Learner Prep Objectives

• The purpose of this prep material is to prepare you for the Opioid Safe-Prescribing Training Immersion (OSTI) Curriculum

• The following slides provide an introduction to some of the key tools that you should be familiar with before undertaking the OSTI.
  • Note that additional information and resources are in the notes section of these slides

• By the end of this prep, you should be familiar with the following tools and concepts:
  • Safety Monitoring Guidelines
  • Converting between forms of opiate dosing
  • Using existing order sets for safe prescribing
  • Counseling patients regarding Naloxone co-prescription with chronic opiate use
  • Informed Consent for Opioids including opioid treatment agreement
Case 108 Learner Tasks

• Develop a treatment plan for the patient’s acute pain episode using opioids and non-pharmacologic treatment in a way that adjusts for baseline of opioid tolerance.

• Discuss the risks of taking opioids in amounts greater than instructed and in combination with other sedating pharmaceuticals (benzodiazepines)

• Build a partnership with the patient and PCP to implement an enhanced monitoring plan to follow up on her pain management and aberrant medication behaviors that is commensurate with her observed level of risk

• Counsel the patient on the signs and symptoms of withdrawal and overdose, and prescribe a nasal naloxone overdose reversal kit for her family members.
Many clinical systems have created tools to promote safe prescribing for opiate medications and complex illnesses

- These tools provide evidence-based recommendations for prescribers
- At UMMS these include
  - Opioid conversion card
  - Physician order set (PCA)
  - Physician order set (chronic pancreatitis)
- See [http://umassmed.edu/opioid/students/student-materials](http://umassmed.edu/opioid/students/student-materials) for examples
Universal Precautions for safe prescribing of opiate medications

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<td>Make a diagnosis with appropriate differential and a plan for further evaluation and investigation of underlying conditions to try to address the medical condition that is responsible for the pain</td>
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<td>Psychologic assessment, including risk of addictive disorders</td>
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<td>3</td>
<td>Informed consent</td>
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<td>4</td>
<td>Treatment agreement</td>
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<td>5</td>
<td>Pre-/post-treatment assessment of pain level and function</td>
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<td>6</td>
<td>Appropriate trial of opioid therapy +/- adjunctive medication</td>
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<td>Reassessment of pain score and level of function</td>
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<td>Regularly assess the “Four As” of pain medicine&lt;sup&gt;a&lt;/sup&gt;</td>
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<td>• Analgesia, Activity, Adverse reactions, and Aberrant behavior</td>
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<td>Periodically review management of the underlying condition that is responsible for the pain, the pain diagnosis and comorbid conditions relating to the underlying condition, and the treatment of pain and comorbid disorders</td>
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<td>Documentation of medical management and of pain management according to state guidelines and requirements for safe prescribing</td>
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## Red and Yellow flag behaviors for substance use disorder

### Red
- Decreased work or social functioning
- Iselling medications, forging prescriptions, or buying medications from nonmedical sources
- Using medications in ways other than prescribed (e.g., injecting or snorting medication)
- Multiple reports of lost or stolen prescriptions
- Resistance to change in medications despite adverse effects
- Refusal to comply with random drug screens, call backs, or pill counts
- Concurrent abuse of alcohol or drugs
- Use of multiple physicians and pharmacies

### Yellow (could be normal but combined may be of concern)
- Frequent requests for more medication
- Drug hoarding
- Nonadherence to recommendations for non-medication pain therapies
- Acquiring similar medications from other providers
- Occasional unsanctioned dose escalation
- Requesting specific pain medications
Urine Toxicology Screening

- No unified guidelines for urine toxicology screening but generally
  - Twice per year for low risk patients
  - At least monthly in higher risk patients or those with aberrant behavior
- One detailed resource regarding testing can be found here
- Urine tox screens differ by labs, you must check those where you work; generally assess for
  - Opiates, benzodiazepines, barbiturates, cocaine, THC (principle active component of cannabis), amphetamine
  - See additional resources on the OSTI website
Urine Screen for Opioids

- Possible reasons for negative urine opiate screens
  - Immunoassays for opiates are based on finding morphine in the urine, which is the metabolite for morphine, codeine, and heroin.
  - These tests do not reliably detect synthetic and semisynthetic opioids, such as oxycodone, hydrocodone, methadone, buprenorphine, or fentanyl.

