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Identifying Drug-Seeking Behavior: A Nursing Duty to Act

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The United States is currently experiencing a public health crisis related to opioid abuse, much of which can be attributed to easy access to prescription pain medications. Emergency Departments are often targeted by drug-seekers because they manage acute pain, provide episodic care, have rotating staff, and frequently lack resources to address patterns of drug-seeking behavior (DSB). Presently, many emergency departments fail to adequately screen patients for potential opioid abuse and DSB. Reasons for this failure include: staff burnout, pressure for fast door-to-discharge times, expectation of good patient satisfaction scores, lack of nursing protocol for identification of DSB, and lack of nursing empowerment to escalate concerns. These barriers make it difficult for nurses to adequately address DSB when they suspect it, a cycle that promotes ongoing apathy and a sense of powerlessness among the nursing staff. If nurses are given the right tools and adequate support, emergency departments can implement practice-changes and reduce inappropriate opioid prescriptions, which will subsequently reduce the availability of opioids in the community. Rather than relying on demographics to identify patients who are at-risk for prescription opioid abuse, observing patients' behaviors in the emergency department can help to better identify drug-seekers. Using an objective screening tool to identify the presence of predictive behaviors, and utilizing a nurse-driven protocol to escalate concerns, empowers nurses to collaborate with prescribers. When patients are identified as potential drug-seekers, establishing multidisciplinary care teams and implementing individualized care plans reduces both opioid abuse and unnecessary visits to emergency departments. Ongoing screening and treatment for DSB will likely have a cumulative effect in reducing the number of drug-seekers in emergency departments, as public perceptions about the availability of opioid prescriptions gradually change. Given the huge social and public health impact of opioid abuse in the United States, and the professional duty of nurses to care for both individuals and populations, it is imperative that evidence-based practice be implemented to reduce the availability of prescription opioids to individuals who would be harmed by them. Emergency departments are uniquely positioned to begin this effort.

Title:

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References:

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Abstract Summary:

Many emergency departments fail to identify signs of opioid abuse and drug-seeking behavior among patients. Utilization of an objective screening tool and escalation protocol will empower nurses and prescribers to collaboratively address opioid abuse, with the goal of decreasing inappropriate prescriptions and improving patients' access to treatment resources.

Content Outline:

*The presentation will be given in poster format, but there is no option to submit the poster in this section. Included here is the evidence-based practice improvement project on which the poster is based. References included in the appropriate section.

Identifying Drug-Seeking Behavior: A Nursing Duty to Act

The United States is currently experiencing an opioid epidemic that is fueled, in part, by the prescribing practices of healthcare providers. Nearly half of fatal opioid overdose deaths occurring in the U.S. involve a prescription opioid (CDC, 2017). It is therefore vital that an effort be made to reduce unnecessary prescriptions and provide resources to help patients battling addiction. Opioid related deaths are preventable, and healthcare providers have an obligation to help correct a problem they clearly helped to create.

A multidisciplinary approach to preventing opioid abuse can be used in various healthcare settings, but the Emergency Department (ED) serves as a high-impact venue to begin the effort. Emergency

Departments are often targeted by drug-seekers because they manage acute pain, provide episodic care, have rotating staff, and frequently lack resources to address patterns of drug-seeking behavior (DSB). By accurately identifying patients with DSB, healthcare providers can connect patients with treatment resources and reduce the number of inappropriate opioid prescriptions circulating in the community.

Ideally, emergency departments should be used for medical emergencies only; however, they are often utilized by uninsured individuals and those who live in medically underserved areas. For many, the emergency department is their only access to healthcare. It is therefore crucial that ED staff are trained to recognize DSB, and are capable of connecting patients with treatment options, when appropriate. Drug addiction is a disease requiring intervention, and failing to recognize affected patients when they present in the ED does a great disservice to the wellbeing of individual patients and society as a whole.

Drug-seeking behavior places a huge burden on Emergency Departments throughout the United States. Patients who are drug-seeking often present with multiple visits to the ED, greatly contributing to overcrowding (Pillow, Doctor, Brown, Carter, & Mulliken, 2013). Not only does overcrowding stretch resources thin in the ED setting, but it also has a negative impact on staff retention and performance. A systematic review of 25 years of research demonstrated that overcrowding is a common cause of burnout among ED nurses (Adriaenssens, De Gucht, & Veronique, 2015). If the issue of overcrowding can be addressed, at least in part, by better management of patients with drug-seeking behavior, it would likely be advantageous for nursing retention.

Slipping Through the Cracks

A community hospital in Hanover, Virginia has one of the busiest emergency departments in the area, treating about 205 patients per day on average. The ED serves surrounding counties and the City of Richmond, and is often overcrowded with patients lying on stretchers or seated in chairs in hallways as they wait for care. The immense congestion is stressful for staff and patients alike.

