Virginia Opioid Addiction ECHO* Clinic

March 6, 2019

*ECHO: Extension of Community Healthcare Outcomes
Helpful Reminders

• Rename your Zoom screen, with your name and organization

Renaming screen example:

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
VCU Team

Clinical Director
Gerard Moeller, MD

Administrative Medical Director
Vimal Mishra, MD, MMCi

ECHO Hub

Clinical Experts
Lori Keyser-Marcus, PhD
Courtney Holmes, PhD
Albert Arias, MD

Didactic Presentation
Gerry Moeller, MD

Program Manager
Bhakti Dave, MPH

Practice Administrator
David Collins, MHA

IT Support
Vladimir Lavrentyev, MBA

Hub and Participant Introductions

- Name
- Organization

Reminder: Mute and Unmute screen to talk

*6 for phone audio

Use chat function for Introduction
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. Gerry Moeller, 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

Let's get started!
Didactic Presentation
The Opioid Epidemic:
Where We are, How We Got Here, and
What Were Doing to Get Out of It

F. Gerard Moeller, M.D.
Division Chair, Addiction Psychiatry
Director, C. Kenneth and Dianne Wright Center for Clinical and Translational Research
and Institute for Drug and Alcohol Studies
Disclosures

• I have grant funding from Indivior Pharmaceuticals for research I will discuss in this presentation and have previous grant funding from Nektar Therapeutics for research unrelated to this presentation.

• I am a consultant for Astellas pharmaceuticals for research unrelated to this presentation.
US is in the Midst of a Drug Overdose Epidemic

Over 70,000 People Died from a Drug Overdose in 2017

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018
US Life Expectancy Decreased for 3 Consecutive Years

Reduced Life Expectancy Driven by Drug Overdose, Alcohol Abuse, Suicides, and Organ Diseases

Life Expectancy and Mortality Rates in the United States, 1959-2017

Steven H. Woolf, MD, MPH; Heidi Schoomaker, MAEd

**IMPORTANCE** US life expectancy has not kept pace with that of other wealthy countries and is now decreasing.

**OBJECTIVE** To examine vital statistics and review the history of changes in US life expectancy and increasing mortality rates; and to identify potential contributing factors, drawing insights from current literature and an analysis of state-level trends.

**EVIDENCE** Life expectancy data for 1959-2016 and cause-specific mortality rates for 1999-2017 were obtained from the US Mortality Database and CDC WONDER, respectively. The analysis focused on midlife deaths (ages 25-64 years), stratified by sex, race/ethnicity, socioeconomic status, and geography (including the 50 states). Published research from January 1990 through August 2019 that examined relevant mortality trends and potential contributory factors was examined.

**FINDINGS** Between 1959 and 2016, US life expectancy increased from 69.9 years to 78.9 years but declined for 3 consecutive years after 2014. The recent decrease in US life expectancy culminated a period of increasing cause-specific mortality among adults aged 25 to 64 years that began in the 1990s, ultimately producing an increase in all-cause mortality that began in 2010. During 2010-2017, midlife all-cause mortality rates increased from 328.5 deaths/100,000 to 348.2 deaths/100,000. By 2014, midlife mortality was increasing across all racial groups, caused by drug overdoses, alcohol abuse, suicides, and a diverse list of organ system diseases. The largest relative increases in midlife mortality rates occurred in New England (New Hampshire, 23.3%; Maine, 20.7%; Vermont, 19.9%) and the Ohio Valley (West Virginia, 23.0%; Ohio, 21.6%; Indiana, 14.8%; Kentucky, 14.7%). The increase in midlife mortality during 2010-2017 was associated with an estimated 33,073 excess US deaths, 32.8% of which occurred in 4 Ohio Valley states.
Increased Age-Specific Mortality Between 1999 and 2017

