THE OPIOID DILEMMA

RETHINKING PAIN MANAGEMENT
A HOLISTIC APPROACH TO REDUCING RISK & INCREASING SAFETY
page 6

ONE TREATMENT DOES NOT FIT ALL
USING INDIVIDUALIZED MEDICATION-ASSISTED TREATMENT
page 9

DISRUPTING THE CYCLE OF CHRONIC PAIN AND OPIOID ADDICTION
TOUGH TALK
page 10

HEALTH PROFESSIONALS & OPIOID ADDICTION
REFRAMING THE PROBLEM WITH COMPASSION
page 14

WHEN YOU NEED TO SAY NO
GETTING BEYOND FEAR OF PATIENT DISSATISFACTION
page 23
WELCOME TO OUR SUMMER ISSUE.
You may not be surprised to find this issue of Brink focused on the nation’s opioid epidemic and the problems it presents for health care providers. Every day brings new media stories on the subject, new challenges for our policyholders trying to balance effective pain treatment and patient safety, and ongoing risks to organizations whose health care practitioners themselves may become ensnared in the misuse of opioids.

What may surprise you is the richness of viewpoints on the problem, the many ways to approach solutions (and their sometimes unintended consequences), and evolving research on the effectiveness of both traditional and emerging treatments. We’ve tried to approach the issue in a thoughtful manner that respects these different starting points while driving toward effective suggestions to help you engage more fully with the problem in your own practice.

A broader discussion we encourage is how to rethink pain management, the subject of our educational program, “Rethinking Pain Management for Community Health and Safety,” which we’re delivering to our policyholders at various sites throughout our coverage territory this year. We share highlights of this program on page 6 of this issue, including findings from our claim data related to opioids and recommendations for safer care. In our claim review on page 18, we provide excellent chronic pain management resources, including assessment tools.

We also focus on the problem of health professionals and opioid addiction, considering factors like stress, burnout, isolation and access to medications that can play a role in the problem. We advocate a compassionate and therapeutic approach and offer resources that can help.

As part of our decades-long commitment to helping healers with addictions get help themselves, MMIC has co-sponsored, since 1981, a Minnesota program called Physicians Serving Physicians (PSP). It’s a discreet resource that provides peer support, assessment, consultation, and referrals for physicians, their families and colleagues who are affected by addiction.

As we point out in our “Rethinking Pain Management” educational program, opioid use disorder is a community problem, and it will take all of us working together to make lasting inroads on the problem.

We welcome your feedback on this issue and encourage you to reach out if we can help you or a colleague in any way.

All my best,

Bill McDonough
President and CEO, Constellation
FEATURE SECTION:

THE OPIOID DILEMMA

6
RETHINKING PAIN MANAGEMENT
Toward increased patient safety with opioid prescriptions.

9
ONE TREATMENT DOES NOT FIT ALL
Customized, medication-assisted treatment is the right choice for many.

10
TOUGH TALK
How clear, evidence-based patient education can disrupt the cycle of chronic pain and opioid addiction.

14
HEALTH PROFESSIONALS AND OPIOID ADDICTION
Reframing the problem with a compassionate and therapeutic approach.

22
SENIORS AND PAIN MANAGEMENT
Prescribing opioids for seniors requires special considerations.

23
WHEN YOU NEED TO SAY NO
Getting beyond the fear of a patient’s dissatisfaction just might save their life.
ENHANCED CYBER COVERAGE IN 2017

MMIC, UMIA and Arkansas Mutual are enhancing cyber coverage throughout 2017 and 2018 to include the following coverages for eligible policyholders:

- BrandGuard® coverage for lost income resulting from an adverse media report or customer notification of a privacy or security breach
- PCI DSS Assessments coverage for defense costs and fines/assessments levied by credit card associations or acquiring banks for non-compliance with the PCI DSS resulting from a privacy or security breach
- Cyber crime coverage for certain losses resulting from financial fraud, telecommunications fraud or phishing attacks
- Privacy response breach costs coverage extended to proactive public relations expenses and voluntary notification
- Medefense Plus® coverage for governmental and commercial payer billing audits and investigations as well as EMTALA, Stark and HIPAA proceedings

Up to $10 million in limits are available. More information will be provided directly to policyholders regarding this coverage and effective dates.

Eligible policyholders include independently owned and operated physician practices, hospitals, senior living and outpatient facilities with revenues less than $250 million and medical professional liability deductibles less than $250,000.

CONTACT YOUR INSURANCE AGENT OR COMPANY UNDERWRITER FOR MORE INFORMATION

MMIC WEBSITE IMPROVED FOR YOUR PHONE OR TABLET

MMICgroup.com now resizes to fit your phone or tablet. We’ve also refreshed our site with:

- Easy navigation, iconography and condensed content—to find what you need fast
- New client and broker login experience

LONG-TERM CARE VENTURES INTO SOCIAL MEDIA

On Wednesday, October 18, Kristi Eldredge, RN, JD, CPHRM, senior patient safety consultant at MMIC, will present her talk, “Best Practices for Social Media in the LTC Environment: Facebook, Twitter and Snapchat … Oh My!” at the AHCA/NCAL Annual Convention & Expo in Las Vegas.

Eldredge will discuss the risks and benefits of social media usage for both residents and facilities, such as resident well-being and privacy, HIPAA, medical malpractice, employee behavior and training, and reputation monitoring.

LEARN MORE AT EVENTSCRIBE.COM/2017/AHCANCAL/INDEX.ASP

FALL CONFERENCE ON RURAL EMERGENCY CARE

The 4th CALS Conference on Rural Emergency Care is scheduled for Friday, September 29 at the University of Minnesota campus in St. Paul, MN. CALS stands for Comprehensive Advanced Life Support, an educational program designed for emergency medical training needs of rural health care teams.

Physicians, nurses, PAs, NPs, paramedics and administrators will come together for hands-on workshops. Constellation’s chief medical officer, Laurie Drill-Mellum, MD, will present on diagnostic error.

SUMMER/FALL SPEAKING EVENTS WITH CMO AND PATIENT SAFETY LEADERS

Laurie Drill-Mellum, MD, MPH
Chief Medical Officer, Constellation
9/20 Hutchinson Health’s Annual Primary Care Nursing Conference, Hutchinson, MN: “The Case for Empathy: Improving the Patient & Clinician Experience One Encounter at a Time” and “Who Heals the Healers?”
10/17 SIDM Diagnostic Error in Medicine Conference, Boston: Laurie Drill-Mellum, MD will speak in the panel discussion, “Building up Your Team”
11/12 AMA Forum for Medical Affairs, Honolulu: “Reclaiming Joy in Medical Life: Personal Practices and Systemic Approaches for Success”

Trish Lugtu, BS, CPHIMS
Senior Manager, Advanced Analytic Solutions, Constellation
10/17 ASHRM Annual Conference, Seattle: “Closing the Loop on Diagnosis with Health IT Risk Management”

Emily Clegg, JD, MBA, CPHRM
Manager and Senior Consultant, UMIA
8/10 Utah Osteopathic Association Annual Conference, Salt Lake City: “Advanced Practice Providers: Roles and Risks”
10/17 ASHRM Annual Conference, Seattle: “Evolving Models of Care: Eight Risks in Telemedicine”

Visit CyberNet®, the newly enhanced website for CyberSolutions® policyholders. Find great resources:

- Sample policies and best practice guidelines
- Training modules and webinars
- Guidance for handling data breaches
- Quarterly newsletters and instant alerts

LOG IN TO MMICGROUP.COM TO BROWSE WHAT CYBERNET OFFERS
In her new book, “What Patients Say, What Doctors Hear,” Danielle Ofri, MD, claims, much as Sir William Osler, MD, did more than a century ago, that the conversation between doctor and patient is still the single most powerful diagnostic tool.

