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MD Anderson  
Cancer Center  
Making Cancer History™

### -----Unique challenges in the Oncologic Pain Patients with substance use disorders

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MD Anderson | Unique Challenges in the Oncologic Pain Patients with Substance Use Disorders

### Cancer patients and the Opioid Crisis



**At least 1 in 5 patients with cancer might be at risk for opioid use disorder**

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MD Anderson | Unique Challenges in the Oncologic Pain Patients with Substance Use Disorders

#### Opioid-associated deaths in patients with cancer: A population study of the opioid epidemic over the past 10 years

- Duke University
- Retrospective review of death certificates from National Center for Health Statistics (2006-2016)
- Cancer
  - 0.5 to 0.7 opioid deaths per 100,000 people (p < 0.001)
- Non-cancer
  - 5.3 to 9.0 opioid deaths per 100,000 people (p<0.001)

**Opioid-related death is 10 X less likely to occur in cancer patients versus the general population.**

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■ **Limitations**

- **Competing risk for death**
  - Coding conflict when opioid OD and cancer co-occur.
- **No differentiation between**
  - nonprescription versus prescription opioids
  - intentional versus accidental OD

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Study	Institution	Type of study	UDS ordering process	# of patients	UDT ordering rate	Abnormality rate
Barclay et al. 2014	Univ. of Virginia	Retrospective	Per clinic policy	114	40%	46%
Childers et al. 2014	Univ. of Pittsburg	Retrospective	per clinician discretion	323	4%	66%
Rauenzahn et al. 2017	Virginia Commonwealth University	Retrospective	Per clinician discretion	204	40%	70%
Arthur et al. 2016	Univ. of Texas MD Anderson Cancer Ctr	Retrospective	Per clinician discretion	1058	6%	64%
Koyyalagunta et al. 2016	Univ. of Texas MD Anderson Cancer Ctr	Retrospective	Per clinician discretion	8,727	2.4%	68%

• Barclay et al. Screening for substance abuse risk in cancer patients using the Opioid Risk Tool and urine drug screen. Support Care Cancer 2014  
• Childers et al. Chronic Pain and Risk Factors for Opioid Misuse in a Palliative Care Clinic. The American journal of hospice & palliative care 2014.  
• Rauenzahn et al. Urine drug screening results among ambulatory oncology patients in a supportive care clinic. Support Care Cancer 2016  
• Arthur et al. Frequency, Predictors, and Outcomes of Urine Drug Testing Among Patients With Advanced Cancer on Chronic Opioid Therapy at an Outpatient Supportive Care Clinic. Cancer 2016  
• Koyyalagunta et al. Compliance with Opioid Therapy: Distinguishing Clinical Characteristics and Demographics Among Patients with Cancer Pain. Pain Medicine, 2016

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### How does the Opioid Crisis affect Palliative Care?

1. Opioids: mainstay of cancer pain Rx (~75-80% on opioids)
2. Early referrals (~ 15-20% early disease or NED)
3. Changing patient population
  - ↑Cancer survival rates and longevity (NED)
  - ↑Stable disease
  - >>>>more patients on opioids>>aberrant opioid use
4. Increased family/ friend exposure to the opioids
  - 55% nonmedical opioid use= friend/family free
  - 15% nonmedical opioid use = friend/family (bought or stolen)
5. Legal liabilities and regulatory scrutiny

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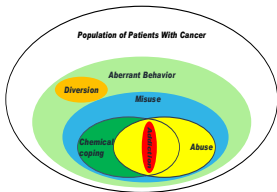
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Figure 1. Spectrum of Aberrant Opioid-Related Behavior



Arthur & Hui. Safe Opioid Use Management of Opioid-Related Adverse Effects and Aberrant Behaviors. *Hospital Oncol Clin North Am.* 2019

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### MDACC Supportive Care Opioid Safety Program

- A standardized program to manage patients receiving opioid therapy.
- *Helps address nonmedical opioid use in our patients.*

#### Goals

- Assist clinicians in their opioid prescribing practices



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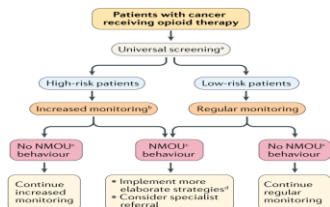
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Arthur & Bruera. *Nat Rev Clin Oncol.* 2018

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### Initial visit (screening)

- Screen ALL patients
  - Clinical interviews
- Risk screening tools:
  - CAGE-AID questionnaire
  - Screener and Opioid Assessment for Patients with Pain(SOAPP)
- Prescription Drug Monitoring Programs (PDMP)
- Informed consent
  - potential adverse effects, risks, benefits, and alternatives
- Opioid management plan (Treatment agreement or contract)
  - defines goals of therapy, how opioids will be prescribed and taken
  - duties an expectations of both parties
- Opioid education material on safe use, storage and disposal

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### Follow up visit (monitoring)

- Routine assessment of the 4 A's of pain management outcome:
  - Analgesia, Activity, Adverse effect, Aberrant behavior
- Prescription Drug Monitoring Programs (PDMP)
  - Every state in the US has an operational PDMP\*
- Urine drug testing (UDT)
- Behavior patterns: "Red flags"
  - Early refills, lost or stolen medications, 'doctor shopping', etc
- Others (e.g. pain medication diaries, pill counts)

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### Once aberrant behavior is diagnosed...

