Virginia Opioid Addiction ECHO* Clinic

March 20, 2020

*ECHO: Extension of Community Healthcare Outcomes
Helpful Reminders

- Rename your Zoom screen, with your name and organization.

Virginia Opioid...
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
- Website Link: www.vcuhealth.org/echo
## Hub and Participant Introductions

### VCU Team

<table>
<thead>
<tr>
<th>Role</th>
<th>Names and Titles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Director</td>
<td>Gerard Moeller, MD</td>
</tr>
<tr>
<td>Administrative Medical Director</td>
<td>Vimal Mishra, MD, MMCi</td>
</tr>
<tr>
<td>ECHO Hub</td>
<td></td>
</tr>
<tr>
<td>Clinical Experts</td>
<td>Vimal Mishra, MD, MMCi</td>
</tr>
<tr>
<td>Didactic Presentation</td>
<td>Lori Keyser-Marcus, PhD</td>
</tr>
<tr>
<td></td>
<td>Courtney Holmes, PhD</td>
</tr>
<tr>
<td></td>
<td>Albert Arias, MD</td>
</tr>
<tr>
<td>Program Manager</td>
<td>Andrew Chapman, MD</td>
</tr>
<tr>
<td>Practice Administrator</td>
<td>Bhakti Dave, MPH</td>
</tr>
<tr>
<td>IT Support</td>
<td>David Collins, MHA</td>
</tr>
<tr>
<td></td>
<td>Vladimir Lavrentyev, MBA</td>
</tr>
</tbody>
</table>

- **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. Andrew Chapman, MD
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
Opioids: Have We Gone too Far?

Are Patients Suffering?

Andrew Chapman MD
Asst. Professor of Anesthesiology
VCU Spine and Pain
Disclosures

• None
Outline

• The Current and Future Crisis
• Risks of Chronic Opioid Therapy
• The CDC Guidelines, re-visited
• Keeping Prescribers and Patients Safe
Has the Pendulum reached Terminal Velocity?

- March 2016: CDC Guidelines released

- May 2017: FSMB releases report \( \rightarrow \) most State Medical Boards subsequently release guidance discouraging high dose Opioids
  
  https://www.dhp.virginia.gov/medicine/leg/Medicine_Opioid_Regs_08082018.doc

- October 2017: President Trump declares state of Emergency

- January 2019: CMS limits Opioid naïve patients to initial 7-day Rx, even for chronic pain. \( > 90 \text{ MED triggers a “safety alert” requires consultation with Pharmacist} \)
Opioid Prescribing in the United States Before and After the Centers for Disease Control and Prevention’s 2016 Opioid Guideline.

Bohnert ASB¹, Guy GP Jr², Losby JL².

• CDC and IQVIA date from 2012-2017 comprising 90% retail Rx’s

• Opioid Prescribing rate and high dose (> 90 MED) prescriptions decreased significantly from 2016-2017

• Average MED dose, short term RXs (< 7 days) and % of patients started on ER/LA Opioids DOWN

• Patients on combination Benzo+Opioids decreased by only 1%
**Figure 1**

Overall prescribing rate and dosage-related outcomes before and after release of the CDC’s *Guideline for Prescribing Opioids for Chronic Pain* in March 2016.
Volumes are Down

Opioid prescriptions in the US, 2006–2016

Prescription opioid volume peaked in 2011 at 240 billion milligrams of morphine equivalents and have declined by 29% to 171 billion.

Chart 16: Narcotic Analgesic Dispensed Volume in Morphine Milligram Equivalents (MME) Bn

Source: CDC

Source: IQVIA "SMART - Launch Edition", Dec 2017
Deaths are Up

3 Waves of the Rise in Opioid Overdose Deaths

Trends in 2017 - 2018

**TABLE 3. Changes in the number and percentage of opioid deaths co-occurring with benzodiazepines, cocaine, and methamphetamine, by type of opioids involved in death — 25 states,* State Unintentional Drug Overdose Reporting System (SUDORS), July—December 2017 to January—June 2018**

