Chronic Pain in the Hospice Patient
Challenges of managing “unrelated” pain syndromes in the hospice patient
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Challenges/Objectives
• Regulatory
  – “Relatedness”
  – Safe Opioid prescribing
• Clinical
  – Relational
  – Progression of disease v. Misuse
  – Managing patient decline
• Interdisciplinary team management
  – Hospice Team
  – Organizational policy
  – Pain specialists

Case # 1: Chronic back pain and HCC
• 54 yo who has cirrhosis and now HCC
  – Not a transplant candidate, no mets
  – No ascites
  – Prognosis told to be a couple of months per referring doctor
• 20 year h/o chronic low back pain
  – h/o construction work
  – Seen in pain clinic
  – * On oxycontin
  – h/o substance use
• Is it related
Challenges: Relatedness in Hospice

• Chronic Low Back pain: ICD 10 code M54.56-59
• Relatedness: per NHPCO relatedness determination
  – Does the condition contribute to the prognosis
  – Is the CONDITION or SYMPTOM caused or exacerbated by the principal diagnosis or
  – Is the CONDITION or SYMPTOM caused or exacerbated by treatment of the Terminal or related diagnoses?
• Does/can it become related?
• Anxiety

Safe Opioid Prescribing

• NC STOP Act:
  – Checking the data base
  – Limited amount of medications in newly prescribed opioids
  – Naloxone
  – (Suggests Treatment agreements)
• Mostly does not apply to hospice/palliative Care patients
  – This provision does not apply to prescriptions issued by practitioners ordering targeted controlled substances to be wholly administered in a hospital, nursing home, hospice facility, or residential care facility.
• If pain is not related, do you follow requirements for STOP? Do you prescribe? Preauthorization.

End of the Story

• Patient changed quickly (late referral)
• Provider asked for opioid prescription, and was concerned due to previous use/abuse/drug seeking behavior and balked: bias
• Prescription did not arrive in time and patient died without pain medications. (main symptom dyspnea/agitation)
Case #2: Chronic back pain and lung cancer

- 67 yo female who has scoliosis, newly diagnosed Non small cell lung cancer. Admitted to inpatient hospice from ER for management of severe pain (patient no longer wanted treatment for cancer).
- Non small cell diagnosed 6 months previously
  - Pleural effusion/ brain met
  - Negative for bony mets
- Followed by pain clinic for many years.
  - Pain syndrome due to severe scoliosis: low back to lower extremities: consistent for years.
  - On Oxycontin
  - Failed opioid contracts twice

Clinical Challenges: Relational

- Two pains: pleural effusion/low back
  - We did not relate the chronic back pain to cancer upon admission
  - Pain in side easily controlled with dexamethasone, Tylenol and prn oxycodone
- Previous history
  - Placed on contract about a year before: diversion in the home
  - Daughter reports that they had a family member living with them who was culprit
- Trust: new relationship
  - Different dynamics/family unit
  - Other opioids will be used as disease progresses
  - Getting on the “same page”: Treatment agreement

Clinical Challenges: progression v. misuse

- Monitoring the prescription
  - Transition home: CM to count opioids
  - 2 week supply
  - Discuss in IDT
- Progression v. Misuse
  - Pill count discrepancy
  - Balance clinical assessment and monitoring
  - Bias: a spectrum of benevolence
- Treating the pain
  - Challenging, teasing out old behaviors
  - Anxiety: patients can take a lot of prn doses, self medication
Challenges: Managing decline

- Clinical assessment of decline
  - ? Worsening pain: the language that the patient uses
  - Other symptoms: dyspnea
  - Functional decline, nutritional decline
- Switching opioids
  - Must take into account ALL opioids used
  - Was there really a contraindication to Morphine
- The emergency kits
  - The prn opioid dose should take into account patient’s chronic dose of opioids

End of the story

- Functionally, nutritionally declined
- actually went to IPU for respite and meds re-dosed/arranged, new contract in place because she had been using oxycodone q 2 hours
- Died one week later: had dyspnea, worsening left flank pain (no complaints of her low back for awhile)

Case # 3: chronic pain in patient with IPF

- 61 yo with end stage Interstitial lung disease, O2 4 liters
- Admitted to hospice for management of dyspnea, no further treatment options, and likely prognosis of less than 6 months.
- Limited family support, home support
- Chronic pain: shoulder back, pain clinic in the past, multiple doctors, slow gradual progression of medications
  - Tylenol #3
  - Percocet
  - Oxycodone/Oxycontin upon admission to hospice
Case #3 continued

• Patient needed more meds for increasing pain
  – Diffuse, overall felt worse
  – 2 months into hospice added Oxycontin
• Dyspnea worsened: added morphine
  – Per nurses “drinking her roxanol”, she was so short of breath.
• Admitted to the IPU for management of worsening dyspnea
  – She walked in with suitcase
  – Looked great using only two doses of oxycodone daily
  – Maybe two doses of roxanol for dyspnea during 4 day stay
• Discharged back to home with an opioid treatment agreement
  – She agreed to a plan for use, and parameters