- Have an open and non-judgmental discussion, communicating concerns about patient safety.
- Decrease the time interval between follow-ups for refills,
- Limit the opioid quantity and doses at each visit
- Set boundaries or limitations
- Taper off strong opioid analgesics if possible.
- Consider referral to specialist clinicians

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### The Compassionate High Alert Team (CHAT)

#### CHAT Team Members

A palliative care physician and 2 or more of the following:

- Nurse
- Pharmacist
- Social work
- Psychologist/ counselor
- Patient advocate
- +/- legal representative and security

#### A Team Approach

- Huddle to review the case, derive strategies, and formulate a plan
- Collectively meet and have a "chat" with patient during the clinic visit
- Debrief after the patient visit
- Encounter= compassionate, supportive and nonjudgmental
- Emphasis is on patient **safety**
- **Documentation** is key

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### A Team Approach

- **Pharmacist**
  - Patient education on meds
  - Helps interpret UDS results
  - Monitors the PDMP database
- **Counselor/ Psychologist**
  - patient/ family counselling
  - emotional support
  - non-pharmacologic/ coping techniques
- **Patient Advocate**
  - Patient support
  - Assists with documentation,
  - hospital guidelines and rules

- **Physician**
  - Determines and approves the need for CHAT team approach
  - formulates final treatment plan
  - reinforces education on opioid safety and guidelines
- **Social Worker**
  - assesses patient, family/caregiver needs,
  - provides counselling,
  - facilitates logistical issues,
  - explores available community resources
  - community support groups & services

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### Benefits of the Opioid Safety Program

#### Clinical staff

- Care is now standardized
  - *Use of a common smart phrase in the EHR*
- Harmony among clinicians
- Support available to team members
- Less care provider stress

#### Patients

- Increased patient understanding of the process
- Increased patient compliance
- Fewer missed clinic appointments for opioids
- Decreased early refills

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**The Oncologist** Symptom Management and Supportive Care

**Outcomes of a Specialized Interdisciplinary Approach for Patients with Cancer with Aberrant Opioid-Related Behavior**

Johns Aronoff <sup>1,2</sup>, Frank Eisenberg <sup>3</sup>, Robert Ritzner <sup>4</sup>, Kristy Noyens <sup>5</sup>, David Pina <sup>6</sup>, Shanna Yonke <sup>7</sup>, Melissa Pina <sup>8</sup>, David Lall <sup>9</sup>, Elizabeth Brucato <sup>9</sup>

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<sup>3</sup>Contributed equally  
 Disclosure of potential conflicts of interest may be found at the end of this article.  
 Key Words: Interdisciplinary approach • Team • Intervention • Opioids • Cancer • Aberrant behavior

**ABSTRACT**

**Background:** Data on the development and outcomes of effective interventions to address aberrant opioid-related behavior (AB) in patients with cancer are lacking. Our outpatient supportive care clinic developed and implemented a specialized interdisciplinary team approach to manage patients with AB. The purpose of this study was to report clinical outcomes of this novel intervention.

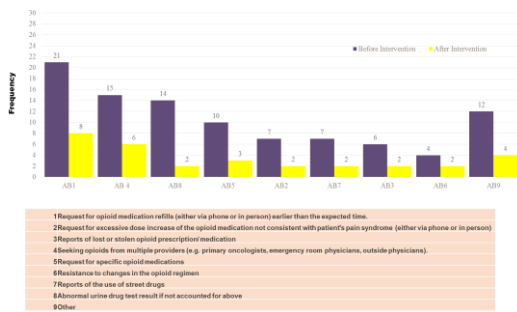
**Materials and Methods:** The medical records of 30 consecutive patients with evidence of AB who received the intervention and a random control group of 30 patients without evidence of AB between January 1, 2013, and August 31, 2016, were reviewed.

**Results:** At baseline, pain intensity ( $p = .002$ ) and opioid dose

0.4 postintervention ( $p < .001$ ). The median morphine equivalent daily dose decreased from 105 mg/day at the first intervention visit to 122 mg/day at the last follow-up ( $p = .038$ ), although pain intensity did not significantly change ( $p = .086$ ). Request for opioid medication refills in the clinic earlier than the expected time<sup>1</sup> was the AB with the highest frequency prior to the intervention and the greatest improvement during the study period. Younger age ( $p < .002$ ) and higher Education Symptom Assessment System anxiety score ( $p = .005$ ) were independent predictors of the presence of AB.

**Conclusion:** The intervention was associated with a reduction in the frequency of AB and opioid utilization among patients with

Frequency of aberrant behaviors before and after the specialized interdisciplinary team approach



**Number of aberrant behaviors per month per patient before and after the intervention**

Aberrant behaviors per month per patient	N	Median (range)	Mean (SD)	p-value
Before intervention	30	3 (1- 6)	3.2 (1.2)	<0.0001
After intervention	23	0.4 (0-3)	0.8 (0.9)	

Response	Number of patients, n (%)		
	1 <sup>st</sup> month* (n=23)	2 <sup>nd</sup> month* (n=22)	3 <sup>rd</sup> month* (n=16)
Complete	11 (48)	15 (68)	14 (88)
Partial	8 (35)	7 (32)	2 (13)
Stable	3 (13)	0 (0)	0 (0)
Worse	1 (4)	0 (0)	0 (0)