Opioid Prescribing for the Cancer Patient with Substance Abuse Disorder

- Managing Pain for Patients with Suspected Substance Abuse
- Regional Conference in Hospice and Palliative Care
  - The Carolinas Center
  - Monday, August 29, 2016

Disclosure Statement

- I, Christopher Powers, have no conflicts of interest in any content that I will be discussing or presenting in this CME lecture presentation today
- Date Aug 29, 2016

Goals and Objectives

- Better understanding of prescription and illicit substance abuse problem and how it impacts the palliative care patient population
- Provider mitigation strategies for detecting, avoiding, and managing disease related pain for palliative care patients with substance abuse problems
- Additional strategies/discussions for institutions, family and formal or informal caregivers
Palliative Care can unknowingly become a “Safety Net” for the challenging patients with substance abuse

Pain Management in Palliative Care Patients with Substance Abuse


– Among patients with chronic nonmalignant pain, the prevalence of substance abuse varies from 0-50%

– Among cancer patients, the prevalence of substance abuse varies from 0-7.7%


Prescription Opioid Abuse Epidemic and Illicit Substance Abuse Problem

• Statistics
• Variety of resources
Cancer Pain and Best Practice Treatment in Patients with Substance Abuse History

- Very Challenging – among the most serious challenges in the clinical setting

- Somatic Pain is one of the most prevalent and debilitating symptoms experienced by patients with cancer
  - 25% of newly diagnosed cancer
  - 33% undergoing active cancer treatment
  - > 75% of patients with advanced disease

- Clinician concerns
  - Legitimacy of request, mutual distrust, safe prescribing practices

Journal of Opioid Mgmt 8:3 May/June 2012

Patients with addiction or substance abuse history

- Should be treated as a whole person (Respect)
  - Many from lower SES and feel alienated from health system
  - Watch out for judgments and marginalization

- At tremendous risk for under treatment

- Often with behavioral challenges
  - Occasional antisocial behavior

- Requires a Palliative Team approach (IDG meetings)

- Uncovering and Dialogue about the Addiction and the Behaviors
  - “Chemically coping”
  - Mental Health Providers with more experience treating drug addiction
Working on the Edge: Palliative Care for Substance Users with AIDS

• Val Robb: 1995 Journal of Palliative Care 11:2, 50-53
• Visiting Nurses and Hospice of San Francisco
• Highlighted Culture, Language barriers, Stigma associated with Hospice (low income clients can view as a push towards less expensive care)
• Harm Reduction and Hospice combination
  – Service provider (sp) assists the client in identifying his/her priorities and strengths.
  – Harm reduction is alternative to 12 step drug treatment programs which demand complete abstinence (meet people where “they” are)
  – Client is seen as competent and his/her behavior seen as functional
  – Addresses caregiver need for understanding diversity, race, culture, class, gender, language, milieu
  – Role of the Provider is as partner and nonjudgmental ally in supporting the client to identify most important concerns
  – Relationship of respect builds trust and allows a principal of gradualness to empower the client/patient
  – Example of housing for homeless requiring drug free x 6 months when a large proportion of the homeless struggle with addiction

Pain and Chemical Dependency
Definitions and Key Terms

• Physical Dependence
• Opioid Tolerance
• Pseudo-addiction
• Aberrant Behaviors
  – Chemical coping
  – Drug Seeking Behavior
  – Abuse
  – Addiction
  – Diversion

American Pain Society 2008 www.ampainsociety.org

Pain and the Addiction Continuum

Courtesy of Mary Lynn McPherson, PharmD, MA, BCPS, CPE
Professor and Executive Director,
Advanced Post-Graduate Education in Palliative Care
Physical Dependence

• A state of adaptation indicated by a medication class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, or administration of an antagonist
• Never labeled addiction
• No problem unless there is abstinence from the drug
• An expected result from long term opioid treatment

Opioid Tolerance

• A declining effect of an opioid with continued exposure
• Never labeled as addiction
• Tolerance to side effects of a drug are desirable; tolerance to analgesia can be problematic

(Separate comment about opioid titration)

Pseudoaddiction

• Is an iatrogenic syndrome with behaviors that mimic addiction and are driven by unrelieved pain.
• It is caused by inadequately prescribed analgesics, leading to patient demands for opioid analgesia that the care team may see as excessive.
• With course correction and proper prescribing the drug seeking behavior generally ceases
Aberrant Drug-Related Behavior

• Ranging from mildly problematic (hoarding medications), to nonadherence to illegal diversion

• Any medication-related behaviors that depart from strict adherence to the prescribed therapeutic plan of care

