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

• 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
## Hub Introductions

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Director</td>
<td>Mishka Terplan, MD, MPH, FACOG, FASAM</td>
</tr>
<tr>
<td>Administrative Medical Director ECHO Hub and Principal Investigator</td>
<td>Vimal Mishra, MD, MMCi</td>
</tr>
<tr>
<td>Clinical Expert</td>
<td>Lori Keyser-Marcus, PhD</td>
</tr>
<tr>
<td>Didactic Presentation</td>
<td>Courtney Holmes, PhD</td>
</tr>
<tr>
<td>Program Manager</td>
<td>Danielle Noreika, MD</td>
</tr>
<tr>
<td>Practice Administrator</td>
<td>Bhakti Dave, MPH</td>
</tr>
<tr>
<td>IT Support</td>
<td>David Collins, MHA</td>
</tr>
<tr>
<td></td>
<td>Vladimir Lavrentyev, MBA</td>
</tr>
</tbody>
</table>
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

Let's get started!
Didactic Presentation
Substance Abuse in Hospice and Palliative Care

Danielle Noreika, MD

Feb 1, 2019
About Palliative Care

ABOUT

About Palliative Care

About CAPC

Training & Technical Assistance

Press Room

Staff

Palliative care sees the person beyond the disease. It is a fundamental shift in focus for health care delivery.

Definition of Palliative Care

Palliative care, and the medical sub-specialty of palliative medicine, is specialized medical care for people living with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.
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.
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

Cancer-Related Factors
- Ischemia or bleed
- Tumor growth
- Infection
- Fracture

Patient-Related Factors
- Chemical coping
- Delirium
- Opioid tolerance
- Depressed mood or somatization

Increased Pain

Del Fabbro E JCO 2014;32:1734-1738
©2014 by American Society of Clinical Oncology
How often does this really happen?

Rauenzahn, Cassel, Del Fabbro MASCC 2015

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

- No UDS ordered
- Appropriate UDS Results
- UDS Inappropriately Positive
- UDS Inappropriately Negative
- UDS Both Inappropriately Negative and Inappropriately Positive
- Patients with at least one UDS ordered

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

Paul D. Tan, MD,†,1 Joshua S. Barclay, MS, MD,1 and Leslie J. Blackhall, MTS, MD1

<table>
<thead>
<tr>
<th>Table 3. Policy and Training Responses</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have a written policy regarding screening patients for substance abuse in patients</td>
<td>40.5%</td>
<td>59.5%</td>
</tr>
<tr>
<td>Have a written policy regarding screening family members for substance abuse</td>
<td>16.22%</td>
<td>83.78%</td>
</tr>
<tr>
<td>Have a written policy regarding screening patients for drug diversion</td>
<td>27.03%</td>
<td>72.97%</td>
</tr>
<tr>
<td>Have a written policy regarding screening family members for drug diversion</td>
<td>10.8%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Have a written policy requiring the use of a screening tool regarding substance abuse and diversion</td>
<td>32.4%</td>
<td>67.6%</td>
</tr>
<tr>
<td>• 18.9% – requires routine screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 13.5% – screening per provider discretion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have mandatory training for staff</td>
<td>47.2%</td>
<td>52.8%</td>
</tr>
<tr>
<td>Have mandatory training for fellows</td>
<td>83.33%</td>
<td>16.67%</td>
</tr>
</tbody>
</table>
Dying on Hospice in the Midst of an Opioid Crisis: What Should We Do Now?

Jennifer Gabbard, MD¹, Allison Jordan, MD, HMDC², Julie Mitchell, DO³, Mark Corbett, MD, MA, HMDC, FAAHPM⁴, Patrick White, MD, HMDC, FAAHPM⁵, and Julie Childers, MD, FAAHPM⁶

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

Mel Clark Taveros,¹ Elizabeth J Chuang²

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?

