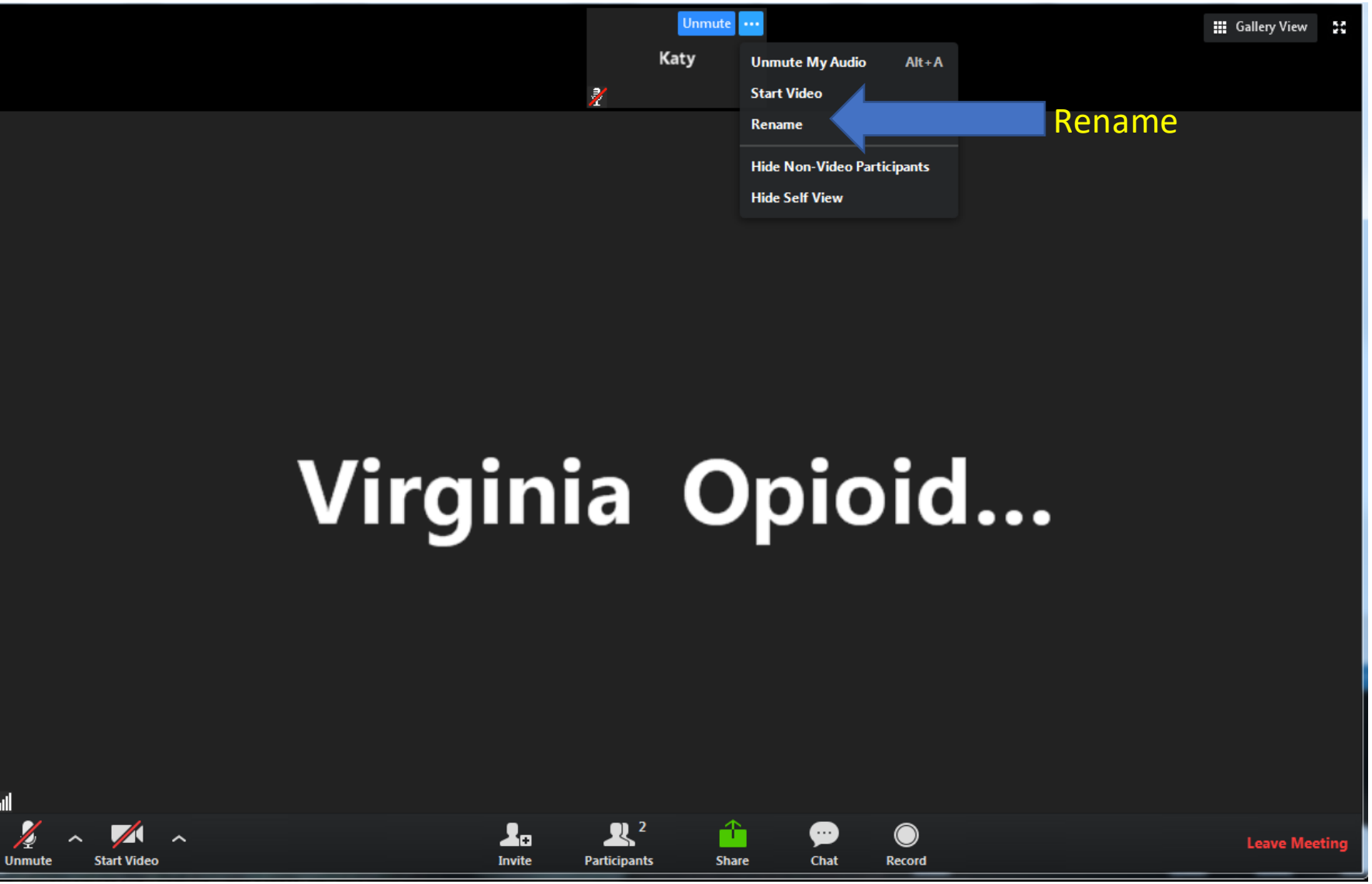
Virginia Opioid Addiction ECHO* Clinic

February 12, 2021

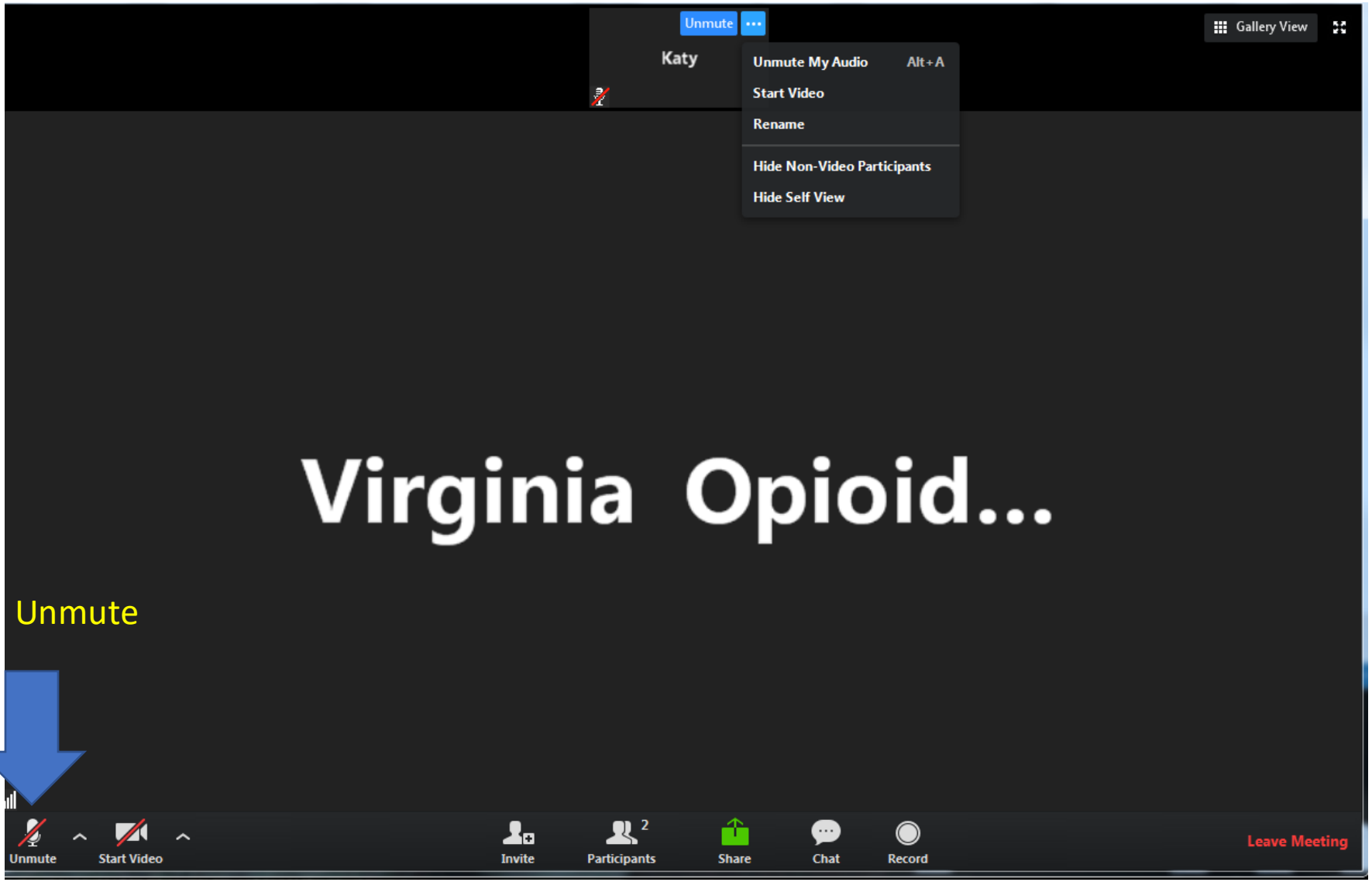
*ECHO: Extension of Community Healthcare Outcomes

Helpful Reminders



