# Community-Based Primary Palliative Care Community of Practice Series 2

## Palliative Care and Substance Use Disorders

Project ECHO
Palliative Care - Canada
BY Pallium Canada

**Facilitator:** Dr. Nadine Gebara

**Presenter:** Dr. Jenny Lau

**Date:** January 18, 2023

# Territorial Honouring

# The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness and their families.

**Stay connected: www.echopalliative.com**

The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

Health Canada Santé Canada

# LEAP Core

- Interprofessional course that focuses on the essential competencies to provide a palliative care approach.
- Taught by local experts who are experienced palliative care clinicians and educators.
- Delivered online or in-person.
- Ideal for any health care professional (e.g., physician, nurse, pharmacist, social worker, etc.) who provides care for patients with life-threatening and progressive life-limiting illnesses.
- Accredited by the CFPC and Royal College.

Pallium Canada

LEAP CORE

Learn more about the course and topics covered by visiting

www.pallium.ca/course/leap-core

# Objectives of this Series

**After participating in this series, participants will be able to:**

- Augment their primary-level palliative care skills with additional knowledge and expertise related to providing a palliative care approach.
- Connect with and learn from colleagues on how they are providing a palliative care approach.

# Overview of Sessions

| Session # | Session Title | Date/ Time |
|---|---|---|
| Session 1 | Pain: Beyond the Basics | Nov 9, 2022 from 1-2pm ET |
| Session 2 | Communication: Part 1 | Nov 23, 2022 from 1-2pm ET |
| Session 3 | Communication: Part 2 | Dec.7, 2022 from 1-2pm ET |
| Session 4 | Palliative Care and Substance Use Disorders | Jan 18, 2023 from 1-2pm ET |
| Session 5 | GI Symptoms in Palliative Care | Feb 1, 2023 from 1-2pm ET |
| Session 6 | Delirium | Feb 15, 2023 from 1-2pm ET |
| Session 7 | Spiritual Care and Rituals around Death and Dying | Mar 1, 2023 from 1-2pm ET |
| Session 8 | Palliative Sedation | Mar 15, 2023 from 1-2pm ET |
| Session 9 | What's in store for Palliative Care in Canada: Policy, Advocacy and Implementation | Mar 29, 2023 from 1-2pm ET |
| Session 10 | Grief and Bereavement: Beyond the Basics | Apr 12, 2023 from 1-2pm ET |
| Session 11 | Practical Tips: Lessons from the Front Line | Apr 26, 2023 from 1-2pm ET |

# Welcome & Reminders

- Please introduce yourself in the chat! Let us know what province you are joining us from, your role and your work setting
- Your microphones are muted. There will be time during this session when you can unmute yourself for questions and discussion.
- You are welcome to use the chat function to ask questions and add comments throughout the session
- This session is being recorded and will be emailed to registrants within the next week.
- Remember not to disclose any Personal Health Information (PHI) during the session
- This 1-credit-per-hour Group Learning program has been certified by the College of Family Physicians of Canada for up to **11 Mainpro+** credits.

# Disclosure

Relationship with Financial Sponsors:

**Pallium Canada**

- Not-for-profit
- Funded by Health Canada

# Disclosure

**This program has received financial support from:**

- Health Canada in the form of a contribution program
- Generates funds to support operations and R&D from Pallium Pocketbook sales and course registration Fees

**Facilitator/ Presenter:**

- Dr. Nadine Gebara: Nothing to disclose
- Dr. Jenny Lau: Research program is funded by Canadian Institutes of Health Research and Health Canada.

# Disclosure

**Mitigating Potential Biases:**

- The scientific planning committee had complete independent control over the development of course content

# Introductions

**Facilitator:**

**Dr. Nadine Gebara,** MD CCFP- PC
Clinical co-lead of this ECHO series
Palliative Care Physician at Toronto Western Hospital, University Health Network
Family Physician at Gold Standard Health, Annex

**Panelists:**

**Dr. Haley Draper,** MD CCFP- PC
Clinical co-lead of this ECHO series
Palliative Care Physician at Toronto Western Hospital, University Health Network
Family Physician at Gold Standard Health, Annex

**Dr. Roger Ghoche,** MDCM CCFP-PC, MTS
Palliative Care and Rehabilitation Medicine, Mount Sinai Hospital- Montreal

# Introductions

## Panelists (continued):

**Elisabeth Antifeau,** RN, MScN, CHPCN(C), GNC(C)
Regional Clinical Nurse Specialist (CNS-C), Palliative End of Life Care
IH Regional Palliative End of Life Care Program
Pallium Canada Master Facilitator & Coach, Scientific Consultant

