Speaker: Daniel Pomerantz, MD, MACP

[00:00:02] Slide 1

Welcome to the third hour of the Opioid and Pain course training. This segment, titled Managing Pain and Opioid Use in Educational Program and Compliance with New York State Prescribing Laws, offers a focused, one hour learning experience. It features four concise presentations and is offered in conjunction with the two hour Scope of Pain course. Together, these sessions fulfill the prescriber training requirements mandated by the State of New York since 2016.

[00:00:29] Slide 2

At the conclusion of the program, you will be able to receive CME, CME, and MOOC credit by completing the post-Test and evaluation and achieve a passing score of 70% or higher to print your certificate.

[00:00:45] Slide 3

This program is provided by the Boston University Chobani and Advertising School of Medicine. Barry M Manuel Center for Continuing Education, in partnership with the New York chapter of the American College of Physicians.

[00:01:00] Slide 4

By the end of this activity, participants will understand recent legislative updates on opioids, naloxone, and medical cannabis. Key issues in opioid use and overdose. And core principles of palliative care, including symptom management and communication for end of life planning.

Speaker: Paula Lester, MD, FACP

[00:01:18] Slide 5

Hi, everyone. I'm doctor Paula Lester, and I'll be talking about the state and federal laws on the prescribing of controlled substances.

[00:01:25] Slide 6

The Prescription Drug Monitoring Program, or PDMP registry in New York is called I STOP, and it provides practitioners and pharmacists with direct, secure access to new prescription history of controlled medications. This is great for us because it lets us see who has prescribed medications, what medicines have been prescribed, what doses and when they were prescribed. It is important to note that a practitioner or a designee must

consult the registry prior to prescribing or dispensing any controlled medication listed on schedule two, three, or four.

A designee is someone generally in your office who is part of your practice, who has their own access to the I STOP registry who can check the registry for the patient you are seeking to provide medication to, or just checking on their registry list, and they're checking it counts as you checking it.

However, it is important that you actually look at what they check so they can print it or download it for you, and then you review it and that counts as you checking it.

[00:02:24] Slide 7

So, there's no changes to the exceptions to the e-prescribing mandate. So, you can pick one of the reasons why you weren't able to do it, a temporary technological, electric failure, etc..

[00:02:35] Slide 8

The exceptions to the duty to consult the PDMP or I STOP have also not changed. So, make sure you continue to do what you were supposed to do.

[00:02:46] Slide 9

Instead of reiterating previous instructions about the PDMP, I thought we would focus on some FAQs so that you can get detailed information about how it's actually working in real practice.

So, the first question is, if I prescribe a five day supply or less of a controlled medication from the following locations, do I need to consult the PDMP prior?

So if you're in an emergency department of a general hospital, you do not need to check the PDMP or I STOP. If you're in a private practice, even if it's five days or less. Yes, you do need to check the registry for an ambulatory surgery center. Yes, you need to check if urgent care dental office clinic. Yes. So basically, being in an emergency room, you can prescribe five days or less without checking the I.

But if you're anyplace else ordering less than five days, doesn’t get you off the hook. You still need to check the registry.

[00:03:33] Slide 10

Here are some more questions. I'm a practitioner working in a nursing home, adult home, adult assisted living, correctional facility, or similar place which is a licensed class three A institutional dispenser. Limited. Am I exempt from consulting the registry?

Yes. You are exempt from consulting the registry unless the patient will consume the medication off premises. For example, if you have someone in a rehab or a nursing home and now they're going home, you need to check the registry before sending them the prescription to be at home.

If they are living in the facility and you're prescribing it in the facility and they're taking the medication in the facility, you do not need to check I STOP with every renewal.

Next question. If my patient is under the care of hospice, am I exempt? Yes, being under hospice means that you do not need to check the PDMP for your patient.

Question: I have patients who receive schedule II prescriptions which require a new prescription with each fill. Do I have to consult the PDMP for the same patient each time when writing the same prescription? Unfortunately, yes. You need to check it every time.

[00:04:35] Slide 11

This rule has not changed if you're prescribing initial opioids for someone for acute pain, for example, resulting from disease or accident or trauma, something that you expected to have a short time course, you can only prescribe a seven-day supply maximum of an opioid for acute pain.

Once that patient has completed their seven-day supply, if you feel it's appropriate to renew it, then you can order at whatever time period you think is appropriate. But for the initial dose, it must be seven days.

Of note, the seven day limit does not include prescribing for chronic pain, pain being treated as part of a cancer care or hospice or other end of life care or pain that's part of a palliative care practice. But for acute pain that's expected to recover, that's not related to those things, it's a seven day limit.

[00:05:22] Slide 12

New York State public health law does still require that a written treatment plan is written for opioid prescribing. If the opioids are going to be used or maintained for more than three months for past the time to expect a normal tissue healing, you must have a written treatment plan.

It is not required if the opioids are used for cancer treatment that is not in remission, or hospice or palliative or other end of life care.

And so make sure that you documented that patients meet these criteria and that's why you have not written a treatment plan for maintaining opioids for more than three months.

[00:05:52] Slide 13

As of May 2025. So this is a relatively new change. The reliance on the physical exam has changed. In the past, because of the medical emergency related to Covid, an in-person medical exam, the physical exam, had been exempt under certain circumstances.

