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Strategies to Improve Opioid Prescribing

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The primary care physician has the daunting daily task of caring for patients who often are in pain from an injury or a disease process, patients who have chronic pain syndromes, and other patients who are seeking opioids for non-medical use or abuse. Opioid analgesics are synthetic drugs that have analgesic properties similar to opium. Commonly prescribed opioid analgesics include oxycodone (Percocet® or OxyContin®) and hydrocodone (Vicodin®). This paper summarizes the epidemic of non-medical use of opioid analgesics, the challenge of recognizing this problem, and strategies to improve opioid prescribing.

Epidemiology

Opioid prescriptions have skyrocketed in the United State during the past decade. From 2000–2010, opioid prescriptions provided to patients increased in both ambulatory encounters and emergency department (ED) visits.^{1,2} In the ambulatory setting, non-opioid analgesic prescribing remained unchanged,¹ whereas in the ED, non-opioid analgesic prescribing decreased.²

In cities where the rate of prescription drug abuse is high, such as New York City, the statistics are staggering. Between 2004 and 2009, the rate of opioid analgesic-related ED visits in New York City doubled from 55 to 110 visits for every 100,000 population.³ In 2009, one in every four deaths from unintentional overdose (158) in New York City involved prescription opioid analgesics, a 20% increase from 2005.³ This increase in deaths from prescription opioid analgesics occurred while the heroin poisoning death rate decreased by 24% during the same time period.³ The Centers for Disease Control (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA) reviewed United States data from 2004–2008 on ED visits involving the non-medical use of prescription drugs from SAMHSA's Drug Abuse Warning Network (DAWN).³ These data showed that the estimated number of ED visits for non-medical use of opioid analgesics increased by 111% between 2004 and 2008 (from 144,600 to 305,900 visits).⁴ The opioid analgesics most commonly reported for non-medical use were oxycodone, hydrocodone, and methadone.⁴

EXECUTIVE SUMMARY

The primary care physician is challenged constantly in the care of chronic pain patients in regard to opioid management. Coordination with local emergency departments is key if treatment goals are going to be met.

- Opioid prescriptions are increasing in both ambulatory and emergency departments, but non-opioid analgesic prescribing is actually decreasing in emergency departments.
- Diversion is a major issue, and essentially all states have Prescription Drug Monitoring Programs (PDMP) in place or pending legislation.
- Establishing oxycodone-free emergency departments is an interesting initiative to remove ED physicians from

contributing to the drug-seeking behavior of local residents and may be a valuable resource for primary care physicians trying to avoid relapses and abuse in their patients.

- Several validated screening tools are available to aid in the risk assessment for opioid use.
- Suspected drug diversion should be reported to the appropriate local and national agencies.
- Generally accepted intervention strategies include development of pain agreements, establishing analgesia protocols, and adopting certain addiction and preventive treatments such as buprenorphine implementation.

Deaths of high-profile figures, such as the actor Philip Seymour Hoffman, who died of an overdose at the age of 46 years, have focused attention on the epidemic of opioid abuse and the link to other illicit drug addictions, such as heroin.⁵ Experts surmise that that addicts have switched to heroin because prescription pills have become more expensive and more difficult to obtain.⁵ Additionally, heroin is stronger, cheaper, and more plentiful than ever before.⁵ National surveys have found that the number of persons meeting criteria for heroin abuse or dependence more than doubled from 2007 to 2012.⁶⁻⁸ Some studies of heroin users show that prescription opioid abuse often precedes heroin use.⁸ CDC data showed that more than 7 out of 10 people who reported past-year heroin use also reported using opioids non-medically during the same year.⁸ From 2002 to 2011, first-time heroin use was 19 times higher among those reporting prior non-medical opioid use than among those who did not report using opioids non-medically.⁹

In light of the widespread epidemic of non-medical use of opioid analgesics, adoption of guidelines and policies to control opioid prescribing have occurred in states, health care systems, hospitals, and individual practitioners.

