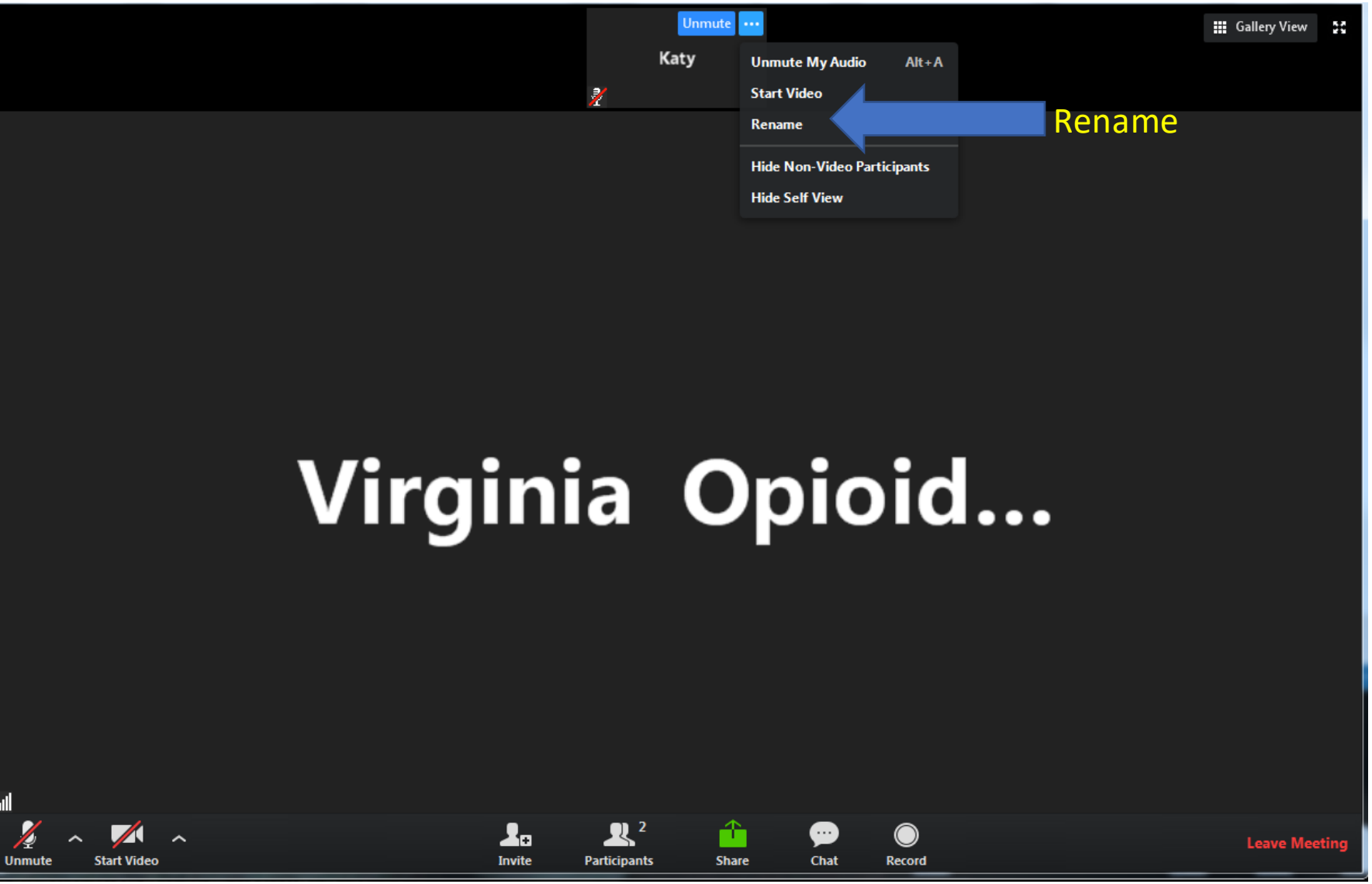
Virginia Opioid Addiction ECHO* Clinic

November 4, 2022

*ECHO: Extension of Community Healthcare Outcomes

