Journal of Life Care Planning, Vol. 15, No. 2, (21-25)

The Opioid Epidemic and Its Effect on Life Care Planning

Melissa Jones Wilkins, Ph.D., CRC, Amanda Connell, M.S, CRC and Sandra Bullins, M.S., CRC

The Opioid Epidemic and Its Effect on Life Care Planning

Every day in the United States, 91 people die from an opioid overdose, either from prescription opioids or heroin (Centers for Disease Control and Prevention, 2016). The number of American deaths, as well as the amount of prescription opioids sold in the United Sates, have both quadrupled since 1999 (CDC, 2016). As more than 183,000 people died between 1999 to 2015 in the U.S. from overdoses related to prescription opioids, over prescribing of medication and overuse of opioids has been deemed an epidemic (CDC, 2016). This epidemic has brought attention to the need for changes to the CDC's guidelines for prescribing opioids for chronic pain, prompted states to create additional laws related to substance abuse, and has driven research to be conducted about future changes that must occur for responsible treatment of chronic pain.

This article is the first of a two-part series of articles intended to educate life care planners about changing pain management policies and practices in America. These changes have resulted in large part from the opioid epidemic in America. These changes, in turn, will affect how life care planners outline chronic pain management in their life care plans. This article will outline proposed changes in policies in the treatment of chronic pain and the second article will outline changes in chronic pain management practices. This information may be of assistance to life care planners when developing plans of care for individuals with pain or other conditions which have historically been treated with opioids.

What is Chronic Pain

Chronic pain is defined as a persistent and unpleasant sense of discomfort that has lasted longer than twelve weeks (Arneric, Laird, Chappell, & Kennedy, 2014; Singh, 2017). According to the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), it is estimated that approximately 35% of Americans (50 million people) experience some element of chronic pain (American Pain Society [APS], 2015). Chronic pain, also referred to as chronic pain syndrome, can be one of the most difficult conditions to diagnose due to the variance in body and organ systems involved, but it differs from acute pain in the aspects of length and receptiveness to treatments (American Pain Society, 2015; Arneric, Laird, Chappell, & Kennedy, 2014; Fiore, Nelson, & Tosti, 2014; Singh, 2017).

Chronic pain is linked to a wide variety of medical conditions including but not limited to: diabetes, fibromyalgia, arthritis, migraines, orthopedic injury, and trauma (Arneric et al., 2014; APS, 2015; Fiore et al., 2014; Singh, 2017). The effects of chronic pain reach further than just the physical manifestation experienced by the individual (Arneric et al., 2014; Fiore et al., 2014). Chronic pain affects not only the individual, but other outside factors as well including employment, relationships, and many activities of daily living (e.g. personal care needs, walking, shopping, preparing a meal) (Arneric et al., 2014; Singh, 2017).

As with any chronic illness or disability, the vast expanse of treatments and therapies have had their successes and failures (Fiore et al., 2014). In the area of chronic pain, treatments have included both pharmacological (e.g. medications) and nonpharmacological (e.g. massage, yoga, counseling, meditation, exercise and transcutaneous electrical nerve stimulation [TENS] units) (Arneric et al., 2014; Fiore et al., 2014; Singh, 2017).

American Medical Association Standards

In the last several years, the American Medical Association (AMA) issued statements to several federal level committees within the U.S. government regarding the growing opioid epidemic (AMA, 2015a; AMA 2015b; AMA, 2016). In their letter to the House Committee on Energy and Commerce, the AMA stated there was no doubt that prescription opioid abuse/misuse had reached the level of epidemic to the United States. The AMA recognized that as it became more difficult for those addicted to opiates to obtain opiates through their usual means, many turned to heroin to satisfy their addiction (AMA, 2015). The increased rate of prescription opioid abuse is intertwined in the growing rate of heroin use, as misuse of prescription opioids has been found to be a significant risk factor for heroin use (Compton, Jones & Baldwin, 2016). They further stated that they are continuously working to create new training for physicians in opiate abuse recognition and are using several screening devices to determine a patient's addiction potential.

