

Review of the CDC Guidelines for Safer Opioid Prescribing

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The speaker has no significant financial conflicts of interest to disclose.

“To hear about pain is to have doubt;
to experience pain is to have certainty.”

Elaine Scarry, The Body in Pain; The
Making and Unmaking of the World

“Pain upsets and destroys the nature of
the person who feels it.” ~ Aristotle

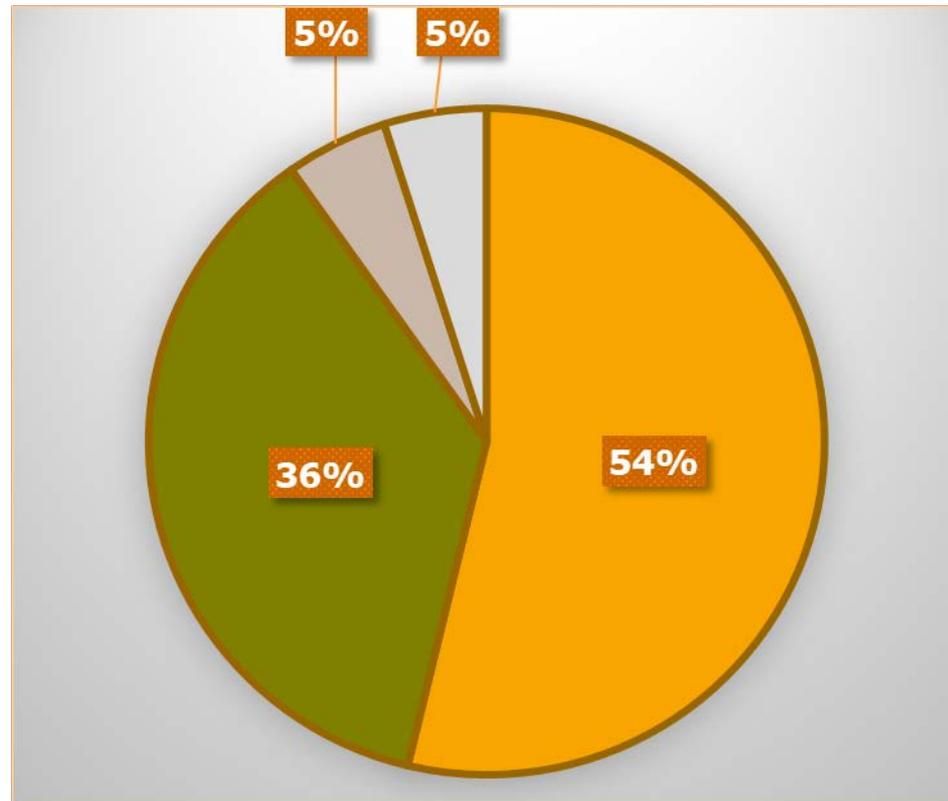
Chronic Pain

- ▶ Pain which lasts more than 3 months or past the period of tissue healing.
- ▶ 11% of Americans experience daily chronic pain.
- ▶ Primary care providers commonly treat non-cancer chronic pain and write for 50% of opioids in the US.
- ▶ Do they feel trained to do this?

Idaho

- ▶ 15.2/100,000 compared to national death rate of 19.8/100,000. But still a steady increase here.
- ▶ Number of Opioid Rx's written per 100 persons in Idaho 77.6 verses 66.5 nationally

SOURCE OF MOST RECENT RX OPIOIDS MISUSERS 2015



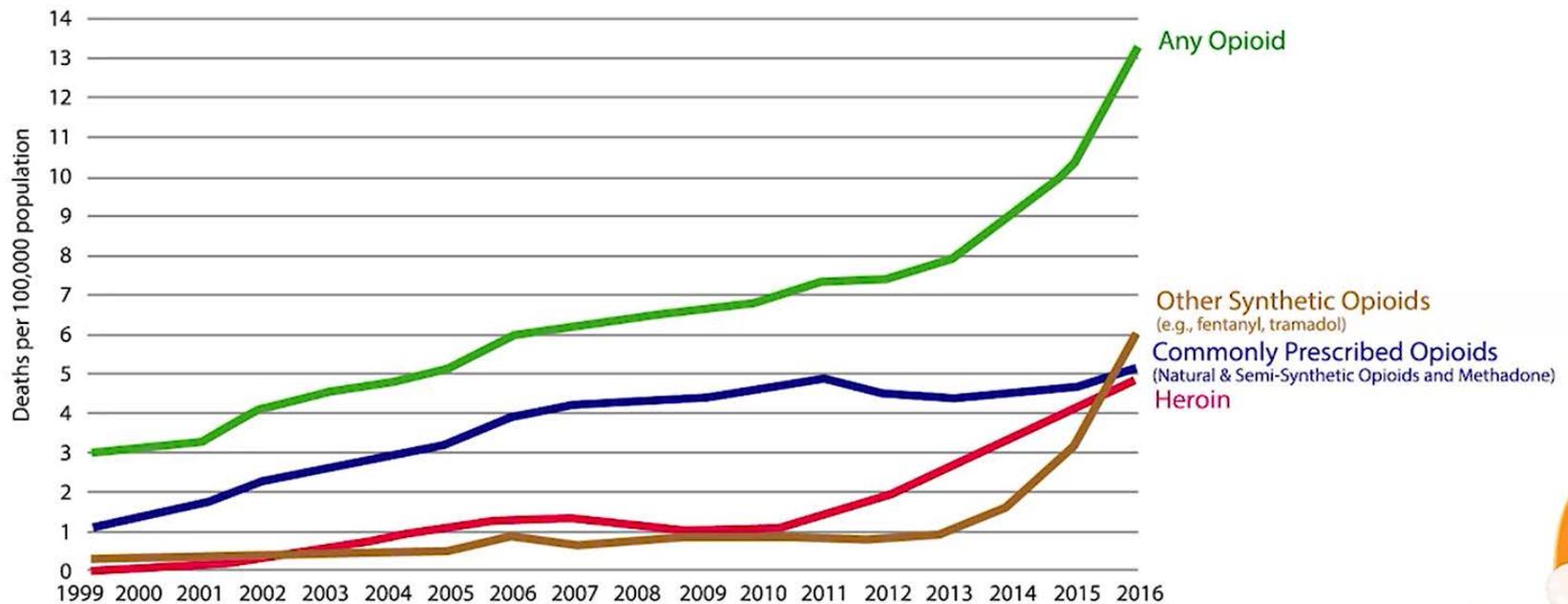
Source where pain relievers were obtained for most recent misuse among 12.5 million people aged 12 or older who misused prescription pain relievers in the past year: percentages, 2015

- 54% - Given by, bought from, or taken from a friend or relative
- 36% - Through a prescription or stolen from healthcare provider
- 5% - Bought from a dealer or stranger
- 5% - Some other way

3 waves of opiate deaths

Overdose Deaths Involving Opioids: By Opioid Type, United States, 1999-2016

Watch later



VIDEOS

CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA:
US Department of Health and Human Services, CDC, 2017. <https://wonder.cdc.gov/>



Fentanyl and Fentanyl Analogues

OD deaths from fentanyl and fentanyl analogues, such as carfentanil, have increased 540% in three years

Street fentanyl is illegally manufactured – generally not a diverted pharmaceutical product

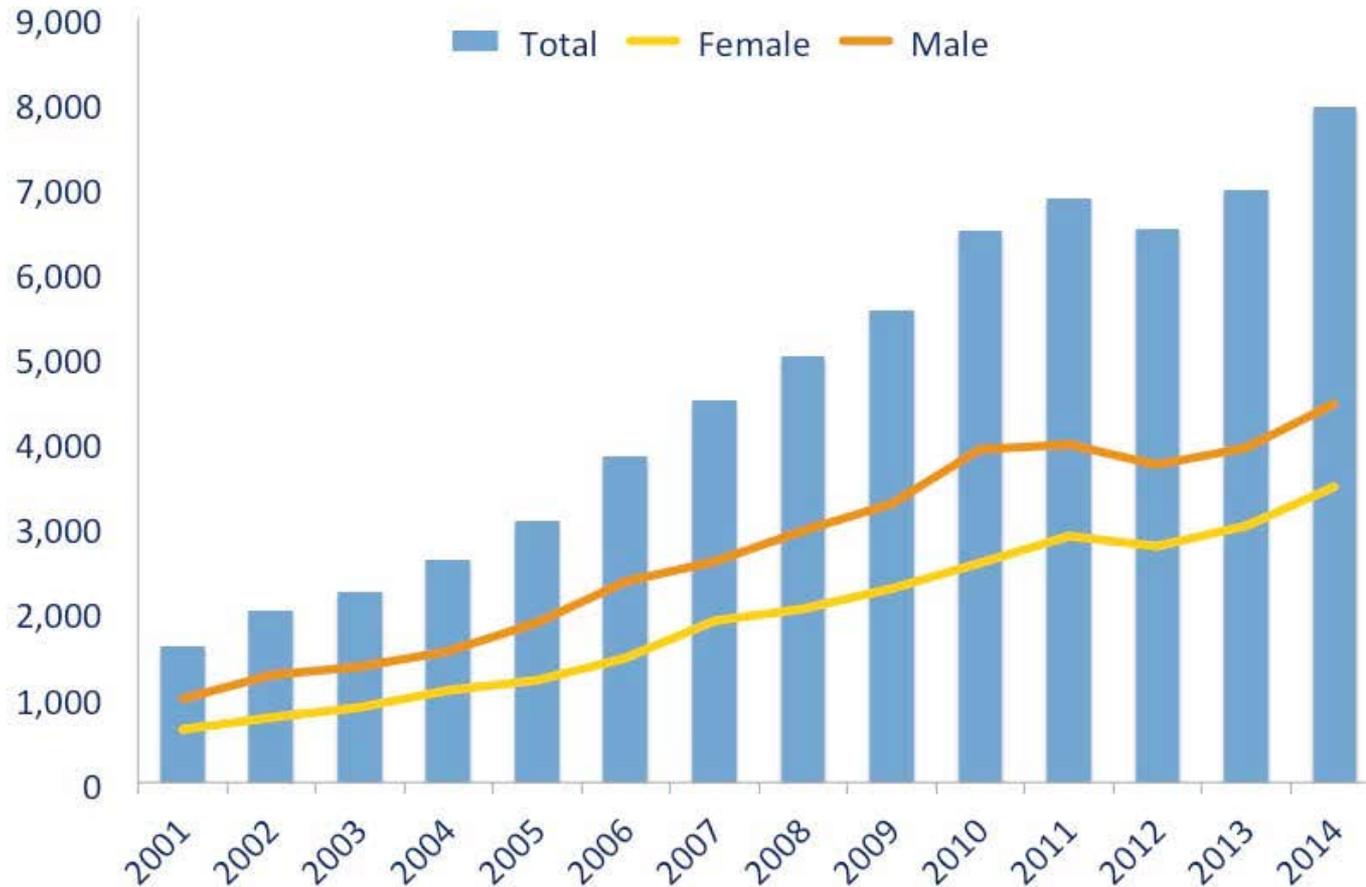
Two causes of fentanyl OD death: Opioid-induced **respiratory depression** and **rigid chest wall syndrome**; higher or repeated doses of naloxone required to reverse fentanyl overdose

Other abused drugs (heroin, cocaine, etc.) are contaminated, cut by or replaced by non-pharmaceutical fentanyl and fentanyl analogues



