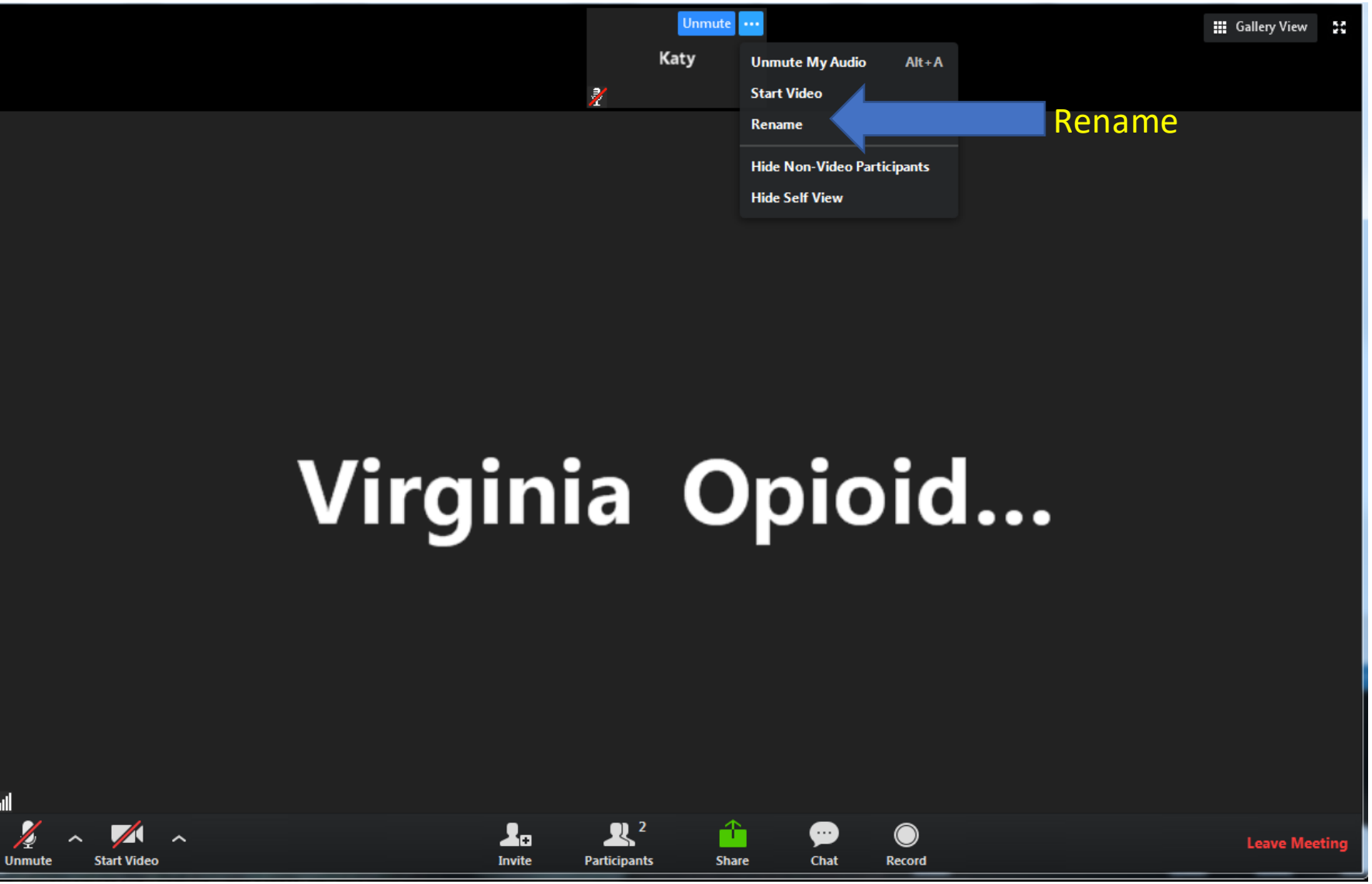
Virginia Opioid Addiction ECHO* Clinic

October 21, 2022

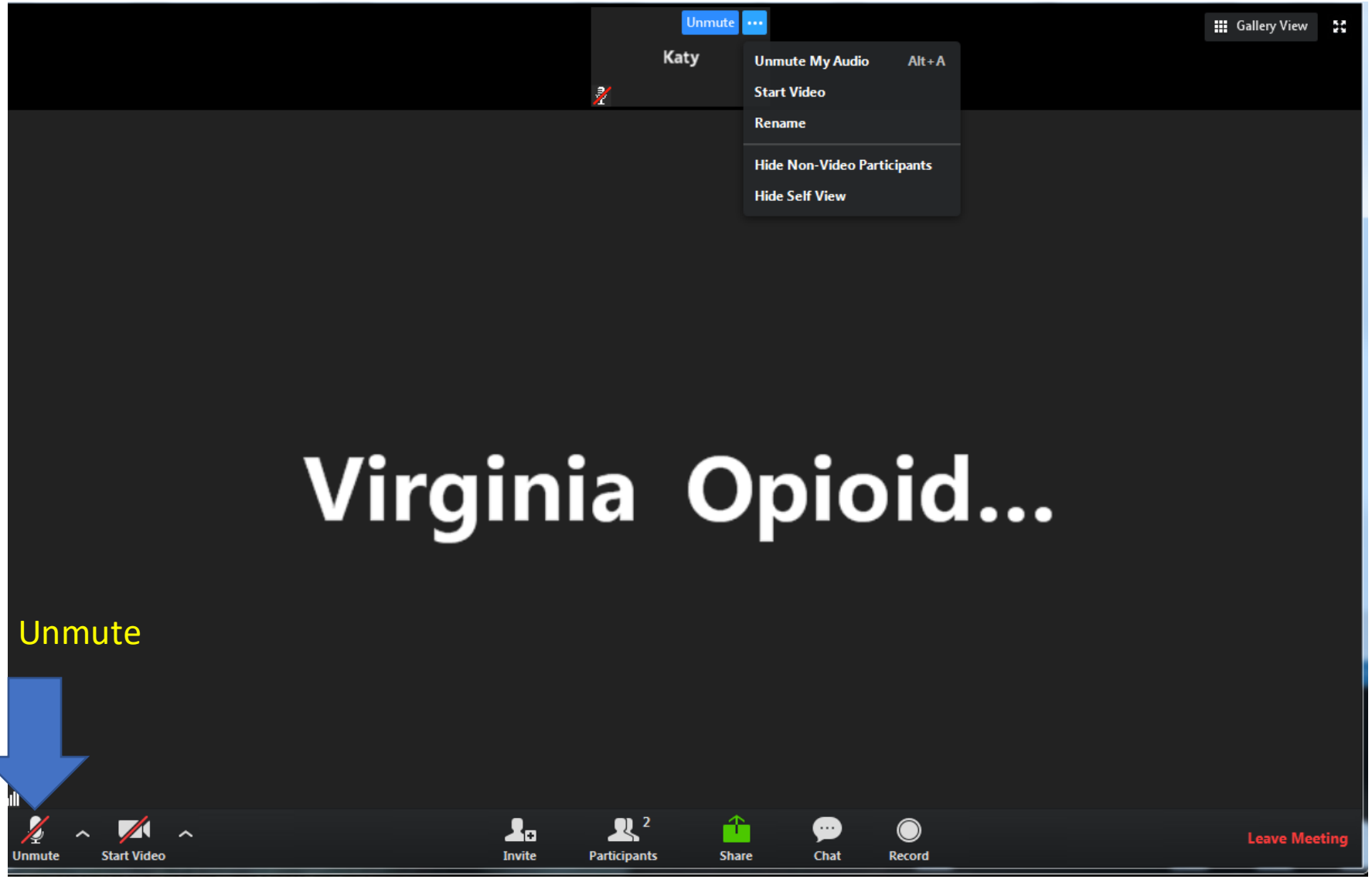
*ECHO: Extension of Community Healthcare Outcomes

