Resources

Virginia Regulatory Town Hall

http://townhall.virginia.gov/

Edmonton Symptom Assessment System Revised

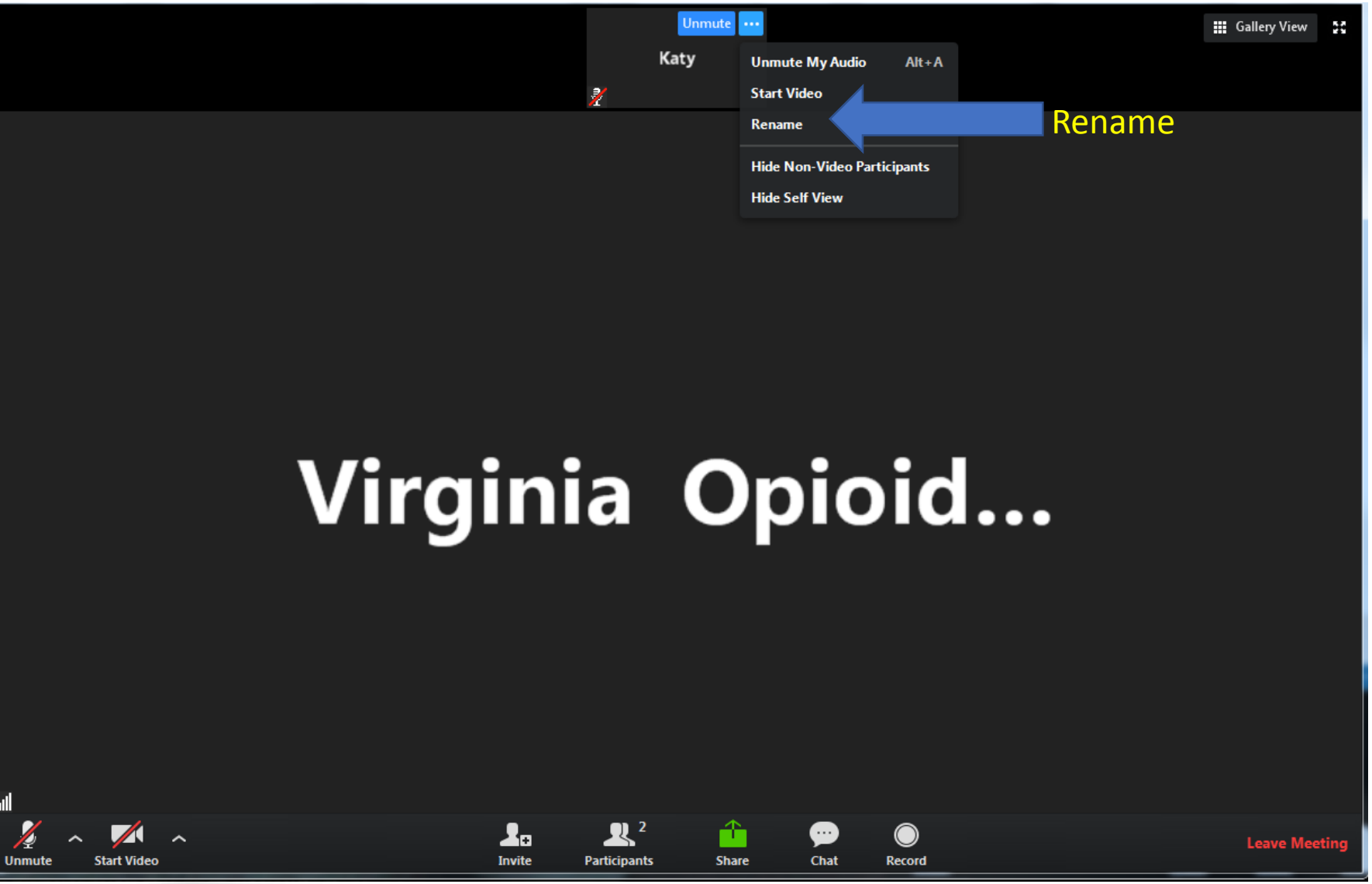
http://www.palliative.org/NewPC/professionals/tools/esas.html

# Virginia Opioid Addiction ECHO* Clinic

February 1, 2019

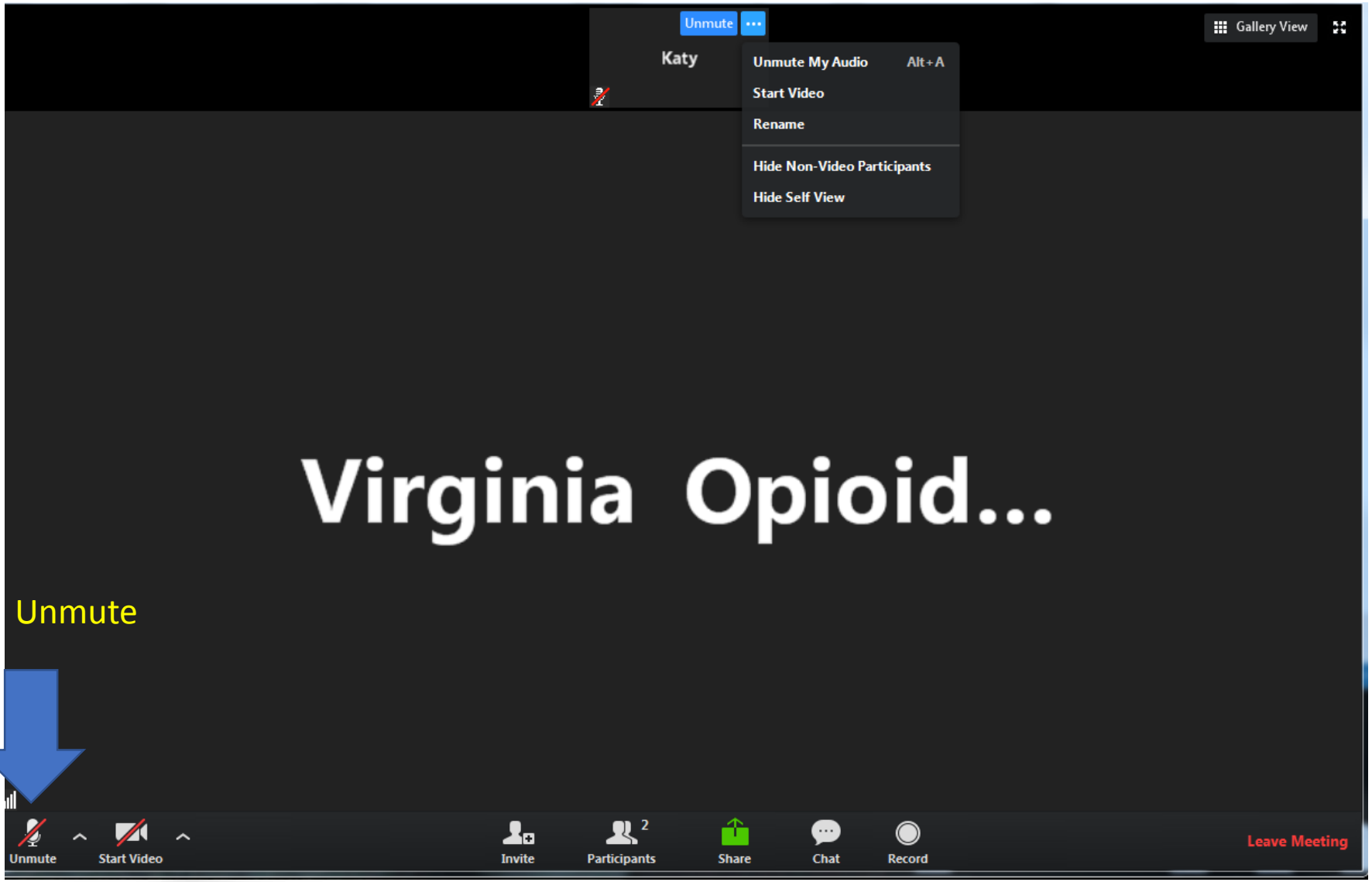
*ECHO: Extension of Community Healthcare Outcomes