National Overdose Deaths

Number of Deaths from Benzodiazepines



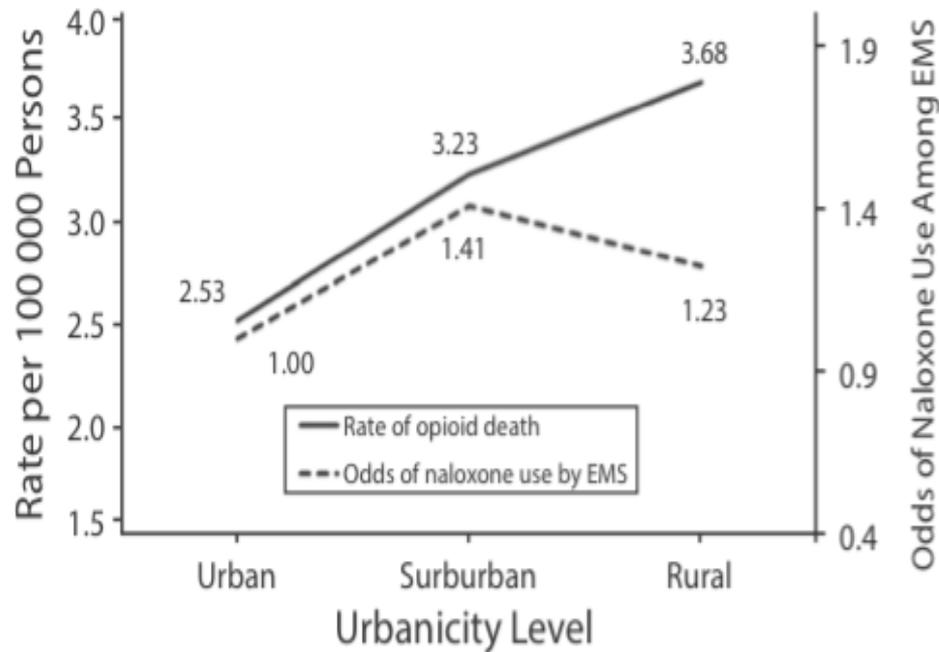
Source: National Center for Health Statistics, CDC Wonder

The Burden on our Rural Communities

- ▶ Overdose/death rates have increased in rural areas greater than urban areas.¹
- ▶ Methadone treatment programs don't exist in rural settings.
- ▶ Limited mental health resources

Martins S, et al. Worldwide Prevalence and Trends in Unintentional Drug Overdose: A Systematic Review of the Literature. Am J Public Health. Nov 2015, 105:11, e29-e49

You are more likely to die from an overdose in a rural setting compared to an urban setting.



Note. EMS = emergency medical services.

FIGURE 1—Overdose rates and odds of naloxone administration by EMS providers by level of urbanicity: National Emergency Medicine Service Information System, United States, 2012.

Faul, et al. Disparity in Naloxone Administration by Emergency Medical Service Providers and the Burden of Drug Overdose in US Rural Communities. *Am J Public Health* 2015; 105:e26-e32.

Review of Recent CDC Recommendations

- ▶ 12 Recommendations
- ▶ Recommendations pertain to patients who have chronic pain outside of cancer patients.
- ▶ Quote from palliative care experts: “Opiate use in patients without underlying serious illness for example sports injuries, headaches, or fibromyalgias, is associated with risk of substance use disorder and unintentional overdose. Pain in this patient population is best addressed in multidisciplinary pain programs with the appropriate psychosocial and behavioral health expertise and supports.”

CDC recs.

- 1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate (recommendation category: A, evidence type: 3).

Quotes

- ▶ “Having a history of a prescription for an opioid pain medication increases the risk for overdose and opioid use disorder , highlighting the value of guidance on safer prescribing practices for clinicians”
- ▶ “Primary care clinicians report having concerns about opioid pain medication misuse, find managing patients with chronic pain stressful, express concern about patient addiction, and report insufficient training in prescribing opioids”
- ▶ “Prescriptions by primary care clinicians account for nearly half of all dispensed opioid prescriptions”

Another Quote from guidelines

- ▶ “In summary, evidence on long-term opioid therapy for chronic pain outside of end-of-life care remains limited, with insufficient evidence to determine long-term benefits versus no opioid therapy, though evidence suggests risk for serious harms that appears to be dose-dependent. These findings supplement findings from a previous review of the effectiveness of opioids for adults with chronic noncancer pain. In this previous review, based on randomized trials predominantly ≤ 12 weeks in duration, opioids were found to be moderately effective for pain relief, with small benefits for functional outcomes; although estimates vary, based on uncontrolled studies, a high percentage of patients discontinued long-term opioid use because of lack of efficacy and because of adverse events”
- ▶ “Few studies have been conducted to rigorously assess the long-term benefits of opioids for chronic pain (pain lasting >3 months) with outcomes examined at least 1 year later.”

Quote

- ▶ “Studies of opioid therapy for chronic pain that did not have a nonopioid control group have found that although many patients discontinue opioid therapy for chronic noncancer pain due to adverse effects or insufficient pain relief, there is weak evidence that patients who are able to continue opioid therapy for at least 6 months can experience clinically significant pain relief and insufficient evidence that function or quality of life improves. These findings suggest that it is very difficult for clinicians to predict whether benefits of opioids for chronic pain will outweigh risks of ongoing treatment for individual patients. ”

OPIOID SIDE EFFECTS

- Respiratory depression - most serious
- Opioid-Induced Constipation (OIC) - most common
- Sedation, cognitive impairment
- Falls and fractures
- Sweating, miosis, urinary retention
- Hypogonadism
- Tolerance, physical dependence, hyperalgesia
- Addiction in vulnerable patients



Prescribers should report serious AEs to the FDA:

www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf

or 1-800-FDA-1088

Other problems with opiates

- ▶ Association with increased cardiovascular events.
- ▶ One study found that opioid dosages ≥ 20 MME/day were associated with increased odds of road trauma among drivers
- ▶ Androgen deficiency
- ▶ Irregular menses
- ▶ Sexual dysfunction

- ▶ Avoid opiate when chronic visceral or central pain syndromes. This differs from palliative care recs.

Other options for pain

- Regular use of Tylenol (efficacy?)
 - Dosing
 - Liver disease , ETOH
- NSAIDS including topical
 - Synergy
 - Concerns
- Topical Capsaicin
- Steroid injections
- SNRI's-Cymbalta (FDA approved for treatment of musculoskeletal pain), Effexor, Pristiq, Savella
TCA's
- Muscle relaxants, Gabapentin.
- Lidoderm patches or gel
- Nitroglycerin patches for chronic tendinitis (.2 mg/hr-cut in quarters)
- Tramadol
 - Mechanism
 - Efficacy-neuropathic, fibromyalgia, Other pain-any better than NSAIDS?
 - Concerns-Death, Suicide, seizures, metabolism in older adults and liver disease.
 - Addicting.
- Anticonvulsants-Neurontin, Lyrica, Tegretol
- Intrathecal opiates.
- PT, CBT, aerobic exercise, smoking cessation, TENS, spinal cord stimulation, acupuncture, OMT, Yoga, Ice, Heat. Baths/showers, exercise, mindfulness.
- Epidural steroids, Biofeedback
- Fascial Distortion Model.
- Address sleep, psych conditions..

CDC Guidelines

- ▶ . Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety (recommendation category: A, evidence type: 4).

PEG Pain Screening Tool

1. What number best describes your pain on average in the past week:

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

To compute the PEG score, add the three responses to the questions above, then divide by three to get a final score out of 10.

The final PEG score can mean very different things to different patients. The PEG score, like most other screening instruments, is most useful in tracking changes over time. The PEG score should decrease over time after therapy has begun.

Monitoring Efficacy

- ▶ Clinically meaningful improvement has been defined as a 30% improvement in scores for both pain and function.
- ▶ Also look at patient centered functional goals like walking the dog, returning to work, ability to do recreational activities ect.

CDC Recs

- ▶ Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy (recommendation category: A, evidence type
 - ▶ Addiction
 - ▶ Complete pain relief, function.
 - ▶ Interactions (benzos, etoh, other CNS depressants)
 - ▶ Side effects like constipation
 - ▶ Motor vehicle issues particularly when first starting or increasing dose. One study showed impaired driving over 20 MME.
 - ▶ Safeguarding from others in house. Lock up
 - ▶ Naloxone (more on this later)
 - ▶ You can integrate this into controlled substance contract or discussion.
 - ▶ Informed consent.

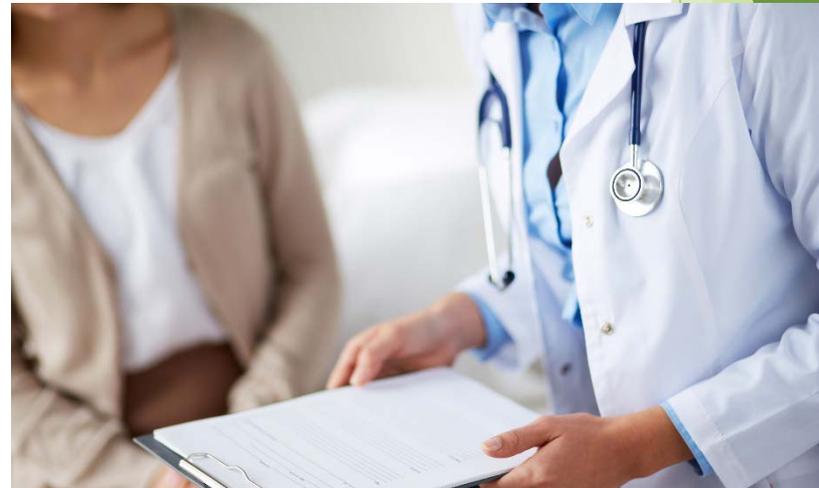
COUNSEL PATIENTS ABOUT PROPER USE *(continued)*

EXPLAIN

- Inform prescriber of ALL meds being taken
- Warn patients not to abruptly discontinue or reduce dose
- Risk of falls
- Caution with operating heavy machinery and when driving
- Sharing or selling opioids can lead to others' deaths and is against the law

OPIOIDS CAN CAUSE DEATH EVEN WHEN TAKEN PROPERLY

- Signs/symptoms are respiratory depression, gastrointestinal obstruction, allergic reactions



WARN PATIENTS

Never break, chew, crush, or snort an oral ER/LA tablet/capsule, or cut or tear patches prior to use

- May lead to rapid release of ER/LA opioid causing overdose and death
- If unable to swallow a capsule whole, refer to PI to determine if appropriate to sprinkle contents on applesauce or administer via feeding tube



Use of CNS depressants or alcohol with ER/LA opioids can cause overdose & death

- Use with alcohol may result in rapid release and absorption of a potentially fatal opioid dose – “dose dumping”
- Other depressants include sedative-hypnotics and anxiolytics, illegal drugs



OTHER METHODS OF OPIOID DISPOSAL

IF COLLECTION RECEPTACLE, MAIL-BACK PROGRAM, OR TAKE-BACK EVENT UNAVAILABLE, THROW OUT IN HOUSEHOLD TRASH

- Take drugs out of original containers
- Mix with undesirable substance
- Place in sealable bag, can, or other container
- Remove identifying info on label



FDA: PRESCRIPTION DRUG DISPOSAL

FLUSH DOWN SINK/TOILET IF NO COLLECTION RECEPTACLE,
MAIL-BACK PROGRAM, OR TAKE-BACK EVENT AVAILABLE

- As soon as they are no longer needed
- Includes transdermal adhesive skin patches
 - Used patch (3 days) still contains enough opioid to harm/kill a child
 - Dispose of used patches immediately after removing from skin
- Fold patch in half so sticky sides meet, then flush down toilet
- Do NOT place used or unneeded patches in household trash
 - Butrans (buprenorphine transdermal system)
exception: can seal in Patch-Disposal Unit
provided and dispose of in the trash



