The Opioid Epidemic: Practice, Policy, and Legislative Overview
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IntNSA

Objectives
• Where are we today and how did we get here?
• Definitions
• Chronic Pain
• Poor Pain Management & Barriers to Effective Care
• National Pain Strategy
• Prescribers as Gatekeepers
• Removing Treatment Barriers
• SUD in Nursing

Where Are We Today?
• 81 Americans die every day from an opioid overdose
• At least half of all opioid overdoses involved a prescribed medicine
• Sales of prescription opioids in the U.S. nearly tripled from 1999 to 2010. However, pain Americans report has not changed
• In 2014, an estimated 1.5 million people had an opioid use disorder related to prescription pain relievers and an estimated 466,000 had an opioid use disorder related to heroin use
• Men were more likely to die from overdose, but the mortality gap between men and women is closing
• Heroin-related overdose deaths have more than tripled since 2010

Where (newea.org)
• 91 Americans die every day from an opioid overdose
• At least half of all opioid overdoses involved a prescribed medicine
• Sales of prescription opioids in the U.S. nearly quadrupled from 1999 to 2014, but the overall amount of pain Americans report has not changed
• In 2014, an estimated 1.9 million people had an opioid use disorder related to prescription pain relievers and an estimated 586,000 had an opioid use disorder related to heroin use.
• Men were more likely to die from overdose, but the mortality gap between men and women is closing
• Heroin-related overdose deaths have more than tripled since 2010.
### Heroin Use

<table>
<thead>
<tr>
<th>Heroin Use Has INCREASED Among Most Demographic Groups</th>
<th>Heroin Addiction and Overdose Deaths are Climbing</th>
</tr>
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<tbody>
<tr>
<td>Age&lt;br&gt;18-25&lt;br&gt;26-35&lt;br&gt;36+</td>
<td>Male&lt;br&gt;Female&lt;br&gt;ANA/YYAI&lt;br&gt;Other&lt;br&gt;Native American &lt;br&gt;Other&lt;br&gt;Native Hawaiian, Other&lt;br&gt;Other&lt;br&gt;Health Insurance Coverage</td>
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### The Interplay

Heroin use is part of a larger substance abuse problem.

Nearly all people who used heroin also used at least 1 other drug.

Most used at least 3 other drugs.

![Image](heroin_ad.png)

**People who are addicted to...**

- Alcohol
- Marijuana
- Cocaine
- Heroin

...more likely to be addicted to heroin.

![Image](heroin_interplay.png)

### Definitions

- **Use:** Taking a substance as prescribed
- **Misuse:**
  - Using a substance for a purpose other than intended reason
  - Taking a substance not prescribed to oneself
- **Abuse:** Taking a substance for a pleasant or euphoric feeling
- **Avenues for misuse and abuse**
  - Crushing, chewing, grinding solids
  - Injecting
  - Insufflating (nasal)
  - Smoking

![Image](heroin_definitions.png)
Definitions

- Tolerance: Reduced response to a drug with repeated use
- Physical dependence: Adaptation to a drug that produces symptoms of withdrawal when the drug is stopped
- Addiction: A chronic, relapsing brain disease that is characterized by compulsive drug seeking, despite harmful consequences
- Substance Use Disorder: occurs when the recurrent use of alcohol and/or drugs causes significant clinical and functional impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home
- Withdrawal: symptoms that occur after long-term use of a drug is reduced or stopped abruptly
  - Restlessness
  - Muscle and bone pain
  - Insomnia
  - Diarrhea
  - Vomiting
  - Cold flashes

How Did We Get Here

- 3400 BC: Sumerians
  - Cultivated the opium poppy— "Hul Gil" “Joy Plant”
  - Assyrians
  - Egyptians
  - Alexander the Great
  - India
  - Asia
- 220 AD forward:
  - Chinese surgeon Hua To documented use of opium and cannabis extracts to minimize pain
  - Substances used for pleasure and spiritual purposes
  - Silk Road: series of interconnected routes that ran from Europe to China
- 1800’s:
  - Morphine extracted from opium
  - Oxycodone synthesized
  - Legislation enacted to curb use of opiates
- 1916: Oxycodone synthesized
- 1924:made illegal
- Late 20th century
  - Oxycodone (Percocet® or Percodan®) increases in popularity
  - 1960’s: Vietnam War, heroin resurgence
  - 1970’s: pain is not being controlled
  - 1980’s: Overdose/Opiate Awareness
    - Video “I Got My Life Back”
    - TJC: “Pain is assessed in all patients”
Recipe for Epidemic?

