PRESTO

Promoting Engagement for Safe Tapering of Opioids (and Benzodiazepines)

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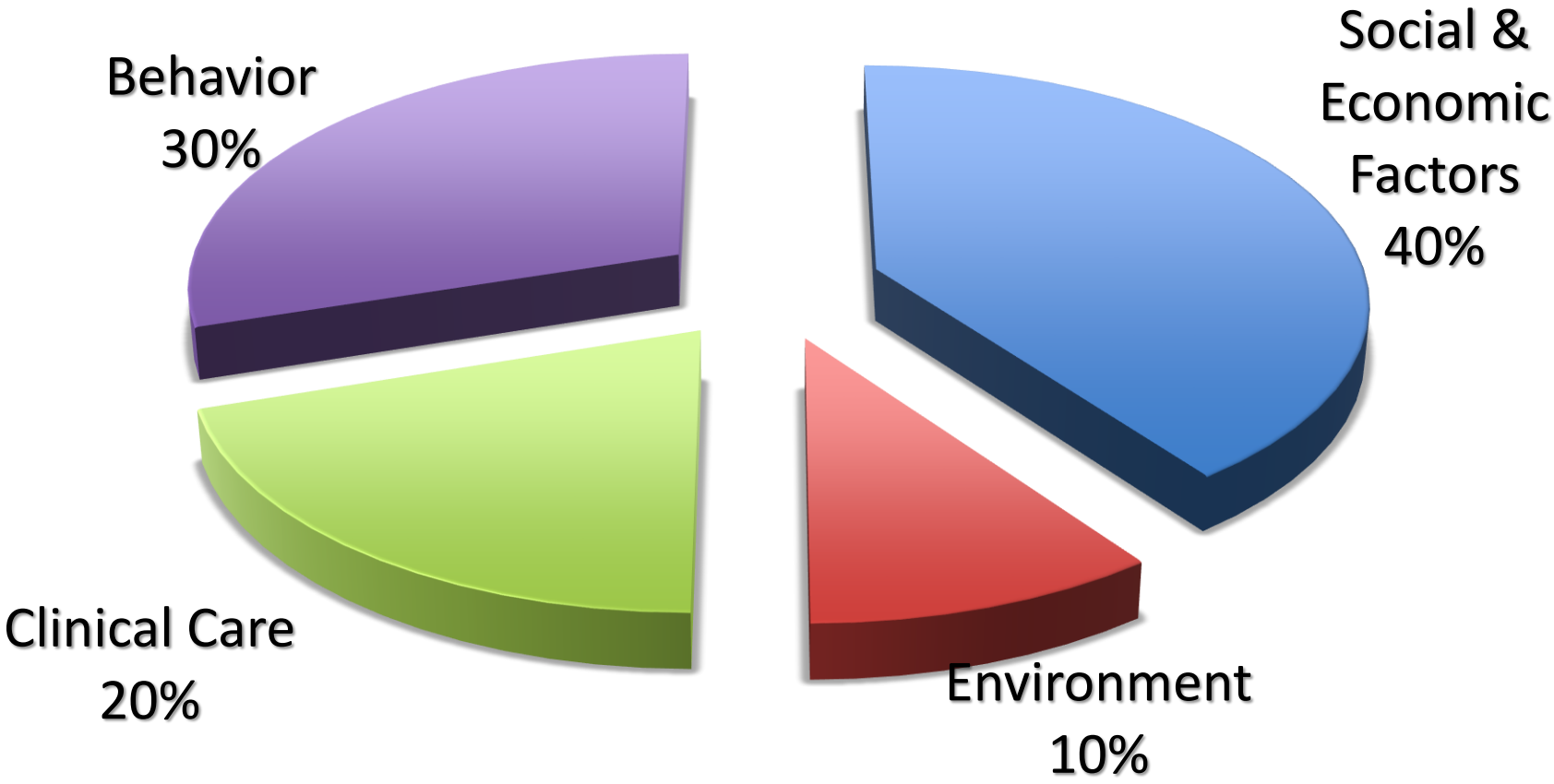
What drives health outcomes?



Robert Wood Johnson Foundation, 2016

JAMA Network Open

Original Investigation | Medical Education

Prevalence of and Factors Associated With Patient Nondisclosure of Medically Relevant Information to Clinicians

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Abstract

IMPORTANCE Patient failure to disclose medically relevant information to clinicians can undermine patient care or even lead to patient harm.

OBJECTIVE To examine the frequency of patients failing to disclose to their clinicians information that is relevant to their care and their reasons for doing so.

DESIGN, SETTING, AND PARTICIPANTS Two national nonprobability samples were recruited to participate in an online survey, one using Amazon's Mechanical Turk (MTurk) from March 16 to 30, 2015 (2096 respondents), followed by one using Survey Sampling International (SSI) from November 6 to 17, 2015 (3011 respondents). Data analysis was conducted from September 28 to October 8, 2018. After dropping respondents meeting the exclusion criteria, the final sample sizes were 2011 (MTurk) and 2499 (SSI).

MAIN OUTCOMES AND MEASURES The primary outcome measures were self-reported nondisclosure of 7 types of information to their clinician (eg, did not understand instructions, medication use) and reasons for nondisclosure (eg, embarrassment, not wanting to be judged).

RESULTS There was a total of 4510 overall respondents. Of 2096 respondents, 2013 completed the MTurk survey (96.0% completion rate) and 2011 were included in the analysis. Of 3011 respondents, 2685 completed the SSI survey (89.2% completion rate) and 2499 were included in the analysis. The mean (SD) age of the participants was 36 (12.4) years for MTurk and 61 (7.59) years for SSI. Both

Key Points

Question What medically relevant information do patients withhold from their clinicians, and why do they do so?