<table>
<thead>
<tr>
<th>Type of opioid involved in death</th>
<th>Benzodiazepines&lt;sup&gt;*&lt;/sup&gt;</th>
<th>Cocaine&lt;sup&gt;†&lt;/sup&gt;</th>
<th>Methamphetamine&lt;sup&gt;†&lt;/sup&gt;</th>
<th>None of the three drugs&lt;sup&gt;†&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>All opioids&lt;sup&gt;§&lt;/sup&gt;</td>
<td>-264 (-5.7)&lt;sup&gt;§&lt;/sup&gt;</td>
<td>-106 (-2.3)&lt;sup&gt;§&lt;/sup&gt;</td>
<td>206 (14.6)&lt;sup&gt;§&lt;/sup&gt;</td>
<td>-437 (-8.0)&lt;sup&gt;§&lt;/sup&gt;</td>
</tr>
<tr>
<td>Any IMF&lt;sup&gt;‡‡&lt;/sup&gt;</td>
<td>256 (11.3)&lt;sup&gt;‡‡&lt;/sup&gt;</td>
<td>445 (14.0)&lt;sup&gt;‡‡&lt;/sup&gt;</td>
<td>241 (31.0)&lt;sup&gt;‡‡&lt;/sup&gt;</td>
<td>217 (6.7)&lt;sup&gt;‡‡&lt;/sup&gt;</td>
</tr>
<tr>
<td>Illicit opioid, no IMF&lt;sup&gt;‡&lt;/sup&gt;</td>
<td>-389 (-39.0)&lt;sup&gt;‡&lt;/sup&gt;</td>
<td>-514 (-42.9)&lt;sup&gt;‡&lt;/sup&gt;</td>
<td>-69 (-14.7)&lt;sup&gt;‡&lt;/sup&gt;</td>
<td>-537 (-43.3)&lt;sup&gt;‡&lt;/sup&gt;</td>
</tr>
<tr>
<td>Prescription opioid, no illicit opioid&lt;sup&gt;‡‡&lt;/sup&gt;</td>
<td>-131 (-9.7)&lt;sup&gt;‡‡&lt;/sup&gt;</td>
<td>-37 (-12.2)&lt;sup&gt;‡‡&lt;/sup&gt;</td>
<td>34 (20.5)&lt;sup&gt;‡‡&lt;/sup&gt;</td>
<td>-117 (-12.0)&lt;sup&gt;‡‡&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

- Heroin and Illicit Fentanyl implicated in <u>83% of > 13K OD deaths</u> from Jan-June 2018

- Chen modeled future trends based on CDC and NSDUH data from 2002-2015

- Total OD deaths expected to rise significantly from 2020-2025
Opioids: Physical Risks

- Long term opioid therapy (LTOT) increases CV risk and reduces testosterone. Doses > 20 MED increase risk of MVA's

- **Opioid use > 30 days independently increased risk for new onset clinical depression**

- Patients on high dose LTOT had increased risk of suicide → behavioral disinhibition???

- Elderly patients on LTOT had *increased risk of fractures* compared with cohort on NSAIDs


Opioids: Misuse and Abuse

- 2015 NSDUH survey: 13% **Opioid misuse** and almost 20% self reported an OUD.

- **Misuse**: Young (18-25), uninsured/unemployed, low SE status, co-existing depression/anxiety, tobacco use.

- **Overdose**: non-Hispanic white males aged 45-54.

- 40% of Opioid Abusers obtain Rx from Friends and Family. CDC estimates that 80% of Heroin users start with prescription opioids

- Meltzer found 23% misuse rate and 85% **aberrant use** at an Urban, Academic center


Opioids: Short Term Rx, Long Term use

- Patients become **physically dependent and tolerant in as little as 2 weeks, with an average of 4 weeks**.

- Brummett: 6% incidence of chronic opioid use (> 6 months postop) in an Opioid-naïve cohort

- **Risks for chronic use**: low SE status, depression, Substance/Tobacco abuse, **preop chronic pain**, BZD use, male sex.