Now, an in-person medical evaluation of the patient is required by the prescriber for the condition being treated. There are a few cases where this does not apply. For example, the absence of an in-person medical evaluation is permitted if the consulting or referring practitioner reviews the record of a different in-person medical evaluation that was done in the past 12 months related to that condition.

For the governing practitioner, in the absence of the prescriber, if the provider is in the same group with access to the records, or is directed adequate consultation with the initial prescriber who assures the need for the medication so you can write it for someone you have not seen if they're in your group, as long as you have access to the record, or you've confirmed that to prescribe it and it's appropriate. Make sure you document that!

You don't need an in-person medical evaluation if it's a new condition in an emergency situation. So, for example, if the practitioners has an established relationship, there is an immediate need or the medication is not available, and you prescribe five days or less, and if it's telemedicine or telehealth, then an in-person medical evaluation is not required.

Although obviously you're still speaking to them through the telemedicine or telehealth, but it's not a hands on evaluation.

[00:07:21] Slide 14

So now I'd like to share with you another recent update. Buprenorphine for medication for addiction treatment for opioid use disorder (OUD). Is fortunately still going to be allowed through telemedicine or telehealth, which will be audio or audio and visual.

If you want more information about using telemedicine to prescribe buprenorphine, please check out this webpage.

[00:07:44] Slide 15

Naloxone remains an important part of our efforts to reduce opioid-related deaths and ensure safe use of medications. All New York State pharmacies can now dispense naloxone through what's called a standing order, which means it's a non-patient specific order. Additionally, anyone can go over the counter and get from the pharmacy naloxone.

So, if you have any patients or people who are interested in getting naloxone, they don't need a prescription. They can go to the pharmacy and just ask for the medication.

And if they have insurance, the insurance generally will cover it. If the insurance does not cover it, there is a naloxone copayment assistance program or N-CAP that covers copayments up to $40 to reduce the cost for most privately insured persons.

And if someone's on Medicaid, there should be no cost. So really, there's no excuse for people, especially if they're on opioids, to not have naloxone available.

And there are people who argue that interactions should be more widely available because you don't know when someone might need it, and you want to be able to save a life.

[00:08:46] Slide 16

In New York State, we still have to follow the annual opioid antagonist prescription requirement. So basically, with your first opioid prescription in a calendar year for a patient. So that could be January or could be later in the year based on how often you see the patient and prescribe.

You also must prescribe an opioid antagonist, such as naloxone, when the following risk factors are present.

There are some exclusions for this. So, if you're prescribing in a hospital or nursing home under article 28 or under article 31 of the Mental Hygiene Law or for hospice patients in general, the nursing homes or hospitals should have their own naloxone. And hospice patients are their own categories.

[00:09:25] Slide 17

Let's speak a little bit about the New York State Medical Cannabis program.

In order for healthcare providers to issue certifications for patients to receive medical cannabis, the provider must be licensed, registered, or certified by New York State to prescribe controlled medications to humans in the state.

You need to take a two-hour course, before you can certify patients for medical cannabis.

You have to prove your certification of passing that course and make sure that you take a two-hour course that is approved by New York State.

Once you completed your medical cannabis training and, submitted it to the state, you use the medical cannabis data management system, which is available through the New York State Health Commerce webpage, to submit why the patient is appropriate for medical cannabis and what the conditions are, and the new system streamlines the certification process.

You complete the form, you send it or give it to the patient, and they then look for one of the authorized medical marijuana dispensaries and then bring the certificate to them.

[00:10:24] Slide 18

So just a few pointers about medical cannabis because it is still not widely used by many providers. Practitioners do not prescribe.

So, we are not saying the ratio of THC or CBD. We can make a suggestion for formulation. We can make a suggestion for the dose, if we want to, but we don't have to.

This is very important if you are going to do the certification for medical cannabis, you must consult the PDMP, the I STOP to see the controlled medication history before issuing or editing a medical cannabis certification.

[00:10:56] Slide 19

Some other information about medical cannabis they have. New York State has simplified the form as I mentioned earlier. In addition, you don't have to list in many details about the qualifying conditions.

Basically, the practitioners decide which conditions are qualifying, which is kind of very open ended. And so, when you look at the list, you can, you know, click down and just pick other and write in what you want.

But make sure after you complete the certification form that the patient gets a copy of the entire certification document; they need to bring that with them to the medical dispensary.

[00:11:29] Slide 20

So, you should make sure that patients have some information about the medical cannabis process because it has been simplified since March of 2023. Right now, once patients are in the cannabis program, they are automatically registered.

Once they get the certificate from a qualified practitioner. The patients no longer need to do the added step of registering with an application to the Office of Cannabis Management.

And now New York State no longer issues medical cannabis cards that are physical card. The certification itself is proof somake sure that they get the certification form and then that will take care of what they need to do at the local medical dispensary.

[00:12:04] Slide 21

So, another great thing that New York State has done is what's called the New York State Drug Takeback Act, or DTB. This New York State Department of Health Drug Takeback

program allows for the safe collection of disposable, unused, covered medications to it, and it has a coordinated single website and a dedicated call center.

The patients who have medications that need to be disposed of in a safe way, such as a controlled substance, you can contact the Med Takeback New York and they will help you find convenient locations for secure disposal.

