

Organizational Response to an Ethical Dilemma:

Drug Diversion

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Learning Objectives

- Gain awareness of the growing problem of prescription drug abuse in the United States
- Discuss the difficulty in balancing opioid available with avoidance of potential for diversion and abuse
- Organize a strategy to address the needs of staff, families and patients

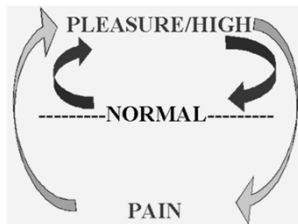


Stephen King

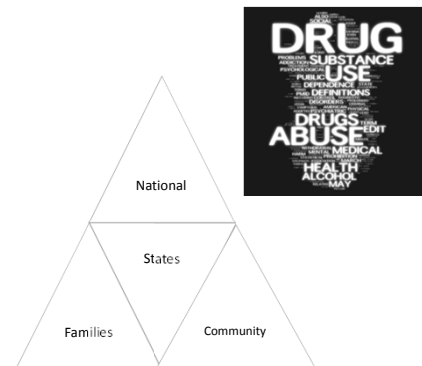
(after started on opioids for an accident)

"The pain was terrible, but the pills made the pain better. They helped the physical pain, but they also cheered you up the way that addictive drugs do. So by, I would say, two years down the road, post-accident, I was a total junkie again. I was using probably somewhere between 280 and 400 milligrams of Oxy a day, and my leg hurt as bad as it ever did, **because your brain basically wants that dope and refers the pain or creates the pain so that you'll continue to get it.**"

Whatever you think of his writing, or his problems with smoking and alcohol, that statement is true. Ask any patient that was able to get off chronic opiates that started with an acute injury. They will tell you that once they are off the drug, they realize the pain was not even there at the end and they had no idea when they went from real pain to opiate-induced "pain" but they do know that it would just take one pill to start that cycle all over again.



http://cope-yp.blogspot.com/2011_04_01_archive.html



National Impact



Prescription drug abuse is the **fastest growing** drug problem in the United States

Drug poisoning deaths surpassed traffic-related crashes as the leading cause of injury **death** in the United States as of 2009

It is estimated that in 2006, non medical use of prescription pain medications imposed a **cost** of about 53.4 billion dollars

National Impact

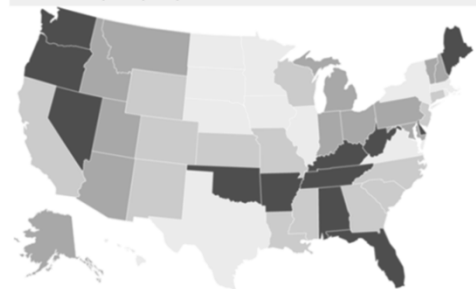


- CDC Grand Rounds: Prescription Drug Overdoses- a US Epidemic (Jan 2012)
- CDC Vital Signs- Prescription Painkiller Overdoses- A growing epidemic especially among women (July 2013)
- Prescription Drug Abuse: Strategies to stop the epidemic (October 2013)
- NIDA- The Science of Addiction

Improve oversight of Part D

- It sent insurers a list of pharmacies whose statistics place them at high risk of fraud and intends to do the same for questionable prescribers.
- It made 31 referrals to law enforcement from July to November based on its own data analysis and initiated 82 new investigations. That's more than the 19 referrals made in the full year between April 2010 and March 2011, according to a January 2013 report [9] from the inspector general of the U.S. Department of Health and Human Services.
- It is considering whether to require that all physicians who prescribe under Part D also be enrolled in Medicare. Currently, any licensed doctor can have their prescriptions filled by the program, even if they aren't a certified Medicare provider. Such a requirement would allow Medicare to terminate doctors engaged in abusive prescribing.
- <http://www.propublica.org/article/medicare-moves-to-tighten-oversight-of-prescribers>

The amount of prescription painkillers sold in states varies.⁴

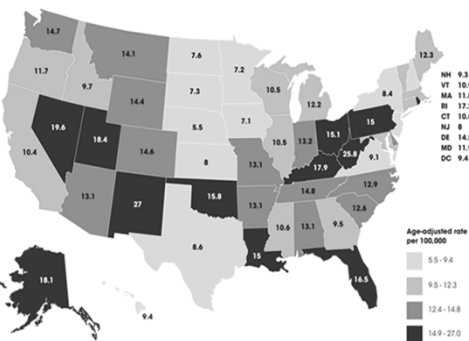


The quantity of prescription painkillers sold to pharmacies, hospitals, and doctors' offices was 4 times larger in 2010 than in 1999. Enough prescription painkillers were prescribed in 2010 to medicate every American adult around-the-clock for one month.

