Proactive Strategies to Reduce Risk for Adults Prescribed Opioids

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Disclosures

- ✓ The presenters have no conflicts of interest related to this session.

Workshop Roadmap

- We will present a standardized patient case today of an adult requesting opioids for chronic pain.
- We will work together as an interprofessional team to develop a treatment plan.
- We will highlight best practice recommendations for substance use.
- **We hope you will share your own lessons learned and expertise!**

Learning Objectives

	By the end of this session, participants should be able to:
1	Evaluate risk of substance misuse and substance use disorder (SUD) for an adult prescribed opioids for chronic pain.
2	Design a plan of care using current, evidence-based treatment principles and guidelines for SUD.
3	Distinguish between medication options for pain with concurrent substance use.

Words Matter – Terms to Use and Avoid

- "Recommended that 'substance use' be used to describe all substances, including alcohol and other drugs, and that clinicians refer to severity specifiers (e.g., mild, moderate, severe) to indicate the severity of the SUD." (NIH/NIDA)
- *"Addiction"* is not used in the DSM-5, but it is used by other organizations, including the National Institute on Drug Abuse. (NIH/NIDA)
- Diagnostic criteria for SUD in the DSM-5 include three criteria-based subclassifications for all SUDs:
  - ✓ Mild (presence of 2-3 symptoms)
  - ✓ Moderate (presence of 4-5 symptoms)
  - ✓ Severe (presence of 6 or more symptoms)

What is the actual risk of opioid use disorder when prescribed opioids for pain?

About 60-80% of adults with OUD have comorbid chronic pain.

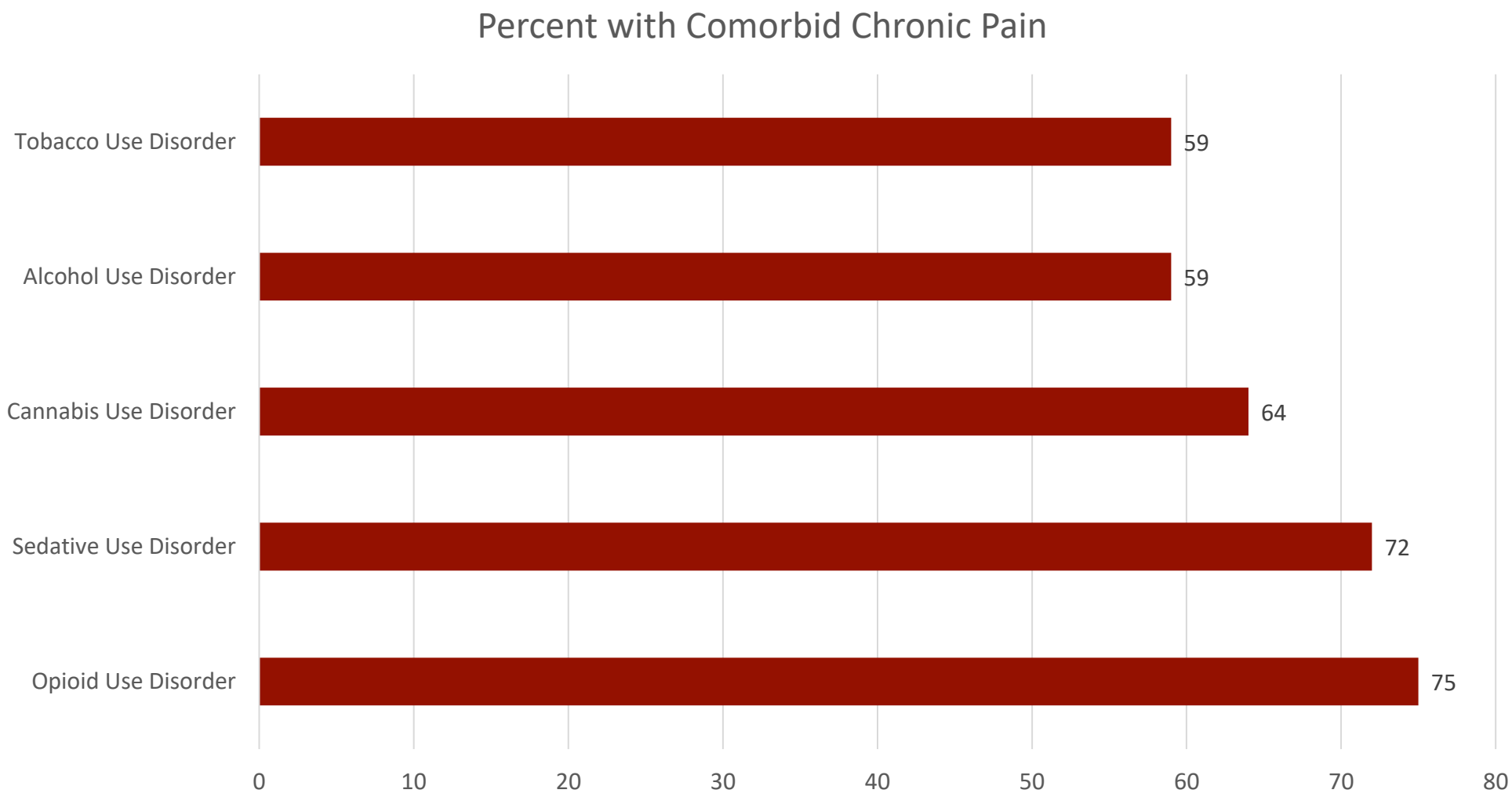
Rates of OUD in adults taking opioids for chronic pain is estimated at 8%-12%.

Some studies find as many as 26% of people with chronic pain exhibit misuse patterns that can be a precursor to SUD.

