

UNDER PAR OR OVER PRESCRIBED: IMPROVING KANSAS OPIOID PRESCRIBING THROUGH COLLABORATIVE ACTION

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DISCLOSURES

Faculty

Tessa Schnelle, faculty for this activity, have no relevant financial relationship(s) with ineligible companies to disclose.

Planners

None of the planners for this activity have any relevant financial relationships with ineligible companies to disclose.

PRE-TEST

1. Non-opioids are the preferred treatment for which type of pain?
2. What are SBIRT and DRAST-10?
3. Declining to dispense buprenorphine can lead to_____?
4. What guideline provides safe treatment recommendations for SUD?

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LEARNING OBJECTIVES

- 1) Describe the key components of the CDC Clinical Practice Guidelines for Prescribing Opioids for Pain (2022) and their relevance to current clinical practice in Kansas.
- 2) Identify barriers and facilitators to implementing opioid prescribing guidelines across diverse Kansas health care settings.
- 3) Demonstrate knowledge of best practices in screening for substance use disorders (SUDs) and how to integrate these practices into routine clinical workflows.
- 4) Evaluate educational and training opportunities for providers and professionals to improve competency in: SUD prevention and treatment, Safe prescribing of controlled substances, Effective use of wraparound services and referral systems.
- 5) Apply strategies for enhancing medication safety, including opioid disposal programs, clinical decision support tools, and prescription monitoring programs (PMPs).
- 6) Develop an actionable plan to expand multidisciplinary education and interprofessional collaboration to support opioid stewardship and SUD management in their local practice or institution.

BACKGROUND

Ranked 8th Nationally
Prescription Opioid
Dispensing

APPROPRIATE
PRESCRIBING
OF OPIOIDS
UNDER PAR



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GUIDELINE OVERVIEW

CDC Clinical Practice Guideline for Prescribing Opioids for Pain

Evolving Guidance on Opioid Prescribing

2016

Centers for Disease
Control and Prevention
(CDC) Guidelines²
Focused on primary
care providers

Aimed to help with
risk differentiation for
opioids in treating
chronic pain

Resulted in
decrease in opioid
prescribing^{3,4}

Noted increase in
use of nonopioid
pain medications^{3,4}

However, state laws
did not always align

2022

Centers for Disease
Control and Prevention
(CDC) Guidelines⁴
Expanded provider focus

Addressed opioid
prescribing for adult
outpatients with pain

Elaborated on
various pain
durations

Did not address
palliative, end-of-life,
cancer, or sickle cell
disease-related pain

Emphasizes effective,
safe, personalized,
and equitable pain
management

Image courtesy of HMG Global Learning Network

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Determining whether or not to
initiate opioids for pain

Selecting opioids and
determining dosages

**CDC Clinical Practice
Guideline for Prescribing
Opioids for Pain (2022)**

Deciding duration of initial opioid
prescription and conducting
follow-up

Assessing risk and addressing
potential harms of opioid use

DETERMINING WHETHER OR NOT TO INITIATE OPIOIDS FOR PAIN

Recommendation 1

Nonopioid therapies are at least as effective as opioids for many common types of acute pain.

Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient. Before prescribing opioid therapy for acute pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy.

(recommendation category: B; evidence type: 3)



DETERMINING WHETHER OR NOT TO INITIATE OPIOIDS FOR PAIN

Recommendation 2

Nonopioid therapies are preferred for subacute and chronic pain. Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient. Before starting opioid therapy for subacute or chronic pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy, should work with patients to establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks.

(recommendation category: A; evidence type: 2)

SELECTING OPIOIDS AND DETERMINING OPIOID DOSAGES

Recommendation 3

When starting opioid therapy for acute, subacute, or chronic pain, **clinicians should prescribe immediate-release opioids** instead of extended-release and long-acting (ER/LA) opioids

(recommendation category: A; evidence type: 4)



SELECTING OPIOIDS AND DETERMINING OPIOID DOSAGES

Recommendation 4

When opioids are initiated for opioid-naïve patients with acute, subacute, or chronic pain, **clinicians should prescribe the lowest effective dosage**. If opioids are continued for subacute or chronic pain, clinicians should use caution when prescribing opioids at any dosage, should carefully evaluate individual benefits and risks when considering increasing dosage, and should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients.

