More Than a Feeling: Strategies to Address Opioid Abuse, Diversion and Staff Safety

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Disclosure

I have no relevant financial relationship with manufacturers of any commercial products and/or providers of commercial services discussed in this presentation.

This discussion will include the use of medications for off-label indications.

Objectives

Identify indicators of drug abuse or diversion in the end of life care setting

Discuss strategies to mitigate medication risk in the presence of abuse or diversion

Describe a best practice approach to minimize risk to the clinician in the community setting when caring for patients in high risk settings

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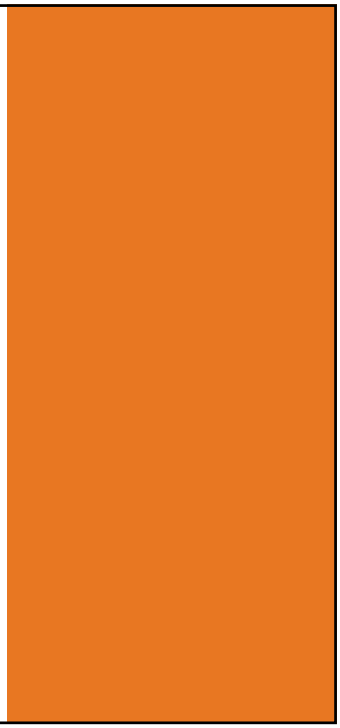
The Nation's Opioid Crisis and Hospice



National Survey on Drug Use and Health (NSDUH) 2016

28.6 million people (>12 yoa) used an illicit drug in the past 30 days=1 in 10

- Illicit:
  - Use of substances/street drugs that are illegal: heroin, cocaine, fentanyl, LSD, marijuana
  - Use of ***legally prescribed substances*** used by someone for whom the prescription was not written
- As high as 1 in 4 for adults 18-25 y.o.
- Primarily marijuana and misuse of prescription pain relievers

24 million used marijuana (higher than 2002-2015)

3.3 million ***misused*** prescription pain relievers

Smaller numbers used cocaine, hallucinogens, methamphetamine, inhalants, heroin or ***misused*** prescription tranquilizers, stimulants or sedatives

- 53% obtained the last pain reliever they misused from a friend or relative

Use of cocaine unchanged from 2007; Use of heroin unchanged from 2014

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National Survey on Drug Use and Health (NSDUH) 2016

20.1 million had a substance use disorder (SUD)

- 15.1 million ETOH
- 7.4 million illicit drug use disorder

Most common was for marijuana=4 million

2.1 million opioid use disorder

- 1.8 million prescription pain reliever disorder
- 0.6 million heroin use disorder

8.2 million had both mental illness and SUD

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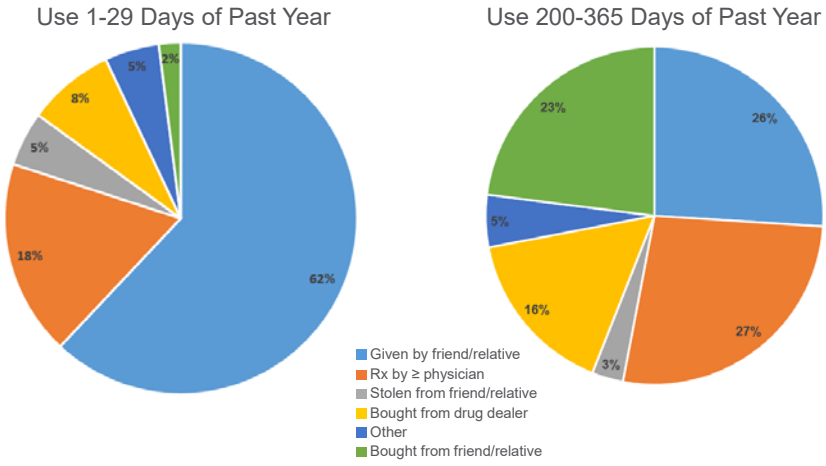
Where Do the Opioids Come From?