<table>
<thead>
<tr>
<th>CAUSE OF DEATH (ICD-10 CODES)</th>
<th>CHANGE MEASURES</th>
<th>CHANGE IN MORTALITY BETWEEN 1999 AND 2017, BY AGE (YRS)</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>&lt;1</td>
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<tr>
<td>ALL-CAUSE MORTALITY</td>
<td>Baseline mortality rate</td>
<td>736.0</td>
</tr>
<tr>
<td></td>
<td>Absolute increase (per 100,000)</td>
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<tr>
<td></td>
<td>Relative increase (%)</td>
<td>-23.0</td>
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<tr>
<td>EXTRANEOUS (EXTERNAL) CAUSES (V01-Y89)</td>
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<td></td>
<td>Relative increase (%)</td>
<td>31.0</td>
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<tr>
<td>Accidental drug poisoning (X40-X44)</td>
<td>Absolute increase (per 100,000)</td>
<td>UR</td>
</tr>
<tr>
<td></td>
<td>Relative increase (%)</td>
<td>UR</td>
</tr>
</tbody>
</table>

Dramatic Increase in Drug Overdose Deaths Across Ages 15-74

Woolf and Shoomaker, 2019
The Overdose Epidemic is Driven by Opioids

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018
Overdose Top Cause of Unnatural Death in Virginia

Overdose Became #1 Cause of Unnatural Death in 2013

On Track to be Highest Ever in 2019
Opioids Drive the Overdose Epidemic in Virginia

1268 of 1546 Overdose Deaths Related to Opioids for 2019
How did We Get Here?

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018

What Changed Between Beginning of Epidemic and now?
How did We Get Here? the First Wave

The amount of opioids prescribed per person was three times higher in 2015 than in 1999.

80% of World Prescription Opioids in the US
US has 4% of World Population

Focus on Eliminating Pain With Opioids Drove Epidemic

As many as one in four patients receiving long-term opioid therapy in a primary care setting struggles with opioid addiction (US CDC)

OPIOIDS ARE NOT FIRST-LINE THERAPY

Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
Opioid Use for Chronic Pain at VCU

Patients with Chronic Pain Diagnosis Ever Treated with Oxycodone

<table>
<thead>
<tr>
<th>Total Patients</th>
<th>Minimum Age</th>
<th>Maximum Age</th>
<th>Mean Age</th>
<th>Standard Deviation</th>
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<tbody>
<tr>
<td>40,990</td>
<td>0</td>
<td>90</td>
<td>56</td>
<td>16</td>
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</table>
Opioid Use at VCU in Last Year

We Are Still Overutilizing Opioids for Chronic Pain

Patients with Chronic Pain Diagnosis Treated with Oxycodone in Last Year

<table>
<thead>
<tr>
<th>Total Patients</th>
<th>Minimum Age</th>
<th>Maximum Age</th>
<th>Mean Age</th>
<th>Standard Deviation</th>
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<tr>
<td>8,680</td>
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Opioid Epidemic: How Do We Get Out of it?

- Reducing Addicting Opioids for Pain
- Increasing Access to Current Treatments
- Developing New and Better Treatments
Reducing Use of Addicting Opioids

**Education**

**Training Dentists to Use Ibuprofen/Acetaminophen for First Line Dental Pain**

VCU professor, who lost son to an opioid overdose, said lack of awareness by prescribers contributed to the opioid crisis

"Doctors and dentists, including myself, were part of this opioid epidemic," Omar Alhabsiok said.

By: Leah Smoll
University Public Affairs
Monday, April 15, 2019

**Training Medical Students on Risks and Alternatives to Opioids for Pain**

To end the opioid epidemic, VCU health sciences faculty are changing the way pain management is taught
Treating Consequences Rather than Severity of Pain Should be the Goal

When assessing pain, ask him or her to rate the pain severity. Finally, find out if the pain interferes with any activity. If the pain is "intolerable," determine whether the pain is so intense as to prevent passive activities. See the chart below for guidelines.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
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<tbody>
<tr>
<td>0</td>
<td>No pain</td>
</tr>
<tr>
<td>1</td>
<td>Tolerable (and does not prevent any activities)</td>
</tr>
<tr>
<td>2</td>
<td>Tolerable (but does prevent some activities)</td>
</tr>
<tr>
<td>3</td>
<td>Intolerable (but can use telephone, watch TV, or read)</td>
</tr>
<tr>
<td>4</td>
<td>Intolerable (but cannot use telephone, watch TV, or read)</td>
</tr>
<tr>
<td>5</td>
<td>Intolerable (and unable to verbally communicate because of pain)</td>
</tr>
</tbody>
</table>
Opioid Epidemic: How Do We Get Out of it?