People with Pain Often Use Substances

- Substance use and Substance Use Disorder are not synonymous.
- Sedatives
  - ✓ Adults with back pain are at highest risk of sedative misuse.
  - ✓ Opioid and sedative co-use is common and results in higher risk of overdose.
- Cannabis: 31% of people with chronic pain use cannabis to manage pain
  - ✓ Adults with pain are at increased risk for Cannabis Use Disorder.
- Alcohol: 28% of people with chronic pain report using alcohol to alleviate suffering

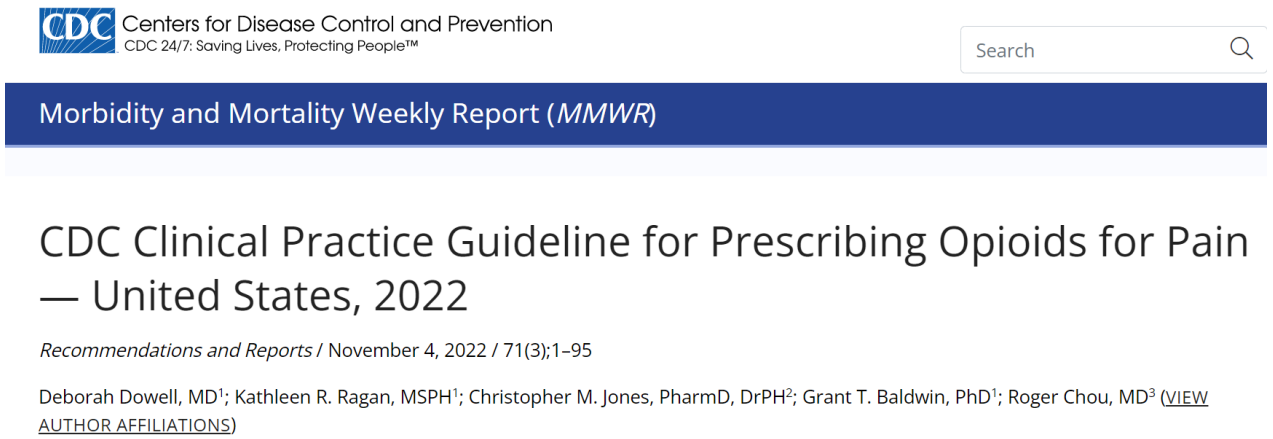
Co-occurring SUDs and chronic pain



CDC guidelines

Four main areas are addressed for clinicians prescribing opioids in outpatient settings for chronic pain or upon discharge from hospitals, EDs, other facilities:

1. Determining whether or not to initiate opioids for pain
2. Selecting opioids and determining opioid dosages
3. Deciding duration of initial opioid prescription and conducting follow-up
4. **Assessing risk** and addressing potential harms of opioid use



Highlights from CDC 2022 Updates to the 2016 Opioid Prescribing Guidelines

- Improve the safety and effectiveness of pain treatment.
  - Pain needs to be **appropriately assessed and treated** whether or not opioids are part of treatment.
  - Maximize use of **nonopioid therapies** [e.g., anti-inflammatory medicine, exercise].
  - **Reduce the risks** associated with opioid pain therapy (including opioid use disorder, overdose, and death).
- Recommendations are **voluntary -** intend to support **individualized, person-centered care. Flexibility** to meet the care needs of a specific patient is paramount.
- A **multimodal and multidisciplinary** approach to pain management is critical.
- **Attend to health inequities**; provide culturally and linguistically appropriate communication [e.g., accessible to persons with disabilities].
- **Ensure access** to an appropriate, affordable, diversified, coordinated, and effective nonpharmacologic and pharmacologic pain management regimen for **all persons.**
- The recommendations **exclude** pain management related to sickle cell disease, cancer-related pain treatment, palliative care, and end-of-life care.

** indicates CDC updates throughout the presentation*

How to Identify and Talk to Patients About Substance Use?

SBIRT

"A public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing these disorders."

You may start with a simple question: *Have you ever used …?*

Screening, Brief Intervention, Referral to Treatment (SBIRT)

Brief screen

- Given at least once a year
- Two questions: Unhealthy alcohol use or unhealthy drug use
- If answer “1 or more,” considered a positive screen
- Identifies who needs full screen

Alcohol: One drink =

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

	None	1 or more
How many times in the past year have you had 5 or more drinks in a day?	O	O

Drugs: Includes methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a drug or used a prescription medication for nonmedical reasons?	O	O

Screening, Brief Intervention, Referral to Treatment (SBIRT)

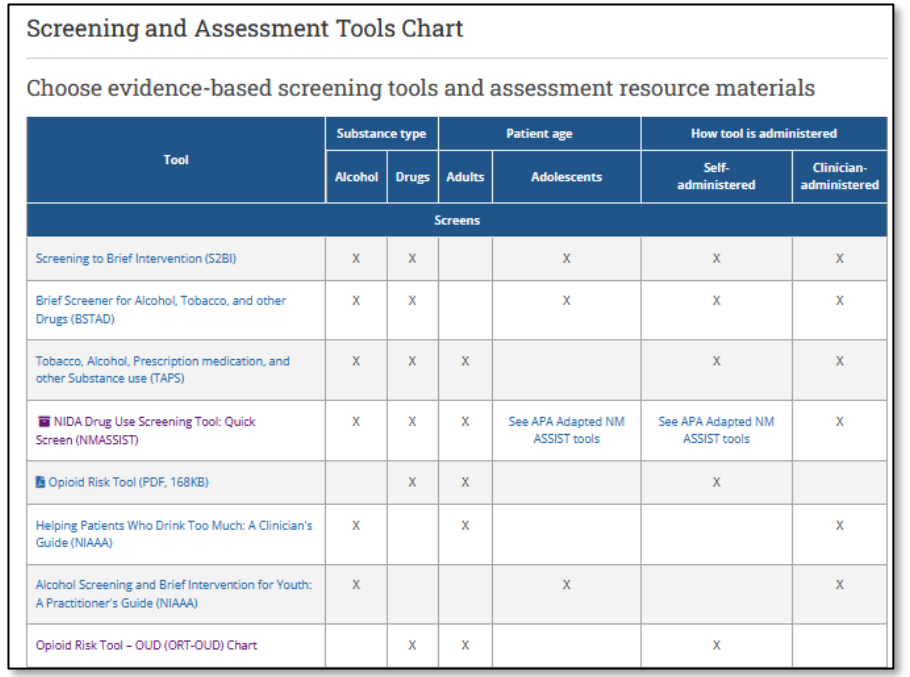
Brief screen

- Given at least once a year
- Two questions: Unhealthy alcohol use or unhealthy drug use
- If answer “1 or more,” considered a positive screen
- Identifies who needs full screen

Full screen

- Given to patients who answer positive on brief screen.
- Use of validated screening tool for either alcohol or substance use
  - Alcohol Use Disorders Identification Test (AUDIT)
  - Drug Abuse Screening Test (DAST)

Full list available at NIDA Screening and Assessment Tool Chart



Screening and Assessment Tools Chart

Choose evidence-based screening tools and assessment resource materials

Tool	Substance type		Patient age		How tool is administered	
	Alcohol	Drugs	Adults	Adolescents	Self-administered	Clinician-administered
Screens						
Screening to Brief Intervention (S2BI)	X	X		X	X	X
Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD)	X	X		X	X	X
Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)	X	X	X		X	X
NIDA Drug Use Screening Tool: Quick Screen (NMASSIST)	X	X	X	See APA Adapted NM ASSIST tools	See APA Adapted NM ASSIST tools	X
Opioid Risk Tool (PDF, 168KB)		X	X		X	
Helping Patients Who Drink Too Much: A Clinician's Guide (NIAAA)	X		X			X
Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide (NIAAA)	X			X		X
Opioid Risk Tool – OUD (ORT-OUD) Chart		X	X		X	

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Response

- Full screens scored during visit
- Brief intervention using motivational interviewing
- Referrals to specialized treatment if indicated

Brief Intervention

Raise the Subject

Ask permission.