- Rename your Zoom screen, with your name and organization

Helpful Reminders



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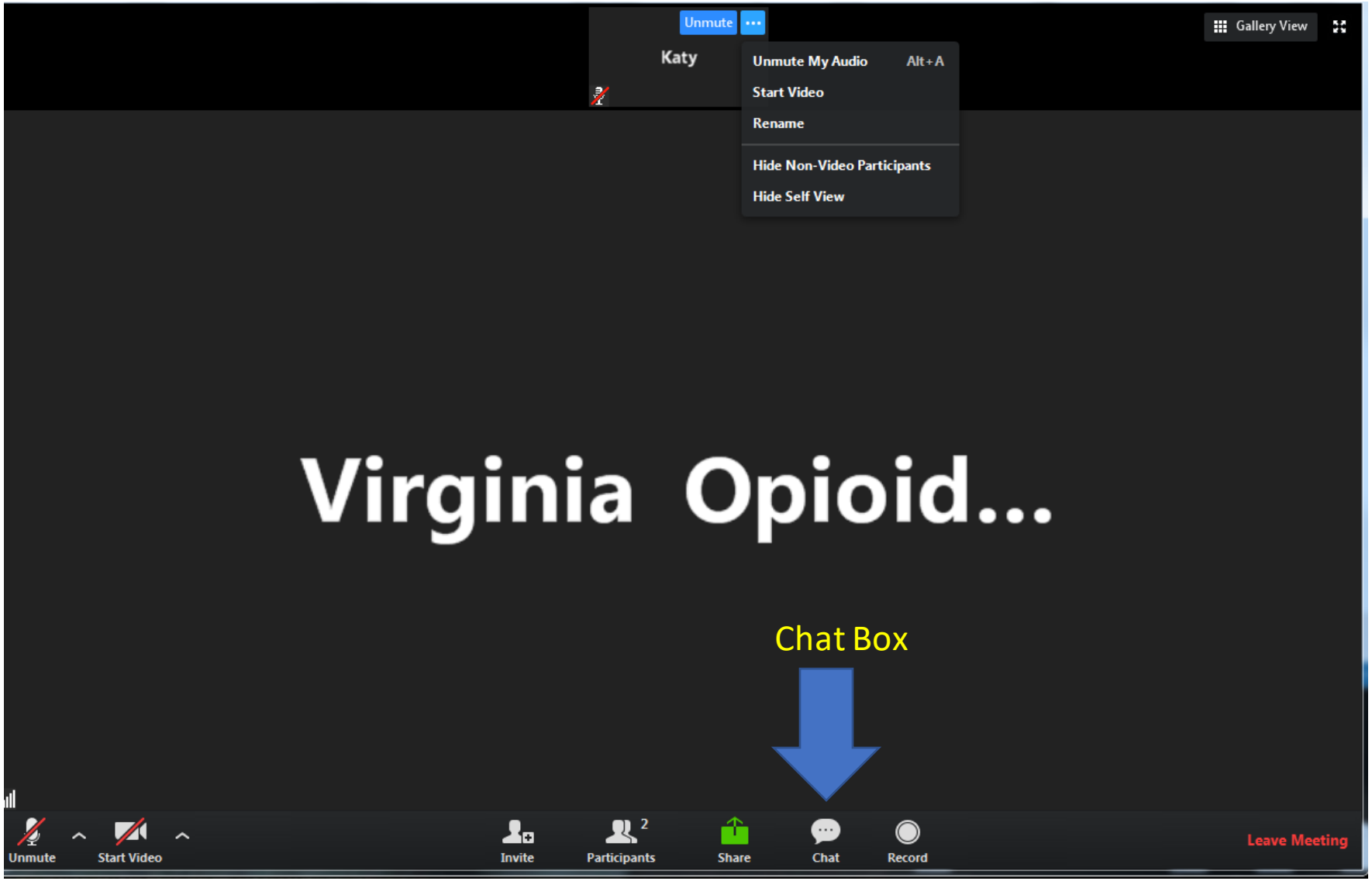
- If joining by telephone audio only, *6 to mute and unmute