Sources of Prescription Opioids Among Past Year Non-Medical Users



Jones et al, 2014

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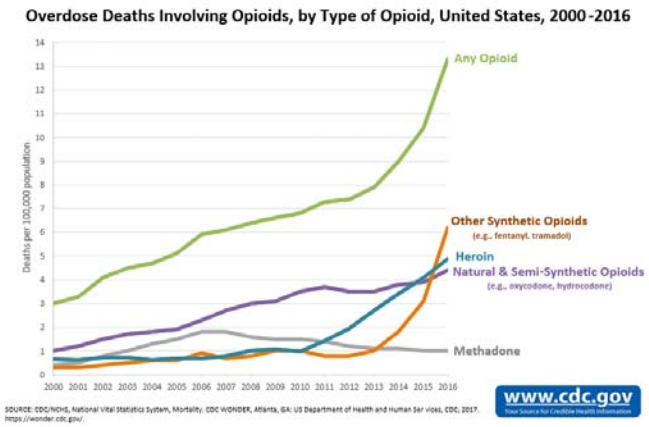
Overdose Deaths and Opioids



- 40% of all US opioid OD deaths in US in 2016 involved a prescription opioid
- Most common prescriptions included:
  - Fentanyl
  - Oxycodone
  - Oxycontin
  - Hydrocodone

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Substance Abuse Disorder (SUD) in Hospice & Palliative Care

Patients with cancer and terminal illnesses are often excluded from federal, state and professional guidelines on improving safety in opioid prescribing.

Poorly studied but likely similar to general population

- 27% alcoholism in one palliative medicine unit
- 18% chemical coping in a palliative medicine clinic

Approximately 25% of palliative care patients have a SUD

- Caregivers often have issues with illicit drug use and may be at risk due to significant exposure to controlled substances

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Opioid Crisis Response Act of 2018

Senate Bill 2680

Designed to improve the ability of federal and state entities and other agencies to:

- Address the nation's opioid crisis
- Address it's effect on children, families and communities
- Help states implement updates to their plans of safe care
- Improve data sharing between states

Allows for hospice personnel to safely and properly dispose of controlled substances to help reduce the risk of diversion and misuse

Encourages states to share Prescription Drug Monitoring Program (PDMP) data with one another, which would streamline federal requirements for PDMPs

Requires manufacturers to make certain drugs, including opioids, available in unit dose packaging

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Substance Abuse Disorder in Hospice & Palliative Care

They're dying! It doesn't matter…does it?

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John: 42 yo male

Hospice diagnosis: Head and neck cancer with metastases to lymph nodes

PMH: COPD; back pain from old sports injury

FH: Married; 2 children; father is an alcoholic

SH: Commercial Real Estate

PPS 50%: Ambulatory

30yr pack history-currently smokes; 2-3 beers/night; uses marijuana occasionally to help him relax

Chief Complaint on admission:

- Pain in lower and upper spine, 8/10, sometimes shooting down front of legs, 6-8/10; neck pain 6/10.
- Anxiety
- Insomnia

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John's Medication Profile on Admission

Morphine SR 60mg PO q8h

Oxycodone 5mg/APAP 325mg 1-2 tabs PO q4h prn
- Has been taking 12 tabs/day on a regular basis

Gabapentin 1200mg PO TID
- Was started 3 years ago for work injury

Alprazolam 0.5mg PO QID
- Occasionally takes 1-2 extra during the day

Albuterol inhaler 1-2 puffs q4h

Senna-S 2 tablets PO BID

Temazepam 7.5mg PO qhs may repeat x 1
- Frequently wakes up at night and repeats dose

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John's Medications 2 Weeks Later

Morphine SR 100mg PO q8h

Morphine 15mg 2 tabs q2h prn for BTP
- He states he takes at least 8 morphine 15mg tabs per day to keep his pain at 7/10

Alprazolam 1mg PO QID
- He states he ***sometimes*** takes 2 extra tabs/day to help with anxiety

Albuterol inhaler 1-2 puffs q4h

Senna-S 2 tablets PO BID

Gabapentin 1200mg PO TID

Temazepam 7.5mg PO qhs may repeat x 1

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John's Medications 3 Weeks Later

Morphine SR 200mg PO q8h

Morphine 30mg 2 tabs q2h prn for BTP

- He states he takes at least 8 morphine 30mg tabs per day to keep his pain at 6/10

Alprazolam 1mg PO QID

- He states he ***often*** takes 2 extra tabs/day to help with anxiety

Albuterol inhaler 1-2 puffs q4h

Senna-S 2 tablets PO BID

Gabapentin 1200mg PO TID

Temazepam 7.5mg PO qhs may repeat x 1

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Indicators of Abuse or Diversion

Is Addiction Pleasurable?

