Pain Management and Opioid Misuse, Abuse, and Diversion for Michigan Nurses

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COURSE OBJECTIVE: The purpose of this course is to enable Michigan nurses who provide pain management to understand and respond to the issue of misuse, abuse, and diversion of opioid pain medications.

LEARNING OBJECTIVES
Upon completion of this course, you will be able to:

- Discuss the scope and contributing factors to the problem of opioid misuse, abuse, and diversion.
- List common opioid medications with high potential for misuse, abuse, or diversion.
- Outline institutional and clinician efforts to address the problem.
- Describe the process of assessing risk for developing substance abuse disorders.
- Explain pain management for individuals with substance abuse disorders.

INTRODUCTION

Recent decades have resulted in attempts to improve the identification and treatment of pain. In the past, opioids were often avoided for pain management because of the fear of addiction, but as knowledge about pain increased, they became more liberally dispensed. Along with this rise in opioid prescribing and dispensing, there has been an equal rise in opioid addiction and abuse. As a result, clinicians have returned to the fear of addiction and have become, once again, reluctant to prescribe them.

Opioid medications are most commonly prescribed for chronic pain; are the drugs most often misused, abused, or diverted; and are associated with deaths from overdose. Clearly, there is a
dilemma between the need to address this issue while continuing to ensure people with chronic pain receive safe, effective treatment.

**DEFINITION OF TERMS**

The following terms are commonly used in relation to opioid misuse, abuse, and diversion:

**Prescription drug misuse:** Taking a legal prescription medication for a purpose other than the reason for which it was prescribed, or when a person takes a drug not prescribed to him or her (FDA, 2015).

**Prescription drug abuse and non-medical use:** Used synonymously and broadly defined as the use of a medication without a prescription, in a way other than as prescribed, or for the experience or feelings elicited (NIDA, 2014).

**Prescription drug diversion:** Diverting prescription drugs from legal and medically necessary purposes toward use that is illegal and typically not authorized or medically necessary (CMS, 2012).

**Illicit drug use:** The abuse of illegal drugs and/or the misuse of prescription medications (OAH, 2016).

**Addiction:** A chronic, relapsing brain disease characterized by drug-seeking behavior and drug use despite harmful consequences (SAMHSA, 2014). There are four core elements to true addiction:

1. Compulsive use with a preoccupation with the drug and the supply
2. Inability to control consistently quantity used
3. A craving for the psychological effects of the drug
4. Continued use regardless of the adverse effects (ACPA, 2014)

**SCOPE OF THE PROBLEM**

Misuse, abuse, and diversion of opioid prescription medications have become an epidemic across the nation. Several explanations have been proposed as contributing factors.

**The National Epidemic**

The CDC estimates that 2.1 million people in the United States have a substance abuse problem. Opioid overdose has increased and unintended overdose death from prescription pain relievers has tripled in the past 20 years. The CDC reports more people died of overdose in the United
States in 2014 than in any other year in the past and that more die every year from drug overdoses than from motor vehicle crashes.

Since 1999 opioid prescribing has quadrupled and has increased along with overdoses involving these analgesics (9% increase in 2014) (CDC, 2016a). In 2012 healthcare providers wrote enough prescriptions for opioids to give every American adult a bottle of pills.

In 2015 surveys were conducted among prescribing healthcare professionals and patients. Most health professionals (88%) reported that they prescribe opioids to their patients, 91% reported they discussed how and when to take opioid medications, 93% included a discussion of side effects, but only 55% discussed safe storage and proper disposal of unused opioids. Fifty-two percent of patient respondents reported they stored unused pills for future use, and only 23% reported throwing them away or returning unused opioids to a pharmacy with disposal programs, leaving a large amount of opioid medications available for misuse, abuse, and/or diversion (Anderson, 2015).

**The Michigan Epidemic**

In 2015 the Michigan Prescription Drug and Opioid Abuse Task Force reported that Michigan ranked tenth in the nation in per-capita prescribing rates of opioids and eighteenth in the number of overdose deaths.

