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Contact Hours: **1**

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

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LEARNING OUTCOME AND OBJECTIVES: Upon completion of this continuing education course, you will be prepared to help prevent prescription drug misuse and diversion. Specific learning objectives to address potential knowledge gaps include:

- Discuss the scope of prescription drug misuse and diversion.
- Identify components of responsible prescribing practices for opioid medications.
- Discuss considerations for the use of the opioid antagonist naloxone.

SCOPE OF THE PROBLEM

The United States has been profoundly affected by the substance use epidemic that began in the 1990s. “Underprescribing” was a predominant issue at the time because of the physiologic 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 then became a driving force behind more liberal opioid prescribing. Over time, this prescribing trend contributed to the drug epidemic the United States continues to face three decades later (U.S. DHHS, 2021).

The serious and deadly consequences of this epidemic prompted the medical community to reevaluate chronic pain treatment and prescribing practices, resulting in the CDC’s release of new evidence-based guidelines for prescribing opioids for chronic pain in 2016. Since that time, the prescription opioid-involved death rate has decreased, with figures showing a 7% drop from 2018 to 2019.

However, the crisis is far from resolved. Disturbing evidence points to a growing number of individuals beginning to misuse prescription drugs. The National Survey on Drug Use and Health estimates that in 2019:

- 9.7 million people ages 12 and older misused prescription pain relievers.
- 4.9 million misused prescription stimulants.
- 5.9 million misused prescription tranquilizers or sedatives.
- Each day, 2,600 new people ages 26 and older began to misuse a prescription pain reliever.
(SAMHSA, 2020)

Opioid addiction remains the driving force behind the prescription drug crisis in America. Alarming, a person is more likely to die today from an accidental opioid overdose than from a motor vehicle crash (NSDUH, 2020; NSC, 2019).

Substance use disorder has specifically impacted the health, well-being, and economy of West Virginia. In 2019, West Virginia had the highest age-adjusted drug overdose death rate in the nation (CDC, 2021a). And from March 2020 to March 2021, West Virginia experienced a 62.1% increase in counts of drug overdose-related deaths (CDC, 2021c).

One of the biggest challenges in healthcare practice is providing safe and appropriate pain care without contributing to this epidemic of prescription drug misuse, drug diversion, and drug overdose deaths. In West Virginia, SB 437 mandates that all healthcare providers who prescribe, dispense, or administer controlled substances receive specific education to help combat the problem of prescription drug abuse and diversion.

Nurses in particular are in a unique position to address this problem since they 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.

FENTANYL AND OVERDOSE DEATHS

Drug overdose deaths accelerated during the COVID-19 pandemic, outpacing overdose death rates from any previous year. Illicitly manufactured fentanyl, which is increasingly found in counterfeit prescription medications, was the main driver of the near 30% increase in overdose deaths from 2020 to 2021 (CDC, 2021d).

The U.S. Drug Enforcement Agency (DEA) reported in 2021 that criminal drug traffickers are mass-producing and falsely marketing counterfeit prescription drugs to exploit the opioid crisis and prescription drug misuse in the United States (DEA, 2021). Approximately 10 million counterfeit pills were seized across all states, which is more than in FY 2018 and 2019 combined. The number of DEA-seized pills containing fentanyl has jumped over 400% since



2019, corresponding to a drastic increase and the highest-recorded number of overdose deaths at more than 100,000.

Fake prescription pills are easily accessible and often sold on social media and e-commerce platforms, making them available to anyone. Many counterfeit pills are made to look like prescription opioids such as oxycodone (Oxycontin, Percocet), hydrocodone (Vicodin), and alprazolam (Xanax); or stimulants like amphetamines (Adderall); they typically contain fentanyl or methamphetamine.

The DEA warns that the only safe medications are those obtained from licensed and accredited medical professionals and that pills purchased anywhere other than a licensed pharmacy are dangerous and potentially lethal (DEA, 2021).



Left: Authentic oxycodone M30 tablet. Right: Counterfeit oxycodone M30 tablet containing fentanyl.
Source: DEA.

RESPONSIBLE OPIOID PRESCRIBING

Responsible prescribing involves individual prescribers following best practices and taking action to balance the risks and benefits of opioid pain management for each patient. Important components to responsible prescribing include

- Thorough patient assessment
- Treatment plan design
- Periodic monitoring
- Following evidence-based prescribing guidelines



Patient Assessment

A thorough patient assessment is critical prior to prescribing opioid medication for chronic pain. It is important to properly diagnose the condition to determine if opioid medication is an appropriate treatment. A well-documented patient history that includes past medical history, medication history, social history, family history, and psychosocial history is critical. Assessing and documenting a personal or family history of substance misuse is also important.

