraindicated medications, both of which may cause severe withdrawal if stopped abruptly). Other prescribed controlled substances of note included stimulants and sleep aids. The clinician had a private practice with multiple office locations in neighboring towns and with no other personnel on-site, other than an office manager. Accepted forms of payment/insurance included Medicare, Medicaid, private insurance, and self-pay/cash. The search warrant would be executed at 9 o'clock in the morning

concurrently at the doctor's 3 office locations, one of which was scheduled to be open that day for patients' scheduled appointments. Law enforcement would ask the physician to voluntarily surrender their DEA registration, which if agreed to, would immediately render them unable to prescribe controlled substances.

Per ORRP protocol, any information about an active law enforcement investigation may be shared with state-trusted contacts only if permission is given by the investigator. In this case, ORRP coordinators were permitted to share with the Connecticut-trusted contacts the name of the town in which the clinic would be open on the day of the action, the specialty of the physician (psychiatrist), the anticipated number of impacted patients, and the suspected prescribing patterns of the clinician, as relayed by the investigator. Based on the active investigation status of the case, ORRP coordinators could not share the clinician's name or exact office locations until the day before the action.

Twelve days before the search warrant, ORRP held a call with their trusted contacts—the deputy commissioner at the Connecticut Department of Public Health (DPH) and the deputy commissioner at the Connecticut Department of Mental Health and Addiction Services (DMHAS)—to share the allowable information. On the call, they discussed concerns about the possibility of patients receiving opioids, benzodiazepines, or both medications and then being at risk of withdrawal if a surrender were to occur. Patients would likely need assistance obtaining immediate referrals to other health care providers. It was anticipated that harm reduction education and supplies would be useful as well as an issuance of alerts to area hospitals and health systems notifying them that they may be seeing patients experiencing withdrawal and asking for prescriptions. Because the physician was a psychiatrist, additional concerns about patients' mental health status were discussed.

In formulating their response plan, the DMHAS arranged to have a mobile van operated by a community behavioral health provider and staffed with a behavioral health professional and substance use recovery support, on-site at the time of the action. In addition, the state-operated local mental health authority was available to provide the support of a mental health clinician. To maintain agents' safety, the integrity of the investigation, and general confidentiality, the exact location and name of the health care provider would not be disclosed to the community behavioral health provider in charge of the mobile unit until the morning of the action. To facilitate additional risk-mitigation planning, the ORRP coordinators negotiated with the HHS OIG investigator to be able to provide the clinician's name and national provider identifier to the state-trusted contacts on the Friday before the action, which was scheduled to take place the following Wednesday.

During the search warrant execution, the physician voluntarily surrendered for cause their DEA registration. Agents on the scene immediately notified the ORRP coordinators, who then relayed the information to the state-trusted contacts.

State Risk Mitigation

Risk mitigation goals

The state's immediate response was guided by the following goals: (1) do not abandon any patient/client/person, (2) provide treatment on demand, (3) inform individuals, families, and communities of resources, and (4) mitigate overdose risk and prevent illegal drug purchases.

Patient risk assessment

As soon as the trusted contacts were provided with the physician's name and national provider identifier, the DMHAS reached out to 2 key partners to assist with patient risk assessment. First, they contacted the Connecticut Department of Consumer Protection Drug Control Division, which manages the state's prescription drug–monitoring program (PDMP). Querying the PDMP provided up-to-date information about the number of patients to whom the physician was prescribing particular medications and doses, such as opioids and benzodiazepines. In addition, based on the PDMP data, the state health officials learned that the physician's highest number of patients lived in another Connecticut city, as opposed to the town in which the search warrant was executed. The second key partner DMHAS contacted was the state's Department of Social Services, whom they informed that an impending disruption might impact a large number of Medicaid beneficiaries. The Medicaid authority would leverage the behavioral health and medical Administrative Service Organizations (ASOs) to identify through claims data patients and prescribing patterns of this physician. These ASOs would also play a critical role in patient outreach.