Findings In 2 national, nonprobability online surveys of 4510 US adults, most participants reported withholding at least 1 of 7 types of medically relevant information, especially when they disagreed with the clinician's recommendations or misunderstood the clinician's instructions. The most commonly reported reasons for not disclosing information included not wanting to be judged or hear how harmful their behavior is.

Meaning Patients commonly withhold medically relevant information from their clinicians, a pattern that likely inhibits the quality of patient care.

Knowledge/Education

Knowledge/education may be necessary but is commonly insufficient to motivate behavior change.

Clinician work: diagnosis, determining treatment options (including medications/dosing, referrals, etc.)

Patient work: decisions about treatment options, adherence, health behavior

$$\frac{\text{knowledge x motivation}}{\text{resistance}} = \text{change}$$

Two important contributors to motivation are ***emotion*** *and/or* ***discrepancy****.*

Resistance involves barriers to change.

- Important to have radar for emotion and discrepancy with patients; listen carefully for what the patient cares about, and the presence of “buts.”

Emotion

- Emotion is typically a stronger driver of change than is reason.
- What is the patient's "why?" What does the patient care about? Where does there appear to be emotion, both in verbal content and in observed affect?
- How is a patient's health connected to their "why?"

Discrepancy

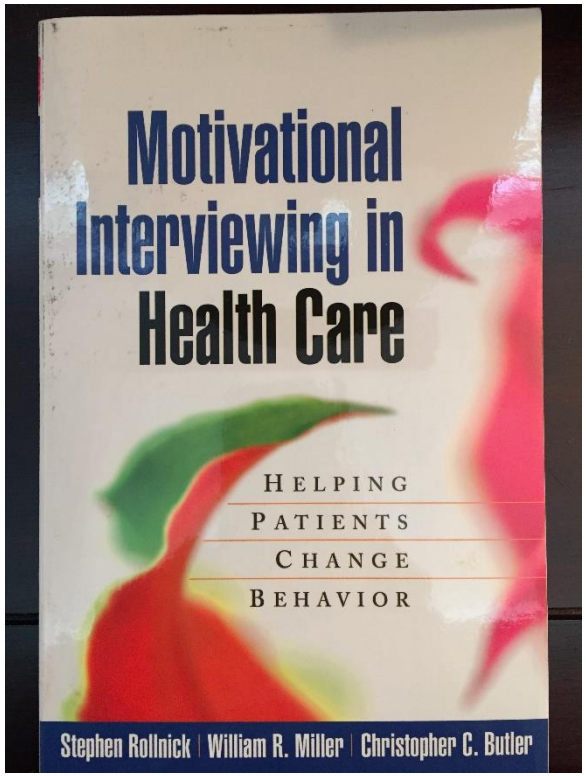
- The “buts”
- “I know I should _____, but I ……..”
- Cognitive dissonance.
- Natural desire for consistency between important goals/values and one’s behavior.
- The discomfort of discrepancy tends to motivate a change, either in goals/values or one’s behavior.