If a provider needs to test for the presence of synthetic and semisynthetic opioids, he or she must order specific testing for these agents and communicate with the lab to make sure that the right type of testing is used for each patient.
Naloxone Co-Prescribing

• Should be considered with all chronic opiate prescriptions
  • Death generally occurs within 1-3 hours of overdose (Kim, 2009)

• Bystander naloxone use is associated with increased odds of recovery (Giglio, 2015)

• Explain signs and symptoms of overdose
  • Classic triad: pinpoint pupils/very small pupils, unconsciousness/not responsive/won’t wake up, respiratory depression/barely breathing/slow

• Share handouts and review naloxone use

• Share website with videos regarding OD recognition and naloxone use by patients and bystanders
NOTE: Administering Naloxone to someone who has NOT used opiates does NO harm.
Opioid treatment agreements

- Treatment Agreements are documents created by different practices to help provide education and information articulating rationale and risks of treatment.
- Helps to counsel patient on the risks and benefits of opioid analgesics, and obtain verbal informed consent for their use.
Notes about treatment agreements

• They are NOT “pain contracts”
  • Using such language can impede patient-provider communication

• Efficacy not well established
  • No standard or validated form
  • No evidence they are detrimental

• But they are helpful
  • They should help a provider and patient have a conversation regarding the planned therapeutic regimen.
  • Takes “pressure” off provider to make individual decisions (Our clinic policy is…)

Adapted from Alford May 2010
Issues to discuss in opioid agreement

• Discuss risks of opioid medications to help determine if benefits outweigh risks and to inform patients
  • Side effects – physical dependence – sedation
  • Drug interactions
  • Risk of misuse – abuse, addiction, death
  • Legal responsibilities – disposing, sharing
• Assign responsibility to look for early signs of harm
• Discuss monitoring, pill counts, drug tests, etc. as ways that help to protect patient from undue harm
  • Compare to statins and LFT monitoring analogy
  • Articulate monitoring (tox screen, pills counts) & action plans for aberrant medication taking behavior
• Use a consistent approach, but set level of monitoring to match risk

Adapted from Alford May 2010
Key concepts for Case 108

- Monitoring for opioid misuse includes a history of behaviors (such as taking other patients’ meds, self-escalating doses), functional assessment and objective sources (PMP, urine toxicology screen, pill counts) over time. Prescribers must know the characteristics of their lab’s urine toxicology screen. Note: Urine toxicology screens do not reliably detect synthetic and semisynthetic opioids (e.g., oxycodone, hydrocodone, methadone, buprenorphine, fentanyl.)

- For a patient that has had stable opioid use and appropriate monitoring, a “yellow flag” may not mean discontinuing opioids but offers an opportunity to reassess benefits vs. risks and review the pain management agreement. It is essential to coordinate this plan directly with the primary prescriber.

- Patient-centered approach to outpatient prescribing of chronic opioids must include periodic review of patient-provider agreement, safe storage (including discussion of cohabitants/children), counseling regarding risks, benefits and side effects of treatment, and consequences of misuse including discontinuation of opioids. Also review of potential interactions with other and new medications.

- Co-prescribing of nasal naloxone should be considered for all patients receiving chronic opioid prescriptions, for instance if a provider using to use opioids as part of a chronic pain management plan (pain lasting greater than 3 months.)
Key Concepts for OSTI

- Opioid use disorder is and should be treated as a chronic illness.
- The opiate epidemic has impacted communities of color for years. The current national focus suggests bias in the healthcare system, policy-makers and media.
- Safe-prescribing does not mean NO prescribing, even for patients in recovery.
- The prescription monitoring program (PMP or MassPAT) provides accurate, up-to-date prescribing information and must be accessed before prescribing.
- Co-prescribing naloxone should be considered for any patient on chronic opiates.
- Best practices include risk assessment (including for diversion), informed consent, monitoring, safe storage and disposal counseling.