There's actually also an option for mailbox supplies. And importantly, this is free of charge to the consumer.

[00:12:42] Slide 22

What's cool about the New York State Drug Takeback act; it actually covers a lot of things. It's the medications that are prescription and non-prescription. It does not include syringe used syringes or vitamins or supplements. But it really covers a lot of medications.

So, if you have patients who have a family member who died and they no longer need the medications, or if someone was on a controlled substance for an acute problem and no longer needs it.

It's really a great way to get the medications safely disposed of at no cost to you.

Speaker 3: Kelly S. Ramsey, MD, MPH, MA, FACP, DFASAM

[00:13:13] Slide 23

Hello, everyone. My name is Kelly Ramsey, and I'm an addiction medicine and internal medicine physician, and I will be discussing a brief overview of issues related to opioid use and other substance use, opioid use disorder, medication for opioid use disorder, and overdoses.

[00:13:27] Slide 24

First, I wanted to address that stigma, unfortunately, is still really common among medical providers, towards individuals with substance use disorder and even individuals who are prescribed medications for opioid use disorder, for their opioid use disorder.

So this was a survey with primary care physicians, and it assessed a variety of beliefs. The first topic is regarding social distance attitudes.

When asked, “are you willing to have a person taking medication for opioid use disorder as a neighbor?”, unfortunately, only 28.2% of physicians were willing to have that happen.

When asked, “are you willing to have a person taking medication for opioid use disorder marry into your family?”, sadly, only 15.4% of physicians were okay with that.

When asked about beliefs about causes of opioid use disorder, fortunately, the answers were better here. A majority of physicians did believe that opioid use disorder is a chronic medical condition, like diabetes. However, when asked specifically about things like people who need medications to stop using opioids lack willpower. Still a little bit over 1 in 10 physicians agree with that statement.

When asked if individuals with opioid use disorder only have themselves to blame for their problem. Again, just about a little over 1 in 10 physicians agreed with that statement. When asked if people with opioid use disorder have poor moral character. Only 6.4% agreed with that statement.

When asked about beliefs about the true ability of opioid use disorder with the following statement: “People with opioid use disorder can, with treatment, get well and return to productive lives”, 92.2% of physicians did agree with that statement.

[00:15:25] Slide 25

Next, I want to talk about the elimination of the X waiver for buprenorphine. So, in 2023, with a consolidated appropriations act, the requirement for a waiver or a notice of intent, the so-called X waiver, that was required previously to prescribe buprenorphine for the treatment of opioid use disorder was completely eliminated.

What that means is that any practitioner who has a current DEA registration that includes schedule three, prescribing authority, may prescribe buprenorphine for opioid use disorder for patients in their practice. They also eliminated the patient limits, of, buprenorphine prescribing as well.

So, in other words, any prescriber with a DEA that covers schedule three medications can prescribe buprenorphine to as many patients as they choose.

[00:16:25] Slide 26

Unfortunately, we had been hopeful that with the elimination of the X waiver, that would really increase access to buprenorphine, and indeed the number of buprenorphine prescribers overall has increased since the X waiver was eliminated. But the actual total number of patients actually prescribed buprenorphine on an ongoing basis, sadly, has not changed.

[00:16:50] Slide 27

I want to speak for a moment on underutilization of medication for opioid use disorder in the adolescent population.

This was a cross-sectional study that was looking at the use of medication for opioid use disorder among adolescents and adults with need for opioid treatment in the United States.

This was a large study with over 2.2 million people with opioid use disorder treatment need being surveyed. Unfortunately, out of that total, only 1 in 4 that participated in that study or 27.8% actually reported past year use of medication for opioid use disorder.

And within that 27.8%, it included no adolescents at all and only 13.2% of older adults. So, adults age 50 and older. So unfortunately, despite the efficacy of MOUD, utilization is very low and particularly for younger age groups and older adults.

[00:18:02] Slide 28

This was another study that was looking at primary care. Pediatricians reported readiness to provide care for adolescents with substance use disorder and asking about current treatment approaches.

So, based on the response to the question: “How well prepared do you feel the council, patients and their families on the following types of substance use?”, greater than 80% of pediatric providers felt prepared to counsel on alcohol, cannabis and vaping use. Less than 50% felt prepared to counsel on opioid use.

Based on the response, “refer to an off site provider” when they responded to the question: “When you identify an adolescent patient who is at risk for any of the following substance use disorders, how are they typically handled?”, about 75% of pediatric providers referred adolescent patients off site for OUD treatment.

In other words, they were not willing to prescribe buprenorphine. So again, we know that that makes access to care challenging for adolescents if they need to see a different provider than their primary care provider.

[00:19:13] Slide 29

This study was looking at contributors to early medication for opioid use disorder discontinuation and retention in care. So, it identified some themes. It identified contributors to early discontinuation.

So, some of that is lack of flexibility for patients to walk in for an appointment, arrive late or missed appointments. Also, there were problems with stigma within clinic settings, but also a challenge to balance staff resources, and appointments with the ability to see individuals for MOUD.

And then there was also an additional contributor when we look at co-morbidities such as poly substance use or chronic pain and substance use, and lack of expertise or comfort level in prescribing to patients with those issues.

