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For Opioid Therapies

The Experiences and Perceptions of Advanced Practice Registered Nurses (APRNs) Caring for Patients with Coexisting SUD and Chronic Pain

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Barbara St. Marie, Disclosures

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- Board of Directors, American Society for Pain Management Nursing.
- Faculty Advisory Panel, CO*RE REMS

Educational Objectives

- At the conclusion of this activity participants should be able to:
  - Understand challenges of prescribing opioids for pain when risk of prescription opioid misuse is unknown or known to be high.
    - Describe practices of individual APRNs across the country and throughout the healthcare continuum.
  - Describe barriers of prescribing opioids to those with Substance Use Disorder when pain must be treated.

The Experiences and Perceptions of Advanced Practice Registered Nurses (APRNs) Caring for Patients with Coexisting SUD and Chronic Pain

Outline

I. What is known about APRNs practices managing pain and prescribing opioids for pain.
II. What is known about patients with coexisting SUD and chronic pain.
III. Research project: APRNs who are specialists in pain management and/or palliative care talk about their clinical practices.
IV. Recommendations on how to improve care for patients with coexisting SUD and chronic pain.

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Prevalence

- Estimates in the United States
  - 116 million people are living with chronic pain (IOM, 2011)
  - Costs up to $635 billion in medical treatment and lost productivity.
- Estimates in the United States
  - 4.5 million Americans used prescription pain relievers for nonmedical reasons during the month they were surveyed (SAMHSA, 2012).
  - Exceeded the number using cocaine and heroin
  - Costing the government $467.7 billion per year.

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Increases in Opioid Misuse

- National Institute on Drug Abuse:
  - Changes in medication prescribing practices
  - Changes in drug formulations
  - Easy access through internet

(Compton, W.M., Volkow, N.D. (2006).

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Legislation, California (9/2013)

- Legislation approved methods to help track overdose of prescription opioids resulting in death.
- Requires coroners to report drug OD to State Medical Board
- Opposing argument: Physicians can be reported even if properly prescribing, because there isn't a distinction between causes of an OD (licit vs illicit).
- National Conference of State Legislatures (posted 7/2014): http://www.ncsl.org/research/health/prevention-of-prescription-drug-overdose-and-abuse.aspx

Challenges of Health Care Providers

- The ambiguity of how to manage patients with these coexisting addiction and pain conditions has been cited as a barrier to care

  (Berg, Arnsten, Sacajiu, Karasz, 2009; Merrill, Rhodes, Deyo, Marlatt, Bradley, 2002; Upshur, Luckmann, Savageau, 2006; Wilsey, Fishman, Crandall, Casamalhuapa, Bertakis, 2008; Miller, Yanoshik, Crabtree, Reymond, 1994; Baldacchino, Gilchrist, Fleming, Bannister, 2010)

- There is also low provider satisfaction in providing health care in this population

  (Upshur, et al., 2006; Merrill, et al., 2002; Miller, et al., 1994; Wilsey, et al., 2008; and Baldacchino, et al., 2010).

Challenges in Primary Care

- Barriers of Primary Care providers to provide chronic pain management
  - Absence of objective or physiological measures
  - Lack of expertise
  - Lack of interest
  - Patient's aberrant behaviors
  - Physician's attitudes
  - **Lack of support**
  - **Limited insurance coverage for everything except opioids**

  (Barry, et al., 2010)

Challenges for Patients

- Lifetime history of SUD (Primary Care)
  - more likely to report borrowing pain medication from friends or family
  - requesting an early refill of pain medication
  - history of SUD are 3-6 times more likely to misuse.
- Patients with SUD more likely to
  - underreport prescription misuse.
  - increased risk of misuse

(Morasco & Dobscha, 2008)

Challenges for Patients

- Associated with prescription medication misuse:
  - Current depression
  - Younger age
  - Poor QOL
- Not associated with prescription medication misuse:
  - Pain duration, severity, and disability

(Morasco & Dobscha, 2008)

Life with Chronic Pain

- Methadone clinic with chronic pain
  - Impact of their lives
  - Uncertain about the future
  - Adapting
    - With medications
    - With non medicine ways

(St. Marie, B. J. Coexisting Addiction and Pain in People Receiving Methadone for Addiction. *West J Nurs Res July 15, 2013 0193945913495315*)

Conclusions when Addiction came first

- Introduced by friends
- Males: crime and episodic incarceration
- Females: domination by the males, sex work, stealing
- Across genders: violence, injuries or illness
  - resulted from substance use
  - leading to further pain and suffering
- When pain became part of their lives, addictions became worse.

