an opioid epidemic: right here, right now

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Institute of Professional Nursing
Kensington Hotel, Ann Arbor, MI
Thursday, October 13, 2016

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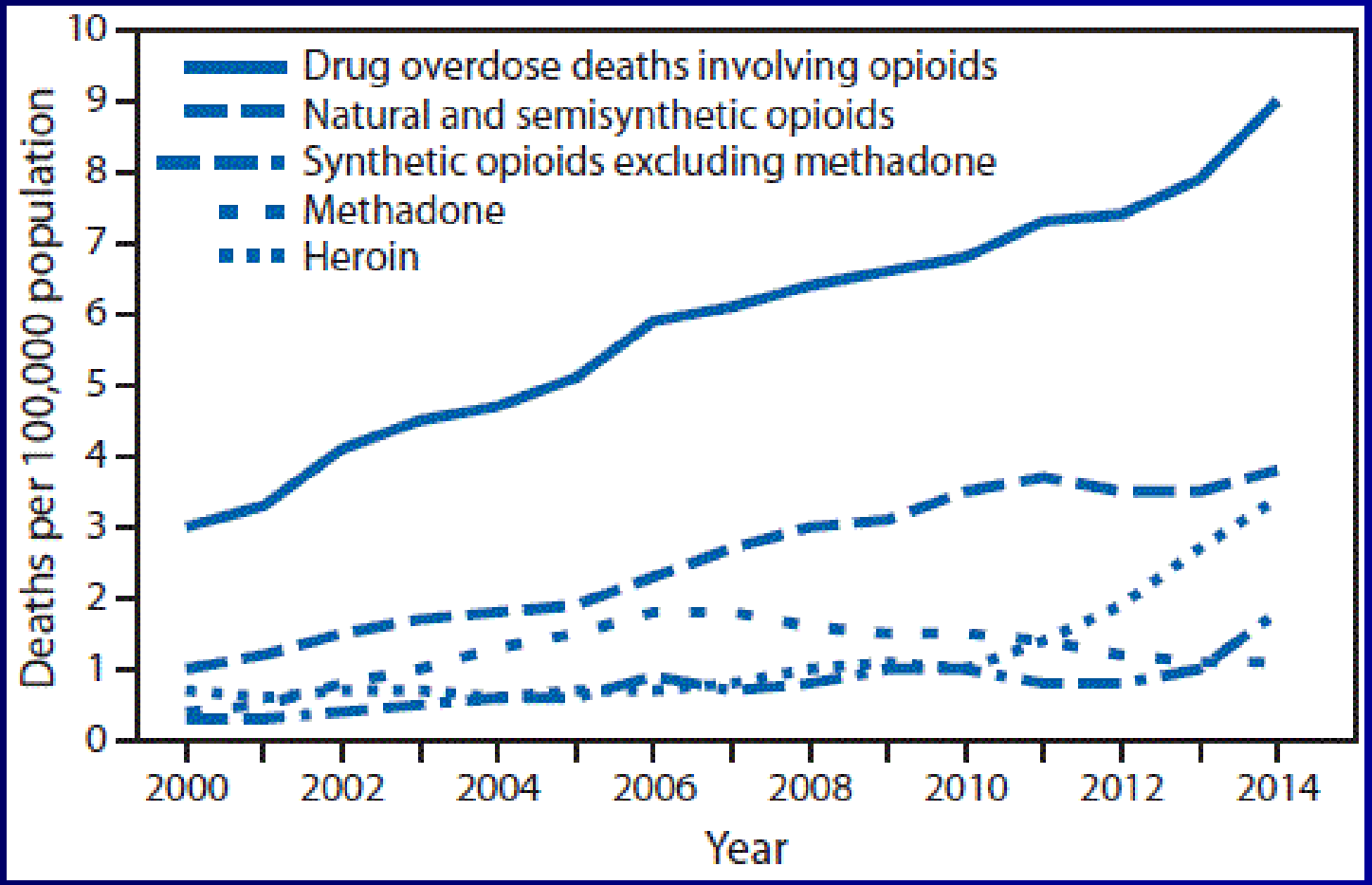
learning objectives

- Explore factors that have contributed to the current opioid epidemic
- Review national and local statistics related to opioid use, overdoses, and deaths
- Consider new CDC guidelines for opioid prescribing
- Discuss elements of the Comprehensive Addiction and Recovery Act (CARA) of 2016
- ADD: Introduce ENA / IntNSA joint position statement, "Substance Use among Nurses and Nursing Students" (in press)

an opioid epidemic

- 40th Annual Educational Conference, International Nurses Society on Addictions
- *"Addressing the Opioid Epidemic: Prevention, Intervention, Treatment, and Recovery"*

opioid overdose deaths (CDC)