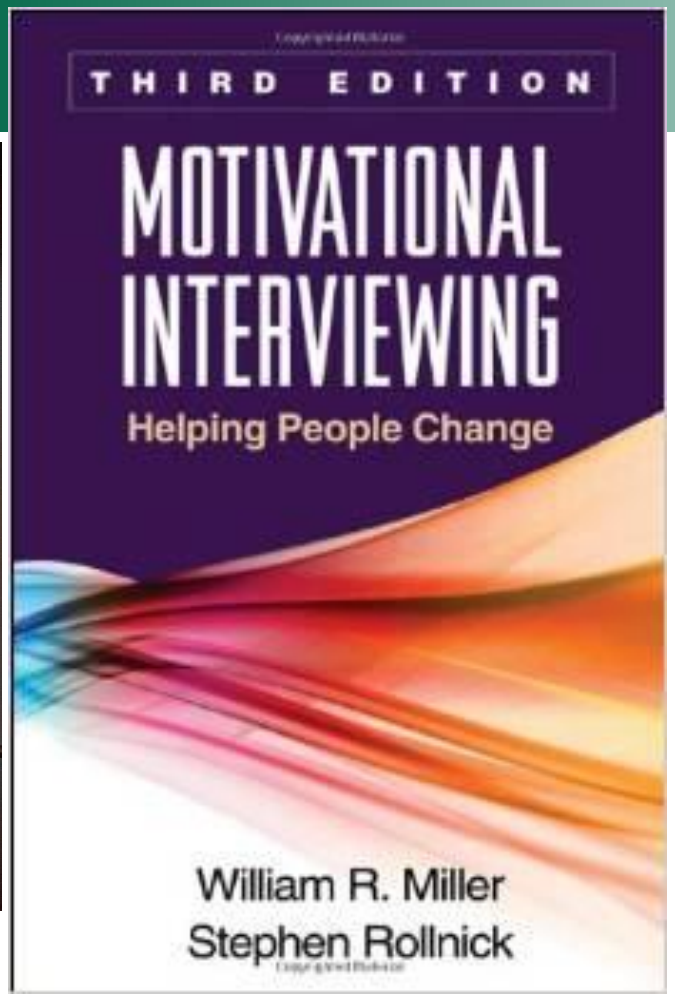
Patient with hypertension

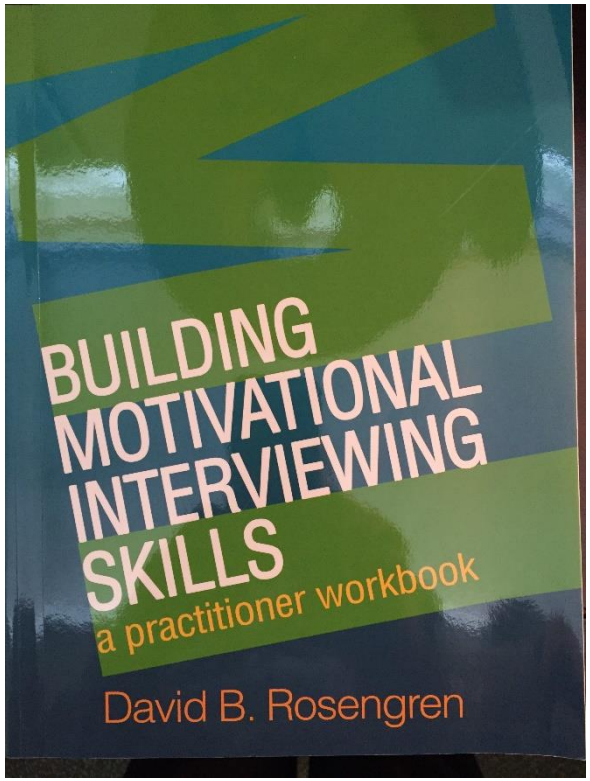
"I don't like taking medication but I want to be around for my grandkids."

"I don't feel bad, but neither did my father before he died of a heart attack."

"I started my own business and love being my own boss. There isn't time to exercise. But having a stroke would ruin it all.







www.motivationalinterviewing.org

Clinician work: diagnosis, determining treatment options (including medications/dosing, referrals, etc.)

Patient work: decisions about treatment options, adherence, health behavior

Motivational Interviewing (MI) is an approach to patient work.

Motivational Interviewing

- A collaborative conversational style for strengthening a person's own motivation and commitment to change that involves addressing the common problem of ambivalence about change.

MI Outcome Research

- Hundreds of studies, including RCTs and meta-analyses.
- Small to medium effect sizes across a range of behavioral domains (strongest evidence with addictive behaviors). (Remember that many factors affect human behavior and behavior change!)
- Variability in outcomes, likely due in part to clinician skill (empathy, MI consistency, strengthening “change talk”).
- “Nonspecific” psychotherapeutic factors (quality of the relationship) are emphasized in MI.

Motivational Interviewing

Approach
(way of thinking about and conversing with patients)

vs.

Technique
(something else to do that will take more time)

MI is characterized by a spirit of…

- COLLABORATION/PARTNERSHIP (vs confrontation)
- ACCEPTANCE (vs judgment) (individual worth/autonomy)
- COMPASSION/EMPATHY
- EVOCATION (vs education)

MI Skills

- **O**pen-ended questions
- **A**ffirmations
- **Reflective Listening**
- **S**ummarizing

- Informing and advising (only done with patient request or permission)

Open-Ended Questions

- Questions that cannot be answered with “yes” or “no.”
- What, how, when, where, who, tell me about…
- “Can you…” “Is there…” “Are you…” “Have you…” are all closed stems, even if what follows asks for an open-ended response.
- Aim for an economy of words (e.g., “Can you tell me what makes it better?” vs “What makes it better?”).

Affirmations

- Statements that accentuate positive patient attributes or behavior
- “I see that you’ve already taken some steps to improve your health.”
- “You did even more than you hoped to accomplish since I last saw you.”

Reflective Listening

- Statements that indicate understanding of what the patient is saying.
- Pausing after a reflective statement nonverbally invites the patient to say more.
- What comes after “Do you mean that…” without the “Do you mean that…” preface.

Reflective Listening

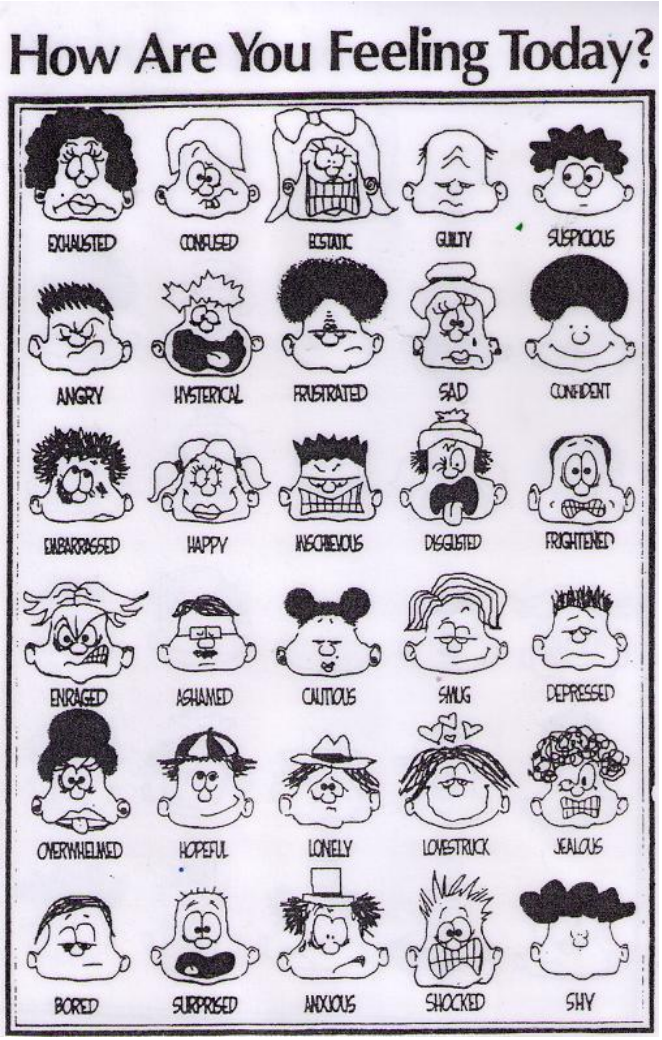
- Simple reflection – paraphrase of what the patient says.
- Complex reflection – adds additional/different meaning to what the patient says; contains a guess.
- “Double-sided reflections” (e.g., “On the one hand you aren’t sure you’d be able to lose weight, and on the other hand you think your weight is making your knee pain worse.”) (important that “sustain talk” is followed by “change talk” with double-sided reflections)

Summarizing

- Combination of several reflections with the intent of drawing together the patient's concerns, intentions, and/or plans.

