Getting started with Minnesota’s opioid prescribing guidelines

Patients with long-term opioid use

Changing the conversation to improve health

There are ways to reframe the conversation about pain management and long-term opioid use, especially when you focus on improving the patient’s quality of life and daily functions. Improving these can make pain less overwhelming over time. Open communication about the risks and benefits of opioids, along with using non-opioid pain management options, means that providers can do more than just write a prescription.

Each safe-prescribing principle includes specific recommendations and conversation starters.

1. Have a plan.
   - Use a multidisciplinary approach. Opioid therapy should not be used in isolation to manage chronic pain.
     - Establish specific, measurable treatment goals with the patient that focus on improved function and quality of life. Assess potential barriers to participation in the treatment plan.
     - Initiate a patient provider agreement.
     - “Let’s come up with a pain management plan together that addresses how pain affects your life. We will likely need to try a number of options to figure out what helps you manage your activities, work or other responsibilities.”

2. Implement universal screenings of all patients on long-term therapy.
   - Strategies and frequency should be commensurate with risk factors and include: routine urine drug screens, pill-count callbacks, Prescription Monitoring Program queries, opioid use disorder assessments and overdose education.
   - Perform a thorough assessment of mental health conditions before initiating chronic opioid therapy and continue assessment during therapy.
   - “Opioid medications carry a risk of harm for anyone who takes them. It is now our policy to regularly screen and assess all patients receiving opioids, so we can address concerns and adverse effects early.”
3. Know which patients are high risk and who receives opioids and benzodiazepines concomitantly.

- Avoid prescribing opioid therapy and benzodiazepines or other sedative-hypnotics concurrently.

Consider sequential tapers for patients on chronic opioid therapy and sedative-hypnotics. The taper approach must be individualized, given the lack of evidence on which to taper first.

“We now know that it is very dangerous to take opioids and anti-anxiety medication at the same time. Can we talk about how the medications interact and possible options for reducing or eliminating one over time?”

4. Talk with your patients about the proportional relationship between dose and the risk of opioid-related harm.

- Prescribe opioids at the lowest appropriate dose. Avoid increasing daily dose to greater than 90 MME/day.

Discuss tapering and discontinuing use routinely. Identify situations in advance that call for a taper.

Individualize taper protocols to the patient’s circumstances. Reasonable starting goals: reduce doses by 10 percent of the original dose per week and taper high-risk patients to less than 50 MME/day.

Provide nonopioid and nonpharmacological therapies to treat pain or withdrawal symptoms.

“Opioid dose is related to the risk of opioid-related harm. Limiting opioid doses reduces the potential for harm. We can introduce other pain management options to keep your pain as low as possible.”

“I am concerned that your current exposure to opioids is unsafe, and there may be better options to manage your pain. Can we discuss how we could work together to reduce your daily dose over time?”

5. Talk about co-prescribing naloxone and opioid therapy with your high-risk patients.

- Consider co-prescribing naloxone to patients at elevated risk for overdose.

“All opioid therapy carries a risk of harm, and one of those risks is that it slows down your breathing. Naloxone is a medicine used to reverse the effects of opioids when your breathing becomes so slow that it stops. You cannot administer Naloxone to yourself in this situation, so we need to teach someone close to you how to use it.”