That’s both reassuring and unnerving. Unnerving because it’s a lot to ask from today’s brief, distracted and often mutually unsatisfying medical encounters. Reassuring because basic communication chops seem to be (at least potentially) within most every clinician’s skill set.

Dr. Ofri explores both angles in her book, weaving together compelling stories of physician-patient pairs who share the frustrations and rewards of their relationships, and research from linguists and other scientists who are gaining new insights into what makes medical interactions effective and how to train clinicians to use communication more effectively.

What she also includes, and this grounds the book nicely, are candid accounts of her experiments incorporating various recommendations in her own practice. Her frankness and good humor shine throughout.

We see her vow to go for one day without interrupting a single patient as they explain the reason for their visit (she measures their talk time on a stopwatch in her pocket). She encourages them to get all their issues on the table: “Each time [they] paused, I asked gamely, ‘Anything else?’”

No spoilers, but her results don’t lend support to those who claim, “We could never do that here.”

We see her resist her urge to harangue patients about their chronic conditions, mindful of research that shows repetition isn’t effective because most patients are very knowledgeable about their conditions. Instead, she asks what their biggest challenges are in dealing with their condition. “Nine times out of ten, that question yields the most important kernel of the medical visit,” she says.

What emerges is a heartening look at how approaching medical interactions with curiosity, respect, humility and courage is the basis for building a trusting relationship with patients.

Language matters
In one chapter, Dr. Ofri explores how the words physicians use can make it sound as though patients are responsible for clinical outcomes. As an example, she describes a patient as having failed chemotherapy, refused radiation and been non-compliant with her medications.

“We could just as easily say that [her] cancer is resistant to chemotherapy, she has declined radiation treatment because of low efficacy, and the side effects of her diabetes meds outweigh the benefits.”

This more careful and respectful use of language acknowledges both “the very hard work of being a patient and the tremendous challenges of being a physician.”

Listening matters, too
In a particularly interesting chapter, Dr. Ofri explores research that points up how meaning is co-created by speaker and listener—each responding to the other’s moves—and how inattentive listening can lead to a drop in the quality of the speaker’s story. That’s a problem when the story is the patient’s history – that vital key to diagnosis.

The book has much to offer both physicians and patients. As Dr. Ofri notes, cultivating good communication can “enhance our lives on both sides of the stethoscope.”

LYNN WELCH
Senior Strategic Communications Consultant
Constellation
Lynn.Welch@ConstellationMutual.com
Opioids and Malpractice Claims

Opioid malpractice risk hotspots

An examination of malpractice risks in pain management offers a unique perspective within the general discourse of the opioid epidemic. For this analysis, MMIC identified 41 professional liability claims asserted 2010 through 2015 involving opioids, excluding treatment involved in managing cancer-related or acute care pain. One striking insight from the study is that medication administration allegations occur with the same frequency regardless of whether opioids are involved; however, outcomes in cases involving opioids are commonly more severe, highlighting the need for stronger diligence during medication administration processes.

What allegations are involved?
The majority of allegations involving opioids are medication-related regardless of setting, such as the administration or ordering of wrong medication or dose. Second highest are medical treatment-related allegations, including improper management of treatment course. The third most frequent are allegations of failure to ensure safety from falls.

The top issues vary between inpatient and outpatient claims. Whereas inpatient issues tend to involve more medication administration errors or behavior issues involving nursing, outpatient claims tend to involve more ordering errors by physicians or patient factors, such as non-compliance with medication or treatment regimen. Outpatient claims also involve more communication issues between patients and providers regarding the risks of medication.

Conclusion
Increasing awareness, training, and diligence for medication ordering and administration is paramount to preventing the avoidable high severity outcomes found in opioid cases. In addition, fall safety measures must be implemented for patients medicated with opioids, and effort must be made to prevent, identify and respond to drug diversion occurring within the health care workplace (see page 21 for strategies for preventing diversion).

This analysis was made possible through MMIC’s partnership with CRICO Strategies and use of their comprehensive risk intelligence platform.

TRISH LUGTU, BS, CPHIMS
Senior Manager, Advanced Analytics Solutions
Constellation
Trish.Lugtu@ConstellationMutual.com

Opioids were involved in 41 PL cases accounting for $3.1 million over a six-year period

<table>
<thead>
<tr>
<th>Major Allegation Categories Involving Opioids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
</tr>
<tr>
<td>68%</td>
</tr>
</tbody>
</table>
Opioids Most Involved

Medication combination resulting in the highest indemnity
- fentanyl and oxycodone

Opioids most often involved
- Dilaudid® (29%)
- methadone (21%)
- oxycodone (14%)

Injury Severity

All Settings

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>24%</td>
</tr>
<tr>
<td>Medium</td>
<td>59%</td>
</tr>
<tr>
<td>Low</td>
<td>17%</td>
</tr>
</tbody>
</table>

The most frequent injury was adverse reaction in 29% of cases.
Death was the outcome in 22% of all cases.

NAIC Clinical Severity Scale
HIGH: Death, Perm Grave/Major/Significant
MED: Perm Minor, Temp Major/Minor
LOW: Temp Insignificant, Emotional/Legal Only

Top Issues Vary Across Settings

Cases by Claimant Type

- Inpatient 44% $2.3M
- Outpatient 49% $803K
- Emergency 7% $14K

Top issues in inpatient claims
- Nursing (67%)
  - Administration of incorrect/inappropriate dose
  - Drug diversion
- General medicine (22%)
  - Family med/internal practice
  - Improper management of treatment course

Top issues in outpatient claims
- Family medicine (45%)
  - Improper medication regimen management
  - Ordering wrong dose or medication
- Nursing (20%)
  - Administration of wrong dose
  - Fall safety

Opioids Most Involved

- Methadone
- Oxycodone
- Fentanyl
- Dilaudid®
- Morphine
- Percocet
- Vicodin
- Ultram
- Lornoxicam
- Propoxyphene
- Baclofen

The most frequent injury was adverse reaction in 29% of cases.
Death was the outcome in 22% of all cases.

Medication combination resulting in the highest indemnity
- fentanyl and oxycodone

Opioids most often involved
- Dilaudid® (29%)
- methadone (21%)
- oxycodone (14%)
Treating patients with chronic pain is complex and challenging. Many clinicians express concern about how to safely manage the needs of an increasing number of pain patients in an environment of federal and state initiatives aimed at reducing opioid prescriptions.

MMIC, UMIA and Arkansas Mutual have responded to policyholder concerns with an education program, “Rethinking Pain Management for Community Health and Safety.” This one-hour in-person education program uses findings from an analysis of malpractice claims and identifies strategies and training to empower clinicians and team members to support this complex issue while managing the emerging risks. The following is a high-level overview of the program and recommended risk mitigation strategies.

Scope of the opioid problem
The Centers for Disease Control and Prevention (CDC) notes that over the past 25 years there has been a dramatic increase in the use of prescription opioids for the treatment of chronic, non-cancer pain. The CDC estimates that 20 percent of patients presenting to physician offices with pain receive an opioid prescription. At the same time, the increasing use of opioids for the treatment of chronic pain has resulted in unintended consequences. The CDC has declared that our nation is in the midst of an unprecedented opioid epidemic, with more than 33,000 people killed by opioids (including prescription opioids and heroin) in 2015. Nearly half of all opioid overdose deaths involve a prescription opioid. In a 2016 study, 91 percent of patients who survived an opioid overdose received more opioid prescriptions upon discharge. The researchers identified this as a missed opportunity to diagnose and treat substance abuse. In another study of more than 35,000 hospitalizations for opioid abuse and overdose, only 16.7 percent of patients received medication-assisted treatment (MAT) for substance abuse in the 30 days following discharge.