- "Is it ok if we talk about substance use today?"

Use motivational interviewing.

Share Information

Discuss the screening tool results.

Explore connections between use and health concerns.

- "Do you think your use is connected to your …"

Elicit reaction "What are your thoughts..."

Enhance Motivation

Summarize and share concerns.

Pros and cons.

Elicit goals.

Gauge readiness and confidence.

Create Plan

"What does reaching this goal look like?"

Referral/follow-up.

Facilitating smooth, bidirectional transitions between primary care and specialty addiction treatment (aka “warm hand offs”).

Thank you

Offer thanks.

- "Thank you for taking the time to discuss this with me."

Invite them back.

- "Can we schedule an appointment to check in and see how your plan is progressing?"

SBIRT is a way to promote screening for risky use of substances and begin conversations about substance use.

Gathering information about substance use is an important part of a comprehensive pain assessment.

Once a diagnosis of a SUD is confirmed, one choice of therapy is Medication for Addiction Treatment (MAT).

The choice of therapy must be individualized and consider the patient's willingness and readiness to engage in therapy.

Let's Get Started with our Standardized Patient Case

Meet Sam Jones

Sam is returning today for an early follow-up telehealth appointment to assess response to recommendations made during a previous visit with an interprofessional team led by PCP Dr. Manriquez.

Key Points

1 Sam was seen 3.5 months ago after a motor vehicle accident by a clinic prescriber who no longer works at the clinic.

2 The team had its first meeting with Sam 3 weeks ago.

Dx: Chronic low back pain (nonradicular). During this visit, Sam agreed to:

- Try physical therapy
- Reduce the amount of opioids he is taking
- Taper and discontinue carisoprodol

3 Sam rescheduled his appointment one week early and is requesting an early refill of hydrocodone today.

Sam's telehealth visit

- **Watch** a video of a Dr. Manriquez interviewing Sam using SBIRT technique in his follow-up visit.
  - Note what provider does well and what you might do differently
  - Consider what information is important for today's actions
  - Construct a problem list and treatment priorities
  - What other information is needed?
- **Active planning:** Using current guidelines for substance use**,** we will draft a Holistic Interprofessional Treatment Plan to recommend next steps for Sam.

If you have poor internet speed, you may prefer to watch the video using the direct link in the Chat: https://vimeo.com/823836091/6f6573ee23?share=copy

Summary of Important Points

- Sam has been taking opioids for ~4 months. Unsuccessful in reducing use of opioids for pain.
- Sam has increased use of alcohol.
- Sam shows increasing risk in use of substances with no improvement in pain management.
- Sam has increased psychosocial concerns (hopelessness, spouse concerns).
- Sam states he is **willing** and **ready** to engage in therapy.
- Sam's goals are to manage pain long-term without relying on substances.

What would be your priority today for Sam's care?

What other information do you need?

Problem list – Safety concerns

- Combining acetaminophen and opioids with alcohol can cause harm to liver and kidneys.
- Daily use opioids and alcohol – physical dependence, tolerance, withdrawal and overdose risks.
- Inability to reduce opioid use.
- Early refill request.

Problem list – Chronic, unresolved pain

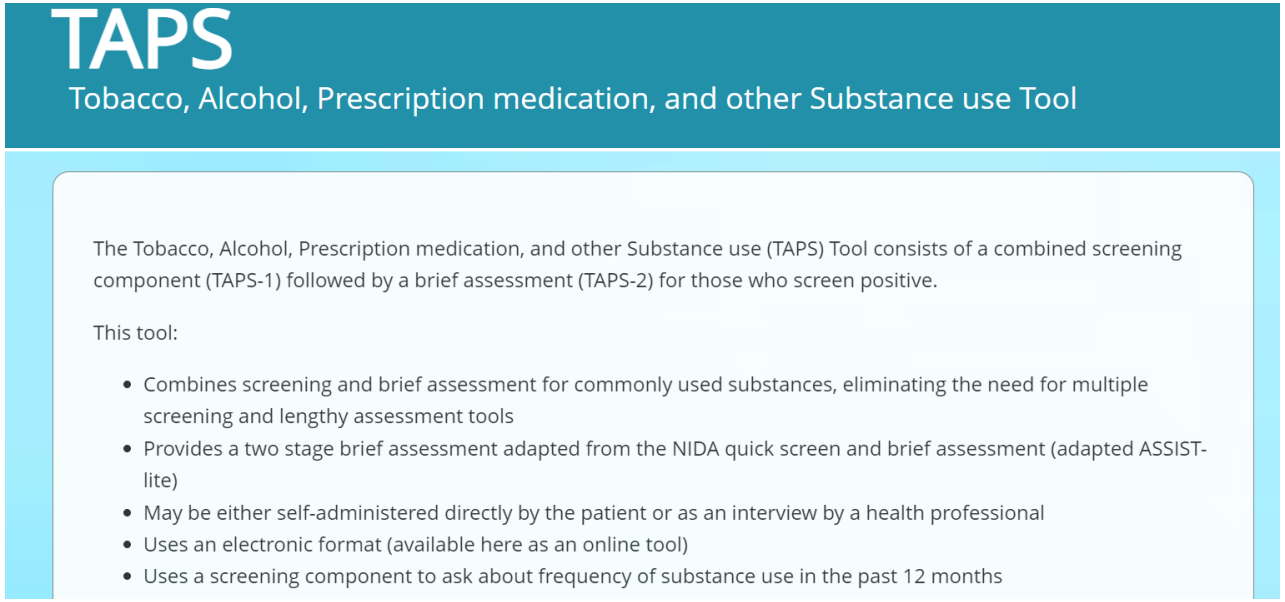
- After 3.5 months, Sam has ***chronic pain*** with no improvement on daily opioids and unable to reduce dose.
  - Current treatment inadequate/ineffective.
  - Poor response to singular non-opioid option of physical therapy.

Problem list – Depression

Sam reports depressed mood, hopelessness, reduced physical activity and strained relationship with spouse.

- People using opioids are more likely to develop depression.
- People with depression are more likely to *misuse* opioids.
- People with chronic pain using opioids are at high risk for suicide and self-harm.