- Reducing Addicting Opioids for Pain
- Increasing Access to Current Treatments
- Developing New and Better Treatments
Reducing Prescription Opioids Alone Won’t Solve the Problem

Source: Centers for Disease Control and Prevention, National Center for Health Statistics.

Prescription Opioids Drove the Epidemic in the Beginning

Source: Centers for Disease Control and Prevention, National Center for Health Statistics.
Without Treatment, Addicted Individuals Switch to other Drugs

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death
Fentanyl Overdose Deaths Continue to Rise in Virginia

Total Number of Fatal Fentanyl Overdoses by Quarter and Year of Death, 2007-2018

1 Historically, fentanyl has been categorized as a prescription opioid because it is mass produced by pharmaceutical companies. However, law enforcement investigations and toxicology results have demonstrated that several recent fentanyl seizures have not been pharmaceutically produced, but illicitly produced. This illicit form of fentanyl is produced by international drug traffickers who import the drug into the United States and often, mix it into heroin being sold. This illicitly produced fentanyl has been the biggest contributor to the significant increase in the number of fatal opioid overdoses in Virginia.

2 Illicit and pharmaceutically produced fatal fentanyl overdoses are represented in this analysis. This includes all different types of fentanyl analogs (acetyl fentanyl, furanyl fentanyl, etc.)
Fatal methamphetamine overdoses increased by 44.3% in 2018 when compared to 2017.

<table>
<thead>
<tr>
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<td>2</td>
<td>4</td>
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<td>0</td>
<td>0</td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>10</td>
<td>21</td>
<td>24</td>
</tr>
<tr>
<td>Total Fatalities</td>
<td>6</td>
<td>9</td>
<td>5</td>
<td>1</td>
<td>8</td>
<td>4</td>
<td>10</td>
<td>21</td>
<td>29</td>
<td>52</td>
<td>88</td>
<td>127</td>
</tr>
</tbody>
</table>
WAVE 4
COCAINE

The number of fatal cocaine overdoses in 2018 compared to 2017 increased by 11.5%.
VIRGINIA DRUG OVERDOSE DEATH RATE VARIES BY COMMUNITY

Rate of All Fatal Drug Overdoses by Locality of Overdose, 2018

Source: Virginia Department of Health, Office of the Chief Medical Examiner
Psychostimulant Deaths Especially Variable Across Communities

Rate of Fatal Methamphetamine Overdoses by Locality of Overdose, 2016-2018

Source: Virginia Department of Health, Office of the Chief Medical Examiner
Psychostimulant Deaths Especially Variable Across Communities

Rate of Fatal Cocaine Overdoses by Locality of Overdose, 2018

Source: Virginia Department of Health, Office of the Chief Medical Examiner
Increasing Access To Current Treatments: VCU Approach

Community Engaged Approach

Increasing care at VCUHealth Multidisciplinary Outpatient Treatment Clinic

Research on Overdose Treatment: Virginia Overdose Treatment Initiative (VOTIVE)
People need access to specialty care for their complex health conditions.

There aren’t enough specialists to treat everyone who needs care, especially in rural and underserved communities.

ECHO trains primary care clinicians to provide specialty care services. This means more people can get the care they need.

Patients get the right care, in the right place, at the right time. This improves outcomes and reduces costs.