# Helpful Reminders



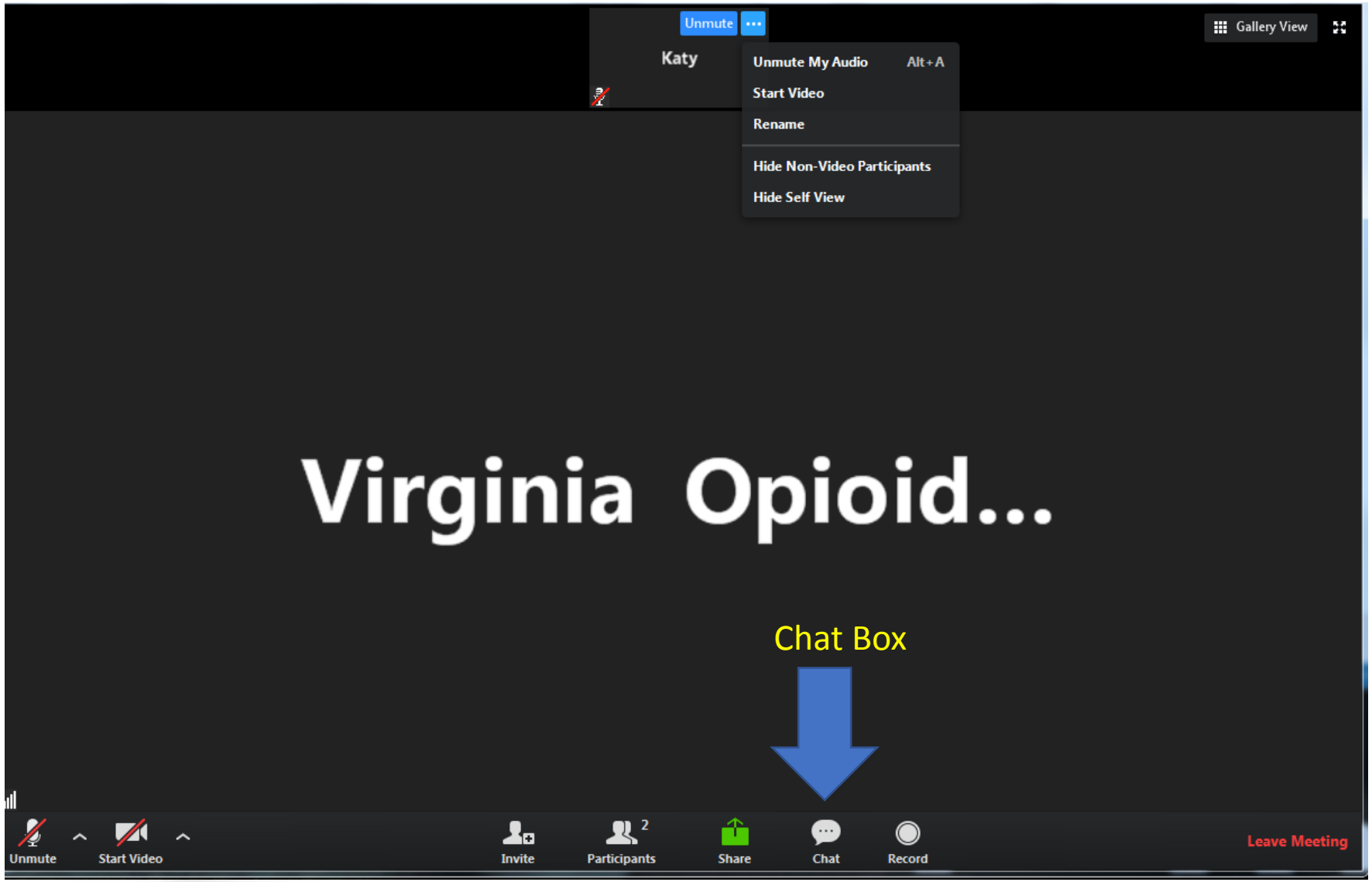

- Rename your Zoom screen, with your name and organization

# Helpful Reminders




- You are all on mute please unmute to talk
- If joining by telephone audio only, *6 to mute and unmute

# Helpful Reminders




- Please type your full name and organization into the chat box
- Use the chat function to speak with IT or ask questions

# VCU Opioid Addiction ECHO Clinics

VCU Health
VCU School of Medicine

VDH Virginia Department of Health | VDHLiveWell.com | Virginia Department of Behavioral Health & Developmental Services

- Bi-Weekly 1.5 hour tele-ECHO Clinics
- Every tele-ECHO clinic includes a 30 minute didactic presentation followed by case discussions
  - Didactic presentations are developed and delivered by inter-professional experts in substance use disorder
- Website Link: www.vcuhealth.org/echo

VCU

# Hub Introductions

| VCU Team | |
|---|---|
| Clinical Director | Mishka Terplan, MD, MPH, FACOG, FASAM |
| Administrative Medical Director ECHO Hub and Principal Investigator | Vimal Mishra, MD, MMCi |
| Clinical Expert | Lori Keyser-Marcus, PhD<br>Courtney Holmes, PhD |
| Didactic Presentation | Danielle Noreika, MD |
| Program Manager | Bhakti Dave, MPH |
| Practice Administrator | David Collins, MHA |
| IT Support | Vladimir Lavrentyev, MBA |

# Spoke/ Participant Introduction

- Name
- Organization

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for Introduction

# What to Expect

I. Didactic Presentation
   I. **Substance Abuse in Hospice and Palliative Care**
   II. **Danielle Noreika, MD**
II. Case presentations
   I. Case 1
      I. Case summary
      II. Clarifying questions
      III. Recommendations

   II. Case 2
      I. Case summary
      II. Clarifying questions
      III. Recommendations

III. Closing and questions

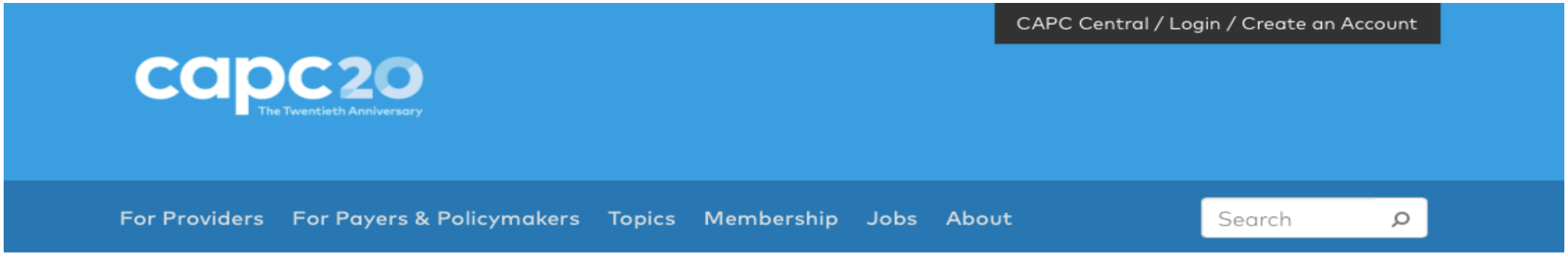
Lets get started!

