

Minnesota Board of Nursing

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President's Message: Deb Haagenson, RN



The National Council of State Boards of Nursing (NCSBN) has developed and released two on-line courses on Substance Use Disorder free for all nurses and nursing students.

The courses are entitled, "Understanding Substance Use Disorder in Nursing" and "Nurse Manager Guidelines for Substance Use Disorder."

NCSBN's substance use disorder toolkit (brochures, posters, a book and two continuing education (CE) courses) was developed to assure that nurses are armed with knowledge to help identify the warning signs of SUD in patients, nurses and the general public and provide guidelines for prevention, education and intervention.

Now all of these resources are available free of charge from www.ncsbn.org. Both CE courses award contact hours upon successful completion. In addition the toolkit includes the "Substance Use Disorder in Nursing" resource manual, the "Substance Use Disorder in Nursing" video, prevention-focused posters for health care facilities and two brochures, "What You Need to Know About Substance Use Disorder in Nursing" and "A Nurse Manager's Guide

to Substance Use Disorder in Nursing."

Substance use disorders are a serious health problem that affects almost every family in some way, and nurse are not exempt. Of particular concern today is the increase in morbidity and mortality associated with the use of opioid pain relievers. A substance-use disorder is a progressive disease that can be prevented, treated and from which an individual can recover. Realizing these factors, the NCSBN is providing these resource free of charge in response to the American Public Health call to action to implement evidence-based provider training programs.

I have found a number of these resources valuable tools in supporting my own understanding and have shared them with other nursing colleagues. I hope you might also find benefit and support in the above resources. The more we understand about SUD the better prepared we will be to implement effective strategies that protect patients and support nurses.

Recognizing opioids are a serious public health threat, much of this newsletter is focused on the opioid epidemic. There are articles addressing Minnesota and national initiatives, including prescribing guidelines.

Addressing the Opioid Abuse and Overdose Crisis in Minnesota and Nationally

Since 1999, opiate overdose deaths have increased 400% in women and 265% in men (Substance Abuse and Mental Health Services Administration [SAMSHA], 2015). The following statistics regarding opioid use and abuse in the US are (National Association of State Alcohol and Drug Abuse Directors, 2015):

- approximately 1.5 million Americans over the age of 12 years used opioid pain relievers for a non-medical use,
- fifty-three percent of Americans who misuse opioids received it from a friend or relative for free, or from a doctor,
- admission for treatment of opioid dependence has increased by 500% from 2000-2012, and
- the United States population accounts for 80% of the prescriptions for opioid consumption worldwide and 99% of the hydrocodone consumption.

The purpose of this article is to provide an overview of local and national initiatives that are addressing the epidemic and may be related to nursing practice.

National Initiatives

The 2016 Federal budget includes \$1.1 billion in funding to address prescription opioid abuse and heroin use, with \$920 million to support states to expand medication assisted treatment (MAT), \$50 million in National Health Service Corps to expand substance abuse (SU) treatment providers, and \$30 million to evaluate MAT for SU and identify new opportunities (Office of the Press Secretary, The White House, February 2, 2016).

In March 2016, recommendations for practitioners who prescribe opioids for chronic pain; excluding active cancer, palliative care, and end of life care, were issued from the Center for Disease Control (<http://mn.gov/boards/nursing/resources/news/#/detail/appId/1/id/191931>). The intent of the guideline is to ensure practitioners and patients consider safer and more effective treatment for chronic pain that results in improved patient outcomes, and reduces the number of persons who develop opioid use disorder, overdose, and experience adverse effects related to opioid use.

In April 2016, a National Pain Strategy was released from the Office of the Assistant Secretary for Health at the US Department of Health and Human Services (<http://mn.gov/boards/nursing/resources/news/#/detail/appId/1/id/225150>). This is the federal government's first coordinated plan to reduce the burden of pain affecting millions of individuals. The National Pain Strategy is a crucial element to addressing the opioid epidemic. The strategy is a roadmap that will assist in pain interventions that are appropriate, high quality and evidenced-based.

For the first time, the US Surgeon General has directly appealed to the 2.3 million health professionals to assist in leading a national movement to address the prescription opioid epidemic through a letter and a website titled "Turn The Tide" (<http://turnthetiderx.org/>). The website provides health care providers with a number of resources to improve prescribing practices (cont. on page 3)

(cont. from page 2) and to educate patients about the proper use of opioids. It is also an avenue to share stories, challenges and best practices on this topic. The appeal has been posted on the Board website and may be accessed here <http://mn.gov/boards/nursing/resources/news/#/detail/appId/1/id/255109>.