[View detailed list of rates](#)

State Impact

Drug Overdose Rates by State, 2008



WHERE DOES IT HURT?

Interstate 75 provides the major link between the Southeast and the Great Lakes, serving the cities of Miami, Naples, Fort Myers, Tampa, Atlanta, Chattanooga, Knoxville, Lexington, Cincinnati, Toledo, and Detroit.




Nevada's per-capita use of oxycodone grew sevenfold between 1997 and 2006

For years, Florida pain clinics funneled pills to all of Appalachia


Rural Maine has a long history of prescription painkiller abuse





DATA: CDC, GRAPHIC BY BLOOMBERG BUSINESSWEEK



Community Impact




• “In a period of nine months, a tiny Kentucky county of fewer than 12,000 people sees a 53 year old mother, her 35 year old son, and seven others die by overdosing pain medications obtained from pain clinics in Florida”

<http://www.kentucky.com/2009/04/12/758845/ky-sees-rise-in-overdose-deaths.html>

Family Impact



“They were all that I had. I tried to watch them as close as I could”

- Unexplained expenses, always requiring more money
- Lying, secretive behavior, hiding drug use
- Risky behavior putting the safety of drug addict and others in jeopardy

<http://www.healthline.com/addiction/drug-addiction/drug-addicts-drug-addict-symptoms-and-life-of-drug-addict/>

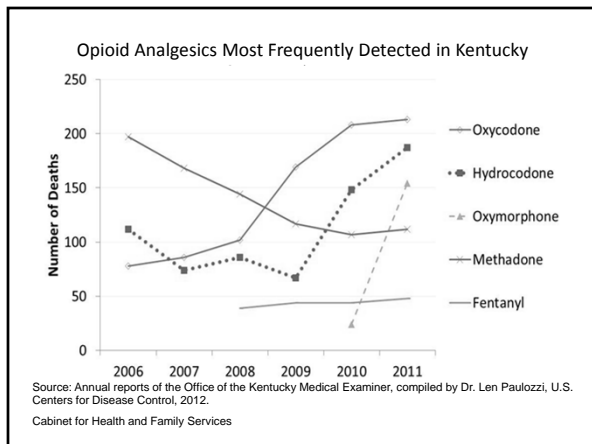
Prescribing Controlled Substances in Kentucky

The war on prescription drug abuse:


- House Bill 1 and the implementing regulations issued by the Kentucky Board of Medical Licensure have forever changed **how and when** a physician may prescribe controlled substances.
- Physicians must take extraordinary efforts to build the procedures and processes required for prescribing into their day- to- day practice.
- Drug Control Branch of Kentucky’s OIG routinely reviews KASPER data and reports the highest prescribers of controlled substances to the KBML for investigation.
- Physician responses to these investigations must be careful and complete with the understanding that there is little recourse if a violation is found.

KASPER

- The Kentucky All Schedule Prescription Electronic Reporting System (KASPER) tracks controlled substance prescriptions dispensed within the state. A KASPER report shows all scheduled prescriptions for an individual over a specified time period, the prescriber and the dispenser. Enhanced KASPER (eKASPER) provides Web-based access to KASPER data.
- KASPER is a reporting system designed to be:
 - A source of information for practitioners and pharmacists.
 - An investigative tool for law enforcement.
- KASPER is **not** intended to:
 - Prevent people from obtaining needed drugs.
 - Decrease the number of doses dispensed.



