


# Opioid Stewardship Program (OSP) | Session 8

# Double Trouble: Benzos and Opioids/ Harm Reduction with Naloxone

Claudia Kinsella, Quality Improvement Specialist

Jeff Francis, Quality Improvement Specialist

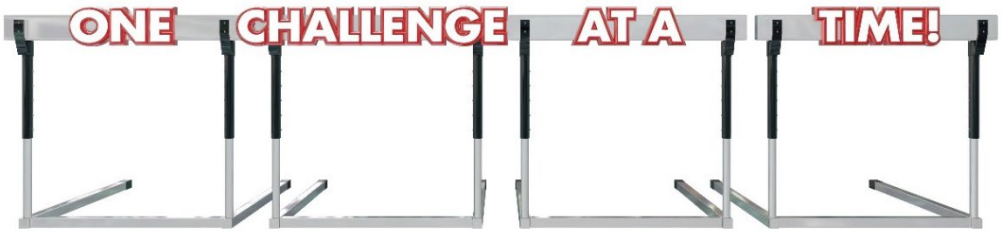
Thursday, March 10, 2022

HSAG HEALTH SERVICES ADVISORY GROUP

# Last Session's Action Items

1. Explore how to better incorporate pharmacist collaboration on your OSP Team.
   (See OSP Assessment Question #7 for Acute, #4 for ED, #8 for SNF)

2. Complete your OSP Assessment and enter it into the QIIP.



# Double Trouble: Benzos and Opioids/Harm Reduction with Naloxone

STEVE DUDLEY, PHARMD, DABAT

# Objectives

- **Session Description:** This presentation will review the increased risk of co-prescribing opioids with benzodiazepines and implementation of naloxone prescribing for identified high-risk patients as a best practice.

- **Learning Objectives:**

  Participants will be able to:

  - Compare the risks of opioid and benzodiazepine overdose and their co-involvement.
  - Characterize the approaches to reducing opioid/benzodiazepine co-prescribing.
  - Identify best practices for discharge naloxone prescribing.

**“Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible”**

- CDC Guideline for Prescribing Opioids for Chronic Pain, 2016

# American Association Of Poison Control Centers Data - 2021

- 17,683 cases of benzodiazepine exposure reported to poison centers
  - Single substance
  - 8 deaths
  - 0.045%
- 26,331 cases of opioid exposures reported to poison centers
  - Single substance
  - 439 deaths
  - 1.66%
- 22,477 cases of benzodiazepine + opioid exposure
  - 469 deaths
  - 2.09%

# Benzodiazepine prescribing patterns and deaths from drug overdose among US veterans receiving opioid analgesics: case-cohort study

Tae Woo Park,[1] Richard Saitz,[2] Dara Ganoczy,[3] Mark A Ilgen,[3 4] Amy S B Bohnert[3 4]

**ABSTRACT**

OBJECTIVE

To study the association between benzodiazepine prescribing patterns including dose, type, and dosing schedule and the risk of death from drug overdose among US veterans receiving opioid analgesics.

increased as daily benzodiazepine dose increased. Compared with clonazepam, temazepam was associated with a decreased risk of death from drug overdose (0.63, 0.48 to 0.82). Benzodiazepine dosing schedule was not associated with risk of death from drug overdose.

