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

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Disclosures

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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.
Prevalence

- 116 million people are living with chronic pain (IOM, 2011)
- Costs up to $635 billion in medical treatment and lost productivity (chronic pain).
- 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 govt $467.7 billion per year (PO misuse)

Societal Concern

- The National Prescription Drug Threat Assessment (2010) has classified the dramatic increase in prescription opioid misuse and diversion as a public health threat.

- Urgent priority is investigation of the high rates of prescription drug abuse among teenagers in the U.S. (Compton, W.M., Volkow, N.D. (2006))

Societal Concern

- Increases in opioid abuse related to:
  - Changes in medication prescribing practices
  - Changes in drug formulations
  - Easy access through internet

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

National Conference of State Legislatures

(Posted 7/2014)

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.

  (Borg, Aronson, Socio, Kaner, 2009; Merrill, Rhodes, Dors, Malott, Bradley, 2002; Upshur, Luedtke, Sturgeon, 2006; Wilson, Fabian, Crandall, Casamassima, Berstein, 2008; Miller, Varen, Dubuis, Repeard, 1994; Baldacchino, Gillett, Herring, Bernstein, 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; Wilson, et al., 2008; and Baldacchino, et al., 2010).
Lack of Education and Clinical Tools

- Providers noted:
  - lack of education regarding clinical tools for identification, assessment, and treatment of coexisting chronic pain and addiction (Merrill et al., 2002; Upshur et al., 2006).

- Quantitative study:
  - attending physicians rated their medical school education (81.5%) and residency training (54.7%) as inadequate regarding chronic pain.
  - mean rating of the chronic pain education for nurse practitioners and physician’s assistant programs was 0.5 (SD = 0.80) on a scale of 0 meaning not at all satisfied and 4 meaning very satisfied (Upshur et al., 2006).

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 and Providers

- 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-medication ways


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.
Conclusion when pain came first

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

Defined by the participants

- Recreational drug use, "meddling", "experimenting"
  - Occasional users of substances of abuse before pain
  - Did not consider themselves addicted, could stop at any time
  - No negative impact by their use and remained functioning in society
- Prescription opioids for treatment of pain … they were surprised at their loss of control

Intersection with Health Care

- Not feeling believed
  - "...they've treat me like I'm not in pain or like I'm lying to 'em when I didn't get nothing." (Irene)
  - Worked hard to be "believable"
- Almost resulting in death
- Pain not treated
### Intersection with Health Care

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

### Voice of the Participants

Regarding receiving prescription opioids for treatment of pain, even while on methadone:

- “I mean it might trigger relapse if I have a whole bunch of pills in my hand. Say I have 30 pills yeah, I might think about taking five, six of ’em. I’m an addict, it’s in our minds.” (Cindy)

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

- Funding by the American Society for Pain Management Nursing
Background

- Over 155,000 APRNs in the US account for 19% of the primary care workforce (Reagan et al., 2010)
- Role delineation study of pain management nurses showed 27% of responding nurses were APRNs (Willens et al., 2010)

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, 394-402)
Top 10 prescribing specialties
immediate-release opioids, 2009

General Practitioners/Family Medicine, 26.7%
Internal Medicine, 15.4%
Dentists, 7.7%
Nurse Practitioners, Physicians Assistants, 4.0%
Emergency Medicine, 4.7%
Other, 20.2%
Physical Med & Rehab, 2.7%
Anesthesiologists, Orthopedist, 3.2%

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

Internal Medicine, 16.8%\nDentists, 8.4%
Nurse Practitioners, Physicians Assistants, 4.0%
Orthopedist, 1.8%
Hematology, 1.7%
Neurologist, 1.9%
Physicians, 13.8%
Neurologist, 2.8%
Unspec., 4.9%
Physical Med & Rehab, 9.3%

Total Outpatient Prescriptions of ER Opioids, by Specialty 1991-2008

Graph showing the trend of total outpatient prescriptions of ER opioids by specialty from 1991 to 2008.
Demographic Data

- Pain certified = 10
- Pain certified and ACHPN = 5
- Years as APRN
  - Range 5-29 years
  - Mean 17.8 years
- Years working with Coexisting SUD and Pain
  - Range 1-1/2 to 24 years
  - Mean 10.7 years

Demographic Data

- Setting
  - Inpatient only = 8
  - Outpatient only = 3
  - Both = 10

- Employment Status
  - Full time = 19
  - Part time = 1
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
  - Across the nation

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
Theme: 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

Theme: 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 wanna 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.
Theme: 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”

Theme: 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.”

Theme: Role of APRNs (cont.)

- Implementing Risk Strategies
  - Always screening for risk
  - 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”

- 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.

Further Research

- Interventions for pain management when patients have existing SUD

- Investigate patient outcomes following APRNs receiving REMS education

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References

References


References