ASSESSING PAIN

Proper diagnosis of the painful condition helps 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, recognizing that perceptions of pain are influenced by culture, environment, emotional state, sleep patterns, and habits.

Any provider must conduct a pain assessment before they can determine what type of pain management is needed. Assessment of pain should include:

- Context (How did the pain begin?)
- Location (Where is the pain felt?)
- Severity (How does the pain rate on a 0–10 scale?)
- Quality (Is the pain sharp, stabbing, dull, pulsating, etc.?)
- Timing (How often does the pain occur?)
- Duration (How long has the pain been persisting?)
- Modifying factors (What makes the pain better or worse?)
- Chronic illness status (What conditions might impact or worsen the pain?)
- Associated signs and symptoms (What else occurs with the pain?)

ASSESSING RISK

When clinicians assess patients with chronic pain, it is important to recognize two categories of risk due to opioid therapy: medical conditions that increase their risk for adverse events (e.g., respiratory depression) and risk of misuse, abuse, or addiction.

Risk of Adverse Events

Risk due to medical conditions are 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 medications.

Risk for Misuse, Abuse, and Addiction

Variables that have been associated with a higher risk for misuse, abuse, and addiction 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. (See also “Recognizing Aberrant Drug-Related Behaviors” later in this course.)

The use of **screening tools** is recommended, and multiple tools are available that can help healthcare providers to assess these risks. The specific tool to be used is determined based on:

- The type of substance of risk (or whether the patient is at a generalized risk to misuse numerous substances)
- The age of the patient (as certain tools are specific to children or adolescents)
- Whether it is preferred to have the patient self-administer the screening or to have a healthcare professional do so

Examples of screening tools include:

- **Opioid Risk Tool:** Administered at initial visit prior to beginning opioid therapy; questions address age, family, and personal history of substance abuse, history of preadolescent sexual abuse, and psychological diseases
- **Screening to Brief Intervention (S2BI):** A series of questions regarding frequency-of-use in adolescent patients of substances most commonly used
- **Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS):** A combined screening and brief assessment that addresses use-related behaviors and generates a risk level for each substance class

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

Treatment Plan

Responsible opioid prescribing requires clinicians to develop treatment plans that focus on patient-centered outcomes that improve quality of life. A function-based treatment strategy that aims to maximize the patient’s quality of life and minimize the burden of their pain includes a mutual understanding between prescriber and patient covering the following principles:

- Complete elimination of all pain is often not possible.
- The goal of treatment is to successfully manage pain and not exclusively to reduce a pain scale score.



- Functional goals will be collaboratively set, with the aim of improving quality of life; these goals must be realistic, achievable, verifiable, and meaningful.
- Risks, benefits, side effects, and potential adverse consequences of opioid use will be fully disclosed.
- Education about safe use, storage, and disposal of opioid medication will be provided.

This treatment plan must be documented, together with informed consent and patient education.

Periodic Monitoring

It is critical to regularly reevaluate the appropriateness of continuing opioid therapy due to changes in pain etiology, health condition, progress toward functional goals, and addiction risk. To corroborate self-reports, review of data within the prescription drug monitoring program should be conducted at each visit (*see “Prescription Drug Monitoring Programs” later in this course*). Periodic monitoring should also include urine tests and pill counts when appropriate.

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 to monitor 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
(Bazzo et al., 2019)	

Periodic monitoring timing will vary with each patient. The CDC (n.d.) recommends checking monitoring every three months at the minimum, and before refilling an opioid prescription at any time. State requirements may vary. The State of West Virginia Office of the Attorney General’s “Best Practices for Prescribing Opioids in West Virginia” (2016) follows the exact same periodic monitoring timing as the CDC.



Guidelines for Prescribing Opioids for Chronic Pain

The CDC provides its **Guidelines for Prescribing Opioids for Chronic Pain**, released in 2016 for use by prescribers when treating all patients other than those who are in treatment for active cancer, palliative care, or at end-of-life.

The draft of an update to the guidelines is currently under review, with the final release anticipated in late 2022. Key themes that will be reflected in the new guidelines include challenges to patient-provider relationships and the need for patients and providers to make shared decisions; the impact of misapplication of the 2016 guidelines; inconsistent and inequitable access to effective pain management solutions; and reducing opioid use through diverse approaches while ensuring appropriate pain management (CDC, 2022).