Addiction Medicine Specialists at VCU Providing Telehealth Support for Addictions Treatment Across Virginia

Project ECHO, A Community Engaged Program led by Internal Medicine
VCUHealth Multidisciplinary Outpatient Treatment Clinic (MOTIVATE)

- Initiated in April of 2017
- Provides evidence-based medication and counseling for addictions
- **470** Patients per Month in Treatment and Rising
- Over 80% Patients with Opioid Use Disorder
Addiction Treatment isn’t Just Psychiatry

• Motivate clinic includes collaborators across disciplines
  – Internal Medicine (3 Providers)
  – Psychiatry (3 Providers)
  – Emergency Medicine (2 Providers)
  – Family Medicine (1 Provider)
  – Obstetrics and Gynecology (1 Provider)
  – Addiction Medicine Fellow (1 Provider)
  – Psychology/Social Work/Nursing
VCU Addiction Medicine Fellowship

TRAINING DIRECTOR: ALBERT J. ARIAS, M.D., M.S.

The Addiction Medicine Fellowship is a one year, with optional second year fellowship. The second year a research-based fellowship.

Fellows will have four 3-month rotations for the first year, which will include:

- VCU Health Outpatient Addictions Clinic (Motivate)
- VCU Outpatient Prenatal Addiction Clinic
- Virginia Health Practitioner Monitoring Program (HPMP)
- VCU Health Addiction Consult-Liaison Service (VCU Medical Center)
- Pain Rotation with VCU Anesthesiology Pain Service
- Research/Quality Improvement Project
- Hunter Holmes McGuire Veterans' Affairs Medical Center

Hunter Holmes McGuire VA Medical Center Outpatient Rotation: Fellows gain experience working in the Outpatient Opioid (Methadone and Suboxone) Treatment Clinics and Intensive Outpatient Substance Abuse Program, where patients receive 9 hours per week of treatment. Fellows follow patients with opioid addiction and patients with other substance abuse disorders long term. Fellows conduct new intake evaluations and provide treatment, including medication management, individual, group and family therapies, and various other modalities of treatment.

Hunter Holmes McGuire VA Medical Center Inpatient Rotation: Fellows gain experience working in the 60-day residential substance abuse treatment program, learning residential-based therapies.

Fellows also receive hands-on training in clinical addictions research. They may apply for funding for pilot studies in which they can serve as principal investigator for research projects. Clinical research in which fellows may participate include:

- A research-dedicated 3T Phillips Ingenia 3.0 Tesla MRI scanner. This MRI scanner is housed the VCU Collaborative Advanced Research Imaging (CARI) Center and is used to study the neurobiology of addictions. Recent upgrades to the CARI research-dedicated MRI scanner include MR shear Elastography (MRE) to measure liver fibrosis, Cardiac Expert Specialist and StarQuart. For more information regarding VCU’s Collaborative Advanced Research Imaging, please go to https://catri.vcu.edu/support/clinical-research-service-providers/cai

- The Institute for Drug and Alcohol Studies (IDAS) seeks to explore the complex problems of drugs through multidisciplinary research and training, with a focus on the neuroscience of addictions and related neurobehavioral disorders. The institute is led by F. Gerard Moeller, M.D., a preeminent researcher whose addiction research has been funded since 1996 by the National Institute on Drug Abuse. His work is published in more than 110 peer-reviewed publications. For more information regarding IDAS, please go to https://idas.vcu.edu/

- The VCU C. Kenneth and Dianne Wright Center for Clinical and Translational Research (CCTR) provides the commonwealth with infrastructure and resources that promote interdisciplinary human health research. As the first federally funded clinical and translational research center in Virginia, CCTR fosters research collaborations across the state and accelerates the translation of scientific discoveries to patient care. For more information regarding CCTR, please go to https://cttr.vcu.edu/
Opioid Overdose Visits at VCUHealth Emergency Department

• Dramatic Increase Over Last few Years
• What can be Done to Reduce OD Visits?
Opioid Overdose Treatment

• After treatment with opioid antagonist naloxone, many overdose victims survive
• However naloxone causes opioid withdrawal & most patients leave emergency room without long-term care
• Nearly 1 in 5 patients have repeat OD/die within 6 Months
How do We Break the Cycle of Drug Use and Overdose?

