PRESTO

Promoting **E**ngagement for the **S**afe **T**apering of **O**pioids (and Benzodiazepines)

Boonshoft School of Medicine
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presto

adverb or adjective

Definition of *presto*

1: suddenly as if by magic; immediately

2: at a rapid tempo -- used as a direction in music

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Learning Objectives:

On completion of this session, participants should be able to…

…summarize the PRESTO protocol, a specific application of the motivational interviewing approach

…identify at least two approaches to developing discrepancy for a patient on chronic opioid medication

…describe how the PRESTO protocol can be incorporated into one's own practice.

The presenters have no conflicts of interest to disclose.

Office Encounter:

58 yo man presents to establish with a new primary care provider. He has a remote history of gunshot injury to his right leg resulting in chronic osteomyelitis. He also has chronic anxiety, and post-traumatic stress disorder (PTSD.) He has OA with chronic pain in various locations including his low back, bilateral shoulders and bilateral knees. He has been prescribed hydrocodone/acetaminophen (Vicodin) for pain and alprazolam (Xanax) for anxiety and has been on that regimen for a number of years. His main concern is chronic pain and anxiety which is fairly well controlled with Vicodin and Xanax.

PMH: osteoarthritis
anxiety disorder
PTSD
chronic osteomyelitis right tibia, from remote gun shot injury
gout

Medications: hydrocodone/acetaminophen 7.5 mg/250 mg, 2 tabs qid;
alprazolam 1 mg tid prn; allopurinol 300 mg daily;
ibuprofen 400 mg qid prn;

SH: no tobacco use; drinks wine, no more than 2 glasses per week; smokes marijuana

What are the challenges of working with patients taking opioids and benzodiazepines?

- Patient goals vs physician goals
- Tolerance/dependence
- Psych co-morbidities
- Aberrant behavior
- Unexpected UDS
- Chronic pain

Why PRESTO?

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

PRESTO Survey

The extent to which I intend to incorporate the PRESTO protocol into my conversations with patients currently taking opioid medications can best be described as…

		Frequency	Percent
	Never	17	6.9
	Rarely	20	8.1
	Occasionally	41	16.7
	A moderate amount	66	26.8
	A great deal	78	31.7
	Total	222	90.2
Missing	System	24	9.8
Total		246	100.0

To what extent do you agree with the following: “Receiving training in the PRESTO protocol will improve my confidence level in discussing a reduction in opioid medication use with relevant patients.”

		Frequency	Percent
	Strongly Disagree	5	2.0
	Disagree	2	.8
	Neither agree or disagree	41	16.7
	Agree	95	38.6
	Strongly Agree	79	32.1
	Total	222	90.2
Missing	System	24	9.8
Total		246	100.0

PRESTO Survey

To what extent do you agree with the following: “Others in my profession should receive training in PRESTO.”

		Frequency	Percent
	Strongly Disagree	1	.4
	Disagree	1	.4
	Neither agree or disagree	30	12.2
	Agree	69	28.0
	Strongly Agree	121	49.2
	Total	222	90.2
Missing	System	24	9.8
Total		246	100.0

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

Ohio

- 2017 – 4,292 OD deaths
- 39/100,000 population
- Estimated 10% patients with chronic noncancer pain on opioids develop OUD

Busse JW, Craigie S, Purlinet al. Guideline for opioid therapy and chronic noncancer pain. CMAJ 2017; 189(18):E659-E66

Chronic Opioid Prescribing in Primary Care: Factors and Perspectives

Sebastian T, Hochheimer C, Marshall Brooks E, et. al. Chronic Opioid Prescribing in Primary Care: Factors and Perspectives. Annals of Family Medicine. 2019. 17(3): 200-206.

