ANA Issue*Brief*

AMERICAN NURSES ASSOCIATION

Briefing nursing professionals

The Opioid Epidemic: Addressing the Growing Drug Overdose Problem

Opioid dependence and associated drug-related overdose and deaths are serious public health problems in the United States.

Registered nurses are on the front lines of addressing this problem by helping patients understand the risks and benefits of pain treatment options, including options that do not involve prescription painkillers.

Changes in the Drug Addiction Treatment Act of 2000 (DATA 2000) allowing advanced practice registered nurses with appropriate training to prescribe buprenorphine could significantly increase access to medication-assisted treatment for patients who need it.

This ANA Issue Brief provides an overview of the opioid epidemic, summarizes initiatives in which ANA is involved, and focuses on how nurses and advanced practice registered nurses (APRNs) can play a role in addressing this epidemic.

Deaths from drug overdose have risen steadily over the past 2 decades and drug overdose has become the leading cause of injury death in the United States. The data are staggering: From 1999 to 2013, the rate for drug poisoning deaths involving opioid analgesics nearly quadrupled (Centers for Disease Control and Prevention [CDC], 2015). Deaths related to heroin have also increased sharply since 2010, including a 39% increase between 2012 and 2013 (Hedegaard, Chen, & Warner, 2015).

Prescription drugs, especially opioid analgesics, increasingly have been implicated in drug overdose deaths over the last decade. Registered nurses (RNs), who often are the care providers best equipped to assess a patient's pain and need for pharmacologic pain relief, are on the front lines of addressing this problem. APRNs, whose advanced education (including advanced pharmacology) prepare them to assume responsibility and accountability for assessment, diagnosis, and management of patients' problems (including the use and prescription of pharmacologic interventions), play a critical role.

First Steps

In response to this public health crisis, on October 21, 2015, in West Virginia, President Obama announced federal, state, local, and private-sector efforts aimed at addressing the prescription drug abuse and heroin epidemic. ANA was invited to participate along with more than 40 provider groups—representing doctors, dentists, APRNs, physician assistants, physical therapists, and educators. From this, over 540,000 health care providers have committed to completing opioid prescriber training in the next 2 years.

President Obama issued a memorandum to federal departments and agencies directing two important steps to combat the prescription drug abuse and heroin epidemic:

- *Prescriber training:* To help ensure that health care professionals who prescribe opioids are properly trained and to establish the federal government as a model, the presidential memorandum requires federal departments and agencies to provide training on the prescribing of these medications to federal health care professionals who prescribe controlled substances as part of their federal responsibilities.
- *Improving access to treatment:* To improve access to treatment for prescription drug abuse and heroin use, the presidential memorandum instructs federal departments and agencies that directly provide, contract to provide, reimburse for, or otherwise facilitate access to health benefits to conduct a review identifying barriers to medication-assisted treatment (MAT) for opioid use disorders and to develop action plans to address these barriers.

In conjunction with the work of the White House, the U.S. Department of Health and Human Services (HHS) has made addressing the opioid abuse problem a high priority. In March 2015, HHS released an Issue Brief that describes evidence-based priority areas. The initiative is focused on two broad goals: 1) reducing opioid overdoses and overdose-related mortality, and 2) decreasing the prevalence of opioid use disorders. To attain these goals, ANA has joined with a large and diverse group of stakeholders to address three priority areas:

- Opioid prescribing practices, to reduce opioid use disorders and overdose;
- Expanded use of naloxone, used to treat opioid overdoses; and
- Expansion in the use of MAT to reduce opioid use disorders and overdose.

These three priorities are grounded in the best available research and clinical science available from federal, state, and stakeholder organizations. HHS has also prioritized the development of an evaluation to identify the most effective strategies for obtaining the greatest public health impact.

The Critical Contribution of Nursing

As ANA noted in comments concerning the National Pain Strategy (HHS, 2016) and developed by a diverse team of experts from around the country, nurses often lead the way in an attitudinal transformation toward pain management. ANA lauded the vision outlined in the National Pain Strategy, specifically the emphasis on:

- Prevention, early recognition, and intervention of pain issues in the primary care setting;
- A patient-centered, interdisciplinary approach to pain management; and
- Support for pain self-management strategies.

Because RNs practice in a variety of direct-care, care-coordination, leadership, and executive roles, they are often in a key position to help patients understand the risks and benefits of pain treatment options and can play a key role in the prevention of opioid overuse and dependence. As educators and patient advocates, nurses are in a unique position to help patients with pain by using a holistic approach, including therapies that do not involve prescription opioids, such as other medication modalities, regional anesthetic interventions, surgery, psychological therapies, rehabilitative/physical therapy, and complementary and alternative medicine (CAM).