Substance abuse-a source of suffering, not a source of pleasure

Addiction is a brain disease manifested by compulsive substance use despite harmful consequence.

Addiction is often motivated by avoidance of unpleasant moods and is self-destructive.

Drugs that are abused do not produce euphoria but induce unpleasant effects.

Mental state of the chemically-dependent is often one of boredom and loneliness.

Think "Comfort Seeker" not Drug Seeker"

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Is it…?

Tolerance: need to increase a drug to achieve the same effect

Physical Dependence: development of a withdrawal syndrome when a drug is suddenly discontinued or an agonist administered

Pseudoaddiction: misinterpretation of relief-seeking behaviors caused by under treatment of pain misidentified by the clinician

Chemical Coping: use of medication in a non-prescribed way to cope with emotional distress

Addiction: psychological dependence; overwhelming involvement with obtaining and using and a drug, characterized by loss of control, compulsive drug use and use despite harm

Diversion: unlawful channeling of regulated pharmaceuticals from legal sources to the illicit marketplace

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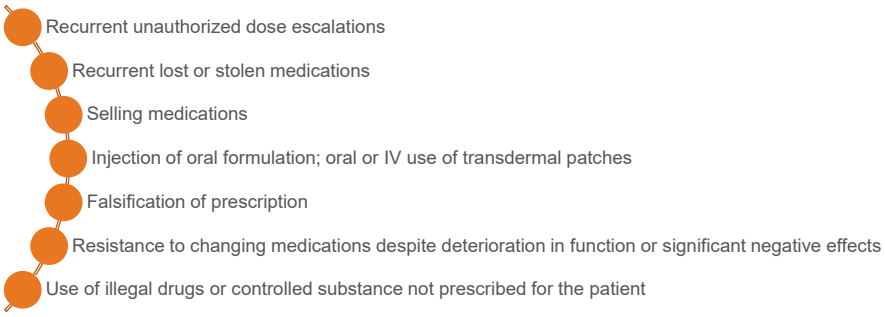
Removing the Guesswork, i.e. Gut Feelings

Aberrant Behaviors

Validated Assessment Tools

Interviewing Techniques

Aberrant Drug-Taking Behaviors



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Screening Tools

- CAGE-AID
- Opioid Risk Tool
- Addiction Behaviors Checklist (ABC)

No conclusions should be made from a single screening tool

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CAGE-AID (CAGE Questions Adapted to Include Drugs)

1. Have you ever felt you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves to or get rid of a hangover?

Scoring: Item responses on the CAGE-AID are scored 0 for "no" and 1 for "yes" answers. A higher score is an indication of problems. A total score of 2 or greater is considered clinically significant.

Used with permission from Brown, R.L, and Rounds, L.A.. Conjoining screening questionnaires for alcohol and drug abuse. Wisconsin Medical Journal 94:135-140, 1995.

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Opioid Risk Tool

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

SCORING:
0-3 indicates low risk: 6% chance of developing problematic behaviors

4-7 indicates moderate risk: 28% chance of developing problematic behaviors

8 or higher indicates high risk: > 90% chance of developing problematic behaviors

Adapted from: Webster, LR and Webster, RM, *Pain Med:* 2005; 6:432-442

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John Risk Assessment Using ORT

Father is an alcoholic (3)

Cigarette, ETOH (3) + marijuana use (4)

Rapidly escalating opioid and benzodiazepine doses (5)

- Self-escalation of doses

Age (1)

Depression (1)

TOTAL SCORE=17 → High Risk!

