Virginia Opioid Addiction ECHO* Clinic

August 2, 2019

*ECHO: Extension of Community Healthcare Outcomes
• Rename your Zoom screen, with your name and organization
Helpful Reminders

- You are all on mute please unmute to talk
- 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

• 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 in substance use disorder
• Website Link: www.vcuhealth.org/echo
Disclosures

There are no financial conflicts of interest to disclose for today’s session.

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

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Director</td>
<td>Gerard Moeller, MD</td>
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<tr>
<td>Administrative Medical Director ECHO Hub</td>
<td>Vimal Mishra, MD, MMCi</td>
</tr>
<tr>
<td>Clinical Expert</td>
<td>Lori Keyser-Marcus, PhD</td>
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<td></td>
<td>Courtney Holmes, PhD</td>
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<td>Albert Arias, MD</td>
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<td>Kanwar Sidhu, MD</td>
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<tr>
<td>Didactic Presentation</td>
<td>Patricia Kinser, PhD, RN</td>
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<tr>
<td>Program Manager</td>
<td>Bhakti Dave, MPH</td>
</tr>
<tr>
<td>Practice Administrator</td>
<td>David Collins, MHA</td>
</tr>
<tr>
<td>IT Support</td>
<td>Vladimir Lavrentyev, MBA</td>
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</tbody>
</table>
Introductions:

• Name
• Organization

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for Introduction
What to Expect

I. Didactic Presentation
   I. Mindfulness for Healthcare Professionals
      II. Patricia Kinser, 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

Let's get started!
Didactic Presentation
MINDFULNESS FOR HEALTHCARE PROFESSIONALS

Project ECHO

Patricia Kinser, PhD, WHNP-BC, RN, FNAP, FAAN

August 2, 2019
Challenges to Healthcare Professional Well-being

• Burnout
• Secondary trauma
• Moral distress
• Patient demands
• Institutional demands
• Clinical errors
• Feelings of inadequacy
It can be easy to unravel in the face of suffering…

… or detach completely:
Can We Maintain Compassion in the Face of Suffering?

The size of the circles indicates the ability to positively impact others.
Mindfulness

• Definition
• Practice
• Way of life
“Mindfulness means paying attention in a particular way; on purpose, in the present moment, and non-judgmentally.”

Jon Kabat-Zinn
Goal of mindfulness: Finding the “sweet spot”
Mindfulness

• Definition

• Practice
  - Formal
  - Informal
Example of a formal practice:

1. Sit cross-legged on a cushion on the floor or in a chair. Keep your back straight and let your shoulders drop. Take a deep breath and close your eyes if you wish.

2. Notice your breath. Don't change your breathing, but focus on the sensation of air moving in and out of your lungs.

3. As thoughts come into your mind and distract you from your breathing, acknowledge those thoughts and then return to focusing on your breathing each time.

4. Don't judge yourself or try to ignore distractions. Your job is simply to notice that your mind has wandered and to bring your attention back to your breathing.

5. Start by doing this 10 minutes a day for a week. The more you meditate regularly, the easier it will be to keep your attention where you want it.
Not Just Meditation
Examples of Informal Practices

Stop. Breathe. Be.
IS THIS NEW-AGE HOCUS-POCUS?
Mindfulness: the next generation of exercise

1970’s and 80’s

• Physical activity was increasingly accepted to be essential for health

Today

Research is showing that mindfulness enhances physical & mental wellness

• In clinical populations: DM2, cancer, chronic pain, heart disease, HIV/AIDS, anxiety disorders, PTSD, depression, substance abuse, eating disorders
• In healthcare professionals
• In healthy populations
Mindfulness training modulates insular cortex signals in ventromedial prefrontal cortex (vmPFC) during meditation.
Enhanced Psychosocial Well-Being Following Participation in a Mindfulness-Based Stress Reduction Program Is Associated with Increased Natural Killer Cell Activity: Mindfulness-Expressive Therapy and Controls in Distressed Breast Cancer Patients.

