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Contact Hours: **2**

Pain and Symptom Management for Michigan Nurses

Opioid Misuse, Abuse, and Diversion

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LEARNING OUTCOME AND OBJECTIVES: Upon completion of this continuing education course, you will be prepared to help prevent prescription drug abuse and diversion through dissemination and implementation of evidence-based information about the current prescription drug abuse epidemic, challenges in managing chronic pain, and best practices for prescribing controlled substances. Specific learning objectives include:

- Discuss the scope of the misuse, abuse, and diversion of prescribed pain medications.
- Identify risk factors and aberrant drug-related behaviors indicating potential misuse/abuse of prescribed pain medications.
- List the most commonly abused and/or diverted drugs and their sources.
- Summarize nonpharmacologic and pharmacologic interventions for managing chronic pain.
- Discuss the components of responsible opioid prescribing and prescribing guidelines for chronic and acute pain.
- Describe Michigan initiatives aimed at preventing prescription drug abuse and diversion.

SCOPE OF THE PROBLEM

The leading cause of accidental death in the United States today is drug overdose. Prescription drugs have been fueling this epidemic for more than a decade, and now heroin and synthetic opioid abuse are on the rise. President Trump has declared the opioid epidemic a national public health emergency, directing federal agencies, under the Public Health Service Act, to provide grant money to combat the problem (Whitehouse, 2017).

Drug overdose deaths continue to increase in the United States:

- From 1999–2016, more than 350,000 people died from an overdose involving any opioid, including prescription and illicit opioids.
- Around 66% of the more than 63,600 drug overdose deaths in 2016 involved an opioid.
- In 2016, the number of overdose deaths involving opioids (including prescription opioids and illegal opioids like heroin and illicitly manufactured fentanyl) was five times higher than in 1999.
- On average, 115 Americans die every day from an opioid overdose.
(Seth et al., 2018; CDC, 2017)

Misuse of psychotherapeutic agents—including opioids, stimulants, sedatives, and tranquilizers—is a problem that affects every age, gender, ethnic group, and socioeconomic class and is contributing significantly to the overall drug abuse epidemic in this country. Serious and deadly consequences from misuse have prompted the medical community to reevaluate chronic pain treatment and prescribing practices, resulting in the development of evidence-based guidelines for prescribing opioids for chronic pain, released by the CDC in March 2016 (Dowell et al., 2016).

Prescription drug abuse is a problem that must be addressed within the healthcare system. Nurses are in a unique position to address the problem and help curb this growing epidemic. Nurses comprise the largest group of healthcare professionals and care for more patients than any other health profession. Nurses who understand the risks associated with prescription drug abuse will be better prepared to identify and intervene with patients and colleagues who may be at risk.

Prescription opioid medications are the drugs most commonly abused, diverted, and associated with overdose deaths. Since they are also the drugs commonly prescribed for treating pain, nurses must be acutely aware of current challenges in managing chronic pain. An understanding of the challenges in chronic pain management as well as current guidelines for prescribing opioids for chronic pain will lead to more responsible opioid prescribing. Nurses will also be prepared to provide better pain care while concurrently helping patients avoid addiction risk.

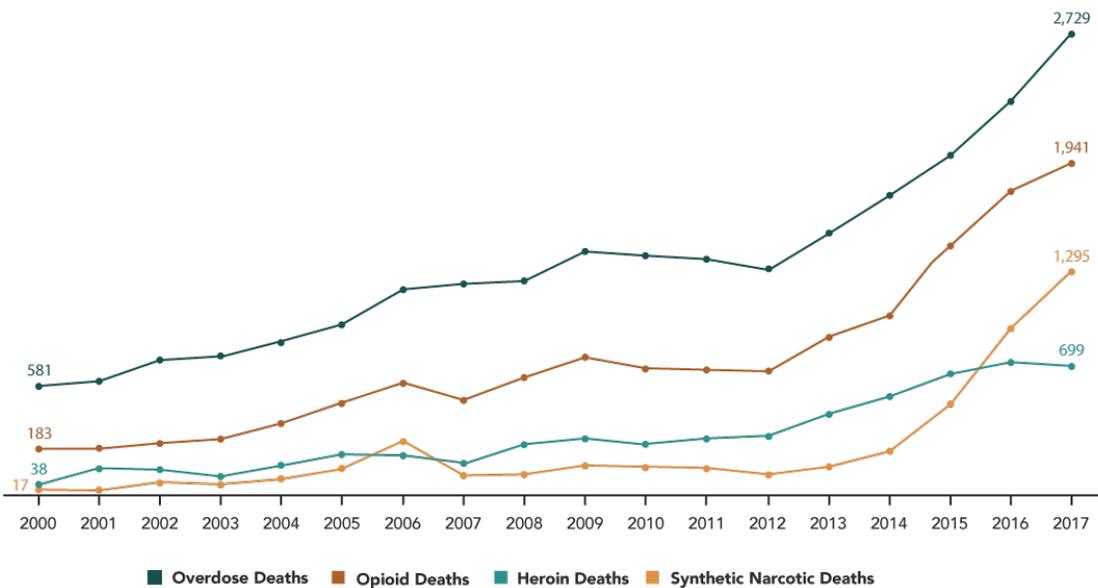
Epidemic in Michigan

Prescription drug misuse is a serious problem in Michigan. Drug overdose deaths are on the rise across the state. Two types of prescription drugs are the leading cause of misuse: painkillers (opioids) and tranquilizers (benzodiazepines). Synthetic opioids, including fentanyl and carfentanil, are contributing to the crisis. The nation's opioid crisis impacts all areas of Michigan, including urban, suburban, and rural communities, and all ages, including young people and older adults. In Michigan:

- 2,729 people died from drug overdoses in 2017, representing more deaths than those from car crashes.



- 1,941 people died from opioid overdoses in 2017.
- 1,295 people died from synthetic narcotic overdoses (including fentanyl) in 2017.
- 699 people died from heroin overdoses in 2017.
- 863 babies were exposed to drugs at birth in 2016 (neonatal abstinence syndrome).
- Overdose deaths increased 17-fold from 1999 to 2016, from 99 to 1,699.
- 11.4 million prescriptions for painkillers were written in 2015, equaling about 115 opioid prescriptions per 100 people.
(Michigan.gov, 2018a)



Overdose deaths in Michigan. (Source: Michigan.gov, 2018a.)

There has also been some progress. For instance, the number of opioid prescriptions dispensed decreased by 10.7% from 2015 to 2017, while the overall number of prescriptions dispensed for Schedules II–V controlled substances (i.e., all drugs classified as having an acceptable medical use) decreased by 7.1% during that same timespan. For the first time since 2011, the total number of controlled substance prescriptions dispensed in Michigan fell below 20 million (LARA, 2018).

