American Academy of Nursing on Policy

Opioid Crisis through the Lens of Social Justice

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Executive Summary

The United States opioid crisis brings into sharp focus the health inequities for persons dependent on opioids due to long-term use for chronic pain and persons with opioid use disorder (OUD). Disparate access to health-care services, however, is widespread for vulnerable populations like frail older adults, children, incarcerated individuals, and members of racial, ethnic and sexual minorities, groups for whom opioid use exacts a heavy burden. Stigma combined with few prevention services and limited access to healthcare for life-saving treatment are costly for the society and its citizens. Principles of social justice maintain that all people deserve the same rights and should have access to the same resources for safe and comprehensive pain management and substance abuse treatment. To address these inequities, the Academy supports: 1) promotion of full practice authority for advanced practice nurses, 2) advocacy for equitable reimbursement for addiction treatment, 3) promotion of access to medication assisted treatment, and 4) advancing models of care for persons at risk due to opioid use and those with acute and chronic pain who may be at risk for opioid dependence.

Background

The lens of social justice on the opioid crisis illuminates the need for alternatives to the current fragmented and under-resourced healthcare delivery systems which are increasingly challenged by conditions linked to social determinants of health. These problems are exemplified in the devastation wrought by prescribed and non-prescribed opioids in impoverished, rural and underserved communities and the toll of high prevalence of OUDs in vulnerable populations. The laws enacted during the "war on drugs" in the 1970's included disproportionate law enforcement and incarceration rates in communities of color, and intersect with challenges faced by imprisoned persons, at least 20% of whom meet criteria for OUD (Lo & Stephens, 2007). On release, they face a risk for overdose 12 times greater than the general public. From 2010-2013, the opioid related hospitalizations for adults over the age of 65 rose by 34% and emergency room visits by 74%. This population is also at increased risks for falls, fractures and suicide (Buckeridge et al., 2010; Miller et al., 2011 & Weiss et al., 2018). People who identify as LGBTQ are more likely to be diagnosed with OUD than those who identify as heterosexual (Duncan, Zweig, Hambrick, & Palamar, 2019). Opioid related fatalities among children and adolescents, increased three-fold from 1999-2016 and opioid-related pediatric ICU admissions increased by 35% (Gaither, Shabanova & Leventhal, 2018; Kane, Colvin, Bartlett & Hall, 2018). Researchers note that as few as 11% but as high as 38% of pregnancy deaths in 2016 were due to opioids (Maryland Department of Health and Mental Hygiene, 2018; Schiff, Nelson & Land, 2018)

Health inequities and infractions of principles of social justice cut across all geographic regions and populations and are blatantly evidenced in the human and economic costs of this epidemic. The total cost to the U.S. economy over the last four years is

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0029-6554/$ -see front matter
https://doi.org/10.1016/j.outlook.2020.08.014

$631 million (Society of Actuaries, 2019). In 2017, there were more than 70,000 U.S. overdose deaths involving opioids [prescription opioids, heroin, and synthetic narcotics] (Centers for Disease Control and Prevention, (CDC) 2019). It is estimated that 130 persons fatally overdose on opioids daily (CDC, 2020). In persons who overdose, inappropriate pain management has contributed to opioid dependence. Aggressive marketing of opioids by pharmaceutical companies fueled high product accessibility and overprescribing in the 1990's (Alpert, Evans, Lieber & Powell, 2019). Pain management as a human right, the obligation to insure access to controlled substances (Brennan, Carr & Cousins, 2015) and the 2000 Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Pain Standards encouraged more widespread use of narcotic analgesics (Phillips, 2000). Current regulatory efforts to curb overprescribing, however, may deny relief to those in acute pain, those with chronic pain, non-problematic long-term use and those at end of life (National Academies of Science, Engineering and Medicine (NASEM), 2017). Societal attitudes and perceptions about opioid use fuel the stigma toward these vulnerable populations, and adversely influence how they are treated by the public, health professionals, and elected officials.

Responses and Policy Actions

Despite the enactment of the Mental Health and Addiction Equity Act of 2008 (MHPAEA) [Pub. L. 104–204], insurance coverage for opioid-related treatment is uneven or absent. Harm reduction programs, despite evidence of their effectiveness, are inadequately funded (Fernandez, et al. 2017; Ritter & Cameron,2009). The inequitable reimbursement for Advanced Practice Registered Nurses (APRNs), physicians, and physician assistants who prescribe and monitor buprenorphine contributes to limited treatment access. Given the dearth of healthcare providers, including APRNs, certified to provide treatment with the opioid-agonist/antagonist, buprenorphine it is one of the significant obstacles to OUD treatment for vulnerable populations.