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**Rev. Jennifer Holtslander,** SCP-Associate, MRE, BTh
Spiritual Care Provider

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Program Delivery Officer, Pallium Canada

**Diana Vincze**
Palliative Care ECHO Project Manager, Pallium Canada

# Introductions

**Presenter:**

**Dr. Jenny Lau**

Dr. Jenny Lau MSc MD CCFP (PC) is the Medical Director of the Harold and Shirley Lederman Palliative Care Centre at Princess Margaret Cancer Center. She is a palliative care specialist who trained in family medicine at the University of Ottawa and then palliative medicine at the University of Alberta. She also has a Master of Science in Medical Science with Collaborative Specialization in Addiction Studies from the University of Toronto. Dr. Lau leads numerous local and national projects focused on addressing opioid use disorder and promoting safer opioid use in the context of life-threatening illnesses.

# Palliative Care and Substance Use Disorders

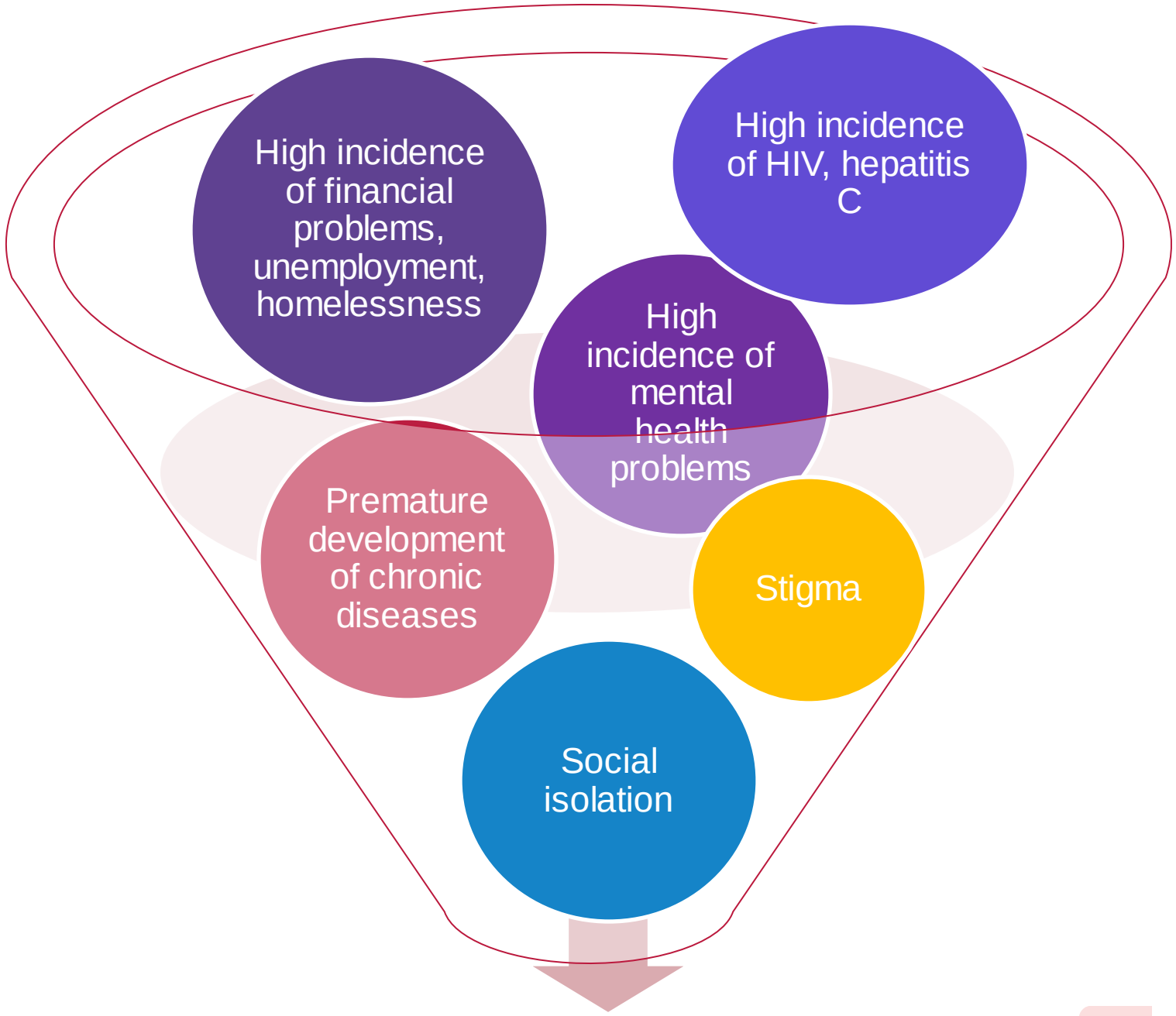
