Making the Case for Palliative Care: Translating Research into Action

Danielle Noreika MD FAAHPM FACP & J. Brian Cassel PhD
Associate Professors, VCU School of Medicine, Division of Hematology/Oncology & Palliative Care
VAHO April 2019
Disclosures

Dr. Noreika has no financial relationships to disclose.

Dr. Cassel has no financial relationships to disclose.

We do not intend to discuss and off-label product during this activity.
Objectives

- Identify palliative care clinical and educational resources in Virginia
- Incorporate specific practices to improve outcomes for oncology patients and families
- Use community resources where available
We’d like to know a bit about you first

• Do you already have a designated provider in your practice for dealing with
  • Refractory symptoms
  • Difficult conversations about prognosis or treatment goals
  • Transitions to hospice

• Is there access to early (community-based) specialist palliative care in your community? Do you use it?

• Are you or your hospital-partner in an ACO, the OCM, relevant BPCI-A bundles?
Specialist Palliative Care

Adds another layer of support for patients with advanced illness and their families
Provides expert prevention and relief of pain and suffering
Helps clarify prognosis and set care goals
Is multi-disciplinary; inter-professional; holistic; addresses bio-psycho-social-spiritual needs
Focuses on complex and advanced illnesses
Bridges gap between “curative” and “end of life” care
In the US, is distinct from hospice care
As of 2015: 67% of hospitals with 50+ beds and 90% with 300+ beds have palliative care programs *

Where in Virginia are palliative specialists?
Palliative care not adopted evenly

ACGME fellowship programs in hospice & palliative medicine

<table>
<thead>
<tr>
<th>Site</th>
<th>Slots</th>
<th>Practice sites</th>
<th>Since</th>
<th>Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>EVMS</td>
<td>2</td>
<td>6 including Hampton VA, 4 Sentara hospitals, Lake Taylor Transitional care</td>
<td>2017</td>
<td>Dr. Marissa Galicia-Castillo</td>
</tr>
<tr>
<td>Carillion / Tech</td>
<td>2</td>
<td>Carillion, Salem VA</td>
<td>2011</td>
<td>Dr. Christi Stewart</td>
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<tr>
<td>UVA</td>
<td>1</td>
<td>UVA, two hospices</td>
<td>2010</td>
<td>Dr. Joshua Barclay</td>
</tr>
<tr>
<td>VCU</td>
<td>4</td>
<td>VCU, McGuire VA, two hospices</td>
<td>2008</td>
<td>Dr. Danielle Noreika</td>
</tr>
</tbody>
</table>
VCU palliative / supportive care

Care settings
  • Supportive care clinics (downtown and suburban)
  • Inpatient consults
  • Inpatient service
  • Inpatient unit
  • Via tele-medicine to CMH oncology clinic

Education
  • Fellowship program
  • Rotations for residents, other students / trainees
  • Annual Symposium (October 22\textsuperscript{nd} in Richmond!)
  • 2 days free clinical shadowing (“Virginia Initiative for Palliative Care”)
  • Palliative Care Project ECHO (“Extending Community Health Outcomes”)

Research
  • Clinical trials
  • Health services research / economics
Case example: Difficult cancer pain

50 year-old man with metastatic non small cell lung cancer. Hospitalized (MedOnc) with dyspnea, transferred to palliative service with uncontrolled pain (spinal mets). Discharged with methadone with oxycodone for breakthrough pain, dexamethasone, gabapentin, and getting XRT. Chaplain, volunteers and others also involved.

Missed f/u appointment with palliative, gets Rx for oxycodone (not methadone) on his next visit in RadOnc. Ended up in ED with uncontrolled pain; seen by palliative in ED and avoided admission. Continues to be seen in clinic.

Not DNR – not a requirement for PC in any setting.
Case example: Timely, concurrent care

49 year-old woman diagnosed with stage IV NSCLC (with brain metastases) developed severe nausea/vomiting & vertigo 4 months into treatment.

Aggressive management of symptoms in supportive care clinic Allowed her to improve & continue with cancer treatment while avoiding hospital admission.

Followed in both supportive care (PC) clinic & MedOnc clinic. Lived 20 months after diagnosis and 16 months after first PC visit, transitioned to hospice in her final weeks of life.