Helpful Reminders



- Please type your full name and organization into the chat box
- Use the chat function to speak with IT or ask questions

VCU Opioid Addiction ECHO Clinics

VCU Health
VCU School of Medicine

VDH Virginia Department of Health | VDHLiveWell.com

Virginia Department of Behavioral Health & Developmental Services

- Bi-Weekly 1.5 hour tele-ECHO Clinics
- Every tele-ECHO clinic includes a 30 minute didactic presentation followed by case discussions
- Didactic presentations are developed and delivered by inter-professional experts
- Website Link: www.vcuhealth.org/echo

Hub and Participant Introductions

VCU Team	
Clinical Director	Gerard Moeller, MD
Administrative Medical Director ECHO Hub	Vimal Mishra, MD, MMCi
Clinical Experts	Lori Keyser-Marcus, PhD Courtney Holmes, PhD Albert Arias, MD Megan Lemay, MD Salim Zulfiqar, MD
Didactic Presentation	Courtney Holmes, PhD
Program Manager	Bhakti Dave, MPH
Practice Administrator	David Collins, MHA
IT Support	Vladimir Lavrentyev, MBA

- Name
- Organization

Reminder: Mute and Unmute screen to talk

*6 for phone audio

Use chat function for Introduction

What to Expect

I. Didactic Presentation
   I. **Courtney Holmes, PhD**
II. Case presentations
   I. Case 1
      I. Case summary
      II. Clarifying questions
      III. Recommendations

   II. Case 2
      I. Case summary
      II. Clarifying questions
      III. Recommendations

III. Closing and questions

Lets get started!

Didactic Presentation

Disclosures

Courtney Holmes, PhD has no financial conflicts of interest to disclose.

There is no commercial or in-kind support for this activity.

Dr. Courtney Holmes, LPC, LMFT, NCC, CRC

Grief in Substance Use and Recovery

Learning Objectives

- Participants will
  - Learn various definitions of grief
  - Understand how grief is paramount to substance misuse and the recovery process
  - Learn how to incorporate loss and grief in work with patients/clients

Loss

- “the real or perceived deprivation of something that is deemed meaningful”
- *Primary loss:* initial loss, comes first (e.g., I lost my job)
- *Secondary loss:* losses that come as a result of the initial loss (e.g., financial security, insurance, daily routine, coworkers, identity as a worker, etc.)
- Primary or secondary losses are not more or less impactful than the other

Loss

- Grief and loss associated with substance abuse have been connected to::
  - early life losses
  - losses that occurred while abusing substances
  - and losses encountered upon entering recovery
- Losses can be CONCRETE: people, possessions, places
- Losses can be ABSTRACT: self-esteem, self-worth, self-respect, hopes/dreams/wishes, feeling of safety, identity

Nonfinite Losses

- A loss that doesn't end (Bates-Maves, 2020)
- Hallmarks of nonfinite losses (Bruce & Shultz, 2001)
  - Ongoing uncertainty about what will happen next
  - Feeling disconnected from the larger world and what is considered "normal."
  - The size and impact of the loss is often unacknowledged by others— it's overlooked or ignored.
  - An enduring sense of powerlessness and hopelessness connected to the loss.
  - Chronic despair and dread as people try to reckon with pre/post loss. Basically, what we thought the world was…. we now question that: that is, *"I thought I was safe, and I now realize that no one is truly safe. What do I do with that?"*
  - https://hbr.org/2020/03/that-discomfort-youre-feeling-is-grief

Trauma

- We cannot really understand grief without understanding trauma
- SAMHSA (2018a) defines trauma as resulting
  - *from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
- Experiencing trauma puts us at higher risk for substance misuse and mental illness

TABLE 1

Percentage of Participants Who Experienced Situation at Each Time Frame and Post Hoc Comparisons Between Time Frames

Experience	T1	T2	T3	T1 × T2	T1 × T3	T2 × T3
1. Divorce/separation of parents	38.2	23.9	10.6	.041	.000*	.021
2. Physical abuse	23.5	20.9	6.2	.791	.013*	.013*
3. Sexual abuse	10.3	10.6	3.1	1.00	.239	.180
4. Verbal abuse	39.7	49.3	23.1	.189	.093	.002*
5. Witnessed violence	64.2	74.2	38.5	.065	.000*	.000*
6. Damage to self-esteem	53.0	59.7	31.8	.227	.007*	.001*
7. Death of someone special	72.1	77.6	31.8	.424	.000*	.000*
8. Loss of support from others	45.5	61.2	28.8	.021	.027	.000*
9. Loss of child(ren) through divorce or separation	12.3	19.7	9.1	.289	.727	.016*
10. Death of child	4.5	3.0	3.0	1.00	1.00	1.00
11. Personal divorce	16.2	24.2	12.1	.180	.754	.021
12. Loss of romantic relationship	50.0	66.2	30.3	.027	.017*	.000*
13. Loss of friendship(s)	41.8	52.2	35.4	.210	.648	.093
14. Loss of independence	35.3	47.1	25.8	.096	.327	.015*
15. Decline in social life	44.8	60.3	30.3	.041	.137	.000*
16. Loss of job	42.6	67.6	21.5	.000*	.012*	.000*
17. Loss of material possessions	41.2	66.2	27.7	.000*	.167	.000*
18. Decrease in status	31.8	48.5	24.2	.017*	.648	.000*
19. Serious health problems	27.3	44.8	26.2	.004*	1.00	.007*
20. Loss of goal/dream	51.5	64.2	22.7	.022	.003*	.000*
21. Financial problems	57.4	76.5	53.8	.011*	.850	.001*
22. Poor academic performance	39.7	47.8	13.8	.383	.000*	.000*
23. Homelessness	28.4	35.8	15.4	.146	.092	.002*
24. Memory problems		64.7	33.8			.000*
25. Loss of ability to think clearly and logically		73.5	32.3			.000*
26. Revocation of driver's license		54.4	34.8			.008*
27. Loss of/damage to spiritual connections		57.4	19.7			.000*
28. Loss of meaning in life		41.2	10.6			.000*
29. Victimized by crime		47.1	12.1			.000*
30. Committed crime		70.6	15.2			.000*
31. Diagnosed with HIV		5.9	3.0			1.00
32. Loss of substance use			75.8			
33. Loss of way of life			50.0			
34. Loss of friendship(s) with those who use			57.6			
35. Loss of places where once used			50.8			
36. Loss of escape from feelings through using			62.1			