- **Degree of Post-Surgical pain irrelevant!!!**


Dramatically increased opioid doses did not reduce reported pain levels. Higher dose opioids worsened pain scores → Opioid induced Hyperalgesia.
Opioids: High Dose = High Risk

Association between opioid prescribing patterns and opioid overdose-related deaths.

Bohnert AS¹, Valenstein M, Bair MJ, Ganoczy D, McCarthy JF, Ilgen MA, Blow FC.

- **1136 OD deaths** among 155,000 VA patients on LTOT between FY 2004-2008

- **Highest Risk**: depressed, middle aged white male with coexisting substance abuse, CV Disease and OSA on **MED > 50**

- Many OD deaths on 0 MED (in VA system) → doctor shopping, **diversion and hoarding of pills**
Chronic Pain: Do Opioids work?

The effectiveness and risks of long-term opioid therapy for chronic pain: a systematic review for a National Institutes of Health Pathways to Prevention Workshop.

Chou R, Turner JA, Devine EB, Hansen RN, Sullivan SD, Blazina I, Dana T, Bougatsos C, Deyo RA.

- Chou's 2015 paper in Annals culled Cochrane database and Medline for studies on LTOT (> 3 months)

- No study evaluated the long term (> 1 year) effectiveness of opioid vs. non opioid treatments

- **Insufficient evidence to support opioids for chronic pain.** Dose reduction lowers risk
• 150 new patients at a Tertiary Pain clinic: Opioid users (56%): higher pain, worsened physical function and depression

• **66.3% of patients reported moderate-high Opioid related difficulties yet continued to assess Opioid therapy as helpful or very helpful**

• 71% of chronic Opioid users reported < 30% pain relief; 27% of patients had < 1 hour of pain relief after taking a pill

*Do patients find Opioids “helpful” only to avoid withdrawal symptoms?*
• SPACE Trial randomized 240 VAMC patients with chronic orthopedic pain into an Opioid and non-Opioid arm

• Primary endpoint: pain related function (BPI). Secondary endpoint: pain intensity

• **No significant difference in pain related function between groups**

• **Non opioid arm had significantly lower pain intensity**

• **Opioid group had significantly higher adverse medication effects and higher dropout**
Opioids: Tapering 101

https://online.stanford.edu/courses/som-ycme0022-how-taper-patients-chronic-opioid-therapy
Opioid Tapers: BRAVO!

- Broach the Subject compassionately
- Risk-Benefit Calculator: Side Effects, Function, Pain Relief
- Addiction Happens: Recognize and treat OUD
- Velocity Matters: Go Slow, Take Breaks, Never go Back!
- Other Ways to talk about Pain: CBT, reframing, support
Opioids: Do Tapers Help?

- Fishbain reviewed 20 retrospective and prospective studies from 1966-2017 in which 2109 patients had opioid dose reduced.

- Half of patients completely tapered off. Avg. Taper length = 45 days. MED Doses < 50 to > 1000.

- 82% studies reported pain improvement by taper completion, 15% reported same pain levels

- Patients offered multidisciplinary treatment did better
Opioids: Do Tapers Help?

- Sullivan et al. randomized patients *voluntarily* tapering Opioids into a taper support and usual care group

- Opioid Doses from < 25 to > 1000 MED. Length of program 22 weeks. **Opioid doses tapered by 50% or to < 120 MED**

- Neither group experienced increase in pain levels. **Supported taper group had significantly less pain interference, better self efficacy and better functional outcomes.**
Opioids: Maybe Tapers Don’t Help?

• Heavily cited 2018 paper surveyed 362 patients tapered down/off ER/LA Opioids with a 16-point online questionnaire post hoc

• *These patients were all members of a Chronic Pain Advocacy Group*

• Majority of respondents (55%) reported either *no change or reduced pain levels*, and only 27% had worse relationship with their Doctor

Opioid Tapers: The New Normal

• Fenton et al. followed over 100,000 LTOT patients from 2008-2017

• Taper cohort increased from 10.7% in 2007 to 23% in 2017

• **Females, high dose (>300 MED) more likely to be tapered** but taper frequency increased for all groups > 50 MED

