Virginia Opioid Addiction ECHO* Clinic

June 7, 2019

*ECHO: Extension of Community Healthcare Outcomes
Helpful Reminders

- 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
# Hub Introductions

<table>
<thead>
<tr>
<th>Role</th>
<th>VCU Team</th>
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</thead>
<tbody>
<tr>
<td>Clinical Director</td>
<td>Mishka Terplan, MD, MPH, FACOG, FASAM</td>
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<tr>
<td>Administrative Medical Director ECHO Hub</td>
<td>Vimal Mishra, MD, MMCi</td>
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<tr>
<td>Principal Investigator</td>
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<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, MS</td>
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<tr>
<td>Didactic Presentation</td>
<td>Laurie Cathers, PhD</td>
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<tr>
<td>Program Manager</td>
<td>Bhakti Dave, MPH</td>
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<tr>
<td>Practice Administrator</td>
<td>David Collins, MHA</td>
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<tr>
<td>IT Support</td>
<td>Vladimir Lavrentyev, MBA</td>
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Introductions:

• Name
• Organization

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

I. Case Presentation
   I. Case summary
   II. Clarifying questions
   III. Recommendations

II. Didactic Presentation
   I. Relationship Centered Care and Shared Decision Making
   II. Laurie Cathers, PhD

III. Case Presentation
   I. Case summary
   II. Clarifying questions
   III. Recommendations

IV. Closing and questions

Let's get started!
Didactic Presentation
Case Presentation #1
Caitlin Martin, MD

• 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 #1
Caitlin Martin, MD

Please state your main question(s) or what feedback/suggestions you would like from the group today?
- Recommendations for how to manage co-morbid behavioral health problems in person centered way using shared decision making and taking advantage of a strong patient-provider relationship
- Would you take over her benzodiazepine prescribing with plan to taper (if the patient would be open to this)

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.)

34 year old female 6 months postpartum from repeat cesarean delivery in treatment for opioid use disorder. Has been in treatment for almost a year, initiated during most recent pregnancy. Since being on suboxone, has not misused opioids. Has a history of depression, anxiety, PTSD. Patient has 3 children for which she is the sole caretaker. She also works a part time job and until this week did not have a drivers license, so transportation has been a huge barrier.
Case Presentation #1
Caitlin Martin, MD

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.)

In past was in and out of psychiatric treatment and methadone programs - this treatment has been most consistent she has ever had. During pregnancy and especially now postpartum her anxiety has not been well controlled and has had worsening depression; she also has had increase in OCD and ADD like symptoms but she does not carry these diagnoses. During pregnancy her coping mechanism was intermittent benzodiazepine use. She has not engaged with behavioral health. Postpartum she has had significant stressors, including her husband being incarcerated when her baby boy was only 2 weeks old with no plan for release soon. Patient has continued with benzodiazepine use but this has become more regular along with intermittent cocaine and stimulant use.

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

Patient has been to a psychiatrist twice postpartum where the diagnoses of PTSD, depression, anxiety were confirmed. Patient has not returned to this provider or another psychiatric provider. Was started on wellbutrin, gabapentin, clonidine and hydroxyzine. Patient has discontinued hydroxyzine stating that it does not work for her anxiety in the acute setting. Has continued with wellbutrin, gabapentin and clonidine. Continues to use xanex as needed for anxiety and now also intermittent cocaine and stimulant use.
Case Presentation #1
Caitlin Martin, MD

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

Further recommendations have been for shorter interval visits with her addiction provider, individual and group behavioral counseling and continued psychiatric co-managed care. Patient has transportation issues, so she is unable to come to clinic more often. She has declined any behavioral counseling stating, "I know what is wrong with me and that I am a mess; I don't see what someone else will tell me that I don't already know". At her most recent visit she was open to the idea of going to a new psychiatrist, but not until she gets a car.