DEFINITION OF TERMS

Prescription drug misuse and nonmedical use: Taking a medication in a manner or dose other than prescribed; taking someone else's prescription, even if for a legitimate medical complaint such as pain; or taking a medication to feel euphoria (i.e., to “get high”). The term *nonmedical use* of prescription drugs also refers to these categories of misuse (NIDA, 2016).



Prescription drug abuse: Taking prescription drugs to feel euphoria (i.e., to “get high”) (NIDA, 2016).

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

Illicit drug use: Illegal use of drugs, including the nonmedical use of prescription drugs (SAMHSA, 2013).

Psychotherapeutic drugs: Drugs that have an effect on the function of the brain and that often are used to treat psychiatric/neurologic disorders; includes opioids, sedatives, tranquilizers, and stimulants (SAMHSA, 2016).

Substance use disorder: Recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment such as health problems, disability, and failure to meet major responsibilities at work, school, or home. The *DSM-5* no longer uses the terms *substance abuse* or *substance dependence* but refers to a spectrum of substance use disorders, which may be classified as mild, moderate, or severe depending on specific diagnostic criteria (SAMHSA, 2015).

Addiction: A chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain’s structure and how it works. These brain changes can be long-lasting and lead to many harmful, often self-destructive, behaviors (NIDA, 2014).

Contributing Factors

A complex interrelationship exists between the therapeutic use of opioids to manage pain and the increase in prescription drug abuse, diversion, and overdose deaths. This relationship parallels an increase in availability of prescription drugs for nonmedical use and our nation’s growing substance abuse problem.

INCREASED PRESCRIBING OF CONTROLLED SUBSTANCES

Increased controlled substance prescribing has contributed to the increase in prescription drug abuse and diversion. Sales of opioid medication drastically increased since the 1990s—from 76 million prescriptions in 1991 to 210 million prescriptions in 2010—creating a significant increase in the environmental availability of opioids and making them more accessible for nonmedical use. In 2012, 259 million prescriptions were written for opioids, which is more than enough to give every American adult their own bottle of pills (CDC, 2014).

A comprehensive nationwide effort in more recent years to reduce the numbers of prescription medication available for misuse is beginning to make a difference. Between 2012 and 2016, the



number of opioid prescriptions written in the United States decreased by 43 million. Every state in the nation decreased prescribing of opioids during this time (Guy et al., 2017).

Between 2015 and 2016 there was a reduction of 5.6% in opioid prescribing in the United States overall. However, even with significant reductions in opioid prescribing, overdose fatalities continue to rise as users turn to cheaper substitutes that are more widely available and less costly.

MORE AGGRESSIVE PAIN MANAGEMENT PRACTICES

In the 1990s, “underprescribing” for pain was the predominant concern because of the physiological and psychological effects caused by unrelieved pain. Concerns about undertreatment of pain despite the availability of effective drugs led to a movement toward more aggressive pain management, which became a driving force behind more liberal opioid prescribing.

The Federation of State Medical Boards responded in 1998 by releasing “reformed guidelines” supporting the use of opioids, even in high doses, for palliative care, oncology care, acute injury care, and even the treatment of chronic noncancer pain (ASAM, 2012). Support from the pharmaceutical industry to increase utilization of opioid analgesics as a preferred treatment for chronic pain may have driven financial incentives that also contributed to more liberal prescribing practices.

The Joint Commission (TJC) supported the efforts to improve pain management in healthcare facilities across the country. In August 1997, a collaborative project was initiated to include pain assessment and management in TJC standards. By 2001, all organizations accredited by TJC, including hospitals, ambulatory care centers, behavioral health, and home care, were required to incorporate pain assessment and management into the treatment plan for all patients. Hospitals and other healthcare organizations were faced with the risk of receiving unsatisfactory accreditation visits if they did not have a formal process in place to proactively probe and properly treat acute and chronic pain (ASAM, 2012). Since opioids are one very effective treatment in the management of pain, more liberal prescribing practices evolved.

More recently, the opioid epidemic in this country has forced the medical community to reevaluate prescribing practices and pain care. Over the past few years, a shift has been occurring that may completely change the way pain is evaluated and treated. In 2016 the American Medical Association (AMA) passed several resolutions aimed at reducing opioid prescribing. The AMA recommended to the Joint Commission that pain be removed as a “fifth vital sign” in professional medical standards. Additionally, the AMA advocated for the removal of the pain management component from patient satisfaction surveys because of its association with reimbursement and quality metrics that impact payment for services (AMA, 2016).

In 2018, the Joint Commission implemented new and revised pain assessment standards. These pain assessment and management standards require accredited hospitals to:

1. Identify a leader or leadership team that is responsible for pain management and safe opioid prescribing



2. Involve patients in developing their treatment plans and setting realistic expectations and measurable goals
3. Promote safe opioid use by identifying high-risk patients
4. Monitor high-risk patients
5. Facilitate clinician access to prescription drug monitoring program databases
6. Conduct performance improvement activities focusing on pain assessment and management to increase safety and quality for patients
(TJC, 2017)

PATIENT PERCEPTION AND LACK OF KNOWLEDGE

Patient perception about the safety and use of prescription drugs has played a significant role in the widespread use and availability of controlled substances. Patients with misguided perceptions that prescription drugs are safer and less addictive believe it is acceptable to share prescription medication with friends or family members. These perceptions account for more widespread distribution of controlled substances to individuals for nonmedical use. In addition, lack of education about proper storage and disposal of controlled substances has left many unused prescriptions in medicine cabinets for months or even years, where these powerful drugs may be a target for nonmedical use and diversion.

CONSUMER CULTURE

The culture we live in today has also contributed to the abuse and diversion of controlled substances. Our culture has evolved to one that demands instant gratification, and taking a pill for any ailment has become acceptable. Direct-to-consumer marketing by the pharmaceutical industry has increased patient demand for prescription drugs by making patients more comfortable about asking their physicians for the drugs they feel they need. The proliferation of drug information on the Internet has also contributed by increasing access to legitimate as well as illegitimate prescription drug information.

Societal and Economic Impacts of Prescription Drug Abuse

There is a tremendous societal burden associated with prescription drug abuse. The number of lives lost to drug overdose—along with an increasing incidence of HIV, hepatitis B, and hepatitis C associated with increased IV drug use—has ignited a nationwide effort to address the problem.

More subtle societal costs are evident as families face increased rates of suicide and depression, children are born to addicted mothers, communities battle increased crime, and workplaces struggle with lost productivity. Prescription drug abuse is a shared burden on society and negatively impacts the criminal justice, healthcare, education, welfare, and workforce systems.



ECONOMIC

In 2013, the economic cost associated with prescription opioid abuse was estimated at \$78.5 billion. Costs were attributed to lost workforce productivity (\$20 billion), healthcare costs (\$28 billion), fatal overdose (\$21.5 billion), and criminal justice costs (\$7.7 billion) (Florence et al., 2016).