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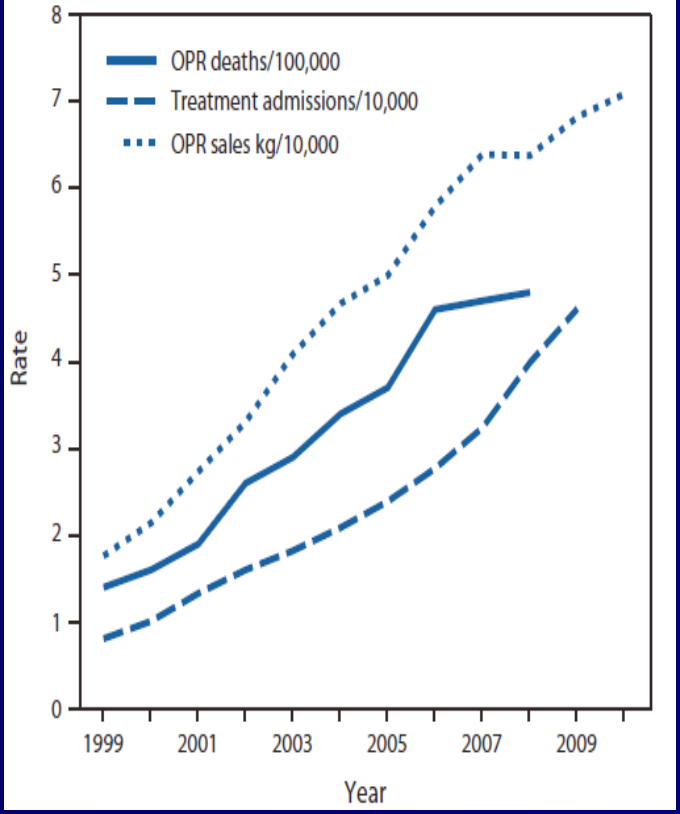
