Strategies for Appropriate Opioid Prescribing: The Florida APRN/PA Requirement

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- Complete the questions at the end of the course.
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Faculty

Mark Rose, BS, MA, LP, is a licensed psychologist in the State of Minnesota with a private consulting practice and a medical research analyst with a biomedical communications firm. Earlier healthcare technology assessment work led to medical device and pharmaceutical sector experience in new product development involving cancer ablative devices and pain therapeutics. Along with substantial experience in addiction research, Mr. Rose has contributed to the authorship of numerous papers on CNS, oncology, and other medical disorders. He is the lead author of papers published in peer-reviewed addiction, psychiatry, and pain medicine journals and has written books on prescription opioids and alcoholism published by the Hazelden Foundation. He also serves as an Expert Advisor and Expert Witness to law firms that represent disability claimants or criminal defendants on cases related to chronic pain, psychiatric/substance use disorders, and acute pharmacologic/toxicologic effects. Mr. Rose is on the Board of Directors of the Minneapolis-based International Institute of Anti-Aging Medicine and is a member of several professional organizations.

Faculty Disclosure

Contributing faculty, Mark Rose, BS, MA, LP, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for all nurses and physician assistants who may alter prescribing practices or intervene to prevent drug diversion and inappropriate opioid use.

Accreditations & Approvals

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About the Sponsor

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Course Objective

The purpose of this course is to provide clinicians who prescribe or distribute opioids with an appreciation for the complexities of opioid prescribing and the dual risks of litigation due to inadequate pain control and drug diversion or misuse in order to provide the best possible patient care and to prevent a growing social problem.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define opioid prescribing and opioid misuse.
2. Apply epidemiologic trends in opioid use and misuse to current practice so at-risk patient populations can be more easily identified, assessed, and treated.
3. Create comprehensive treatment plans for patients with chronic pain that address patient needs as well as drug diversion prevention.
4. Identify state and federal laws governing the proper prescription and monitoring of controlled substances.
5. Evaluate behaviors that may indicate drug seeking or diverting as well as approaches for patients suspected of misusing opioids.

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

Pain is the leading reason for seeking medical care, and pain management is a large part of many healthcare professionals' practice. Opioid analgesics are approved by the U.S. Food and Drug Administration (FDA) for moderate and severe pain and are broadly accepted in acute pain, cancer pain, and end-of-life care, but are controversial in chronic noncancer pain. In response to the long-standing neglect of severe pain, indications for opioid analgesic prescribing were expanded in the 1990s, followed by inappropriate prescribing and increasing abuse, addiction, diversion, and overdose through the 2000s. In tandem with the continued undertreatment of pain, these practice patterns led to needless suffering from uncontrolled pain, opioid analgesic addiction, and overdose. Opioid analgesic prescribing and prescription opioid overdose peaked in 2010, with both now in multi-year decline, but information on these important trends is largely absent in the medical literature and media reporting.

Patients show substantial opioid response variations in analgesia and tolerability and may exhibit a range of psychologic, emotional, and behavioral responses that reflect inadequate pain control, an emerging opioid use problem, or both. Clinician delivery of best possible care to patients with pain requires appreciation of the complexities of opioid prescribing and the dual risks of inadequate pain control and inappropriate use, drug diversion, or overdose. A foundation for appropriate opioid prescribing is the understanding of factual data that clarify the prevalence, causality, and prevention of serious safety concerns with opioid prescribing.

DEFINITIONS

Definitions and use of terms describing opioid analgesic misuse, abuse, and addiction have changed over time, and their current correct use is inconsistent not only among healthcare providers, but also by federal agencies reporting epidemiologic data such as prevalence of opioid analgesic misuse, abuse, or addiction. Misuse and misunderstanding of these concepts and their correct definitions have resulted in misinformation and represent an impediment to proper patient care.

Inappropriate opioid analgesic prescribing for pain is defined as the non-prescribing, inadequate prescribing, excessive prescribing, or continued prescribing despite evidence of ineffectiveness of opioids [1; 40]. Appropriate opioid prescribing is essential to achieve pain control; to minimize patient risk of abuse, addiction, and fatal toxicity; and to minimize societal harms from diversion. The foundation of appropriate opioid prescribing is thorough patient assessment, treatment planning, and follow-up and monitoring. Essential for proper patient assessment and treatment planning is comprehension of the clinical concepts of opioid abuse and addiction, their behavioral manifestations in patients with pain, and how these potentially problematic behavioral responses to opioids both resemble and differ from physical dependence and pseudo-addiction. Prescriber knowledge deficit has been identified as a key obstacle to appropriate opioid prescribing and, along with gaps in policy, treatment, attitudes, and research, contributes to widespread inadequate treatment of pain [2]. For example, a survey measuring 200 primary care physicians' understanding of opioids and addiction found that [3]:

- 35% admitted knowing little about opioid addiction.
- 66% and 57% viewed low levels of education and income, respectively, as causal or highly contributory to opioid addiction.

- 30% believed opioid addiction "is more of a psychologic problem," akin to poor lifestyle choices rather than a chronic illness or disease.
- 92% associated prescription analgesics with opioid addiction, but only 69% associated heroin with opioid addiction.
- 43% regarded opioid dependence and addiction as synonymous.

This last point is very important because confusion and conflation of the clinical concepts of dependence and addiction has led to accusations of many non-addicted patients with chronic pain of misusing or abusing their prescribed opioid and in the failure to detect treatment-emergent opioid problems [4]. Knowledge gaps concerning opioid analgesics, addiction, and pain are related to attitude gaps, and negative attitudes may interfere with appropriate prescribing of opioid analgesics. For example, when 248 primary care physicians were asked of their prescribing approach in patients with headache pain with either a past or current history of substance abuse, 16% and 42%, respectively, would not prescribe opioids under any circumstance [5]. Possibly contributing to healthcare professionals' knowledge deficit in pain treatment is the lack of educational exposure in school. A 2011 study found that U.S. medical school students received a median seven hours of pain education and Canadian medical students a median 14 hours, in contrast to the median 75 hours received by veterinarian school students in the United States [6]. Additionally, less than 3% of medical schools incorporated pain management into their curriculum in the 2010s, despite chronic pain being the most common reason patients see a provider, accounting for 40% of all visits in primary care [7]. Therefore, it is very likely that many currently practicing physicians received suboptimal proper pain management, addiction medicine, and substance use education. In a 2022–2023 Association of American Medical Colleges survey of 166 medical college deans, 98% indicated that pain management was covered in the curriculum, but it is unclear how many hours are devoted to teaching about pain management [45]. It was noted that, "while the recognition of undermanaged and mismanaged pain and substance use disorders were covered in the curriculum, these topics were covered by fewer medical schools."

The terms related to addiction are often inconsistent, inaccurate, and confusing, partially reflecting the diverse perspectives of those working in the related fields of health care, law enforcement, regulatory agencies, and reimbursement/payer organizations. Changes over time in the fundamental understanding of addiction have also contributed to the persistent misuse of obsolete terminology [8]. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association, is the standard reference for the diagnosis of addiction and all other psychiatric disorders. Prior to the 2013 release of the DSM-5, versions of the DSM eschewed the term "addiction" in favor of "substance dependence," with a separate diagnostic entity of "substance abuse" representing a less severe version of dependence [9]. Also, in earlier DSM versions, physiologic dependence, manifesting as substance tolerance and withdrawal, was considered a diagnostic criterion of substance dependence. The result was the perpetuation of patient and healthcare professional confusion between physical and substance dependence and the belief that tolerance and withdrawal meant addiction. This confusion also enhanced provider and patient fears over addiction developing from opioid analgesics and contributed to the undertreatment of pain. The DSM-5 has eliminated substance dependence and substance abuse by combining them into the single diagnostic entity of substance use disorder. The disorder is measured on a continuum from mild to severe [9].