Regulation of Opioid Prescriptions

In the United States, the Controlled Substances Act (CSA) regulates the prescription of drugs with potential for abuse or addiction. The CSA was passed by the 91st United States Congress as Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and signed into law by President Richard Nixon. The CSA regulates the manufacture, transportation, possession, use, and distribution of drugs that have a potential for abuse.^{10,11} The legislation created five schedules or classifications of drugs, with qualifications for classifying prescribed substances. The potential for abuse becomes less for each advancing schedule number. The opioid medications fall into schedule II and III. Schedule II opioids include morphine, oxycodone, oxycodone-combination products, and hydro-morphone.^{12,13} Schedule III opioids include combination products of hydrocodone and acetaminophen (i.e., Vicodin®, Lortab®).^{12,13} The Drug Enforcement Administration and the FDA decide which substances are added to or removed from the various schedules.

Drug Diversion of Opioid Analgesics

One of the greatest challenges that physicians from all specialties face is ascertaining when a patient

is seeking opioid analgesics for non-medical use. There is no uniformly effective method to distinguish these patients from those seeking appropriate pain relief. Due to its purely subjective nature and the many factors that influence it, pain is a difficult quantity to measure. EPs treat patients with pain daily, with up to 42% of ED visits caused by painful medical conditions.¹² Additionally, EPs often do not adequately recognize or treat a patient's pain, according to numerous studies.¹⁴⁻¹⁶ Bias is a factor in the treatment of pain as well. Gender, race, and other patient characteristics contribute to oligoanalgesia.¹⁷⁻²⁷ Although screening tests have historically been utilized in pain management and primary care settings, no currently available test provides adequate accuracy to identify a patient who is seeking opioids for non-medical use.^{28,29}

Some of the potential methods used to obtain medications include "physician shopping" (seeking out multiple physicians to obtain controlled substances), deception and manipulation of health care providers, and forging, altering, and stealing prescriptions.³⁰

Drug diversion is the illegal distribution or abuse of prescription drugs or their use for purposes not intended by the prescriber, such as recreation, fostering addiction, or for financial gain.³¹ Diverted drugs may also be provided by others — family

Table 1. Diversion Method and Definition³³

Diversion Method	Definition
Selling prescription drugs	Patients and other individuals selling prescription drugs that were initially obtained legally
Doctor shopping	Soliciting multiple physicians using a variety of false pretenses to receive prescriptions for controlled substances
Illegal Internet pharmacies	Illegal websites posing as legitimate pharmacies that may provide controlled substances to individuals without prescriptions and evade state licensing requirements and standards by operating across state and international borders
Drug theft	Robberies that occur at any step of the prescription drug supply chain — from a manufacturer to a patient, thefts from relatives, friends, or health care professionals (i.e., nurses, doctors, pharmacists, and other providers)
Prescription pad theft and forgery	Printing or stealing prescription pads to write fraudulent prescriptions, or altering a prescription to obtain an unauthorized quantity of prescribed drugs
Illicit prescribing	Providing unnecessary prescriptions, or prescribing larger quantities of tablets or pills than medically necessary

or friends, purchased on the street, or stolen from others.^{12,32} (See Table 1.)

Drug Diversion of Opioid Analgesics by Health Care Providers and Others

Although the patient is often the focus of drug diversion, health care providers and others may be diverting opioid analgesics knowingly or unknowingly. Although the majority of cases occur unknowingly, there are numerous cases of physicians and other health care providers who knowingly diverted opioid analgesics with serious legal implications. For example, in a recent federal indictment in New York City, 24 defendants were charged with their connection with a massive drug distribution ring that operated out of a fake medical clinic with multiple locations in the Bronx, NY.³⁴ The company, called Astramed, was owned and operated by a medical doctor who profited millions of dollars by charging cash for thousands of medically unnecessary prescriptions, including high doses of

oxycodone, that were written by the clinic doctors.³⁴

On a smaller scale, health care providers have been presented with legal action and loss of licensure from prescribing opioids to family members, friends, and other associates without keeping medical records.^{35,36} For example, one physician lost his New York state medical license for writing prescriptions for friends and family members without keeping medical records on them for both controlled and non-controlled medications.³⁵ However, other individuals who are not the health care provider or patient may also purposely or unknowingly divert opioids or opioid prescriptions. For example, family sharing of medications is common. The majority of non-medical use of prescription medications occurs from prescription sharing among family or friends.^{10,37,38}