Opioid use disorder (OUD) is a substance use disorder identified and described in the DSM-5. OUD and opioid addiction are two terms that are often used interchangeably to describe a chronic, relapsing disease, not a lifestyle choice—one of the common myths surrounding addiction (see page 13, Addiction Myths).

Every community is different in terms of patients, clinicians, prescription opioid use and OUD. According to the CDC, “Prescribing rates for opioids vary widely across different states and regions with clinicians in the highest-prescribing state writing almost three times as many opioid prescriptions per person in 2012 as those in the lowest prescribing states.” In 2016, the CDC released the “CDC Guideline for Prescribing Opioids for Chronic Pain” aimed at changing these unsafe prescribing patterns to ensure the safest and most effective chronic pain treatment.

Risks to patients and health care providers
Treating chronic pain with prescription opioids involves risks for patients, clinicians and health care organizations, including:
- Adverse outcomes, including addiction, overdose and death
- Licensing actions for improper prescribing
- Drug diversion on the part of the patient or health care professional. Drug diversion is the transfer of any legally prescribed controlled substance from the individual for whom it was prescribed to another person for illicit use.
- DEA criminal prosecution for prescribing without a legitimate medical purpose
- Medication-related malpractice claims

Licensing actions
Rules and regulations relating to pain management are found in nearly every state outlining clinician education requirements, treatment plans, informed consent, patient examination and screening for substance abuse, patient referral to specialists,
limitations on prescribing schedule II and III controlled substances, and regulation of pain clinics and treatment programs.5

Many states also require clinicians to access their state’s prescription drug monitoring program to determine whether a patient is receiving prescription controlled substances from other clinicians.6

When clinicians and licensed health care professionals don’t follow these rules and regulations, state licensing boards can take actions that may include public warnings, fines, practice restrictions, remedial education, probation, and suspension or revocation of license.

Medication-related malpractice claims

An analysis of MMIC medication-related malpractice claims involving chronic pain and opioids revealed that the contributing factors in the outpatient setting were often related to selection and management of therapy. The claims involved patients with high numbers of refills combined with a lack of pain and function assessments, unsafe drug combinations, inadequate assessment for comorbidities, lack of opioid risk stratification and undiagnosed opioid use disorder.

In the outpatient setting, patient noncompliance and ineffective communication regarding the risks of opioids were also factors, while diversion by health care professionals and a lack of policy and procedures contributed to the allegations in the inpatient setting.

Organizations should begin immediately to assess their prescribing practices and policies and implement strategies to protect their communities and stem the tide of the growing opioid epidemic.

References


Reducing risk, increasing safety

These three strategies can help reduce risks inherent in prescription opioid use and enhance patient safety.

1. Incorporate evidence-based guidelines into practice.

Federal, state and specialty-based clinical treatment guidelines can be used as resources to develop chronic pain management policies to ensure consistent evidence-based practice. Most of these clinical guidelines are voluntary and based on emerging evidence, so when writing policies, be sure to allow for patient-specific treatment plans based on the patient’s condition, risks and unique needs. State requirements such as prescribing and refill limits should be incorporated as well, so policies need frequent review and updates.

2. Implement reliable patient management processes to assess, monitor and communicate.

/Assess/. Standard tools and algorithms (e.g., PEG, ORT, ICSI Pain Assessment Algorithm) should be used to assess and document a patient’s pain intensity, functional status, quality-of-life impact, opioid addiction, behavioral health co-morbidities and aberrant drug-related behaviors (e.g., early refill requests, falsification of a prescription, illegal drug use) to ensure consistent care across your organization.

/Monitor/. Patient monitoring systems that include patient dashboards, state prescription drug monitoring programs, and urine drug tests are a data-driven approach to evaluating the treatment plan and the progress toward patient goals.

/Communicate/. Motivational interviewing and shared decision-making2 are patient-centered ways to facilitate communication. When assessments reveal that opioids are doing more harm than good, a respectful conversation with the patient is in order (see “When You Need To Say No,” page 23). Clinicians need to use empathetic communication skills to discuss the behaviors revealed on the assessments and engage patients in revisiting the treatment plan.

3. Provide training, tools and education.

Research indicates that although clinicians are in need of additional training on pain management and prescription opioids, the majority are in support of clinical and regulatory strategies to reduce the harm caused by opioids.8

Education and training should focus on:

/Acute and chronic pain pathophysiology/

/Pain treatment modalities including non-opioids, opioids and non-pharmacologic treatments/

/Pain and function assessment tools; risk stratification tools/

/Evidence-based guidelines and policies/

/Monitoring for adverse effects and aberrant behavior/

/Opioid use disorder and medication-assisted treatment (MAT) /

/Empathetic communication skills/

LORI ATKINSON, RN, BSN, CPHRM, CPPS

Research & Education Manager

MMIC

Lori.Atkinson@MMICgroup.com
The American College of Physicians issued a policy statement in March emphasizing that substance use disorders are chronic medical conditions and should be treated that way.

It’s the way Mark Willenbring, MD, a psychiatrist and addiction specialist practicing in St. Paul, MN, has thought about substance use disorders for years, including during a stint as director of the Division of Treatment and Recovery Research of the National Institute on Alcohol and Alcohol Abuse.

Over time, Dr. Willenbring grew increasingly impressed by the “pristine research” being done on the effectiveness of medication-assisted treatment (MAT) models, and increasingly frustrated that that research “never gets to the people [the public] who paid for it.” Instead, the treatment landscape has been overwhelmingly based on 12-step models that, in Dr. Willenbring’s view, lack the scientific rigor and evidence of effectiveness that guide treatment advances for other chronic conditions.

“Twenty years ago, I was more diplomatic in how I talked about it,” Dr. Willenbring says. Now, with the explosion in the number of opioid and heroin overdoses, the stakes are higher. He is quick to point out that abstinence-based models can not only fail their patients, but kill them. “Substance use disorder is a relapsing disorder,” he explains. “When relapses occur, patients who have spent time off the substance tend to start using at the same level they did before entering treatment, and they overdose.”

**Individualized care**

When Dr. Willenbring opened Alltyr Clinic five years ago, his outpatient-based, medication-assisted treatment model enabled patients to get help without unnecessarily disrupting their lives, and without losing their dignity—factors that have no doubt contributed to the growth of the practice.

One patient, a police officer injured in the line of duty, began taking opioids for multiple physical symptoms and became dependent on them. He first sought help from his GP, who worked with him to create a taper plan, “but I just couldn’t stick to it,” he said. He then entered treatment at Hazelden, a nationally recognized rehab facility in Minnesota, but something in him resisted the message he got there, he says, that “You can never be normal again.”

“I just never believed that,” he said. “I was normal for 35 years! Bad stuff happened. I self-medicated. I got addicted.” He needed help from an expert who acknowledged that.

Seeking out Dr. Willenbring enabled him to recover a sense of normalcy, a fact for which he credits both Dr. Willenbring and “an amazing therapist” (patients see both at Alltyr). Together, the three created a customized, medication-assisted treatment plan. Today, the patient is pursuing studies in criminal justice and raising his 11-year-old daughter. “She’s an A student. I’m an A student,” he smiles. “Thank God I’m here for it. I almost wasn’t.”