Helpful Reminders



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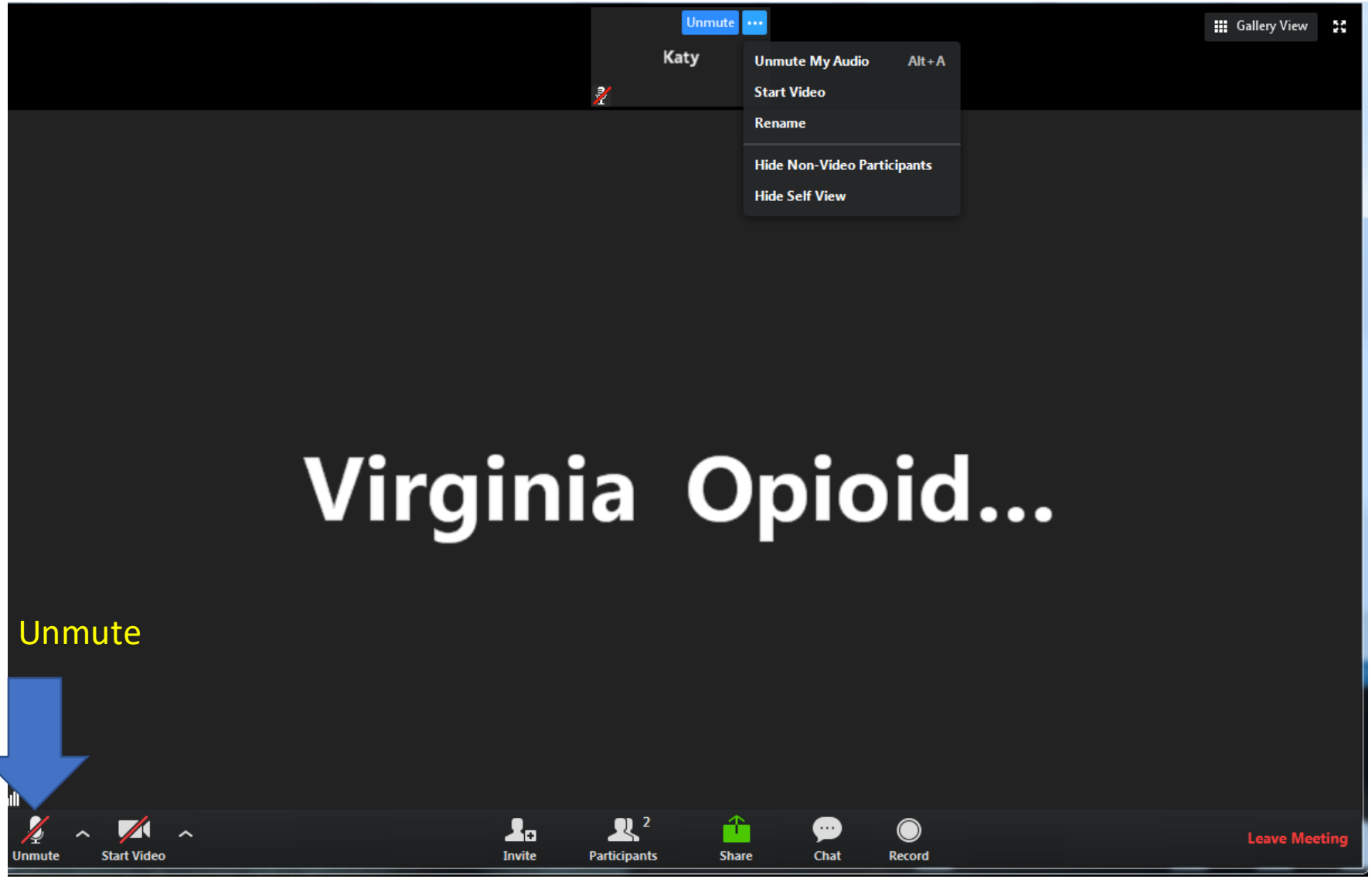
Helpful Reminders



