VCU Palliative Care ECHO*

September 26, 2019

Outpatient Palliative Care

*ECHO: Extension of Community Healthcare Outcomes

Continuing Medical Education

September 26, 2019| 12:00 PM | teleECHO Conference

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Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Continuing Nursing Education: 1.5 CE Contact Hours

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September 26, 2019| 12:00 PM | teleECHO Conference

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The following Planning Committee and Presenting Faculty Members report having no relevant financial relationships:

Egidio Del Fabbro, MD
Danielle Noreika, MD

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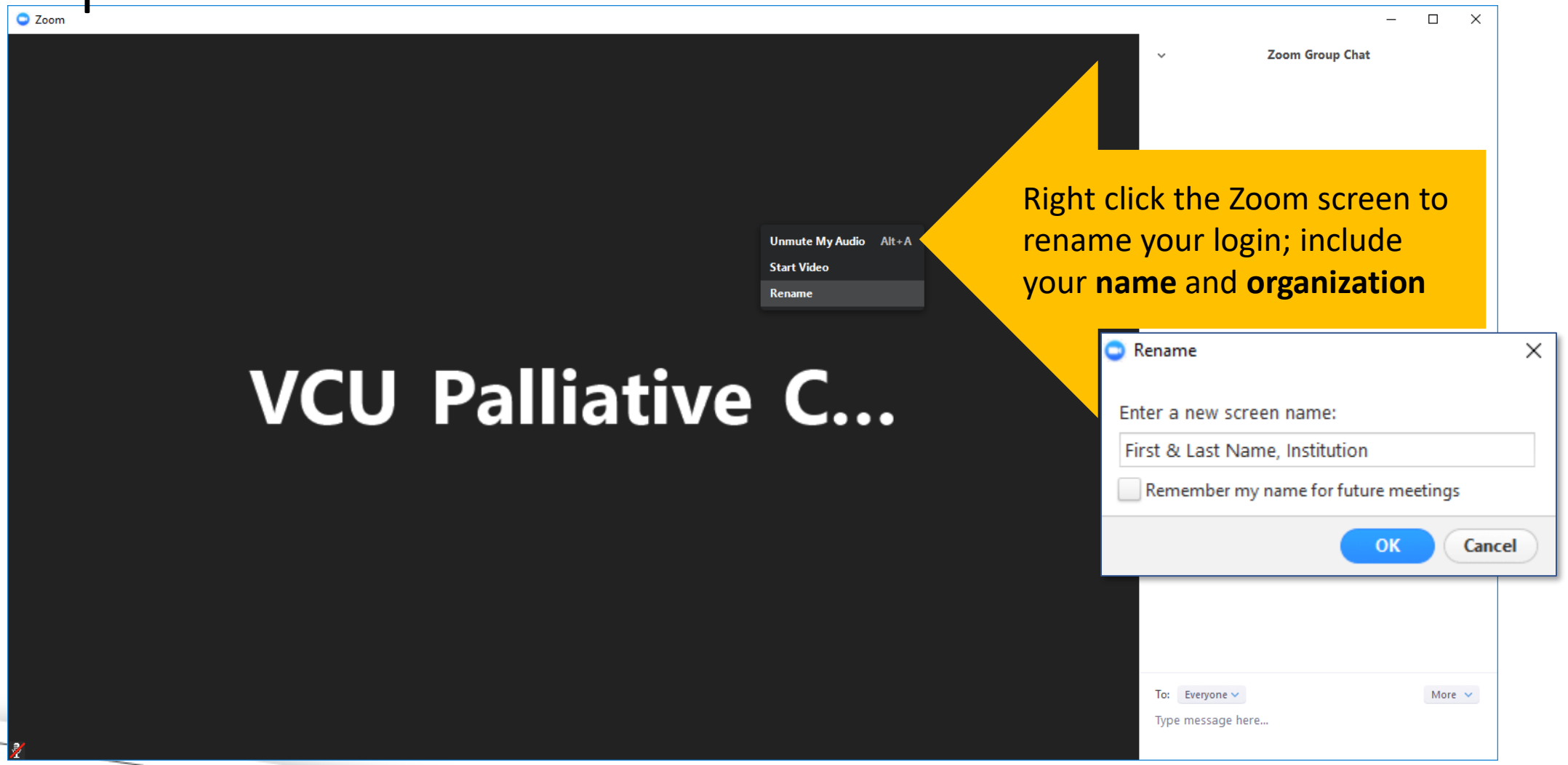
Helpful Reminders



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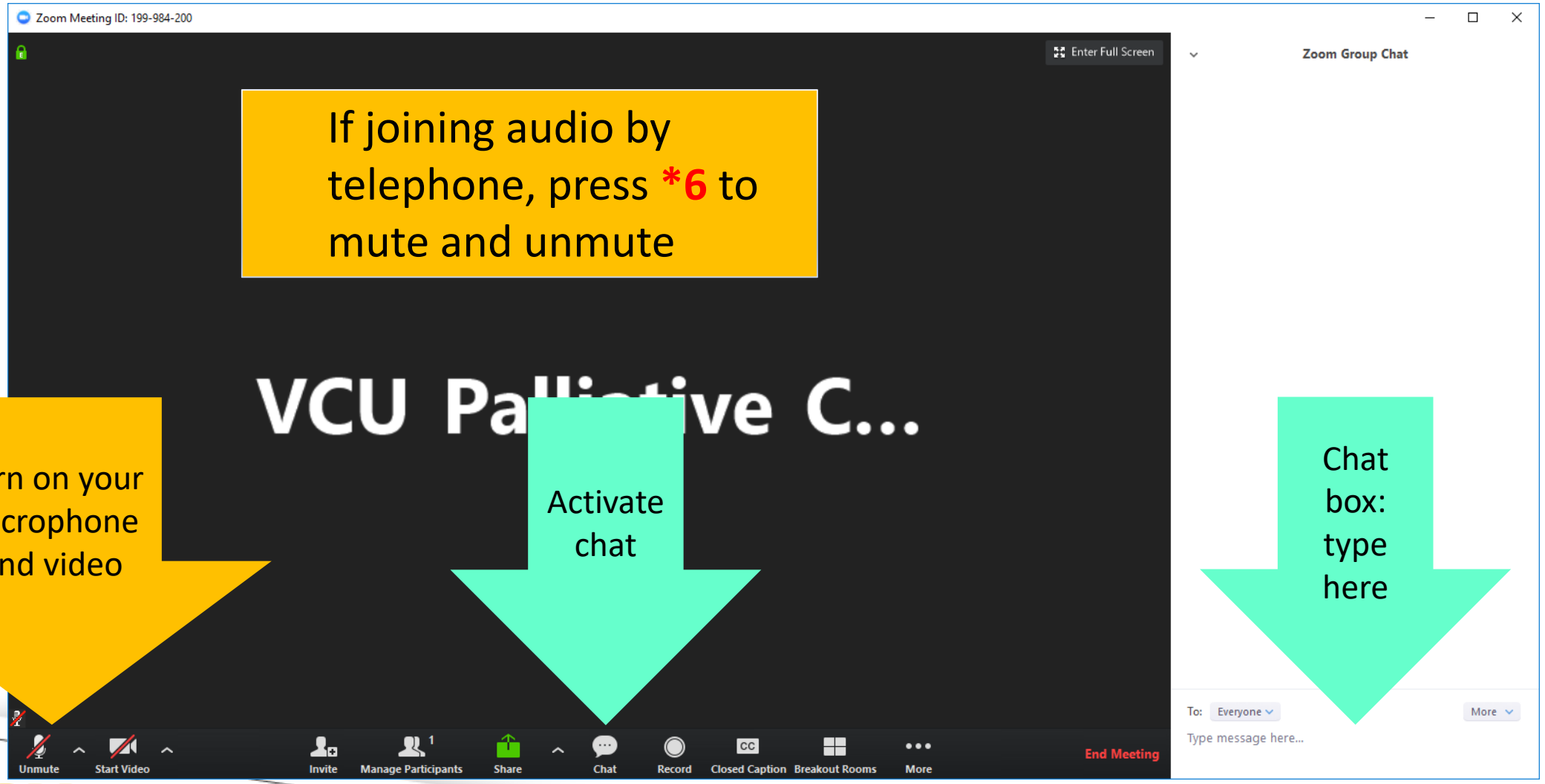


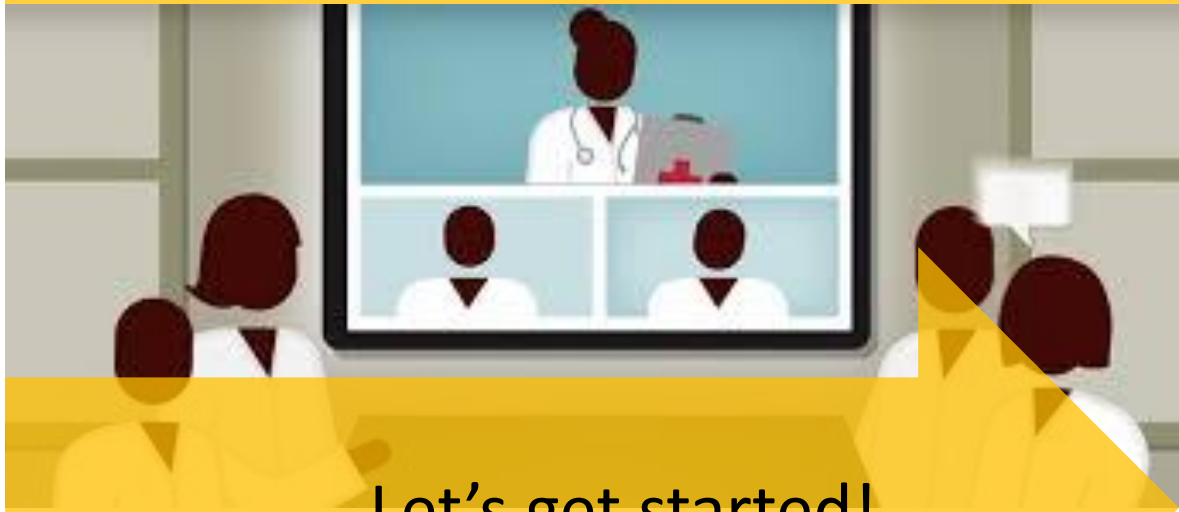
What to Expect

I. Didactic Presentation
   20 minutes + Q&A

II. Case Discussions
   - Case Presentation
     5 min.
   - Clarifying questions from spokes, then hub
     2 min. each
   - Recommendations from spokes, then hub
     2 min. each
   - Summary (hub)
     5 min.