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

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 identification of the 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)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Worst Possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Worst Possible Pain</td>
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<tr>
<td>No Tiredness (Tiredness = lack of energy)</td>
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<td></td>
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<td></td>
<td></td>
<td>Worst Possible Tiredness</td>
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<tr>
<td>No Drowsiness (Drowsiness = feeling sleepy)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Worst Possible Drowsiness</td>
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<tr>
<td>No Nausea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Worst Possible Nausea</td>
</tr>
<tr>
<td>No Lack of Appetite</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Worst Possible Lack of Appetite</td>
</tr>
<tr>
<td>No Shortness of Breath</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Worst Possible Shortness of Breath</td>
</tr>
<tr>
<td>No Depression (Depression = feeling sad)</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td>Worst Possible Depression</td>
</tr>
<tr>
<td>No Anxiety (Anxiety = feeling nervous)</td>
<td></td>
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<td></td>
<td></td>
<td>Worst Possible Anxiety</td>
</tr>
<tr>
<td>Best Wellbeing (Wellbeing = how you feel overall)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Worst Possible Wellbeing</td>
</tr>
<tr>
<td>Other Problem (for example constipation)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Worst Possible Other Problem</td>
</tr>
</tbody>
</table>

Patient's Name ____________________________  Completed by (check one):

- Patient
- Family caregiver
- Health care professional caregiver
- Caregiver-assisted
Emergency Text

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;
3. A patient enrolled in a clinical trial as authorized by state or federal law.

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 a 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 malignant 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 1/2 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 drank 1/6th of liquor daily for 6 to 8 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 couldn’t get anymore. She could not be more specific about quantity or duration, she states she was addicted to it.

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 she was in prison was 5 years in 2001.).
- Job/employment/school: yes.
- Relationships: yes.

**Substance 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 03/29/16 @ 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 remember 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 education and has 2 children. She has worked as a nurse aide and as a cook. Has not worked since 2009.
## TOXICOLOGY

<table>
<thead>
<tr>
<th>Substance</th>
<th>Result</th>
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<tbody>
<tr>
<td>Acetone</td>
<td>Negative mg/L *</td>
</tr>
<tr>
<td>Ethanol L</td>
<td>Negative mg/L *</td>
</tr>
<tr>
<td>Isopropanol</td>
<td>Negative mg/L *</td>
</tr>
<tr>
<td>Methanol</td>
<td>Negative mg/L *</td>
</tr>
<tr>
<td>Barbiturates, S</td>
<td>Negative *</td>
</tr>
<tr>
<td>Benzodiazepine L Ser</td>
<td>Negative *</td>
</tr>
<tr>
<td>Cocaine, S</td>
<td>Negative *</td>
</tr>
<tr>
<td>Opiates S</td>
<td>Negative *</td>
</tr>
<tr>
<td>Acetaminophen L</td>
<td>&lt;3.0 mg/L L</td>
</tr>
<tr>
<td>Salicylate Quant</td>
<td>&lt;50 mg/L L</td>
</tr>
</tbody>
</table>
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
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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](http://www.vcuhealth.org/echo)

• To claim CME credit for today's session
Access Your Evaluation and Claim Your CME

Virginia Opioid Addiction ECHO

Welcome to the Virginia Opioid Addiction Extension for Community Health Outcomes or ECHO, a virtual network of health care experts and providers tackling the opioid crisis across Virginia. Register now for a TeleECHO Clinic!

Network, Participate and Present

- Engage in a collaborative community with your peers.
- Listen, learn, and discuss didactic and case presentations in real-time.
- Take the opportunity to submit your de-identified study for feedback from a team of addiction specialists.
- Provide valuable feedback & claim CME credit if you participate in live clinic sessions.

Benefits

- Improved patient outcomes.
- Continuing Medical Education Credits: This activity has been approved for AMA PRA Category 1 Credit™.
- Virtual networking opportunities using two-way video conferencing.
- No cost to participate.
- If unable to attend a live clinic session, learn how to access the CME website to view the recording and claim credit.

Telehealth

For Patients

For Providers

Education

Virginia Opioid Addiction ECHO

Register Now

Submit Your Case Study

Continuing Medical Education (CME)

Curriculum & Calendar

Resources

Our Team

Contact Us

Telehealth Programs
Access Your Evaluation and Claim Your CME
Access Your Evaluation and Claim Your CME

- [www.vcuhealth.org/echo](http://www.vcuhealth.org/echo)

- To view previously recorded clinics and claim credit
Access Your Evaluation and Claim Your CME
Access Your Evaluation and Claim Your CME
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!
       “Introduction to Palliative and Supportive Care”  Danielle Noreika, MD

Please refer and register at vcuhealth.org/pcecho
THANK YOU!

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