Didactic Presentation

# Substance Abuse in Hospice and Palliative Care

Danielle Noreika, MD

Feb 1, 2019

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Virginia Commonwealth University

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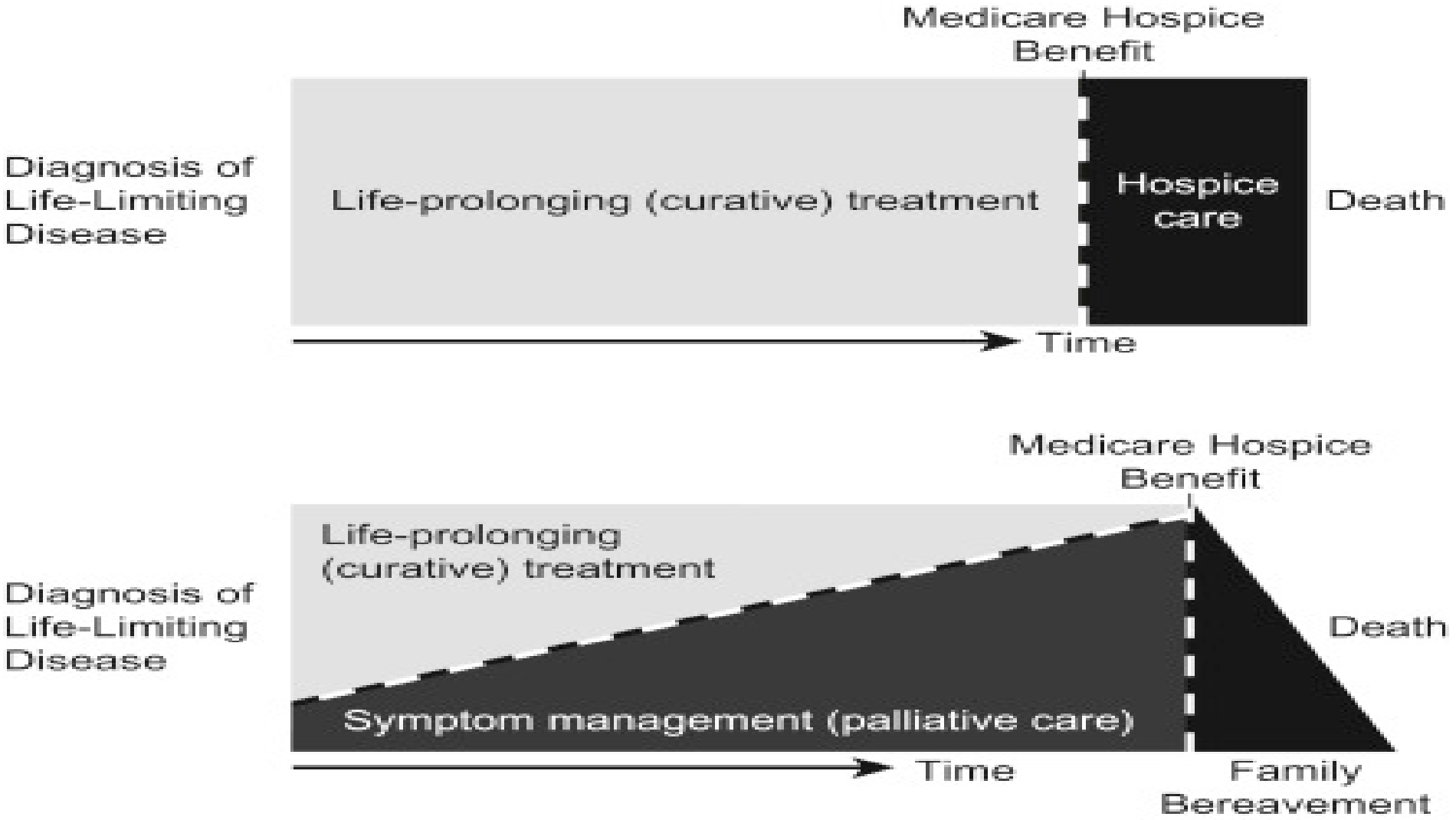
**Hospice**

- Medicare Hospice Data
- Hospice Transmittals
- Hospice Regulations and Notices
- Hospice Wage Index
- Ask a Question

# Hospice

According to Title 18, Section 1861 (dd) of the Social Security Act, the term "hospice care" means the following items and services provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan (for providing such care to such individual) established and periodically reviewed by the individual's attending physician and by the medical director (and by the interdisciplinary group described in paragraph (2)(B)) of the program—

- (A) nursing care provided by or under the supervision of a registered professional nurse,
- (B) physical or occupational therapy, or speech-language pathology services,
- (C) medical social services under the direction of a physician,
- (D)(i) services of a home health aide who has successfully completed a training program approved by the Secretary and
  - (ii) homemaker services,
- (E) medical supplies (including drugs and biologicals) and the use of medical appliances, while under such a plan,
- (F) physicians' services,
- (G) short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management) in an inpatient facility meeting such conditions as the Secretary determines to be appropriate to provide such care, but such respite care may be provided only on an intermittent, nonroutine, and occasional basis and may not be provided consecutively over longer than five days,
- (H) counseling (including dietary counseling) with respect to care of the terminally ill individual and adjustment to his death, and
- (I) any other item or service which is specified in the plan and for which payment may otherwise be made under this title.




www.Netcestudents.com

# Why does this matter?

- Most commonly heard: “well they’re dying anyway just give them whatever they want”
- Multiple issues with that construct HOWEVER
- There are a number of challenges in managing substance abuse disorders in the context of palliative care and hospice