Timing of inpatient hospital PC before death: 3 weeks
Timing of clinic-based PC before death: 5 months
Case example: Symptoms, function improved

55 year old male
Recurrence of SCC base tongue (IV-A)
Latest treatment: cisplatin + radiation
17% weight loss in 3 months
Referred for pain and cachexia
Supportive care clinic 8 weeks
Opioid rotation to methadone
Metoclopramide: nausea, early satiety
Compliant with duloxetine, psychologist
Total testosterone=132, replaced
Gained: +5 kg (11%)
BMI: 15.4 → 17.3
SPPB: 6/12 → 9/12
6MW: 485 → 1252 feet
Handgrip: 33 → 38

SBBP = Short Physical Performance Battery
6MW = Six minute walk test
5 practices to adopt for optimal outcomes for patients with advanced cancer

1. Use ESAS or similar to standardize symptom assessment
2. Assess and reduce opioid risks
3. Give patients access to advance care planning
4. Submit a challenging case for Palliative Care Project ECHO
5. Designate an internal expert for supportive / palliative care
# Edmonton Symptom Assessment Scale

<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>
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<tr>
<td>No pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Not tired</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Not nauseated</td>
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<td>Not depressed</td>
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<tr>
<td>Not anxious</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not drowsy</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Best appetite</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Best feeling of well-being</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>No shortness of breath</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Other =Insomnia</td>
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</tbody>
</table>

1. Standardize Symptom Assessment
Mean ESAS scores over time for 10752 cancer patients

Hsien Seow et al. JCO 2011;29:1151-1158

©2011 by American Society of Clinical Oncology
Why Do Standardized Symptom Assessment?

- “10/10” pain generally = “10/10” other symptoms
- May identify need for other assessment, treatment, resources (e.g., psych)
- Allows tracking and reporting of PRO’s
- Identify patients for timely referral to supportive care if available
- Simple and free to do
How implement this efficiently?

1. Pick a scale (ESAS, MSAS, POS, etc.)

2. Incorporate into clinic workflow
   1. Registration desk / DIY
   2. LPN/CNA when rooming patient
   3. RN if not already completed (attend to literacy issues)
   4. MD/NP – reflect and incorporate into care

3. Incorporate into EMR
Screening questionnaires and urine drug screens indicate at least one in five patients with cancer may be at risk of opioid use disorder.

Several studies demonstrate associations between high-risk patients and clinical outcomes, such as
• Aberrant behavior
• Prolonged opioid use
• Higher morphine-equivalent daily dose
• Greater health care utilization
• Symptom burden

### Table 1. Approach to Managing Opioid Risk and Chemical Coping in Patients With Cancer Based on Universal Precautions

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Differential diagnosis: identify tumor-related causes of pain and patient-related factors influencing pain perception and expression</td>
</tr>
<tr>
<td>2</td>
<td>History of risk factors for chemical coping: tobacco use, depression, history of substance abuse, personality disorder, somatization, sexual abuse</td>
</tr>
<tr>
<td>3</td>
<td>Screening instrument at first visit to identify those at high risk (eg, CAGE, SOAPP, ORT, STAR)</td>
</tr>
<tr>
<td>4</td>
<td>Informed consent including patient education about addiction, tolerance, and opioid adverse effects and treatment plan that de-emphasizes opioids as sole treatment for pain</td>
</tr>
<tr>
<td>5</td>
<td>Opioid agreement (written or verbal) that includes outline of patient obligations (eg, receive opioids prescriptions from single provider, no early refills, random UDS)</td>
</tr>
<tr>
<td>6</td>
<td>Pre- and postassessment of pain level and function; routine assessment of four As: analgesia, activities of daily living, adverse effects, and aberrant behavior[^38]</td>
</tr>
<tr>
<td>7</td>
<td>Psychological support, motivational interviews, and increased vigilance and structure for those at high risk for opioid misuse (eg, pill counts, shorter intervals between visits); consider integrated comanaged model with interdisciplinary palliative care or chronic pain team</td>
</tr>
<tr>
<td>8</td>
<td>Periodically review differential diagnosis; contribution of tumor- and patient-related factors to pain may have changed (eg, patients with no evidence of disease should receive stable scheduled dose or tapered opioids, whereas patients with progressive advanced cancer will require additional breakthrough-dose opioids)</td>
</tr>
<tr>
<td>9</td>
<td>Documentation of all prescriptions, office visits, agreements, and instructions</td>
</tr>
<tr>
<td>10</td>
<td>Ethical concerns: discharging patient with advanced cancer and substance misuse; comanagement with substance abuse specialists should be initial step</td>
</tr>
</tbody>
</table>