So, some of the retention improvement strategies include increasing a staffing ratio to provide buffer time for walking and late arriving patients, to have a dual scheduling system.

So maybe to have a system that addresses more stable patients in care and then another appointment system for helping individuals who need more supportive services with respect to their care. Finally, addressing comorbidities, doing some comprehensive comorbidity management.

So again, multidisciplinary care or specialized training, etc., building interdisciplinary collaboration in primary care and offering additional funding and staffing positions for adjunctive staff such as therapists, case managers, peer support workers, etc. to better meet more complex patients' needs.

[00:21:06] Slide 30

I want to talk a moment about high dose buprenorphine. So some patients with high opioid tolerance, which we see far more frequently with the unregulated drug supply being dominated by high potency synthetic opioids such as fentanyl.

Individuals may require buprenorphine doses greater than 24mg a day during treatment, stabilization, and even on an ongoing basis. You can prescribe buprenorphine in New York State up to 32mg without a prior authorization.

Additionally, physiological changes during pregnancy alter buprenorphine metabolism, so this may necessitate adjusted buprenorphine dose and dosing intervals in the second and third trimesters.

Also consider dose and frequency adjustments, psychosocial supports, and a higher level of care if individuals are unable to stabilize with buprenorphine, they may require full agonist MOUD treatment with methadone.

Consider a reassessment of higher dose greater than 24mg per day long term doses once patients have entered long term treatment without ongoing use of opioids.

But again, to restate, individuals may require greater than 24mg per day over time.

[00:22:13] Slide 31

Higher doses of buprenorphine are associated with less urgent care or emergency department utilization, which is certainly a great outcome for individuals who are stabilized on buprenorphine at higher doses.

[00:22:41] Slide 32

Want to talk a moment about pregnancy and substance use disorder.

So, co-occurrence of mental health conditions and substance use disorder is common. And it is also very common amongst pregnant persons. About 5% of pregnant persons use one or more substances. About 5% of pregnant persons ages 18 to 49 reported recent binge drinking.

34% to 60% of persons of childbearing age who use cannabis continue cannabis use during pregnancy. Greater than 30% of pregnant persons in substance use disorder treatment screen positive for moderate to severe depression and over 40% reported symptoms of postpartum depression.

So again, a high co-occurrence of mental health conditions and SUD in pregnant persons. Suicide and overdose are leading causes of birthing parent death within the first year postpartum. So, particularly counseling around overdose prevention is very important in this population.

Many health care providers lack training or feel uncomfortable treating perinatal mental health conditions as well as perinatal substance use disorder.

13% of outpatient only and residential substance use treatment facilities offer special treatment programs for pregnant and postpartum persons and among hospital inpatient treatment facilities. That figure, unfortunately, is even lower at 7%.

So, a lot of facilities lack expertise regarding pregnancy and substance use.

[00:24:17] Slide 33

I wanted to mention a little bit about harm reduction tools. There is more information in our resources section on harm reduction philosophy.

Some of the best known harm reduction tools include syringe service programs providing sterile equipment for people who are actively using substances.

Overdose prevention centers, (we have two in New York City, run by On Point NYC) where people can bring pre-purchased substances in and be monitored while they are using in case they overdose, providing substance use substance testing strips such as fentanyl test strips, benzodiazepine test strips, sizing test strips, etc., and more formal drug checking

with an FTIR or other technologies which can identify major and minor substances within a sample.

So again, target harm reduction education with individuals for safer use, providing naloxone kits and overdose response trainings. Harm reduction also comprises substance use disorder treatment facilities, support groups, and medical services, including wound care, vaccinations and Covid 19 masks, sex education, STI or sexually transmitted infection testing and treatment, condoms and pre-exposure prophylaxis are all other critical harm reduction tools and services.

[00:25:44] Slide 34

We have started to see a decline in the number of overdose deaths in the United States. However, it is important to point out there are disparities both geographically and within racial ethnic groups with respect to overdose deaths.

So unfortunately, among Alaska Native American Indian and black individuals, overdose rates have not declined to the same degree as in other race ethnicities.

[00:26:14] Slide 35

I want to speak a moment about adulterants in and the unpredictability of the unregulated drug supply. First, I want to say and emphasize there will always be other and newer adulterants in the unregulated drug supply.

When we are responding to overdose, we want to assume poly substance overdose and really not perseverate on which substances someone may have taken but rather do an assessment and respond to the symptoms that you are witnessing in the person who may be overdosing.

Despite the presence of fentanyl, fentanyl analogs, and another highly potent synthetic opioid, the netizens, there is no evidence that additional naloxone (so higher dose naloxone or longer acting opioid antagonists such as now morphine) are needed.

There is not a linear relationship between the potency of an opioid and then the naloxone requirement. Additionally, sedatives such as Xylazine and Medetomidine, as well as synthetic benzodiazepines are added to the unregulated drug supply, and these adulterants and other adulterants are not affected by naloxone because they are not opioids.

Therefore, if first aid including rescue, breathing, and/or oxygen administration are not included in the response to an overdose, then it appears that more naloxone is needed.

Though the naloxone has already played its role in reversing the opioid portion of the overdose.