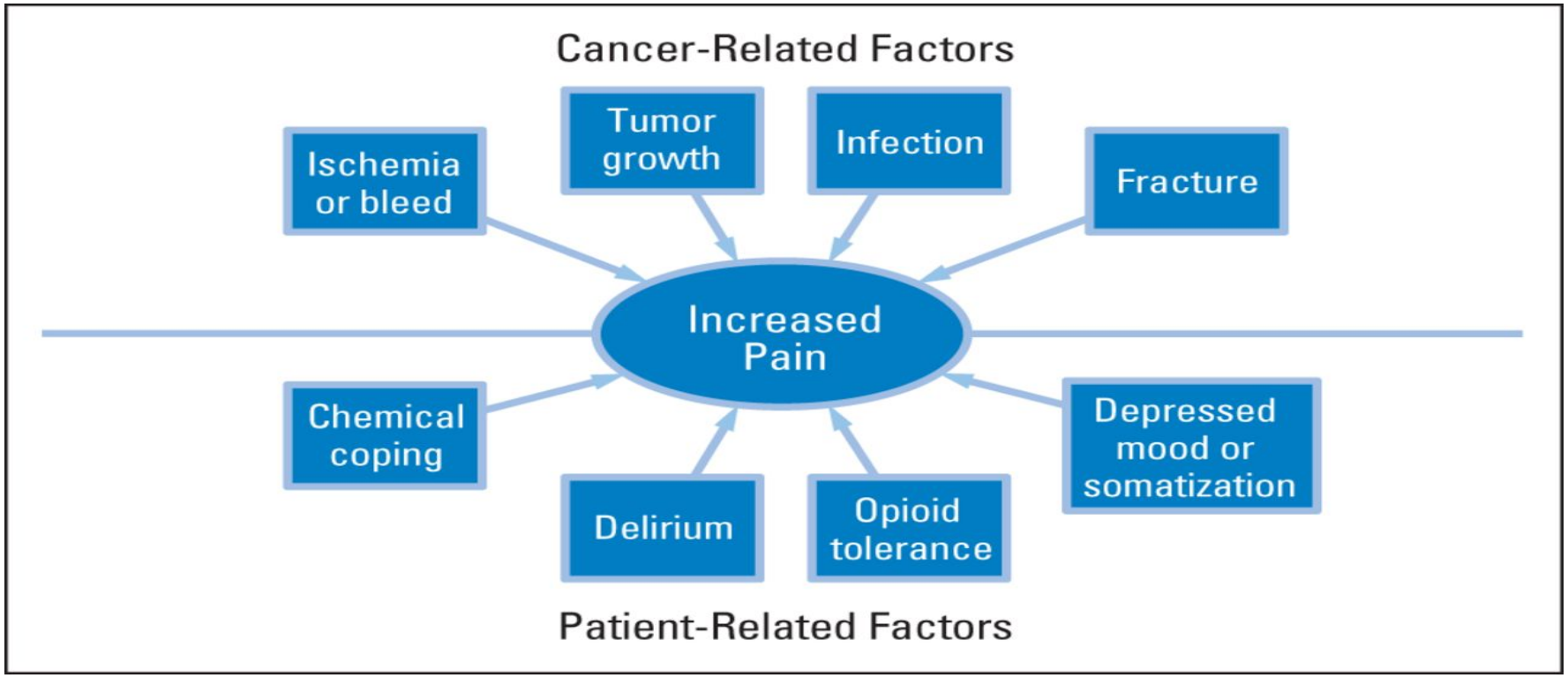
# Case #1

- 59 yom, end stage CHF, long history of substance abuse per family although details hard to ascertain due to strained relationships
- Additional challenges to dying of HF:
  - Strained family relationships
  - Little to no coping skills
  - Need for security on the unit (patient + what he termed “friends”)
  - Tolerant to multiple classes of medications necessary for adequate symptom management
  - Disposition options incredibly limited

# Case #1

- What were we able to accomplish?
  - Was able to reconnect with some family members
  - Negotiated time outside (had been in hospitals for months)
  - Support for family who were very distressed at times
  - Safety for patient
  - Establish and support goals of care for patient
  - Some degree of symptom management
- What did we maybe fall short on?
  - Symptom management was a challenge on multiple fronts, incl. baseline vs delirium
  - Patient mostly did not talk about his suffering, distress, life history etc
  - Team frustration with baseline coping skills

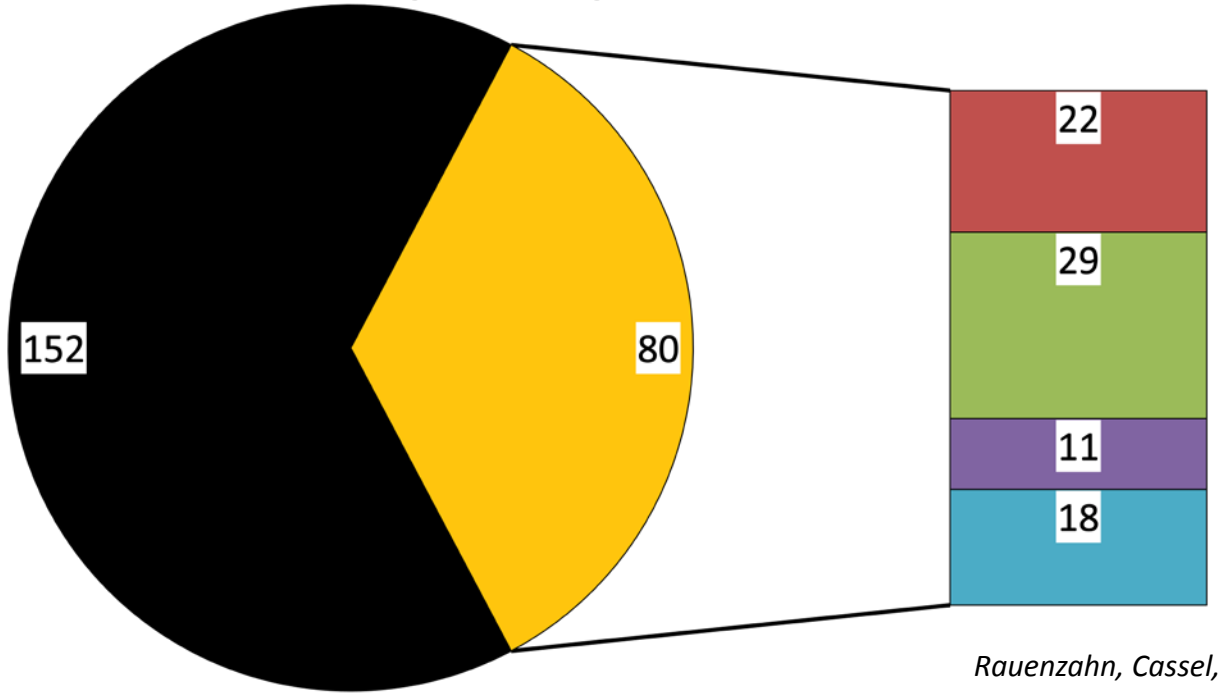
# Cancer- and patient-related factors contributing to pain




Del Fabbro E JCO 2014;32:1734-1738

# How often does this really happen?

FIGURE 1. Urine Drug Screening for Patients in a Palliative Care Clinic




*Rauenzahn, Cassel, Del Fabbro MASCC 2015*

JOURNAL OF PALLIATIVE MEDICINE
Volume 18, Number 9, 2015

DOI: 10.1089/jpm.2015.0098

# Do Palliative Care Clinics Screen for Substance Abuse and Diversion? Results of a National Survey

Paul D. Tan, MD,[1,2] Joshua S. Barclay, MS, MD,[1] and Leslie J. Blackhall, MTS, MD[1]

Table 3. Policy and Training Responses

| | *Yes* | *No* |
|---|---|---|
| Have a written policy regarding screening patients for substance abuse in patients | 40.5% | 59.5% |
| Have a written policy regarding screening family members for substance abuse | 16.22 | 83.78% |
| Have a written policy regarding screening patients for drug diversion | 27.03% | 72.97% |
| Have a written policy regarding screening family members for drug diversion | 10.8% | 89.2% |
| Have a written policy requiring the use of a screening tool regarding substance abuse and diversion | 32.4%<br>• 18.9% – requires routine screening<br>• 13.5% – screening per provider discretion | 67.6% |
| Have mandatory training for staff | 47.2% | 52.8% |
| Have mandatory training for fellows | 83.33% | 16.67% |

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American Journal of Hospice & Palliative Medicine®
1-9

DOI: 10.1177/1049909118806664
journals.sagepub.com/home/ajh
SAGE

# Dying on Hospice in the Midst of an Opioid Crisis: What Should We Do Now?

**Jennifer Gabbard, MD[1], Allison Jordan, MD, HMDC[2], Julie Mitchell, DO[3], Mark Corbett, MD, MA, HMDC, FAAHPM[4], Patrick White, MD, HMDC, FAAHPM[5], and Julie Childers, MD, FAAHPM[6]**

## Abstract

The current opioid crisis in the United States is a major problem facing health-care providers, even at the end of life. Opioids continue to be the mainstay treatment for pain at the end of life, with the prevalence of pain reported in up to 80% of patients and tends to increase as one gets closer toward the end of life. In the past year, 20.2 million Americans had a substance use disorder (SUD) and SUDs are disabling disorders that largely go untreated. In addition, the coexistence of both a mental health and SUD is very common with the use of opioids often as a means of chemical coping. Most hospice programs do not have standardized SUD policies/guidelines in place despite the increasing concerns about substance abuse within[illegible]rticle is to review the literature on this topic and

# Pain management strategies for patients on methadone maintenance therapy: a systematic review of the literature

Mel Clark Taveros,[1] Elizabeth J Chuang[2]

► Additional material is published online only. To view please visit the journal online (http://dx.doi.org/10.1136/bmjspcare-2016-001126).