The economic cost is far reaching and can also be seen in government programs. Thousands of Medicaid beneficiaries and providers have been involved in potentially fraudulent purchases of controlled substances. This has resulted in millions of dollars in payments for prescriptions to patients who obtained controlled substances from multiple health practitioners without the prescribers' knowledge of the other prescriptions (i.e., "doctor shopping") (U.S. DHHS, 2012). Likewise, there is a staggering economic burden to care for babies born exposed to drugs and babies with a diagnosis of neonatal abstinence syndrome, which is a group of problems that occur in newborns who were exposed to addictive illegal or prescription drugs in utero.

RISK FACTORS FOR DRUG ABUSE/DIVERSION

To examine risks for substance abuse or drug diversion, it is important to look at general risk factors as well as specific population risk indicators. There are a number of physiologic, behavioral, and genetic risk factors that can predispose any person to abuse of opioid medication. The factor that appears to be most strongly predictive of drug abuse, misuse, or other aberrant drug-related behaviors after initiation of chronic opioid therapy is a personal or family history of alcohol or drug abuse (Chou et al., 2009). Recognizing and responding to risk indicators is an important nursing responsibility that can help reduce prescription drug abuse and diversion among patients and colleagues.

Some patients who are prescribed opioid pain medication are at increased risk for opioid abuse and diversion. These patients may demonstrate opioid misuse behaviors that can provide clues to the clinician. ***Aberrant drug-related behavior (ADRB)*** is the term commonly used to describe a set of behaviors that may be associated with misuse of prescription opioids.

ADRB may occur because a patient is experiencing poor pain control or has fear of uncontrolled pain, which can lead to hoarding of medication. The behaviors may also be attributed to elective use of opioid medication for the euphoric effect or for non-pain-related symptoms such as anxiety, depression, insomnia, and stress.

ADRB in patients who are prescribed opioids should trigger clinicians to the possibility of addiction. Current literature suggests a range of aberrant drug-related behaviors, with some more predictive of addiction than others. The information in the following box is based on research literature and can help guide clinicians who are treating and monitoring patients who are receiving prescription opioid therapy for long-term pain management.



EXAMPLES OF ADRBs**Behaviors more likely to be associated with medication abuse/addiction:**

- Selling medications or obtaining them from nonmedical sources
- Falsification of prescription (forgery or alteration)
- Injecting medication meant for oral use; oral or IV use of transdermal patches
- Resistance to changing medication despite deterioration in function or significant negative effects
- Loss of control over alcohol use
- Use of illegal drugs or prescriptions that are not prescribed for the patient

Behaviors that look aberrant but may be more a part of stabilizing a patient's pain condition and less predictive of medication abuse/addiction:

- Asking for, or even demanding, more medication
- Asking for specific medications
- Stockpiling medications during times when pain is less severe
- Use of the pain medications during times when pain is less severe
- Use of the pain medications to treat other symptoms
- Reluctance to decrease opioid dosing once stable
- And, in the earlier stages of treatment:
 - Increasing medication dosing without instructions to do so from the provider
 - Obtaining prescriptions from sources other than the primary pain provider
 - Sharing or borrowing similar medications from friends/family

(Manchikanti et al., 2008)



COMMONLY DIVERTED/ABUSED DRUGS

There are many types of prescription drugs that have high potential for abuse (see table below). Three specific classes are most commonly abused and thus most susceptible to diversion for nonmedical use:

- **Pain medications/narcotics.** Opioid pain relievers (narcotics) are the most commonly diverted controlled prescription drugs (SAMHSA, 2013). Opioid medications are effective for the treatment of pain and have been used appropriately to manage pain for millions of people, however increased rates of abuse and overdose deaths have raised concerns about proper use of these medications in the treatment of chronic pain.
- **Central nervous system (CNS) depressants/sedatives/hypnotics.** CNS depressants slow brain activity and are useful for treating anxiety and sleep disorders. Since many patients with pain also experience anxiety or sleep disturbances, increased prescribing of sedative hypnotics has paralleled the increase in prescribing of opioids. Clinicians who add sedative hypnotics to the treatment plan for chronic pain patients may potentiate the risk for patients who are also prescribed opioid medication.
- **Stimulants.** Stimulants are prescribed primarily for treatment of attention deficit hyperactivity disorder (ADHD) and narcolepsy. They may also be used as an adjunct medication in the treatment of depression. When taken nonmedically, stimulants can induce a feeling of euphoria and thus have a high potential for abuse and diversion. They also have a cognitive enhancement effect that has contributed to nonmedical use by professionals, athletes, and older individuals. Nonmedical use of stimulants poses serious health consequences, including addiction, cardiovascular events, and psychosis (NIDA, 2017).



DRUGS WITH HIGH POTENTIAL FOR DIVERSION/ABUSE		
Category	Drugs	Schedule/ Category*
Narcotics and opioids	Codeine	II, III, V
	Morphine (Roxinol, Duramorph)	II, III
	Methadone (Methadose, Dolophine)	II
	Buprenorphine (Buprenex, Suboxone, Subutex)	III
	Fentanyl (Actiq, Duragesic, Sublimaze)	II
	Hydrocodone (Vicodin, Lortab)	II
	Hydromorphone (Dilaudid)	II
	Meperidine (Demerol)	II
	Nalbuphine (Nubain)	not controlled
	Oxycodone (Tylox, Percodan, Oxycontin)	II
	Propoxyphene (Darvon)	IV
	Tramadol (Ultram)	IV
CNS depressants	Barbiturates: pentobarbital (Numbutal), mephobarbital (Mebaral)	II, IV
	Benzodiazepines: alprazolam (Xanax), clonazepam (Klonopin), diazepam (Valium), lorazepam (Ativan)	IV
	Sleep medication (hypnotics): eszopiclone (Lunesta), zaleplon (Sonata), zolpidem (Ambien)	IV
Stimulants	Amphetamines (Adderall, Dexedrine, Biphphetamine)	II
	Methylphenidate (Concerta, Ritalin, Metadate, Methylin, Focalin)	II
* See table “Controlled Substances and Dispensing Restrictions” later in this course.		
Source: NIDA, 2017.		

Sources of Drug Diversion

Drug diversion can occur anywhere along the continuum: manufacturer, wholesale distributor, retail pharmacy, hospitals and other healthcare organizations, prescribers, healthcare professionals who administer the medication, or the patient for whom the medication is prescribed.

Data reveals that a primary source of drug diversion for nonmedical use comes from friends and relatives, and users often obtain the drugs free of charge (SAMHSA, 2013). The perception that prescription drugs are safe and that it is acceptable to share them with friends and family members has fueled this disturbing trend.



