Managing Pain and Opioid Use

An Educational Program on Compliance with New York State Prescribing Laws

Boston University School of Medicine
Barry M. Manuel Continuing Medical Education Office

ACP American College of Physicians
Leading Internal Medicine, Improving Lives
New York Chapter

1

Obtaining your CE Credit

At the conclusion of the program if you wish to receive CME, CNE, or ABIM MOC Part II credit, you must take a post-test and complete an evaluation. With a passing score of 70% or greater, you'll be able to print your certificate.

2

Program Support

This program is provided by Boston University School of Medicine in partnership with the New York Chapter of the American College of Physicians.

3

Program Support

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Educational Objectives

At the conclusion of this activity, participants will be better able to:

- Describe the New York State laws governing the safe prescribing of opioids.
- Explain relevant issues related to opioid misuse, opioid use disorder, and opioid overdose.
- Communicate with patients about palliative care and end-of-life decisions.
- Appropriately document communication with patients about health care proxies and advance directives and describe the appropriate use of advance care planning CPT codes.

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State and Federal Laws on the Prescribing of Controlled Substances

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NYS Internet System for Tracking Over-Prescribing (I-STOP)

- Prescription Drug Monitoring Program (PDMP)
- Electronic Prescribing

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I-STOP

- Practitioner must consult the registry prior to prescribing or dispensing any controlled substance listed on schedule II, III or IV
- Practitioners may consult the registry prior to prescribing or dispensing any other controlled substance
- Certain exceptions apply

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Exceptions to the Duty to Consult I-STOP

The duty to consult the registry shall not apply to:

I. Veterinarians

II. Methadone programs

III. A practitioner administering a controlled substance

IV. A practitioner prescribing or ordering a controlled substance for use on the premises of an institutional dispenser

V. A practitioner prescribing a controlled substance in the emergency department of a general hospital, provided that the quantity of controlled substance prescribed does not exceed a five day supply if the controlled substance were used in accordance with the directions for use

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Exceptions to the Duty to Consult I-STOP
cont'd

The duty to consult the registry shall not apply to:

VI. A practitioner prescribing a controlled substance to a patient under the care of hospice

VII. A practitioner when:

A. it is not reasonably possible for the practitioner to access the registry in a timely manner;

B. no other practitioner or designee authorized to access the registry, pursuant to paragraph (b) of this subdivision, is reasonably available; and

C. the quantity of controlled substance prescribed does not exceed a five day supply if the controlled substance were used in accordance with the directions for use;

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Exceptions to the Duty to Consult I-STOP
cont'd

The duty to consult the registry shall not apply to:

VIII. A practitioner acting in compliance with regulations that may be promulgated by the commissioner as to circumstances under which consultation of the registry would result in a patient's inability to obtain a prescription in a timely manner, thereby adversely impacting the medical condition of such patient;

IX. A situation where the registry is not operational as determined by the department or where it cannot be accessed by the practitioner due to a temporary technological or electrical failure, as set forth in regulation.

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Exceptions to the Duty to Consult I-STOP
cont'd

The duty to consult the registry shall not apply to:

X. A practitioner who has been granted a waiver due to technological limitations that are not reasonably within the control of the practitioner, or other exceptional circumstance demonstrated by the practitioner, pursuant to a process established in regulation, and in the discretion of the commissioner.

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Seven Day Limitation on Initial Opioid Prescribing for Acute Pain

- Effective July 22, 2016, a practitioner may not initially prescribe more than a seven-day supply of an opioid medication for acute pain
  - Acute pain: defined as pain, whether resulting from disease, accidental or intentional trauma, or other cause, that the practitioner reasonably expects to last a short period of time
- Upon any subsequent consultations for the same pain, the practitioner may issue, in accordance with existing rules and regulations, any appropriate renewal, refill, or new prescription for an opioid

Seven-day limit does not include prescribing for chronic pain, pain being treated as a part of cancer care, hospice or other end-of-life care, or pain being treated as part of palliative care practices.

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E-Prescribing–Basic Requirements

New York Education Law §6810 - all prescriptions must be transmitted electronically. NYS is the only state to mandate e-prescribing of controlled and non-controlled substances

1. Practitioner must use e-prescribing software that has been certified and audited in accordance with US Drug Enforcement Agency (DEA) regulations.
2. The practitioner must also complete an identity proofing process and obtain two factor authentication in accordance with the DEA regulations.

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E-Prescribing–Basic Requirements, *con't*

3. Practitioner must register the controlled substance e-prescribing software with the Bureau of Narcotic Enforcement (BNE). The registration with BNE needs to be updated at least every two years or whenever the DEA requires a new third party audit of the software, whichever occurs first.
4. If the practitioner works at multiple locations or different e-prescribing software is used at such sites, the practitioner will need to register each software program used to prescribe controlled substances.
5. A prescriber must make a notation in the patient's medical record indicating when he/she has issued a paper prescription noting the applicable statutory exception for why an e-prescription was not possible.

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E-Prescribing–Mandate Exceptions

The e-prescribing regulations include several exceptions to the mandate including when:

- Prescriptions are issued by veterinarians;
- Electronic prescribing is not available due to temporary technological or electronic failure;
- Prescriptions issued by a practitioner under circumstances where the practitioner reasonably determines that it would be impractical for the patient to obtain substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the patient's medical condition. In addition to these circumstances, the quantity of controlled substances cannot exceed a five day supply if the controlled substance were used in accordance with the directions for use;

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E-Prescribing–Mandate Exceptions, *con't*

- Prescriptions issued by a practitioner are to be dispensed by a pharmacy located outside the state; and
- Practitioners have received a waiver from the requirement to use electronic prescribing.

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Federal Prescribing Requirements

- A prescription for a controlled substance must include the following information:
  - Date of issue
  - Patient's name and address
  - Practitioner's name, address, and DEA registration number
  - Drug name
  - Drug strength
  - Dosage form
  - Quantity prescribed
  - Directions for use
- Prescriptions must be written in ink and signed by the practitioner

In NYS, controlled substance prescriptions must be ***electronically prescribed***

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Who May Issue A Prescription

- A prescription for a controlled substance may only be issued by a physician, dentist, podiatrist, veterinarian, mid-level practitioner or other registered practitioner who is:
  - Authorized to prescribe controlled substances by the jurisdiction of licensure
  - Registered with DEA or exempted from registration via Public Health Service, Federal Bureau of Prisons or military personnel
  - An agent or employee of a hospital or other institution acting in its normal course of business or employment under the registration of the hospital or institution
- Lists of Schedule II controlled substances are issued by the federal government and may vary slightly by State requirements
- In New York, there is a limit of a 7 day supply for an original controlled substance prescription (some exemptions apply)

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Written Treatment Plan for Opioid Prescribing

- Public Health Law §3331 by adding subparagraph (8), as amended 1 April 2018
- Requires a written treatment plan in the patient's medical record if a practitioner prescribes opioids for pain that has lasted for more than three months or past the time of normal tissue healing
- Unless the patient
  - is being treated for cancer that is not in remission
  - is receiving hospice or other end-of-life care, or palliative care

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Written Treatment Plan for Opioid Prescribing

Treatment plan must be done at least annually and include:

- goals for pain management and functional improvement based on diagnosis, and a discussion on how opioid therapy would be tapered to lower dosages or tapered and discontinued if benefits do not outweigh risks;
- a review with the patient of the risks of and alternatives to opioid treatment; and
- an evaluation of risk factors for opioid-related harms.

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Disposing of Unused Medication

- Currently some police stations in most NYS counties have collection boxes for disposing of unused medication (https://www.health.ny.gov/professionals/narcotic/medication_drop_boxes/ accessed 27 May 2019)
- More options will become available under the NYS Drug Take Back Act
  - Article 2-B
  - Public Health Law (PHL) §§290-294
  - Implemented and Administered by the Bureau of Narcotic Enforcement, with DEC
  - Effective Date: January 6, 2019
  - Implementation: Late 2019 or after

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NYS Drug Take Back Act

- Requires manufacturers of "covered drugs" to develop a program to take back unused medication
- Pharmacies will be designated "collectors" of medication, offering one or more of:
  - On-Site Collection/Drop boxes
  - Mail-back envelopes
  - Other DEA-approved methods
- Pharmacies will be required to have signage promoting the program
- Large cities (population > 125,000) will have a dropbox program for drug collection: NYC, Yonkers, Syracuse, Rochester, and Buffalo

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Brief Overview of Issues Related to Opioid Misuse and Opioid Use Disorder (OUD)

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Vulnerability Factors for Substance Use Disorder (SUD)

- Genetic predisposition
- Concomitant mental health diagnoses:
  - bipolar disorder
  - anxiety (GAD/PTSD/social anxiety)
  - Depression
  - ADHD/ADD
  - personality disorders (borderline, antisocial)
  - antisocial conduct disorder (especially in adolescence)
  - Especially when undiagnosed, undertreated, untreated, or treated inappropriately

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Vulnerability Factors for Substance Use Disorder (SUD)

- History of trauma and/or abuse
- Poor coping mechanisms; escapism
- Impulsivity
- Sensation/novelty seeking
- Environmental triggers: sensory cues
- Lack of homeostatic reward regulation; reward "deficiency": orientation towards pleasurable rewards

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Stigma Regarding OUD, Medication-Assisted Treatment (MAT), and People Who Use Drugs

- Patients on MAT for OUD may be subject to stigma or negative pressure from friends, family, loved ones, substance use treatment programs, 12-step programs (AA, NA), probation/parole/drug court to be off MAT (specifically buprenorphine and methadone)
- Counter this stigma with evidence-based data which supports MAT as first-line treatment for OUD
- Consider alternative social supports for patients
  - *In the Rooms* app and *SMART Recovery* meetings and app, community-based peers/recovery coaches

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Stigma Regarding OUD, Medication-Assisted Treatment (MAT), and People Who Use Drugs

- *Language: what we say and how we say it matters!*
- Avoid stigmatizing and disparaging language with PWUD and/or have a substance use disorder
  - *Say "person who uses drugs", NOT "drug addict", "junkie", "dope fiend"*
  - *Say "positive" or "negative" or "expected" or "unexpected" for UDS results, NOT "clean" or "dirty" (NEVER describe a person as "clean" or "dirty" either)*
  - *Say "substance use disorder" or "opioid use disorder", NOT "drug abuse", "substance abuse", or "addiction"*

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Goals for MAT

- **Decrease risk for overdose (methadone and buprenorphine)**
- Alleviate physical withdrawal symptoms
- Create a "narcotic blockade" (saturate the opioid mu receptors)
- Alleviate drug cravings
- Normalize brain changes: anatomy
- Normalize brain physiology: neurotransmitters
- Improve functionality for the patient: goals are individualized
- Decrease harm (incidence of infectious disease: HIV/HCV/HBV, incidence of infections: endocarditis/abscesses, etc.)