In 2011, the American Society of Addiction Medicine (ASAM) published their latest revision in defining the disease of addiction. Owing to the increased public understanding and acceptance of addiction as a chronic brain disease, ASAM published an updated definition of addiction in 2019, with the goal of making it more accessible to patients, the media, and policy makers. The updated definition states that [10]:

> Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.
>
> Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

The ASAM Task Force also recommended that definitions for medication-assisted recovery (MAR) and medication-assisted treatment (MAT), which had been previously identified as transitional terms, be retired from use in ASAM documents. With the evolution of addiction treatment and its increasing integration with general medical care, the Task Force recommended that ASAM adopt general medical terminology to describe addiction treatment [10].

EPIDEMIOLOGY OF CHRONIC PAIN AND OPIOID MISUSE

Chronic pain affects about one-quarter of American adults in any given year and is the leading cause of long-term disability [2; 46]. It also costs the nation up to $635 billion each year in medical treatment and lost productivity and is the leading reason for receiving disability insurance [3; 11]. The lifetime prevalence of chronic pain ranges from 54% to 80%, and among adults 21 years of age and older, 14% report pain lasting 3 to 12 months and 42% report pain that persists longer than one year [2]. While 5 to 8 million Americans receive long-term opioids for the management of chronic pain, an estimated 41% of patients with chronic pain report their pain is uncontrolled, and 10% of all adults with pain suffer from severe, disabling chronic pain [11].

The increasing prevalence of chronic pain is the result of multiple factors, including the aging population; rising rates of obesity and obesity-related pain conditions, such as joint deterioration; advances in life-saving trauma interventions; poorly managed post-surgical pain; and greater public awareness of pain as a condition warranting medical attention [2]. In addition, many armed forces veterans returned from military deployments in Afghanistan and Iraq with traumatic injuries and chronic pain, and veterans' care clinicians have reported the perception that long-term pain management is lacking support in the veteran healthcare infrastructure [12].

There is a widespread misperception that opioid analgesic prescribing and overdose continues to grow, fueling an opioid epidemic [13; 14; 15; 16; 17]. Data from a 2019 Centers for Disease Control and Prevention (CDC) surveillance report show that between 2006 and 2018, the annual prescribing rate per 100 persons decreased from 72.4 to 51.4 for all opioids, an overall reduction of 29.0% [18]. Between 2019 and 2024, the annual prescribing rate per 100 persons decreased from 46.8 to 35.4 [47]. (Opioid prescriptions, including codeine, fentanyl, hydrocodone, hydromorphone, methadone, morphine, oxycodone, oxymorphone, propoxyphene, tapentadol, tramadol, and buprenorphine, were identified using the National Drug Code. Cough and cold formulations containing opioids were not included.) The rate for all opioid prescriptions initially increased annually by 1.9% from 2006 to 2012, but then decreased annually by 5.2% from 2012 to 2016, and continued to decrease annually by 12.4% from 2016 to 2018 [18].

Although the epidemic of drug overdoses that began in the 1990s primarily involved prescription opioids prescribed for analgesia, the rapid increase in overdose deaths in 2010 was primarily attributed to heroin, and beginning in 2013, to synthetic opioids, particularly illicitly manufactured fentanyl [18]. A total of 75,118 drug overdose deaths occurred in 41 states and the District of Columbia in 2023, a rate of 33.4 per 100,000 persons. Although deaths might have involved more than one drug, illicit fentanyl was involved in 75.1% (56,413) of these drug

overdose fatalities [113]. Prescription opioids, which include natural and semisynthetic opioids (e.g., oxycodone, hydrocodone) and methadone, were solely involved in 1.4% (1,085) of overdose deaths. An additional 10.9% (8,182) of deaths involved a prescription opioid and other drug(s), typically other illicit opioids (60.0%), fentanyl (57.7%), non-opioid sedatives (45.3%), or stimulants (40.3%).

There is nearly universal agreement that opioid analgesics were injudiciously overprescribed during the 2000s. Interpretation of the broader trend of increased prescribing from 1990 might be viewed by public health professionals as entirely problematic and by pain medicine professionals as necessary in part, given the past neglect of patients in pain. This reflects the polarized nature of pain care and opioid analgesic prescribing in particular. Efforts to reduce opioid analgesic overprescribing and associated overdose have come at a cost to patients who have faced increasing barriers to access, including stigma and abuse in the healthcare system, tapering of opioids without consideration for pain or functional improvements, and difficulty finding a physician [14; 19; 20]. It has been found that reducing prescriptions of opioids does not lead to fewer overdoses and disproportionately harms low-income patients, and the overwhelming majority of overdoses are not among those with opioid prescriptions [20].

Worldwide consumption of opioid analgesics increased dramatically over the past few decades, driven primarily by U.S. consumption. For example, the global consumption of oxycodone was 3 tons (2,722 kg) in 1990 and 77 tons (69,853 kg) in 2009, with 62 tons (81%) consumed in the United States [21]. Global manufacture of oxycodone increased from 69.5 tons in 2022 to 103.6 tons in 2024 [22]. Consumption remained concentrated in the United States, which consumed 42.1 tons (62.3%) of the world total [22]. Global stocks of oxycodone rose to 84.6 tons in 2024, with the United States holding 30 tons, or 35.4% of the world's total [22]. The United States also accounted for almost all of the global consumption (98.4%) and manufacture (99.6%) of hydrocodone [22]. This is partially because access to opioid analgesics is virtually or entirely non-existent for much of the world's population. An estimated 3.6 billion people (50% of the global population who reside in the poorest countries) receive less than 1% of the distributed opioids [23]. Other countries with adequate opioid access prefer dihydrocodeine or low-dose morphine over hydrocodone for use in moderate or moderately severe pain [24].

Many prescribed opioid analgesic fatalities result from the co-ingestion of central nervous system (CNS)/respiratory depressants (especially benzodiazepines) or prescribed methadone. The National Institute on Drug Abuse reported that benzodiazepines contributed to 13.4% of opioid analgesic fatalities in 2020 (compared with 24% in 2017), but this may underestimate the true contribution [25]. A Canadian study evaluated 607,156 adults prescribed opioids for noncancer pain, and of those whose deaths were related to opioids, co-prescribed benzodiazepines were detected in 84.5% [26]. In another study of 2,182,374 North Carolina residents receiving one or more opioid analgesics in 2010, benzodiazepines were present in 61.4% who fatally overdosed [27]. A cross-sectional study of 386,457 ambulatory care visits in the United States from 2003 through 2015 found that the use of benzodiazepines increased substantially from 3.8% to 7.4% of visits, including co-prescribing with other sedating medications [28]. Use for back and chronic pain increased more significantly than use for anxiety and insomnia, which remained relatively unchanged. This increase likely reflected not only a growing number of individuals receiving benzodiazepines, but also an increase in those receiving them on a long-term basis, despite the lack of evidence supporting their use past 8 or 10 weeks [28].