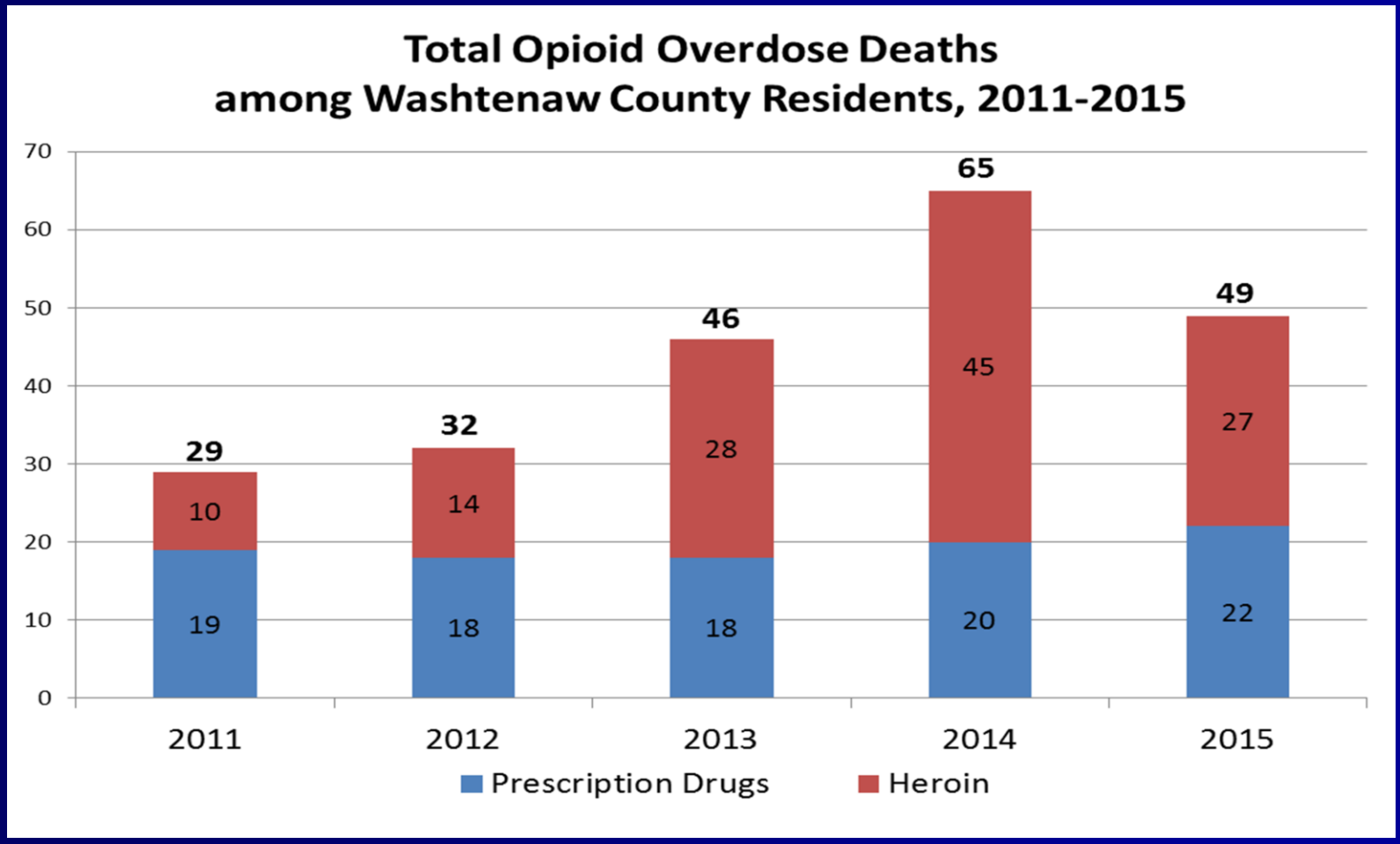
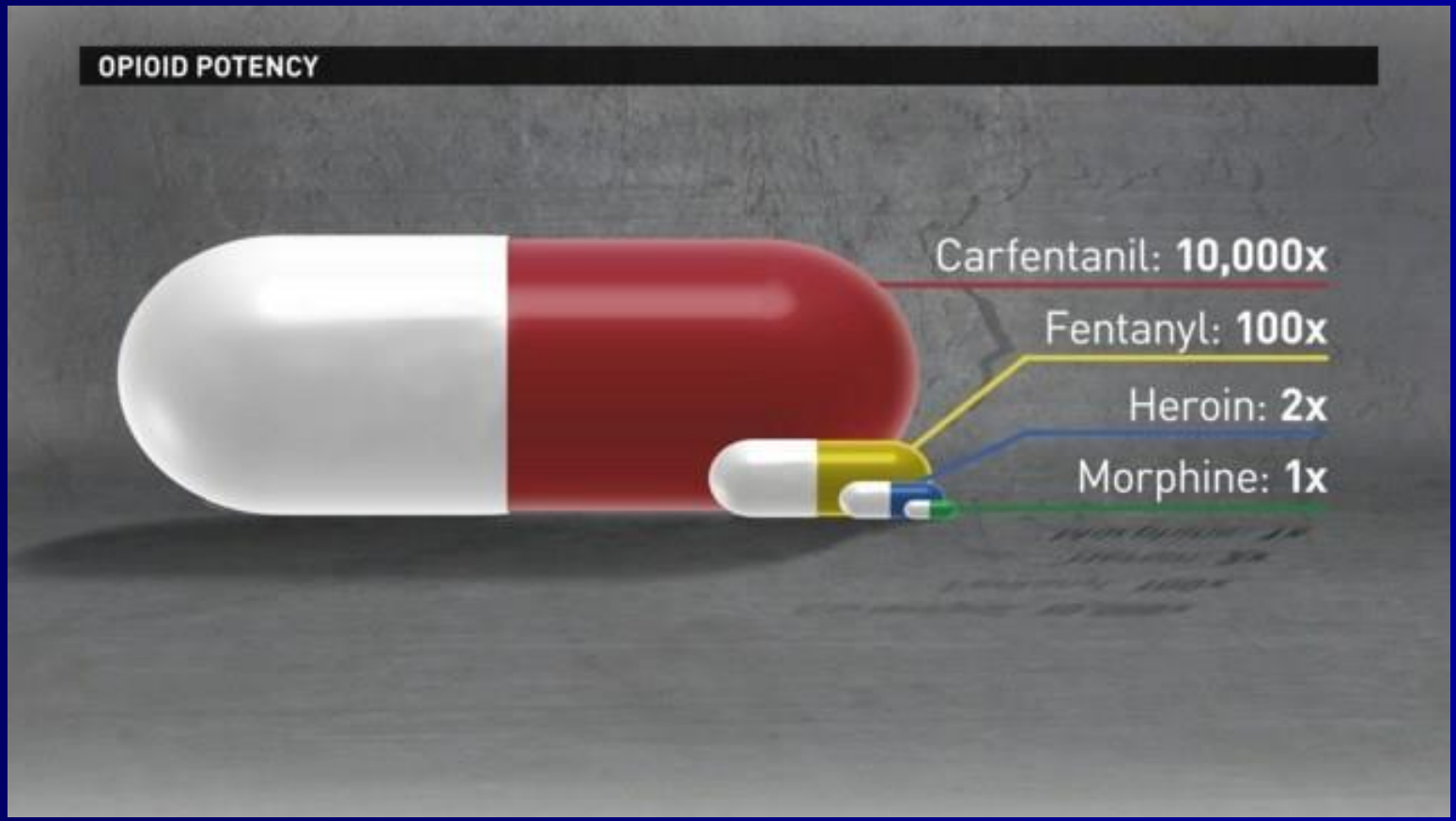