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Who Can Get a DATA Waiver to Prescribe Buprenorphine?

- *Physicians:* since 2000, physicians can take an 8-hour course to meet criteria to obtain a DATA waiver and DEA certification to prescribe buprenorphine
- *Nurse practitioners and physician assistants:* since 2016, NPs and PAs can take a 24-hour course to meet criteria to obtain a DATA waiver and DEA certification to prescribe buprenorphine
- *Certified nurse midwives, nurse anesthetists, and other advanced practice nurses:* in 2018, legislation passed to allow additional qualifying practitioners to take a 24-hour course to meet criteria to obtain a DATA waiver and DEA certification to prescribe buprenorphine

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Patient-Prescriber Agreements

- *Best practice for both pain management patients and MAT patients*
- *Elements of a standard patient-prescriber agreement:*
  - Responsibilities should be outlined bi-directionally: expectations for the patient and responsibilities of the provider towards the patient
  - Should be clear regarding refills, visits, lost prescriptions (i.e. no replacement of controlled medications), etc.
  - Should outline means of discontinuation of medication as applicable (i.e. in lack of efficacy for pain)
  - Should be non-punitive
  - Should use respectful language and tone
  - Should outline the risks and benefits of using the medication

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Checking the PDMP

- *Required:*
  - Before writing any controlled prescription in New York State
- *Optional, but Informative:*
  - Consider checking the PDMP on all patients every visit
  - It can be informative: your patient may be on controlled medications and you were unaware (potential drug-drug interactions, at risk for misuse or development of a SUD)
  - Caveat: methadone received for the treatment of OUD (i.e., dispensed at a MMTP) will NOT be listed in the PDMP
    - the only way to know is if your patient tells you

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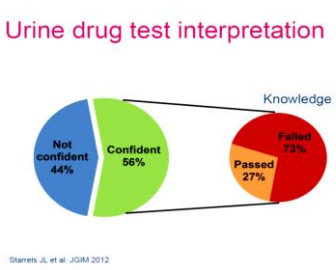
UDS Interpretation: Most Medical Providers Receive NO Training



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Pre-operative Management of Patients on MAT

- MAINTAIN maintenance buprenorphine or methadone dose; DO NOT STOP IT
- Discuss with the patient post-operative pain management to set expectations and goals of care
  - manage acute pain with additional full agonist opioids ON TOP of maintenance buprenorphine or methadone dose or
  - increase buprenorphine dose/dosing frequency with patients on buprenorphine

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Post-operative Management of Patients on MAT

- CONTINUE maintenance buprenorphine or methadone dose; DO NOT STOP IT
  - otherwise, for patients on buprenorphine, they will have to go into opioid withdrawal syndrome (OWS) in order to restart buprenorphine
- Treat any acute pain with full agonist opioids IN ADDITION TO baseline buprenorphine or methadone maintenance dose; or for buprenorphine patients, increase the dose/dosing frequency of buprenorphine
- ANTICIPATE that the patient on MAT will need a HIGHER dose of opioid pain medication for acute pain due to opioid tolerance and blockade of opioid mu receptors

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MAT and Hepatic/Renal Co-morbidities

- *Buprenorphine:*
  - No dose adjustment needed for chronic liver disease (CLD) or cirrhosis; monitor clinically
  - No dose adjustment needed for chronic kidney disease (CKD) or hemodialysis
  - Minimal drug-drug interactions
- *Methadone:*
  - Dose adjustment likely needed for cirrhosis, due to decreased hepatic metabolism
  - No dose adjustment needed for CKD or hemodialysis
  - Significant drug-drug interactions

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Who Is at Risk for Opioid Overdose?

- Reduced tolerance
- Using alone (risk factor for fatal OD)
- Chronic medical illness
- Unstable housing
- Concomitant mental illness
- Mixing drugs
- Changes in the drug supply
- History of previous overdose
- Doses ≥ 90 mg morphine-equivalent doses
- Shooting versus sniffing

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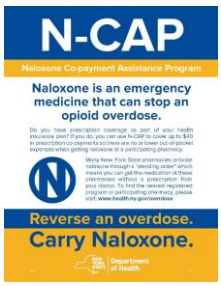
N-CAP: Naloxone Co-payment Assistance Program



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How Does Naloxone Work?

Naloxone: Mechanism of Action

- **Reverses** opioid overdose and prevents fatalities
- Mu-opioid receptor **antagonist**
  - No clinical effect in the absence of opioid agonists
  - Inert: no drug-drug interactions
  - Displaces opioids from the receptors
- Takes effect in **2-3 minutes**
  - May cause acute opioid withdrawal
  - Lasts for 30-90 minutes (longer for newest formulation)
- **Hepatic metabolism**; renal excretion
- **Safe in children**

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New York State's Good Samaritan Law

Protects:

- The individual who experiences an overdose
  and
- The person who summons EMS (calls 911)

Prevents prosecution for:

- Possession of up to 8 oz of a controlled substance
- Alcohol (for underage drinkers)
- Marijuana (any amount)
- Paraphernalia offenses
- Sharing of drugs (in NYS, sharing can be a "sales" offense)

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Resources

- www.pcssnow.org
- www.asam.org
- www.harmreduction.org

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Palliative Medicine

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Palliative Care Access Act

Effective February 9, 2011, PHL Section 2997-d requires the "attending health care practitioner" to offer to provide patients with a terminal illness (or surrogates) with information and counseling regarding palliative care and end-of-life options appropriate to the patient, including:

- Prognosis;
- Range of options appropriate to the patient;
- Risks and benefits of various options;
- Patient's "legal rights to comprehensive pain and symptom management at the end of life."

www.health.ny.gov/professionals/patients/patient_rights/palliative_care/information_act.htm

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Palliative Care Information Act

Effective September 27, 2011, PHL Section 2997-d requires that hospitals, nursing homes, home care agencies, special needs assisted living residences, and enhanced assisted living residences, provide access to information and counseling regarding options for palliative care appropriate to patients with advanced life limiting conditions and illnesses [or their surrogates].

These providers and residences must also facilitate access to appropriate palliative care consultation and services, including associated pain management consultation and services, consistent with the patient needs and preferences.

www.health.ny.gov/professionals/patients/patient_rights/palliative_care/information_act.htm

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What is Palliative Care?

"Palliative care" means health care treatment, including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient's quality of life, including hospice care under article forty of [the Public Health Law]

- Specialized medical care for people living with serious illness
- Focused on providing relief from the symptoms and stress of a serious illness
- To improve quality of life for both the patient and the family
- Provided by a team of palliative care doctors, nurses and other specialists who work together with a patient's other doctors to provide an extra layer of support

Appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.

45 www.capc.org/about/palliative-care
www.health.ny.gov/professionals/patients/patient_rights/palliative_care/phl_2997_d_memo.htm

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Who Can Palliative Care Help?

- Patients with a serious, chronic illness
- Patients with metastatic or locally advanced cancer progressing despite systemic treatments with or without weight loss and functional decline

https://getpalliativecare.org/resources/clinicians/

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Who Can Palliative Care Help?

Patients in **ICU** with any of the following:

- Admission from a nursing home in the setting of one or more chronic life-limiting conditions (e.g., dementia)
- Two or more ICU admissions within the same hospitalization
- Prolonged or difficult ventilator withdrawal
- Multi-organ failure
- Consideration of ventilator withdrawal with expected death
- Metastatic cancer
- Anoxic encephalopathy
- Consideration of patient transfer to a long-term ventilator facility
- Family distress impairing surrogate decision-making

https://getpalliativecare.org/resources/clinicians/

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Who Can Palliative Care Help?

Patients in the **Emergency Department** with any of the following:

- Multiple recent prior hospitalizations with same symptoms/problems
- Long-term-care patient with Do Not Resuscitate (DNR) and/or Comfort Care (CC) orders
- Patient previously enrolled in a home or residential hospice program
- Patient/caregiver/physician desires hospice but has not been referred
- Consideration of ICU admission and or mechanical ventilation in a patient
  - With metastatic cancer and declining function
  - With moderate to severe dementia
  - With one or more chronic diseases and poor functional status at baseline

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https://getpalliativecare.org/resources/clinicians/

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Early Palliative Care: Better Patient Outcomes

- 2010 study included patients with advanced Stage 4 non-small cell lung cancer who were immediately referred to a palliative care team upon diagnosis
- Patient findings:
  - Quality of life scores were better
  - Symptoms of depression were less
  - Aggressive end of life care was reduced
  - Survival rate increased from 8.9 months to 11.6 months

Temel JS, et al. *N Engl J Med*. 2010;363:733-42

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Palliative Care – When is it time?