Dr. Dennis Sandlin



Associated Press Photo, The Mountain Eagle, December 10, 2009

Cabinet for Health and Family Services

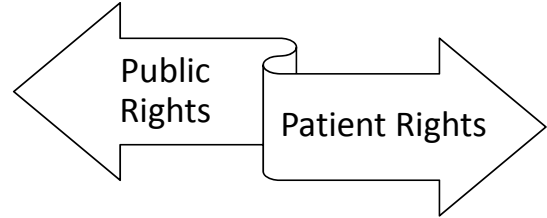
Six Strategies to address Prescription Drug Abuse

- Monitoring programs
- Enhance enforcement by coordinating operations
- Ensure proper disposal
- States role as regulator and purchaser – Medical licensing boards
- Partnerships among key stakeholders
- Promote public education



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Ethical Dilemma



Ethical Dilemma

- Patient rights Exercise rights
 - Have property/person treated with respect
 - Have voice heard
 - Not subject to discrimination

Ethical Dilemma

- Patient rights
- Receive effective **pain management** and symptom control from the hospice for conditions related to the terminal illness
- Be involved in Care plan
- Refuse care/treatment
- Be free from mistreatment neglect verbal, mental sexual physical abuse, including injuries of unknown source and misappropriation of patient property
- Information on services, including scope and limitations

Ethical Principles

- Beneficence
- Nonmaleficence
- Autonomy
- Justice
- Veracity



What Do We Tell Staff to Do?

- Consult with your team members
 - Never act alone
- If needed, Consult with your supervisor
 - Never take a questionable position without the supervisor
- If needed, consult with Ethics Committee

Organizational Challenges

- Ethical considerations
 - Concern that we are contributing to the drug problem
- Concern that patients aren't receiving their medications
 - Are we contributing to the problem of addiction
- Organizational support for personal/professional challenges
- Culture of awareness v. suspicion
- Provision for staff safety
- Where does the information 'live' within EMR

Organizational Perceptions

- Pill count is off= diversion
- Is it the patient? Is it the caregiver? Is it family in and out?
- Pills too accessible- let's change to a pump
- Its not safe at home- let's send to the care center
- Care center- why do we have to address this?
- Why don't they just stay away/leave alone?

Organizational Perceptions

- How can they let them do this?
- Why is the doctor ordering it?
- Why is the pharmacy filling it?
- Why do we still keep the patient?

Motivation To Develop The Pain Task Force

- Provision of excellent pain management as integral to service (Mission)
- Need to stay current in our Mission (Research)
- Increased regulatory scrutiny (DEA, Compliancy)
- Changing legal environment impacting our referral base (HB1)
- Increased concern regarding our role in availability of prescription medications in addiction/diversion/abuse (society)
- Safety issues – patients/families/staff/community (P&P)
- HOB leaders in hospice industry (Vision)

Pain Task Force

- Clinicians from home teams, inpatient unit, Medical Director, Pharmacy, Compliance, Education, Clinical Operations
- Format
 - Case presentation
 - Discussion
 - Division of effort (sub-groups formed)
 - Tasks assigned

The Task Force

- | | |
|--------------------------|------------------------|
| • Salli Whisman MD ; | • Sue Snider, RN |
| • Todd Cote MD, | • Turner West, MPH |
| • David Blair | • Eugenia Smither |
| • Susan A. Byars | • Gail Ott , SW |
| • Debra Kelley, PharmD | • Anne Monroe, MHA |
| • Kellie Wade RN | • Vicki Merrill , LCSW |
| • Diana Potts RN | • Amy Cox , RN |
| • Marilyn Morrow RN | • Amy Quinn, RN |
| • Nancy McKay Lynch SW | • Monica Couch, RN |
| • Wendell Short Pharm D | • Stephanie Ritter, RN |
| • Donna Jones, RN | • Suzanne Leabee, MS |
| • David Carper, Chaplain | |

How ARE We Going to Address THIS?