[1]Hospice and Palliative Medicine, Montefiore Medical Center, Bronx, New York, USA
[2]Department of Family and Social Medicine, Palliative Care Service,

## ABSTRACT

**Context** Prescription opioid and heroin abuse has increased substantially in recent years. Enrolment on opioid agonist therapy programmes is consequently increasing as well. As a result of these trends, more patients who present with acute pain secondary to a malignancy are also on chronic methadone maintenance therapy (MMT) for substance

## INTRODUCTION

Palliative care teams are often consulted to assist in managing complex pain syndromes related to advanced disease and serious illnesses. More than half of patients with cancer develop pain, either from tumour burden, complications of advanced or progressive disease or from the effects of treatment regimens, including surgery,

# What do we have to guide us in caring for these patients?

Substance Abuse and Rehabilitation

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open access to scientific and medical research

Open Access Full Text Article

REVIEW

## Identifying and assessing the risk of opioid abuse in patients with cancer: an integrative review

This article was published in the following Dove Press journal:
Substance Abuse and Rehabilitation
2 June 2016
Number of times this article has been viewed

Ashley-Nicole Carmichael[1]
Laura Morgan[1]
Egidio Del Fabbro[2]

[1]School of Pharmacy, [2]Division of Hematology, Oncology, and Palliative Care, Virginia Commonwealth University, Richmond, VA, USA

**Background:** The misuse and abuse of opioid medications in many developed nations is a health crisis, leading to increased health-system utilization, emergency department visits, and overdose deaths. There are also increasing concerns about opioid abuse and diversion in patients with cancer, even at the end of life.

**Aims:** To evaluate the current literature on opioid misuse and abuse, and more specifically the ide e risk in patients with cancer. Our secondary aim is to offer the most current evidence of best clinical practice and suggest future directions for

# Edmonton Symptom Assessment Scale (ESAS)

**Edmonton Symptom Assessment System:**
**(revised version) (ESAS-R)**

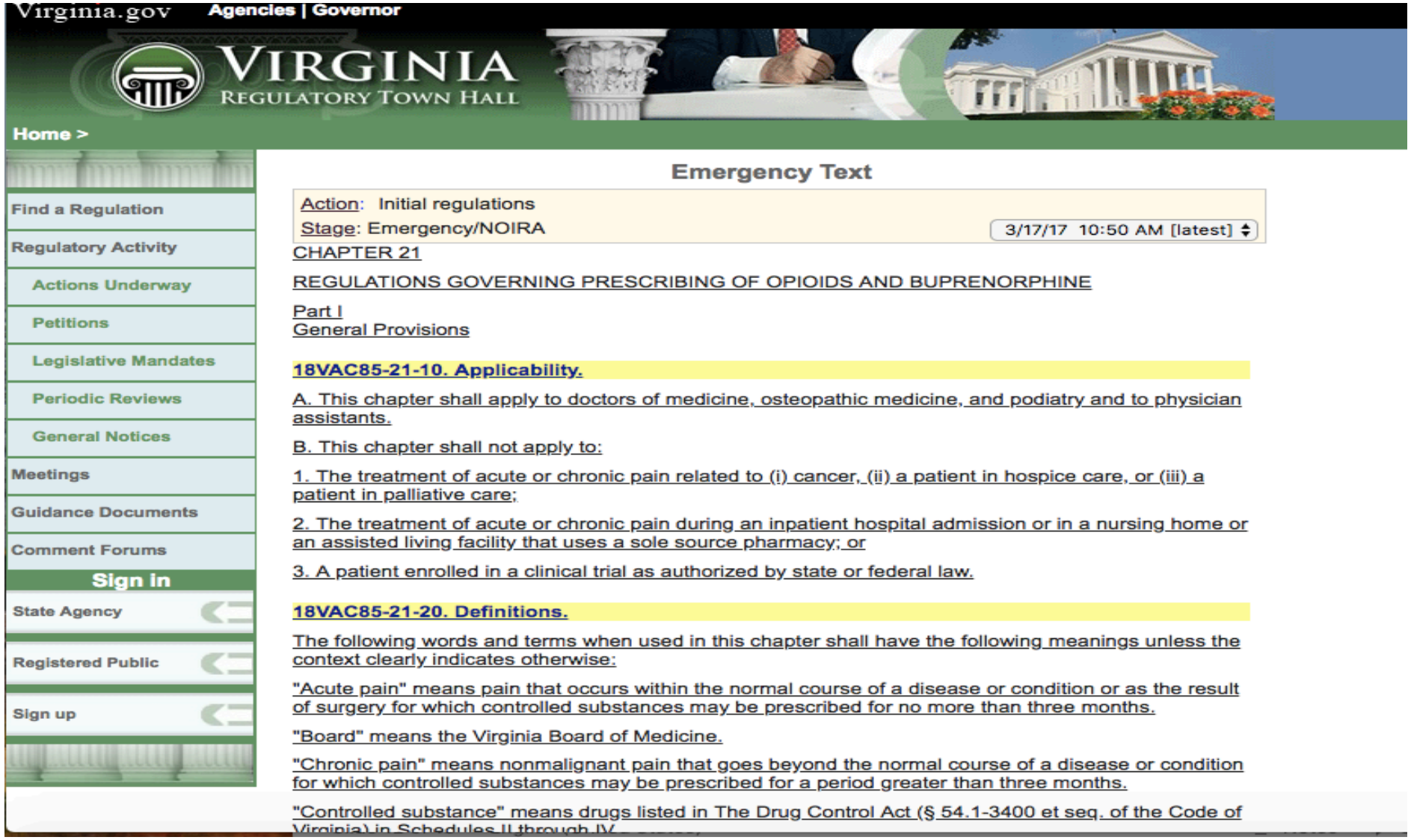
**Please circle the number that best describes how you feel NOW:**

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Possible Pain |
| No Tiredness *(Tiredness = lack of energy)* | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Possible Tiredness |
| No Drowsiness *(Drowsiness = feeling sleepy)* | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Possible Drowsiness |
| No Nausea | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Possible Nausea |
| No Lack of Appetite | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Possible Lack of Appetite |
| No Shortness of Breath | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Possible Shortness of Breath |
| No Depression *(Depression = feeling sad)* | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Possible Depression |
| No Anxiety *(Anxiety = feeling nervous)* | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Possible Anxiety |
| Best Wellbeing *(Wellbeing = how you feel overall)* | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Possible Wellbeing |
| No _____ Other Problem *(for example constipation)* | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Possible _____ |

Patient's Name _____

Date _____ Time _____

Completed by (check one):
- ☐ Patient
- ☐ Family caregiver
- ☐ Health care professional caregiver
- ☐ Caregiver-assisted


Virginia.gov
Agencies | Governor
VIRGINIA
REGULATORY TOWN HALL
Home >
Find a Regulation
Regulatory Activity
Actions Underway
Petitions
Legislative Mandates
Periodic Reviews
General Notices
Meetings
Guidance Documents
Comment Forums
Sign in
State Agency
Registered Public
Sign up
Emergency Text
Action: Initial regulations
Stage: Emergency/NOIRA
3/17/17 10:50 AM [latest]
CHAPTER 21
REGULATIONS GOVERNING PRESCRIBING OF OPIOIDS AND BUPRENORPHINE
Part I
General Provisions
18VAC85-21-10. Applicability.
A. This chapter shall apply to doctors of medicine, osteopathic medicine, and podiatry and to physician assistants.
B. This chapter shall not apply to:
1. The treatment of acute or chronic pain related to (i) cancer, (ii) a patient in hospice care, or (iii) a patient in palliative care;
2. The treatment of acute or chronic pain during an inpatient hospital admission or in a nursing home or an assisted living facility that uses a sole source pharmacy; or
3. A patient enrolled in a clinical trial as authorized by state or federal law.
18VAC85-21-20. Definitions.
The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:
"Acute pain" means pain that occurs within the normal course of a disease or condition or as the result of surgery for which controlled substances may be prescribed for no more than three months.
"Board" means the Virginia Board of Medicine.
"Chronic pain" means nonmalignant pain that goes beyond the normal course of a disease or condition for which controlled substances may be prescribed for a period greater than three months.
"Controlled substance" means drugs listed in The Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia) in Schedules II through IV

