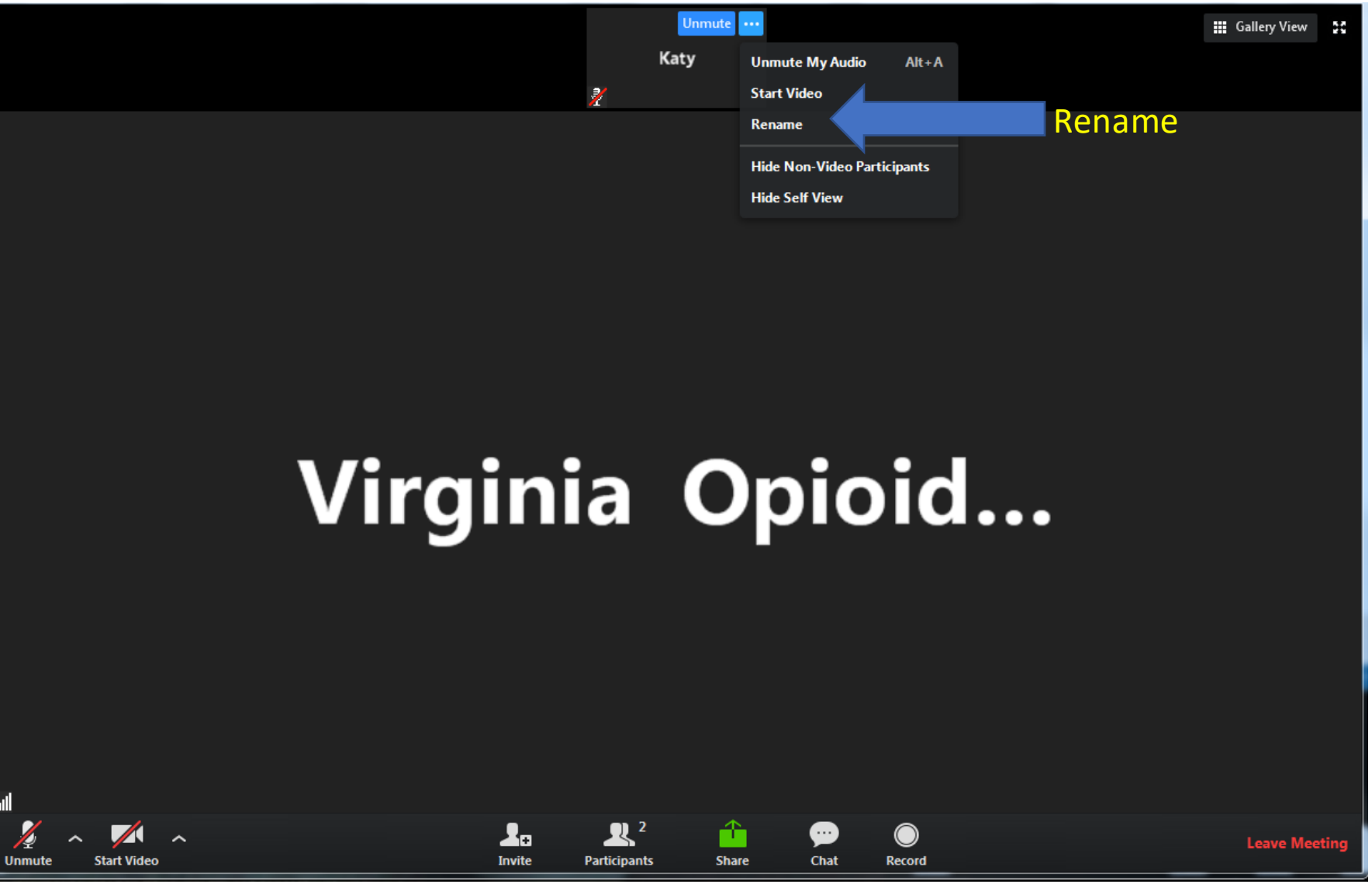
Virginia Opioid Addiction ECHO* Clinic

November 5, 2021

*ECHO: Extension of Community Healthcare Outcomes

Helpful Reminders



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