Prescription Drug Monitoring Programs

Prescription drug monitoring programs (PDMPs) are state-based monitoring programs for controlled

substances that are prescribed by licensed practitioners and dispensed by pharmacies.¹² Although PDMPs have existed for many years, the White House Office of National Drug Control Policy recommended the use of PDMPs to reduce abuse in 2011.³⁹

Background. PDMPs have existed in one form or another since the 1930s, when Hawaii and California mandated duplicate or triplicate prescription forms for controlled substances.⁴⁰ Programs continued to expand, and in the 1990s, states began to utilize computer technology to monitor prescription writing of controlled substances.⁴⁰ Although the specific process by each state to administer its PDMP varies, each PDMP shares common features to collect, analyze, and disseminate prescribing and dispensing data from pharmacies.⁴⁰ These data are made available to individuals or organizations authorized under state law, which may include prescribers, law enforcement officials, licensing boards, or others.⁴¹

In 2002, Congress established the Harold Rogers PDMP grant, which is administered by the Department of Justice to assist law enforcement, regulatory entities, and public health officials in analyzing data on prescriptions for controlled substances.⁴¹ In 2005, Congress passed the National All Schedules Prescription Electronic Reporting Act (NASPER) requiring the Secretary of Health and Human Services (HHS) to award grants to states to establish or improve PDMPs.^{40,41} Unfortunately, the amount of funding to support this program has been limited, and the plan to fully integrate the PDMPs across the country has yet to be realized.^{12,40} Currently, 48 states and one territory either have PDMPs or have passed legislation to implement them.⁴²

Goal of Prescription Drug Monitoring Programs. From a global and systems standpoint,

PDMPs allow state agencies to better identify individuals (patients or providers) and pharmacies who divert controlled substances, and allow for evaluation of prescribing trends.¹² At the grass-roots level, most states allow health care providers and pharmacists to access PDMPs in real time for patients directly under their care.¹² For example, in October 2006, Ohio initiated a statewide prescription monitoring program called the Ohio Automated Rx Reporting System, a registry that tracks prescription drugs in schedules II, III, IV, and V, as well as carisoprodol and tramadol products.

New York state's PDMP became effective on August 27, 2013.⁴³ The NY PDMP, also known as I-STOP, has higher levels of regulation on health care provider prescribing. The NY state regulations require that most health care providers consult the NY PDMP prior to prescribing schedule II, III, or IV controlled substances.⁴³ Reports allow for prescription data regarding specific patients to be transmitted in an encrypted manner so that it is available to enrolled health care providers taking care of patients in real time.³⁰ Although most practitioners who prescribe controlled substances are required to consult I-STOP prior to providing a prescription for or dispensing a controlled substance, the duty to consult was allowed some exceptions.⁴⁴ Among these exceptions is that a practitioner may prescribe a controlled substance in the emergency department of a general hospital, provided that the quantity of controlled substance prescribed does not exceed a 5-day supply if the controlled substance were used in accordance with the directions for use.⁴⁵

Because the PDMPs are state-based, their use varies based on state and specialty.^{46,47} For example, Washington state uses its PDMP for public health purposes.⁴⁸ In its innovative data-sharing initiative, Washington state's PDMP provides