Note. $N = 68$. T1 = time prior to abusing; T2 = time while abusing; T3 = time during recovery; T1 × T2 = Time 1 compared to Time 2; T1 × T3 = Time 1 compared to Time 3; T2 × T3 = Time 2 compared to Time 3.
*$p \leq .017$.

68 participants involved in outpatient, aftercare, residential or intensive outpatient substance use tx. (Furr et al., 2014)

A person who is actively using substances is involved in a perpetual state of grief—

a response to the many losses that are experienced over the years of uncontrolled use (Friedman, 1984) –

as well as a response to manage the grief of the many losses experienced prior to use

What is Grief

- *“Grief, of course, is a profound and often complex response for that which has been lost.”*
  - Pain accompanies the realization that we cannot bring back what has been lost
- Four types of whole body responses (Rando, 1993; Worden, 2009)
  - *Emotional/psychological/cognitive*
  - *Physical*
  - *Social*
  - *Behavioral*
- NO right or wrong way to experience grief (grief is a reaction to a loss, *not* just a sad one) (Bates-Maves, 2020)

Complicated Grief (CG)

- *“Similar to inflammation following a physical wound, complications interfere with healing and tend to intensify and prolong pain”* Shear et al. (2011)

- A deviation from the normal (in cultural and societal terms) grief experience in either time course, intensity, or both, entailing a chronic and more intense emotional experience, which either lacks the usual symptoms or in which the onset of symptoms is delayed (Stroebe et al., 2007).

Disenfranchised Grief

- Disenfranchised grief is grief that is not acknowledged or valued by society
  - Loss is undervalued or seen as less worth of grief
  - Stigmatized relationships
  - Method of death is stigmatized
  - Individual experiencing grief isn't recognized as deserving
  - How someone grieves is judged as unacceptable

Models of Grief

- Kubler-Ross model (5 stages: denial, anger, bargaining, depression, acceptance)
- Two-track model of bereavement
- Dual process model of coping
- Four tasks of mourning
- Four stages of grief
- Six “R” processes of mourning
- Loss and adaptation model

(Bates-Maves, 2020)

Substance use/Recovery/Grief Data

- Link between intense grief and worsening of substance use (Prigerson et al., 1997)
- Parents who lost a child were found to be at significantly higher risk for hospitalization for substance abuse than parents who had not lost a child (Li, Laurson, Precht, Olsen, & Mortensen, 2005)
  - Particularly for bereaved mothers, whose relative risk of hospitalization was more than double that of mothers who were not bereaved.
- High rate of complicated grief among patients in a methadone maintenance program (Shear et al., 2005)

Coping

- Behavioral, emotional, and cognitive strategies used to manage stress
- When we experience a crisis (which can include a loss) it taxes our coping skills that we rely on.
- Could be healthy (adaptive) and/or unhealthy (maladaptive)
  - Substance use
  - Withdrawing from friends
  - Exercise
  - Prayer or finding religious support
  - Listening to music
  - Journaling

Coping and SUD

- People with SUD, generally have already taxed coping mechanisms
- Experiencing and managing painful and intense feelings is difficult
- Levels of maladaptive coping and disengagement strategies are higher
  - Self-criticism
  - Social isolation
  - Emotional avoidance

What can we do?

- Keep the importance of grief in your worldview (this includes a trauma informed lens - relates to MI)
- Assess for the presence of grief in your patients (talk about loss and model conversations about hard topics)
- Educate about grief
  - Provide some common experiences of people who are grieving (physical, emotional, etc.)
  - Provide information around disenfranchised grief and ambiguous loss
  - Normalize grieving around loss associated with recovery
- Discuss coping skills and opportunities for resilience and growth
  - What is the patient/client doing to cope or manage painful feelings? What are some alternatives? Help them brainstorm.

Case Study

- You have been working with a patient for several months, they keep making their appointments but you still feel as if they have some resistance to fully engaging in their recovery. One day they make a comment regarding how they are angry they can't do something they used to do when they were using
- At this time, perhaps you use this as an opening to engage in dialogue around that anger.
  - Help frame that anger as a normal response to grief
  - Provide brief definition of grief and the three points in time that may feel relevant for a person in recover (pre use, during use, entering recovery)
  - Discuss potential coping skills to use when anger (disguised grief) comes up

Questions?

References

- Bates-Maves, J. (2020). *Grief and Addiction: Considering loss in the recovery process.* Routledge
- Bruce, E. J., & Schultz, C. L. (2001). *Nonfinite loss and grief: A psychoeducational approach*. Paul H. Brookes.
- Caparros, B., & Masferrer, L. (2021). Coping strategies and complicated grief in a substance use disorder sample. *Frontiers in Psychology, 11,* 1-8.
- Friedman, M. A. (1984). Grief reactions: Implications for treatment of alcoholic clients. *Alcoholism Treatment Quarterly, 1*, 55–69.
- Furr, S., Johnson, D., Goodall, C. (2014). Grief and recovery: The prevalence of grief and loss in substance abuse treatment. *Journal of Addictions and Offender Counseling, 36,* 10.1002/j.2161-1874.2015.00034.x
- Rando, T. (1993). *Treatment of complicated mourning*. Research Press.
- Shear, M. K., Boelen, P. A., & Neimeyer, R. A. (2011). Treating complicated grief: Converging approaches. In R. A. Neimeyer, D. L. Harris, & H. R. Winokuer (Eds.), *Grief and bereavement in contemporary society: Bridging research and practice* (pp. 139–162). Routledge.

