UNDER PAR OR OVER PRESCRIBED:

IMPROVING KANSAS OPIOID PRESCRIBING THROUGH COLLABORATIVE ACTION

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ACPE UAN 0143-9999-25-071-L08-P/T

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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?

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

GUIDELINE OVERVIEW

CDC Clinical Practice Guideline for Prescribing Opioids for Pain

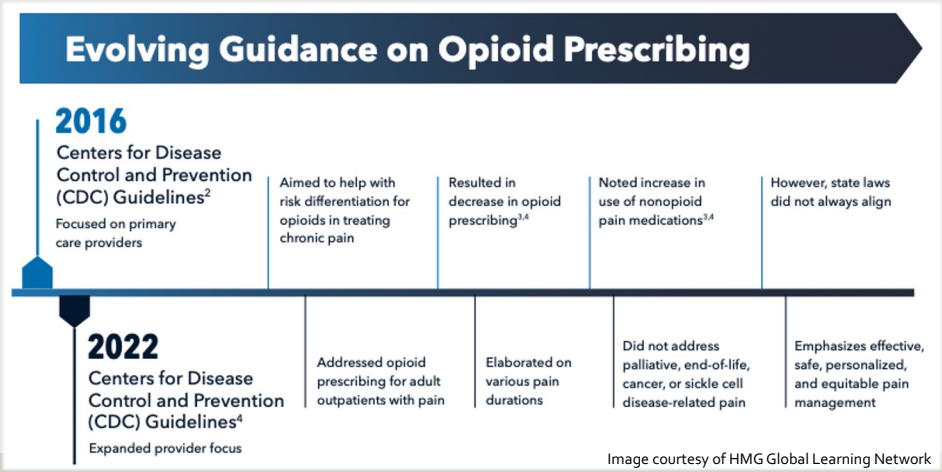


Image courtesy of HMG Global Learning Network

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.

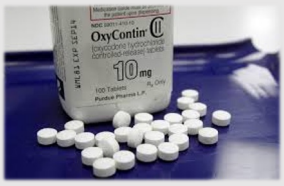
(recommendation category: A; evidence type: 2)

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)



Xtampza ER (oxycodone) EXTENDED-RELEASE CAPSULES II

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)

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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)

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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)

K-TRACS
Prescription Drug Monitoring Program

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)

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)

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)

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SCREENING TOOLS

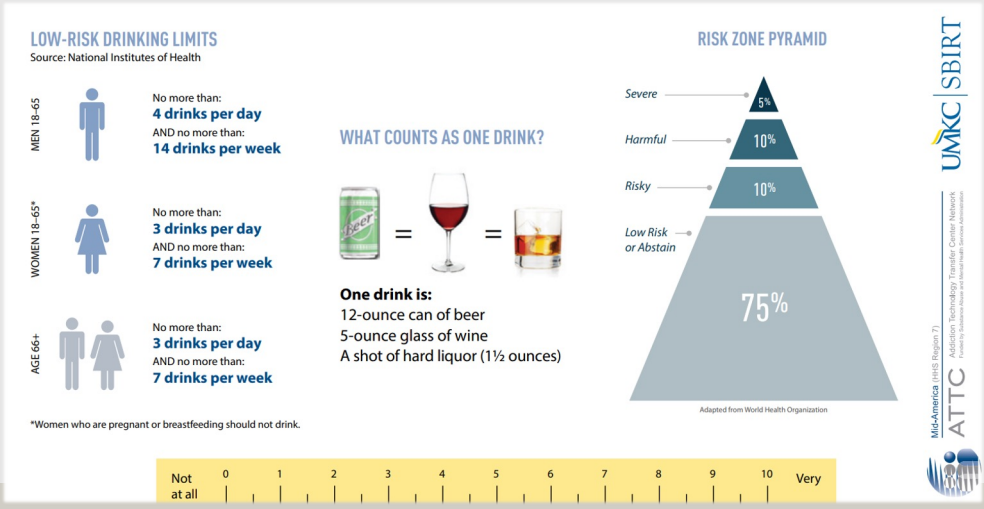
Screening, Brief Intervention, and Referral to Treatment for Substance Use