Table 2. Guidelines to Improve Opioid Prescription Writing³³

<p>Protect Prescriptions</p> <ul style="list-style-type: none"> • Protect access to prescription pads. • Keep prescription pads in a locked office or drawer. • Keep track of prescriptions that are used (prescription numbers).
<p>Take Caution in the Manner that Prescriptions Are Written or Dispensed</p> <ul style="list-style-type: none"> • Limit the number of pills prescribed. • Write out the number of pills prescribed ("ten" instead of "10"). • Write the prescription clearly to reduce forgery. • Utilize electronic prescriptions instead of paper if available.
<p>Adhere to Strict Policies Regarding Prescribing</p> <ul style="list-style-type: none"> • Safeguard license and DEA numbers and only utilize them as required by state law. • Enforce a strict refill policy and guidelines on lost prescriptions. • Obtain unused prescription bottles if the patient switches from one controlled substance to a different one. • Use state Prescription Drug Monitoring Programs (PDMPs), where available, to monitor patient prescribing before refilling or adding new medications. • Limit the number of refills . • Specify on prescriptions for controlled substances that photo ID needs to be presented prior to dispensing of medication.⁵⁶

data to Medicaid and workers' compensation programs.^{48,49} The initiative has already shown results, as evidenced by the Patient Review Coordination Program for Medicaid enrollees.^{48,49} The Patient Review Coordination Program has already resulted in decreased ED visits, decreased physician visits, and a reduction in unnecessary prescriptions (average savings of \$6000 per patient/year).⁴⁸⁻⁵⁰

Local Strategies

Oxycodone-free Emergency Departments. Some frustrated health care providers have taken initiatives into their own hands to reduce drug diversion. One of these strategies is providing an "oxycodone-free" emergency department. For example, Dr. Gary Swart, medical director for the emergency departments at Wheaton Franciscan's Elmbrook Memorial, St. Joseph, and The Wisconsin Heart Hospital campuses, is part of a network of emergency department administrators who will be implementing tighter restrictions on

how prescription pain medications are used.⁵¹ In the oxy-free ED environments, such as the southeastern Wisconsin area EDs, patients are informed even prior to registration that they will not receive intravenous pain medications for chronic pain, the ED will not refill lost or stolen prescriptions for oxycodone and OxyContin®, and the ED will not provide methadone or suboxone therapy.⁵¹

The oxy-free EDs try to relieve chronic pain with non-narcotic solutions.⁵¹ Other hospitals and health systems have implemented similar strategies in response to opioid diversion and abuse problems, such as creating algorithms to treat pain.⁵²⁻⁵⁴ For example, the physicians at the Swedish Medical Center's four EDs (Ballard, Cherry Hill, First Hill, and Issaquah) in Seattle, WA, have created an algorithm for the rational use of scheduled drugs.⁵³ The algorithm categorizes patients presenting with acute pain as either opiate-naïve or opiate-tolerant, and sets parameters for prescribing pain medication.⁵³ Opiate-naïve patients

receive the lowest effective dose and amount to relieve pain. Opiate-tolerant patients and patients with chronic pain are treated conservatively in the ED and referred back to their personal physicians.⁵³ This approach ensures that the opiate-tolerant patient is linked with one provider and one pharmacy to help prevent abuse or increased drug dependency.⁵³ Although it is considered somewhat controversial to create an oxycodone-free emergency department, more and more EDs are following suit.⁵⁵

Prescriber's Role to Improve Opioid Prescription Writing. HHS and the Centers for Medicare and Medicaid Services have published guidelines for the prescriber to prevent the diversion of opioids and other controlled substances.³³ (See Table 2.)

Improving Clinical Practice to Reduce Drug Diversion. Identifying patients who are at risk for diverting drugs is a first step. The history and physical examination, social history, and screening tools for opioid abuse may assist in identifying prescription abuse. Additionally, trends in use and abuse of opioids may help physicians identify prescription abuse.

According to DAWN data, prescription drug abusers tend to have the following characteristics:^{10,37,57}

- white;
- use opiates;
- women (tranquilizers and sedatives);
- mix medications with alcohol;
- use prescription medication, over-the counter medication, and alcohol to attempt suicide;
- obtain prescription medication from health care providers, friends, or by purchasing on the black market.