**Expanding access**

Access to medication-assisted treatment is still a problem as doctors must be specifically credentialed and are limited in the number of patients they can treat. It will likely be a while before treatment rates for people with substance use disorders, currently 18 percent of those who need it, according to the ACP paper, approach those for other chronic conditions (above 70 percent).

Dr. Willenbring believes opioid use disorder will eventually be treated by primary care physicians, much like depression is today. In his view, treatment with Suboxone and similar drugs is a valuable addition to the physician’s tool bag. “There are very few treatments in all of health care with this kind of dramatic and rapid improvement,” he says.

**Reference**

Years before the evidence started rolling in and the media exploded with staggering statistics, Bret Haake, MD, had been giving talks on a better way to treat chronic pain without opioids, which confuse the brain and inhibit the ability to improve, both physiologically and psychologically. “If someone comes to me with chronic pain and they’re on opioids,” Dr. Haake says, “I describe to them that the best way to get rid of their pain is to stop the opioids.”

Research has shown that opioids are not very effective for chronic pain, and long-term use—defined as greater than three months—poses the greatest risk for addiction and overdose. In 2016, the CDC released long-awaited guidelines for treating chronic pain, recommending non-pharmacologic therapies, such as exercise and cognitive behavioral therapy, and non-opioid pharmacologic therapies. Now it’s widely acknowledged: it’s critical to get patients off opioids as soon as possible.

To assess his new patients already on opioids, Dr. Haake takes a good history, listens to their story, and does a thorough examination to rule out other diagnoses, such as a pathology that is progressive. “And then we discuss their current strategy and how it is not working for them. Because patients with chronic pain on opioids—every one of them—will tell you they’re in severe pain and the pain is getting worse over time. They just haven’t made the connection that it is because of the opioids they’re using.”

It can be a delicate situation to help patients understand. “I’ll say, ‘This may be new to you today, but I want to present to you another way that you can have less pain in the future, by
taking a different approach to your pain.” In that initial visit, there’s some level of dissonance because they are hearing something they haven’t heard before. At the same time, they’ve had a sense that something is wrong. “It’s interesting the amount of openness people will have to a discussion about the idea that they need to come off of the opioids,” says Dr. Haake.

What evidence can convince them further? Dr. Haake explains, “If you do a PET scan of someone’s brain, you can see the areas active with pain, and you can see what areas of the brain make compounds to relieve pain. People that are given opioids for their pain, they don’t make their own natural pain relieving compounds anymore; in fact, they are relying on the medication to get that pain relief. It’s only coming off the opioids—sometimes months later—that their brain starts to make their own feel-good compounds again.”

**Weaning and alternative treatments**

Alternative treatments, concurrent with weaning, are always part of the plan and can include behavioral therapy, physical therapy, and sleep and exercise regimens. Patients need to understand and have confidence in their treatment plan. According to Dr. Haake, positive thought is extremely important, because the treatment is not easy and it’s not quick.

“Patients need to be warned that as they wean off the opioids, their pain will actually get worse and that will persist for several weeks after they are off the opioids—until they start to make their own pain relieving compounds again,” says Dr. Haake.

For those who stick with Dr. Haake’s program, the initial time coming off the opioids, and then for about six weeks off of the opioids, is not fun since the pain can be as bad or worse during that time. A few weeks later, though, they start to feel better.

“By that third month off the opioids, they’re thrilled with their care. Then 6–12 months later, they feel better than they have in years, and they become strong advocates for this kind of work,” says Dr. Haake.

But not all patients follow through with weaning. “For patients who are addicted, it actually hijacks their brain, and they will do whatever it takes to get more medication. If I suggest to start the patient on their current dose, and then begin to wean off 10 percent, and the patient refuses to be weaned, first line is asking them if they know why they are here to see me. Sometimes they do, if they’ve been prepped. If they say, ‘No,’ then I’ll say, ‘My name is Anne Pylkas and I’m an addiction specialist and just because you’re here doesn’t mean you are necessarily addicted to anything; this is an open and non-judgmental place to talk about addiction.’ I explain that I’m here to help people get off pain medications.”

Dr. Pylkas notes that a lot of patients don’t know what addiction means. “Addiction means there’s a behavioral disorder. There’s a fine line between physical dependence and addiction—physical dependence means, ‘If I stop it, I will go through withdrawal,’ which is true for anyone on opioids. With addiction there’s also behavioral dysregulation including use of a substance despite known harm. Harm can be anything from legal issues to relationship issues to medical issues.” Dr. Pylkas has found that patients are quick to diagnose themselves as addicts because they realize they rely on the drugs for pain, even if they’re frustrated with the diminishing effects over time, which may have caused them to take more and more to feel relief.

If they weren’t prepped well, or if they don’t know why they’re here, it can be difficult to navigate the conversation. “Patients worry that anytime we say ‘addiction’ it automatically means they need to go to treatment. I address this upfront, letting them know that just because they’re here doesn’t mean we’re going to lock them away.”

**Hyperalgesia is “a paradoxical response whereby a patient receiving opioids for the treatment of pain could actually become more sensitive to certain painful stimuli.”**

— National Center for Biotechnology Information

**Not everyone is ready**

Dr. Pylkas recognizes that some people just aren’t ready for treatment. “For those people,” she says, “it depends on how dangerous their behavior is. If they’re frequently overusing, or they’re getting it from the street, or they’re injecting, then I would say, ‘You have three options. You can go on Suboxone® (buprenorphine) with me—and I explain that it’s a medication for addiction—you can use this other medication, or you can use abstinence.’”

Still, she remains clear when telling them, “Because the opioids interfere with how your brain feels pain, it’s impossible to treat your pain until we treat your addiction first.” For high-risk patients who refuse the treatment options, Dr. Pylkas lets them know she is available to talk more if they come back, but that she will not be prescribing any opioids.

The majority of patients, however, are open to treatment that includes weaning, while also engaging in other treatments, including physical therapy, pain psychology, and injections if needed. “The first thing they’ll say is, ‘I’ve done all these**

**Patients with chronic pain on opioids—every one of them—will tell you they’re in severe pain and the pain is getting worse over time.”**

that’s usually the first flag that there’s a stronger issue than just physical tolerance. If they go to an ER and ask for more medication, or game your colleague down the hall for more, then it’s clear there’s an addiction issue.”

**The addiction conversation**

Anne Pylkas, MD, a physician and addiction medicine specialist, handles referrals needing special treatment for addiction or dependence. She explains the initial patient conversation: “My
things,” Dr. Pylkas says, “but the reality is that when you are on opioids and you’re addicted or you’re headed to addiction, you can try all those things and they’re not going to work.”

The longer they’ve been taking opioids, the longer it can take for the brain to recover from the effects of the drugs. Often, it can take a year or even two, making it a long journey back to a healthy approach to their chronic condition.

“Opioids totally disengage you from what your body is feeling,” says Dr. Pylkas. At some point, people don’t know what they’re feeling anymore, and they haven’t felt anything for a very long time because they can just take a pill whenever they’re going to start to feel anything. So I do really long, slow tapers—like over a year or two. If they’re high risk, then I will speed up the taper.”

The good news, according to Dr. Pylkas, is that “after a while, they start understanding that this was never helpful, and it never will be helpful, and these other things that we’re doing are much more helpful.”