Best practices: What screening/assessment tools are pertinent?



Screening tools should be used as diagnostic aids only in conjunction with complete patient information and appropriate clinical judgement.

Examples include:

- Opioid Risk Tool – OUD (ORT-OUD)
- Alcohol Use Disorders Identification Test (AUDIT)
- Pain, Enjoyment, General Activity (PEG) Scale
- Depression: Patient Health Questionnaire (PHQ-9)

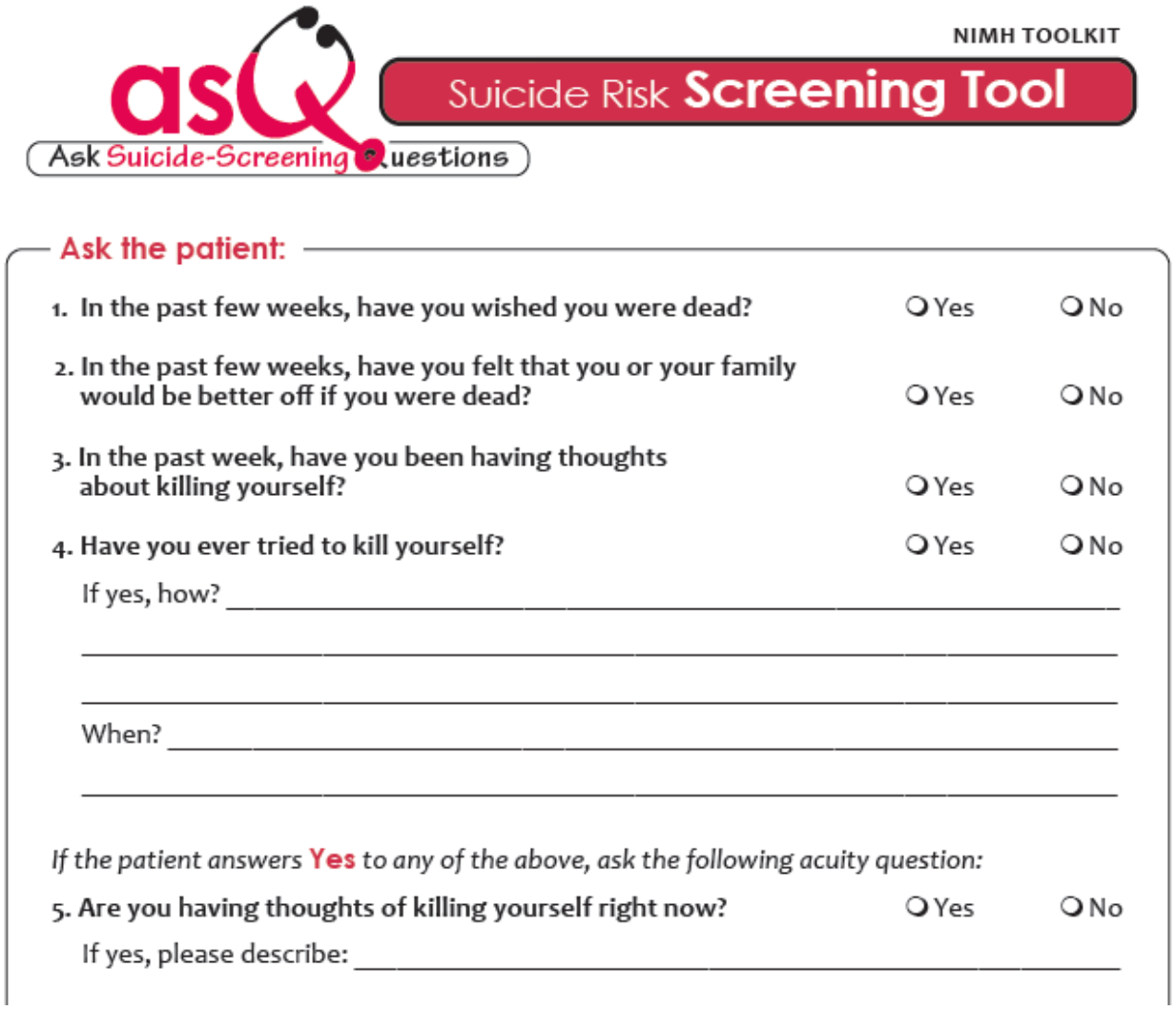
Are there barriers to your use of screening tools for pain/substance use disorders?

ASQ

Suicide:

Ask Suicide-Screening Question

- Emotional support is critical.
- May need to screen for suicide one of the many screening tools:
  - Ask Suicide Screening Questions toolkit
  - More detailed assessment: Columbia Suicide Severity Rating Scale



asQ Ask Suicide-Screening Questions

NIMH TOOLKIT

Suicide Risk Screening Tool

Ask the patient:

1. In the past few weeks, have you wished you were dead? ❍ Yes ❍ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ❍ Yes ❍ No
3. In the past week, have you been having thoughts about killing yourself? ❍ Yes ❍ No
4. Have you ever tried to kill yourself? ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. Are you having thoughts of killing yourself right now? ❍ Yes ❍ No

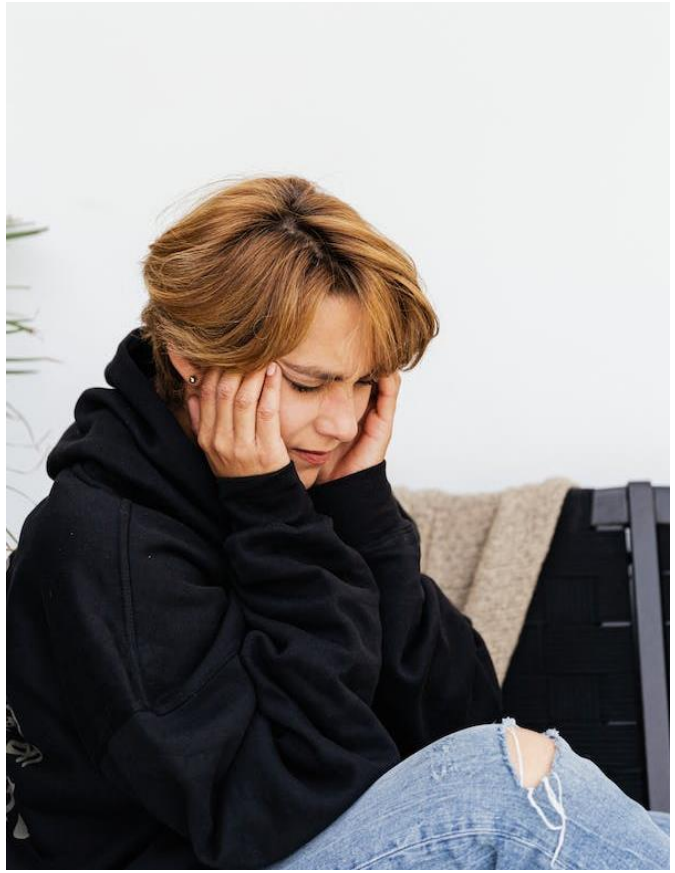
   If yes, please describe: _____

Review Prescription Monitoring Program (PMP) Information

Best practice: check PMP w/each prescription.
Calculate Morphine Equivalent Dose (MED)