# Session Learning Objectives

**Upon completing the session, participants will be able to:**

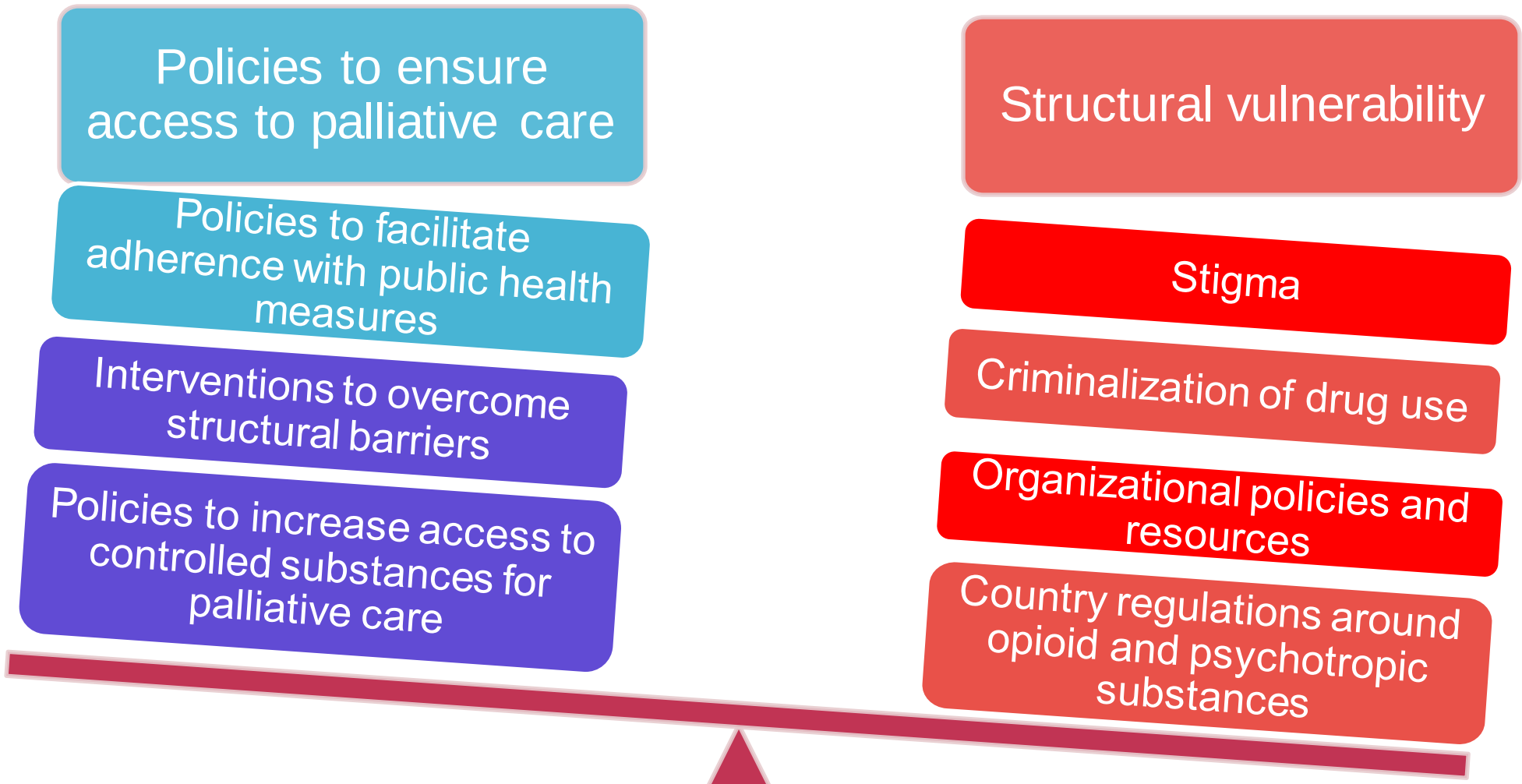
- Describe approaches for providing pain and symptom management for people who non-medically use opioids
- Express the importance of harm reduction for people who use drugs

# People who use drugs need palliative care

- Prevalence of drug use and substance use disorders are increasing around the world
- Ageing process among people with substance use problems is accelerated by 15 years
- Communicable disease outbreaks restrict access to healthcare services and magnify inequities experienced by people who use drugs



# Access to Palliative Care



# Strategies to overcome barriers

- Interdisciplinary collaboration to provide care for people who use drugs.
- Partnership with patients, caregivers, medical, community supports and home care teams.
- Reduce health disparities through strategies like service coordination and facilitating transitions in care.
- Integration of harm reduction measures into palliative care.