- Opioid overdose deaths
  - A function of Rx opioid sales
  - Quadrupled from 1999 to 2014
  - Approximately 48,000 in 2015
    - "129" a day
    - 5 per hour
  - Exceeded motor vehicle fatalities
  - Enough prescriptions written in the US for every adult to have received a bottle of opioid pain medications
  - Increased numbers, percentages involve fentanyl, now carfentanil

Washtenaw Health Initiative (WHI) Opioid Project

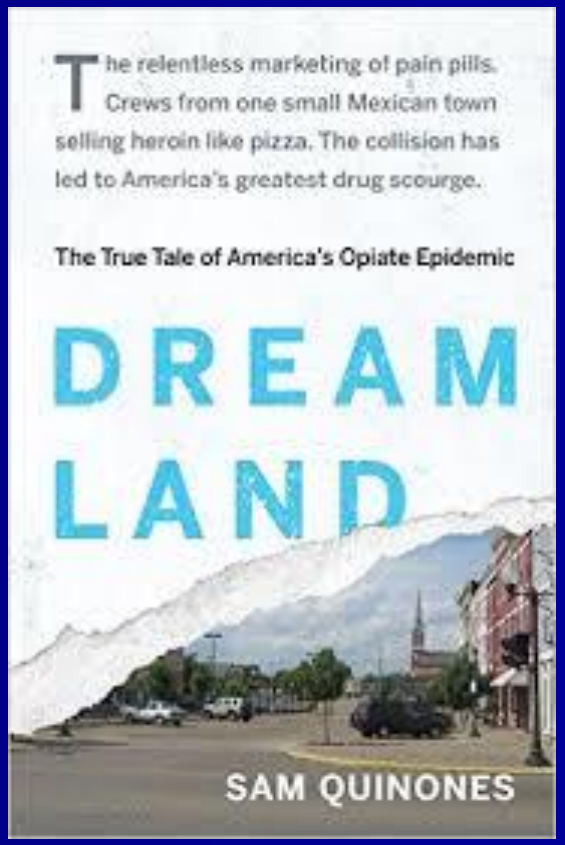


carfentanil



state of the nation

- Contributing factors
  - Lack of adequate training to health care providers: pain, addictions
  - Marketing
    - Pharma to physicians: promotion of opioid medications as safe, non-addictive if used for pain
    - Unscrupulous "pill mills"
    - "Black tar" heroin
    - Conversion from opioid medications (licit or illicit) to use of heroin
  - Pain as the 5th vital sign
    - Patient satisfaction surveys
    - Lack of support for research for non-opioid pain relief
  - Sociocultural factors



Letter from Vivek Murthy, MD, MBA 19th U.S. Surgeon General

"I am asking for you help to solve an urgent health care crisis facing America: the opioid epidemic…we arrived at this place on a path paved with good intentions. Nearly two decades ago, we were encouraged to be more aggressive about treating pain, often without enough training and support to do so safely. This coincided with heavy marketing of opioids to doctors. Many of us were even taught—incorrectly—that opioids are not addictive when prescribed for legitimate pain…The results have been devastating…"

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

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3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

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3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.
4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended release/long-acting (ER/LA) opioids.