The American Medical Association has also discussed increasing the use of naloxone availability. Naloxone is a medication that binds to opioid receptors that can reverse or block the effects of other opioids (National Institute of Drug Abuse [NIDA], 2016). This aids in restoring normal respiration very quickly to a person whose breathing has stopped or is dangerously slow because of an overdose of opioids. It is delivered through a nasal spray or injection. Naloxone can be purchased at some pharmacies, such as CVS and Walgreens, without a prescription in the following states: Ohio, Arkansas, California, Minnesota, Mississippi, Montana, New Jersey, North Dakota, Pennsylvania, South Carolina, Tennessee, Utah, and Wisconsin (NIDA, 2016). The AMA has also discussed how to increase access to

naloxone by police, fire and EMT personnel (and even the public). There has also been discussion of the need for introducing "Good Samaritan" laws so that those administering naloxone in the event of an overdose, do not pay for their assistance as if they had committed a crime (AMA, 2015).

The American Medical Association has created a task force to promulgate the ideas of Prescription Drug Monitoring Programs with the goal of adding to physician knowledge about prescribing practices for opioids (AMA, 2015). The task force is comprised of 20+ states and some medical associations. They have developed a Providers' Clinical Support System for Opioid Therapies that contains free physician educational materials related to opioid use and misuse (AMA, 2015b).

In his letter to Thomas Frieden, the CDC director at the time, James L. Madara, the Executive Vice President and CEO of the AMA made 12 recommendations to the CDC during the commenting phase of the proposed guidelines. In the letter's closing Dr. Madara wrote:

> We sincerely hope that CDC will seize the opportunity to align itself with other ongoing efforts designed to foster a balanced, public health-based approach to improving pain management practices while minimizing the diversion of controlled substances, reducing unintentional overdoses and deaths from opioid analgesics, and supporting improved access to treatment for patients with substance use disorders (AMA, 2016).

The AMA continues to write letters such as these to state government officials and federal committees and organizations such as the FDA with the fervent hope that some of their recommendations will alter the long-standing upward trend of opiate overdose deaths.

State Efforts

Between 2006 and 2012, states created 81 laws related to substance abuse for both prescription drug abuse and illegal substance use (Meara et al., 2016). By 2012, all states had at least one type of law, with Florida, Tennessee, and Vermont having the most intensive legislative activity (Meara et al., 2016). Since that time, state legislation and educational progress has continued to increase, however, many states are still lagging. A 2016 report by the National Safety Council examined state progress and categorized the states in "Making Progress", "Lagging Behind" or "Failing" based on evaluation of efforts in six indicators: Mandatory Prescriber Education, Opioid Prescribing Guidelines, Eliminating Pill Mills, Prescription Drug Monitoring Programs (PDMPs), Increased Access to Naloxone, and Availability of Opioid Use Disorder (OUD) Treatment (National Safety Council [NSC], 2016). The three states scoring the lowest (meeting zero indicators) included Michigan, Missouri, and Nebraska. The states scoring the highest (meeting 5 of the indicators) were Kentucky, New Mexico, Tennessee, and Vermont. However, by 2016, there were no states that had met all six indicators (NSC, 2016).

As of April 2017, there are more than 750 newly filed bills and resolutions for state legislation of prescription drugs (National Conference of State Legislation, 2017). In 2017, 70 bills have been enacted in 24 states (NCSL, 2017). The states that have enacted the most bills so far in 2017 include Virginia (16), Arkansas (6), Utah (5), Arizona (4), District of Columbia (4), Montana (4), and West Virginia (4) (NCSL, 2017).

Future Changes to Chronic Pain Treatment

Education and Standardized Instruction

One of the most common areas where change is necessary is in the education and training of medical students, residents, and even prescribing physicians who work in clinic or emergency room settings (Khidir & Weiner, 2016). Currently, medical students and residents do not get a uniform education on evidence-based practices of assessing a patient's drug-seeking behavior or evaluating if the individual is a good candidate for opioid treatment. Having standardized instruction in all teaching hospitals and training sites for doctors would be beneficial to improve clinician knowledge of how to effectively manage patient's pain, change prescribing practices that may reduce the over prescribing of opioid medication, and ultimately benefit patient health (Karon, 2017; Pearson, Eldrige, Moeschler, & Hooten, 2016; Rosenblum, Marsch, Joseph & Portenoy, 2008).