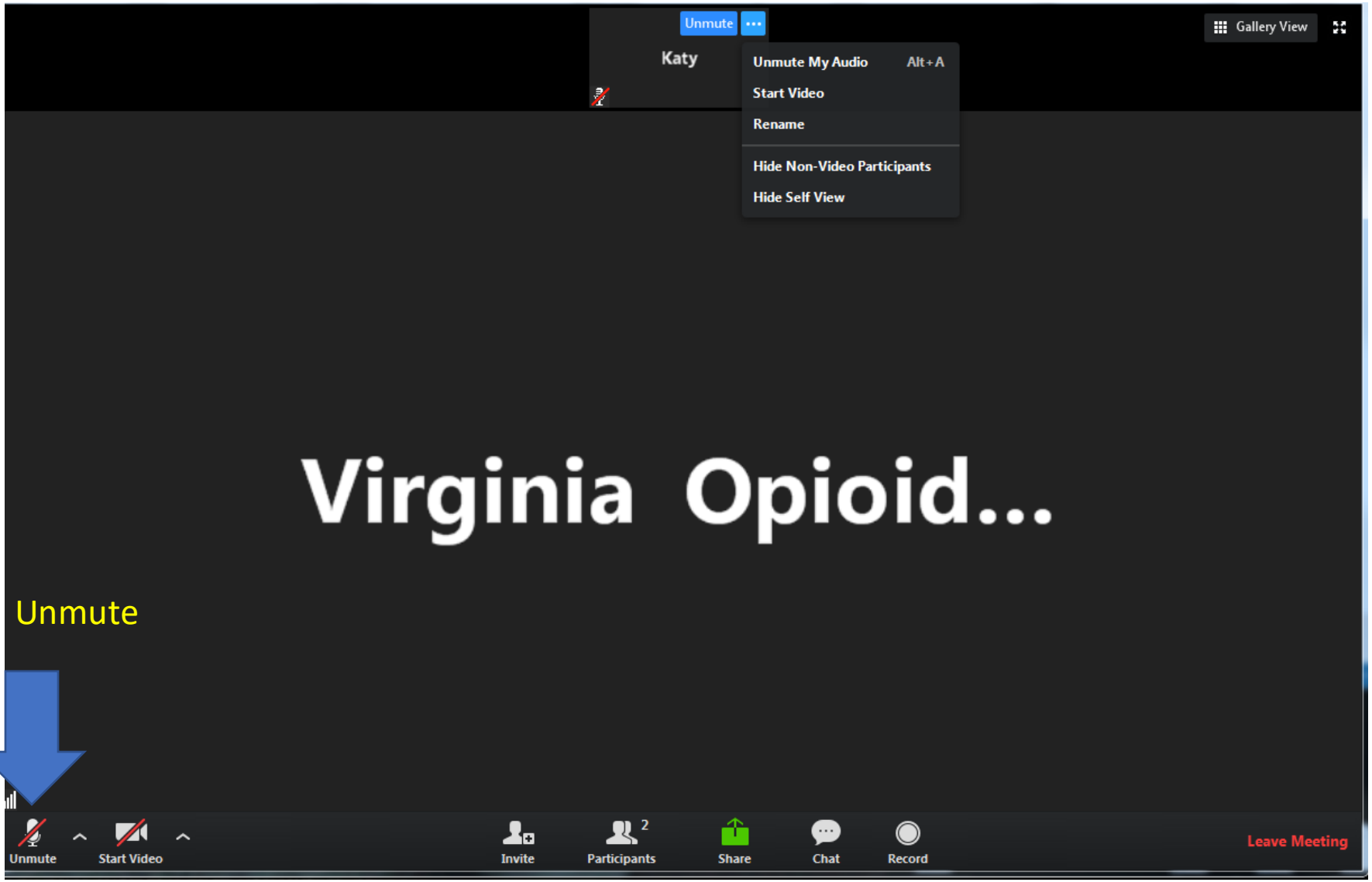
Helpful Reminders



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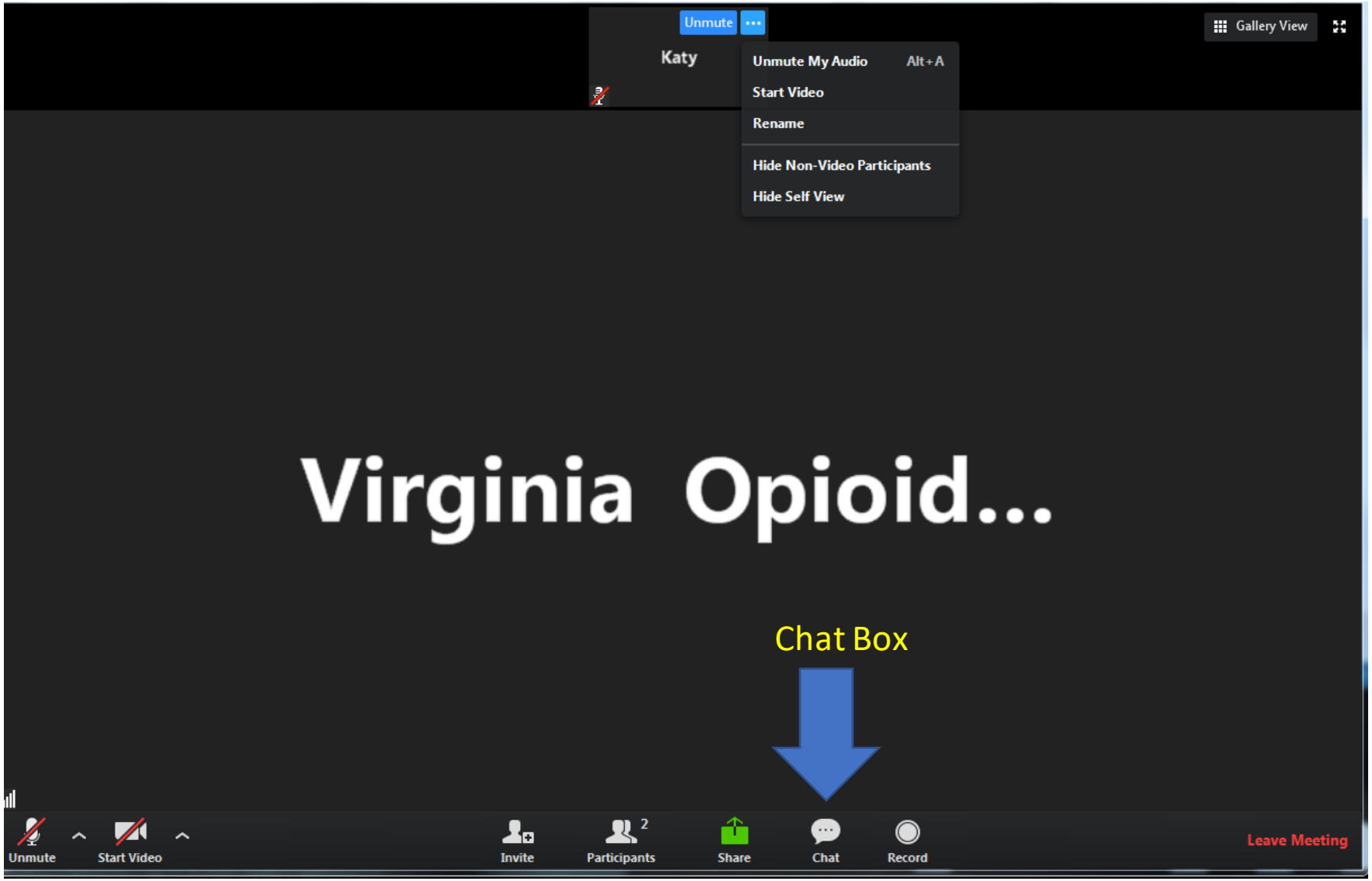
- If joining by telephone audio only, *6 to mute and unmute