From the nursing perspective, factors that influence the high rate of DSB include: staff burnout, pressure for fast door-to-discharge times, expectation of good patient satisfaction scores, lack of nursing protocol for identification of DSB, and lack of nursing empowerment to escalate concerns. These barriers make it difficult for nurses to adequately address DSB when they suspect it, a cycle that promotes ongoing apathy and a sense of powerlessness among the nursing staff.

Other contributing factors to DSB in this emergency department include: inconsistent medical management of DSB, lack of interdisciplinary collaboration, infrequent use of the Virginia Prescription Monitoring Program (PMP), and lack of internal software to track patterns of suspicious behavior among repeat-patients. All of these barriers can be removed by implementation of evidence-based practice improvements, but a coordinated multidisciplinary effort is required to do so.

The Evidence

According to Peirce et al, a drug seeker is a consumer who typically utilizes multiple emergency department visits in an effort to obtain prescriptions, who often has a reported allergy to non-steroidal anti-inflammatory drugs (NSAIDS), and frequently requests opioids by name (Peirce, Smith, Abate, & Halverson, 2012). Additional cues for DSB include overlapping or frequent prescriptions for narcotic pain medicines, and reported or observed symptoms disproportionate to examination findings (Weiner et al., 2013).

According to a cohort observational study in 2015, establishing care plans for patients exhibiting DSB significantly reduced their average number of yearly visits (Feisseler et al.). In the study, patients and their primary care providers were informed of the care plan initiation, and follow-ups were performed after patient discharge. In addition to reduced visits, patient outcomes included improved access to resources like case management, pain management, and follow-up care with primary care providers (Feisseler et

al., 2013). In fact, care plans related to DSB should consistently utilize an interdisciplinary care team for best results, and should include case management, psychiatry, emergency medical services, and primary care providers when possible (Pillow et al., 2012).

DSB is a common source of job-dissatisfaction among many Emergency Department nurses. Patients displaying DSB are often seen as being aggressive, routinely noncompliant, and frequently show no signs of gratitude towards the nurse, rendering feelings of low self-worth and creating stereotypes (McCreaddie et al., 2010). Nursing job satisfaction may improve as DSB is adequately addressed in emergency departments.

Despite an abundance of evidence-based practice recommendations, many emergency departments do not adequately identify and treat patients with DSB. By improving methods of identification, treatment, and follow-up, drug-seeking visits could be significantly reduced. A well-designed clinical initiative could decrease the number of opioid prescriptions circulating in the community and increase participation in drug treatment programs, outcomes that benefit both the nursing staff as well as all the patients in their charge.

Clinical Initiative

A clinical initiative was designed to address several root causes of escalating DSB in the ED. The initiative specifically targets these major contributors: inconsistent medical management of patients with drug-seeking behavior, lack of nursing protocol to identify DSB, infrequent use of the Virginia Prescription Monitoring Program, paucity of nursing empowerment, and sporadic use of interdisciplinary collaboration. The initiative includes a nurse-initiated algorithm for identifying and treating patients with DSB, as well as a dashboard to organize data, monitor efficacy, guide practice changes, and improve patient outcomes.

The Algorithm

There are many indicators of potential for DSB among patients. A large body of evidence correlates certain demographic features with increased likelihood of DSB. While the information is useful, particularly in context of primary prevention strategies, it is not appropriate to use demographics as a screening tool to identify DSB. Assessing someone's likelihood of DSB based on their race, gender, socioeconomic status, or insurance status is discriminatory in nature, and while some demographic features may be fairly sensitive for DSB, they are not very specific. Instead, a screening tool was devised to focus on predictive behavior, rather than demographics, when evaluating likelihood of DSB. Predictive behaviors are much more specific to DSB than demographics alone.

The "Identifying Drug-Seeking Behavior (IDSB) Screening Tool" was designed to assist ED nurses in quickly identifying cues for potential DSB. The tool assigns a point value to each of four predictive behaviors including: requesting opioids by name, having multiple ED visits for the same complaint, reporting symptoms disproportionate to exam findings, and reporting an allergy to NSAIDS. The first two predictive behaviors, respectively, are weighted with a two-point score due to their increased specificity for DSB as compared to the second two behaviors, which are weighted with one point each. A total score of three or greater is considered a positive screening, and it triggers the next phase of the algorithm.

Any patient with a positive screening will be entered by the physician into the Virginia Prescription Monitoring Program (PMP) to check for frequent or overlapping narcotic prescriptions. If such prescriptions are found, the patient will be placed on a list for evaluation by a multi-disciplinary care team. The patient will be informed of their placement on this list by the physician.

A 2013 study indicated that when physicians routinely screen all of their patients using a PMP, they actually prescribe more narcotic pain medications rather than less (Weiner et al., 2013). Perhaps because these clinicians always use a PMP, they come to view it as the sole deciding factor, making them less likely to consider clinical presentation or presence of predictive behaviors when prescribing narcotics. For

this reason, the algorithm states that only patients with a positive score on the IDSB Screening Tool be routinely screened in the Virginia PMP.