Although data such as the DAWN data may be helpful, more information is necessary to provide a risk assessment of the patient. If opioids are considered for a patient, the risks of opioid abuse, misuse, and diversion should be carefully assessed.⁵⁸

Table 3. Opioid Risk Tool⁵⁹

Category	Item	Item score if female	Item score if male
Family history of substance abuse	Alcohol	1	3
	Illegal drugs	2	3
	Prescription drugs	4	4
Personal history of substance abuse	Alcohol	3	3
	Illegal drugs	4	4
	Prescription drugs	5	5
Age	Between 16 and 45	1	1
History of preadolescent sexual abuse	Yes	3	0
Personal history of a psychological disorder	Attention defect disorder, OR obsessive compulsive disorder, OR schizophrenia	2	2
	Depression	1	1
TOTAL			
	Low risk	0-3	0-3
	Moderate risk	4-7	4-7
	High risk	≥ 8	≥ 8

Physicians should assess patients for known risk factors for opioid abuse, including smoking, psychiatric disease, and personal or family history of substance abuse.⁵⁸⁻⁶¹

Screening tests are available to aid in risk assessment for opioid abuse, including the Opioid Risk Tool (ORT), the Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R), and the Screening Instrument for Substance Abuse Potential (SISAP).^{59,62,66}

The ORT, a self-administered, five-question test that measures risk factors associated with substance abuse, may be useful if honest answers are provided.⁵⁹ (See Table 3.) This screening tool has a high degree of sensitivity and specificity for determining which patients are at risk for opioid abuse, misuse, and diversion.⁵⁹ The SISAP is a five-item, physician-administered instrument that identifies patients at risk by inquiring about age and drug, alcohol, and cigarette use,

but does not ask about psychiatric comorbidities.⁶⁶

Screening, Brief Intervention, and Referral to Treatment (SBIRT) for alcohol and drug addiction has existed for many years, but has gained popularity.^{67,68} SBIRT is an evidence-based practice that identifies patients who use substances in ways that increase their risk of physical and emotional health problems, work, family, and social problems, and may assist in reducing their use. SBIRT is based on motivational interviewing techniques and is not intended to replace specialized chemical dependency treatment. Rather, it is intended to identify patients with at-risk substance use and to provide such patients with information about the risks of alcohol or drug use and about appropriate treatment alternatives. Research, summarized in systematic reviews, has documented evidence of positive outcomes (primarily reduced alcohol consumption) associated

with SBIRT.⁶⁹⁻⁷² Although many of the studies focus on alcohol abuse, SBIRT is also intended to screen and provide intervention for other substance use and abuse, including prescription opioid abuse.⁷² SBIRT has been shown to be effective in the primary care setting.^{70,73,74} SBIRT also takes screening for substance abuse a step further by providing the motivational interviewing intervention in even busy settings such as the ED.^{75,76,77}

Utilize Guidelines. Providers should also keep up to date regarding local, regional, state, or national guidelines that may assist in the clinical care of their patients regarding analgesia. For example, the American College of Emergency Physicians (ACEP), in collaboration with the American Society for Pain Management Nursing (ASPMN), the Emergency Nurses Association (ENA), and the American Pain Society (APS), has a position statement regarding optimizing the treatment of pain in patients with acute presentations.⁷⁸ The core principle revolves around recognizing the prompt need for safe and effective pain management.⁷⁸ Additionally, each patient's self-report of pain is a critical component of a comprehensive pain assessment, along with the clinical assessment and treatment.⁷⁸ Although there is no evidence that guidelines diminish opioid misuse, physicians report that they are useful communication tools to explain to patients why they will not receive outpatient opioid prescriptions.⁷⁹ Special attention should be given to vulnerable patient populations such as children, the elderly, and the cognitively impaired. Awareness should also be made to the cultural differences in the expression of pain.⁷⁸

What to Do When Drug Diversion Is Suspected

The first priority should be to take care of the patient's medical complaint to the best of the physician's ability. When drug diversion is

considered, a review of past medical records, screening tests for substance abuse, and utilizing the PDMP may assist.