[00:27:44] Slide 36

So, when we're thinking about responding in the context of a poly substance overdose, first assess the person. You can assess for responsiveness, or try to agitate them with a sternal rub, or by calling the person's name if you know it.

But again, with powerful sedatives in the drug supply, people may be unconscious for long periods of time. So, it's really important to assess airway, breathing (so look, listen and feel), set a timer and count respirations for one minute and assess circulation with a pulse and you can bicycle the person's legs.

Again depending on what you find in your assessment,only administer naloxone if indicated. The respiratory rate is less than 12 per minute and the oxygenation is less than 90%.

Whether 911 is indicated to be call depends on the individual who is responding, their training, their expertise, where that person is located. If you're in a clinical setting, you may have more wiggle room to respond to that overdose effectively.

Four, support airway and breathing if that is indicated. With Oxygen administration, you want to start low. So two liters via nasal cannula and titrate up to achieve a an oxygenation level of 90% or above.

[00:29:11] Slide 37

So again, focus on airway and breathing and not responsiveness. So, we don't need people to wake up or respond. But they do need to be oxygenating adequately.

For oxygen administration. You can have standing orders for nursing and medical personnel. And you can specify oxygen administration for when a physician is not on site. In emergency situations, oxygen administration can be done by nurses without a standing order.

But notably, the FDA distinguishes between medical and emergency oxygen, so oxygen standing orders for non-medical personnel should involve pre-approved protocols that allow individuals (they could be first responders or workplace safety personnel, but they could be any personnel that have been trained and assessed adequately) that they can administer oxygen without a direct physician order in specific emergency situations.

These orders often specify the conditions under which oxygen should be given and the equipment to be used, ensuring a quick and appropriate response in cases of respiratory distress.

[00:30:17] Slide 38

The recommended opioid antagonist for reversal of an opioid overdose include 0.4mg per ML generic naloxone for intramuscular use. This is the only formulation that can be titrated in an overdose response. Three milligram per ML naloxone for intranasal use and four milligram per ML intranasal naloxone.

So, despite the clear benefits of medications for alcohol use disorder, they remain under utilized.

[00:30:49] Slide 39

In 2021, only 2% of Americans who reported alcohol use disorder received pharmacotherapy. On the right hand side, I have a chart showing the number needed to treat for MAUD versus other common medications such as SSRI, statins and DVT prophylaxis that we use in our medical practice.

So, you can see that the number needed to treat are actually better for medications for alcohol use disorder than they are for statins and DVT prophylaxis.

[00:31:25] Slide 40

Additional topics on substance use disorder: SAMHSA's is 42 CFR part eight, which are the rules overseeing the use of methadone were updated in 2024. The updated rules are more person-centered and more flexible regarding take home doses of methadone. So, see our additional resources for more information.

Despite FDA approved medications only available for opioid use disorder, alcohol use disorder, and tobacco use disorder, there are many medications which can be used off label for stimulant use disorders.

See, again, our resources for additional information.

And finally, tapering benzodiazepines can be clinically challenging. There is a new person-centered benzodiazepine tapering guideline available. See our resources for more information.

Speaker 4: Diana Martins-Welch, MD, FACP

[00:32:17] Slide 41

Hello. My name is Diana Martins-Welch, and I'm a palliative medicine physician with Northwell Health. And I'll be speaking on palliative medicine.

[00:32:25] Slide 42

In 2011, two laws were enacted in New York state that were amendments to the public health law.

In the Palliative Care Information Act. It was required that the attending practitioner offered patients with terminal illnesses information about their prognosis and appropriate options for treatments for their chronic illness, as well as their patient's legal rights to comprehensive pain and symptom management at the end of life.

It's important that patients are aware and informed of their options when they're confronting a serious illness. And understanding that palliative care is an option for them at any point in the continuum of care.

As far as the Palliative Care Access Act, it requires that hospitals, nursing homes and other agencies and facilities provide appropriate information about palliative care to patients or surrogates and facilitate the appropriate consultation to palliative care.

[00:33:25] Slide 43

So, what is palliative care? This is a field of medicine, and it is staffed by an interdisciplinary team of practitioners who provide specialized medical care for people who have serious illness.

The care that is provided is focused on providing relief from the symptoms and stress of serious illnesses, with the goal of improving quality of life for the patient as well as their family and caregivers.

Palliative care is appropriate at any stage or age. So patients do not have to have a terminal illness in order to qualify to receive palliative care.

It can be provided alongside curative intent treatment.

[00:34:07] Slide 44

So, who can palliative care actually help? Well, certainly patients with serious chronic illnesses. Patients with metastatic or locally advanced cancer that's progressing despite systemic treatments with or without weight loss and functional decline.

Patients with complicated ICU courses and who have a poor prognosis. Patients who present to the emergency room for recurrent or chronic severe problems who hold a poor

prognosis, especially if ICU consultation is being considered. And patients and their families whose distress is impairing their decision making.

[00:34:45] Slide 45

Palliative care leads to better patient outcomes. So, it's really important to note here that in the various settings in which palliative care can be administered, we see improved outcomes across the board. These are pretty significant benefits that prove the importance of, implementing palliative care in all settings of care.

[00:35:10] Slide 46

So, when is it time to include palliative care in the in the care of patients. So, it's important to note, once again, that it's really not about terminal illness or being based in prognosis, but rather about addressing patient's symptoms and their psychosocial burden.