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Addiction Behaviors Checklist (ABC)

***Instructions*: Code only for patients prescribed opioid or sedative analgesics on behaviors exhibited "since last visit" and "within the current visit" (NA = not assessed)**

Addiction behaviors—since last visit				
1.	Patient used illicit drugs or evidences problem drinking*	**Y**	**N**	**NA**
2.	Patient has hoarded meds	**Y**	**N**	**NA**
3.	Patient used more narcotic than prescribed	**Y**	**N**	**NA**
4.	Patient ran out of meds early	**Y**	**N**	**NA**
5.	Patient has increased use of narcotics	**Y**	**N**	**NA**
6.	Patient used analgesics PRN when prescription is for time contingent use	**Y**	**N**	**NA**
7.	Patient received narcotics from more than one provider	**Y**	**N**	**NA**
8.	Patient bought meds on the streets	**Y**	**N**	**NA**
Addiction behaviors—within current visit				
1.	Patient appears sedated or confused (e.g., slurred speech, unresponsive)	**Y**	**N**	**NA**
2.	Patient expresses worries about addiction	**Y**	**N**	**NA**
3.	Patient expressed a strong preference for a specific type of analgesic or specific route of administration	**Y**	**N**	**NA**
4.	Patient expresses concern about future availability of narcotic	**Y**	**N**	**NA**
5.	Patient reports worsened relationships with family	**Y**	**N**	**NA**
6.	Patient misrepresented analgesic prescription or use	**Y**	**N**	**NA**
7.	Patient indicated she or he "needs" or "must have" analgesic meds	**Y**	**N**	**NA**
8.	Discussion of analgesic meds was the predominant issue of visit	**Y**	**N**	**NA**
9.	Patient exhibited lack of interest in rehab or self-management	**Y**	**N**	**NA**
10.	Patient reports minimal/inadequate relief from narcotic analgesic	**Y**	**N**	**NA**
11.	Patient indicated difficulty with using medication agreement	**Y**	**N**	**NA**

ABC Score: _____
Score of ≥3 indicates possible inappropriate opioid use and should flag for further examination of specific signs of misuse and more careful patient monitoring (i.e., urine screening, pill counts, removal of opioid).

Checklist developed by Bruce D. Naliboff, Ph.D. with support from VA Health Services Research and Development. SM Wu, P Compton, R Bolus, et al. The addiction behaviors checklist: validation of a new clinician-based measure of inappropriate opioid use in chronic pain. J Pain Symptom Manage. 006;32(4):342-351.

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Interviewing Techniques for Patient Self-Reporting

Factors Affecting Patient Self-Reporting

Clinician anxiety	Patient's anxiety	The "how" of asking
• What might be the cause of your anxiety? • How could your anxiety effect the information obtained?	• Common worries, fears, and concerns: ✓ Embarrassment ✓ Being judged ✓ Confidentiality ✓ Relevance to care	• Wording • Form • When

NIDA Centers of Excellence for Physician Information

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Addressing Clinician Anxiety

Be aware of what is going on in your head and with your own feelings.

Your own anxiety may prevent getting a thorough history.

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Addressing Patient Anxiety

Prepare the patient to discuss the topic

Normalizing

- *"Many people find it awkward to talk about their use of recreational drugs."*

Transparency

- *"I need to ask you some very specific questions about your use of street drugs in order to better understand how we can safely care for you."*

Ask Permission

- *"Would it be alright with you if I asked you some questions about your use of alcohol?"*

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Normalizing, Transparency and Permission

Helpful to use all 3 together:

"I ask all my patients about their alcohol use as part of gathering information about their medication history because it can have an important impact on what medications we use to treat their symptoms. Would it be ok if I asked you some questions about your marijuana use?"

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Addressing Patient Anxiety

Confidentiality Concerns

- Not a black and white issue; 100% confidentiality may not be possible
- Don't make a promise you can't keep-patient's have a right to be informed about this

Documentation

- Organizational P&P's
- Is it important to overall health status or care?
- Does it present a safety concern for the patient, caregivers, staff?
- Do not need to report illegal drug use to law enforcement (follow organizational P&P's)

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The "How" of Asking

- Wording
  - Closed-ended questions
  - Offer response choices
  - Careful word choice
  - Assume behavior is occurring
- Order
- Form
  - Asks for facts, not judgments or opinions
  - Use specific close-ended questions (denial of the specific)
    - Open-ended questions tend to increase anxiety and discomfort