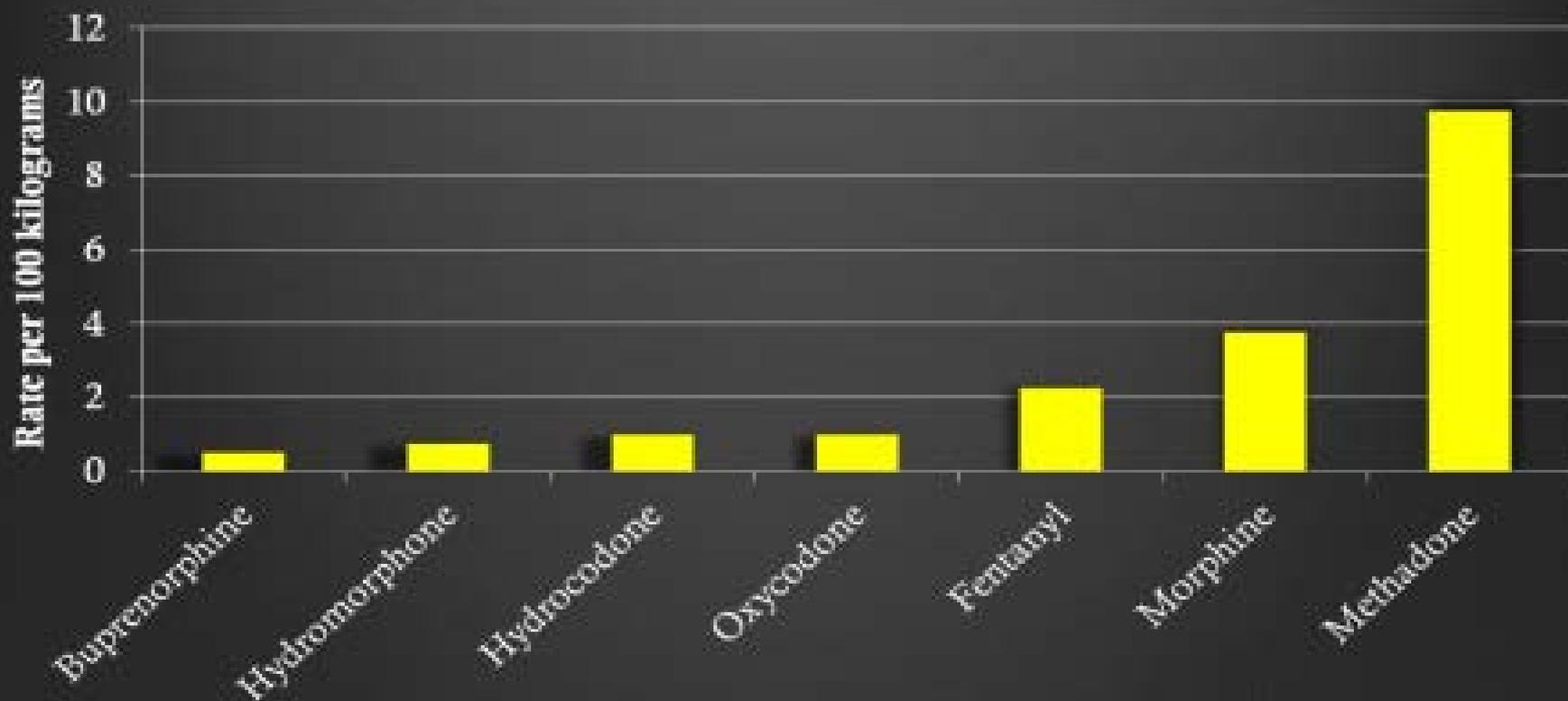
CDC recs

- ▶ . When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids (recommendation category: A, evidence type: 4)
 - ▶ ER/LA opioids include methadone, transdermal fentanyl, and extended-release versions of opioids such as oxycodone, oxymorphone, hydrocodone, and morphine
 - ▶ Evidence review found a fair-quality study showing a higher risk for overdose among patients initiating treatment with ER/LA opioids than among those initiating treatment with immediate-release opioids
 - ▶ And not more effective.
- ▶ Time-scheduled opioid use was associated with substantially higher average daily opioid dosage than as-needed opioid use in one study

Quotes

- ▶ “ER/LA opioids should be reserved for severe, continuous pain and should be considered only for patients who have received immediate-release opioids daily for at least 1 week. ”
- ▶ “Although there might be situations in which clinicians need to prescribe immediate-release and ER/LA opioids together (e.g., transitioning patients from ER/LA opioids to immediate-release opioids by temporarily using lower dosages of both), in general, avoiding the use of immediate-release opioids in combination with ER/LA opioids is preferable, given potentially increased risk and diminishing returns of such an approach for chronic pain.”
- ▶ When an ER/LA opioid is prescribed, using one with predictable pharmacokinetics and pharmacodynamics is preferred to minimize unintentional overdose risk. In particular, unusual characteristics of methadone and of transdermal fentanyl make safe prescribing of these medications for pain especially challenging.
- ▶ “Methadone should not be the first choice for an ER/LA opioid”
 - ▶ Only physicians who familiar with the dosing and problems with methadone and Fentanyl should prescribe them and monitor/educate their patients closely.

Death Rate from Overdose Caused by a Single Prescription Painkiller



Adapted from: Substance Abuse and Mental Health Administration, Center for Behavioral Statistics and Quality, Drug Abuse Warning Network Medical Examiner Component, 2009

It is effective as an analgesic when dosed bid

- ▶ Not really.
- ▶ More frequent dosing usually needed.

Methadone Continued

- Extremely variable, idiosyncratic dose response.
- Variable speed of metabolism.
- Extremely Long Half life (128 Hours)
- Only comes in 5 and 10 mg which by MME's are very potent.
- Can take weeks to reach a steady state. May not be controlling pain optimally during that time, but can cause dangerous respiratory suppression.
- Special concern (as always but probably more here) for combination with sleep apnea, benzos etoh, other cns depressants.
- DON'T make any change to dose for at least the first 7 days, then must be titrate up very slowly. Don't be fooled or lulled by the dose you see heroine addicts on.
- Also cardiac concerns for arrhythmias and QT prolongation. It is contraindicated in patients with prolonged QT's. Consider EKG to look for prolonged QT before starting and definitely get one if giving 100 mg or more a day.
- Don't ever use on opiate naive patient (cutoffs for opiate naive-60mg oral morphine/day, 30 mg oral oxycodone, 8 po Dilaudid) NOT no opiates.
- In fact, I wouldn't use it. Palliative care literature states should only be prescribed by pain palliative or pain specialists.

Transdermal Fentanyl

- ▶ Gradually increasing serum concentration during the first part of the 72-hour dosing interval.
- ▶ Variable absorption based on factors such as external heat.
- ▶ Dosing of transdermal Fentanyl in mcg/hour, which is not typical for a drug used by outpatients, can be confusing.
- ▶ Increased body fat seen in elderly can make it stick around for long time even after removed.
- ▶ Only clinicians who are familiar with the dosing and absorption properties of transdermal Fentanyl and are prepared to educate their patients about its use should consider prescribing it, and NEVER prescribe it to an opiate naive patient. Neither should parenteral Fentanyl.

Conversion Tables

- ▶ Dangerous to rely on these.
- ▶ People respond to different molecules of opiates differently. (hyperalgesia, euphoria, sedation, resp depression). Incomplete cross tolerance. Also consider renal and liver disease.
- ▶ Designed for 24 hour acute pain periods after surgery.
- ▶ In rotating to another opioid decrease the equianalgesic dose by 25 to 50 percent. 50% of pain is well controlled and 25% if it is not. Also 50 if on high doses or elderly or medically frail.
- ▶ In rotating to Methadone, reduce the dose by 75 to 90 percent, and remember the equivalent morphine dose changes with different doses (dangerous).

Compared to oral morphine on per mg basis...

- Codeine is 1/10th as potent
- Tramadol is 1/10th as potent
- Hydrocodone is ~ 1 -1.5 times as potent
- Oxycodone is ~ 1.5 times as potent
- Parenteral morphine is ~3 times as potent
- Hydromorphone is ~ 4 times as potent
- Parenteral hydromorphone is ~20 times as potent

CONSIDERATIONS FOR CHANGE FROM IR TO ER/LA OPIOIDS

DRUG AND DOSE SELECTION IS CRITICAL

Some ER/LA opioids or dosage forms are only recommended for **opioid-tolerant** patients

- ANY strength of transdermal fentanyl or hydromorphone ER
- Certain strengths/doses of other ER/LA products (check drug prescribing information)

MONITOR PATIENTS CLOSELY FOR RESPIRATORY DEPRESSION

Especially within 24-72 hours of initiating therapy and increasing dosage

INDIVIDUALIZE DOSAGE BY TITRATION BASED ON EFFICACY, TOLERABILITY, AND PRESENCE OF AEs

Check ER/LA opioid product PI for minimum titration intervals

Supplement with IR analgesics (opioids and non-opioid) if pain is not controlled during titration

OPIOID TOLERANCE

If opioid tolerant caution should still be used at higher doses

Patients considered opioid tolerant are taking at least

- 60 mg oral morphine/day
- 25 mcg transdermal fentanyl/hour
- 30 mg oral oxycodone/day
- 8 mg oral hydromorphone/day
- 25 mg oral oxymorphone/day
- An equianalgesic dose of another opioid

Still requires caution when rotating a patient on an IR opioid to a different ER/LA opioid



**FOR 1 WEEK
OR LONGER**

IMPORTANT

CDC Guidelines

- ▶ When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day (recommendation category: A, evidence type: 3)

Quotes

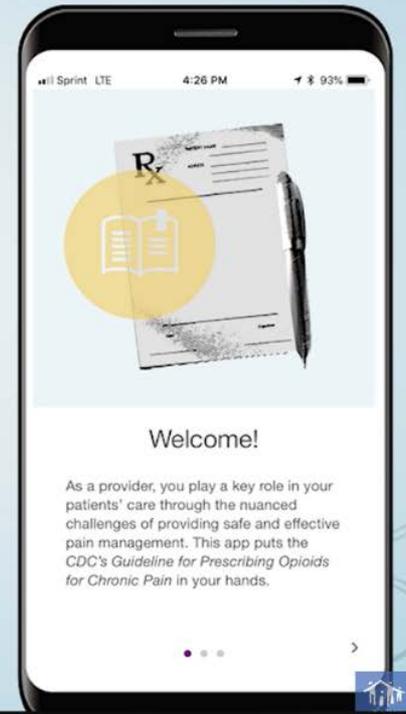
- ▶ “The contextual evidence review found that although there is not a single dosage threshold below which overdose risk is eliminated, holding dosages <50 MME/day would likely reduce risk among a large proportion of patients who would experience fatal overdose at higher prescribed dosages”
- ▶ “No single threshold could be identified.”
- ▶ 0-20 safer than 20-50
- ▶ Randomized trial found no difference in pain or function between a more liberal opioid dose escalation strategy and maintenance of current dosage (40 verses 52).
- ▶ “Most experts agreed that, in general, increasing dosages to 50 or more MME/day increases overdose risk without necessarily adding benefits for pain control or function”
- ▶ “Most experts also agreed that opioid dosages should not be increased to ≥ 90 MME/day without careful justification based on diagnosis and on individualized assessment of benefits and risks”.
- ▶ Extra caution in the elderly or renal or hepatic impairment
- ▶ Wait at least 5 half lives before going up on dose and at least a week before going up on Methadone.
- ▶ If going over 50, what are goals, need closer monitoring, precautions, Naloxone.