Helpful Reminders



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- 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 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 Katie Adams, PharmD
Didactic Presentation	Morgan Reid, MS, PhD
Program Manager	Bhakti Dave, MPH
Practice Administrator	Tamera Barnes, MD
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. **Morgan Reid, MS, 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

Morgan Reid, MS, PhD has no financial conflicts of interest to disclose.

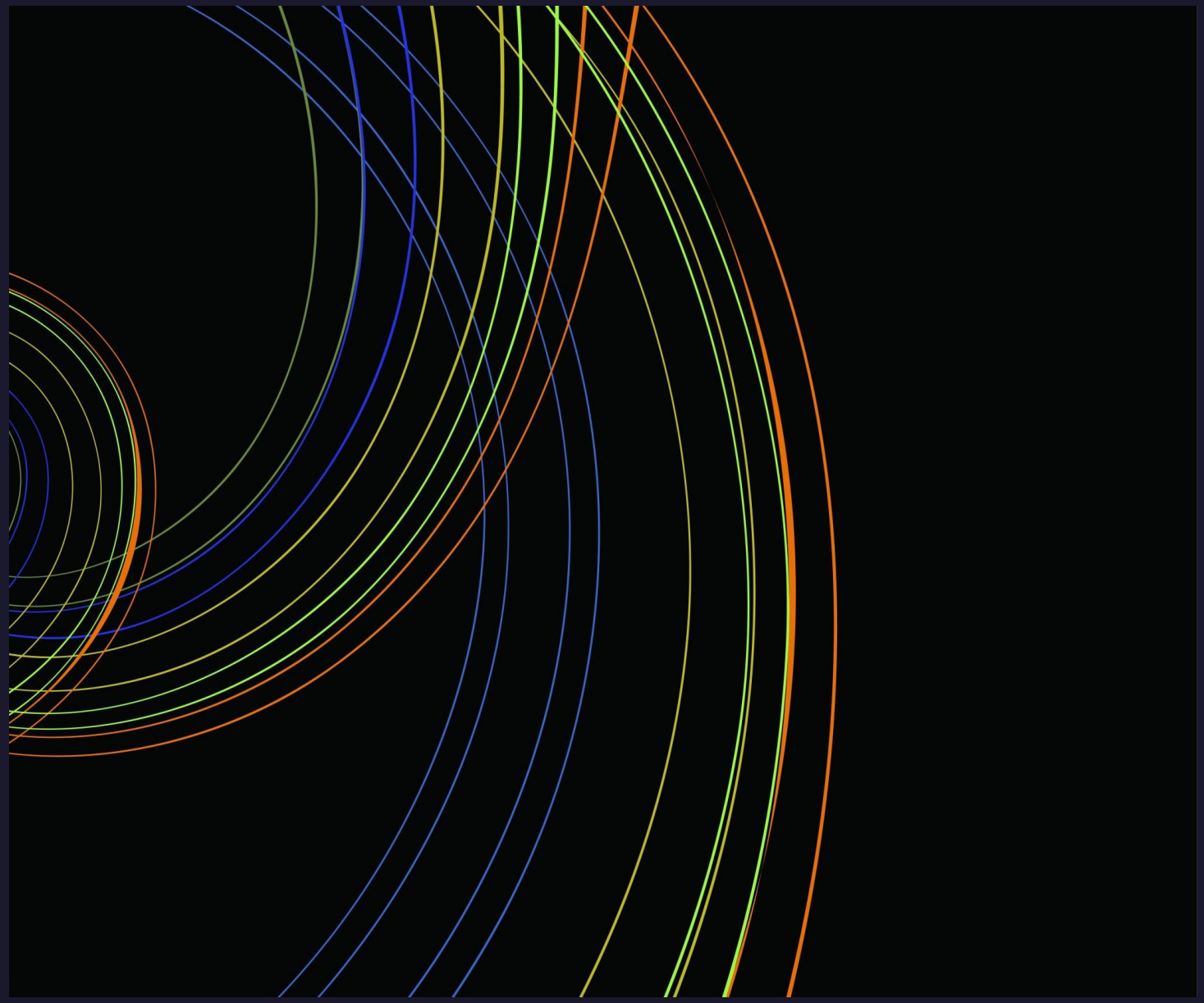
There is no commercial or in-kind support for this activity.