Information campaigns that target clinics in areas with higher incidences of opioid overdose and/or deaths have been shown to be effective in reducing the number of deaths from overdose (Hawk, Vaca & D'Onofrio, 2015; Kattan et al., 2016). Kattan et al. (2016) surveyed 1,069 health care providers following a 2-month campaign in New York City about opioid analgesic prescribing. They also compared prescribing data from the 3-month period before the campaign with two sequential three-month periods following the campaign. The information campaign focused on three ideas: (1) that acute pain patients be given enough opioid pain medication for only three days, (2) professionals were to refrain from prescribing opioid medications to patients with chronic pain not associated with cancer and (3) professionals stop prescribing high dosages of opioids (Kattan et al., 2016). The researchers found that after this type of campaign, the overall prescribing rate decreased (Kattan et al., 2016).

New Medications

Because of the continued high rates of abuse of prescription opioids, the United States Food and Drug Administration (FDA) considers the development of abuse-deterrent opioids to be a priority. This has led to the development of seven new drugs that have met the FDA's new criteria for abuse-deterrency, with each of them being extended-release formularies (Pezalla et al., 2017). One in particular, Oxycodone DETERx®, is the first extended-

release (ER) opioid that makes it possible for the medication to be crushed or chewed. It can also be administered in several ways, including through feeding tubes and sprinkled on food. This separates it from all other current ER opioids and makes it less likely to be abused, because the slower release of medication is maintained, even when the medication chewed or crushed. This takes away the more rapid drug high that abusers are able to get from current oral ER opioids due to their large opioid load.

Screening Tools

To help mitigate the high rates of opioid abuse, the Food and Drug Administration (FDA) now requires a comprehensive screening and documentation of assessment. Appropriate screening tools are now being used as part of the comprehensive screening. One such screening tool is the Opioid Abuse Risk Screener (OARS). The OARS is comprised of 43 items and is self-administered using an IPad or other tablet (InteraSolutions, 2015). It takes an estimated 15 minutes to complete and then an immediate summary report is sent to the physician. It is recommended that this be completed before the patient meets with the practitioner to allow practitioners to assess the risk of abuse prior to consulting with the patient (Henrie-Barrus, Averill, Sudweeks, Averill, & Mota, 2016; InteraSolutions, 2015). Along with the OARS, other assessment tools can be utilized by practitioners and patients to screen for substance abuse. The National Institute on Drug Abuse provides a chart of evidence-based screening tools with directions on what type of substance each screening tool should be used for, the appropriate patient age, and how the tool is administered.

Conclusion/ Implications for Life Care Planners

As life care planners are frequently called upon to address issues of chronic pain, it is important to be knowledgeable of recent research about pain practices, outcomes of chronic pain treatment, as well as the current best practices (Stewart, Jakubowicz, Beard, Cyphers, & Turner, 2016). It is also important for life care planners to be able to differentiate between patients that are abusing opioid medication and those taking it safely as prescribed for pain management. Life care planners can help ensure the safety of clients by ensuring that appropriate recommendations for pain management programs are included in the life care plan. Such a program would be broad-based with pharmacologic approaches including anti-inflammatories, muscle relaxants, antidepressants, and/or neuroleptics combined with the use of topical compounded creams, supplements, and modalities including physical therapies and/or electrical stimulation. The goal such a program is to effectively manage pain and when used in combination, these medications and therapies should also reduce reliance upon opioids. Based upon information above, an additional item to be considered by the life care planner is medication such as Narcan, to be used in the event of an overdose. This would also necessitate inclusion of family or caregiver education about how to administer this medication.

As mandated in the Consensus and Majority Statements Derived from Life Care Planning Summits, a "review of evidence-based research, review of clinical practice guidelines, medical records, medical and multidisciplinary consultation, and evaluation/assessment of evaluee/family are recognized as best practice sources that provide foundation in Life Care Plans" (Johnson, 2015, p.37). In addition to being best practices in life care planning, having a working knowledge of the recent state laws and AMA standards will also allow for better communication between life care planners and physicians involved in life care plan development. This knowledge will enable the life care planner to fully understand the context of pain management treatment and properly communicate about the items necessary to effectively manage a pain condition. The second of this two-part article series will address additional changes in pain management techniques with accompanying recommendations for life care planners.

