Opioid Misuse and Abuse Epidemic
The Nurse Practitioner Association New York State Position Statement

The Nurse Practitioner Association New York State (The NPA) recommends a multifaceted approach for safe and effective pain management and prevention of opioid misuse, abuse and diversion. The aim of this position statement is to provide nurse practitioners with evidence-based strategies for safe prescribing of opioid analgesics for management of acute and chronic pain. The goal is to obtain optimal pain management and safer usage of opioids along with a recommendation for initial screening and ongoing assessment for abuse and misuse.

According to the CDC, the death rates in the United States have nearly tripled from 1994 to 2014 (Rudd, Seth, David, & Scholl, 2016). Furthermore the death rates in 2015 which opioids were involved accounted for 63.1% of the cases (Rudd et al., 2016). In New York State (NYS), there has been a significant increase in opioid drug overdose fatalities 2014 to 2015 representing a 135.7% change. According to the New York State Association of Counties report released in July 2016:

“Heroin and opiates are now the leading cause of accidental death in New York State, outnumbering homicides. Between 2005-2014, the state documented a 115% increase in heroin treatment admissions in upstate New York and a 116% increase on Long Island. In all, approximately 1.4 million New Yorkers suffer from a substance abuse disorder.” (New York State Association of Counties, 2016).

Heroin, fentanyl, synthetic designer opioids and legally or illegally obtained prescription opioids account for this increase in fatality statistics and are recognized as a significant public health concern (Rudd et al., 2016). Compounding this problem is the prevalence of individuals who have chronic pain. The Institute of Medicine of the National Academies (IOM) estimated that approximately 116 million adult Americans are directly affected by chronic pain and impose a huge economic burden to society costing $560-635 million annually in lost productivity and direct medical treatment. (Institute of Medicine Committee on Advancing Pain Research & Education, 2011). The National Institutes of Health National Health Interview Survey of 2012 (year the latest data is available) estimates that approximately 25.3 million US citizens suffer from daily chronic pain (Nahin, 2015). Within this population are individuals who have severe, unremitting and debilitating pain syndromes that negatively influence functional capability and quality of life. These are complex health problems and require a multifaceted approach to reduce initial and ongoing use of opioids for acute and chronic pain.

Nurse practitioners are prescribers whose scope of practice aligns with the provisions of the Federal Comprehensive Addiction and Recovery Act (CARA). Nurse practitioners are well suited to provide holistic care to patients with acute and chronic pain and Opioid Use Disorder (OUD). This includes using both pharmacological and non-
pharmacological modalities. Furthermore, evidence supports that non-pharmacological therapies can provide significant benefits to many patients with chronic pain. The Centers for Disease Control and Prevention (CDC), the American Society for Pain Management Nurses (ASPMN) and the IOM all have recommended non-pharmacological or integrative therapies including physical therapy, exercise, yoga, tai chi, cognitive-behavioral therapy, acupuncture, biofeedback as well as other modalities (Dowell, Haegerich, & Chou, 2016; Institute of Medicine Committee on Advancing Pain Research & Education, 2011; Oliver et al., 2012). However, only some of the aforementioned therapies are wholly or minimally covered by medical insurance plans making them cost prohibitive. This economic barrier limits access to appropriate care for many individuals.

OUD is defined as a challenging pattern of opioid use manifesting in many behaviors that can lead to significant impairment or distress. (American Psychiatric Association, 2013). It is characterized by having two of the following behaviors: strong desire or urge to use opioids; reduced important social, occupational or recreational activities; inability to control or reduce usage; development of tolerance; spending a great deal of time obtaining and using opioids; continued usage despite recurrent problematic social or interpersonal interactions; and withdrawal symptoms that occur after stopping or reducing usage. (American Psychiatric Association, 2013). As such, there is a high rate of recidivism among this population (Schuckit, 2016). Treatment of these patients needs to include the following three elements: treatment engagement, stabilization and harm reduction, and sustained abstinence (Sohail, 2016). Treatment engagement includes forming a therapeutic alliance with patients in order to gain their trust and retain them in therapy or counseling. Providing psychosocial support is a critical element to clients and may include addressing social determinants of health such as assistance with employment, housing, education and legal affairs (World_Health_Association, 2009).

Stabilization and harm reduction along with sustained abstinence are the goals of treatment strategies so that patients can achieve individual wellbeing and decrease the chance of relapse (Sohail, 2016). The most current CDC guidelines for prescribing opioids for patients with chronic pain have found insufficient accuracy for classification (screening) of patients as low or high risk for potential abuse (Dowell et al., 2016). However, those are recommendations for primary care providers to follow in prescribing for and managing their patient with chronic pain. For those diagnosed with OUD, screening for potential abuse is considered an important part of prevention (Atluri, Akbik, & Sudarshan, 2012). The most common tools used for this purpose are the Screener and Opioid Assessment of Patients with Pain (SOAPP), the Opioid Risk Tool, and the Brief Risk Interview (Dowell et al., 2016) although there is no “gold standard” that can be universally applied to all patients (Atluri et al., 2012). Additionally, the CDC’s review of the evidence in compiling their guidelines found that the aforementioned tools did not demonstrate sufficient accuracy for classifications of patients as lower or high risk for abuse or misuse (Dowell et al., 2016). Providers should ask patients about their drug and alcohol usage using standard tools such as Drug Abuse Screening Tool (DAST), CAGE
The mainstay of treatment of OUD is Medication Assisted Treatment (MAT), which combines cognitive-behavioral therapy along with medication. Cognitive behavioral therapy is a short-term, goal oriented psychotherapy treatment that aims to change patterns of negative thinking or behavior (Dobson, D. & Dobson, K., 2017). In randomized controlled trials comparing psychosocial treatment of OUD with medication versus placebo or no medication, the abstinence outcome rates at least doubled (Connery, 2015). The most common and effective medications prescribed for OUD are the opioid agonists, which include buprenorphine, methadone and naloxone (Schuckit, 2016).