Treating Insomnia in Patients with OUD

Morgan Reid, M.S.

Counseling Psychology Doctoral Student

Virginia Commonwealth University



Learning Objectives

- I. Explain the relationship between chronic opioid use, acute withdrawal, and sustained abstinence (recovery) and sleep
- II. Know the consequences of poor sleep, particularly for individuals with OUD
- III. Become familiar with insomnia assessment techniques that can be integrated into a healthcare setting
- IV. Understand the basis of non-pharmacological insomnia treatment

Relationship between OUD and Sleep

Diagnostic Criteria for Insomnia[1]

- **Insomnia Disorder (G47.00)**
- A. A predominant complaint of dissatisfaction with sleep quantity or quality, associated with one (or more) of the following symptoms, that are present for at least 3 months
  - 1. Difficulty initiating sleep
  - 2. Difficulty maintaining sleep, characterized by frequent awakenings or problems returning to sleep after awakenings.
  - 3. Early-morning awakening with inability to return to sleep.
- B. The sleep disturbance causes clinically significant impairment in social, occupational, educational, academic, behavioral, or other important areas of functioning.
- C. The sleep difficulty occurs at least 3 nights per week.
- D. The sleep difficulty occurs despite adequate opportunity for sleep.

Diagnostic Criteria for Insomnia (cont.)[1]

- E. The insomnia is not better explained by and does not occur exclusively during the course of another sleep-wake disorder (e.g., narcolepsy, a breathing-related sleep disorder, a circadian rhythm sleep-wake disorder, a parasomnia).
- F. Coexisting mental disorders and medical conditions do not adequately explain the predominant complaint of insomnia.
- G. The insomnia is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication).

Chronic Opioid Use + Sleep

- Disrupts sleep architecture[2]
  - Shortened slow-wave sleep
  - Reduced REM sleep
- Reduction in sleep efficiency[2]
- Worse perceived sleep quality, daytime sleepiness[3]
- Respiratory depression → central sleep apnea, objective sleep apnea[2]

Acute Withdrawal and Sleep

- Initially gets worse before it gets better[4]
  - Substances were treating pre-existing sleep disturbance[5]
  - Some shared genetic basis of circadian disruption + oversensitivity of dopaminergic pathway[6]
- Following complete detoxification…[7]
  - Lower sleep duration
  - Longer sleep latencies
  - More awakenings
  - Worse perceived sleep quality

Sustained Abstinence (Recovery)

- Patients with MOUD (> 1 month) had significantly poorer sleep than opioid naïve patients, although sleep does slightly improve over course of treatment[8]
  - **40.0% of patients with MOUD classified as "poor sleepers" vs. 30.8% of opioid-naive patients**
- At initiation of MOUD, 60.5% diagnosed with insomnia; only decreased to 55.4% following one year of treatment[9]
- Patients with MOUD less likely to have sleep problems than non-MOUD opioid dependence[10]
  - **87.7% non-MOUD classified as "poor sleepers" vs. 78.5% MOUD**
- Correlates of continuous sleep problems: higher MOUD dose; psychiatric comorbidity; pain; use of nicotine, cannabis, hypnotics, benzodiazepines[11]

Consequences of Poor Sleep

Global Consequences of Untreated Insomnia

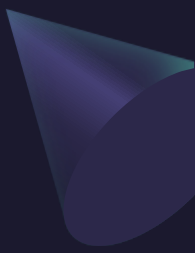
- Poor sleep associated with
  - Increased risk of obesity, diabetes, heart attack, stroke, coronary artery disease12
  - Poorer immune system functioning[13]
  - Greater mortality[14]
  - Impairments in working memory, attention, abstract problem-solving, attentional set shifting[15]
  - Increased risk of mood disorders[16]

OUD-Specific Consequences of Untreated Insomnia

- Sleep disturbances significantly related to recurrence
  - For AUD: 1% increase in sleep-onset latency associated with 2.4% increase in likelihood of recurrence[17]
  - 29.8% of patients with MOUD reported that they might use again to cope with sleep problems[18]

- Poor sleep associated with riskier decision-making, emotional instability– risk factors for recurrence[19]

Assessment



Questionnaires

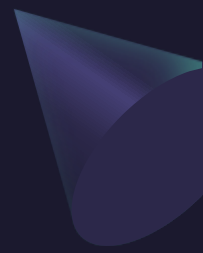
- Insomnia Severity Index
- Pittsburgh Sleep Quality Index
- Epworth Sleepiness Scale