Most recently, the Saving Lives: Innovative Solutions for the Opioid Crisis symposium was held in Minneapolis. This symposium brought law enforcement and public health experts from across the nation to Minnesota to discuss how to establish partnerships and effective programs to combat the heroin, fentanyl, and prescription opioid crisis.

The Comprehensive Addiction and Recovery Act (CARA) passed in 2016 is the first major, federal addiction legislation in 40 years. It is a comprehensive effort to address the opioid epidemic. There are six key elements required for a coordinated approach:

- prevention,
- treatment,
- recovery,
- law enforcement,
- criminal justice reform, and
- overdose reversal.

Of specific interest to APRNs, is how CARA will impact MAT. This change in legislation will allow APRNs and PAs to prescribe buprenorphine if they have additional training on the use of buprenorphine for MAT and will go into effect after January 1, 2018. Action taken in Minnesota to address naloxone, expansion of disposal sites for unwanted prescriptions, and strengthening the Prescription Monitoring Program (PMP) are described below.

Minnesota Initiatives

Minnesota has taken action with the kickoff event of “Pain.Pill.Problem” conference held in August of 2015. This conference was sponsored by the Office of Governor Dayton, Minnesota Department of Health, and Minnesota and US Department of Justice, Hennepin County Sheriff, the University of Minnesota, Mayo Clinic, Minnesota Medical Association, and the Hazelden Betty Ford Institute. The conference brought stakeholders from a variety of professions and the community together to address the problem. Seven initiatives to be addressed by the Minnesota State Opioid Oversight Project (SOOP) were introduced.

The SOOP has members from the Department of Human Services, Public Safety, Health, Education, Corrections, Labor and Industry, Public Safety, Board of Pharmacy, Dentistry, Medical Practice, Podiatry, and Nursing. There SOOP has seven areas of work:

- Neonatal Abstinence Syndrome, (cont. on page 4):

(cont. from page 3)

- Medication Assisted Treatment,
- Opioid Prescribing,
- Prescription Monitoring Program (PMP),
- Increasing Access to Naloxone,
- Prevention, and

Increasing Prescription Take Back Opportunities.

The goal of the Opioid Prescribing Work Group (OPWG), a subgroup of the SOOP, is to help shape the opioid prescribing improvement and monitoring program. The OPWG will recommend protocols that address all phases of the opioid prescribing cycle, and oversee the development of educational resources and message for providers to use when communicating to patients about pain and the use of opioids to treat pain. The OPWG will also develop and recommend quality improvement measures to assess variation in prescribing practices of opioids to support clinical practice. Thresholds directed at Minnesota Health Care Plan enrolled providers will be developed and used to evaluate concerning prescribing practices. The OPWG meetings are open to the public and meet monthly. (<https://mn.gov/dhs/opwg>)

Strengthening the PMP

The law governing the PMP has been amended to add butalbital and gabapentin as medications that must be reported, and will require all authorized prescribers, which includes APRNs, who hold DEA registration to register and maintain an account with the PMP by July 1, 2017.

Increasing Access to Naloxone

Pharmacists may now enter into a collaborative agreement with an APRN, physician, or physician assistant (PA) that will allow the pharmacist to issue a prescription for and dispense naloxone (Minn. Stat. Sec. 151.01 subd. 27(10)). The written agreement must be kept by the pharmacist at each location for which they dispense. The APRN, physician, or PA will be the prescriber of record. An individual may request naloxone for use for themselves or an individual they are in contact with who may use or abuse opiates. The Board of Pharmacy is developing the naloxone protocol in collaboration with stakeholders including APRNs, physicians, and pharmacists.

Increasing Prescription Take Back Opportunities

Prescription take back opportunities have increased by allowing pharmacies to collect legend drugs, including controlled substances, as long as they are collected and disposed of according to applicable laws and , (cont. on page 5)

(cont. from page 4) rules such as hazardous waste/pollution control and controlled substances (Minn. Stat. Sec. 151.37 subd. 6a).

Work on the remaining initiatives is on-going. Nurses, and in particular APRNs (as prescribers of opioids), must be aware of safe opioid prescribing practices, current guidelines, laws governing prescribing of controlled substances and what may be on the horizon that will impact prescribing practices. For further information on safe opiate prescribing practices, see the fall 2015 Board newsletter, *For Your Information*, for the article titled Safe Prescribing of Opioids (http://mn.gov/boards/assets/Newsletter_Fall_2015_tcm21-70835.pdf).