- Palliative care is about **addressing the patient's symptoms and psychosocial burden**—it is not prognosis-based.
- It is almost never "too soon" to introduce palliative care, AND physician prognosis is unreliable, and often overly optimistic—especially when there is a longstanding physician-patient relationship

Warm E. Prognostication. 3rd Ed. Fast Facts and Concepts. May 2015. http://www.mypcnow.org/

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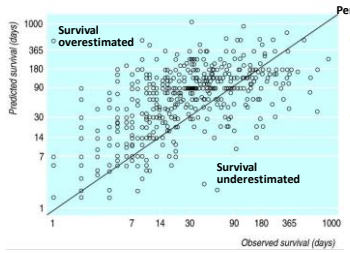
Palliative Care – When is it time?

Extent and Determinants of Error in Doctor's Prognoses in Terminally Ill Patients: Prospective Cohort Study



- Predicted vs. observed survival in 468 terminally ill hospice patients
- Diagonal line represents perfect prediction, above the line survival was overestimated; below the line survival was underestimated

51 Christakis NA, Lamont EB. *BMJ*. 2000;320:469-72

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Enhancing Patient Communication

- Discuss the patient's agenda first
- Observe and note the patient's emotional and cognitive data
- Talk with the patient, explain anticipated treatment agenda and express empathy
- Speak with the patient about what CAN be done prior to sharing what and why something cannot be done
- Outline long term goals first and available treatments options second
- Give patients your undivided attention

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Questions to Ask Your Patients

- Do you understand your illness/diagnosis and its implications for the future?
- Are you afraid?
- What are you worried about?
- What does your future look like (i.e. priorities, goals, challenges, etc.)?
- What is your expectation of outcome?
- Do you need help in talking with your family?

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What About Hospice Care?

- Palliative care for patients who appear to have a life expectancy of 6 months or less
- Covered under Medicare Part A. Many commercial insurance plans and NYS Medicaid also provide hospice benefits
- Provided by hospice care agencies, in coordination with the patient's primary physician

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How to Identify Patients in Need of Hospice Care

"Would you be surprised if your patient died some time within the next six months?"

~ Ira Byock, M.D.
Professor of Medicine and Community & Family Medicine
Geisel School of Medicine at Dartmouth
Hanover, NH

Founder/Chief Medical Officer
Institute for Human Caring of Providence Health and Services
Torrance, CA

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Facing a Serious or Life Threatening Illness, New Diagnosis

- Engage in the difficult conversation with patient/caregivers
- Help patient/caregivers understand severity of illness
- Help patient identify and assign a Health Care Proxy

Goal:
Show support, advocacy, match needs and treatment options with goals of care

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Addressing Serious News

- Make sure you have privacy
- Minimize distractions and interruptions
- Check the patient's understanding before you start
- Ask for permission before sharing new information
- Use empathy
- Check the patient's understanding again, before you finish

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Talking About Prognosis

- Acknowledge the uncertainty
- Use ranges of time
  - Months to a few years
  - Weeks to a few months
  - Days to a few weeks
  - Hours to a few days
- Use empathy
- Consider using, "I wish…" rather than, "I'm sorry…"

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End-of-Life Care

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Care of Actively Dying Patients

- Stop any IV fluids
  - Recognize that not eating or drinking is a natural part of dying process
  - Recognize that giving IVF while someone is actively dying usually causes burden without benefit (increased strain on heart and kidneys while causing dyspnea, pleural effusions, and edema)
- Dyspnea management
  - Turn on a fan or open the window
  - Flow of air eases breathing
  - Avoid BIPAP as it would not resolve underlying issue (it can be very uncomfortable because it is tight on the face)
- Limit vitals
  - Only monitor HR and RR as markers of distress (goal HR<100, RR<24)
  - Checking BP is uncomfortable

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Refocus Care

- As patients near end-of-life, discontinue medical treatments that:
  - Will not improve quality of life
  - Cause excessive pain
  - Are expensive for the patient
  - Cause burdens or side effects that outweigh the benefits
- Eliminate unnecessary medications/treatments that may no longer be beneficial:
  - Cholesterol medications, dementia medications, vitamins, protein supplements, minerals, DVT prophylaxis, compression devices, antibiotics, anti-diabetic meds

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Medications for Dying Patients at EOL

- Morphine IV or SL or SQ
  - Initial dose for opioid naive patient
    - **Oral morphine (2.5-5 mg)**
    - **Parenteral (IV/SQ) morphine (1-2 mg)**
  - When dyspnea is acute and severe, parenteral is the route of choice: 2-5 mg IV every 5-10 minutes until relief
  - A continuous opioid infusion, with a PRN dose will provide the timeliest relief in the inpatient setting
- Lorazepam (Ativan®) IV or SL
  - Anxiolytics can reduce anxiety component of dyspnea
  - Starting dose usually 0.5mg IV q8h PRN
  - Oral liquid dose is 2mg/ml, so give 0.5mg (0.25ml) SL q6h prn

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Non-pharmacological Interventions

- Offer social work or pastoral services
  - Usually appropriate at end of life and other potentially difficult times of illness
- Update caregivers/family
  - Provide realistic expectations and emotional support
  - Explain that not eating/drinking is a natural part of the dying process and it is not uncomfortable for the patient or a "starvation" state
- Encourage families on how to express their love and concern
  - Hand holding, music therapy, massage, reading

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Advance Directives – Planning

- Appointment of Health Care Proxy
- Living Will – outline expectations for end-of-life care
- Organ Donation
- Power of Attorney – financial and other non-health care decisions
- MOLST – Medical Orders for Life Sustaining Treatment
- Non-Hospital DNR

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Why Are Advance Directives Important?

- Life expectancy is increasing with people living longer with chronic illnesses
- Our region has an aging population
- Health care has evolved to provide increased technology and interventions
- This results in more complex decisions to be made about medical interventions and procedures
- Decisions are more stressful in times of crises
- Advanced planning allows for goals and preferences about care to be known and honored

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When to Address Advance Directives?

- Initial or annual outpatient visit
- Prior to hospitalization for elective surgery or procedure
- Any acute hospitalization
- Return visit after a recent hospitalization
- Follow up office visit, especially if chronic illness
- Diagnosis of serious or life threatening illness

Basically – consider the discussion at any clinical interaction

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Medicare Pays for Advance Care Planning

CPT Code 99497	CPT Code 99498
Advance care planning including explanation and discussion of advance directives by physician or other qualified health care professional **First 30 minutes, face-to-face with patient, family member(s), and/or surrogate**	**Each additional 30 minutes** *List separately, in addition to code 99497*

Appropriate documentation:

- An account of discussion with regarding the voluntary nature of the encounter
- Documentation indicating the explanation of advance directives (along with completion of those forms, when performed)
- Who was present
- Time spent in face-to-face encounter

Does the beneficiary/practice have to complete an advance directive to bill the service?

- No, the CPT code descriptors indicate "when performed," so completion of an advance directive is not a requirement for billing the service

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Advance Directives for Adults

Health Care Proxy (HCP)

- **Legal document that appoints a Health Care Agent to make decisions in the event patient is unable to do so due to illness or injury**

Living Will

- **Document that outlines medical procedures that patients do or do not want in case they are unable to do so for them self due to a terminal, irreversible condition**
- **Not a legal document but helps establish clear and convincing evidence of patient's preferences**


Health Care Proxy

(1) I,

hereby appoint

(name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint

(name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (Optional: If you want this proxy to expire, state the date or conditions here.) This proxy shall expire (specify date or conditions)

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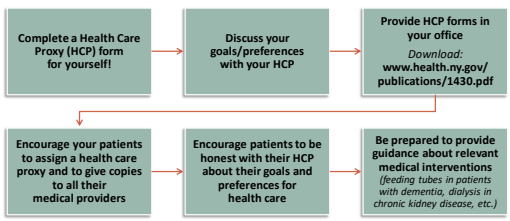
Health Care Proxy Steps



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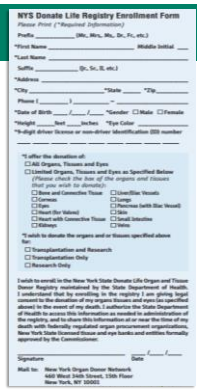
Other Advance Directives

Organ Donation

Check off the donor box on driver's license application or renewal form or complete online Donor Registry enrollment form[1]


NYS Donate Life Registry Enrollment Form

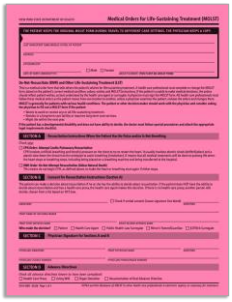
Power of Attorney

A separate document designating a person to make financial and other non-health care decisions

1. https://www.health.ny.gov/professionals/patients/donation/organ/

Actionable Medical Orders: MOLST

Medical **O**rders for **L**ife-**S**ustaining **T**reatment


Medical Orders for Life-Sustaining Treatment (MOLST)

Documents a patient's treatment preferences concerning life-sustaining treatment

- Only authorized NYS form for documenting both non-hospital DNR and DNI orders
- Form is beneficial to patients and clinicians:
  - Provides specific medical orders (feeding tube, IVF, antibiotics, DNH)

https://www.health.ny.gov/forms/doh-5003.pdf

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Got MOLST? Patients should if…

- Patient has one or more advanced chronic conditions or a serious new illness with a poor prognosis
- Patient has specific preferences regarding medical interventions (which may change as condition progresses)
- Patient lives in a nursing home, or receives long term care services at home or in an assisted living facility
- Clinician would NOT be surprised if the patient died in the next year
- Patient has decreased function, frailty, progressive weight loss, or two or more unplanned hospitalizations in last 12 months