III. Closing and Questions

- Bi-weekly tele-ECHO sessions (1.5 hours)
- Didactic presentations developed by inter-professional experts in palliative care
- Website: www.vcuhealth.org/pcecho
- Email: pcecho@vcuhealth.org



Let's get started!

Hub Introductions

VCU Team	
Clinical Directors	Egidio Del Fabbro, MD VCU Palliative Care Chair and Program Director Danielle Noreika, MD, FACP, FAAHPM Medical Director/Fellowship Director VCU Palliative Care
Clinical Experts	Candace Blades, JD, RN – Advance Care Planning Coordinator Brian Cassel, PhD – Palliative Care Outcomes Researcher Jason Callahan, MDiv – Palliative Care Specialty Certified Felicia Hope Coley, RN Diane Kane, LCSW – Palliative Care Specialty Certified Tamara Orr, PhD, LCP – Clinical Psychologist
Support Staff Program Manager Telemedicine Practice Administrator IT Support	 Teri Dulong-Rae & Bhakti Dave, MPH David Collins, MHA Frank Green

Spoke Participant Introductions

Name and Institution

Objectives

- Define delirium
- Overview tools of delirium screening
- Overview of management strategies for delirium

Delirium in palliative care

Egidio Del Fabbro, MD

Rotation, Escalation, Combination, Or Reduction to treat Delirium Study (RECORD)

A Randomized Controlled Trial

PI: Dr. Hui

Local PI: Dr. Del Fabbro

VCU Study Coordinator: Sarah Womack

MASSEY CANCER CENTER VCU

HOSPITAL DE CÂNCER DE BARRETOS Fundação Pio XII

THE UNIVERSITY OF TEXAS MD Anderson Cancer Center

NIH NATIONAL CANCER INSTITUTE

Perspective of the family

"How people die remains in the memories of those who live on"

- 55% were conscious during their last 3 days
- 40% severe pain most of the time
- 80% severe fatigue *(Lynn,Teno Ann Int Med 1997)*
- >25% were dysphoric

Delirium

- Core criteria from DSM-IV: Inattention
  Disorganized thinking
  Acute onset organic etiology

- Screening and diagnostic tools

Mechanisms

- Decreased acetylcholine or Increased dopamine. More complex
- Clinical presentation

  Hypoactive or hyperactive or Mixed
- Survival/outcomes for the subsets inconsistent
- Treatment may be slightly different for the purely hypoactive patient

Table 2 Neurotransmitter targets and pharmacological agents studied in delirium management

Table 2 | Neurotransmitter targets and pharmacological agents studied in delirium management

Neurotransmitter (receptor)	Drug class	Specific drug and study reference
Dopamine (dopamine [primarily D2] receptors)	Typical antipsychotics	Haloperidol (less sedating);[188,191] levomepromazine (more sedating)[192]
	Atypical antipsychotics	Olanzapine;[193] risperidone;[194] quetiapine[197]
5-hydroxytryptamine (5-HT serotonin receptors)	Atypical antipsychotics	Olanzapine;[193] risperidone;[194] quetiapine[197]
Acetylcholine (acetylcholine receptors)	Cholinesterase inhibitors*	Donepezil;[116,117] rivastigmine[204]
Norepinephrine (α_2-adrenergic receptors)	α_2-receptor agonists	Dexmedetomidine[134] (used specifically for sedation in ICU setting)‡
GABA (GABA receptors)	GABA agonists (benzodiazepines)	Lorazepam[198] (in alcohol withdrawal delirium) Midazolam[199] (sedation in palliative care)

*No evidence of efficacy from randomized controlled trials. ‡Mixed evidence of preventive efficacy in ICU settings only. Abbreviations: 5-HT, 5-hydroxytryptamine; GABA, γ-aminobutyric acid; ICU, intensive-care unit.

Lawlor, P. G. & Bush, S. H. (2014) Delirium in patients with cancer: assessment, impact, mechanisms and management
Nat. Rev. Clin. Oncol. doi:10.1038/nrclinonc.2014.147

nature REVIEWS CLINICAL ONCOLOGY

Clinical features of delirium in patients with cancer.

Disturbance in level of consciousness (alertness or arousal)
Attentional disturbances
Rapidly fluctuating clinical course and abrupt onset of symptoms
Disorientation
Cognitive disturbances (ie, memory impairment, executive dysfunction, apraxia, agnosia, visuospatial dysfunction, and language disturbances)
Increased or decreased psychomotor activity
Disturbance of sleep-wake cycle
Mood symptoms (depression, dysphoria, mood lability, euphoria)
Perceptual disturbances (hallucinations or illusions) or delusions
Disorganized thought process
Incoherent speech
Neurologic findings (may include asterixis, myoclonus, tremor, frontal release signs, changes in muscle tone)

Breitbart W , and Alici Y JCO 2012;30:1206-1214

Prevalence

- In advanced cancer patients 25-50% experience delirium
- Prospective obs study in PCU 40% delirium hui 2015 pall med
- Days/hours before death 90% experience delirium
- Geriatric patients -25%

PCU, consults and missed Delirium

- Geriatrics >40% misdiagnosed as depression

Farrell 1995 Arch Int Med

- Delirium recall =delusions are distressing for hyper & hypo

Breitbart 2002 Psychosom

  - Misdiagnosis of hypoactive or mixed delirium– missed in 25% when no objective assessment

- 252 of 771 pall care consults=delirium and missed in 61% (153)
  Pain most common reason for consult
  Most common etiology of delirium=opioid related

De La Cruz Oncologist 2015
De la Cruz Supp care 2013

Reversibility of Delirium *Lawlor et al. Arch Intern Med, 2000*

De la cruz Supp care cancer 2105

- Prospective study, 104 admissions to PCU

42% delirium on admission

68% delirium at some stage

49% were reversible

Reversibility associated with psychoactive medication

Delirium =poorer survival

- 556 PCU patients =323 (58%) diagnosed with delirium

71% on admission and 29% developed delirium

26% were reversible

Delirium=poorer survival

Table 1 Delirium assessment tools and criteria

Table 1 | Delirium assessment tools and criteria

Tool or criteria	DSM-5 criteria covered (A–E)	Use to date in cancer and palliative care	Administration characteristics
Screening			
MMSE*[32]	A, C	Used in nonvalidation studies	Brief; verbal tasks and manual task; minimal training needed
SOMCT*[33]	A, C	Used in nonvalidation studies	Brief; verbal tasks only; minimal training needed
CAM*[37]	A (attention), B	Used in validation and nonvalidation studies	Brief; moderate level of training needed; verbal; co-administration of brief cognitive test required
MDAS*[40]	A, C	Limited use	Potentially burdensome; can prorate scores
NuDESC‡[34]	A (awareness)	Used in nonvalidation studies and in studies validated according to DSM-IV	Brief; criteria are easily rated; moderate training needed
DOSS‡[35]	A, C	Used in studies validated according to CAM criteria	Brief; criteria are easily rated; moderate training needed
SQiD‡[36]	B (onset or change)	Used in studies validated according to DSM-IV	Brief; single question to friend or relative; no specific training required
Diagnosis			
DSM-5§[14]	(A–E)	Not used	Limited data available as the criteria were published in 2013; high level of training required
ICD-10§‖[15]	A, B, C and E	Used in nonvalidation studies	Broadly similar to DSM-5 criteria except for criteria D; high level of training needed
Severity rating			
MDAS‖[40]	A, C	Used in nonvalidation and validation studies according to DSM-IV	Comprehensively captures distressing features; suitable mainly for research study
DRS-R-98‖[44]	A, B, C	Used in nonvalidation and validation studies according to DSM-IV	Comprehensively captures distressing features; suitable mainly for research study
DOM‡[29]	A, B (fluctuation), C	Not used	Brief; moderate training required; validated in geriatric population using DSM-IV criteria
NuDESC‡[34]	A (awareness)	Used in nonvalidation studies	Captures most distressing features
DOSS‡[35]	A, C	Used in nonvalidation studies	Captures most distressing features
Agitation/sedation			
RASS-PAL‡[47]	A (awareness)	Used in nonvalidation studies	Brief; easily administered by interprofessional team members; minimal training needed

*Cognitive, ‡observational, §operationalized, or ‖active tool format. Abbreviations: CAM, Confusion Assessment Method; DOM, Delirium-O-Meter; DOSS, Delirium Observation Screening Scale; DRS-R-98, Delirium Rating Scale-Revised; DSM-5, Diagnostic and Statistical Manual, 5th edition; DSM-IV, Diagnostic and Statistical Manual, 4th edition; ICD-10, International Classification of Diseases, 10th edition; MDAS, Memorial Delirium Assessment Scale; MMSE, Mini-Mental State Examination; NuDESC, Nursing Delirium Screening Scale; RASS-PAL, Richmond Agitation–Sedation Scale in Palliative Care; SOMCT, Short Orientation Memory Concentration Test; SQiD, Single Question in Delirium.