(St. Marie, B. J. Coexisting Addiction and Pain in People Receiving Methadone for Addiction. *West J Nurs Res July 15, 2013 0193945913495315*)

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Conclusion when pain came first

- Health care providers: initial exposure
- Abusing prescription opioids
- Transitioned to illicit substances
- Abused both prescription opioids and illicit substances

(St. Marie, B. J. Coexisting Addiction and Pain in People Receiving Methadone for Addiction. *West J Nurs Res July 15, 2013 0193945913495315*)

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Intersection with Health Care

- Over prescribing
  - Large volumes
  - High doses
- Little to no monitoring
- No other interventions offered

(St. Marie, B. J. Coexisting Addiction and Pain in People Receiving Methadone for Addiction. *West J Nurs Res July 15, 2013 0193945913495315*)

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The Experiences of People Living with Chronic Pain

… **While Receiving Opioids To Manage Their Pain in the <u>Primary Care Setting</u>**

- Aim: Examine the narratives of people who experience chronic pain and receive opioids for the treatment of chronic pain through a primary care clinic

Healthcare experiences while seeking relief for their pain

- Positive healthcare experience:
  - One participant stated:

    "… because they care, I care."

- When they felt confident in healthcare, they experienced less stress, more ability to cope with pain even when pain intensity was high.

Healthcare experiences while seeking relief for their pain

- Negative healthcare experience:
  - Receiving inconsistent communication about their care, and feeling stigmatized.
  - Receiving "run around"

Fears of SUD, relapse or losing access to opioids for pain

- **Fear of SUD or relapse:**
- "I don't wanna screw up my sobriety, I don't wanna get addicted, I was very frightened about getting addicted and frightened about craving [the drug of abuse]."

- **Fear of losing access to opioids:**
- Participants stated that individuals who misuse their prescription opioids were "wrecking it for those who need it for pain."

- They reflected that media coverage of people overdosing was why healthcare providers were "cracking down" on prescribing opioids for those with pain.

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Use of non-medicine methods of managing pain

- "You can't just treat yourself with drugs."
- Massage
- Physical therapy
- Walking dogs
- Changing their diet to healthy food
- Exercise and stretching on their own
- Distraction by working at their jobs
- Background noise
- Sitting and walking with good posture
- Swimming, fishing, meditation
- Keeping company with healthy people, "If you hang with people that use, you're a user."

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Background

- Over 155,000 APRNs in the US account for 19% of the primary care workforce (Reagan et al., 2010)

- Workforce of pain management nurses:
  - Role delineation study of pain management nurses showed 27% of responding nurses were APRNs (Willens et al., 2010)

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Advanced Practice Registered Nurse

- Factors that influence the prescribing practices of APRNs for patients with chronic nonmalignant pain.
  - Culture of practice setting
  - Self protection
  - Societal consequences
- These are direct conflict with the individual needs of the patient.