Background: majority of primary care providers receive little or no training in prescribing opioids or managing substance use disorders; Few primary care clinicians feel prepared to screen, diagnose, and treat prescription medication misuse

Methods: descriptive analysis of patient and clinician characteristics associated with opioid prescribing

extracted EHR data for patients seen 1 Jan 2016- 31 Dec 2016
21 primary care practices, 271 clinicians
demographics, diagnoses, prescriptions
exclusions: <18 years old, sickle cell disease, palliative care patients, buprenorphine use

Interview themes

- Inheriting patients on chronic opioids
- Co-morbidities
- Benefits of opioids for chronic pain management
- Challenges with weaning
  - Clinicians lack time to manage chronic opioids
  - Lack of control over other sources of opioids
  - Hard time justifying weaning stable patients on long-term opioid for pain management

Conclusion

- Primary care patients with co-morbidities are more likely to receive chronic opioid prescriptions and at higher dosages (MME)
- Multiple barriers prevent weaning
- ***"New interventions to help primary care clinicians overcome these barriers must be developed and tested in order for primary care clinicians to successfully wean patients from chronic opioids."***

Reasons to Consider Tapering

- Patient requests
- No meaningful improvement in function (<30%)
- Risk of opioid is high or exceeds benefit
- Severe adverse outcome / overdose event
- Patient has substance use disorder
- Use of opioids is not compliant with medical law
- Aberrant behaviors

Interagency Guideline on Prescribing Opioids for Pain. www.agencymeddirectors.wa.gov

Potential Harms of Chronic Opioid Use

- aggravation of sleep apnea
- hypogonadism, sexual dysfunction
- opioid hyperalgesia
- immunosuppression
- osteopenia / fractures
- falls
- substance use disorder
- aggravation of depression
- overdose/death

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Recommendations and Reports / Vol. 65 / No. 1
March 18, 2016

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

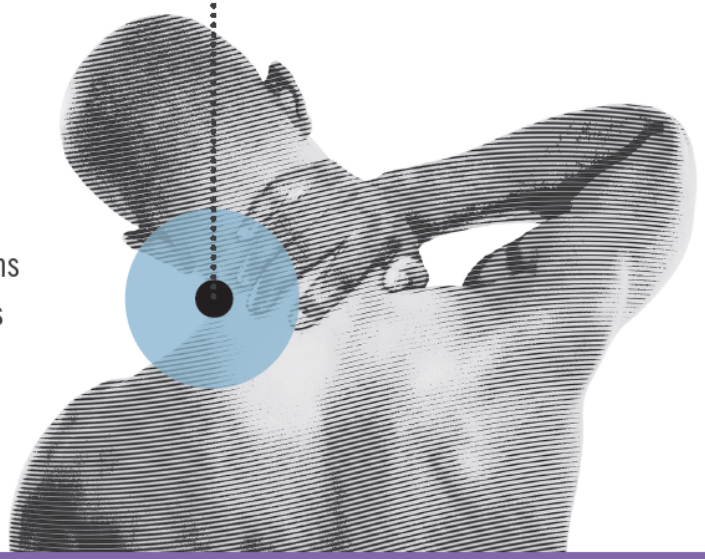
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic 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



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

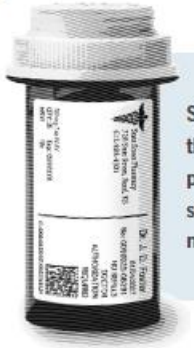
- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if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

CDC OPIOID PRESCRIBING GUIDELINE MOBILE APP

Safer Opioid Prescribing at Your Fingertips

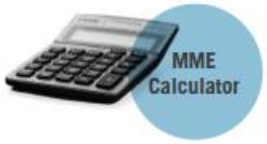
THE OPIOID GUIDE APP

Opioids can have serious risks and side effects, and CDC developed the CDC Guideline for Prescribing Opioids for Chronic Pain to encourage safer, more effective chronic pain management. CDC's new Opioid Guide App makes it easier to apply the recommendations into clinical practice by putting the entire guideline, tools, and resources in the palm of your hand.



Since 1999, the amount of prescription opioids sold in the U.S. has nearly quadrupled.

FEATURES INCLUDE:



Patients prescribed higher opioid dosages are at higher risk of overdose death. Use the app to quickly calculate the total daily opioid dose (MME) to identify patients who may need closer monitoring, tapering, or other measures to reduce risk.

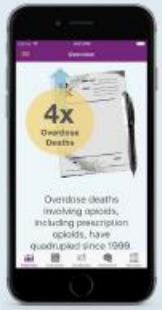
Access summaries of key recommendations or link to the full Guideline to make informed clinical decisions and protect your patients.

