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Contact Hours: **1**

Best-Practice Prescribing and Drug Diversion Training for West Virginia Nurses (1 Hour)

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BY Loretta Ann Bostic, DNP, MS, MBA, APRN, CRNA

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 trends in prescription drug abuse and diversion.
- Identify risk factors for potential misuse/abuse of prescribed pain medications.
- Describe the classes of and sources for drugs that are most commonly abused and/or diverted.
- Summarize CDC guidelines for prescribing opioids for chronic pain.
- Discuss West Virginia Safe and Effective Management of Pain (SEMP) guidelines.

INTRODUCTION

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).

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 Centers for Disease Control and Prevention (CDC) in March 2016 (Dowell et al., 2016).

TRENDS IN PRESCRIPTION DRUG MISUSE

Overdose Deaths

In 2015, an estimated 119 million Americans, or 44% of the population ages 12 or older, used prescription psychotherapeutic drugs in the past year:

- Pain relievers: 97.5 million
- Tranquilizers: 39.3 million
- Stimulants: 17.2 million
- Sedatives: 18.6 million

During this same period, 18.9 million people ages 12 or older misused prescription psychotherapeutic agents. The most common reason for misuse was to relieve physical pain (62.6%), and the most misused prescription drugs were opioids (SAMHSA, 2016).

Since 1999, the number of American overdose deaths involving opioids has quadrupled. From 2000 to 2015, more than 500,000 people died of drug overdoses, and opioids account for the majority of those. The CDC (2017) found that around 64,000 people died from drug overdoses in 2016. Despite significant efforts to curb this epidemic, these 2016 overdose statistics reveal a consistent and continuing escalation of the problem.

West Virginia drug overdose fatalities have exceeded the national average for more than a decade. In 2016, West Virginia had the highest drug overdose mortality rate in the nation, with 52 drug overdose deaths per 100,000 population. According to a report by the state's chief medical examiner in 2016, the drugs most commonly associated with overdose in West Virginia include alprazolam, diazepam, methadone, fentanyl, oxycodone, hydrocodone, heroin, and oxymorphone (GACSA, 2016a). Despite efforts to change prescribing practices and reduce the number of opioids available for misuse, drug overdose deaths have consistently risen in West Virginia (WV DHHR, 2016).

Opioid Prescribing

A comprehensive nationwide effort over 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. Compared to other states, West Virginia had the most significant reduction (15.6%) during this time period (Guy et al., 2017). 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.

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.

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)



RISK FACTORS AND INDICATORS FOR DRUG ABUSE/DIVERSION

To examine risk 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.

Aberrant Drug-Related Behaviors

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.

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

Source: Manchikanti et al., 2008.

COMMONLY DIVERTED/ABUSED DRUGS

There are many types of prescription drugs that have high potential for abuse. 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, 2013a). 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, 2017b).

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 is from friends and relatives, and users often obtain the drugs free of charge (SAMHSA, 2013a). 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

Source: SAMHSA, 2016.

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: medical conditions that increase their risk for adverse events (e.g., respiratory depression) and 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 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. 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.

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
Source: FSMB, 2013.	

BEST-PRACTICE PRESCRIBING GUIDELINES

CDC Guidelines for Prescribing Opioids for Chronic Pain

Opioids are widely accepted in the treatment of chronic pain related to cancer or other end-of-life processes. However, there is much controversy about the efficacy of opioids for management of chronic pain not associated with cancer or other end-of-life processes. Based on extensive research into the efficacy of opioids, **CDC guidelines strongly discourage use of opioids for long-term chronic pain management**, citing evidence that other pain modalities are more effective and less risky (Dowell et al., 2016).



PRINCIPLES

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 guidelines below).

CDC GUIDELINES

- **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 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 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** 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 3 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)

CATEGORIES OF PAIN

- **Nociceptive:** Pain arising from noxious stimuli affecting thermal, mechanical, or chemical receptors (e.g., sprains, bone fractures, burns, bumps, bruises, inflammation from arthritis, mechanical lower back pain, sports/exercise injury)
- **Neuropathic:** Abnormal processing of sensory input by the central nervous system and/or peripheral nervous system (e.g., postherpetic neuralgia; reflex sympathetic dystrophy; phantom pain; trigeminal neuralgia; peripheral neuropathy that may result



from diabetes, chronic alcohol use, exposure to toxins such as chemotherapy, or vitamin deficiencies)

- **Mixed:** Combination of nociceptive and neuropathic pain (e.g., migraine headaches, fibromyalgia, myofascial pain syndrome)
(WVEPMP, 2016)

West Virginia Safe and Effective Management of Pain (SEMP) Guidelines

West Virginia is one of 29 states receiving funding from the CDC Prescription Drug Overdose: Prevention for States Program. Funding from this program was directed to creating a professionally diverse expert statewide panel to build upon the CDC guidelines for prescribing opioids for chronic pain. The panel's WV Safe and Effective Management of Pain Guidelines are intended for both prescribers and dispensers as an expansion to the 2016 CDC guidelines and were developed with a focus on clinical treatment of pain and risk reduction strategies (WVEPMP, 2016).