- We need to understand addiction
 - Addiction Specialist from
- Working committees
 - Education
 - Clinical
 - Regulatory
- Bring back talking points, concerns, direction
 - Tools (screening tools, and toolkit for staff)
 - Options
 - Recommendations
 - Direction for implementation for the larger group from their perspective as many issues will overlap



Awareness Assessment

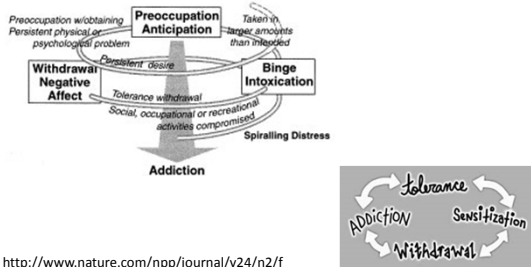


Proactive Caring

Universal Precautions

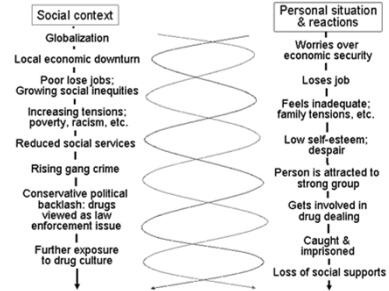
First we learn

Criteria for Substance Dependence (DSM-IV)

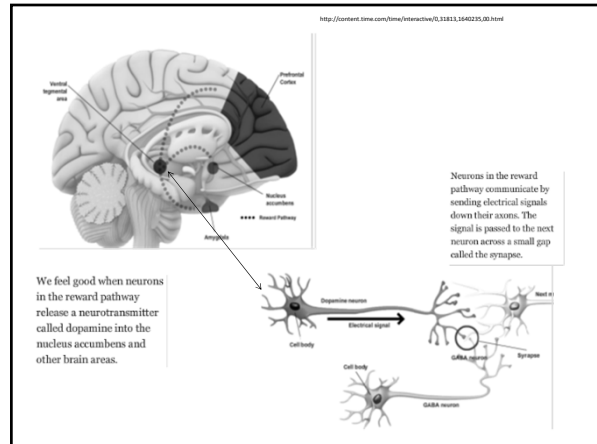
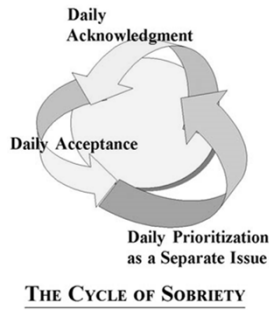
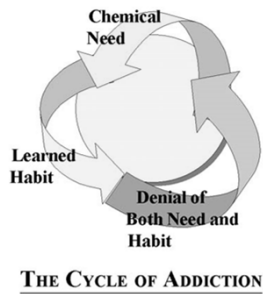