PATIENT DIVERSION

Patients may be involved in drug diversion by:

- Sharing medication with family members or friends to help alleviate their pain
- Selling prescription drugs they obtained legally
- Soliciting multiple physicians (“doctor shopping”) to obtain pain medication under false pretenses
- Purchasing prescription medication from rogue websites that exist under the guise of a legitimate pharmacy
(U.S. DHHS, 2012)

HEALTHCARE PROVIDER DIVERSION

Physicians, nurses, and other healthcare providers may knowingly or unknowingly be involved in drug diversion by:

- Prescribing controlled substances to patients who have given false information
- Prescribing controlled substances to patients involved in “doctor shopping”
- Prescribing controlled substances to patients who are selling their prescription drugs
- Intentionally prescribing controlled substances for illegal purposes
- Diverting controlled substances for personal use or financial gain
(U.S. DHHS, 2012)

SOURCES WHERE DRUGS WERE OBTAINED FOR NONMEDICAL USE

(Among past users ages 12 or older, United States, 2013–2015)

- 40.5%, free from friend/relative
- 9.4%, bought from friend/relative
- 3.8%, took from friend/relative without asking
- 34.0%, prescription from one doctor
- 1.7%, prescriptions from more than one doctor
- 0.7%, stole from doctor’s office, clinic, hospital, pharmacy
- 4.9%, bought from drug dealer/stranger
- 4.9 %, some other way
(SAMHSA, 2016)



RED FLAGS FOR DRUG DIVERSION

The U.S. DEA has provided a number of “red flags” for healthcare professionals to be aware of so that they can report suspected drug diversion by both prescribers and dispensers.

Prescribers

- Cash-only patients and/or no acceptance of worker’s compensation or private insurance
- Prescribing of the same combination of highly abused drugs
- Prescribing the same, typically high, quantities of pain drugs to most or every patient
- High number of prescriptions issued per day
- Out-of-area patient population

Dispensers

- Dispensing a high percentage controlled to noncontrolled drugs
- Dispensing high volumes of controlled substances generally
- Dispensing the same drugs and quantities prescribed by the same prescriber
- Dispensing to out-of-area or out-of-state patients
- Dispensing to multiple patients with the same last name or address
- Sequential prescription numbers for highly diverted drugs from the same prescriber
- Dispensing for patients of controlled substances from multiple practitioners
- Dispensing for patients seeking early prescription refills

(WVEPMP, 2016)

MANAGEMENT OF CHRONIC PAIN

Effective management of chronic pain requires a multimodal, interdisciplinary approach that addresses not just physical functioning but also psychological and social functioning. Chronic pain treatment goes beyond relieving the physical symptoms of pain and aims to:

- Improve quality of life
- Increase functional ability
- Relieve associated psychological stressors
- Minimize risk of addiction



Approaches that incorporate physical and psychological components of pain management and utilize the expertise of various healthcare specialties are most effective. Recognizing the complex biological and psychosocial aspects of chronic pain challenges clinicians to tailor pain care to each person's experience of pain. It is important to incorporate pharmacologic as well as nonpharmacologic modalities of treatment and to promote self-management as much as possible. Treating the physical, as well as using the mind's ability to heal, will optimize the treatment process.

Nonpharmacologic Interventions

There are many nonpharmacologic methods that can be used to help manage chronic pain. Some treatments are passive and require the assistance of trained specialists. Some treatments aim to improve function through restorative exercises. Other treatments focus on helping patients cope with chronic pain. Self-managed treatments may focus on improving function and coping in order to enhance quality of life.

PASSIVE TREATMENTS

Passive treatments are professionally directed and generally require the assistance of a specialist trained in the specific modality. Passive treatments aim to reduce pain at the tissue or regional level to improve functional ability. They may include interventions such as nerve blocks, surgically implanted stimulators, transcutaneous electrical stimulation, trigger point injections, acupuncture, and physical manipulation techniques such as those applied by a chiropractor.

FUNCTIONAL RESTORATION THERAPY

Functional restoration therapy aims to enhance function and improve strength, endurance, flexibility, and cardiovascular fitness. Personalized exercise activities and physical therapy are two common restorative interventions that have been used to treat chronic pain and improve functional goals.

PSYCHOTHERAPEUTIC INTERVENTIONS

Psychotherapeutic interventions focus on helping patients cope with chronic pain to improve their quality of life. Cognitive-behavioral therapies and relaxation techniques such as progressive relaxation and biofeedback are interventions that have been used effectively to improve quality of life for patients with chronic pain.

SELF-MANAGED TREATMENTS

For chronic pain, self-managed treatments are an important part of the treatment plan. These may include self-massage; using braces, assistive devices, or compression devices; and applying heat/cold compresses.

Self-management activities aimed at preventing, reducing, or coping with chronic pain may also include healthy dietary habits, pacing of activities, distraction techniques such as reading or



engaging in hobbies, keeping a pain diary, meditation, Reiki, self hypnosis, and movement exercises such as tai chi, swimming, and yoga.

Pharmacologic Interventions

There are many different categories of medication that can be used alone or in combination to help relieve pain. Some medications have an analgesic effect, while others work synergistically with other medications to reduce the experience of pain.

OPIOID MEDICATIONS

Opioid analgesics are widely accepted in the treatment of severe acute pain and chronic pain that is associated with malignant disease or end of life. However, **there is much controversy about opioid use** in the treatment of chronic noncancer pain.

A number of studies aimed at evaluating the effectiveness of opioid therapy in chronic pain have been published. Based on current evidence, the value of long-term opioid use in the treatment of chronic pain is questionable, and epidemiological studies report the failure of opioids to actually improve function and quality of life in chronic pain patients (Dowell et al., 2016). Long-term use of opioids can lead to a number of adverse consequences, including hormonal and immune system compromise, tolerance, hyperalgesia, and addiction.

NONSTEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs)

For most pain conditions, NSAIDs are the cornerstone of treatment. They reduce inflammation and relieve pain without inducing tolerance or dependence. They have proven to be effective for relief of pain resulting from trauma, arthritis, surgical procedures, and cancer, but a ceiling effect (maximum level of pain relief that cannot be exceeded even with more medication) reduces their efficacy with more severe pain conditions. NSAIDs are also associated with risk for gastric irritation and bleeding.

There are three categories of NSAID medication: aspirin, ibuprofen/naproxen, and celecoxib (Celebrex).

ACETAMINOPHEN

Acetaminophen is a commonly used nonsalicylate analgesic with antipyretic properties like aspirin but without the antiplatelet effects. Acetaminophen does not compromise the gastric mucosa, making it a better alternative for some patients.

ANTIDEPRESSANT MEDICATIONS

Antidepressants are commonly used in the treatment of chronic pain even when patients are not specifically diagnosed with depression. They may provide relief of pain due to arthritis, peripheral neuropathy and other types of nerve pain, tension headaches, fibromyalgia, low back



pain, and pelvic pain. The mechanism by which antidepressant medication works to relieve pain is not fully understood.