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Wording

Closed-ended Questions

- *"How many drinks of alcohol do you have in an average week?"*

Careful Word Choice

- Use formal terms for activities, not slang: "*Have you ever used marijuana?"*
- Avoid potentially slanderous words, e.g. "illicit drugs" → "street/recreational drugs": *"Do you use recreational drugs to relieve pain or to help you relax?"*

Assume Behavior is Occurring

- Tends to "normalize" the behavior: *"How often do you use marijuana?"*

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Form

Facts, not judgments or opinions

AVOID: *"Do you drink often?"* BETTER: *"How often do you drink in a week?"*

AVOID: "*Do you get drunk?"* BETTER: "*How many drinks do you typically have on a single occasion?"*

Closed-ended questions (denial of the specific)

"AVOID: *"Have you ever used street drugs?"*

BETTER: *"*Have you ever used *marijuana?"*

BETTER: "*Have you ever used cocaine?"*

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When to Ask

Suggested sequence for asking about substance use:

- Caffeine and Tobacco use
- Alcohol use
- Over-the-counter medication use
- Street drug use, prescription medications
- Prescription medication abuse/misuse

"Have you ever used marijuana, cocaine…"

"When was your most recent usage within the last year of …"

"Have you ever tried and failed to control, cut down, or stop using…."

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Addiction in Health Care Professionals

Why Hospice is a High Risk Area

Organizational P&P's need to address prevention of staff diversion & interventions in event of diversion.

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Identifying Addiction in Health Care Professionals

- Absenteeism without notification; excessive number of sick days used
- Unreliability in keeping and meeting deadlines
- Work performance alternates between periods of high and low productivity
- Ordinary tasks require greater effort and consume more time
- Unpredictable work performance
- Difficulty concentrating
- Interpersonal conflict
- Personality change: mood swings, anxiety, depression, lack of impulse control, suicidal gestures or thoughts
- Personal and professional isolation
- Patient complaints about changing attitude/behavior

Health care professionals have up to a 5 times higher rate of abuse of benzos and opiates.

"*Professional colleagues have a responsibility to provide help and support to the impaired coworker, not only because of shared fellowship but also because of the investment in their training and the societal need for qualified healthcare workers.*"

"Impaired Healthcare Professionals", Marie Baldisseri, Crit Care Med 2007 Vol. 35, No.2

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Strategies to Mitigate Medication Risk

Strategies to Address SUD

1. Staff education
   - Knowledge of SUD
   - Realistic goal(s)
   - Treatment of co-morbid psychiatric conditions
2. IDT involvement
   - Assessments that are discipline specific
   - Look for opportunities to draw in team members
     - Ask chaplain or SW to visit spouse or children
     - Ask a team member to deliver supplies or paperwork
     - "My expertise as a nurse is in helping to to relieve your physical pain. The social worker is skilled at helping you cope with emotional pain. We work as a team."
     - "The social worker and I make joint visits every Wednesday."

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Strategies to Address SUD

3. Use of Evidence-Based Pain Management Principles

Non-Pharmacological Interventions	Pharmacological Interventions
• Psycho-social support • Art therapy • Music therapy • Massage therapy • Spiritual care • Aroma therapy • Pet therapy • Heat or ice • Positioning • Acupuncture	• Right drug, dose, route • Long acting medications • Medications with lower street value • ATC dosing • Limited or no prn dosing with short acting opioids • Non-opioid adjuvants

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Strategies to Address SUD

4. Involve caregivers
5. Limited days supply of medications
6. Lock box
7. Treatment Agreement
8. Urine Drug Screen
9. Prescription Monitoring Program

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Utilization of Treatment Agreement

Monitoring is not punishment

Define expectations of patient ***and*** staff

Review line by line

Consider reading comprehension

Consider language/cultural barriers

Use is controversial and no studies to prove effectiveness

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"Simply being handed a document without the concurrent discussion, I can see where a patient might feel that this was intended only as a punitive measure, rather than a collaborative measure to responsibly use these strong medications," Jankowski said. "One ought not replace the other."

"I don't disagree with how patients feel, and I can mostly blame physicians for not doing the job they are capable of doing," in explaining the agreements, he said.