Other relevant information
Pt with significant trauma history

REMINDER: Please ensure that NO patient specific identifiable information (PHI) is included in this submission. Please read, sign, and click SUBMIT when completed.
Relationship Centered Care and Shared Decision Making

Opioid Addiction Project ECHO Presentation
June 7, 2019

Dr. Laurie Cathers
Director, Doctoral Program in Health Related Sciences
College of Health Professions
Lauretta A. Cathers, PhD

- PhD in health related sciences with a concentration in rehab counseling leadership (VCU)
- Masters in Social Work (VCU)
- Bachelors in Journalism (Webster University)

- Director, PHD HRS Doctoral Program
- Focus areas: HIV, substance use, vulnerable populations, behavior change
- Interdisciplinary education
Learning Objectives

We will discuss the concepts of relationship centered care as it relates to building trusting relationships with individuals with substance use disorder.

Objective 1: Learners will identify the primary components of relationship centered care.

Objective 2: Learners will discuss how relationship centered care enhances shared decision making.
From Definition to Experience

**Favorite Provider**
- Environment
- Provider characteristics
- Staff
- Overall experience
- One thing you remember most

**Least Favorite**
- Environment
- Provider characteristics
- Staff
- Overall experience
- One thing you remember most

X ECC in Charge
What resonated most with you about this discussion?

In thinking about your own patients, choose one and ask yourself, what matters to this patient and how does that fit into the plan of care?
When you hear the term “relationship centered care,” what comes to mind?
Defining RCC

- Originated from Pew-Fetzer Taskforce on Advancing Psychosocial Health Education

- Expanded by Beacher, et al

- Theories: social construction, complexity theory, appreciative inquiry, self-determination theory, self-relationship, narrative

(Soklaridis, Ravitz, Nevo and Lieff, 2016)
Defining RCC

- Move from cure to care
- Recognizes the contribution of the family and community
- Non-paternalistic, collaborative approach
- Strengths-based, individual capacities, preferences and goals.

(Soklandis, Ravitz, Nevo and Lieff, 2016)
RCC within PCC

- Complementary
- Focus is on the relationship
- Patient Centered Care
- Wagner Chronic Disease model
- Shared Decision Making
Positive Outcomes Associated with RCC

- Maintain healthy behavior change
- Greater satisfaction (both)
- Medication adherence
- Better physical and mental health
- Fewer healthcare visits
- Less likely to initiate legal action

(Soklaridis, Ravitz, Nevo and Lieff, 2016)
Four Aspects of RCC
(Nundy, Oswald, 2014; Beach, Inui, RCC Research Network, 2005; Kirkegaard and Ring, 2017)

Aspect 1
- Personhood of patients
- Unique

Aspect 2
- Emotion and affect are important in the relationship

Aspect 3
- Reciprocal Influence
- Relationships do not occur in isolation

Aspect 4
- Morally Valuable
Aspect 1: Personhood of the patient

People are unique
Own set of experiences, values and perspectives (Both YOU and them!)
Find and explore common ground
Understand the patient
Be authentic

(Nundy, Oswald, 2014; Beach, Inui, RCC Research Network, 2005; Kirkegaard and Ring, 2017)
Aspect 2: Emotion and Affect

Important in developing, maintaining and terminating the relationship

“Emotional support through emotional presence”

Empathize

(Nundy, Oswald, 2014; Beach, Inui, RCC Research Network, 2005; Kirkegaard and Ring, 2017)
Aspect 3: Reciprocal Influence

Relationships do not occur in isolation. Look to patient to achieve goals and their journey, but also acknowledge the impact on you. It is a way of honoring the patient.

Not friendship between unequals (expert role), but friendship of virtue – develop character.

(Nundy, Oswald, 2014; Beach, Inui, RCC Research Network, 2005; Kirkegaard and Ring, 2017)
Aspect 4: Moral Foundation/Genuineness

Generating interest and investment
It’s about the service to others
How we grow when we are in service to others.
Service versus acting out a role

(Nundy, Oswald, 2014; Beach, Inui, RCC Research Network, 2005; Kirkegaard and Ring, 2017)
(Nundy, Oswald, 2014; Beach, Inui, RCC Research Network, 2005; Kirkegaard and Ring, 2017)
Clinician to Patient

Center of RCC

- Interactive
- Active Listening and Empathy
- Shared Decision Making
- Values
- Active Participants
- Being Present

(Nundy, Oswald, 2014; Beach, Inui, RCC Research Network, 2005; Kirkegaard and Ring, 2017)
Clinician to Clinician/Team

Contributing to your well-being and growth

Coordination of Care

Outcome: Lower admissions, lower complications

(Nundy, Oswald, 2014; Beach, Inui, RCC Research Network, 2005; Kirkegaard and Ring, 2017)
Clinician to Community

Patients are influenced by community (family, friends, environment)

Determinants of health to be addressed

Overcoming barriers and using community strengths.

