Substance Use Disorders in Hospice

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Bio and Disclosures

- University of Kentucky Addiction Medicine Fellow 2021-2022
- CAPC Virtual Office Hours Faculty - “Hospices providing palliative care”
- UK HEALing Communities Study - Bluegrass Care Navigators HEALing Transitions Linkage and Retention Programs Medical Director
- KY Society of Addiction Medicine board member
- Previously employed at Bluegrass Care Navigators

- No financial disclosures nor conflicts of interest

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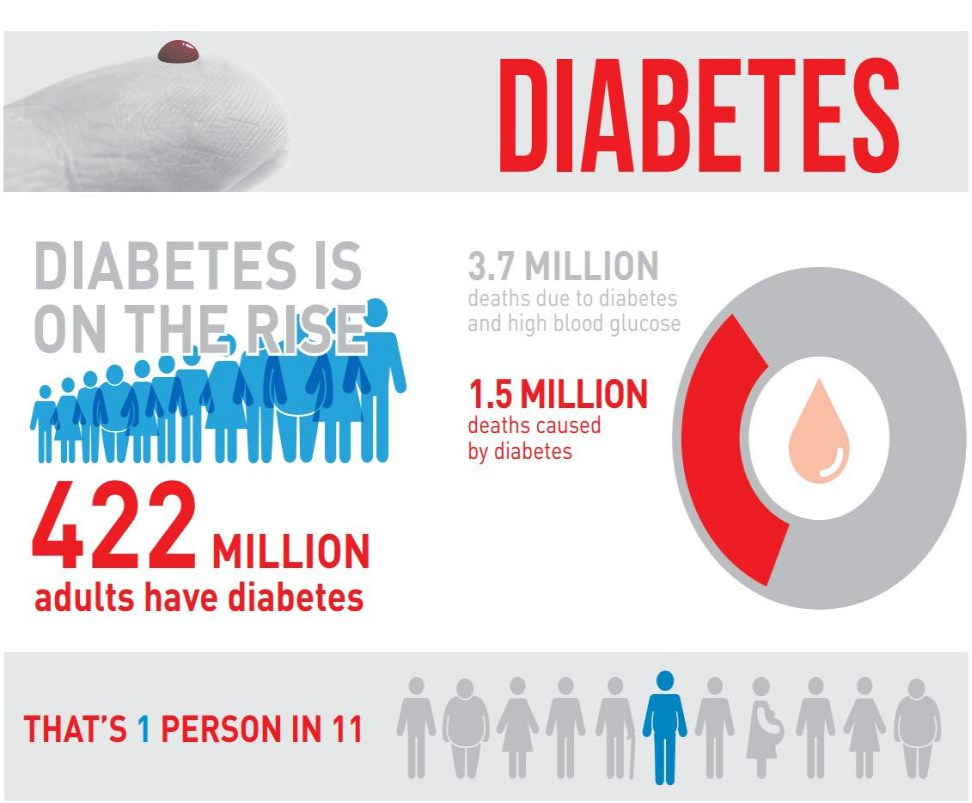
Objectives

1. Recognize the epidemiology of substance use disorders
2. Recall expert consensus recommendations for safe opioid prescribing and monitoring in hospice
3. Identify the six dimensions of an addiction assessment in guiding level of patient care placement
4. Explain the role of harm reduction including overdose education and naloxone access in healthcare during the opioid overdose epidemic

US 2018

- *1 in 10 had diabetes*
- *4 out of 5 were diagnosed*

https://www.diabetes.org/resources/statistics/statistics-about-diabetes



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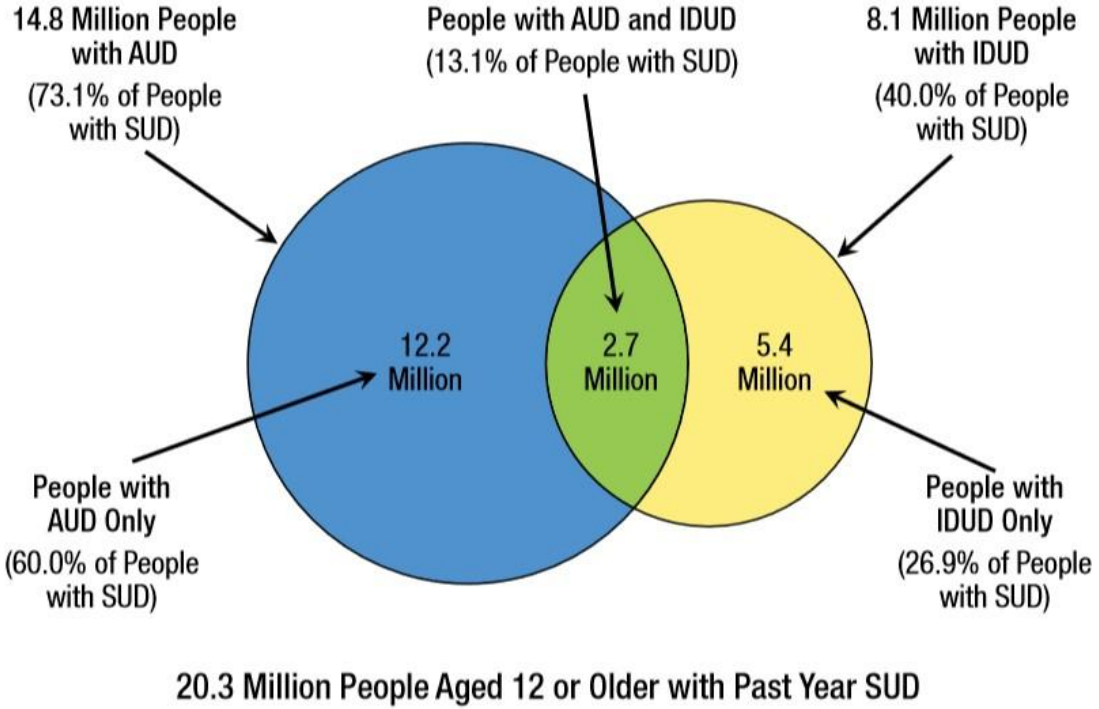
US 2018

- ***1 in 13 people had a substance use disorder***

HHS Publication No. PEP19-5068 2019 U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality www.samhsa.gov

Figure 43. Alcohol Use Disorder (AUD) and Illicit Drug Use Disorder (IDUD) in the Past Year among People Aged 12 or Older with Past Year Substance Use Disorder (SUD): 2018