A Growing Epidemic of Pain

- IOM Report, 2011
  - Pain is a warning sign
  - Subjective, unique
  - Complex
    - Biological: factors that affect pain tolerance or thresholds
    - Psychological: pain represents something worse than it does
    - Social: response of significant others to the pain
  - Types
    - Acute: sudden onset, short duration
    - Recurrent: episodic
    - Chronic: lasting > several months
    - Maladaptive, debilitating

Chronic Pain by the Numbers

- 100 million—approximate number of U.S. adults with common chronic pain conditions
- $540 to 635 billion—conservative estimate of the annual cost of chronic pain in America
- $93 billion—2008 cost to federal and state governments of medical expenditures for pain
- 10 to 50 percent of patients with postoperative pain develop chronic pain
- 2011 survey of U.S. soldiers returned from deployment, 44 percent reported chronic pain and 15.1 percent reported recent use of opioid pain relievers

(IOM, 2011; JAMA, 2014)
Poor Pain Management

• How Pain Occurs Poorly Understood
  • The relationship between injury and pain is not consistent
  • Consistent pain and tissue damage are sometimes different
  • Pain can persist long after tissue healing
  • Nature of pain and its location can change over time
  • Individuals respond to a given therapy

• Variable Data Collection
  • Experience of pain is subjective
  • Few standardized, validated self-reporting tools
  • Varying assessment by location
  • Meeting a standard vs comprehensive patient assessment

• Clinician education varies
  • Misperceptions about misuse and abuse of opioids
  • Comprehensive education lacking
  • Education does not translate to competency

(ANA, 2011)

Barriers to Effective Pain Management

• System-level barriers:
  • Clinical services (and research endeavors) organized along disease-specific lines
  • Pain management belongs to everyone and therefore, belongs to no one
  • Clinical (and research) silos prevent cross-fertilization of ideas and best practices

• Clinician-level barriers:
  • Practitioners not well educated current best practices
  • Unable to ID or engage other clinicians skilled at treating chronic pain

(ANA, 2011)

Barriers to Effective Pain Management

• Patient-level barriers:
  • Societal stigma
    • Is the pain real?
    • Drug or disability benefit-seeking behavior?
  • Religious or moral judgement
  • Popular culture: suck it up; no pain, no gain

• Insurance and third-party payer level barriers
  • Payers do not encourage interdisciplinary team care
  • Payers frequently limit reimbursement
  • CAM therapies not covered

(ANA, 2011)
### National Pain Strategy

- National effort of public and private organizations to transform how the nation understands and approaches pain management

  - Six key areas:
    - Population research
    - Prevention and care
    - Disparities
    - Service delivery and payment
    - Professional education and training
    - Public education and communication

  - Specifics:
    - Develop metrics to improve the prevention and management of pain
    - Support a system of patient-centered integrated pain management practices
    - Take steps to reduce barriers to pain care; improve care for vulnerable, stigmatized and underserved populations
    - Increase public awareness of pain; increase patient knowledge of treatment options and risks; help develop a better informed health care workforce

(NIH, 2016)

### Population Research

- 2011 IOM underscored the impact of pain on the health, productivity, and well-being of the U.S. population
- Core responsibility of public health agencies is assessing the significance of health problems in the population
- Data collection needs to improve
- Improved data will drive federal and state initiatives

  - Objectives:
    - Estimate the prevalence of chronic pain and high-impact chronic pain
    - Refine and employ standardized electronic health care data methods to determine use and costs of care
    - Develop a system of metrics to track changes in prevalence, impact, treatment, and costs

(NIH, 2016)

### Prevention and Care

- Preventable causes of acute and chronic pain are not addressed throughout the health care delivery system
- People who have pain do not receive appropriate assessments or evidence-based care that is coordinated across providers and personalized
- Poor understanding of the factors that cause pain to become persistent

  - Objectives:
    - Articulate the benefits and costs of current prevention and treatment approaches
    - Develop nation-wide pain self-management programs
    - Develop standardized, consistent, and comprehensive pain assessments and outcome measures

(NIH, 2016)
Disparities

- Vulnerable/marginalized populations due to conscious and unconscious biases about higher-risk groups or about pain itself
  - English as a second language
  - Race and ethnicity
  - Income and education
  - Sex and gender identification
  - Age group
  - Geographic location
  - Military veterans
  - Cognitive impairments
  - Cancer patients
  - EOL

Objectives:
- Reduce bias and its impact on care
- Improve access to high-quality care for vulnerable groups
- Facilitate communication among patients and providers
- Highlight data on the impact of pain on high-risk populations

Service Delivery and Payment

- Commonly used single-modality treatments often fail as first-line therapies for chronic pain
- Insurance limitations affect consumer choices of treatments and their adherence to treatment regimens
- CAM poorly covered, takes time and repeated Rx
- Providers constrained in the time they can spend with individual patients

Objectives:
- Define and evaluate integrated, multimodal, and interdisciplinary pain care
- Enhance evidence for care
- Incentivize payments for quality care based on integrated, cost-effective, and comprehensive models

Professional Education and Training

- IOM report found education key to the needed cultural transformation to effective pain management
- Most health care professions’ education programs devote little time to education and training about pain and pain care
- Preventive approaches are underutilized almost universally
- Practitioners often experience negative emotions in caring for people with pain