Sleep Diary

Sample

Today's Date	4/5/08							
1. What time did you get into bed?	10:15 p.m.							
2. What time did you try to go to sleep?	11:30 p.m.							
3. How long did it take you to fall asleep?	55 min.							
4. How many times did you wake up, not counting your final awakening?	6 times							
5. In total, how long did these awakenings last?	2 hours 5 min.							
6a. What time was your final awakening?	6:35 a.m.							
6b. After your final awakening, how long did you spend in bed trying to sleep?	45 min.							
6c. Did you wake up earlier than you planned?	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6d. If yes, how much earlier?	1 hour							
7. What time did you get out of bed for the day?	7:20 a.m.							
8. In total, how long did you sleep?	4 hours 10 min.							
9. How would you rate the quality of your sleep?	☐ Very poor ☑ Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐ Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐ Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐ Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐ Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐ Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐ Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐ Poor ☐ Fair ☐ Good ☐ Very good

Treatments



Pharmacological Treatments for Insomnia in OUD

- Nonpharmacological treatments preferred[20]
- Dietary supplements[21]
  - Valerian: mixed evidence
  - Melatonin: some evidence suggesting useful for chronic insomnia
- Ramelteon & Doxepin = only unscheduled medications approved by FDA for insomnia
  - Some evidence of effectiveness for individuals in recovery[22]

Cognitive Behavioral Therapy for Insomnia (CBTi)[23]

- **Sleep Hygiene Education**
  - Screen Time: Turn off TV's, computers, phones, tablets 1 hour before bed
  - Caffeine: Avoid caffeine 6-8 hours before bed
  - Nicotine & Alcohol: Limit use, avoid before bed
  - Regular Exercise: at least 20 minutes each day, not within 2 hours of bedtime
  - Hot Baths: 20 minutes in a hot bath an hour or two before bedtime
  - Bedroom Environment: cool, dark, quiet, clocks out of sight
  - Avoid/Limit Naps
  - Stick to a Regular Sleep Schedule

Cognitive Behavioral Therapy for Insomnia (CBTi)[23]

- **Stimulus Control**
  - Brain needs to make an association between bed and sleep
  - Go to bed only when sleepy
  - Not doing anything from bed besides sleep and sex
  - Getting out of bed during nighttime awakenings
  - Wake up at a regular time regardless of how long/well you slept

Cognitive Behavioral Therapy for Insomnia (CBTi)[23]

- **Cognitive Restructuring**
    - Challenging unhelpful thoughts about sleep (e.g., “If I can’t get a good night’s sleep, my day tomorrow will be shot.”

- **Relaxation Techniques**

Resources

- Behavioral Sleep Medicine provider directory
- Web Resources:
  - Relaxation:
    - https://positivepsychology.com/progressive-muscle-relaxation-pmr/
    - https://www.uofmhealth.org/health-library/uz2209
  - Sleep Health Tips:
    - https://www.sleepfoundation.org/sleep-hygiene/relaxation-exercises-to-help-fall-asleep
    - https://www.cdc.gov/sleep/about_sleep/sleep_hygiene.html
    - https://www.sleepfoundation.org/sleep-hygiene
- Apps: Headspace, Calm, Sanvello, CBT Coach

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Questions?

Case Presentation #1
Heidi Kulberg, 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
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Use chat function for questions

Main Question

Rxs: Would it be appropriate to add bupropion and increase frequency of Vivitrol to attempt to address her newly diagnosed cocaine use disorder? How would that alter the medications currently being used for her bipolar? Are there other rxs to address the truly polysubstance nature of her disorders?
Behavioral: What are the best therapies for persons with such a varied range of polysubstance use? What am I missing?

Demographic Information

EB is a 24 yo cisgender Caucasian female who had spent the last 4 months living with her boyfriend (who deals drugs) but has recently returned to her parents' home where she was initially living when she entered treatment in December 2020. She earned her GED in 2019; had left high school when she turned 18 because "I feel in love"; that relationship became abusive, and she left him. Has been working as a waitress in a sushi restaurant. During treatment, she was accepted to a medical assistant program that she was to start in September 2021; she withdrew before it began as she relapsed with multiple substances when she returned to her prior boyfriend. Her parents are her primary source of support. She is on Medicaid and is enrolled in the ARTS program.

Background Information

EB presented to clinic in December 2020 seeking help for "my drinking problem/addiction to smoking weed".
*Alcohol use disorder: First drink age 9, with first drunk age 13. H/o drinking up to a gallon of liquor a day for 6 years. Recurrent hospitalization for pancreatitis in 2020; at least 5 times. Underwent detox x 2 in 2020. Was admitted to Life Center of Galax for residential care in Dec. 2020 though was medically discharged after 3 days due to severe nausea/vomiting. Initiated naltrexone in Dec. 2020; initially oral then IM Vivitrol. Has been relatively consistent with use for the past 10 months. Last drink 12/2/2020.
*Cannabis use disorder: First use age 12 and has used daily since then. Reports it "calms" her and believes it helps reduce her extreme nausea, vomiting and anxiety. Over her 10 months of treatment, she had decreased from smoking every hour (>3 grams a day) while awake to < 1 gram a day. Within past month, has increased back up to initial usage as compensation for trying to stop all other substances abruptly.
*Cocaine use disorder: on initial presentation (12/16/2020) she reported a distant h/o use. In late August, she began dating an ex-boyfriend who deals substances and relapsed with cocaine, ketamine, mushrooms, and various prescriptions (Seroquel, Xanax, Adderall, Valium). Unable to provide exact amounts of substances but has been utilizing them all multiple times a week when she moved back in with him. At most recent visit on 10/14/21, she had just been seen by ENT who told her she will need surgery for her perforated septum that is a result of her cocaine use. Reports last using on 10/10/2021 when she moved back in with her parents.
All mental health disorders have been diagnosed in 2021 as she shared her parents "do not believe in mental health disorders" so she was never taken to be evaluated before. She is under the care of a MH-NP who used to work with our practice.
*Bipolar
*PTSD/trauma
*ADHD
*Anxiety

