MAYO CLINIC

SERIOUS ILLNESS & SUBSTANCE USE

PAIN MANAGEMENT 2023 CNE CONFERENCE

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LEARNING OBJECTIVES

Patient with serious illness + substance use

- How an interdisciplinary team provides medical care with a harm reduction approach.
- Assessment/screening
- Symptom management
- Guidelines for monitoring/follow up
- Psychosocial aspects
- Importance of team approach

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A HIGH PERCENTAGE OF PATIENTS WITH SERIOUS ILLNESS WILL NEED PAIN AND SYMPTOM MANAGEMENT THAT REQUIRES CONTROLLED SUBSTANCES.

****ESPECIALLY THE ONCOLOGY POPULATION****

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SUBSTANCE ABUSE AND MISUSE ARE PREVALENT

According to the 2014 National Survey on Drug Use and Health, in a 30-day period in Americans aged 12 years or older:

- 23% reported binge drinking (five or more drinks on one occasion)
- 10% reported using an illicit drug
- 8% reported using marijuana specifically
- 2.4% reported nonmedical use of prescription drugs, and of those, 58% were prescription opioids.

(Quinlan & Cox, 2017)

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SERIOUS ILLNESS & SUBSTANCE USE

- People with cancer have higher rates of substance use disorder, and certain types of substance use (eg, tobacco, alcohol) are risk factors for the development of cancer.
- Approximately 20%of patients with cancer receiving opioids have elevated risk for developing nonmedical opioid use as demonstrated by screening using the CAGE, SOAPP, or similar tools.
- Among patients treated with opioids for cancer pain by a supportive care team, approximately 20% develop behaviors consistent with non-medical opioid use within 8 weeks of follow up.
  - Non-medical opioid use behaviors such as taking more opioids than prescribed or using nonprescribed medications that increase opioid-related risks

(Jones et al., 2022; Dalal & Bruera, 2019; Arthur & Bruera, 2019; Yennurajalingam S, Arthur J, Reddy S, et al., 2021)

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Provider (MD & APP) Approach

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INITIAL ASSESSMENT

- Thorough history including use of tobacco, alcohol, recreational drug use and Rx drug misuse.
- Know the differences: Active SUD vs at-risk behaviors vs recovery vs engaged in a treatment program
- Mental Health: Evaluate/refer to optimize treatment of depression and anxiety
  - common in SUD, pain, and life limiting illness
  - Screening Tools: GAD-7 (anxiety), PHQ-9 (depression)

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INITIAL ASSESSMENT

- Review medication list
  - Concomitant use of sedatives – benzos and muscle relaxants
- Social Situation: Family members/caregivers with current or history of substance use disorder who have access to patient's medications.

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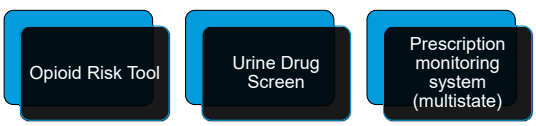
TOOLS TO USE



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OPIOID RISK TOOL – OUD (ORT-OUD)

Mark each box that applies	Yes	No
Family history of substance abuse		
Alcohol	1	0
Illegal drugs	1	0
Rx drugs	1	0
Personal history of substance abuse		
Alcohol	1	0
Illegal drugs	1	0
Rx drugs	1	0
Age between 16-45 years	1	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	1	0
Depression	1	0
Scoring totals		

Cheatle M, Compton P, Dhingra L, Wasser T, O'Brien. Development of the Revised Opioid Risk Tool to Predict Opioid Use Disorder in Patients with Chronic Non-Malignant Pain. *Journal of Pain*. 20 (7): 842-851, 2019.

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A BLURB ABOUT URINE DRUG SCREENS

- Do not make rash decisions with the results
- Fire the controlled substance – not the patient
- Know your toxicologist well – ask questions when you get results back that don't make sense
- Dialysis patients need serum drug screens

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PRESCRIPTION MONITORING SYSTEM

- Reviewing the Prescription Monitoring Program – look for patterns of behavior.
  - Running out of medications early
  - Lost prescriptions/inability to account for medications
  - Early refills
  - How many prescribers
  - How many pharmacies

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HARM REDUCTION APPROACH

- Aim is to keep people stable
  - Reducing frequency and severity of relapse
  - Safety is the goal, not abstinence (unless that is the patient's goal)
- Maximize life functioning, meet their treatment goals
- Frequent visits
  - Provide constancy for patients who's normal is chaotic
  - patients know what to expect

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HARM REDUCTION APPROACH

- Shared/team model of care
  - Coordinated care model is needed with a case manager, addiction specialists, local partnerships, or other care workers to avoid people slipping through the cracks.
  - Burnout prevention
- COMMUNICATION!! – when we are sharing responsibilities, communication is that much more important
- "It takes two" approach

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WE HAVE TO...

