ACCEPT

Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics

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Session Date: Friday, February 18, 2022

Didactic Topic and Presenter:
When Patients Overdose: Supporting Providers

Ritu Bhatnagar, M.D., M.P.H., FASAM
President, Wisconsin Society of Addiction Medicine
NewStart Co-Medical Director
UnityPoint Health-Meriter
Content Experts:
Ritu Bhatnagar, MD; Lindsey Peterson, MS, CRC; Sheila M. Weix, MSN, RN, CARN

- 12:15 PM: Attendance text-in – Introductions
- 12:25 PM: Case Presentation and Discussion
  - Presenter: Paula Hensel, DNP, APNP, BC-FNP - *Family Health Center Alcohol & Drug Recovery Centers*
- 1 PM: Didactic Presentation
  - Presenter: Ritu Bhatnagar, M.D., M.P.H., FASAM
- 1:15 PM End of Session

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Interprofessional Continuing Education Partnership
UNIVERSITY OF WISCONSIN-MADISON
School of Medicine and Public Health
School of Nursing
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Project ECHO
University of Wisconsin

ECHO ACCEPT
Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics
2020-2022
When Patients Overdose: Supporting Providers
2/18/2022

Didactic Presenter: Ritu Bhatnagar, M.D., M.P.H., FASAM
Case Presenter: Paula Hensel, DNP, APNP, BC-FNP

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:

Nurses, Nurse Practitioners, Pharmacists, Physicians, Physician Assistants, Pharmacy Technicians, Psychologists, Social Workers, Patient/Caregivers, Students

Objectives:

As a result of this educational regularly scheduled series, learners as members of the healthcare team will be able to:

1. Describe the diversity of emotional reactions and challenges faced after a patient overdose
2. Identify the need for programs to provide proactive support for providers after patient overdoses
3. Describe strategies and resources to help providers

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Ritu Bhatnagar	Planner	No relevant financial relationships to disclose	Yes	3/12/21
Paul Hutson	Planner	No relevant financial relationships to disclose	Yes	3/11/21
Susan Mindock	Planner	No relevant financial relationships to disclose	No	3/11/21
Lindsey Peterson	Planner	No relevant financial relationships to disclose	No	3/11/21
Sheila Weix,	Planner	No relevant financial relationships to disclose	No	3/11/21
Kellene Eagen	Planner	No relevant financial relationships to disclose	No	6/23/21
Joseph Galey	Planner	No relevant financial relationships to disclose	Yes	6/23/21

Ritu Bhatnagar	Presenter	No relevant financial relationships to disclose	No	2/2/2022
Paula Hensel	Presenter	No relevant financial relationships to disclose	No	2/14/2022

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Case Presentation

Paula Hensel, DNP, APNP, BC-FNP
Family Health Center Alcohol & Drug Recovery Centers

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Case Introduction

- Introduction: 50 y.o. white male with a history of Diffuse large B-cell lymphoma testicle with central nervous system involvement, diagnosed July 2011 resulting in complex regional pain syndrome type 2 of right upper and lower extremity

- Primary question for discussion: Is this guy really a drug seeker or what is going on? What is up with these behaviors?

Medical & Behavioral Health Diagnosis:	Current Medications:
• Testicular cancer with mets to thalamus (2011) • Complex regional pain syndrome on right • Hyperesthesia. • Hypotestosteronemia. • Pulmonary embolus • Shingles • Mood Disorder- hmmm	• Buprenorphine-nalonxone 4-1 mg. ½ film bid • Testosterone injection every 3 weeks (started 2021) • Fall of 2021: trial of gabapentin

Substance Use

- History: Started in pain clinic in 2013. Subutex 4 mg qid. Attempted to wean off in 2020. Was able to lower dose and was grateful. At referral, 4-6 mg a day. Occasional THC use. Won't use bup, if uses THC.
- Consequences of Substance Use: was able to control his pain.
  - Social/occupational/educational: Pain clinic wanted to discontinue meds. "rapid fire phone calls"- anxiety on both sides. Patient labeled a disruptive patient in pain clinic. "Fired" from the service.
  - Physical (including evidence of tolerance/withdrawal): no withdrawal, pain was a concern.
  - Behaviors: hoarding tablets (130+), angry outbursts, staff fearful of him.