The PDMP and the Medicaid claims data revealed that the physician wrote approximately 12 times the average number of anxiolytic/sedative/hypnotic medication prescriptions prescribed by physicians across the state and more than 15 times the average dosage units prescribed in both the second and third

quarters of 2020. Common medications and dosages included 2-mg tablets of alprazolam (Xanax) in 60 to 90 quantities every 30 days; 2-mg tablets of clonazepam (Klonopin) in 60 to 120 quantities every 30 days; 15-mg or 30-mg tablets of oxycodone in 90 quantities every 30 days; and 30-mg tablets of dextroamphetamine-amphetamine (Adderall) in 60 to 90 quantities every 30 days. The data also revealed that the clinician had approximately 700 patients receiving controlled substances, as opposed to the 500-patient panel size estimate given by law enforcement.

On-site support for patients

The DMHAS, Connecticut' mental health and substance use authority, operates 6 local mental health authorities (3 of which include hospital level of care) in addition to a psychiatric hospital and a forensic hospital. The DMHAS also contracts with more than 130 private health care providers across the state to provide a continuum of behavioral health services. This public-private partnership provides a comprehensive safety net for adults with substance use disorder and serious mental illness. As such, the DMHAS was able to immediately leverage resources in the area of disruption. Most of the community health care providers enlisted to assist were funded by the DMHAS; some were not but were aligned with community health initiatives. As the action unfolded, and with patients in 2 additional regions of the state being identified, the DMHAS engaged providers operating mobile vans (intended for outreach and engagement of individuals who might benefit from medication for opioid use disorder—MOUD) to provide support, printed materials on local resources, assistance with referrals to clinicians and treatment and recovery support, harm reduction materials (ie, naloxone, fentanyl test strips), and bridge prescriptions (for a limited supply of medication) in urgent situations. The initial mobile team was staffed by a psychiatric advanced practice registered nurse/nurse practitioner (APRN/NP) and a recovery coach. The strategy of the on-site team was to engage patients arriving for scheduled appointments to mitigate self-referral to emergency departments or illegal drug purchases, which could increase overdose risk. The team was able to offer MOUD with linkage to ongoing treatment, if appropriate. The patients were seen every 15 minutes in the morning hours of operation by the APRN/NP. Once on-site, the APRN/NP noted that rather than opioid prescriptions, most individuals were receiving benzodiazepine and stimulant prescriptions and did not report medication misuse, nor did they perceive any danger associated with their medications.

Partner coordination, outreach, and alerts

Partner engagement included sister state departments and agencies, the state's behavioral health and medical ASOs serving Medicaid members, emergency departments, and other entities that could help facilitate risk mitigation among affected patients. Community health care providers and the state-operated local mental health authorities in 3 Connecticut regions contributed resources to the response.

Alerts were issued by several partner agencies. By querying the PDMP, the Connecticut Department of Consumer Protection was able to identify pharmacies at which the patients had been filling their prescriptions and sent a communication to those pharmacies through the PDMP notifying them of the disruption. The *Connecticut Hospital Association* was leveraged to notify area emergency departments about the possibility of patients experiencing withdrawal from benzodiazepines and needing care continuity. The DMHAS notified freestanding withdrawal management facilities and informed the Medicaid behavioral health ASO of the potential for authorizations for extended withdrawal management patient stays to accommodate benzodiazepine withdrawal protocols. The *New England High Intensity Drug Trafficking Area (HIDTA) program and Overdose Response Strategy* were alerted to disseminate risk communication to area first responders. *Harm reduction organizations* were notified and prepared to address any community need for naloxone and fentanyl test strips. And finally, *area treatment providers at all levels of care* were alerted and advised of a new client profile characterized by benzodiazepine and stimulant dependency.