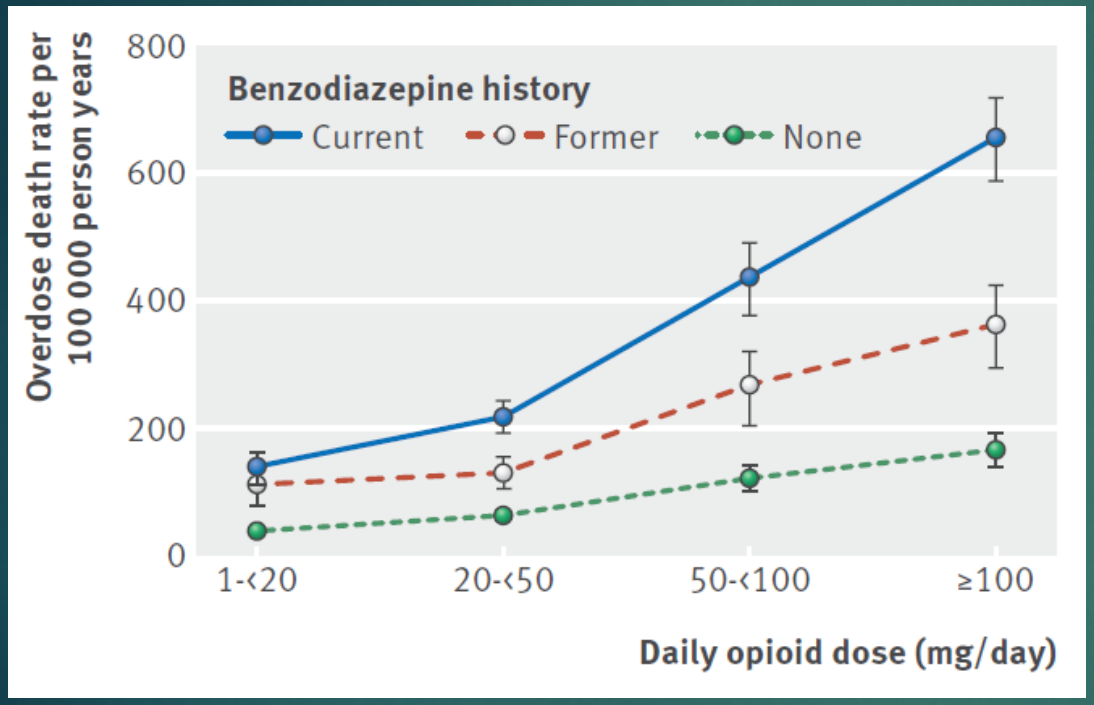



**Table 3 | Adjusted hazard ratios for deaths from drug overdose by history of benzodiazepine prescription, daily benzodiazepine dose, benzodiazepine type, and benzodiazepine schedule**

| | Hazard ratio (95% CI) |
|---|---|
| **Model 1*** | |
| Benzodiazepine prescription history: | |
| None | 1.00 (reference) |
| Former | 2.33 (2.05 to 2.64) |
| Current | 3.86 (3.49 to 4.26) |
| **Model 2†** | |
| Daily benzodiazepine dose (mg/day): | |
| >0-10 | 1.00 (reference) |
| >10-20 | 1.69 (1.42 to 2.01) |
| >20-30 | 2.34 (1.91 to 2.86) |
| >30-40 | 2.65 (2.10 to 3.33) |
| >40 | 3.06 (2.38 to 3.92) |
| Benzodiazepine type: | |
| Clonazepam | 1.00 (reference) |
| Alprazolam | 0.93 (0.75 to 1.14) |
| Diazepam | 0.93 (0.77 to 1.13) |
| Lorazepam | 0.79 (0.62 to 1.00) |
| Temazepam | 0.63 (0.48 to 0.82) |
| Other | 1.09 (0.67 to 1.77) |
| Multiple | 1.05 (0.83 to 1.33) |
| Benzodiazepine schedule: | |
| Regularly scheduled | 1.00 (reference) |
| As needed only | 0.98 (0.86 to 1.13) |
| Both | 1.07 (0.80 to 1.43) |

# Reducing Benzo and Opioid Co-Prescribing

- Clinicians should check the PDMP for concurrent controlled medications prescribed by other clinicians
  - Caution about "OTC opioids"

Morbidity and Mortality Weekly Report (*MMWR*)

CDC

# *Notes from the Field:* Unintentional Drug Overdose Deaths with Kratom Detected — 27 States, July 2016–December 2017

*Weekly* / April 12, 2019 / 68(14);326–327

Emily O'Malley Olsen, PhD[1]; Julie O'Donnell, PhD[1]; Christine L. Mattson, PhD[1]; Joshua G. Schier, MD[1]; Nana Wilson, PhD[1] (View author affiliations)

View suggested citation

Kratom (*Mitragyna speciosa*), a plant native to Southeast Asia, contains the alkaloid mitragynine, which can produce stimulant effects in low doses and some opioid-like effects at higher doses when consumed

TOXICOLOGY/BRIEF RESEARCH REPORT

# Epidemiologic Trends in Loperamide Abuse and Misuse

J. Priyanka Vakkalanka, ScM; Nathan P. Charlton, MD; Christopher P. Holstege, MD*

*Corresponding Author. E-mail: ch2xf@virginia.edu, Twitter: @blueridgepoison.

**Study objective:** Loperamide abuse has been increasing in the United States as a potential alternative to manage opioid withdrawal symptoms or to achieve euphoric effects of opioid use. In June 2016, the Food and Drug Administration warned health care providers and the general public about potential serious adverse outcomes, including cardiac dysrhythmias and death. The purpose of this study is to determine recent trends in intentional loperamide abuse and misuse, reported clinical effects and management, and medical outcomes as reported to poison centers across the United States.