---

**Addiction Myths**
What we don’t know (or what we falsely believe) can hurt our patients

<table>
<thead>
<tr>
<th>Myths and Misconceptions</th>
<th>Truth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction is simply a set of bad choices. 30% of providers believed addiction is a lifestyle choice rather than a chronic disease.</td>
<td>The risk of opioid addiction varies substantially among persons. Genetic vulnerability accounts for 35-40% of the risk associated with addiction.</td>
</tr>
<tr>
<td>Pain protects patients from addiction to their opioids.</td>
<td>Patients who are prescribed opioids can become addicted even if they take their medicine as directed.</td>
</tr>
<tr>
<td>Only long-term use of certain opioids can cause addiction.</td>
<td>All opioid use can lead to addiction. U.S. medical schools allot fewer than 11 teaching hours to pain management and addiction.</td>
</tr>
<tr>
<td>Only patients with certain characteristics are vulnerable to addiction. 57% of providers viewed low income as causal/contributory to addiction.</td>
<td>Although some patients are more vulnerable than others, no patient is immune to opioid addiction. Opioid addiction is genetically modulated with heritability rates similar to those of diabetes, asthma, and hypertension.</td>
</tr>
<tr>
<td>Medication-assisted therapies are just substitutes for heroin or opioids.</td>
<td>Opioid-agonist medications such as buprenorphine have slower pharmacokinetics that help stabilize physiologic processes, and they help protect against abuse while facilitating recovery.</td>
</tr>
</tbody>
</table>

**References**
Health Professionals and Opioid Addiction
Reframing the problem with a compassionate and therapeutic approach.
By Anne Geske

Just like airline pilots, the ability of health professionals to place public safety first, doing their job well and unimpaired, is essential. Health professionals are keenly aware of their ethical and moral responsibilities. But through the lens of addicted thinking, an individual may rationalize that their use of opioids won’t lead to impaired judgement. That their diversion—appropriating patients’ prescription medication—won’t affect patient safety or lead to malpractice claims.

Unique factors and risks
Generally speaking, health professionals experience chemical dependency at the same rate as the rest of the population. But when the substance is opioids, unique factors and risks come into play for people in the health professions.

First, there can be extreme stress on the job. Physicians have a much higher risk of depression and burnout (emotional exhaustion, depersonalization, and a low sense of personal accomplishment) compared to the general population.2 Marc Myer, MD, works at Hazelden Betty Ford as medical director for Adult Services Minnesota, as well as the Health Care Professionals Program. According to Dr. Myer, for the health professional population subset, addiction to opioids frequently does not begin after long-term use of opioids prescribed for pain, but as a coping mechanism—a way to self-medicate stress.

Second, there’s access. When stress leads health professionals to reach for a substance as a coping mechanism, access to opioids is there, especially for those who administer anesthesia and medications. Third, physicians’ and nurses’ very knowledge about disease and medication can lead them to intellectualize their substance use behavior, thinking I know how they work, so I’ll be able to control their use.3

And then there’s shame and isolation. Dr. Myer believes that addiction is a disease driven by shame. “I find that health care professionals are riddled with shame at a much greater degree even than the general population because,” he says, “due to their substance use, they oftentimes violate their own ethical and moral standards. And then they end up becoming isolated because of fear of retribution or loss of licensure, loss of income,

Stressful work environments, burnout, access, intellectualization, and isolation may create a unique set of risks.
Stressful work environments, burnout, access, intellectualization, and isolation may create a unique set of risks for health professionals, but the results of opioid use disorder (OUD) are every bit as deadly. “The scary thing for me,” says Dr. Myer, “is that those folks out there who are deep in the throes of addiction feel alone, like they can’t reach out. And many will die of their addiction before they get to treatment. So I hope that as a society we focus our approach more on a therapeutic intervention to a chronic disease rather than a punitive one. That doesn’t mean that physicians and other health care professionals shouldn’t take responsibility for their actions, but it should be considered within the context of their state of mind while addicted.”

Compassion, not punishment
Employers of health care professionals know they have a responsibility to the public. How much do they also have a stake in the success, well-being and careers of their employees? Laurie Drill-Mellum, MD, chief medical officer of Constellation, says, “We have to make sure that people are treated fairly, with dignity and respect. We see the effects of addiction and how it can land on patient care and safety, which we all care about—including the people who struggle with this issue.”

A compassionate, not punitive, model of chemical dependency treatment is known to be most effective. To that end, most states have a confidential program for medical professionals that operates outside of the state licensing board. Participants can seek help without risk of losing their license if they follow the program. Once enrolled, their adherence is monitored. If they’re noncompliant, they could lose their license.

One such successful program is South Dakota’s Health Professionals Assistance Program (SDHPAP), which monitors health professionals identified as having a substance abuse disorder. Craig Uthe, MD, a family medicine physician and

Addiction Self-Assessment

- I continue my addictive behavior after experiencing serious consequences.
- I regret my behavior.
- I can’t stop my addictive behavior whenever I want.
- Others express concern about me.
- I’m worried about my behaviors.
- I don’t limit my behaviors to certain times of the day or to certain places.
- I get into arguments with family members or friends about my behavior.
- My behavior causes me shame and embarrassment.
- I use my behavior to make me feel better.
- My work is in jeopardy because of my addictive behaviors.
- I have had financial difficulties because of my behaviors.
- I engage in addictive behaviors to boost my self-confidence or self-esteem.
- I would be concerned if my clients knew about my behaviors.
- I have put my family in embarrassing or potentially dangerous situations.
- I have lied about or minimized my addictive behaviors.
- I have changed my circle of friends/acquaintances in order to more easily engage in my behavior.
- I have not been aware of the needs and well-being of my family.
- I celebrate good news by engaging in my addictive behaviors.
- I have considered suicide because of my behavior.
- I am preoccupied with my past, present or future behaviors.

See Resources in this article for where to find help in your state.

Adapted with permission. Physicians Serving Physicians, Edina, MN. http://psp-mn.com/
medical adviser to SDHPAP, states that the two cornerstones of the program are accountability and consequences. “We have a personal plan of action that’s individualized for every participant, using guidelines and policies that are generally followed by the Federation of State Physician Health Programs,” says Uthe. “Addiction is a disease. It was recognized that physicians wouldn’t acknowledge [admit or seek treatment for] their disease if the result was going to be punishment. So many states, including South Dakota, have created trusted, confidential and protected programs away from board disclosure if the individual is willing to get treatment for their disease and not be a risk to the public’s health.”

Dr. Myer believes such programs make a positive difference. He says, “It’s very clear that when health professionals are able to reach out to a non-punitive program, they will self-report and get help earlier at much greater rates than if they have to go straight through a licensing board. We know from this model that the earlier they get help—and the more support they get—the better the outcomes.”

The good news is that after completing treatment and obtaining ongoing support, the five-year success rate for physicians is greater than 80 percent—much higher than the general population.3

**Awareness and communication**

Administrators of medical facilities and owners of private practices will want to evaluate awareness and planning around their employees and OUD. What can a medical facility do to update efforts around awareness and communication? First, understand that there’s no need to reinvent the wheel. Ruth Martinez, executive director at the Minnesota Board of Medical Practice, says she has seen groups “examining this issue in silos, redundantly going through processes without bringing their information together and aggregating information in a way that more broadly communicates a message.” Each state’s medical board has its own list of resources.

Policyholders of MMIC, UMIA, and Arkansas Mutual have access to online resources and phone consultations. When necessary, phone consultants refer policyholders to Walt Flynn, a human resources consultant at W.J. Flynn and Associates, LLC. Flynn frequently talks to small- and medium-sized practices about employees suspected of using substances. “Broadly speaking,” he says, “the best practice is to actually confront the behavior. You’d be amazed at how many times things go unexamined because people are afraid to confront or call out the behavior.”

