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FEATURE ARTICLE

Opioid stewardship in action

BY: TIANA TILLI, BSC (HONS), PHARMD, RPH, ACPR

Over 6,000 Canadians died last year from opioid poisonings.1 The term “opioid poisoning” is used rather than “opioid overdose” to shift the blame from individuals to underlying perpetuating factors within society.2 One such factor is high-risk opioid prescribing, which includes high-dose opioid prescriptions, opioids co-prescribed with benzodiazepines, and multiple co-prescribed opioids.3,4

Opioid stewardship is the term used to describe coordinated interventions that improve, monitor, and evaluate the use of opioids to support and protect human health.4,5 Opioid stewardship includes measures to address high-risk opioid prescribing and increase the safety of pain management plans for patients. Pharmacists, in collaboration with prescribers, have an important role in opioid stewardship.6 Pharmacist intervention has been found to decrease pain intensity for patients, reduce overall opioid doses, increase adherence to guidelines, and improve patient safety.7

At the UBC Pharmacists Clinic, we see many complex patients with chronic, uncontrolled, non-cancer pain despite numerous medication trials. They may self-refer or be referred by their primary care provider or specialist for pharmacist input. Our approach to opioid stewardship includes:

Person-Centered Care

- Start by asking patients what successful pain management means for them. This guides our decision-making and helps patients set personalized, realistic goals.
- Ask patients what they want to know about their medications and talk through their questions and concerns.
- Track social history in detail and align treatment recommendations with their circumstances. For example, patients with financial concerns are directed to resources for low- or no-cost CBT or counselling.
- Review care plans with patients so they understand in practical terms what is going to happen.

Medication Assessment

- Collect a full pain medication history, including the name, dose, duration and patient experience with all current and past medication trials.
- Assess each trial to distinguish between failed trials and inadequate trials. Signs of a failed trial include: timeframe too short, dose too low, side effects not managed. Failed trials may warrant retrial.
- When necessary, research primary and grey literature to identify evidence-informed alternative treatment options.

Recommendations

- Take extra care to optimize non-opioid analgesics such as gabapentinoids or other antiepileptics, anti-inflammatories, tricyclic antidepressants, serotonin norepinephrine reuptake inhibitors, topical compounds, corticosteroids, and/or cannabis as indicated. Recommend deprescribing plans for ineffective or unsafe medications.
- Explore opioid rotations* where appropriate.
- Include harm reduction strategies (e.g., naloxone, opioid agonist therapy).

Collaboration with Prescribers

- Ensure the patient's prescriber is on-board with working together upfront.
- Define the roles each will play in patient education and monitoring.
- Confirm how timely communication, supportive therapy and dosing adjustments or treatment changes will be managed.

*About Opioid Rotations[8,9]

- When a patient is switched from one opioid to another specifically to address uncontrolled pain, intolerable side effects, and/or the need for higher doses of the initial opioid.
- Best practices for an opioid rotation include:
  - Ensure the patient and prescriber are committed to collaboration
  - Calculate the current daily total milligrams of morphine equivalent
  - Identify an alternate opioid agent
  - Calculate a reduced dose of the alternate agent to account for cross-tolerance
  - Choose a suitable dosage form of the alternate agent, explaining withdrawal/overdose symptoms/management
  - Provide a naloxone kit with training, and
  - Provide close follow-up.

We recognize the time and commitment required for the care of patients with uncontrolled pain. We also recognize that some pharmacists and prescribers do not have the time or capacity to provide this level of intense, ongoing care to individual patients. We encourage colleagues to reach out to our Clinic team if you are concerned about a patient or would like our input in the care of a patient with uncontrolled, chronic non-cancer pain.

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