• Average dose taper 18% per month; **higher MED dose and 2015-2017 tapers exceeded 40% per month**
Bad Press

Faced with an outcry over limits on opioids, authors of CDC guidelines acknowledge they’ve been misapplied

By ANDREW JOSEPH @DrewJoseph and ED SILVERMAN @Pharmalot / APRIL 24, 2019

CDC Advises Against Misapplication of the Guideline for Prescribing Opioids for Chronic Pain

Some policies, practices attributed to the Guideline are inconsistent with its recommendations

How aggressive opioid tapering nearly drove an Oregon couple to suicide

Could CDC guidelines be driving some opioid patients to suicide?

Opioid Tapers: Too Much, Too Soon?

• A group of experts met in late 2017 to discuss consequences of CDC guideline application

• Many high dose (>90 MED) patients reported abrupt and involuntarily tapers. Some had worse pain and withdrawal symptoms

• **Panel cited lack of insurance coverage for multidisciplinary care**, Naloxone underutilization (<50% OD deaths in WA state) and need for comprehensive OUD treatment

• Concern that high dose Opioid patients abruptly dismissed may turn to Heroin and illicit drugs

• Suicidal ideation and self harm rare and anecdotal; unclear whether taper was causative

---

The CDC Guidelines


What They Say

• Opioids lack evidence for chronic pain and have well known health risks

• Don’t use Opioids as first line treatment, document encounters, avoid risky polypharmacy (Benzos)!

• Review PDMP, do urine drug testing periodically, and caution when escalating past 50 MED

• Consider taper for patients > 90 MED if poor function, SE problems. Consider consult with Pain Specialist

What They Don’t Say

• That you need to taper everyone to < 90 MED

• That a Pain Specialist or third party needs to take over prescribing responsibility for your Opioids

• That you must immediately discontinue Opioids if a patient is taking Benzodiazepines

• That you can’t prescribe long acting ("ER/LA") Opioids - Methadone, OxyContin, Fentanyl
“The CDC regulations are reasonable and provide practitioners great latitude in treatment. The regulations do not have ceiling doses for opioids and do not require reductions to levels that are ineffective for the patient’s pain.”

The CDC Regulations “**Do require that the rationale for continuing treatment and the dose written be clearly documented in the patient's medical record**”

“If the clinical decision is to reduce the amount of opioid, the tapering should be done safely and competently. The Board recommends the Stanford Course on tapering by Anna Lembke, MD; it is an excellent guideline for tapering opioids safely with as little discomfort and risk to the patient as possible”
The Bottom Line from the CDC

“Clinicians should not interpret opioid reduction messages...to automatically and immediately reduce or stop LTOT or dismiss patients with risk factors from care”
Mea Culpa?

Perspective

No Shortcuts to Safer Opioid Prescribing

Deborah Dowell, M.D., M.P.H., Tamara Haegerich, Ph.D., and Roger Chou, M.D.

- Chou and CDC authors in 2019 re-affirmed risks of Long-term Opioid Therapy and lack of evidentiary benefit
- Patients should have access to multidisciplinary pain treatment as well as Addiction resources
- Tapers should be gradual and individualized. Voluntary taper = more successful taper

“Patients who most need an opioid taper may be least open to discussion or consensual taper and may react belligerently”
In Summary

• No Level 1 evidence that Opioids improve chronic pain; abundant evidence of dose-dependent risk

• Opioids should be a treatment of last resort for chronic pain

• Be alert for Opioid Misuse and OUD: Treat it and refer!

• Read August 2018 VA BOM guidelines. Rx Naloxone and check PDMP every visit!

• High Risk and High Dose? Think about a gradual, supported and voluntary taper
AY is a 62 YO male taking chronic opioids. He has a history of low back pain and had a lumbar fusion in 2010. He has been on chronic Opioids for 9 years and his current MED dose is 135. He takes Oxycontin 30 mg BID and Percocet 10/325 Q8H PRN for breakthrough pain.

He is married with 3 children and works full time as a construction supervisor. He does not smoke Tobacco, and quit drinking ETOH 3 years ago, previously he had 2-4 drinks a day on weekends. He does not take sedatives or sleep aids.