Nurses and other staff see physicians as holding a position of power within the organization, and they might be afraid to report. “I’m always impressed with how courageous people are in being willing to deal with this,” says Flynn. “If you’re an administrator for a physician group, and one of the physicians is a partner or owner of the practice, it’s a lot to step up and confront. Basically, you’re going to the owner of your group and calling them out. I’ve seen many situations where that’s exactly what’s occurred, and thank goodness.” Flynn also makes referrals as necessary for impairment assessment, drug testing, and fitness-for-duty exams. Physicians require confidentiality, so often referrals will be made to out-of-town resources.

Dr. Drill-Mellum acknowledges that OUD in health professionals poses significant risks, and reiterates that competent, legal, and compassionate intervention is what works. “We are a company that was formed by and for physicians,” she says. “We recognize this is a problem, and we offer services to help mitigate these issues, whether it’s potential patient litigation or stress-related dependency. We try our best to be of service to our colleagues and peers.”

**References**


**Confronting impairment: Starting the conversation**

“We want organizations to have safe, competent physicians who are not impaired taking care of our patients,” says Walt Flynn, HR consultant. Here are three basic steps that Flynn uses to broach the subject of potential impairment.

1. **Explain why you’re having this conversation.**
   “Here’s what we’ve seen, can you help explain what’s going on?” Talk about observed behavior or verbalizations that have been out of the norm.

2. **Help them understand why there’s a concern.**
   “Here’s why we’re concerned.” Discuss potential patient safety concerns, how coworkers are affected, and risks to the organization.

3. **Talk about steps toward remediation.**
   “Where do we go from here?” Come prepared with what next steps might look like depending upon the direction the conversation takes.

**ANNE GESKE**
Health Care Feature Writer
Failure to Provide Appropriate Pain Treatment

After violating his opioid treatment agreement and no longer able to obtain his prescription pain medication, a patient suffering from opioid addiction and withdrawal symptoms overdoses on heroin and is hospitalized.

Facts of case
A family physician (FP) treated a 57-year-old man with an extensive history of work-related injuries for seven years with muscle relaxants and opioids for complaints of chronic pain. Over the years, the patient requested and received many refills prior to his next scheduled appointment without a physical examination. After the clinic initiated a new chronic pain treatment policy, the patient was required to sign an opioid treatment agreement mandating routine urine drug testing. Several months later when the patient’s urine drug test was positive for amphetamines, the clinic sent him a letter indicating that he was in violation of the treatment agreement and would no longer be prescribed pain medication. He was advised to see a pain specialist.

Two weeks later, the patient called complaining of severe withdrawal symptoms, and a nurse advised him to go to the emergency room. Two months later, the patient was found at home unresponsive due to an overdose of heroin and was hospitalized.

The patient filed a malpractice claim against the FP alleging improper pain treatment resulting in opioid addiction.

Disposition of case
The case was settled against the FP.

Patient safety and risk management perspective
The experts who reviewed this case were critical of the FP for a lack of documented pain and function assessments, lack of treatment goal planning, refills without exams and assessments, failure to treat opioid withdrawal symptoms and failure to diagnose and treat opioid use disorder. The patient testified he sought relief for his opioid withdrawal symptoms by using heroin. The malpractice case was settled with a payment on behalf of the FP and his clinic. The state licensing board also fined the physician for failing to provide appropriate pain treatment.
Chronic Pain Management Resources

Links to these resources can be found on the MMIC and UMIA websites by navigating as follows: www.MMICgroup.com or www.UMIA.com Login > Risk Management > Bundled Solutions > Chronic Pain Management

Academy of Integrative Pain Management http://www.aapainmanage.org/
American Academy of Pain Medicine http://www.painmed.org/
American Pain Society http://americanpainsociety.org/
American Society for Pain Management Nursing http://www.aspmn.org
American Society of Addiction Medicine http://www.asam.org/asam-home-page
CDC: Guideline for Prescribing Opioids for Chronic Pain – United States, 2016 https://tinyurl.com/cdcopiodischronicpain
CDC: Guideline Resources: Clinical Tools https://www.cdc.gov/drugoverdose/prescribing/clinical-tools.html
CDC: Opioid Overdose https://www.cdc.gov/drugoverdose/index.html
ICSI: Pain: Assessment, Non-Opioid Treatment Approaches and Opioid Management https://tinyurl.com/icsipainguidelines
Physicians for Responsible Opioid Prescribing http://www.supportprop.org/
SAMHSA Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders. Appendix B Assessment Tools and Resources https://www.ncbi.nlm.nih.gov/books/NBK92056/
Turn the Tide: The Surgeon General’s Call to End the Opioid Crisis http://turnthetiderx.org/

LORI ATKINSON, RN, BSN, CPHRM, CPPS
Research & Education Manager
MMIC
Lori.Atkinson@MMICgroup.com

Key strategies for patient safety and risk management

Create and maintain policies

- Enlist a multidisciplinary team to provide coordinated care across the continuum.
- Develop a chronic pain management policy using evidence-based resources (e.g., CDC, ICSI, AAPA) to outline chronic pain therapy modalities, when to initiate or continue opioids for chronic pain, opioid selection, dosage, duration, follow-up, tapering and discontinuing opioid treatment.
- Incorporate state-specific prescribing rules (e.g., limits on refills, numbers of pills, informed consent, treatment plan) into the chronic pain management policy.
- Evaluate your chronic pain practice using a risk management self-assessment tool.

Assess patients

- Assess the risk of addiction prior to initiating opioid therapy and during treatment using standard risk stratification tools.
- Query the state prescription drug monitoring program to review the patient’s controlled substance prescription history prior to initiating opioid therapy and routinely during therapy.
- Use standard tools and algorithms to assess pain, function, behavioral health co-morbidities and aberrant drug-related behaviors.
- Evaluate aberrant drug-related behaviors (unintended behaviors involving acquisition or use of prescribed opioids such as early refill requests, falsification of a prescription, use of illegal drugs), establish a differential diagnosis list (e.g., uncontrolled pain, progressive disease/condition, tolerance to opioids, poor coping skills, behavioral health co-morbidities, diversion, opioid use disorder) and reassess opioid therapy to determine whether opioids are causing more harm than good.

Monitor and communicate with patients

- Obtain informed consent for opioid therapy outlining benefits and risks, including addiction and overdose.
- Utilize a patient dashboard to monitor pain and function status, opioid risk and progress towards treatment goals.
- Use treatment agreements for long-term opioid therapy to clarify expectations and responsibilities, outline the refill and monitoring process, and discontinuation therapy.

Educate your team and patients

- Educate clinicians and team members on the use of empathetic communication skills, motivational interviewing and shared decision-making for informed consent to opioid therapy.
- Educate clinicians and team members on pain management, assessment tool use, evidence-based guidelines, risk stratification tool use, opioid use disorder and medication-assisted treatment.
- Educate patients and families about the risks of opioids, safe storage of opioids in the home and safe disposal of unused opioids.
Diversion of Controlled Substances

After a series of patients developed unusual infections during their hospitalizations, an extensive investigation revealed a nurse diverted IV opioids for personal use and contaminated the IV bags.

### Facts of case
A physician admitted a 62-year-old man with a longstanding history of low back pain to the hospital for pain control and opioid withdrawal symptoms when his intrathecal pump malfunctioned. While waiting for the pump to be replaced, the physician prescribed IV Dilaudid. A week into the patient’s hospitalization, his temperature rose to 102 degrees. The physician ordered blood cultures that were positive for a gram-negative bacteria. The patient was treated with antibiotics and discharged after his intrathecal pump was replaced.