(recommendation category: A; evidence type: 3)

SELECTING OPIOIDS AND DETERMINING OPIOID DOSAGES

Recommendation 5

For patients already receiving opioid therapy, **clinicians should carefully weigh benefits and risks and exercise care when changing opioid dosage**. If benefits outweigh risks of continued opioid therapy, clinicians should work closely with patients to optimize nonopioid therapies while continuing opioid therapy. If benefits do not outweigh risks of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to lower dosages or, if warranted based on the individual circumstances of the patient, appropriately taper and discontinue opioids. Unless there are indications of a life-threatening issue such as warning signs of impending overdose (e.g., confusion, sedation, or slurred speech), opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages. *(recommendation category: B; evidence type: 4)*

DECIDING DURATION OF INITIAL OPIOID PRESCRIPTION AND CONDUCTING FOLLOW-UP

Recommendation 6

When opioids are needed for acute pain, **clinicians should prescribe no greater quantity than needed** for the expected duration of pain severe enough to require opioids.

(recommendation category: A; evidence type: 4)

DECIDING DURATION OF INITIAL OPIOID PRESCRIPTION AND CONDUCTING FOLLOW-UP

Recommendation 7

Clinicians should evaluate benefits and risks with patients within 1–4 weeks of starting opioid therapy for subacute or chronic pain or of dosage escalation. Clinicians should regularly reevaluate benefits and risks of continued opioid therapy with patients.

(recommendation category: A; evidence type: 4)

ASSESSING RISK AND ADDRESSING POTENTIAL HARMS OF OPIOID USE

Recommendation 8

Before starting and periodically during continuation of opioid therapy, **clinicians should evaluate risk for opioid-related harms and discuss risk with patients.** Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone.

(recommendation category: A; evidence type: 4)



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ASSESSING RISK AND ADDRESSING POTENTIAL HARMS OF OPIOID USE

Recommendation 9

When prescribing initial opioid therapy for acute, subacute, or chronic pain, and periodically during opioid therapy for chronic pain, **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 combinations that put the patient at high risk for overdose.**

(recommendation category: B; evidence type: 4)



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ASSESSING RISK AND ADDRESSING POTENTIAL HARMS OF OPIOID USE

Recommendation 10

When prescribing opioids for subacute or chronic pain, **clinicians should consider the benefits and risks of toxicology testing** to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances.



(recommendation category: B; evidence type: 4)

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ASSESSING RISK AND ADDRESSING POTENTIAL HARMS OF OPIOID USE

Recommendation 11

Clinicians should use particular caution when prescribing opioid pain medication and **benzodiazepines concurrently** and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants.



(recommendation category: B; evidence type: 3)

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ASSESSING RISK AND ADDRESSING POTENTIAL HARMS OF OPIOID USE

Recommendation 12

Clinicians should offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder. Detoxification on its own, without medications for opioid use disorder, is not recommended for opioid use disorder because of increased risks for resuming drug use, overdose, and overdose death.



(recommendation category: A; evidence type: 1)

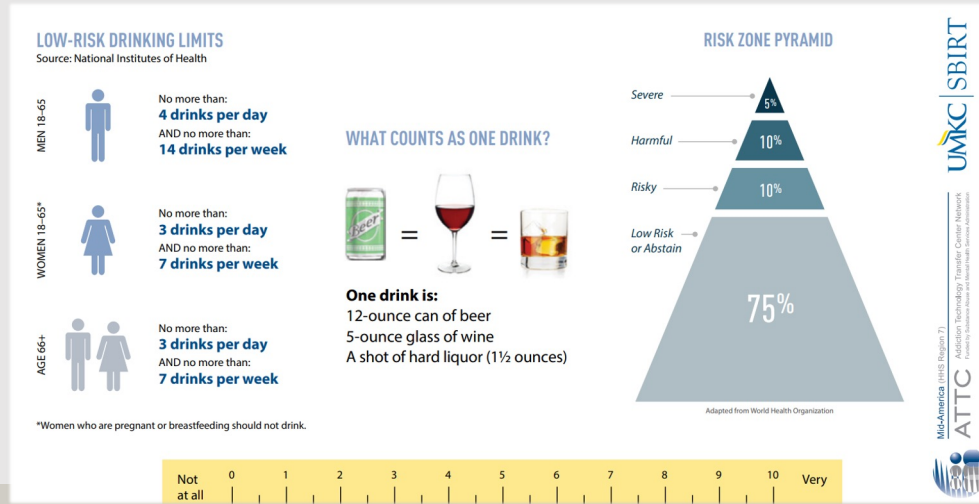


SCREENING TOOLS

Screening, Brief Intervention, and Referral to Treatment for Substance Use



SBIRT



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DAST-10

In the past 12 months...		Circle	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop abusing drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No
Scoring: Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point.		Score:	