It's almost never too soon to introduce palliative care. And we know that physician prognosis has been shown to be unreliable and often it's overly optimistic. Especially when there's a long standing relationship between the physician and patient.

We certainly want to be involved earlier upstream in the course of care. It's important for palliative best when possible to have a long-standing relationship with the patient or had the ability to build rapport and trust over time with patients. So, bringing in palliative care earlier on in the disease course can be very important.

[00:36:07] Slide 47

And in 2016, the American Society of Clinical Oncology put out a guideline about implementing or including palliative care in the care of cancer patients. In 2024, they updated this guideline and some of the of the key points from this guideline are listed here.

For example, when we look at the core elements of palliative care and what that means for the care of cancer patients, such as building rapport, as I talked about with patients and families. We know that in cancer care there is a multitude of, symptoms and, and pain that come along with dealing with cancer and cancer treatment.

So, it's very important that palliatives are brought in in time to help patients relieve their suffering and their pain so they can withstand treatments for a longer period of time, if that's their goal.

We also really have to focus on clarifying understanding goals and preferences for patients as they navigate their cancer journey. And then we are there to help assist and be at the side of the patient and the oncologist when difficult decision making has to happen.

We often find ourselves in a position where we are helping to connect and communicate across disciplines, across specialties, which it helps to provide some streamlined aspect to the very disjointed care that we can often find in this in this complex medical world,

As I said already including palliative upstream in the care of the patient, early referrals, can be very important even ahead of or in anticipation of some of the physical symptoms that are going to be coming down the pike.

And this is both in the inpatient and outpatient settings.

And so, when to refer and some bullet points here, we know that as patients are going through different treatment options in different lines of therapy, once there's discussion of phase two and even phase one trials, it may be an indicator of less and less options that exist for treatment. So certainly, that should be a trigger for including palliative care.

[00:38:32] Slide 48

So, let's talk about how to enhance patient communication. So, these are some tips here on how to better develop communication even in the setting of limited time with patients. So first, what does a patient have in mind. Maybe it has to be limited.

They may want to talk about ten things in their visit, but you only have time to talk about two of those things and really have that as the forefront of your conversation, because that's what's important to the patient.

When discussing sensitive topics, it's important to attend to the patient's emotional state and if you notice them starting to shut down, it may not be wise to continue talking.

They are likely, not likely to under- to really be comprehending and absorbing what's being said.

You want to present choices for treatment and express empathy. You want to speak with the patient about what can be done prior to sharing; why something cannot be done. Patients don't want to feel like there’s no options for them.

But there's always something that can be done, even if it's not necessarily a traditional treatment option for them.

We can bring in home care. We might be able to bring in some physical therapy. We might be able to help treat their pain. So, some things that can be done that are more palliative minded and not necessarily treatment minded.

You want to outline long term goals first and available treatment options second.

So really thinking about the bird's eye view. What are we looking to achieve. What are our goals here.

And even if it's only brief, you do want to try your best to give patients undivided attention. It doesn't feel good as a patient or a caregiver to be talking to a clinician who is looking down at their computer or their phone at the same time.

So really trying to make sure that you're engaged and giving some eye contact.

[00:40:31] Slide 49

So, some questions to ask your patients to help you better understand where their mind is at when they're thinking about their illness. These are things that are really key in the palliative interview for understanding where patients mindsets are.

When a patient tells me that their hope is that they're going to be cured and going back to their life, their life as it was before cancer, and I know that they have a terminal cancer, it sheds light for me that they might not have a good grasp of what's happening to them.

A very important question here is what matters most to you. It gives them a chance to reflect on what's important to them right now.

How can I help you talk with your family. So if patients you know need help talking to their loved ones, their spouse, their children, their parents, whatever it might be, it feels good to them to know that their doctor's on their side to help them if they don't feel equipped to discuss themselves.

[00:41:39] Slide 50

So, in terms of hospice care, it's palliative care that's given to patients who have an expected or an estimated life expectancy of six months or less.

It’s an insurance benefit. It's covered under Medicare Part A. And many commercial insurances as well as Medicaid provide hospice benefits as well. Hospice care is provided by agencies. Hospice care agencies in coordination with the patient's primary physician.

Now hospice care, given that it's tied in with insurance, it typically does not coincide with life prolonging therapies.

So, these are things that we really have to have serious conversations with patients about. They have to be willing to cease these therapies before initiation of hospice care.

And another thing that it's really important to point out to patients ahead of them signing onto hospice care is that this is not around the clock care unless they fit the inpatient criteria, which are quite stringent.

It is not a place. A lot of people think of hospice as a place they go to, rather than a benefit that's afforded to them.

[00:42:55] Slide 51

When to consider hospice. So, Ira Byock here talks about would you be surprised if your patient died sometime within the next six months? If you're not surprised by that, you really should be considering hospice care for that patient.

[00:43:09] Slide 52

So, some tips here on how to address serious news. Or bad news, right. Breaking bad news to patients. So, you want to make sure you have a private setting to have this sort of serious conversation. You want to be able to minimize distractions and interruptions that you may be getting.

What is the patient and family's understanding of the clinical situation? Just going right into discussing things without actually knowing what they know, would be wrong. You have to know where to start, because they may be understanding a lot less than you actually, think.