(Fontana, J.S. [2008]. The social and political forces affecting prescribing practices for chronic pain. *Journal of Professional Nursing, 24,1,30-45.)*

Advanced Practice Registered Nurse

- Differences in practice patterns between Nurse Practitioners and Physicians
  - Fewer NPs have read and/or applied the guidelines than physicians (40.1% of NPs vs 70.9% of physicians, P < .01)
  - NPs had less access to opioid prescribing policies and tools (68.1% physicians vs 48.5% NPs, P < .01)

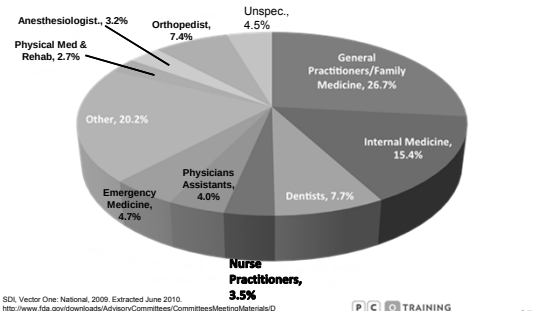
(Franklin et al., [2013] Changes in opioid prescribing for chronic pain in Washington State. *Journal of the American Board of Family Medicine, 24*(4), 394-400)

Advanced Practice Registered Nurse

- Differences in practice patterns between Nurse Practitioners and Physicians (cont.)
  - NPs had less access to electronic prescription records linked to EHR (84.1% vs 62.5%) to assist in supporting opioid prescribing
  - NPs were more than twice as likely to stop prescribing opioids, and in the survey less likely reported prescribing opioids to most patients.

(Franklin et al., [2013] Changes in opioid prescribing for chronic pain in Washington State. *Journal of the American Board of Family Medicine, 24*(4), 394-400)

Top 10 prescribing specialties immediate-release opioids, 2009



SDI, Vector One: National, 2009. Extracted June 2010.
http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/AnestheticAndLifeSupportDrugsAdvisoryCommittee/UCM217510.pdf

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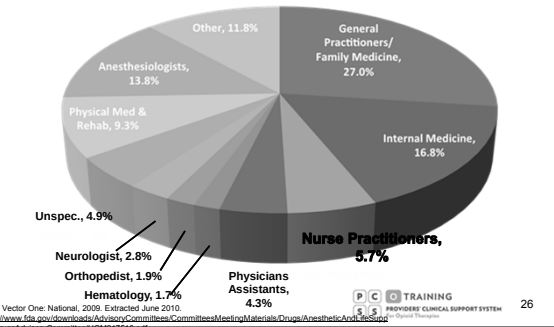
Top 10 prescribing specialties extended-release/long-acting opioids, 2009



SDI, Vector One: National, 2009. Extracted June 2010.
http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/AnestheticAndLifeSupp

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The Experiences and Perceptions of Advanced Practice Registered Nurses (APRNs) Caring for Patients with Coexisting Substance Use Disorder and Chronic Pain

- Funded by the American Society for Pain Management Nursing

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Methods

- Qualitative Design: Narrative inquiry
- 20 Advanced Practice Nurses with Prescriptive Authority, DEA licensure
- Most were members of the American Society for Pain Management Nursing
  - Inpatient or outpatient setting
  - Nation-wide

Methods…

- Asked to describe their experiences in caring for patients living with **coexisting SUD and chronic pain**
- Asked to identify barriers
- Primary data-collection: in-depth interviews
- Thematic analysis
  - Capture the dimensions created from the interplay of chronic pain and SUD as perceived by APRNs.

Themes

- Shifting of Patients
- Difficulties accessing non-medicine ways of managing pain
- Role of APRNs was consistent throughout all settings across the nation
- Recommendations to improve healthcare to patients with coexisting SUD and pain

Shifting of Patients

- Healthcare providers do not want to prescribe opioids
  - Feel uncomfortable
  - Do not want to prescribe long-term opioids
  - Do not want to prescribe long-acting opioids
  - Do not want to manage pain in those with SUD

Shifting of Patients (cont.)

- "You should prescribe it, you are the pain specialist."
- "I'm not allowed to prescribe it [opioids] anymore."
- Pain clinics no longer accepting patients for med management, only procedures
  - "Actually, the pain management doctors in my community [want to] have less to do with opioids than the family doctors do."

Pain management Advanced Practice Registered Nurses are consistently called to manage pain in patients with substance use disorder.