After a series of patients were found to have unusual bacterial bloodstream infections during their hospitalizations, the hospital began an extensive investigation and concluded that all were cared for on the same hospital unit, all had received IV pain medication and all were cared for by the same nurse. The nurse admitted to numerous occasions of withdrawing controlled substance pain medication from patient IV bags, replacing it with saline to make it appear that nothing had been taken and injecting it for personal use. The investigators concluded that the IV bags were contaminated when the nurse withdrew the pain medication.

The hospital suspended the nurse and a criminal investigation was initiated. A review of the controlled substance access logs indicated that nurse had access rates several times greater than any other nurse for over six months. The nurse later pled guilty in federal court to a felony of obtaining a controlled substance by fraud. Multiple patients filed malpractice claims against the hospital alleging improper treatment resulting in an infection, negligent hiring and supervision, and failure to prevent and detect drug diversion.

### Disposition of case
The malpractice cases were settled against the hospital.

### Patient safety and risk management perspective
The experts who reviewed the cases were critical of the hospital’s detection and response to the infection outbreak and drug diversion, noting the hospital had not been routinely reviewing the controlled substance access logs, did not immediately pull all potentially contaminated IV pain medication bags from service, did not objectively investigate the health care professional and did not immediately report the theft to federal and state authorities.
Controlled substance diversion

The Centers for Disease Control and Prevention (CDC) cites the epidemic of opioid addiction as a major driver of drug diversion. Sales of prescription opioids in the United States nearly quadrupled from 1999 to 2014, which increased the availability of opioids for diversion. Diversion is one way to get opioids—both for addicted patients and addicted health care professionals—especially now, when physicians have cut back drastically on prescribing opioids with the new CDC guidelines. When health care professionals divert controlled substances, the risks to patient safety include unsafe care delivered by an impaired health care professional, untreated pain, and exposure to infectious disease from contamination. Health care organizations face regulatory and legal risk, fraudulent billing claims, professional liability, claims and damage to their reputation in the community. Health care organizations have a duty to protect patients from potential harm related to controlled substance diversion and must have a strong program to prevent, detect, respond, investigate and report drug diversion.

References


Diversion Prevention Resources

Links to these resources can be found on the MMIC and UMIA websites by navigating as follows: www.MMICgroup.com or www.UMIA.com Login > Risk Management > Bundled Solutions > Chronic Pain Management

ASHP Guidelines on Preventing Diversion of Controlled Substances PDF (includes self-assessment tool) http://www.ajhp.org/content/early/2016/12/22/ajhp160919


CMS: What Is a Prescriber’s Role in Preventing the Diversion of Prescription Drugs? PDF https://tinyurl.com/prescriberrolepreventdiversion

Department of Justice Drug Enforcement Administration: Diversion Control Division https://www.deadiversion.usdoj.gov/index.html

Mayo Clinic: Diversion of Drugs Within Health Care Facilities, a Multiple-Victim Crime: Patterns of Diversion, Scope, Consequences, Detection, and Prevention https://tinyurl.com/diversionofdrugs

Minnesota Hospital Association: Drug Diversion Toolkit and Resources https://tinyurl.com/MHAdvictiontoolkit

LORI ATKINSON, RN, BSN, CPHRM, CPPS
Research & Education Manager
MMIC
Lori.Atkinson@MMICgroup.com

Key strategies to ensure patient safety and prevent diversion

Create and implement policies

- Implement a controlled substance diversion prevention program administered by a multidisciplinary team.
- Include and enforce zero tolerance for drug diversion in the provider and employee substance abuse policy.
- Run background checks and drug testing on potential employees/clinicians as a condition of employment/medical staff privileges.
- Implement a Fitness for Duty policy, including for-cause drug testing and return to work criteria.
- Implement a controlled substance handling and administration policy that includes controlled substance counts; wastes, storage, access, security, discrepancies, and waste retrieval system monitoring; and surveillance systems audits.
- Ensure organizational policies comply with federal and state requirements including reporting to local law enforcement, DEA and applicable licensing boards.

Assess and monitor locations, inventory, and processes for diversion risk points

- Perform diversion risk assessments of high risk areas (e.g., surgery, anesthesia, pharmacy, emergency departments) and high risk processes (e.g., known diversion points) to identify and mitigate diversion risk.
- Use automated technology such as automated dispensing and diversion monitoring software to assist in the management of controlled substance inventory, documentation of removal, administration, waste, billing and auditing.
- Review automated dispensing reports at least monthly to compare automated dispensing activity with medication administration records to detect unusual patterns.

Monitor patients for infection and pain relief

- Utilize an infection surveillance system to review and analyze infection data regularly.
- Conduct random patient interviews to verify that patients receiving pain medication obtain adequate pain relief.

Provide education and training

- Provide clinician and team member education and training on how to prevent, recognize and report impairment or diversion.
Opioid use among older adults can provide health care professionals with challenging considerations, especially for chronic pain conditions. Clinicians should consider certain factors before ordering and managing opioid therapy for seniors.

The aging process can cause many of the human organ systems to slow or to change in ways that impact the absorption, motility, and excretion of medications—including opioids. In aging adults, the liver and kidneys go through a decrease in mass and blood flow, reducing their ability to remove wastes from the body. While muscle mass decreases, the proportion of body fat typically increases. These processes increase the potential for harm for older adults who use opioids.

Some reports indicate a higher number of grandparents caring for grandchildren in recent years, including children born addicted to opioids or other substances. Grandparents may be caring for grandchildren because one or both parents is jailed or has overdosed from opioid addiction. In this situation, the grandparent’s legitimately prescribed medication may be at risk from theft by relatives or acquaintances. Opioid-addicted relatives may view their elders as easy targets for exploitation, exposing them to the potential of physical, emotional or financial abuse.

Reducing risks for seniors
Opioids should not be the first line of treatment for pain in seniors. Depending on the individual, using nonpharmacological techniques such as physical therapy or other alternative therapies may be a better alternative. In addition to following best practices for all adults, practitioners should consider additional guidelines for seniors:

- Review all medications to determine possible drug interactions.
- Conduct physical exams, including lab tests for renal and liver functions. Evidence shows that opioids should be prescribed at doses 25–50 percent lower than the typical adult dose.1 Smaller quantities of pills should be prescribed, and more frequent assessments conducted.
- Assess seniors for signs of increased injuries to determine if they have been a victim of abuse. Increased injuries could also indicate the possibility of misuse, adverse reactions, or abuse of opioid medications.
- Be aware that symptoms associated with aging may mask signs of opioid abuse. Ask about changes in appetite, balance and social habits.
- Be cognizant of requests for early refills and frequently reporting lost or stolen medications. Demands for prescriptions at office visits are a potential indicator of abuse.

Proper opioid management in seniors can be even more complex than in younger adults. Comorbidities, the aging process, polypharmacy, and multiple care providers contribute to the potential harm of opioid use in this at-risk population. Health care professionals need to be alert to the potential risk of prolonged or mismanaged opioid use.

Reference

D. MICHELLE KINNEER, RN, MSN, JD, CPHRM, CHPC, CHC
Senior Risk and Patient Safety Consultant
MMIC
michelle.kinneer@MMICgroup.com

Seniors and Pain Management
Prescribing opioids for seniors requires special considerations.

Reducing Risk
- Consider alternatives
- Prescribe in lower doses
- Prescribe in small quantities
- Require frequent follow-ups
- Avoid time ranges in prescription dosing instructions
- Avoid symptom bias in assessments
- Utilize prescription monitoring drug programs
When You Need to Say No
Getting beyond the fear of a patient’s dissatisfaction just might save their life.