Additionally, if a prescriber suspects that drug diversion has occurred, the activity can be documented and a report should be made to the appropriate agencies. These agencies include:

- Local law enforcement and local fraud alert networks;
- DEA, for reporting theft or loss of controlled substances, at <https://www.deadiversion.usdoj.gov/web-forms/dtlLogin.jsp> on the DEA Office of Diversion Control website;
- HHS-OIG National Hotline, by calling 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950 or by visiting <https://forms.oig.hhs.gov/hotlineoperations/> on the HHS-OIG website.³²

Other Strategies

Pain Agreements, Pain Contracts, Medication Contracts, or Opioid Contracts. A contractual agreement in the medical setting is defined as an "explicit bilateral commitment to a well-defined course of action."⁸⁰ Contracts are widely used in the chronic administration of drugs with potential for abuse in the primary care and pain management setting.⁸¹⁻⁸³ Although not well-studied, some data show that they can be effective.^{84,85} For example, a retrospective cohort study by Hariharan et al revealed that more than 60% of 330 patients who were placed on pain contracts in an internal medicine clinic adhered to the agreement, with a median follow-up of 22.5 months.⁸⁴

Although the electronic medical record may assist in tracking patients who are frequent utilizers of the emergency department for opioid use and misuse, opponents have argued against the ethical concerns that such a system raises.⁸⁶

Physicians need to put personal biases and preconceptions aside and treat pain to the best of their ability. They must also assure that

harm does not come to patients as a result of either undertreating or inappropriately labeling them.⁸⁶ When there is doubt about whether a patient's pain is real, despite the physician's best effort to determine this, it is better to administer an analgesic agent to a patient who may be diverting drugs, rather than withholding or delaying treatment for a person who is truly suffering.^{86,87}

For entry into the medical record, Geiderman suggests that the following be verified prior:⁸⁶

- patients whose private physicians have verified a pattern of drug abuse or non-therapeutic drug-seeking behavior;
- patients with numerous visits for multiple subjective painful conditions that are repeatedly accompanied by a specific analgesic regimen (along with outpatient prescriptions) and who often claim a long list of undocumented drug allergies (i.e., ketorolac, ibuprofen, metoclopramide, dihydroergotamine, and sumatriptan);
- repeated claims to various physicians of lost or stolen prescriptions;
- a pattern of making verbal contracts with treating physicians that are not maintained (i.e., promising outpatient follow-up); or
- discovery of a patient who is overtly diverting drugs.⁸⁶

Analgesia Protocols. Some experts and national organizations have recommended the development and use of analgesia protocols.⁷⁸ The use of analgesia protocols for diseases such as sickle cell disease and trauma has shown some benefit, such as a significant reduction in pain scores and reduction in delay to administration of pain medication.⁹³⁻⁹⁷ Although more research needs to be conducted regarding the use of analgesia protocols, hospitals and health systems have adopted such practices.⁹⁸ For example, the Banner Health System has a clinical practice guideline for the management of an adult with acute pain.⁹⁸ In this guideline, patients with acute

pain rated ≥ 7 on a 10-point pain scale receive a first dose of 0.1 mg/kg to a maximum 10 mg if they are 54 years or younger, and a first dose of 0.05 mg/kg to a maximum of 10 mg if they are 55 years or older.⁹⁸

Pain scales such as the Visual Analog Scale (VAS), the Verbal Numeric Rating Pain Scale, and the Wong-Baker Faces Pain Rating Scale have been validated and may assist in guiding the use of opioid medications.^{99,100} However, some critics have argued that the pain scales may have limitations such as not reliably predicting the level of pain and need for pain medication.¹⁰¹⁻¹⁰⁵

Addiction and Preventive

Treatment. Some experts have advocated the distribution of antidotes and treatment for heroin and opioid overdose and abuse such as naloxone and buprenorphine.^{106,107} Given its effectiveness and minimal risk of complications, some have advocated the distribution of naloxone intranasal kits, which can be easily administered by a bystander to a victim of an opioid overdose.^{106,107} One such program was initiated by the Boston Public Health Commission in August of 2006.¹⁰⁷ The program provided training and intranasal naloxone to 385 participants who reported 74 successful overdose reversals.¹⁰⁷