To provide safer, more effective pain management, talk to your patients about the risks and benefits of opioids and work together towards treatment goals. Use the interactive MI feature to practice effective communication skills and prescribe with confidence.

MANAGING CHRONIC PAIN IS COMPLEX, BUT ACCESSING PRESCRIBING GUIDANCE HAS NEVER BEEN EASIER.

Download the free Opioid Guide App today!

www.cdc.gov/drugoverdose/prescribing/app.html



Available on the App Store

Google play

This App, including the calculator, is not intended to replace clinical judgment. Always consider the individual clinical circumstances of each patient.

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

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"

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

HOP 16050882

Dowell D, Haegerich T, and Chou R. No Shortcuts to Safer Opioid Prescribing. NEJM. June 13, 2019. 380(24): 2285-2287

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

Opioid Use Disorder DSM V

- Great deal of time spent to obtain, use, or recover from use
- Opioids in larger amounts or longer period of time than intended
- Persistent desire or unsuccessful effort to cut down/control use
- Craving / strong desire to use
- Failure to fulfill major obligations at work/school/home
- Continued use despite persistent social, interpersonal problems caused/exacerbated by effects of opioids
- Recurrent use despite physically hazardous
- Continued use despite knowledge of physical/psychological problem caused by opioids
- Tolerance defined by a) need for increased amounts to achieve desired effect
  b) diminished effect with use of same amount
- Withdrawal manifested by: a) characteristic opioid withdrawal syndrome
  b) same or similar substance taken to relive/avoid withdrawal symptoms

Severity: **Mild**: 2-3 symptoms. **Moderate**: 4-5 symptoms. **Severe**: $\geq$6 symptoms

Medication Assisted Treatment

Buprenorphine products

PRESTO not for OUD

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, patients 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 patients 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

There are currently three PDMP based additional risk indicators

More than 5 providers in any year (365 days)

Hall AJ, Logan JE, Toblin RL, et al. Patterns of Abuse Among Unintentional Pharmaceutical Overdose Fatalities. *JAMA.*2008;300(22):2613-2620.

More than 4 pharmacies in any 90 day period

Yang Z, Wilsey B, Bohm M, et al. Defining Risk of Prescription Opioid Overdose: Pharmacy Shopping and Overlapping Prescriptions Among Long Term Opioid Users in Medicaid. The Journal of Pain. 16(5):445 – 453.

More than 40 morphine milligram equivalent per day (40 MED) average and more than 100 MME total

Paulozzi L, Kilbourne E, Shah N, et. al. A History of Being Prescribed Controlled Substances and Risk of Drug Overdose Death. Pain Medicine. Jan 2012; 13(1): 87-95.

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.

Risk Indicators

NARX SCORES

Narcotic	Sedative	Stimulant
572	491	000

Explanation and Guidance (/narx-content/content/narxcare2/explain-these-scores.pdf)

OVERDOSE RISK SCORE

430

(Range 000-999)

Explanation and Guidance (/narx-content/content/narxcare2/explain-overdose-risk-score.pdf)

ADDITIONAL RISK INDICATORS (2)

- >= 5 opioid or sedative providers in any year in the last 2 years
- > 100 MME total and 40 MME/day average

Explanation and Guidance (/narx-content/content/narxcare2/explain-these-red-flags.pdf)

This NarxCare report is based on search criteria supplied and the data entered by the dispensing pharmacy. For more information about any prescription, please contact the dispensing pharmacy or the prescriber. NarxCare scores and reports are intended to aid, not replace, medical decision making. None of the information presented should be used as sole justification for providing or refusing to provide medications. The information on this report is not warranted as accurate or complete.

Graphs

RX GRAPH (?) Narcotic Sedative Stimulant

All Prescribers

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

Opioid taper

- Taper one med at a time (start with opioid, then BZP)
- Determine rate (5-10% every 1-4 weeks)
- Maintain current short-acting medication
- Frequent visits to assess and reinforce behavior support
- Pain management
- Psychologic adjuncts
- Continually reassess risk- UDS, pill counts, PDMP
- Consider supportive meds (antidepressants, gabapentin, NSAID, anti- nausea, anti-diarrhea)

Tapering concerns

- Withdrawal (2-3 half lives after last dose; peak 48-72 hrs; last 7-14 d)
- Secondary abstinence syndrome (up to months)
- Increased pain (brief, 1-2 weeks)
- Drop out (30-70%);
- Relapse
- Function
- Medical legal

Wesson D.R. & Ling, W. The Clinical Opiate Withdrawal Scale (COWS). Journal of Psychoactive Drugs 35(2):253-259.