Of APRNs, which includes four roles, Nurse Practitioners (NPs) are more likely to obtain waivers to prescribe buprenorphine in states which allow full practice authority rather than those in restricted states (American Association of Nurse Practitioners (AANP), 2019). Twenty-five U.S. states and territories permit full practice for NPs, yet jurisdictions remain where NP practice is reduced or restricted, and three states (Tennessee, Wyoming, and Oklahoma) expressly prohibit NP prescribing of buprenorphine. In these states, patients cared for by NPs are denied this evidence-based, life-saving treatment unless referrals are made to physicians authorized to provide this medication assisted treatment. Only 5.57% of U.S. physicians and 3.17% of NPs have obtained waivers (Spetz, Toretsky, Chapman, Phoenix & Tierney, 2019). Patients are then at risk for continued opioid use when medication for the treatment of addictions is not readily available (Lo and Stephens, 2000). Eighty percent of nurses with waivers reported writing buprenorphine prescriptions in rural settings, demonstrating a willingness to treat this population (Andrillo, Jones & Patterson, 2019). The Substance Abuse and Mental Health Services Administration's (SAMSHA) unequal waiver requirements, however, which stipulate 8 hours of continuing education for physicians versus 24 hours for APRNS, contribute to restrictions on APRN capacity to treat patients with OUDs (Binswanger et al., 2007; SAMHSA, 2020).

Funding for federal legislation, the Comprehensive Addiction and Recovery Act (2016) and Support for Patients and Communities Act (2018) is appraised by experts as inadequate to fully address the recommendations, automatically limiting the scope and efficacy of these bills. Further, current legislation does not include federal agency initiatives for health professional programs to strengthen education on acute and chronic pain management and substance use disorders. The inadequacy of both are evidenced in research and reports (U.S. DHHS, 2016; NASEM, 2016; NASEM, 2017; Compton & Blacher, 2020). The American Academy of Nursing (Academy) policy brief (Naegle et al., 2017), *Opioid misuse epidemic: Addressing opioid prescribing and organization initiatives for holistic, safe and compassionate care* (2017) enumerated recommendations for collaboration among healthcare providers, consumers and patients. The Academy proposes actions to promote equitable access to treatment of opioid use disorder, lift constraints on nursing practice, encourage state and federal policymakers to allocate funds, and modify reimbursement rates for providers and comprehensive OUD programs.

The Academy's Position

The Academy serves the public and the nursing profession through policies which advocate for equitable access to quality healthcare for all regardless of age, race, gender, national origin, mental or physical abilities, gender identity and sexual orientation. The widespread obstacles to equitable access to multimodal pain management and comprehensive, evidence-based treatment and support services for vulnerable populations with OUDs and at-risk populations are in conflict with the principles of social justice. These obstacles include limited access to care, failure to recognize full scope of practice for APRNs, inadequate funding streams, inadequate comprehensive health professional education on pain and the risks associated with opioid use and widespread public, professional and political stigma experienced by these vulnerable populations.

Policy Recommendations

1 Federal policymakers should pass legislation permanently allowing all four APRNs roles to prescribe buprenorphine and other medications for addiction to increase accessibility of this life-saving treatment for all patients regardless of location in all federal healthcare programs.
2 The Centers for Medicare and Medicaid Services should increase and provide equitable reimbursement for MAT regardless of healthcare provider discipline.
3 Increase funding to the National Institutes of Health and the Substance Abuse and Mental Health Administration for the care of persons at risk of opioid use and those in vulnerable populations with acute and chronic pain who may be at risk of opioid dependence in particular.
4 The Agency for Healthcare Research and Quality should evaluate and disseminate innovative nursing care models, including telehealth to increase treatment access for severe OUDs, multimodal pain management and education on evidence-based treatment for OUDs.
5 Policymakers are encouraged to endorse and fiscally support evidence-based harm reduction programs that recognize the health and humanitarian challenges faced by persons who use drugs.
6 The Department of Health and Human Services (USDHHS) should develop and fund comprehensive health professional education on OUD screening, assessment and treatment and pain management.

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