Helpful Reminders



- Rename your Zoom screen, with your name and organization

Helpful Reminders



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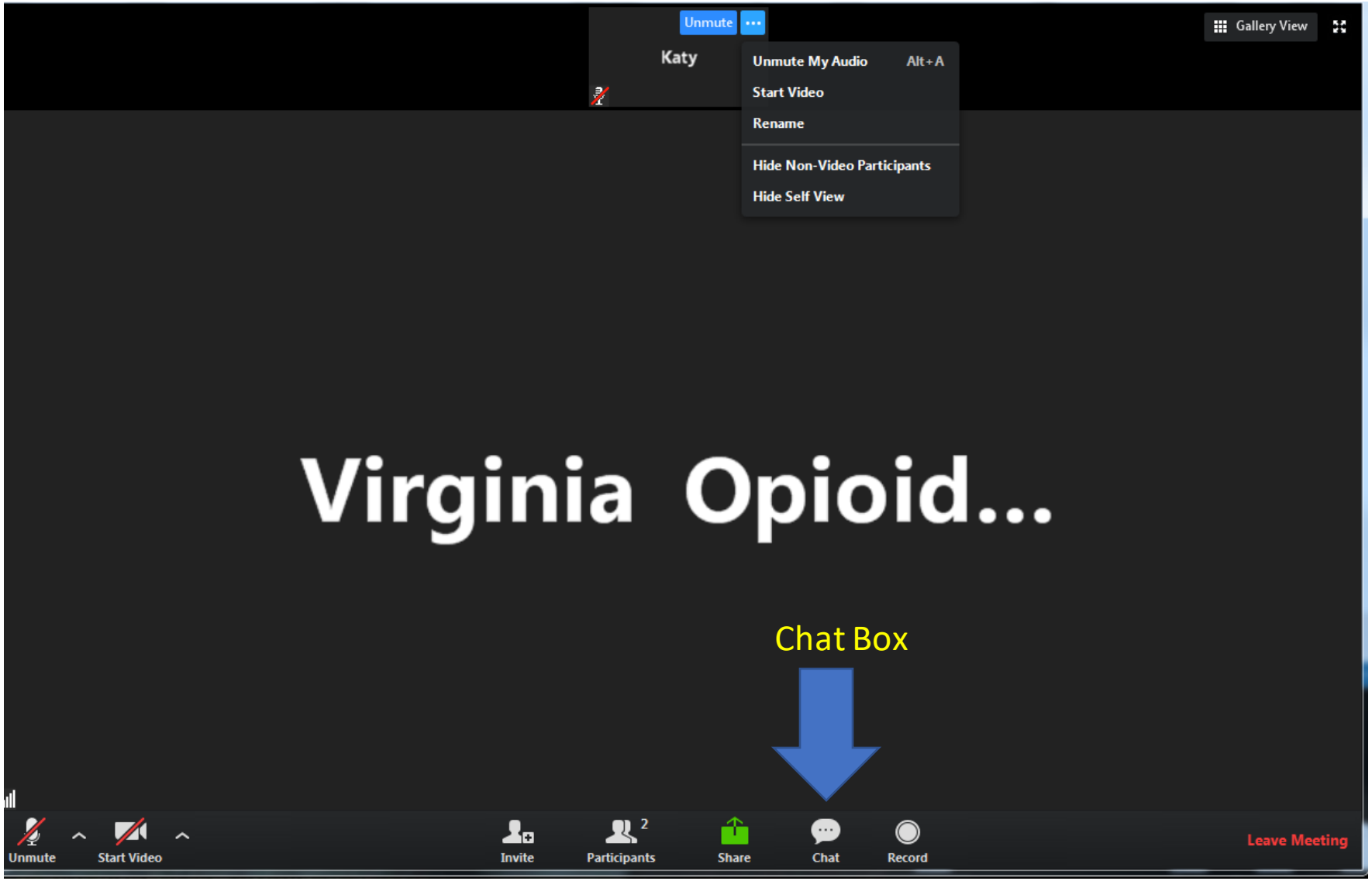
- If joining by telephone audio only, *6 to mute and unmute

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 hour teleECHO Clinics
- Every teleECHO clinic includes a 30 minute didactic presentation followed by case discussions
- Didactic presentations are developed and delivered by interprofessional experts
- Website Link: www.vcuhealth.org/echo

Hub and Participant Introductions

VCU Team	
Clinical Director	Gerard Moeller, MD
Administrative Medical Director ECHO Hub	Gerard Moeller, MD
Clinical Experts	Lori Keyser-Marcus, PhD Courtney Holmes, PhD Albert Arias, MD Megan Lemay, MD
Didactic Presentation	Brandon Wills, DO
Subject Matter Expert	Albert Arias, MD
Program Manager	Leslie Bobb, MPH
Senior Program Coordinator	Lillie Lattimore, MA

- 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. **Brandon Wills, DO**
II. Case presentations
    I. Case 1
        I. Case summary
        II. Clarifying questions
        III. Recommendations

III. Closing and questions

Lets get started!

Didactic Presentation

Disclosures

Brandon Wills, DO has no financial conflicts of interest to disclose.

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

Harm Reduction:
ED Take-home Naloxone

Brandon Wills, DO, FACEP, FAACT
Professor, Addictions Division
Department of Psychiatry & Emergency Medicine
Medical Director, MOTIVATE Clinic
Fellowship Director, Medical Toxicology
VCU Medical Center

Disclosures

- None

Objectives

- Present relevant OUD epidemiology
- Define & review harm-reduction strategies in OUD (briefly)
- Summarize barriers to dispensing naloxone from hospitals
- Describe processes to legally dispense from the ED
- Introduce VA-Naloxone Project

Warning:
This video contains images of overdose and a distressed child

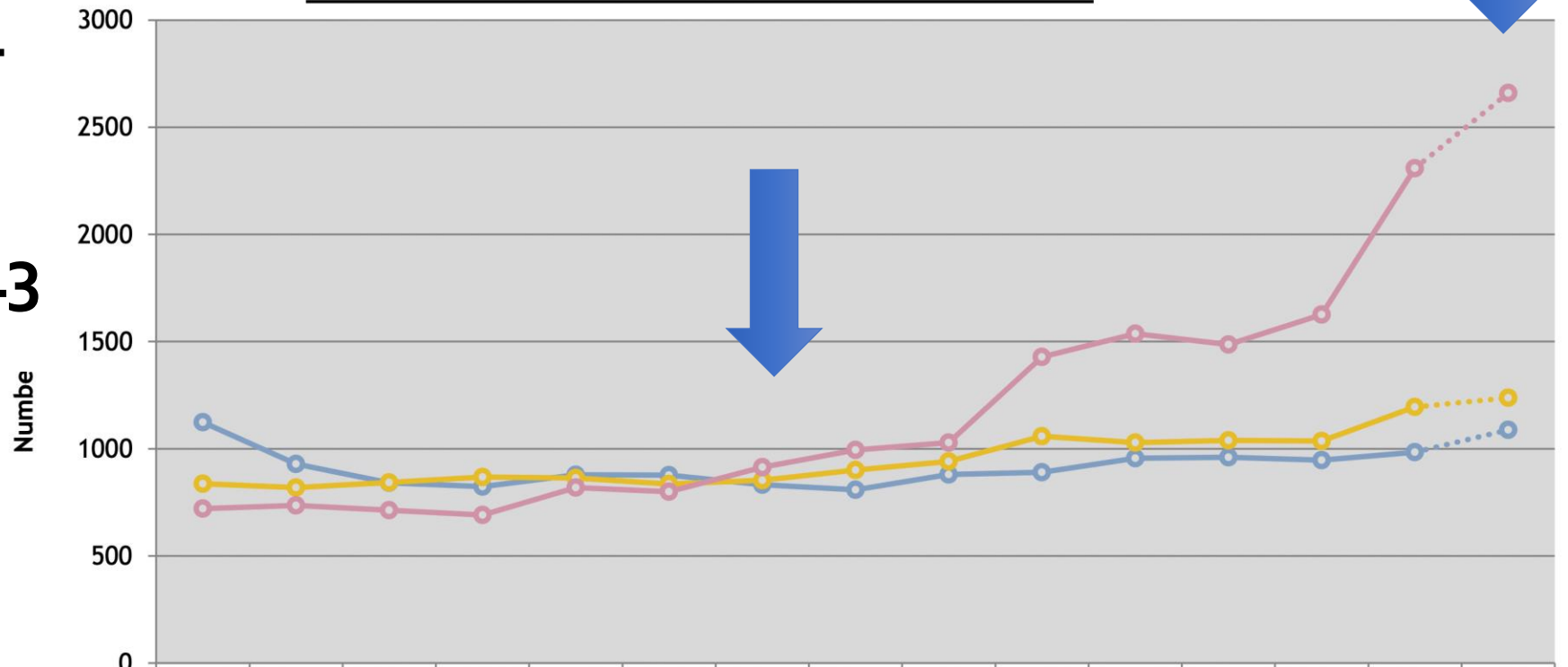
https://www.youtube.com/watch?v=bDJ4sn7tgk8&t=25s

Mandy McGowan, 38, walked along “Methadone Mile” in Boston, picking up used drug needles. “It’s going to be a long road for me,” she said.