Addiction Research Foundation

SAMHSA Substance Abuse and Mental Health Services Administration

UMKC | SBIRT
Screening, Brief Intervention, and Referral to Treatment for Substance Use

SBIRT



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:**	

PHARM-OUD GUIDELINE

The Pharmacy Access to Resources and Medication for Opioid Use Disorder

NCPA NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

NABP National Association of Boards of Pharmacy

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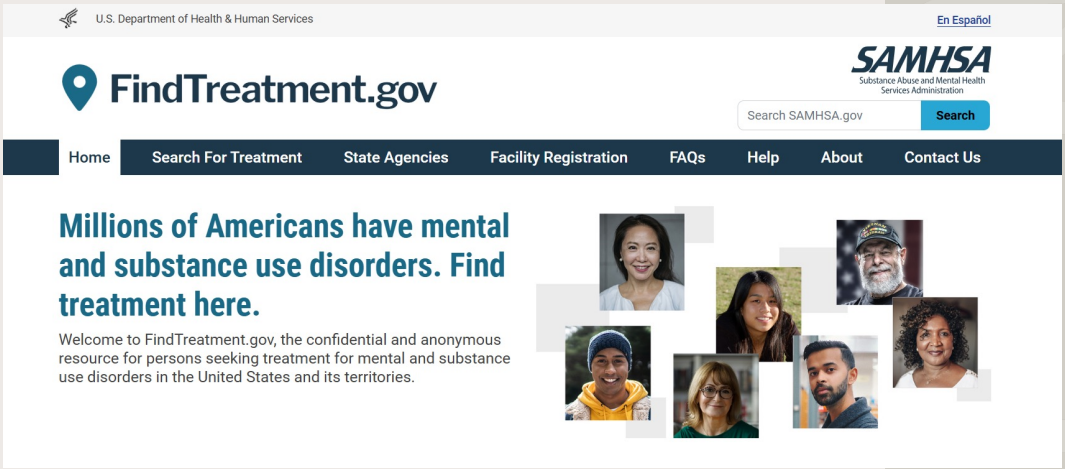
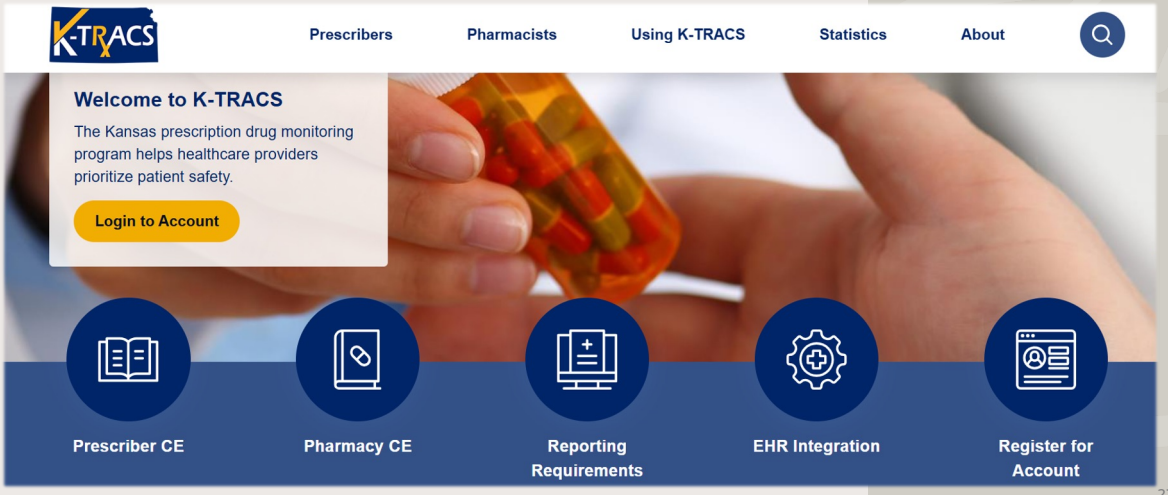
Maintenance pharmacotherapy with buprenorphine	Potential indicators of misuse or diversion and prescription drug monitoring programs	Early refills
Telehealth	Buprenorphine monoproduct	Optimizing safety and effectiveness of buprenorphine pharmacotherapy
Care coordination and prescriber communication	Stigma towards persons with OUD	Employer oversight