The NPA supports ongoing evidence-based practice in opioid prescribing for patient with acute and chronic pain using risk mitigation strategies. We are in agreement with the broad approach outlined in the recommendations from the New York State Heroin and Opioids Task Force report but acknowledge that there may be unintended consequences for those patients with persistent pain who require chronic opioid therapy (New York Heroin and Opioids Task Force, 2016). We also support evidence-based practice for screening and treating patients with OUD. Furthermore, it is our position that mandatory education in these areas should be extended into the primary care setting as well as schools of nursing. The NPA is in support of public education to de-stigmatize both the chronic pain and opioid use disorder populations.

The NPA makes the following recommendations:

I. Education

1. Mandatory continuing education related to management of acute and chronic pain, safe prescription of opioids, treatment and recognition of Opioid Use Disorders.
2. Pursuant to Public Health Law Article 33, Title 1, Section 3309-A, Number 3: “Course work or training in pain management, palliative care and addiction. (a) every person licensed under title eight of the education law to treat humans, registered under the federal controlled substances act and in possession of a registration number from the drug enforcement administration, United State Department of Justice or its successor agency and every medical resident who is prescribing under a facility registration number from the Drug Enforcement Administration, United States Department of Justice or its successor agency, shall, on or before July first, two thousand seventeen and once within each three year period thereafter, complete three hours of course work or training in pain management, palliative care, and addiction approved by the department (Prescription Pain Medication Awareness Program, 2016).
3. Pain management course work and training should include education on frequently occurring comorbid conditions such as depression, anxiety and OUD.
4. Nurse practitioners should familiarize themselves with state regulations and guidelines, which may require referral at certain milestones such as milligram limits. For example, the CDC guidelines recommend extra precautions when prescribing 50 mg or more morphine equivalents a day and avoiding 90 mg or a patient not receiving sufficient acute pain relief after a seven-day supply of opioid analgesic has been prescribed. Referral of patients hitting these thresholds may be advisable for expert guidance as these thresholds indicate greater risk.

5. Pain management training should begin in pre-licensure nurse training and continue throughout advance practice training. At a minimum, interpretation and application of the CDC guidelines for prescribing opioid analgesics for chronic pain should be included in nursing curricula. Attention to pain as both a symptom and a disease should be threaded throughout the curricula.

II. Employ safe practice for patients requiring pain management
   1. When treating patients with acute pain, a multimodal treatment plan should be utilized to optimize pain relief.
   2. Such modalities include nerve blocks, non-opioid analgesics, opioids, physical therapy and psychosocial interventions such as deep breathing, meditation, guided imagery and other pain coping skills for self-management.
   4. Opioids should only be used when the benefit outweighs the risk for improved pain and physical function.
   5. Before starting opioids, treatment goals should be established with the patient and discontinued if the benefit does not outweigh the risk or continued use does not achieve expected goals.
   6. The lowest effective dose should be used and risks verses benefits should be carefully weighed when increasing the dosage.
   7. Patients should be re-evaluated every three months or sooner to determine the continued need for opioid medication.
   8. The NYS Prescription Monitoring Program should be used not only to track appropriate prescriptions but also to monitor data for high-risk drug combinations.
   9. Patient should be screened for OUD and those diagnosed should be offered evidence-based treatment programs.

III. Patient education prior to start of therapy
   1. Set goals of treatment for pain management.
   2. Provide an opioid treatment agreement that delineates patient and provider treatment expectations. Educate patients regarding proper storage of opioid medications including locked box and disposal of unused medications (Take Back Programs).
   3. Narcan® (naloxone) should be readily accessible to patients receiving opioids for pain control as well as their families.
IV. Employ safe practices for those with OUD

1. Nurse practitioners develop competencies in bio-psychosocial approaches to care that include cognitive-behavioral strategies and motivational interviewing techniques.

2. Nurse practitioners appropriately apply the Diagnostic and Statistical Manual V classification criteria for diagnosing Opioid Use Disorder and avoid assigning this diagnosis to those on chronic opioid therapy without OUD.

3. Nurse practitioners employ appropriate screening tools such as, but not limited to DAST, CAGE and COWS tools when treating patients with OUD.

4. Nurse practitioners should train and apply to become DATA-Waiver practitioners. These nurse practitioners should develop competencies in Medication Assisted Treatment protocols. Medication Assisted Treatment protocols combine behavioral therapy and medications to treat substance abuse disorders such as Suboxone® (buprenorphine).

V. Advocate for insurance coverage for non-pharmacological treatments

1. Recommend increased access and insurance coverage for inpatient, outpatient and non-pharmacological modalities for treatment of acute and chronic pain as well as treatment of OUD.

2. Recommend that nurse practitioners work with their professional organization’s legislative committees to advocate for payors to:
   - Provide coverage for interdisciplinary integrative pain management programs
   - Provide coverage for cognitive-behavioral therapy specifically for pain management
   - Develop bundle payment models to include medical and non-pharmacological therapies for pain management
References