Data from the Michigan Automated Prescription System (MAPS) showed that more than 21 million prescriptions for controlled substances were written in 2014, nearly 4 million more than in 2007 in spite of the fact that Michigan’s population had decreased over the same time period. Of these 21 million prescriptions, over half were for Schedule II controlled drugs, which have a high potential for abuse, dependence, and addiction. Hydrocodone was noted to be the most often prescribed medication in Michigan in 2012.

MAPS also tracked the **pill counts** of these drugs and found that in 2007, 180 million pills were prescribed. In 2014 this number rose to 745 million.

The Michigan Department of Community Health reported in 2014 that from 2009 to 2012, 4,772 Michigan residents died from **overdose**, and of these, 19.4% were “definitively” opioid-related. Thirty-five percent of deaths due to drug overdose were the result of an unspecified drug, and of these 83% had filled a prescription for an opioid in the past 30 days.

**Contributing Factors**

A number of factors have been found to contribute to the growth of this epidemic over the past two decades. As knowledge has been gained about the physiologic and psychological effects of unrelieved pain, the **push to prevent undertreatment of pain** led to more aggressive management using opioids. Regulating and professional organizations such as the Joint Commission, Centers for Medicare and Medicaid Services, and the American Pediatric Association have recommended or demanded that pain assessment and management be a part of
the treatment plans for all patients, with a resulting increase in prescribing and dispensing of opioids.

The **public’s lack of awareness** concerning the safety and proper use of prescription drugs has also contributed to this epidemic. Without such awareness, patients often share prescription medications with family members or friends or fail to properly store and dispose of them, leaving them available in medicine cabinets to be easily targeted for nonmedical use or diversion.

### OPIOID ANALGESICS COMMONLY MISUSED, ABUSED, OR DIVERTED

There are many types of prescription drugs that have high potential for abuse, but prescribed opioids are often most commonly related to substance abuse or diversion. These include:

- Codeine
- Morphine (Apokyn, Astramorph, Duramorph, Infumorph, Kadian, MS Contin, Morphabond)
- Methadone (Methadose, Dolophine)
- Buprenorphine (Belbuca, Bunavail, Buprenex, Butrans, Suboxone, Zubsolv)
- Fentanyl (Abstral, Actiq, Duragesic, Fentora, Ionsys, Lazanda, Sublimaze, Subsys)
- Hydrocodone (Norco, Reprexain, Vicoprofen)
- Hydromorphone (Dilaudid, Exalgo)
- Meperidine (Demerol)
- Nalbuphine
- Oxycodone (Oxaydo, Oxyct, Oxycontin, Percocet, Percodan, Roxicet, Roxicodone, Xartemis)
- Tapentadol (Nucynta)
- Tramadol (not an opioid, but works primarily on the same receptors) (Conzip, Ultracet, Ultram)

*Source: FDA, 2016.*

### INSTITUTIONAL EFFORTS TO ADDRESS THE PROBLEM

The effort to prevent misuse, abuse, and diversion of opioids involves government and regulatory agencies, drug researchers and manufacturers, as well as healthcare institutions and professional organizations.
Controlled Substance Act

In 1971, in response to the growing misuse and abuse of drugs in the 1960s, Congress passed the Comprehensive Drug Abuse, Prevention, and Control Act. The act created a schedule of controlled substances, ranking them according to their potential for abuse.