# Prevalence of opioid use disorder (OUD)

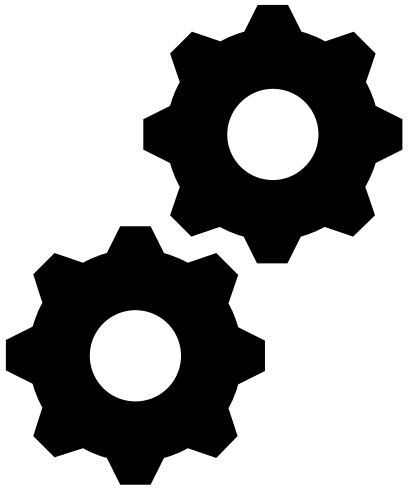
**1.6% to 4.6%**
**for people over 11 years old**

- Opioid use disorder is a *complex, chronic biopsychosocial disorder where people engage in persistent opioid use despite harmful consequences*
- 26.8 million people were living with OUD worldwide in 2016

# DSM-V: OUD

- Tolerance*
- Withdrawal*
- More use than intended
- Craving for the substance
- Unsuccessful efforts to cut down
- Spends excessive time in acquisition
- Activities given up because of use
- Uses despite negative effects
- Failure to fulfill major role obligations
- Recurrent use in hazardous situations
- Continued use despite consistent social or interpersonal problems

*Not counted if opioid is prescribed by physician



Average age of death for people with OUD: 40 years

Average age of death for people on opioid agonist treatment: 49 years

# Importance of identifying OUD

- High risk of comorbid medical and psychiatric conditions
- Restricted access to palliative care due to limited social supports, poverty and stigma
- Symptoms can be result of drug use and withdrawal
- Opioid use history is important
  - Avoid opioid of “choice”
  - May require higher opioid doses
  - Consider medication routes and formulations less likely to be diverted or used non-medically
  - Collaboration with opioid agonist treatment providers

# Problematic opioid use ("aberrant behaviors")

- **Observations or reports of prescription forgery***
- **Reported theft or "borrowing" of opioids***
- **Route alteration of prescribed opioids***
- Reports of lost or stolen prescriptions
- Observable intoxication or withdrawal in clincal setting
- Insistence on initation of opioids, higher doses and/or quantities of opioids
- Observed or reported opioid hoarding
- Self-titration of opioid doses without clinical approval
- Resisting changes to opioids despite adverse effects

*High priority as per Canadian Society of Palliative Care Physicians



Source: https://seapointcenter.com/what-is-

# Managing Concerning Behaviors in Patients Prescribed Opioids for Chronic Pain: A Delphi Study

*Jessica S. Merlin, MD, MBA[1,2], Sarah R. Young, MD, MBA[1,3], Joanna L. Starrels, MD, MBA[4], Soraya Azari, MD, MBA[5], E. Jennifer Edelman, MD, MBA[6], Jamie Pomeranz, MD, MBA[7], Payel Roy, MD, MBA[8], Shalini Saini, MD, MBA[9], William C. Becker, MD, MBA[6,10], and Jane M. Liebschutz, MD, MBA[8]*

**Strategies are provided on how to manage the following concerning behaviors:**

- Missing appointments
- Taking opioids for symptoms other than pain
- Using more opioid medications than prescribed
- Asking for an increase in opioid dose
- Aggressive behavior towards provider or staff
- Substance use

**Regardless of the behavior, study participants agreed that stopping opioids immediately is not important.**

**Across behaviors, patient education and information gathering are important approaches**

# Assessment of Risk of Problematic Opioid Use

- **Post-traumatic stress***
- **Sexual abuse history***
- Personal or family history of alcohol use disorder
- Current or history of tobacco use
- Current or history of non-medical drug use
- Current or history of injection drug use
- Criminal records related to substance use disorders
- Past history of use of prescriptions not as prescribed
- Family history of problematic substance use
- Age: 18 – 24 years, 65 years+
- History of depression, anxiety, personality disorders, somatization, chronic pain
- Unstable housing
- Financial instability

*High priority as per Canadian Society of Palliative Care Physicians



Source: https://seapointcenter.com/what-is-

# Assessment of Risk of Opioid Overdose

- **Receiving opioid prescriptions from two or more physicians***
- Benzodiazepene use
- Alcohol use
- History of previous opioid overdose
- Active or past history of substance use disorder
- Urine drug tests
- Older age (65+ years)
- Renal or liver impairment
- Muscle relaxant use
- Sleep medication or hypnotic use
- Methadone use for pain or opioid use disorder management
- Opioid naïve patients
- Untreated psychiatric conditions
- Obstructive sleep apnea