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PHARM-OD GUIDELINE

The Pharmacy Access to Resources and
Medication for Opioid Use Disorder



Maintenance
pharmacotherapy
with buprenorphine

Potential indicators of
misuse or diversion
and prescription drug
monitoring programs

Early refills

Telehealth

Buprenorphine
monoproduct

Optimizing safety and
effectiveness of
buprenorphine
pharmacotherapy

Care coordination and
prescriber
communication

Stigma towards
persons with OUD

Employer oversight

HELPFUL RESOURCES FOR SUBSTANCE USE DISORDER

FIND TREATMENT LOCATIONS

 U.S. Department of Health & Human Services

[En Español](#)

 **FindTreatment.gov**

SAMHSA
Substance Abuse and Mental Health
Services Administration

Search SAMHSA.gov

Search

[Home](#)

[Search For Treatment](#)

[State Agencies](#)

[Facility Registration](#)

[FAQs](#)

[Help](#)

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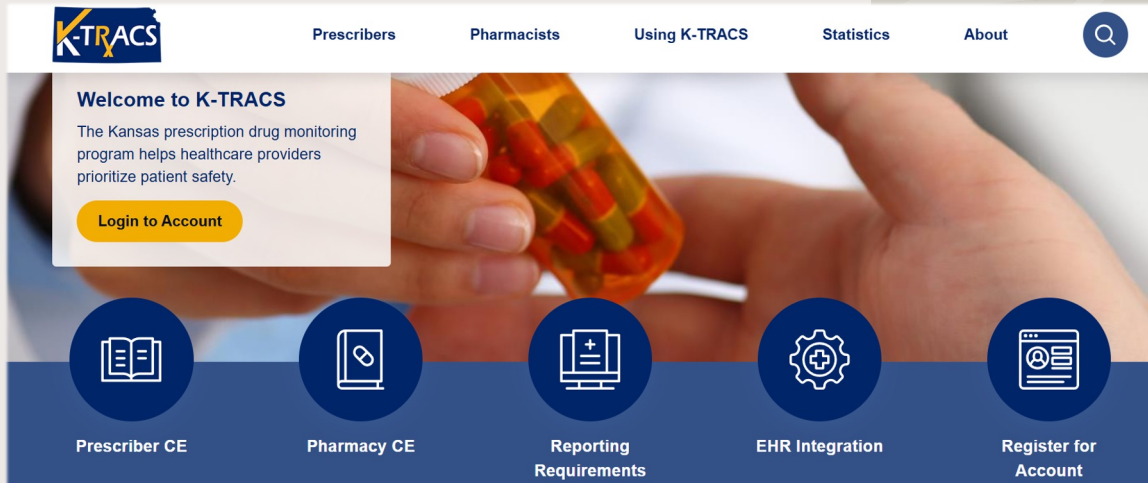
[Contact Us](#)

Millions of Americans have mental and substance use disorders. Find treatment here.

Welcome to FindTreatment.gov, the confidential and anonymous resource for persons seeking treatment for mental and substance use disorders in the United States and its territories.



UNDERSTAND PATIENT HISTORY



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LOCATE PROVIDERS & DISPENSING SITES

The screenshot shows the Vivitrol website. The top navigation bar includes links for UNDERSTANDING ADDICTION, ALCOHOL DEPENDENCE, OPIOID DEPENDENCE, Medication Guide, Prescribing Information, Important Safety Information, For Healthcare Professionals, and a GET MORE INFO button. Below the navigation bar is a hero section with a background image of a man in a brown jacket. On the left, the text reads 'VIVITROL® (naltrexone for extended-release injectable suspension) 380 mg/vial'. To the right of the image are links for WHY VIVITROL?, THE RECOVERY JOURNEY, TALKING TO YOUR HEALTHCARE PROVIDER, and STARTING VIVITROL, along with a search icon and buttons for FIND A PROVIDER and EXPLORE CO-PAY. Below the hero section is a yellow box with text about VIVITROL being a prescription injectable medicine used to treat alcohol dependence and prevent relapse to opioid dependence. Below this is a large image of the same man in the brown jacket. To the right of the image is a white box with the heading 'IMPORTANT SAFETY INFORMATION' and a list of conditions under which one should not receive VIVITROL.