Tristan Spinski for The New York Times

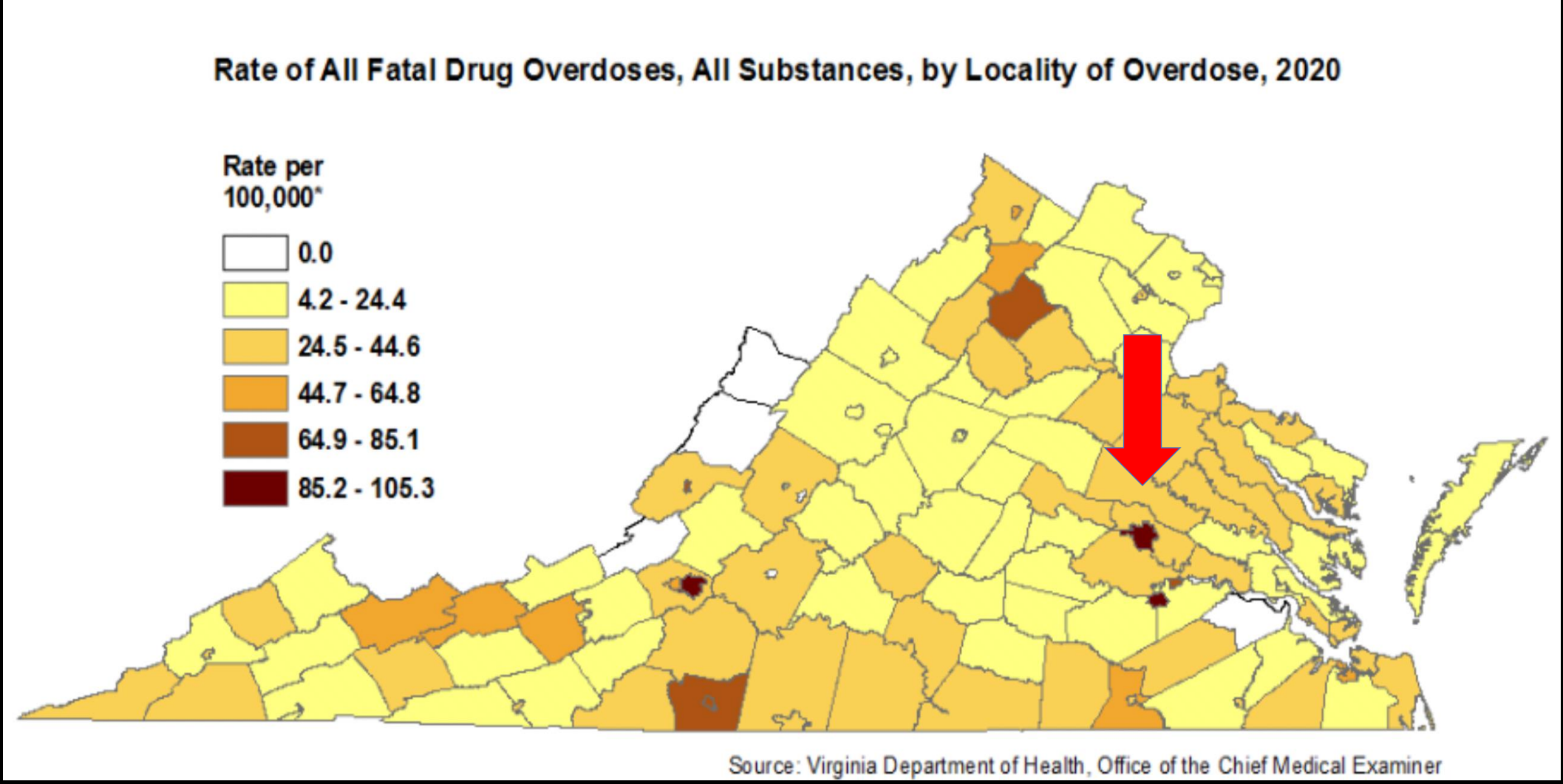
Efforts to increase treatment have not Impacted Overdose Deaths in Virginia

Overdose Became #1 Cause of Unnatural Death in 2013



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021*
Motor Vehicle Related	1124	928	841	823	878	877	832	808	879	890	955	960	947	984	1088
Gun Related	836	818	843	868	863	835	852	901	940	1058	1028	1038	1036	1195	1238
Fatal Drug Overdose	721	735	713	690	819	799	914	994	1028	1428	1537	1486	1627	2309	2660

Richmond is at the Epicenter of the Overdose Epidemic in Virginia



Relevant numbers

- US drug OD deaths > 100K in 2021 for the first time ever (1)
  (71,000 were related to fentanyl)
- Approx 1,000,000 non-fatal OD are treated in US ED's annually (2)
- Non-fatal overdose has significant risk of death after discharge (next slide)
- Engagement in OUD treatment utilizing buprenorphine markedly reduces all-cause mortality (3)

1. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm
2. PMID: 32240125
3. PMID: 28446428, 29913516

TOXICOLOGY/BRIEF RESEARCH REPORT

One-Year Mortality of Patients After Emergency Department Treatment for Nonfatal Opioid Overdose

Scott G. Weiner, MD, MPH*; Olesya Baker, PhD; Dana Bernson, MPH; Jeremiah D. Schuur, MD, MHS

*Corresponding Author. E-mail: sweiner@bwh.harvard.edu, Twitter: @scottweinermd.

N=11,000 opioid overdoses

<u>Subsequent death</u>

5% dead within 1 year (1 in 20!)

1% dead within 1 month

0.25% dead within 2 days

Letters

RESEARCH LETTER

Nonfatal Opioid Overdoses at an Urban Emergency Department During the COVID-19 Pandemic

JAMA October 27, 2020 Volume 324, Number 16

Taylor A. Ochalek, PhD
Kirk L. Cumpston, DO
Brandon K. Wills, DO
Tamas S. Gal, PhD
F. Gerard Moeller, MD

Nonfatal opioid overdose presenting VCU ED (4 month blocks)

Pre-pandemic March-June = 102

Early pandemic March-June = 227

More local (VCU) data

Group	N=	Number of patients with repeat OD within 6 months after index OD (%)	Number of patients who died within 6 months of the index OD (%)
2020-2021 Overdose patients seen in VCU ED after hours (standard referral procedures)	548	98 (18%)	33 (6%)

What % reduction in ER visits is seen when overdose education / naloxone is prescribed to primary care patients on chronic opioid therapy?

A. 2%

B. 10%

C. 27%

D. 54%

E. 63%

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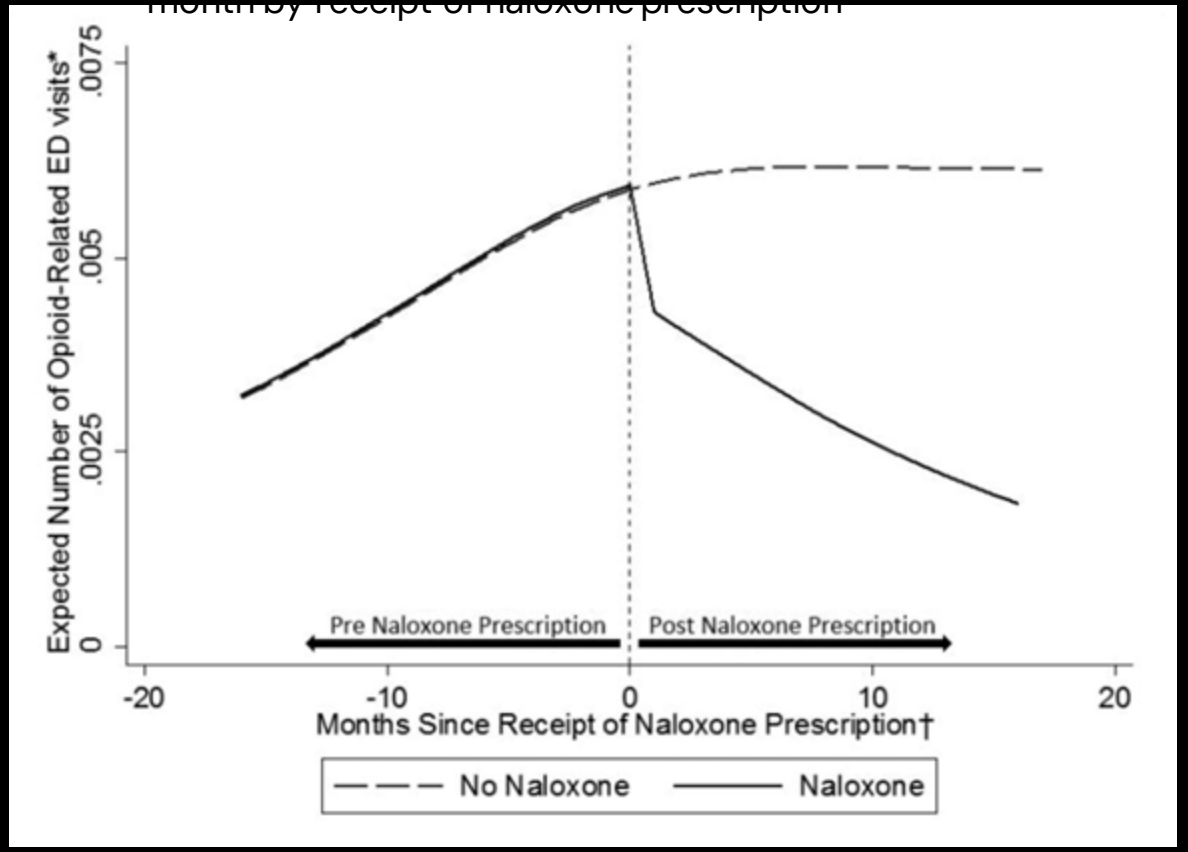
Best Practice: Co-Prescribe Naloxone

Multicenter Study > Ann Intern Med. 2016 Aug 16;165(4):245-52. doi: 10.7326/M15-2771. Epub 2016 Jun 28.