References

- Li, J., Laurson, T. M., Precht, D. H., Olsen, J., & Mortensen, P. B. (2005). Hospitalization for mental illness among parents after the death of a child. *New England Journal of Medicine, 352,* 1190–1196.
- Prigerson, H. G., Bierhals, A. J., Kasl, S. V., Reynolds, C. F., III, Shear, M. K., Day, N., et al. (1997). Traumatic grief as a risk factor for mental and physical morbidity. *American Journal of Psychiatry, 154,* 616–623.
- Shear, K., Frank, E., Houck, P. R., & Reynolds, C. F. (2005). Treatment of complicated grief: A randomized controlled trial. *Journal of the American Medical Association, 293,* 2601–2608.
- Winokuer, H. R. & Harris, D. L. (2012). *Principles and practices of grief counseling*. Springer Publishing
- Worden, J. W. (2009). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (4th ed.). Springer Publishing.
- Zuckoff, A., Shear, K., Frank, E., Daley, D., Seligman, K., & Silowash, R. (2006). Treating complicated grief and substance use disorders: A pilot Study. *Journal of Substance Abuse Treatment, 30*, 205-211.

Case Presentation #1
Faisal Mohsin, MD

- 12:35-12:55 [20 min]
  - 5 min: Presentation
  - 2 min: Clarifying questions- Spokes
  - 2 min: Clarifying questions – Hub
  - 2 min: Recommendations – Spokes
  - 2 min: Recommendations – Hub
  - 5 min: Summary - Hub

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions

Main Question

Please state your main question(s) or what feedback/suggestions you would like from the group today?

How should we address this issue with the Drug Court ..... insistence on Sublocade injection vs. sublingual Suboxone?

Demographic Information

30 yr. Married Caucasian female with a history of OUD in remission is currently in Phase IV of Drug Court (DC). There is a past history of heavy alcohol use but unknown whether she has actually been diagnosed with Alcohol Use Disorder.

Background Information

A couple of weeks ago, during random testing, she was found to be positive for Bupg and Et G (alcohol metabolite). This constituted a violation of the Drug Court policy and she was awarded a sanction. I was asked to see the patient on an emergency basis and met with her last week.

UDS=Bupg+

She reports she has been getting Suboxone from a friend for the past 3 months after she started experiencing sudden and severe cravings for heroin. In order to avoid a full blown relapse she resorted to taking Suboxone but fearing sanctions and other legal repercussions, chose not to disclose this to her Drug Court counselor.

She is currently getting a 4/1mg strip daily. Some days more, depending upon her finances at the time.

Previous Interventions

The Judge passed on the message that he would prefer the patient be considered for Sublocade injections and monitored frequently.

She did not feel the 4/1 mg strip was adequately suppressing her cravings for opiates. I communicated to the DC counselor that the simplest and most practical approach to treating this patient would be getting her off illegally procured Suboxone onto legally prescribed Suboxone.

Started on Suboxone 8/1mg 1/2 BID.

Plan for Future Treatment

What is your plan for future treatment? What are the patient's goals for treatment?

The following week, the patient turned her self in after she was sanctioned by Drug Court and is serving a 10 day sentence. The jail in that particular jurisdiction is NOT allowing her to take the prescribed Suboxone.

The DC official informs me that this is one of the reasons why the Judge wants the Sublocade prescribed instead of the strips. The Judge wants the enrollees receiving partial agonist bases MAT to be on Sublocade injections to prevent diversion of the strips and should the enrollee receive a sanction, he or she would not require the jail to prescribe sublingual Suboxone during incarceration.

Other Relevant Information

one injection Sublocade=$1500 approx.

Not easy to get. Requires lots of paperwork to get approval from the manufacturer and insurance.

Manufacturer's requirement = pt. must be on sublingual Suboxone for at least 2 weeks prior to switching to Sublocade.

Starting Sublocade injections as primary treatment of OUD is not evidence based treatment.

Sublocade is not a "magic treatment". Does not work for everybody!

Reminder: Main Question

Please state your main question(s) or what feedback/suggestions you would like from the group today?

How should we address this issue with the Drug Court ..... insistence on Sublocade injection vs. sublingual Suboxone?

Case Presentation #2
Michelle Tanner, LPC

- 12:55pm-1:25pm [20 min]
  - 5 min: Presentation
  - 2 min: Clarifying questions- Spokes (participants)
  - 2 min: Clarifying questions – Hub
  - 2 min: Recommendations – Spokes (participants)
  - 2 min: Recommendations – Hub
  - 5 min: Summary - Hub

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions

Main Question

Recommendation on engagement with psychiatry, residential treatment, and counseling.

Demographic Information

26 yr old, AA female, divorced, high school education, unstable employment at a restaurant/door dash, unstable housing due to financial issues, some support from parents, client identifies as bi-sexual

Background Information

- 6/20/20 client entered treatment reported seeking counseling related to managing past trauma and court ordered MH eval related to custody case
- Reported daily use of marijuana
- Past diagnosis of bi-polar, childhood trauma, physically abusive relationships, family history of alcohol issues, psychiatrically hospitalized 3x as adolescent and 2x as adult in 2018 and 12/2020
    - Diagnosis changed to PTSD chronic 7/2020 as MH symptoms appeared to be linked to trauma and personality DX to rule out
- Medical issues reported- HPV, Herpes simplex 1, with poor follow up for physicals, presents with pressured speech, tangential, and labile mood
- Past outpatient counseling services- not engaged since 2012
- Declined SA treatment, reported only using marijuana
- Voluntarily gave up custody, allowed visitation, struggling with on/off relationship she identified as toxic
- Was working on emotional management, coping skills and life stability with counselor
- She appeared to need higher level of care and PHP recommended but declined, patient did not want to commit