Background Information

PMHx:
*Pancreatitis: Hospitalized over 5 times in 2020. Denies ICU or intubation. Mother has h/o pancreatitis that is supposedly not related to alcohol use.
*Chronic nausea with intermittent extreme emesis: Pt has undergone extensive GI work-up and per pt none of the results have been positive, thus etiology is unknown. Certain foods and restaurants exacerbate it; she avoids these.
*Seizure- single event after "huffing too much nitrous oxide" age 20.

Medications:
*Vivitrol 380 mg IM
*Buspar 15 mg bid
*Abilify 10 mg qd
*Gabapentin 300 mg 1 qam and afternoon, 2 qhs
*Strattera 25 mg qd
*Promethazine 25 mg tid prn N
*Zofran 8 mg qd prn N
*Propranolol 10 mg tid prn anxiety

Labs: Her most recent UDSs have been negative for EG and ES but positive for cannabis and numerous other substances to include cocaine, amphetamine, methamphetamine (which she denies using and thinks is showing up as an additive in the Adderall they were getting from China), and MDMA.

Previous Interventions

EB is currently being treated by myself (Addiction Medicine), a MH-NP, and a LCSW therapist with over 30 years of experience. When she is consistent with treatment, she sees the therapist weekly and each prescriber monthly.
She has been intermittently engaged with AA over the past 10 months. She was initially very active for 2-3 months with a sponsor and regular meetings. Then she stopped as was still smoking pot and felt guilty. She has reengaged over the past week with 5 meetings in past week and she found a new sponsor.
She has attended our practice's Healthy Recovery weekly group 29 times in the past 10 months. The Healthy Recovery group is for persons with various SUDs, primarily persons with AUD, facilitated by a LCSW.
She does not have a consistent PCP so there has not been one to coordinate with regarding her specialty consultations (GI, ENT).

Plans for Future Treatment/ Patient's Goal

EB would like to cease using any substances of abuse. She would like to pursue a career, e.g. medical assistant. She would like her bipolar to be stable and to no longer have any nausea.

Other Information

EB has amazingly maintained abstinence from alcohol for 10 months despite continued use of cannabis and relapse with numerous substances when she rekindled relationship with an old boyfriend. She believes Vivitrol is the reason she has stayed sober from alcohol.

Reminder: Main Question

Rxs: Would it be appropriate to add bupropion and increase frequency of Vivitrol to attempt to address her newly diagnosed cocaine use disorder? How would that alter the medications currently being used for her bipolar? Are there other rxs to address the truly polysubstance nature of her disorders?
Behavioral: What are the best therapies for persons with such a varied range of polysubstance use? What am I missing?

Case Studies

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

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
- **Candace Fletcher, PharmD Candidate** from Hopkins Medical Association
- **Susan Cecere, LPN** from Hampton Newport News
- **Kimberly Dexter, DNP** from Hampton Newport News CSB
- **Candace Fletcher, PharmD** from Hopkins Medical Association
- **Michael Fox, DO** from VCU Health
- **Shannon Garrett, FNP** from West Grace Health Center
- **LaShawna Giles, MSW** from Hampton Newport News CSB
- **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
- **Jennifer Melilo, FNP** from Chesapeake Integrated Behavioral Health
- **Dawn Merritt, QMHP** from Eastern Shore CSB
- **Maureen Murphy-Ryan, MD** from AppleGate Recovery
- **Faisal Mohsin, MD** from Hampton-Newport News CSB
- **Jeromy Mullins, PharmD Candidate** from Hopkins Medical Association
- **Stephanie Osler, LCSW** from Children's Hospital of the King's Daughters
- **Davina Pavie, QMHP** from Hanover County CSB
- **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
- **Manhal Saleeby, MD** from VCU Health Community Memorial Hospital
- **Jenny Sear-Cockram, NP** from Chesterfield County Mental Health Support Services
- **Elizabeth Signorelli-Moore, LPC** from Region 1 CSB
- **Amber Sission, QMHP** from Eastern Shore CSB
- **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
- **Michelle Tanner, LPC** from Hanover County CSB
- **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?