**CONTROLLED SUBSTANCES AND DISPENSING RESTRICTIONS**

<table>
<thead>
<tr>
<th>Category/Schedule and Abuse Potential</th>
<th>Dispensing Restrictions</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-I High, possible severe psychological and physical dependency; no approved medical use</td>
<td>Only with approved protocol</td>
<td>Heroin, marijuana, LSD, mescaline, peyote, psilocybin, methaqualone</td>
</tr>
<tr>
<td>C-II High, possible severe physical or psychological dependency</td>
<td>Written prescription only signed by the practitioner, oral order permitted only in an emergency, no prescription refills, container warning label required</td>
<td>Combination products with less than 15 milligrams of hydrocodone per dosage unit (Vicodin), cocaine, methamphetamine, methadone, hydromorphone (Dilaudid), meperidine (Demerol), oxycodone (OxyContin), fentanyl, Dexedrine, Adderall, Ritalin</td>
</tr>
<tr>
<td>C-III Less than C-II drugs, moderate to low physical or high psychological dependency</td>
<td>Written or oral prescription that expires in 6 months, no more than 5 refills in 6 months, container warning label required</td>
<td>Products containing less than 90 milligrams of codeine per dosage unit (Tylenol with codeine), ketamine, anabolic steroids, testosterone</td>
</tr>
<tr>
<td>C-IV Less than C-III, limited physical or psychological dependency</td>
<td>Written or oral prescription that expires in 6 months, no more than 5 refills in 6 months, container warning label required</td>
<td>Xanax, Soma, Darvon, Darvocet, Valium, Ativan, Talwin, Ambien, Tramadol</td>
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<tr>
<td>C-V Less than C-IV, limited physical or psychological dependency</td>
<td>Written prescription or over-the-counter, varies with state law</td>
<td>Cough preparations with less than 200 milligrams of codeine or per 100 milliliters (Robitussin AC), Lomotil, Motofen, Lyrica, Parepectolin</td>
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CDC Pain Management Guidelines

In 2016, the CDC issued new pain management guidelines for the treatment of chronic pain. These recommendations are:

- Do not use opioids as the first-line or routine therapy for chronic pain. If opioids are used, combine with nonpharmacologic therapy such as physical therapy or psychotherapy and nonopioid pharmacologic therapy.

- Establish and measure goals for pain and function, including how opioids will be discontinued if benefits do not outweigh risks.

- Discuss benefits, risks, and responsibilities as well as availability of nonopioid therapies with patients before starting and periodically during opioid therapy.

- Prescribe immediate-release opioids when starting therapy for chronic pain. Do not use extended-release/long-acting (ER/LA) opioids because of the increased potential for overdose.

- Initially prescribe the lowest effective dose and carefully reassess benefits and risks when justifying a decision to increase dosage.

- When opioids are used for acute pain, prescribe the lowest effective dose of immediate-release opioids and in a quantity for three days or less.

- Follow-up and reevaluate risk of harm within one to four weeks of starting opioid therapy for chronic pain or of dose escalation. Reassess at least every three months, and if benefits do not outweigh harms, reduce dose or taper and discontinue.

- At start of and periodically during opioid therapy, evaluate risk factors for opioid-related harms, such as nonmedical prescription opioid use or addiction.

- Check the prescription drug monitoring program (PDMP) for data about the patient’s history that includes high dosages and prescriptions from other providers.

- Use urine drug testing to identify prescribed substance, other prescribed drugs, and illicit drugs at the start of opioid treatment for chronic pain and at least annually.

- Avoid prescribing opioid medication and benzodiazepines concurrently.

- Arrange evidence-based treatment for opioid use disorder for patients, if needed.

(CDC, 2016b)
Prescription Drug Monitoring Programs (PDMPs)

PDMPs are state-run electronic databases used to track the prescribing and dispensing of controlled prescription drugs to patients. Such programs are designed to monitor this information for suspected abuse or diversion. They can provide critical information about a patient’s controlled substance prescription history, which can help identify those at high risk who would benefit from early intervention.

**MICHIGAN AUTOMATED PRESCRIPTION SYSTEM (MAPS)**

MAPS is the prescription monitoring program for the State of Michigan, collecting data on Schedule II through V controlled substance prescriptions dispensed by pharmacies and clinicians. This allows prescribing professionals to ask for patient-specific reports in order to review a patient’s controlled substances prescription records. The practitioner can thereby determine if patients are receiving controlled substances from other providers and assist in the prevention of prescription drug abuse.

Only those persons authorized by the Michigan Public Health Code are allowed access to the information contained in the database. This includes health professionals and law enforcement agencies.