COWS (Clinical Opiate Withdrawal Scale)

Resting Pulse Rate

0 pulse rate ≤ 80; 1 rate 81-100; 2 rate 101-120; 4 >120

Sweating

0 no chills or flushing;1 subjective chills or flushing; 2 flushed or observable moistness on face;

3 beads of sweat on brow or face; 4 sweat streaming off face

Restlessness

0 able to sit still;1 reports difficulty sitting still, but is able to do so; 3 frequent shifting or extraneous movements of legs/arms; 5 Unable to sit still for more than a few seconds

Pupil size

0 pupils pinned or normal size for room light; 1 pupils larger than normal for room light; 2 pupils moderately dilated; 5 pupils so dilated that only the rim of the iris is visible

Bone or Joint aches

0 not present; 1 mild diffuse discomfort; 2 patient reports severe diffuse aching of joints/ muscles

4 patient is rubbing joints or muscles and is unable to sit still because of discomfort

Runny nose or tearing

0 not present; 1 nasal stuffiness or unusually moist eyes;

2 nose running or tearing; 4 nose constantly running or tears streaming down cheeks

GI Upset

0 no GI symptoms; 1 stomach cramps; 2 nausea or loose stool; 3 vomiting or diarrhea; 5 Multiple episodes of diarrhea or vomiting

Tremor

0 No tremor; 1 tremor can be felt, but not observed; 2 slight tremor observable; 4 gross tremor or muscle twitching

Yawning

0 no yawning; 1 yawning once or twice during assessment;

2 yawning three or more times during assessment; 4 yawning several times/minute

Anxiety or Irritability

0 none; 1 patient reports increasing irritability or anxiousness; 2 patient obviously irritable;

4 patient so irritable or anxious that participation in the assessment is difficult

Gooseflesh skin

0 skin is smooth; 3 piloerection of skin can be felt or hairs standing up on arms; 5 prominent piloerection

Total score (sum of all 11 items)

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

Treatment for symptoms of opioid withdrawal

- Restless, sweating, tremor – clonidine
- Nausea – ondansetron, prochlorperazine
- Diarrhea – loperamide, dicyclomine
- Muscle pain, myoclonus, neuropathic pain — NSAIDs, gabapentin, cyclobenzaprine, methocarbamol
- Insomnia — nortriptyline, mirtazapine, trazadone
  Do NOT use Benzodiazepine or sedative hypnotic

Patient Health Questionnaire-9

Chronic Pain Management Toolkit

Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving a lot more than usual	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐ 0	☐ 1	☐ 2	☐ 3

FOR OFFICE CODING 0 + _____ + _____ + _____

= Total Score: 0

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Generalized Anxiety Disorder seven-item (GAD-7) Scale

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on the edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about difficult things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Column totals: _____ + _____ + _____