He has been compliant with random pill counts, brings his pill bottle to every appointment, and has never had aberrant urine drug testing.

He has done physical therapy and still does a HEP. His BMI is 32. He sees a pain specialist twice a year for epidural injections and takes low dose Gabapentin. He tried acupuncture but it did not help.

He has heard about the CDC guidelines and worries about having his dose reduced - a previous taper attempt with last PCP was not successful.
Case # 1

A. Maintain patient at current dose. See at least every 3 months for refills, check PDMP at every visit and check UDS Q6 months. Make sure Naloxone prescribed.

B. Gradually taper patient’s MED dose by 10% monthly, starting with short acting Oxycodone until patient’s dose < 90 MED

C. Advise patient that the CDC guidelines mandate that you cannot continue prescribing, give a list of community 2nd opinions, 1 month of medication and refer to pain management

D. Rotate patient to Buprenorphine 16 mg daily
Case #2

SK is a 25 YO female taking chronic Opioids. She is new to your practice and recently moved to the state from FL. Her MED dose is 180. She takes Oxycodone 30 mg Q6H PRN and has been on Opioids for 3 years after a car accident.

She is single and has been unemployed since the car accident. She is on Medicaid and is applying for disability. She takes Zoloft for depression and Xanax for anxiety. She smokes 1 ppd, and self reports “3-4 beers” “on the weekends.”

She has been late for several appointments, and at her last appointment “forgot” to bring her pill bottle.

A random urine drug test from 2 weeks ago was negative for Oxycodone and oxymorphone and positive for THC and 6-mono-acetyl morphine.
Case # 2

A. Refill medication at current dose. Reduce medication refill interval to q 1 month and randomly pill count in 2 weeks.

B. Advise the patient her dose is too high, and gradually taper by 10% per week, until patient's dose is < 90 MED.

C. Advise patient that you cannot continue prescribing because of UDS + for THC, give list of community 2nd opinions, 2 weeks of medication with a taper plan and refer to pain management

D. Discuss UDS results with patient. Refer for Addiction services. Prescribe medication for withdrawal, offer psychological counseling and support services
Case # 3

HJ is a 48 YO male taking chronic Opioids. He has a history of cervicalgia and had an anterior cervical spinal fusion in 2015. He has been on Opioids since 2013. His current MED dose is 195. He takes MS Contin 45 mg TID and Norco 10/325 Q4H PRN. He previously worked as a roofer but has been disabled and out of work since the surgery.

He is married with 2 children. He takes Paxil for depression and Valium TID PRN for anxiety and sleep disturbance. He smokes ½ PPD and admits to 1-2 drinks of liquor nightly.

He looked slightly disheveled at his last appointment. He was accompanied by his wife who wonders if the medication is even helping, saying “he can barely even get out of bed lately.”

The patient has been compliant with urine drug screening and brings his pill bottle to every appointment. He takes medication for constipation and complains of low sex drive.

The patient is apprehensive about having his dose reduced; “the guy before you tried that, and I had terrible withdrawal- I felt like I was going to die.”
A. Advise patient that the CDC guidelines do not allow you to co-prescribe Benzodiazepines and Opioids, give medications for withdrawal, refer to Pain Management.

B. Discuss risks of MED dose and Benzodiazepines with patient. Offer slow, supported taper by 10% per month. Ensure Naloxone prescribed. Refer to Pain Specialist for recommendations and interventional treatment. Offer counseling referral.

C. Advise patient that his dose is too high, and initiate rapid taper, 10% per week starting with MS Contin, until patient is < 90 MED.

D. Discontinue Valium increase Paxil dose. Continue Opioids at current dosing but reduce refill interval to every 1 month and initiate random pill counts.
THANK YOU

How To Taper Patients Off Of Chronic Opioid Therapy
SOM-YCME0022
STANFORD SCHOOL OF MEDICINE

https://online.stanford.edu/courses/som-ycme0022-how-taper-patients-chronic-opioid-therapy

PROP
Physicians for Responsible Opioid Prescribing

https://www.supportprop.org/

Oregon Pain Guidance
The Oregon state resource for healthcare professionals treating pain

https://www.oregonpainguidance.org/resources/difficult-conversations/
Questions?
Case Presentation #1
Maureen Murphy-Ryan, 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
Please state your main question(s) or what feedback/suggestions you would like from the group today?