All practitioners who prescribe controlled substances have the ability to register and request reports on their patients. Practitioners cannot give MAPS reports to anyone but can notify local law enforcement to state their concerns. A MAPS report can only be requested for individuals who are a current patient of the practitioner, and practitioners may not request reports on other practitioners.

Online registration is necessary for obtaining patient and practitioner history reports. If a practitioner does not have online computer capabilities (e.g., in remote areas), a MAPS waiver form must be completed and approved. Once approved, a paper claim form is completed and sent to the program for manual entry into the database.

MAPS recommends accessing the program when a practitioner suspects or discovers:

- Patients are in possession of controlled substances and lack documentation
- Patients are selling, sharing, or borrowing controlled substances
- Forged or altered prescriptions
- Practitioner issues arise based on DEA registration
- Red flags are present

Source: MAPS, 2016.
Abuse-Deterrent Opioids

In an attempt to respond to the abuse of opioids, abuse-deterrent products are being formulated and approved for use by the U.S. Food and Drug Administration. Abuse-deterrent formulations can be classified as a physical/chemical barrier that prevents drug release following manipulation of the drug or changes the physical form of the drug using chemicals that render it less amenable to abuse.

**Agonist/antagonist** combinations interfere with, reduce, or defeat the euphoria associated with abuse. The antagonist can be sequestered and released only when the product is manipulated. It is not clinically active when the drug is swallowed but becomes active when it is injected or snorted.

An **aversion** type of abuse-deterrent drug has a substance added that produces an unpleasant effect if the drug is manipulated or taken at a higher dosage than directed. It can include a substance that irritates the nasal mucosa if ground and snorted.

**Delivery system** methods can also offer resistance to abuse. Sustained-release depot injectable or subcutaneous implant formulations may be difficult to manipulate.

Other drugs may be classified as combinations in which two or more of the above methods could be combined to deter abuse.

Currently there are four abuse-deterrent drugs approved by the FDA:

- Hysingla ER (hydrocodone bitartrate)
- Zohydro ER (hydrocodone bitartrate)
- Embeda ER (morphine sulfate; naltrexone hydrochloride)
- Targiniq ER (oxycodone hydrochloride; naltrexone hydrochloride (USDHHS, 2015)

Universal Precautions

To guide healthcare professionals who prescribe and administer Schedule II medications, the American Society for Pain Management Nursing (ASPMN, 2012) recommends following these “universal precautions”:

1. Make a diagnosis with an appropriate differential.
2. Conduct a patient assessment, including risk for substance use disorders.
3. Discuss the proposed treatment with the patient and obtain informed consent.
4. Have a written treatment agreement that sets forth the expectations and obligations of both the patient and the treating physician.
5. Initiate an appropriate trial of opioid therapy, with or without adjunctive medication.
6. Perform regular assessments of pain and function.
7. Reassess the patient’s pain score and level of function.
8. Regularly evaluate outcomes of pain management.
9. Periodically review the pain diagnosis and any comorbid conditions, including substance use disorders, and adjust the treatment regimen accordingly.
10. Keep careful and complete records of the initial evaluation and each follow-up visit.

**CLINICIAN EFFORTS TO REDUCE OPIOID ABUSE**

Prescribing clinicians can reduce the risk of misuse, abuse, and diversion by:

- Ensuring there is only one prescriber and one pharmacy
- Stressing proper medication storage and disposal
- Considering the use of abuse-deterrent opioids
- Offering office-based treatment for opioid addiction
- Keeping prescription pads locked up or in the prescriber’s possession
- Prescribing small amounts more frequently
- Writing tamper-proof prescriptions; always writing out numbers on prescriptions, including number of refills
- Discussing diversion of medications with patients

(Anderson, 2015)

**Recognizing Drug-Seeking Behaviors**

Most patients who complain of pain are honestly seeking relief from discomfort. Others seek drugs in order to cope with addiction or to provide income. Differentiating between the two can be very difficult. Drug seekers are experts at taking advantage of weak links in a system, and the subjectivity of pain makes it hard to evaluate truthfulness.