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

5. When opioids are started…prescribe the lowest effective dosage…carefully reassess benefits and risks when considering increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day...and avoid increasing dosage to ≥ 90 MME/day…

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

5. When opioids are started…prescribe the lowest effective dosage…carefully reassess benefits and risks when considering increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day...and avoid increasing dosage to ≥ 90 MME/day…
6. Long-term opioid use often begins with treatment of acute pain…prescribe lowest effective dose of immediate-release opioids…prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

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7. …evaluate benefits and harms…within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation…evaluate benefits or harms…every 3 months or more frequently…If benefits do not outweigh harms…optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

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8. …incorporate strategies to mitigate risk…offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present.

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

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11. …avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

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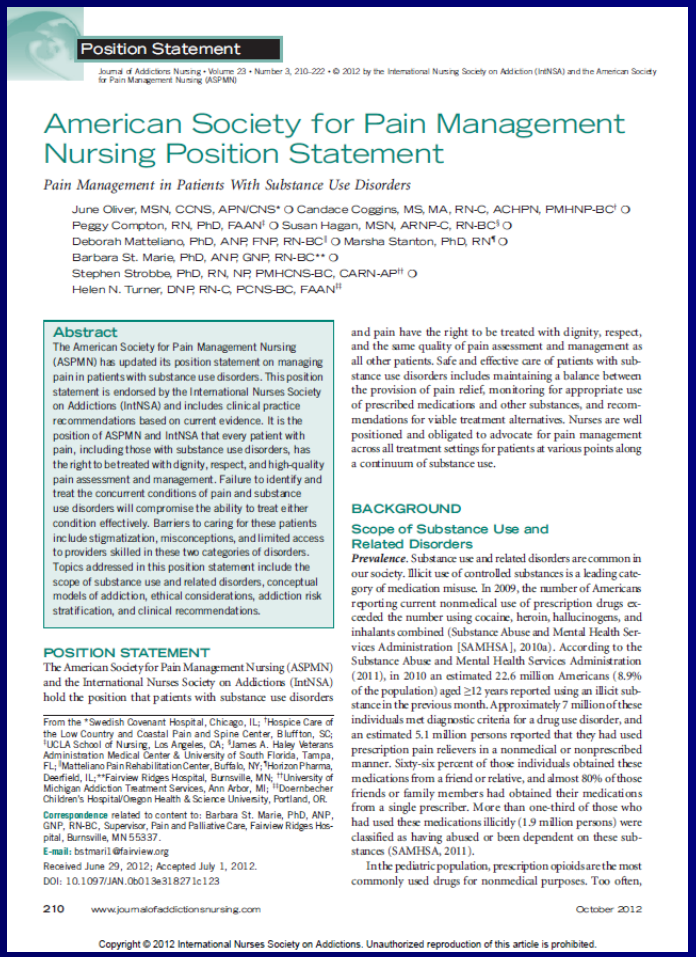
10. …use urine drug testing before starting opioid therapy and consider…at least annually to assess for prescribed medications…other controlled prescription drugs and illicit drugs.
11. …avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. …offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

clinical reminders

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient
- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed
- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid current benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

ASPMN Position Statement: Pain Management in Patients with Substance Use Disorder



Position Statement

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American Society for Pain Management Nursing Position Statement

Pain Management in Patients With Substance Use Disorders

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Abstract

The American Society for Pain Management Nursing (ASPMN) has updated its position statement on managing pain in patients with substance use disorders. This position statement is endorsed by the International Nurses Society on Addictions (IntNSA) and includes clinical practice recommendations based on current evidence. It is the position of ASPMN and IntNSA that every patient with pain, including those with substance use disorders, has the right to be treated with dignity, respect, and high-quality pain assessment and management. Failure to identify and treat the concurrent conditions of pain and substance use disorders will compromise the ability to treat either condition effectively. Barriers to caring for these patients include stigmatization, misconceptions, and limited access to providers skilled in these two categories of disorders. Topics addressed in this position statement include the scope of substance use and related disorders, conceptual models of addiction, ethical considerations, addiction risk stratification, and clinical recommendations.

POSITION STATEMENT

The American Society for Pain Management Nursing (ASPMN) and the International Nurses Society on Addictions (IntNSA) hold the position that patients with substance use disorders and pain have the right to be treated with dignity, respect, and the same quality of pain assessment and management as all other patients. Safe and effective care of patients with substance use disorders includes maintaining a balance between the provision of pain relief, monitoring for appropriate use of prescribed medications and other substances, and recommendations for viable treatment alternatives. Nurses are well positioned and obligated to advocate for pain management across all treatment settings for patients at various points along a continuum of substance use.