- Each state's PMP centrally tracks prescription drug dispensing of controlled substances.
- WA state opioid prescribing guidelines recommend checking the PMP prior to new prescriptions and refills (depending on profession).
- **Consider who is responsible for checking and documenting the PMP in your clinic. Are there barriers to consistent practice? Can delegate.**

Review Prescription Monitoring Program (PMP) Information



- **Avoid bias in interpreting PMP and urine drug screening.***
- Diagnosis, payment method [cash], age have been linked to bias in provider use of PMP information.
- Checking PMP w/each prescription can reduce bias.


Share your treatment plan ideas

Treatment plan priorities – Safety concerns

- Overdose risk: WA state requires that patients on >120 MEDs:
  - **Confirm or prescribe naloxone to high-risk patients. Determine availability.**
  - Provide naloxone training to the patient and spouse.
- Acetaminophen – patient education.
  - Educate on risks of excessive dose and combining alcohol and opioids.
- Screen for substance use, combine with motivational interviewing techniques
- Consider consult/referral to an addiction specialist to assess potential and risk for OUD/AUD.

Treatment plan options – Chronic, unresolved pain

- Complete physical exam
- **Shared decision-making** with Sam to develop realistic goals for pain and function.*
  - Review risks [OUD, OD] and benefits of using opioids for chronic pain.*
- Consider consultation/referral to a pain specialist or pain self-management program:
  - Specialist Needed *if continuing* **> 120 mg/day MED** (WA State Prescribing Requirements).
  - Primary care clinicians can become or be recognized as a "pain management specialist”
  - See specific licensing board requirements: https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/opioid-prescribing/healthcare-providers/toolkits

Treatment plan options – Chronic, unresolved pain

- Consider risks and benefits of **individualized**, patient-centered opioid tapering plan*
  - If receiving opioids for 1 to 3 months (the timeframe for subacute pain), **avoid continuing** opioid treatment without carefully reassessing treatment goals, benefits, and risks.*
  - 10% per month or slower is better tolerated* – see CDC and VA guidelines
  - "Patients should receive safe and effective pain treatment options"*

Opioids should not be tapered rapidly or discontinued suddenly given risk of significant opioid withdrawal, exacerbated pain, psychological distress, violence and suicide risk. Avoid patient abandonment.*

Treatment plan options – Non-opioid therapies

Discuss therapies and align with Sam's preferences + CDC guidelines for non-opioid tx:

- Movement therapies: Exercise, physical therapy, yoga, tai chi, aquatic therapy
- Non-opioid medications: NSAIDs [short term], antidepressants, topical ointments/gels
- Cognitive behavioral therapy, pain reprocessing, or mindfulness meditation to address pain-related fear/anxiety, improve pain coping skills; assess for **trauma – *red flags? ACEs?***
- Hypnotherapy/relaxation techniques
- Acupuncture, massage, TENS unit [transcutaneous electrical nerve stimulation]

Re-evaluation recommended every 1 to 4 weeks after changes; every 3 months if stable

Treatment plan options – Depression

Overlap with pain control → double benefit of treatment

- Consider referral for Counseling and/or Cognitive behavioral therapy (CBT).
  - Encourage exercise and other complementary approaches (previous slide).
- Consider initiation of anti-depressant medication therapy.
- Because of increased risk and access to opioids → Discuss and reassess patient safety and support frequently.

Does Sam show evidence of Substance Use Disorders (SUDs)?

- **If clinicians suspect SUD, discuss concerns directly in a nonjudgmental manner.***
- Use DSM-5 criteria for diagnoses.
  - Patients must have 2 of the 11 listed criteria within a 12-month period.
  - SUDs may be mild (2-3), moderate (4-5), or severe (6 or more).
- SUDs cannot be diagnosed by a screening tool.

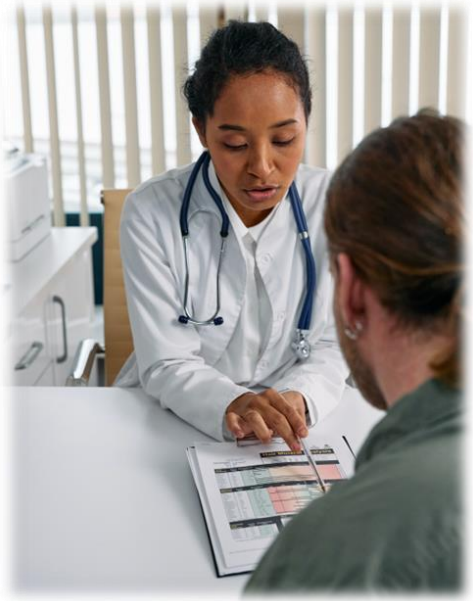
"Occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home."

Examples of specific SUDs:
Opioid use disorder (OUD)
Alcohol use disorder (AUD)
Tobacco use disorder
Cannabis use disorder

Source:
1. Mental Health and Substance Use Disorders. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/find-help/disorders.

Opioid use disorder (OUD)

"A problematic pattern of opioid use that leads to serious impairment or distress."



To confirm a diagnosis of OUD, at least two of the following should be observed within a 12-month period:

- ❑ Opioids are often taken in larger amounts or over a longer period than was intended.
- ❑ There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- ❑ A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- ❑ Craving, or a strong desire or urge to use opioids.
- ❑ Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
- ❑ Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- ❑ Important social, occupational, or recreational activities are given up or reduced because of opioid use.
- ❑ Recurrent opioid use in situations in which it is physically hazardous.
- ❑ 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.
- ❑ Exhibits tolerance
- ❑ Exhibits withdrawal

Source:
1. https://pcssnow.org/resource/opioid-use-disorder-opioid-addiction/
2. UpToDate. DSM-5 diagnostic criteria for opioid use disorder. Opioid use disorder: Epidemiology, pharmacology, clinical manifestations, course, screening, assessment, and diagnosis.