Social History:	Family History:
• Social Factors/History: Married. No children • Education/Literacy: Associates degree. Well read. • Income source: County employee and a part time retail position. Wife also employed	• Father has a history of alcohol use

Patient strengths & protective factors:	Risk factors:
• Well spoken, educated and read • Wife is supportive. • PCP is connected and trusted. • No legal history • No nicotine use	• Cancer history • Occasional THC use

Labs

- Correcting testosterone levels and have stabilized
- UDTs only show minimal THC level at 0.81. Treatment drug fully appropriate level

- Updated MRI: he dodged this appointment and with the supportive encouragement of his wife and Addiction Medicine NP, he followed through and it was clear.

Patient Goals & Motivations for Treatment

- He wants adequate pain control.
- And to be HEARD.

Proposed Diagnoses

- The real question is:
  - Does he have a Substance Use Disorder in the face of chronic pain?
  - How real is his pain?
  - Is he truly a difficult patient?
  - What is going on?

  - Are we as healthcare providers really listening?

Proposed Treatment Plan

- Reviewed medical records and spoke with pain clinic staff
- Joint appointment with patient and wife
- Explained how treatment of chronic pain can lead to SUD.
  - Hoarding pills, time spent thinking about medication
- Explained how to maximize medication-dosing & administration
- How can I help?

Discussion:

- Current state:
  - Suboxone 4-1 mg ½ film bid
  - MAT provider appointment once a month telehealth
  - Counseling once a month and likely graduating
  - Medical care is stable.
  - Life satisfaction scores are very high
  - Portal communication expression appreciating his appreciation of PCP and A&DRC staff

STIGMA

- Medical trauma
- Emotional trauma
  - Trust issues
- Circle back to the mood disorder
  - Pain response ?
  - Situational ?

- How can we be better as health care providers?

DSM-5 Substance Use Disorder ("Addiction")

- Tolerance
- Withdrawal

} **Physical Dependence ≠ Use Disorder**

- Larger amts/longer periods than intended
- Persistent desire/failed attempts to quit/control use
- Much time obtaining/using/recovering
- Important activities sacrificed
- Continued use despite known adverse effects
- Failure to fulfill major obligations
- Recurrent hazardous use
- Craving
- Ongoing use despite interpersonal problems

2-3 = mild
4-5 = moderate
≥ 6 = severe

By initialing here ___PH____ you have acknowledged that Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any ECHO clinician and any patient whose case is being presented in a teleECHO clinic.

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When Patients Overdose: Supporting Providers

Ritu Bhatnagar, MD MPH FASAM

February 18, 2022

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Disclosures

None

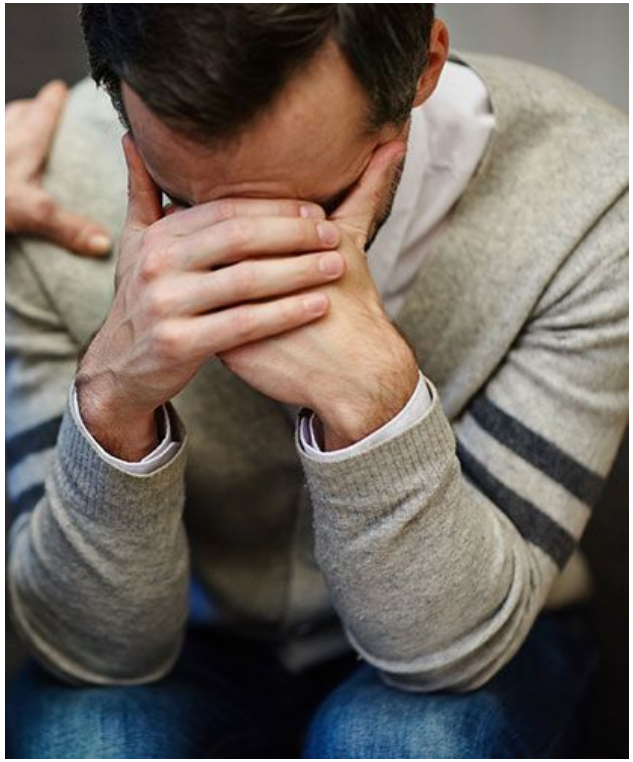
Overview

Discuss impact of overdose on providers
Review of literature of program responses
Share some effective approaches

Objectives

As a result of this program, participants will be able to:

- Describe the diversity of emotional reactions and challenges faced after a patient overdose
- Identify the need for programs to provide proactive support for providers after patient overdoses
- Describe strategies and resources to help providers



Impact of Overdoses Beyond the Patient

- Community- family and survivors- well documented (Dasgupta et al)
- First responders: some documented effects (Kasarla, Zezima)

- **Counselors, providers of care**: 1 article in March 2019, American Journal of Psychiatry (Yule and Levin)
- Impact of COVID-19 on health care providers of drug related deaths (Callaghan and Lambert, January 2022).