Carolyn Y. Fang, Ph.D., Diane K. Reibel, Ph.D., Margaret L. Longacre, Ph.D., Steven Rosenzweig, M.D., Donald E. Campbell, Ph.D., and Steven D. Douglas, M.D., Linda E. Carlson, Ph.D., Tara L. Beattie, Ph.D., Janine Giese-Davis, Ph.D., Peter Faris, Ph.D., Hiro Tamagawa, Ph.D., Laura J. Fick, Ph.D., Erin S. Degelman, MSc., and Michael Specia, PsyD.
"Awareness is the first step": An interprofessional course on mindfulness & mindful-movement for healthcare professionals and students

Patricia Kinser a,b, Sarah Braun b, George Deeb c, Caroline Carrico d, Alan Dow e

<table>
<thead>
<tr>
<th>Study variable</th>
<th>Baseline mean (SD) or n (%)</th>
<th>End of intervention mean (SD) or n (%)</th>
<th>p</th>
<th>95% CI on the difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived stress (PSS)</td>
<td>23.0 (5.5)</td>
<td>20.8 (3.8)</td>
<td>0.0372</td>
<td>(0.14–4.37)</td>
</tr>
<tr>
<td>Depression (PHQ9)</td>
<td>5.3 (3.7)</td>
<td>4.3 (4.1)</td>
<td>0.188</td>
<td>(−0.52 to 2.52)</td>
</tr>
<tr>
<td>State anxiety (STAI)</td>
<td>39.5 (11.6)</td>
<td>31.9 (9)</td>
<td>0.0036</td>
<td>(2.75–12.59)</td>
</tr>
<tr>
<td>Ruminations (RRS)</td>
<td>15.8 (8.7)</td>
<td>15.5 (8.8)</td>
<td>0.7095</td>
<td>(−1.49 to 2.15)</td>
</tr>
<tr>
<td>Emotional exhaustion (MBI subscale)</td>
<td>22.5 (11.9)</td>
<td>16.9 (9.7)</td>
<td>0.0023</td>
<td>(2.20–9.06)</td>
</tr>
<tr>
<td>Burnout: depersonalization (MBI subscale)</td>
<td>63.5 (5.3)</td>
<td>43.2 (4.2)</td>
<td>0.0106</td>
<td>(0.53–3.62)</td>
</tr>
<tr>
<td>Personal accomplishment (MBI subscale)</td>
<td>37.5 (6.8)</td>
<td>38.8 (6.4)</td>
<td>0.0945</td>
<td>(−2.83–0.24)</td>
</tr>
</tbody>
</table>

Note: lower scores indicate decreased symptoms in the PHQ9, PSS, RRS, and STAI; in the personal accomplishment score of the MBI, a higher score indicates enhanced personal accomplishment.
Study #2:

Reductions in Burnout
( on emotional exhaustion sub-scale)

Braun, S. et al (2019, in review)
In Conclusion: Putting It All Together
Mindfulness is…

• Formal practices- using an app for meditation, going to yoga class, scheduling a seated meditation practice
• Informal practices—
  • Avoiding multitasking; one task at a time is good for the brain
  • Walking meditation, no phone; focus on the walking and what is around you.
  • Eating a meal silently, no phone, tablet, computer.
  • Taking 3 deep breaths when you awaken and just before sleep.
  • Stop-Breathe-Be before entering a patient room/ starting a patient encounter
  • Scheduling play time.
  • Laughing because you can
  • Listening to what your body tells you; rest when tired and stretch when tense
  • Practicing gratitude
Remember:

• Evidence suggests that it does not matter whether you practice alone or in a group

• It also does not matter the pattern of practice

• What matters is finding what works for you and staying with it over time
Want to Learn More?

Resources:

- Videos-
  - Dan Harris- “Why Mindfulness is a Superpower”:
    https://www.youtube.com/watch?v=w6T02g5hnT4
  - David Foster Wallace- “This is Water”:
    https://vimeo.com/188418265
  - Brene Brown- on empathy:
    www.youtube.com/watch?v=1Evwgu369Jw

- Apps- “Insight Timer”; “Headspace”; “Calm”; “Ten Percent Happier”
A Small Sample of Great Books-
- Dan Harris: “Ten Percent Happier”; “Meditation for Fidgety Skeptics”
- Kabat-Zinn, J.: “Mindfulness for Beginners”; “Wherever you go, there you are”; “Meditation is Not What You Think”, etc.
- Chozen Bays, J. “How to Train a Wild Elephant”
- O’Hara, R. “Most Intimate: A Zen Approach to Life’s Challenges”
Questions?

Contact me:

Patricia Kinser
kinserpa@vcu.edu
Case Presentation #1
Dan Spencer, 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
Case Presentation
Dan Spencer, MD

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

We'd like to understand how others are managing agitation during detox? What type of protocols, staffing, resources are you utilizing to maintain patient and staff safety during a complicated detox situation with aggressive behavior? What are the legal/ethical implications of keeping a minor patient against his/her will to complete the detox due to serious complications once started?

Case History

Attention: Please DO NOT provide any patient specific information nor include any Protected Health Information!

Demographic Information (e.g. age, sex, race, education level, employment, living situation, social support, etc.)