# So what can we do?

- Take a deep breath and…..
- Adapt risk mitigation strategies to patient + context + timing
- Involve interdisciplinary team support
- Training for HPM staff on caring for patients with substance abuse
- **Research on how best to manage this patient population ☺**

# Questions?

## Thursday, Feb. 14, 12-1:30pm
## Palliative Care Project ECHO
### Topic: Introduction to Palliative and Supportive Care
### Register: vcuhealth.org/pcecho

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions

# Case Presentation #1
## Danielle Noreika, MD


- 12:35pm-12:55pm [20 min]
  - 5 min: Presentation
  - 2 min: Clarifying questions- Spokes (participants)
  - 2 min: Clarifying questions – Hub
  - 2 min:  Recommendations – Spokes (participants)
  - 2 min:  Recommendations – Hub
  - 5 min:  Summary - Hub

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions

# Case #1

**Substance Abuse History**

**Alcohol**

Age started: 10 years old.

Pattern of use: Pt reports drinking /12 gallon of liquor daily when she was between age 10 and 17. Questioned her whether this was an accurate amount but she reinforced that this was true. Went to jail at age 17. at age pt went back to drinking and darank 1/5th of liquor daily for 5 to6 years. Pt reports she stopped drinking so much in her 30s and now only drinks a glass of wine on the holidays.

Last use: Christmas 2015.

**Heroin**

Age started: 15 years old.

Pattern of use: pt snorted and used heroin IV daily for 1 year at age 15..

Last use: 15.

**Cocaine**

Age started: 25 years old.

Pattern of use: Pt reports smoking crack daily off and on for 10 years. She would smoke it until her money ran out and could't get anymore. She could not be more specific about quantity or duration. she states she was addicted to it..

Last use: 2001.

**Tobacco**

Age started: 9 years old.

Pattern of use: 1ppd. Slowed down until she quit at age 55.

Last use: 55.

**Marijuana**

Pattern of use: denies use.

**Club drugs**

Pattern of use: States she used acid once in her 30s.

**Benzodiazepine**

Pattern of use: Prescribed Xanax in the last year.

**Barbituates**

Pattern of use: denies use.

**Prescription meds**

Pattern of use: Pt reports having been on percocet, oxycontin, and fentanyl patches.

**Other**

Other PMP shows no results for the last 12 months.

# Case #1

**Substance Abuse HPI**
**CAGE questions**
Cut down.
Guilty.
Eye opener.
**Trauma test - since 18th birthday**
Been in fight/assaulted when intoxicated.
**Patient has experienced**
Blackouts.
Loss of control of use.
**Withdrawal symptoms**
Alcohol: none (Pt does not remember going through alcohol withdrawal in the past).
Opiates: yes.
**History of IV drug use**
Yes.
**Shared needles**
No.
**Problems of alcohol or drug use**
Jail time: yes (reason: . ) (Pt has been in prison over 10 times for writing checks that she had no money for . She states the longest time whe was in prison was 5 years in 2001.).
Job/employment/school: yes.
Relationships: yes.
**Susbtance abuse treatment history**
12 step: year many years.
Longest abstinence: 5 years while in prison .

**Histories**
**Past Medical History**:
**Problem List (All Medical)** This information was current as of 03/21/16 @ 13:51:00.

Active:
-**Chronic kidney disease**
-**Hypertension**
, Pt reports that she has bipolar disorder and has seen a psychiatrist in Georgia for the last 2 years. She does not remeber the name of the medications she is on now but she has been on Lithium and depakote in the past
**Family History**: "everybody" in my family has had a little substance abuse
**Social History**: Pt is divorced and recently moved here from Atlanta Georgia to live with her sister. Pt has a 6th grade educuation and has 2 children. She has worked as a nurse aide and as a cook. Has not worked since 2009.

# Case #1

| TOXICOLOGY | | | | |
|---|---|---|---|---|
| Acetone | | | Negative mg/L * | |
| Ethanol L | | | Negative mg/L * | |
| Isopropanol | | | Negative mg/L * | |
| Methanol | | | Negative mg/L * | |
| Barbiturates, S | | | Negative * | |
| Benzodiazepine L Ser | | | Negative * | |
| Cocaine, S | | | Negative * | |
| Opiates S | | | Negative * | |
| Acetaminophen L | | | <3.0 mg/L L | |
| Salicylate Quant | | | <50 mg/L L | |

# Case Presentation #2

## Mishka Terplan, MD


- 12:55pm-1:25pm [20 min]
  - 5 min: Presentation
  - 2 min: Clarifying questions- Spokes
  - 2 min: Clarifying questions – Hub
  - 2 min:  Recommendations – Spokes
  - 2 min:  Recommendations – Hub
  - 5 min:  Summary - Hub

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions

# Case Presentation #2

- Demographics
  - 48 yr old, female
  - Re-enrolled in school, has gotten custody of her 2 children, employed, desiring taper
  - In treatment for 18 months and stable in recovery on 16mg bupe/day for past at least 12 months
  - currently monthly visits, attends group when comes to clinic
- Treatment Plan
  - Gradual versus more rapid discussed – desires gradual
  - Decreased to 12mg/day – and rtc 2 weeks
  - Decreased to 8mg/day – and rtc 2 weeks
  - Self-decreased to 4mg/day when returned to clinic –
  - Continued at 4mg/day for 1 week – wanted to continue taper at follow up visit
  - Written for 2mg/day – pt returned to clinic 3 days early in withdrawal having run out of medication due to inability to tolerate 2mg/day
- Discussed continued taper vs maintenance – rx for 4mg/day w f/u in 1-2 weeks