HELPFUL RESOURCES FOR SUBSTANCE USE DISORDER

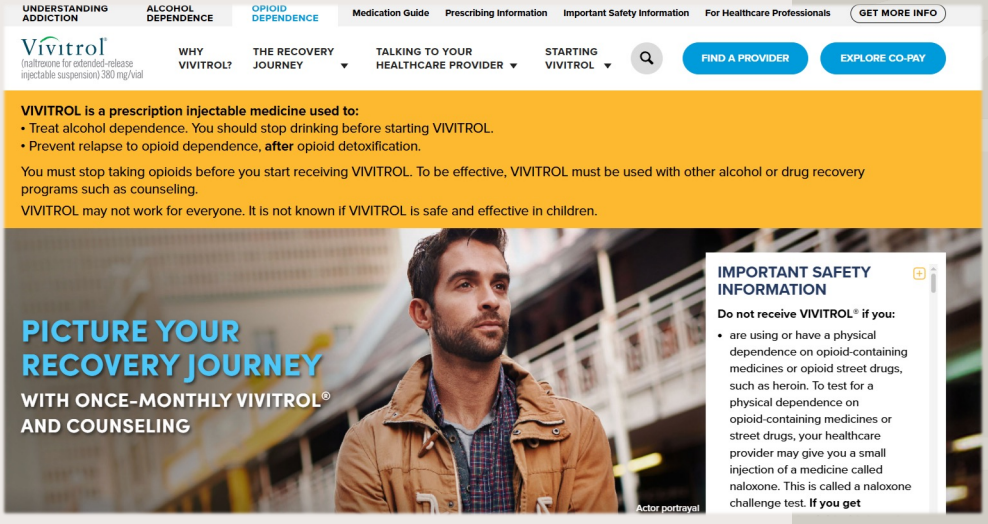
FIND TREATMENT LOCATIONS



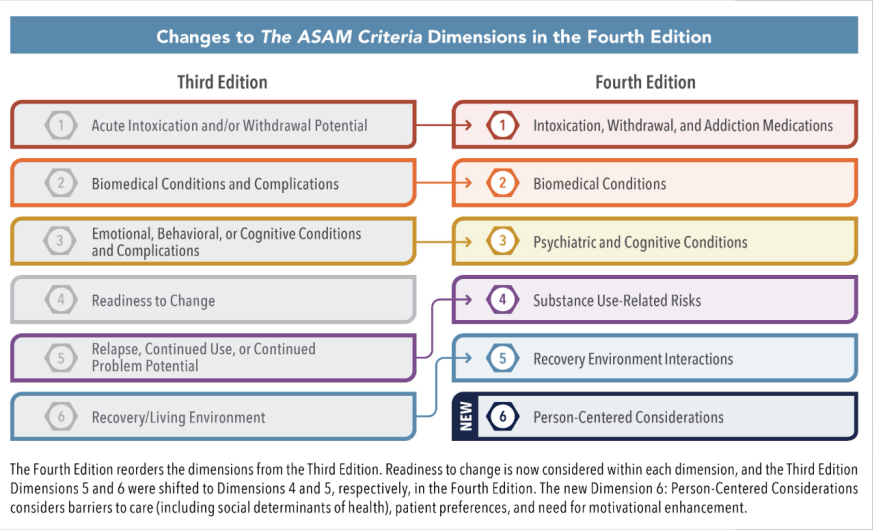
UNDERSTAND PATIENT HISTORY



LOCATE PROVIDERS & DISPENSING SITES



DIG DEEPER…



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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

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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-OUD
e) ASAM

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THANK YOU!

Questions?

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