Before you share information that may be new or surprising to the patient and family, ask for permission to share it. That gives them a chance to prepare themselves. It gives them a chance to say no if they're not ready to receive it.

Some patients want their loved ones to take on the burden of the news, and they don't want to know. You want to make sure you use empathy and validate emotions that are being expressed. And then, check back in at the end to assess the understanding of the new information that was shared.

[00:44:21] Slide 53

When talking about prognosis, acknowledge that there is a level of uncertainty associated with prognosis.

You want to use ranges of time. Rather than giving a specific number of days or weeks or months, use ranges. That will give people a better understanding of, oh, this could happen today, or it could happen 2 or 3 days from now. Okay.

It allows them to prepare for something impending. Use empathy, allow pauses for emotional responses. I know a lot of people aren't used to silences.

They want to fill those gaps of silence but allow emotion to be expressed and for the news to be absorbed. Talking through the silences is not helpful.

And consider saying the term I wish rather than I'm sorry. I wish things were different. I wish there was something that could provide you longer time with your family. I wish there was another treatment option. Something along those lines.

[00:45:39] Slide 54

Now transitioning to end of life care in the next section.

[00:45:45] Slide 55

When patients are actively dying, they may be at home on hospice care. They may be in the hospital. They may be in the nursing home receiving hospice care. Hopefully they're receiving hospice care.

You want to stop any IV fluids. You want to recognize that not eating or drinking is a natural part of the dying process. This is something that comes up a lot. Families are very tied into making sure that their loved one is not going hungry, is not going into a state of dehydration.

So, you recognize that. You point it out that this is a natural part of the process. As the body starts to shut down, it's not going to want the calories that nutrition will provide them.

Good dying, caring includes good oral care. Making sure that if their mouth is dry, that it's that it's hydrated.

If there is, if there is expression from the patient for wanting to have something to eat, comfort feeding, pleasure feeding, certainly. Usually things like applesauce or something that's very smooth and easy to go down.

You want to recognize that giving fluids when someone is actively dying typically causes burden without benefit, and you can point out things like pleural effusions that cause dyspnea, increased strain on the heart and the kidneys that where fluids at a certain point in the dying process are no longer helpful.

In terms of managing dyspnea. So, turning on a fan or opening the window for some breeze. We know that pointing a small fan towards the face can activate the facial nerve that helps lessen that feeling of dyspnea.

We want to avoid non invasive positive pressure ventilation like BiPAP, CPAP. It does not resolve the underlying issue and can be very uncomfortable to patients.

And opioids can help with that sensation of air hunger as we call it. That feeling that patients can't get enough air, that one, you know, just can't get enough oxygen. Opioids can take the edge off. So, starting them on a PRN basis or even scheduling them may be a good idea.

Limit the checking of vital signs. if they have to be checked, monitor them as markers of distress. For example, tachycardia or tachypnea potentially could show signs of a patient being in pain or discomfort.

[00:48:36] Slide 56

So, we want to refocus care. So when we're when we're talking about dying care, we want to make sure that we're stopping treatments that will not improve the patient's quality of life.

We want to stop treatments that may be causing patients pain or that are expensive or can cause burdens or side effects that don't outweigh the benefits.

We want to eliminate unnecessary medications or treatments that aren't really in line with the philosophy of comfort care.

So, trim the fat, as I call it.

[00:49:10] Slide 57

Now, medications that are used for dying patients at end of life. So, we're oftentimes talking about different opioids, benzodiazepines.

So, when we're starting from scratch with an opioid, we want to use a small dose something like oral morphine for example, or an equivalent to it at about 2.5 to 5mg to start or I.V. morphine, Subcu morphine, being about 1 to 2mg.

When we're talking about dyspnea, when we're doing a parenteral, we want to do 2 to 5mg of IV every five to ten minutes until there's relief. When you find the right dose, you can start to schedule it.

Oftentimes when patients are in the active dying process and they are they are necessitating opioids on a regular schedule, it may make sense to provide a continuous opioid infusion. And then having PRN doses available for staff to administer for any breakthrough symptoms or pain.

As far as benzodiazepines, these are important to, helping patients reduce anxiety, restlessness, terminal agitation. A starting dose of Atavan, for example, is usually around 0.5mg. And that can be given via IV.

You can also give an oral liquid dose. And we talk about doing a lot of things through a non-ingestible manner at the end of life as patients will start to lose the ability to swallow.

Right. So we're thinking about things that are sublingual if, if the mouth is moist enough to absorb something or parenteral, meaning either Subcu or IV.

[00:51:02] Slide 58

Some non-pharmacologic interventions that are very important at the end of life are listed here. We want to think about social work and pastoral services, chaplaincy. We want to provide updated information to caregivers and family, provide realistic expectations and emotional support.

Not everybody is going to understand what dying looks like. We may walk into a room and see an overtly dying patient. Many family members have never seen someone die before. They don't know what that looks like. It's important that they understand what's happening.

And you want to encourage families on how to express their love and concern and their overall presence. I always talk about, you know, talking and physical touch being so important. Just the presence of family members around the patient during this time.