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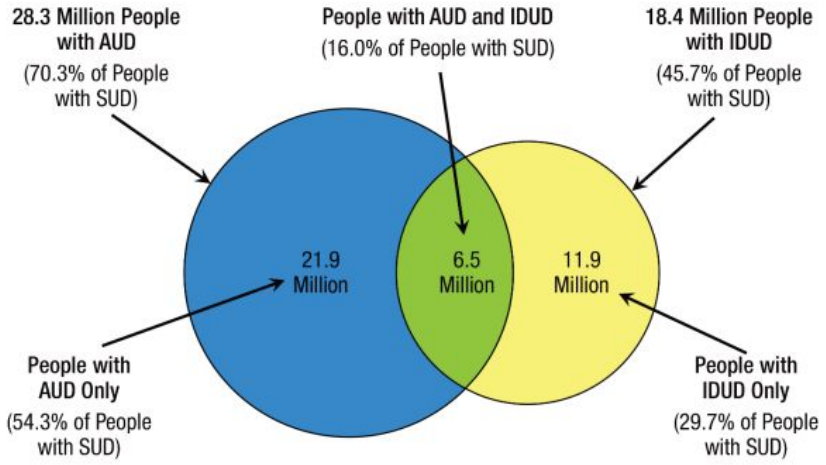
FFR1.28

Alcohol Use Disorder (AUD) and Illicit Drug Use Disorder (IDUD) in the Past Year: Among People Aged 12 or Older with a Past Year Substance Use Disorder (SUD); 2020

US 2020

- ***1 in 7 with SUD***
  - DSM-5
  - Web based survey



40.3 Million People Aged 12 or Older with Past Year SUD

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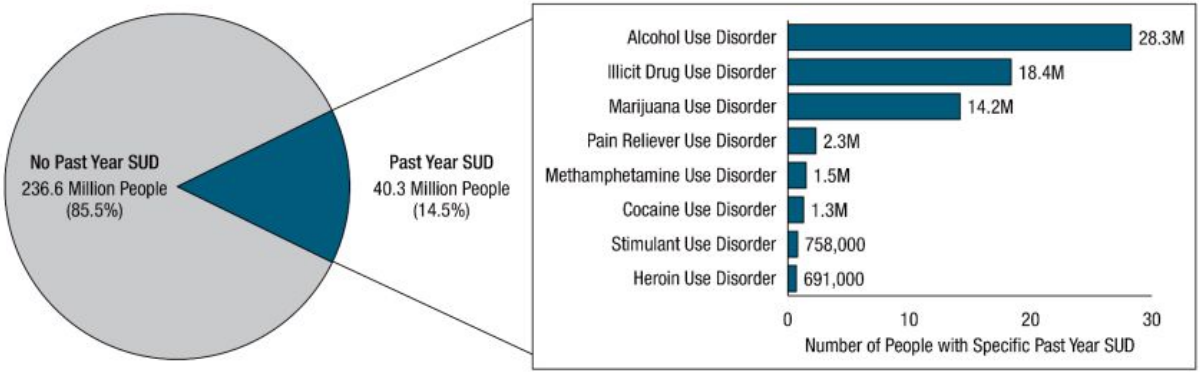
People Aged 12 or Older with a Past Year Substance Use Disorder (SUD); 2020



Note: The estimated numbers of people with substance use disorders are not mutually exclusive because people could have use disorders for more than one substance.

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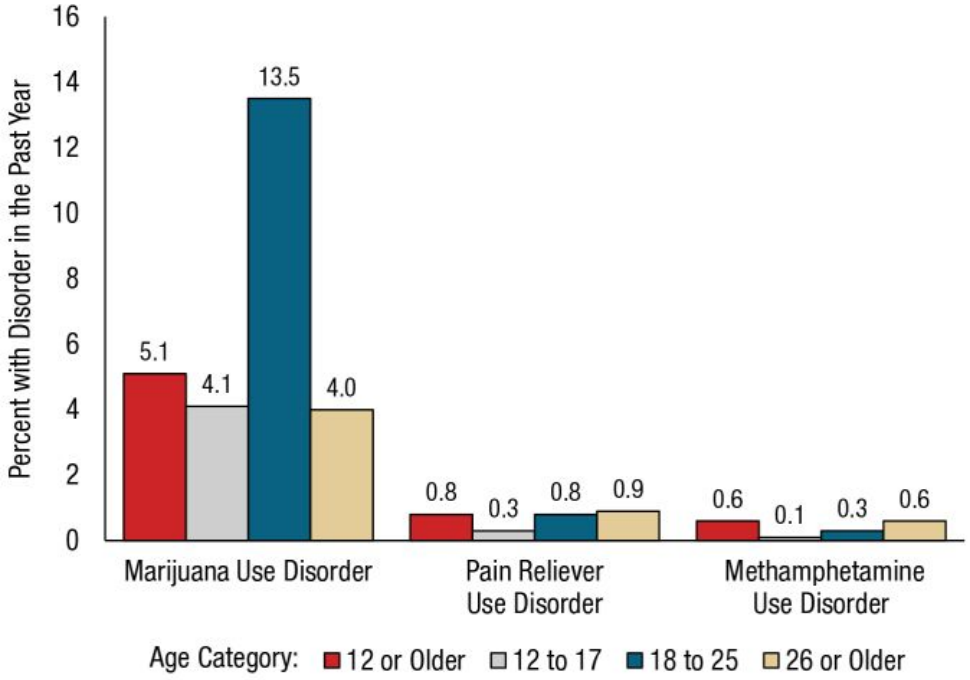
Marijuana Use Disorder, Pain Reliever Use Disorder, and Methamphetamine Use Disorder in the Past Year: Among People Aged 12 or Older; 2020