Add totals together: _____

8. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

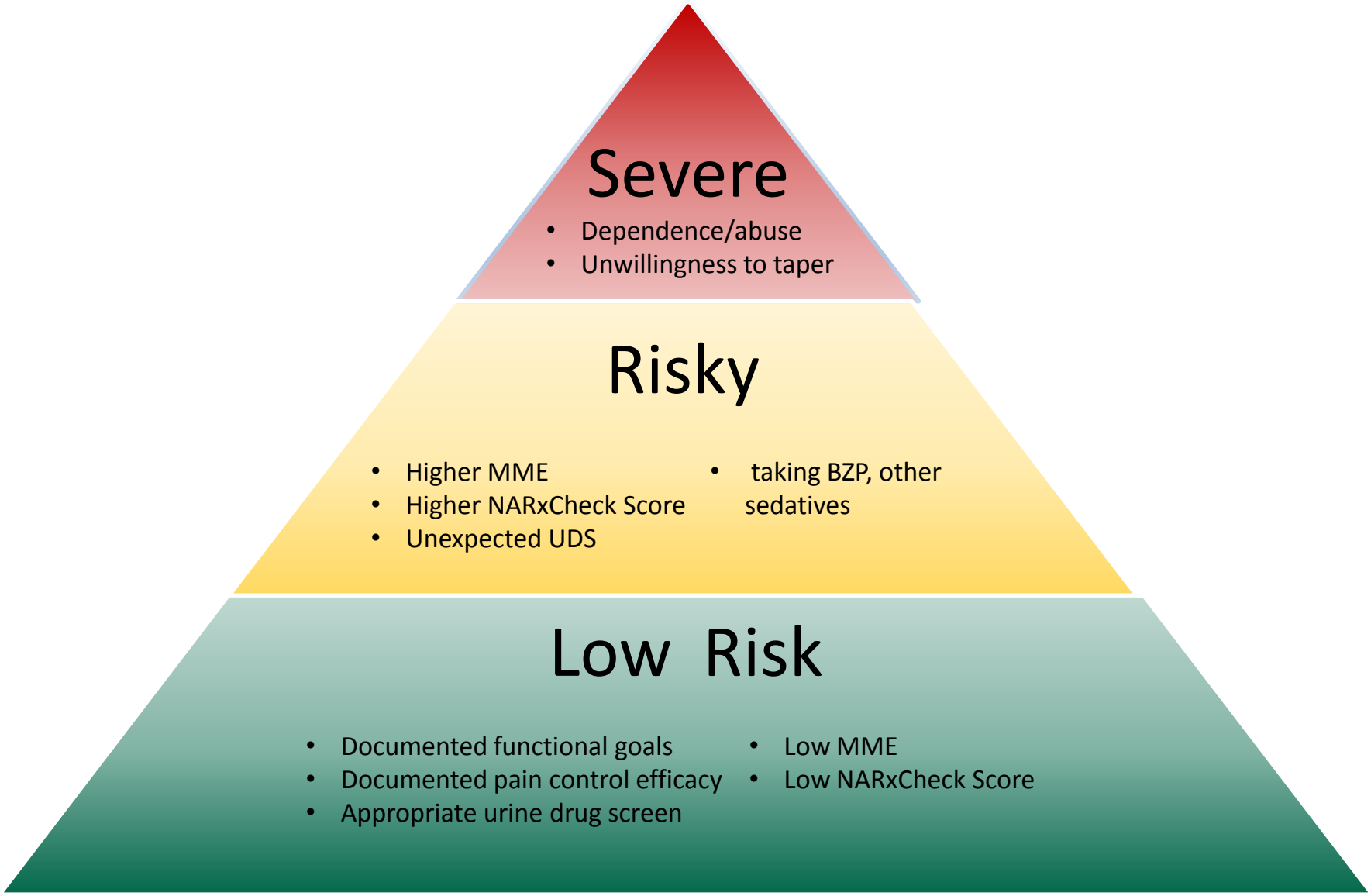
☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. Arch Intern Med. 2006;166:1092-1097.

Assessing risk

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

PRESTO


Severe
• Dependence/abuse
• Unwillingness to taper
Risky
• Higher MME
• Higher NARxCheck Score
• Unexpected UDS
• taking BZP, other sedatives
Low Risk
• Documented functional goals
• Documented pain control efficacy
• Appropriate urine drug screen
• Low MME
• Low NARxCheck Score

PRESTO

Severe

- Dependence/abuse
- Unwillingness to taper

Risky

- Higher MME
- Higher NARxCheck Score
- Unexpected UDS
- taking BZP, other sedatives

Low Risk

- Documented functional goals
- Documented pain control efficacy
- Appropriate urine drug screen
- Low MME
- Low NARxCheck Score

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

Common components of a brief intervention

- With respect to the prospect of tapering opioids/benzodiazepines, feedback early in the conversation may elicit patient defensiveness.
- In the PRESTO model, we integrate feedback into the process of enhancing motivation.

PRESTO Steps

Raise subject & assess risk

Tell me about your history with _____ (opioid or benzodiazepine medication).
Explore and determine risk

- Higher MME
- Higher NARxCheck Score
- Unexpected UDS
- taking BZP, other sedatives

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?