Three categories of antidepressant medications are commonly used in combination with other medication for chronic pain. They include:

- **Tricyclic antidepressants (TCAs).** Well known for their antidepressant properties; have analgesic properties that are independent of their effects on depression; affect multiple receptor systems and thus may have many side effects that can limit their use for many patients. Examples: clomipramine (Anafranil), amitriptyline (Elavil), nortriptyline (Pamelor), doxepin (Sinequan).
- **Selective serotonin reuptake inhibitors (SSRIs).** Work synergistically with other analgesics to reduce pain; may not have direct analgesic effects, but since depression can sometimes magnify a patient's experience of pain, any drug that relieves depression may also help reduce pain. Examples: citalopram (Celexa), paroxetine (Paxil), fluoxetine (Prozac), sertraline (Zoloft).
- **Serotonin and norepinephrine reuptake inhibitors (SNRIs).** Relieve depression and work synergistically with other analgesics to reduce pain; have fewer side effects than tricyclic antidepressants. Examples: duloxetine (Cymbalta), venlafaxine (Effexor), mirtazapine (Remeron).

NEUROLEPTIC DRUGS

Neuroleptic drugs (antiseizure medications) are often prescribed in combination with other analgesic medication to help patients with nerve pain and neuropathies. These drugs are membrane-stabilizing medications that can help relieve pain related to peripheral and central nervous system dysfunction. The mechanism that allows these drugs to produce neuropathic analgesia is not well known but may be through multiple actions on the nerve cells. These drugs are well tolerated by most patients and seem to have some efficacy in the relief of pain caused by fibromyalgia, postherpetic neuralgia, diabetic neuropathy, and pain caused from spinal cord injury. Gabapentin (Neurontin) and pregabalin (Lyrica) are two commonly prescribed neuroleptic drugs.

OTHER ADJUNCT MEDICATIONS

Other medications that may be used as adjuncts to chronic pain treatment include calcium channel blockers, corticosteroids, alpha-2 agonists, muscle relaxants, local anesthetics, N-methyl-aspartate receptor agonists (NMDAs), and topical agents.



COMPONENTS OF RESPONSIBLE OPIOID PRESCRIBING

Responsible opioid prescribing requires balancing the risks with the benefits of opioids in the management of chronic pain. A balanced approach revolves around three key components:

- Patient assessment
- Treatment plans
- Periodic monitoring

Patient Assessment

A thorough patient assessment is critical prior to prescribing opioid medication for chronic pain. It is important to properly diagnose the painful condition to determine if opioid medication is an appropriate treatment. A well-documented patient history that includes past medical history, medication, habits such as smoking and alcohol use, family history, psychosocial history, and personal or family history of substance abuse is also important.

ASSESSING PAIN

Proper diagnosis of the painful condition is important to assure that opioid medication is an appropriate treatment. It can be challenging, however, since pain is subjective and multidimensional. The patient's self report of pain is the most reliable indicator, but perceptions of pain are influenced by many factors, including culture, environment, emotional state, sleep patterns, and habits.

Assessment of pain should include pain characteristics such as duration, location, intensity, and quality. Clinicians should also assess exacerbating and alleviating factors, present and past pain management interventions, and impact of pain on quality of life. There are many assessment tools available for use by clinicians (*see "Resources" at the end of this course*).

ASSESSING RISK

When clinicians assess chronic pain patients for opioid therapy, it is important to recognize two categories of risk: 1) medical conditions that increase their risk for adverse events (e.g., respiratory depression) and 2) physiologic, behavioral, and genetic risk factors.

Risk due to medical conditions should be assessed and documented as part of the patient's history and physical examination and the treatment plan adjusted accordingly to reduce risk of adverse events with opioid therapy. Older adults may be at higher risk because of cognitive decline and increased potential for falls. Patients with impaired renal or hepatic function, cardiopulmonary disease, mental health conditions, obesity, and sleep apnea are also at higher risk for adverse consequences when prescribed opioid medication.



Patients may also present with physiologic, behavioral, and genetic risk factors that may predispose them to abuse of opioid medication. A number of variables have been associated with a higher risk for misuse, abuse, and addiction. These include history of addiction in biological parents, current drug addiction in the family, regular contact with high-risk groups or activities, and personal history of illicit drug use or alcohol addiction. Screening tools that identify such potential risks are important in the assessment of all patients who are prescribed opioid medication.

Treatment Plans

Responsible opioid prescribing calls for clinicians to develop treatment plans that focus on patient-centered outcomes that improve quality of life. A function-based treatment strategy aims to maximize the patient's quality of life and minimize the burden of their pain.

The following **principles** are important when developing a patient-centered treatment plan:

- Elimination of all pain is often not possible and should not be the primary goal of the treatment plan.
- Treatment goals should not focus exclusively on reducing a pain score.
- Functional goals that improve quality of life must be set collaboratively between the patient and the clinician.
- Functional goals established in the treatment plan must be realistic and achievable, verifiable, and meaningful to the patient.
- The treatment plan should include education about risks, benefits, side effects, and potential adverse consequences of opioid use.
- The treatment plan should include education about safe use, storage, and disposal of opioid medication.

A mutually agreed-upon treatment plan with specific functional goals should be documented, together with informed consent and patient education.

Periodic Monitoring

It is important to periodically reevaluate the appropriateness of continuing opioid therapy for chronic pain. As time passes, there are changes in pain etiology, health condition, progress toward functional goals, and addiction risk. All of these should be monitored on a regular basis to assure patient-centered outcomes. To corroborate self-reports, periodic monitoring should include urine tests and pill counts when appropriate and reports from the prescription drug monitoring program.

Identifying and managing chronic pain is a joint responsibility of the patient and the care provider. Working toward realistic goals and attention to balancing risk/benefit concerns are



only effective with input from both partners. Clinicians must utilize screening and monitoring for all patients on chronic opioid therapy to document patient outcomes and progress toward functional goals. The Pain Assessment and Documentation Tool (PADT) is a practical tool that clinicians can use at each patient visit and incorporate into electronic records (*see “Resources” at the end of this course*). It offers a simple checklist approach for monitoring the “Five As” of pain management:

- **Analgesia:** A reduction in pain
- **Activities of daily living:** Improvement in level of function
- **Affect:** Changes in mood
- **Adverse effects:** Falls, decreased cognitive function, constipation, etc.
- **ADRBs:** Aberrant drug-related behaviors
(FSMB, 2013)

PRESCRIBING GUIDELINES AND RESTRICTIONS

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		
Category/Schedule and Abuse Potential	Dispensing Restrictions	Examples
C-I High, possible severe psychological and physical dependency; no approved medical use	Only with approved protocol	Heroin, marijuana, LSD, mescaline, peyote, psilocybin, methaqualone
C-II High, possible severe physical or psychological dependency	Written prescription only signed by the practitioner, oral order permitted only in an emergency, no prescription refills, container warning label required	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



C-III Less than C-II drugs, moderate to low physical or high psychological dependency	Written or oral prescription that expires in 6 months, no more than 5 refills in 6 months, container warning label required	Products containing less than 90 milligrams of codeine per dosage unit (Tylenol with codeine), ketamine, anabolic steroids, testosterone
C-IV Less than C-III, limited physical or psychological dependency	Written or oral prescription that expires in 6 months, no more than 5 refills in 6 months, container warning label required	Xanax, Soma, Darvon, Darvocet, Valium, Ativan, Talwin, Ambien, Tramadol
C-V Less than C-IV, limited physical or psychological dependency	Written prescription or over-the-counter, varies with state law	Cough preparations with less than 200 milligrams of codeine or per 100 milliliters (Robitussin AC), Lomotil, Motofen, Lyrica, Parepectolin
Source: U.S. DEA, 2018.		