Background Information Continued

- Linked to internal psychiatry services, assessed to meet DX for PTSD, MDD, and rule out Narcissstic Personality disorder
- Past substance abuse revealed during eval to include during high school- Adderall (reports it was prescribed but she abused), mucinex, alcohol, weed, crack (2 days), opiates at one time
  - Cocaine use in attempt to overdose a couple of months prior
  - Current use of hallucinogens and marijuana
- Past history of opiate/heroin use by mother who used her to go to hospitals and fake injuries for pain killers
  - Removed from mother's home but returned a year later with her father
  - Mom continued to use throughout childhood and then she began to use in high school
- No medication was prescribed by psychiatrist at the time and client not interested in medication
- Client focused on past trauma, continued to have mood regulation issues becoming more severe
- Began having interpersonal issues at work, eating and sleeping were disturbed, increased anxiety, denial of other substance use besides marijuana, sporadic engagement with services
- Discharge summary revealed cocaine use for past 8 months, DX of bipolar I from hospital, medication was tried but discontinued due to not liking how it made her feel, she left AMA after TDO was released
- Engaged with therapist and denying need for SA treatment
- She wanted to work on trauma counseling but client is not stable enough for this work
- Clinician made several recommendations and referrals to SA inpatient and outpatient facilities with no follow up by client
- Currently client's phone is off and cannot be reached. Attempt to contact mother without success

Previous Interventions

Outpatient counseling- MI, CBT, DBT skills
Psychiatric
Inpatient Hospital
Referred/Recommended to:
PHP at Parham
Inpatient SA TX:
Galax
Bethany Hall

Outpatient SA TX:
MCAM
Pinnacle

Plan for future treatment

Re-engage client

Reminder: Main Question

Recommendation on engagement with psychiatry, residential treatment, and counseling.

Case Studies

- Case studies
  - Submit: www.vcuhealth.org/echo
  - Receive feedback from participants and content experts
  - Earn **$100** for presenting

Thank You

The success of our telehealth program depends on our participants and those who submit case studies to be discussed during clinics. We recognize the following providers for their contributions:

- **Ademola Adetunji, NP** from Fairfax County CSB
- **Tara Belfast-Hurd, MBA-PA** from Department of Behavioral Health and Developmental Services
- **Michael Bohan, MD** from Meridian Psychotherapy
- **Ramona Boyd, NP** from Health Wagon
- **Diane Boyer, DNP** from Region Ten CSB
- **Melissa Bradner, MD** from VCU Health
- **Kayla Brandt, B.S.** from Crossroads Community Service Board
- **Susan Cecere, LPN** from Hampton Newport News
- **Michael Fox, DO** from VCU Health
- **Shannon Garrett, FNP** from West Grace Health Center
- **Sharon Hardy, BSW, CSAC** from Hampton-Newport News CSB
- **Kara Howard, NP** from Southwest Montana Community Health Center
- **Sunny Kim, NP** from VCU Health
- **Heidi Kulberg, MD** from Meridian Health
- **Thokozeni Lipato, MD** from VCU Health
- **Caitlin Martin, MD** from VCU Health
- **Maureen Murphy-Ryan, MD** from AppleGate Recovery
- **Faisal Mohsin, MD** from Hampton-Newport News CSB
- **Stephanie Osler, LCSW** from Children's Hospital of the King's Daughters
- **Winona Pearson, LMSW** from Middle Peninsula Northern Neck CSB
- **Jennifer Phelps, BS, LPN** from Horizons Behavioral Health
- **Crystal Phillips, PharmD** from Appalachian College of Pharmacy
- **Jashanda Poe, MA** from Rappahannock Area CSB
- **Tierra Ruffin, LPC** from Hampton-Newport News CSB
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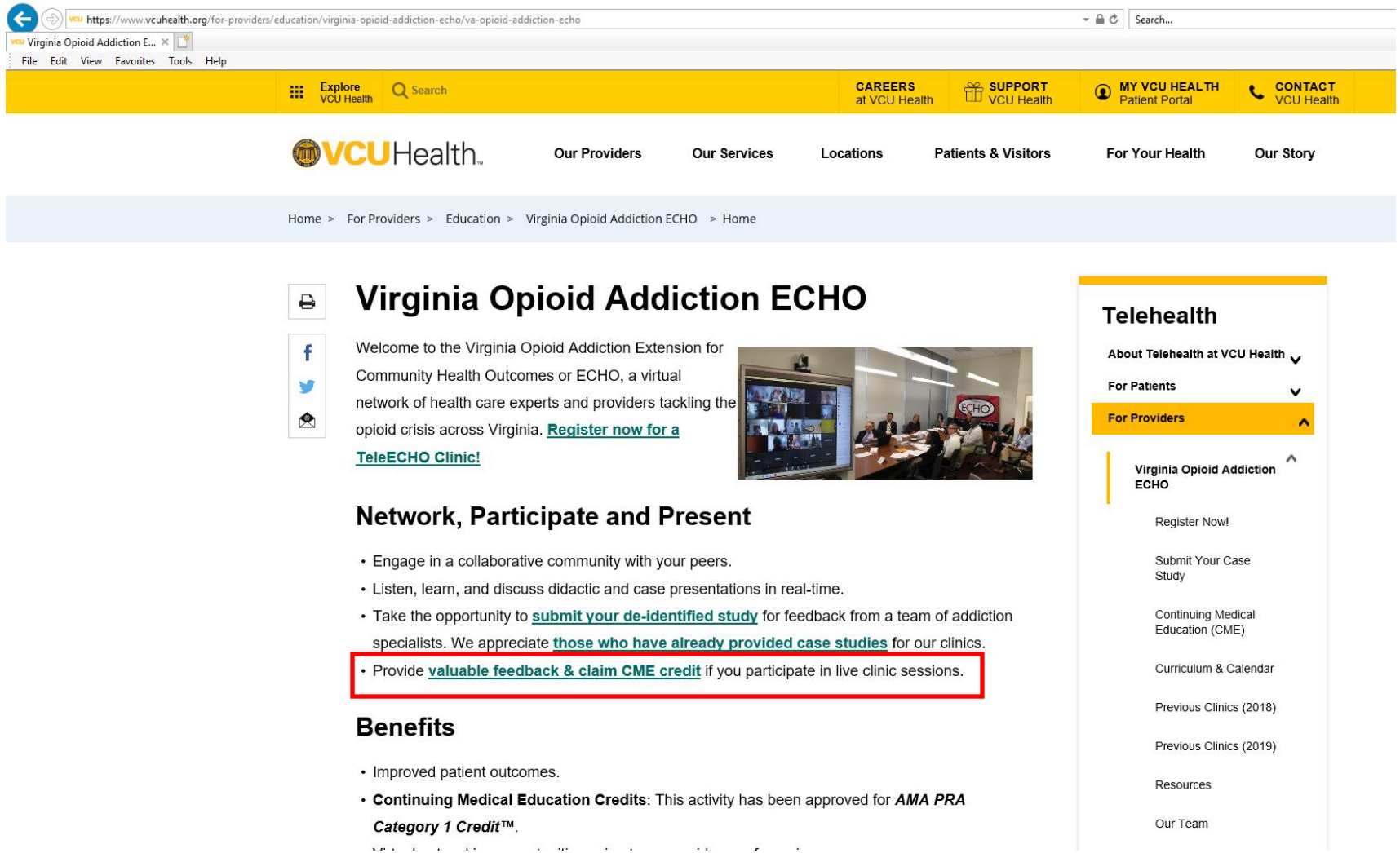
- **Daniel Spencer, MD** from Children's Hospital of the King's Daughters
- **Linda Southall, QMHP** from Alleghany Highlands CSB
- **Cynthia Straub, FNP-C, ACHPN** from Memorial Regional Medical Center
- **Saba Suhail, MD** from Ballad Health
- **Barbara Trandel, MD** from Colonial Behavioral Health
- **Bill Trost, MD** from Danville-Pittsylvania Community Service
- **Art Van Zee, MD** from Stone Mountain Health Services
- **Ashley Wilson, MD** from VCU Health
- **Sarah Woodhouse, MD** from Chesterfield Mental Health
- **Susan Mayorga, BA, CBIS** from Community Health Center of the New River Valley
- **Jordan Siebert, Peer Recovery Specialist** from Daily Planet Health Services