Nonrandomized Intervention Study of Naloxone Coprescription for Primary Care Patients Receiving Long-Term Opioid Therapy for Pain

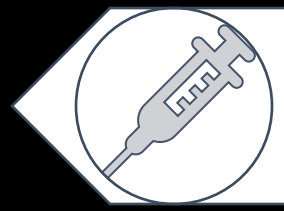
Phillip O Coffin, Emily Behar, Christopher Rowe, Glenn-Milo Santos, Diana Coffa, Matthew Bald, Eric Vittinghoff



- 38.2% of 1,986 patients on long-term opioids were prescribed naloxone
- Patients who received a naloxone rx had <u>63% fewer opioid-related ED visits after 1 year</u>

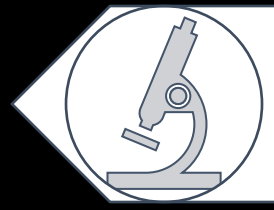
Harm Reduction

Harm Reduction Strategies



Safer (injection) use

Monitored use environments



Prevent/ screen for infections

Overdose prevention/ treatment

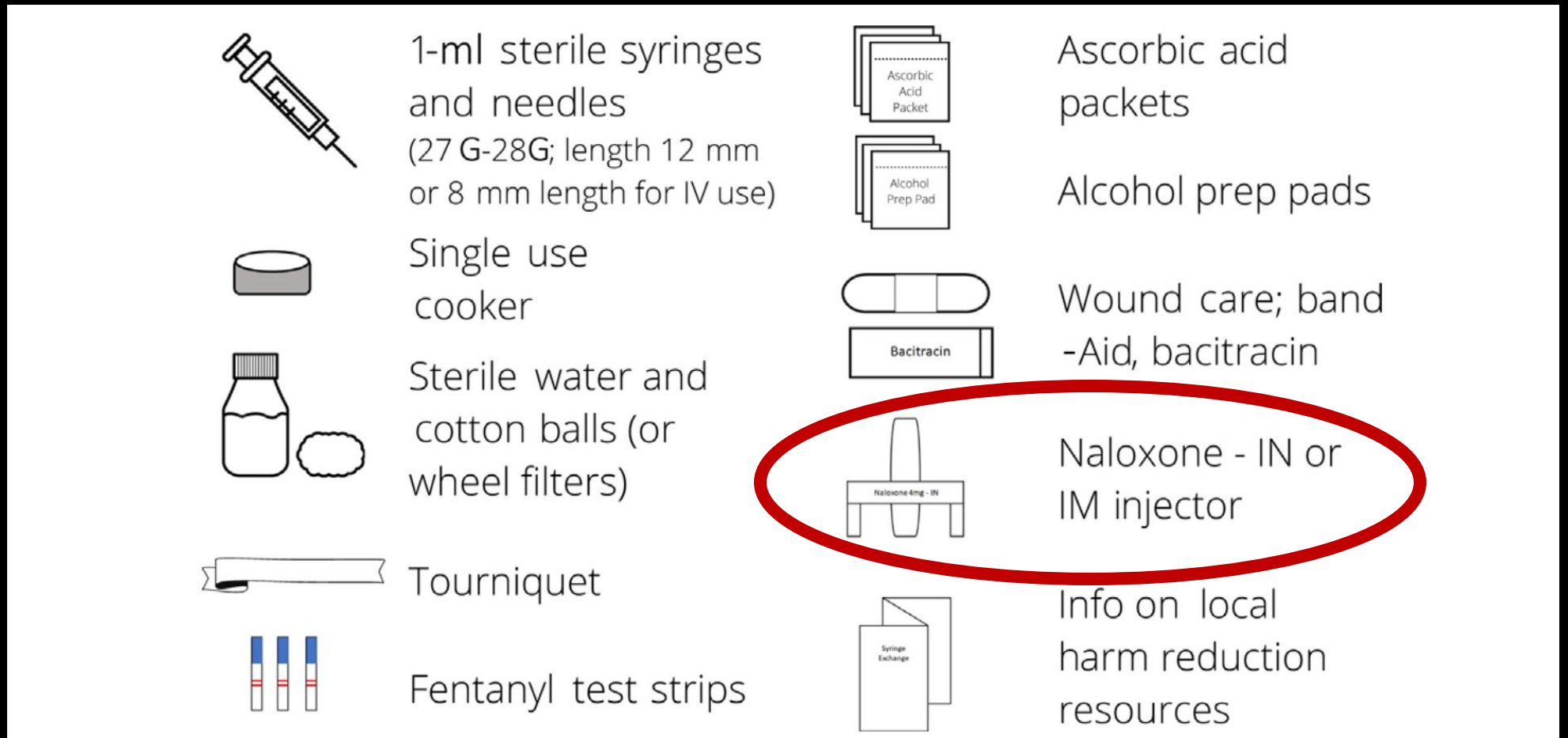


Fig. 2. Harm reduction kits for injection drug use can be distributed to patients and contain a variety of items for safer substance use. Items that can be included as part of this kit are listed. Depending on local use patterns, ascorbic acid packets may not be applicable. Adding wound care agents should also be considered, such as gauze, topical bacitracin, and Band-Aid. IM, intramuscular; IN, intranasal; IV, intravenous.

Chan et al. *Med Clin N Am*. 2022

Communities where naloxone kits are distributed have fewer opioid overdose deaths

Naumann RB, Durrance CP, Ranapurwala SI, et al. Impact of a community-based naloxone distribution program on opioid overdose death rates. Drug Alcohol Depend 2019;204:107536.

Walley AY, Xuan Z, Hackman HH, et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. BMJ 2013;346:f174.

Fairbairn N, Coffin PO, Walley AY. Naloxone for heroin, prescription opioid, and illicitly made fentanyl overdoses: challenges and innovations responding to a dynamic epidemic. Int J Drug Policy 2017;46:172–9.


COLORADO NALOXONE PROJECT
NARCAN
4 mg

Market growing more competitive (Teva, Kloxxado, Zimhi)

4 mg

8 mg

NOW APPROVED!

5 mg

FDA approves second generic naloxone spray

Jun 22, 2022 - 02:24 PM

Community Naloxone

VDH VIRGINIA DEPARTMENT OF HEALTH

Healthy People in Healthy Communities
www.vdh.virginia.gov

Statewide Standing Order for Naloxone

Virginia Department of Health
109 Governor Street, 13th Floor
Richmond, VA 23219

Date Issued: January 14, 2022

The persons identified below are authorized to dispense naloxone pursuant to this standing order and in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health. Additionally, this standing order authorizes a licensed pharmacy, wholesale distributor, third party logistics provider or manufacturer to distribute the naloxone formulations specified below via invoice to entities designated by this standing order in accordance with Virginia Board of Pharmacy Guidance Document 110-44.

This order supersedes the orders issued by the State Health Commissioner on April 13, 2018 and March 19, 2020.

Authorized Dispensers:

The following individuals may dispense naloxone pursuant to this standing order to a person to administer to another person believed to be experiencing or about to experience a life-threatening opioid overdose and shall follow Board of Pharmacy protocol when dispensing naloxone as authorized in §54.1-3408 (X) and (Y):

- Pharmacists who maintain a current active license practicing in a pharmacy located in Virginia that maintains a current active pharmacy permit, and
- Emergency medical services personnel as defined in § 32.1-111.1

REVIVE!

Opioid Overdose & Naloxone Education for Virginia

What is "REVIVE!"?

REVIVE! is the Opioid Overdose and Naloxone Education (OONE) program for the Commonwealth of Virginia. REVIVE! provides training on how to recognize and respond to an opioid overdose emergency using naloxone.

REVIVE! offers two types of trainings:

- Lay Rescuer trainings are between 1-1.5 hours long. This training covers understanding opioids, how opioid overdoses happen, risk factors for opioid overdoses, and how to respond to an opioid overdose emergency with the administration of Naloxone*.
- Lay Rescuer Training of Trainers includes the basic level "Lay Rescuer training" and prepares you to become a REVIVE! instructor. This course is 3 hours long and covers the administrative requirements to lead REVIVE! trainings*.

How can I get naloxone?

Although naloxone is a prescription medicine, Virginia – like many states – has passed laws making it available as a standing order. The statewide standing order allows pharmacists in Virginia to dispense naloxone without requiring an individual prescription. Many community based organizations have also established a standing orders to allow community dispensing.

Anyone can access naloxone by:

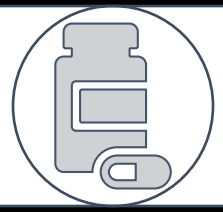
- Getting a prescription from their doctor; or
- using the standing order written for the general public; or
- Virginia's Local Health Departments and some Community Services Boards at no cost. Please call your local agency to check for availability.

What about hospitals & emergency departments?

ED Naloxone

Challenges getting naloxone to ED patients

Clinician awareness/ willingness



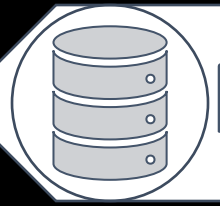
Rx fill rate tend to be low (<30%)

VA pharmacy regulations= barrier to dispensing

Verdier, Am J Emerg Med, 2019

How to legally dispense naloxone from the ED?