CDC App

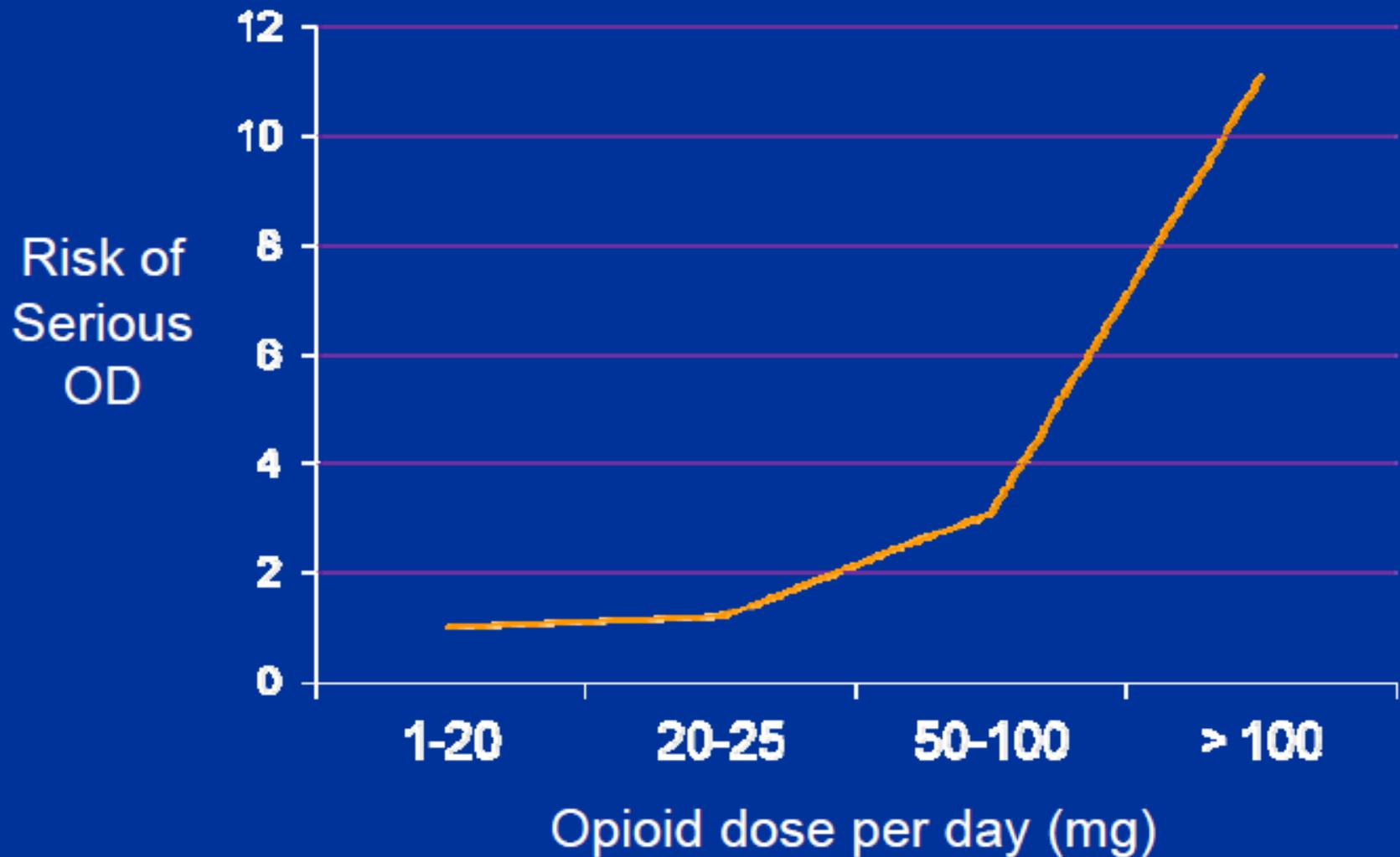
CDC Opioid Prescribing Guideline Mobile App

- CDC's new Opioid Guide App makes it easier to apply the recommendations into clinical practice
- Features include:
 - MME Calculator
 - Prescribing Guidance
 - Motivational Interviewing Practice
- Available today, download for free from your app store (iOS or Android)
- For more info, visit:
www.cdc.gov/drugoverdose/prescribing/app.html

Recommendation category A: Evidence type: 3

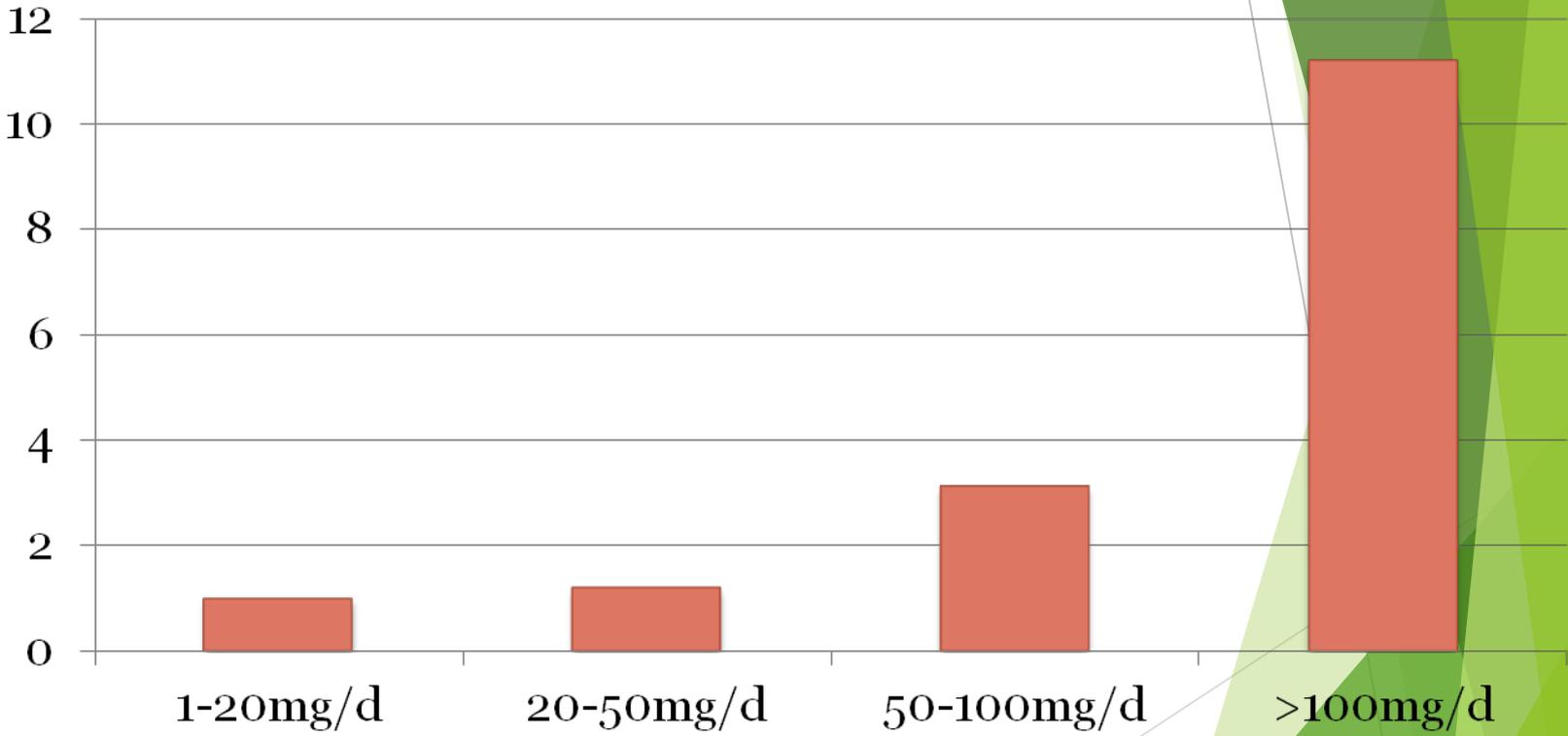


Risk of OD + Daily Dose



Lower Doses

HR for Overdose by Morphine Equivalents



Ann Intern Med. 2010;152:85-92.



Opiate Induced Hyperalgesia and Allodynia

- ▶ Well established easily, reproducible in labs.
- ▶ Studies have shown that Methadone-maintained individuals reliably show poor tolerance for experimental pain.
- ▶ Hyperalgesia and spontaneous bone and pain are cardinal symptoms of opioid withdrawal.
- ▶ Is this clinically relevant?
- ▶ Definitely suspect if more pain, more diffuse pain, or possibly delirium with increased dosing.
- ▶ Palliative care literature talks about accompanying neuroexcitation (agitation, anxiety, restlessness) and risk factors being DME of over 200, renal failure, dehydration with accumulation of toxic metabolites as possible mechanism.
- ▶ Can be good reason to not use high doses and also to justify tapering dose.
- ▶ Tolerance to the analgesic effect of opiates almost never occurs, as opposed to tolerance to sedation, nausea, itching.

CDC Guidelines

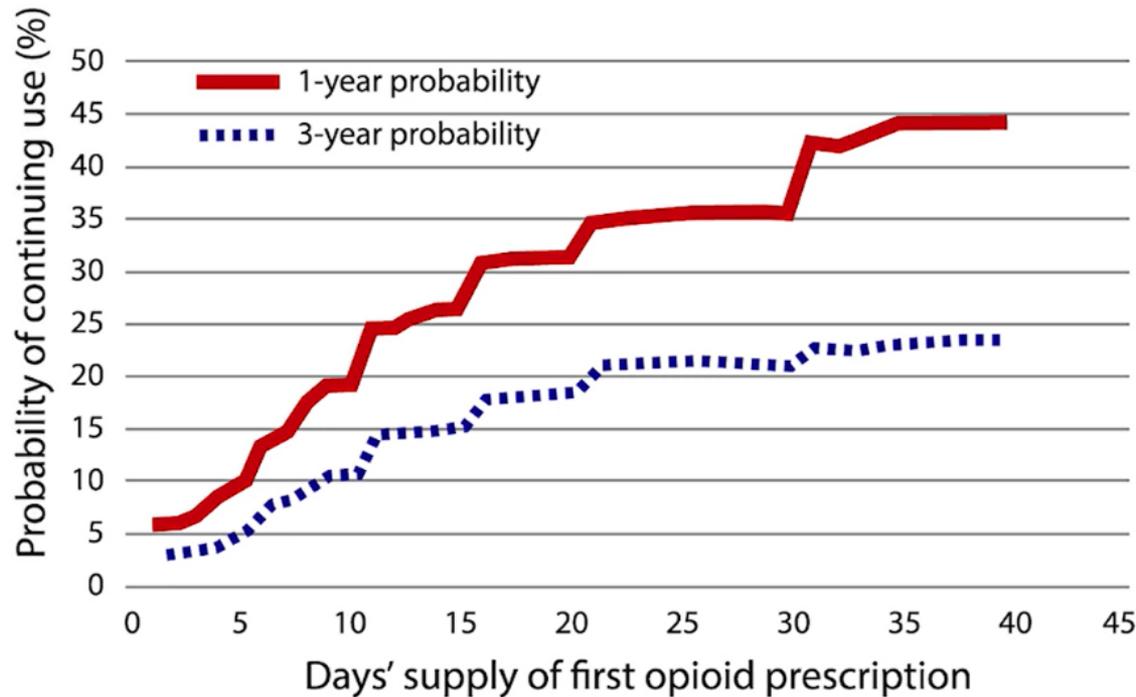
- ▶ Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed (recommendation category: A, evidence type: 4)

Acute pain

- ▶ Opiate use is associated with long term use and the more opiates used the bigger the risk.
- ▶ Physical dependence after a few days.
“Experts noted that more than a few days of exposure to opioids significantly increases hazards, that each day of unnecessary opioid use increases likelihood of physical dependence without adding benefit”
- ▶ More pills, more risk of diversion
- ▶ Most cases of acute pain, excluding surgery or trauma, 3 or less days of opiates is adequate. In many other cases, no longer than 3-5 days. Up to 7-there is disagreement.