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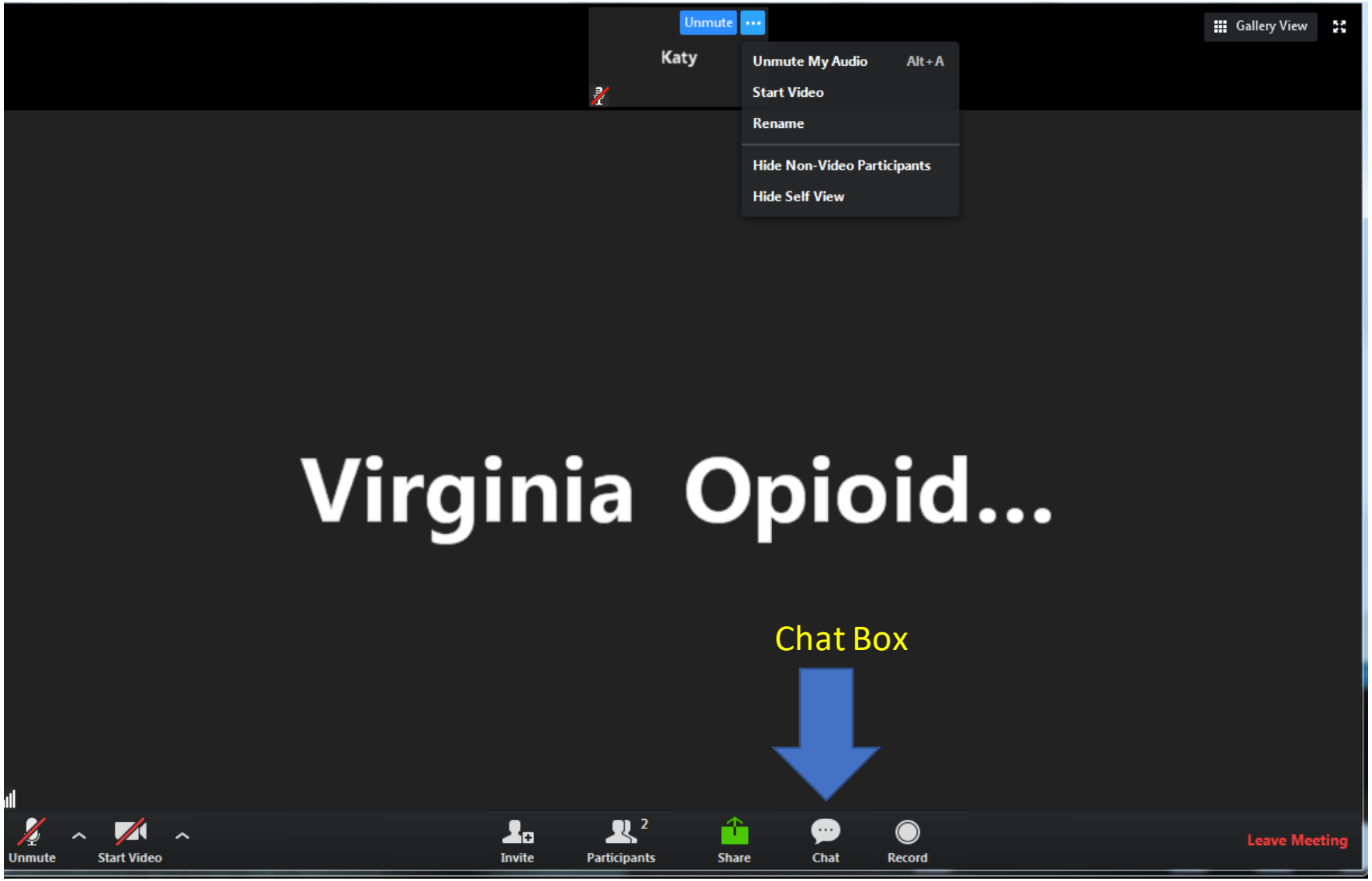

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VCU Opioid Addiction ECHO Clinics

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	F. Gerard Moeller, MD
Administrative Medical Director ECHO Hub	F. Gerard Moeller, MD
Clinical Experts	Lori Keyser-Marcus, PhD Courtney Holmes, PhD Albert Arias, MD Megan Lemay, MD
Didactic Presentation	Valerie L'Herrou, JD
Subject Matter Expert	Albert Arias, MD
Program Manager	Leslie Bobb, MPH
Senior Program Coordinator	Lillie Lattimore, MA

- Name
- Organization

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What to Expect

I. Didactic Presentation
    I. **Valerie L'Herrou, JD**
II. Case presentations
    I. Case 1
        I. Case summary
        II. Clarifying questions
        III. Recommendations

III. Closing and questions

Lets get started!

Didactic Presentation

Disclosures

Valerie L'Herrou, JD has no financial conflicts of interest to disclose.

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

VPLC | Virginia Poverty Law Center

Through Advocacy, Education, Litigation the Virginia Poverty Law Center (VPLC) breaks down systemic barriers keeping low-income Virginians in the cycle of poverty

ECHO: CPS AND ADDICTION IN FAMILIES

VALERIE L'HERROU
Staff Attorney for Family Law & Child Welfare
CENTER FOR FAMILY ADVOCACY

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Through Advocacy, Education, Litigation

The Virginia Poverty Law Center (VPLC) breaks down systemic barriers keeping low-income Virginians in the cycle of poverty

VPLC's Center for Family Advocacy:

Domestic violence, family law (divorce, child support, custody, visitation) and child welfare (child protection, foster care, family integrity, family defense), as well as elder law.

NB: This presentation is not legal advice; no attorney/client relationship is created as a result of this presentation

RESPONDING TO PATIENTS & FAMILY MEMBERS WITH SUBSTANCE USE DISORDER

“People-first” language: PERSON with a substance use disorder vs “addict” “alcoholic” “substance abuser” (a person is not their diagnosis)

Medical condition: not a personal weakness or moral failure. *Remember!* when speaking to patient, family members, other professionals

Treat patient as partner: most important member of the care team. Ensure patient feels in control of plan

Holistic approach: patient and child, are part of the family system. Solutions must work as a whole: family-centered treatment

HOW TO TALK ABOUT IT

“[S]tigma may actually enhance or reinstate drug use, playing a key part in the vicious cycle that drives people to continue using drugs.”[10]

Stigma and shame: Stigma around SUDs and our beliefs that SUD is a moral failure creates shame.

Barriers to treatment: These feelings can exacerbate underlying causes.

Encourages denial; limits help-seeking: Stigma leads both to denialism ("I'm in control so I can stop at any time") and a belief that they don't/shouldn't need help (avoid judgment, belief they ought to have enough strength).

Fear of stigmatization: loss of/avoiding interactions in their social network due to fear of stigma creates isolation which can drive/activate SUD and use/relapse.