- Buprenorphine Combined with Counseling Reduces Opioid Use and Overdose
- After OD Patients Use Again before Starting Buprenorphine
- How do we Engage Patients in Treatment after Overdose?
Virginia Opioid Overdose Treatment Initiative (VOTIVE)

- Partnership Between VCU, Vtech-Carilion, EVMS, Inova
- Funded by Indivior-Virginia Catalyst

- Buprenorphine given in ED/Hospital
- Rapid transition to outpatient treatment with medication and behavioral therapy
- Goal is to reduce repeat OD and Death
VOTIVE Results To Date

• VCU continues to see multiple OD patients per week
• It is possible to rapidly treat patients who recover after opioid overdose
  – About a third of patient approached are interested in treatment
• Opioid overdose symptom profile changing over time
  – Patients with less withdrawal after naloxone, making standard treatment methods challenging
  – Have a new protocol to admit patients to CDU overnight with direct referral to outpatient clinic the next day
Opioid Epidemic: How Do We Get Out of it?

- Reducing Addicting Opioids for Pain
- Increasing Access to Current Treatments
- Developing New and Better Treatments
Developing New and Better Treatments

- CURRENTLY 3 FDA APPROVED MEDICATIONS FOR OPIOID USE DISORDER: METHADONE, BUPRENORPHINE, NALTREXONE
- NOT ALL PATIENTS RESPOND TO TREATMENT
- CAN WE DEVELOP NEW MEDICATIONS USING TRANSLATIONAL RESEARCH?

VCU C. Kenneth and Dianne Wright Center for Clinical and Translational Research
VCU is a Leader in Addictions Research

VCU Sponsored Program Awards: NIH Portfolio
FY 2018

FY 2018 Total: $271,022,724
FY 2018 NIH: $78,931,098

For FY 2018 VCU NIDA Funding was over 2X any other NIH Institute
Novel Treatments for Opioid Use Disorder

Yan Zhang, Ph.D.
VCU School of Pharmacy

Mu Opioid Receptor Modulator Development to Treat Opioid Use Disorder

Qingguo Xu, Ph.D. Matt Halquist, Ph.D.
VCU School of Pharmacy

Charles O’Keeffe, MBA, F. Gerard Moeller, M.D. VCU School of Medicine

LAAM formulations to treat Opioid Use Disorder

Recently Funded Grants as Part of NIH HEAL initiative
VCU Aggressively Responding to the Opioid Epidemic

- Reducing addicting opioids for pain
- Increasing access to current treatments
- Developing new and better treatments
Summary

• Tackling the Opioid Epidemic is a **Team Sport** involving Education, Prevention, Research and Treatment across Multiple Specialties

• Addictions are a Broader Problem that Extend Beyond Opioids

• The Same Methods will be Needed to Tackle the Problem of Addictions
The Team

**Institute for Drug and Alcohol Studies/Wright Center for Clinical and Translational Research**
- Joel L. Steinberg, M.D.
- Albert Arias, M.D.
- James Bjork, Ph.D.
- Jasmin Vasilev, Ph.D.
- Lori Keyser-Marcus, Ph.D.
- Liangso Ma, Ph.D.
- Caitlin Martin, M.D., M.Ph.
- Brian Taylor, Ph.D.
- Katie Schwintech, Ph.D.
- Taylor Ochaleck, Ph.D.
- Andrew Snyder, M.D.
- Kyle Woisard B.S.
- Marianne Harmon, N.P.
- Mary Bowman, N.P.

**MOTIVATE Clinic**
- Albert Arias, M.D.
- Lori Keyser-Marcus, Ph.D.
- Caitlin Martin, M.D., M.Ph.
- Kanwar Sidhu, M.D.
- Megan Lemay, M.D.
- Ashley Wilson, M.D.
- Rachel Waller, M.D.
- Kirk Cumpston, M.D.
- Brandon Wills, M.D.
- Chethan Bachireddy, M.D.
- Sunny Kim, N.P.
- Danielle Wittig, N.P.
- Suzanne Guinta, M.D.
- Abhay Khashu, M.D.