• Always investigate why patients are requesting early refills

Medication Misuse

• The use of a medication (with therapeutic intent) other than as directed or indicated, whether willful or unintentional, and whether it results in harm or not

• Increase medication dose without clinical approval (whether due to dependence, tolerance, desire to achieve greater therapeutic effect, or forgetfulness)

• Staff education reminder

• Case discussion

Abuse

• Defined as the intentional misuse of a medication

  – For nonprescribed effects such as mood alteration

• Drug use outside of socially accepted norms

  – Illicit drugs and aberrant use of prescription drugs

• DMS IV: Psychoactive Substance Abuse

  – A maladaptive pattern of drug use that results in harm or places the individual at risk
Substance Abuse

• Use of a substance in a manner outside of sociocultural conventions; according to this definition, all use of illicit drugs is abuse, as is use of a licit drug in a manner not dictated by convention (i.e., according to a physician’s order).

• A particular challenge is medical marijuana – legal in some states. Not always abuse.

• Case discussion - KF

Addiction

• A primary, chronic, neurobiological disease; influenced by genetic, psychosocial, and environmental factors

• Characterized by one or more of the following:
  – impaired control over the drug use
  – compulsive use
  – continued use despite harm
  – and craving

J Pain Symptom Management 2003;26:655-667

Multiple pain and addiction societies support: APS, ASAM, AAPM

Diversion

• The intentional removal of a medication from legitimate distribution and dispensing channels

• Also involves sharing or purchasing prescription medications between family members and friends or individual theft from family and friends
Our Balancing Act

Appropriate Prescribing

Healthcare professionals often underutilize opioids in pain treatment due to unrealistic concerns about addiction. Indiscriminant prescribing of opioids, or failure to monitor, can lead to serious morbidity and mortality.

Do Palliative Care Clinics Screen for Substance Abuse & Diversion?

• Methods
  – National Survey (ACGME HPM fellowship directors) regarding substance abuse perception, policies, training and screening to 94 accredited palliative medicine fellowship program directors

• Results
  – Usable responses from 38 (40.4%) programs. Policies for screening patients (40.5%) or family members (26.3%), dealing with diversion (27%), and use of a screening tool (32.4%) were reported infrequently.
  – Despite this, one-half of respondents indicated that substance abuse and diversion was an issue for their clinics, with only 25% indicating substance abuse was not an issue.
  – Additionally, the majority of fellows (83%) and about half (47%) of staff received mandatory training for dealing with substance misuse. All programs provided some screening of patients, with 48.7% screening all patients for abuse. Screening of family members was relatively rare, as was routine use of the urine drug screen (1.0%).

At Risk Cancer Patients

- Methods: Retrospective chart review of cancer patients seen at the Palliative Medicine Clinic at the University of Virginia (Sept. 2012)
  - Evaluation of patients using Opioid Risk Tool and urine drug screen results
- Results
  - 43% of patients were defined as medium to high risk by the ORT
  - 40% of patients screened with UDS, 47% with abnormal findings


Universal Risk Management During Opioid Therapy for Pain

<table>
<thead>
<tr>
<th>Principle</th>
<th>Goal</th>
<th>Strategy</th>
<th>Comment</th>
</tr>
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<tbody>
<tr>
<td>Stratify Risk</td>
<td>Clarify the likelihood of future aberrant drug related behaviors</td>
<td>Consider higher risk if: - h/o ETOH/drug abuse - major psychiatric d/o</td>
<td>All patients should undergo risk assessment and stratification</td>
</tr>
<tr>
<td>Structure therapy commensurate with risk</td>
<td>Develop practices to match monitoring with risk</td>
<td>- Prescription monitoring - limited Rx’s (even weekly) - single pharmacy/provider - pill counts, consultations</td>
<td>Clinical judgment dictates decisions to implement</td>
</tr>
<tr>
<td>Assess drug related behaviors over time</td>
<td>Track use to trends with relevant outcomes</td>
<td>Monitor drug related behavior (early refill, multiple Rx’s)</td>
<td>Broad monitoring of outcomes is consistent with integration of pain management into palliative care model</td>
</tr>
<tr>
<td>Respond to aberrant drug related behaviors</td>
<td>Clinic compliance with laws, regulations</td>
<td>Assess for pt. behavior, diagnosis addiction, family issues, criminal intent</td>
<td>Even advanced illness does not free providers from laws and regulations. If diversion occurs, stop Rx’s</td>
</tr>
</tbody>
</table>
Universal 10 step pain mgmt. strategy

1. Make a diagnosis including an appropriate differential
2. Psychological assessment (SW) including risk of addictive disorders
3. Informed consent
4. Treatment agreement (Pain contract)
5. Pre- and post-intervention assessment of pain level and function (short interval f/u)