17-year old Caucasian female rising 12th grader, living with her mother (who has her own significant alcohol use disorder and mental illness), step-father and younger brother. Reported close relationship with brother, patient/mother have a difficult relationship. Bio father not involved. Often gone from the home several days at a time, only returns home when she is ill. Extensive legal history, has been in juvenile detention, homeland security involved due to concerns of human trafficking. Intermittent CPS involvement, currently not for patient, but for brother.

Daily alcohol usage. Started at age 11, has been daily for past year. Consumes hard alcohol, at least 1 liter/day (sometimes more). Benzo misuse (alprazolam), previous overdose on clonazepam.

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physical, Behavioral, and Mental health background information (e.g. medical diagnosis, reason for receiving opioids, lab results, current medications, current or past counseling or therapy treatment, barriers to patient care, etc.)

Medical diagnoses of asthma, seizure disorder by history, acute alcohol intoxication/withdrawal (no prior medically supervised detox). Herpes without medication compliance, treated previously for multiple STI’s, HIV negative. Medication non-compliance throughout history. History of residential treatment for 1-year during which she did well, then unable to maintain progress once returned home. Several acute psychiatric inpatient admissions, unknown if any routine outpatient care participation. Closely followed by our child advocacy center case manager.

Barriers include relationship with mother, mother’s own addiction, suspected involvement in human trafficking (victim) with an extensive trauma history dating back to early childhood. Age precludes her from care in adult facilities that have more experience managing detox.
Case Presentation
Dan Spencer, MD

What interventions have you tried up to this point?
Additional case history (e.g. treatments, medications, referrals, etc.)

Treatment included a 17-day medical hospitalization for acute alcohol detox. Presented to emergency department after altercation with mother and given options of going to detention vs going to the hospital for treatment. BAC on arrival was 453, positive THC. Sodium, Magnesium and Chloride high, calcium low. During approximately 12 hour ED course, she received 8 mg IM Ativan, additional 3mg IV Ativan, Haldol 5mg, as well as Thiamine 100mg IV. She slept for some of the time and was agitated when awake, pulled out IV, aggressive toward staff and mechanically restrained, then admitted to the PICU, in restraint. She was started on Precedex drip, Ativan 2mg IV q6h, and Ativan 2mg IV q1h PRN agitation; Ativan increased to max of 4mg q2h and Precedex increased to max of 1mcg/kg/hour. Ongoing breakthrough agitation, with 3 doses of Haldol 5 mg IM (3 different days). 8-days of management of considerable aggression/agitation (difficult to differentiate withdrawal from underlying psyh symptoms), on the 8th day was able to better self-regulate and would respond to behavior planning. Ativan weaned to 4mg every 3 hours, and slowly continued based on CIWA scoring. Weaned off Precedex by day 10, then restarted day 11 secondary to agitation; weaned off again day 13 after started on 0.1mg Clonidine patch on day 12 (concern for withdrawal from precedex). Restarted on prior home med Seroquel on day 8 targeting poor sleep and mood and behavioral dysregulation/lability, end dose 50mg qAM, 150mg qhs; Zoloft restarted on day 9, for depression 50mg. Transferred to medical floor on day 14, Ativan weaned to 2mg q6h while awake.

Patient has several outbursts during course that resulted in destruction of property in the room, first day punched a police officer in the face (while intoxicated), CSB evaluated for acute inpatient, patient voluntary at the time. Patient successfully transferred to acute inpatient on day 17. From there patient reportedly going to juvenile detention with team hopes of transitioning to a RTC for continued dual diagnosis care. Of note, patient had a seizure at acute facility on day 19, was taken to adult ER, treated and returned to acute.

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Use chat function for questions
What is your plan for future treatment? What are the patient's goals for treatment?

Our child advocacy center will remain involved. Unless patient presents to emergency department or needs inpatient medical care we will likely not re-engage for treatment. We will be referring her to adult substance use and mental health treatment, as she is 18 this fall. Patients goals for treatment unknown at this time. She vacillates between reporting desire to stop using alcohol and wanting to continue use due to not wanting to engage in trauma treatment.

Other relevant information

We are looking to establish formal protocols for management of acute withdrawal. We had daily multidisciplinary meetings to coordinate care which was very resource intensive. We are hoping to learn from others so we can be more proactive and efficient and less reactive, as we believe this will improve care.

REMINDER: Please ensure that NO patient specific identifiable information (PHI) is included in this submission. Please read, sign, and click SUBMIT when completed.
Case Presentation #2
Diane Boyer, MD

• 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

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Case Presentation
Diane Boyer, MD

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

Patient in Suboxone treatment for Opioid Use Disorder - long history of opioid use disorder - past history of methadon treatment and Suboxone treatment. Currently being treated for Cancer related pain. Prescribing MD wanting to continue Suboxone and had added Morphine. Looking for additional information on how best to treat opioid use disorder and cancer related pain.