What is the evidence or the faculty's experiences regarding impact of alcohol use on either risk of overdose or success abstaining from illicit opioids for patients on buprenorphine/naloxone maintenance therapy for OUD? How do you communicate with patients about alcohol use or incorporate information about risk (or lack of risk) when combined with buprenorphine into clinical practice? We currently do not test for alcohol in any form at my clinic as it is perceived to be a low risk high benefit to maintain MAT treatment in these situations and my clinic has a strong harm reduction philosophy.

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.)

25 year old male who is African-American, a high-school graduate, unemployed but looking, living with mother and toddler-age sibling, mother and one mentor from high school are the patient's only two contacts not using illicit substances and alcohol regularly and around him. Released from one year jail sentence for opioid distribution charges several weeks prior to initiating treatment with this physician. Other medical conditions include orthopedic injuries related to football requiring multiple surgeries during high school and obesity.
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.)

Diagnosis at this time is Opioid Use Disorder, severe. Received MAT in the form of buprenorphine at another clinic within days of release from incarceration due to intense, constant cravings for opioids after release and a desire to stay out of trouble. On the evening of first buprenorphine dose of 8mg, patient received a drunk in public charge for violent behavior after having 3 or 4 drinks at a bar with old friends. Faces probation violation and re-incarceration for up to multiple years if convicted. Continues to use alcohol, guarded about this. First UDS with this provider positive for cocaine. I continued buprenorphine/naloxone as he had already been on this treatment for several days and did not wish to d/c treatment for 1 week to switch to naltrexone. In-office UDS’s have been negative for 1 month for all tested substances except buprenorphine since then.

Barriers include limited social support, anxiety related to going to community support groups alone, highly dysregulated sleep schedule, pending court case causing anxiety, desire to continue to drink with other family/friends despite serious negative consequence, barrier to employment and self-support for self-worth and educational goals from prior felony record.

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

Buprenorphine/naloxone 8mg/2mg PO SL strip BID (16mg total daily buprenorphine dose)
Psychoeducation (sleep hygiene, other addictive substances, anxiety, cravings, coping skills)
Motivation Enhancement Therapy
Supportive Psychotherapy
Connecting with recovery support resources in the community including direct connection by phone to a local Peer Recovery Specialist to meet him at a Narcotics Anonymous meeting
Weekly meetings for 30 minutes with this clinician

Psyllium for constipation side effect of buprenorphine, has been effective
What interventions have you tried up to this point?
Additional case history (e.g. treatments, medications, referrals, etc.)

Buprenorphine/naloxone 8mg/2mg PO SL strip BID (16mg total daily buprenorphine dose)
Psychoeducation (sleep hygiene, other addictive substances, anxiety, cravings, coping skills)
Motivation Enhancement Therapy
Supportive Psychotherapy
Connecting with recovery support resources in the community including direct connection by phone to a local Peer Recovery Specialist to meet him at a Narcotics Anonymous meeting
Weekly meetings for 30minutes with this clinician

Psyllium for constipation side effect of buprenorphine, has been effective
What is your plan for future treatment? What are the patient's goals for treatment?

Patient's goal is to graduate probation and not get into any more trouble with the law, to get a college degree and then a Master's degree and become an addiction counselor. To not worry his mother and be a good example for younger cousins and sibling.

My goal- help patient develop better coping skills for anxiety and a social network that does not include alcohol. To better understand the research around alcohol use (compared to the dangers of using benzodiazepines with buprenorphine) and how to communicate with patients and other staff around this.