Claim Your CME and Provide Feedback

- www.vcuhealth.org/echo

- To claim CME credit for today's session
- Feedback
  - Overall feedback related to session content and flow?
  - Ideas for guest speakers?

Access Your Evaluation and Claim Your CME



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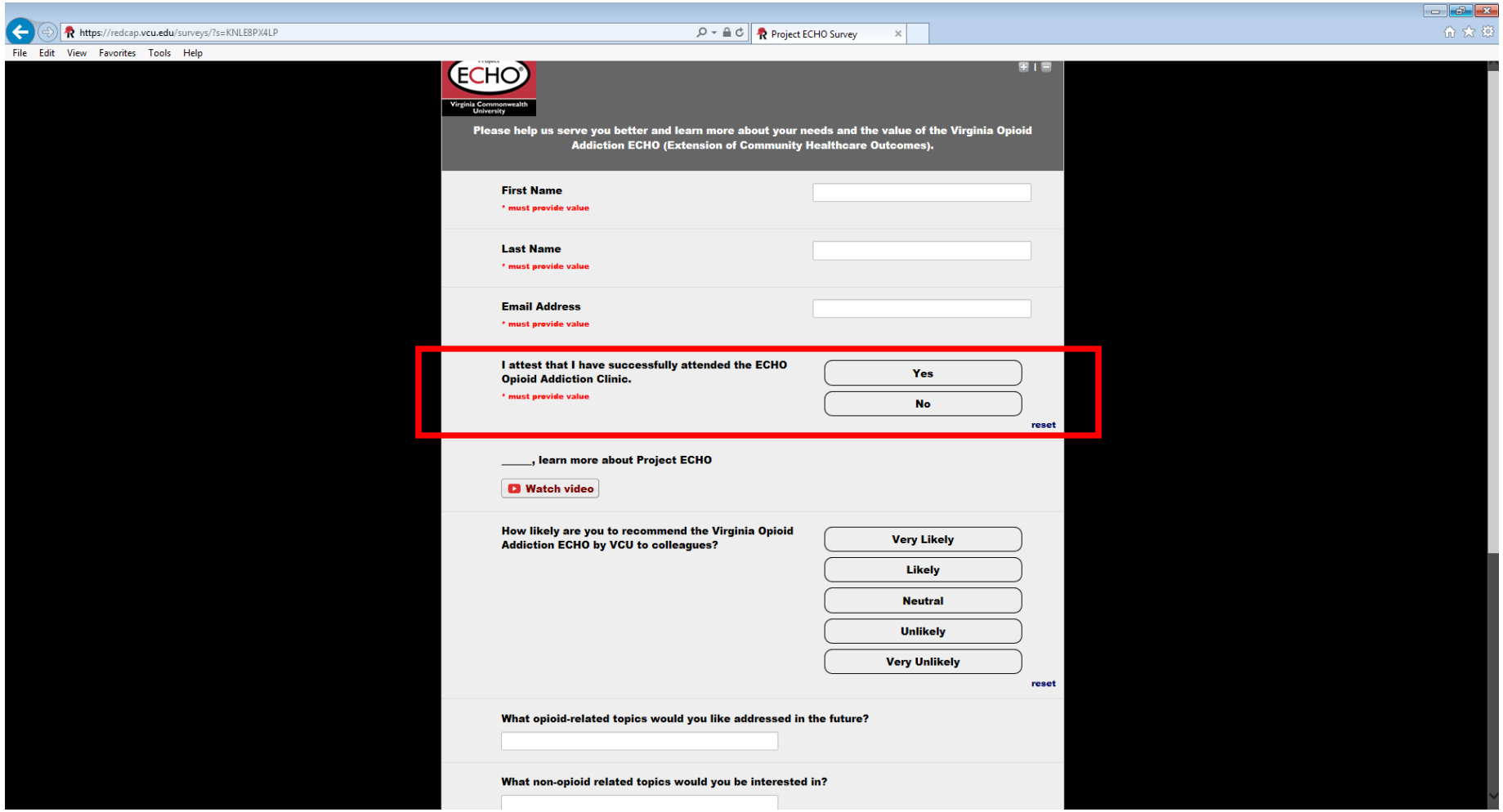