SUBSTANCE USE DISORDER MAY HAVE MULTIPLE CAUSES, TREATMENT CHALLENGES

Self-medicating other conditions: Depressive/anxiety disorders; unacknowledged trauma including Hx of sexual assault/abuse victimization; past injury and poor pain treatment/management

SCREEN: for depression, domestic violence, Hx of trauma

Appropriate referrals: MH treatment for underlying causes, Rx

Dysregulation: familial Hx, emotional regulation & treatment response

Relationships/Family: family engagement; treat patient & family as a system

Postpartum depression: this may be a risk factor/relapse point

Treatment opportunity: Medicaid now covers up to 1-year post-partum

PREGNANCY CAN BE A HIGHLY MOTIVATING MOMENT FOR RECOVERY.

Prenatal care is best predictor of healthy perinatal outcomes

Epiphany: help this be a moment to access treatment to benefit herself and child

Evidence: parents and children are most effectively served through a family-centered treatment approach

AFFIRM patient's choice to access prenatal care; encourage access treatment

BEST PRACTICE: Develop "Plan of Safe Care" with patient, family members

EDUCATE: harm reduction, risk management—with patient & family members

UNDERSTAND that SUD recovery is not linear. Setbacks are a medical symptom

BIRTH / NEONATAL

Newborn Abstinence Syndrome: Canadian study found skin-to-skin maternal care ("rooming in") associated with better outcomes than intensive care: proportion of infants requiring pharmacotherapy decreased from 83.3% to 14.3%; average length of stay decreased from 25 to 8 days*

Maternal/infant dyad bonding, with paternal/partner/familial support, is predictor of healthy outcomes

CPS intervention can result in interruption of bonding which is vital for neonatal/early childhood development.

Alternative: Home Visiting programs can help any parent with struggles.

"Mothers highlighted the value of reassurance and education from providers" and "nonjudgmental support" from peers and coparents.[11]

PARENTS OF OLDER CHILDREN

CPS intervention is highly traumatic to children. Multiple studies show worse outcomes for children removed by CPS versus children who stayed in family of origin with services in place.

Jurisdictional differences: While some local CPS agencies have adjusted their practices in response to 2018 changes in federal law (preferencing in-home services), some continue to remove children based on parental SUDs.

Recovery impact: the distress removal causes to parents can result in relapse, difficulty in treatment plan adherence.

QUERY before reporting: is THIS child, in THIS family, being neglected or abused? Talk to patient about familial supports, harm reduction, risk management.

CPS REPORT TRIGGER

When/what/why: Not during pregnancy. Fetus is NOT a child; confidentiality

"The results of such medical history screening and of any specific substance abuse evaluation which may be conducted **shall be confidential**" (Va Code §54.1-2403.1(B))

Risk factor, not evidence: Substance use disorder and/or current use are risk factors for neglect, not evidence of neglect. SUD ≠ neglect.

Statutory language: duty to report if "in professional or official capacity," you have *reason to suspect* that a child is an abused or neglected child." (Va Code § 63.2-1509(A))

→ Must be an observable effect of substance exposure on child.

In this context: Infant "born *affected* by" exposure (not merely *exposed*); or diagnosis of NAS (withdrawal symptoms) ((Va Code § 63.2-1509(B)).

Despite popular belief, "substance exposure does not directly cause specific impairments to children who are prenatally exposed."[4]

CPS REPORT: WHAT HAPPENS

Local DSS/CPS have their own local protocols. "Differential response" (i.e., "assessment" vs "investigation") may both have same outcome.

→Risk of family separation; impacts maternal recovery & infant outcomes

Plan of Safe Care: legal responsibility for implementation on local DSS.

POSC *Best practice:* establish with patient, partner, family—during pregnancy; IF a report is made to CPS, ensure DSS worker knows why/how to implement upon discharge

CPS: ALTERNATIVES TO CALLING

Over-reporting can overwhelm CPS—signal vs noise

Referrals to services: know what's available in your community

Family engagement: patient's partner, family, community can help

Safety planning with patient: If they are actively using or fear relapse, what steps will they take to keep themselves and child safe

Harm reduction strategies: many patients devise these for themselves, but encourage them to think broader; provide information

Why?? "Harm reduction incorporates strategies including safer use, managed use, abstinence… reflects individual and community needs"

REFERRALS FOR TREATMENT/SUPPORT

During pregnancy: Medicaid ARTS https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/information-and-provider-map/

Post-partum: avoid interruptions in treatment; plan with patient for SUD provider follow-up including any MAT; consider dyadic in-patient treatment

At discharge: each licensed hospital must develop and implement a protocol requiring **written discharge plans** for identified, substance-abusing, postpartum women and their infants… **notify the community services board** of the jurisdiction in which the woman resides **to appoint a discharge plan manager**. (Va Code § 32.1-127(B)(6))

REFERRALS FOR TREATMENT/SUPPORT

Family-based in-patient treatment: some programs allow children up to age 5; 6-7 centers in Virginia

MAT: well-managed MAT can prevent OD and help patient manage daily and family life. *NB*: CPS/courts may be hostile to MAT