- Ensure people feel worthy of help
- See each new patient as a fresh & new identity
- Offer compassionate presence, not pity
- Use intention, safe boundaries, and consider impacts of **both** patient and family/caregiver
- Realize our role is not always to change, but to observe

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Social Work Approach

Social workers play a vital role in helping those battling SUD and those struggling with a mental health disorder

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COMPLETION OF COMPREHENSIVE PSYCHOSOCIAL ASSESSMENT

- Chemical Health History-Personal and Family History
- Mental Health History-Personal and Family History
- Other Psychosocial stressors
- Coping Skills-Maladaptive versus Adaptive, history of
- Financial Stressors
- Support System (Formal and Informal)
- Sleep Assessment

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CONNECTION TO RESOURCES

- Formal Chemical Dependency Evaluation-Rule 25 Assessment
  - Determination of Inpatient or Outpatient Treatment Program
  - AA/NA Supports, Sponsor
  - Mental Health Therapist-Cognitive Behavioral Therapy, Complementary Integrative Therapy, Family Therapy, Support Groups and Lifestyle Changes
  - Address coping with Stress as stress often leads patients to resume maladaptive coping such as chemical use

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RN Approach

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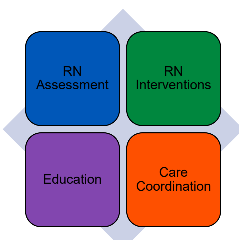
KEY RN DOMAINS



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RN ASSESSMENT

Pain and Symptom Assessment

- Focused assessment of pain and symptoms
- Individualized plan of care

Psychosocial Assessment

- Focused assessment of psychosocial issues including:
  - Caregiver/Family/Social Support
  - Financial barriers
  - Coping/Mental health/Behavioral
  - Spiritual concerns

Safety Assessment

- Medication Management
  - Prescription Monitoring Programs
  - Medication counts
  - Storage & disposal
- Social environment
- Frequent touchpoints
  - In person, virtual, and phone assessment
  - Frequency based on individual need and situation

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RN INTERVENTIONS & EDUCATION

Physiologic	• Interventions and education focused on physical comfort and managing symptoms
Behavioral	• Interventions and education focused on coping and support including therapeutic relationship, building on patient strengths, supporting healing behaviors and mindset.
Safety	• Interventions and education focused on patient and family safety including medication management, home environment
Social Support	• Interventions and education that support caregivers and connects patient with support resources

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RN CARE COORDINATION

Identify personal & informal supports	Internal IDT	Other Medical teams	Specialty referrals	Community supports
• Family • Friends • Religious community clubs, other groups	• Use the specialties already available within your team	• Primary care provider • Primary coordinating teams • Pharmacy	• Psychiatry • Addiction Medicine • PT/OT • Pain Medicine	• County services • Local charities • Community organizations

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Case Studies

CASE #1 JB

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CASE 1: JB

- 51 year old female with metastatic rectal cancer
  - Medical history includes: hepatitis C, polysubstance dependency, generalized anxiety disorder, and bipolar disorder
  - Medical release from drug related prison sentence
  - Multiple missed appointments due to transportation issues
  - Her sister was her only consistent support

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CASE 1: JB

- UDS: methamphetamine in system as she admits to smoking methamphetamine, use of Ritalin, and use of marijuana
  - Addiction/drug counseling offered, patient declines and states "what is the point, I'm going to die".
  - She finds benefit in her drug use in providing energy and minimizes use "it's not a problem".
- As disease worsens, so does pain
- Goal to manage cancer related pain in a safe manner in the setting of ongoing substance use
- **How do we do this?**

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CASE 1: JB – RN ASSESSMENT

- **Pain and Symptom Assessment**
  - Review plan of care with the provider
  - Joint visits with provider with each clinic visit
  - Thorough review of JB's EMR prior to each RN phone call, reviewing plan of care from the prior week provider visit
  - Had to work to adapt to JB's needs and abilities
  - Identified non-pharmacological strategies used or willing to use
  - Ongoing monitoring of medication side effects

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CASE 1: JB – RN ASSESSMENT

- **Psychosocial Assessment**
  - Identifying IDT supports she was willing to work with
  - Identifying her informal supports; sister, couple of close friends, adult children
  - Financial and transportation concerns
  - No reliable internet access for virtual visits or communication via online patient portal
  - Assessed spiritual needs, declined formal support and no religious affiliation