Opioid tolerance and withdrawal are expected with regular use

- DSM-5 diagnostic criteria for OUD define tolerance and withdrawal.
- Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
  - A markedly diminished effect with continued use of the same amount of an opioid.
- Withdrawal, as manifested by either of the following:
  - The characteristic withdrawal syndrome for opioids.
  - Opioids (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

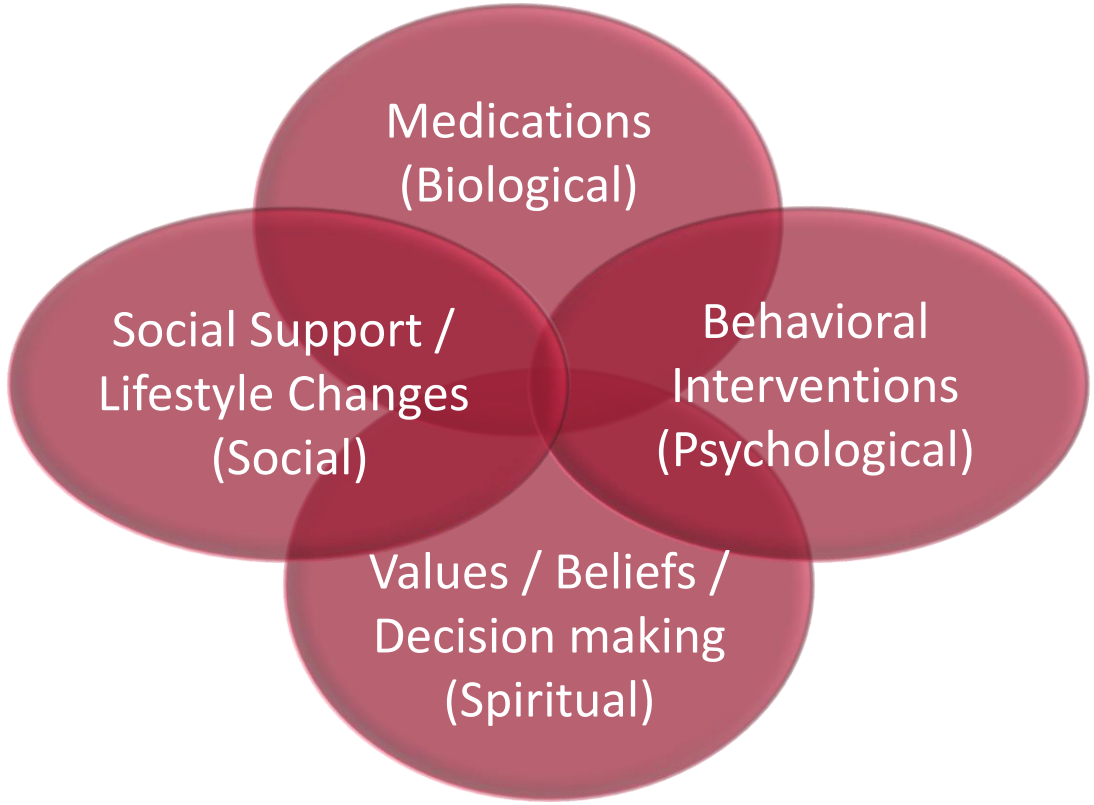
- Note from DSM-5: ***These criterion do not apply for those individuals taking opioids solely under appropriate medical supervision***.

Source:
1. UpToDate. Clinical Opioid Withdrawal Scale (COWS). Medically supervised opioid withdrawal during treatment for addiction.

Consider Medication for Addiction Treatment (MAT)

- MAT combines FDA-approved medications with counseling and behavioral therapies to provide a "whole-patient" approach to the treatment of SUDs.[1]
- MAT includes medications for alcohol use disorder (AUD), opioid use disorder (OUD), and tobacco use disorder.
- Currently, 1.27 million Americans are receiving MAT.[2]

Medications may be used as a tool within a comprehensive treatment plan following a biopsychosocial-spiritual model.



Sources:
1. Substance Abuse and Mental Health Services Administration (SAMHSA). Medication and counseling treatment.
2. https://www.hhs.gov/opioids/about-the-epidemic/opioid-crisis-statistics/index.html

Benefits of Medication for Addiction Treatment (MAT)

- Stabilizes brain chemistry
- Reduces cravings and reduces substance use recurrence
- Blocks reinforcing effects of substances, e.g., 'euphoria'
- Promotes engagement and retention in recovery-oriented activities, employment
- Reduces morbidity (e.g., HIV/Hep C) and mortality
- Improves mental health
- Strengthen person's social and spiritual protective factors

Barriers to Medication for Addiction Treatment (MAT)

- Intervention stigma – beliefs about abstinence
- Inadequate/inconsistent health plan coverage
  - Medicaid coverage varies by state
- Access to qualified providers
  - Medication availability varies by clinic & providers
  - Methadone is only available at designated Opioid Treatment Programs
  - Buprenorphine can be prescribed for OUD in other settings by prescribers with DEA registration [state specific]

Statistics

- 10-20% of patients in primary care/hospitals have a diagnosable AUD (nearly 6% of adult population).
- Fewer than 10% of patients with AUD receive MAT; 13% with OUD receive MAT.

Source:
1. https://www.ajmc.com/view/an-overview-of-medication-assisted-treatment-for-opioid-and-alcohol-use-disorders
2. https://www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines
3. https://www.samhsa.gov/medication-assisted-treatment/removal-data-waiver-requirement.
4. https://www.sciencedirect.com/science/article/pii/S0955395922002031?via%3Dihub

Guiding Principles of SUD Treatment

Providers must:

- Develop a comprehensive treatment plan with **shared decision-making**
- Arrange for evidence-based SUD treatment to assess need for MAT*
- Assess need for medically supervised withdrawal (detoxification)
- Encourage psychosocial treatment
  - Behavioral health/cognitive behavioral therapy, individual/family counseling, support group, 12-step program
- Monitor patient progress
- Ensure the patient fully understands the information conveyed

Shared decision-making (SDM) is a collaborative process that allows individuals to make informed choices about their treatment in partnership with their providers, taking into account the best scientific evidence available, as well as the individual's values, preferences, and lifestyle.

Assess Sam for signs of opioid withdrawal

- Occurs when a patient with physiological dependence abruptly reduces or stops opioid use.
- Opioid withdrawal can be severe.
  - Monitored with Clinical Opiate Withdrawal Scale (COWS).
  - Medically supervised opioid withdrawal completed to help transition patients to MAT.
- Time course of withdrawal dependent on how long opioid stays in the body (i.e., half-life).
  - Fentanyl: Onset 3-5 hours, peak 8-12 hours, nearly complete in 4-5 days
  - Methadone: Onset 24-72 hours, peak 4-6 days, nearly complete in 14-21 days
- Some OUD medications may precipitate withdrawal. Timing of initiation important to consider.