EHR Order for Naloxone

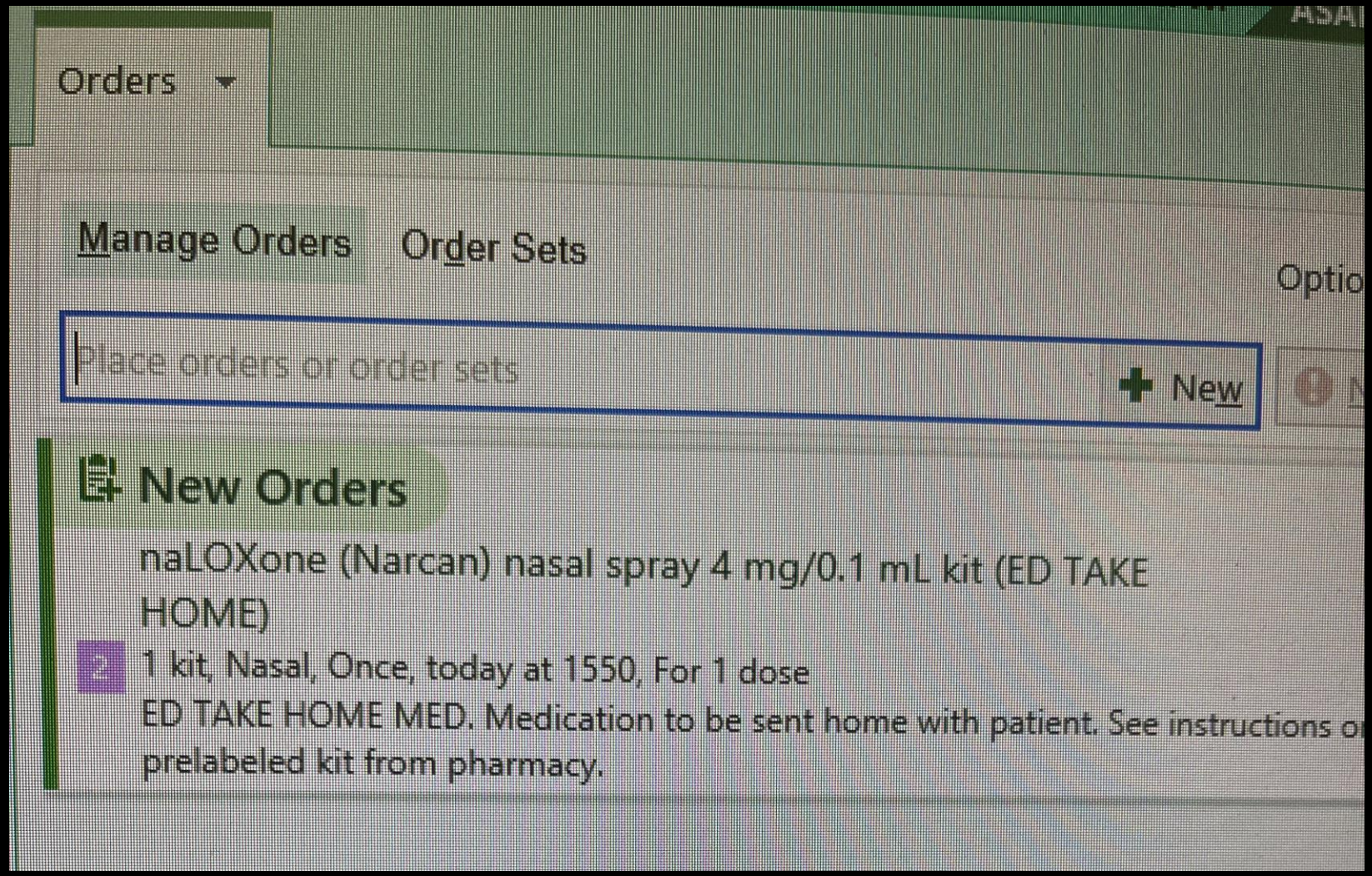


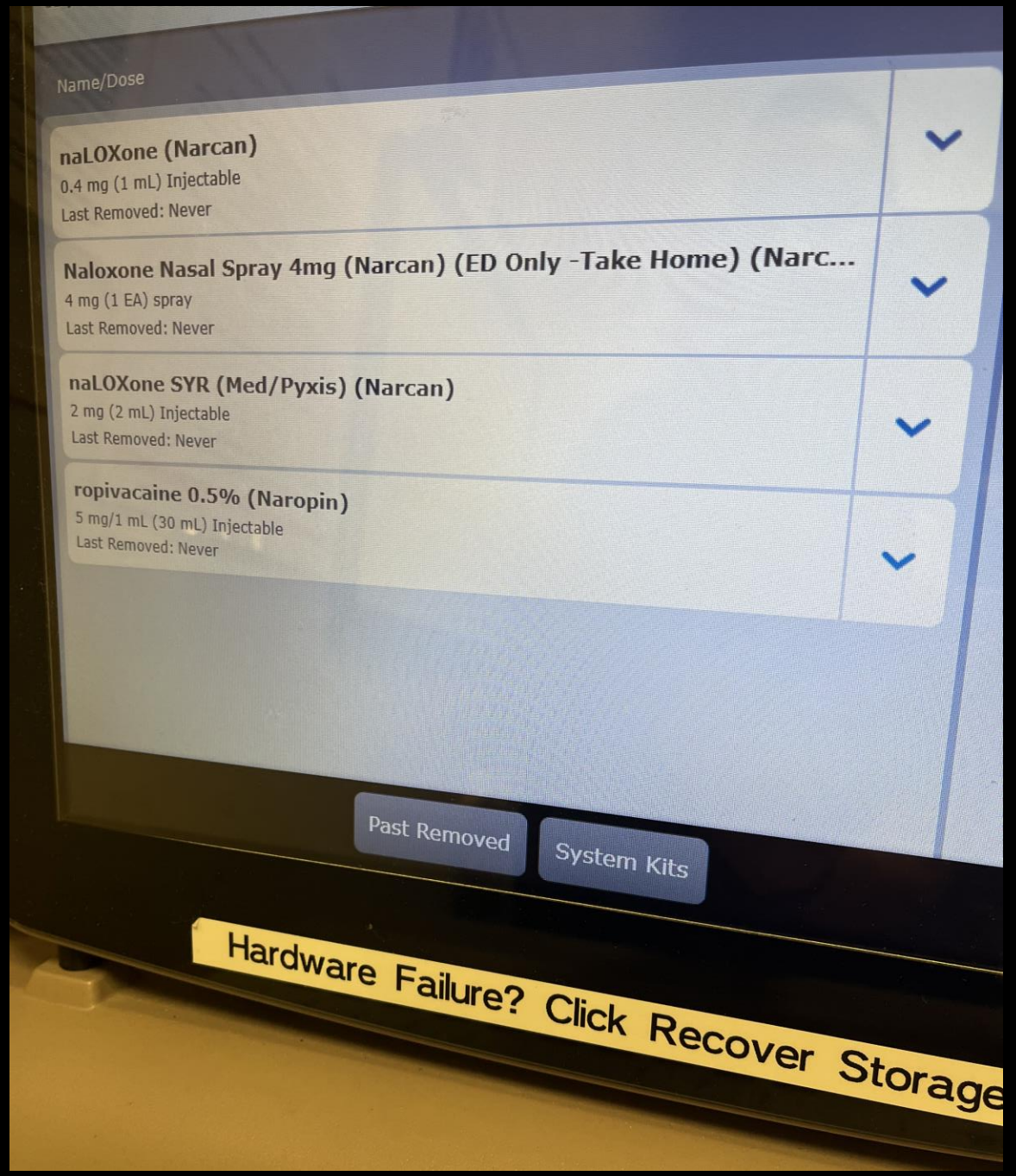
Retrieve from Pyxis machine

Apply fixed label

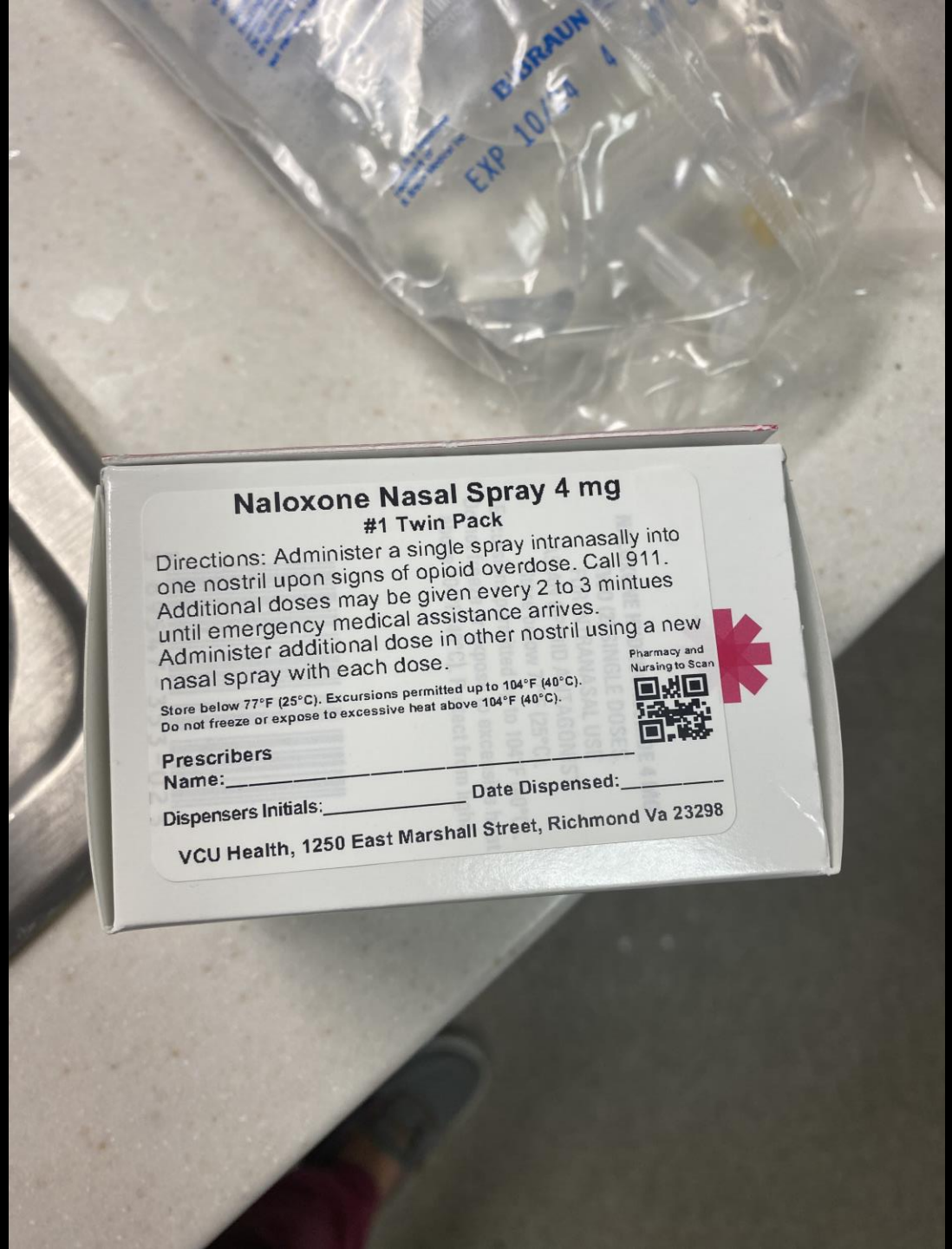
RN provides education

VCU Emergency Department




Name/Dose
naLOXone (Narcan)
0.4 mg (1 mL) Injectable
Last Removed: Never
Naloxone Nasal Spray 4mg (Narcan) (ED Only -Take Home) (Narc...
4 mg (1 EA) spray
Last Removed: Never
naLOXone SYR (Med/Pyxis) (Narcan)
2 mg (2 mL) Injectable
Last Removed: Never
ropivacaine 0.5% (Naropin)
5 mg/1 mL (30 mL) Injectable
Last Removed: Never
Past Removed
System Kits
Hardware Failure? Click Recover Storage