If after reviewing the PMP, a physician agrees that the patient is drug-seeking, he or she will use predetermined guidelines for medical management of the patient's pain, aiming to minimize or eliminate opioid prescriptions at the time of discharge. Every case is different, and no single approach is appropriate in all situations, therefore the physician will retain ultimate discretion in pain management strategy. This detail is necessary to obtain physician buy-in and compliance with the algorithm.

After patient discharge, a multi-disciplinary care team will review the case and a designated member will perform a follow-up phone interview with the patient. A needs assessment will be completed with patient input, and additional resources and services will be offered as appropriate, including: referral to a pain management clinic, primary care provider, mental health counselor, or substance abuse treatment program. The needs assessment generated during this phone call will help guide the creation of an individualized care plan for the patient moving forward. The care plan will be noted in the chart so that all clinicians involved with the patient will have access to it, particularly if the patient presents to the ED with a pain-related complaint.

The Dashboard

The impetus for this clinical initiative is patient-centered, but the operational flow of the ED should improve as a result of successful implementation. Less unnecessary visits to the ED means more bed-availability and access to services for other patients. To monitor the efficacy of the IDSB Algorithm, a dashboard will be utilized to track various trends in the emergency department (see Appendix C). The success of each individual case is important, but the dashboard measures overall impact on the unit.

Patients that present to the ED with an Emergency Severity Index (ESI) level of four or five are considered the lowest levels of acuity, and require either one or no department resources for diagnosis and treatment, respectively (Gilboy, Tanabe, Travers, & Rosenau, 2011). The IDSB Dashboard will track patients with an ESI level of four or five, who have multiple visits to the ED with pain-related complaints. According to Feisseler et al. (2015), the median number of ED visits among drug seekers was 26.5 per year, so setting the threshold at two or more visits in 30 days should capture a large portion of drug seekers without being overly sensitive.

The dashboard will track the following data on a monthly basis: total number of positive DSB screenings, total number of care plans initiated, total number of hours patients occupied beds or chairs in the ED, total number of patients given narcotic pain medications during their visit, total number of narcotic prescriptions at discharge, and total number of patients who returned for another pain related complaint within 30 days of care plan initiation.

To demonstrate efficacy of the clinical initiative, all dashboard metrics should steadily decrease over time. If this trend is not observed, specific augmentations to the algorithm can be made to improve patient outcomes, and the dashboard may be adjusted to more accurately capture results as appropriate.

Practice Implications

Collaboration is vital for the IDSB algorithm to produce positive results. By using a nurse-driven protocol to screen patients for DSB, nurses become empowered to communicate their concerns with prescribers, and are able to do so using objective data. This improved communication and empowerment will likely result in increased nurse satisfaction, while also supporting a culture of nurse-physician collaboration in the workplace.

If the clinical initiative is successful in reducing unnecessary visits to the ED, then it will have a positive impact on the issue of overcrowding, previously identified as a major contributor to burnout among nurses

(Adriaenssens et al., 2015). As overcrowding decreases, nurses will have more time to spend with each patient, which improves the nurse-patient relationship and creates safer working conditions in the ED.

Low levels of nursing job satisfaction correlate with high levels of burnout, so nursing satisfaction should be a priority if hospitals are to remedy the high turnover rates that are universally felt in emergency departments across the country. Addressing DSB in the emergency department is one way to help improve nursing satisfaction, and should be part of the strategic plan to retain qualified nurses and combat the national nursing shortage.

The Path Forward

The proposed clinical initiative has been well-received in the community-based ED for which it was designed. A multidisciplinary team has been created in the ED with the express intent of addressing DSB. The team is reviewing the proposed clinical initiative for possible implementation. In addition to physicians, buy-in is required from the case managers, mental health social workers, and nurses who will be tasked with implementing the initiative. All disciplines have expressed sincere interest; However, lack of budgeted work-hours seems to be a potential barrier. A team meeting has been scheduled to discuss barriers to implementation and brainstorm problem-solving strategies.

The opioid crisis in the United States should be addressed by a multi-faceted approach, in which health care providers should play a significant role. As the gate-keepers for opioid prescriptions, nurses and physicians are uniquely able to address the issue, but to be successful there must be excellent communication, implementation of evidence-based practice, and effective multi-disciplinary collaboration. Involvement in this issue is not optional, but vital for the health and wellbeing of patients and society, and nurses are called to care for the individuals and populations affected by the opioid epidemic.

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Professional Experience: I am a registered nurse with about 9 years of clinical experience in the emergency department setting. For the first 6 years of my career, I worked in a single community emergency department, but for the last few years I have been employed as a flex team nurse for Bon Secours Health System, rotating among 4 emergency departments in the region. I am a Certified Emergency Nurse and I completed my Bachelor's of Science in Nursing at the University of Virginia in 2018. This fall, I will begin the FNP/DNP program at the University of Virginia.
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