Lawlor, P. G. & Bush, S. H. (2014) Delirium in patients with cancer: assessment, impact, mechanisms and management
Nat. Rev. Clin. Oncol. doi:10.1038/nrclinonc.2014.147

nature REVIEWS CLINICAL ONCOLOGY

Management

- Treat the cause
- Treat symptoms

Etiology

- ***I WATCH DEATH*** (Infections, Withdrawal, Acute metabolic causes, Trauma, CNS pathology, Hypoxia, Deficiencies, Endocrinopathies, Acute vascular, Toxins or drugs, Heavy metals);
- ***DELIRIUM*** (Drugs, Electrolyte disturbances, Lack of drugs withdrawals, Infection, Reduced sensory input, Intracranial infection, Urinary/fecal retention, Myocardial/pulmonary causes);
- ***THINK*** (Toxic Situations such as CHF, shock, dehydration, deliriogenic medications, organ failure, e.g., liver, kidney; Hypoxemia; Infection/sepsis (nosocomial), Immobilization; Non-pharmacological interventions such as hearing aids, glasses, reorient, sleep protocols, music, noise control, ambulation; K+ or electrolyte problems);
- ***DIMES*** (Drugs, Infections, Metabolic, Environmental, Structural)

Evidence-based management recommendations for patients with cancer with delirium.

I. Current evidence is supportive of short-term use of antipsychotics in the treatment of symptoms of delirium (ie, agitation, sleep-wake cycle disturbances, delusions, hallucinations) with close monitoring for possible adverse effects especially in elderly patients with multiple medical comorbidities.

The longest clinical and research experience and safety/efficacy data available is for haloperidol. Low-dose haloperidol is still considered the gold standard in treatment of delirium. There is growing evidence for the efficacy of atypical antipsychotics in the management of delirium as well. The choice of antipsychotic medication for the treatment of delirium should be based on the clinical presentation of the patient and the adverse effect profile of each antipsychotic drug, given that none of the antipsychotics were found to be superior to others in comparison trials.

II. It is strongly recommended to implement nonpharmacologic interventions in the routine care of patients who are at risk for delirium and of patients with established delirium, based on the evidence from nononcology settings. There are no known risks associated with the use of nonpharmacologic interventions.

III. There is no evidence to support the use of cholinesterase inhibitors in treatment or prevention of delirium in patients with cancer.

IV. The use of psychostimulants in the treatment of hypoactive subtype of delirium in terminally ill patients has been considered. In the absence of randomized controlled trials psychostimulants cannot currently be recommended in the treatment of patients with cancer with delirium.

V. Current evidence is not supportive of the use of antipsychotics for the prevention of delirium in patients with cancer.

VI. The evidence supporting the use of intravenous dexmedetomidine for the prevention of delirium has been mixed and is limited to patients in intensive care settings only; there is currently no evidence to support its use in patients with cancer as a treatment for delirium.

Breitbart W , and Alici Y JCO 2012;30:1206-1214

JOURNAL OF CLINICAL ONCOLOGY ASCO

Table 3 Behavioral and educational intervention as a part of the management of delirium (from [1••], adapted and modified)

Patient

- Environment: having the patient in a single room, reduction of the noises—nursing activity, beeps, alarms, ringing bells, respirators, etc.—keeping the room quiet and well lit, to improve confusion and decrease frightening illusions; availability of objects—photographs, pictures, personal objects—that are familiar to the patient; returning aids—eyeglasses, hearing aids—in order to ameliorate the quality of sensory input and in decreasing misinterpretation of the surroundings)
- Orientation: reorienting the patients to time and space by repeating the date and the time, in having a room with a calendar and a big clock; reorientation to space, context, and persons by repeating where the patient is, why he is there, and the identity of the people assisting him
- Information: regular explanation of the procedures the staffs are applying (e.g., blood exams, pharmacological treatment and route, restraints when needed) and reassurance about what is happening; after delirium is cleared, information about the symptoms and their meaning as a reassurance

Family

- Allow company: family members and close relatives or friends should be permitted to visit the patient and stay with him/her both to reassure the patient, to reduce his/her feelings of abandonment and strangeness determined by unknown persons, to help the staff in reorienting him/her to time and space, and to give the staff information about fluctuation of symptoms
- Information and support: explanation to the family of the causes and characteristics of delirium and its symptoms as a reassurance to what family members are witnessing to; explanation about procedures the staff are applying; elicit and respond to the family concerns, problems, and needs and identify and accept the family emotional reactions

Staff

- Schedule: when possible, avoid that the patient is attended by new, unknown, and unfamiliar health care professionals, by maintaining them in their rotation scheme
- Training: train the staff on communication skills (e.g., maintaining the communication channels open, active listening, give meaning to symptoms); training to the use of delirium assessment tools (e.g., CAM), implementation of application of protocols for delirium management

Table 2 Antipsychotics for the management of delirium (adapted, modified, and expanded from [36•])

Drug	Mechanism of action	Dosing per day/Route of administration	Clinical characteristics and pearls	Side effects and precautions
Typical APs				
Haloperidol	DA	0.5–10 PO, IV, IM, SC	1st choice in delirium (recommended by guidelines) RCTs available Antiemetic properties	Monitor QTc Extrapyramidal effects common
Chlorpromazine	DA	12.5–200 mg IV, IM, SC	Anxiolytic and sedative effects RCTs available	Monitor QTc Sedation, hypotension
Methotrimeprazine		PR 6.25–12.25 PO, IV, SC	Analgesic, antiemetic, and sedating effects	Anticholinergic side effects common (constipation, dry mouth, blurred vision, tachycardia): NB in patients in opioid treatment and poly-drug therapy
Atypical APs				
Olanzapine	MARTA	2.5–20 PO, IM, SC	Sedating effects Appetite stimulant and antiemetic properties RCT available (vs risperidone)	Monitor QTc Anticholinergic side effects (constipation, dry mouth)
Quetiapine	MARTA	25–300 PO	Sedative effects Hypotension RCT available (vs haloperidol; vs amisulpride)	Monitor QTc Sedation
Risperidone	SDA	0.25–6 mg PO	Less side effects vs typical APs if in low doses (otherwise as haloperidol) RCT available (vs olanzapine)	Monitor QTc Possible extrapyramidal effects
Ziprasidone	SDA	40–160 PO, IM	Sedating profile No RCT	Monitor QTc and EKG Few research in delirium
Other atypical APs				
Aripiprazole	DPA	5–20 PO, IM	Less side effects of typical APs Data on efficacy in hypoactive delirium	Monitor QTc Agitation, possible extrapyramidal symptoms
Perospirone	SDA	5–15 PO	Effective in 86.8 % of cases Effect within several days No RCT	Reported low incidence of side effects (fatigue, sleepiness, akathisia, hypotension) Few data in delirium and drug available only in Japan
Amisulpride	DA (D2 and D3); GA	150 PO	Effective in delirium RCT available (vs quetiapine)	Few side effects

DA dopamine antagonist, *SDA* serotonin-dopamine antagonist, *MARTA* multi-acting receptor-targeted antipsychotics, *DPA* dopamine partial agonist, *GA* γ-hydroxybutyrate agonist

a. Recommendations in oncology and palliative care settings [34•]

1. Neurological symptoms (e.g., extrapyramidal symptoms, including dystonias, akathisia, and Parkinsonian symptoms; reduction of seizure threshold): monitor at baseline and daily; 2. Cardiological symptoms: blood pressure and pulse at baseline and at least daily (closer or continuous monitoring for at risk or medically unstable patients); EKG at baseline and with every AP dose increase or daily if high doses of AP are used (closer attention to patients with underlying unstable cardiac disease, electrolyte disturbances, on other QTc prolonging medications for the increased risk of *torsades des pointes*)

From: **Efficacy of Oral Risperidone, Haloperidol, or Placebo for Symptoms of Delirium Among Patients in Palliative CareA Randomized Clinical Trial**

JAMA Intern Med. 2017;177(1):34-42. doi:10.1001/jamainternmed.2016.7491

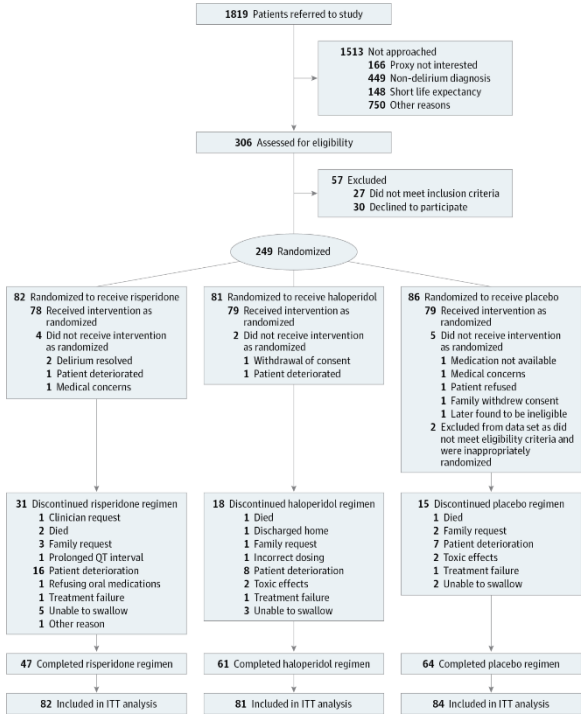


Figure Legend:

Numbers of Participants Assessed and Enrolled in the TrialITT indicates intention-to-treat.