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MOLST Protocols

1. **Prepare** for discussion
   - Understand patient's health status, prognosis, ability to consent
   - Retrieve any completed Advance Directives
   - Determine decision-maker and NYS public health law legal requirements
2. **Determine** what the patient and family know re: condition, prognosis
3. **Explore** goals, hopes and expectations
4. **Suggest** realistic goals
5. **Respond** with empathy
6. **Use MOLST** to guide choices and finalize patient wishes
   - Shared and informed medical decision-making
   - Conflict resolution
7. **Complete** and sign MOLST
8. **Review and revise** periodically

http://www.compassionandsupport.org/pdfs/homepage/MOLST_8_Step_Protocol._revised_032911_.pdf

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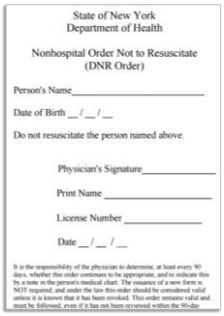
Actionable Medical Orders: Non-Hospital DNR

Non-hospital Do Not Resuscitate (DNR) Order

- Legally recognized statewide for DNR requests occurring *outside* of hospitals and nursing homes
- Patient with valid non-hospital DNR may wear standard metal bracelet which includes a caduceus and words "Do Not Resuscitate"
- Form must be authorized and signed by a physician
- MOLST form can be used as an alternative to the Non-Hospital DNR form



State of New York
Department of Health

Nonhospital Order Not to Resuscitate
(DNR Order)

Person's Name_____

Date of Birth __ / __ / __

Do not resuscitate the person named above.

Physician's Signature_____

Print Name _____

License Number _____

Date __ / __ / __

It is the responsibility of the physician to determine, at least every 90 days, whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart. The issuance of a new form is NOT required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the 90-day

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Directives Should be Consistent

- Having a DNR order does not limit the patient's access to any other life sustaining treatments
- It does NOT make sense to be DNI but "full code"
- It is impossible to provide true CPR without intubation

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Frequently Asked Questions

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New York Chapter American College of Physicians

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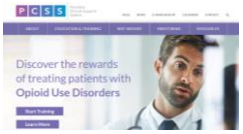
How Can I learn More About Opioid Use Disorder?

- There are myriad resources online for learning about opioid use disorder: screening, diagnosis, treatment, etc.
- www.pcssnow.org (Providers Clinical Support System)
  - Education and Training modules:
  - SUD (Substance Use Disorder) 101
  - Chronic Pain
  - Webinars, videos, and "Success Stories"
  - Resources:
    - clinical tools
    - clinical resources
    - family/patient resources
    - mentoring opportunities



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How Can I Learn More About Opioid Use Disorder?

- NEW YORK STATE DEPARTMENT OF HEALTH AIDS INSTITUTE: Clinical Guidelines Program www.hivguidelines.org/substance-use/
- Updated SUD Guidelines
  - "Harm Reduction Approach to Treatment of All SUD"
  - "Treatment of OUD"
  - The Guidelines are geared towards primary care providers and other non-addiction medicine specialists interacting with patients using opioids, misusing opioids, or with OUD
  - Comprehensive and can be utilized by providers while with patients
  - Is extensively referenced

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What Else Should I Understand When Treating Patients Misusing Opioids or With OUD?

- Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use
- Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs
- *As medical providers, we do harm reduction with all our patients routinely*
- We need to apply the same principles to our patients who are PWUD (people who use drugs)

www.harmreduction.org

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What Else Should I Understand When Treating Patients Misusing Opioids or With OUD?

- Trauma-Informed Care
  - Individual trauma results from an event, series of events, or set of circumstances experienced as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.
  - Health care providers need to recognize that trauma is highly prevalent, can impact a person at any time during their lifespan, and may present as mental health, substance use or physical health conditions.
  - Ensuring that the physical and emotional safety of an individual is addressed is the first important step to providing Trauma-Informed Care.
  - 5 Principles: Safety, choice, collaboration, trustworthiness, and empowerment

https://www.integration.samhsa.gov/clinical-practice/trauma-informed

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What Do I Do If A Family Member Asks Me Not To Share Information With The Patient?

- "Please don't tell my loved one…" is a common request from family members worried about frightening their loved one with bad news
- Autonomy requires that patients with capacity be given the information they need to make decisions; however,
- Patients can delegate responsibility for making decisions, or the authority to manage information sharing to another person they trust

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Communication Tips

- Consider saying this to the person making the request:
  - It sounds like you are worried about how your loved one might handle the news.
  - I will ask the patient how they would like to manage getting information now.
  - I will let them know that they can choose to have someone else receive information for them.
- Consider saying this to the patient:
  - Your family is worried that getting more information about your illness is making things harder for you.
  - They are willing to take this responsibility and even to make decisions, if you want them to.
  - How would you like to go from here?

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My Patient Lacks Capacity. How Do I Talk To Their Family About Making Decisions?

- Patients with serious illnesses often lack capacity to make health care decisions
- If you are uncertain about your patient's capacity, you can use a tool like the Aid for Capacity Evaluation

http://jcb.utoronto.ca/tools/ace_download.shtml

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My Patient Lacks Capacity. How Do I Talk To Their Family About Making Decisions?

- If your patient lacks capacity you will need to get help from others to make health care decisions, usually family members or other surrogate decision-makers (SDM)
- If you are not sure whom to talk to, or if your patient has no one to speak for them, call your local bioethics consultant

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My Patient Lacks Capacity. How Do I Talk To Their Family About Making Decisions?

- When talking to SDMs make sure you and the others are focusing on the patient's goals, values and preferences
- If you have not had previous discussions with the patient, ask the SDMs to tell you about what the patient valued, enjoyed and considered most important
- Ask the SDMs to help you figure out how the patient would answer this question: Given what is happening, what should we do now?

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What's The Deal With "eMOLST"?

- eMOLST is an electronic form to document the NYS DOH MOLST.
- eMOLST includes programming to avoid missed sections and inconsistent directives (e.g. full code with DNI).
- At the end of the eMOLST process, both a MOLST form and the appropriate MOLST Chart Documentation Form or OPWDD checklist are created.
- eMOLST works for all patients: adults, children and persons with developmental disabilities.
- eMOLST may be used with paper records or integrated in an EMR or hybrid system.

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What's The Deal With "eMOLST"?

- The system allows physicians to sign MOLST orders electronically.
- An accessible electronic format allows health care providers (including EMS), to access MOLST forms at all sites of care, including in an emergency, with the same form shared across the care continuum.
- Accessible at NYSeMOLSTregistry.com

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Do I Need To Call Palliative To Refer To Hospice?

- No. Anyone can initially refer a patient to Hospice – physician, nurse, social worker, clergy, family, friends, or the patient themselves.
- After the referral is made, the Hospice team will ask for records regarding a patient's diagnosis and prognosis from the medical providers.
- Early referrals are encouraged. Even if the patient is not eligible for Hospice, the referral helps the patient and family know more about Hospice services.
- Hospice care allows patients to maintain greater consistency in symptom management and live each day to the best of their ability.

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Acknowledgements

NYACP Pain Course Task Force Members:
- Paula E. Lester, MD, FACP, CMD - Chair
- Daniel H. Pomerantz MD, MPH, FACP
- Kelly S. Ramsey, MD, MPH, MA, FACP

Other NYACP Contributors:
- Linda S. Efferen, MD, MBA, MACP

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Thank You

Thank you for participating in Managing Pain and Opioid Use: An Educational Program on Compliance with New York State Prescribing Laws. You can receive CME, CNE, or ABIM MOC Part II credit, you must take a post-test and complete an evaluation. With a passing score of 70% or greater, you'll be able to print your certificate.

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Managing Pain and Opioid Use:

An Educational Program on Compliance with New York State Prescribing Laws

Transcript

MODERATOR: Welcome to Managing Pain and Opioid Use, an educational program on compliance with New York State prescribing laws. This educational activity consists of four brief presentations and, in conjunction with SCOPE of Pain, fulfills the opioid education requirements of the State of New York.

At the conclusion of the program, if you wish to receive CME, CNE, and ABIM MOC part 2 credits, you must take a post test and complete an evaluation. With a passing score of 70 percent or greater you'll be able to print your certificate.

This program is provided by Boston University School of Medicine in partnership with the New York Chapter of the American College of Physicians. This program is also funded through a federal grant from the Centers for Medicare and Medicaid Services to the American College of Physicians, Inc. for its role in the Transforming Clinical Practice Initiative Support and Alignment Network Project.

At the conclusion of this activity, participants will be better able to:

- describe the New York State laws governing the safe prescribing of opioids
- explain relevant issues related to opioid misuse, opioid use disorder, and opioid overdose
- communicate with patients about palliative care and end of life decisions
- appropriately document communication with patients about healthcare proxies and advance directives, and describe the appropriate use of advanced care planning CPT codes.

First, please welcome Dr. Kelly Ramsey and Dr. Daniel Pomerantz on behalf of the New York Chapter, American College of Physicians, who will discuss state and federal laws governing the prescribing of controlled substances.

KELLEY RAMSEY, MD: The New York State Internet System for Tracking Overprescribing, or I-STOP, consists of several elements including the prescription drug monitoring program (or PDMP) and electronic prescribing regulations.

With respect to I-STOP, the practitioner must consult the registry prior to prescribing or dispensing any controlled substance listed on Schedule II, III, or IV. Practitioners may consult the registry prior to prescribing or dispensing any other controlled substance and certain exceptions apply.