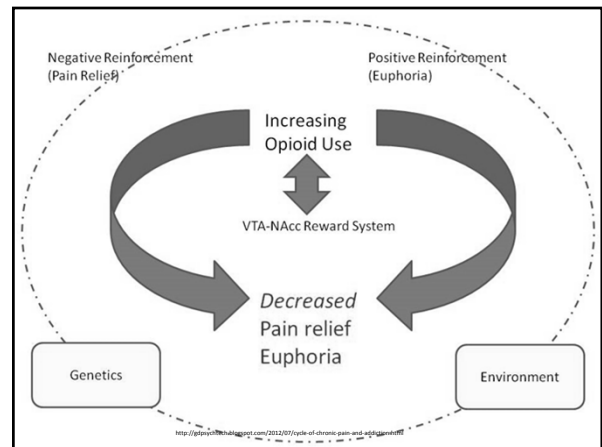
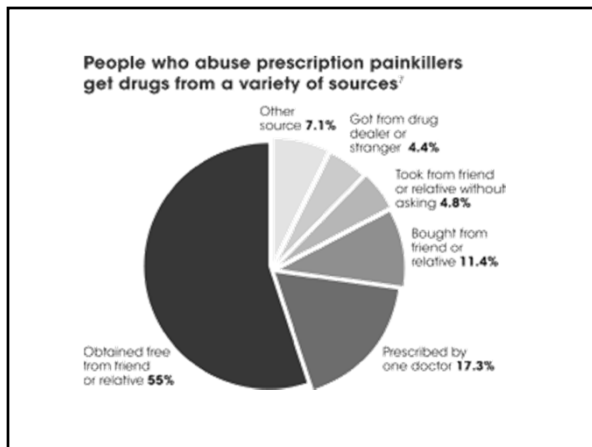
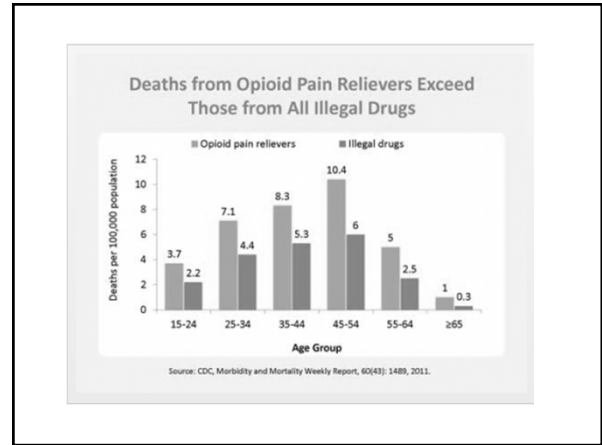
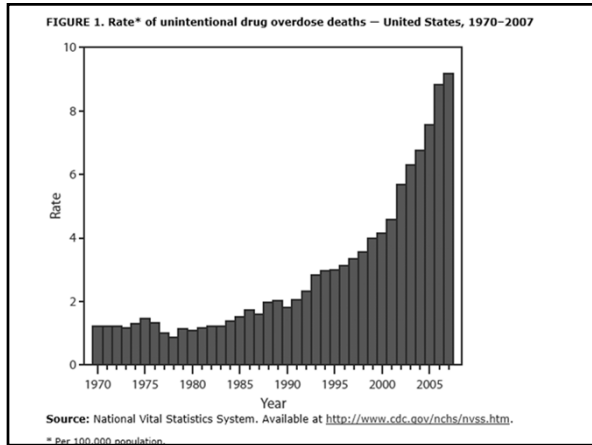
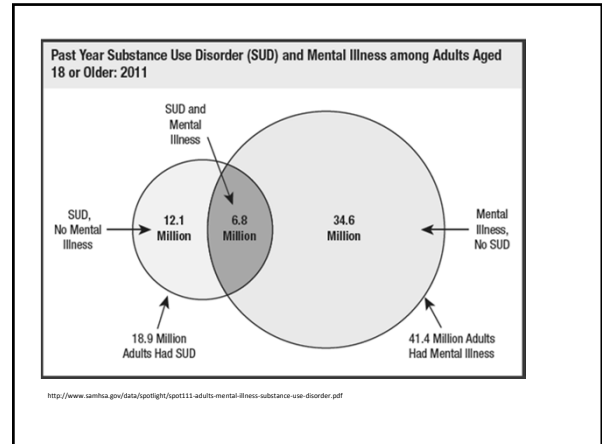
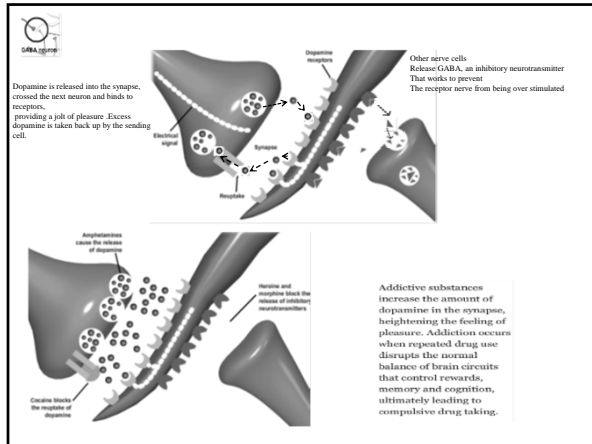
http://www.nature.com/npp/journal/v24/n2/fig_tab/1395603f1.html#figure-title