*High priority as per Canadian Society of Palliative Care Physicians

Source: https://seapointcenter.com/what-is-collaboration/

*Review Article*

PALLIATIVE MEDICINE

# Assessment tools for problematic opioid use in palliative care: A scoping review

**Jenny Lau[1,2,3], Paolo Mazzotta[2,4], Rouhi Fazelzad[5], Suzanne Ryan[3,6], Alissa Tedesco[4], Andrew J. Smith[7], Abhimanyu Sud[2,8], Andrea D. Furlan[9,10,11] and Camilla Zimmermann[3,6,12]**

*Palliative Medicine*
2021, Vol. 35(7) 1295–1322

DOI: 10.1177/02692163211015567
journals.sagepub.com/home/pmj
SAGE

Identified 32 studies that used **questionnaires:** CAGE, CAGE-AID, ORT, SOAPP, SOAPP-R, SOAPP-SF

**None of the studies developed or validated the questionnaires for patients receiving palliative care**

# Opioid Prescribing Practices

The following **opioid prescribing practices** for patients receiving care in **outpatient palliative care clinics or home palliative care visits** are strongly recommended:

- **Physicians should have access to regional prescription monitoring programs to track previously dispensed prescriptions**
- **If the primary prescriber of opioids is absent, detailed pain management plans and documentation should be provided to the covering clinician**
- **Patients who have opioid use disorder or are at high-risk of problematic opioid use and overdose should receive daily to weekly dispensing of opioids**
- Clinicians should provide a max of one month supply of opioids with each prescription
- Each patient should have only one prescriber

*High priority as per Canadian Society of Palliative Care Physicians

# Structured Opioid Therapy

- Continued opioid prescribing under conditions that limit aberrant drug related behaviours.

- **Treatment agreement**
- **Dispense small amounts** frequently (e.g., 1–2 times per week)
- **Monitor closely** with urine drug tests, pill counts, office visits
- **Switch to buprenorphine or methadone treatment** if structured opioid therapy fails (e.g., patient continues to access opioids from other sources)

# Collaborative care


Patients with symptom management concerns and active problematic opioid use, opioid use disorder and/or history of overdose should be **jointly managed with an addictions medicine** specialist.

Source: https://www.piquenewsmagazine.com/bc-news/grant-funding-awarded-to-help-addiction-support-services-3303901

# Managing pain for patients with OUD

- Buprenorphine
- Methadone
- Structured opioid therapy
- Non-opioid adjuvants
- Interventional modalities
- Non-pharmacologic modalities

**Buprenorphine:**
Pain Management

**ADVANTAGES:**

- Ceiling effect for respiratory depression
- Less development of tolerance
- Antihyperalgesic effect
- Less effect on hypogonadism
- Less immunosuppression compared with morphine and fentanyl
- Ease of use un elderly and in renal impairment
- Possible efficacy in neuropathic pain

**Buprenorphine:**
Dosing

- Buprenorphine-naloxone
- Naloxone has no major clinical effect when administered sublingually.
- Dose to effect
- Analgesic efficacy: 6-8 hrs
- **For acute-on-chronic pain (eg surgery), consider gently tapering dose as much as possible without destabilizing patient. DO NOT DISCONTINUE.**

# Methadone: Pain Management

- Methadone maintenance therapy only prevents withdrawals and cravings
- **If patients are experience acute pain…**

  *Mild – moderate pain:* Non-opioid medications

  *Moderate – severe pain:* Appropriately prescribed opioids similar for people with similar pain
- There is limited evidence but **dividing methadone** into every 4 to 8 hour doses or by **continuous infusion** may be useful for analgesia.

JAMA Network Open™

Consensus Statement | Substance Use and Addiction

# Expert Panel Consensus on Management of Advanced Cancer–Related Pain in Individuals With Opioid Use Disorder

Jessica S. Merlin, MD, PhD; Dmitry Khodyakov, PhD; Robert Arnold, MD; Hailey W. Bulls, PhD; Emily Dao, MS; Jennifer Kapo, MD, MSCE; Caroline King, PhD; Diane Meier, MD; Judith Paice, PhD, RN; Christine Ritchie, MD, MSPH; Jane M. Liebschutz, MD, MPH

Patient with advanced cancer and OUD taking **buprenorphine-naloxone…**

- Regardless of prognosis, appropriate to continue buprenorphine-naloxone with TID dosing
- Discontinue buprenorphine-naloxone and start methadone with TID dosing
- For patients with prognosis of weeks to months: continue buprenorphine-naloxone and add full agonist opioid, Note: “uncertain appropriateness” to discontinue buprenorphine-naloxone and start full agonist opioid other than methadone
- For patients with prognosis of months to years: “uncertain appropriateness” to add full agonist opioid