Barriers to Effective Pain Management

Nurses at all levels can facilitate the breaking of barriers to effective pain management. According to the Institute of Medicine (IOM, 2011) report, "Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research," four barriers can occur—at the system, clinician, patient, and insurance levels.

At the system level, barriers arise as a consequence of clinical services (and research endeavors) being organized along disease-specific lines. Since acute and chronic pain transverse those services, pain management belongs to everyone and therefore, in a sense, belongs to no one. Existing clinical (and research) silos prevent cross-fertilization of ideas and best practices and impede the interdisciplinary approach needed for effective pain care.

At the clinician level, health care professionals generally are not well educated regarding emerging clinical understanding and best practices in pain prevention and treatment. Should primary care practitioners want to engage other types of clinicians, including physical therapists, psychologists, or CAM practitioners, it may not be easy for them to identify which specific practitioners are skilled at treating chronic pain.

Patient-level barriers include societal stigma applied, consciously or unconsciously, to people reporting pain, particularly if they do not respond readily to treatment. Is the pain real? Is it drug or disability benefit–seeking behavior? Religious or moral judgments may also come into play: Mankind is destined to suffer. Finally, popular culture has a role: Suck it up; no pain, no gain.

Insurance and third-party payer limitations constitute another barrier. On the whole, payers do not encourage interdisciplinary team care. Payers frequently limit reimbursement for or do not cover psychosocial and rehabilitative care, which are essential components of comprehensive care. Rehabilitation services also face insurance limits, especially under Medicare. In addition, many CAM therapies widely used in pain management frequently are not covered by health insurance.

By recognizing all the potential barriers to effective preventive and pain management strategies, nurses can lead the cultural transformation in pain prevention, care, education, and research and facilitate development of "a comprehensive population health-level strategy" (IOM, 2011).

Prescribers as Gatekeepers for Prescription Opioids

Although actions to address prescription opioid abuse must target all caregivers, prescribers, and patients, prescribers are the gatekeepers for preventing inappropriate access. Interventions to improve safe and appropriate prescribing must balance the legitimate need for these drugs with the need to curb dangerous practices. Within this priority are three objectives:

- Improve clinical decision making to reduce inappropriate prescribing;
- Enhance prescription monitoring and health information technology (health IT) to support appropriate pain management; and
- Support data sharing to facilitate appropriate prescribing.

Opioid Prescribing Guidelines for Chronic Pain

The Centers for Disease Control and Prevention (2016) has developed guidelines for opioid prescribing for chronic pain to improve clinical decision making and reduce inappropriate opioid prescribing. To ensure effective implementation of guidelines, the Office of the National Coordinator for Health Information Technology is exploring opportunities to convert guidelines into standardized, shareable, health IT–enabled clinical decision support interventions.

Prescription Drug Monitoring Programs

The HHS plan includes working with states and prescribers to increase utilization of prescription drug monitoring programs (PDMPs), with a specific goal to double the number of health care providers registered with their PDMP in the next 2 years. PDMPs are state-run electronic databases that can provide a prescriber or pharmacist information regarding a patient's prescription history, thereby allowing providers to identify patients who are potentially knowingly or unknowingly misusing medications.

Forty-six states and Washington, D.C. can legally share PDMP data across state borders. Many states allow out-of-state health care professionals to query their databases directly. Some jurisdictions send their prescription information to other states' PDMPs for access by health care providers in those states. States exchange data through arrangements with one or two separate and distinct technological hubs: PMP Interconnect (PMPi) and RxCheck. The National Association of Boards of Pharmacy administers and funds PMPi, through which 30 states actively share information. Forty-one states and D.C. allow prescribers or dispensers to assign agents to check the PDMPs. Both APRNs and RNs may act as a designee of a physician prescriber (CDC, 2014; Congressional Research Service, 2014; Office of National Drug Control Policy, 2011).

It is this delegation, as well as the inability to distinguish whether providers are working together in the same practice that makes it difficult to precisely understand the use of PDMPs by individual providers. As the use of PDMPs increases, it is important that data not be

misinterpreted in a way that limits access to appropriate pain management for patients, or that data not be used as a justification to limit the prescribing ability of APRNs.