Enhance motivation with integrated feedback

Ask permission and provide information
Review benefits and harms
Review NaRxCare Score
Suggest a tapering strategy and what it might look like
Review support you will provide
Recall benefits in other patients
What do you like about taking opioids (benzodiazepines)? What don't you like?
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?
What have you noticed about your breathing? 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 for you. What are your thoughts about this?
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?"

Negotiate 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.)

PRESTO Steps

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

Raise Subject & Assess Risk

- Tell me about your history with _____ (opioid or benzodiazepine medication, or both).
- Explore and determine risk

Raise Subject & Assess Risk

- **Tell me about your history with _____ (opioid or benzodiazepine medication, or both).**
- Explore and determine risk

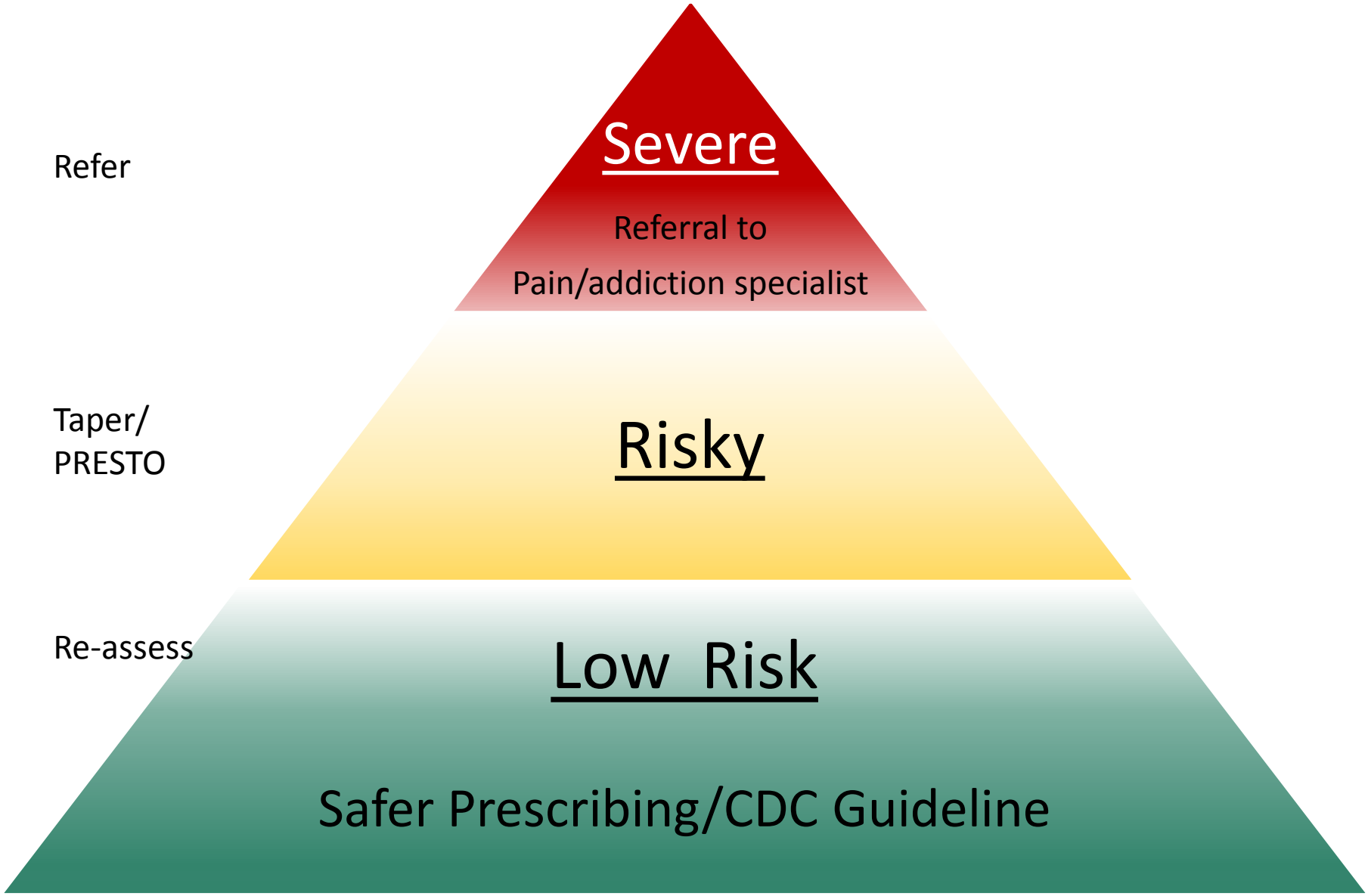
Open questions

- 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?

