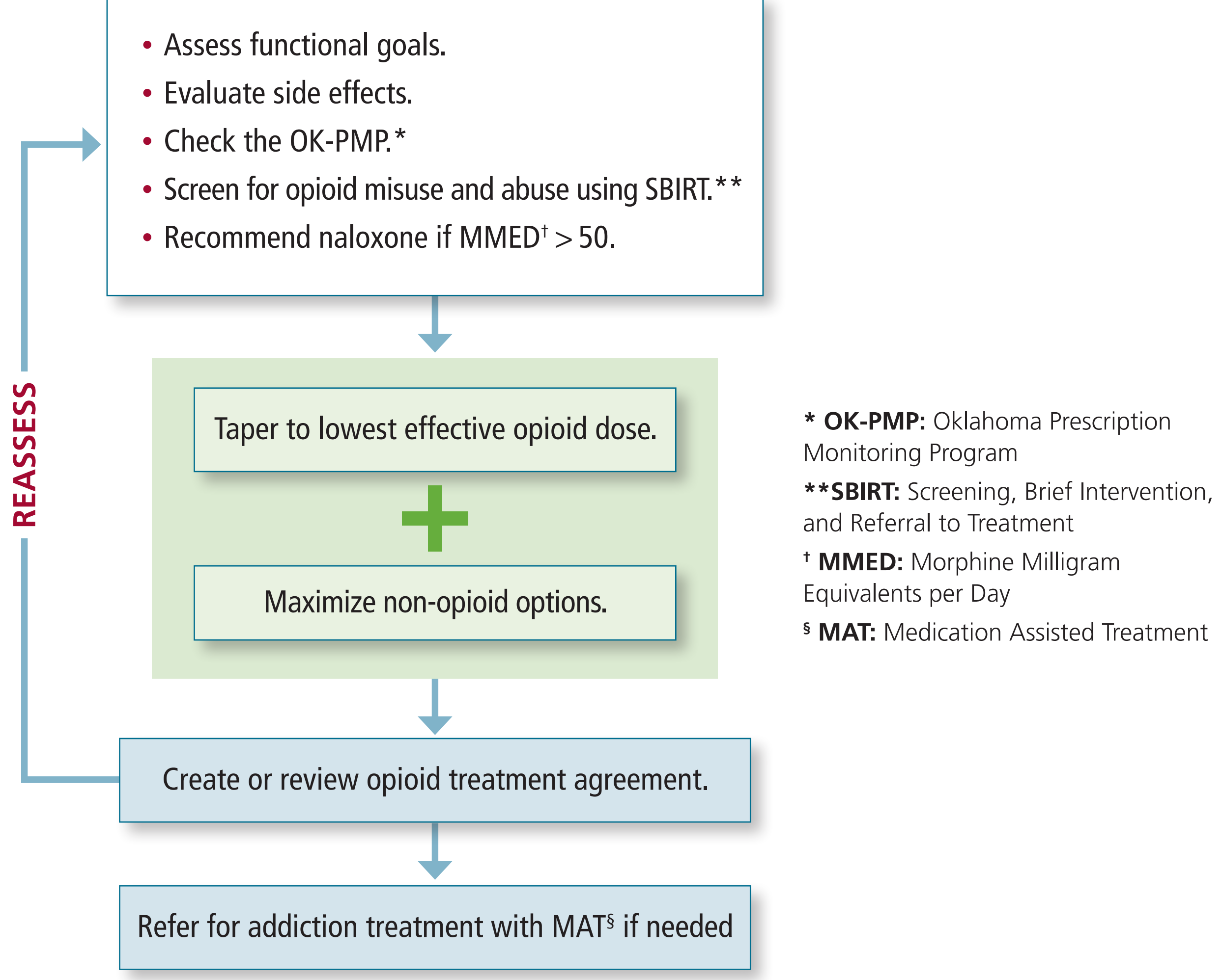
Reducing risk for patients on long-term opioids

Safer prescribing of opioids

Algorithm for managing patients already receiving long-term opioids



*** OK-PMP:** Oklahoma Prescription Monitoring Program

****SBIRT:** Screening, Brief Intervention, and Referral to Treatment

† MMED: Morphine Milligram Equivalents per Day

§ MAT: Medication Assisted Treatment

- ☑ Ask the patient what they want to do but cannot do because of pain.
- ☑ Use SBIRT to screen for substance use disorder or mental illness such as depression.
- ☑ Ask patients about how they take their opioids to detect diversion or misuse.
- ☑ Check the OK-PMP and perform urine drug tests.
- ☑ Remember that tolerance, dependence, withdrawal, and Opioid Use Disorder may occur in any patient taking opioids, not just those with risk factors.