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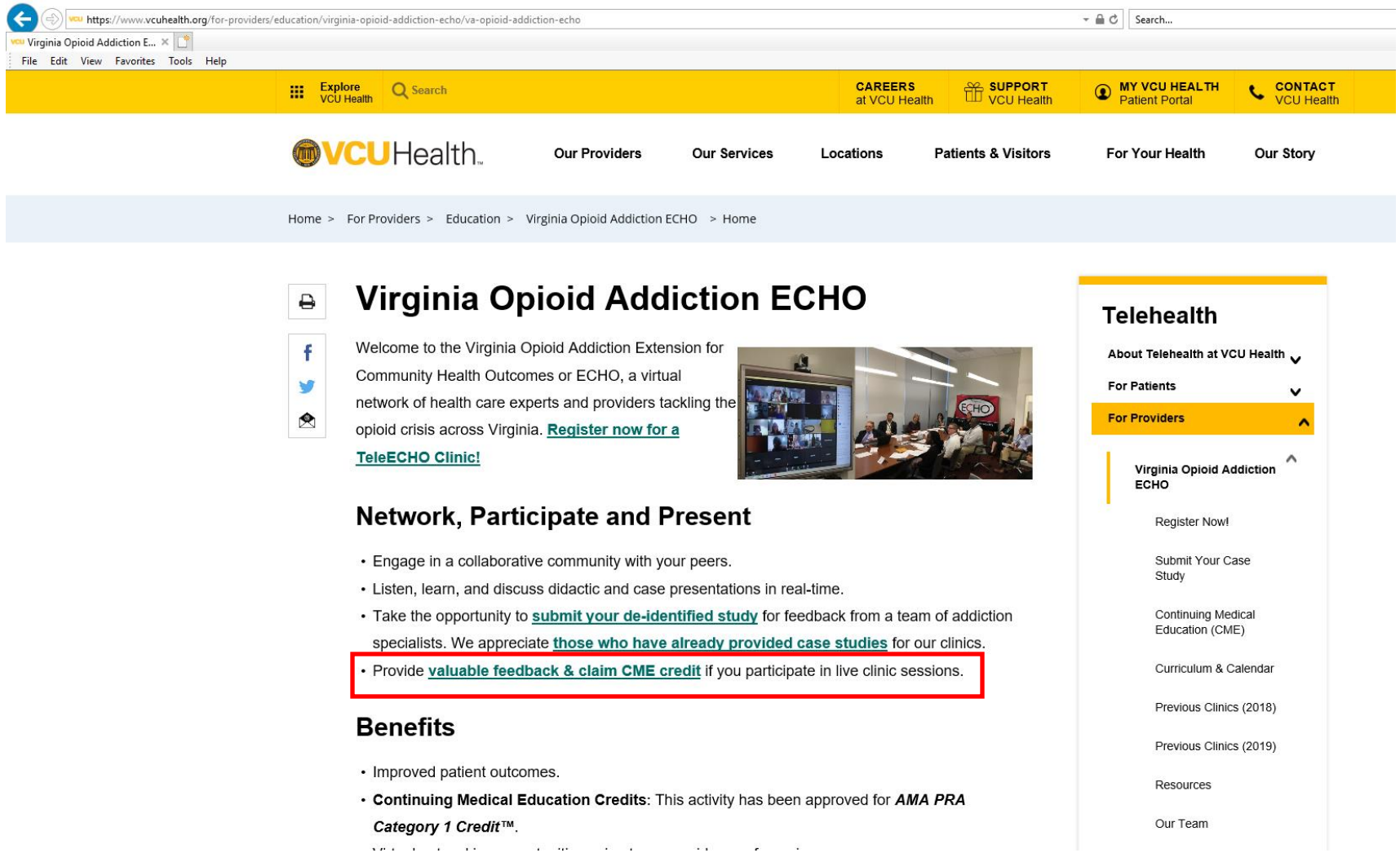

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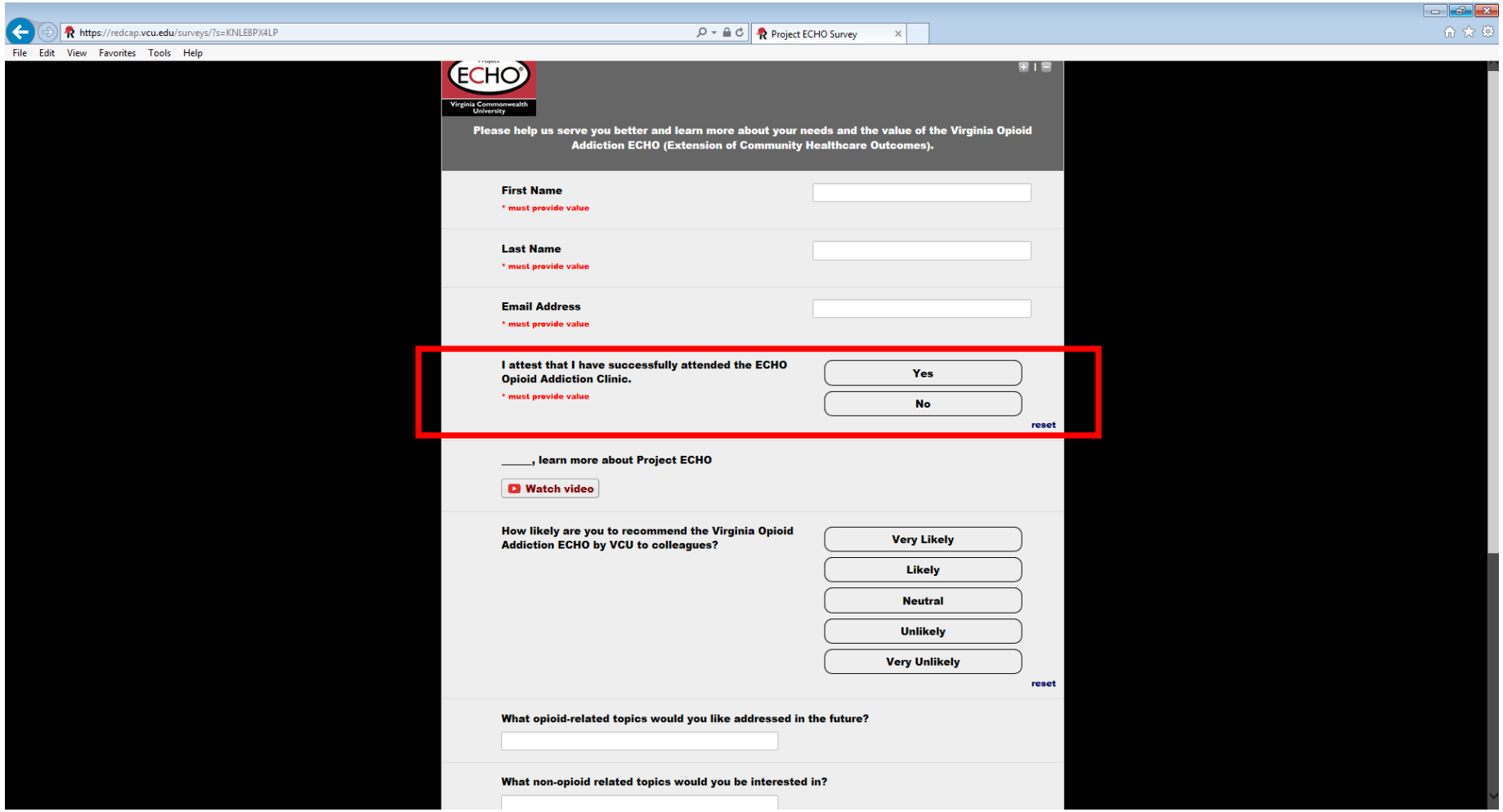