Access Your Evaluation and Claim Your CME

- www.vcuhealth.org/echo
  - To view previously recorded clinics and claim credit

Access Your Evaluation and Claim Your CME

Telehealth

- About Telehealth at VCU Health +
- For Patients +
- For Providers –
  - **Opioid Addiction ECHO** –
    - Register Now!
    - Submit Your Case Study
    - Continuing Medical Education (CME)
    - Curriculum & Calendar
    - Previous Clinics (2018)
    - Previous Clinics (2019)
    - Previous Clinics (2020)

Virginia Opioid Addiction ECHO

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

Network, Participate and Present

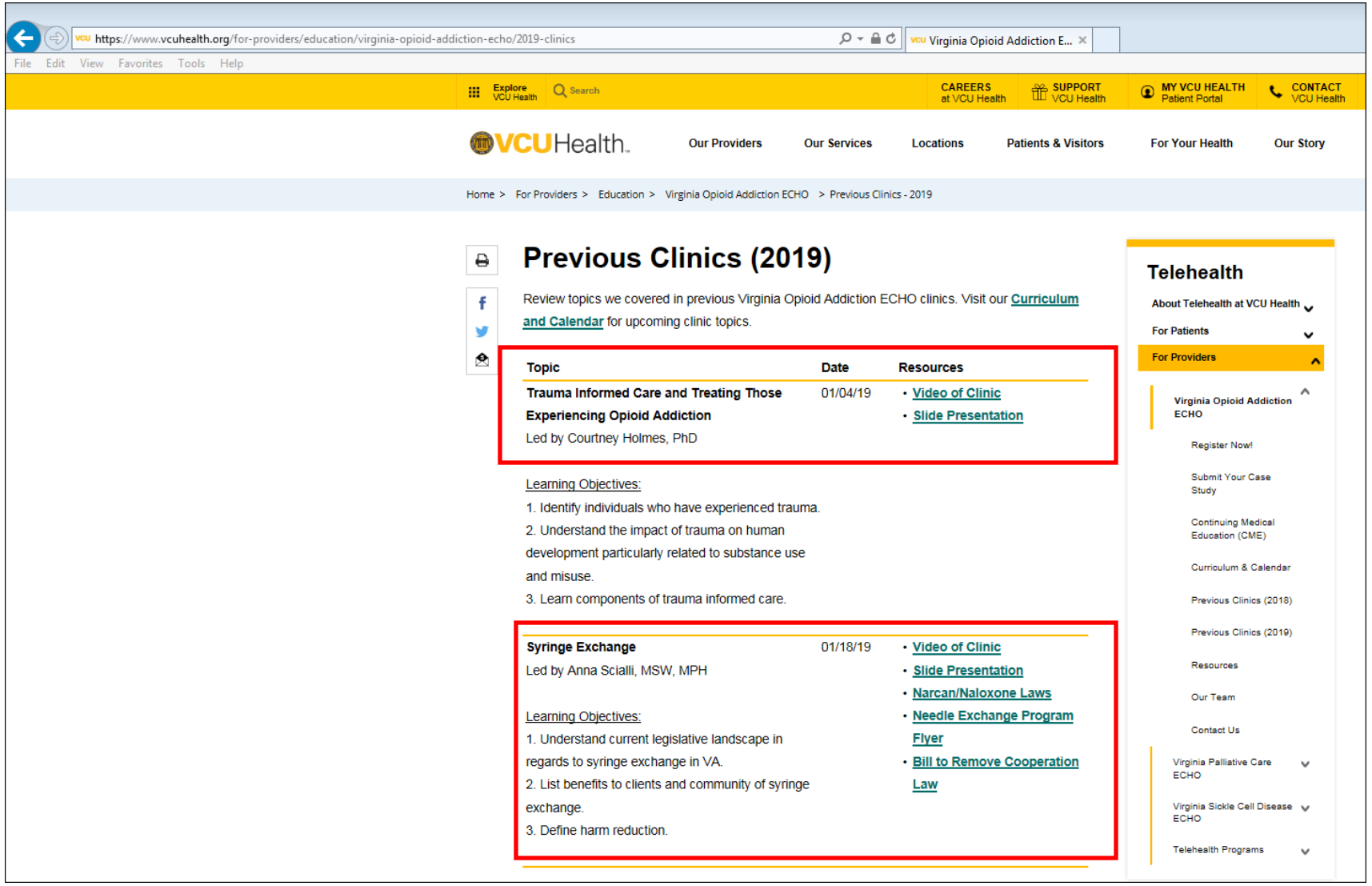
- Engage in a collaborative community with your peers.
- Listen, learn, and discuss didactic and case presentations in real-time.
- Take the opportunity to submit your de-identified study for feedback from a team of addiction specialists. We appreciate those who have already provided case studies for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

Benefits

- Improved patient outcomes.
- **Continuing Medical Education Credits**: This activity has been approved for ***AMA PRA Category 1***

? Need help

Access Your Evaluation and Claim Your CME



VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

Mark Your Calendar --- Upcoming Sessions

Feb. 26: Virginia Drug Court System — Melanie Meadows, Chesterfield Drug Court

March 12: COVID and Recovery, Panel Discussion — Thomas Bannard, Omri Morris, Raymond Barnes

Please refer and register at vcuhealth.org/echo

Project ECHO®
Virginia Commonwealth University

THANK YOU!

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions

VCU