Recommend naloxone to prevent opioid overdose death

Recommend it to those:[1]

- taking more than 50 MMED
- with renal insufficiency or hepatic dysfunction
- co-prescribed benzodiazepines
- with reductions in their opioid doses

It takes as little as one week to lose tolerance. Opioid dose reductions, voluntary or involuntary, put patients at increased risk of overdose.

Several naloxone products are available:

	Intranasal (w/atomizer)	Intranasal	Intramuscular (IM)	Auto-IM
Brand name		Narcan		Evzio
Strength	1 mg/1 mL	4 mg/0.1 mL	0.4 mg/1 mL	0.4 mg/1 mL
Sig for suspected overdose	Spray 1 mL into each nostril.	Spray full dose into one nostril.	Inject 1 mL into shoulder or thigh.	Use as directed by voice-prompt. Press firmly on outer thigh.
Second dose	Repeat after 2-3 min if no or minimal response.	Repeat into other nostril after 2-3 min if no or minimal response.	Repeat after 2-3 min if no or minimal response.	Repeat after 2-3 min if no or minimal response.
How supplied	Vial + mucosal atomizer	2 sprays	2 syringes	2 injectors
Cost	$	$Free in OK	$	$$$$$

Opportunities to improve opioid safety

Ask SBIRT questions at every visit.

- Any patient on opioids can develop Opioid Use Disorder (OUD) or depression.
- SBIRT is an evidence-based practice to identify and intervene early in substance use or mental health problems.
- It is billable and can be initiated in the primary care office.
- Intervention with SBIRT can improve patient outcomes.

Check the OK-PMP.

If OK-PMP identifies opioids filled from another provider:

- Discuss reasons for seeking additional opioids.
- Review the terms of the pain plan.
- When appropriate, offer referral for OUD treatment.

Review the OK-PMP for any co-prescribed benzodiazepines.

- Benzodiazepines double the risk of overdose and should be avoided when possible. Talk to patients about their benzodiazepine use, if identified.

Use urine drug testing.

- Understand metabolites of prescribed opioids (see mytopcare.org).
- If other substances such as marijuana or heroin are positive:

—**Discuss use of these drugs with patients.**

—**Refer to treatment for substance use disorder if needed.**

—**Increase frequency of urine drug screens to every visit.**

—**Establish a clear action plan if further urine tests are positive for illicit drugs.**

Tapering opioid doses

Patients who may benefit from an opioid taper are those with:

- no reduction in P.E.G. score
- presence of opioid-related side effects
- dose above 50 MMED
- medical comorbidities (e.g., sleep apnea)
- mental health comorbidities (e.g., depression, anxiety)
- concomitant use of benzodiazepines

Engaging the patient in the plan to taper

Discuss
- listen to patient
- acknowledge fears

Set goals
- discuss life goals
- ask about needed support

Educate
- offer non-opioid therapies
- slowly taper

Taper
- reduce dose by 5-20% each month[1]

Assess
- evaluate function and pain control
- monitor for withdrawal symptoms

Dose reductions are recommendations only. Actual tapers may be slowed or paused based on patient response; avoid re-increasing the dose.

Withdrawal symptoms from reducing opioids

All patients who take opioids for a long period of time will develop tolerance, leading to the need for higher doses over 24 hours to achieve drug effect. Increased dosage may heighten adverse effects including fatigue, drowsiness, and feeling less well.

Most patients who take opioids for a long period of time will develop physiological dependence with withdrawal symptoms of anxiety and feeling unwell when opioids are stopped.

Tolerance and dependence are **NOT** addiction.

Clearly articulating the benefits of tapering and addressing the concerns patients may have about reduced opioid doses is part of a collaborative tapering plan.[2,3]

Concerns of tapering

Some patients experience:

- Withdrawal symptoms
- Anxiety about increased pain
- Fear of abandonment

Benefits of tapering

For most patients:

- Pain does not worsen
- Mental functioning improves
- Well-being is enhanced

Typical progression of withdrawal symptoms[4]

Early symptoms (hours to days)	Late symptoms (days to week)	Prolonged symptoms (weeks to months)
• Anxiety / restlessness • Rapid short respirations • Runny nose, tearing eyes, sweating • Insomnia • Dilated reactive pupils	• Runny nose, tearing eyes • Rapid breathing, yawning • Tremor, diffuse muscle spasms/aches • Piloerection • Nausea, vomiting, diarrhea • Abdominal pain • Fever, chills • Increased white blood cells if sudden withdrawal	• Irritability, fatigue • Bradycardia • Decreased body temperature • Craving • Insomnia