BACKGROUND

Scope of Substance Use and Related Disorders

Prevalence. Substance use and related disorders are common in our society. Illicit use of controlled substances is a leading category of medication misuse. In 2009, the number of Americans reporting current nonmedical use of prescription drugs exceeded the number using cocaine, heroin, hallucinogens, and inhalants combined (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010a). According to the Substance Abuse and Mental Health Services Administration (2011), in 2010 an estimated 22.6 million Americans (8.9% of the population) aged ≥12 years reported using an illicit substance in the previous month. Approximately 7 million of these individuals met diagnostic criteria for a drug use disorder, and an estimated 5.1 million persons reported that they had used prescription pain relievers in a nonmedical or nonprescribed manner. Sixty-six percent of those individuals obtained these medications from a friend or relative, and almost 80% of those friends or family members had obtained their medications from a single prescriber. More than one-third of those who had used these medications illicitly (1.9 million persons) were classified as having abused or been dependent on these substances (SAMHSA, 2011).

In the pediatric population, prescription opioids are the most commonly used drugs for nonmedical purposes. Too often,

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- Oliver, J., Coggins, C., Compton, P., Hagan, S., Matteliano, D., Stanton, M., St. Marie, B., **Strobbe, S.,** & Turner, H.N. (2012). [Dual publication]. Pain management in patients with substance use disorders. *Pain Management Nursing Journal, 13* (3), 169-183. *Journal of Addictions Nursing, 23* (3), 210-222.

- "It is the position of ASPMN and IntNSA that every patient with pain, including those with substance use disorders, has the right to be treated with dignity, respect, and high-quality pain assessment and management."

Comprehensive Addiction and Recovery Act (CARA) 2016

IntNSA Position Paper: The Prescribing of Buprenorphine by Advanced Practice Addictions Nurses

- **Strobbe, S.,** & Hobbins, D. (2012). The prescribing of buprenorphine by advanced practice addictions nurses. *Journal of Addictions Nursing, 23* (2), 82-83.
- "In order to increase safe access to buprenorphine treatment for patients with opioid dependence, it is the position of the International Nurses Society on Addictions (IntNSA) that the Drug Addiction Treatment Act of 2000 (DATA 2000) to be amended to allow for the prescribing of buprenorphine by qualified advanced practice nurses who have both prescriptive authority and specialty certification in addictions nursing."

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POSITION PAPER

The Prescribing of Buprenorphine by Advanced Practice Addictions Nurses

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In order to increase safe access to buprenorphine treatment for patients with opioid dependence, it is the position of the International Nurses Society on Addictions (IntNSA) that the Drug Addiction Treatment Act of 2000 (DATA 2000) be amended to allow for the prescribing of buprenorphine by qualified advanced practice nurses who have both prescriptive authority and specialty certification in addictions nursing.

Keywords addictions nurses, advanced practice, buprenorphine, IntNSA, opioid dependence, prescribing

INTRODUCTION

Misuse of opioids, including prescription opioid medications, has become an increasingly important public health problem, from adolescence through older adulthood (SAMHSA, 2007). The prevalence of prescription opioid abuse now greatly exceeds that of illicit opioids such as heroin, and prescription opioid dependence has come to dominate the profile of opioid dependence in the United States (Sullivan & Fiellin, 2008).

Buprenorphine (Suboxone, Subutex), a medication developed by the National Institute on Drug Abuse (NIDA) and approved by the U.S. Food and Drug Administration (FDA), has been shown to be a safe and effective form of pharmacotherapy for the treatment of opioid dependence (Orman & Keating, 2009), including detoxification and maintenance therapy. However, as part of the original legislation guiding the use of this medication, prescriptive authority was limited to a relatively small percentage of physicians meeting certain qualifications (SAMHSA, n.d.).

As a result, patient access to this medication is limited, and insufficient to meet a serious and growing healthcare need. This disparity could be lessened, and access to quality addictions treatment enhanced, by expanding the field of potential buprenorphine prescribers to include Advanced Practice Registered Nurses (APRNs) with independent or delegated prescriptive authority, and added qualifications as a Certified Addictions Registered Nurse-Advanced Practice (CARN-AP).

RECOMMENDATIONS

The International Nurses Society on Addictions recommends that DATA 2000 be amended to allow for the prescribing of buprenorphine by Advanced Practice Registered Nurses (APRN), i.e., Nurse Practitioners (NP) and/or Clinical Nurse Specialists (CNS) with independent or delegated prescriptive authority, consistent with the requirements of his or her respective State(s), who also hold

- A current State nursing license;
- A Drug Enforcement Administration (DEA) Controlled Substance Registration Certificate, and;
- Specialty certification as a Certified Addictions Registered Nurse-Advanced Practice (CARN-AP), as obtained through the Addictions Nursing Certification Board (ANCB).