From: **Efficacy of Oral Risperidone, Haloperidol, or Placebo for Symptoms of Delirium Among Patients in Palliative CareA Randomized Clinical Trial**

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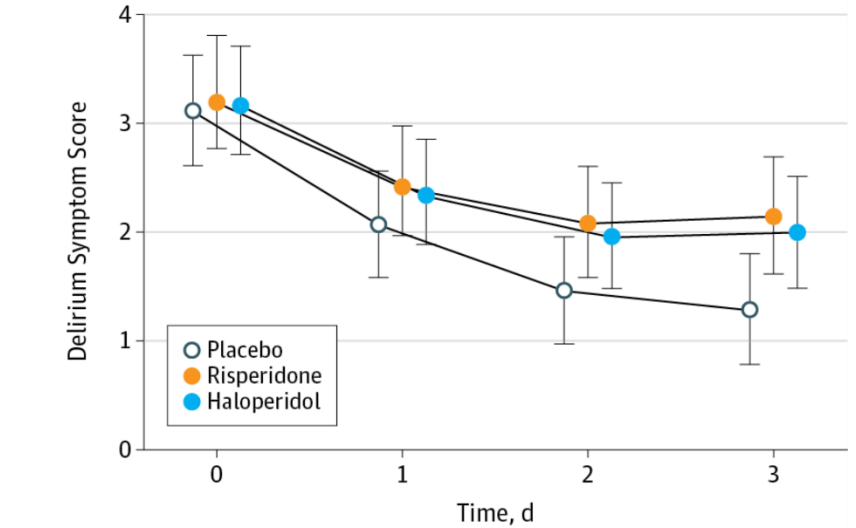


No. at risk				
Placebo	84	63	59	55
Risperidone	82	58	49	39
Haloperidol	81	64	55	51

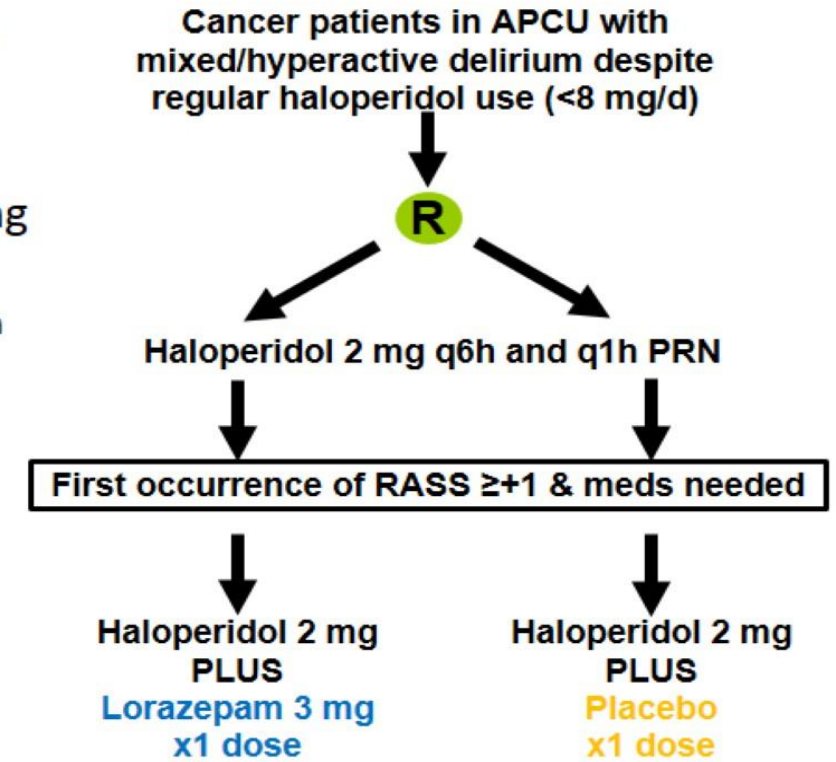
Figure Legend:

Secondary Multivariable Mixed-Model Analysis of DeliriumThe dependent variable was delirium score at each day. The independent variables comprise the covariates in Table 2, group, time, and 2 interaction terms, time × risperidone and time × haloperidol. The relative difference in improvement between groups at 72 hours was determined using the lincom function in Stata. Placebo vs risperidone: P < .001; placebo vs haloperidol: P = .002. Error bars indicate 95% CIs.

Haloperidol ± Lorazepam

Palliative Care, Persistent Agitation

- Double-blind, randomized controlled trial
- Single dose instead of repeated dosing
  - Short survival (i.e. hours to days)
  - Uncertain risks associated with lorazepam in a frail population
- Study outcomes:
  - Richmond Agitation Sedation Scale (1°)
  - Use any additional psychotropic agents
  - Perceived patient comfort
  - MDAS, ESAS, DEQ
  - Communication capacity
  - Adverse effects
  - Discharge outcomes, survival



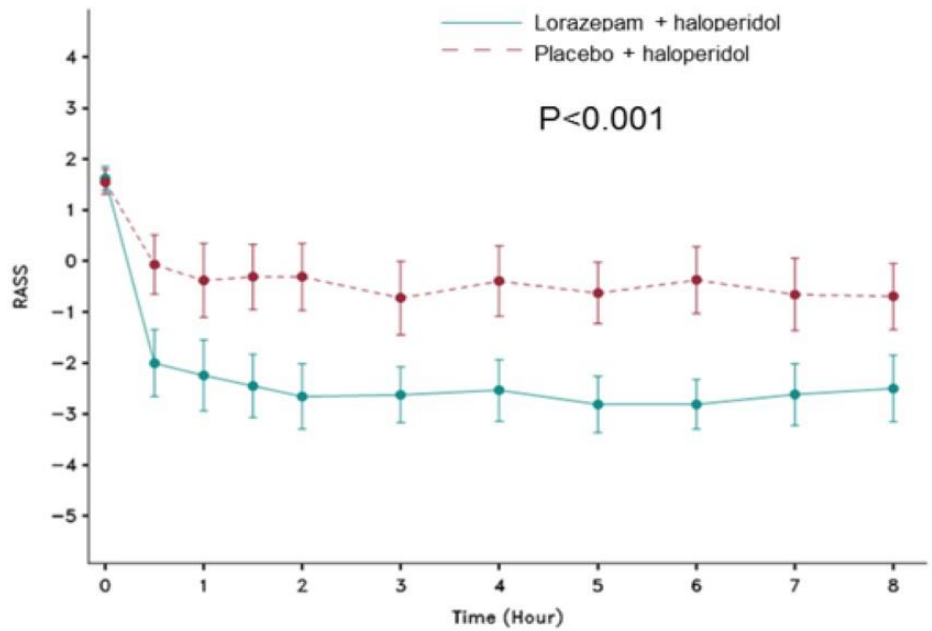
Hui et al. *JAMA* 2017

Credit to: Dr. David Hui, PI, MD Anderson

Haloperidol ± Lorazepam

Palliative Care, Persistent Agitation

- Lorazepam/haloperidol was associated with a significantly greater reduction of RASS compared to placebo
  - 0-30 min: mean Δ -2.0, 95% CI -2.9, -1.1, P<0.001
  - 0-8 h: mean Δ -1.9, 95% CI -2.8, -0.9, P<0.001



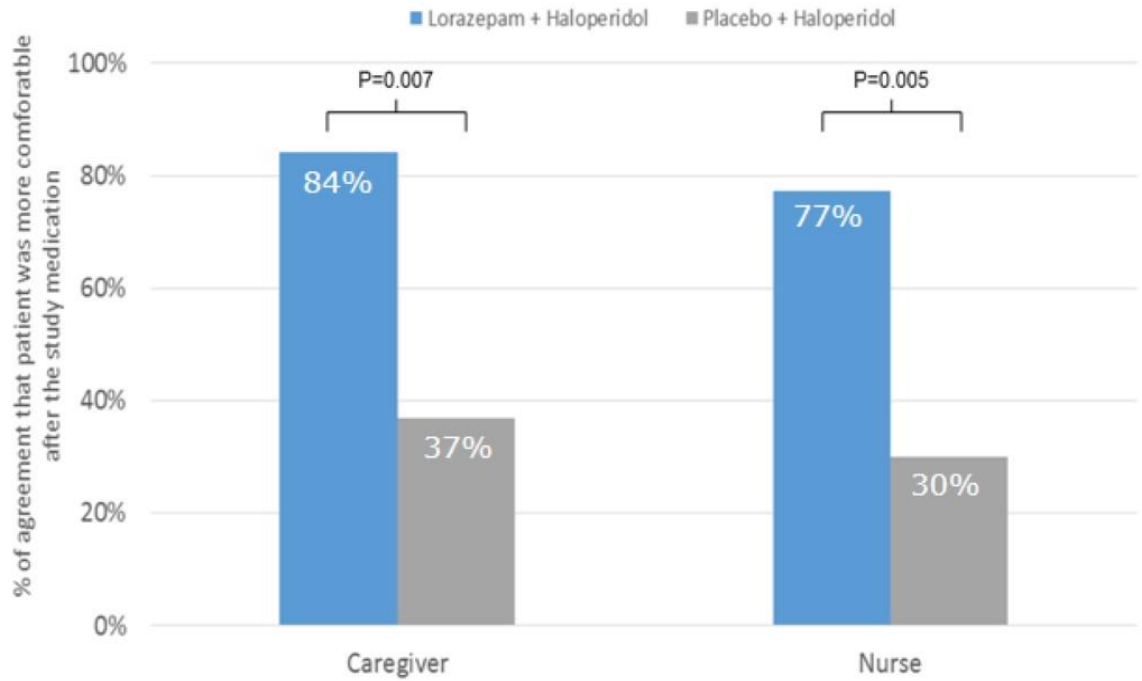
Hui et al. *JAMA* 2017

Credit to: Dr. David Hui, PI, MD Anderson

Haloperidol ± Lorazepam

Palliative Care, Persistent Agitation

Patients on lorazepam/haloperidol arm were perceived to be more comfortable after the study medication by *blinded* caregivers and nurses



Hui et al. *JAMA* 2017

Credit to: Dr. David Hui, PI, MD Anderson

Haloperidol ± Lorazepam

Palliative Care, Persistent Agitation

- Lorazepam and haloperidol, given to the *right* individuals for the *right* reason at the *right* time, may reduce agitation and improve comfort.