Conversations about opioids are sometimes about more than symptoms and treatment. There can be unspoken fears and motivations swirling beneath the surface if the patient feels entitled to opioids, or feels frightened by the prospect of coping without them. The patient may be dishonest, overly emotional, or even aggressive. The provider may fear backlash from the patient if the answer is no, but also knows that saying no could save a life.

Dan O’Connell, PhD, is a clinical psychologist who trains, coaches and consults with health care professionals on improving communication and patient relationships. He uses his psychology background to help clinicians through tough conversations about pain management and opioids. Dr. O’Connell promotes a simple mantra: Patients are not the problem. The provider is not the problem. The problem is the problem. “Namely,” he says, “the problem that opioids may be causing more harm than good.” It’s not the patient’s fault they’re struggling with psychological cravings, but the provider saying “no” isn’t the bad guy either. The problem is the problem.

Talking points for saying no
Sometimes the answer needs to be “no.” Algorithms and assessment tools are available to help screen for risks, alcohol and substance abuse, or depression. A conversation, however, is the place to start. Dr. O’Connell promotes three key talking points for those conversations: drug safety, drug effectiveness, and (balancing those two), is the drug doing more harm than good?

Safety
Probe about tolerance, addiction, or diversion, drawing out the patient’s own understanding of the safety. Then educate to fill in gaps.
Questions to ask:
/ Do you find yourself needing more and more?
/ How would you know if you were becoming addicted?
/ Can you account for every pill?
Effectiveness
Reflect the patient’s own complaints back to them.
Questions to ask:
/ If opioids were really the most effective way to help, I would expect them to be making more of a difference. Instead, I’m hearing…
/ It sounds like you’re struggling with stress and lack of sleep. Opioids are not the most effective treatments for those. Let me propose a more effective approach.
Balancing safety and effectiveness
Reframe the conversation as balancing necessity vs. risk:
/ I’m open to considering any plan we both agree is the safest and most effective way to help your pain, and which we are both certain could not do more harm than good.

Concluding the conversation
After following this format, clinicians need to present a clear conclusion. Some examples:
/ I’ve come to the conclusion that the way you’re using opioids is causing more harm than good and we need to agree to a different plan.

Dr. O’Connell advises, “Be soft on the people, but be hard on the problem.”

/ I’m willing to prescribe opioids if we can agree to a contract that includes the elements we need to watch for safety and effectiveness, and to be sure they are not causing more harm than good. Let me describe those, and you decide if you can commit to each one.
If a patient grows angry or disagrees, Dr. O’Connell suggests using a defusing technique such as getting a second opinion or the input of a specialist.
It’s important for clinicians to remember the mantra that the patient is not the problem, but neither are you. The problem is the problem. Dr. O’Connell advises, “Be soft on the people, but be hard on the problem.”

EMILY CLEGG, JD, MBA, CPHRM
Manager & Senior Consultant
UMIA
eclegg@UMIA.com
Most of us who were drawn to medicine were enticed by the opportunity to serve people requiring medical care. Yet the emphasis in medical education has been greatly biased toward the technical parts of the profession: general anatomy, embryology, histology, physiology, pathology, pharmacology, pathophysiology, microbiology, diagnosis and treatment.

Many of us didn’t receive much training in listening, empathy, and compassion; perhaps there was an assumption we didn’t need it, or that such skills weren’t that important. As it turns out, these habits of engaging with people can separate the “good enough” physician from the great physician, and might be what our patients remember most about their time with us. They can increase diagnostic accuracy and efficiency and decrease the chance that adverse outcomes will develop into malpractice claims.

Sadly, by the time many of us have endured the challenges of medical school and the demands of specialty training, remnants of the idealistic yearnings we expressed in our medical school applications may be hard to trace. These negative outcomes are well documented in the vast research on burnout in medicine. Less well documented is their effect on our patients.

Take our attitudes toward patients who are dependent on opioids, whom many of us reflexively dismiss as “drug seekers,” though we (the “big We”) have surely played a role in creating the problem, just a bit downstream from Big Pharma and the push to make pain the fifth vital sign. I have witnessed how the labeling and judgment can land on a patient and their family.

Several years ago, a friend had both knees replaced. She experienced tremendous post-operative pain and was seen by a pain management specialist. She was treated aggressively for her pain, and during her convalescence became physiologically dependent on the prescribed opioids; this, in turn, impacted her mood, her spirit, her sleep patterns, and of course, her bowels. When she requested help from her primary physician, my friend was told: “Go back to whoever put you on these meds; I didn’t create this problem and I’m not going to be the one to fix it.”

I felt awful for my friend, who hadn’t done anything wrong, and a sense of indictment toward our current disjointed practice of medicine. I guided my friend to a colleague with the knowledge, skills and compassion necessary to wean her from the opioids.

How can we do better? I hope we have given you both good data and good ideas for reflection on the vexing problem of opioid use and abuse. We are interested in continuing the conversation.

LAURIE C. DRILL-MELLUM, MD, MPH
Chief Medical Officer
Constellation
Laurie.Drill-Mellum@MMICgroup.com
**opi•oids** noun

a class of drugs that includes the illicit drug heroin as well as the legal prescription pain relievers oxycodone, hydrocodone, codeine, morphine, fentanyl and others.1

---

**80%**

OF WORLDWIDE OPIOID CONSUMPTION IS FROM THE UNITED STATES WHICH REPRESENTS ONLY **5%** OF THE WORLD’S POPULATION2

---

**STEEP SITUATION**

Of patients taking opioids longer than one month, NEARLY 30% will still be on them a year later.3

1 in 7 people who got a refill or second prescription were on opioids a year later.3

---

**DEADLY COMBINATIONS**

Nearly 60% of patients taking opioid prescriptions for long-term conditions were also prescribed potentially dangerous mixtures of medications during the same time period.

**OF THESE PATIENTS:**

- 2/3 were prescribed the drugs by two or more physicians.
- 27% were taking multiple opiate pain treatments simultaneously.
- Nearly 40% filled their prescriptions at more than one pharmacy.
- Nearly 1 in 3 patients were on an opiate and a benzodiazepine, a combination that is the most common cause of multiple-drug overdose deaths.

---

UPCOMING WEBINARS ON WEDNESDAYS
To register for a webinar, go to MMICgroup.com > News & Events
All webinars are presented noon–1 CST and are available on demand at ArkansasMutual.com after the initial presentation.

JULY
19
NAVIGATING THE JOURNEY: HIPAA PRIVACY AUDITING
Presenter: D. Michelle Kinnee, RN, MSN, JD, CPHRM, CHPC, CHC, MMIC
Senior Risk & Patient Safety Consultant

AUGUST
9
REMAINING INDEPENDENT OR SELLING YOUR PRACTICE
Presenter: Ryan S. Johnson, Shareholder, Fredrikson & Byron

SEPTEMBER
20
ADVANCED PRACTICE PROVIDERS: ENHANCING THEIR ROLES, REDUCING THEIR RISKS
Presenter: Robert S. Thompson, RT, JD, MBA, LLM, AIC, ARM, ARE, RPLU, CPCU, MMIC Business Development Consultant, Strategic Relationships

OCTOBER
11
CREATING A JUST CULTURE OF ACCOUNTABILITY
Presenters: Betty VanWoert, RN, BSN, CCM, CPHRM, MMIC Senior Risk and Patient Safety Consultant and Kristi Eldredge, RN, JD, CPHRM, MMIC Senior Risk and Patient Safety Consultant

RISK MANAGEMENT EDUCATION
Dates and locations for “Rethinking Pain Management for Community Health and Safety” will be announced later this year.