Dialogue is the key!

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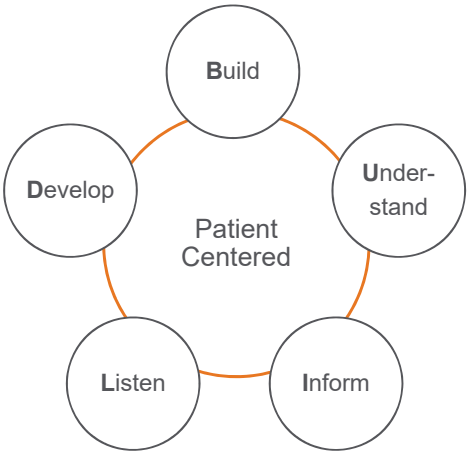
Universal Treatment Agreement Conversation



BUILD

- **B**uild trust and establish boundaries
- **U**nderstand what the patient is trying to accomplish with his medication
- **I**nform the patient what can be expected from the medication and of consequences of violating boundaries
- **L**isten to the patient's goals and expectations
- **D**evelop a collaborative plan of care

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Suggested Items for a Treatment Agreement

Hospice Commitment

Honesty:
- Realistic expectations re: pain relief, team approach, response time
- Safety regarding use of opioids

Pain and symptom relief:
- Regular and consistent pain assessments
- Non-pharmacologic & pharmacologic interventions
- Involvement of Interdisciplinary Team Members

Communication:
- Hospice will facilitate meeting(s) with the patient and caregiver(s)
- Hospice will communicate regularly with the physician & other team members
- Frequency of visits will be _____

Accountability:
- Hospice will routinely and intermittently utilize a validated Opioid Risk Assessment Tool
- Hospice will provide a lock box for safe storage of medications
- Hospice will assist in safe and appropriate disposal of medications no longer needed
- _____

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Suggested Items for a Treatment Agreement

Patient and Caregiver Commitment

Honesty:
- Pain & symptoms
- Medication use
- Safety concerns

Pain relief:
- Pain & symptom medications will be prescribed only by my hospice attending physician or the Hospice Medical Director(s)
- Only one pharmacy will be used
- I will take my medication exactly as prescribed

Communication:
- If I run out of medication early, for any reason, I will notify hospice immediately.
- If there are safety concerns in my home or neighborhood I will inform the hospice staff.

Accountability:
- If my medication is lost or stolen I agree to complete a police report & provide a copy of the report to hospice
- I agree to provide a urine sample for drug screening if requested
- I understand I can be discharged from the Hospice program if I choose not to follow the conditions outlined here
- I understand I can choose to transfer to another hospice
- _____

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Urine Drug Screening and Testing

Urine Drug Screen (UDS)

Immunoassay screen
- Initial test
- Results in minutes
- Detects a few drug classes, medications and illicit substances

Cross-reactivity is common
- Higher incidence of false positives

Higher cut-off levels for detection
- More false negatives

Should not be used as sole basis for treatment decisions.

Urine Drug Test (UDT)

Gas chromatography / mass spectrometry
- Confirmation test
- Results in days
- Detects small quantities of substances

Confirms presence of specific drugs
- Definitive identification and analysis
- False positives are rare
- False negatives are rare

Place in therapy:
- After a positive result on immunoassay
- As confirm on negative screen

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Prescription Drug Monitoring Program (PDMP)

Statewide electronic database that collects specific data on substances dispensed in the state.

Each state controls who can access the PDMP information and for what purpose

Each state designates a state agency to oversee its PDMP:

- e.g. health departments, pharmacy boards, state law enforcement

Benefits of a PDMP:

- Support access to legitimate medical use of controlled substances
- Identify drug abuse and diversion
- Facilitate identification, intervention and treatment of persons addicted to prescription drugs
- Provide education:
  - PDMPs
  - Use, abuse and diversion of prescription drugs
  - Addiction to prescription drugs

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John's Medications 4 Weeks Later

Again offer methadone but John again declines this option

Continue morphine SR 200mg PO q8h-3 day supply

Continue morphine 30mg 2 tabs q2h prn for BTP, max of 3 doses per day-3 day supply