Case #3 continued

• Fired multiple nurses: not addressing her complaints and also not getting her medications ordered in a timely fashion
• Re evaluated the agreement: various MD providers
• Identified a single caregiver
• 6 months into hospice stay, she was found with AMS in her front yard, and brought to IPU for further care
  – She had been drinking (1/2 gallon wild Turkey)
  – She had been using opioids, though she had less

Aberrant Drug use in Hospice

• No real data on prevalence of Substance Use Disorders in Hospice (we presume that it is that of the general population).
• No data on Diversion
• Recent paper: HPM fellows regularly see patients at risk for opioid abuse and do not feel competent in treating these patients.
• In a survey of hospices in VA in 2013, most did not have mandatory training and policies on misuse and theft of drugs.
• Clinical pearls:
  – The spectrum of benevolence
  – Why is a non cancer patient on oxycotin/oxycodone
How do you monitor opioid use in hospice?

- The concept of Universal precautions
  - Opioid Risk
  - Opioid treatment agreements
- When diversion/abuse is suspected
  - Behavioral contracts
- Drug screens
- Consulting with pain service/clinics
  - If unrelated: can continue with pain service
  - If related, how would you partner with a pain clinic?
- Referral for substance abuse

So how do you monitor opioid use in hospice?

- Assumes anyone is at risk
  - Do the same thing for all patients coming into hospice
  - Even if the patient has unrelated pain, opioids WILL be prescribed at some point by the hospice organization: E kits
- Opioid Treatment agreement: Two purposes
  - outlines responsibilities of providers and patient/families
  - Provides written education about opioids
- Opioid Risk Tool
  - Validated tool to assess risk of abuse: newly prescribed
  - Use as a guide for evaluation
  - Who/When to discuss in IDT

Example of an opioid treatment agreement

- Patient Name: ______________________
- Date: ____________
  - Opioid (name of medication) treatment for pain or shortness of breath can reduce your symptoms and improve what you are able to do each day. Along with opioid treatment, other medical care is important to help improve your ability to do daily activities. This may include exercise, use of non-opioid medications such as Tylenol, Motrin, steroids and others, psychological counseling or other therapies or treatments.

- Patient Agreement

  - I, ______________________, understand and voluntarily agree that (initial each statement after reviewing):
    - I will take ALL medications only at the dose and frequency prescribed.
    - I will not increase or change medications without the approval of Duke Hospice team.
    - I will not request opioids or any other pain medicine from providers other than Duke Hospice providers.
    - I will inform my Duke Hospice Case Manager of all other medications that I am taking.
    - I will protect my prescriptions and medications. I will keep all medications from children. I will not share or sell my prescriptions/medications.
    - I agree to social work support/evaluation, if necessary.
    - I agree to hospice team visits as appropriate and needed to evaluate my symptoms and use of medications at least weekly.
    - I understand that I will consent to random drug screening, if deemed necessary by the hospice team. This test will determine if I am taking my opioids appropriately.
    - I acknowledge that my RN case manager will count pills at every visit.

- Patient Signature
- Date
- Physician Signature
- Date
Opioid Risk Tool:

- This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management.
- 3 or lower indicates low risk for future opioid abuse,
- 4 to 7 indicates moderate risk for opioid abuse, and a score of
- 8 or higher indicates a high risk for opioid abuse.

When diversion/abuse is suspected

- Here is our protocol: based on Virginia REMS tool for hospice
- Immediate IDT: at least, Medical Director, CM, SW and nursing leadership
  - Be sure to notify family of concerns
- Discuss situation
  - Is more information needed?
- Develop a plan
  - Get more data
  - Possibly a family meeting
  - Likely a behavioral contract
- Re-evaluate: regroup IDT or discuss in large IDT
  - Next steps: At what point do you discharge? Get into substance abuse counseling, or stop prescribing opioids

Drug screens

- Are expensive
- Useful:
- If used, thoughtful and judicious use of this test
Consider clinical partners

- Pain Specialists/clinic to help manage medications in unrelated pain
- Pain Specialists to help with complex pain management: blocks/injections/neuraxial pain techniques
- Would patient #3 benefit from pain clinic co management
  - A bit more history: opioid prescriptions were very controlled prior to hospice
  - She did doctor shop a bit
  - She had real pain (MVA with severe shoulder damage)
- Substance abuse specialist partners
  - Usually more though about this in Palliative Care
  - Have managed pain with suboxone

Opioid Management v. Pain Management

- Opioid Management
  - Know the medications
- Pain Management
  - Know the patient

And then there is Anxiety

- Vicious cycle
- Self Medicating
- Benzodiazepines and opioids
• Discharged from hospice due to prolonged prognosis
  – Seen by her pulmonologist who confirmed this.
• Got her back into her primary care doctor: very supportive
  – We agreed that we would get her into outpatient Palliative Care
• One ED admission for chest pain
• Readmitted to a different hospice
  – Admitted on 8/29
  – Found dead in her apartment by a family member
  – 14/30mls of her Roxanol was gone out of the 30 ml bottle she had received two days before
  – Referred to ME.

The End of the Story