Number of days and risk

Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use



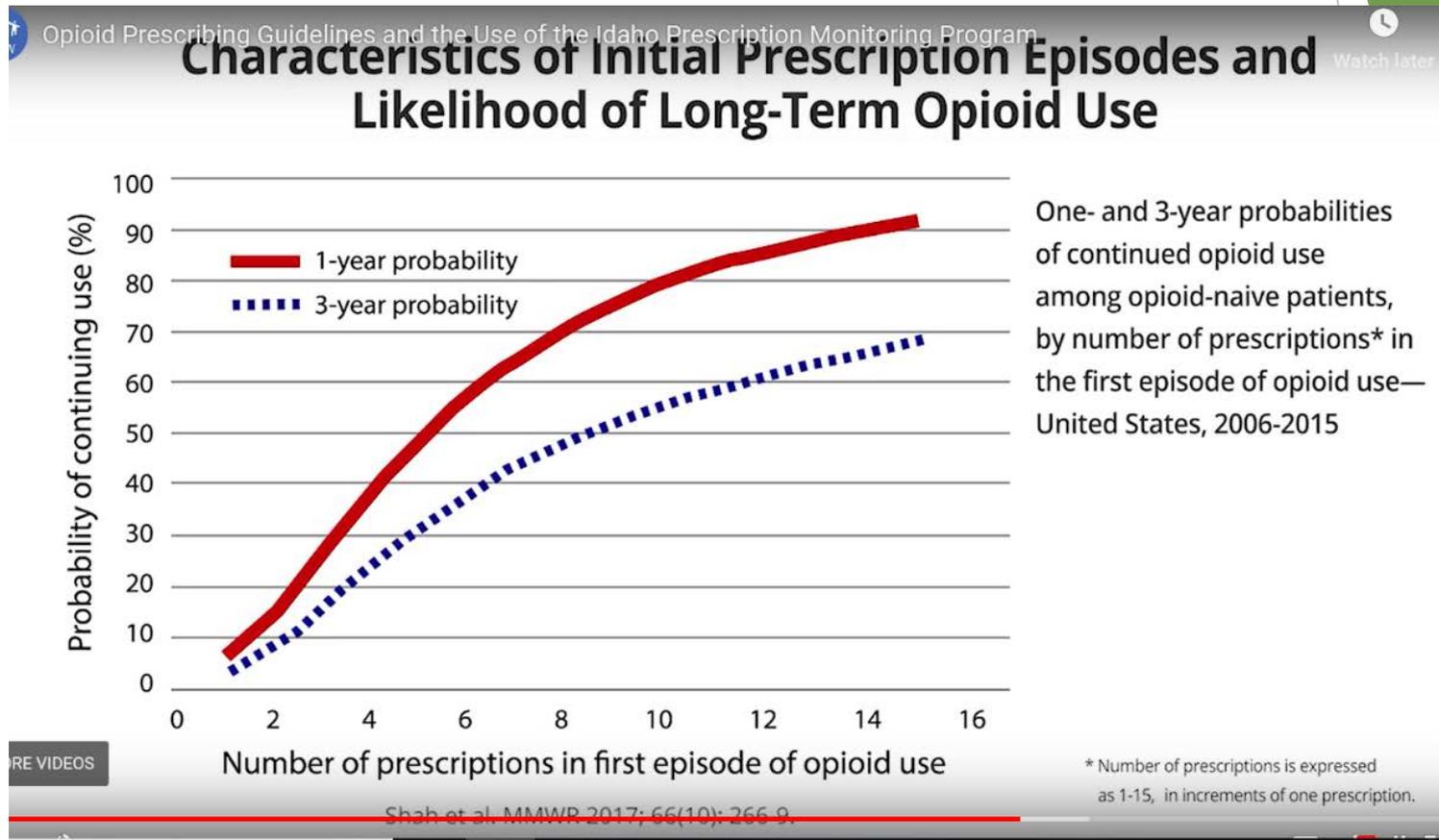
One- and 3-year probabilities of continued opioid use among opioid-naive patients, by number of days' supply* of the first opioid prescription—United States, 2006-2015

* Days' supply of the first prescription is expressed in days (1-40) in 1-day increments. If a patient had multiple prescriptions on the first day, the prescription with the longest days' supply was considered the first prescription.

Shah et al. MMWR 2017; 66(10): 266-9.



Number of refills and long term risk



CDC Recs

- ▶ Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids (recommendation category: A, evidence type: 4)

Quotes and Statements

- ▶ “Continuing opioid therapy for 3 months substantially increases risk for opioid use disorder.”
- ▶ “The contextual evidence review found that patients who do not have pain relief with opioids at 1 month are unlikely to experience pain relief with opioids at 6 months.”
- ▶ Risk for overdose associated with ER/LA opioids might be particularly high during the first 2 weeks of treatment .”
- ▶ Experts noted that risks for opioid overdose are greatest during the first 3-7 days after opioid initiation or increase in dosage, particularly when Methadone or transdermal Fentanyl are prescribed; that follow-up within 3 days is appropriate when initiating or increasing the dosage of methadone; and that follow-up *within 1 week* might be appropriate when initiating or increasing the dosage of other ER/LA opioids.

So what should follow-up be

- ▶ Follow-up in 1-4 weeks.
- ▶ Shorter end if 50 or more MME.
- ▶ Follow-up *within week* if on ER/LA
- ▶ Within 3 days if starting or increasing dose of Methadone
- ▶ I would do the same with transdermal Fentanyl

What do you assess

- ▶ Pain average, interference with enjoyment of life, and interference with general activity (PEG) Assessment Scale
- ▶ Side effects: ie constipation, drowsiness.
- ▶ Warning signs for OD, sedation, slurred speech.
- ▶ Warnings for opiate abuse disorder: cravings, wanting to increase use, difficulty controlling use, disruption of job, family.
- ▶ Consider using the Current Opioid Misuse Measure (COMM):
<http://www.opioidprescribing.com/documents/09-comm-inflexxion.pdf>

Long term follow-up

- ▶ At least q 3 months
- ▶ More frequent indications
 - ▶ 50 MME or more.
 - ▶ Psych issues.
 - ▶ On CNS depressants also.
 - ▶ History of OD
 - ▶ Greater risk of opioid abuse disorder

Opiates not the way to go. Risks outweigh benefits or problems.

▶ Taper:

- ▶ 10-50% of original dosage q week. But may have to go slower ie. 10% /month eg..particularly if they have been on them for years.
- ▶ You want to minimize S and S of withdrawal. 10%/week may be good place to start.
- ▶ Signs of withdrawal: early signs are drug craving, agitation, anxiety, insomnia, diaphoresis, mydriasis, tremor, tachycardia, insomnia, tearing, piloerection, yawning. Later signs are abdominal cramping, diarrhea, nausea, vomiting.
- ▶ CINA
- ▶ They talk about rapid over 2-3 weeks if severe event like OD, but I would consider stopping all together and using Clonidine and other meds.
- ▶ Clinicians should discuss with patients undergoing tapering the increased risk for overdose on abrupt return to a previously prescribed higher dose.
- ▶ Tapering may have to paused and/or slowed when you get to lower doses.
- ▶ Psychosocial support and treatment
- ▶ Naloxone if off but opiate use disorder

CDC guidelines

- ▶ Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present (recommendation category: A, evidence type: 4)

Risk factors and situations

- ▶ Sleep disorder breathing including sleep apnea, chf, obesity. Avoid opiates whenever possible if moderate to severe. Adjust dose in others.
 - ▶ Tolerance to respiratory effects of opiates not what we thought.
 - ▶ Sleep apnea very common.
 - ▶ Decrease dose of opiates 50% when patient has an acute respiratory condition. (eg. infection).
 - ▶ Sleep studies of patients on morphine equivalent doses of 150 mg or more or on Methadone of 50 mg a day or more.
- ▶

More Risk factors

- ▶ Pregnancy: Not covered in depth here. Codeine taken by breast feeding mothers associated with neonatal toxicity and death.
- ▶ Hepatic, renal insufficiency. Don't use codeine in either and don't use morphine in renal failure, and dosing/frequency of all opiates should be reduced for both renal and hepatic failure.
- ▶ Neurological diseases.
- ▶ Elderly (cognitive problems may also play a role). Avoid morphine and codeine in the frail elderly.
- ▶ Psych issues (especially anxiety), depression.
- ▶ Prior nonfatal overdose
- ▶ Substance abuse.
- ▶ Don't overestimate risk assessment tools. Current evidence does not show great evidence for identifying who is at risk, but I would still use them.

Other risk factors

- Personal and family history.
- Males, smokers.
- DUI's
- Unemployed
- Isolated
- Tools ORT, SOAPP, DIRE
- History of preadolescent sexual or other abuse.
- PTSD
- Assess for psych conditions using tests (eg. GAD7, PHQ9). Treatment can help.

Risk factors continued

- ▶ The question “How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?” (with an answer of one or more considered positive) was found in a primary care setting to be 100% sensitive and 73.5% specific for the detection of a drug use disorder compared with a standardized diagnostic interview.
- ▶ AUDIT, DAST
- ▶ Educate patients regarding the risk of combining opiates with etoh, benzos or other cns depressants.
- ▶ Opiate Risk Tool (see next slide):
http://www.partnersagainstpain.com/printouts/Opioid_Risk_Tool.pdf
- ▶ Also consider the Screener and Opioid Assessment for patients (SOAPP) with pain:
<https://nhms.org/sites/default/files/Pdfs/SOAPP-14.pdf>
- ▶ And/or the DIRE questionnaire:
http://www.emergingsolutionsinpain.com/content/tools/esop_9_instruments/pdf/DIRE_Score.pdf
- ▶ Check PMP

Some warning signs of medication misuse

- Assertive personality
- Unusual knowledge of controlled substances
- Textbook or vague answers to medical history questions
- No regular doctor and/or health insurance
- Wants specific drug and reluctance to try another (eg. specific non narcotics don't work or they are allergic to them)
- No interest in diagnosis and often fails to keep appointments for diagnostic tests or with consultants.
- Does not permit review of past records
- Insists on being seen right away
- Makes appointments at the end of business day
- Calling or coming in after business hours
- Has providers but says they are not available
- Lost Rx and wants replacement
- Unexplained dose escalations and/or non-adherence to treatment plans

OPIOID RISK TOOL (ORT)

Mark each box that applies		Female	Male
1	Family history of substance abuse		
	Alcohol	<input type="checkbox"/> 1	<input type="checkbox"/> 3
	Illegal drugs	<input type="checkbox"/> 2	<input type="checkbox"/> 3
	Prescription drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4
2	Personal Hx of substance abuse		
	Alcohol	<input type="checkbox"/> 3	<input type="checkbox"/> 3
	Illegal drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4
	Prescription drugs	<input type="checkbox"/> 5	<input type="checkbox"/> 5
3	Age between 16 and 45 yrs	<input type="checkbox"/> 1	<input type="checkbox"/> 1
4	Hx of preadolescent sexual abuse	<input type="checkbox"/> 3	<input type="checkbox"/> 0
5	Psychologic disease		
	ADD, OCD, bipolar, schizophrenia	<input type="checkbox"/> 2	<input type="checkbox"/> 2
	Depression	<input type="checkbox"/> 1	<input type="checkbox"/> 1