- John takes all 3 BT doses each day, rates pain 6-8/10 depending on activity
- Focus of conversation is on functional ability instead of pain rating

Continue alprazolam to 1mg PO QID (no prn)-3 day supply

Add dexamethasone 4mg PO BID

Add sertraline 25mg PO qd

Albuterol inhaler 1-2 puffs q4h

Senna-S 2 tablets PO BID

Gabapentin 1200mg PO TID

Temazepam 7.5mg PO qhs may repeat x 1

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John's Plan of Care

IDT involvement
- Social Worker
- Volunteer

Non-pharmacological interventions
- Massage therapist

Increase frequency of visits and include wife at least once/week
- Provide education to wife re: pain management

Implement a lock box

Implement a Treatment Agreement

Dispose of oxycodone/apap

Realistic expectations

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Minimizing Clinician Risk in the Community Setting

Staff Safety

Organizational P&P

Assessment

Interventions

Discharge plan

Boundaries, including exit plan

Communication

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Safety Assessment and Re-assessment

- ✓ At admission
- ✓ At every visit
- ✓ At every team meeting
- ✓ Always after a safety/security incident
- ✓ Significant change in patient's condition
- ✓ Significant change in family dynamics
- ✓ Change in patient's location

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Rapid Risk Assessment Tool

1.Do I know the patient and family?	Yes =1	No =3
2.If not, am I able to access information from other services: social services, local authorities, colleagues?	Yes= 1	No= 3
3.Is there a known history of violence or harassment?	Yes=6	No=1
4.Is the area known to be unsafe?	Yes= 3	No=1
5.Is there a way for co-workers to know my whereabouts?	Yes=1	No=3
6.Do I have a cell phone and/or personal alarm?	Yes=1	No=3
7.Can a co-worker make a joint visit with me?	Yes=1	No=3
8.Do I have training in de-escalation skills?	Yes=1	No=3
9.Do I have the ability to break away from a violent person?	Yes=1	No=3
10.Is the task I'm about to undertake likely to trigger violence?	Yes=3	No=1

Scoring: 10-15=low risk, 16-23=medium risk, above 24=high risk

Adapted from The Rapid Assessment Tool (Walter Brennan, 2010)

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Safety Assessment **and Plan**

	Risks	Interventions
0-3	• Unsafe entry • Animals without hx of aggression • Patient or c/g with hx of mental illness	• Ongoing assessment • Communicate risks to team
4-7	• Neighborhood with known drug or crime activity • Loaded weapon in home • Family conflict • Patient with Treatment Agreement in place	• Daytime or joint visits • Require animal to be locked up • Require weapons be removed from immediate vicinity • Security escort
8-10	• Known hx of violence • Smoking with oxygen on in presence of staff • Verbal threats	• Leave immediately • Transport patient to inpatient setting for evaluation/treatment

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Team Communication

Communication with Staff	Special Consideration
Written documentation • Patient chart • POC Verbal communication • Team updates • IDT	Inpatient staff • Limit visitors when warranted • Room close to nurse's station • Frequent contact with staff • Search possessions & packages brought by visitors • Restrict mobility to room or floor

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Commitment to helping people should never replace good judgment.

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Discharge for Cause

Behavior of the patient or of person(s)
in the patient's home is
disruptive, abusive or uncooperative
to the extent that delivery of care
to the patient or the ability of the hospice
to operate effectively is seriously impaired.

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Discharge for Cause

Hospice must:

- Advise patient that discharge for cause is being considered
- Make effort to resolve the problem

Document these efforts

- Obtain discharge order from hospice medical director

Consult attending physician

- Minimize sense of abandonment

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Discharge for Cause

Discharge should not be due to time, effort or cost factors

Discharge should not be a surprise to the patient

Exception is an situation that presents an immediate danger to the staff

Patient may choose to revoke if expectations are beyond their willingness to meet them

Discuss conditions for re-admission

Provide referrals to other agencies

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Key Points

Medications central to the opioid crisis are medications that we use every day in hospice. We can choose to be part of the problem or part of the solution.

We use assessment tools every day to determine various risk factors. There are validated opioid risk assessment tools available.

The bedside clinician is a hospice's most valuable resource. A wise hospice will protect that resource.

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