**Project ECHO**
- Vimal Mishra, M.D.
- Lori Keyser-Marcus, Ph.D.
- Kanwar Sidhu, M.D.
- Albert Arias, M.D.

**Addiction Consult Service**
- Salim Zulfiqar, M.D.
- Rachel McLaughlin, NP
- Elizabeth Maguire, NP
Wright Center for Clinical and Translational Research

Accelerating the science that supports healthy communities

Supported by NCATS UL1TR002649
Questions?
Case Presentation #1
Faisal Mohsin, MD

• 12:35-12:55 [20 min]
  • 5 min: Presentation
  • 2 min: Clarifying questions - Spokes
  • 2 min: Clarifying questions – Hub
  • 2 min: Recommendations – Spokes
  • 2 min: Recommendations – Hub
  • 5 min: Summary - Hub

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

Can this patient be 'safely' prescribed an amphetamine based stimulant or methylphenidate?

OR

Is there an indication for treating this patient's ADHD at all?

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.)

48 yr old single female, currently homeless (staying with a friend) and unemployed.

Reports working part time (likely under the table) at a local mechanic shop, cleaning.

Poor support system. Has two daughters, one in the 20s and the other nearing 18 yr. Both daughters reportedly have histories of polysubstance use disorders. Older daughter also has a history of OUD and her treatment status is unknown.

Patient and daughter's have extensive legal histories.
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.)

Is being treated for recurrent major Depression with anxiety. Also receiving Methadone at the CSB's OTP and her current dose is 90 mg daily. OUD is considered largely in remission. Receiving daily dosing. No ‘take homes’ yet. Is also receiving substance abuse counseling at the Methadone program.

Currently on Cymbalta. Dose was increased to 90 mg/day at her last appointment on 2.19.20. Trazadone 100 mg daily at bedtime for sleep.

More recently, also diagnosed with ADHD for chronic symptoms of inattention, inability to focus, restlessness and excessive aimless animation, forgetfulness, inability to complete tasks on time, poor impulse control. History of poor academic performance in school. Never graduated high school and does not have a GED. Reports no formal evaluation for ADHD while in school. Describes a history of emotional and sexual abuse growing up. Has been in several foster homes. No consistent work history.

Urine Drug screens:

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<th>Date</th>
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<td>2.19.20</td>
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<td>2.4.20</td>
<td>COC, EDDP, MTD, THC</td>
</tr>
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<td>1.30.20</td>
<td>MTD, EDDP, THC</td>
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<tr>
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<td>EDDP, THC, MTD</td>
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<td>MTD</td>
</tr>
<tr>
<td>9.3.19</td>
<td>COC, MTD, THC</td>
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Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions
What interventions have you tried up to this point?  
Additional case history (e.g. treatments, medications, referrals, etc.)

Did not respond well to a previous trial of Wellbutrin last year. It was prescribed for depression and ADHD. Patient was subjectively dissatisfied with the medication and chose not to continue taking it.

Most recent addition was Strattera (Atomoxetine) for ADHD. Started at 40 mg daily. Felt no benefit. Asking for "something else".

Last visit, on 2.19.20, reluctantly agreed to increase the dose to 80 mg day.

Remains unemployed.

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

The goal is to steadily titrate up Strattera until therapeutic effect. Max. dosage 120mg/day.

If patient gives negative urine screens and no response to Strattera, could she be considered for the traditional stimulants?
Other relevant information

Housing situation generally unstable.

History of prior incarcerations. Currently on probation.

Extensive criminal history related to her drug use (history of alcohol, cocaine, cannabis, opiate use disorders). Is currently on probation and has a court case coming up for a possession charge she caught more than a year ago.

Main Question:

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

Can this patient be 'safely' prescribed an amphetamine based stimulant or methylphenidate?

OR

Is there an indication for treating this patient's ADHD at all?
Case Presentation #2
Diane Boyer, DNP

• 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?

Has anyone had patients experience worsening hyperalgesia while on suboxone?

**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.)

39 yo caucasian woman and mother with teenage and young adult children who do not live with her. Completed GED while incarcerated, unemployed, Has worked in in telemarketing. would like another job and will need support finding employment, has been referred to DARS. Most recently incarcerated for 1.5 years. Was seen shortly after release for a Substance Use Disorder/Psych Eval.