OPIOID MISUSE IN FLORIDA

In Florida, misuse of prescription opioids became a serious problem in the 1990s and 2000s, but efforts to stem the problem appear to be working. The rate of drug overdose deaths increased 58.9% during 2003–2010, and in 2009, one in eight deaths in Florida was attributable to drug overdose [29; 30]. In 2023, there were 7,235 opioid-related deaths (5,476 opioid-caused deaths) reported in Florida out of 231,925 recorded deaths; of these, fentanyl was responsible for 4,962 deaths [31; 114]. Opioid-related deaths decreased by 10%, and opioid-caused deaths decreased by 11% compared with the previous year [31]. Of the 5,476 opioid-caused deaths reported in Florida in 2023, 1,015 were attributed to oxycodone, a 4% increase in oxycodone-caused deaths over the previous year [31]. The trends that occurred in the first two decades of the 2000s resulted in the enactment of several measures to address prescribing that was inconsistent with best practices, and partnership with the U.S. Drug Enforcement Administration (DEA) to close and prevent "pill mills" from introducing millions of opioid dose units into illicit markets [32; 33]. In May 2017, former Florida Governor Rick Scott signed an executive order declaring the opioid epidemic a public health emergency, providing additional funding and empowering state health professions to take steps to address this pressing issue [33]. As part of this order, the State Health Officer has issued a standing order for opioid antagonists to ensure emergency responders have access [33]. The order has been extended several times (last in 2019) [34].

Drug overdose fatalities in Florida have continued rising from increased use of heroin, synthetic cannabinoids, and novel psychoactive substances such as alpha-PVP ("flakka"). An influx of clandestine fentanyl into Florida in early 2014, and several fentanyl analogs and other novel non-pharmaceutical opioids more recently, has largely driven the increases in opioid overdose fatalities [31]. Several overdose fatalities in Florida were linked to counterfeit alprazolam, oxycodone, and hydrocodone tablets that contained fentanyl [35]. The decrease in prescription opioid fatalities, offset by increasing overdose fatalities from other opioid and non-opioid agents, reflects the intervention focus on the supply side ("pill mill laws") and neglect of treatment funding that would address the demand side of problematic drug use [36].

In Florida, fatalities with benzodiazepines present peaked in 2010 with 6,188, falling to 3,419 in 2023 (32.3% were alprazolam) [31]. Of the 34,274 deaths investigated by Florida authorities, toxicology results determined that drugs were present at the time of death in 14,798 individuals, with the vast majority revealing more than one drug occurrence [31]. Other primary contributors to opioid analgesic-related fatalities include alcohol and prescribed methadone [31; 37; 38].

In addition to the executive order issued in 2017 (and subsequently extended), several new state laws were passed in 2018 to impose additional legal requirements on controlled substance prescribers [39]. These laws will be discussed in detail later in this course.

INITIATION AND MANAGEMENT OF THE PATIENT WITH PAIN

In 2016, the CDC issued opioid prescribing guidelines for chronic pain that addressed when to initiate or continue opioids for chronic pain; opioid selection, dosage, duration, follow-up, and discontinuation; and assessing risk and addressing harms of opioid use [40]. Some of the recommendations were standard risk mitigation approaches, but others were criticized by pain medicine physicians and patient advocates. A common criticism was the sole focus on curtailing prescribing and patient access to needed medications or needed dosages, which left many chronic pain patients with few other avenues for care [41; 42; 43; 44]. The 2016 guidelines communicated the intent to evaluate and reassess evidence and recommendations as new evidence became available.

In 2022, the CDC updated the guidelines, based on systematic reviews of new evidence [40]. In the update, the CDC acknowledged that policies stemming from their 2016 guidance could be harmful to patients [40].

It can be difficult to balance the benefits and harms of prescription opioids. This is exacerbated by inadequate education and by opioid prescribing guidelines based on expert opinion instead of scientific evidence. This has resulted in wide variation in clinical practice, inconsistent prescriber guidance, and clinician confusion [48]. For instance, the 2016 CDC and other opioid guidelines stated that opioids should be considered only after non-opioid therapy fails. However, when pain is severe and patients require powerful analgesic control, there is little choice because no other pain medications are as effective as opioids with lower addiction risk [49]. The first recommendation in the 2022 CDC guidelines states that physicians should "only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient. Before prescribing opioid therapy for acute pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy" [40]. They no longer suggest switching only after failure of non-opioid therapy [40].

However, many guidelines do share common recommendations. These represent the current "conventional wisdom" in opioid analgesic prescribing and can inform healthcare professionals of the best clinical practices in opioid prescribing that include approaches to the assessment of pain and function and pain management modalities. Pharmacologic and nonpharmacologic approaches should be used on the basis of current evidence or best clinical practice. Patients with moderate-to-severe chronic pain without adequate pain relief from non-opioid or nonpharmacologic therapy should be considered for a trial of opioid therapy [40; 50]. Initial treatment should always be considered individually determined and as a trial of therapy, not a definitive course of treatment [40; 51].

The Centers for Disease Control and Prevention recommends that clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient.

(https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm. Last accessed July 24, 2026.)

Level of Evidence: Expert Opinion/Consensus Statement

ACUTE PAIN

Long-term opioid use often begins with treatment of acute pain. In many instances, such as low back pain, neck pain, and other pain related to other musculoskeletal injuries (e.g., sprains, strains, tendonitis, and bursitis), opioids do not provide a greater benefit than NSAIDs and are associated with the most harms [40]. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids in a quantity no greater than that needed for the expected duration of severe pain. In most cases, a few days or less will be sufficient; more than seven days will rarely be needed [40]. Florida law dictates that, for the treatment of acute pain, a prescription for an opioid drug may not exceed a three-day supply; an exception may be made for a seven-day supply if [52]:

- The prescriber, in his or her professional judgment, believes that more than a three-day supply of such an opioid is medically necessary to treat the patient's pain as an acute medical condition.
- The prescriber indicates "ACUTE PAIN EXCEPTION" on the prescription. (For the treatment of pain other than acute pain, a practitioner must indicate "NONACUTE PAIN" on a prescription.)

RISK STRATIFICATION FOR PATIENTS PRESCRIBED OPIOIDS
Low Risk
No past or current personal history of alcohol/substance use disorder (AUD/SUD) No or minimal co-occurring psychiatric disorders No family history of alcoholism or substance abuse
Medium Risk
Past history of AUD or SUD Moderate concomitant psychiatric disorders Family history of alcoholism or substance abuse/addiction Patient history of physical, emotional or sexual abuse, especially in childhood
High Risk
Patient actively addicted to or abusing opioids, illicit drugs or alcohol Untreated or poorly controlled major psychiatric disorder History of diversion, prescription forgery, selling their prescription drugs
Source: [58; 59; 60] *Table 1*

- The prescriber adequately documents in the patient's medical records the acute medical condition and lack of alternative treatment options that justify deviation from the three-day supply limit.

With postoperative, acute, or intermittent pain, analgesia often requires frequent titration, and the two- to four-hour analgesic duration with short-acting hydrocodone, morphine, and oxycodone is more effective than extended-release formulations. Short-acting opioids are also recommended in patients who are medically unstable or with highly variable pain intensity [53; 54; 55].

As part of House Bill 21, passed in 2018, the Florida Board of Medicine and the Board of Osteopathic Medicine are required to establish guidelines for prescribing controlled substances for acute pain [52]. In 2019, the Florida Board of Medicine approved and published *Rule No. 64B8-9.013, Standards for the Prescribing of Controlled Substances for the Treatment of Acute Pain* to satisfy this requirement [56].