CLINICAL TREATMENT OF PAIN GUIDELINES

The pain treatment algorithms described in the tables below were developed by the SEMP panel to provide the best course of action for progression through increasing levels of pain based on current evidence and experience.

1st LINE CLINICAL TREATMENT ALGORITHMS		
Nociceptive Pain	Neuropathic Pain	Mixed Pain
<ul style="list-style-type: none"> • Nonpharmacologic (active & passive) • OTC APAP then +/- NSAID (based on GI/cardio pt. history) • Topical agents (NSAID, lidocaine, or capsaicin) 	<ul style="list-style-type: none"> • Nonpharmacologic (active & passive) • Acute trial of NSAID/APAP (based on GI/cardio pt. history) • Add-on topical agent (lidocaine or capsaicin) • L-methylfolate; Gabapentinoids (gabapentin* or pregabalin) (*abuse potential as a non-controlled substance) • SNRIs (duloxetine, venlafaxine, etc.) • TCAs 	<ul style="list-style-type: none"> • Nonpharmacologic (active & passive) • Acute trial of NSAID/APAP (based on GI/cardio pt. history) • Topical agent (NSAID, lidocaine, or capsaicin)



2nd LINE CLINICAL TREATMENT ALGORITHMS		
Nociceptive Pain	Neuropathic Pain	Mixed Pain
<ul style="list-style-type: none"> • SNRIs (duloxetine, venlafaxine, etc.) • TCAs (2° class: nortriptyline, etc.) • Controlled substance class 4 (tramadol or pentazocine/naloxone) • Consider referral to specialist 	<ul style="list-style-type: none"> • Anti-epileptic drugs or AEDs (CBZ*, VPA, lamotrigine, topiramate, etc.) (*trigeminal neuralgia only) • Controlled substance class 4 (tramadol or pentazocine/naloxone) • Consider referral to specialist 	<ul style="list-style-type: none"> • Gabapentinoids (gabapentin* or pregabalin) (*abuse potential as a non-controlled substance) • SNRIs (duloxetine, venlafaxine, etc.) • TCAs • Controlled substance class 4 (tramadol or pentazocine/naloxone) • Consider referral to specialist

3rd LINE CLINICAL TREATMENT ALGORITHMS		
Nociceptive Pain	Neuropathic Pain	Mixed Pain
<ul style="list-style-type: none"> • Combination 1st & 2nd line agents • Acute add-on: muscle relaxer PRN (antispasticity sub-class) (watch for concomitant CNS depression) • Controlled substance class 3 (buprenorphine or APAP/codeine) • Interventional therapy • Controlled substance class 2 (IR) • Referral to specialist needed 	<ul style="list-style-type: none"> • Combination 1st & 2nd line agents • Acute add-on: muscle relaxer PRN (antispasticity sub-class) (watch for concomitant CNS depression) • Controlled substance class 3 (buprenorphine or APAP/codeine) • Interventional therapy • Controlled substance class 2 (IR) • Referral to specialist needed 	<ul style="list-style-type: none"> • Combination 1st & 2nd line agents • Acute add-on: muscle relaxer PRN (antispasticity sub-class) (watch for concomitant CNS depression) • Controlled substance class 3 (buprenorphine or APAP/codeine) • Interventional therapy • Controlled substance class 2 (IR) • Referral to specialist needed



RISK REDUCTION GUIDELINES

The following components are part of the SEMP risk reduction strategy:

1. **Risk Screenings.** All patients being considered for chronic opioid therapy should be screened for risk of substance misuse before opioids are prescribed. Screening tools include the Opioid Risk Tool (ORT) and the Drug Abuse Screening Test (DAST). Patients who have been on long-term opioid therapy should also be routinely screened for misuse. Screening tools include the Current Opioid Misuse Measure (COMM) and the Pain Medication Questionnaire (PMQ). (*See also “Resources” at the end of this course.*)
2. **Drug Interaction and Pharmacologic Review.** Recognizing that genetic variability can alter drug responses for a variety of pain medications, it is suggested that pharmacogenetic testing be used when available and appropriate to the treatment regimen.
3. **Patient and Provider Agreements.** Providers and patients should review treatment goals and have realistic expectations of therapy (e.g., pain reduction and improved functional status). Patient and provider agreements are an invaluable tool to ensure mutual commitment to the treatment goals.
4. **Pain Reduction and Function Improvement Goal.** Pain should be thoroughly evaluated before prescribing medications or other pain treatments. Treatment of chronic pain requires a long-term process of monitoring and adjusting treatment as necessary. While severity of pain is important to evaluate, it is equally important to evaluate how pain affects a patient’s functional status and performance of daily activities.
5. **End of Therapy Goal.** An appropriate timeline in regards to achieving and maintaining a reduction in pain is necessary. For acute pain treatment, an end of therapy goal for any pain medication should be consistent with the expected timeframe for the healing process. For chronic pain conditions, the elimination of pain may not be realistic. However, there should still be an end of therapy goal for any pharmacologic interventions to reduce unnecessary long-term effects (i.e. adverse effects, dependency, etc.).
6. **Psychological Evaluations.** Patients who are prescribed opioid medications should have initial psychological evaluations that should be repeated annually. This allows for objective quantification of the benefits of opioid therapy and allows for reassessment of modifiable risk factors such as depression. The PHQ-2 depression screening instrument is a suggested screening tool to be used as a first step for depression screening.
7. **Proper Medication Storage and Disposal.** Education about safe use, storage, and disposal of controlled prescription drugs should be part of the conversation between patients and clinicians whenever controlled substances are prescribed. Patients should be reminded that if there are children or individuals with a history of substance abuse in the household, medications should be locked in a safe place. Excess medications should be returned through DEA-sponsored “take-back” programs.