Consistent with physicians who are authorized to prescribe buprenorphine, the Advanced Practice Addictions Nurse will

- Complete not less than 8 hours of approved training specific to the treatment and management of opioid-addicted patients, or an acceptable alternative;

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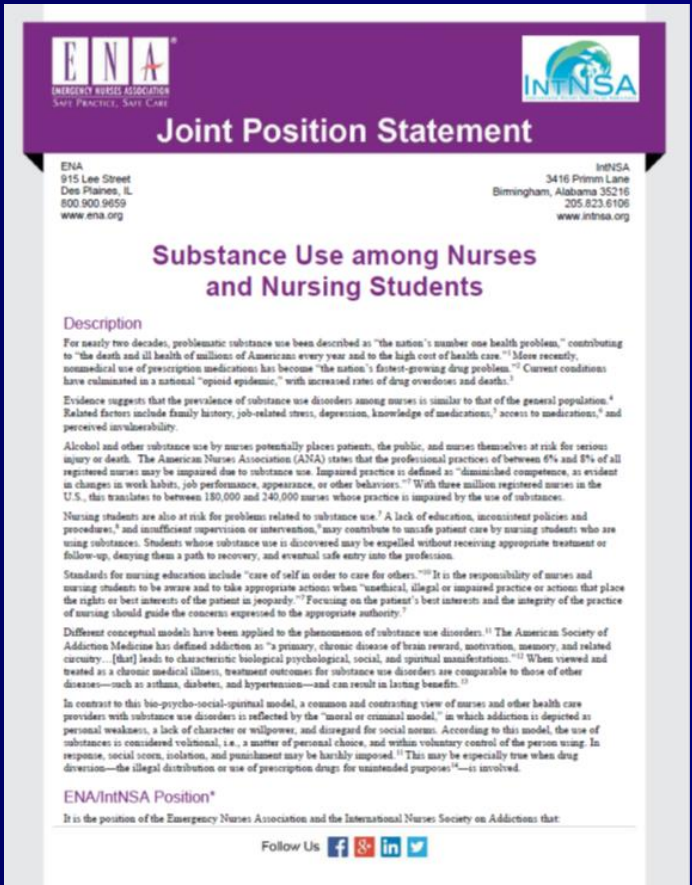
ENA / IntNSA Joint Position Statement



ENA
EMERGENCY NURSES ASSOCIATION
SAFE PRACTICE, SAFE CARE

INTNSA

Joint Position Statement

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Substance Use among Nurses and Nursing Students

Description

For nearly two decades, problematic substance use been described as "the nation's number one health problem," contributing to "the death and ill health of millions of Americans every year and to the high cost of health care."[1] More recently, nonmedical use of prescription medications has become "the nation's fastest-growing drug problem."[2] Current conditions have culminated in a national "opioid epidemic," with increased rates of drug overdoses and deaths.[3]

Evidence suggests that the prevalence of substance use disorders among nurses is similar to that of the general population.[4] Related factors include family history, job-related stress, depression, knowledge of medications,[5] access to medications,[6] and perceived invulnerability.

Alcohol and other substance use by nurses potentially places patients, the public, and nurses themselves at risk for serious injury or death. The American Nurses Association (ANA) states that the professional practices of between 6% and 8% of all registered nurses may be impaired due to substance use. Impaired practice is defined as "diminished competence, as evident in changes in work habits, job performance, appearance, or other behaviors."[7] With three million registered nurses in the U.S., this translates to between 180,000 and 240,000 nurses whose practice is impaired by the use of substances.

Nursing students are also at risk for problems related to substance use.[7] A lack of education, inconsistent policies and procedures,[8] and insufficient supervision or intervention,[9] may contribute to unsafe patient care by nursing students who are using substances. Students whose substance use is discovered may be expelled without receiving appropriate treatment or follow-up, denying them a path to recovery, and eventual safe entry into the profession.