Emotion

- Pay particular attention to patient content that carries emotion (e.g., “I’m afraid of…” “I really want to be able to…”).
- Motivation to change is much greater when there are strong feelings about a goal.



Ambivalence/Discrepancy

- Ambivalence is about the “buts.”
- “I know I should exercise more but I just don’t have the time.”
- Explore both sides of the “but.”
- “Sustain talk” is about the status quo whereas “Change talk” is about reasons for change.
- Develop the discrepancy between what the patient says is important to her/him, and what he/she is currently doing.

Informing and Advising

- Only done with patient's request or permission.
- First elicit what the patient already knows (often there isn't a need for patient education).
- "If it's OK with you, I could share some of the reasons…"
- Good to follow "education" with open-ended inquiry about patient's reaction to the information.
- "How does hearing this affect your thoughts about…?"

0-10 scales

- Ask patients to rate importance, confidence, or readiness to change on 0-10 scales.
- “On a scale of 0-10, with 0 meaning that you aren’t even considering quitting, and 10 being ready to quit right now, how ready are you to quit smoking?”
- If patient says “3”…
- “What makes you a 3, and not a 1 or 2?”
- “What would it take to move you to a 4 or 5?”

Video illustration

https://www.youtube.com/watch?v=URiKA7CKtfc

Cultivating Engagement

- Tell me more about current behavior.
- What do you like about current behavior? *Summarize*
- What don't you like about current behavior?
- How might your current behavior be related to your medical concern?
- Suppose you don't make any change. How does that look to you going forward? (How would this affect something the patient cares about?)
- Given that there are some things you don't like about current behavior and that you have some concerns about not making any change, how ready would you be to make a change? (0-10 scale)
- Why not a lower number? (skip if 7-10)
- What would change look like for you?

Time

- Most common perceived barrier to using MI on the part of providers.
- No evidence that being directive is more effective than MI when there is limited time.
- Instead of “You need to quit smoking” use a 0-10 scale for readiness to quit. This yields a more useful progress note than does just stating that patient was advised to quit smoking.
- New behavior will initially take more time, and likely will feel clumsy. When the approach becomes second nature, time becomes a non-issue.

Win-Win

- Better for clinician as well as the patient.
- Less stressful to be collaborative rather than confrontational.
- Clinician avoids taking responsibility for what he/she doesn’t control --- patient behavior.
- There is enough “clinician work” for the clinician to do (diagnosis, determining treatment options, etc.); let the patient do “patient work” (i.e., adherence, lifestyle change, problem-solving).

Why PRESTO?

- OD
- Prescribing guidelines
- Medical law
- PDMP
- Challenges with tapering (patient engagement)

Opioids and abuse

- 10 million US adults prescribed long-term opioid tx
- Higher dose associated with OD risk
- Associations with incidence of opioid use disorder

Edlund MJ, Martin BC, Russo JE, et al. The Role of Prescription in Incident Opioid Abuse and Dependence Among Individuals with Chronic Non-cancer Pain: The Role of Opioid Prescription. Clin J Pain. 2014: 30(7):557-564.

Low dose (1-36 MME), acute OR = 3.03
Low dose, chronic OR = 14.92

Medium dose (36-120 MME) acute OR = 2.80
Medium dose, chronic OR = 28.69

High dose (> 120 MME) acute OR = 3.10
High dose, chronic OR = 122.45

The STATS

- > 42,000 OD deaths in 2016, US;
- Prescription opioids involved in 40%
- 2.1 million opioid use disorder
- 11.5 million misused prescription pain relievers in 2016
- 215 million opioid prescriptions dispensed per year
- 66.5 dispensed opioid prescriptions per 100 persons
- 45% of opioid prescriptions by primary care physicians

Aberrant behaviors

- Frequent requests for early refills (lost, stolen prescriptions)
- Use is more frequent or higher dose than prescribed
- Use to treat non pain symptoms
- Borrowing or hoarding meds
- Using alcohol to relieve pain
- Requesting more or specific opioids
- Frequent ED visits for pain
- Concerns by family members
- Abnormal urine drug tests
- Inconsistencies in history

Aberrant behavior suggestive of addiction

- Buying street drugs
- Stealing or selling drugs
- Multiple prescribers
- Trading sex for drugs
- Illicit drugs
- Forging prescriptions
- Aggressive demands for opioids
- Injecting oral or topical meds
- Signs of intoxication

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

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.

2. 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.

3. 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.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5. 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.

6. 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.

7. 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.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8. 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.

9. 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.

10. 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.

11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12. 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.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

Krebs EE, Lorenz KA, Bair MJ, et al. Development and initial validation of the PEG, a three-item scale assessing pain intensity and interference. J Gen Intern Med 2009;24:733–8

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores
(30% improvement from baseline is clinically meaningful)

Q1: *What number from 0–10 best describes your **pain** in the past week?*

0="no pain", 10="worst you can imagine"

Q2: *What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*

0="not at all", 10="complete interference"

Q3: *What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?*

0="not at all", 10="complete interference"

Chronic Pain Management Toolkit

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Opioid Medication for Chronic Pain Agreement

This is an agreement between _____ (patient) and Dr. _____.