ADMINISTER
 On initial visit
 Prior to opioid
 therapy

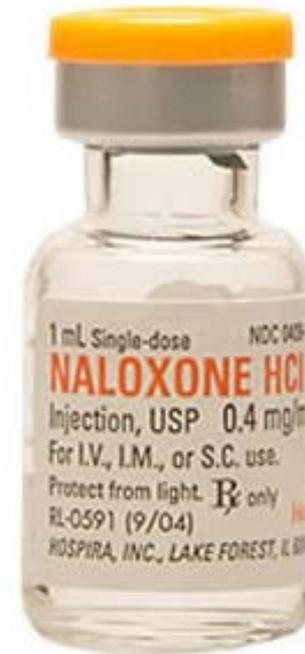
SCORING (RISK)
 0-3: low
 4-7: moderate
 ≥8: high

Scoring Totals:

RISK ASSESSMENT TOOLS

TOOL	# OF ITEMS	ADMINISTERED BY
PATIENTS CONSIDERED FOR LONG-TERM OPIOID THERAPY		
ORT Opioid Risk Tool	5	patient
SOAPP® Screener and Opioid Assessment for Patients with Pain	24, 14, & 5	patient
DIRE Diagnosis, Intractability, Risk, and Efficacy score	7	clinician
CHARACTERIZE MISUSE ONCE OPIOID TREATMENT BEGINS		
PMQ Pain Medication Questionnaire	26	patient
COMM Current Opioid Misuse Measure	17	patient
PDUQ Prescription Drug Use Questionnaire	40	clinician
NOT SPECIFIC TO PAIN POPULATIONS		
CAGE-AID Cut Down, Annoyed, Guilty, Eye-Opener tool, Adapted to Include Drugs	4	clinician
RAFFT Relax, Alone, Friends, Family, Trouble	5	patient
DAST Drug Abuse Screening Test	28	patient
SBIRT Screening, Brief Intervention, and Referral to Treatment	Varies	clinician

Naloxone HCl = Generic
Narcan, Evzio = Brand Name



Naloxone resources

Prescribing Guidelines and the Use of the Idaho Prescription Monitoring Program

Evaluate and Address Risks for Opioid-Related Harms

How to Prescribe Naloxone

- Resources for prescribing naloxone available at <http://prescribetoprevent.org>
 - Sample prescribing directions
 - Information for patients and their family or household members
 - Information for pharmacists
- Naloxone co-prescribing can be facilitated by collaborative practice models with pharmacists



Naloxone for Overdose Prevention

Watchlist Share

Rx

Naloxone HCl 0.4 mg/mL (Narcan)
1 x 10 mL as one fliptop vial (NDC 0409-1219-01) OR
2 x 1mL single dose vials (NDC 0409-1215-01)

Refills: _____

Intramuscular (IM) syringe, 23 G, 3cc, 1 inch

Qty: _____ Refills: _____

Sig: For suspected opioid overdose,
inject 1mL IM in shoulder or thigh.
Repeat after 3 minutes if no or minimal response.

Physician Signature: _____

8



Recommendation category: A; Evidence type: 4

Great instructional videos offered on the Idaho Office of Drug Policy site
<https://healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/tabid/105/Default.aspx>

Opioid Overdose Information

Naloxone is an "opioid antagonist" used to counter the effects of opioid overdose. Legislation passed in 2015 made Naloxone available to anyone in Idaho by simply asking their pharmacist. The following two videos contain instructions for administering naloxone.

Links to Videos In English

- [Naloxone Instruction Video - Injection](#)
- [Naloxone Instruction Video - Nasal](#)

Links to Videos in Spanish

- [Naloxone Instruction Video \(Spanish\) - Injection](#)
- [Naloxone Instruction Video \(Spanish\) - Nasal](#)

Opioid Overdose Resuscitation Card

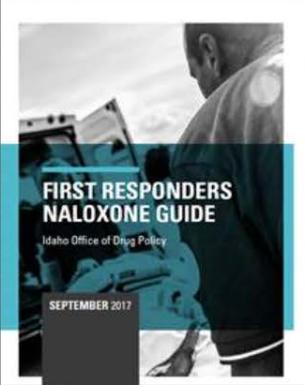
Free resources from Idaho ODP

Order Resource Materials Naloxone

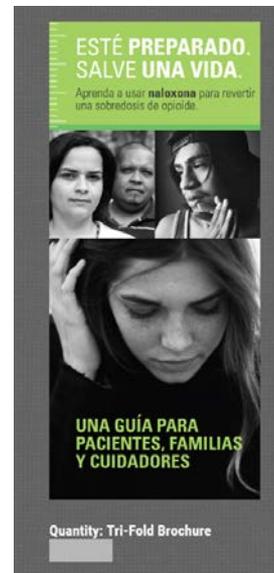
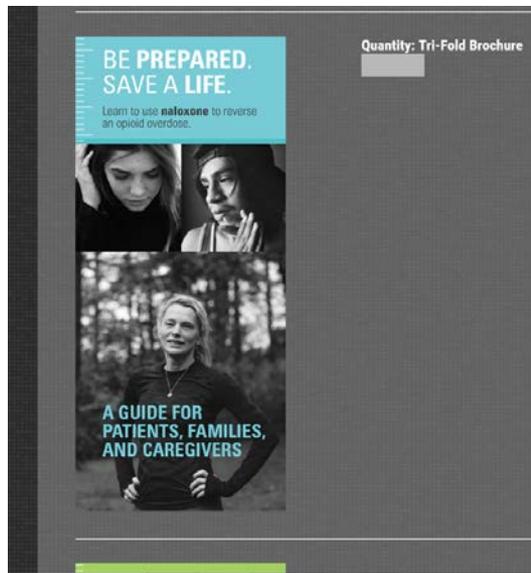
If you would like to obtain resource materials, please fill out the following form.

Naloxone Materials Order Form

These items will be sent to you at no charge. The Office of Drug Policy maintains the right to limit quantities and out-of-state orders.

	Quantity: Naloxone Guidebook <input type="text"/>
--	--

More free resources (brochures) from Idaho ODP



Idaho ODP Order Form

Street Address Line 2

City

State

Zip Code

Please Select

Material Usage

- Community Event
- School Event
- Health Fair
- Classroom Use
- Workplace Education
- Clinical Setting
- Pharmacy Setting

Questions?

Idaho Office of Drug Policy

Gayle Hines

(208)854-3040 | gayle.hines@odp.idaho.gov

Naloxone Resources Continued

Guidelines and the Use of the Idaho Prescription Monitoring Program

Evaluate and Address Risks for Opioid-Related Harms

odp.idaho.gov

Watch later Share

If you know someone who might be at risk for an opioid overdose, keep naloxone on hand in case of an emergency. In Idaho, naloxone is available directly from your pharmacist.

Naloxone reverses an overdose by helping the victim begin breathing again.

Common Opioids

Generic	Brand Name
Buprenorphine	Buprenex, Butrans, Suboxone, Zubsolv, Zubsolv XL
Codaine	Talwin with Codeine, Tylo, Tyloval, Tyloval XL
Fentanyl	Duragesic
Heroin	
Hydrocodone	Licorid, Lortab, Nemo, Vicodin, Zohydro
Hydroxyzine	Sibaxin
Morphone	Duonid
Methadone	Degobase, Methadone
Morphine	Morona, Estrimex, Exelon, MFCoin
Oxycodone	OxyContin, Percocet, Percodan, Roxicodone
Oxycodone	Oxyne

BE PREPARED. SAVE A LIFE.

Learn to use **naloxone** to reverse an opioid overdose.

What are opioids?

Opioids include illegal drugs like heroin as well as pain prescription medications like morphine, codeine, methadone, and oxycodone.

Who's at risk of an overdose or reaction?

Opioid overdoses can happen even if you've been prescribed a low dosage of pain medications for a short time. Please secure naloxone if you or a family member

- has been prescribed a new opioid medication or if the dosage has changed,
- is taking an opioid pain medication with other medications.

Avoid an accidental overdose

- Don't mix opioids with alcohol, benzodiazepines (Xanax, Ativan, Klonopin, Valium), or medicines that make you sleepy.
- Be extra careful if you miss or change doses, feel ill, or start new medications.

Questions?

Idaho Office of Drug Policy
(208) 654-3040
odp.idaho.gov/facts/opiates.html

Idaho Department of Health and Welfare
www.healthandwelfare.idaho.gov

A GUIDE FOR PATIENTS, FAMILIES, AND CAREGIVERS

8

IDHW

High Risk Situations

- Recent rehab
 - Recent prison
 - Recent dose increase
 - Recent overdose
 - High dose (>50 morphine-equivalents/day)
 - Concomitant use of depressants, including benzodiazepines and alcohol
 - Obesity with OSA/OHS, liver disease, renal disease
 - Acute illness reducing tolerance
- But should really provide it for anyone on opiates. And, it should not just be at home but rather on their person if they think they might be exposed to person who has overdosed.

Prescribing Naloxone

- ▶ Teaching takes about 5 minutes - plus 7 minutes for watching video (which an MA can facilitate).
- ▶ Getting family, friends, housemates to watch is key.
- ▶ Great opportunity when
 - ▶ Renewing pain agreement
 - ▶ New prescription
 - ▶ Dosage change
 - ▶ Establishing care



CDC Guidelines

- ▶ Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months (recommendation category: A, evidence type: 4).

Quotes

- ▶ “Most fatal overdoses were associated with patients receiving opioids from multiple prescribers and/or with patients receiving high total daily opioid dosages.”
- ▶ “Experts agreed that clinicians should not dismiss patients from their practice on the basis of PDMP information. Doing so can adversely affect patient safety, could represent patient abandonment, and could result in missed opportunities to provide potentially lifesaving information (e.g., about risks of opioids and overdose prevention) and interventions (e.g., safer prescriptions, nonopioid pain treatment [see Recommendation 1], naloxone [see Recommendation 8], and effective treatment for substance use disorder” [see Recommendation 12]).
- ▶ Use this as an opportunity to: discuss OD risk, taper meds, talks about dangerous combos (eg. benzos and opioids), Naloxone, weight risks, goals, and benefits. Do they need rx for OUD

Idaho PMP

- ▶ Collects data on schedule II-V dispensed in Idaho or shipped to Idaho resident from a mail order Pharmacy.
- ▶ Naloxone is now also reported.
- ▶ Data must be reported by the end of the next business day

Things to know about the PMP

- ▶ There is a federal law which exists which protects the privacy of patients who go to opiate treatment/recovery centers, such that any Methadone, Suboxone, or Buprenorphine which patients get from these clinics are dispensed and not prescribed and therefore DO NOT show up on the PMP. The three local clinics where this is occurring are: Raise the Bottom in Boise and Nampa, and the two Centers for Behavioral Health clinics-one in Boise and one in Meridian. Also, controlled substances filled at some VA do not show up. They do for the Boise VA
- ▶ Samples dispensed won't show up.

More things to know about the PMP

- ▶ You have to be registered to get a controlled substance license in Idaho, but this is not dependent on use. In states where it is, over doctor shopping down significantly.
- ▶ You can have a delegate check it for you. A delegate can be a nurse or medical office worker, or student health sciences student under supervision of person using pmp.
- ▶ A provider may have four delegates, and there is no limit to how many providers a staff or nurse can be a delegate for. You have to go on site and approve your delegate.
- ▶ You should run a report on what rx's you have written and look for unfamiliar or suspicious names. Most of the time it is office staff.
- ▶ There may be different names for patient..
- ▶ Usually can download report

You can search other states for an individual patient.

The screenshot shows a web browser window with the URL https://idaho.pmpaware.net/rx_search_requests/new. The page features a search bar with a "Select State" dropdown menu. Below the search bar is the "PMP Interconnect Search" section, which includes a heading and a sub-heading: "To search in other states as well as your home state for patient information, select the states you wish to include in your search". The search options are organized by the first letter of the state name, with each letter followed by a list of states and their corresponding checkboxes.