Standards for nursing education include "care of self in order to care for others."[10] It is the responsibility of nurses and nursing students to be aware and to take appropriate actions when "unethical, illegal or impaired practice or action that place the rights or best interests of the patient in jeopardy."[7] Focusing on the patient's best interests and the integrity of the practice of nursing should guide the concerns expressed to the appropriate authority.[7]

Different conceptual models have been applied to the phenomenon of substance use disorders.[11] The American Society of Addiction Medicine has defined addiction as "a primary, chronic disease of brain reward, motivation, memory, and related circuitry…[that] leads to characteristic biological psychological, social, and spiritual manifestations."[12] When viewed and treated as a chronic medical illness, treatment outcomes for substance use disorders are comparable to those of other diseases—such as asthma, diabetes, and hypertension—and can result in lasting benefits.[13]

In contrast to this bio-psycho-social-spiritual model, a common and contrasting view of nurses and other health care providers with substance use disorders is reflected by the "moral or criminal model," in which addiction is depicted as personal weakness, a lack of character or willpower, and disregard for social norms. According to this model, the use of substances is considered volitional, i.e., a matter of personal choice, and within voluntary control of the person using. In response, social scorn, isolation, and punishment may be harshly imposed.[11] This may be especially true when drug diversion—the illegal distribution or use of prescription drugs for unintended purposes[14]—is involved.

ENA/IntNSA Position*

It is the position of the Emergency Nurses Association and the International Nurses Society on Addictions that:

Follow Us

- International Nurses Society on Addictions (IntNSA) contacted by Emergency Nurses Association (ENA) to collaborate on revised position statement on nurses and substance use (2015)
- Strobbe designated as IntNSA lead, first author
- Agreed on basic philosophic principles set forth by IntNSA
  - apply to all nurses
  - view addiction as disease
  - promote alternative-to-discipline (ATD) approach
  - include nursing students
- To be disseminated widely among professional nursing and related organizations

position statement 1

- 1. Health care facilities provide education to nurses and other employees regarding alcohol and other drug use, and establish policies, procedures, and practices to promote safe, supportive, drug-free workplaces.

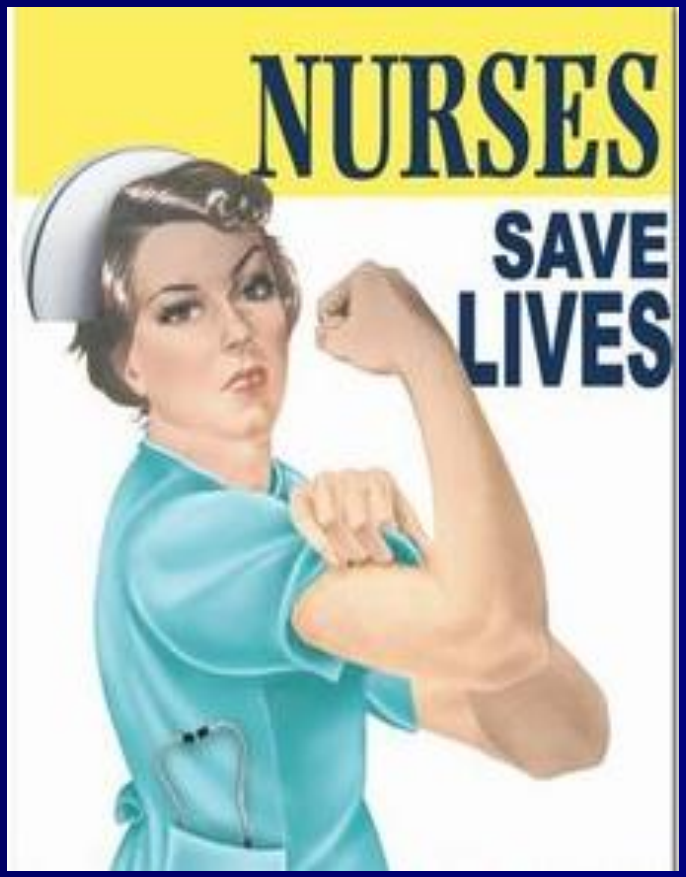
position statement 2

2. Health care facilities and schools of nursing adopt alternative-to-discipline (ATD) approaches to treating nurses and nursing students with substance use disorders, with stated goals of retention, rehabilitation, and re-entry into safe, professional practice.

position statement 3

3. Drug diversion, in the context of personal use, is viewed primarily as a symptom of a serious and treatable disease, and not exclusively as a crime.

position statement 4



4. Nurses and nursing students are aware of the risks associated with substance use, impaired practice, and drug diversion, and have the responsibility and means to report suspected or actual concerns.

in closing…

- https://vimeo.com/135620252

questions, answers, discussion