- Limitations:
  - Single center study
  - Small study not powered to examine secondary outcomes
  - Only examined a single dose of lorazepam (3 mg)

More Research is Needed

- Further research is needed to examine the role of benzodiazepines and neuroleptics in delirium management.

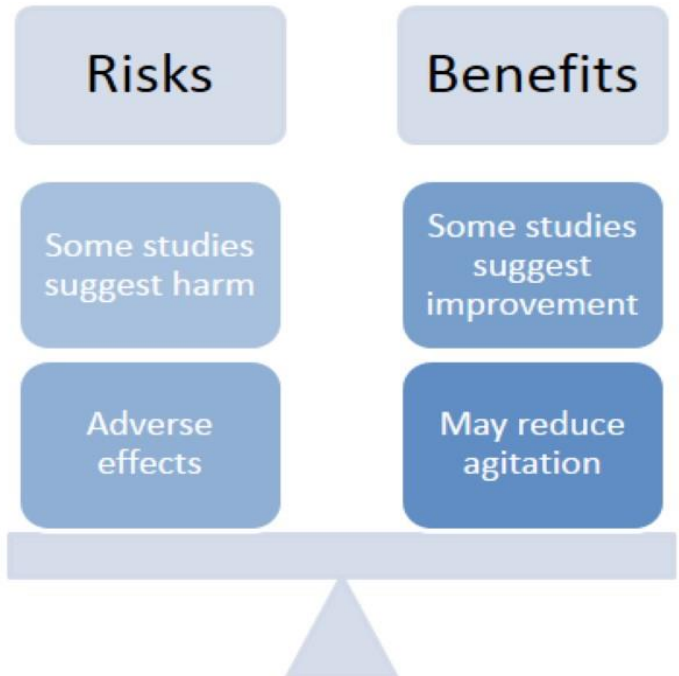
Hui et al. *JAMA* 2017

Credit to: Dr. David Hui, PI, MD Anderson

Pharmacologic Therapies

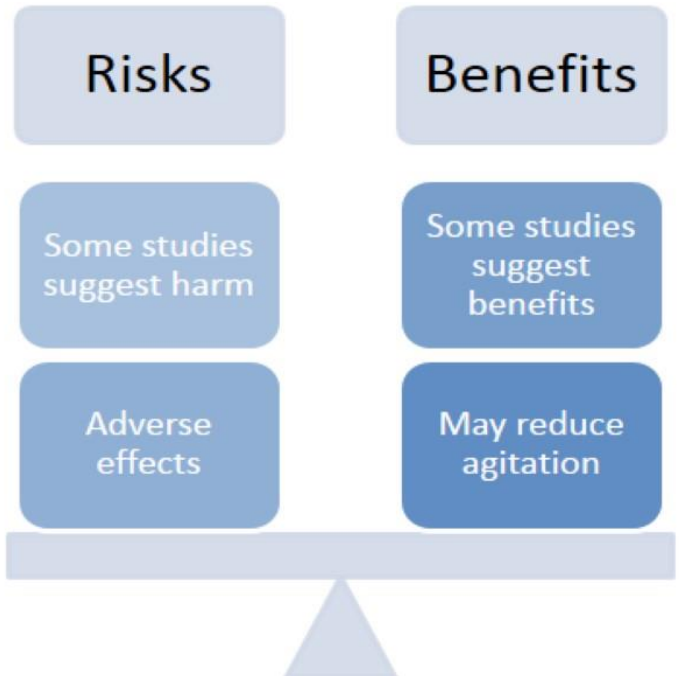
Take Home Message

Neuroleptics



Prevention: Mixed evidence
Treatment: Limited evidence; however, *may be* considered for selected patients given limited options

Benzodiazepines

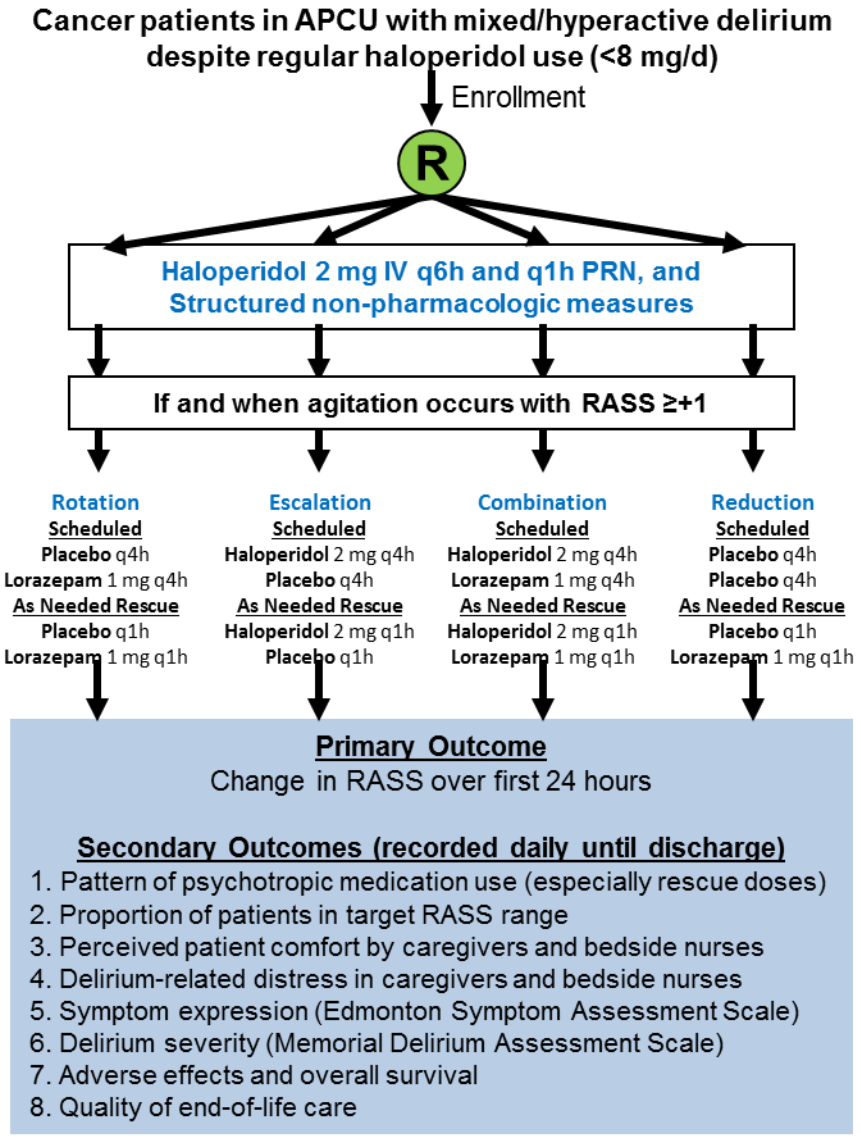


Prevention: No evidence
Treatment: Some evidence for agitation control; use with great caution

Credit to: Dr. David Hui, PI, MD Anderson

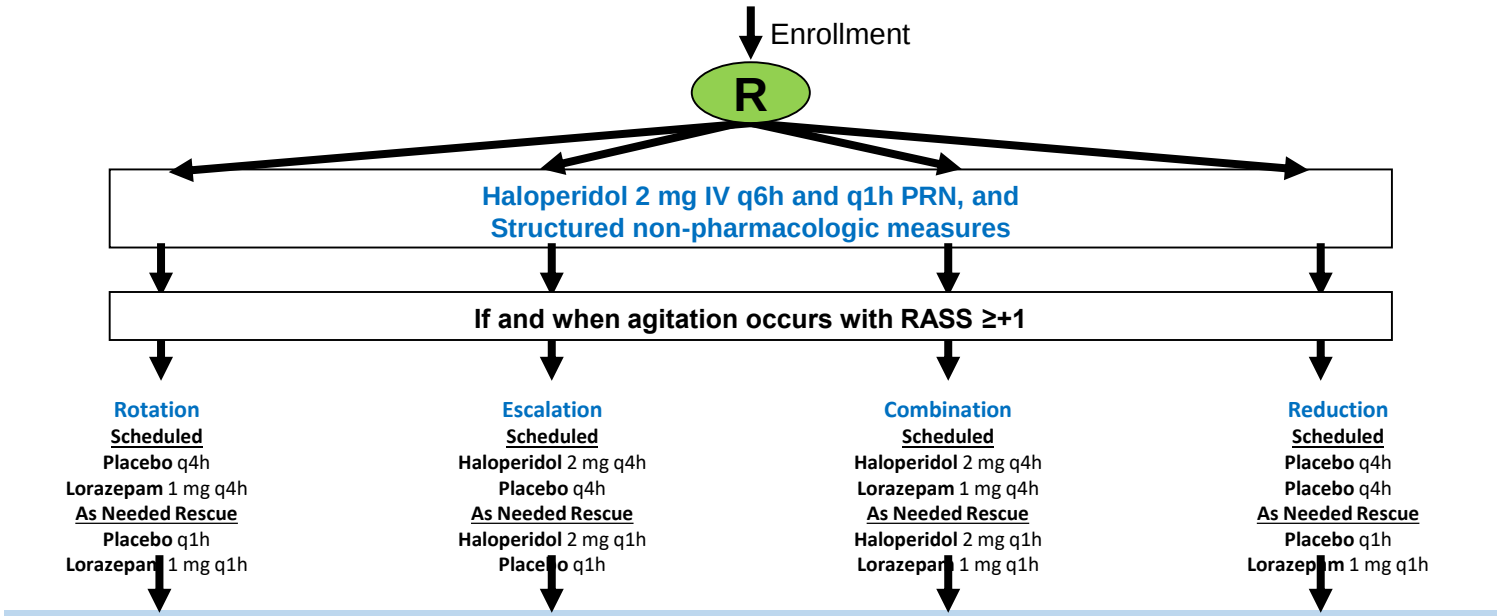
Goal of the RECORD Study

- Not all patients respond to current standard treatment (Haldol, non-pharmacological interventions)
- What are other options and are the effective?