**NOTE.** Data adapted[^35][^36][^37]

Abbreviations: ORT, Opioid Risk Tool; SOAPP, Screener and Opioid Assessment for Patients With Pain; STAR, Screening Tool for Addiction Risk; UDS, urine drug screen.
# Validated Risk Assessment Tools

<table>
<thead>
<tr>
<th>Acronym of Tool</th>
<th>Questions (#)</th>
<th>Completion</th>
<th>Time to complete</th>
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</thead>
<tbody>
<tr>
<td>SOAPP®-R</td>
<td>24 items</td>
<td>Self-report</td>
<td>&lt; 10 minutes</td>
</tr>
<tr>
<td>DIRE</td>
<td>7 items</td>
<td>Clinician administered</td>
<td>&lt; 5 minutes</td>
</tr>
<tr>
<td>ORT</td>
<td>5 items</td>
<td>Clinician administered</td>
<td>&lt; 5 minutes</td>
</tr>
<tr>
<td>COMM</td>
<td>40 items</td>
<td>Self-report</td>
<td>&lt; 10 minutes</td>
</tr>
<tr>
<td>CAGE</td>
<td>4 items</td>
<td>Either</td>
<td>&lt; 5 minutes</td>
</tr>
<tr>
<td>PDUQ</td>
<td>42 items</td>
<td>Clinician administered</td>
<td>20 minutes</td>
</tr>
<tr>
<td>STAR</td>
<td>14 items</td>
<td>Self-report</td>
<td>&lt; 5 minutes</td>
</tr>
<tr>
<td>SISAP</td>
<td>5 items</td>
<td>Clinician administered</td>
<td>&lt; 5 minutes</td>
</tr>
<tr>
<td>PMQ</td>
<td>26 items</td>
<td>Self-report</td>
<td>&lt; 10 minutes</td>
</tr>
</tbody>
</table>

**SOAPP®-R** (Screener and Opioid Assessment for Patient’s in Pain-revised);
**DIRE** (Diagnosis, Intractability, Risk, and Efficacy);
**ORT** (Webster’s Opioid Risk Tool);
**COMM** (Current Opioid Misuse Measure);

**CAGE** (Cut-down, Annoyed, Guilt, Eye-opener);
**PDUQ** (Prescription Drug Use Questionnaire);
**STAR** (Screening Tool for Addiction Risk);
**SISAP** (Screening Instrument for Substance Abuse Potential);
**PMQ** (Pain Medication Questionnaire)
Cut Down-Annoyed-Guilty-Eye Opener questionnaire adapted to include drug use (CAGE-AID)

<table>
<thead>
<tr>
<th>Questions</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>C: Have you ever felt that you ought to Cut down on your drinking or drug use?</td>
<td>+1</td>
</tr>
<tr>
<td>A: Have people Annoyed you by criticizing your drinking or drug use?</td>
<td>+1</td>
</tr>
<tr>
<td>G: Have you ever felt bad or Guilty about your drinking or drug use?</td>
<td>+1</td>
</tr>
<tr>
<td>E: Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?</td>
<td>+1</td>
</tr>
</tbody>
</table>

Regard one or more positive responses to the CAGE-AID as a positive screen.
All 24 questions contained in the SOAPP®-R have been empirically identified as predicting aberrant medication-related behavior six months after initial testing.

To score the SOAPP, add the ratings of all the questions. A score of 18 or higher is considered positive.
1. How often do you have mood swings?
2. How often have you felt a need for higher doses or medication to treat your pain?
3. How often have you felt impatient with your doctors?
4. How often have you felt that things are just too overwhelming that you can’t handle them?
5. How often is there tension in the home?
6. How often have you counted pain pills to see how many are remaining?
7. How often have you been concerned that people will judge you for taking pain medication?
8. How often do you feel bored?
9. How often have you taken more pain medication than you were supposed to?
10. How often have you worried about being left alone?
11. How often have you felt a craving for medication?
12. How often have others expressed concern over your use of medication?
13. How often have any of your close friends had a problem with alcohol or drugs?
14. How often have others told you that you had a bad temper?
15. How often have you felt consumed by the need to get pain medication?
16. How often have you run out of pain medication early?
17. How often have others kept you from getting what you deserve?
18. How often, in your lifetime, have you had legal problems or been arrested?
19. How often have you attended an AA or NA meeting?
20. How often have you been in an argument that was so out of control that someone got hurt?
21. How often have you been sexually abused?
22. How often have other suggested that you have a drug or alcohol problem?
23. How often have you had to borrow pain medications from your family or friends?
24. How often have you been treated for an alcohol or drug problem?