Levetiracetam
1000 mg/100 mL
(10 mg/mL)
For Intravenous Infusion Only
Rx only
LOT:
20656
EXP:
04/2024
NARCAN NASAL SPRAY
Naloxone Nasal Spray 4 mg
Actavis
Rx Only
Lidocaine
Patch 5%
One patch (10 cm x 14
Potassium
10 mEq


B.BRAUN
EXP 10/
Naloxone Nasal Spray 4 mg
#1 Twin Pack
Directions: Administer a single spray intranasally into one nostril upon signs of opioid overdose. Call 911. Additional doses may be given every 2 to 3 mintues until emergency medical assistance arrives. Administer additional dose in other nostril using a new nasal spray with each dose.
Store below 77°F (25°C). Excursions permitted up to 104°F (40°C).
Do not freeze or expose to excessive heat above 104°F (40°C).
Pharmacy and Nursing to Scan
Prescribers Name:_____
Dispensers Initials:_____ Date Dispensed:_____
VCU Health, 1250 East Marshall Street, Richmond Va 23298

1 Identify Opioid Overdose and Check for Response

ASK person if he or she is okay and shout name.

Check for signs of opioid overdose:

- Will not wake up or respond to your voice or touch
- Breathing is very slow, irregular, or has stopped
- Center part of their eye is very small, sometimes called "pinpoint pupils"

Lay the person on their back to receive a dose of NARCAN® Nasal Spray.

2 Give NARCAN® Nasal Spray

Remove NARCAN® Nasal Spray from the box.

Peel back the tab with the circle to open the NARCAN® Nasal Spray

Hold the NARCAN® Nasal Spray with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle.

Gently insert the tip of the nozzle into either nostril.

- Tilt the person's head back and provide support under the neck with your hand. Gently insert the tip of the nozzle into one nostril, until your fingers on either side of the nozzle are against the bottom of the person's nose.

Press the red plunger firmly to give the dose of NARCAN® Nasal Spray.

- Remove the NARCAN Nasal Spray from the nostril after giving the dose.

3 Call for emergency medical help, Evaluate, and Support

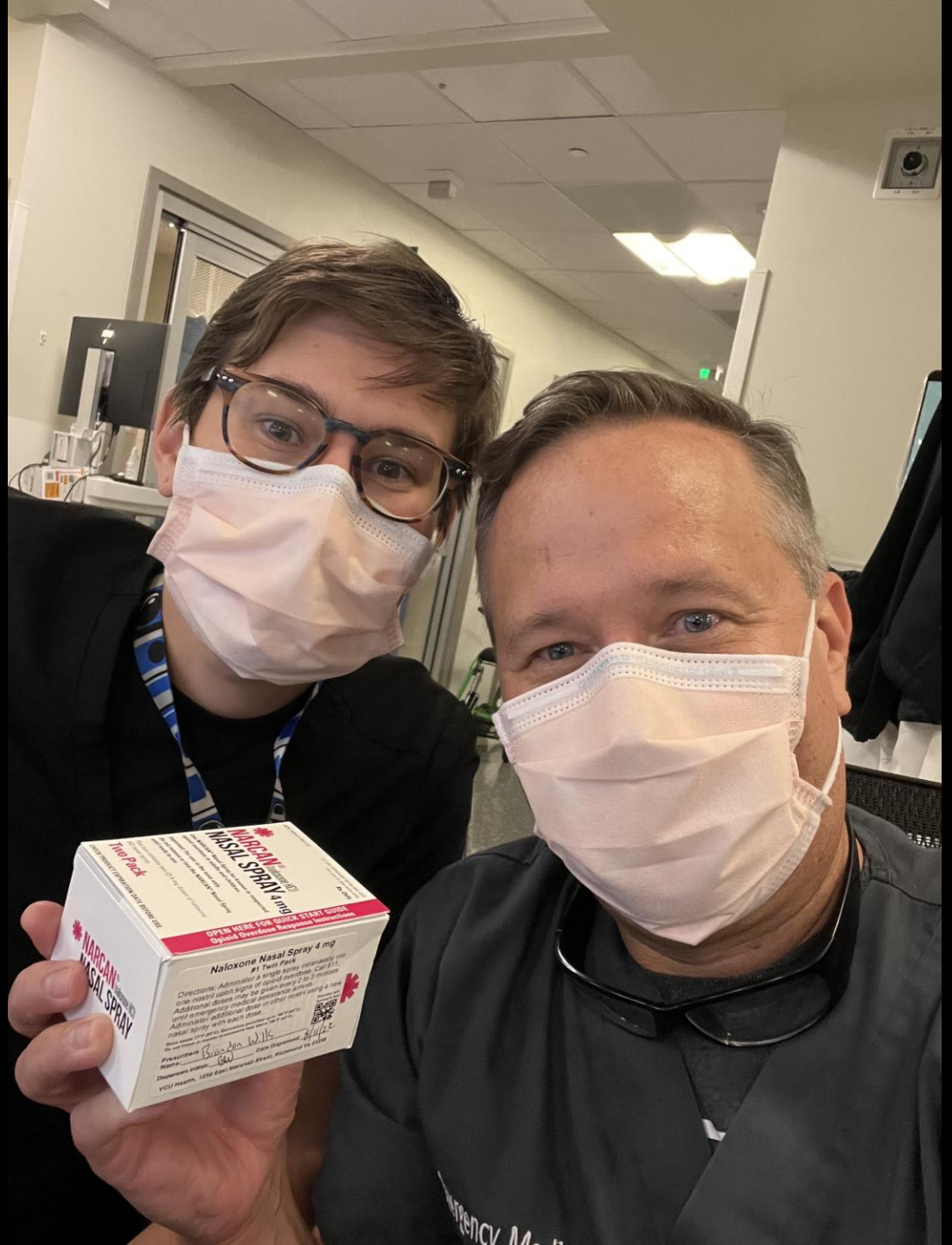
Get emergency medical help right away.

Move the person on their side (recovery position) after giving NARCAN Nasal Spray.

Watch the person closely.

If the person does not respond by waking up, to voice or touch, or breathing normally another dose may be given. NARCAN Nasal Spray may be dosed every 2 to 3 minutes, if available.

Repeat Step 2 using a new NARCAN Nasal Spray to give another dose in the other nostril. If additional NARCAN® Nasal Sprays are available, repeat step 2 every 2 to 3 minutes until the person responds or emergency medical help is received.


NARCAN
NASAL SPRAY 4 mg
Two Pack
OPEN HERE FOR QUICK START GUIDE
Opioid Overdose Response Instructions
Naloxone Nasal Spray 4 mg
#1 Twin Pack
NARCAN
NASAL SPRAY