While incarcerated had been prescribed 225mg Seroquel and Haldol 5 mg for sleep, no hx of auditory or Visual hallucinations while not under the influence of polysubstances, experiencing EPS with no treatment for EPS. She wanted Suboxone - had been opioid naive for a year and half and was using cocaine and alcohol daily - Offered assistance for reducing EPS and help with alcohol and cocaine abuse and coverage for overdose(Naltraxone). She had a scheduled psychiatry appointment elsewhere and preferred to try and keep that appointment. She never followed through due to living in the county and having difficulty with transportation.

She relapsed on heroin per her report. ASAM In early December. Was negative for all opioids, positive for cocaine. Started residential treatment. Prescribing psychiatrist started her on Suboxone while in residential treatment early January, 4mg. At that time she was no longer on Seroquel 225 mg, still taking Haldol 5 mg and she was started on cogentin for continued symptoms of EPS. She was seen by this writer on Thursday (yesterday) for transition of suboxone treatment to OBOT clinic as she is starting transition out of residential rehab into a subsidized apartment while being closely monitored by multiple teams within region Ten. No relatives in town, new acquaintances form woman's Residential rehab. Social support is treatment team from residential rehab, has CM and MHSS, will be entering IOP and individual therapy.

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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.)

Current diagnoses of MDD unspecified rule out substance induced mood disorder, with history of Cannabis use disorder daily use starting at 13 yo for next 13 years. Now smokes when she can afford it.
Alcohol use disorder starting in teens, heavy use for most of her adult life per medical records,
Cocaine use disorder starting in teens and daily when she is not incarcerated (medical records of 02/25/2015 - cocaine induced psychotic disorder with hallucinations with daily 4 LOCO use)
Heroin use disorder appearing in medical records 6 years ago.
PMH of severe blepharitis, Claustrophobia, HCV s/p harvoni 2016, asthma. multiple suicide attempts while using poysubstances predominatley ETOH and cocaine
Current medications:
suboxone 2 8mg film one 4 mg film for 3 weeks -
Venlafaxine ER 75 mg qd
Mirtazapine 30mg 1.5 qhs
Trazodone 100 mg tablet
Haldol 5mg qhs
Benztropine 1mg bid
clonidine HCL 0.2mg tablet one tid prn
Naproxyn
Promethazine
Omeprazole
Albuterol
What interventions have you tried up to this point?
Additional case history (e.g. treatments, medications, referrals, etc.)

Was quite sedated in morning appointment - discussed decreasing Haldol dosing
Her suboxone was increased from 16 mg daily to 20 mg daily three weeks ago when she complained of "overall body pain and some cravings" after she takes her morning dosing of suboxone. Next appt she asked for increase to three 8mg film daily. She was reminded of 20 mg being highest dosing available in clinic she was attending. 
She has been referred many years ago after orthopedic injuries to Pain Management clinic
Today her discharge team and PCP were notified about another referral to pain management

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

Monitor while weaning off of Haldol and eventually cogentin while patient moves into independent living with multiple layers of support
Monitor for possible sedative effects of Suboxone once off of Haldol
Pending evaluation of pain management clinic

Main Question:

Has anyone had patients experience worsening hyperalgesia while on suboxone?
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 Saleeb, 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 Suhaill, MD from Ballad 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?
Access Your Evaluation and Claim Your CME

Virginia Opioid Addiction ECHO

Welcome to the Virginia Opioid Addiction Extension for Community Health Outcomes of 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

- www.vcuhealth.org/echo

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

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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>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma Informed Care and Treating Those Experiencing Opioid Addiction</td>
<td>05/14/19</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.

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<tr>
<td>Syringe Exchange</td>
<td>05/19/19</td>
<td>Video of Clinic, Slide Presentation, Needle Exchange Program, Flyer, 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 5: Medical and Non-Medical Cannabis: An evidence-based review - Mishka Terplan, MD

April 19: Addressing Vocational Needs of People with SUD— Rebecca Farthing, MS, CRC
Elizabeth Phillips, MS, CRC

May 3: Peer Recovery from OUDs- Tom Bannard, MBA

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

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