CDC Pain Management Guidelines

Amidst a growing opioid epidemic in the United States, the CDC developed new guidelines in 2016 for prescribing opioids for chronic pain. (These guidelines are not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.) The **purpose** of the guidelines is to:

1. Improve communication between clinicians and patients about the benefits and risks of using prescription opioids for chronic pain
2. Provide safer, more effective care for patients with chronic pain
3. Help reduce opioid use disorder and overdose

Three **principles** clearly articulated in the CDC guidelines for prescribing opioids for chronic pain are as follows:

1. Nonopioid therapy is preferred for chronic pain outside of active cancer, palliative, and end-of-life care.
2. When opioids are used, the lowest possible effective dosage should be prescribed to reduce risks of opioid use disorder and overdose.
3. Clinicians should always exercise caution when prescribing opioids and monitor all patients closely (as described in the recommendations below).

The **recommendations** are divided into three specific areas for consideration: 1) determining when to initiate or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up, and discontinuation; and 3) assessing risk and addressing harms of opioid use.



- **Opioids are not first-line therapy.** Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
- **Establish goals for pain and function.** Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
- **Discuss risks and benefits.** Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.
- **Use immediate-release opioids when starting.** When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting opioids.
- **Use the lowest effective dose.** When opioids are started, clinicians should prescribe the lowest effective dosage.
- **Prescribe short durations for acute pain.** Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
- **Evaluate benefits and harms frequently.** Clinicians should evaluate benefits and harms with patients within one to four weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every three months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.
- **Use strategies to mitigate risk.** Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering **naloxone (Narcan)** when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present.
- **Review PDMP data.** 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 dangerous combinations that



put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every three months.

- **Use urine drug testing.** When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
- **Avoid concurrent opioid and benzodiazepine prescribing.** Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
- **Offer treatment for opioid use disorder.** Clinicians should offer or arrange evidence-based treatment (usually **medication-assisted treatment** with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

(Dowell et al., 2016)

Michigan Acute Pain Recommendations

The Prescription Drug and Opioid Abuse Commission, Opioid Prescribing Engagement Network (OPEN), and University of Michigan Injury Prevention Center partnered to create acute pain recommendations for surgeons, emergency departments, and dentists when treating acute pain. The recommendations are part of a preventative approach intended to provide alternatives to opioids and controlled substances for the treatment of acute pain.

Addressing opioid prescribing during the acute-care period among those patients not using opioids has the greatest potential to reduce the number of new chronic opioid users and minimize unintended distribution of prescription opioids into communities. Existing public health measures currently focus on palliative strategies that target chronic opioid use. A strategy that focuses on the prevention of opioid dependence requires targeting opioid-naive patients prior to opioid dependence (OPEN, 2018a).

A summary of selected best practices is included in the tables below.



SURGICAL DEPARTMENT RECOMMENDATIONS	
For patients in . . .	Recommendations
Preoperative counseling (and not using opioids before surgery)	<ul style="list-style-type: none"> • Discuss the expectations regarding recovery and pain management goals with the patient. • Educate the patient regarding safe opioid use, storage, and disposal. • Determine the patient's current medications (e.g., sleep aids, benzodiazepines), and any high-risk behaviors or diagnoses (e.g., substance use disorder, depression, or anxiety). • Do not provide opioid prescription for postoperative use prior to surgery date.
Intraoperative care	<ul style="list-style-type: none"> • Consider nerve block, local anesthetic catheter, or an epidural when appropriate. • Consider nonopioid medications when appropriate (e.g., ketorolac).
Postoperative care	<ul style="list-style-type: none"> • Meperidine (Demerol) should not be used for outpatient surgeries. • If opioids are deemed appropriate therapy, oral is preferred over IV route. • Ensure all nursing, ancillary staff, and written discharge instructions communicate consistent messaging regarding functional pain management goals.
Discharge from surgical department with an opioid prescription	<ul style="list-style-type: none"> • The prescription drug monitoring program (PDMP) must be accessed prior to prescribing controlled substances Schedules II–V, in compliance with Michigan law. • Nonopioid therapies should be encouraged as a primary treatment for pain management (e.g., acetaminophen, ibuprofen). • Nonpharmacologic therapies should be encouraged (e.g., ice, elevation, physical therapy). • Do not prescribe opioids with other sedative medications (e.g., benzodiazepines). • Short-acting opioids should be prescribed for no more than 3–5 day courses (e.g., hydrocodone, oxycodone). • Fentanyl or long-acting opioids (e.g., methadone, OxyContin) should not be prescribed to opioid naive patients. • Consider offering a naloxone co-prescription to patients who may be at increased risk for overdose, including those with a history of overdose, a substance use disorder, those already prescribed benzodiazepines, and patients who are receiving higher doses of opioids (e.g., >50 MME/Day).



	<ul style="list-style-type: none"> • Educate patient and parent/guardian (for minors) regarding safe use of opioids, potential side effects, overdose risks, and developing dependence or addiction. • Educate patient on tapering of opioids as surgical pain resolves. • Refer to the website opioidprescribing.info for free prescribing recommendations for many types of surgeries. • Refer and provide resources for patients who have or are suspected to have a substance use disorder.
Source: PDOAC, 2018a.	

EMERGENCY DEPARTMENT RECOMMENDATIONS	
For patients . . .	Recommendations
Presenting with acute exacerbation of chronic noncancer pain	<ul style="list-style-type: none"> • Nonopioid therapies should be used as first-line therapy. • Lost or stolen prescriptions should not be replaced. • The prescription drug monitoring program (PDMP) must be accessed prior to prescribing Schedules II–V controlled substances, in compliance with Michigan law. • Consider care coordination and/or effective ED-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) with patients who have suspected risky opioid use or frequent ED visits.
In methadone maintenance programs	<ul style="list-style-type: none"> • Replacement methadone should not be provided in the ED.
Presenting with acute painful conditions	<ul style="list-style-type: none"> • Nonopioid therapies (e.g., acetaminophen, ketorolac) are encouraged as primary or adjunctive treatments. • Nonpharmacologic therapies (e.g., ice, splinting) should be utilized. • The prescription drug monitoring program (PDMP) must be accessed prior to prescribing opioids, in compliance with Michigan law. • Meperidine (Demerol) should not be used.