Drug seekers include people of every age, gender, and socioeconomic status. Often these people initially used prescription drugs for valid medical conditions and drug-seeking behaviors may have developed due to disease progression, undertreatment of pain, tolerance to the medication, or unrecognized addiction. Only a small number of drug seekers do so to divert opioids for money.
Common characteristics that can provide clues to the nature of a patient’s intent include:

1. Inconsistent behaviors from waiting room to treatment room
2. Assertive personality often demanding immediate action
3. Intoxicated or unkempt appearance
4. Repeated calls during and after office hours demanding refills
5. Frequent claims of lost or stolen medication
6. Unusual knowledge of controlled substances
7. Providing a medical history with textbook symptoms
8. Offering vague or evasive answers about medical history
9. Inconsistent description of an injury with the patient’s current complaints
10. Unwillingness to provide information about past healthcare providers or denial of having a regular doctor
11. Requests for a specific drug and reluctance to try a different one
12. Failure to keep appointments for further diagnostic tests or to be referred for consultation
13. Evidence of mood or thought disorder or suicidality
14. Cutaneous signs of drug use such as skin tracks or scars
15. Excessive flattery after receiving a prescription for opioids
   (Yasgur, 2012)

**Addressing Drug-Seeking Behaviors**

There are a number of strategies healthcare providers can utilize in the management of those individuals with drug-seeking behaviors.

- Document all medications taken by or prescribed for a patient, including medical samples dispensed, and file a copy of written prescriptions in the patient’s record.
- Request a picture or other I.D. and Social Security number. Place a photocopy in the patient’s file.
- Confirm the patient’s current address and phone number at each visit.
- Consider written refill protocols for refilling prescriptions by another provider other than a clinician with prescriptive authority.
- Write prescriptions for a limited quantity, with reevaluation as a condition for refills.
• Maintain the security of prescribers’ DEA (Drug Enforcement Administration) numbers and maintain accurate counts of medications and prescription pads. Promptly report thefts.

• Coordinate care with the patient’s other healthcare providers. Verify history with the patient’s current treating physician.

• Conduct an assessment of the patient’s complaints. Do not rely solely on records of the referring physician or the patient’s description of the problem.

• Consider a referral if a substance abuse problem is identified.

• Consider the use of a pain management agreement (see below) to make sure the prescribing practitioner and the patient understand the guidelines for long-term opioid therapy.

(Adams, 2016)

PAIN MANAGEMENT AGREEMENT

A pain management agreement documents the understanding between a prescriber and a patient to prevent misunderstandings about medications and to help the prescriber and patient comply with laws regarding controlled substances. A typical pain management agreement:

• Requires the patient use one pharmacy only for all prescription refills
• Identifies expected benefits of medications and risks associated with their misuse
• Lists possible side effects that can occur
• Requires notification when the same or similar medication is prescribed by other healthcare providers
• Lists conditions for issuing refills or replacement prescriptions
• Requires regular evaluations of pain
• Requires random screenings for misuse of medication
• Describes conditions under which therapy can be changed or discontinued

SCREENING TOOLS

In addition, practitioners can consider the use of screening tools when dealing with a possibly drug-seeking individual. Such tools include:

• Current Opioid Misuse Measure (COMM), a 17-item measure designed to identify drug-seeking behaviors in patients with chronic pain who are receiving opioids
• Addiction Behaviors Checklist (ABC), a 20-item questionnaire designed to track behaviors that are characteristic of opioid addiction in chronic pain populations
• **Pain Assessment and Documentation Tool** (PADT), allows a practitioner to measure the “4 As” of pain treatment outcomes (analgesia, activities of daily living, adverse effects, aberrant drug behaviors) (Yasgur, 2012)

Confronting patients believed to be seeking drugs can be difficult. Confrontation may turn out to be therapeutic, but it can also be dangerous. It is best to avoid confronting a drug-seeking patient alone. The practitioner should consider psychiatric support, social service assistance, facility security, and in some instances, local law enforcement.