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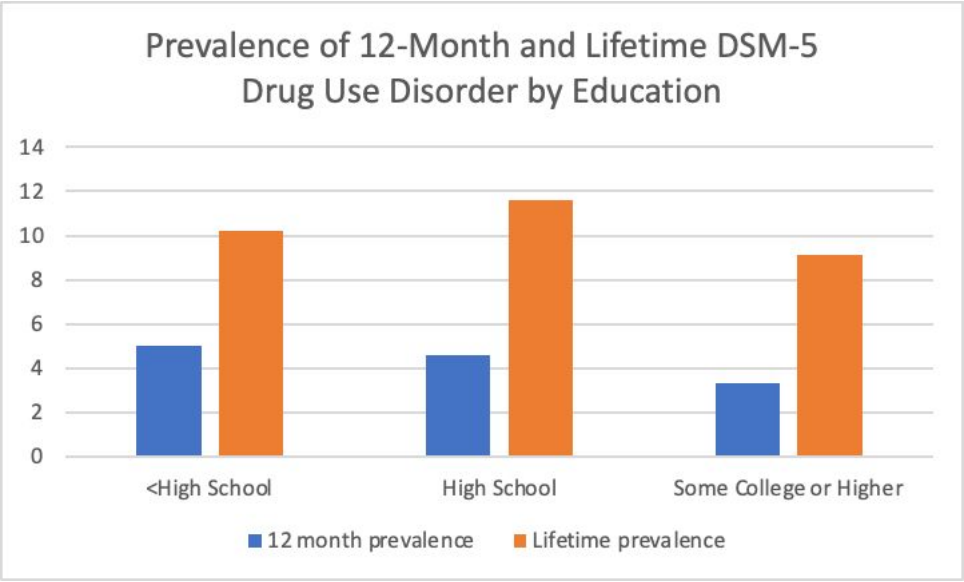
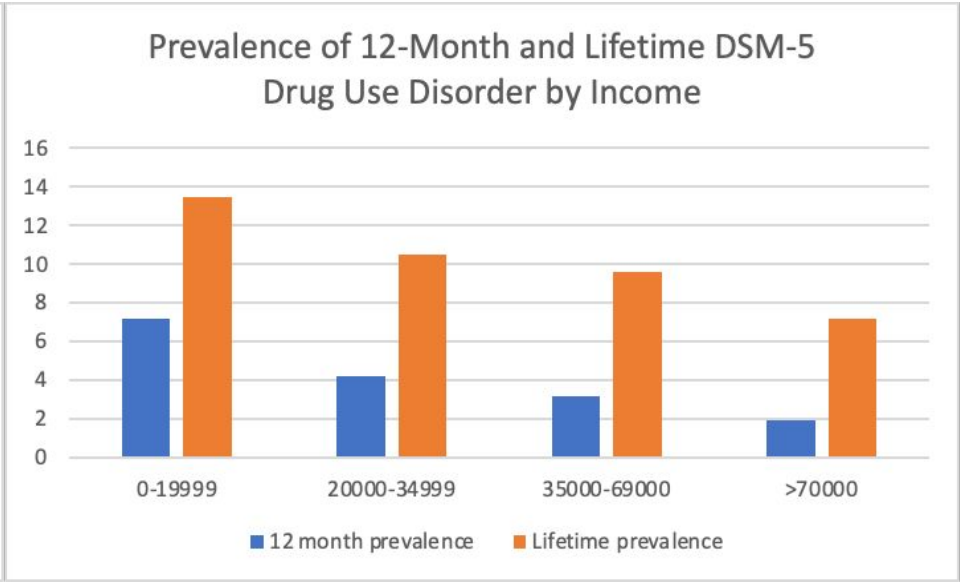
Substance Use Disorder Does Not Discriminate





Grant BF, Saha TD, Ruan WJ, et al. Epidemiology of *DSM-5* Drug Use Disorder: Results From the National Epidemiologic Survey on Alcohol and Related Conditions–III. *JAMA Psychiatry.* 2016;73(1):39–47. doi:10.1001/jamapsychiatry.2015.2132

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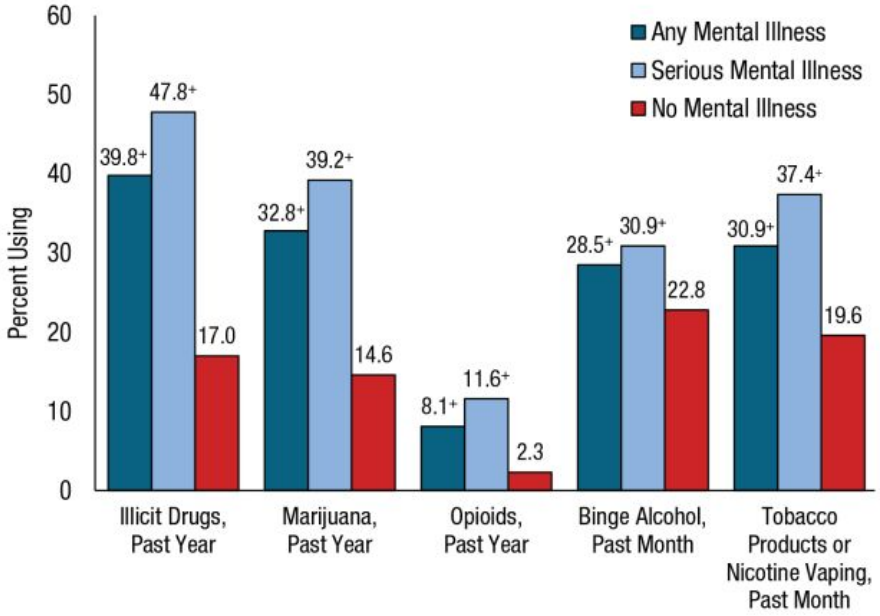
Substance Use: Among Adults Aged 18 or Older; by Mental Illness Status, 2020



* Difference between this estimate and the estimate for adults without mental illness is statistically significant at the .05 level.

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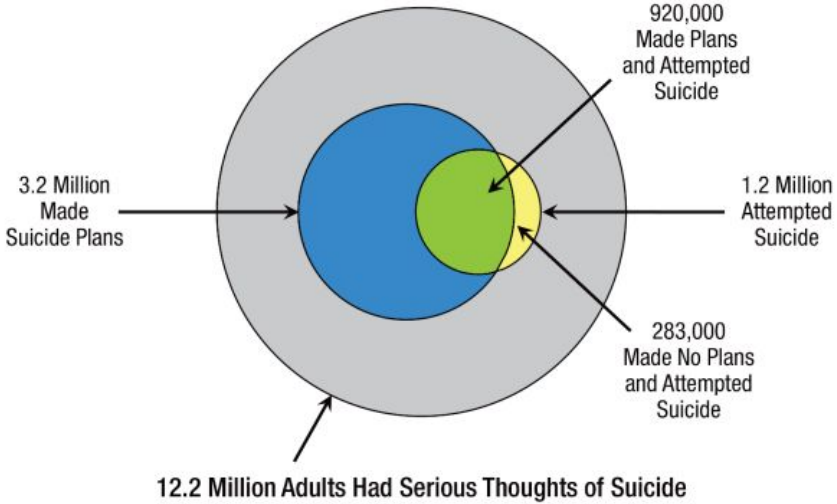
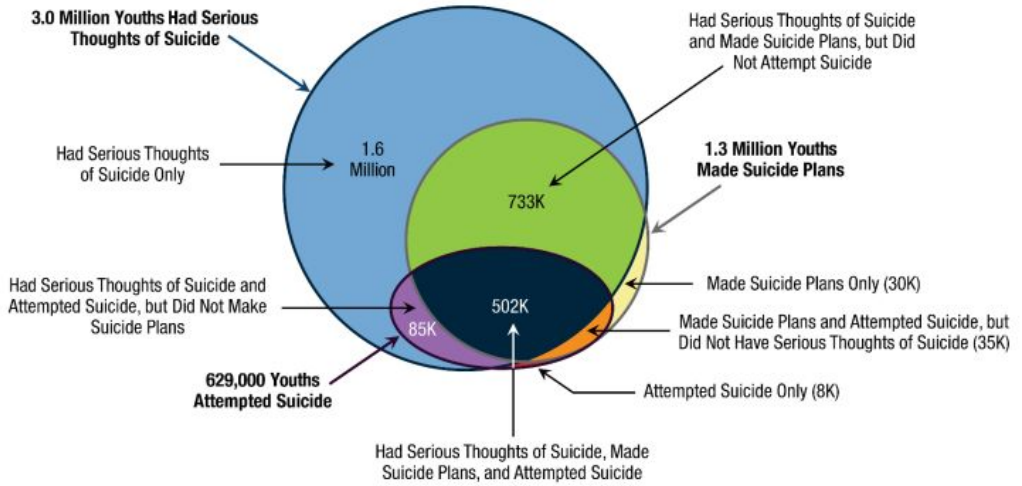
Adults Aged 18 or Older with Serious Thoughts of Suicide, Suicide Plans, or Suicide Attempts in the Past Year; 2020