<p>Discharged from the ED with an opioid prescription for acute pain</p>	<ul style="list-style-type: none"> • Long-acting opioids (e.g., fentanyl, methadone, OxyContin) should not be prescribed. • Short-acting opioids (e.g., hydrocodone, oxycodone) should be prescribed for no more than 3-day courses. • Do not prescribe opioids with benzodiazepines and other sedatives. • Information should be provided about opioid side effects, overdose risks, potential for developing dependence or addiction, avoiding sharing and nonmedical use, and safe storage and disposal. • Consider offering a naloxone co-prescription to patients who may be at an increased risk for overdose, including those with a history or overdose, a substance use disorder, those already prescribed benzodiazepines, and patients who are receiving a higher doses of opioids (e.g., >50 MME/day). • Refer and provide resources for patients who have or are suspected to have a substance use disorder.
<p>Source: PDOAC, 2018b.</p>	

Michigan-OPEN offers the following **counseling recommendations** for postoperative pain control in surgical patients:

- Set expectations. “Some pain is normal. You should be able to walk and do light activity but may be sore for a few days. This will gradually get better.”
- Set norms. “Half of patients who have this procedure take under 10 to 15 pills.”
- Nonopioids. “Take acetaminophen and ibuprofen around the clock and use the stronger pain pills only as needed for breakthrough pain.” (Avoid NSAIDs in patients with peptic ulcer disease and associated risk factors [smoking, drinking], bleeding disorders, renal disease, and specific operations at surgeon discretion.)
- Appropriate use. “These pills are for pain from your surgery and should not be used to treat pain from other conditions.”
- Adverse affects. “We are careful about opioids because they have been shown to be addictive, cause you harm, and even cause overdose if used incorrectly or abused.”
- Safe disposal. “Disposing of these pills prevents others, including children, from accidentally overdosing. You can take pills to an approved collector (including police stations), or mix pills with kitty litter in a bag and throw them in the trash.” (OPEN, 2018b)



ADDITIONAL PRESCRIPTION DRUG ABUSE PREVENTION EFFORTS IN MICHIGAN

One of the biggest challenges in healthcare practice today is how to provide safe and appropriate pain care without contributing to the widespread epidemic of prescription drug abuse and drug overdose deaths. To meet this challenge, Michigan and its state agencies have introduced various collaborative efforts aimed at combatting the opioid epidemic. Some of these efforts include:

- A **“one-stop shop” website** (Michigan.gov/opioids) and other online resources for patients, health professionals, and communities about prevention and treatment of opioid abuse
- The **Michigan Automated Prescription System (MAPS)**, which provides real-time prescription data and resources to better assess a patient’s risk for substance use disorder (see below)
- Ensuring the life-saving overdose reversal drug, **naloxone (Narcan)**, is available to residents statewide through a standing order that allows a pharmacist to dispense naloxone without an individual prescription and without identifying a particular patient

Michigan has also passed a number of laws aimed at addressing the opioid abuse epidemic on numerous fronts. Some of these laws include:

- **Michigan’s Good Samaritan Law of 2016.** Prevents drug possession charges against those who seek medical assistance for an overdose
- **Public Act 246 of 2017.** Requires the disclosure of prescription opioid information and risks to minors and patients, including the “Start Talking” form or equivalent (see below)
- **Public Act 248 of 2017.** Requires a licensed prescriber be registered with and review MAPS prior to prescribing or dispensing to a patient a controlled substance in a quantity that exceeds a 3-day supply
- **Public Act 249 of 2017.** Provides sanctions for failing to comply with the new MAPS usage mandates, failure to establish bona fide prescriber-patient relationships, and failure to inform patients regarding the risks associated with the prescription of opioid drugs
- **Public Act 250 of 2017.** Requires health professionals who treat patients for opioid-related overdoses to provide information regarding substance use disorder services
- **Public Act 251 of 2017.** Requires prescribers treating for acute pain to not prescribe more than a 7-day supply of an opioid within a 7-day period (Michigan.gov, 2018b)



Patient Education

Michigan state law (PA 246 of 2017) requires prescribers to provide opioid education using the Michigan DHHS (or similar) **Opioid Start Talking form** when prescribing an opioid, and the form must be completed and saved to the patient's medical record. (The form does not have to be used when prescribing a controlled substance that does not contain an opioid.)

Opioid education that addresses the following points must be acknowledged by both prescriber and patient:

- Risks of substance use disorder and overdose associated with opioids
- Increased risk of addiction for individuals with mental illness and substance use disorders (for minors)
- Serious health risks (including death or disability) of mixing opioids with benzodiazepines, alcohol, muscle relaxers, or other drugs that may depress the central nervous system
- Heightened risk of short- and long-term effects of opioids, including but not limited to neonatal abstinence syndrome (for females who are pregnant or of reproductive age)
- Any other information on drug safety and effectiveness found in the patient counseling information section of the drug labeling
- Proper disposal of expired, unused, or unwanted controlled substances through community take-back programs, local pharmacies, or local law enforcement agencies
- Possible felony conviction for delivering, distributing, or sharing a controlled substance without a prescription

(See also "Resources" at the end of this course.)

Michigan Automated Prescription System (MAPS)

Prescription drug monitoring programs (PDMPs) are statewide electronic databases that gather information from pharmacies on controlled substances. Growing recognition that PDMPs are a vital tool for clinicians to address the prescription drug epidemic has led to increased public and private funding to support widespread expansion of these programs. According to a survey by the AMA Opioid Task Force, registrations with state-based PDMPs by physicians and other healthcare professionals grew from 471,896 in 2014 to 1,322,996 in 2016, demonstrating a 180% increase in use of PDMPs (AMA, 2017).

MAPS is the prescription monitoring program for Michigan. MAPS is used to track controlled substances (Schedules II–V drugs). Dispensing practitioners who dispense Schedules II–V controlled substances are required to electronically report this prescription data to MAPS on a



daily basis. Prescribers and dispensers can utilize the information in the MAPS database to assess patient risk, determine if patients are receiving controlled substances from other providers, and thus prevent drug abuse and diversion at the prescriber, pharmacy, and patient levels.

MAPS online is available 24/7 to request MAPS reports. MAPS also allows law enforcement, government agencies, and benefit plan managers to register and submit requests for MAPS data. Requests are reviewed and approved by the MAPS administrator.

MAPS can be utilized 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
(MAPS, 2018)

Drug Disposal

Organized statewide and community efforts have been implemented in Michigan to improve the safe storage and disposal of prescription drugs. For example, Michigan-OPEN works with healthcare organizations, law enforcement, and community organizations to hold community opioid and medication “**take-back**” events twice a year. Through 27 simultaneous events held around the state in the spring of 2018, hundreds of families safely removed a total of more than 2,000 pounds of medication, including approximately 54,000 opioid medications from their homes, while also increasing awareness in the community about safe medication disposal.

Michigan-OPEN online drug disposal resources also include an interactive map showing opioid **disposal locations** throughout the state.

(See also “Resources” at the end of this course.)