# Case Studies and Feedback

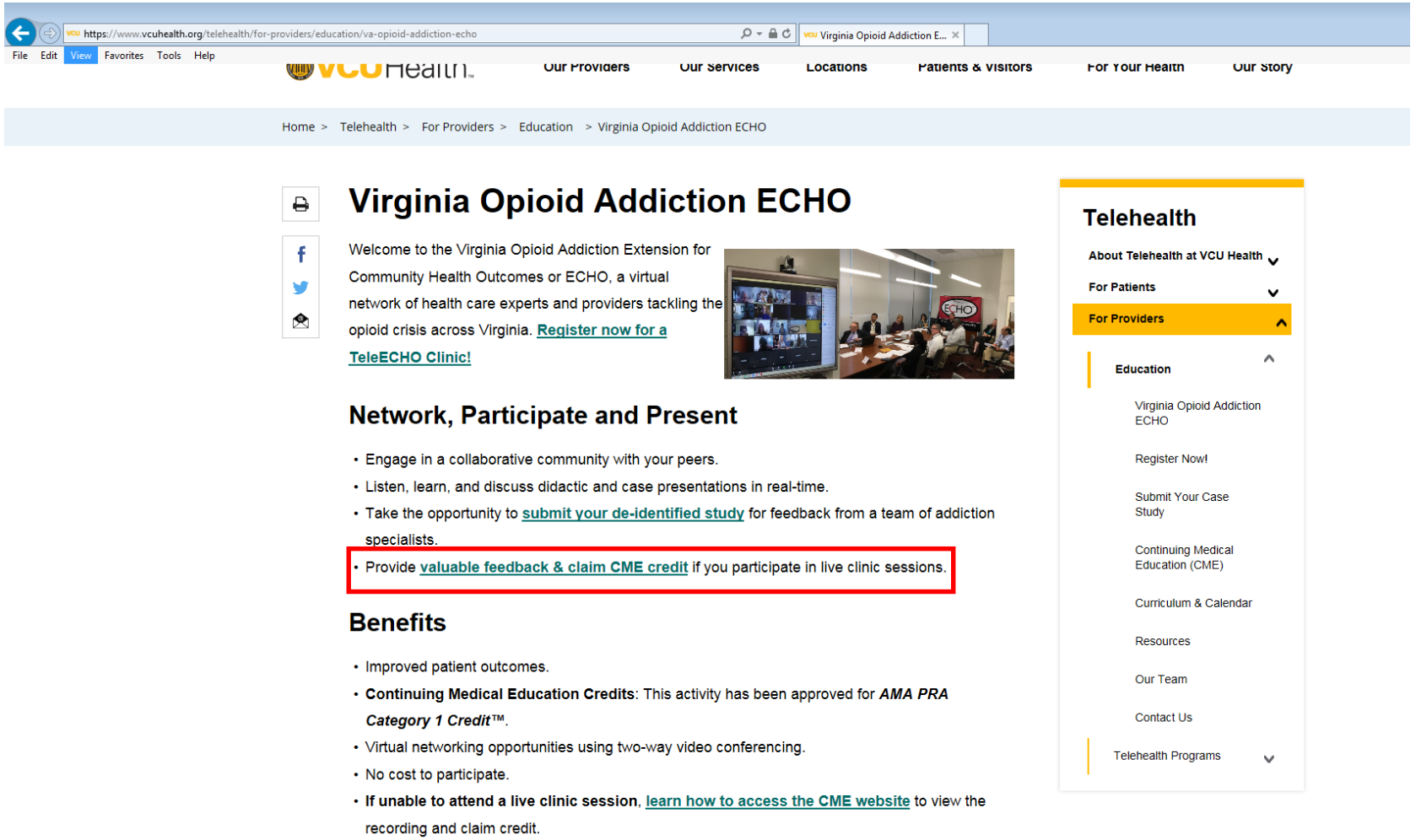
- Case studies
  - Submit: www.vcuhealth.org/echo
  - Receive feedback from participants and content experts
- Opportunity to formally submit feedback
  - Survey: www.vcuhealth.org/echo
  - Overall feedback related to session content and flow?
  - Ideas for guest speakers?