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Minnesota Department of Health Request for Comments on Rules Governing X-ray \ Machines and Other Sources of Ionizing Radiation

The Minnesota Department of Health (MDH) is requesting comments on its proposed amendments and new rules governing X-ray machines and other sources of ionizing radiation. The MDH is developing amendments and possible rules to update Minnesota Rules, Chapter 4732. These rules will address advances in equipment technology, scope of practice for operators of X-ray equipment, service provider responsibilities, and inspection requirements.

To receive or send information regarding the rule revision, use one of the following dedicated rule tools:

- MDH rule webpage at www.health.state.mn.us/divs/eh/radiation/xray/rules/xrayrulerev.html
 - Email address to send Request for Comments at x-rayrules@state.mn.us
 - Questions or comments regarding the rules can be directed to Jacqueline Cavanagh, can be reached at x-rayrules@state.mn.us or 651-201-4151
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Journal Article Review: Standard of Care for Opioid Prescribing: What every APRN Prescriber and Investigator Needs to Know.

The April, 2016 edition of the *Journal of Nursing Regulation* contained an article titled “Standards of care for opioid prescribing: What every APRN prescriber and investigator need to know.” This article describes the four phases of assessing pain management, safe practices to which an APRN should adhere to, and provides a road map that a board of nursing investigator may use to evaluate a complaint regarding an APRN’s opioid prescribing practices. Two case studies are presented that APRNs may find useful to evaluate their practice of prescribing opioids and other controlled substances. This review will provide highlights from the original piece focusing on safe prescribing practices.

The pain management care process is described as having four phases:

- History and physical assessments
- Decision to treat with opioids or refer to a specialist
- Prescribing a trial of opioids
- Ongoing treatments and evaluations.

Prescribers of opioids should be cognizant of the phase of treatment the patient is in and adhere to current standards of care within that phase of prescribing. The APRN demonstrates adherence to the standards of care through supporting documents in the medical record.

Phase One: History and physical assessments

The first phase of opioid prescribing includes the history and physical assessment of the patient, and the illness or injury that has caused the pain. Assessment tools to support the diagnosis may also include laboratory and imaging reports. Phase one should include the use of screening tools that assess the patients self-reported pain levels, current opioid use which may include urine drug tests, risk for opioid abuse screening tools, and prescription monitoring program reports for the patient. Prior to prescribing opioids, an APRN should assess the risk for or current substance use disorder (SUD) in any form, family history of SUD, history of legal issues related to SUD, comorbidities, social background, and mental health factors that may increase the risk for SUD. The presence of any risk factors will not necessarily exclude the use of opioids for pain treatment but should assist the APRN in the decision to treat with opioids and prescription choices.

Phase Two: Decision to treat with opioids

Informed consent for opioid treatment, signed by both the APRN and the patient, should be present in the medical record. Informed consent should include risks, benefits, and goals of treatment. Use of a pain management contract, also called a patient and provider agreement (PPA) between the APRN and the patient that (cont. on pager 7)

(cont. from page 6) outlines expectations of treatment compliance and non-compliance, consequences for non-compliance, and potential termination of opioids or care for reasons of non-compliance should be signed by both the APRN and the patient and kept in the medical record. Compliance with treatment expectations may include routine urine drug screens, pill counts, and review of the PMP to ensure the patient is not receiving opiates or other controlled substance prescriptions from more than one provider. Discussion with the patient should also include safe handling of opiates that includes secure storage and that the patient should not share the medication with others.

Phase Three: Prescribing a trial of opioids

A trial of opioids allows for dosage adjustment and transition between types if needed. The PPA should be reviewed during this phase and used to determine ongoing treatment and adjustments as needed.

Phase Four: Ongoing treatments and evaluations

The vigilance from the first three phases should not end with ongoing care. Investigators will look for documentation that the APRN is using the PPA along with clinical assessments to continually evaluate the patient response to pain treatment. Self-reported pain levels, common side effects of opioids, compliance and non-compliance with the PPA should be found in the medical records. The PMP should be reviewed with each visit. Non-compliance issues should be documented and addressed. An APRN is accountable for recognizing if and when the patient needs referral to another health care provider, including a pain management or SUD specialist.