Credit to: Dr. David Hui, PI, MD Anderson

Cancer patients in APCU with mixed/hyperactive delirium despite regular haloperidol use (<8 mg/d)



Primary Outcome

Change in RASS over first 24 hours

Secondary Outcomes (recorded daily until discharge)

1. Pattern of psychotropic medication use (especially rescue doses)
2. Proportion of patients in target RASS range
3. Perceived patient comfort by caregivers and bedside nurses
4. Delirium-related distress in caregivers and bedside nurses
5. Symptom expression (Edmonton Symptom Assessment Scale)
6. Delirium severity (Memorial Delirium Assessment Scale)
7. Adverse effects and overall survival
8. Quality of end-of-life care

Credit to: Dr. David Hui, PI, MD Anderson

Secondary Outcomes

Patient Initials/MRN: _____
Subject study ID: _____

Protocol 2018-0706
Rev. March 6, 2019
Page **24** of **39**

Appendix L. Proxy Comfort Goal

To be completed by caregiver and bedside nurse at baseline

Questionnaire completed by:
☐ Caregiver
☐ Bedside nurse

Assessment completed on:
Date (MM/DD/YY): _____ (Study day [#]:_____)
Time (HH:MM): _____

The following questionnaire consists of several scenarios to help study staff better understand the ideal level of sedation for patients with agitation/restlessness and confusion. At the end, we will also ask what is the desirable level of sedation for your specific family member or patient.

For the purpose of this questionnaire, please imagine that you are the main caregiver/bedside nurse for a patient with advanced cancer who is staying at a palliative care unit. She has been confused for the last few days. She is no longer on active cancer treatment. You have been spending the last few days with her in the hospital.

Scenario #1

She is awake most of the day, and sometimes quite agitated. She keeps moaning and sometimes pulls

Credit to: Dr. David Hui, PI, MD Anderson

Discussion and Questions

Case Presentation

Case presentation

How to better manage end-of-life delirium

- 51-year-old female
- History of metastatic rectal cancer, hypertension
- Presented to the hospital with acute limb ischemia
- Found to have complete occlusion of the left iliac artery, underwent open thrombectomy and fasciotomy, and the clot was found to be tumorigenic;
- Also found to have an AV Vegetation also likely tumorigenic in nature.
- Hospital course was complicated by acute liver injury and acute kidney injury and acute delirium
- After a goals of care discussion with the patient's mother (mPOA) they decided to make her comfort measures only and she was transferred to the palliative care unit for end-of-life care

Social/Spiritual History

Lives with her young son. No history of smoking, alcohol use or illicit drug use

Symptom Assessment

Pain, Dyspnea, Agitation

Pertinent Findings: Physical Exam

General exam: Sedated, does not respond to verbal stimuli; does not appear to be in overt distress

HEENT: Moist mucous membranes

Lungs: Clear to auscultation bilaterally

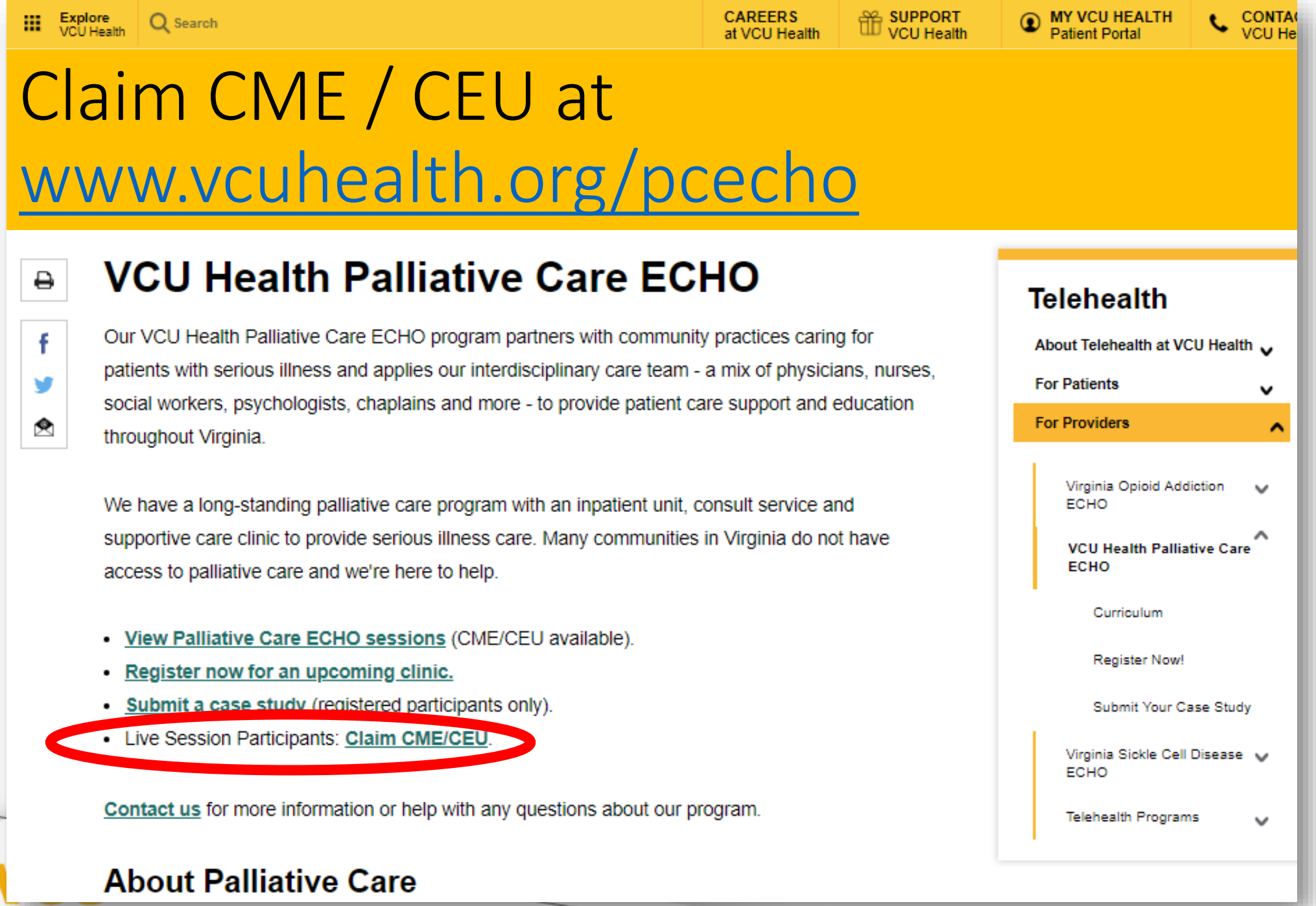
CVS: regular rate & rhythm, systolic murmur, tachycardic

Abdomen: BS+, soft

Extremities: LLE wrapped in dressing: cool LLE extremity; no dorsal pedis pulses appreciated on LLE; RLE warm, dorsalis pedis pulse present on the RLE; b/l lower extremity edema +2 till mid-thigh

