15 Recommendations for Preventing Medication Diversion & Misuse in Hospice Care

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The recommendations presented in this document were developed through a multi-stage process as part of an effort to provide guidance to hospice personnel on evidence-informed strategies to prevent medication diversion and misuse. The process for developing and refining the recommendations involved a modified Delphi approach with a team of ten interdisciplinary panelists with overlapping expertise in hospice or palliative care practice and substance use disorder. Recommendations were preliminarily informed by a 2018 national survey of hospice agencies which provided information about drug diversion, opioids left in the home after a patient death, and screening of patient/family members for diversion risk. Panelists met in early 2019 to discuss, critique, and revise draft recommendations. There were three subsequent rounds of voting to achieve consensus on the final wording and approval of recommendations. All recommendations listed in this document were endorsed by at least 80% of panelists, with the majority of recommendations reaching 90% consensus or better. Support for this work was provided by the University of Maryland CARES Science-to-Systems grant program, the University of Maryland School of Social Work, and the Hospice Foundation of America. The process and timeline for developing the recommendations is outlined below:

**June-September 2018 – National Survey of Hospice Providers**
An interdisciplinary scientific team conducted a national survey of hospice providers exploring issues of medication diversion and risk mitigation efforts.

**April 2018-March 2019 – Review of Available Evidence**
Using an over-the-phone conference call, expert panel members reviewed and discussed the existing literature on drug diversion and misuse in hospice care, as well as a summary of results from the national survey.

**January-March 2019 – Creation of Draft Recommendations**
An initial list of draft recommendations was developed by members of the scientific team.

**March-August 2019 – Expert Panel Consensus**
An interdisciplinary panel of ten subject matter experts met for a half-day face-to-face meeting at the 2019 Scientific Meeting of the American Academy of Hospice and Palliative Medicine and Hospice and Palliative Nurses Association in Orlando followed by three rounds of anonymous voting to revise and endorse the proposed recommendations.

**March 2019 – Stakeholder Feedback**
An interdisciplinary group of 25 hospice and palliative care clinicians, which included physicians, nurses, social workers, and chaplains, provided critical feedback on each draft recommendation. Draft recommendations were also reviewed and critiqued by leaders of hospice advocacy organizations, legal experts, and hospice researchers. Input from these various stakeholders were summarized and used to modify early versions of the recommendations.

**August 2019 – Final Recommendations**
After the final round of panel voting, 15 total recommendations were endorsed for dissemination.
EXPERT PANEL MEMBERS

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RECOMMENDATION 1: Balancing Prevention Efforts with Quality of Care

Efforts to mitigate medication diversion and misuse should be considered a standard component of quality of care. However, such efforts should not unduly impede patient care and supportive services. Relatedly, providers are encouraged to adopt a ‘universal precautions’ approach for preventing diversion and misuse congruent with high quality care. This approach involves staff, patient, and family education on opioid safety and shared expectations for medication management.

RECOMMENDATION 2: Screening Clinical Job Candidates

For potential new hires (and volunteers) with direct patient contact, candidates should be screened for risks for substance misuse, possibly including a urine drug screen, prior to making any unsupervised patient visits. Positive screens should be weighed in the context of a candidate’s situation (e.g., do they have a prescription for any substances detected during the screen?) and practice setting.

RECOMMENDATION 3: Post-Incident Employee Screening

In the event of an on-the-job accident, suspected diversion, or aberrant behavior (e.g., appearing sedated, slurred speech) on the part of an employee, the employee involved should be required to complete a urine drug screen at the earliest possible opportunity.
RECOMMENDATION 4: Clinical Screening For Risk

For home-based care — As part of the interdisciplinary comprehensive psychosocial assessment, hospice clinicians should screen for a history of addiction and risk for misuse/diversion within the home – including the patient, family caregivers, and other residents or frequent visitors. If a history of addiction or risk for misuse/diversion is identified within a household, providers should then work with the family to develop a:

1. context-specific care plan, and
2. risk mitigation plan

RECOMMENDATION 5: Patient & Family Education

Patients and family members should be educated about the safe and effective use of opioids, including:

- Appropriate dose, dosing interval, and instructions on proper administration
- Limiting the source of medications to one prescribing entity/practice
- Side effects, and what to do if side effects occur
- Secure storage
- Medication monitoring
- Who to call with questions
- Medication disposal

RECOMMENDATION 6: Medication Monitoring

Medication monitoring (e.g., pill counts, monitoring liquid medication levels or transdermal patch use) should be conducted and documented consistently with a frequency indicated by the clinical situation.