Patient with advanced cancer and OUD taking **methadone…**

- Regardless of prognosis, appropriate to take over prescribing and dose BID or TID
- For patients with prognosis of weeks to months: continue methadone and add full agonist opioid
- For patients with prognosis of months to years: “uncertain appropriateness” to add full agonist opioid

# Harm reduction

Canadian Mental Health Association defines harm reduction as *”evidence based, client-centred approach that seeks to reduce the health and social harms associated with addiction and substance use, without necessarily requiring people who use substances from abstaining or stopping.”*

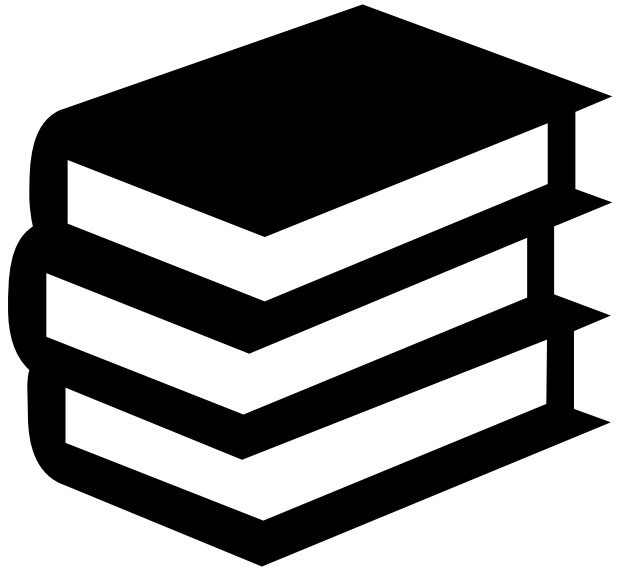
- Provides people who use drugs a choice of how they will minimize harms through non-judgemental and non-coercive strategies
- Examples:
  - Nicotine patch for smoking cessation
  - Needle exchange programs for people who inject drugs
  - Supervised injection sites
  - Safer supply (i.e. provision of prescription medications as a safer alternative to toxic illegal drug supply)

# Patient Education

All **patients** receiving palliative care and opioid prescriptions and their **caregivers** should be educated on the following topics:

- Indications for opioid use
- Opioid adverse effects
- Difference between physical dependence and opioid use disorders
- Chemical coping with opioids
- Opioid overdose signs and symptoms
- Opioid withdrawal symptoms
- Driving or operating machinery
- **Safe storage of opioids***
- **Safe disposal of opioids***

*High priority as per Canadian Society of Palliative Care Physicians



# Typical Withdrawal Symptoms

Cold shakes.

Chills and sweating.

Fever-like symptoms.

Mood swings.

Anxiety and depression.

Bone pain.

Vomiting.

Insomnia.

Diarrhea.

# PREVENT MEDICATION ACCIDENTS

## 1. Store medications out of sight and reach of:

Children and teens | Visitors | Pets

## 2. Place unused medications in a bag and bring to a pharmacy.


## 3. For locations that accept returns:

1-844-535-8889 | healthsteward.ca

**Ask a healthcare provider if you have questions.**

Download from https://www.ismp-canada.org/download/OpioidStewardship/storage-disposal-information.pdf

# Case-Based Discussion

# CASE

Ms. B is a 50-year-old woman who was recently diagnosed with metastatic breast cancer after she was admitted to hospital from acetaminophen toxicity. During the hospital admission, she informed the inpatient palliative care consultation team that she was using large quantities of Tylenol #1 and illegal fentanyl to manage her severe chest wall pain. She also stated that she was regularly using crack but did not believe it was problematic. She was offered to be referred to the addictions medicine team but declined the offer. She was discharged home with outpatient appointments with oncology and palliative care.

**Social situation:**

- Lives alone in a supportive housing complex
- 12 year old son is living with aunt because he was removed from his mom's home by child protection services
- 25 year old daughter lives in BC
- Main supports are two sisters who live outside of the city
- Unemployed, financial assistance programs

**If you were her primary care or outpatient palliative care provider:**

- **What are the challenges you anticipate that you would face with providing palliative care?**
- **How would you manage her pain?**
- **What other teams or individuals would you want to involve in her care?**

# Session Wrap Up

- Please fill out our feedback survey, a link has been added into the chat.
- A recording of this session will be emailed to registrants within the next week.
- We hope to see you again at our next session taking place on **Feb 1, 2023 from 1-2pm ET** on the topic of **GI Symptoms in Palliative Care**.
- Thank you for your participation during our second series!