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CASE 1: JB – RN ASSESSMENT

- **Safety Assessment**
  - Verification of medication supply; Oxycodone pill counts, Fentanyl patch counts, Review of MN PMP (prescription monitoring program) to verify when medications were sold by pharmacy and which quantity
  - Open discussion about her illicit drug use and worries regarding contamination of her illicit substances for both methamphetamine and recreational marijuana use
  - Assessing for falls, safety of home environment

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CASE 1: JB – RN INTERVENTIONS & EDUCATION

- **Physiologic**
  - Symptom management
    - Use of her medications to manage her symptoms and mitigate side effects: key medications for symptoms included oxycodone, methadone, Lyrica
    - Identified she was unable to achieve TID dosing schedule
    - She successfully utilized: Ice, heat, OTC topical lidocaine, sits baths, distraction, balancing rest and activity to support symptoms management
    - Ongoing management of constipation and diarrhea
    - Supported goal to be at home versus in the hospital as much as possible

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CASE 1: JB – RN INTERVENTIONS & EDUCATION

- **Behavioral**
  - Helped JB identify personal strengths
  - Supported healing behaviors: support her love of the outdoors, supported travel goals (i.e., Camping on the North Shore)
  - Supported open conversations about medical decision making and end-of-life
  - Socializing: going to Bingo in her community
  - JB worried about being a "burden" - helped support activities that helped her have meaning (i.e., Household chores, outdoor chores)
  - Balancing her medical care and visits with her personal life activities and goals

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CASE 1: JB – RN INTERVENTIONS & EDUCATION

- **Safety**
  - Clinic policies regarding opioid prescribing
  - Storage and disposal
  - Medication schedule and use of pill boxes
- **Social Support**
  - Supported sister, her primary caregiver
  - Supported relationship between adult children and grandchildren

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CASE 1: JB – RN CARE COORDINATION

- **Personal & Informal supports**
  - Sister
  - 2 adult children
  - A couple close friends
- **Internal IDT**
  - Offered Palliative Chaplain referral
  - Palliative social worder input, no formal referral
  - Ongoing RN visiting alternating with provider visits
  - Monthly discussion at Palliative Complex Care Forum
  - Managed between both outpatient palliative care team and inpatient teams

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CASE 1: JB – RN CARE COORDINATION

- **Other Medical teams**
  - Ongoing communication between palliative care and oncology team
  - Close relationship with oncology social worker
  - Local pharmacy and clinic
- **Specialty referrals**
  - Offered Addiction Medicine
  - Pain Medicine referral
  - Infectious Disease referral
  - Offered Psychiatry referral – involved inpatient
- **Community supports**
  - Transportation mileage reimbursement through the county
  - Recommendation for CADI waiver to explore qualification of services
  - In-home hospice care at end-of-life

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Case Studies

CASE #2 MM

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CASE 2: MM

- 41 year old female with colorectal cancer
- Has an ileostomy due to history of cancer related colon perforation
  - Compromised self-image
- History of alcohol abuse, depression
  - Used alcohol to cope in difficult times, depression was untreated as she was no longer connected to psychiatrist, therapist, and had self-discontinued SSRI
- She could not identify one family member or friend that she could trust or whom supported her.
  - Relationships over years were tumultuous

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CASE 2: MM

- Clinically she described poorly controlled pain
- Frequent ER visits/hospitalizations for pain, anxiety, suicidal ideation
- Symptoms improved quickly when in hospital, then deteriorated again within days
- Conflicting focus of care:
  - **Palliative care – improve mental health, substance use treatment first**
  - **Oncology – manage symptoms to keep her out of hospital so that she can get treatment**

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CASE 2: MM – RN ASSESSMENT

- **Pain and Symptom Assessment**
  - Pain scale inadequate tool - had to focus on function, such as ability to be with and play with her child
  - Difficult to differentiate between physical and emotional pain
  - Worked hard to identify non-pharmacologic strategies to manage anxiety and depression
    - Could identify that talking with a trusted friend was helpful
    - Desired to work for distraction and coping, but was unable to do so
    - Overall difficulty identifying non-medication strategies to support mood management

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CASE 2: MM – RN ASSESSMENT

- **Psychosocial Assessment**
  - Identified suicidal ideation and past suicide attempts
  - Ongoing relationship difficulties: separated from spouse, isolated from family and friends
  - Lived with her mother with whom she had a strained relationship

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CASE 2: MM – RN ASSESSMENT

- **Safety Assessment**
  - Assessed for suicide plan
  - Verified with mother to assure MM's physical safety
  - Verification of medication supply, small prescriptions, pill counts

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CASE 2: MM – RN INTERVENTIONS & EDUCATION