PMP Interconnect Search
To search in other states as well as your home state for patient information, select the states you wish to include in your search

A Alaska Arizona Arkansas

C Colorado

I Illinois Indiana

K Kansas

M Maine Massachusetts Michigan Minnesota Mississippi Montana

N Nevada New Mexico North Carolina North Dakota

O Ohio Oklahoma Oregon

R Rhode Island

S South Carolina

T Texas

U Utah

Or you can have default states which will be searched every time, but this may slow things down some.

Home	RxSearch	User Profile	Training	PDMP Links
Dashboard PMP Announcements	Patient Request Bulk Patient Search Requests History MyRx Patient Alerts	My Profile Default PMPi States Delegate Management Password Reset Log Out	Aware User Guide Help	Washington PMP - ... Utah PMP - 801.53... Montana PMP - 406... Idaho Dept of H&W... More Links...

Default InterConnect PMPs

- Alaska
- Arizona
- Arkansas
- Colorado
- Illinois
- Indiana
- Kansas
- Maine
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Montana
- Nevada
- New Mexico
- North Carolina
- North Dakota
- Ohio
- Oklahoma

- Michigan
- Minnesota
- Mississippi
- Montana
- Nevada
- New Mexico
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Oregon
- Rhode Island
- South Carolina
- Texas
- Utah

Update Defaults

PMP Continued

- ▶ Notice Washington not on there, but you can register separately with their PMP and have access.
<http://www.wapmp.org/practitioner/pharmacist/>
- ▶ Wyoming and Washington coming by end of year.
- ▶ PMP is being integrated into many EMR's at clinics and hospitals with no lead to log in.
 - ▶ Gateway
 - ▶ Narcs Care
 - ▶ Grant for the first year-license and implementation.

Unsolicited reports to providers from Idaho PMP

- ▶ Generated and sent via email to providers and pharmacists involved when patient has received controlled substances from 5 or more providers in a given month.

CDC Guidelines

- ▶ When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs (recommendation category: B, evidence type: 4).

Urine tox screens

- ▶ Do “real time” urine tox screens. Try to make them somewhat random and unpredictable to patient.
- ▶ Can do them when patients come in to pick up Rx. Or you can ask them to come in within 24-48 hours (better) and include a pill count.

SPECIFIC WINDOWS OF DRUG DETECTION *(continued)*

Drug	How soon after taking drug will there be a positive drug test?	How long after taking drug will there continue to be a positive drug test?
Marijuana/Pot	1-3 hours	1-7 days
Crack (Cocaine)	2-6 hours	2-3 days
Heroin (Opiates)	2-6 hours	1-3 days
Speed/Uppers (Amphetamine, methamphetamine)	4-6 hours	2-3 days
Angel Dust/PCP	4-6 hours	7-14 days
Ecstasy	2-7 hours	2-4 days
Benzodiazepine	2-7 hours	1-4 days
Barbiturates	2-4 hours	1-3 weeks
Methadone	3-8 hours	1-3 days
Tricyclic Antidepressants	8-12 hours	2-7 days
Oxycodone	1-3 hours	1-2 days

URINE SPECIMEN INTEGRITY

SPECIMEN COLOR RELATED TO CONCENTRATION

Concentrated samples more reliable than dilute samples

TEMP WITHIN 4 MINUTES OF VOIDING IS 90-100°F

PH FLUCTUATES WITHIN RANGE OF 4.5-8.0

CREATININE VARIES WITH HYDRATION

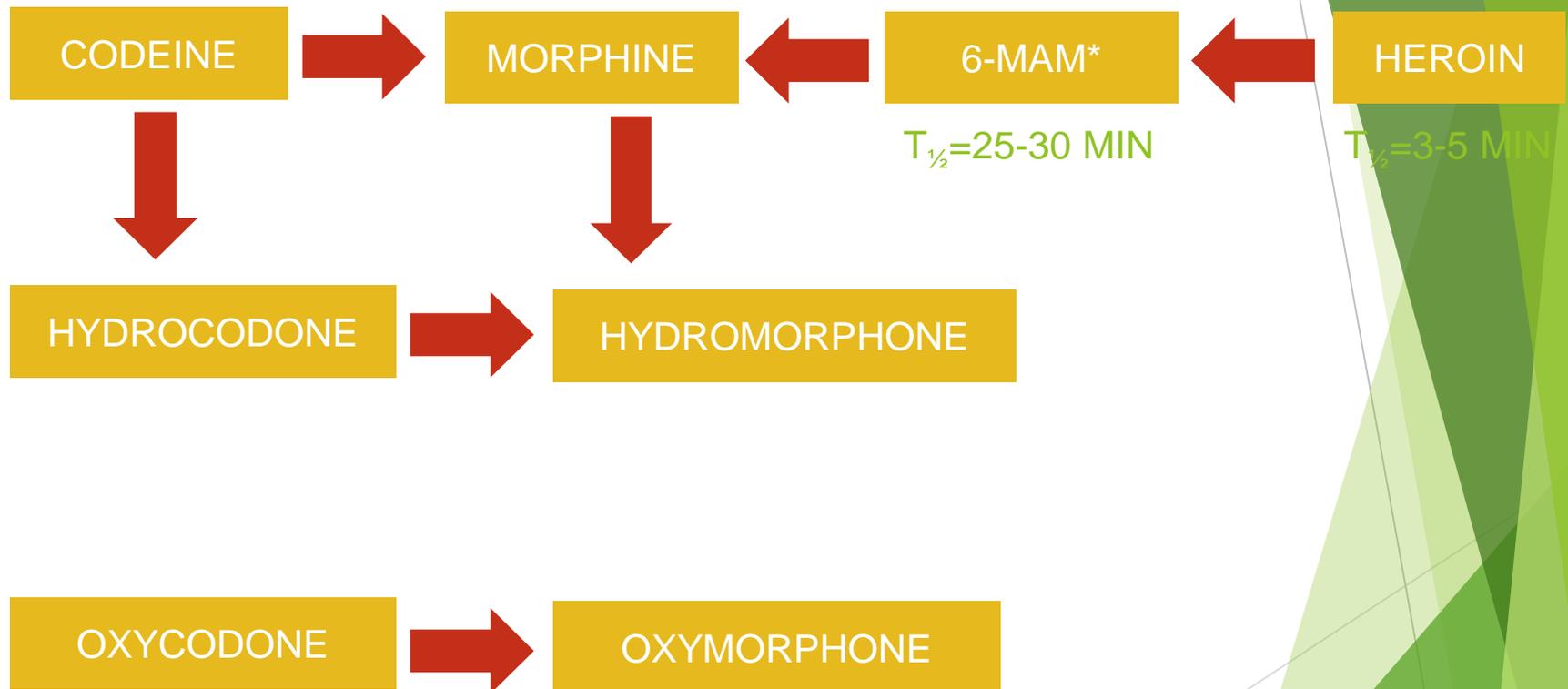
Normal urine:
>20 mg/dL

Dilute: creatinine
<20 mg/dL and specific
gravity <1.003

Creatinine <2 mg/dL not
consistent with
human urine



EXAMPLES OF METABOLISM OF OPIOIDS



*6-MAM=6-MONOACETYLMORPHINE

Quotes

- ▶ “Clinicians should not dismiss patients from care based on a urine drug test result because this could constitute patient abandonment and could have adverse consequences for patient safety, potentially including the patient obtaining opioids from alternative sources and the clinician missing opportunities to facilitate treatment for substance use disorder.”

CDC Guidelines

- ▶ Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible (recommendation category: A, evidence type: 3)
- ▶ Taking benzos with opiates nearly quadruples your risk of death.

Quotes

- ▶ “Experts agreed that although there are circumstances when it might be appropriate to prescribe opioids to a patient receiving benzodiazepines (e.g., severe acute pain in a patient taking long-term, stable low-dose benzodiazepine therapy), clinicians should avoid prescribing opioids and benzodiazepines concurrently whenever possible.”
- ▶ “Because of greater risks of benzodiazepine withdrawal relative to opioid withdrawal, and because tapering opioids can be associated with anxiety, when patients receiving both benzodiazepines and opioids require tapering to reduce risk for fatal respiratory depression, it might be safer and more practical to taper opioids first”
- ▶ “A commonly used tapering schedule that has been used safely and with moderate success is a reduction of the benzodiazepine dose by 25% every 1-2 weeks (213,214). CBT increases tapering success rates and might be particularly helpful for patients struggling with a benzodiazepine taper”

- ▶ Need to carefully look at risks verses benefits of other CNS depressants (etoh, muscle relaxants, hypnotics, Phenergan, Visteril, ect.) and try to avoid with opiates.

CDC Guidelines

- ▶ Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder (recommendation category: A, evidence type: 2).

Opioid Use Disorder. Need at least two of the following

- 1. Opioids are often taken in larger amounts or over a longer period than was intended.
- 2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- 3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- 4. Craving, or a strong desire or urge to use opioids.
- 5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
- 6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- 7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
- 8. Recurrent opioid use in situations in which it is physically hazardous.
- 9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- 10. Tolerance, as defined by either of the following: a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect. b. A markedly diminished effect with continued use of the same amount of an opioid. Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.
- 11. Withdrawal, as manifested by either of the following:
 - a. The characteristic opioid withdrawal syndrome (refer to Criteria A and B of the criteria set for opioid withdrawal).
 - b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

Medication Options

- ▶ Methadone: we can't use methadone for opiate addiction maintenance outside of an approved addiction treatment clinic
- ▶ Naltrexone: IM Naltrexone but very expensive. PO Naltrexone doesn't really work for OUD.
- ▶ Buprenorphine or Suboxone

Idaho Care Line

- ▶ Dial 211 to get help finding resources.



**Idaho Board of Medicine Policy for the Use of Opioid
Analgesics in the Treatment of Chronic Pain**

[https://bom.idaho.gov/BOMPortal/BOM/PDF FORMS/oa_guide.pdf](https://bom.idaho.gov/BOMPortal/BOM/PDF%20FORMS/oa_guide.pdf)

Tips

- Use alternative meds/treatments for pain whenever possible.
- Be stingy with opiates-even for acute pain (3 days or less).
- In general opioid prescribing, keep less than 50 MME (and often lower) and don't go over 90.
- In general don't give opiates for chronic pain on the first visit (I have made exceptions if I have good records and have talked to the prior provider). Check picture ID. Do point of care urine tox screens before prescribing.
- Look closely at risk factors. Do good H and P, do labs (eg. do you have renal or hepatic failure). Urine tox, Cbc, cmp, Pregnancy test. Syphilis?, HIV, hepatitis serologies.
- Co-prescribe Naloxone and do teaching.
- Also at first visit, pmp, functional assessment (PEG), psych assessment PHQ9, GAD 7 for anxiety, PTSD screen, Opiate Risk tool. Refer to behavioral health if results abnormal.
- Consider a criminal background check:
<https://www.idcourts.us/repository/start.do>
- Work up their pain syndrome. Refer to PT/OT specialist as needed. Don't ever put in chart chronic pain as diagnosis. Be specific.