References

American Medical Association (2016). Letter Re: Docket No. CDC-2015-0112; *Proposed Guideline for Prescribing Opioids for Chronic Pain*. Retrieved from: http://www.painmed.org/files/ama-letter-to-cdc-proposed-2016-guidelines-for-prescibing.pdf

American Medical Association (2015a). Statement of the American Medical Association to the Committee on Energy & Commerce Subcommittee on Oversight and Investigations United States House of Representatives Re: *"Combatting the opioid abuse epidemic: Professional and academic perspectives"*. Retrieved from: http://docs.house.gov/meetings/IF/IF02/20150423/103367/HHRG-114-IF02-Wstate-HarrisP-20150423.pdf

American Medical Association (2015b). *Task force to reduce opioid abuse*. Retrieved from: https: www.ama-assn.org/delivering-care/task-force-reduce-opioid-abuse

American Pain Society. (2015). *NIH study shows prevalence of chronic or severe pain in U.S. adults*. Retrieved from http://americanpainsociety.org/about-us/press-room/nih-study-shows-prevalence-of-chronic-or-severe-pain-in-u-s-adults

Arneric, S. P., Laird, J. M. A., Chappell, A. S., & Kennedy, J. D. (2014). Tayloring chronic pain treatments for the elderly: Are we prepared for the challenge? *Drug Discovery Today, 19*(1), 8. Doi: 10.1016/j.drudis.2013.08.017

Centers for Disease Control and Prevention. (2016). Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, *National Center for Health Statistics*. Retrieved from http://wonder.cdc.gov.

Compton, W.M., Jones, C.M., & Baldwin, G.T. (2016). Relationship between nonmedical prescription-opioid use

and heroin use. *The New England Journal of Medicine, 374*, 154–63.

Fiore, R., Nelson, R., & Tosti, E. (2014). The use of yoga, meditation, mantram, and mindfulness to enhance coping in veterans with PTSD. *Therapeutic Recreation Journal, 48*(4), 337-340 4p.

Governor's Cabinet Opiate Action Team (2016). *Expanding Ohio's opioid prescribing guidelines*. Retrieved from: http://mha.ohio.gov/Portals/0/Acute%20Prescribe%20Guidelines%20FINAL%20PRINT.pdf

Gufin, J. (2016). Oxycodone DETERx®: A novel abuse-deterrent, extended-release analgesic option for the treatment of patients with chronic pain. *Pain and Therapy, 5*, 171-186. doi:10.1007/s40122-016-0062-1

Hawk, K. F., Vaca, F. E., & D'Onofrio, G. (2015). Reducing Fatal Opioid Overdose: Prevention, Treatment and Harm Reduction Strategies. *The Yale Journal of Biology and Medicine, 88*(3), 235-245.

Henrie-Barrus, P., Averill, L. A., Sudweeks, R. R., Averill, C. L., & Mota, N. (2016). Development and preliminary validation of the Opiod Abuse Risk Screener. *Health Psychology Open*, 1-12. doi:10.1177/2055102916648995

InteraSolutions. (2015). Opioid abuse & risk screener (OARS). *InteraSolutions*. Retrieved from http://interasolutions.com/opioid-abuse-risk-screener-oars/

Johnson, C. (2015). Consensus and majority statements derived from Life Care Planning Summits held in 2000, 2002, 2004, 2006, 2008, 2010, 2012 and 2015. *Journal of Life Care Planning, 13*(4), 35-38.

Jones, C. M., Campopiano, M., Baldwin, G., & McCance-Katz, E. (2015). National and state treatment need and capacity for opioid agonist medication-assisted treatment. *American Journal of Public Health, 105*(8), e55-e63. doi:10.2105/AJPH.2015.302664

Karon, A. (2017). Medical schools respond to the opioid epidemic. *ACP Internist*. Retrieved from https://acpinternist.org/archives/2017/01/opioids-medical-education.htm.

Kattan, J. A., Tuazon, E., Dowell, D., Vo, L., Starrels, J. L., Jones, C. M., & Kunins, H. V. (2016). Public health detailing-a successful strategy to promote judicious opioid anagesic prescribing. *American Journal of Public Health, 106*(8), 1430-1438. doi:10.2015/AJPH.2016.303274

Khidir, H. & Weiner, S. G. (2016). A call for better opioid prescribing training and education. *Western Journal of Emergency Medicine, 17*(6), 686-689. doi:10.5811/westjem.2016.8.31204

Lim, J. K., Bratberg, J. P., Davis, C. S., Green, T. C., & Walley, A. Y. (2016). Prescribe to prevent: Overdose prevention and naloxone rescue kits for prescribers and pharmacists. *Journal of Addiction Medicine, 10*(5), 300-308. doi:10.1097/ADM.0000000000000223