CONCLUSION

Currently, there is an epidemic of prescription drug abuse, diversion, and overdose deaths both in Michigan and across the country. Recent governmental reports indicate that death rates from drug overdose are still on the rise despite stepped-up efforts by public health authorities.

The complexity of this crisis creates special challenges for federal, state, and local governments as well as nongovernmental partners who must confront the growing impacts on our communities. Overprescribing opioids for more than a decade has not only contributed to prescription opioid addiction but has led to a sharp increase in opioid addiction overall, which is



associated with a significant increase in heroin abuse, IV injection use, HIV, hepatitis, and overdose deaths involving all opioids. A multifaceted public health approach is necessary in order to effectively reduce opioid-related morbidity and mortality.

The opioid epidemic in this country has evolved and escalated along with an epidemic of chronic pain. With current evidence affirming that less-risky pain alternatives are just as effective as opioids for managing chronic pain, it is clear that there must be a cultural shift away from treating chronic pain with opioid medication.

Nurses are in a unique position to address this dual epidemic, but they must gain clinical skills and knowledge in both the assessment and management of addiction risk and best practices for safe opioid prescribing. A comprehensive approach that supports safe and effective pain management without increasing patient risk for addiction must become a priority in every clinical practice setting.



RESOURCES

CDC Guideline for Prescribing Opioids for Chronic Pain
<https://www.cdc.gov/drugoverdose/prescribing/guideline.html>

CDC Guideline Resources
<https://www.cdc.gov/drugoverdose/prescribing/clinical-tools.html>

Michigan-OPEN (Opioid Prescribing Engagement Network)
<https://michigan-open.org>

Opioid Risk Tool
<http://www.prescriberesponsibly.com/sites/default/files/pdf/risk/Opioid%20Risk%20Tool.pdf>

Opioid Start Talking form (MDHHS-5730)
https://www.michigan.gov/documents/mdhhs/MDHHS-5730_621248_7.dot

Pain Assessment and Documentation Tool
<http://www.prescriberesponsibly.com/sites/default/files/pdf/pain/PADT.pdf>

Tools and resources (National Institute on Drug Abuse Medical and Health Professional Resources)
<https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice>



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TEST

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1. Which is a **true** statement regarding the scope of the drug epidemic in Michigan?
 - a. From 2015 to 2017, the number of opioid prescriptions dispensed decreased by over 10%.
 - b. Nearly the same number of people died from drug overdoses as from motor vehicle crashes in 2017.
 - c. In 2017, the number of overdose deaths from synthetic narcotics was about equal to the number of overdose deaths from heroin.
 - d. Drug overdose deaths have increased by a factor of five during the period from 1999 to 2016.

2. Which statement **best** describes recent trends in opioid prescribing in the United States?
 - a. Between 2015 and 2016, the number of opioid prescriptions in the United States increased by nearly 6% over the previous year.
 - b. A decrease in the number of opioid prescriptions in the United States in recent years has led to a decrease in the number of overdose deaths.
 - c. The widespread availability of opioid prescriptions continues to rise in the United States, but deaths from overdose are declining.
 - d. Between 2012 and 2016, the number of opioid prescriptions nationwide decreased by 43 million.

3. Which patient is **most** likely to abuse or misuse drugs if prescribed opioids for chronic pain?
 - a. A 42-year-old man with no personal or family history of substance abuse but who has many friends who drink alcohol and smoke marijuana
 - b. A 23-year-old woman with a past history of sexual abuse
 - c. A 28-year-old nursing student with a father who is a recovering alcoholic and a mother who is on opioid treatment for chronic migraine headaches
 - d. A 38-year-old home health nurse struggling with anxiety and depression but who has no personal or family history of substance abuse

4. A 42-year-old male patient has been taking oxycodone to help alleviate chronic shoulder pain sustained in a motorcycle accident last year. Which patient behavior would a clinician consider to be the **most likely** example of aberrant drug-related behavior (ADRB)?
 - a. He is somewhat demanding in his request for additional pain medication at a follow-up visit.
 - b. His wife reports he has been drinking excessively in the evenings to deal with the pain.
 - c. He specifically asks for Lortab, 10 mg, orally for pain relief.
 - d. His wife reports he has saved extra medications from previous prescriptions.



- 5.** Which class of prescription drugs is most commonly associated with abuse, diversion, and overdose deaths?
- Sedatives
 - Opioids
 - Stimulants
 - Muscle relaxants
- 6.** Statistics indicate that the most common source from which individuals obtain controlled substances for nonmedical use is:
- Purchasing from drug dealers.
 - Through a prescription from a doctor.
 - Free from friends or relatives.
 - Stealing from a doctor's office, clinic, hospital, or pharmacy.
- 7.** Which is a "red flag" that may indicate drug diversion by a prescribing healthcare provider?
- Prescribing tramadol to a patient who was previously prescribed hydrocodone
 - Prescribing an opioid medication to a new patient who was previously treated with opioids
 - Prescribing opioids to patients who pay only with cash
 - Prescribing adequate quantities of pain medication to a patient who is experiencing pain
- 8.** An aim of treatment within the realm of chronic pain management is:
- Letting the patient know they cannot have opioids.
 - Decreasing exercise.
 - Limiting treatment to physical functioning.
 - Relieving associated psychological stressors.
- 9.** When assessing a patient who has been prescribed an opioid medication for chronic pain management, the nurse considers the "Five As" by asking questions about the patient's:
- Family history of chronic pain.
 - Functional level in activities of daily living.
 - Satisfaction with the prescribing provider.
 - Ability to refill his or her prescription.



- 10.** Which principle is articulated in the CDC guidelines for management of chronic pain?
- Nonopioid therapy is preferred for chronic pain outside of active cancer, palliative, and end-of-life care.
 - Opioids are safe and effective in the management of all types of chronic pain.
 - When opioids are used for chronic pain, dosage should be based on an evidence-based pain scale.
 - Nonopioid therapy is not recommended for active cancer, palliative, and end-of-life pain treatment.
- 11.** Which is **not** one of Michigan’s acute pain recommendations for surgical or emergency department (ED) patients?
- Upon discharge following surgery, prescribe short-acting opioids for no more than 10-day courses.
 - Nonopioid therapies (e.g., acetaminophen, ibuprofen) should be encouraged as a primary treatment for pain management after discharge from surgery.
 - Upon discharge from the ED, consider offering a naloxone co-prescription to a patient who may be at an increased risk for overdose.
 - Nonopioid therapies should be used as first-line therapy in ED patients presenting with acute exacerbations of chronic noncancer pain.
- 12.** Which is a **true** statement regarding Michigan’s “Opioid Start Talking” form?
- Prescribers are encouraged but not required to complete this form or its equivalent when prescribing an opioid.
 - This form must be completed when prescribing any Schedule II–V controlled substance.
 - The patient must acknowledge on the form that they will maintain naloxone (Narcan) in their possession in the event of an overdose.
 - The form documents that a patient has been educated about possible felony conviction for sharing a controlled substance without a prescription.