Exceptions to the duty to consult I-STOP include the following: Veterinarians; methadone maintenance treatment programs; a practitioner administering a controlled substance; a practitioner prescribing or ordering a controlled substance for use on the premises of an institutional dispenser; a practitioner prescribing a controlled substance in the emergency department of a general hospital, provided that the quantity of controlled substance prescribed does not exceed a five-day supply if the controlled substance were used in accordance with the directions for use; a practitioner prescribing a controlled substance to a patient under the care of hospice; a practitioner when it is not reasonably possible for the practitioner to access the registry in a timely manner, no other practitioner or designee authorized to access the registry pursuant to paragraph B of this subdivision is reasonably available and the quantity of controlled substance prescribed does not exceed a five-day supply if the controlled substance were used in accordance with the directions for use; a practitioner acting in compliance with regulations that may be promulgated by the commissioner as to circumstances under which consultation of the registry would result in a patient's inability to obtain a prescription in a timely manner, thereby adversely impacting the medical condition of such patient; a situation where the registry is not operational as determined by the department or where it cannot be accessed by the practitioner due to a temporary technological or electrical failure as set forth in regulation; a practitioner who has been granted a waiver due to technological limitations that are not reasonably within the control of the practitioner; or other exceptional circumstance demonstrated by the practitioner pursuant to a process established in regulation and in the discretion of the commissioner.

There is a seven-day limitation on initial opioid prescribing for acute pain in New York State. Effective July 22, 2016, a practitioner may not initially prescribe more than a seven-day supply of an opioid medication for acute pain.

Acute pain is defined as pain, whether resulting from disease, accidental or intentional trauma or other cause that the practitioner reasonably expects to last a short period of time. Upon any subsequent consultation for the same pain, the practitioner may issue in accordance with existing rules and regulations any appropriate renewal, refill or new prescription for an opioid.

The seven-day limit does not include prescribing for chronic pain, pain being treated as part of cancer care, hospice or other end of life care, or pain being treated as part of palliative care practices.

E-prescribing basic requirements: New York education law 6810 states that all prescriptions must be transmitted electronically. New York State is the only state to mandate E-Prescribing of controlled and non-controlled substances. A practitioner must use E-Prescribing software that has been certified and audited in accordance with the U.S. DEA regulations. The practitioner must also complete an identity proofing process and obtain two factor authentication in accordance with the DEA regulations. A practitioner must register the controlled substance E-Prescribing software with the Bureau of Narcotic Enforcement or BNE.

The registration with BNE needs to be updated at least every two years or whenever the DEA requires a new third-party audit of the software, whichever occurs first.

If the practitioner works at multiple locations and different E-Prescribing software is used at such sites, the practitioner will need to register each software program used to prescribe controlled substances.

A prescriber must make a notation in the patient's medical record indicating when he or she has issued a paper prescription, noting the applicable statutory exception for why an E-Prescription was not possible.

The E-Prescribing regulations include several exceptions to the mandate, including the following: Prescriptions issued by veterinarians; electronic prescribing is not available due to temporary technological or electronic failure; prescriptions issued by a practitioner under circumstances where the practitioner reasonably determines that it would be impractical for the patient to obtain substances prescribed by electronic prescription in a timely manner and such delay would adversely impact the patient's medical condition. In addition to these circumstances, the quantity of controlled substances cannot exceed a five-day supply if the controlled substance were used in accordance with the directions for use; prescriptions issued by a practitioner are to be dispensed by a pharmacy located outside the state, and practitioners have received a waiver from the requirement to use electronic prescribing.

Federal prescribing requirements: A prescription for a controlled substance must include the following information: Date of issue, patient's name and address, practitioner's name, address and DEA registration number, drug name, drug strength, dosage form, quantity prescribed and directions for use. Prescriptions must be written in ink and signed by the practitioner. However, please note that in New York State controlled substance prescriptions **must** be electronically prescribed.

Who may issue a prescription? A prescription for a controlled substance may only be issued by a physician, dentist, podiatrist, veterinarian, mid-level practitioner or other registered practitioner who is authorized to prescribe controlled substances by the jurisdiction or licensure, registered with DEA or exempted from registration by a public health service, federal bureau of prisons or military personnel, an agent or employee of a hospital or other institution acting in its normal course of business or employment under the registration of the hospital or institution.

Lists of Schedule II controlled substances are issued by the federal government and may vary slightly by state requirements. Remember, in New York State there is a limit of a seven-day supply for an original controlled substance prescription. Some exemptions do apply.

DAN POMERANTZ, MD: Public Health Law in New York State was amended in April of 2018, to require a treatment plan whenever a practitioner prescribes opioids for longer term use. The public health law requires a written treatment plan in the patient's medical record if a

practitioner prescribes opioids for pain that has lasted for more than three months or past the time of normal tissue healing, unless the patient is being treated for cancer that is not in remission or is receiving hospice or other end of life care or palliative care. The written treatment plan must be done at least annually and include goals for pain management and functional improvement based on the diagnosis and a discussion of how opioid therapy would be tapered to lower dosages or tapered and discontinued if benefits do not outweigh risks. It must include a review with the patient of the risks of and alternatives to opioid treatment and an evaluation of risk factors for opioid related harm.

To help dispose of unused medications there are a number of options in New York State. Currently some police stations in most New York State counties have collection boxes for disposing of unused medications. The locations can be found on the Department of Health website. More options will become available under the New York State Drug Takeback Act, Article 2B of Public Health Law section 290 – 294, which will be implemented and administered by the Bureau of Narcotic Enforcement with the Department of Environmental Conservation. The law became effective in January of 2019, and will be implemented in late 2019, or after.

The New York State Drug Takeback Act requires manufacturers of covered drugs to develop a program to take back unused medications. Pharmacies will be designated collectors of medications, offering one or more of the following: Onsite collection or drop boxes, mail-back envelopes, or other DEA approved methods. Pharmacies will be required to have signage promoting the program. Large cities in New York, those with populations more than 125,000, will have a drop-box program for drug collection. Those are New York City, Yonkers, Syracuse, Rochester and Buffalo.

MODERATOR: Next, Dr. Ramsey will offer a brief overview of issues related to opioid misuse and opioid use disorder.

KELLEY RAMSEY, MD: It's important to understand the vulnerability factors for substance use disorder. About 50 percent of our vulnerability is due to genetic predisposition. So, having a family history of any substance use disorder puts one at risk for developing a substance use disorder.

Having a concomitant mental health diagnosis is also very common in persons with substance use disorder, particularly with the following diagnoses: Bipolar disorder; anxiety, whether it be generalized anxiety disorder, PTSD or social anxiety; major depression; ADD or ADHD; specific personality disorders including borderline personality disorder and antisocial personality disorder; antisocial conduct disorder especially in adolescents. And especially when any of these mental health diagnoses are either undiagnosed, undertreated, untreated or treated inappropriately it puts the person at risk for developing substance use disorder. Having a history of trauma and/or abuse is very common; in females, particularly a history of preadolescent sexual abuse. In males, they may not be as quick to recognize experiences in

their lives as abuse, but often they are victims of violence or witness to violence, particularly in the home when growing up.

Pretty universal among my patients with substance use disorder is an inability to cope effectively or having poor coping mechanism. Perhaps initially when people are trying drugs, it's for escapism or for sensation- or novelty-seeking. However, once the person develops criteria for a substance use disorder they no longer have control over their substance use and instead have a compulsion to use. Impulsivity, which goes along with many of the mental health diagnoses which I already outlined, is part of substance use disorder vulnerability as well.

Environmental triggers which include all types of sensory cues, whether it's a visual cue or an auditory cue, etc., often lead people to relapse. And then the formal definition of the most notable vulnerability factor is a lack of homeostatic reward regulation or reward deficiency. So, this is an orientation in the brain towards pleasurable rewards. When people use any substance they get a surge of dopamine and this leads to reinforcement in the brain in seeking pleasure by using drugs.

It's also important to understand is stigma regarding opioid use disorder, medication assisted treatment for opioid use disorder, and towards people who use drugs in general. Often persons on medication assisted treatment for opioid use disorder may be subject to stigma or negative pressure from friends, family, loved ones, substance use treatment programs, 12-step programs including AA and NA, probation, parole or drug court to be off of MAT. Specifically buprenorphine and methadone, which are agonists used to treat opioid use disorder.

It's very important to counter this stigma with evidence based data, which supports medication assisted treatment with agonist therapy including buprenorphine and methadone as first line treatment for opioid use disorder.

Consider alternative social supports for patients where they're less likely to encounter stigma towards being on MAT. This includes the "intherooms" app and SMART Recovery meetings and app, and community based peers and recovery coaches.

It's also very important that we use appropriate language when speaking about persons who use drugs and about substance use disorder. What we say and how we say it matters. Avoid stigmatizing and disparaging language with people who use drugs and/or with persons who have a substance use disorder. Say "a person who uses drugs," not "drug addict," "junky," "dope fiend," etc. Say "positive or negative" or "expected or unexpected" or "appropriate or inappropriate" for urine drug screen results. Don't use the terms "clean and dirty" to describe a person or a urine drug screen. Say "substance use disorder" or "opioid use disorder," not "drug abuse," "substance abuse" or "addiction."

So, what are our goals for medication assisted treatment for opioid use disorder? First and foremost, is to decrease the risk for both fatal and nonfatal opioid overdose. Both methadone and buprenorphine decrease a person's risk for overdose. Notably naltrexone does not.

Also to alleviate the physical withdrawal symptoms that a patient experiences; physical withdrawal symptoms or acute opioid withdrawal syndrome are what drive a patient compulsively to use drugs. To create a narcotic blockade: this means to saturate the opioid neuroreceptors, so that even if a person does relapse with opioids they actually won't feel the high from it. To alleviate drug cravings; actually the DSM-5 criteria added cravings for using drugs to the criteria in its latest iteration, recognizing that when somebody experiences drug cravings, this is often the prelim to relapse.