Although the DMHAS notified a wide range of behavioral health providers, they placed emphasis on enlisting clinicians open to a harm reduction treatment approach to receive patient referrals. The needs of the patients necessitated a willingness to prescribe for and engage individuals in a way that might differ from a physician's usual prescribing practice and comfort level but were necessary to prevent withdrawal or death while remaining patient-centered. Providers notified included state-operated local mental health authorities, DMHAS-funded behavioral health providers, federally qualified health centers, hospital intensive outpatient programs, and community health care vans. Because of the proliferation of counterfeit pills in the illicit market, some of which may contain illicitly manufactured fentanyl, local prevention partners were alerted to the need to

educate clients of the harms of obtaining drugs illicitly and provide them with naloxone and fentanyl test strips.

Direct patient outreach

Connecticut State statute allows health officials to obtain deidentified data from their PDMP for epidemiological or educational purposes, but neither state nor local health departments can access identifiable patient data that would enable them to conduct direct outreach to high-risk patients or track patient outcomes.[13] Nevertheless, in addition to those few patients encountered on-site on the day of the action, health officials leveraged their state payer system to try to notify impacted patients and facilitate care continuity. Specifically, the state's contracted behavioral and medical ASOs for Medicaid members immediately began calling all patients of the clinician who surrendered his DEA registration to inform them of the office closure and attempt to provide care continuity assistance. Repeated efforts (at least 3 attempts) to reach members took place for more than 3 weeks, and mailings or emails were sent to all Medicaid beneficiaries for whom contact information was available. The ASO also called prescribers in the 3 affected areas to see whether they were accepting new patients. At least 46 patients were given referrals to new health care providers, and some were referred to their primary care physicians. Although most behavioral health prescribers in private/group practices were not accepting patients, the DMHAS was able to intervene in some cases to assist with access to publicly funded providers. Mailings were also sent to all members, notifying them of the need to find a new clinician. Finally, the ORRP coordinators notified the *Healthcare Fraud Prevention Program*, who issued an alert to insurance members, encouraging them to identify and notify their patient members who may have been affected by the event and to facilitate care continuity.

Surveillance of adverse health outcomes

Both DPH and local health agencies have access to the statewide syndromic surveillance database to monitor nonfatal suspected overdose-related emergency department or urgent care visits. These agencies use this near real-time database to examine acute care visits among residents in their jurisdictions for situational awareness of a medical condition. In addition, many first responders throughout Connecticut use the Overdose Detection Monitoring Application Program. These systems were leveraged in the weeks following the disruption to identify anomalies or spikes in overdose activity. Fortunately, no closure-associated spikes were detected during the time period the records were examined. One area hospital reported an increase in emergency department admissions of affected patients, though the reasons for the admissions were not shared.

Lessons Learned

The Table lists multiple areas of strength and opportunities for improvement identified by state response coordinators during a facilitated after-action debrief. Among the identified opportunities for improvement were ways to more quickly and accurately understand patient-specific risks and clinical needs. Other key opportunities related to the need for resources to assist clinicians likely to encounter the affected patients. These included resources to address stigma and concerns about liability or licensing vulnerabilities; emergency department protocols and practices for caring for patients prescribed high-dose medications; and general clinician training on the types of needs of the affected patients. Response efforts were labor and resource intensive and benefited from state agencies' commitment to saving lives and reducing overdose deaths as exhibited by their contribution of in-kind staff as well as DMHAS' contracted service provider involvement; preexisting relationships with contracted and noncontracted health care providers statewide; and the ability to leverage these common goals and existing partnerships.