FFR1.40

Youths Aged 12 to 17 with Serious Thoughts of Suicide, Suicide Plans, or Suicide Attempts in the Past Year; 2020



3.0 Million Youths Aged 12 to 17 Had Serious Thoughts of Suicide, Made Suicide Plans, or Attempted Suicide in the Past Year

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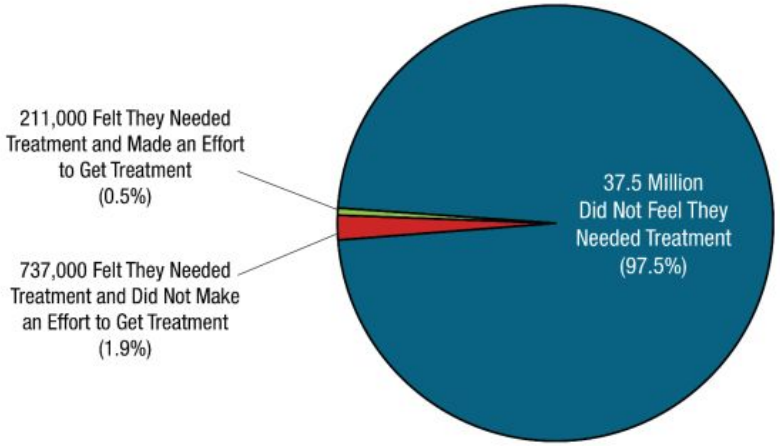
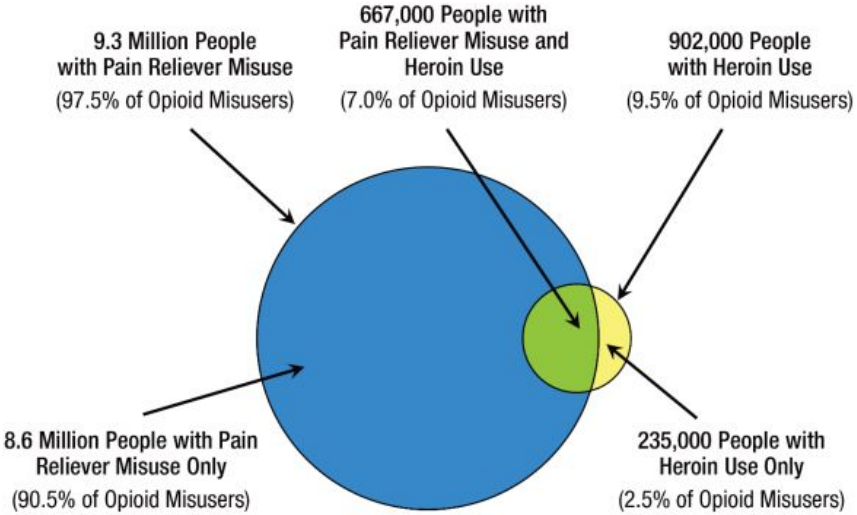
Perceived Need for Substance Use Treatment: Among People Aged 12 or Older with a Past Year Substance Use Disorder (SUD) Who Did Not Receive Substance Use Treatment at a Specialty Facility in the Past Year; 2020



38.4 Million People with an SUD Who Did Not Receive Substance Use Treatment at a Specialty Facility

Note: People who had an SUD were classified as needing substance use treatment.
Note: The percentages do not add to 100 percent due to rounding.

Past Year Opioid Misuse: Among People Aged 12 or Older; 2020



9.5 Million People Aged 12 or Older with Past Year Opioid Misuse

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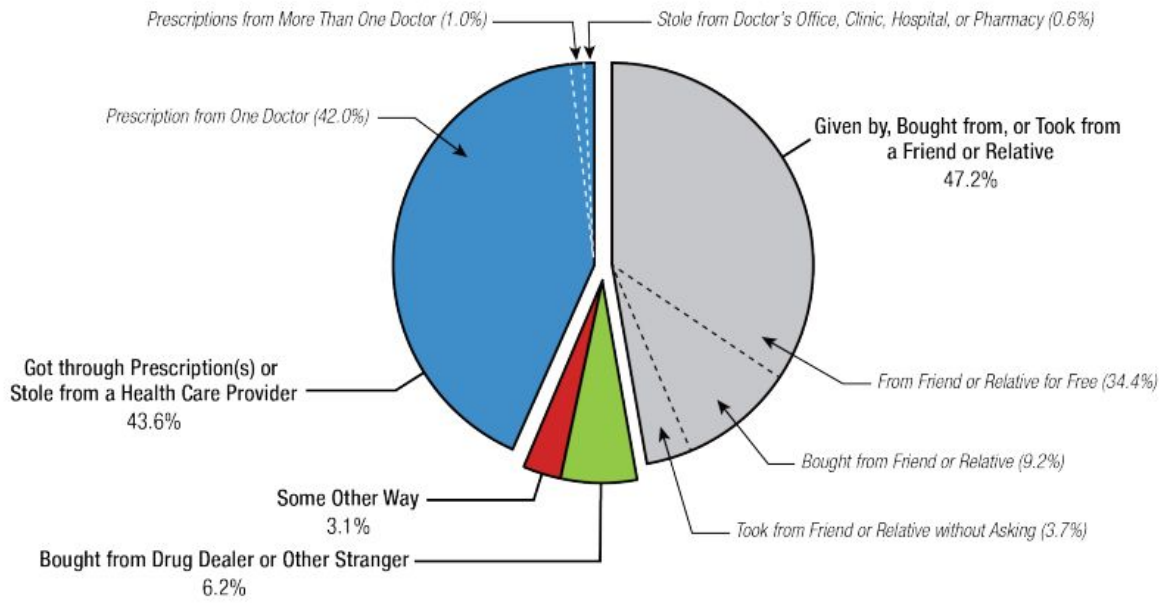
Source Where Pain Relievers Were Obtained for Most Recent Misuse: Among People Aged 12 or Older Who Misused Pain Relievers in the Past Year; 2020



9.3 Million People Aged 12 or Older Who Misused Pain Relievers in the Past Year

Note: Respondents with unknown data for the Source for Most Recent Misuse or who reported Some Other Way but did not specify a valid way were excluded.
Note: The percentages do not add to 100 percent due to rounding.