**Patient Education**

Clinicians have a vital role to play in educating patients about proper use of opioids in the effort to combat the opioid abuse epidemic. For example, nurses are able to provide critical anticipatory guidance each time a patient receives prescription medications. Three interventions in which nurses can play a vital role include:

• Teaching patients about the risks of opioid diversion
• Providing patients with information on safekeeping and proper disposal of opioids
• Tracking patients’ analgesic use in order to improve knowledge of prescription analgesic requirements for pain management
  
  (Manworren & Gilson, 2015)

**PAIN MANAGEMENT IN INDIVIDUALS WITH SUBSTANCE USE DISORDERS**

Pain management for individuals with substance use disorders (SUDs) presents additional challenges. It is a particularly serious concern because the drugs that relieve pain are the very ones that are misused. To better address the complex issues of pain management for people with SUDs, the American Society for Pain Management Nursing (ASPMN, 2012) published a position paper which:

• Affirms the right of every patient with pain, including those with substance use disorders, to be treated with dignity, respect, and high-quality pain assessment and management
• Recommends that adults be assessed at three levels of risk for addiction: low, moderate, or high, and that children be assessed for nonmedical opioid use or abuse
• Applies ethical principles to clinical practice
Assessing Risk for Developing SUDs

Before introducing any opioids into a patient’s treatment regimen, assessment of risk for developing substance abuse should be done, and the first step is urine testing to screen for illicit drugs, a sign of potential abuse.

Risk assessment can also include the use of tools such as the Screener and Opioid Assessment for Patients with Pain–Revised (SOAPP-R) or the Opioid Risk Tool (ORT). Risk assessment places patients into low-, moderate-, or high-risk categories.

**LOW RISK**

Patients may be managed in primary care settings.

- No past or current history of SUD
- No family history of a SUD
- Presence of social support system.

**MODERATE RISK**

Patients may be managed in primary care settings.

- History of treated SUD
- Significant family history of SUD
- Past or concurrent psychiatric disorder
- Current pharmacotherapy for addiction
- Younger than 25 years old

**HIGH RISK**

Patients pose significant risk requiring a specialist in addiction, pain management, and frequent monitoring.

- Active SUD or aberrant behaviors
- Active addiction
- Major untreated psychiatric disorder
  (Kaye et al., 2015)
Managing Pain Relative to Risk in Patients with SUDs

Providing pain control for patients with a substance abuse disorder is challenging. It is important that caregivers understand that when a patient with a substance abuse disorder has pain, they are less likely to receive adequate pain management than the general population, and inadequate pain relief is a significant risk factor for the patient’s relapse.

As with any patient with pain, nonopioid analgesics are first-line drugs of choice. Persons with SUDs, however, may have pain that is resistant to nonopioids yet responsive to opioids. It is crucial to treat both the substance abuse problem and the pain concurrently. It is recommended that patients be engaged in addiction treatment while being treated with opioids (Alford, 2016).

Safe treatment for a recovering substance abuser with acute pain involves:

- Making certain opioids are held and administered by a trusted other person
- Understanding that the patient may require higher-than-average doses for appropriate relief
- Administering drugs on a timed schedule rather than as needed (“PRN”)
- Converting as soon as possible to a nonopioid regimen and nonpharmacologic modalities
- Increasing recovery support during a bout with acute pain

Chronic pain is best addressed using a pain management team approach and includes:

- Comprehensive pain assessment
- Thorough exploration of drug use history
- Development of a pain management plan that effectively controls pain without using opioids
- Structured, written protocol to increase the patient’s sense of active participation in and control of treatment (which is also beneficial for involved family and other caregivers)
- Consideration of nonpharmacologic modalities
- Encouraging involvement in group therapy led by a therapist offering cognitive behavior techniques and supportive interventions for improving outlook and attitude
- Ensuring that comorbid psychiatric disorders are being managed
- A structured plan and clear agreement if pain is not responsive to such approaches and opioids are to be considered (should be written, reviewed by all parties, and signed by the patient and all those involved in treatment as well as participating family members)
- One physician prescribing all controlled drugs and one pharmacy filling all prescriptions (Hausotter, 2013)
CONCLUSION

Across the nation and in Michigan there has been an increase in chronic pain that has resulted in an increase in the prescribing and dispensing of opioid analgesics. Concurrently, misuse, abuse and diversion of those opioid medications have swollen to epidemic proportions.