6. Appropriate trial of opioid therapy +/- adjunctive medication
7. Reassessment of pain score and level of function (short weeks for follow up)
8. Regularly assess the “A’s” of pain medicine
9. Regularly review pain diagnosis and comorbid conditions, including addictive disorders, random drug screening
10. Documentation

The important A’s of pain medicine

• Analgesia
• Activities of Daily Living
• Adverse Events
• Aberrant Drug Related Behaviors
• The Affect of the Patient
Concerning Behaviors

- Vague, non-specific description of pain
- Is the reported pain congruent with patient history and presentation? (know your medicine – review scans, oncology notes, presentations and referrals patterns of the pain)
- Overwhelming interest in a particular analgesic (particularly by family member)
- Resistance to change (referring to the ROA, medication, use of adjuvants) (education)
- Pattern of running out on weekends, evenings, when another doc is on call

Comprehensive Risk Assessment

- Clinical screening tools
- Clinical assessment
  - First clinic visit UDS
  - Hospital versus clinic environment
- Prescription Monitoring Programs
- Opioid Treatment Agreements
- Urine drug screen (UDS)
- Abuse-deterrent medications
Opioid Agreement - Written and Signed

- One prescriber
- One pharmacy
- Patient agrees to safeguard medication
- No replacement of lost or stolen medication
- No illegal substances (we have a 1 strike policy)
- No diversion (selling, sharing)
- Problems in Terminal patients?

Opioid Risk Tool

Screener and Opioid Assessment for Patients with Pain
Prescription Monitoring Programs

- New York State 1918 (Cocaine, Morphine, Heroin)
- Oldest continuous in California began 1939.
- Most record schedule II – IV
- Purpose
  - Law Enforcement
  - Control Division
- 49/50 states have programs (Missouri legislation pending)\(^1\)
- 22/49 states have some requirement for providers to use the system before writing prescriptions for patients.
- Example South Carolina – SCRIPTS
  - South Carolina Reporting and Identification Program
  - Retail and outpatient hospital pharmacies
  - Short lag time 24-48 hours
  - Delegate policy
  - Physician/Pharmacy access and supervision of delegates
  - We use in our clinic visits


Review Article: Opioid Abuse in Chronic Pain – Misconceptions and Mitigation Strategies

<table>
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<tr>
<th>Table 1. Mitigation Strategies against Opioid Diversion and Misuse.</th>
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<tr>
<td>Several mitigation strategies for risk assessment of opioid misuse have been proposed. These include the following:</td>
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**Scoring tools to identify patients with a substance use disorder:** Such tools include the Opioid Risk Tool, the Screener and Opioid Assessment for Patients with Pain (SOAPP), the Principles of Opioid Risk Evaluation (PROBE) test, and the Addiction Severity Index (ASI). Each has its own advantages and disadvantages. The Opioid Risk Tool and the SOAPP are free, while the PROBE and ASI are more comprehensive and expensive. The ASI is also available in a computerized version. The Opioid Risk Tool and the SOAPP have been shown to be effective in identifying patients who are at risk for opioid misuse, but the PROBE and ASI have not been extensively studied.

**Use of data from the Prescription Drug Monitoring Program:** Such data can be used to identify patients who are at risk for opioid misuse. The PDMPs are complex systems that require significant resources to operate. The data from PDMPs can be used to identify patients who are at risk for opioid misuse, but the data can also be used to identify patients who are at risk for adverse events.

**Use of data from the Prescription Drug Monitoring Program:** Such data can be used to identify patients who are at risk for opioid misuse. The PDMPs are complex systems that require significant resources to operate. The data from PDMPs can be used to identify patients who are at risk for adverse events.

Volkow ND and McLellan AT: NEJM 374;13 March 2016 1253-63

Review Article: Opioid Abuse in Chronic Pain – Misconceptions and Mitigation Strategies

Volkow ND and McLellan AT: NEJM 374;13 March 2016 1253-63
If patient has a substance abuse history

• Social Context
• Duration
• Frequency
• Specific Drug Preferences
• Desired Effect of Drug Use

Case Discussions

• Patient KF
  — Metastatic colorectal, increasing pain, frequent calls
• Patient WH
  — h/o substance abuse (crack cocaine), stage IV colorectal CA, depression, and worsening RUQ pain
• Patient LV
  — h/o chronic pancreatitis from ETOH abuse
  — Missing clinics
  — Noncompliant with prescription monitoring
  — Hospitalized with severe abdominal pain

Patient Triage – 3 Groups

• Group I
  — No past or current history of substance abuse disorders
  — Noncontributory family history with respect to substance use disorders
  — Lack major or untreated psychopathology
  — Represents the majority of patients seen in palliative care
Management of Group I

