PRESTO

**Promoting Engagement for the Safe Tapering of Opioids (and Benzodiazepines)**
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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Associate Program Director IM Residency
Department of Internal Medicine

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Director of Research
Director of Behavioral Health
Department of Family Medicine
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.
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)
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...

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<td>20</td>
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<tr>
<td>Occasionally</td>
<td>41</td>
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<tr>
<td>A moderate amount</td>
<td>66</td>
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<tr>
<td>A great deal</td>
<td>78</td>
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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.”

<table>
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<td>2</td>
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<tr>
<td>Neither agree or disagree</td>
<td>41</td>
</tr>
<tr>
<td>Agree</td>
<td>95</td>
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<tr>
<td>Strongly Agree</td>
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<td>Total</td>
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<td>24</td>
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<tr>
<td>Total</td>
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To what extent do you agree with the following: “Others in my profession should receive training in PRESTO.”

<table>
<thead>
<tr>
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<tr>
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<td>246</td>
<td>100.0</td>
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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


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

Chronic Opioid Prescribing in Primary Care: Factors and Perspectives


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.”

Sebastian T, et. al.
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](http://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
CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016
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.

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.

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
**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.
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.

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.

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.

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

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.
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.

FEATURES INCLUDE:

- **MME Calculator**
  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.

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

- **Motivational Interviewing (MI)**
  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](http://www.cdc.gov/drugoverdose/prescribing/app.html)

**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
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

Buprenorphine products

PRESTO not for OUD
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 prescribes benzo, hypnotic, carisoprodol, tramadol, gabapentin, or has a substance use disorder.

If on 50mme prior to Dec 2018, document obtaining at least one of the following:
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.

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:
1. Consultation with a specialist related to the pain.
2. Consultation with pain management specialist
3. Consultation with pharmacy for medication therapy management review.
4. Consultation with addiction medicine specialist or addiction psychiatry if suspicion of medication misuse or SUD.
### 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.

<table>
<thead>
<tr>
<th>Drug Name</th>
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<th>Multiplier</th>
<th>Quantity</th>
<th>Days</th>
<th>Daily MED</th>
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<tr>
<td></td>
<td>0</td>
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</table>

**Active Cumulative Morphine Equivalent:** 0
There are currently three PDMP based additional risk indicators

More than 5 providers in any year (365 days)


More than 4 pharmacies in any 90 day period


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

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
Apprisi, Inc.
# Risk Indicators

<table>
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<tr>
<th>NARX SCORES</th>
<th>OVERDOSE RISK SCORE</th>
<th>ADDITIONAL RISK INDICATORS (2)</th>
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<td>Narcotic 572</td>
<td>Sedative 491</td>
<td>Stimulant 000</td>
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Explanation and Guidance ([narx-content/content/narxcare2/explain-these-scores.pdf](https://content/content/narxcare2/explain-these-scores.pdf))

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

Explanation and Guidance ([narx-content/content/narxcare2/explain-these-red-flags.pdf](https://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

[Color bar chart with various colors]
### NARxCheck Table of Overdose Risk

<table>
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<th>Odds Ratio of Unintentional Overdose Death</th>
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<td>000-200</td>
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<td>201-300</td>
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<tr>
<td>901-990</td>
<td>329</td>
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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
### COWS (Clinical Opiate Withdrawal Scale)

<table>
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<tr>
<th>Symptom</th>
<th>Scoring Criteria</th>
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</thead>
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<td><strong>Resting Pulse Rate</strong></td>
<td>0 pulse rate ≤ 80; 1 rate 81-100; 2 rate 101-120; 4 &gt;120</td>
</tr>
<tr>
<td><strong>Sweating</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Restlessness</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Pupil size</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Bone or Joint aches</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Runny nose or tearing</strong></td>
<td>0 not present; 1 nasal stuffiness or unusually moist eyes; 2 nose running or tearing; 4 nose constantly running or tears streaming down cheeks</td>
</tr>
<tr>
<td><strong>GI Upset</strong></td>
<td>0 no GI symptoms; 1 stomach cramps; 2 nausea or loose stool; 3 vomiting or diarrhea; 5 Multiple episodes of diarrhea or vomiting</td>
</tr>
<tr>
<td><strong>Tremor</strong></td>
<td>0 No tremor; 1 tremor can be felt, but not observed; 2 slight tremor observable; 4 gross tremor or muscle twitching</td>
</tr>
<tr>
<td><strong>Yawning</strong></td>
<td>0 no yawning; 1 yawning once or twice during assessment; 2 yawning three or more times during assessment; 4 yawning several times/minute</td>
</tr>
<tr>
<td><strong>Anxiety or Irritability</strong></td>
<td>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</td>
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<tr>
<td><strong>Gooseflesh skin</strong></td>
<td>0 skin is smooth; 3 piloerection of skin can be felt or hairs standing up on arms; 5 prominent piloerection</td>
</tr>
</tbody>
</table>

**Total score** (sum of all 11 items)
- Score: 5-12 = mild
- 13-24 = moderate
- 25-36 = moderately severe
- More than 36 = severe withdrawal

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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

**Over the last two weeks, how often have you been bothered by any of the following problems?**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>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</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**FOR OFFICE CODING**

\[0 + \_\_\_ + \_\_\_ + \_\_\_ + \_\_\_\]

\[\text{Total Score: } 0\]

---

*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?*

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Generalized Anxiety Disorder seven-item (GAD-7) Scale

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

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

Assessing risk

• hx substance use disorder
• depression/PTSD
• aberrant behavior
• unexpected UDS
• high dose (MME >50)
• PDMP
• multiple prescribers
• multiple pharmacies
• hx of OD
Documented functional goals
Documented pain control efficacy
Appropriate urine drug screen
Low MME
Low NARxCheck Score
Higher MME
Higher NARxCheck Score
Unexpected UDS
taking BZP, other sedatives
Dependence/abuse
Unwillingness to taper
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
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
• 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.
Tell me about your history with _______ (opioid or benzodiazepine medication).

- 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?

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 ready to start today?”

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
• 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?
• 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
Severe
Referral to Pain/addiction specialist

Risky
Taper/ PRESTO

Low Risk
Re-assess

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.
• 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
• 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 (Narcan) 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 ready 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


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


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