To normalize changes that have occurred in the brain due to drug use, both in anatomy and physiology; to try to create more of a balance of neurotransmitters in the brain, which have been altered by substance use. Importantly for the patient is to increase functionality for the patient. So, goals are individualized. It's really important that we focus on what a patient hopes to achieve by not using drugs. Whether that's getting their teeth fixed or getting their children back or returning to work or to school, or improving relationships with people in their lives. It's important that we not focus on what the provider hopes to achieve or what the urine drug screen shows. It's really about the person becoming more functional in their life.

We also want to decrease the person's harm from using the substances. So, that would include the incidence of infectious disease, whether with HIV, hepatitis C, hepatitis B; or of infection such as endocarditis or abscesses that are associated with drug use.

Who can get a DATA waiver to prescribe buprenorphine? Since 2000, physicians can take an eight-hour course to meet criteria to obtain a DATA waiver and DEA certification to prescribe buprenorphine. That can be done half live and half online or completely online.

Since 2016, nurse practitioners and physician assistants can take a 24-hour course to meet criteria to obtain a DEA waiver and DEA certification to prescribe buprenorphine.

And in 2018, legislation passed to allow additional qualifying practitioners including certified nurse midwives, nurse anesthetists and other advanced practice nurses to take a 24-hour course to meet criteria to obtain a DATA waiver and DEA certification to prescribe buprenorphine.

Patient-prescriber agreements are considered best practice for both pain management patients and for MAT patients. What do we consider to be the elements of a standard patient-prescriber agreement? Responsibilities should be outlined bidirectionally: expectations for the patient and responsibilities of the provider towards the patient. The agreement should be clear regarding refills, visits, lost prescriptions (i.e., no replacement of controlled medications, etc.).

It should outline the means for discontinuation of medications as applicable, for example, in lack of efficacy for pain. It should be non-punitive. It should use respectful language and tone and should outline the risks and benefits of using the medications.

How about checking the PDMP? In New York State, it is required before writing any controlled prescription. It's optional otherwise but it can be informative in practice. Consider checking the PDMP on all patients on every visit. Your patient may be on a controlled medication that you were unaware of and this could lead to potential drug-drug interactions or put a person at risk for misuse or development of a substance use disorder.

An important caveat is that methadone received for the treatment of opioid use disorder, i.e. dispensed at an OTP or methadone maintenance treatment program will not be listed in the PDMP. The only way to know if your patient is on methadone is if you ask your patient and your patient opts to tell you.

How about urine drug screen interpretation? Most medical providers, regardless of the program they attend, receive no training regarding interpreting urine drug screens. This slide shows a questionnaire that was given to physicians about their confidence regarding interpreting urine drug screens.

As you can see from the slide, 56 percent of the physicians were confident that they knew how to interpret a urine drug screen. However, when they were tested on their knowledge, 73 percent failed the test.

If you're going to use urine drug screens in your clinical practice, it's important that you receive education on this and have a mentor who understands how to interpret urine drug screens so that you understand what you're seeing when you are reading them regarding your patients. It's also important that the urine drug screen just be used as a data point and not be used punitively with patients.

Preoperative management of patients on MAT. The recommendation is to maintain maintenance buprenorphine or methadone. Do not stop the patient's medication. Discuss with the patient postoperatively pain management to set expectations and goals of care. Acute pain can be managed with additional full agonist opioids on top of maintenance buprenorphine or methadone. Or, you can increase the person's Buprenorphine dose or dosing frequency with patients on buprenorphine.

Postoperative management of patients on MAT. Continue maintenance Buprenorphine or Methadone. Do not stop it. Otherwise, for patients on Buprenorphine, they will have to go into opioid withdrawal in order to restart Buprenorphine. Treat any acute pain with full agonist opioids in addition to the baseline Buprenorphine or Methadone maintenance dose. Or for Buprenorphine patients you can increase the dose or dosing frequency of Buprenorphine.

Anticipate that the patient on MAT will need a higher dose of opioid pain medication for acute pain due to opioid tolerance and blockade of the opioid mu-receptors.

MAT and hepatic/renal comorbidities. With respect to Buprenorphine, no dose adjustment is needed for chronic liver disease or cirrhosis. Monitor the patient clinically. No dose adjustment is needed for chronic kidney disease or hemodialysis patients. There are minimal drug-drug interactions between Buprenorphine and most other medications.

For Methadone, dose adjustment likely is needed for cirrhosis due to decreased hepatic metabolism. No dose adjustment is needed for chronic kidney disease or patients on hemodialysis. There are significant drug-drug interactions with respect to Methadone. So, it is important that you're aware if your patient is on Methadone so you can be cautious with prescribing other medications.

Who is at risk for opioid overdose? Persons with reduced tolerance, that includes persons who do not have access to their opioid drug supply, including patients in detox, rehab and incarcerated settings, hospitalized patients, etc. Persons who are using alone. This is particularly a risk factor for fatal opioid overdose as a person cannot administer Naloxone to themselves. A person with chronic medical illness, including any persons with underlying cardiac or pulmonary conditions. Unstable housing, as this may lead a person to be using in a location where they might not be found, such as an abandoned building or an abandoned car.

Concomitant mental illness; mixing drugs, whether that's other illicit drugs or prescribed drugs; changes in the drug supply, because illicit drugs are not regulated in any way, every batch is different and particularly with new Fentanyl analogs that are increasingly stronger, it puts the person at risk each time they use.

History of a previous nonfatal overdose puts a person at risk for a fatal overdose. Doses greater than equivalent of 90 milligrams of morphine and shooting versus sniffing, however, a person can overdose by any means by which they use drugs.

There is a Naloxone copayment assistance program in New York State for persons whose insurance has a copay associated with Naloxone and it will pay up to 40 dollars. You can find information about that on the New York State Department of Health website.

How does Naloxone work? Naloxone reverses opioid overdose and prevents fatality. It is a mu-opioid receptor antagonist. It has no clinical effect in the absence of opioid agonists. In other words, it is inert and will not have drug-drug interactions with other medications. It only displaces opioids from the mu-opioid receptors. It takes effect quickly, usually within two to three minutes. And it can cause acute opioid withdrawal, and the effect lasts for about 30 to 90 minutes, 90 minutes generally with the newer formulation intranasally. However if a person has enough opioids on board they can go back into an opioid overdose. So it is important that persons be monitored after they receive Naloxone. It's metabolized by the liver and it's excreted by the kidneys. It is safe in children as well as adults.

New York State has a Good Samaritan law, which protects persons who are experiencing an overdose and the person who summons EMS or calls 911. It prevents prosecution for

possession of up to eight ounces of a controlled substance, alcohol for underage drinkers, marijuana in any amount, paraphernalia offenses and the sharing of drugs. In New York State, sharing drugs can be considered a sales offense.

It's important to educate patients regarding the Good Samaritan law as it offers them quite a bit of protection in the context of an opioid overdose, hopefully alleviating people's fears regarding involving EMS.

MODERATOR: Let's turn now to Dr. Pomerantz, who will review palliative care.

DAN POMERANTZ, MD: New York State has passed several laws regarding palliative care. The Palliative Care Access Act and the Palliative Care Information Act. The Palliative Care Access Act, passed in February of 2011, requires the attending healthcare practitioner to offer to provide patients with a terminal illness or surrogates with information and counseling regarding palliative care and end of life options appropriate to the patient, including prognosis, range of options appropriate to the patient, risks and benefits of various options, and the patient's legal rights to comprehensive pain and symptom management at the end of life.

The Palliative Care Information Act, passed in September of 2011, requires hospitals, nursing homes, homecare agencies, special needs assisted living residences and enhanced assisted living residences provide access to information and counseling regarding options for palliative care appropriate to patients with advanced life-limiting conditions and illnesses, or their surrogates.

These providers and residences must also facilitate access to appropriate palliative care consultation and services including associated pain management consultation and services consistent with the patient's needs and preferences.

What is palliative care? New York State defines palliative care as healthcare treatment including interdisciplinary end of life care in consultation with patients and family members to prevent or relieve pain and suffering and to enhance the patient's quality of life including hospice care under Article 40 of the Public Health Law. This means specialized medical care for people living with serious illness, focused on providing relief from the symptoms and stress of a serious illness, to improve quality of life for both patient and the family, provided by a team of palliative care doctors, nurses and other specialists who work together with the patient's other doctors to provide an extra layer of support.

It is appropriate at any age and any stage in a serious illness and can be provided along with curative treatment. That last definition is from the Center to Advance Palliative Care.

Who can be helped by palliative care? Patients with serious chronic illnesses, patients with metastatic or locally advanced cancer, progressing despite systemic treatment with or without weight loss and functional decline. Patients in critical care settings like ICUs who have any of the following may benefit from palliative care: admission from a nursing home in the setting of one or more life limiting conditions like dementia; two or more ICU admissions within the same

hospitalization. Prolonged or difficult ventilator withdrawal; multi-organ failure; if there's consideration of ventilator withdrawal with expected death; patients in ICUs with metastatic cancer or anoxic or hypoxic ischemic encephalopathy; or patients who are considering transfer to a long-term ventilator facility; or if there is family distress that is impairing surrogate decision making.

In emergency department settings, patients with any of the following should be considered potentially to benefit from palliative care: Patients with multiple recent hospitalizations with similar symptoms and problems; patients transferred to EDs from long-term care who have do not resuscitate or comfort care orders; patients who were previously in a home or residential hospice program. If the patient, the caregiver or their physician desires hospice but the patient has not yet been referred. Or for patients in EDs who are being considered for ICU admission or mechanical ventilation who have metastatic cancer and declining function, moderate or severe dementia, or one or more chronic diseases and poor functional status.

Early palliative care can benefit many patients. A 2010 study of patients with advanced lung cancer, stage IV non-small-cell lung cancer, were either referred for routine care or early palliative care consultation. Patients who received early palliative care had better quality of life scores, reported fewer symptoms of depression, had less aggressive care at end of life and had prolonged survival with survival increased from 8.9 months to 11.6 months in the intervention group.