Objectives:
- Develop and update core competencies for pain care education, licensure, and certification at the undergraduate and graduate levels
- Develop a pain education portal that contains a comprehensive set of materials to enhance curricula
Public Education and Communication

- High-quality, evidence-based communications:
  - Increase public awareness of the complexity of chronic pain
  - Change cultural attitudes about chronic pain, debunking stereotypes
  - Foster coalitions

- Objectives:
  - Develop and implement a public awareness campaign about the impact of chronic pain to counter stigma and misperceptions
  - Develop and implement an educational campaign encouraging safer medication use, especially opioid use for patients with pain

Prescribers as Gatekeepers

- Interventions to improve safe and appropriate prescribing must balance the legitimate need for opioids with the need to curb dangerous practices

- 2016 CDC Guideline for Prescribing Opioids for Chronic Pain
  - Articulation of National Pain Strategy
  - Objectives:
    - Determine when to initiate or continue opioids for chronic pain
    - Select right dosage, duration, follow-up and discontinuation
    - Assess risk and address harms of opioid use

Prescription Drug Monitoring Programs

- Status of Prescription Drug Monitoring Programs (PDMPs)
Do PDMPs Work

- A PDMP with a mandate (registration or use) was associated with a 9–10% reduction in prescriptions for Schedule II opioids by Medicaid enrollees.
- Issues:
  - PDMPs do not collect the same data.
  - It can be difficult to identify the correct individual.
  - Each PDMP has a unique mandate from the state.
  - Changing a PDMP to allow a change in provider access or data sharing may require the passage of new legislation.

The Science of Addiction

- Drugs change the brain
- Reasons to use:
  - To feel good
  - To feel better
  - To do better
  - To fit in
- How does addiction occur:
  - More need to just feel normal.
  - More needed to feel old high.
- Risk factors
- Protection factors
  - Aggressive behavior in mother
  - Good self-control
  - Lack of parental supervision
  - Parental monitoring and support
  - Poor social skills
  - Positive relationships
  - Drug experimentation
  - Drug competence
  - Availability of drugs at school
  - School anti-drug policies
  - Community poverty
  - Neighborhood pride

The Problem with Tough Love

- Remember, addiction includes compulsive drug seeking and use, despite harmful consequences.
- Addiction as a chronic disease:
  - From quick, reactive to slow, continuous.
  - Treatment in specific stages of intervention.
  - Includes self-management component.
  - Can utilize a wide range of treatments (including medication) during each phase.
### Treatment Options
- Individual and group counseling
- Inpatient and residential treatment
- Intensive outpatient treatment
- Partial hospital programs
- Case or care management
- Medication
- Recovery support services and 12 Step
- Peer supports
- FDA approved medications available to treat opioid addiction
  - Methadone (Dolophine®)
  - Naltrexone: Oral (ReVia®, Depade®); ER injectable (Vivitrol®)
  - Buprenorphine/naloxone (Suboxone®, Zubsolv®)
  - Buprenorphine (Subutex®)

### Removing Treatment Barriers
- Addiction treatment system
  - Separate from mainstream health care
  - Built on infrastructure and financing models that treat addiction under an acute care model
  - Public and private insurers deny prescribing opportunities against medications to treat opioid addiction
  - Medication-Assisted Treatment (MAT)
    - With counseling, most effective form of treatment
    - Issues:
      - A paucity of trained prescribers
      - Negative attitudes and misunderstandings about addiction medications held by the public, providers, and patients
      - Replacing one addictive medication with another
      - Need for concomitant counseling

### Expanding Treatment Access
  - Permits qualified practitioners to treat opioid dependency with FDA approved narcotic medications
  - Required training and obtaining a special DEA license
  - Patient limits
  - Care could not be delegated
  - Barriers:
    - Inadequate reimbursement by insurance plans
    - Detailed training and treatment protocols
    - Access to referral agencies
    - "Undesirable" clientele
- The Recovery Enhancement for Addiction Treatment Act (TREAT Act, S.1455)
  - Revise the definition of a "qualifying practitioner" to include NPs and PAs
  - Amend the Controlled Substances Act to increase the number of patients that a qualifying practitioner can treat from 30→100
- Naloxone
  - Immediate reversal of opiod
  - Expand access to first responders, family, friends, and caregivers
SUD in Nursing

- No higher than national average
- 8-20% combined use/abuse
- Top 4 risks for nurses to develop SUD in the workplace:
  - Access
  - Attitude
  - Stress
  - Lack of education about SUD
- Signs of SUD:
  - Job performance
  - Personality and mental status changes
  - Diversion of drugs
- ANA advocates for comprehensive and consistent access to alternative-to-discipline programs
- All States, DC, and Territories have some form of Peer Assistance or Chemical Dependency program

ANA Opioid Website

http://www.nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Work-Environment/Opioid-Epidemic

References