Main Question

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

What is the evidence or the faculty's experiences regarding impact of alcohol use on either risk of overdose or success abstaining from illicit opioids for patients on buprenorphine/naloxone maintenance therapy for OUD? How do you communicate with patients about alcohol use or incorporate information about risk (or lack of risk) when combined with buprenorphine into clinical practice? We currently do not test for alcohol in any form at my clinic as it is perceived to be a low risk high benefit to maintain MAT treatment in these situations and my clinic has a strong harm reduction philosophy.
Case Presentation #2
Heidi Kulberg, 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

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions
Please state your main question(s) or what feedback/suggestions you would like from the group today?

1. What evidence-based medicine approaches are recommended to treat the dual diagnosis of opioid use disorder and benzodiazepine dependence?
2. What evidence-based medicine approaches work best to motivate patient's toward active engagement in recovery?

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.)

Patient is a female in her 50s with concomitant opioid use disorder and iatrogenic benzodiazepine dependence. She is college-educated and previously owned a print newspaper business. She experienced a severe MVA four years ago resulting in TBI that she reports impacted her memory acquisition and retention. After a bad break-up of a long-term relationship, she moved from the New England to VA ~ 2 years ago. She initially lived off the profits of selling her property and did not work for 18 months. She recently tried a job in marketing/sales but left due to problems with technology and learning new skills. She is currently unemployed, running out of money, and living with nephew. She is in the process of looking for a new job and a new place to live. She has one close friend; however, that person drinks and utilizes illicit drugs. She does not have any significant support system.
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.)

*Opioid Use Disorder
*Anxiety disorder
*Benzodiazepine dependence

OUD: Patient reports being diagnosed with an OUD in another state over 10 years ago after experiencing severe withdrawals after years of taking opioid pain medications following a ski accident. She initially reported being treated with Suboxone continually for over 10 years and indicated she had been abstinent from opioids that entire time. Recently, she reported her clean date from opioids is 10/18/18. She currently utilizes Suboxone 8/2 mg strips bid. Tolerates these well and denies any cravings.

Anxiety: Pt reports a long h/o of anxiety disorder and treatment with Xanax for over 20 years. Abruptly ceased use of Xanax in early 2018 when moved to VA as she ran out of medications and was unable to get rx refilled. She experienced significant withdrawals to include confusion, agitation, irritability, shakiness, difficulty functioning and problems providing self-care. She enrolled herself in residential rehabilitation at a 30-day program in VA. She spent one month there trying to detoxify from Xanax and from Suboxone. She did not do well and reports the program restarted all her medications and discharged her.

Benzodiazepine dependence: Pt began seeing a psychiatrist at our program in Feb. 2019. The provider continued her on Suboxone and initiated a switch from Xanax to Diazepam to follow the Ashton Protocol for the withdrawal from benzodiazepines. Her initial dose of Diazepam was 20 mg a day. With that provider she was decreased to 15 mg a day by June 2019 and then was transferred to my care when provider left the practice. She is currently on 8 mg a day. She resists decreases in dose and does not appear motivated to rid herself of benzodiazepines. She continues to allow it only when she feels she is at risk of being discharged from the program and losing access to her Suboxone.
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.)

She reports some h/o depression. She reports various trials with rx to include Mirtazapine, Seroquel, Paxil and Celexa, which she states did not help. She reports a h/o OCD but it is not documented in any records. She denies any other mental health disorders. She denies any hospitalization for mental health disorders other than the aforementioned residential treatment program in 2018. She denies any h/o self-harm or suicidal ideation.

She is a very challenging historian. Pt has exhibited various moods over the 8 months in her care with me. At times she appears manic, talking with rapid, pressured speech with tangential thought processes. Other times, she is thoroughly apathetic. At one group, she was noted to be nodding off during the session. She consistently presents with baseline anxiety and perseverates on the things that are going wrong in her life. She denies any h/o bipolar and this was diagnosed by the initial psychiatrist to have this disease. Throughout the 8 months, she has remained abstinent from opioids, has intermittently followed the dosing of her Diazepam (each time she did not self-taper as had been discussed, she appeared on history to be confounded with the recommendations even though they had been discussed at prior visit and usually written down for her). She did slip and engage in use of cocaine in Oct. 2019 which was found on a random UDS. Her frequency of visits and UDS were increased as was points of accountability. She has not had any further unexpected UDSs.