VCU ED Take-home Naloxone Utilization to Date

2 months

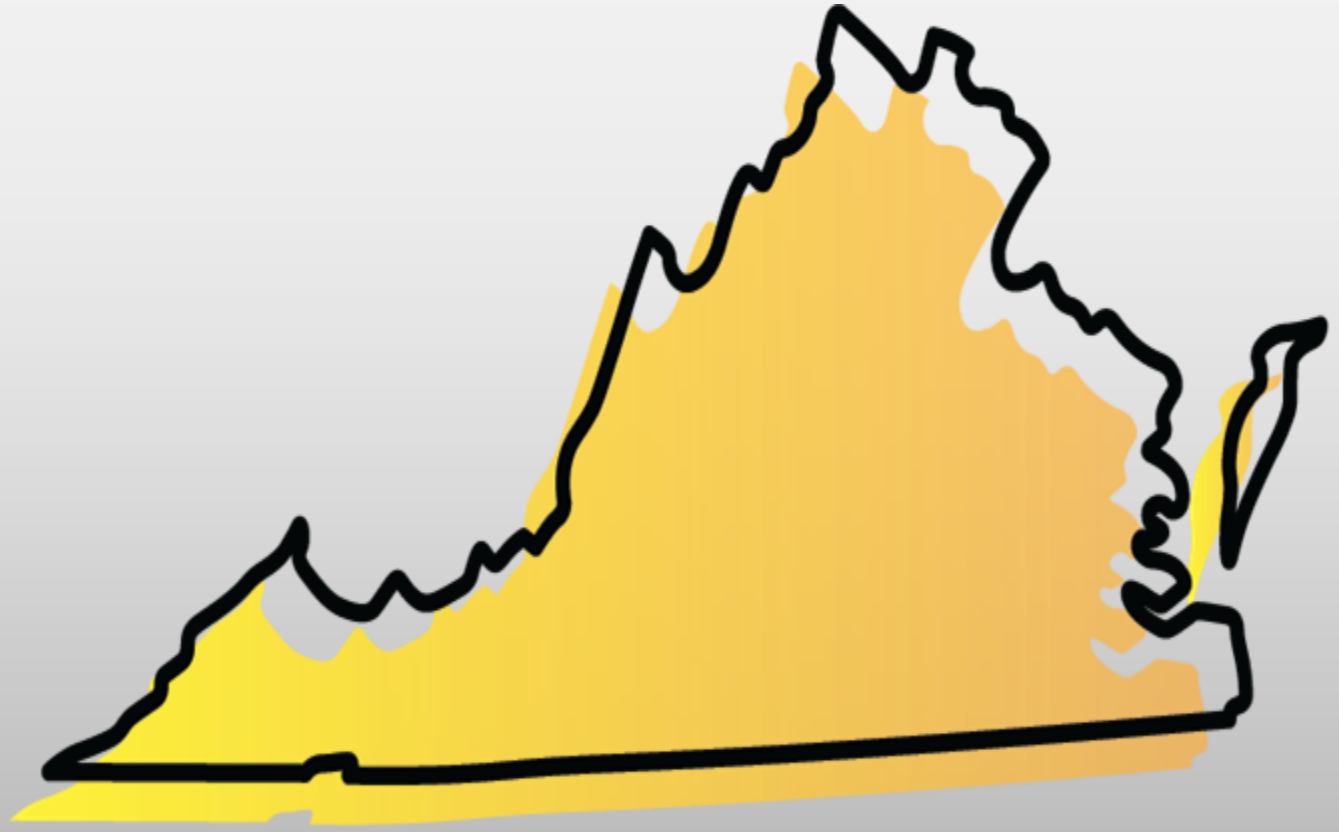
- 55 kits
- 75% overdoses
- 65% received prehospital naloxone
- 13% seeking treatment

VA Naloxone Project

Goal: All CO hospitals and emergency departments distribute naloxone to at-risk patients, placing naloxone - a lifesaving medication - in patients' hands prior to their departure from the hospital.

Dr. Don Stader, MD FACEP
Founder & Chair of The Naloxone Project

COLORADO NALOXONE PROJECT



Virginia NALOXONE PROJECT

Dr. Brandon Wills, Chair of The Virginia Naloxone Project

Dr. Donald Stader, Founder & Chair of The Naloxone Project

WE PROVIDE NALOXONE HERE.

NALOXONE
SAVES LIVES

COLORADO NALOXONE PROJECT

NALOXONE
SAVES LIVES

COLORADO NALOXONE PROJECT

WE PROVIDE NALOXONE HERE

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- Present relevant OUD epidemiology
- Define & review harm-reduction strategies in OUD (briefly)
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- Describe processes to legally dispense from the ED
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Questions?

Brandon Wills, DO, FACEP, FAACT
Professor, Addictions Division
Department of Psychiatry & Emergency Medicine
Medical Director, MOTIVATE Clinic
Fellowship Director, Medical Toxicology
VCU Medical Center
brandon.wills@vcuhealth.org

Questions?

Case Presentation #1
Dana DeHart, Piedmont CSB

- 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

The client with chronic pain: Suggestions to help us think outside of the box. We have a client we have been serving since October 2020 where has chronic pain from a shotgun injury from 2012 (and other pain) - 9 surgeries, 3 rods replaced, back pain, shoulders are in pain, neck pain, pain in both arms, other "good leg" is in pain as well; chronic pain, sleep disorder, possibly high blood pressure.

Has been on Suboxone since October 2020 and, while this helps, continues to struggle with pain, and has relapsed many times citing the choric pain. It has been a struggle to get client to go to regular PCP, let alone get client to consider a pain clinic. We recently have been able to get client back in with an SUD Case Manager and we will be hiring another SUD Peer soon, so we hope these extra eyes and help will be the encouragement client needs.

Any suggestions would be so appreciated.

Demographics

White male, 36 yrs. old, completed High School, receives disability, lives with his mother, younger brother and his son and relies on family a great deal for support and issues around mobility.

Reminder: Mute and Unmute to talk
*6 for phone audio
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Medical, Behavioral, Mental Health History

hypertension, gout, chronic pain, walks with crutch due to leg injury, cardiac issues.
Began using drugs when he was 17 or 18YO and use increased after leg injury in 2012 (shot gun injury). Initially requested services to get off pain medication as he was experiencing withdrawal symptoms from being out of medications because he was not taking them as prescribed (began to purchase off street when ran out of prescribed pain meds).

1. Diagnosis: (F11.11) Opioid abuse, in remission
2. Diagnosis: (F15.11) Other stimulant abuse, in remission
3. Diagnosis: (F33.9) Major depressive disorder, recurrent, unspecified
4. Diagnosis: (F17.220) Nicotine dependence, chewing tobacco

Client has been in our most intensive SAIOP program, OBOT/suboxone, Community Recovery Program, and SUD case management.

Current medications:

- propranolol 20 mg tablet - take 1 tab bid at 8 and 8 and one at 4 pm if needed for anxiety
- gabapentin 600 mg tablet -take 1 tab bid and 2 at hs Start On: 3/14/2022
- buprenorphine 8 mg-naloxone 2 mg sublingual film-take 1 film in the am and 1 film in the afternoon and 1/2 film at hs if needed- 17.5 Film
- docusate sodium 100 mg capsule-take 1-2 caps 2 times a day
- Wellbutrin XL 300 mg 24 hr tablet, extended release-take 1 tab daily
- naloxone 4 mg/actuation nasal spray-0.4 Milliliter
- clonidine HCl 0.2 mg tablet-take 2 tablets at hs
- amlodipine 10 mg tablet
- hydrochlorothiazide 25 mg tablet

Barriers to treatment include reporting issues with driving due to leg (family provides transport). Client very hesitant to follow up around recommendations to see PCP around chronic complaints client has/wanting client to follow up with blood work. For example, on 10/12/2022 reported "I have been feeling run down, tired and not having much energy". He states that his bp "hasn't been too bad". He has a PCP appointment tomorrow at PCFP and is going to ask for some labs because he has been "really tired and worn out lately." Doctor suggested he get his thyroid checked and also some vitamin levels d/t his increase in fatigue and feeling tired all the time. When followed up with about how this appointment went by SUDCM, client stated "I had to reschedule it". SUDCM asked why he did not make the scheduled appointment and he reports "I ate something" and explained "I knew I would have blood work and eating would cause my results to be different". Explained to CM he was told not to eat, and he forgot. CM inquired of when new appointment is and he states, "October 24th at 11:15".

Reminder: Mute and Unmute to talk
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Past Interventions

Client has been in our most intensive SAIOP program, OBOT/suboxone, Community Recovery Program, and SUD case management. Medications as listed above are current and client reports last visit with Doctor on 10/12/2022 that meds working/no changes were made during that visit.

Has been referred several times to pain management, but will not follow up.

Client started off well in SUDIOP and was able to step down to a less intensive group. Client then began developing additional physical health issues in August/September 2021(hypertension and cardiac problems-had several ED visits within the last year due to blood pressure and heart problems) and he then began to regularly miss groups since the end of November due to not feeling well as well as COVID scares in his family. After a heart to heart with client about what client can genuinely do in terms of services, we were able to step client down to receive ongoing OBOT services, along with SUDCM.

Future Plans, Patient's Treatment Goals

Right now the client states "trying to figure out ways to be healthier...like eating...support getting my medical stuff lined up and figured out"

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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
- **Candace Fletcher, PharmD Candidate** from Hopkins Medical Association
- **Susan Cecere, LPN** from Hampton Newport News
- **Kimberly Dexter, DNP** from Hampton Newport News CSB
- **Shokoufeh Dianat, DO, MAS** from Virginia League from Planned Parenthood
- **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
- **Dana DeHart**, from Piedmont 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
- **Heather Stone, PhD, LCSW** from Central Virginia Health Services of Petersburg
- **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

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- Feedback
  - Overall feedback related to session content and flow?
  - Ideas for guest speakers?