# Thank You

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Palliative Care - Canada
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**www.echopalliative.com**

# Urine Drug Screens (UDS)

- **Reduces illicit drug use** in chronic pain patients receiving opioids
- Illicit drug use reduced by 50% in a group with urine testing compared to previous data

Manchikanti L et al.. Pain Physician. 2006 Jan;9(1):57-60.

# UDT: Immunoassay - “Screening Test”

- Uses antibodies to detect specific substance or class
- VERY SENSITIVE: Detection time 3-5 days
- LOW SENSITIVITY for SEMI-SYNTHETIC OPIOIDS
- NOT SENSITIVE for SYNTHETIC OPIOIDS (unless specified)
- Cheap, Rapid, Point-Of-Care
- NEED TO CONFIRM ABNORMALS

# Opioids

## Opiates

Opium
Morphine
Codeine

## Semi-Synthetic

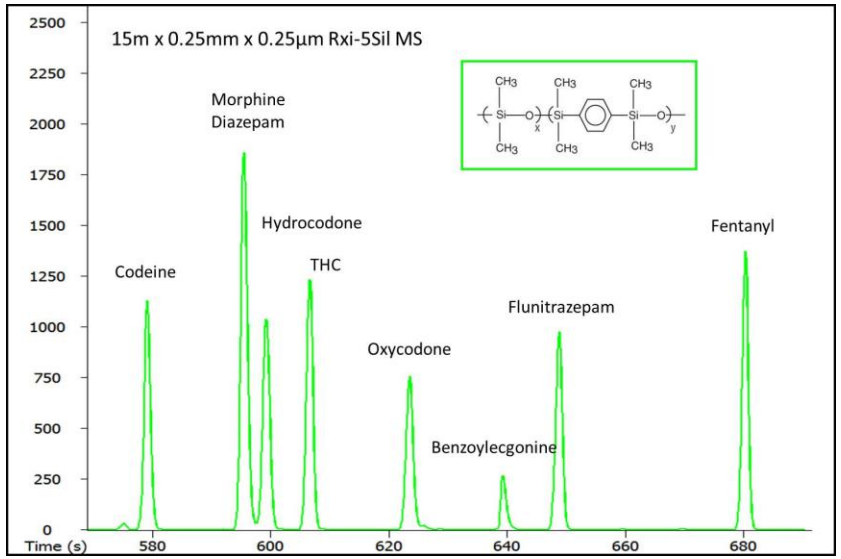
Heroin
Hydrocodone
Hydromorphone
Oxycodone
Oxymorphone
Buprenorphine

## Synthetic

Fentanyl
Methadone
Tramadol

# UDT: Gas Chromatography/Mass Spectroscopy (GCMS) "Confirmatory Test"

- Sensitivity depends on cut-off criteria
- MUCH MORE SPECIFIC
  - Occasional False + for Amphetamines
- Often used as confirmatory testing
- Distinguishes molecules among a class
- Can detect semi- and synthetic opioids
- Expensive
- Must be sent to lab
- Detection Time 1-2 days