It is imperative that Michigan healthcare professionals understand their role in managing pain as one of their primary obligations and responsibilities. In order to best carry out these obligations and responsibilities, it is necessary for them to continue to expand their knowledge and skills in both the management of pain and the prevention of misuse, abuse and diversion of opioid analgesics.

RESOURCES

American Society for Pain Management Nursing
http://www.aspmn.org

MAPS (Michigan Automated Prescription System)
http://www.michigan.gov/lara/0,4601,7-154-72600_72603_55478-232708-,00.html

Opioid and pain management CMES/CEs (National Institute on Drug Abuse)
https://www.drugabuse.gov/opioid-pain-management-cmesces

Report of Findings and Recommendations for Action (Michigan Prescription Drug and Opioid Abuse Task Force)

REFERENCES


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TEST

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1. Which is a true statement regarding the scope of opioid use and misuse?
   a. In 2012 healthcare providers wrote enough prescriptions for opioids to give every American adult a bottle of pills.
   b. Fewer people in the United States died from opioid drug overdose than from motor vehicle crashes in 2014.
   c. Nearly 100% of professionals discuss safe storage and proper disposal of unused opioids with patients.
   d. Prescription pill counts in Michigan declined from 2007 to 2014.

2. Which factor has been described as contributing to the current epidemic of opioid misuse, abuse, and diversion?
   a. Clinicians’ fear of prescribing potentially addictive pain medications
   b. Increasing public awareness about the proper disposal of unused opioids
   c. An increase in the number of prescriptions for pain medications
   d. A push to treat pain less aggressively than in the past.

3. Opioid analgesics with high potential for abuse and diversion include:
   a. Valium
   b. Fentanyl
   c. Naproxen
   d. Naloxone

4. For chronic pain, the CDC’s 2016 pain management guidelines recommend:
   a. Using opioids as first-line or routine therapy.
   b. Reassessing once a year for risk of harm due to opioid therapy.

5. The Michigan Automated Prescription System (MAPS) recommends healthcare practitioners access this program when:
   a. A patient requests the practitioner to do so.
   b. A patient resides in a remote area of the state.
   c. A forged or altered prescription is discovered.
   d. Any patient is being treated for chronic pain.
6. What is the term for an abuse-deterrent opioid containing a substance that produces an unpleasant effect if the drug is manipulated or taken at a higher dosage than directed?
   a. An aversion drug
   b. A physical/chemical barrier drug
   c. A sustained-release depot injectable drug
   d. An agonist/antagonist combination drug

7. When a patient is suspected to be drug seeking, it is best to:
   a. Obtain informed consent and then start medication.
   b. Confront the patient alone in a private location.
   c. Prescribe the lowest effective dose of a nonopioid medication.
   d. Consider a referral if a substance abuse problem is identified.

8. The Pain Assessment and Documentation Tool (PADT):
   a. Measures the “4 As” of pain treatment outcomes.
   b. Determines risk for substance abuse.
   c. Tracks behaviors characteristic of opioid addiction.
   d. Identifies drug-seeking patients.

9. A patient with a history of substance use disorder and currently receiving pharmacotherapy for addiction is at what level of risk for opioid abuse?
   a. No risk
   b. Low risk
   c. Moderate risk
   d. High risk

10. When providing pain control for patients with a substance use disorder, it is important to:
    a. Know they may require lower-than-average doses for appropriate relief of pain.
    b. Use only nonopioid and nonpharmacologic modalities for acute pain.
    c. Administer drugs only as needed (PRN) for chronic pain.
    d. Understand they are less likely to receive adequate pain management.