Assessment of rationale in refusal of take-home naloxone by Veterans at risk for opioid overdose in the primary care setting

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BACKGROUND

- Over the past few decades, the United States has experienced a 400% increase in rates of opioid prescribing and a parallel increase in prescription opioid overdose[1]
- Utah Veterans have the highest prescription opioid overdose mortality rate in the nation[2]
- Several risk factors for accidental opioid overdose have been identified[3], including:
  - History of a previous opioid overdose
  - Opioid use disorder
  - Opioid + CNS depressants
  - Daily morphine equivalent dosage ≥50mg
  - Unstable compromising medical or psychiatric condition
- Overdose education and naloxone distribution (OEND) has been demonstrated to save lives[4,5] through education about:
  - Opioid safety and risks of overdose
  - Overdose recognition and response
  - Take-home naloxone (THN)
- Significant stigma surrounds both naloxone and chronic pain, limiting the likelihood that patients receive adequate resources to reduce their risk of accidental overdose[6,7]
- Stigma, defined by Merriam-Webster[8] as "a set of negative and often unfair beliefs that a society or group of people have about something", has been shown to reduce patients' desire to access care[9] and worsen outcomes[10]
- Sufficient data exists describing the attitudes of providers[11], patients with substance use disorders[12], and family members[13] regarding THN
- However, data on perceptions of naloxone is lacking in patients prescribed chronic opioid therapy for pain who are appropriate for THN

OBJECTIVES

1. Examine Veterans' reasons for refusal of take-home naloxone in the primary care setting, with specific interest in stigma-related responses
2. Determine whether an association exists between patient characteristics and reason for refusal
3. Develop strategies to further encourage appropriate patients to accept take-home naloxone

METHODS

Note Update

- Consulted local experts on common reasons for refusal of THN
- Collaborated with local information-technology personnel to update Medication Risk Assessment note template (Figure 2)
- Informed providers of new update to ensure proper documentation

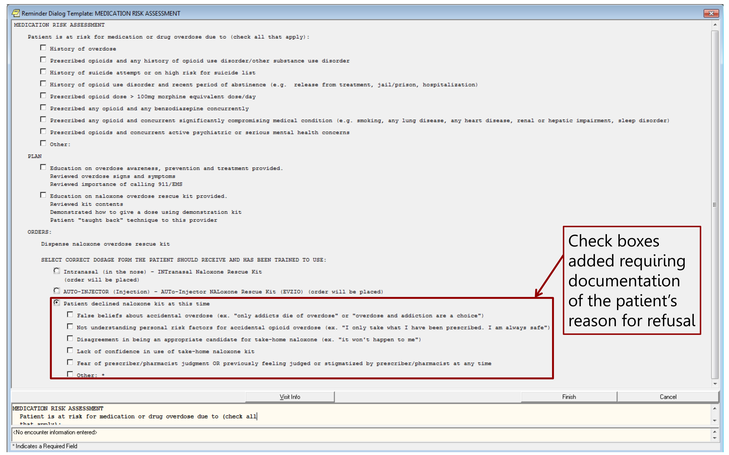

Figure 2. Screenshot of Medication Risk Assessment note template

Data Collection

- Retrospective chart review
- October 1, 2015 – February 28, 2016
- Inclusion Criteria: Patients on chronic opioid therapy refusing THN
- Exclusion Criteria: Patients refusing THN offered outside of primary care

Outcomes

- Primary: Most common reason for patient refusal of take-home naloxone
- Secondary: Correlation between reason for refusal and patient characteristics

RESULTS

Patient Characteristics (n=12)	
Average age	59.3 years
Male	6 (50%)
Psychiatric condition Depression Substance use d/o PTSD	11 (91.7%) 8 (66.7%) 3 (25%) 5 (41.7%
Sleep apnea	6 (50%)

Medication Use	
Morphine equivalent daily dose (MEDD) Average (past 30 days – 2/26/16) Range Patients with ≥50mg	 77.2mg 5 – 188mg 8 (66.7%)
Active benzodiazepine	4 (33.3%)

RESULTS (cont.)

Number of respondents

"I feel that whether or not you say that it isn't held against us, it still feels that way"

Disagreement in being appropriate candidate			
Male vs. Female	5 (83.3%) vs. 3 (50%)	MEDD <50mg	3 (75%)
Depression	5 (62.5%)	MEDD 50-100mg	2 (50%)
PTSD	4 (80%)	MEDD >100mg	3 (75%)
Sleep apnea	6 (100%)	Benzodiazepine	3 (75%)

FUTURE APPLICATIONS

- Determine method of more effectively explaining patient's personal risk of accidental overdose
- Identify appropriate recommendations for Veterans who live alone
- Continue to provide education to healthcare providers about OEND to help reduce patient-experienced stigma

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