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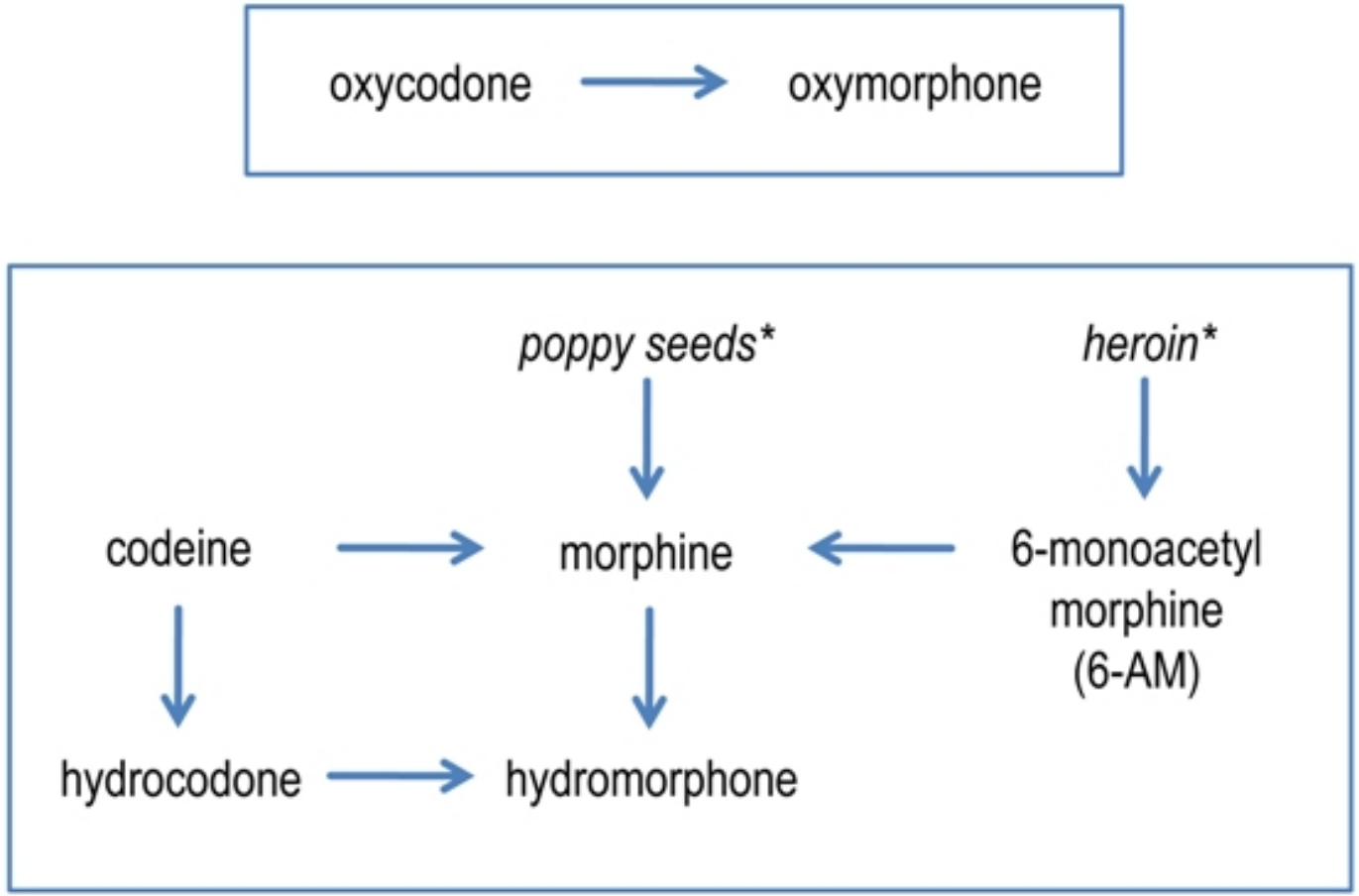
# Simplified Schematic of Metabolic Pathways for Opioids




* *Not specifically detected by the assay*

| Detection times for immunoassay and chromatography | | |
|---|---|---|
| **Drug** | **Number of days drug is detectable** | |
| | Immunoassay | Chromatography |
| Benzodiazepines (regular use) | 20+ days for regular diazepam use<br><br>Immunoassay does not distinguish different benzodiazepines<br><br>Intermediate-acting benzodiazepines such as clonazepam often undetected at therapeutic doses | Can distinguish specific benzodiazepines |
| Cannabis | 20+ | Not used for cannabis |
| Cocaine + metabolite | 3–7 | 1–2 |
| Codeine | 2–5 | 1–2 (codeine metabolized to morphine and also hydrocodone when used at high doses) |
| Hydrocodone | 2–5 | 1–2 |
| Hydromorphone | 2–5 | 1–2 |
| Meperidine | 1 (often missed) | 1 |
| Morphine | 2–5 | 1–2: Morphine can be metabolized to hydromorphone at high doses |
| Oxycodone | Often missed unless a specific test strip is used | 1–2 |
| Source: Adapted from Brands, 1998.<br><br>This table is adapted with permission from the *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain* © 2010 National Opioid Use Guideline Group (NOUGG). | | |

Source:
CAMH
https://www.porticonetwork.ca/web/opioid-toolkit/assessment/urine-drug-testing

I understand that I am receiving opioid medication from Dr. _____ to treat my pain condition. I agree to the following:

1. I will not seek opioid medications from another physician. Only Dr. _____ will prescribe opioids for me.
2. I will not take opioid medications in larger amounts or more frequently than is prescribed by Dr. _____.
3. I will not give or sell my medication to anyone else, including family members; nor will I accept any opioid medication from anyone else.
4. I will not use over-the-counter opioid medications such as 222's and Tylenol® No. 1.
5. I understand that if my prescription runs out early for any reason (for example, if I lose the medication, or take more than prescribed), Dr. _____ will not prescribe extra medications for me; I will have to wait until the next prescription is due.
6. I will fill my prescriptions at one pharmacy of my choice; pharmacy name: _____
7. I will store my medication in a secured location.

**I understand that if I break these conditions, Dr. _____ may choose to cease writing opioid prescriptions for me.**

**Source:**
Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain
Appendix B-5

http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b05.html