Epilogue

Advanced notice was critical in helping the state prepare for and mobilize resources for the response. Other keys to the fluid and timely response were access to a mental health clinician deployed by the state-operated local mental health authority and the mobile unit staffed with a recovery coach and a psychiatric APRN/NP able to offer MOUD (the mobile unit is funded by State Opioid Response grant dollars provided by the Substance Abuse and Mental Health Services Administration). Notably, however, some of the information received from law enforcement did not provide an accurate picture of the patients' risks, perhaps because the information obtained was incomplete or outdated. In addition to there being more affected patients than anticipated, the physician's prescribing profile involved more benzodiazepines and stimulants and fewer opioid prescriptions than expected. This meant that fewer patients were candidates for MOUD and required flexible clinical decision making related to bridge prescriptions combined with patient education and referrals. A few patients were voluntarily admitted to a local hospital

TABLE
After-Action Debrief Strengths and Opportunities for Improvement

Patient Risk Assessment—Strengths	Patient Risk Assessment—Opportunities for Improvement
Early/timely notification about the disruption	Reviewing Department of Social Services (claims) data more
Inclusion of public health overdose prevention and treatment and recovery service leadership as trusted contacts	Using the state's PDMP to identify the clinician's prescribing history (ie, prescribed medications and doses for impacted patients)
Knowing types of insurance among patients (to leverage Medicaid)	
Communication and Coordination—Strengths	**Communication and Coordination—Opportunities for Improvement**
Partnership with Medicaid ASO—Repeated efforts to reach patients by phone and email (for those with emails listed in Medicaid)	Identify all sectors that need to be notified about what medications patients were on and how they should be clinically managed.
Medicaid ASO met every week and a half, kept open communication to ensure that they knew where patients should be referred	Develop/disseminate provider resources on liability, stigma, protecting licenses
Statewide meeting with providers, hospitals, and emergency departments to discuss impact	Develop/disseminate additional resources for health care providers to assist impacted patients by providing information about the types of patients who may be coming in and their potential needs
Partnerships with local mental health authorities and federally qualified health centers	Consider a plan to facilitate patient assessments to determine their needs, including education and support services
Reached out to local mental health authority to have a response right away, then engaged regional managers in the 3 locations that provide services within that area	Take a more statewide approach to meet the needs of patients living in different areas; focus on knowing providers and resources statewide to leverage when needed
A notice was posted in the state's PDMP to notify pharmacists and providers	Be mindful of limitations of state PDMP data—patient changes of address are not always up to date
A notice was posted on the DMHAS Web site	Partner with Connecticut Hospital Association to facilitate clinician trainings moving forward
DPH notified syringe services clinics and other community-based organizations	Develop/disseminate protocols or best practices resources for emergency departments
DPH issued a health alert network notice to local health agencies to provide situational awareness about residents in their jurisdictions	Share information about patient location with syringe services/harm reduction programs
Reaching out to providers to let them know that they might be receiving calls from patients who have lost access to their provider	

Abbreviations: ASO, Administrative Service Organization; DMHAS, Department of Mental Health and Addiction Services; DPH, Department of Public Health; PDMP, prescription drug–monitoring program.

for monitored withdrawal from benzodiazepines on the day the action occurred. In addition, according to the on-site health care team, many of the patients were emotionally distraught witnessing the law enforcement activity and unexpectedly losing access to their doctor. Thus, immediate on-site support was critically important for those patients arriving on the day of the surrender and subsequent days.

The limitations of this case study include a lack of available data and evaluation protocols to assess patient-level care continuity and health outcomes for the affected patients. Additional evaluation efforts are needed to report on the efficacy of rapid response interventions in preventing negative health consequences.

In conclusion, ensuring a successful risk mitigation response to a law enforcement action that disrupts patients' access to controlled substance medications begins with law enforcement entities trusting state health authorities with sensitive investigative information. Advanced notification is needed to allow state health authorities to assess patient risk and identify and mobilize available resources. As evidenced in this case example, an effective response requires a multifaceted approach involving segments of the medical, behavioral health, and public health care system, including state and local agencies, hospitals, payers, pharmacies, and licensing boards. Immediate care continuity for all patients is not an easily achievable goal for various individual and health systems–level reasons. Nevertheless, timely communication and coordination of resources can facilitate appropriate, patient-centered risk mitigation. Because of the complexities, intensive resource needs, and multiple actors involved in these types of responses, ongoing investments in preparedness

and rapid response for these types of disruptions might benefit states and result in improved health outcomes.

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