When is it time for palliative care? Palliative care is about addressing the patient's symptoms and psychosocial burden. It is not prognosis based. It is almost never too soon to introduce palliative care and physician prognosis is unreliable and often overly optimistic, especially when there is a longstanding physician/patient relationship.

In a study of 468 terminally ill hospice patients, marked overestimate of survival predictions by clinicians including experienced clinicians can be seen. The diagonal line represents a perfect correlation between observed and estimated survival. As you can see, some patients were observed to survive for only one day, including one patient whose estimated survival was greater than one year.

How do we talk about palliative care with patients? First, discuss the patient's agenda. Pay attention to the patient's emotional state and the information they already have. Talk to patients, explaining anticipated treatments and use empathy. Acknowledge their emotional experience. Speak to patients about what can be done before talking about what can't be done. Outline long-term goals first and then talk about treatment that aligns with long-term goals. Make sure you're giving patients your undivided attention. When talking to patients about palliative care, think about questions like these. Ask your patients: Do you understand your illness and your diagnosis and what it means for your future? Are you afraid of anything? What are you worried about? How does your future look to you? What do you think is going to happen? How can I help you talk to your family?

What about hospice care? Hospice care is palliative care for patients who appear to have a life expectancy of six months or less. It's covered under Medicare Part A and many commercial plans and New York State Medicaid also provide hospice benefits. Hospice care is provided by hospice care agencies in coordination with the patient's primary physician.

How can you identify patients in need of hospice care? There are a number of relatively complicated prognostic models for particular diseases but the general guideline is the surprise question developed by Dr. Ira Byock. Ask yourself: Would you be surprised if your patient died sometime within this next six months? If you would **not** be surprised by your patient's death within six months, that patient will likely benefit from hospice care.

Patients facing serious or life-threatening illness and getting a new diagnosis require serious care in how you discuss it with them. When you're engaging with these difficult conversations with patients you need to help them understand the severity of the illness and help them to identify someone who can speak for them if they're not able to speak for themselves, and indicate their selection on a healthcare proxy form. You want to show support, you want to advocate for them, and you want to match their needs with the treatment options in light of their goals of care.

When you're addressing serious news with patients and their family, make sure you have privacy, minimize distractions and interruptions. Make sure you know what the patient understands already before you begin. And ask for permission before you give them any new serious news. Use empathy and pay attention to their emotional reactions. And before you finish make sure they tell you what they understand about what you have told them.

In talking about prognosis you should acknowledge uncertainty and talk in ranges of time rather than particular amounts of time; months to years, weeks to a few months, days to a few weeks. Again, remember this is difficult and acknowledge their emotional experience and use empathic statements. Consider saying: I wish, rather than I'm sorry, when discussing serious news. As in – I wish we didn't have to discuss this now. Rather than – I'm sorry to give you this news. I'm sorry makes the patient feel an obligation to apologize or to accept your apology, which is awkward and not really appropriate.

MODERATOR: Welcome Dr. Paula Lester on behalf of the New York Chapter American College of Physicians, who will discuss end of life decision making.

PAULA LESTER, MD: When taking care of actively dying patients there are several things that you can do. An important step is to stop any IV fluids. We need to recognize that not eating and drinking is a natural part of the dying process. We need to understand that as clinicians as well as to explain it to family members.

We need to recognize that giving someone intravenous fluids while they're actively dying can actually cause a burden without benefit. It increases strain on the heart, kidneys and extra

work for the body to process the fluids. And it can lead to dyspnea, pleural effusion and edema.

Additionally if someone has dyspnea, another thing that can be done to help them would be to turn on a fan or open the window. The flow of air on the face eases the work of breathing so people feel more comfortable.

Additionally if someone's getting bi-pap, it's important to consider stopping it at the end of life because it's generally not going to resolve the underlying issue and it can be very uncomfortable because it is so tight on the face and presses the face as it works.

Additionally if someone's actually dying you should consider what vital signs you really need to monitor. In general, monitoring heart rate and respiratory rate are very useful as markers of distress and they're not invasive or uncomfortable for the patient. We generally try to have a goal of heart rate less than 100 and a respiratory rate less than 24, as signs of being more comfortable. Checking blood pressure can be uncomfortable for someone and at the end of life is not going to change your management.

Additionally, as patients near the end of life we need to refocus our care. We need to focus on things that will help the patient feel better and not focus on things that will cause harm or be unpleasant for the patient.

Other things to avoid are things that will not improve quality of life, treatments that can cause excessive pain, treatments that are expensive for the patient or treatments that can cause burdens or side effects that outweigh the benefits.

Some examples of medications or treatments that may no longer be beneficial include cholesterol medications, dementia medications, vitamins, minerals, DVT prophylaxis, those shots can be painful; compression devices, antibiotics and antidiabetic medications.

When patients are actively dying at end of life, they also need medications to reduce their symptom burden. The mainstay opioid to use is morphine, which can be used IV, sublingual or SubQ. The initial dose for someone who is opioid naïve is generally recommended to be oral morphine of 2.5 to 5 milligrams or IV SubQ morphine 1 to 2 milligrams. If the dyspnea is acute and severe, parenteral is the route of choice because it can be given more quickly and have a quicker effect. Generally, the dose is 2 to 5 milligrams IV every five to ten minutes until symptom relief occurs.

In the inpatient setting, a patient can receive a continuous opioid infusion along with a PRN dose for breakthrough symptoms as a way to provide the timeliest and most consistent relief for their symptom burden. In general, it's recommended to avoid morphine, at least repeated doses of morphine, in patients with renal insufficiency. However, sometimes at end of life, clinicians may choose to use morphine if it's the only medication available.

Another medication that's used for end of life dying patients is Lorazepam. It can be given IV or sublingual or PO. As an anxiolytic benzo, it can reduce the anxiety component of dyspnea as well as help with restlessness. Additionally the dose that we usually use is 0.5 milligrams IV every eight hours PRN. An oral dose is available, liquid as 2 mg/ml, which also can be helpful for patients who need symptomatic relief.

In addition to medications which are available for patients at end of life, it is important to consider and institute non-pharmacological interventions. Social work and pastoral services can be very helpful at end of life and other potentially difficult times of illness. They can help both the patient and the caregivers and family.

It's also important for us as providers and clinicians to update the caregivers and family and provide realistic expectations as well as emotional support. We need to help them understand that not eating and not drinking is a natural part of the dying process and it's not uncomfortable for the patient. It's not that the patient is starving or hungry; it's part of the natural process of dying.

Sometimes it helps to explain with an example of when a patient themselves might have had the flu or some other illness and they didn't feel like eating. It wasn't that they were starving. It was that they were sick and their bodies recognized that they couldn't handle the food. Sometimes that analogy will help families understand what the patient is going through.

It's also important to encourage families on how to express their loving concern, especially when food and sometimes talking is not available. While we can talk to patients they might not be able to answer us, but it's still valuable to talk to them. Also, you can do handholding, music therapy, massage, and reading, and any other thing that will help the patients connect with their family members.

Now, we're going to speak about different types advance directives. So, advance directives are important because life expectancy is increasing with people living longer and longer, along with chronic illnesses. And our region in particular has an aging population. While healthcare has evolved to provide increased technology and intervention, this actually leads us to have more complex decisions to make about whether or not the medical interventions and procedures are appropriate or indicated or of value to the patient. Unfortunately, decisions of this nature are definitely more difficult and stressful when it's a time of crisis. Therefore advance planning is helpful because it allows us to figure out patient's goals and preferences about care and then honor and acknowledge and enforce their preferences and desires.

When should healthcare providers address advance directives? It can be done almost any time; it can be done at an initial our annual outpatient visit. It should be done prior to hospitalization for an elective surgery or procedure. It can be done with any acute hospitalization. It can be done at a return visit after a recent hospitalization. It can be done in an office follow-up visit especially if there's chronic illness. And it can be done at the time or soon after the diagnosis of

a serious or life-threatening illness. Basically, it can be done at any clinical interaction. But it is important that it gets addressed.

So Medicare now actually pays for advance care planning. There are two CPT codes that can be used. One is a shorter visit and the other is a longer visit. This code CPT 99497 is advance care planning including explanation and discussion of advance directives by a physician or other qualified healthcare professional. It's a 30 minute visit but according to Medicare, that's anywhere between 16 and 45 minutes. It must be done face to face with the patient or family member or surrogate or all of them together. The documentation must include that the discussion was of voluntary nature, documentation to include that the advance directives were discussed and what issues were raised. If those forms were completed, such as a MOLST and other forms we will speak about, it should be included in the documentation. The note should say who was present and it should specify the amount of time spent face to face in the encounter.

If someone spends more than 46 minutes, they can bill the 99498 code. It's in addition to the 99497. It's very important to know the patient does not need to actually sign a MOLST or DNR form in order to bill for this service. The code is for the discussion, the advance care planning discussion.

There are lots of different advance directives available for adults. The most basic one a lot of people think of is a healthcare proxy. It is a legal document that appoints a healthcare agent to make decisions in the event a patient is unable to do so because of illness or injury. This is different than a living will. A living will is one which outlines what medical decisions, or procedures should be made in the event of a certain case or scenario. Many people: it says what they would want in the event of a terminal or irreversible condition. A living will is not a legal document but establishes clear and convincing evidence of the patient's preferences. It's generally not as helpful because sometimes it's not clear whether or not the patient meets the criteria for which the living will is meant to go into effect. But it is helpful in terms of giving the patient's general philosophy about care.