2. Opioid risk reduction

VCU Health
Webster’s Opioid Risk Tool (ORT)

Score 0 – 3: low risk
Score 4 – 7: moderate risk
Score ≥ 8: high risk

In a preliminary study, among patients prescribed opioids for chronic pain, the ORT exhibited a high degree of sensitivity and specificity for determining which individuals are at risk for opioid-related, aberrant behaviors.

What about function?

<table>
<thead>
<tr>
<th>PAININ9</th>
<th>How much did pain interfere with your day to day activities?</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PAININ22</th>
<th>How much did pain interfere with work around the home?</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PAININ31</th>
<th>How much did pain interfere with your ability to participate in social activities?</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PAININ3</th>
<th>How much did pain interfere with your enjoyment of life?</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
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<td>4</td>
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</table>

<table>
<thead>
<tr>
<th>PAININ12</th>
<th>How much did pain interfere with the things you usually do for fun?</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>Very much</th>
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<tbody>
<tr>
<td>6</td>
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<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
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</table>

<table>
<thead>
<tr>
<th>PAININ36</th>
<th>How much did pain interfere with your enjoyment of social activities?</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
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<td>2</td>
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<td>4</td>
<td>5</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PAININ34</th>
<th>How much did pain interfere with your household chores?</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>Very much</th>
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<tbody>
<tr>
<td>7</td>
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<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PAININ13</th>
<th>How much did pain interfere with your family life?</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Are Oncology patients at risk?
Urine drug screen (UDS) findings in a supportive care clinic

Rauenzahn, Cassel, Del Fabbro MASCC 2015

2. Opioid risk reduction

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

152
80
22
29
11
18
Opioid Medication Treatment Agreement for Chronic Pain

Opioid Prescriber (name and clinic location): __
Pharmacy Name/Phone Number: __
Date of Agreement: __

I understand that I, a patient at VCU Health System, am giving consent for Opioid Treatment for Chronic Pain.

I understand that I am also entering into a Treatment Agreement with the above named provider at VCU Health System.

I understand that this Agreement will be available to and upheld by ALL VCU Health System Providers.

Purpose of Opioid Treatment for Chronic Pain

I understand that the goal of using this opioid medication is to control my pain symptoms enough to improve my quality of life and ability to function.

I understand that starting this medication is a trial. The decision to continue the opioid is based on whether or not:

- It helps my pain symptoms
- I have any side effects
- I take the medication as ordered by the provider.

Alternatives and Non-Medication Treatments for Chronic Pain

I understand that there are treatments for my pain other than opioids. I agree that I will follow the instructions and plan of care given to me. This plan may include non-medication treatments for pain. These can include but are not limited to:

- Attending a pain management class
- Seeing a psychological counselor
- Exercise
- Physical Therapy

I have read this form, or it has been read to me. I have had an opportunity to ask questions and have had my questions answered.

By my signature, I voluntarily give my consent.

SIGNED:

Provider:

Provider Signature

Provider Printed Name

Date

Time

Individual Obtaining Informed Consent (two individuals for telephone consent)

Clinic Name/Location:

Interpreter:

Signature/Printed name/Cyracom number

Date

Time

Check the following:

[ ] The patient has been given a copy of this agreement.

[ ] The signed copy of this agreement has been submitted to be scanned into Cerner.
Proper opioid disposal methods (76% vs. 28%; p ≤ .0001)
Share opioids with someone else (3% vs. 8%; p = .0311)
Practice unsafe use of opioids (18% vs. 25% p = .0344)
Danger of opioids when taken by others (p = .0099)
Unused medication at home (38% vs. 47%; p = .0497)
Keep medications in a safe place (hidden, 75% vs. 70%; locked, 14% vs. 10%; p = .0025)
In VA, pharmacists are allowed to give naloxone to patients (not to third parties) after naloxone education has been provided.
Promote and Facilitate Advance Care Planning

- Elicit patient preferences
- Encourage patients to name a proxy/agent (or two)
- Encourage completion and sharing of Advance Directive
- Consider using POST especially for patients at risk of bouncing from SNF to hospital

- Reduce confusion, surprises, anger, frustration
- Avoid unwanted procedures at end-of-life
Advance Care Planning and POST in Virginia

ACP:
- Richmond area: Honoring Choices Virginia (trained clinical facilitators)
- Tidewater: 5 wishes (DIY)
- Northern Virginia:
- Roanoke:

POST (Physician Orders for Scope of Treatment)
Sudore’s “Prepare for your care” model

https://prepareforyourcare.org/advance-directive-state/va

Virginia PREPARE Advance Directive

Click the button below to open the Virginia PREPARE Advance Directive.