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  - To view previously recorded clinics and claim credit

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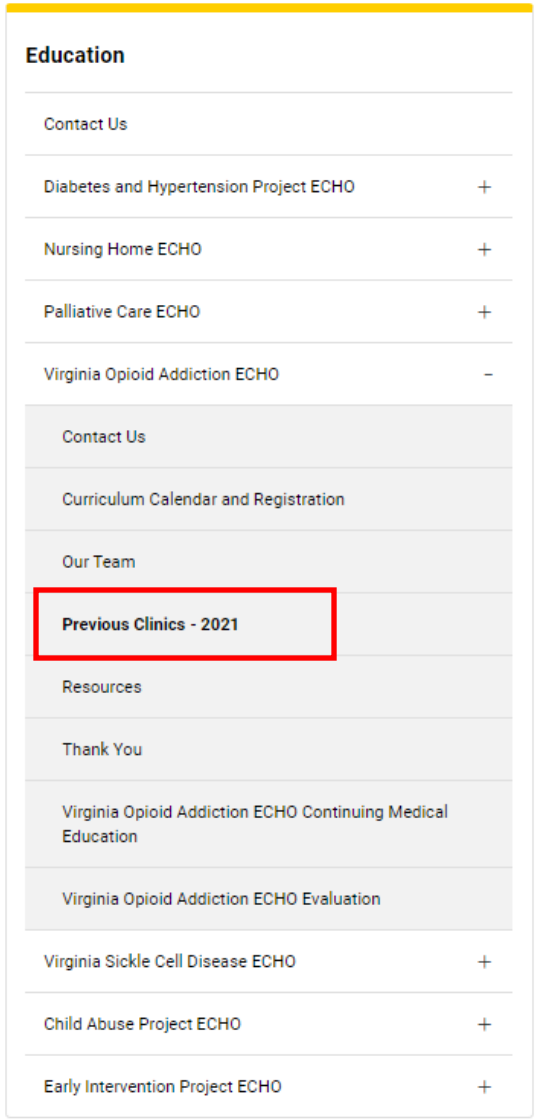

Previous Clinics - 2021

Review topics we covered in previous Virginia Opioid Addiction ECHO clinics.

January 15, Buprenorphine Taper
Presented by Masaru Nishiaoki, MD

- View Presentation
- View Video

January 29, Panel Discussion: COVID and Chronic Conditions
Panelists: Albert Arias, MD, Alex Krist, MD and Katherine Rose, MD

- View Presentation
- View Video

February 12, Grief Impacting Recovery
Presented by Courtney Holmes, PhD

- View Presentation
- Video Video

February 26, Virginia Drug Court System
Presented by Melanie Meadows

- View Presentation
- View Video

March 12, COVID and Recovery: Panel Discussion
Presented by Tom Bannard, MBA Omri Morris, CPRS Raymond Barnes, CPRS Erin Trinh, CPRS

- View Presentation
- View Video

March 26, Effects of Pharmacology on Cognitive Function
Presented by Gerry Moeller, MD

- View Presentation
- View Video
- View Resource

April 9, PropER Clinic and SUD Virtual Bridge Clinic: Linking Patients from ED to PCP and SUD Care
Presented by Taruna Aurora, MD and Brandon Wills, MD

- View Presentation
- View Video

VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

Mark Your Calendar --- Upcoming Sessions

Nov. 16	New X Waiver Guidelines	TBD
Dec. 3	Treating Co-Occuring Stimulant Use Disorder in OUD	TBD
Dec. 17	Buprenorphine Microdose Induction	Katie Adams, Pharm D David Ryan, MD

Please refer and register at vcuhealth.org/echo

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