Tips Continued

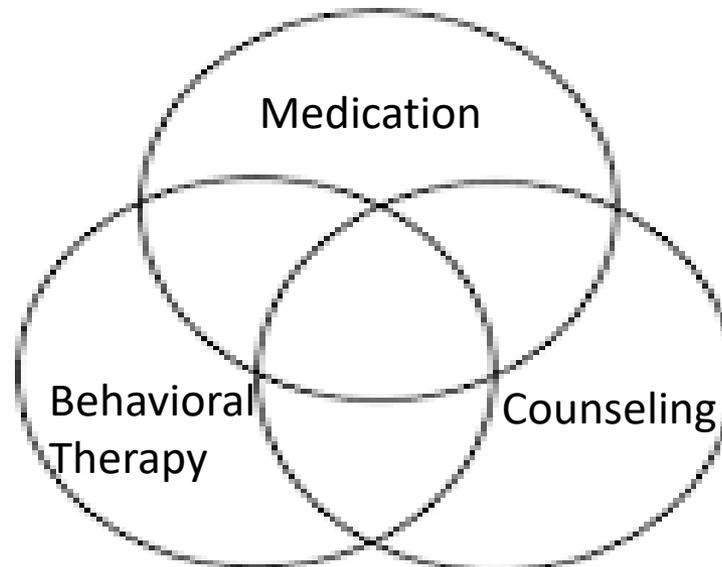
- ▶ Don't start with long acting opiates and be very selective regarding who you put on these, and wait at least a week after starting short acting opiates. Don't rely too much on conversion tables, and adjust new opiate downward.
- ▶ Use controlled substance contract and integrate education into it, like not taking opiates together with benzos or other CNS depressants. Safe storage. This can also function as informed consent about the risks of opiates.
- ▶ Frequent visits and monitoring, FUNCTION IS KEY. Opiates only given on trial basis. Need to see improvement. Consider using PEG.
- ▶ Use nurse case managers to help you manage these patients.
- ▶ Establish a registry. Calculate MME on every patient.
- ▶ Do random pill counts. Patient must respond within 24 hours and come in within 48.
- ▶ Develop tier system based on ORT, early refill requests ect.
- ▶ Higher risk patients get lesser amount of pills (eg. week at a time), more frequent pill counts, tox screens, maybe giving meds to trusted family member.
- ▶ Re-sign controlled substance contracts every year. Do teach backs.
- ▶ Obtain permission to contact other providers, family/friends when appropriate, inform you will be checking the PMP.

Tips Continued

- ▶ Check PMP initially and then at least 3 months if not with every refill. (nurse case managers). Several states mandating a PMP check with every Rx.
- ▶ Do urine tox screens at least once a year and more frequent as needed. (nurse case managers).
- ▶ Consider using the COMM
- ▶ Don't use Methadone and know what you are doing with Fentanyl, and be careful especially in the elderly. Don't use either in the opiate naive patient.
- ▶ Make teaching about Naloxone part of your work flow and have patients (and hopefully friends and family) watch video before they leave your office, and prescribe it. Give URL for ODP web site.
- ▶ Integrate psychosocial treatments (e.g., contingency management, community reinforcement, psychotherapeutic counseling, and family therapy).
- ▶ Offer evidence based treatment if Opioid Use disorder exists
- ▶ Consider becoming a Suboxone provider, or expand and encourage access/use of substance use treatment (Methadone/Suboxone/Subutex).

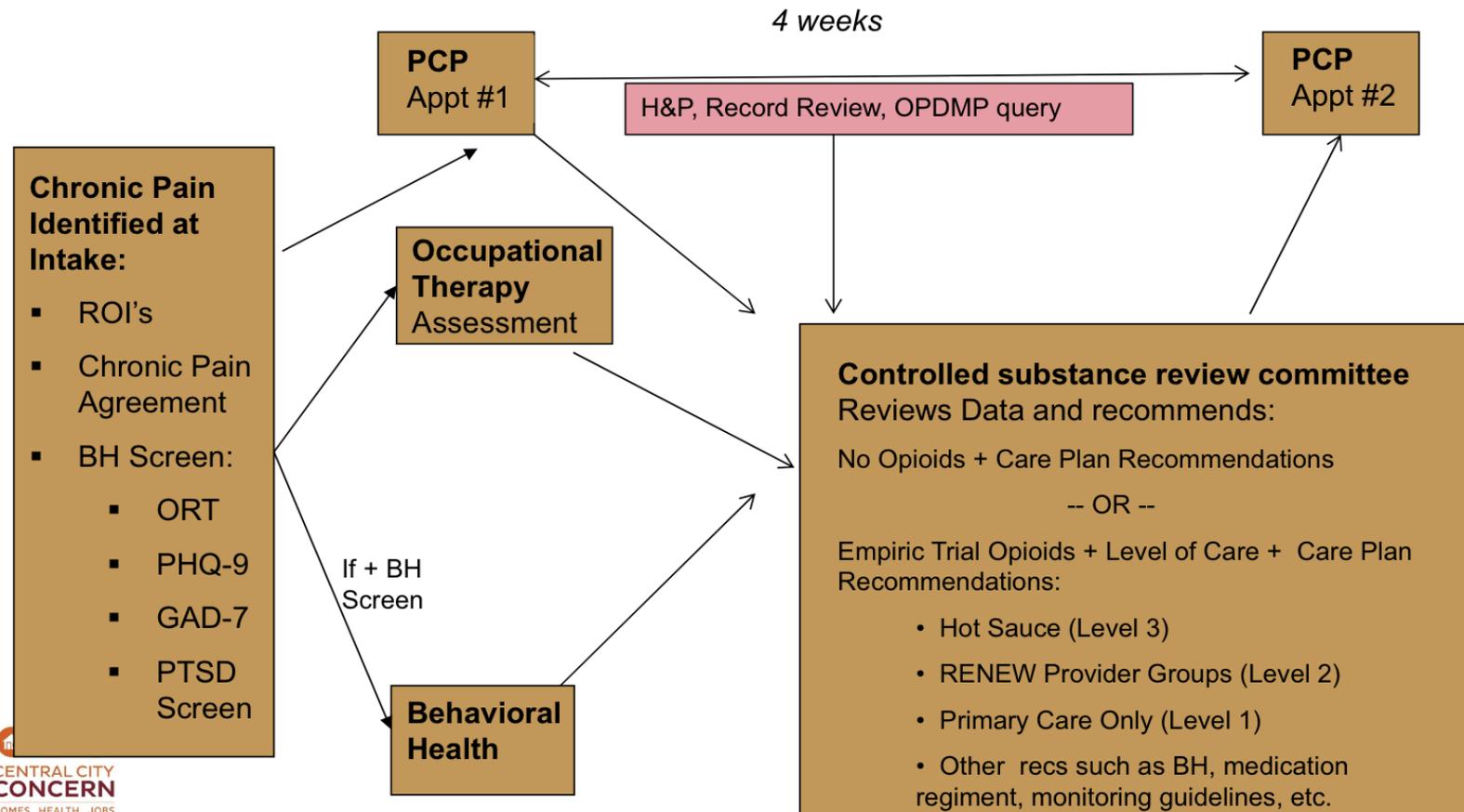
What is medication-assisted treatment (MAT)?

MAT is a combination of counseling and behavioral therapy and medication that is effective in treating opioid dependency.



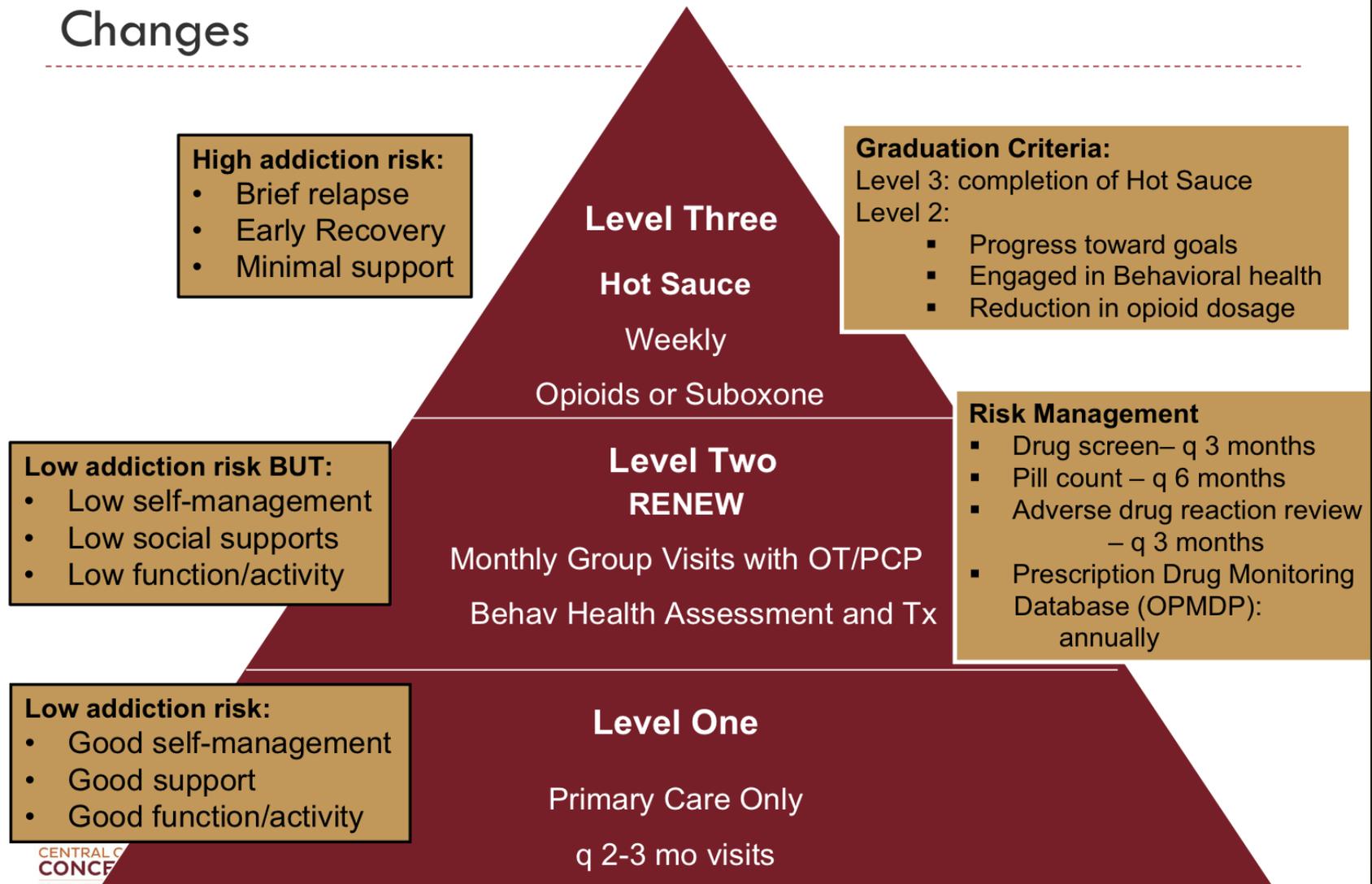
A beautiful example of MAT

Chronic Pain and Substance Use Assessment Map



Solotaraff, Rachel. Addressing the Opioid Crisis at Old Town Clinic. Clinical Guidelines and Controlled Substances Review Committee. Webinar PPT, April 1, 2015.

Step 3: Segment the Population and “Hardwire” the Changes



Solotaraff, Rachel. Addressing the Opioid Crisis at Old Town Clinic. Clinical Guidelines and Controlled Substances Review Committee. Webinar PPT, April 1, 2015.

- 
- ▶ Do a QI project in your clinic.
 - ▶ Performance measures
 - ▶ Documented screening for depression
 - ▶ Documented pain assessment
 - ▶ Opioid agreement form
 - ▶ Policy around urine drug testing
 - ▶ Documented Board of Pharmacy reviews
 - ▶ Documented goals and follow up plan

- ▶ Create a quick text/smart phrase for opioid prescribing.

Quick text example:

- Pain assessment:
- Current dose:
- Date treatment started:
- BOP:
- UDS:
- Controlled substance agreement, signed:
- Harm/benefit discussion:
- Counseling/non-pharm:
- Goals:
- Scripts given today: (include do not fill dates and date rx will be out)
- Follow up plan:

Contact Information

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- ▶ todd.palmer@fmridaho.org
- ▶ Phone: 208-514-2500