Current medications include:
*Suboxone 8/2 mg bid
*Diazepam 2 mg tabs, 1 qam and 3 qhs in process of taper
*Clonidine 0.1 mg bid for anxiety
*Seroquel 100 mg- which she rediscovered and has started retaking to assist with sleep
*Mirtazapine 15 mg- just began as trying to address anxiety in more constructive manner and have benefit of sleep aid. Have recommended she d/c the Seroquel.

Therapy:
*Weekly attendance at Suboxone group sessions. She is currently compliant with this requirement of our program.
*Individual counseling. She was initially in good counseling from Feb-June 2018 but the therapist left the practice. She was unable to return to IC until recently. She just began with another LCSW a month ago.
*NA/AA: Is attending as directed however does not appear actively engaged in peer recovery.
What interventions have you tried up to this point?
Additional case history (e.g. treatments, medications, referrals, etc.)

As noted in background information.

She has declined referral to another inpatient detoxification programs for the dual substances. Her resistance is partially due to lack of facilities available as she is on Medicaid and partly because of the horrible experience she had the first time.

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

Continue Suboxone. Continue Diazepam taper per Ashton Protocol; however, would like to be able to decrease dose more rapidly than we have thus far. Stimulate active engagement in her recovery (no idea how to accomplish this).

Patient's goals for treatment:
To be happy. To get everything in order so that she can focus on herself.

Main Question

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

1. What evidence-based medicine approaches are recommended to treat the dual diagnosis of opioid use disorder and benzodiazepine dependence?
2. What evidence-based medicine approaches work best to motivate patient's toward active engagement in recovery?
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
- Michael Bohan, MD from Meridian Psychotherapy
- Diane Boyer, DNP from Region Ten CSB
- Melissa Bradner, MD from VCU Health
- Kayla Brandt, B.S. from Crossroads Community Service Board
- Susan Cecere, LPN from Hampton Newport News
- Michael Fox, DO from VCU Health
- Shannon Garrett, FNP from West Grace Health Center
- Sharon Hardy, BSW, CSAC from Hampton-Newport News CSB
- Sunny Kim, NP from VCU Health
- Thokozeni Lipato, MD from VCU Health
- Caitlin Martin, MD from VCU Health
- Maureen Murphy-Ryan, MD from AppleGate Recovery
- Faisal Mohsin, MD from Hampton-Newport News CSB
- Stephanie Osler, LCSW from Children's Hospital of the King's Daughters
- Jennifer Phelps, BS, LPN from Horizons Behavioral Health
- Crystal Phillips, PharmD from Appalachian College of Pharmacy
- 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
- Daniel Spencer, MD from Children's Hospital of the King's Daughters
- Cynthia Straub, FNP-C, ACHPN from Memorial Regional Medical Center
- Saba Suhail, MD from Ballard Health
- Barbara Trandel, MD from Colonial Behavioral Health
- Bill Trost, MD from Danville-Pittsylvania Community Service
- Art Van Zee, MD from Stone Mountain Health Services
- Ashley Wilson, MD from VCU Health
- Sarah Woodhouse, MD from Chesterfield Mental Health
Claim Your CME and Provide Feedback

- [www.vcuhealth.org/echo](http://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?
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 clinic.
• 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

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

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>
</tr>
</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>
</tbody>
</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.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Date</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syringe Exchange</td>
<td>01/19/19</td>
<td>Video of Clinic, Slide Presentation, Needle Exchange Program, Bill to Remove Cooperation Law</td>
</tr>
</tbody>
</table>

Learning Objectives:
1. Understand current legislative landscape in regards to syringe exchange in VA.
2. List benefits to clients and community of syringe exchange.
3. Define harm reduction.
VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

Mark Your Calendar --- Upcoming Sessions

April 3: Hep C and Opioids  Richard Sterling, MD

April 17: Helping Special Populations with SUD  Ari Laoch, MS, LPC

May 1: Synthetic Drugs  Ruddy Rose, PharmD, FAACT

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

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