Home Visiting programs: provide pregnant and parenting families with access to high-quality, early childhood education and support, through programs that best match their needs. https://www.earlyimpactva.org/directory

RESOURCES FOR PROVIDERS

1. "Implementing a Family-Centered Approach For Families Affected by Substance Use Disorders and Involved With Child Welfare Services," National Center on Substance Abuse and Child Welfare, 2021 https://ncsacw.acf.hhs.gov/files/fca-practice-module-1.pdf
2. "Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and their Infants," Substance Abuse and Mental Health Services Administration, https://store.samhsa.gov/sites/default/files/d7/priv/sma18-5054.pdf
3. Virginia Department of Health Division of Women's and Infant's Health http://www.vdh.virginia.gov/vdhlivewell/women/
4. "Confronting Pregnancy Criminalization: A Practical Guide for Healthcare Providers, Lawyers, Medical Examiners, Child Welfare Workers, and Policymakers," National Advocates for Pregnant Women, https://www.nationaladvocatesforpregnantwomen.org/wp-content/uploads/2022/06/1.Confronting-Pregnancy-Criminalization_6.22.23-1.pdf.

See p. 22 for research about the effects of prenatal substance exposure.

RESOURCES FOR PROVIDERS

5. Providers' Clinical Support System: https://pcssnow.org/resources/clinical-tools/
6. "Recovering Together: Mothers' Experiences Providing Skin-to-Skin Care for Their Infants With NAS," *Adv Neonatal Care* (1):16-22 (2021) https://pubmed.ncbi.nlm.nih.gov/33350710/
7. SAMSA resources: https://store.samhsa.gov/?f%5b0%5d=series:5602
8. VCU OB MOTIVATE clinic: https://www.vcuhealth.org/services/womens-health/our-services/substance-use-disorder-treatment
9. Virginia Department of Social Services, "Perinatal Substance Use: Promoting Healthy Outcomes" https://www.dss.virginia.gov/files/division/dfs/mandated_reporters/cps/resources_guidance/Perinatal_Substance_Use_Promoting_Healthy_Outcomes.pdf
10. "Addressing the Stigma that Surrounds Addiction," Dr. Nora Volkow, https://nida.nih.gov/about-nida/noras-blog/2020/04/addressing-stigma-surrounds-addiction.
11. "Trying to Do What Is Best: A Qualitative Study of Maternal-Infant Bonding and Neonatal Abstinence Syndrome," https://pubmed.ncbi.nlm.nih.gov/31166199/#affiliation-1.

RESOURCES FOR PATIENTS

- "Pregnancy & Substance Use - A Harm Reduction Toolkit" https://issuu.com/harmreduction/docs/pregnancy_and_substance_use-_a_harm_2fa242e7fb6684
- "Good Care While Receiving Opioid Use Disorder Treatment" https://store.samhsa.gov/sites/default/files/d7/priv/sma18-5071fs4.pdf
- SAMHSA National Helpline, 1-800-662-HELP (4357); TTY: 1-800-487-4889 confidential, free, 24-hours; for individuals / family members facing mental and/or substance use disorders. Online: https://findtreatment.samhsa.gov/ ; or text zipcode to 435748 (HELP4U)
- VA ARTS fact sheet for members https://www.dmas.virginia.gov/media/5160/arts-member-one-pager-10-05-2022.pdf Spanish language: https://www.dmas.virginia.gov/media/5159/arts-member-one-pager-spanish-10-05-2022.pdf

Thank You!

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Questions?

Case Presentation #1
Heather Stone, PhD, LCSW
CVHS Health Services

- 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

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Main Question

Suggestions regarding continued work with patients who do not go to higher level of care when needed.

Demographics

Patient is an attractive 25yo white female working almost full time as a server in a chain restaurant. This is patients' second job since being in our program. She lost a previous job because of her substance use. Patient graduated high school and attended some college at an out of state university reportedly with 3.0GPA. She originally went to university on an athletic scholarship but did not participate in her sport after her sophomore year. She initially reported that she was diagnosed with supraventricular tachycardia which was the reason for stopping her sport; however she also suffered a gang rape around the same time. Its unclear how much of her degree she completed, she has reported both that she would like to return to college to complete her degree but at other times she's reported that she did complete her degree.

Pt. has been in our program since late January 2021. She moved home from the state where she went to college. Reportedly, for four years, she and her boyfriend were actively using heroin together (IV use). Patient was typically the one to secure product from other men to support the habit of both herself and her boyfriend. in 2020, patient was hospitalized for endocarditis. Subsequently, the patients' father and brother encouraged her to come home so that she could 'get clean'. Since early 2021, Patient has been living with different family members (father, brother, great aunt, grandmother) all whom live near each other in a rural area; however, living situations have not been comfortable. Some of the places she has stayed have not had running water, some do not have appliances (no refrigerator or stove), or family members have odd restriction, e.g. not allowing people to use the toilet. The family is highly critical of the patient. Her mother is disappointed in that she had so much promise but is caught up with drugs. The men in the family (father and brother) reportedly apply power dynamics to get patient to give them money or care for her niece and nephew; sometimes there is physical force and threatening (e.g., patient has come in with bruises and once a small puncture wound reportedly from a knife). Pt's hygiene is typically fair. Patients' family history is significant for substance use, patient has two maternal aunts who died from drug overdoses. Patient typically presents as talkative and cheerful and minimizes negative feelings.