8. **Naloxone Prescribing and Administration.** West Virginia Senate Bill 431, passed in 2016, makes naloxone (an antidote or reversal agent for opioid overdose) available without a prescription. A pharmacist or pharmacy intern who dispenses naloxone must provide education to the patient who receives naloxone, to include: 1) proper administration, 2) importance of contacting EMS after administering naloxone, 3) risks associated with failure to contact EMS following administration of naloxone, and 4) educational material on opioid-related overdose prevention and treatment.
9. **Prescription Drug Monitoring Program (PDMP).** West Virginia Senate Bill 437, passed in 2012, requires healthcare prescribers to utilize the PDMP. All licensees who dispense controlled substances to residents of WV must provide the dispensing information to the WV Board of Pharmacy at least every 24 hours. All licensed prescribers must also check the PDMP at the initiation of opioid therapy and at minimum every year thereafter.
10. **Urine Drug Screening/Testing.** Urine drug screening/testing should be utilized to monitor compliance of patients who are prescribed controlled substances. Urine drug screening can help detect use of illicit substances and trigger reassessment of the treatment plan when indicated.
11. **Pill Counts.** Pill counts are one way of improving medication adherence and preventing/detecting diversion of medication. Pill counts can be random or scheduled based on scheduled appointments.
12. **DEA “Red Flags.”** Healthcare professionals have an ethical and legal obligation to both prevent prescription drug diversion and to ensure safe and effective care to patients. 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 or dispensers (see box below).

RED FLAGS FOR DRUG DIVERSION

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 non-controlled 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)

CONCLUSION

Currently, there is an epidemic of prescription drug abuse, diversion, and overdose deaths not only in West Virginia but also 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 National Center for Health Statistics reported that overdose deaths reached a record high in 2016, and with state data and anecdotal information, many experts fear this opioid epidemic has still not reached its peak.

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 the country and the state 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>

Opioid Risk Tool

<https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf>

Overdose Prevention in States

<https://www.cdc.gov/drugoverdose/states/index.html>

Pain Assessment and Documentation Tool

<https://www.drugabuse.gov/sites/default/files/files/PainAssessmentDocumentationTool.pdf>

State Prescription Drug Laws

<https://www.cdc.gov/drugoverdose/policy/laws.html>

Tools and resources (National Institute on Drug Abuse Medical & Health Professional Resources)

<https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice>

West Virginia SEMP Guidelines

<http://sempguidelines.org/>

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TEST

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1. Which statement best reflects current trends in the prescription drug abuse problem?
 - a. Due to public health efforts, drug overdose deaths nationwide have been declining since 2016.
 - b. To reduce physical pain is no longer the most common reason people misuse prescription drugs.
 - c. West Virginia overdose deaths have exceeded the national average for more than a decade.
 - d. Drug abuse has become the leading cause of all deaths in the United States.

2. Which statement best describes recent trends in opioid prescribing in the United States?
 - a. In 2016 the number of opioid prescriptions in the United States increased by nearly 6% over the previous year.
 - b. Between 2015 and 2016, West Virginia was the state with the highest percentage reduction in opioid prescribing.
 - 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 increased by 43 million.

3. Which patient is **most** at risk for abusing opioid medication?
 - 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 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 prescribed 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.
8. According to West Virginia's SEMP clinical treatment algorithms, a 1st-line intervention for chronic pain is:
- Nonpharmacologic treatment.
 - Antispasticity sub-class muscle relaxer.
 - Controlled substance class 2.
 - Referral to a specialist.
9. 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 cash-only patients
 - Prescribing adequate quantities of pain medication to a patient who is experiencing pain



10. Recommended risk reduction strategies for preventing drug diversion in West Virginia include:

- a. Not prescribing opioids to anyone under the age of 21.
- b. Requiring all licensees who dispense controlled substances to residents of WV to provide the dispensing information to the WV Board of Pharmacy annually.
- c. Encouraging patients to dispose of unused opioid medications by flushing them down the toilet.
- d. Having an appropriate end-of-therapy goal for pharmacologic interventions.