I am being treated with opioid medication for my chronic pain, which I understand may not completely rid me of my pain, but will decrease it enough that I can be more active. I understand that, because this medication has risks and side effects, my doctor needs to monitor my treatment closely in order to keep me safe. I acknowledge my treatment plan may change over time to meet my functional goals, and that my doctor will discuss the risks of my medicine, the dose, and frequency of the medication, as well as any changes that occur during my treatment. In addition, I agree to the following statements:

I understand that the medication may be stopped or changed to an alternative therapy if it does not help me meet my functional goals.

To reduce risk, I will take medication as prescribed. I will not take more pills or take them more frequently than prescribed.

I will inform my doctor of all side effects I experience.

To reduce risk, I will not take sedatives, alcohol, or illegal drugs while taking this medication.

I will submit to urine and/or blood tests to assist in monitoring my treatment.

I understand that my doctor or his/her staff may check the state prescription drug database to prevent against overlapping prescriptions.

I will receive my prescription for this medication only from Dr. _____.

I will fill this prescription at only one pharmacy. (Fill in pharmacy information below.)

I will keep my medication in a safe place. I understand if my medicine is lost, damaged, or stolen, it will not be replaced.

I will do my best to keep all scheduled follow-up appointments. I understand that I may not receive a prescription refill if I miss my appointment.
Medication name, dose, frequency _____
Pharmacy name _____
Pharmacy phone number _____

By signing below, we agree that we are comfortable with this agreement and our responsibilities.
_____ Patient signature Date
_____ Physician signature Date

Ohio Medical Law

Before prescribing any opioid

1. H&P
2. Prior tx's, response, adherence
3. Substance Use Screen (AUDIT/DAST) (If positive a urine drug screen)
4. Relevant Labs or diagnostic data
5. Functional Pain Assessment: ability to work, pain intensity, ADL's, quality of life, social activities, family activities.
6. Treatment Plan: dx, goals, rationale for medication and dose, planned duration.
7. Discussion to include: Benefits and Risks, including addiction and overdose, patient's responsibility to safely store and dispose medication.
8. Offer prescription for **Narcan** if: hx of opioid use disorder, dose exceeds 80 mme, patient co prescribed benzo, hypnotic, carisoprodol, tramadol, gabapentin, or has a substance use disorder.

50 MME

1. Review and update previous documentation
2. Formulate and document new tx plan
3. Obtain written informed consent that includes: benefits and risks, including addiction and overdose, and patient's responsibility.

If on 50mme prior to Dec 2018, document consideration of:

1. Consult with specialist related to pain.
2. Consult with pain management specialist.
3. Consult with pharmacy for medication therapy management review.
4. Consult addiction medicine specialist or addiction psychiatry if suspicion of medication misuse or SUD
5. Offer prescription for Naloxone

Every 3 months:

1. Review course and pt response, adherence.
2. Interval history, physical exam, appropriate tests.
3. Assessment of patient adherence
4. Rationale for continue opioid tx and nature of benefits is present
5. Result of OARRS check
6. Screening for medication misuse or substance use, UDS based on clinical assessment, frequency based on clinical judgement.
7. Tapering of opioids if continued benefit cannot be established.

80 MME

1. All previous
2. Written permission with patient that includes
   - a. Permission for drug screening and release to speak with other practitioners about patients tx.
   - b. Cooperation with pill counts
   - c. Understanding the patient will receive opioid medication only from physician treating chronic pain.
   - d. Understand dosage may be tapered if not effective or patient not abiding by agreement.
3. Prescribe naloxone

If on 80 mme prior to Dec 2018 document obtaining at least one of the following:

a. Consultation with a specialist related to the pain.

b. Consultation with pain management specialist

c. Consultation with pharmacy for medication therapy management review.

d. Consultation with addiction medicine specialist or addiction psychiatry if suspicion of medication misuse or SUD.

Prescription Drug Monitoring Program (PDMP)

OARRS | OHIO AUTOMATED RX REPORTING SYSTEM

PROVIDED BY: STATE OF OHIO BOARD OF PHARMACY

ABOUT | REGISTER | DOCUMENTS | RESOURCES | MED CALCULATOR | REPORTS & STATISTICS | FAQS | CONTACT US | INTEGRATION

MED CALCULATOR
PRESCRIPTION HISTORY

What is Morphine Equivalent Dose (MED)?

The MED Calculator is designed to assist in the calculation of a patient's opioid intake. Fill in the mg per day for whichever opioids your patient is taking to automatically calculate the total morphine equivalents per day. Providers treating chronic, non-terminal pain patients who have received opioids equal to or greater than 80 mg MED for longer than three continuous months should consult Ohio's opioid prescribing guidelines.

Drug Name	Strength		Multiplier		Quantity		Days		Daily MED	
	0	x	0	x	1	÷	1	=	0	Remove

New Row

Active Cumulative Morphine Equivalent: 0

NARxCHECK® Score as a Predictor of Unintentional Overdose Death

Huizenga J.E., Breneman B.C., Patel V.R., Raz A., Speights D.B.

October 2016
Appriss, Inc.

NARxCheck Table of Overdose Risk

Overdose Risk Score	Odds Ratio of Unintentional Overdose Death
000-200	1
201-300	10
301-400	12
401-500	25
501-600	44
601-700	85
701-800	141
801-900	194
901-990	329

HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics

This *HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics* provides advice to clinicians who are contemplating or initiating a reduction in opioid dosage or discontinuation of long-term opioid therapy for chronic pain. In each case the clinician should review the risks and benefits of the current therapy with the patient, and decide if tapering is appropriate based on individual circumstances.