- **Physiologic**
  - Symptom management
    - Use of medications to manage symptoms: hydromorphone, lorazepam, pregabalin. Despite many medication changes, physical symptoms did not improve
    - Monitor for side effects
    - Unable to manage PRN medication – very small quantities of controlled substances, sometimes only a few tablets at a time
    - Attempted to help MM understand Total Pain – became apparent most physical symptoms were driven by emotional pain and turmoil
    - Non-pharmacologic interventions: Did participate in Reiki once, overall unwilling to participating in non-pharmacologic strategies, often verbalized only wanting medications for management

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CASE 2: MM – RN INTERVENTIONS & EDUCATION

- **Behavioral**
  - Encouraged her to spend time with her son as this was one thing that brought her joy
  - Encouraged more social activities and finding other meaningful activities, though MM was often paralyzed by her anxiety and depression
  - Struggled with body image and feelings of self-worth – this caused difficulty in initiation of medications that would potentially cause weight gain
  - Encouraged her to seek local therapy resources to deal with emotional pain

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CASE 2: MM – RN INTERVENTIONS & EDUCATION

- **Safety**
  - Frequent touch points
  - Assured physical safety at home
  - Clinic policies regarding opioid prescribing
  - Storage and disposal
  - Medication schedule and use of pill boxes
- **Social Support**
  - Did agree to allow nursing to contact her mother for follow up calls, though had a strained relationship
  - Separated from spouse
  - Had one close friend and good relationships with co-workers

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CASE 2: MM – CARE COORDINATION

- **Personal & Informal supports**
  - Mother
  - Close friend and a few coworkers
  - Struggled with isolating self from others
- **Internal IDT**
  - Palliative Social worker
  - Offered Chaplain support, RN support for non-pharmacologic therapies
  - Monthly discussion complex care forum
  - Continual communication between inpatient and outpatient palliative care teams

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CASE 2: MM – CARE COORDINATION

- **Other Medical teams**
  - Ongoing communication with oncology team
- **Specialty referrals**
  - Offered Addiction Medicine
  - Psychiatry
  - Pain Medicine
  - Integrative Medicine
- **Community supports**
  - Encouraged connection with local therapist, resources provided
  - Referral to local DBT program

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Case Review

Successes & Barriers

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SUCCESSES

JB

- Improved symptom management, especially pain in the setting of substance abuse
- Kept the patient safe with harm reduction strategies
- Established trusting relationship with patient, family, and collaborating teams
- Open, honest communication
- Met patient's goals of family time, traveling, and gardening
- Prevented patient from being lost to follow up
- Seamless transition to hospice

MM

- Trust was established with our inpatient hospital team
- Patient felt safe in hospital
- Successful referral to psychiatry
- SW connected patient to dialectical behavioral therapy program
- Prevented patient from being lost to follow up
- Successful harm reduction strategies in medication management

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BARRIERS

Team

- Bias
- Lack of education on SUD management
- Lack of access to needed resources
- Amount of time required in care
- Disagreement in management amongst providers

JB

- Initial lack of trust with medical teams
- Low health literacy
- Financial
- Transportation
- Unreliable internet access and mobile phone service

MM

- Unable to achieve any improvement in symptom management
- Unable to assist with improvement of social situation or supports
- Unwillingness to engage with offered interventions and recommendations
- Unable to develop a meaningful, trusting relationship with the outpatient palliative team

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IMPORTANCE OF TEAM APPROACH!

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DEALING WITH YOUR OWN MORAL DISTRESS

- Mayo Employee Assistance Program: http://intranet.mayo.edu/charlie/employee-assistance-rst/
- Mayo Employee Well-being Resources: https://intranet.mayo.edu/charlie/well-being/resources-for-you/
- Mayo Nurse Mentorship Program: https://mynursing.mayo.edu/education-text/ro-mentorship-program/
- Mayo H.E.L.P. Program (Healing Emotional Lives of Peers): http://intranet.mayo.edu/charlie/help-program/
- Free mental health apps: http://intranet.mayo.edu/charlie/section-social-work-rst/files/2021/02/Mental-Health-Apps.pdf
- DAHLC virtual wellness coaching: http://intranet.mayo.edu/charlie/healthy-living-program-rst/wellness-coaching-support/
- Debrief difficult situations with your colleagues either formally or informally.
- Leave your judgement at the door for your colleagues and yourself.
- If you are advocating for your patient based on their goals, values, and preferences, you are doing it right!
- Practice self-compassion: https://greatergood.berkeley.edu/article/item/try_selfcompassion/
- Engage with the people and activities you enjoy outside of work.
- Things to remember:
  - Some things cannot be fixed.
  - People are allowed to make bad choices.
  - Often, decisions are not "right" or "wrong".

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QUESTIONS & ANSWERS

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