The author highlights red flags that may indicate inappropriate prescribing of controlled substances by an APRN including; lack of documented clinical findings, lack of a PPA, high volume and all cash payments, prescribing of high dosages and large quantities, practice that does not follow national guidelines, medical record entries that do not change between visits, attention given to the APRN or practice setting from law enforcement or the Drug Enforcement Agency, questioning of prescribing practices or refusal to fill from pharmacies, and lack of training in pain management.

The risk for opioid abuse can be found in all types of patients. APRNs should be vigilant in ensuring their practice addresses the recommendations for all phases of opioid prescribing. Lack of adherence may lead to unsafe patient care and environments where the patient lives and works. Nurses, and in particular APRNs as prescribers of opioids, must be aware of safe opioid prescribing practices, current guidelines, laws governing prescribing of controlled substances and what may be on the horizon that will impact prescribing practices. This article is a helpful review of standards of care for opioid prescribing from the perspective of APRNs and boards of nursing.

Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥ 3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When **CONSIDERING** long-term opioid therapy

- Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- Check that non-opioid therapies tried and optimized.
- Discuss benefits and risks (eg, addiction, overdose) with patient.
- Evaluate risk of harm or misuse.
 - Discuss risk factors with patient.
 - Check prescription drug monitoring program (PDMP) data.
 - Check urine drug screen.
- Set criteria for stopping or continuing opioids.
- Assess baseline pain and function (eg, PEG scale).
- Schedule initial reassessment within 1–4 weeks.
- Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If **RENEWING** without patient visit

- Check that return visit is scheduled ≤ 3 months from last visit.

When **REASSESSING** at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- Assess pain and function (eg, PEG); compare results to baseline.
- Evaluate risk of harm or misuse:
 - Observe patient for signs of over-sedation or overdose risk.
 - If yes: Taper dose.
 - Check PDMP.
 - Check for opioid use disorder if indicated (eg, difficulty controlling use).
 - If yes: Refer for treatment.
- Check that non-opioid therapies optimized.
- Determine whether to continue, adjust, taper, or stop opioids.
- Calculate opioid dosage morphine milligram equivalent (MME).
 - If ≥ 50 MME/day total (≥ 50 mg hydrocodone; ≥ 33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
 - Avoid ≥ 90 MME/day total (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone), or carefully justify; consider specialist referral.
- Schedule reassessment at regular intervals (≤ 3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- Benefits of long-term opioid therapy for chronic pain not well supported by evidence.
- Short-term benefits small to moderate for pain; inconsistent for function.
- Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score – average 3 individual question scores (30% improvement from baseline is clinically meaningful)

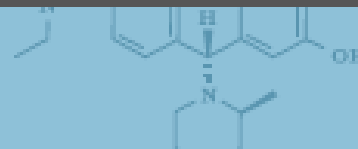
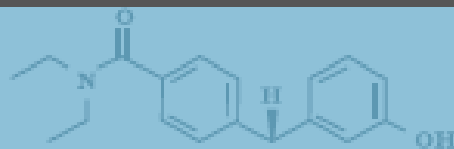
- Q1:** What number from 0–10 best describes your pain in the past week?
0 = “no pain”, 10 = “worst you can imagine”
- Q2:** What number from 0–10 describes how, during the past week, pain has interfered with your enjoyment of life?
0 = “not at all”, 10 = “complete interference”
- Q3:** What number from 0–10 describes how, during the past week, pain has interfered with your general activity?
0 = “not at all”, 10 = “complete interference”



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TO LEARN MORE

WWW.CDC.GOV/DRUGOVERDOSE/PREScribing/GUIDELINE



WHAT SHOULD I CONSIDER WHEN PRESCRIBING OPIOIDS?



High Dosage

Talk to your patient about the risks for respiratory depression and overdose. Consider offering to taper opioids as well as prescribing naloxone for patients taking 50 MME/day or more.



Multiple Providers

Counsel your patient and coordinate care with their other prescribers to improve safety and discuss the need to obtain opioids from a single provider. Check the PDMP regularly and consider tapering or discontinuation of opioids if pattern continues.



Drug Interactions

Whenever possible, avoid prescribing opioids and benzodiazepines concurrently. Communicate with other prescribers to prioritize patient goals and weigh risks of concurrent opioid and benzodiazepine use.

WHAT SHOULD I DO IF I FIND INFORMATION ABOUT A PATIENT IN THE PDMP THAT CONCERNS ME?