# Access Your Evaluation and Claim Your CME

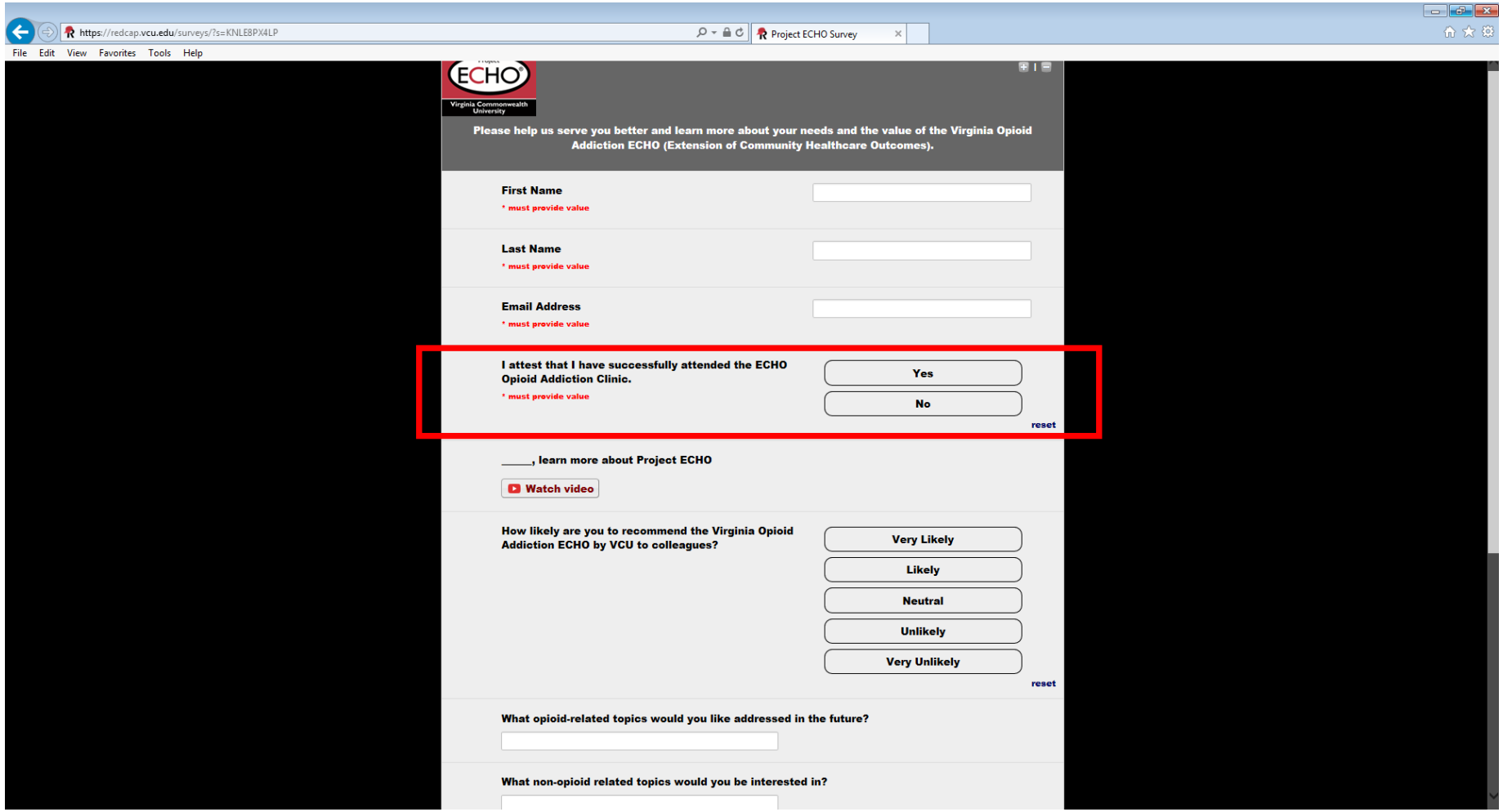
- www.vcuhealth.org/echo

  - To claim CME credit for today's session

# Access Your Evaluation and Claim Your CME



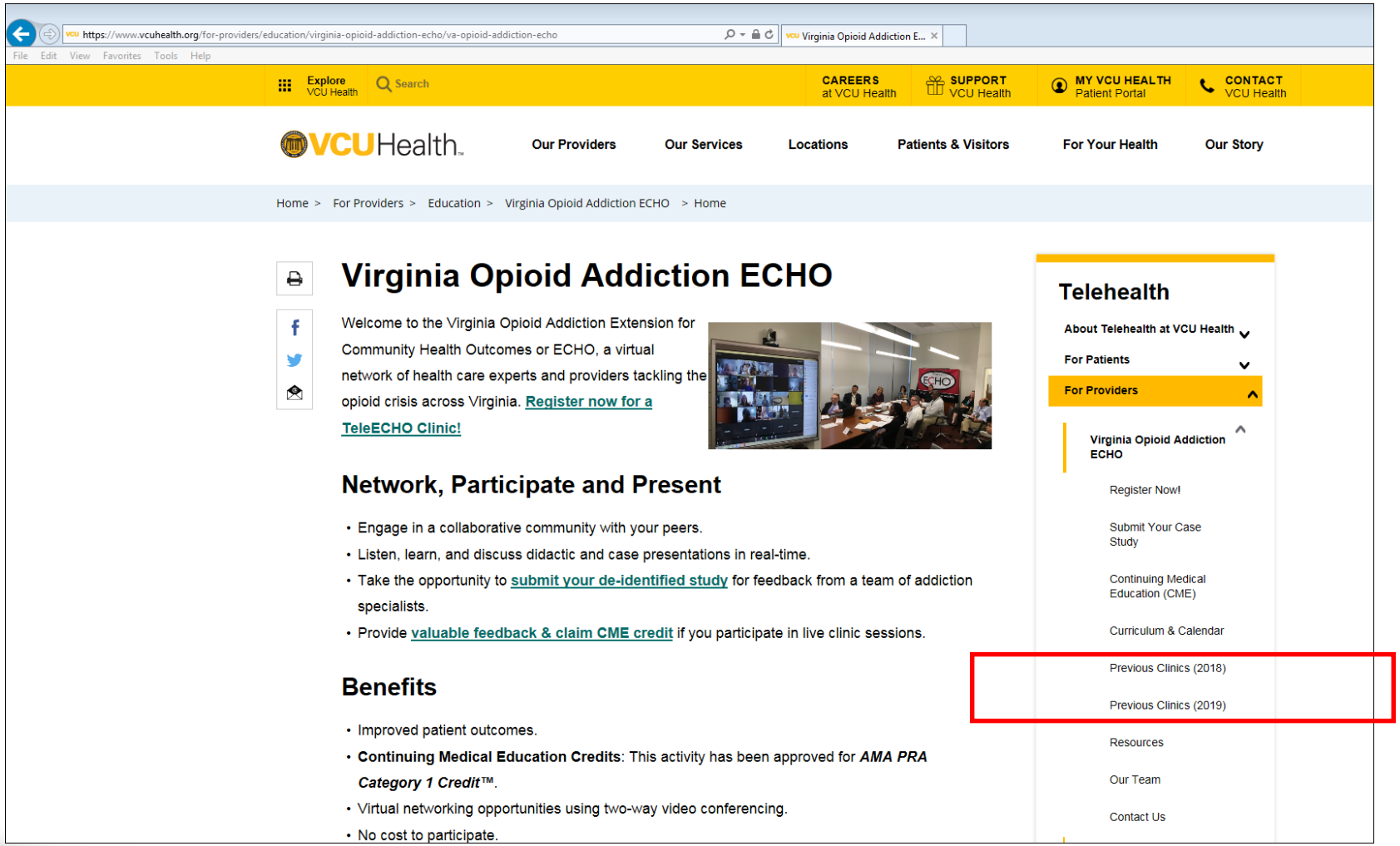
# Access Your Evaluation and Claim Your CME



# Access Your Evaluation and Claim Your CME

- www.vcuhealth.org/echo
  - To view previously recorded clinics and claim credit

# Access Your Evaluation and Claim Your CME



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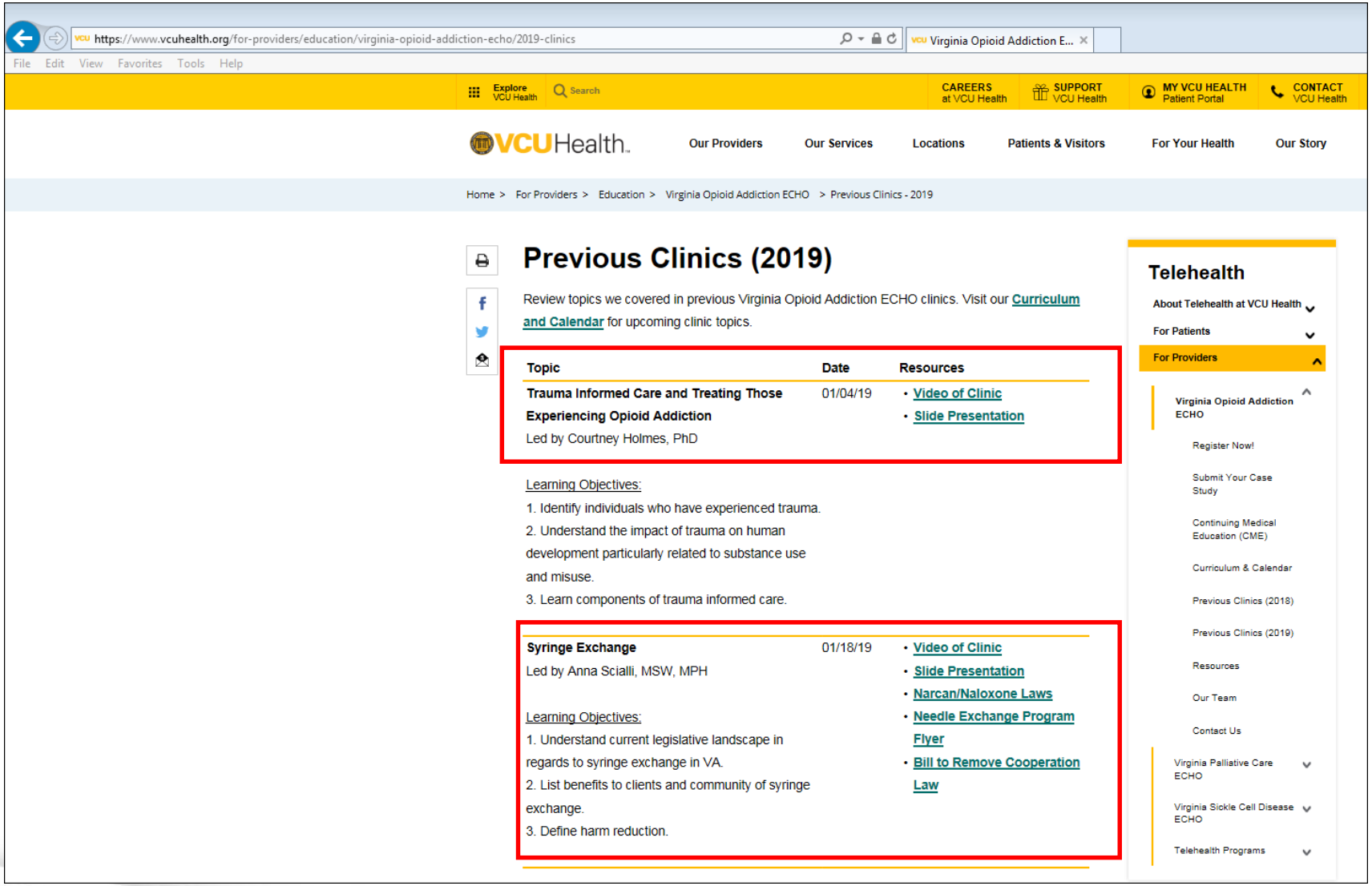

# VCU Virginia Opioid Addiction TeleECHO Clinics

## Bi-Weekly Fridays - 12-1:30 pm

## Mark Your Calendar --- Upcoming Sessions

| | | |
|---|---|---|
| 02/15 | Naltrexone | Mishka Terplan, MD |
| 03/01 | Identifying Substance Abuse Disorder in Primary Care | Thokozeni Lipato, MD |
| 03/15 | Policy with Maternal Substance Use Disorder | Valerie L'Herrou, JD |

**Please refer and register at vcuhealth.org/echo**

| | | |
|---|---|---|
| 02/14 | Launch of Virginia Palliative Care Project ECHO!<br>"Introduction to Palliative and Supportive Care" | Danielle Noreika, MD |

**Please refer and register at vcuhealth.org/pcecho**

Project ECHO®
Virginia Commonwealth University

# THANK YOU!

VCU

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions