OPIOID AWARENESS
DO NO HARM 2.0

Pain management and opioid safety in primary care

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NaRCAD

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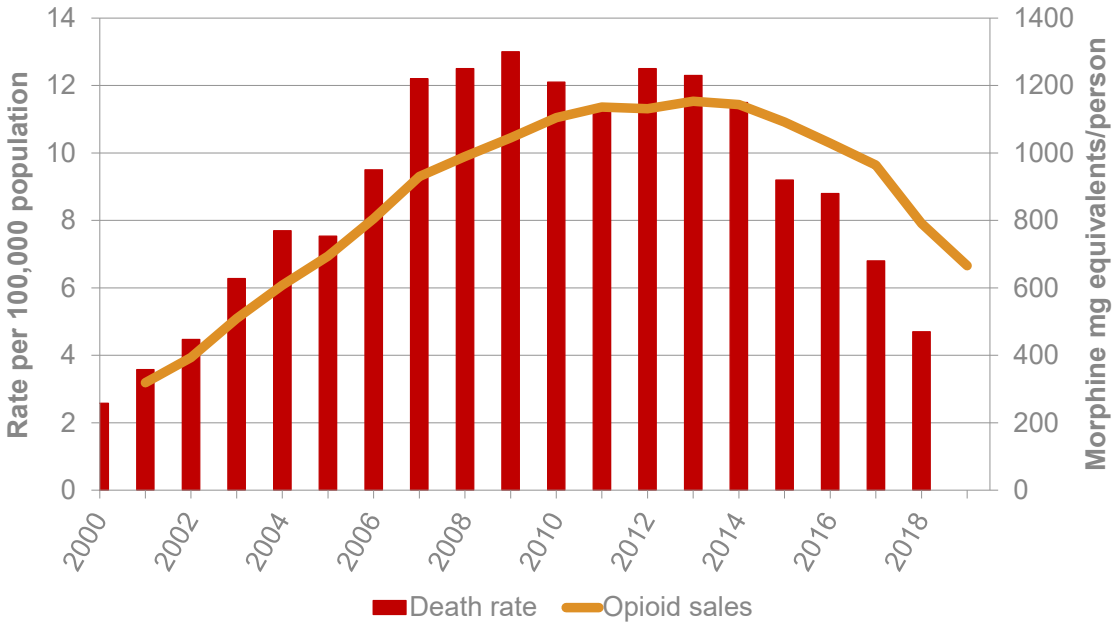
The opioid epidemic in Oklahoma

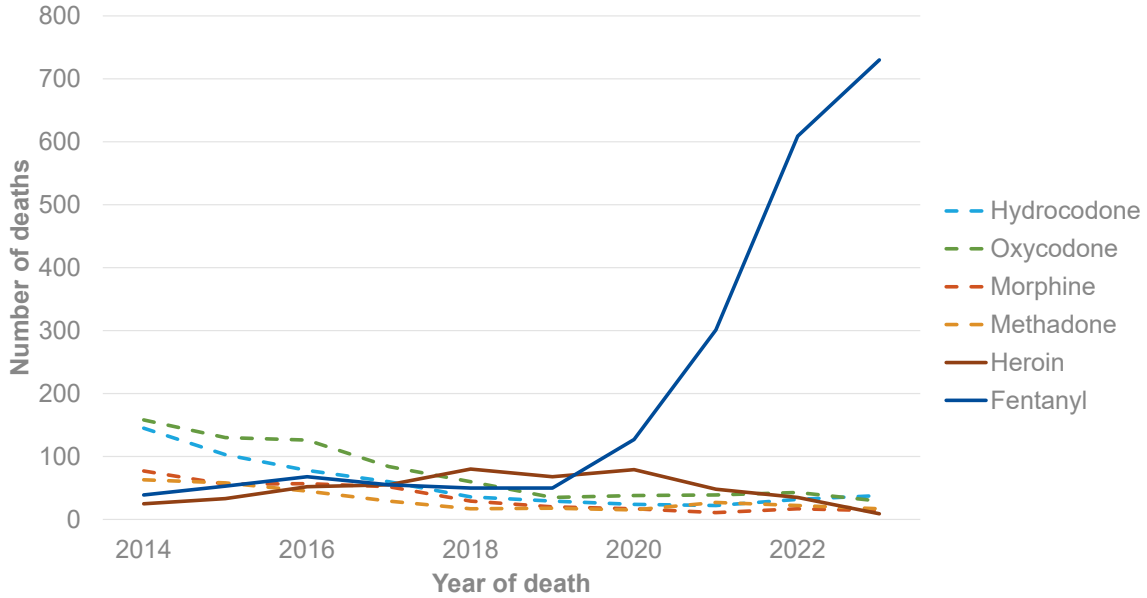
Although the rate of opioid prescribing has decreased in Oklahoma, the opioid crisis is not over, and responsible prescribing continues to be a priority. Opioid prescriptions written for acute pain conditions frequently result in unused medication, which increases **the risk of addiction, accidental overdose, and diversion.**

Unintentional Prescription Opioid Overdose Death Rates and Opioid Sales per Person, Oklahoma, 2000-2019[1]



Over most of the last 25 years, prescription opioids were the most common type of drug involved in overdose deaths in Oklahoma. The rate of unintentional prescription opioid overdose death decreased 68% from 2013 to 2019. This decrease paralleled a 42% decrease in dispensing of common prescription opioids. **The recent increase in opioid overdose deaths is due to an increase in the availability of illicitly manufactured fentanyl, and fentanyl now accounts for 90% of all opioid overdose deaths in Oklahoma.**

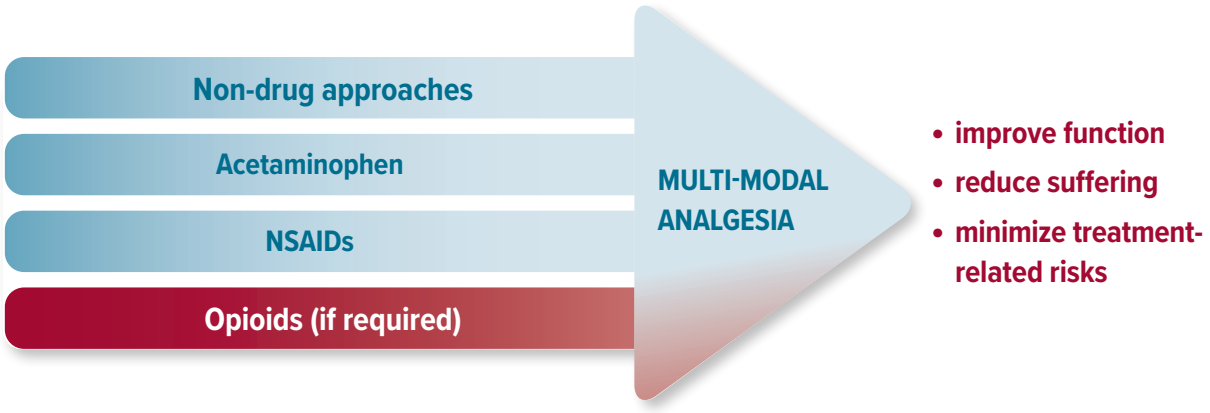
Unintentional Opioid Overdose Deaths by Drug, Oklahoma, 2014-2023[2]



Limit opioid prescribing for acute pain

Patients often first receive opioids for acute pain conditions, such as wisdom tooth extractions, minor surgery, or musculoskeletal injuries. These short-term pain conditions typically resolve over time, usually in no more than three days.

When pain treatment is needed, use multiple options to get patients back to regular activities.



DO NO HARM if newly prescribing opioids for acute pain.

- ☑ **Prescribe short courses of immediate release opioids at low doses,** ideally three days or fewer. Each refill or additional week of opioid prescribed increases the risk of misuse by 20%.[3]
- ☑ **Continue non-opioid treatments.** Emphasize to patients that non-opioid modalities can have a greater effect on functional improvement than opioids.
- ☑ **Check the Oklahoma Prescription Monitoring Program** prior to prescribing.
- ☑ **Avoid co-prescribing with benzodiazepines,** as this doubles the risk of overdose death.[4]

If prescribing opioids for acute pain in patients on long-term opioids:

- Use lowest effective dose of additional immediate release opioid for the shortest time.
- Continue to emphasize multi-modal approaches, including non-opioid medications and non-drug options.
- Taper acute pain opioid as pain resolves.
- Counsel patients on naloxone and risk of opioid overdose.

For patients with acute pain requiring opioids who have OUD or substance use disorder, collaborate with an addiction treatment provider to develop a safe care plan.

Prescribe naloxone to prevent opioid overdose death

Recommend it to those:[5]

- taking more than 50 MMED
- with renal insufficiency or hepatic dysfunction
- co-prescribed benzodiazepines
- with reductions in their opioid doses
- with respiratory issues and sleep apnea
- with a diagnosis of substance use disorder or opioid overdose

It takes as little as one week to lose tolerance. Opioid dose reductions, voluntary or involuntary, put patients at increased risk of overdose.

Examples of naloxone products available:

	Intranasal (Narcan®)	Intranasal (Kloxxado®)	Injectable prefilled syringe (Zimhi™)
Preferred option • no prescription needed (*Narcan Only*)			
Strength	4 mg/0.1 mL	8 mg/0.1 mL	5 mg/0.5 ml
Sig for suspected overdose	Spray full dose into one nostril.	Spray full dose into one nostril.	Inject 0.5 ml (5 mg) into the outer thigh. Can be used through clothing.
Second dose	Repeat into other nostril after 2-3 min if no or minimal response. 1 nasal device = 1 dose	Repeat into other nostril after 2-3 min if no or minimal response. 1 nasal device = 1 dose	Give a second dose after 2-3 min if no or minimal response, using second prefilled syringe.

Opportunities to improve opioid safety

Ask SBIRT questions at every visit.

- Any patient on opioids can develop Opioid Use Disorder (OUD) or depression.
- SBIRT is an evidence-based practice to identify and start treatment in patients with substance use disorder or mental health problems.
- It is billable and can be initiated in the primary care office.
- Intervention with SBIRT can improve patient outcomes.

Check the OK-PMP.

If OK-PMP identifies opioids filled from another provider:

- Discuss reasons for seeking additional opioids.
- Review the terms of the pain plan.
- When appropriate, offer referral for OUD treatment.

Review the OK-PMP for any co-prescribed benzodiazepines.

- Benzodiazepines double the risk of overdose and should be avoided when possible. Talk to patients about their benzodiazepine use, if identified.

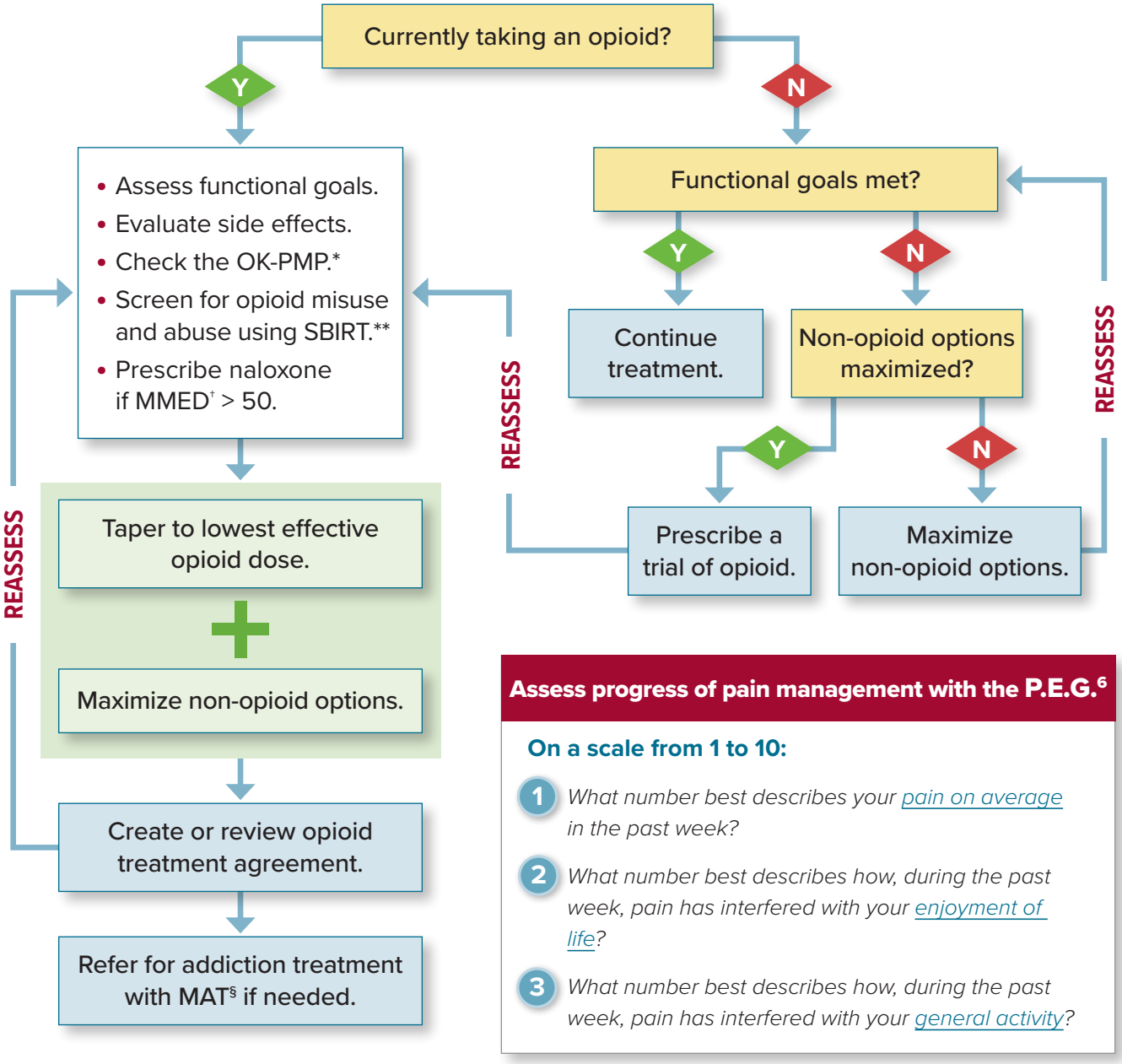
Use urine drug testing.

- Understand metabolites of prescribed opioids (see mytopcare.org).
- If other substances such as marijuana or heroin are positive:
  - Discuss use of these drugs with patients.
  - Refer to treatment for substance use disorder if needed.
  - Increase frequency of urine drug screens to every visit.
  - Establish a clear action plan if further urine tests are positive for illicit drugs.

Transitioning from acute to chronic pain

Managing pain in compliance with Oklahoma SB 1446 includes closely assessing functional goals, establishing a written treatment plan, optimizing additional non-drug and drug treatment options, and reducing risk if prescribing opioids.

An algorithm for managing chronic pain



Assess progress of pain management with the P.E.G.[6]

On a scale from 1 to 10:

1. *What number best describes your pain on average in the past week?*
2. *What number best describes how, during the past week, pain has interfered with your enjoyment of life?*
3. *What number best describes how, during the past week, pain has interfered with your general activity?*

* **OK-PMP:** Oklahoma Prescription Monitoring Program

****SBIRT:** Screening, Brief Intervention, and Referral to Treatment

† **MMED:** Morphine Milligram Equivalents per Day

§ **MAT:** Medication Assisted Treatment

Evidence for non-opioid chronic pain management options

	TREATMENT OPTIONS	Neuropathic pain	Nociceptive pain
DRUG OPTIONS	**acetaminophen** (Tylenol, generics)	○	●
	NSAIDs—oral (ibuprofen, naproxen)	○	◉
	NSAIDs—topical (diclofenac gel)	○	◉
	lidocaine patch (Lidoderm, generics)	●	○
	selective serotonin reuptake inhibitors (SSRIs)	○	○
	tricyclic antidepressants (amitriptyline, nortriptyline)	◉	○
	serotonin-norepinephrine reuptake inhibitors (SNRIs)		
	duloxetine (Cymbalta, generics)	◉	●
	milnacipran (Savella)	◉	○
	venlafaxine (Effexor, generics)	◉	○
	anticonvulsants (gabapentin, pregabalin)	◉	○
NON-DRUG OPTIONS	**exercise** (physical therapy, tai chi)	○	◉
	acupuncture	○	◉
	massage	○	●
	transcutaneous electrical nerve stimulation	●	○
	cognitive behavioral therapy	○	●
	self-management/empowered relief therapy[7]	○	●
	mindfulness meditation	○	●

Coding based on quality of data for use in the elderly:

◉ = data from at least 1 randomized controlled trial (RCT) or meta-analysis of RCTs, with consistent efficacy

● = data from non-experimental studies or inconsistent efficacy

○ = inadequate data or not effective

Implement structured visits for chronic pain

Initial visit

- ☑ **Complete comprehensive exam** and confirm diagnosis.
- ☑ **Evaluate for medical conditions** (e.g., sleep apnea).
- ☑ **Screen for behavioral health risks** such as depression (PHQ 9), anxiety (GAD 7), drug abuse (DAST-10), alcohol use (AUDIT).
- ☑ **Check OK-PMP.**
- ☑ **Establish goals for better function.**
- ☑ **Create a multi-modal pain plan and a signed treatment agreement.**

If using an opioid:

- **Advise on the risks of opioids:**
  - –Constipation, low testosterone, fractures
  - –Dependence, abuse, overdose, and death
- **Monitor for appropriate opioid use:**
  - –OK-PMP check at least every three months
  - –Urine screens (see mytopcare.org)
- **Discuss management of opioids:**
  - –Store in locked place, refill policies
  - –Taper opioids if not achieving goals
- **Refer or discuss co-management with appropriate specialists, as needed.**
- **Sign informed consent.**

Follow-up visits for chronic pain

- ☑ **Monitor progress** toward functional goals using a standard assessment like P.E.G.
- ☑ **Review responses to SBIRT questions.**
- ☑ **Check OK-PMP.**
- ☑ **Screen for side effects of pain medications.**
- ☑ **Monitor opioid use,** if prescribing, through urine drug screens, pill counts, and asking patients about how they are using their opioids.
- ☑ **Review the multi-modal pain plan.**
- ☑ **Schedule follow up in 1-3 months** and review pain plan at least annually.

Ensuring safer pain care

DO	• assess pain • create a pain management plan • set goal for improved function • recommend naloxone
NO	• opioid prescription without assessment and plan • sedating medications with opioids • overdose deaths and suicides
H	**HARM REDUCTION by avoiding or tapering opioids if:** • ineffective • side-effects • opioid use disorder (OUD) • behavioral health problems
A	**AGREE in writing on:** • opioid risks and benefits • 1 prescriber, 1 pharmacy • no early refills • monitoring visits • urine drug testing • OK-PMP checks
R	**RX opioids using:** • lowest effective dose • immediate release formulations • acute pain < 3 days, rarely 7 • chronic pain < 50 MMED
M	**MONITOR for:** • progress toward functional goal • misuse • side-effects • treating or referring OUD or behavioral health problems

Key messages

- Optimize non-opioid treatments for acute pain.
- For patients with severe pain requiring opioids, prescribe lowest dose, shortest course.
- Understand efficacy of non-opioid management options for chronic pain.
- Establish a process of identifying and monitoring patients with chronic pain, especially if opioids are prescribed.
- Remember to **DO NO HARM** for patients prescribed opioids.

DO NO HARM SELF-ASSESSMENT

Goals, Objectives, and Strategies

GOAL	OBJECTIVE	TARGET STRATEGY	ASSESSMENT	PRIORITY
Quality of Care	Better Pain Plan	Chronic pain assessment		
		Multi-modal pain plan		
		Patient and practice education		
	Safer Opioid Prescribing	Guideline-based decisions		
		Opioid risk assessment		
		Prescriber refill policy		
		Patient informed consent		
		Monitoring opioid risk and misuse		
	Better Mental Health	Alcohol screening and referral		
		Depression and suicide screening (Zero Suicide)		
		Referral and co-management		
Financial Security	Better Primary Care	Chronic pain/opioid registry		
		Access and continuity of care		
		ED/Hospital follow-up protocol		
	Document, Code and Bill	EHR/PMS changes		
	Data-Driven Quality	QI teams, dashboards, measures		
		Improve information technology		
Joy in Practice	Teamwork	Huddles, roles, protocols		
	Patient Centered Care	Patient surveys or PFAC		
Healthy Community	No OD/Suicide Deaths	OEND project, OKIMREADY and Zero Suicide		
	Meet Social Needs	Screening and referral for SDoH		

ASSESSMENT	CODE
Not answered	0
No protocol and/or not used	1
Partial protocol, rarely used	2
Partial protocol, used some of the time	3
Protocol, used most of the time	4
Protocol, used all the time	5

PRIORITY

Rank in order of priority from 1 to 5, with 1 as most important to the practice.