Consider taper when:

- Pain improves
- Patient requests
- Pain & function not meaningfully improved
- Escalating doses
- Evidence of misuse
- Risks outweigh benefit
- Overdose, serious event, or signs of impending event
- Concurrent benzodiazepine (other sedating rx)
- Risky co-morbidity (lung, liver, renal dz, OSA, falls risk..)
- Prolonged use with unclear risk: benefit ratio

Risks – rapid opioid taper could provoke:

- Withdrawal symptoms
- Exacerbation of pain
- Serious psychological distress
- Seeking alternate source — including illicit opioid

Considerations:

- Don’t insist if benefits outweighs risk (ie cancer pain)
- Don’t misinterpret cautionary dose thresholds as mandates
- Don’t do it alone (collaborate w pt, other providers)
- Don’t dismiss patients
- Don’t forget risks

Do…

- Optimize non-opioid pain therapies
- Treat co-morbid psychiatric disorders
- Arrange behavior health consultation for high SI risk
- Assess and treat opioid use disorder (including MAT)
- Arrange consultation for pregnant patients
- Advise increased risk for OD if abrupt return to prior dose

Share decision-making

- Discuss perceptions of risks, benefits, concerns
- Obtain buy-in
- Collaborate on tapering plan

Individualize taper rate

- Slow 5-10% every month
- Consider pause
- Progress = success
- Minimize withdrawal symptoms
- Provide behavior health support
- Ask how you can support the patient
- Acknowledge fear
- Assure your support
- Provide frequent follow up

Tapering Worksheet

Medication: _____

Current dose: _____

Target dose: _____

Date	Dose (mg)	Frequency	# of weeks	total dose/day (mg)

Adapted from AAFP Chronic Pain Management Toolkit

Comfort Pack

Withdrawal symptom order set		
Cholinergic Overload		
	Clonidine 0.1 mg 1 tab tid for 3 days, then 1 tab bid for 3 days, then1 tab daily for 3 days and stop hold for BP <90/60	# 18
Nausea/Vomiting/Insomnia		
	dipheyhydramine 25 mg 1 - 2 caps po q 4 hours prn	# 36
or		
	hydrxyzine 50 mg 1 cap po q 4 hours prn	# 18
Diarrhea		
	Loperamide 2 mg 2 tabs first dose, then 1 q 3 hours prn	# 24
Muscle spasms		
	clyclobenzaprine 10 mg one-half tab po q 8 hours prn	# 6
Aches		
	acetominophen 325 mg 2 tabs po q 6 hours prn	# 24

Patient's Experience with Opioid Tapering: a Conceptual Model with Recommendations for Clinicians

Henry SG, Paterniti DA, Feng B, et. al. The Journal of Pain. 2019; 20(2):181-191.

- Patient's perceived need for opioids fluctuate daily & is influenced by social relationships, emotional state, health status
- Tapering requires substantial effort
- Patients use a variety of strategies to manage the process
- Clinicians should identify the social, emotional, health factors that will impact tapering (address fears, emphasize tapering for patient's best interest, help them know what to expect, develop individualized tapering plan)

At Each Follow-up Visit:

Assess risk

- hx substance use disorder
- depression/PTSD
- aberrant behavior
- unexpected UDS
- high dose (MME >50)
- PDMP
- multiple prescribers
- multiple pharmacies
- hx of OD

At Each Follow-up Visit:

Maximize benefit

- Connect w/ patient
- Review goals from last visit
- Assess analgesia, enjoyment, general activity (PEG)
- Assess adjuncts
- Assess for depression
- Review drug screen results
- Assess for aberrant behaviors
- Reflect and express potential concerns
- Explain monitoring and safeguards
- Collaboratively formulate plan
- Express empathy, optimism, mutual goals

https://www.cdc.gov/drugoverdose/training/online-training.html

Interactive Training Series

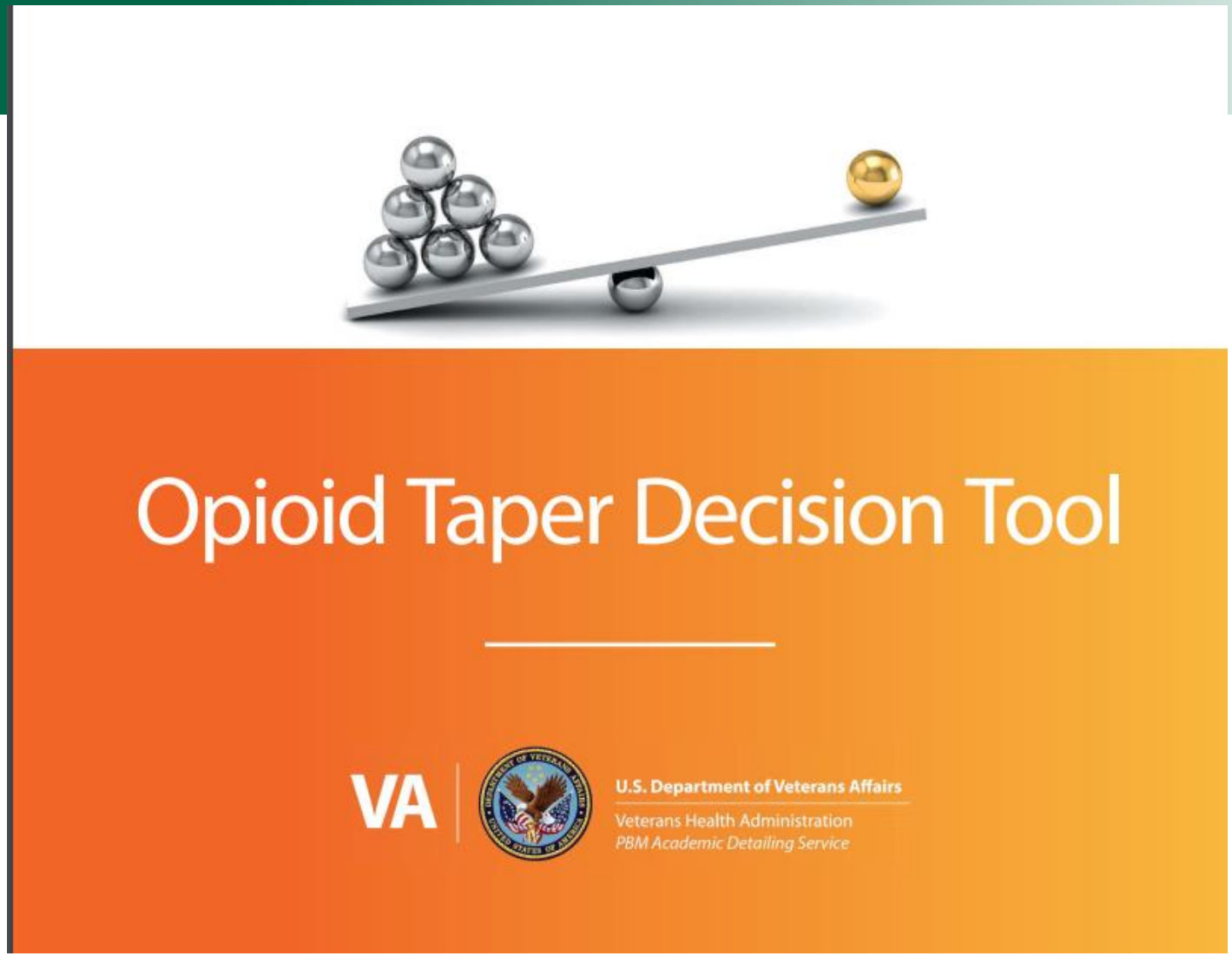
Applying CDC's Guideline for Prescribing Opioids