- Apply good principles of pain management
- Use common sense and prudently monitor patient; recognize lower addiction risk
- Remain alert for substance abuse in the home (not the patient necessarily)
- Differentiate physical dependence from addiction
- Don’t mistake pain relief seeking (pseudoaddiction) for drug-seeking

Monitoring Analgesic Therapy

- **Subjective Therapeutic**
  - Pain rating
  - Perceived well-being
  - Decreased associated symptoms (e.g., sadness)
- **Objective Therapeutic**
  - Increased sleep time
  - Ability to walk 50 feet
  - Minimal use of breakthrough analgesic

- **Subjective Toxicity**
  - c/o constipation
  - c/o sleepiness
  - c/o nausea
  - c/o itching
- **Objective Toxicity**
  - BM frequency
  - # hours sleeping/24 hrs
  - # episodes of emesis
  - Excoriation

Signs (left) and symptoms (right) of opioid withdrawal

- Sweating
- Pupillary dilation
- Tachycardia
- Hypertension
- Vomiting, diarrhea
- Yawning
- Fever, chills
- Rhinorrhea
- Lacrimation
- Piloerection
- Restlessness
- Irritability
- Nausea
- Abdominal cramps
- Increased sensitivity to pain
- Myalgia (muscle pain)
- Dysphoria (opposite to euphoria)
- Insomnia, anxiety
- Craving for opioids
The important A’s of pain medicine

• Analgesia
• Activities of Daily Living
• Adverse Events
• Aberrant Drug Related Behaviors
• The Affect of the Patient

Patient Triage – 3 Groups

• Group II
  – May be a past history of treated substance use disorder, or a significant family history of problematic drug use
  – May have a past or concurrent psychiatric disorder
  – Not actively addicted, but are at increased risk
  – May include patients in recovery (opioid maintenance)


Patient Triage – 3 Groups

• Group III
  – Complex cases due to active substance abuse or major, untreated psychopathology
  – Patient are actively addicted and pose significant risk to both themselves and to practitioners

Management of Group II and III

- Frequent clinic visit and multidisciplinary approach
- Write Rx's for 1 week at a time
- Clinical Tools – UDS, PMP
- Communication with Oncology, Cancer Navigators, Social Workers, Counselors
- Family Meetings
- Methadone and Methadone clinics

Table 1. Basic principles for prescribing controlled substances to patients with advanced illness and excess of addiction

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<thead>
<tr>
<th>Principle</th>
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<tbody>
<tr>
<td>Choose an opioid based on around-the-clock dosing</td>
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<tr>
<td>Choose long-acting agents when possible</td>
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<tr>
<td>As much as possible, limit or eliminate the use of short-acting or</td>
</tr>
<tr>
<td>&quot;breakthrough&quot; doses</td>
</tr>
<tr>
<td>Use non-opioid adjuvants when possible and monitor for compliance</td>
</tr>
<tr>
<td>with those medications</td>
</tr>
<tr>
<td>Use nonopioid adjuvants whenever possible (i.e., relaxation techniques,</td>
</tr>
<tr>
<td>distraction, biofeedback, TMD, communication about thoughts and</td>
</tr>
<tr>
<td>feelings of pain)</td>
</tr>
<tr>
<td>If necessary, limit the amount of medication given at any one time (i.e.,</td>
</tr>
<tr>
<td>write prescriptions for a few days' worth or a week's worth of</td>
</tr>
<tr>
<td>medication at a time)</td>
</tr>
<tr>
<td>Utilize pill counts and urine toxicology screens as necessary</td>
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<tr>
<td>If compliance is suspect or poor, refer to an addictions specialist</td>
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</table>
Lean In

• Additionally consider spiritual history, dignity therapy, acknowledgement of the disease and the addiction
• Watching our own internal cues and words and judgments
• Respect
• Compassion

Set Realistic Goals for Therapy

• Contracting with Patients – written AND verbal: trust and respect
• Frequent and short term follow up
  – Palliative versus hospice patients
• Patients should understand that safe and effective prescribing requires cessation of illicit drug use and increased adherence to monitoring
• Comorbid psychiatric disorders including personality disorders, depression, and anxiety should be evaluated and treated
• Additional referral to pain management/mental health
• Discharge for cause (certified letters, policy reminders – 1 strike)

Barriers in our program

• Communication process barriers
Selected References

- Cancer Investigation, 24;425-431, 2006
- Volkow ND and McLellan AT: NEJM 374;13 March 2016 1253-63
- Journal of Opioid Management 8:3 May/June 2012

The End

Though the pressure is real...hang in there!!!!!