RECOMMENDATION 7: Missing Medications

For controlled prescriptions, instances of missing medications should be investigated, documented, communicated to the relevant members of the patient care team, and reported to the appropriate supervisor. If diversion or misuse is suspected or confirmed, reasonable efforts should be made to minimize risk of future diversion/misuse.
RECOMMENDATION 8: Responding to Medication Diversion or Misuse

If medication diversion or misuse is confirmed or strongly suspected, and therapy using controlled medications (such as opioids) is still determined to be warranted, hospice providers should, in a step-wise fashion:

1. Inform the patient/family of the issue.
2. Ensure that the patient has access to – and is getting – needed treatments.
3. Attempt to identify the individual(s) who are diverting and restrict their access to patient medications.
4. Develop and document a risk mitigation plan, which may include some or all of the steps below, in the patient plan of care; documentation should include all related observations and concerns.
5. Establish a treatment agreement with the patient/family, if applicable.
6. For home-based patients, identify a trusted individual to track and manage medications.
7. Alert relevant entities (e.g., members of the interdisciplinary care team, supervisors, pharmacies, prescribers, protective services).
8. Consider referral to addiction resources, if needed.
9. Consider reassigning staff, if staff members could be implicated.
10. Consider changing the patient’s level of care (e.g., continuous care if eligible) or location of care.
11. Consider use of a lockbox or self-dispensing device.
12. Consider limiting the supply, a therapeutic alternative, an alternate pharmaceutical formulation of the controlled substance, or as a last resort eliminate use of controlled substances.

RECOMMENDATION 9: Discharges Due to Cause

Discharging a living patient from hospice service due to cause related to drug diversion or misuse should be considered a measure of last resort (e.g., after all measures listed in Recommendation 8 have failed).

RECOMMENDATION 10: Communicating Concerns with the IDT

Concerns about diversion and misuse should be communicated to all relevant members of the care team, documented in the medical record, and routinely discussed during interdisciplinary team meetings.
RECOMMENDATION 11: Informing Families that Medication Disposal is Expected

At enrollment, providers should inform families that the disposal of all controlled medications is a standard expectation after a patient death or after changes to the patient’s medication regimen. This can be incorporated into routine patient/family education as part of a larger conversation about opioid safety, use, and storage.

RECOMMENDATION 12: Medication Disposal

For a hospice death at home – Working within all federal, state, tribal, and local laws, hospice providers should work with family members to dispose of all unused controlled medications in the home that had been prescribed for the patient, including opioids, in accordance with FDA recommendations.² Note: some states may not allow hospice staff to destroy medications after a patient death. In these cases, the surviving family members should be strongly advised to dispose of all controlled medications in a timely, safe, and effective manner and, ideally, while under the supervision of hospice staff.

RECOMMENDATION 13: Witnessing Medication Disposal

For a hospice death at home – Whenever possible, the disposal of medications should be witnessed by an additional person (e.g., family member, paid caregiver, clinician) other than the individual disposing of the medications.

RECOMMENDATION 14: Medication Disposal Documentation

For a hospice death at home – The disposal of controlled medications (amount, drug name, type, mode of disposal) should be meticulously documented and included in the medical record. If a witness is present to observe the disposal, the individual should affirm by signature that they observed the disposal of medications as described in the documentation.

RECOMMENDATION 15: Transportation of Controlled Medications

As standard practice, hospice staff should avoid transporting opioid medications or any other controlled substances (either for the purposes of patient use or drug disposal) on their person or in their personal vehicle.
REFERENCES


https://www.fda.gov/drugs/safe-disposal-medicines/disposal-unused-medicines-what-you-should-know

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