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

- Nonopioid therapy is preferred for chronic pain outside of active cancer, palliative, and end-of-life care.
- When opioids are used, the lowest possible effective dosage should be prescribed to reduce risks of opioid use disorder and overdose.
- Clinicians should always exercise caution when prescribing opioids and monitor all patients closely (as described in the guidelines below).
(CDC, 2016)

The CDC recommendations are grouped into three areas for consideration:

- Determining when to initiate or continue opioids for chronic pain
- Opioid selection, dosage, duration, follow-up, and discontinuation
- Assessing risk and addressing harms of opioid use

Likewise, in 2016, a diverse panel of West Virginia experts was convened to build upon the CDC guidelines for prescribing opioids for chronic pain. The panel developed its **Safe and Effective Management of Pain (SEMP) Guidelines** for prescribers and dispensers, with a focus on clinical treatment of pain and risk reduction strategies. Its pain treatment algorithms provide the best course of action for progression through escalating levels of pain based on current evidence and experience. These algorithms are meant to be referred to along with the CDC guidelines (CDC, 2017; WVEPMP, 2016).

The SEMP guidelines provide healthcare professionals with a risk reduction process to improve patient care and minimize provider anxiety. The twelve elements of this risk-reduction strategy include:

- Opioid risk screenings
- Drug interaction and pharmacologic review



- Pain reduction and function improvement goal
- End of therapy goal
- Initial and annual psychological evaluations
- Proper medication storage and disposal
- Naloxone prescribing and administration
- Prescription drug monitoring program (PDMP)
- Urine drug screening/testing
- Pill counts
- DEA “red flags”
- Patient and provider agreements (WVEPMP, 2016)

DEA 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 form multiple practitioners
- Dispensing for patients seeking early prescription refills

(WVEPMP, 2016)



PRESCRIBING AND ADMINISTERING OPIOID ANTAGONISTS (NALOXONE)

Nearly 50,000 people died of opioid-related overdose in 2019 alone, and provisional data indicate a likely increase in that number for 2021 (NIDA, 2021). The availability of the opioid overdose-reversal drug naloxone has been shown to reduce the rate of these overdose deaths, and laws have been enacted in all U.S. states, including West Virginia, to expand access to this life-saving medication (*see “West Virginia Laws on Naloxone” below*).

Prescribing Naloxone

Naloxone is an opioid antagonist that blocks opioid receptors. The drug comes in intravenous, intramuscular, and intranasal formulations and is FDA-approved for use in an opioid overdose and for the reversal of respiratory depression associated with opioid use. The CDC (2016) guidelines recommend that naloxone be coprescribed to any individual who is prescribed high-dose opioid therapy (≥ 50 MME per day) or any combination of opioids and benzodiazepines. Recommendations also call for overdose prevention education to both patient and household members.

Candidates for naloxone are those who:

- Take high doses of opioids for long-term management of chronic pain
- Receive rotating opioid medication regimens
- Have been discharged from emergency medical care following opioid poisoning or intoxication
- Take certain extended-release or long-acting opioid medication
- Have had a period of abstinence from opioids, including those recently released from incarceration

Pregnant women can be safely given naloxone in limited doses under the supervision of a doctor (SAMHSA, 2021).

Patient Education regarding Naloxone Administration

Patient education includes showing patients, their family members, or caregivers how to administer naloxone. The medication can be given by intranasal spray or intramuscular, subcutaneous, or intravenous injection.

Patients given an automatic injection device or nasal spray should keep the item available at all times. The medication must be replaced when the expiration date passes and if exposed to temperatures below 39 °F or above 104 °F.



Naloxone is effective if opioids are misused in combination with other sedatives or stimulants. It is **not effective** in treating overdoses of benzodiazepines or stimulant overdoses involving cocaine and amphetamines (SAMHSA, 2021).

SIGNS OF OPIOID OVERDOSE

Recognizing the signs of opioid overdose can save a life. They include:

- Small, constricted “pinpoint pupils”
- Falling asleep or losing consciousness
- Slow, weak, or no breathing
- Choking or gurgling sounds
- Limp body
- Cold and/or clammy skin
- Discolored skin (especially in lips and nails)
(CDC, 2021e)

Side effects of naloxone may include an allergic reaction from naloxone, such as hives or swelling in the face, lips, or throat, for which medical help should be sought immediately. Use of naloxone also causes symptoms of opioid withdrawal. Opioid withdrawal symptoms include:

- Feeling nervous, restless, or irritable
- Body aches
- Dizziness or weakness
- Diarrhea, stomach pain, or nausea
- Fever, chills, or goose bumps
- Sneezing or runny nose in the absence of a cold

Since naloxone is a temporary treatment and its effects will wear off, medical assistance must be obtained as soon as possible after administering/receiving naloxone (SAMHSA, 2021).