ANA will be working with its constituent/state nurses associations to increase awareness of PDMPs and the number of APRN prescribers who are registered. The National Council of State Boards of Nursing has information on its website (www.ncsbn.org) about PDMPs, including the APRN experience of using PDMPs. ANA will also be monitoring state legislation that has an impact on PDMPs as well as other efforts to address opioid abuse.

Naloxone for Prescription Opioid and Heroin Overdose

Naloxone is a life-saving medication that rapidly blocks the effects of opioids when signs and symptoms of a prescription opioid or heroin overdose first appear. Although not effective with overdoses associated with benzodiazepines, barbiturates, or stimulants, naloxone is consistent with the Food and Drug Administration (FDA)-approved indications for opioid abuse and was included in the new overdose toolkit released by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2016).

To support the important role of naloxone in overdose prevention, HHS is focusing on three objectives:

- Accelerate the development and availability of new naloxone formulations and products;
- Identify and disseminate best practice naloxone delivery models and strategies; and
- Expand utilization of naloxone.

HHS actions include:

- *Conducting research trials on implementation and dissemination of overdose prevention programs,* including the efficacy of prescribing take-home naloxone for individuals at high risk of prescription opioid or heroin overdose or at high risk of witnessing an overdose. The FDA is also encouraging the development of new opioid overdose treatments through its expedited review programs.
- *Expanding utilization of naloxone through grants program to states.* The FY 2016 President's Budget proposes $12 million in grants to states to purchase naloxone, equip first responders in high-risk communities, provide education and the necessary materials to assemble overdose kits, and cover expenses incurred from dissemination efforts.

Medication-Assisted Treatment for Opioid Use Disorders

MAT, the most effective form of treatment for opioid use disorders, includes the use of medication along with counseling and other support. Combined with behavioral therapy, effective MAT programs for opioid addiction can decrease overdose deaths, be cost-effective, reduce transmissions of HIV and hepatitis C related to IV drug use, and reduce associated criminal activity.

While the ultimate goal of MAT is to have the patient reach a drug-free state, some patients with severe addiction issues will need to stay on MAT indefinitely. The HHS plan is focused on two objectives:

- Support research that informs effective use and dissemination of MAT and accelerates development of new treatment medications; and
- Increase access to clinically effective MAT strategies.

SAMHSA is providing $12 million through a demonstration grant program to expand treatment services for opioid dependence. Grants will provide accessible, effective, comprehensive, coordinated, and evidence-based MAT recovery support services, including the use of methadone, buprenorphine products, and naltrexone products.

Expanding Access to MAT

The increase in persons with substance abuse disorder has quickly outpaced the availability of substance abuse treatment centers. The Drug Addiction Treatment Act of 2000 (DATA 2000) was intended to address that problem and improve access for patients with substance abuse disorder *outside* of the usual treatment facilities, like the traditional methadone clinic. When originally passed, DATA 2000 allowed qualified physicians to apply for a waiver to prescribe Schedule III, IV, and V narcotic drugs for maintenance treatment or detoxification treatment in the private-office setting (SAMHSA, 2000).

Two years later, the FDA approved the combination of buprenorphine and naloxone (Suboxone) to be prescribed under this waiver. Physicians were given the authority after completing required training and obtaining a special license from the Drug Enforcement Agency (DEA). They were not allowed to delegate prescribing Suboxone to other health care providers, such as APRNs and physician assistants.

Unfortunately, primary care physicians have been slow to apply for the waiver and can only accept a limited number of patients (30 in the first year, then up to 100). Of 26,045 physicians currently granted the waiver, only 16,454 physicians are currently listed with the SAMHSA online locator. It is estimated that 60% of these physicians actually prescribe buprenorphine or Suboxone for addiction treatment; about half are not accepting new patients because of the limitations in the number of patients permitted by law; and an estimated 1 in 10 have outdated contact information or have requested to be removed from the listing. Reasons for not participating in MAT include inadequate reimbursement by insurance plans (even though most insurance plans now accept claims for Suboxone treatment), the need for detailed training and treatment protocols and access to referral agencies, the service is beyond the scope of practice of office-based physicians, or opioid-addicted patients are considered undesirable for their clinic settings (Fornili & Burda, 2009; Hutchinson, Catlin, Andrilla, Baldwin, & Rosenblatt, 2014; Jenkinson & Ravert, 2013; Netherland et al., 2009; Olsen, Bass, McCaul, & Steinwachs, 2004).

In many settings, APRNs are prepared to address the need for increased access to treatment. APRNs have prescriptive privileges in 49 states and can prescribe Schedule III through V

controlled substances with an active DEA license in all except three states (Alabama, Hawaii, and Missouri).