Overdose education and naloxone distribution (OEND) programs educate people at risk for overdose and bystanders in how to prevent, recognize, and respond to an overdose.¹⁰⁸ Participants in OEND are trained to recognize signs of overdose, seek help, rescue breathe, use naloxone kits, and stay with the person who has overdosed until help arrives.¹⁰⁸ OEND has shown some benefit. Between 1996 to 2010, more than 50,000 potential bystanders were trained by OEND programs in the United States, resulting in more than 10,000 opioid overdose rescues with naloxone.¹⁰⁸ Studies of OEND programs have demonstrated feasibility,

increased knowledge, and a reduction in fatal overdoses.^{107,109-117}

Buprenorphine in tablet form was approved by the FDA in 2002 for the long-term treatment of opioid addiction.^{118,119} Certain physicians were permitted to provide treatment following the Drug Addiction Act of 2000.¹²⁰ This act permits physicians who meet certain qualifications to treat opioid addiction with schedule III, IV, and V narcotic medications that have been specifically approved by the FDA for that indication.¹²⁰ Results from the National Drug Abuse Clinical Trials Network (CTN) have shown success in the inpatient and outpatient settings.^{118,121}

Summary and Conclusions

Primary care physicians frequently are faced with the challenge of caring for the patient who is at risk for opioid drug diversion. Although drug diversion is difficult to recognize and ascertain, many tools and resources exist. Physicians should be familiar with state and local guidelines and policies, as well as those within their own hospital or health care system to improve their own opioid prescribing. Physicians should perform an appropriate history and physical examination, attempt not to maintain any bias or preconceived notions regarding patients, refer to the state PDMP if available, and report suspected drug diversion when appropriate.

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CME Questions

1. How many states have PDMPs?
 - A. fewer than 5
 - B. between 10 and 20
 - C. between 20 and 30
 - D. between 30 and 40
 - E. Most states have functional PDMPs.
2. Which is the correct definition of drug diversion?
 - A. the use of drugs for oncological pain
 - B. the use of drugs for chronic back pain
 - C. the use of prescription drugs for recreational purposes
 - D. the unlawful channeling of regulated pharmaceuticals from legal sources to the illicit marketplace
 - E. C and D
3. Which of the following is not a drug diversion strategy?
 - A. doctor shopping
 - B. illegal Internet pharmacies
 - C. stealing prescription pads
 - D. renewing a prescription for opioids for a patient that you have been following for chronic pain
 - E. writing for a higher quantity of medication that a patient needs for a patient that you have been following for chronic pain
4. Which of the following can be used to treat opioid overdose?
 - A. naloxone alone
 - B. buprenorphine alone
 - C. naloxone and buprenorphine
 - D. methadone
 - E. none of the above
5. According to DAWN data, which of the following is not a typical characteristic of a prescription drug abuser?
 - A. white
 - B. black
 - C. female
 - D. young
 - E. obtain medications from friends
6. Which state has an innovative data-sharing initiative that provides data to Medicaid and workers' compensation programs?
 - A. Hawaii
 - B. Kansas
 - C. New Jersey
 - D. Washington, D.C.
 - E. Washington
7. Over the past decade (2000-2010), opioid prescriptions have:
 - A. nearly doubled
 - B. increased slightly
 - C. stayed level
 - D. decreased slightly
 - E. nearly tripled
8. Which of the following is not used to screen for opioid abuse?
 - A. ORT
 - B. SISAP
 - C. SOAPP-R
 - D. SBIRT
 - E. CSDD

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Upon completion of this educational activity, participants should be able to:

- Summarize recent, significant studies related to the practice of primary care medicine;
- Evaluate the credibility of published data and recommendations related to primary care medicine;
- Discuss the advantages and disadvantages of new diagnostic and therapeutic procedures in the primary care setting.

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