Expanding Access to Naloxone

Recommendations regarding increased access to naloxone include:

- Allowing providers to prescribe naloxone to third parties who may witness an overdose (i.e., family and friends of people who use opioids)



- Removing the need for individual prescriptions by allowing naloxone to be dispensed without a patient-specific prescription
- Allowing and equipping law enforcement officers to carry and administer naloxone
- Providing naloxone to people at risk of overdose who are leaving hospital, treatment, or corrections settings
- Permitting local agencies and organizations to distribute naloxone to community members who may be likely to witness an overdose
- Enacting “Good Samaritan” laws that provide immunity to people who experience or witness an overdose to encourage them to call 911 for help without fear of arrest
- Reducing costs for individuals and state governments by mandating public and private insurance coverage and negotiating with manufacturers for lower-cost bulk purchases (PEW, 2020)

WEST VIRGINIA LAWS ON NALOXONE

West Virginia has enacted laws to make opioid antagonists more accessible to individuals most likely to have or encounter an overdose.

- SB 335 (2015) authorizes licensed healthcare providers to prescribe an opioid antagonist to first responders, individuals at risk of having an overdose, and relatives and friends of individuals at risk of having an overdose. Providers dispensing opioid antagonists must provide educational materials on overdose prevention and treatment programs as well as materials on administering opioid antagonists to recipients.
- SB 431 (2016) authorizes pharmacists to dispense an opioid antagonist without a prescription according to an established protocol. A dispenser providing an opioid antagonist without a prescription must provide educational materials and mandatory patient counseling to the individual receiving the opioid antagonist.
- SB 272 (2018) requires local and state government agencies to require first responders to carry opioid antagonists subject to certain conditions as long as there are sufficient supplies and funding. Additionally, the State Health Officer may use standing orders to prescribe an opioid antagonist on a statewide basis to certain recipients. (WV OIG, 2019)

Additionally, West Virginia’s “Good Samaritan” law (WV Code §55-7-15) protects both civilians and licensed medical practitioners from civil liability when offering aid in an emergency.



CONCLUSION

Currently, there is an epidemic of prescription drug abuse, diversion, and overdose deaths not only in West Virginia but also across the country. The complexity of this crisis creates challenges for federal, state, and local governments as well as nongovernmental partners who must confront the growing impacts on the community.

Overprescribing opioids for more than a decade has contributed to prescription opioid addiction and led to a sharp increase in opioid addiction, which is associated with a significant increase in heroin abuse, health compromise, and overdose deaths. 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 with the right clinical skills and knowledge in 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 be priority in every clinical practice setting.



RESOURCES

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

Drug overdose prevention in States
<https://www.cdc.gov/drugoverdose/states/index.html>

Opioid prescribing guideline resources (CDC)
<https://www.cdc.gov/opioids/providers/prescribing/index.html>

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

Opioid safety: veteran/patient education (Veteran's Administration)
https://www.va.gov/PAINMANAGEMENT/Opioid_Safety/Patient_Education.asp

Pain Assessment and Documentation Tool (PADT)
<https://www.drugabuse.gov/sites/default/files/PainAssessmentDocumentationTool.pdf>

Screening and assessment tools chart (National Institute on Drug Abuse)



<https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools>

State prescription drug laws

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

West Virginia SEMP Guidelines

<http://sempguidelines.org>

REFERENCES

Bazzo D, Crossno R, Galluzzi K, Havens C, Hudspeth RS, Rivenburgh D, Salsitz EA, & St. Marie B. (2019). Pain management and opioids: balancing risks and benefits. *Medscape*. Retrieved from https://www.medscape.org/viewarticle/917714_3

Centers for Disease Control and Prevention (CDC). (2022). Draft CDC clinical practice guideline for prescribing opioids—United States, 2022: overview of community engagement and public comment opportunities. Retrieved from <https://www.regulations.gov/document/CDC-2022-0024-0005>

Centers for Disease Control and Prevention (CDC). (2021a). 2019 drug overdose death rates. Retrieved from <https://www.cdc.gov/drugoverdose/deaths/2019.html>

Centers for Disease Control and Prevention (CDC). (2021c). NVSS vital statistics rapid release: provisional drug overdose death counts. Retrieved from <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>