English  Spanish

* Help us make these forms available in other languages.
Please click here to donate to PREPARE.

Choose a Different State

Or click here to see all states and languages.

Legal Review help from:
- UCSF/UC Hastings Consortium on Law, Science and Health Policy
- State Medical-Legal Partnerships (MLPs), and
- Legal Aid
Project ECHO at VCU

Tele-mentoring program

- Moves knowledge instead of patients
- Sessions once or twice a month for continuity of care

Videoconference technology

- Brief expert presentations from lead site
- Interactive, practical case presentations from spoke sites

Hub and spoke knowledge-sharing networks create a learning loop:

Community providers learn from specialists.

Community providers learn from each other.

Specialists learn from community providers as best practices emerge.

4. Submit a case to ECHO
Figure 2: Graphic and visual conceptual framework used with permission from Kent Unruh and Project ECHO.
4. Submit a case to ECHO
## Brief didactic material

### Safety in Opioid Use in Serious Illness

**Learning Objectives:**
2. Compare and contrast risk assessment for chronic non-malignant pain to pain management in serious illness.

<table>
<thead>
<tr>
<th>Title</th>
<th>Date</th>
<th>Author</th>
</tr>
</thead>
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<tr>
<td>Safety in Opioid Use in Serious Illness</td>
<td>04/25/19</td>
<td>Egidio DelFabbro, MD</td>
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### The Virginia Physician Order for Scope of Treatment (POST)

**Learning Objectives:**
1. Define the POST form.
2. Describe patient care circumstances that apply to the POST form.
3. Discuss how to determine the medical care plan with a POST.

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<tr>
<th>Title</th>
<th>Date</th>
<th>Author</th>
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<tbody>
<tr>
<td>The Virginia Physician Order for Scope of Treatment (POST)</td>
<td>05/09/19</td>
<td>Danielle Noreika, MD</td>
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### Delirium in Palliative Care Patients

**Learning Objectives:**
1. Define delirium.
2. Overview of tools of delirium screening.

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<tr>
<td>Delirium in Palliative Care Patients</td>
<td>05/23/19</td>
<td>Egidio DelFabbro, MD</td>
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How to submit a case

http://www.vcuhealth.org/PCecho

VCU Health Palliative Care ECHO

Our VCU Health Palliative Care ECHO program partners with community practices caring for patients with serious illness and applies our interdisciplinary care team - a mix of physicians, nurses, social workers, psychologists, chaplains and more - to provide patient care support and education throughout Virginia.

We have a long-standing palliative care program with an inpatient unit, consult service and a supportive care clinic to provide serious illness care. Many communities in Virginia do not have access to palliative care and we're here to help. Learn more about palliative care.

Register now for an upcoming clinic.

Submit a case study (registered participants only).

Contact us for more information or help with any questions about our program.

Virginia Palliative Care ECHO: Case Study Submission

Thank you for submitting a case study.

You must be registered for a Palliative Care ECHO session in order to present a case. Please register for ECHO sessions.

DO NOT provide any identifying patient information or Protected Health Information.

Questions? Contact us: pcecho@vcuhealth.org

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<th>Presenter Email:</th>
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Designate an internal expert / point-person

- Additional expertise in
  - Symptom assessment
  - Refractory pain and symptom management
  - Opioid risk assessment and reduction
  - Prognostication
  - Communication with patients, families
  - Slowing weight-loss, cachexia, loss of function
  - Connecting with community resources such as specialist palliative care

- Keeps all providers and staff up-to-date on
  - Opioid issues
  - Local advance care planning and POST activity
  - Specialist palliative care pushed from payers (e.g., Anthem / Aspire)

4. Submit a case to ECHO
Questions and discussion

1. Use ESAS or similar to standardize symptom assessment
2. Assess and reduce opioid risks
3. Give patients access to advance care planning
4. Submit a challenging case for Palliative Care Project ECHO
5. Designate an internal expert for supportive / palliative care