Patients should not be dismissed from care based on PDMP information. Use the opportunity to provide potentially life-saving information and interventions.

1

Confirm that the information in the PDMP is correct.

Check for potential data entry errors, use of a nickname or maiden name, or possible identity theft to obtain prescriptions.

2

Assess for possible misuse or abuse.

Offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients who meet criteria for opioid use disorder. If you suspect diversion, urine drug testing can assist in determining whether opioids can be discontinued without causing withdrawal.

3

Discuss any areas of concern with your patient and emphasize your interest in their safety.

HOW CAN I REGISTER AND USE THE PDMP IN MY STATE?

Processes for registering and using PDMPs vary from state to state.

For information on your state's requirements, check The National Alliance for Model State Drug Laws online: ●

www.namsdl.org/prescription-monitoring-programs.cfm



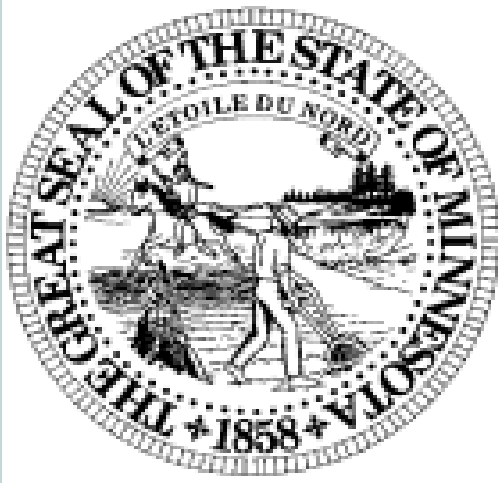
National Council of State Boards of Nursing Publish National Guidelines for Nursing Delegation

Making decisions to delegate or assign tasks and activities to other nurses or unlicensed assistive personnel requires nursing judgment and can be one of the more challenging aspects of nursing. Recently, the National Council of State Boards of Nursing (“NCSBN”) published important guidelines to assist nurses. Beginning in 2015, NCSBN worked with panels of experts representing education, research, and practice to discuss the delegation literature and key issues and to evaluate delegation research findings. The goal was the development of national guidelines to facilitate and standardize the nursing delegation process. The resulting “National Guidelines for Nursing Delegation” build on previous work by NCSBN and the American Nurses Association, and provide clarification on the responsibilities associated with delegation. Additionally, the guidelines are meant to address delegation with respect to the various levels of nursing licensure (i.e., APRN, RN, and LPN).

The delegation process is multifaceted. It begins with decisions made at the administrative level of the organization and extends to the staff responsible for delegating, overseeing the process, and performing the responsibilities. It involves effective communication, empowering staff to make decisions based on their judgment and support from all levels of the health care setting. A unique aspect of the Guidelines is the explication of specific responsibilities of the employer/nurse leader, the individual licensed nurse, and the delegatee within the delegation process. Responsibilities of the employer/nurse leader include communication regarding the delegation process and the competency level of delegates.

The overlapping responsibilities of the parties is depicted below. For more information about the Guidelines, see [Delegation | NCSBN](#) or the Board of Nursing website <http://mn.gov/boards/nursing/practice/topics/national-guidelines-nursing-delegation.jsp>.





Minnesota Board of Nursing

Link to Board member profiles:

<http://mn.gov/health-licensing-boards/nursing/about-us/about-the-board/current-board-members.jsp>

How to become a Board member:

<http://mn.gov/health-licensing-boards/nursing/about-us/about-the-board/current-board-members.jsp>

Minnesota Board of Nursing Members

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Jan Rainey	Public Member
Christine Renne	Public Member
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Steven Strand	RN Member
Eric Thompson	LPN Member

National Council of State Boards of Nursing edition of In Focus Summer 2016

“In Focus” is NCSBN’s e-magazine. It offers a behind the scenes look at NCSBN products and services, giving readers a peek at the inner workings of the organization. Highlights from the summer edition include

- Pathways to Leadership: Holistic Leadership
- NCSBN’S One-on-One Executive Officer Mentor Program
- Enhanced Nurse Licensure Compact (e-NLC) Rulemaking Explained
- Leading Transformation: Architects of Nursing Regulation– a 2016 Annual Meeting Recap
- Pearson VUE Testing Center Updates
- NCSBN Grant Program

https://www.ncsbn.org/InFocus_Summer2016_spreads.pdf



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