[00:51:57] Slide 59

Now we're going to touch on advanced directives and how do we plan ahead of the dying process. So, things like completing a health care proxy form. The importance of this cannot be understated.

A living will that outlines expectations for end-of-life care. Does a patient want to donate their organs? I recently had a patient ask me about about donating his body to science after he dies.

These are things to really think about ahead of time, because patients have to declare them.

Having a power of attorney for financial and other non-health care decisions is very important. And, you know, meeting with elder care attorneys or, or attorneys to help put together these documents ahead of time, even when things are okay and patients are healthy, is something that that people should be planning for.

And then there's a medical order for life sustaining treatment. MOLST form, as we call it in New York state. And I'll talk about that in a subsequent slide. And then there's also a website called prepareforyourcare.org that lists out what all these tools that are needed ahead of time.

[00:53:07] Slide 60

So why are advanced directives important? People are living longer with chronic illnesses. This results in more complex decisions that have to be made about medical interventions and procedures. For example, having a defibrillator in place.

Decisions are more stressful in times of crises. So, we want to have these discussions ahead of time when things are okay. And preface it by saying just because we talk about it doesn't mean something bad is going to happen. We have to dispel that.

Advanced planning allows patients to express their goals and their values so they can be honored, even when that patient is no longer able to speak for him or herself.

[00:53:50] Slide 61

So, when to address. At the initial visit, you can kind of make it part of your routine standard, questionnaire, annual outpatient visits, you know, well visits, annual checkups, prior to hospitalization for elective surgery procedure.

Any acute hospitalization is a good time to refresh and bring it back up. Or after a hospitalization when they're back in the community setting with their outpatient provider. At follow up office visits, especially if there's chronic illnesses. You know, it's never a bad time to bring it up.

[00:54:28] Slide 62

Medicare pays for advanced care planning discussions. This is not that old. And it was very helpful for those of us who have these discussions on a regular basis to be able to bill for our time. The CPT code, 99497 is for having these discussions, advanced care planning discussions that include explanation and discussion of advanced directives by the physician or another qualified health care professional.

And it goes for the first 30 minutes. You have to have it have to indicate at least 16 minutes, having been used to discussion of advanced care planning. And some appropriate documentation is listed here on this slide.

And then if you go above 30 minutes, each additional 30 minutes, you can use the 99498 code. And you can list this separately in addition to code 99497.

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So, our health care proxy; it's a legal document that appoints a health care agent to make decisions in the event that the patient is unable to do so due to illness or injury. So, this is the most important document.

They really, the patients should really think strongly about whom they appoint. A lot of people think, well, it has to be my spouse or it has to be my eldest child.

I often tell people, you want to feel comfortable with that person making decisions on your behalf and not speaking on their own wishes for you. And sometimes that isn't their spouse or their eldest child. Sometimes it's their cousin who's a nurse who's seen a lot of things or is a social worker and has a lot of experience in this realm.

And then once the health care proxy is filled out, I always make sure patients understand they have to then talk to that appointee or appointees, if they choose an alternate agent, and tell them that they're being appointed a health care proxy. That these are my wishes. This is what is important to me. This is what I would not want done.

Very important to have those discussions. I always say it's a two step process of doing the form and then having those discussions with the appointees.

The living will, this is a document that allows you to outline medical procedures that you do or do not want in the case that you're unable to do so for yourself due to terminal, irreversible conditions, for example.

The living will is not a legal document, but it helps to establish the clear and convincing evidence that's required by New York State. And it's helpful, if one exists, to help the health care proxy in decision making.

[00:57:21] Slide 64

Now, what is a legal document is the medical orders for life sustaining treatment form. And when patients have serious medical illnesses, it really should be brought up to them. A copy should be provided to the patient for them to review with their loved ones and encourage completion of the form.

It is the only authorized New York state form for documenting both non-hospital DNR and do not intubate orders. And it provides specific medical orders. These things have been added in recent years to the form to further help delineate what patient's specific preferences are.

[00:58:05] Slide 65

So, what are the steps here? So first of all, all of us as clinicians should have our own health care proxy forms completed for ourselves. It helps when I have discussions with patients about health care proxy to tell them that I've completed my own and had those discussions with my own proxy.

You should have the health care forms, the health care proxy forms in your office to be able to provide them to patients. And then encourage patients to assign a health care proxy, encourage them to consider who they would want.

And if they're not ready to fill one out during the visit, tell them you're going to be following up with them about it and to have them take a form home with them. And then once they do provide, or complete the form, you want patients to be encouraged to have honest and open discussions with their appointed health care proxy about their goals and preferences. And be prepared to answer questions about certain recommendations regarding medical interventions, like for example, feeding tubes in patients with dementia.

Speaker 1: Daniel Pomerantz, MD, MACP

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In addition to the materials provided in this course, an appendix document is available for download. It includes helpful links, additional resources, and answers to frequently asked questions.

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This program has been made possible by the New York chapter of the American College of Physicians and members of the Pain Course Task Force.

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Thank you for participating in the one-hour program, Managing Pain and Opioid Use, An Educational Program on Compliance with New York State Prescribing Laws. To earn CME, CNE, or MLC credit, please complete the post-test and evaluation. Achieving a score of 70% or higher will allow you to download and print your certificate. This concludes our opioid and pain management training.

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Thank you.