Implications for Mothers and Newborns

The need to identify and treat patients in the outpatient setting extends to expectant mothers. Over the past decade, an increase in the rate of maternal opioid use in pregnancy and subsequent neonatal abstinence syndrome (NAS) has been documented (Patrick et al., 2012). In light of the increased rate of substance abuse, additional capacity to identify and treat patients in outpatient settings is needed. Pregnant women should be included in and expansion of community-based treatment modalities and nurses and midwives involved in prenatal care should be included in provider training.

Methadone has been considered the gold standard for treatment of maternal opioid use for decades, and there is good evidence that maintaining pregnant women on methadone can reduce adverse pregnancy outcomes caused by frequent withdrawal and the multiple health risks that accompany illegal drug use (Jones et al., 2010). Recent studies have examined the effects of buprenorphine on NAS as well as the rate of maternal adherence to treatment and there is good evidence that buprenorphine is at least as effective as methadone in preventing NAS.

Congressional Action—TREAT Act

The growing opioid addiction and overdose epidemic gripping the nation has spurred Congress to action. Over the past year, lawmakers have sought to address the crisis comprehensively by advancing bills that would expand access to naloxone, reduce the prevalence of unused pain pills, expand prevention education, and increase collaboration with law enforcement and local criminal justice systems.

Expanding access to MAT has also been a central component of the reform effort. Specifically, the Recovery Enhancement for Addiction Treatment Act (TREAT Act, S.1455), which seeks to improve treatment options by harnessing the benefits of buprenorphine and Suboxone, has served as one of the primary expansions of treatment in the broader initiative.

Championed by Senators Ed Markey (D-MA) and Rand Paul (R-KY) in 2014, the TREAT Act would amend DATA 2000 (Pub.L. 106–310) to expand access to specialized treatment for prescription drug and heroin addiction. The legislation revises the definition of a "qualifying practitioner" to include NPs who are licensed under state law to prescribe schedule III, IV, or V medications for pain, who have specified training or experience that demonstrates specialization in the ability to treat opiate-dependent patients, who have practiced under the supervision of, or

Psychiatric Nurses Support the Expansion of APRN Prescriptive Authority

In July 2013, the American Psychiatric Nurses Association (APNA) released a statement that noted the alarming rise in the number of patients addicted to opioids and the shortage of physicians who can provide office-based treatment. APNA "fully supports the expansion of advanced practice registered nurses' prescriptive authority to include the prescription of buprenorphine and Suboxone in the treatment of persons who are addicted to opiates" (American Psychiatric Nurses Association, 2013).

prescribed opioid addiction therapy in collaboration with, a licensed physician who holds an active waiver to prescribe schedule III, IV, or V opioids for opioid addiction therapy, and who have practiced in a qualified practice setting. Additionally, the bill would amend the Controlled Substances Act to increase the number of patients that a qualifying practitioner dispensing opioids for detoxification treatment is initially allowed to treat from 30 to 100 patients per year.

In March 2016, the Senate Health, Education, Labor, and Pensions (HELP) Committee considered and passed the TREAT Act. ANA successfully advocated for an amendment that changed the language to allow NPs to prescribe buprenorphine in accordance with state law—a vast improvement over the supervision-laden language in the original version.

Following Senate action, the House Energy & Commerce Committee immediately set course to consider its own version of the TREAT Act. ANA urged the House to adopt similar language during its deliberations. While the language reported out of Energy & Commerce did not directly mirror the Senate HELP Committee language, ANA successfully influenced a change from the original language that allows NPs to prescribe in accordance with state law. Additionally, ANA successfully advocated for the inclusion of language that would allow the American Nurses Credentialing Center to serve as a potential source of credentialing and continuing education training of NPs as it pertains to the expanded authorities in the bill.

Though ANA has called for the bill's expanded authority to encompass all APRNs, the language provides flexibility to the Secretary of HHS to examine the demand for further provider expansions. Ultimately, ANA believes the bill takes a vital step forward, one that will greatly increase the number of providers who can treat opioid-dependent patients with approved MATs.

Leadership in both the House and Senate has expressed a strong commitment to passing meaningful reform. ANA will continue to work closely with key lawmakers and coalition partners to ensure greater access to this life-saving treatment.

Next Steps

ANA will continue working with HHS, the White House, ANA's organizational affiliates, and other stakeholders to engage RNs and APRNs in this initiative to address opioid drug-related dependence, overdose, and death.

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