PATIENT EVALUATION AND ASSESSMENT OF ADDICTION RISK

Information obtained by patient history, physical examination, and interview, from family members, a spouse, or state prescription drug monitoring program (PDMP), and from the use of screening and assessment tools have been used to help the clinician stratify the patient according to level of risk for developing problematic opioid behavioral responses (***Table 1***). Low-risk patients receive the standard level of monitoring, vigilance, and care. Moderate-risk patients are considered for an additional level of monitoring and provider contact, and high-risk patients are likely to require intensive and structured monitoring and follow-up contact, additional consultation with psychiatric and addiction medicine specialists, and limited supplies of short-acting opioid formulations [57]. The 2022 CDC guidelines state that screening or risk assessment tools demonstrate limited and variable accuracy for classification of patients as at low or high risk for opioid use disorder or misuse. If these tools are used, they should be supplemented with other assessments, such as discussions with patients, family, and caregivers; clinical records; PDMP data; and toxicology screening data. Clinicians should always

use caution when considering or prescribing opioids and should not overestimate the ability of available risk stratification tools to rule out risks of long-term opioid therapy [40].

Anxiety disorders, major depressive disorder, and intense emotional distress alter pain perception and response. Intensity and perception of reported pain is also influenced by factors such as mood, cultural background, social supports, and financial resources. A biopsychosocial model is required to inform pain assessment in order to address the biologic basis of pain and presence of social and psychologic contributors [49].

Before deciding to prescribe an opioid analgesic, clinicians should perform and document a detailed patient assessment that includes [1]:

- Medical history and physical examination targeted to the condition causing pain
- Co-existing disease(s) or condition(s), particularly those which could complicate treatment (e.g., obesity, renal disease, sleep apnea, COPD)
- Description of the nature and intensity of the pain and the effect of pain on physical and psychological functioning
- Medical indication(s) for use of opioids
- Current and past treatments, including interventional treatments, with response to each treatment
- Current medications (prescription, over-the-counter drugs, and natural remedies)
- Tests of urine, blood, or other types of biological samples, and diagnostic markers
- Review of state PDMP results
- Personal and family history of substance use disorder
- History of behavioral health disorders

Depression is perhaps the single most important comorbidity in patients with chronic pain and is vastly underdiagnosed and untreated. Patients with unrecognized and untreated depression are less likely to respond to opioids and other pain therapies, but successful treatment of depression can promote analgesia [61].

If substance abuse is active, in remission, or in the patient's history, consult an addiction specialist before starting opioids [1]. In active substance abuse, do not prescribe opioids until the patient is engaged in treatment/recovery program or other arrangement made, such as addiction professional co-management and additional monitoring. When considering an opioid analgesic (particularly those that are extended-release or long-acting), one must always weigh the benefits against the risks of overdose, abuse, addiction, physical dependence and tolerance, adverse drug interactions, and accidental exposure by children [40; 62].

Screening and assessment tools can help guide patient stratification according to risk level and inform the appropriate degree of structure and monitoring in the treatment plan. It should be noted that despite widespread endorsement of screening tool use to help determine patient risk level, most tools have not been extensively evaluated, validated, or compared to each other, and evidence of their reliability is poor [63].

Opioid Risk Tool (ORT)

The Opioid Risk Tool (ORT) is a five-item assessment to help predict aberrant drug-related behavior. The ORT is also used to establish patient risk level through categorization into low, medium, or high levels of risk for aberrant drug-related behaviors based on responses to questions of previous alcohol/drug abuse, psychologic disorders, and other risk factors [64; 65].

Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R)

The Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R) is a patient-administered, 24-item screen with questions addressing history of alcohol/substance use, psychologic status, mood, cravings, and stress. Like the ORT, the SOAPP-R helps assess risk level of aberrant drug-related behaviors and the appropriate extent of monitoring [66; 67].

CAGE and CAGE-AID

The original CAGE (Cut down, Annoyed, Guilty, and Eye-opener) Questionnaire consisted of four questions designed to help clinicians determine the likelihood that a patient was misusing or abusing alcohol. These same four questions were modified to create the CAGE-AID (adapted to include drugs), revised to assess the likelihood of current substance abuse [68; 69].

Diagnosis, Intractability, Risk, and Efficacy (DIRE) Tool

The Diagnosis, Intractability, Risk, and Efficacy (DIRE) risk assessment tool is a clinician-rated questionnaire that is used to predict patient compliance with long-term opioid therapy [70; 71]. Patients scoring lower on the DIRE tool are poor candidates for long-term opioid analgesia.

CREATING A TREATMENT PLAN

Opioid therapy should be presented as a trial for a pre-defined period (e.g., ≤30 days). The goals of treatment should be established with all patients prior to the initiation of opioid therapy, including reasonable improvements in pain, function, depression, anxiety, and avoidance of unnecessary or excessive medication use [1; 40]. The treatment plan should describe therapy selection, measures of progress, and other diagnostic evaluations, consultations, referrals, and therapies. All patients prescribed an opioid for pain related to a traumatic injury (severity score ≥9) should be concurrently prescribed an antagonist (e.g., naloxone) [40; 52]. Florida law requires concurrent prescription of an emergency opioid antagonist if an opioid is prescribed for the treatment of pain related to a traumatic injury with an Injury Severity Score of 9 or greater [116].

In opioid-naïve patients, start at the lowest possible dose and titrate to effect. Dosages for opioid-tolerant patients should always be individualized and titrated by efficacy and tolerability [1]. The need for frequent progress and benefit/risk assessments during the trial should be included in patient education. Patients should also have full knowledge of the warning signs and symptoms of respiratory depression.

Prescribers should be knowledgeable of federal and state opioid prescribing regulations. Issues of equianalgesic dosing, close patient monitoring during all dose changes, and incomplete cross-tolerance with opioid conversion should be considered. If necessary, treatment may be augmented, with preference for non-opioid and immediate-release opioids over long-acting/extended-release opioids. Taper opioid dose when no longer needed [62].

Non-Opioid Pain Management Options

Nonpharmacologic Approaches

Several nonpharmacologic approaches are therapeutic complements to pain-relieving medication, lessening the need for higher doses and perhaps minimizing side effects. These interventions can help decrease pain or distress that may be contributing to the pain sensation. Approaches include palliative radiotherapy, complementary/alternative methods, manipulative and body-based methods, and cognitive/behavioral techniques. The choice of a specific nonpharmacologic intervention is based on the patient's preference, which, in turn, is usually based on a successful experience in the past.

Methods to provide distraction from pain come in a wide variety, including reciting poetry, meditating with a calm phrase, watching television or movies, playing cards, visiting with friends, or participating in crafts. Music therapy and art therapy are also becoming more widely used as nonpharmacologic options for pain management.

Non-Opioid Analgesics

Non-opioid analgesics, such as aspirin, acetaminophen (Tylenol), and nonsteroidal anti-inflammatory drugs (NSAIDs), are primarily used for mild pain and may also be helpful as coanalgesics for moderate and severe pain. Acetaminophen is among the safest of analgesic agents, but it has essentially no anti-inflammatory effect. Toxicity is a concern at high doses, and the maximum recommended dose is 3–4 g per day [73]. Acetaminophen should be avoided or given at lower doses in people with a history of alcohol abuse or renal or hepatic insufficiency [73].

NSAIDs are most effective for pain associated with inflammation. Among the commonly used NSAIDs are ibuprofen (Motrin, Advil), naproxen (Aleve, Naprosyn), and indomethacin (Indocin). There are several classes of NSAIDs, and the response differs among patients; trials of drugs for an individual patient may be necessary to determine which drug is most effective [74]. NSAIDs inhibit platelet aggregation, increasing the risk of bleeding, and also can damage the mucosal lining of the stomach, leading to gastrointestinal bleeding. There is a ceiling effect to the non-opioid analgesics; that is, there is a dose beyond which there is no further analgesic effect. In addition, many side effects of non-opioids can be severe and may limit their use or dosing.