Ver 2.3, 10/24/2022

RPR Exchange (Research to Practice to Research Exchange): A convenient way for clinicians and researchers to communicate about information relevant to clinical practice. Learn more at: rpr.lib.ok.us.

DO NO HARM 2.0 is a practice improvement program helping primary care practices implement delivery system changes, technology, clinical decision support, and patient self-management to adopt guidelines for safer pain and opioid management.

Partnering organizations

NaRCAD is a national resource center that supports clinical outreach education programs across the United States. With NaRCAD's trainings and ongoing program support, clinical educators have a greater impact when visiting front line clinicians, helping those clinicians to make the best, evidence-based decisions. Learn more at narcad.org.

This material was produced by Alosa Health, a nonprofit organization that produces educational content and manages and provides consulting for clinical outreach education initiatives. Alosa Health is not affiliated with any pharmaceutical company. For more information, visit AlosaHealth.org.

Located in the Oklahoma Clinical and Translational Science Institute at The University of Oklahoma Health Campus, the Oklahoma Primary Healthcare Improvement Cooperative (OPHIC) is the academic research arm of a community-engaged system with a mission to facilitate the diffusion of research innovations into community clinical delivery systems. OPHIC partners include our state's County Health Improvement Organizations and other entities critical for translational research in community settings.

The Oklahoma Department of Mental Health and Substance Abuse Services provides educational resources and clinical services to improve the mental health of the citizens of Oklahoma.

REFERENCES: (1) Oklahoma State Department of Health (OSDH), Injury Prevention Service. Drug Overdose in Oklahoma: Data Update. Oklahoma City, OK: OSDH; 2000-2019. Accessed December 10, 2025. **(2)** Oklahoma State Department of Health (OSDH), Injury Prevention Service. Drug Overdose Data Graphs and Maps. Oklahoma City, OK: OSDH; 2014-2023. Accessed September 24, 2025. **(3)** Brat GA, Agniel D, Beam A, et al. Postsurgical prescriptions for opioid naive patients and association with overdose and misuse: retrospective cohort study. *BMJ* (Clinical research ed). 2018;360:j5790. **(4)** Sun EC, Dixit A, Humphreys K, Darnall BD, Baker LC, Mackey S. Association between concurrent use of prescription opioids and benzodiazepines and overdose: retrospective analysis. *BMJ* (Clinical research ed). 2017;356:j760. **(5)** Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain–United States, 2016. *MMWR Recomm Rep.* 2016;65(1):1-49. **(6)** Krebs EE, Lorenz KA, Bair MJ, et al. Development and initial validation of the PEG, a three-item scale assessing pain intensity and interference. *J Gen Intern Med.* 2009;24(6):733-738. **(7)** Darnall BD, Roy A, Chen AL, Ziadni MS, Keane RT, You DS, Slater K, Poupore-King H, Mackey I, Kao MC, Cook KF. Comparison of a single-session pain management skills intervention with a single-session health education intervention and 8 sessions of cognitive behavioral therapy in adults with chronic low back pain: a randomized clinical trial. JAMA network open. 2021 Aug 2;4(8):e2113401.

Counsel patients on safe storage and disposal of opioids and other controlled substances.

- Store all controlled substances in a locked place.
- Safely dispose of any unused prescriptions:
  - Use activated charcoal disposal bags.
  - Mix meds with an unpalatable substance (e.g., coffee grounds, kitty litter) and place in a plastic bag within household trash.
  - Find DEA Take Back events: **www.dea.gov/takebackday**
  - Bring to a prescription drop off bin: **https://enet.obn.ok.gov/TakeBack**
  - Review your pharmacy's drug disposal options: **https://safe.pharmacy/drug-disposal**