Pt. is not married and does not have any of her own children. Pt. says that her brother interferes when men express an interest in her.

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Medical, Behavioral, Mental Health History

Medical diagnoses include: Reportedly supraventricular tachycardia; Hx of hospitalization for endocarditis; patient reports that she is supposed to be followed by a cardiologist and should have EKG's weekly to monitor her heart function. Referral was sent, but pt is not in the care of a cardiologist now. Pt had Hep C but was treated with Mavyret in our program.
Pt. has repeated cold sores treated with acyclovir 400mg
Pt also has dental discomfort; she has been recommended to have all her teeth pulled. Pt. lives in an area where there is no fluoridation of the water; however our dentists reported excessive damage from meth. Pt. was embarrassed at the shock our dentist displayed about her dental decay and would not return to see him but reportedly is scheduled for denture care at another practice.

Substance use diagnoses include opioid use disorder and stimulant use disorder (meth). OUD is treated with suboxone (8-2 mg film- once a day) and we believe she has been taking these as prescribed. Patient has tested positive for stimulants almost weekly. The longest period of time that she had UDS not positive for stimulants was 6 weeks after she learned of the death of her former boyfriend. But she returned to active use and about 6 weeks ago, She had a car accident that totaled her car; she fell asleep at the wheel subsequent to meth use. Patient also smokes cannabis daily. When she has stopped meth use briefly, she typically says that she gets meth from the person from whom she gets cannabis.

Patient's mental health diagnoses is primarily PTSD and MDD-moderate. Pt's index trauma for recent symptoms (flashbacks/nightmares) have been the recent death of her former boyfriend (April 2022); prior symptoms (flashbacks/nightmares) related to the group rape; developmental trauma includes sexual abuse at age 5yo; emotional abuse from father; witnessing overdose death of aunt as a child; she was also a victim of domestic violence in her relationship with her former boyfriend. Pt. takes Venlafaxine HCl ER 150mg capsule once a day.
MDD- moderate; pt's PHQ9 scores generally indicate a moderate level of depression although she presents as cheerful and friendly. Pt. takes Wellbutrin XL (150 mg tablet once at day) - its also hoped this could help with stimulant cravings.

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Past Interventions

Pt. reports that our program is her first experience in substance use disorder or mental health treatment. Pt has remained in the 'red' phase of treatment meaning she has weekly group therapy, UDS, and medical visits. Because her rural community is almost a 2 hr drive from our site, we have allowed patient to have alternating virtual visits for medical and group and she does her UDS at our site located in her community. Pt. has participated in some individual therapy as well that has focused on recognizing the effects of trauma, providing support, encouraging relapse prevention, and also interpersonal therapy recognizing some of the relationship dynamics that keep her in a cycle of pleasing others to the detriment of her own well being.

After pt. had her single car accident from falling asleep, we did have one family session with patient and her mother where patient acknowledged using to her mother. Patient was able to verbalize how she feels she is on the edge of life and death. We strongly recommended a higher level of care. Said that she really wanted her father's approval to go to treatment. Mother had promised to discuss this with father. Patient has continued to see us weekly and when we ask about moving to higher level of care, she says she is still thinking about it, but is constantly saying she cannot go because she needs to provide financial for her parents, and provide care for her niece and nephew.

Pt's brother and the mother of patient's niece and nephew have also been in our program.

Future Plans, Patient's Treatment Goals

We had encouraged patient to go to residential treatment so that she could have time away from her family to focus on herself. We've encouraged more individual sessions; Pt seems to have excellent insight in individual sessions; but then she also has a tendency to try to say what we might want to hear.

For the long term, Pt. has said that she wants to complete her degree. She likes care giving and would like to be a teacher. She would like to live independently.

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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:

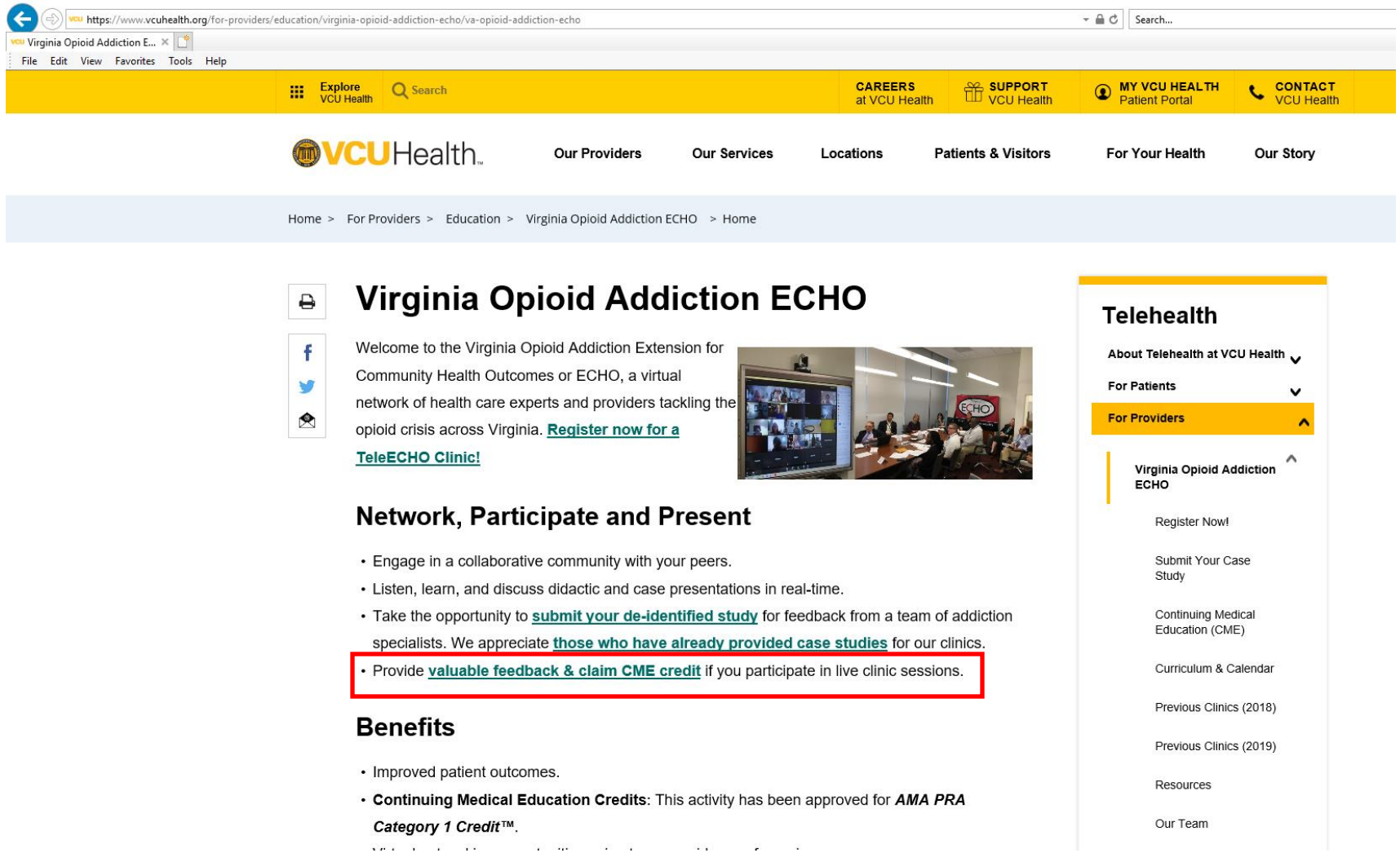
- **Ademola Adetunji, NP** from Fairfax County CSB
- **Tara Belfast-Hurd, MBA-PA** from Department of Behavioral Health and Developmental Services
- **Michael Bohan, MD** from Meridian Psychotherapy
- **Ramona Boyd, NP** from Health Wagon
- **Diane Boyer, DNP** from Region Ten CSB
- **Melissa Bradner, 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