An Online Training Series for Healthcare Providers

In 2017, almost 57 million American patients had at least one prescription for opioids filled or refilled. The average number of opioid prescriptions per patient was 3.4, and the average days of supply per prescription was 18 days.[1] Taking opioids for longer periods of time or in higher doses increases the risk of addiction, overdose, and death. The *CDC Guideline for Prescribing Opioids for Chronic Pain* provides recommendations for safer and more effective prescribing of opioids for chronic pain in patients 18 and older in outpatient settings outside of active cancer treatment, palliative care, and end-of-life care.

This interactive online training series aims to help healthcare providers apply CDC's recommendations in clinical settings through patient scenarios, videos, knowledge checks, tips, and resources. Providers can gain a better understanding of the recommendations, the risks and benefits of prescription opioids, nonopioid treatment options, patient communication, and risk mitigation. Each stand-alone module is self-paced and offers free continuing education.

Module #	Title and Description
1 (WB2857)	Addressing the Opioid Epidemic: Recommendations from CDC Get an overview of the CDC Guideline for Prescribing Opioids for Chronic Pain. This module explains the rationale for the Guideline's creation, highlights key recommendations, and describes the benefits of implementing the Guideline.
2 (WB2859)	Treating Chronic Pain Without Opioids Review various options and tools for managing chronic pain. Skills include identifying appropriate nonopioid medications and nonpharmacologic treatments and facilitating a patient-centered approach.



- https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf

- https://takechargeohio.org/Toolkits/Healthcare-Professionals

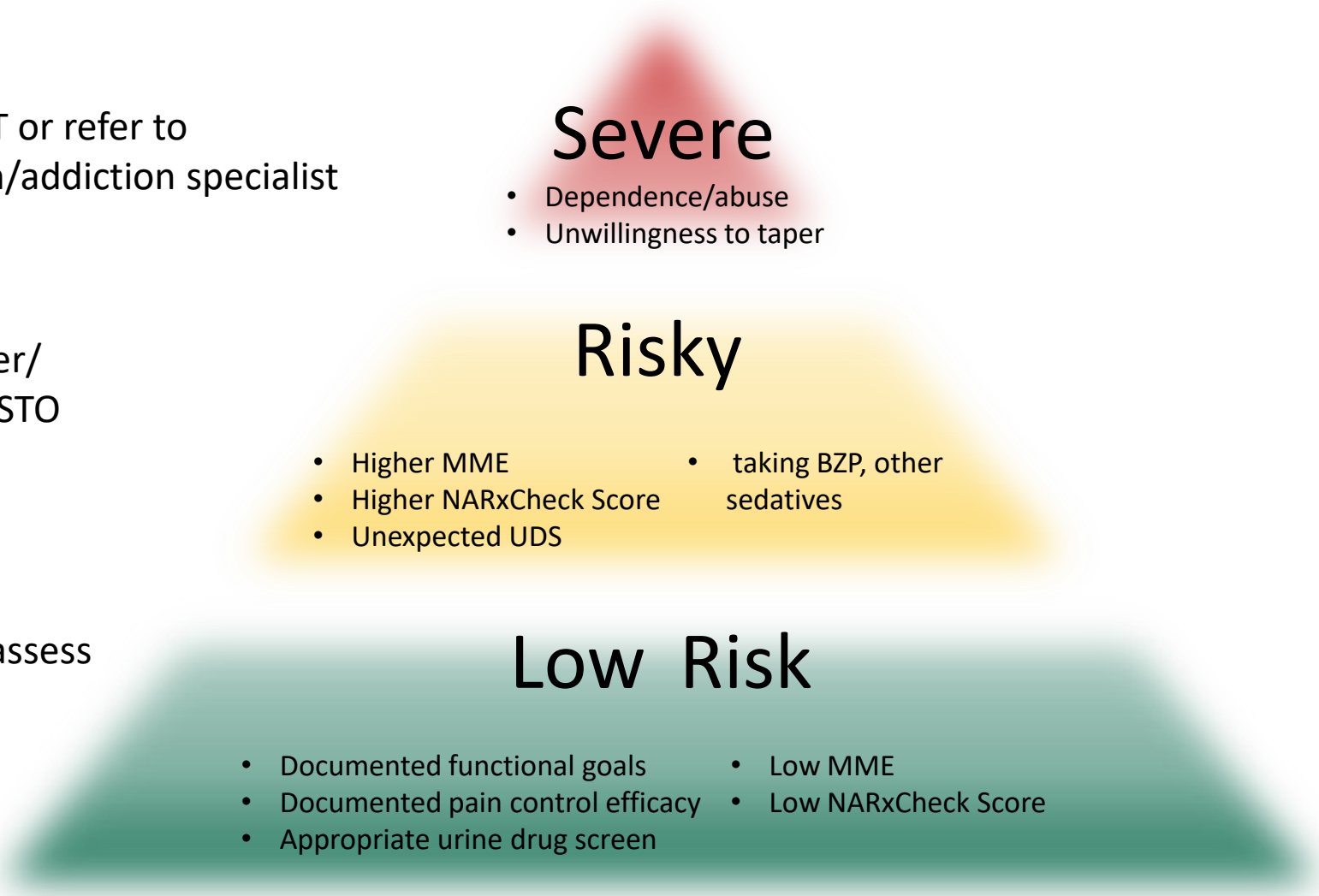
- https://www.aafp.org/patient-care/public-health/pain-opioids/cpm-toolkit.html