In terms of healthcare proxies, we recommend that everyone have one for themselves. Every adult should have a healthcare proxy. So, if you don't have one, please do so. It's important also for your proxy to know what you want. As well as it's important for your patients' proxies to know what they want. If you need, you can access that New York State healthcare proxy form easily from the internet. It's important to encourage your patients to have a healthcare proxy and the copy of that proxy should be with them when they go to doctor's visits and to the hospital and their medical providers as well as their proxy should have copies.

It's important for patients to be honest with their healthcare proxy about what they want and their goals and preferences for healthcare. Someone can't honor your wishes if they don't know what they are. And sometimes as medical providers we need to guide patients. Certain patients might have more specific questions about if they have chronic kidney disease would

they want dialysis. Or if they have dementia or have a stroke, would they want a feeding tube. So, it's important to be specific when needed to help people plan their future goals.

Other advance directives include organ donation. One way to do that is to mark off the donor box on your driver's license or complete it in the donor registry form that's available online. Also available is a power of attorney, which is a separate document that designates a person to make financial and other non-healthcare decisions. So, power of attorney does not help with medical decisions but helps with other directives that people may need.

The MOLST form is becoming more popular and prevalent in use in New York State. The MOLST form is the Medical Orders for Life-Sustaining Treatment. It's generally a hot pink form, although those copies may not be hot pink. It documents a patient's treatment preferences for life sustaining treatment. It is actually the only New York State form that documents both non-hospital Do Not Resuscitate and Do Not Intubate orders. It's really very helpful for patients and clinicians because it gives specific instructions about feeding tube, IV fluids, antibiotics, do not hospitalize, comfort measures only.

The first page, as we see in the images, CPR versus DNR. And the inside page has more options about intubation and other medical treatments. It needs to be updated and maintained. And again, people should have copies of it.

So, who should have a MOLST? People should have a MOLST if they have one or more advanced chronic illness or they have a new serious diagnosis with a poor prognosis. If someone has specific preferences regarding medical interventions, then keep in mind this can change. You might think that you want a feeding tube in the future but then if you have a stroke you might change your mind and not want a feeding tube. So, these are changeable documents.

If someone lives in a nursing home or gets long-term care services at home or an assisted living facility, those chronic conditions are generally prevalent and having a MOLST would help them plan for the future.

Another thing to think about is whether a clinician would not be surprised if the patient died within the next year, they should have a MOLST so that discussion could be held and documented. Also consider a MOLST if the patient has decreased function, frailty, progressive weight loss, or two or more unplanned hospitalizations in the last 12 months.

In terms of completing the MOLST, the first step is to prepare for the discussion. You want to understand the patient's health status, prognosis, their ability to complete the form and the ability to consent to the treatment that they would want or not want. You want to retrieve any completed advance directives and be consistent or document why there are changes. And determine who the decision maker is and Public Health Law requirements if the patient themself is not able to sign. You want to find out what the patient and family know about their condition and prognosis so they can make realistic decisions based on their condition. You

want to explore their goals, hopes and expectations. Sometimes this means suggesting realistic goals and that could be a heavy discussion but it's important to have. You want to respond with empathy as described elsewhere in the course.

You can use the MOLST to guide choices and finalize patient wishes. This can help to provide shared, informed medical decision making. And can also hopefully have conflict resolution if there is disagreement amongst the family and the caregivers. The MOLST needs to be completed and signed with witnesses. Of note, the physician who signs the MOLST can also be one of the witnesses.

And then the MOLST should be reviewed and revised periodically and there's a page for showing that it's been reviewed and whether or not it's been updated.

So, the non-hospital DNR form is a form that is being used less often now because the MOLST has become more prevalent. But the non-hospital DNR is still a valid form. It is a New York State form that is legally recognized statewide for DNR requests occurring outside of the hospital or nursing home. So, if someone is in their home and they wish to be DNR, they need to have either a non-hospital DNR or MOLST form. The non-hospital DNR form does not work in the hospital. There needs to be a separate order. This form needs to be authorized and signed by a physician and it is supposed to be updated but it remains valid even if it is not updated.

It's important when patients decide on their advance directives, that they be consistent. If someone has a DNR or do not resuscitate, it does not mean they are foregoing all other treatments. They can still have antibiotics and other treatments that are deemed appropriate for them. However, if someone has a do not intubate order, they really cannot be full code. In order to be full code, a patient needs to be able to have the full CPR, which would be intubation, chest compressions, chemicals and electric shock. It's really impossible to provide true CPR without intubation. But if patients choose to be DNR and they wish for their last moments to not have chest compressions and to hopefully be comfortable and to die naturally then that is their choice and we need to honor that.

KELLEY RAMSEY, MD: Hello, again. This is Dr. Kelley Ramsey. And on behalf of myself, Dr. Paula Lester and Dr. Dan Pomerantz, I would like to present the final segment, entitled Frequently Asked Questions.

The first four slides pertain to opioids and opioid use disorder and they will be followed by five slides focused towards palliative care and three slides relating to end of life care.

How can I learn more about opioid use disorder? There are myriad resources online for learning about opioid use disorder, regarding screening, diagnosis, treatment, etc. One website is at www.pcssnow.org. This is the Providers Clinical Support System. They have education and training modules on substance use disorder 101, chronic pain, webinars, videos and success

stories. They also have resources, clinical tools, clinical resources, family and patient resources and mentoring opportunities. You can also find information on Buprenorphine waiver training.

Another helpful website is www.hivguidelines.org/substanceuse. This is the New York State Department of Health AIDS Institute clinical guideline program. Currently there are updated substance use disorder guidelines on this website regarding harm reduction approach to treatment of all substance use disorders and the treatment of opioid use disorder. The guidelines are geared towards primary care providers and other non-addiction medicine specialists who are interacting with patients using opioids, misusing opioids, or with opioid use disorder. They are comprehensive and can be utilized by providers in real time with their patients. The guidelines are extensively referenced.

What else should I understand when treating patients misusing opioids or with opioid use disorder? Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief and respect for the rights of people who use drugs.

As medical providers, we do harm reduction with all of our patients routinely. We need to apply the same principles to our patients who are using drugs or PWUD. There is more information at www.harmreduction.org.

What else should I understand when treating patients misusing opioids or with opioid use disorder? Trauma informed care. Individual trauma results from an event, series of events or set of circumstances experienced as physically or emotionally harmful or life-threatening, with lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual wellbeing. Healthcare providers need to recognize that trauma is highly prevalent, can impact a person at any time during their lifespan, and may present as mental health, substance use or physical health conditions.

Ensuring that the physical and emotional safety of an individual is addressed is the first important step to providing trauma informed care.

Five principles of trauma informed care include safety, choice, collaboration, trustworthiness and empowerment. You can find more information online at SAMHSA and the website is listed on the bottom of the slide.

What do I do if a family member asks me not to share information with the patient? "Please don't tell my loved one" is a common request from family members worried about frightening their loved one with bad news. Autonomy requires that patients with capacity be given the information they need to make decisions. However, patients can delegate responsibility for making decisions or the authority to manage information sharing to another person they trust.

Communication tips. Consider saying this to the person making the request: "It sounds like you're worried about how your loved one might handle the news. I will ask the patient how they would like to manage getting information now. I will let them know that they can choose

to have someone else receive information for them." Consider saying this to the patient: "Your family is worried that getting more information about your illness is making things harder for you. They're willing to take this responsibility and even to make decisions if you want them to. How would you like to go from here?"

My patient lacks capacity, how do I talk to their family about making decisions? Patients with serious illnesses often lack capacity to make healthcare decisions. If you are uncertain about your patient's capacity, you can use a tool like the Aid for Capacity Evaluation. Please see the website at the bottom of the slide.

My patient lacks capacity, how do I talk to their family about making decisions? If your patient lacks capacity, you will need to get help from others to make healthcare decisions, usually family members or other surrogate decision makers, or SDMs. If you are not sure whom to talk to or if your patient has no one to speak for them, call your local bioethics consultant. When talking to SDMs make sure you and the others are focusing on the patient's goals, values and preferences. If you have not had previous discussions with the patient, ask the SDMs to tell you about what the patient valued, enjoyed and considered most important. Ask the SDMs to help you figure out how the patient would answer this question: "Given what is happening, what should we do now?"

What's the deal with e-MOLST? E-MOLST is an electronic form to document the New York State Department of Health MOLST. E-MOLST includes programming to avoid missed sections and inconsistent directives. At the end of the e-MOLST process, both a MOLST form and the appropriate MOLST chart documentation form or OPWDD checklist are created. E-MOLST works for all patients: adults, children and persons with developmental disabilities. E-MOLST may be used with paper records or integrated in an EMR or hybrid system. This system allows physicians to sign MOLST orders electronically. An accessible electronic format allows healthcare providers including EMS to access MOLST forms at all sites of care including in an emergency, with the same form shared across the care continuum. The e-MOLST is accessible at www.nystateemolstregistry.com. Please see the reference at the bottom of the slide.

Do I need to call palliative care to refer to hospice? No. Anyone can initially refer a patient to hospice: a physician, a nurse, a social worker, members of the clergy, family, friends or the patient themselves. After the referral is made the hospice team will ask for records regarding a patient's diagnosis and prognosis from the medical providers. Early referrals are encouraged. Even if the patient is not eligible for hospice, the referral helps the patient and family know more about hospice services. Hospice care allows patients to maintain greater consistency and symptom management and live each day to the best of their ability.

MODERATOR: This program has been made possible by the New York Chapter American College of Physicians and its Pain Course Task Force, with additional contributions from Dr. Linda Efferen.

Thank you for participating in Managing Pain and Opioid Use, an educational program on compliance with New York State prescribing laws. To receive CME, CNE, or ABIM MOC part 2 credit you must take a post test and complete an evaluation; with a passing score of 70 percent or greater, you'll be able to print your certificate.

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