Symptoms of opioid withdrawal:
GI distress (cramps, diarrhea, N/V)
Tachycardia
Sweating
Tremor
Restlessness
Yawning
Dilated pupils
Anxiety, irritability
Runny nose, tearing
Bone and joint aches
Goosebumps
Drug craving

Source:
1. UpToDate. Clinical Opioid Withdrawal Scale (COWS). Medically supervised opioid withdrawal during treatment for addiction.
2. UpToDate. Opioid withdrawal in adults: Clinical manifestations, course, assessment, and diagnosis.
3. Opioid Use and Opioid Use Disorder in Pregnancy. ACOG.

Assess Sam for alcohol tolerance and withdrawal

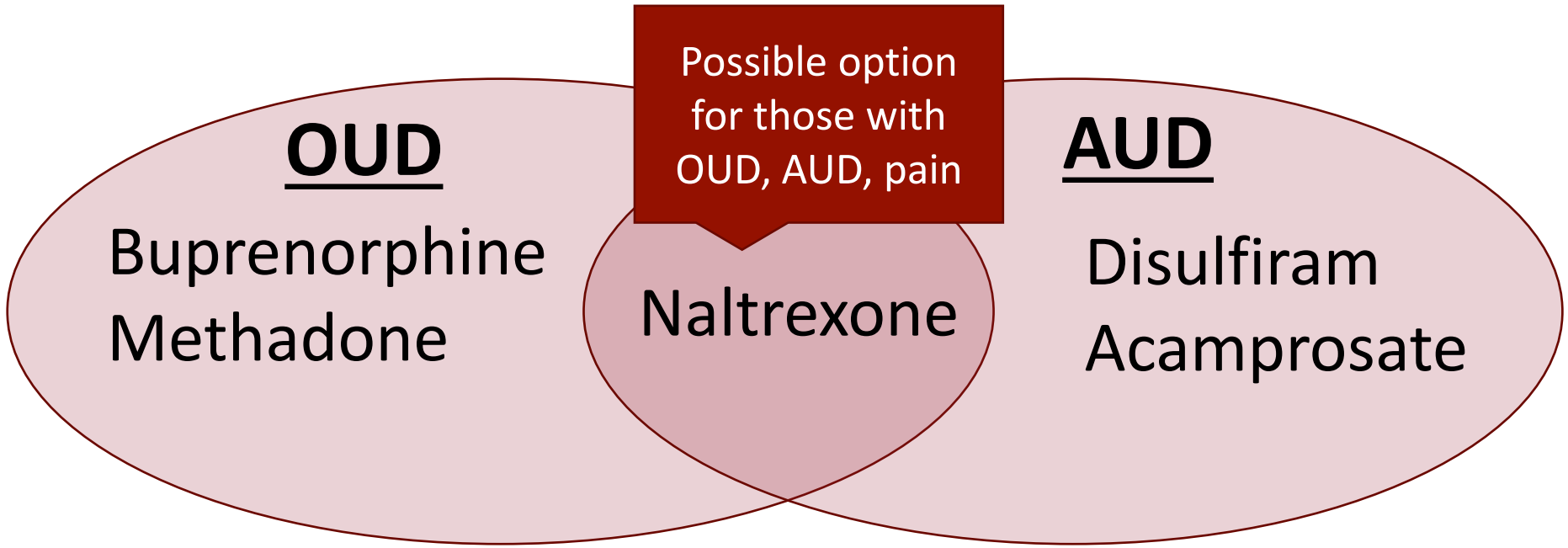
- Alcohol withdrawal syndrome can be **severe and potentially fatal.**
  - Important to assess the need for medically-managed withdrawal.
  - Patients who need medically supervised detoxification may need to be referred to an addiction specialist or addiction treatment program that can provide medically monitored withdrawal treatment.

Symptoms of alcohol withdrawal:		Onset after last drink
Minor withdrawal	Trembling, anxiety, headache, sweating, palpitations, GI upset, anorexia	6 to 36 hours
Seizures	Generalized tonic-clonic seizures	6 to 48 hours
Alcoholic hallucinosis	Visual, auditory, and/or tactile hallucinations	12 to 48 hours
Delirium tremens	Delirium, agitation, tachycardia, hypertension, fever, sweating	48 to 96 hours

Source:
1. UptoDate. Timing of alcohol withdrawal syndromes. Management of moderate and severe alcohol withdrawal syndromes.

Selection of Medication for Addiction Treatment (MAT)

- Medication selection depends on patient-specific situation, response to past therapies, mechanism of action, timing of last substance used, etc.
- Best used in combination with psychosocial treatment –should **not** be withheld in the absence of counseling.



Medications for Alcohol Use Disorder

	Naltrexone	Acamprosate (Campral)	Disulfiram (Antabuse)
Therapy place	First-line agent	First-line agent	Second-line agent
Forms	Oral (ReVia) and intramuscular injection (Vivitrol)	Oral	Oral
Mechanism	Discourages drinking by blocking opioid receptors which reduces euphoria when alcohol is consumed - *reduces positive reinforcement*	Reduces post-acute withdrawal symptoms that may cause cravings of alcohol for relief – *reduces negative reinforcement*	Discourages drinking by making a person physically ill when alcohol is consumed – *aversive effect*
Usual initiation	Best to begin after person stops drinking; will precipitate alcohol and opioid withdrawal. [IM use for OUD – anyone can prescribe, no DEA license needed.]	Typically initiated 5 days after cessation of alcohol use. Can be used by patients taking opioids and during recurrence of alcohol use.	Effective principally when taken under supervised conditions. Typically initiated 48 hours after cessation of alcohol use.

I am interested in incorporating buprenorphine into my practice. Where can I find more information about this medication, and how to prescribe it?

SAMHSA's Quick Start Guide (PDF | 1.4 MB) and Buprenorphine Quick Start Pocket Guide (PDF | 211 KB) provide advice on initiating treatment with buprenorphine among those individuals who screen positive for opioid use disorder. For more comprehensive information, please refer to TIP 63: Medication for Opioid Use Disorder and Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings (PDF | 25.2 MB).

An often-cited barrier to prescribing buprenorphine is the perception that patients must engage in counseling and other services in order to start or continue receiving the medication. While counseling and other services form part of a comprehensive treatment plan, the provision of medication should not be made contingent upon participation in such services.

An important treatment principle is to provide interventions in a person-centered manner. This means assessing and taking into account a person's stage of change[1] as treatment begins and progresses, incorporating the patient's goals and priorities into the treatment plan, and applying a shared decision-making approach.