Medication Assisted Treatment

Buprenorphine products

PRESTO not for OUD

PRESTO


MAT or refer to pain/addiction specialist
Severe
• Dependence/abuse
• Unwillingness to taper
Taper/ PRESTO
Risky
• Higher MME
• Higher NARxCheck Score
• Unexpected UDS
• taking BZP, other sedatives
Re-assess
Low Risk
• Documented functional goals
• Documented pain control efficacy
• Appropriate urine drug screen
• Low MME
• Low NARxCheck Score

PRESTO Steps

- Raise Subject & Explore/Determine Risk with the Patient
- Enhance Motivation (w integrated feedback)
- Negotiate a Plan

Raise Subject

- **Tell me about your history with _____ (opioid or benzodiazepine medication, or both).**
  - Open-ended exploration
    - Let's assess your pain and how you are functioning.
    - How do you think the opioid is helping?
    - How is your life now compared to before you started the opioid?
    - What concerns do you have about the opioid?
    - What don't you like about taking the opioid?

Raise Subject

- **Explore and determine risk, in the context of your desire to work with the patient on managing their pain and enhancing their function.** (Review of medical record also informs assessment of risk.)
  - Higher MME
  - Higher NARxCheck Score
  - Unexpected UDS
  - Taking BZP, other sedatives

Enhance Motivation

- Highlight your desire to work with the patient on managing their pain/anxiety (i.e., shared goals).
- Emphasize elicitation of the patient's thoughts, feelings, and perspectives. Be attentive to emotion and potential discrepancies. Develop (create) discrepancy.
- Use reflective listening and open-ended questions liberally.
- Ask permission to educate when indicated. Provide small bits of information and then elicit patient response to the information (i.e., "How does knowing this affect your thoughts about…?")

Reflections

- So opioids seem to have helped in the past but aren’t as effective any longer.
- It sounds like you don’t want to be dependent on pain meds, but you’re afraid to come off.
- You think other treatments will not work.
- It sounds like our pain medicine isn’t allowing you do the things you want.
- You’re aware of opioid overdose deaths, but don’t see how that could happen to you.

Enhance Motivation (1)

- What do you like about taking opioids (benzodiazepines)?
- What don't you like about taking opioids (benzodiazepines)?
- What concerns do you have about taking this (these) medication(s)?
- What do you know about hyperalgesia?
- What do you know about osteoporosis?
- What have you noticed about your sexual function since you've been on these medications?

Enhance Motivation (2)

- What have you noticed about your breathing?
- What concerns do you have about driving while taking this(these) medication(s)?
- How much risk of overdose death are you willing to have in your pain management regimen? (compare to NarX Check score)
- With your current medication, it's recommended that I prescribe naloxone (Narcan) for you. What are your thoughts about this?
- What would be the downside and upside to tapering from your perspective?

Enhance Motivation (3)

- Summarize what the patient likes about their current meds, and then summarize concerns that have been raised. “Given these concerns, how ready would you be to start a slow taper of _____, on a scale of 0-10 with 0 being not ready at all, and 10 being reading to start today?”
  - If response is in the 8-10 range, move to discussion of tapering protocol.
  - If response is in the 1-7 range, ask, “Why not a lower number?”
  - If response is 0, acknowledge the unreadiness to change and ask, “What would it take for you to move from a 0 to a 1 or 2?”

Ask permission and provide information

- Review benefits and harms
- Review NaRxCheck Score
- Suggest a tapering strategy and what it might look like
- Review support you will provide
- Recall benefits in other patients

Negotiate a Plan

- Discuss the recommended tapering protocol. Elicit patient reaction to this.
- Address any potential barriers/challenges/concerns that the patient has identified, with emphasis on eliciting from the patient how she/he might manage the concerns.
- Summarize the benefits that have been discussed regarding the tapering.
- Review specifics (e.g., follow-up, UDS, etc.)

Resources

- https://medicine.wright.edu/family-medicine/presto
- PRESTO pocket card will be sent to you.
- You will receive email with link to post-training survey, required for CME. This will include a prompt to register for a 1-hour follow-up training session.

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