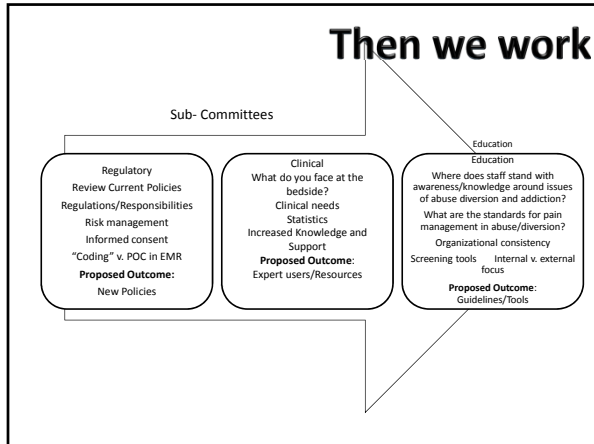
Spiral of addictions



http://www.med.utexas.edu/med/Gen/Addictions_spiral.htm







Regulatory SWAT Analysis

<p>S Strengths</p> <ul style="list-style-type: none"> •Have P&P related to medications, disposal of medications, diversion, medication agreements. •Staff receive training on disposal of medications, and patients receive information. •Hospices are exempt from KY HB 1, and PCCB is not a "pain mgmt" facility. •PCCB is currently following 201 KAR 9:260. <p>O Opportunities</p> <ul style="list-style-type: none"> •Annual pain management in-service for all clinical staff •Community coalition participation and possible leadership. •Create resource list by site of official medication take-back centers. •Medication agreement policy could be revised to use the agreement whenever a controlled substance is in the home. 	<p>W Weaknesses</p> <ul style="list-style-type: none"> Staff comfort addressing questions of diversion issues (related to P&P on diversion) •Policy on the medication agreement may not be used consistently across the agency. •Medication agreement (and P&P) is only with patient not caregivers or family. •Clinical staff reporting missing medications immediately to the pharmacy department. (Regulation: HOB has 3 days to report) <p>T Threats</p> <ul style="list-style-type: none"> •Conflicting disposal of medication guidance between EPA and FDA. •Previous diversion experiences likely impact current clinical practice (refer to clinical and education sub-committees) •Policies regarding use of KASPER
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Regulatory Tasks

Substance Abuse and Mental Health Service Administration

- Utilizing the SAMHSA guidelines; the informed consent for pain and symptom management agreement was developed/ revised
- Two part form recommended– one for Chart/Home
All patient's sign this form for organizational consistency. (universal precautions)

Regulatory Tasks

- Review of ICD9-CM conducted; risks due to specific guidelines in EMR when listing substance abuse as a diagnosis – reviewed our EMR to identify area for documentation in the POC for substance abuse issues
- Identify safe ways for medication disposal including controlled substances, building coalitions (local, regional, national requirements)
- Reviewed all policies re: pain and symptom management and Patients Bill of Rights
- HB1 – Pharmacy required reporting frequency to the KASPER database increased

Clinical Subcommittee

<p>S Strengths</p> <p>Because we are an interdisciplinary team we have different perspectives/assessment, The current approach and existing knowledge in pain mgt., pharmacology.</p> <p>O Opportunities</p> <p>Minimize bias/assumptions, increased understanding of how to treat pts. with addiction</p>	<p>W Weaknesses</p> <p>Inconsistency in the Plans of Care, , diagnostic knowledge, treatment guidelines</p> <p>T Threats</p> <p>Community impact, legal challenges</p>
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Clinical Tasks

- Issues around provision of EOL care in settings of abuse, addiction and diversion
 - Bedside care of known addict
- What is needed for staff to provide excellence in symptom management in this setting?
 - (Staff support)
- Safety in the midst of suspicion
 - (situational awareness)
- How are we treating pt./families with addiction/abuse issues
 - (Staying present, boundaries, protocol)
- How/where do we document addiction/diversion in the POC.
 - (Documentation)

Our process/Our words

Clinical ISSUES

Disease Process	Medication Mgt	Support/Education	Family System
Supplemental Pseudo addiction Escapism Suicidal Withdrawal Humanism Not taking Mgt Safety Triggers	Selling Safety Not taking Sharing Oversteering Supplementing Withdrawal Mgt Controlled Opioid Timing	INTUITION/awareness Containment/mgt Professionalism Withdrawal Coping Suspicion Assessment Tool Advocacy Boundary Language Triggers Burden Responsibility	Start Family Mgt Family System Humanism Disease process Interaction Intention Language

Commonalities in Families with Addiction

- **Don't Talk** – why would we tell these people our secrets?
- **Don't Feel** – Families are taught not to feel – some feelings are ruled in while others are ruled out (positive vs. negative)
- **Don't Trust** – If one is not allowed to talk or feel, there is distrust for the family system, others and for ones self
- Denial-Defense mechanism to interpret one's circumstances
- Boundary issues-Permeable, nonexistent
- Multiple Losses-Tangible and intangible
- Ambivalence-Inconsistency/ difficulty following suggestions

Hospice professionals may come into the family system expecting openness, honesty and an emotional connection.