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Diversion in Hospice

- 600 Medicare-certified hospice agencies, 371 (61.8%) response rate
- Clues
  - Frequent refills, missing meds, uncontrolled sxs, SUD/misuse hx, reluctance to comply with med counts and disposal, intoxication, higher dose requested, family discord, conflicting accounts
- Means of confirmation
  - Pill counts
  - Informed by family/facility staff/police
  - UDS
  - Firsthand witness by staff
  - Observation after transfer to inpatient care
  - Overdose of family member
- Who diverted
  - Informal caregiver/family member > Unidentified > Patient > Family friend > Hired caregiver > facility staff

Ware, Orrin et al. “Confirmed Medication Diversion in Hospice Care: Qualitative Findings From a National Sample of Agencies”. Journal of Pain and Symptom Management 61.4 (2021)789-795

Hospice Agency Responses to Diversion

- Notify prescriber, pharmacy, APS, police
- Increase visit frequencies
- Limit supply
- Restrict access (lockbox)
- Use alternate dose/medication/formulation
- Confront family
- Establish contract
- Increase Monitoring
- Transfer to inpatient setting

Hospice Diversion Risk Mitigation Strategies

Ware, Orrin et al. “Recommendations for Preventing Medication Diversion and Misuse in Hospice Care: A Modified Delphi Study.” Journal of pain and symptom management 62.6 (2021): 1175–1187.

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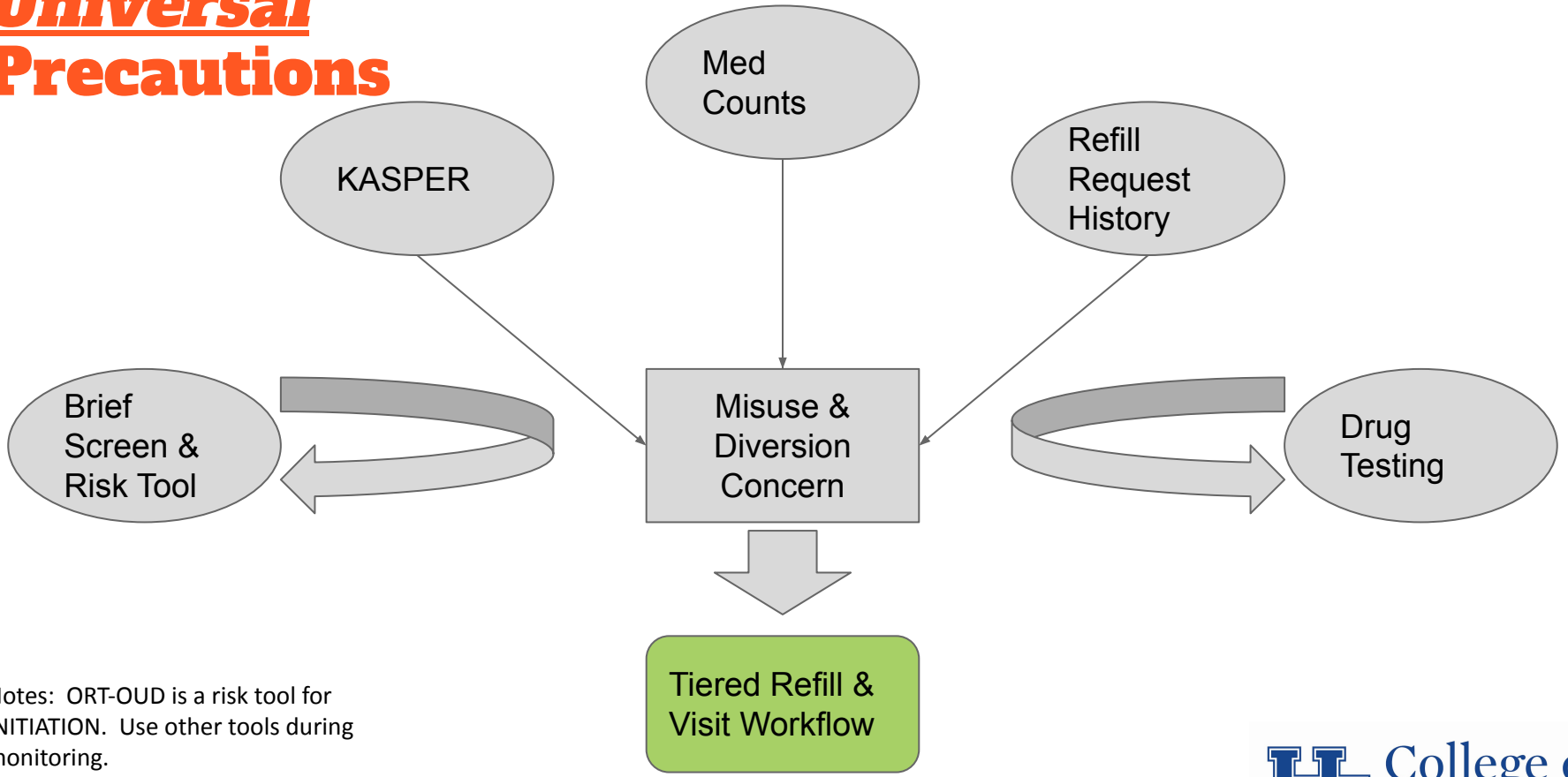
Universal Precautions



Notes: ORT-OUD is a risk tool for INITIATION. Use other tools during monitoring.
No screening tools validated in cancer pain population.

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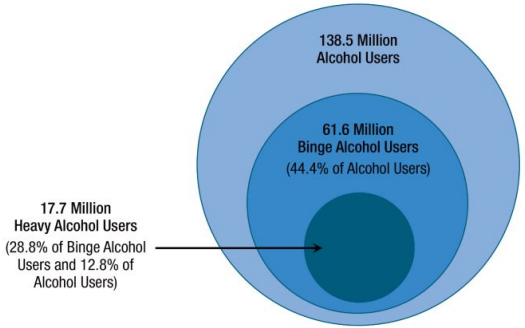
Assessment

- ORT-OUD
  - Low vs high risk of developing OUD with long term opioid prescription
- https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools

Spectrum of Use

Current, Binge, and Heavy Alcohol Use: Among People Aged 12 or Older; 2020



Note: Binge Alcohol Use is defined as drinking five or more drinks (for males) or four or more drinks (for females) on the same occasion on at least 1 day in the past 30 days. Heavy Alcohol Use is defined as binge drinking on the same occasion on 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

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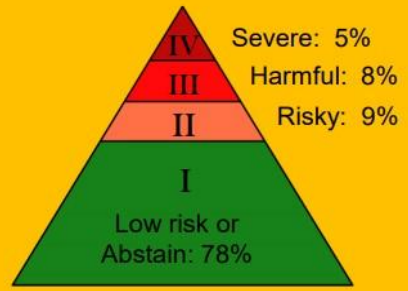
Low-risk drinking limits:

	Drinks per week	Drinks per day
Men	14	4
Women	7	3
All ages >65	7	3
Pregnancy	0	0

Categories of patient drinking:



Readiness ruler:

Not at all 0 1 2 3 4 5 6 7 8 9 10 Very

Conversation Tool: www.sbirtoregon.org

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Unhealthy use vs. Substance Use Disorder

Categories of Symptoms

CATEGORIES OF SUD SYMPTOMS

Symptoms of substance use disorders in the DSM 5 fall into four categories: 1) impaired control; 2) social problems; 3) risky use, and 4) physical dependence.