Informed Consent and Treatment Agreements

The initial opioid prescription is preceded by a written informed consent or "treatment agreement" [1]. This agreement should address potential side effects, tolerance and/or physical dependence, drug interactions, motor skill impairment, limited evidence of long-term benefit, misuse, dependence, addiction, and overdose. Informed consent documents should include information regarding the risk/benefit profile for the drug(s) being prescribed. The prescribing policies should be clearly delineated, including the number/frequency of refills, early refills, and procedures for lost or stolen medications [1].

The treatment agreement also outlines joint physician and patient responsibilities. The patient agrees to using medications safely, to obtain opioids from only one clinician or practice (when possible), having prescriptions filled at only one pharmacy (when possible), and consenting to routine urine drug testing (when clinically appropriate). The prescriber's responsibility is to address unforeseen problems and prescribe scheduled refills. Reasons for opioid therapy change or discontinuation should be listed. Agreements can also include sections related to follow-up visits, monitoring, and safe storage and disposal of unused drugs.

PERIODIC REVIEW AND MONITORING

When implementing a chronic pain treatment plan that involves the use of opioids, the patient should be frequently reassessed for changes in pain origin, health, and function [1]. This can include input from family members or other close contacts and/or the state PDMP. During the initiation phase and during any changes to the dosage or agent used, patient contact should be increased. At every visit, chronic opioid response may be monitored according to the "5 A's" [75]:

- Analgesia
- Activities of daily living
- Adverse or side effects
- Aberrant drug-related behaviors
- Affect (i.e., patient mood)

Signs and symptoms that, if present, may suggest a problematic response to the opioid and interference with the goal of functional improvement include [76]:

- Excessive sleeping or days and nights turned around
- Diminished appetite
- Short attention span or inability to concentrate
- Mood volatility, especially irritability
- Lack of involvement with others
- Impaired functioning due to drug effects
- Use of the opioid to regress instead of re-engaging in life
- Lack of attention to hygiene and appearance

The decision to continue, change, or terminate opioid therapy is based on progress toward treatment objectives and absence of concerning adverse effects and risks of overdose or diversion [1]. Satisfactory therapy is indicated by improvements in pain, function, and quality of life. It is important to remember that for some patients with severe

chronic pain, improved function may take longer than pain control. Either pain or function (not both) will improve. In some cases, preventing worsening pain/functional impairment is the best achievable outcome. Brief assessment tools to assess pain and function may be useful, as may urine drug tests (UDTs). Treatment plans may include periodic pill counts to confirm adherence and minimize diversion.

Involvement of Family

Family members or the partner of the patient can provide the clinician with valuable information that better informs decision making regarding continuing opioid therapy [1]. Family members can observe whether a patient is losing control of his or her life or becoming less functional or more depressed during the course of opioid therapy. They can also provide input regarding positive or negative changes in patient function, attitude, and level of comfort [1]. The following questions can be asked of family members or a spouse to help clarify whether the patient's response to opioid therapy is favorable or unfavorable [76]:

- Is the person's day centered around taking the opioid medication? Response can help clarify long-term risks and benefits of the medication and identify other treatment options.
- Does the person take pain medication only on occasion, perhaps three or four times per week? If yes, the likelihood of addiction is low.
- Have there been any other substance (alcohol or drug) abuse problems in the person's life? An affirmative response should be taken into consideration when prescribing.
- Does the person in pain spend most of the day resting, avoiding activity, or feeling depressed? If so, this suggests the pain medication is failing to promote rehabilitation. Daily activity is essential, and the patient may be considered for enrollment in a graduated exercise program
- Is the person in pain able to function (e.g., work, do household chores, play) with pain medication in a way that is clearly better than without? If yes, this suggests the pain medication is contributing to wellness.

Assessment Tools

VIGIL

VIGIL is the acronym for a five-step risk management strategy designed to empower clinicians to appropriately prescribe opioids for pain by reducing regulatory concerns and to give pharmacists a framework for resolving ambiguous opioid analgesic prescriptions in a manner that preserves legitimate patient need while potentially deterring diverters. The components of VIGIL are:

- Verification: Is this a responsible opioid user?
- Identification: Is the identity of this patient verifiable?
- Generalization: Do we agree on mutual responsibilities and expectations?
- Interpretation: Do I feel comfortable allowing this person to have controlled substances?
- Legalization: Am I acting legally and responsibly?

The foundation of VIGIL is a collaborative physician/pharmacist relationship [77; 78].

PATIENT RISK LEVEL AND FREQUENCY OF MONITORING			
Monitoring Tool	**Patient Risk Level**		
	Low	**Medium**	**High**
Urine drug test	Every 1 to 2 years	Every 6 to 12 months	Every 3 to 6 months
State prescription drug monitoring program	Twice per year	3 times per year	4 times per year

Source: [81] *Table 2*

Current Opioid Misuse Measure (COMM)

The Current Opioid Misuse Measure (COMM) is a 17-item patient self-report assessment designed to help clinicians identify misuse or abuse in patients with chronic pain. Unlike the ORT and the SOAPP-R, the COMM identifies aberrant behaviors associated with opioid misuse in patients already receiving long-term opioid therapy [57]. Sample questions include: In the past 30 days, how often have you had to take more of your medication than prescribed? In the past 30 days, how much of your time was spent thinking about opioid medications (e.g., having enough, taking them, dosing schedule)?

Pain Assessment and Documentation Tool (PADT)

Guidelines by the Federation of State Medical Boards (FSMB) and the Joint Commission stress the importance of documentation from both a healthcare quality and medicolegal perspective. Research has found widespread deficits in chart notes and progress documentation for patients with chronic pain who are receiving opioid therapy, and the Pain Assessment and Documentation Tool (PADT) was designed to address these shortcomings [79]. The PADT is a clinician-directed interview, with most sections (e.g., analgesia, activities of daily living, adverse events) consisting of questions asked of the patient [80]. However, the potential aberrant drug-related behavior section must be completed by the physician based on his or her observations of the patient.

Urine Drug Tests

UDTs may be used to monitor adherence to the prescribed treatment plan and to detect unsanctioned drug use. They should be used more often in patients receiving addiction therapy, but clinical judgment is the ultimate guide to testing frequency (***Table 2***) [81]. The CDC recommends clinicians should use UDT before starting opioid therapy and consider UDT at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs [40]. UDT is not used in a punitive manner (i.e., to dismiss patients), and patients should be informed that this will not occur. UDT is only used to inform and improve patient care.

Initially, testing involves the use of class-specific immunoassay drug panels [1]. If necessary, this may be followed with gas chromatography/mass spectrometry for specific drug or metabolite detection. It is important that testing identifies the specific drug rather than the drug class, and the prescribed opioid should be included in the screen. Any abnormalities should be confirmed with a laboratory toxicologist or clinical pathologist. Immunoassay may be used point-of-care for "on-the-spot" therapy changes, but the high error rate prevents its use in major clinical decisions except with liquid chromatography coupled to tandem mass spectrometry confirmation.

Urine test results suggesting opioid misuse should be discussed with the patient using a positive, supportive approach. The test results and the patient discussion should be documented.

CONSULTATION AND REFERRAL

It is important to seek consultation or patient referral when input or care from a pain, psychiatry, addiction, or mental health specialist is necessary. Clinicians who prescribe opioids should become familiar with opioid addiction treatment options (including licensed opioid treatment programs for methadone and office-based opioid treatment for buprenorphine) if referral is needed [1].