Difficulties accessing non-medicine ways of managing pain

- Insurance pay only for opioids
- Non-medicine modalities not available in their area.
- Patient doesn't want these interventions:

"We live in a pill oriented society"
"Quick fix"

Role of APRNs

- Educating patients
  - Parameters of care
  - Other modalities for pain management
    - Guiding patients in process of change

"I don't need to force people to change; they need to change themselves and find their own solutions…."

- Educating other healthcare providers

"…blaming the patient."

Role of APRNs

- Implementing Risk Strategies
  - Always screening for risk (ORT)
    - If moderate to high risk then adjust the treatment plan
  - Give opioids to manage acute pain
    - then taper by schedule
  - Use multimodal analgesia
    - non-medicine modalities

- "There aren't enough addiction specialists [to go] around"
  Addiction specialists who care for those with chronic pain or to consult.
- Often times it falls to the APRN

Recommendations to improve care

- DON'T fire the patient
- Be smart, cautious and "not be rogue about how you prescribe [opioids]"
- Manage acute pain so it won't become chronic
- See whole person not just their SUD issue

Recommendations…

"The plan of care is agreed upon by everybody and [no one] can stick their head in the sand and say 'we don't care,, we're just caring about the…'"

Recommendations…

"If the plan of care is, "We're going to be decreasing his dose, then nobody else is going,

'Oh, I'm sorry you ran out,
here's a big prescription for a month'"

Conclusions

Practice

- Consistent and deliberate (non-avoidant) pain management for people with SUD is imperative
- Recommendations to healthcare providers on providing sensitive and appropriate care for individuals with coexisting SUD and pain

Conclusions

Social Policy

- **Insurance coverage** for non-opioid and non-medicine modalities for pain
- SUD and chronic pain must be addressed at a policy level
  - United States HHS
    - Providing **training and educational resources** including guidelines
    - **Increasing use of naloxone**
    - **Expanding use of Medication-assisted treatment**

Conclusions

Education

- Education for APRNS regarding risk
- Educate on pain management interventions that protect sobriety
- Mandate REMS education

Buprenorphine

- APRNs cannot prescribe buprenorphine
  - Effective for treatment of opioid use disorder
  - Potential for use in subpopulation with chronic pain and opioid use disorder
  - International Nurses Society on Addictions
    - Amend DATA 2000 allowing APRNs prescribing of buprenorphine with independent or delegated prescriptive authority.

(Strobbe, S., & Hobbins, D. [2012]. The prescribing of buprenorphine by advanced practice addictions nurses. *Journal of Addictions Nursing, 23*(2), 82-83.
Chen, K.Y., Chen, L., Mao, J [2014]. Buprenorphine-naloxone therapy in pain management. *Anesthesiology, 120*, 1262-1274.)

Further Research

- Interventions for pain management when patients have existing SUD
- Investigate patient outcomes following APRNs receiving REMS education

Thank You

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PCSS-O Colleague Support Program

- PCSS-O Colleague Support Program is designed to offer general information to health professionals seeking guidance in their clinical practice in prescribing opioid medications.
- PCSS-O Mentors comprise a national network of trained providers with expertise in **addiction medicine/psychiatry and pain management.**
- Our mentoring approach allows every mentor/mentee relationship to be unique and catered to the specific needs of both parties.
- The mentoring program is available at no cost to providers.

For more information on requesting or becoming a mentor visit:
www.pcss-o.org/colleague-support

- **Listserv:** A resource that provides an "Expert of the Month" who will answer questions about educational content that has been presented through PCSS-O project. To join email: pcss-o@aaap.org.

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PCSS-O is a collaborative effort led by American Academy of Addiction Psychiatry (AAAP) in partnership with: Addiction Technology Transfer Center (ATTC), American Academy of Neurology (AAN), American Academy of Pain Medicine (AAPM), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Dental Association (ADA), American Medical Association (AMA), American Osteopathic Academy of Addiction Medicine (AOAAM), American Psychiatric Association (APA), American Society for Pain Management Nursing (ASPMN), International Nurses Society on Addictions (IntNSA), and Southeast Consortium for Substance Abuse Training (SECSAT).

For more information visit: www.pcss-o.org
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