Raise Subject

- Tell me about your history with _____ (opioid or benzodiazepine medication, or both).
- **Explore and determine risk**
  - Higher MME
  - Higher NARxCheck Score
  - Unexpected UDS
  - taking BZP, other sedatives

PRESTO


Refer
Severe
Referral to
Pain/addiction specialist
Taper/
PRESTO
Risky
Re-assess
Low Risk
Safer Prescribing/CDC Guideline

PRESTO Steps

- Raise Subject & Assess Risk
- **Enhance Motivation (w integrated feedback)**
- Negotiate a Plan

Agriculture

Behavior Change

- Providing education and advice tends to be the default for health professionals with respect to addressing patient behavior.
- Knowledge/education may be necessary but is commonly insufficient to motivate behavior change.

Cultivating a Need for Change

- Find and explore emotion
- Find, develop, and/or create discrepancy
- Ideally, work the soil until the patient expresses a need/desire to make a change.

Enhancing motivation (tilling soil)
Small Group Discussion

- How can you avoid “educate and advise?”
- What questions could you ask the patient to find emotion and/or potentially develop discrepancy between the patient’s goals and their current medication regimen?
- How can you create a need where the patient may not perceive a need?

- Write your suggested questions on the card provided to you.

Enhance Motivation

- Emphasize elicitation of the patient's thoughts, feelings, and perspectives. Be attentive to emotion and potential discrepancies. Develop (create) discrepancy.
- 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…?")
- Check, chunk, check…
- Use reflective statements liberally.

Open questions

- How concerned are you about driving?
- What would be the upside and downside to tapering from your perspective?

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

Ask permission and provide information

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

Enhance Motivation (1)

- What do you like about taking opioids (benzodiazepines)? What don't you like?
- 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?
- What have you noticed about your breathing?

Enhance Motivation (2)

- 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?

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?”

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.)

Small group discussion

- What key issues came up?
- What benefits to you see with PRESTO approach?
- What concerns do you have?

References

Bema C, Kulich RJ, and Rathmell JP. Tapering Long-term Opioid Therapy in Chronic Noncancer Pain: Evidence and Recommendations for Everyday Practice. Mayo Clin Proc. 2015; 90(6): 828-842.

Dowell D, Haegerich T, and Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016. MMWR. 2016; 65(1):1-50.

Dowell D, Haegerich T, and Chou R. No Shortcuts to Safer Opioid Prescribing. NEJM. June, 2019; 380(24):2285-2287.

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.

Frank JW, Lovejoy TI, Becker WC, et. al. Patient Outcomes in Dose Reduction or Discontinuation of Long-term Opioid Therapy. A Systematic Review. Ann Intern Med. 2017; 167:181-191.

Han B, Compton WM, Blanco C, et.al. Prescription Opioid Use, Misuse, and Use Disorder in U. S. Adults: 2015 National Survey on Drug Use and Health. Ann Intern Med. 2017; 167(5);293-301.

Interagency Guideline on Prescribing Opioids for Pain. AMDG Agency Medical Director's Group. 2015; 36-41.

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.

Kroenke K, Alford DP, Argoff C, et. al. Challenges with Implementing the Centers for Disease Control and Prevention Opioid Guideline: A Consensus Panel Report. Pain Medicine. 2019; 20(4):724-735.

Lembke a, Papac J, and Humphreys K. Our Other Drug Problem. NEJM 2018; 378(8):693-695.

Rollnick S, Miller WR, Butler CC. Motivational Interviewing in Health Care: Helping Patients Change Behavior. New York: Guilford Pr; 2008.

Sun E, Dixit A, Humphreys K, et. al. Association Between Concurrent Use of Prescription Opioids and Benzodiazepines and Overdose: Retrospective Analysis. BMJ. 2017; 356:j760

Tong ST, Hochheimer CJ, Marshall Brooks E, et. al. Chronic Opioid Prescribing in Primary Care: Factors and Perspectives. Ann Fam Med. 2019; 17:200-206

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