Ideally, providers should be able to refer patients with active substance abuse who require pain treatment to an addiction professional or specialized program. In reality, these specialized resources are scarce or non-existent in many areas [1]. Therefore, each provider will need to decide whether the risks of continuing opioid treatment while a patient is using illicit drugs outweigh the benefits to the patient in terms of pain control and improved function [82].

MEDICAL RECORDS

As noted, documentation is a necessary aspect of all patient care, but it is of particular importance when opioid prescribing is involved. All clinicians should maintain accurate, complete, and up-to-date medical records, including all written or telephoned prescription orders for opioid analgesics and other controlled substances, all written instructions to the patient for medication use, and the name, telephone number, and address of the patient's pharmacy [1]. Good medical records demonstrate that a service was provided to the patient and that the service was medically necessary. Regardless of the treatment outcome, thorough medical records protect the prescriber.

PATIENT EDUCATION ON THE USE AND DISPOSAL OF OPIOIDS

Patients and caregivers should be counseled regarding the safe use and disposal of opioids. As part of its mandatory Risk Evaluation and Mitigation Strategy (REMS) for extended-release/long-acting opioids, the FDA has developed a patient counseling document with information on the patient's specific medications, instructions for emergency situations and incomplete pain control, and warnings not to share medications or take them unprescribed [62]. A copy of this form may be accessed online at https://www.fda.gov/media/79776/download.

When prescribing opioids, clinicians should provide patients with the following information [62]:

- Product-specific information
- Taking the opioid as prescribed
- Importance of dosing regimen adherence, managing missed doses, and prescriber contact if pain is not controlled
- Warning and rationale to never break or chew/crush tablets or cut or tear patches prior to use
- Warning and rationale to avoid other central nervous system depressants, such as sedative-hypnotics, anxiolytics, alcohol, or illicit drugs
- Warning not to abruptly halt or reduce the opioid without physician oversight of safe tapering when discontinuing
- The potential of serious side effects or death
- Risk factors, signs, and symptoms of overdose and opioid-induced respiratory depression, gastrointestinal obstruction, and allergic reactions
- The risks of falls, using heavy machinery, and driving
- Warning and rationale to never share an opioid analgesic

- Rationale for secure opioid storage
- Warning to protect opioids from theft
- Instructions for disposal of unneeded opioids, based on product-specific disposal information

There are no universal recommendations for the proper disposal of unused opioids, and patients are rarely advised of what to do with unused or expired medications [83]. According to the Office of National Drug Control Policy, most medications that are no longer necessary or have expired should be removed from their containers, mixed with undesirable substances (e.g., cat litter, used coffee grounds), and put into an impermeable, nondescript container (e.g., disposable container with a lid or a sealed bag) before throwing in the trash [84]. Any personal information should be obscured or destroyed. The FDA recommends that certain medications, including oxycodone/acetaminophen (Percocet), oxycodone (OxyContin tablets), and transdermal fentanyl (Duragesic Transdermal System), be flushed down the toilet instead of thrown in the trash [85]. Patients should be advised to flush prescription drugs down the toilet only if the label or accompanying patient information specifically instructs doing so and no other disposal method is appropriate [85].

The American Society of Health-System Pharmacists has established best practices to avoid diversion of unused drugs and educate patients regarding drug disposal [83; 115]:

- Consider writing prescriptions in smaller amounts.
- Educate patients about safe storing and disposal practices.
- Give drug-specific information to patients about the temperature at which they should store their medications. Generally, the bathroom is not the best storage place. It is damp and moist, potentially resulting in potency decrements, and accessible to many people, including children and teens, resulting in potential theft or safety issues.
- Refer patients to pharmacies or community "take back" services overseen by law enforcement that collect controlled substances, seal them in plastic bags, and store them in a secure location until they can be incinerated.
- The FDA recommends that patients type "drug disposal" or "medication disposal" into Google maps to check their local area for take back options, which typically returns results for all pharmacies in the area. Returning unused portions to a pharmacy is typically the easiest way for individuals to dispose of unused medications. To find a nearby pharmacy, they can also visit https://apps.deadiversion.usdoj.gov/pubdispsearch/spring/main?execution=e1s1.

DISCONTINUING OPIOID THERAPY

The decision to continue or end opioid prescribing should be based on a physician-patient discussion of the anticipated benefits and risks. An opioid should be considered for discontinuation with resolution of the pain condition, intolerable side effects, inadequate analgesia, lack of improvement in quality of life despite dose titration, deteriorating function, or significant aberrant medication use [1; 40].

Clinicians should provide physically dependent patients with a safely structured tapering protocol. Withdrawal is managed by the prescribing physician or referral to an addiction specialist. Patients should be reassured that opioid discontinuation is not the end of treatment; continuation of pain management will be undertaken with other modalities through direct care or referral.

As a side note, cannabis use by patients with chronic pain receiving opioid therapy has traditionally been viewed as a treatment agreement violation that is grounds for termination of opioid therapy. However, some now argue against cannabis use as a rationale for termination or substantial treatment and monitoring changes, especially considering the increasing legalization of medical use at the state level [82]. Cannabis use for chronic pain in patients receiving opioid therapy continues to receive increased interest and support; however, experts caution that more evidence of improved patient outcomes is needed [86; 87; 88].

CONSIDERATIONS FOR NON-ENGLISH-PROFICIENT PATIENTS

For patients who are not proficient in English, it is important that information regarding the risks associated with the use of opioids and available resources be provided in their native language, if possible. When there is an obvious disconnect in the communication process between the practitioner and patient due to the patient's lack of proficiency in the English language, an interpreter is required. Interpreters can be a valuable resource to help bridge the communication and cultural gap between patients and practitioners. Interpreters are more than passive agents who translate and transmit information back and forth from party to party. When they are enlisted and treated as part of the interdisciplinary clinical team, they serve as cultural brokers who ultimately enhance the clinical encounter. In any case in which information regarding treatment options and medication/treatment measures are being provided, the use of an interpreter should be considered. Print materials are also available in many languages, and these should be offered whenever necessary.

CRISIS INTERVENTION: MANAGEMENT OF OVERDOSE

Individuals who have first contact with persons suspected of experiencing an opioid-related overdose are in the position to intervene to prevent the potentially devastating consequences. In these cases, care begins with crisis intervention directed at immediate survival by reversing the potentially lethal effects of overdose with an opioid antagonist.

Opioid antagonists have obvious therapeutic value in the treatment of opioid overdose. A 2012 study found that wider distribution of naloxone and training in its administration might have prevented numerous deaths from opioid overdoses in the United States [89]. The first community-based opioid overdose prevention program began distributing naloxone in 1996, and between 1996 and 2010, more than 10,000 overdoses were reversed [89].

In Florida, licensed healthcare providers may prescribe and pharmacists may dispense opioid antagonists (even as a standing order) for at-risk individuals, these individuals' relatives or other caregivers, and emergency responders to be used in their course of duties [90]. Emergency responders include (but are not limited to) law enforcement officers, paramedics, and emergency medical technicians [90]. As noted, there is a statewide standing order for naloxone for all emergency responders in Florida [33].

OPIOID ANTAGONISTS

Relatively minor changes in the structure of an opioid can convert an agonist drug into one with antagonistic actions at one or more opioid receptor types. Opioid antagonists include naloxone, naltrexone, and nalmefene. Interestingly, naloxone also appears to block the analgesic effects of placebo medications and acupuncture. These agents have no abuse potential [91].