Accessing CME and CEU Credits

Claim CME / CEU at www.vcuhealth.org/pcecho



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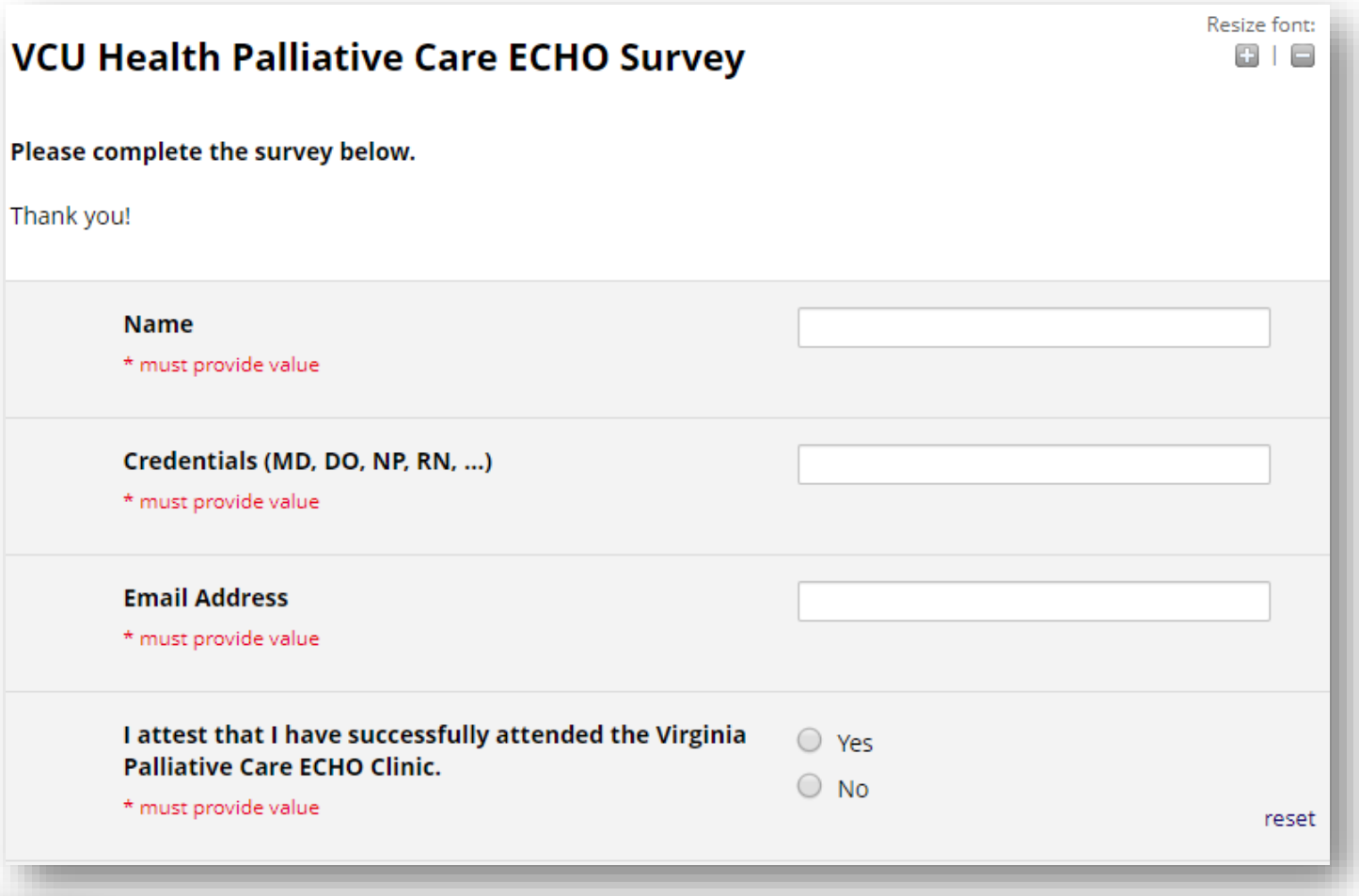
Submit your evaluation to claim your CME



Resize font:

VCU Health Palliative Care ECHO Survey

Please complete the survey below.

Thank you!

Name

* must provide value

Credentials (MD, DO, NP, RN, ...)

* must provide value

Email Address

* must provide value

I attest that I have successfully attended the Virginia Palliative Care ECHO Clinic.

* must provide value

- Yes
- No

reset

View recorded sessions at www.vcuhealth.org/pcecho

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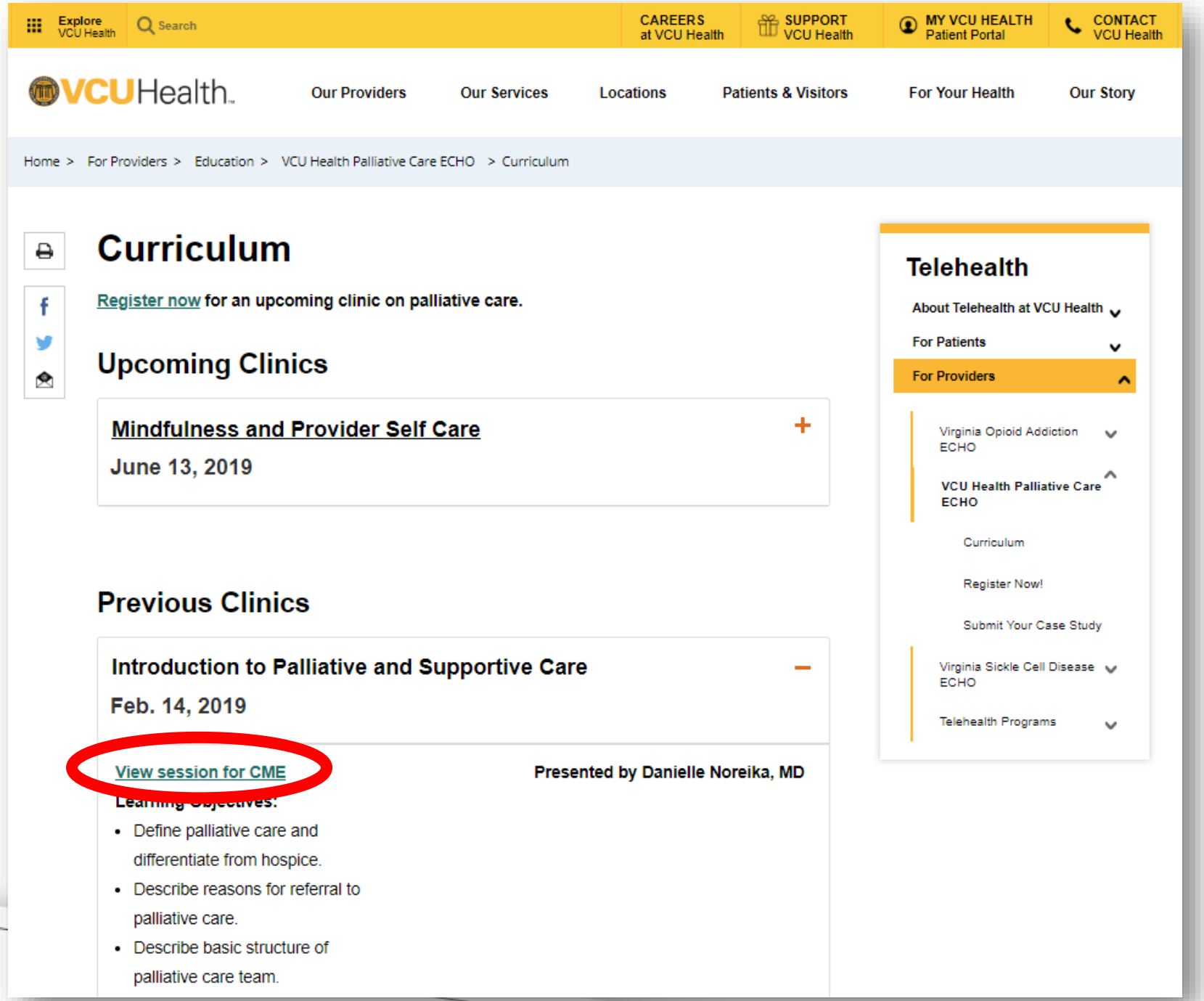