Impaired Control	Social Problems	Risky Use	Physical Dependence
Using more of a substance or more often than intended Wanting to cut down or stop using but not being able to	Neglecting responsibilities and relationships Giving up activities they used to care about because of their substance use Inability to complete tasks at home, school or work	Using in risky settings Continued use despite known problems	Needing more of the substance to get the same effect (tolerance) Having withdrawal symptoms when a substance isn't used

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Treatment Agreements

- ***USE UNIVERSALLY***
- Think Informed Consent
- Think Expectation Management
- Avoid The Ten Commandments “I SHALL NOT”
- Recommend wording for 4th grade literacy

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When the agreement is broken

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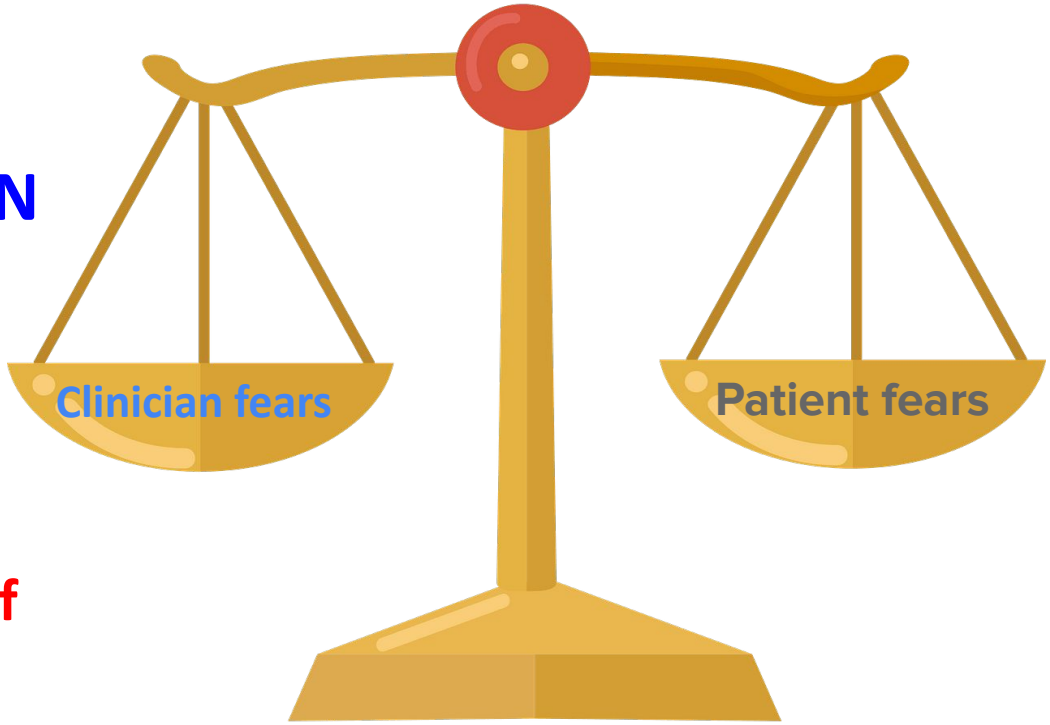
It's a balancing act

RISK MITIGATION

HARM REDUCTION



SAFETY

EFFICACY

Beware of Stigma

Beware of Bias

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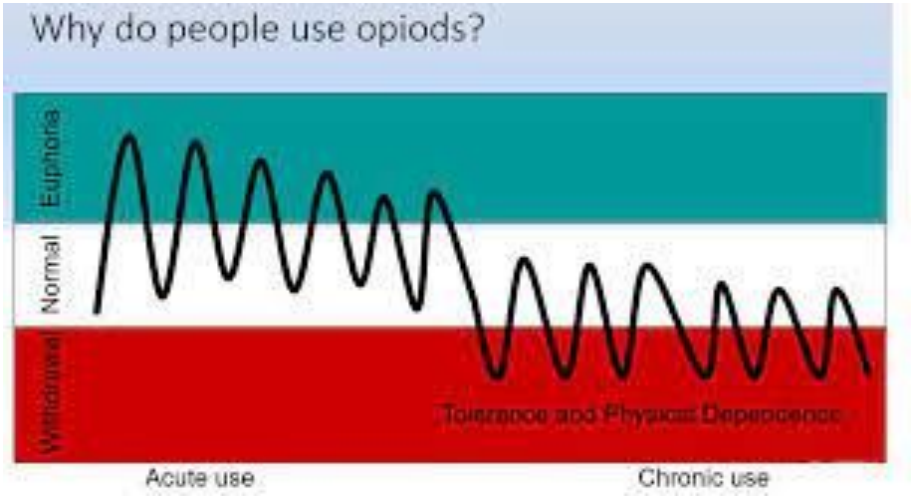
Table 2. Philosophical clashes between the harm reduction and medical models

	Harm reduction model	*Medical model*
Structural philosophy	Inclusive, community decisions, process	Hierarchical chain of command
Institutional legitimacy	New, always becoming, in process; controversial	Established early 20th century; acceptance in mainstream society
Theoretical framework for understanding drug use	Drug, set, setting	Pharmacology/disease model
System design	Low threshold for accessing care	Prescribed procedures for getting care; higher threshold
Provider perspective on approach to care	Actively questioning assumptions, avoiding judgmental stance (fluid)	Expert knowledge (discrete)
Provider role	Provide information, collaborative decision-making	Prescribe treatment; seek "compliance" and "adherence"
User role	Understand options, make choices, small changes, reduce harms	Accept and comply with treatment
Locus of control	User-centered	Physician-centered

Heller D, McCoy K, Cunningham C. An invisible barrier to integrating HIV primary care with harm reduction services: philosophical clashes between the harm reduction and medical models. Public Health Rep. 2004 Jan-Feb;119(1):32-9. doi: 10.1177/003335490411900109. PMID: 15147647; PMCID: PMC1502252.