In response to acute overdose, the short-acting opioid antagonist naloxone is considered the gold standard, and it remains the most widely used opioid antagonist for the reversal of overdose and opioid-related respiratory depression. It acts by competing with opioids at receptor sites in the brain stem, reversing desensitization to carbon dioxide, and reversing or preventing respiratory failure and coma. There is no evidence that subcutaneous or intramuscular use is inferior to intravenous naloxone. This has prompted some states to pass laws allowing opioid antagonists to be available to the general public for administration outside the healthcare setting to treat acute opioid overdose [92].

When used for opioid overdose, a dose of 0.4–2 mg of naloxone is administered intravenously, intramuscularly, or subcutaneously [93]. If necessary, the dose may be repeated every two to three minutes for full reversal. For ease of use, naloxone is also available in a 10-mg pre-filled auto-injection device. An intranasal formulation is also available in doses of 2 mg, 4 mg, or 8 mg [93]. It is important that standard Advanced Cardiac Life Support (ACLS) protocols be continued while naloxone is being administered and that medical treatment (at a healthcare facility) be given immediately.

COMPLIANCE WITH STATE AND FEDERAL LAWS

In response to the rising incidence in prescription opioid abuse, addiction, diversion, and overdose in the late 1990s and 2000s, the FDA has mandated opioid-specific REMS to reduce the potential negative patient and societal effects of prescribed opioids. Other elements of opioid risk mitigation include FDA partnering with other governmental agencies, state professional licensing boards, and societies of healthcare professionals to help improve prescriber knowledge of appropriate and safe opioid prescribing and safe home storage and disposal of unused medication [76].

Several regulations and programs at the state level have been enacted in an effort to reduce prescription opioid abuse, diversion, and overdose, including [94]:

- Physical examination required prior to prescribing
- Tamper-resistant prescription forms
- Pain clinic regulatory oversight
- Prescription limits
- Prohibition from obtaining controlled substance prescriptions from multiple providers
- Patient identification required before dispensing
- Immunity from prosecution or mitigation at sentencing for individuals seeking assistance during an overdose

CONTROLLED SUBSTANCES LAWS/RULES

The DEA is responsible for formulating federal standards for the handling of controlled substances. In 2011, the DEA began requiring every state to implement electronic databases that track prescribing habits, referred to as PDMPs. Specific policies regarding controlled substances are administered at the state level.

According to the DEA, drugs, substances, and certain chemicals used to make drugs are classified into five distinct categories or schedules depending upon the drug's acceptable medical use and the drug's abuse or dependency potential [95]. The abuse rate is a determinate factor in the scheduling of the drug; for example, Schedule I drugs are considered the most dangerous class of drugs with a high potential for abuse and potentially severe psychologic and/or physical dependence.

In Florida, the prescribing, dispensing, and consumption of certain controlled substances are governed by Chapter 893 of the Florida Statutes [96]. This law establishes the standards for controlled substance prescribing, including reporting system requirements, for prescribers and pharmacists in Florida. As of 2022, the Florida schedule of controlled substances aligns with the DEA schedule [97].

THE ELECTRONIC FLORIDA ONLINE REPORTING OF CONTROLLED SUBSTANCES EVALUATION PROGRAM

Emerging trends and patterns of prescription opioid abuse, addiction, and overdose are monitored by several industry and government agencies through data collection from a variety of sources. These include health insurance claims; the Automation of Reports and Consolidated Orders System, a DEA-run program that monitors the flow of controlled substances from manufacturing through distribution to retail sale or dispensing; the Treatment Episode Data Set, which monitors treatment admissions; the National Center for Health Statistics state mortality data; and the Researched Abuse, Diversion, and Addiction-Related Surveillance System, which monitors prescription drug abuse, misuse, and diversion [98; 99; 100; 101].

Almost all states, including Florida, have enacted PDMPs to facilitate the collection, analysis, and reporting of information on controlled substances prescribing and dispensing [1]. All prescribers must consult the Electronic Florida Online Reporting of Controlled Substances Evaluation (E-FORCSE) to review a patient's controlled substance dispensing history before prescribing or dispensing a controlled substance to a patient 16 years of age or older [39; 102]. This is mandated even for existing patients and should be done each time a controlled substance is prescribed or dispensed [39]. If the system is nonoperational or cannot be accessed due to a temporary technologic or electrical failure, the prescription may be issued (with documentation of the exception) for up to a maximum three-day supply.

All clinicians who prescribe or dispense controlled substances are required to report the action to E-FORCSE as soon as possible, but no later than the close of the next business day [39]. This should be repeated each time the substance is dispensed. This reporting requirement is waived in certain circumstances, including for [103]:

- The dispensing of a controlled substance in the healthcare system of the Department of Corrections
- The dispensing of a controlled substance to a person younger than 16 years of age
- All acts of administration of a controlled substance

IDENTIFICATION OF DRUG DIVERSION/SEEKING BEHAVIORS

Research has more closely defined the location of prescribed opioid diversion into illicit use in the supply chain from the manufacturer to the distributor, retailer, and the end user (the patient with pain). This information carries with it substantial public policy and regulatory implications. The 2020 National Survey on Drug Use and Health asked 9.3 million non-medical users of prescription opioids how they obtained their most recently used drugs [104]. Among persons 12 years of age or older, 47.2% obtained their prescription opioids from a friend or relative. Of this, 34.4% got the prescription opioids from a friend or relative for free, 9.2% bought them from a friend or relative, and 3.7% took them from a friend or relative without asking. Another 42.0% got their opioids through a prescription from one doctor (vs. 35.4% in 2016) [104]. Less frequent sources included a drug dealer or other stranger (6.2%); multiple doctors (1.0%); theft from a doctor's office, clinic, hospital, or pharmacy (0.6%) (vs. 0.7% in 2016); and some other way (3.1%) [104].

As discussed, UDTs can give insight into patients who are misusing opioids. A random sample of UDT results from 800 patients with pain treated at a Veterans Affairs facility found that 25.2% were negative for the prescribed opioid while 19.5% were positive for an illicit drug/unreported opioid [105]. Negative UDT results for the prescribed opioid do not necessarily indicate diversion but may indicate the patient halted his/her use due to side effects, lack of efficacy, or pain remission. The concern arises over the increasingly stringent climate surrounding clinical decision-making regarding aberrant UDT results and that a negative result for the prescribed opioid or a positive UDT may serve as the pretense to terminate a patient rather than guide him/her into addiction treatment or an alternative pain management program [106].

In addition to aberrant urine screens, there are certain behaviors that are suggestive of an emerging opioid use disorder. The most suggestive behaviors are [82; 107; 108]:

- Selling medications
- Prescription forgery or alteration
- Injecting medications meant for oral use
- Obtaining medications from nonmedical sources
- Resisting medication change despite worsening function or significant negative effects
- Loss of control over alcohol use
- Using illegal drugs or non-prescribed controlled substances
- Recurrent episodes of:
  - Prescription loss or theft
  - Obtaining opioids from other providers in violation of a treatment agreement
  - Unsanctioned dose escalation
  - Running out of medication and requesting early refills

Behaviors with less association with opioid misuse include [82; 107; 108]:

- Aggressive demands for more drug
- Asking for specific medications
- Stockpiling medications during times when pain is less severe
- Using pain medications to treat other symptoms
- Reluctance to decrease opioid dosing once stable
- In the earlier stages of treatment:
  - Increasing medication dosing without provider permission
  - Obtaining prescriptions from sources other than the pain provider
  - Sharing or borrowing similar medications from friends/family

INTERVENTIONS FOR SUSPECTED OR KNOWN DRUG DIVERSION

There are a number of actions that prescribers and dispensers can take to prevent or intervene in cases of drug diversion. These actions can be generally categorized based on the various mechanisms of drug diversion.