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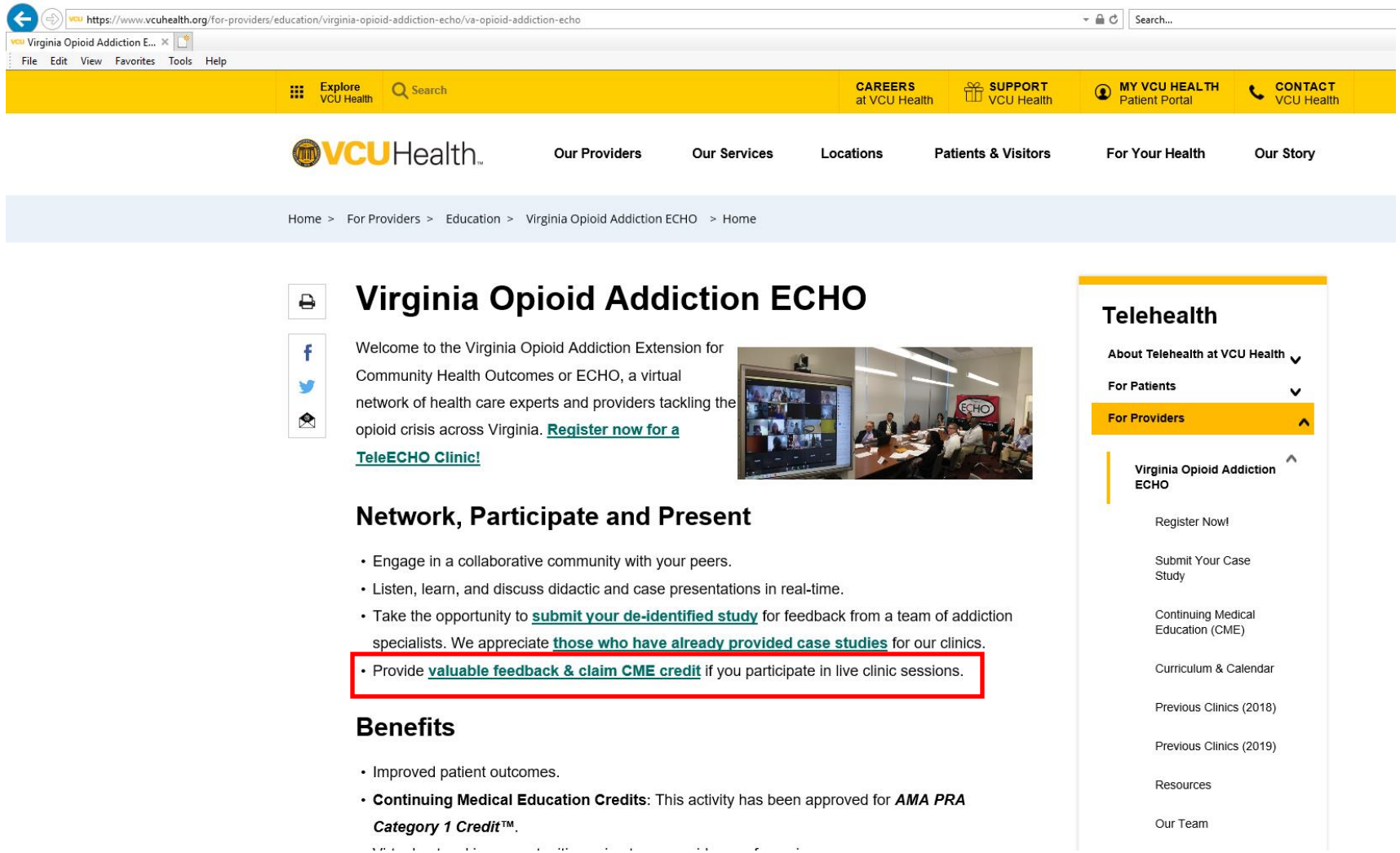

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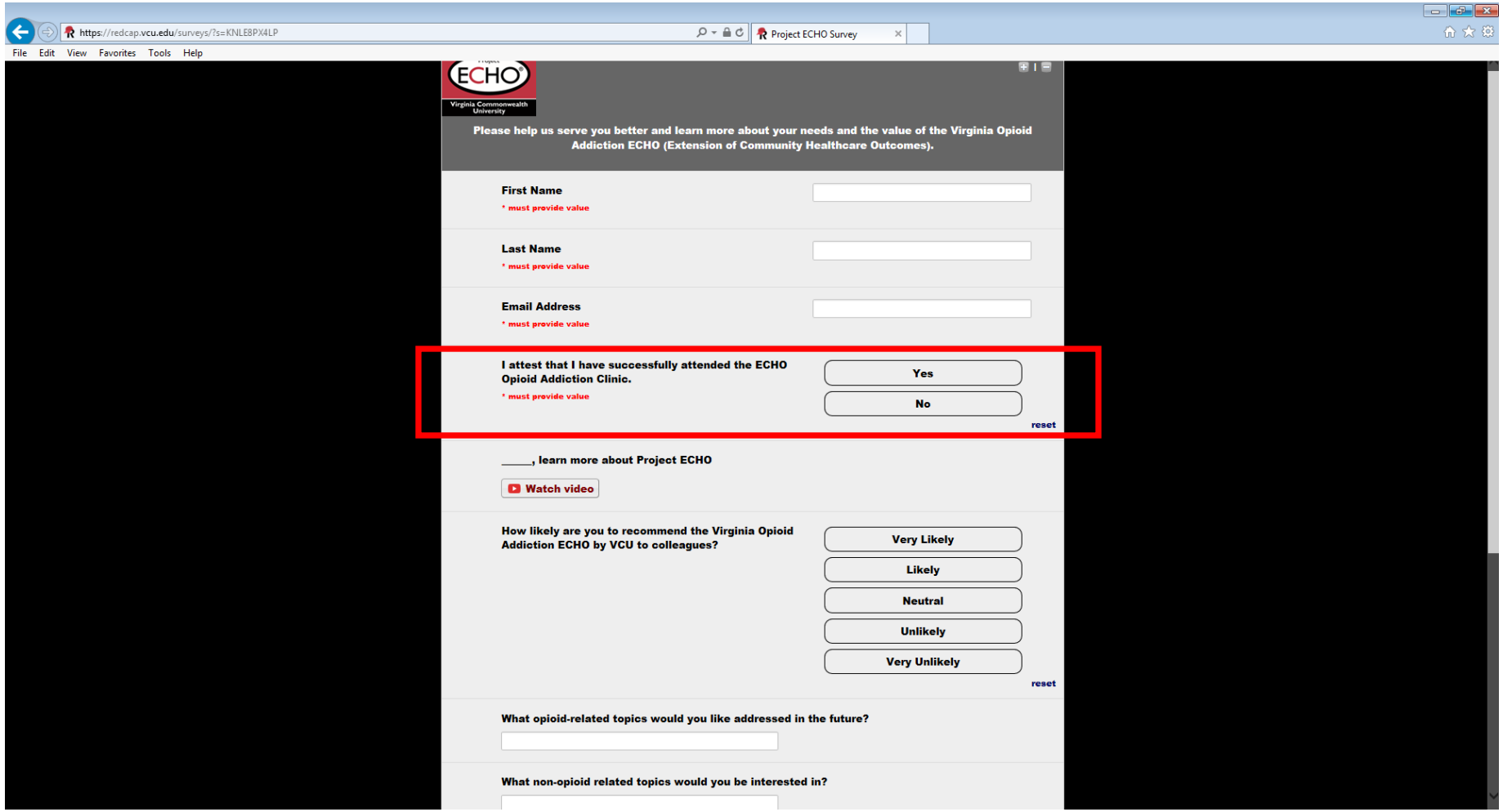

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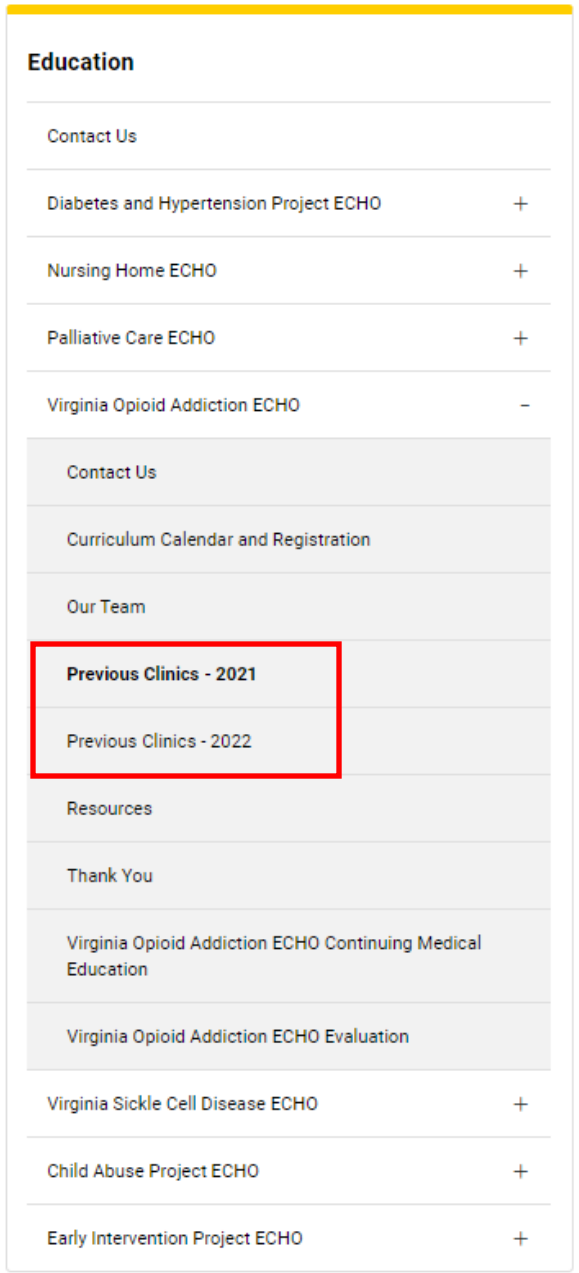

Previous Clinics - 2021

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

VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12:00-1:00 pm

Mark Your Calendar --- Upcoming Sessions

Nov. 4: CPS and Addiction in Families- Valerie L'Herrou, JD

Nov. 18: Transitioning from Methadone to Buprenorphine- Bishoy Samuel, MD

Dec. 2: Overdose Risk for Patients Coming Out of Controlled Environments- F. Gerard Moeller, MD

Dec. 16: Communication with Patients on Risk of Overdose- Lori Keyser Marcus, PhD

Please refer and register at vcuhealth.org/echo

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Virginia Commonwealth University

THANK YOU!

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

VCU