Continuum of Drug Use

OUD is a chronic illness



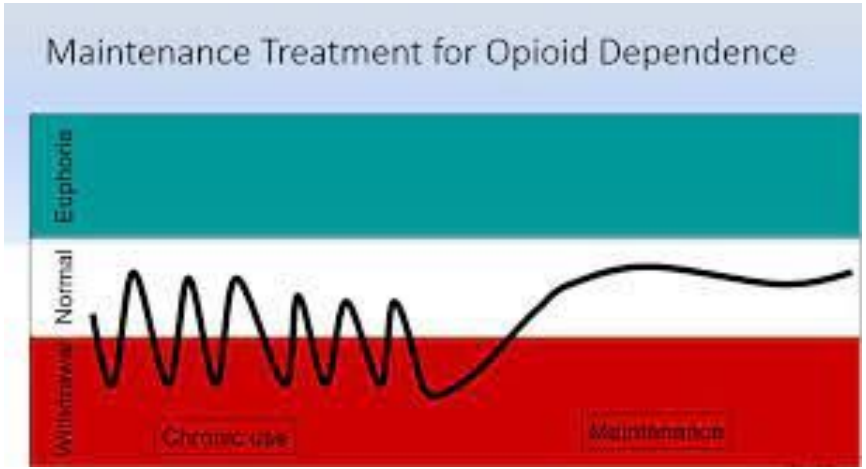


Image: Alex Walley, MD

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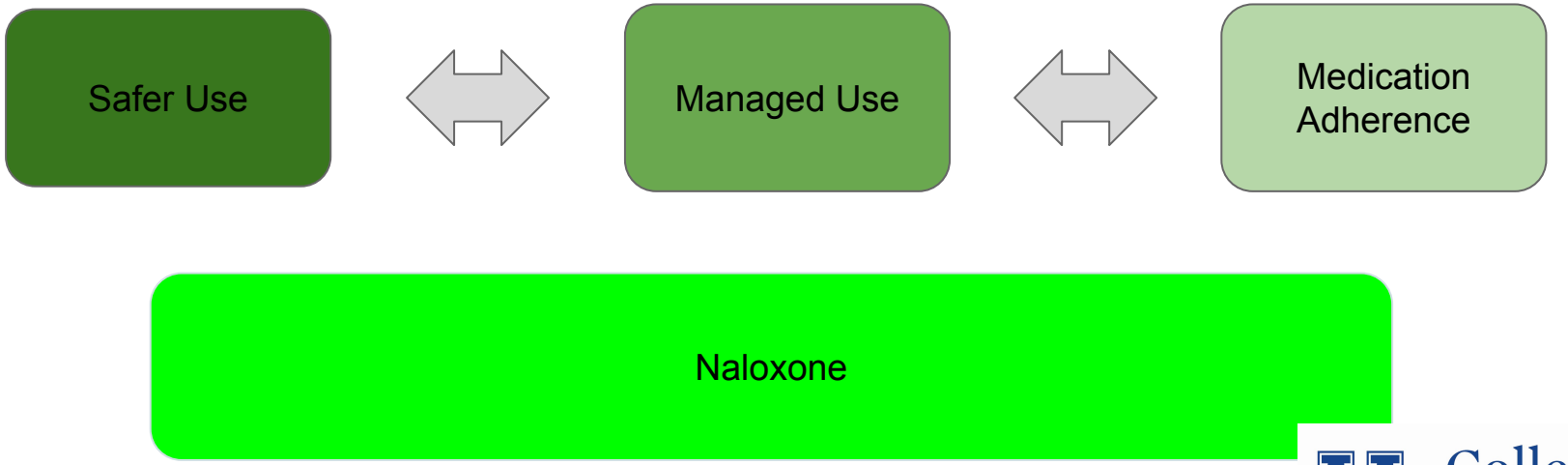
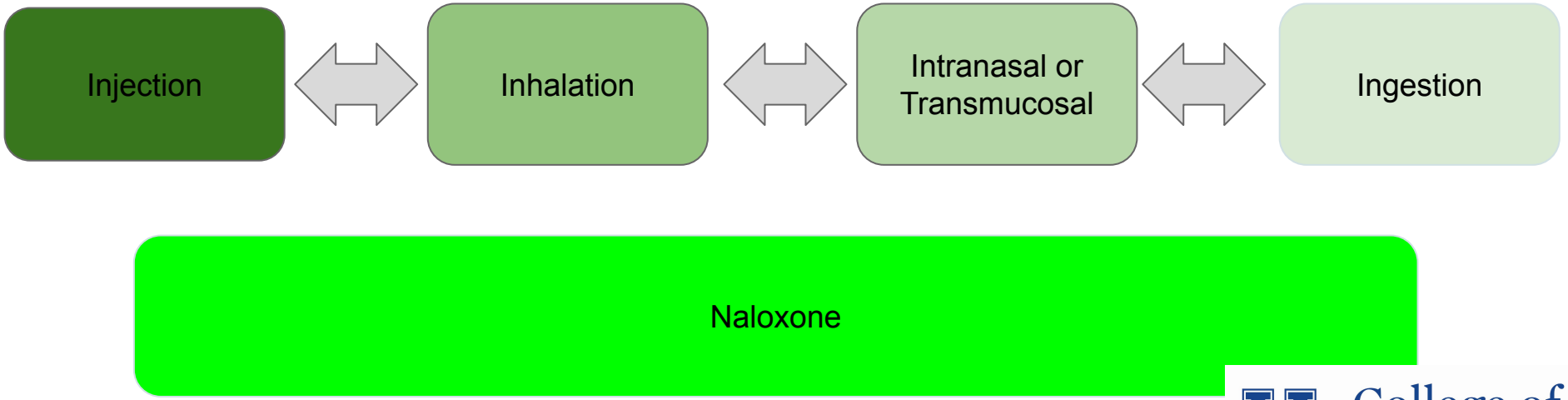
Harm Reduction Goal Setting



Harm Reduction Counseling: Safer Use



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Overdose Education and Naloxone

https://kiprc.uky.edu/programs/overdose-data-action/county-profiles

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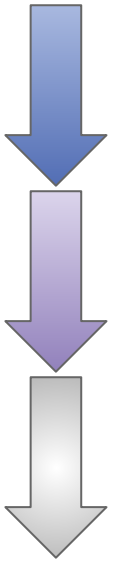
Harm Reduction Practices