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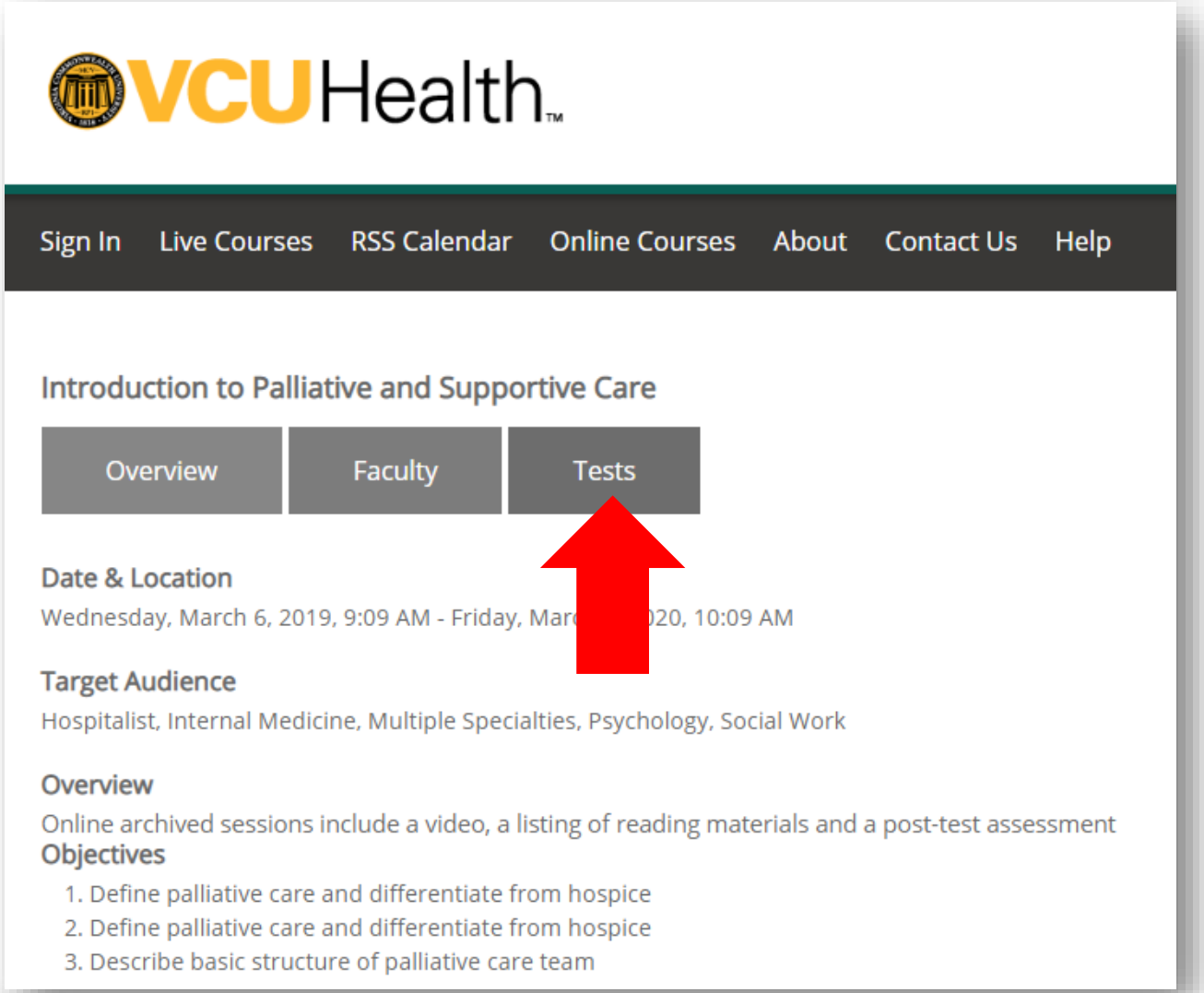
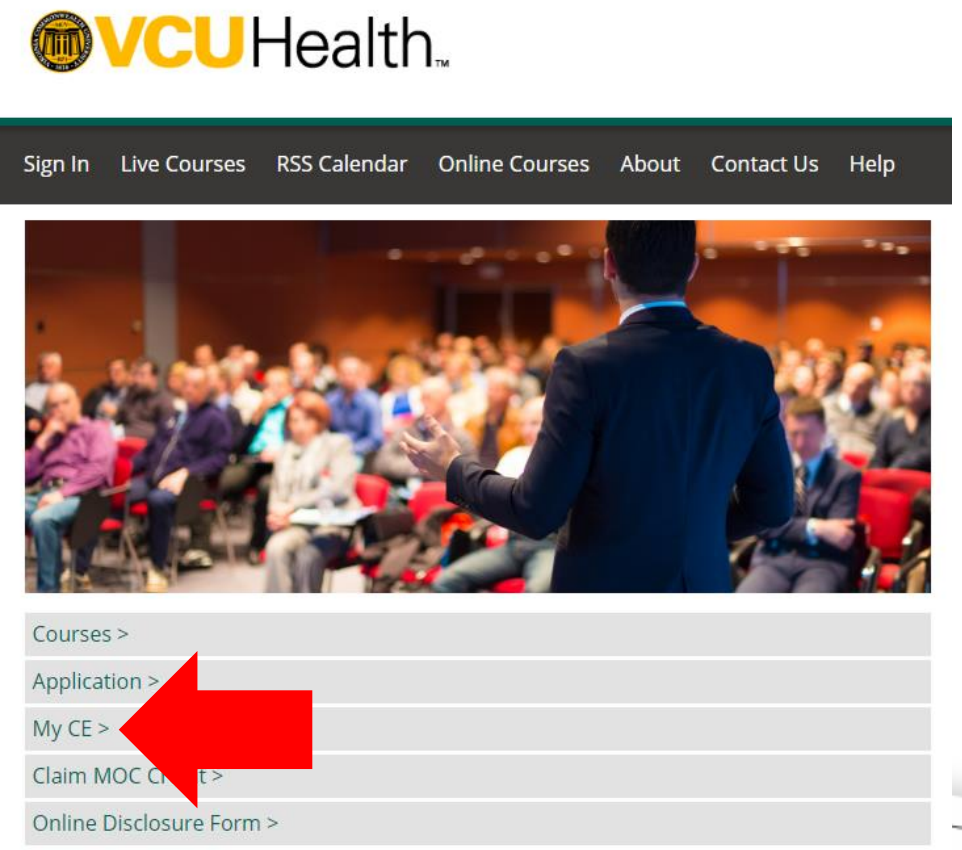
View previously recorded ECHOs for CME

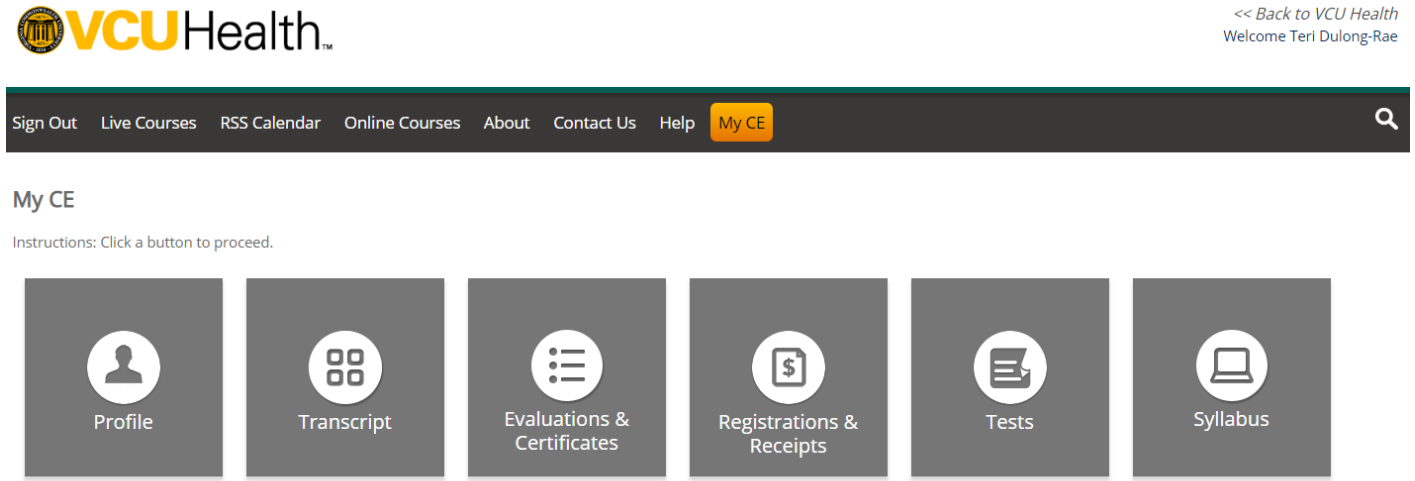
Click “Tests” to view video of the session and take a short quiz for continuing education credit



View your CME/CEU transcript

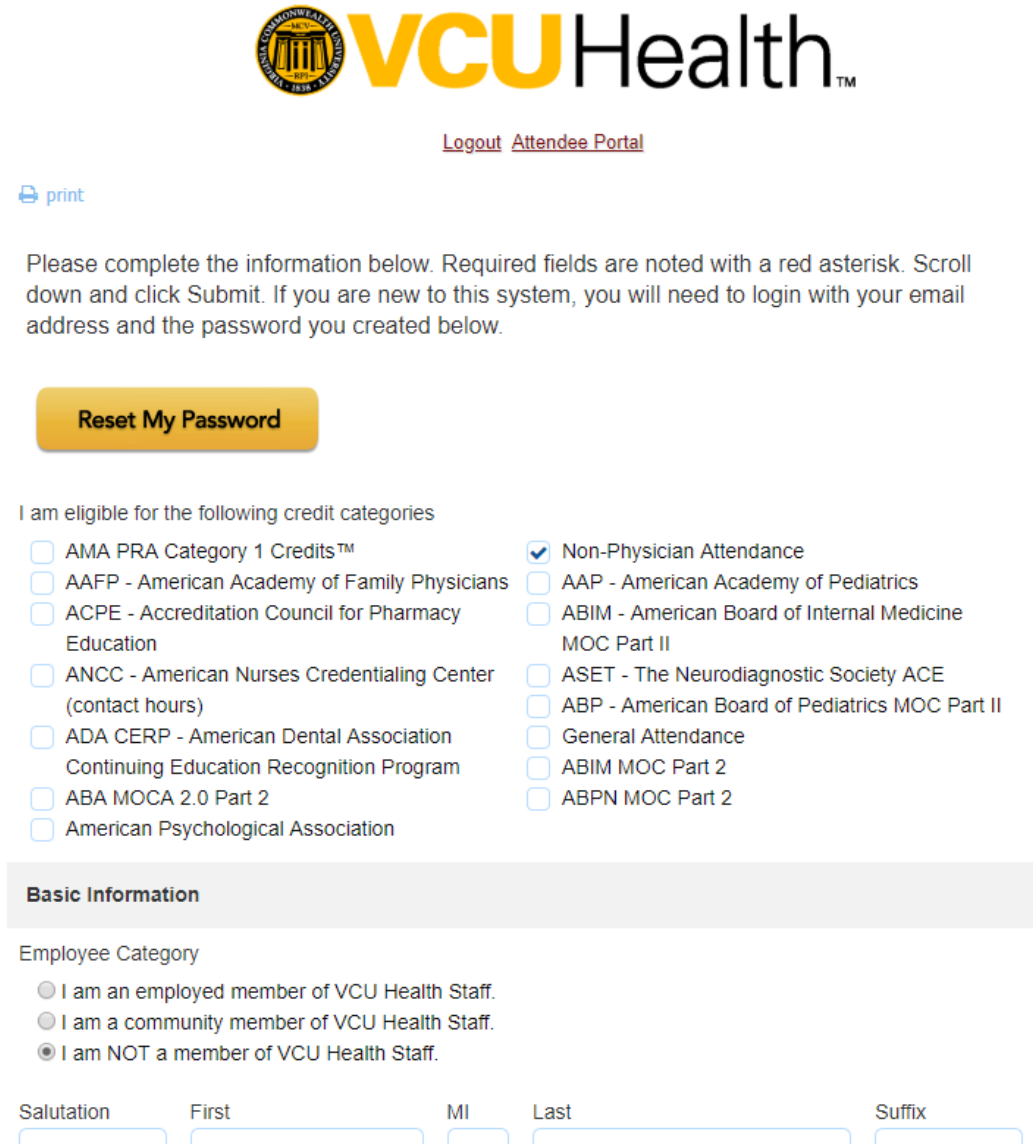
- Go to vcu.cloud-cme.com and click “My CE”
- Log in with the email you used to register for our ECHO session





View your CME/CEU transcript

If you have never logged in before, you may be prompted to enter more information before you can view your transcript



THANK YOU!

We hope to see you at our next ECHO