- Do we understand the family dynamics when working with abuse/addiction/diversion?
- What language do we use when assessing abuse/addiction? In professional interactions?
- Are we aware of personal biases or the impact of our own histories when dealing with substance abuse/addiction?

The Drug Dance

A pliable dynamic interaction between the patient, staff and family members.

Components influencing the dance:

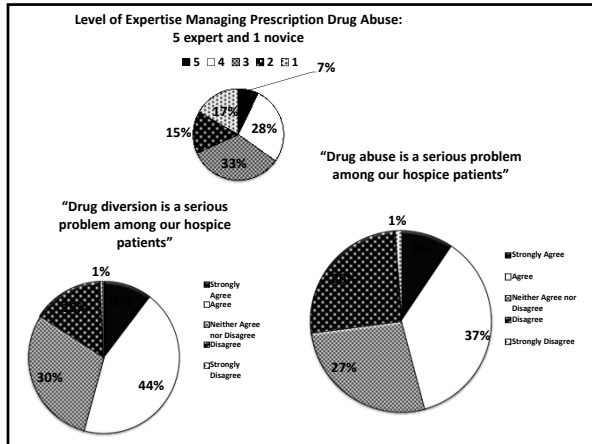
- Clinicians: Medication Management, Professionalism, Advocacy, Language, Burden
- Family System: Disease Process, Dignity, Coping skills
- Professional interaction: Intentionality, Language

Education Committee

- Where do we initially focus?
 - Internal v. external education efforts
- How large is the problem at HOB
 - What do we know?
- Survey staff perceptions regarding addiction and diversion
- How will we educate pt./families regarding safety issues when taking pain/symptom management medications
- How will we assimilate information to staff, patients, community?

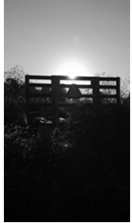
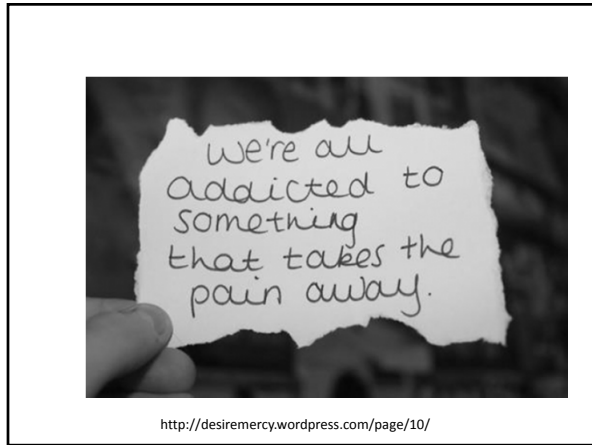
Start with Staff Survey

- Differentiate between abuse/addiction and diversion
- Define abuse/addiction and diversion
- Understand current perceptions around prevalence of abuse/addiction and diversion as percent of caseload
- Understand staff perception of their own expertise in handling cases of abuse/addiction and diversion
- Understand staff perception of efficacy of our current policy regarding abuse/addiction and diversion
- Tease out discipline specific issues related to the above as well as differences across our diverse service area



Still Work to be Done

- Partnering opportunities with our communities
- External Education
- Work plan for education
 - Assessments/screening tools
 - Updates to policies and procedures

Helpful Websites

- <http://www.cdc.gov/homeandrecreationalafety/rxbrief/>
- <http://www.cdc.gov/HomeandRecreationalSafety/rxbrief/index.html>
- <http://www.healthyplace.com/addictions/drug-addiction/drug-addicts-drug-addict-symptoms-and-life-of-drug-addict/>
- <http://www.drugabuse.gov/publications/science-addiction>
- <http://www.drugabuse.gov/>
- <http://www.samhsa.gov>



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Thank –You!