Meara, E., Horwitz, J., Powell, W., McClelland, L., Zhou, W., O'Malley, A., & Morden, N. (2016). State legal restrictions and prescription-opioid use among disabled adults. New England Journal of Medicine, 375(1), 44-53. doi: 10.1056/NEJMsa1514387

National Conference of State Legislation. (2017). Prescription drug state database. *National Conference of State Legislation*. Retrieved from http://www.ncsl.org/research/health/prescription-drug-statenet-database.aspx

National Institute of Drug Abuse. (2016). Chart of evidence-based screening tools for adults and adolescents. National *Institute of Drug Abuse*. Retrieved from https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/screening-assessment-drug-testing-resources/chart-evidence-based-screening-tools-adults

National Institute of Drug Abuse. (2016). Opioid overdose reversal with naloxone. *National Institute of Drug Abuse*. Retrieved from https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio.

National Safety Council. (2019) Prescription nation 2016. *National Safety Council*. Retrieved from http://www.nsc.org/RxDrugOverdoseDocuments/Prescription-Nation-2016-American-Drug-Epidemic.pdf

Pearson, A. C., Eldrige, J. S., Moeschler, S. M., & Hooten, W. M. (2016). Opioids for chronic pain: a knowledge assessment of nonpain specialty providers. *Journal of Pain Research, 9*, 129.

Pezalla, E. J., Rosen, D., Erensen, J. G., Haddox, J. D., & Mayne, T. J. (2017). Secular trends in opioid prescribing in the USA. Journal of Pain Research, 10, 383-387. http://dx.doi.org/10.2147/JPR.S129553

Rosenblum, A., Marsch, L. A., Joseph, H., & Portenoy, R. K. (2008). Opioids and the treatment of chronic pain: controversies, current status, and future directions. *Experimental and Clinical Psychopharmacology, 16*(5), 405.

Singh, M. (2017) Chronic pain syndrome: Practice essentials, etiology, patient education. Retrieved from http://emedicine.medscape.com/article/310834-overview

Stewart, D.E, Jakubowicz, B., Beard, K., Cyphers, G., & Turner, D.V. (2016). Revisiting chronic pain in the life care plan. *Journal of Life Care Planning, 14*(2), 39-45.

Traynor, K. (2014). Rhode Island's opioid epidemic response features collaborative practice model. *American Journal of Health-System Pharmacy, 71*(16), 1328-1332. https://doi.org/10.2146/news140057

Traynor, K. (2016). Thoughtful pain management looks beyond opioids, CDC says. *American Journal of Health-Systems Pharmacy, 73*(9), e116-e117. Retrieved from: https://doi.org/10.2146/news160027

Traynor, K. (2016). Opioid control law in Vermont addresses provider status for pharmacists. *American Journal of Health-System Pharmacy 73*(12), 1024-1026.https:doi.org/10.2146news160044

Traynor, K. (2016). Maine enacts statewide limits on opioid prescribing. American Journal of Health-System

Pharmacy 73(10), 854-856. https://doi.org/10.2146/news160038

U. S. Department of Health and Human Services Centers for Disease Control (2016). Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report: CDC guidelines for prescribing opioids for chronic pain-United States, 2016. Retrieved from: https://www.cdc.gov/media/modules/dpk/2016/dpk-pod/rr6501e1er-ebook.pdf

Author Note

Melissa Jones Wilkins received her doctorate in rehabilitation from the University of Arkansas. She is currently a rehabilitation counselor for Owen Vocational Services and associate professor at Northwest Arkansas Community College. She has past experience as a rehabilitation counselor for Arkansas Rehabilitation Services at Arkansas Career Training Institute and as an adjunct professor at the College of the Ouachita's.

Amanda Connell received her Master's degree in Vocational Rehabilitation Counseling from the University of Arkansas. She is currently the Northwest and West Arkansas Area Manager for DHS Division of Services for the Blind. She has past experience as a rehabilitation counselor for Arkansas Rehabilitation Services and as an adjunct professor at the University of Arkansas- Fort Smith.

Sandra Bullins is currently a Ph.D. candidate at the University of Arkansas. She received her Master's in Rehabilitation Counseling from Mississippi State University. She currently serves as an Independent Living Skills specialist at Sources, Inc.