Case History

Attention: Please DO NOT provide any patient specific information nor include any Protected Health Information!

Demographic Information (e.g. age, sex, race, education level, employment, living situation, social support, etc.)

54 yo, male, caucasian, post high school, carpentry work with father, with mother and father and two children

Physical, Behavioral, and Mental health background information (e.g. medical diagnosis, reason for receiving opioids, lab results, current medications, current or past counseling or therapy treatment, barriers to patient care, etc.)

Non small cell cancer of spinal chord with brain mets, opioid use disorder. Suboxone, Morphine Amitriptyline, has completed Gamma knife and radiation interventions is again able to complete ADLs and is working some in carpentry. Was being seen monthly in OBOT before diagnosis and receiving therapy monthly.

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Case Presentation
Diane Boyer, MD

What interventions have you tried up to this point?
Additional case history (e.g. treatments, medications, referrals, etc.)

No relapse in over a year while dealing with severe chronic pain for last 5 months without diagnosis. MRI during pain management eval revealed cancer

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

Working closely with Palliative Care MD, my role opioids disorder treatment, his role pain management. Patient's goal - to live as long as he can and be as highly functioning as possible, enjoys working, wants to be around for his children as long as possible, children are pre-teenagers. Patient's parents are reliable and supportive.

Other relevant information

Pain is being well controlled after addition of Morphine to Suboxone

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Case Studies

• Case studies
  • Submit:  www.vcuhealth.org/echo
  • Receive feedback from participants and content experts
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:

- Michael Bohan, MD from Meridian Psychotherapy
- Diane Boyer, DNP from Region Ten CSB
- Melissa Bradner, MD from VCU Health
- Michael Fox, DO from VCU Health
- Shannon Garrett, FNP from West Grace Health Center
- Sharon Hardy, BSW, CSAC from Hampton-Newport News CSB
- Sunny Kim, NP from VCU Health
- Thokozeni Lipato, MD from VCU Health
- Caitlin Martin, MD from VCU Health
- Faisal Mohsin, MD from Hampton-Newport News CSB
- Stephanie Osler, LCSW from Children’s Hospital of the King’s Daughters
- Jennifer Phelps, BS, LPN from Horizons Behavioral Health
- Crystal Phillips, PharmD from Appalachian College of Pharmacy
- Tierra Ruffin, LPC from Hampton-Newport News CSB
- Jenny Sear-Cockram, NP from Chesterfield County Mental Health Support Services
- Daniel Spencer, MD from Children’s Hospital of the King’s Daughters
- Cynthia Straub, FNP-C, ACHPN from Memorial Regional Medical Center
- Barbara Trandel, MD from Colonial Behavioral Health
- Bill Trost, MD from Danville-Pittsylvania Community Service
- Art Van Zee, MD from Stone Mountain Health Services
- Sarah Woodhouse, MD from Chesterfield Mental Health
Claim Your CME and Provide Feedback

- [www.vcuhealth.org/echo](mailto: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

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 Credit™.
Access Your Evaluation and Claim Your CME
Access Your Evaluation and Claim Your CME

- [www.vcuhealth.org/echo](http://www.vcuhealth.org/echo)

- To view previously recorded clinics and claim credit
Access Your Evaluation and Claim Your CME

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Benefits

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## Previous Clinics (2019)

Review topics covered in previous Virginia Opioid Addiction ECHO clinics. Visit our [Curriculum and Calendar](#) for upcoming clinic topics.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Date</th>
<th>Resources</th>
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</thead>
<tbody>
<tr>
<td>Trauma Informed Care and Treating Those Experiencing Opioid Addiction</td>
<td>01/04/19</td>
<td>Video of Clinic Slide Presentation</td>
</tr>
<tr>
<td>Syringe Exchange</td>
<td>05/15/19</td>
<td>Video of Clinic Slide Presentation Needle Exchange Program Flyer Bill to Remove Cooperation Law</td>
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</table>

Learning Objectives:

1. Identify individuals who have experienced trauma.
2. Understand the impact of trauma on human development particularly related to substance use and misuse.
3. Learn components of trauma informed care.
4. Understand current legislative landscape in regards to syringe exchange in VA.
5. List benefits to clients and community of syringe exchange.
6. Define harm reduction.
VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

Mark Your Calendar --- Upcoming Sessions

**August 16:** Pain Management and Prescribing Practices with Dental and Surgical Procedures
Presenter: Omar Abubaker, DMD, PhD

Please refer and register at vcuhealth.org/echo
THANK YOU!

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