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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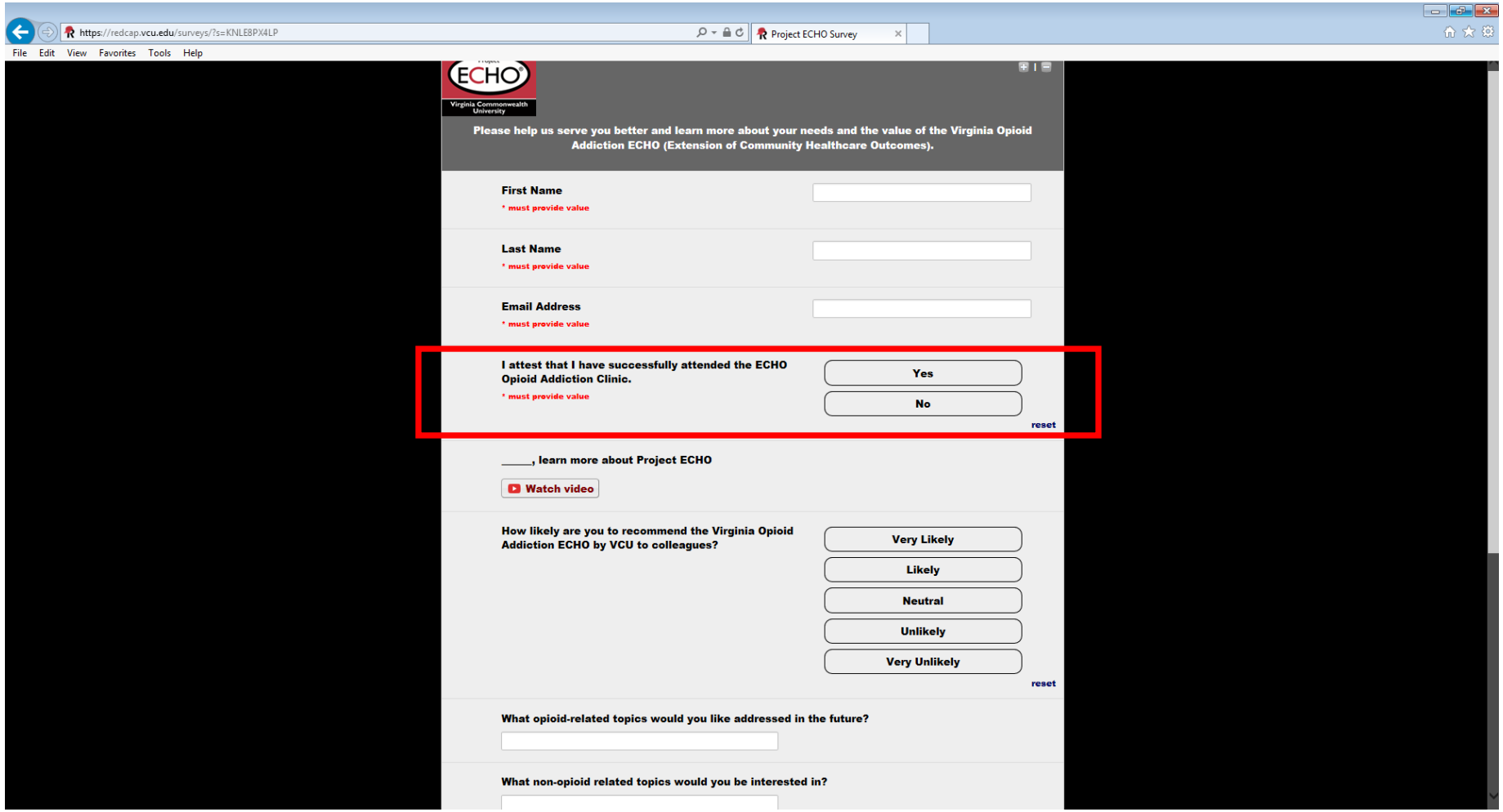

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- www.vcuhealth.org/echo
  - To view previously recorded clinics and claim credit

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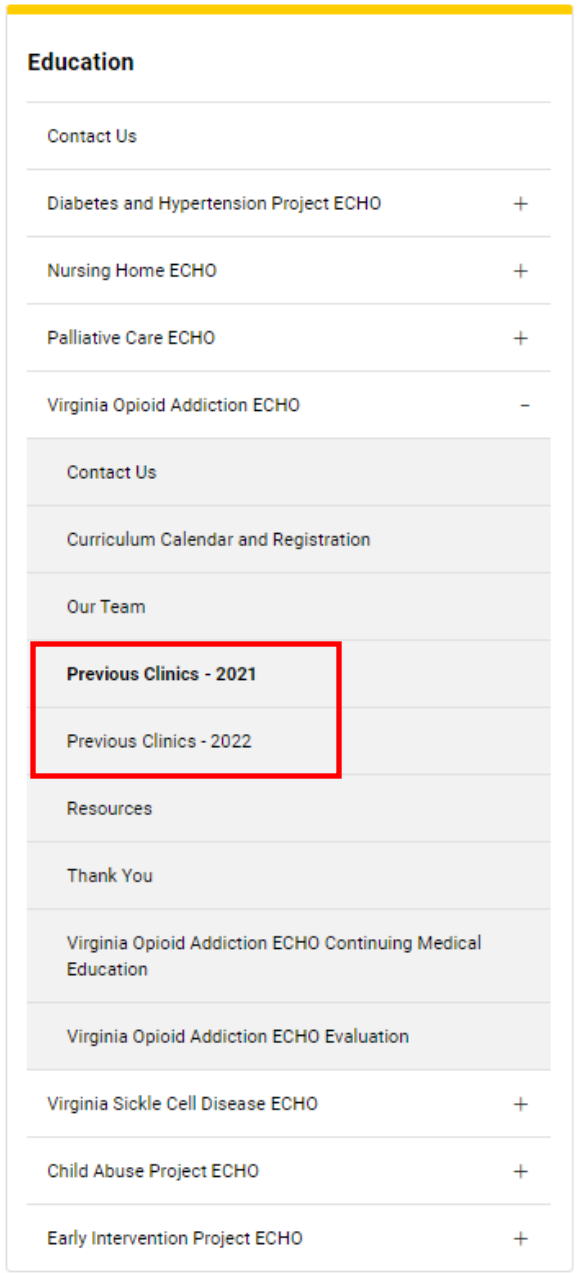

Previous Clinics - 2021

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

VCU Virginia Opioid Addiction TeleECHO Clinics

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

Mark Your Calendar --- Upcoming Sessions

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

Project ECHO®
Virginia Commonwealth University

THANK YOU!

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