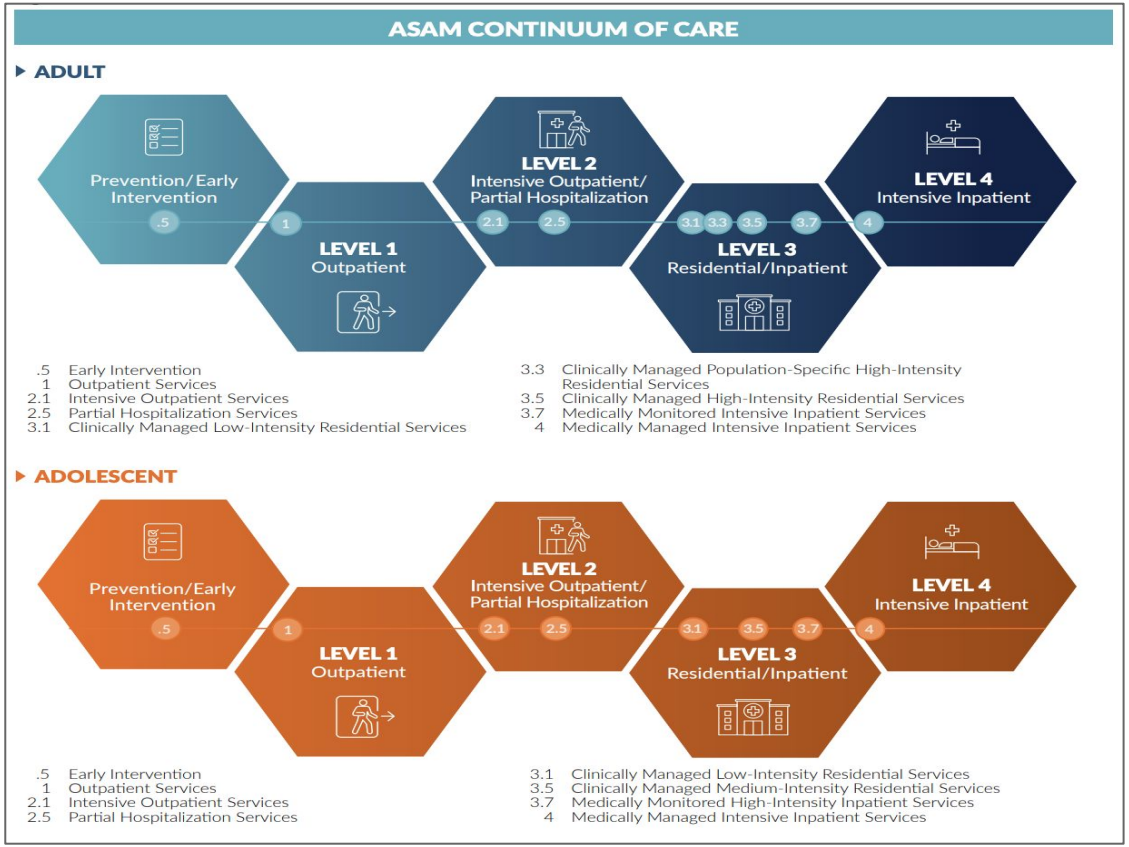
1. Naloxone education and access
2. Discussing use of prescribed medication
3. Discussing substance use (all including alcohol)
4. Assessing substance use (all including alcohol)
5. Discussing safer route of substance use
6. Discussing safer injection practices (from start to finish)
7. Counseling regarding PrEP
8. Fentanyl test strips
9. Safe Syringe Programs
10. Supervised Injection Facilities/Overdose Prevention Sites



Comfort Zone

Buprenorphine treatment

ASAM Levels of Care



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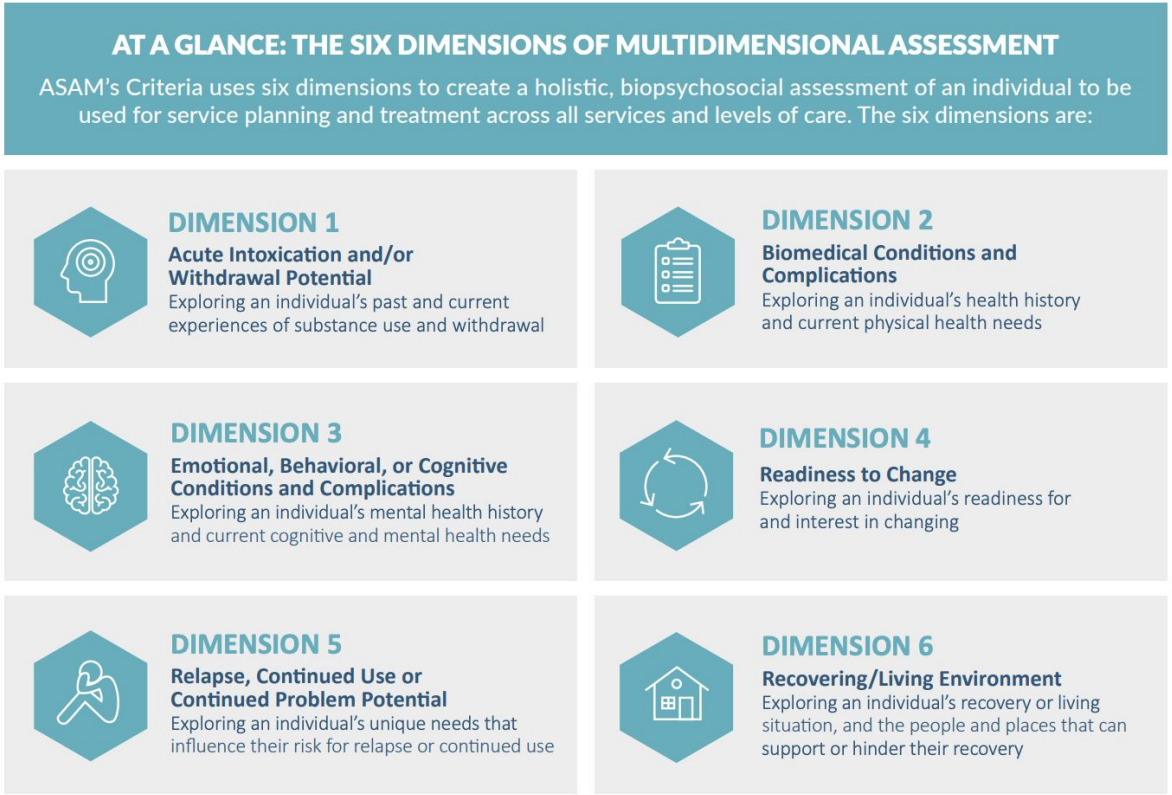
Addiction Perspective



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ASAM PLACEMENT CRITERIA	1. Outpatient	2. Intensive Outpatient	3. Residential/ Inpatient	4. Intensive Inpatient
Withdrawal/ Intoxication	No risk	Minimal	Some risk	Severe risk
Medical	No risk	Manageable	Needs monitoring	24 hr acute medical care required
Emotional/ Behavioral	No risk	Mild severity	Moderate severity	24 hr psychiatric care required
Readiness to Change	Cooperative	Cooperative but requires structure	Resistant, needs 24 hr monitoring	
Relapse Potential	Maintains abstinence	Symptoms for close monitoring	Unable to control use outpatient	
Recovery Environment	Supportive	Less support, but can cope with structure	Danger	

HOSPICE PLACEMENT	Home	Long Term Care	Hospice Unit	Hospital
Symptom Acuity	Managed	Managed	Severe	Severe
Medical	Manageable	24/7 skilled caregiver and LPN available	24 hr skilled RN, pharmacy, provider	24 hr acute medical care required
Emotional/ Behavioral	Manageable	24/7 support staff	Daily IDT	24 hr psychiatric care required
Goals of Care	Concordant	Concordant	Concordant	Discordant
Crisis Potential	Manageable	Closer monitoring	Active crisis	Active crisis
Safety Environment	Supportive	Benefits from structure	Danger	Danger

Takeaways

- Alcohol and substance use is prevalent
- Set expectations and have standard processes, applied universally
- Total adherence or abstinence of drug use is not mandated for services
- Multidimensional assessments are helpful in determining appropriate levels and places of care
- Overdose education and increasing naloxone access is every healthcare worker's opportunity to combat the overdose epidemic

Questions??

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