(Nundy, Oswald, 2014; Beach, Inui, RCC Research Network, 2005; Kirkegaard and Ring, 2017)
Clinician to Self

Depth of self-awareness

Emotional Intelligence

Wholeness

Our own personal transformation

(Nundy, Oswald, 2014; Beach, Inui, RCC Research Network, 2005; Kirkegaard and Ring, 2017)
RCC in Substance Use Treatment

A Discussion
Shared Decision Making

Having a dialogue within a trusting helping relationship

- Understanding their condition/patient education
- How information applies to treatment options and decisions
- Pros and cons of treatment options
- Supporting patients – they need to clarify their values as well as you.
- Making decision – even if no treatment
- Support through implementation

(Bradley, K and Kivlahan, DR, 2014)
Bridging RCC and Shared Decision Making

Discussion Questions

I. In thinking of RCC, how do you discuss treatment options, both MAT and behavioral interventions with your patients?

II. How do you come to a treatment plan with your patients that incorporates evidence based practices, provider recommendation and patient preference?

III. How do you assist your patients in clarifying their values and goals?

IV. What are some strategies you can use to help increase support for the relationship between you and your patient?
Questions?
References


Case Presentation #2
Cindy Straub, FNP-C

• 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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Use chat function for questions
Patient Presentation

ECHO

3/29/19
Cynthia Straub, FNP-C, ACHPN
48 y/o female

- **PMH:** IV and intranasal polysubstance use, osteomyelitis of L-spine, endocarditis s/p tricuspid valve replacement, hepatitis
- Admitted in toxic shock syndrome with DIC
- Suboxone 4/24/18 (confirmed) remission (3/1/19 16/4mg, 12/24/18 Sublocade 300mg)
- UDS pos cocaine, amphetamines, opiates
- ~ 1 week PTA intranasal cocaine
HPI

• Flu like symptoms, general malaise, arthralgia

• Fever 102

• 3-4 days feet became very painful and toes became dusky, menstruation, right knee swollen, painful

• ABIs right 0.89, left 0.96 toe indexes absent
LEFT HAND
LEFT FOOT
RIGHT FOOT
Pylonephritis

• Acrocyanosis: progressive ischemia of bilateral toes and left hand, lesions on bilateral dorsum of feet and BUE consistent with DIC

• Right knee arthroscopic washout

• TEE

• Toxic shock syndrome, streptococcus bacteremia, DIC
Pain management

• Severe pain in all joints, muscles, “everything hurts from my neck down, feels just like the bone pain when I had osteomyelitis”, sharp, constant 10/10 with movement, 8/10 lying still after 2mg IV Dilaudid.
Current pain regimen

• Dilaudid 4mg IV q. 2 hours prn, hold for sedation.

• Tylenol 650mg PO q. 4 hours scheduled.

• Gabapentin 300mg q. HS x 2 days, then 300mg bid x 2 days, then 300mg tid.

• Narcan 0.4mg IV q. 2 min prn RR<8.

• Nursing order: do not give Narcan unless respiratory
April 25th

- **PAIN:** 4/23 converted basal rate of dilaudid to oral. Even though using the globalrph.com calculator that converted the IV daily dose of dilaudid 9.6mg to 48mg oral dilaudid (divided by 6 (q. 4 hours)) equals 8mg q. 4 hours, pt reports her sats dropped while sleeping overnight, plus, she felt sleepy. 4/24: Her pain is very well controlled (3/10), **pt requested a decrease in dose.**
• **PLAN:** continue:
  - Gabapentin 600mg tid.
  - Continue Dilaudid PCA: 0.3mg with 10 min lockout, NO basal, 7.2mg 4 hour limit. evaluate and consider d/c PCA Monday 4/29/19.