UNDERSTANDING ADDICTION **ALCOHOL DEPENDENCE** **OPIOID DEPENDENCE** Medication Guide Prescribing Information Important Safety Information For Healthcare Professionals GET MORE INFO

Vivitrol®
(naltrexone for extended-release injectable suspension) 380 mg/vial

WHY VIVITROL? **THE RECOVERY JOURNEY** **TALKING TO YOUR HEALTHCARE PROVIDER** **STARTING VIVITROL** **FIND A PROVIDER** **EXPLORE CO-PAY**

VIVITROL is a prescription injectable medicine used to:

- Treat alcohol dependence. You should stop drinking before starting VIVITROL.
- Prevent relapse to opioid dependence, **after** opioid detoxification.

You must stop taking opioids before you start receiving VIVITROL. To be effective, VIVITROL must be used with other alcohol or drug recovery programs such as counseling.

VIVITROL may not work for everyone. It is not known if VIVITROL is safe and effective in children.

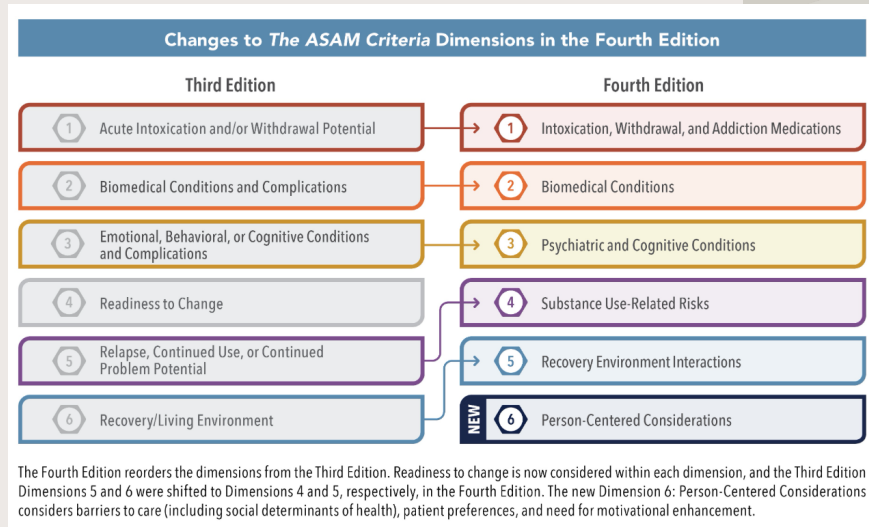
IMPORTANT SAFETY INFORMATION

Do not receive VIVITROL® if you:

- are using or have a physical dependence on opioid-containing medicines or opioid street drugs, such as heroin. To test for a physical dependence on opioid-containing medicines or street drugs, your healthcare provider may give you a small injection of a medicine called naloxone. This is called a naloxone challenge test. **If you get**

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DIG DEEPER...



POST-TEST

1. Non-opioids are the preferred treatment for which type of pain? Select all that apply.

- a) Sickle Cell Pain
- b) Acute Pain
- c) Cancer Related Pain
- d) Subacute Pain
- e) Chronic Pain

POST-TEST

2. SBIRT and DRAST-10 are:

- a) Pain Scales
- b) Treatment Plans for SUD
- c) Screening Tools for SUD

POST-TEST

3. Declining to dispense buprenorphine can lead to?

- a) Interruptions in OUD treatment
- b) Force patients into withdrawal
- c) Increase use of recurrent opioid use
- d) Death
- e) All of the above

POST-TEST

4. What guideline provides safe treatment recommendations for SUD?

- a) CDC Clinical Practice Guideline for Prescribing Opioids for Pain
- b) SBIRT
- c) DRAST-10
- d) PhARM-OD
- e) ASAM

REFERENCES

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THANK YOU!

Questions?

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UNDER PAR
OR OVER
PRESCRIBED

Collect Your CE

The Lecture Panda
code for this session is:

*All course credits from this
conference must be submitted by
Oct. 15, 2025.*