**Methods:** Loperamide exposures reported to the National Poison Data System indicating intentional misuse, abuse, and suspected suicide between January 1, 2010, and December 31, 2015, were assessed. Demographic and temporal trends, as well as reported clinical effects, medical management, and health outcomes, were analyzed.

**Results:** There was a 91% increase in reported exposures from 2010 to 2015, of which half were single-agent loperamide use only. Loperamide exposures reported to the National Poison Data System increased at approximately 38 cases per year (95% confidence interval [CI] 32.5 to 42.9; $P<0.0001$). Fifteen deaths were reported during this time frame, of which 8 involved single-agent loperamide abuse.

**Conclusion:** Loperamide abuse and misuse are projected to increase in the absence of any methods to reduce exposure or curb abuse. Health care providers should consider the potential for loperamide toxicity when managing patients with opioidlike toxicity. [Ann Emerg Med. 2017;69:73-78.]

Please see page 74 for the Editor's Capsule Summary of this article.

# Reducing Benzo and Opioid Co-Prescribing

- Clinicians should check the PDMP for concurrent controlled medications prescribed by other clinicians
- Consider nonpharmacologic and nonopioid pharmacologic treatments
  - Cognitive Behavioral Therapy
  - Exercise Therapy
  - Biopsychosocial Rehabilitation
  - APAP, NSAIDs, SNRIs, TCAs

# Reducing Benzo and Opioid Co-Prescribing

- Clinicians should check the PDMP for concurrent controlled medications prescribed by other clinicians
  - Caution about "OTC opioids"
- Consider nonpharmacologic and nonopioid pharmacologic treatments
- Consider involving pharmacists and pain specialists as part of the management team when opioids are co-prescribed with other central nervous system depressants

*pharmacy*

MDPI

*Article*

# Preliminary Investigation of Pharmacist-Delivered, Direct-to-Provider Interventions to Reduce Co-Prescribing of Opioids and Benzodiazepines among a Medicare Population

**Jennifer M. Bingham [1,*], Ann M. Taylor [2], Kevin P. Boesen [1] and David R. Axon [2]**

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CO-MORBID PAIN & SUBSTANCE USE DISORDERS SECTION

# Impact of Implementing an Academic Detailing Program on Opioid-Benzodiazepine Co-Prescribing Trends at the U.S. Department of Veterans Affairs

Mark Bounthavong, PharmD, PhD,*,†,‡,§ Marcos K. Lau, PharmD, MS, BCPS,*
Chad L. Kay, PharmD, BCPS,* Daina L. Wells, PharmD, MBA, BCPS, BCPP,*
Sarah J. Popish, PharmD, BCPS, BCPP,* Michael A. Harvey, PharmD, BCPS,*
Julianne E. Himstreet, PharmD, BCPS, BCPP,* Andrea Grana, JD, MPH,* Blake A. Freeman, MPP, MBA,*
Christina M. Morillo, BPA,* and Melissa L.D. Christopher, PharmD*

› Subst Abus. Apr-Jun 2017;38(2):157-160. doi: 10.1080/08897077.2017.1290011. Epub 2017 Feb 6.

# Implementation of a pharmacy consult to reduce co-prescribing of opioids and benzodiazepines in a Veteran population

Deborah Pardo [1], Lacey Miller [1], Dana Chiulli [1]

Affiliations + expand

# Naloxone At Discharge

- Naloxone should be offered to patients at an increased risk for overdose
  - History of overdose
  - History of substance use disorder
  - Co-prescribed benzos and opioids
  - Reduced tolerance/return to high dose (i.e. post-incarceration)
  - >50 MME/day
- Reduce Barriers!
  - High risk patients should leave with naloxone in hand
- Address Stigma

# Resources

- Opioid Assistance and Referral Line
  - Created in response to Arizona Opioid Epidemic Act
  - Statewide, run by Arizona's two poison centers
  - Staffed by trained pharmacists, nurses, and physicians
  - Open 24/7, free, confidential

# For Health Care Providers / Prescribers:

- Treating patients with acute opioid complications or withdrawal.
- Real-time consultation about prescribing opioids (including acute or chronic pain).
- Managing high-dose or complicated medications. Assistance with opioid dosing
- Outpatient resources for medical, behavioral health and Medications for Opioid Use Disorder (MOUD) services.