Overdose : An Occupational Hazard Unique to Addiction Treatment

Oncology or Palliative Care

- High risk of pt death during provider care
- Outcome of pt death is not unexpected
  - Provider anticipated timeline

Well-established support mechanisms for providers

Addiction

- High risk of pt death during provider care
- Death of patient often unexpected
  - Often sudden

No Well-established support mechanisms for providers

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Literature Search of Training Programs

- RNs, SW, Psychology: none
  - many are now online, and have varied curricula
- Limited literature on provider experience with OD
- MD/ DO- by discipline: none, only related to experience of patient suicide in Psychiatry training programs
- Much more exists regarding provider experience with suicide

Literature Search and Survey of Training Programs

- 2018 Survey of Addiction Psychiatry Fellowship programs in Midwest and East Coast = no formal training or process on how to deal with patient OD
- 2022: “Fellows are encouraged to process with their clinical supervisors and with [program director] through one-on-one supervision, as well as with each other in a group. They also have full access to mental health services through GME.”
  - No clear process for identifying the need for this- puts the onus on the provider to both recognize that they need it and to seek out help.

Wisconsin Training Programs 2022

- At UW:
  - Addiction medicine: support built in with bi-weekly meetings, make known to Fellows that immediate conversation is available and encouraged. Informed about it during routine onboarding process (change made this academic year).
  - Addiction Psychiatry: no formal policy created, in progress
- UW-M Addiction Psychiatry: institutional support built in through Resident Mental Health program, no formal connection to these beforehand

Provider Impact of Patient Suicides

- 30-70% of psychiatry residents experience patient suicide during training.
- Younger, earlier in training felt more impacted by patient suicide.
- Impact is both personal and professional.
- We still don't have a characterization of provider experience with drug overdose.

Provider Responses to Patient Suicide

Personal/ emotional

- Shock and disbelief
- Guilt, shame, fear of blame
- Self-doubt of having missed sign that would have indicated imminent suicide
- Numb, anger, confusion

Professional impact:

- Increased / decreased peer consultation
- Changes in record keeping procedures
- Increased use of hospitalizations
- Greater selectivity of populations served
- Intellectualized reactions
- **Leaving the field**

Yule and Levin; VA DOD Postvention Slides

Impact on Providers

Patient Suicide

- There is often tendency for providers to be hesitant or reluctant to take care of patients who are at higher risk of suicide.

Patient Overdose

- The risk of overdose applies to ALL patients with addiction (especially to opioids).

Selective provision of care is **not** an option

- Can lead to intense feeling of professional vulnerability
- Treat less addiction or **leave the field**

Survey of Provider Experience

- Qualitative survey of 10 providers in addiction specialty (9 addiction psych, 1 addiction med), asked 10 questions regarding their experience with OD.

Notified:

- Via inconsistent means
  - another pt, social media, newspaper, EMS for safety check
- Medical examiner's note on desk without explanation
- Email with intro line ***PATIENT DEMISE*** in scary font

Bhatnagar et al 2019

Provider Reactions to Patient Overdose- Survey

Personal/ emotional

- Shock and surprise
- Strange mixed feelings
- Not surprised
- Sad
- Frustration
- Guilt, fear of blame
- Self-doubt of having missed something to predict overdose
- Relentless review of chart
- Disconnected at home

Professional impact:

- Slowed work performance due to worry about missing next overdose
- Changes in record keeping procedures
- Distracted from next pt care
- Scared for other pts
- More cautious with controlled prescriptions
- Tend to isolate

Aware of distress for 1-2 weeks after event

Bhatnagar et al 2019

Provider Reactions to Patient Overdose- Survey

Ripple effects

- Emotional reactions towards other staff
- Wonder about impact on training
- Feeling like a failure, “This is hopeless”, “What’s the point?”
- Vicarious Trauma - there are others on staff that may be struggling, too- how to support their process and your own?
- Effects on other patients in the clinic groups
- Succession of overdoses (e.g., tainted supply of heroin in the area)

Bhatnagar et al 2019

Provider Reflection on Patient Overdose- Survey

Overdose different than death from other means:

- Yes: gunshot suicide was harder
- Overdose was more unexpected than suicide
- More questioning what provider could have done differently compared to a-fib

Bhatnagar et al 2019

Provider Resilience and Support-Survey

Some felt prepared to handle the fatal overdose:

- Intellectualization (just my share of tragedy)
- Prior personal experience with other pt deaths
  - medical (MI)
  - psychiatric (suicide)
- Prior experience supporting colleague through pt death

Some did not (5/10)

Support received:

- Colleagues talked individually
- Clinic debriefing of event
- Team meeting discussion
- Formal staff process group
- Family of deceased
- NONE

Support sought:

- spouse
- prayer
- NONE (most common)

Bhatnagar et al 2019

Personal/ Environmental Responses to Overdose- Survey

Helpful:

- Personal support from colleagues/ family
- Acknowledging feelings to other staff
- Prior experience
- Prayer

Unhelpful:

- Relentlessly reviewing the chart
- Obsessing
- Gossip
- “I shouldn’t feel like this”
- “I can’t appear vulnerable to the team”
- **NOBODY** discussed it

Bhatnagar et al 2019

Provider Responses to Patient Overdose- Survey

Things that would have helped:

- Know more details about the event
- Reschedule pts that day
- Lighter schedule for that day or next
- Explicit reminder about EAP
- Talk with colleague who knew the pt
- Peer support group
- Expected plan to support providers (i.e., mandatory team process session)

Bhatnagar et al 2019

Trainee and Provider Support

What Works After Patient Overdose: Lessons learned*

* Bhatnagar et al, 2019.

Disclaimer: Please adjust the suggestions to your training/ work environment

- Smaller training programs may leave trainees feeling more responsible
- Smaller programs may lack resources but could be more connected
- Larger training settings may have more resources for support for provider
- Larger settings may also have higher expectations of performance

Develop an Institutional Culture of Support

- Remember to acknowledge positive outcomes
- Make it standard practice to process challenging outcomes
- Develop a strategy
- Teach and practice the strategy
- Reduce isolation
- Identify the **crisis experts** on staff
- Inform **ALL** staff in timely manner
  - Cancel future appointments for patient
- Family contact? Depends on provider/ situation

Develop an Institutional Culture of Support (cont.)

- Consider group debriefing:
  Create time and provide a safe space for staff to express emotions, support each other and process the loss.
- Emotional support tailored to individual's unique adaptive styles

Suggestions for Program Director or Unit Leader

- Be prepared
- Pre-incident training - consider didactic training
- Know your trainees well
- Take time to communicate directly with trainee
- Ask if time off to process would be helpful
- Invest in improving crisis communication training skills

Suggestions for Program Director or Unit Leader (cont.)

- Assure confidentiality
- Useful to share own experience with patient loss
- It is ***not helpful*** to provide premature reassurance of no wrongdoing
- Provide calming support - closing the case: “Let’s sit down and do it together.”
- Support and model self-efficacy and self-care
- Ongoing check-in and availability for delayed need for support

Suggestions for Trainee/ Provider

- Seek support at work and at home
- Accept the help offered
- Understand and accept your emotional reactions
- **Feelings of guilt or self doubt do not equate to wrongdoing**
- Allow yourself feelings of sadness and loss
- Practice healthy self-care strategies
- Utilize EAP, PTO or wellness hours as needed
- Ask for additional support if you notice it's needed

Advice for Program

Delivery of support

- Proactive
- As close to event as possible
- As soon as possible
- Voluntary
- Manager driven
- Confidential
- Free

Advice for Program

Response Strategy Focus

- Safety
- Connectedness
- Calming
- Self-efficacy
- Hope

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Resiliency Resources

American Psychiatric Association Well-being and Burnout Toolkit: https://www.psychiatry.org/psychiatrists/practice/well-being-and-burnout/well-being-resources

TheHappyMD.com

American Psychological Association Resilience toolkit: https://www.apa.org/helpcenter/road-resilience

Provider Resilience app

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"Ask for help not because you are weak, but because you want to remain strong."– Les Brown

Conclusions

- Patient overdose events are an occupational hazard of treating addiction.
- Few providers receive training for how to handle the event or its aftermath.
- It's common for providers and staff to have complex reactions.
- Addiction training and treatment programs need to proactively have a plan that is unique to their setting to address the complex reactions of an overdose event.

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