Centers for Disease Control and Prevention (CDC). (2021d). CDC Launches new education campaigns aimed at preventing drug overdose deaths. Retrieved from <https://www.cdc.gov/media/releases/2021/p1027-Preventing-Drug-Overdose-Deaths.html>

Centers for Disease Control and Prevention (CDC). (2021e). Lifesaving naloxone. Retrieved from <https://www.cdc.gov/stopoverdose/naloxone/>

Centers for Disease Control and Prevention (CDC). (2017). Prevention for states. Retrieved from https://www.cdc.gov/drugoverdose/states/state_prevention.html

Centers for Disease Control and Prevention (CDC). (2016). CDC guideline for prescribing opioids for chronic pain—United States, 2016. Retrieved from <https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>

Centers for Disease Control and Prevention (CDC). (n.d.). Prescription drug monitoring programs (PDMPs). Retrieved from https://www.cdc.gov/drugoverdose/pdf/pdmp_factsheet-a.pdf

National Institute on Drug Abuse (NIDA). (2021). Overdose death rates. Retrieved from <https://www.drugabuse.gov/drug-topics/trends-statistics/overdose-death-rates>

National Safety Council (NSC). (2019). For the first time, we're more likely to die from accidental opioid overdose than motor vehicle crash. Retrieved from <https://www.nsc.org/in-the-newsroom/for-the-first-time-were-more-likely-to-die-from-accidental-opioid-overdose-than-motor-vehicle-crash>

Pew Charitable Trusts. (2020). Expanded access to naloxone can curb opioid overdose deaths. Retrieved from https://www.pewtrusts.org/-/media/assets/2020/11/expanded_access_to_naloxone.pdf



Substance Abuse and Mental Health Services Administration (SAMHSA). (2021). Naloxone. Retrieved from <https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/naloxone>

Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). Key substance use and mental health indicators in the United States: results from the 2019 *National Survey on Drug Use and Health* (HHS Publication No. PEP20-07-01-001). Rockville, MD: Author. Retrieved from https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-07-01-001-PDF.pdf

U.S. Department of Health & Human Services (U.S. DHHS). (2021). What is the U.S. opioid epidemic? Retrieved from <https://www.hhs.gov/opioids/about-the-epidemic/index.html>

U. S. Drug Enforcement Administration (DEA). (2021). Counterfeit pills fact sheet. Retrieved from <https://www.dea.gov/factsheets/counterfeit-drugs>

West Virginia Expert Pain Management Panel (WVEPMP). (2016). SEMP guidelines. Retrieved from <http://sempguidelines.org/guidelines/>

West Virginia, Office of Inspector General (WV OIG). (2019). Fact sheet: West Virginia's oversight of opioid prescribing and monitoring of opioid use. Retrieved from https://oig.hhs.gov/oas/reports/region3/31803302_Factsheet.pdf





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TEST

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1. Which is an **accurate** statement regarding the scope of prescription drug misuse?
 - a. Nearly 10 million Americans ages 12 and older misused prescription pain relievers in 2019.
 - b. In West Virginia, the number of drug overdose-related deaths decreased from 2020 to 2021.
 - c. Deaths due to accidental opioid overdose are second only to deaths due to motor vehicle crashes.
 - d. In 2019, an average of over 10,000 new people ages 26 and older began misusing prescription pain relievers each day.

2. When monitoring the “Five As” of pain management, which question will the prescriber ask?
 - a. “Do you have a family history of drug misuse?”
 - b. “Has your level of function improved?”
 - c. “How satisfied are you with me as a prescriber?”
 - d. “Are there problems with your pharmacy filling your prescriptions?”

3. Which statement describes a principle articulated in the CDC’s 2016 guidelines for management of chronic pain?
 - a. Nonopioid therapy is preferred for chronic pain outside of active cancer, palliative, and end-of-life care.
 - b. Opioids are safe and effective in the management of all types of chronic pain.
 - c. When opioids are used for chronic pain, dosage should be based on an evidence-based pain scale.
 - d. Extended-release/long-acting (ER/LA) opioids are preferred when starting opioid therapy for chronic pain.

4. When educating the patient and family regarding the use of naloxone in cases of drug overdose, the clinician states that:
 - a. Naloxone is effective in treating overdoses due to cocaine and amphetamines.
 - b. It is never safe to administer naloxone to pregnant women.
 - c. There are no known side effects from naloxone use.
 - d. Both intranasal spray and parental forms of the drug are available.