# For Patients, Caregivers and Family Members:

- Emergent and non-urgent information about opioid medications and effects.
- Assistance with opioid use, chronic pain and opioid withdrawal.
- Referrals for patient support and outpatient opioid and treatment services.
- Referrals for patients seeking behavioral health treatment services. Routine follow-up calls for ongoing assistance and support.

# Resources

- Opioid Assistance and Referral Line
- Providers Clinical Support System
  - https://pcssnow.org/
  - Train primary care providers in the evidence-based prevention and treatment of OUD and treatment of chronic pain.
- Sonoran Prevention Works
  - Grassroots group working to reduce vulnerabilities faced by individuals and communities impacted by drug use in Arizona
  - Naloxone
  - Peer support
  - HIV/HCV screenings
  - Staff trainings

# Questions?

# References


- Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e
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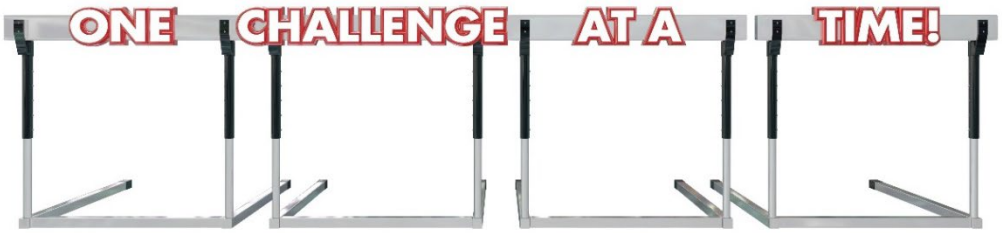
- Vakkalanka, J. P. et al. "Epidemiologic Trends in Loperamide Abuse and misuse." *Ann Emerg Med*, vol. 69, no. 1, 2017, pp. 73-78, doi:10.1016/j.annemergmed.2016.08.444.

# Action Items by Next Quickinar (4/14/2022)

1. Complete your OSP Assessment in the HSAG QIIP.

   **If you have difficulty, email Claudia at ckinsella@hsag.com**

2. Identify and commit to two strategies to reduce the risk from co-prescribing opioids and benzodiazepines



# OSP "Quickinar" Schedule: Mark Your Calendars

| | |
|---|---|
| **OSP Quickinar Kickoff: Introduction to Opioid Stewardship and Quickinar Format**<br>Thursday, October 21, 2021 \| 10:30–11:00 a.m. PT | **Partnering with Pharmacists for ongoing Medication Management**<br>Thursday, February 10, 2022 \| 10:30–11:00 a.m. PT |
| **OSP Assessment Overview**<br>Thursday, October 28, 2021 \| 10:30–11:00 a.m. PT | **Double Trouble: Benzos and Opioids \| Harm Reduction with Naloxone**<br>Thursday, March 10, 2022 \| 10:30–11:00 a.m. PT |
| **Interpreting the OSP Assessment Results/Developing an Action Plan**<br>Thursday, November 18, 2021 \| 10:30–11:00 a.m. PT | **Medication for OUD (MOUD): Prescribing Buprenorphine**<br>Thursday, April 14, 2022 \| 10:30–11:00 a.m. PT |
| **Developing a Dashboard**<br>Thursday, December 9, 2021 \| 10:30–11:00 a.m. PT | **Getting Patient Buy-in through Education**<br>Thursday, May 12, 2022 \| 10:30–11:00 a.m. PT |
| **Screening Patients for OUD Risk and Opioid Withdrawal**<br>Thursday, January 13, 2022 \| 10:30–11:00 a.m. PT | **Reevaluating Your Program and Celebrating Success**<br>Thursday, May 26, 2022 \| 10:30–11:00 a.m. PT |
| **A Good Discharge Plan for Pain Management with Opioids**<br>Thursday, January 27, 2022 \| 10:30–11:00 a.m. PT | |

**Register for the entire OSP "Quickinar" series today!**

bit.ly/OpioidStewardshipProgramQuickinars



HSAG Health Services Advisory Group

# Please Take 5 Seconds and Let Us Know


We want this call to be meaningful to you, so we need your input.

At the end of the webinar, you will be asked **one question** to determine if this call equipped your organization to begin implementing opioid stewardship practices.

# Thank you!

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HSAG HEALTH SERVICES ADVISORY GROUP

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