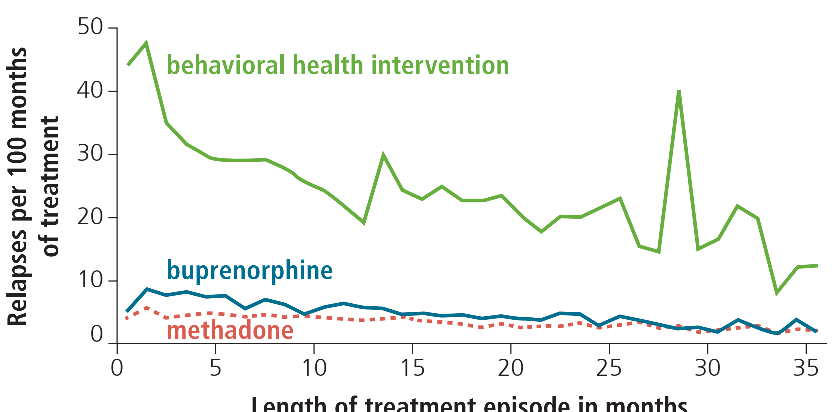
Anxiety about reducing opioids is common and addressing concerns and fears improves tapering success.

OUD and Medication Assisted Treatment (MAT)

OUD is problematic opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:[5*]

- persistent craving to use or unsuccessful attempts to control or reduce use
- great deal of time spent obtaining, using, or recovering from substance use
- craving, or a strong desire or urge to take opioids
- tolerance and withdrawal in patients taking opioids other than as prescribed

MAT is the most effective intervention for patients with OUD.[6]



MAT is more effective than either inpatient or outpatient treatment programs that did not use MAT.[6]

Access to MAT varies by the medication option used.

- Buprenorphine/naloxone (Suboxone) can be prescribed by clinical providers for OUD who obtain a DEA X number. For physicians, DEA X waiver training is an 8-hour course. No cost training and support resources may be found at **pcssnow.org/medication-assisted-treatment**.
- Naltrexone ER injection (Vivitrol) requires 7-10 days of opioid abstinence before it can be given.
- Methadone is provided at designated clinics, often requiring directly observed therapy.

Key messages

- Recommend naloxone to prevent overdose death.
- Taper opioids slowly, especially in patients with poor response, side effects, or other concerns.
- Support patients through withdrawal symptoms when tapering.
- Refer patients with problematic opioid use or OUD for medication assisted treatment.

*Full criteria available in DSM-5 or online at **tinyurl.com/yb2udqoh**.

Obtaining a DEA X waiver

To prescribe or dispense buprenorphine for opioid use disorder treatment:

- For physicians, DEA X waiver training is an 8-hour course. No cost training and support resources may be found at **pcssnow.org/medication-assisted-treatment**.
- https://oklahomamat.org/home

RPR Exchange (Reseach to Practice to Research Exchange): A convenient way for clinicians and researchers to communicate about information relevant to clinical practice. Learn more at: **rpr.lib.ok.us**.

DO NO HARM is a practice improvement program helping primary care practices implement delivery system changes, technology, clinical decision support, and patient self-management to adopt guidelines for safer pain and opioid management.

Partnering organizations

NaRCAD is a national resource center that supports clinical outreach education programs across the United States. With NaRCAD's trainings and ongoing program support, clinical educators have a greater impact when visiting front line clinicians, helping those clinicians to make the best, evidence-based decisions. Learn more at narcad.org.

This material was produced by Alosa Health, a nonprofit organization that produces educational content and manages and provides consulting for clinical outreach education initiatives. Alosa Health is not affiliated with any pharmaceutical company. For more information, visit AlosaHealth.org.

Located in the Oklahoma Clinical and Translational Science Institute at The University of Oklahoma Health Sciences Center, the Oklahoma Primary Healthcare Improvement Cooperative (OPHIC) is the academic research arm of a community-engaged system with a mission to facilitate the diffusion of research innovations into community clinical delivery systems. OPHIC partners include our state's County Health Improvement Organizations and other entities critical for translational research in community settings.

The Oklahoma Department of Mental Health and Substance Abuse Services provides educational resources and clinical services to improve the mental health of the citizens of Oklahoma.

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