Prevention is the best approach to addressing drug diversion. As noted, the most common source of nonmedical use of prescribed opioids is from a family member or friend, through sharing, buying, or stealing. To avoid drug sharing among patients, healthcare professionals should educate patients on the dangers of sharing opioids and stress that "doing prescription drugs" is the same as "using street drugs" [83]. In addition, patients should be aware of the many options available to treat chronic pain aside from opioids. As stated, to prevent theft, patients should be advised to keep medications in a private place and to refrain from telling others about the medications being used.

Communication among providers and pharmacies can help to avoid inappropriate attainment of prescription drugs through "doctor shopping." Prescribers should keep complete and up-to-date records for all controlled substance prescribing. When possible, electronic medical records should be integrated between pharmacies, hospitals, and managed care organizations [83]. It is also best practice to periodically request a report from the E-FORCSE to evaluate the prescribing of opioids to your patients by other providers [39; 83].

When dealing with patients suspected of drug seeking/diversion, first inquire about prescription, over-the-counter, and illicit drug use and perform a thorough examination [83; 109]. Pill counting and/or UDT may be necessary to investigate possible drug misuse. Photo identification or other form of identification and social security number may be required prior to dispensing the drug, with proof of identity documented fully. If a patient is displaying suspicious behaviors, consider prescribing for limited quantities [109].

If a patient is found to be abusing prescribed opioids, this is considered a violation of the treatment agreement and the clinician must make the decision whether or not to continue the therapeutic relationship. If the relationship is terminated, it must be done ethically and legally. The most significant issue is the risk of patient abandonment, which is defined as ending a relationship with a patient without consideration of continuity of care and without providing notice to the patient. The American Medical Association Code of Ethics states that "physicians' fiduciary responsibility to patients entails an obligation to support continuity of care for their patients" [110]. While physicians have the option of withdrawing from a case, they cannot do so without giving notice to the patient, the relatives, or responsible friends sufficiently long in advance of withdrawal to permit another medical attendant to be secured or to facilitate the transfer of care, when appropriate [110]. The notice of termination should be sent in writing, should specifically note the cause(s) for the termination, and should give a period of time prior to termination, usually 30 days [111]. Patients may also be given resources and/or recommendations to help them locate a new clinician.

Patients with chronic pain found to have an ongoing substance abuse problem or addiction should be referred to a pain specialist for continued treatment. Theft or loss of controlled substances is reported to the DEA. If drug diversion has occurred, the activity should be documented and a report to law enforcement should be made [112].

CASE STUDY

An unemployed man, 64 years of age, is brought to an emergency department by ambulance, after his wife returned from work to find him lying on the couch, difficult to arouse and incoherent. He has a past history of hypertension, diabetes (non-insulin dependent), mild chronic obstructive pulmonary disease, and chronic back and shoulder pain, for which he has been prescribed hydrocodone/acetaminophen for many years. His wife reports that while he seemed his usual self when she left for work that morning, he had, in recent weeks, been more withdrawn socially, less active, and complained of greater discomfort from the back and shoulder pain. She knows little about his actual medication usage and expresses concern that he may have been taking more than the prescribed amount of "pain medicine."

On evaluation, the patient is somnolent and arouses to stimulation but is non-communicative and unable to follow commands. His blood pressure is normal, he is afebrile, and there are no focal neurologic deficits. Oxygen saturation, serum glucose, and routine laboratory studies (blood counts and metabolic profile) are normal except for mild elevation in blood urea nitrogen (BUN) and creatinine; the urine drug screen is negative except for opioids. Additional history from the family indicates that the patient has been admitted to other hospitals twice in the past three years with a similar presentation and recovered rapidly each time "without anything being found."

Following admission, the patient remains stable-to-improved over the next 12 to 18 hours. By the following day, he is awake and conversant and looks comfortable. On direct questioning, he reports recent symptoms of depression but no suicidal ideation. The patient describes an increased preoccupation with his pain syndrome, difficulty sleeping at night, and little physical activity during the day, in part because of physical discomfort. He is vague about his medication regimen and admits to taking "occasional" extra doses of hydrocodone for pain relief.

The family is instructed to bring in all his pill bottles from home, which they do. In addition to the hydrocodone prescribed by his primary care physician, there is a recent refill of a prescription for the medication given to the patient at the time of his last hospital discharge six months earlier.

ASSESSMENT

A full evaluation, including radiographic studies and consultation with psychiatry and physical therapy, is completed. The working diagnosis for the patient's acute illness is toxic encephalopathy caused by the sedative side effects of opioid medication on the CNS. It is explained that the combination of his advancing age and diabetes likely reduced the efficiency of his kidneys in clearing the medication and its metabolites, making him more susceptible to CNS sedation. It is noted that the patient and his wife have little understanding of the rationale, proper use and safeguards, potential side effects, and limited effectiveness of opioid use for chronic pain.

In addition, the patient is diagnosed with poorly controlled chronic pain syndrome secondary to osteoarthritis and degenerative disc disease; exacerbating factors include deconditioning and reactive depression. The use of an opioid analgesic, at least for the near term, is considered appropriate, if dosed properly, monitored closely, and integrated into a comprehensive, multidisciplinary plan that includes treatment of depression and the use of adjunctive, nonpharmacologic modalities of care. In the setting of possible early diabetic nephropathy, the option of utilizing an NSAID, except for very brief periods of break-through pain, is not considered to be a safe option.

At discharge, and in consultation with his primary care physician, a written treatment and management plan addressing all aspects of the patient's care is presented to the patient and his wife for discussion and consent. Among the key issues addressed are:

- Goals: Improvement in subjective pain experience; improved function of daily living manifested by regular walking exercise and improved social interaction with family and friends; relief of depression; and in the long-term, anticipated withdrawal of opioid medication and resumption of part-time work and/or volunteer community activity
- Outpatient physical therapy and back exercise program to increase core muscular strength, improve flexibility, reduce pain, and increase exercise tolerance
- Patient and family counseling regarding the safe use, dosage regulation, side effects, and proper disposal of opioid medication
- Joint patient-physician responsibilities as regards to regular follow-up, monitoring of goals and treatment effectiveness, avoidance of "doctor-shopping," and assent to single provider for prescription medication

FOLLOW-UP

On follow-up six weeks after discharge, the patient is noticeably improved. He reports that he feels stronger and is sleeping better. His affect is brighter, and he is getting out more. He has maintained his physical therapy and exercise routine and is compliant with his medication. Though he still has pain, it is noticeably less and he is coping better. He and his wife are encouraged by his progress, particularly in regard to his improved functional status.

CONCLUSION

For patients suffering from pain, prescribed opioid analgesics may substantially lessen pain, distress, and impairment. Inappropriate overprescribing and overdose related to opioid analgesics increased dramatically in the 2000s. These trends are in multi-year reversal, but patient safety and risk mitigation remains no less important, and clinical tools, guidelines, and recommendations are available for use when prescribing opioids to patients with pain. By implementing these tools, the clinician can effectively address issues related to the clinical management of opioid prescribing, opioid risk management, regulations surrounding the prescribing of opioids, and problematic opioid use by patients. In doing so, healthcare professionals are more likely to achieve a balance between the benefits and risks of opioid prescribing, optimize patient attainment of therapeutic goals, and avoid the risk to patient outcome, public health, and viability of their own practice imposed by deficits in knowledge.

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

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