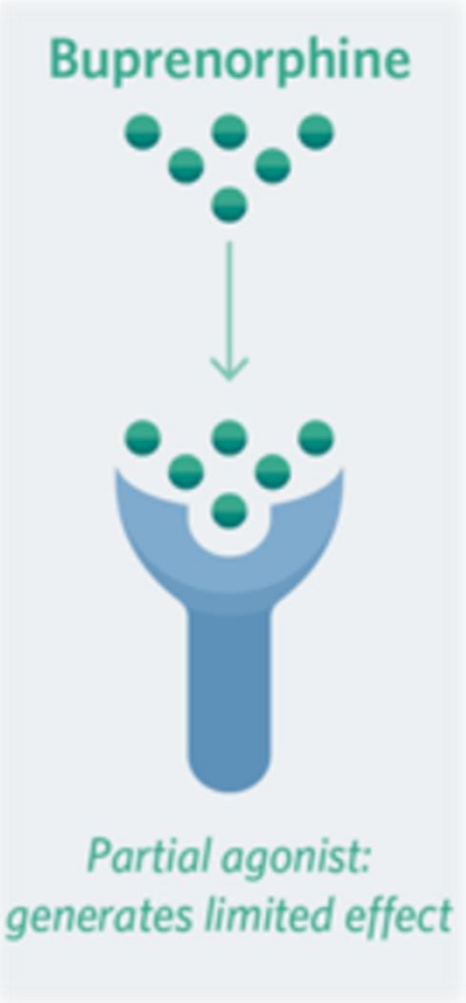
More Information:

https://www.samhsa.gov/medications-substance-use-disorders/removal-data-waiver-requirement

Buprenorphine

- Diminishes withdrawal symptoms or precipitates withdrawal – depending on if opioids in system
  - Initiate when patient abstinent from opioids (12-24 hours) and entering mild to moderate withdrawal
- Multiple formulations: Sublingual tablets, films, transdermal patch, injections
  - Naloxone combination products (Suboxone) are used to decrease misuse/diversion => will precipitate withdrawal if injected
- Can be used in pregnancy
- Can be used for pain – **consider "exit plan"**
- Buprenorphine can be prescribed for the treatment of OUD by:
  - Opioid treatment programs (OTPs)
  - Physicians, PAs, and NPs with DEA registration number if permitted by state laws
  - Data Waiver (X-waiver) requirement lifted 2023 – no patient caps
    Note: Education requirements June 2023: https://www.samhsa.gov/medications-substance-use-disorders/removal-data-waiver-requirement

Possible option for Sam - consider last dose



Source:

1. https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2020/12/medications-for-opioid-use-disorder-improve-patient-outcomes

Methadone

- *Long-acting, full opioid agonist*
  - Prevents withdrawal symptoms for ≥24 hours, reduces craving for opioids, reduces the euphoric effects of subsequent opioid use by maintaining high level of opioid tolerance.
  - Close monitoring on initiation. Electrocardiogram recommended to monitor for potential QT- prolongation (screening and periodic surveillance)
  - Multiple drug interactions
- >40 years of data to support safety and efficacy
- Stigma persists "substituting one drug for another"
- Can be used in pregnancy
- When prescribed for OUD, **must be dispensed as part of an Opioid Treatment Program (OTPs) and includes mandatory counseling.**

Source:

1. https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2020/12/medications-for-opioid-use-disorder-improve-patient-outcomes

Naloxone (Narcan)

- Naloxone rapidly reverses an opioid overdose.
  - May need repeat dose – especially in cases of unprescribed fentanyl.
- Need to confirm or prescribe naloxone when prescribing opioids to a high-risk patient or when clinically indicated.
  - Requirements vary by professional license and state.
  - Need to provide training to patient and household members.
  - Good Samaritan laws apply: Does not require reporting to law enforcement or medical attention if a bystander administers.

- WA Department of Health Naloxone Instructions

https://doh.wa.gov/you-and-your-family/drug-user-health/overdose-education-naloxone-distribution/naloxone-instructions

Source:

1. https://www.webmd.com/mental-health/addiction/news/20190401/local-leaders-back-narcan-to-stop-overdose-deaths
2. https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2020/12/medications-for-opioid-use-disorder-improve-patient-outcomes

Naloxone (Narcan)

FDA approved March 2023 Over-the-Counter

- Nasal spray 4mg/ml.
- Does NOT need a prescription.
- Available in drug stores, grocery stores.
- WA State residents may use the state *Standing Order* for insurance to reimburse.
- At least 17 states have passed laws requiring or recommending the co-prescription of naloxone in the presence of overdose risk factors, such as high dosages of opioids or concomitant opioid pain medications and benzodiazepines.*
- Access may remain an issue – summer 2023 expected to be available.
  - Insurance coverage varies [WA Medicaid covers].
  - Find free options [vending machines, grants]] http://phra.org/mail-order-naloxone
  - stopoverdose.org

Source:

1. https://www.fda.gov/news-events/press-announcements/fda-approves-first-over-counter-naloxone-nasal-spray

Resources to Build Pain Management Capacity

- American Academy of Pain Medicine. (2022). https://painmed.org/cme-program/
- American Society for Pain Management Nursing. (2022). Certification (aspmn.org)
- CDC Opioid Tapering Guide https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf
- CDC Healthcare Professionals Resources https://www.cdc.gov/opioids/healthcare-professionals/index.html
- Chronic Pain Self-management Program (2022). https://selfmanagementresource.com/programs/small-group/chronic-pain-self-management-small-group/
- Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC clinical practice guideline for prescribing opioids for pain—United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. https://doi.org/10.15585/mmwr.rr7103a1
- Pain Reprocessing Therapy Institute.(2022) https://www.painreprocessingtherapy.com/learning-resources
- Providers Clinical Support System (PCCS). https://pcssnow.org/
- VA Opioid Tapering Tool https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf

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6. SBIRT Oregon. https://www.sbirtoregon.org/training-curriculum/
7. NIDA. https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools
8. Ask Suicide-Screening Questions (ASQ) Toolkit. https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials
9. Witry MJ, St Marie BJ, Viyyuri BR, Windschitl PD. Factors Influencing Judgments to Consult Prescription Monitoring Programs: A Factorial Survey Experiment. *Pain Manag Nurs*. 2020;21(1):48-56. doi:10.1016/j.pmn.2019.04.001
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Thank you!

https://wsu.co1.qualtrics.com/jfe/form/SV_6AwHPpLLHjT3h7o

Please provide feedback using the QR code

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