• Continue Dilaudid PO 6mg q. 4 hours scheduled.

• Continue Dilaudid 1mg IV q. 3 hours prn breakthrough pain not controlled with PCA Dilaudid.

• Ice pack to knee.

• Narcan 0.4mg IV q. 2 min prn RR<8.

• Do not administer Narcan for somnolence, only respiratory problems.

• Discussed with Dr. Jadali: titrating this patient off opioids is a day to day assessment. This patient has been very cooperative with my decreasing her dose, even asking me to decrease the dose (4/24) and refusing a dose (4/24). She will be very cooperative as long as you work with her and allow her to participate in adjusting her doses. I will be happy to provide assistance by phone (517-1601).
May 1

• Chart check, noted nurse’s note today indicating concerns about pt’s dilaudid dose and oversedation. I called the nurses station and left a message for Emily to return my call. I called and spoke with Kelley, who agrees that she has been sleepy, her pain is fairly controlled, she denies withdrawal symptoms and is agreeable to reducing the dilaudid dose. Will reduce the dose by 25%.

• PLAN:
  - decrease dilaudid to 4mg q. 4 hours scheduled. Changed start time from 4pm to 2pm since her last dose of dilaudid was at 8am this am.
  - message left for RN to call to discuss changes.
  - paged Dr. Varma to let her know about the order change.
  - PLEASE CALL ME FOR QUESTIONS OR CONCERNS REGARDING PAIN MANAGEMENT. (804-517-1601) We do not have daily staffing at RCH, it is a social worker, not an RN who comes to RCH on Thursday and she is not able to make adjustments to patients medications.
May 3

- I am signing Palliative Medicine services off this patient’s case: she is not an appropriate Palliative referral, she needs to be followed by Addiction specialist and or Pain Management. I have been using the CDC’s Pocket Guide on Tapering Opioids for Chronic Pain, which I will recommend to the attending physician. There is no set schedule to follow when tapering opioids, it is suggested to start at reducing by 10% of the daily dose per week, however, if the patient is experiencing significant pain or withdrawal symptoms, do not continue to taper until the pain or symptoms have stabilized. I recommend case management or attending contact VCU Health Motivate Clinic (804-628-6777) where pt has been going for Suboxone treatment for further advice, as pt might be better off transitioning to Methadone for pain and addiction, however, before that is done be sure there is a Methadone clinic that will accept pt and that pt can afford to go to a Methadone clinic.

- I have paged Dr.______, who is the attending today, to discuss my recommendations.

- Cynthia Straub, FNP-C, ACHPN  517-1601
May 31

• discharged to the home of a friend temporarily with home health, OT and PT
• f/u appt with ID, Ortho, cardiology, PCP
• NO f/u made or offered for rehab, however, CM provided resources for housing and substance use.
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:

- Diane Boyer, DNP from Region Ten CSB
- 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
- Faisal Mohsin, MD from Hampton-Newport News CSB
- Jennifer Phelps, BS, LPN from Horizons Behavioral Health
- Jenny Sear-Cockram, NP from Chesterfield County Mental Health Support Services
- Bill Trost, MD from Danville-Pittsylvania Community Service
- Art Van Zee, MD from Stone Mountain Health Services
- Sarah Woodhouse, MD from Chesterfield Mental Health
Submit Feedback

Opportunity to formally submit feedback

• Survey: [www.vcuhealth.org/echo](http://www.vcuhealth.org/echo)
• Overall feedback related to session content and flow?
• Ideas for guest speakers?
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
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
## Previous Clinics (2019)

### Trauma Informed Care and Treating Those Experiencing Opioid Addiction
- **Date:** 01/04/19
- **Resources:**
  - Video of Clinic
  - Slide Presentation

#### 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.

### Syringe Exchange
- **Date:** 05/19/19
- **Resources:**
  - Video of Clinic
  - Slide Presentation
  - Needle Exchange Law
  - Needle Exchange Program Flyer
  - Bill to Remove Cooperation Law

#### 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 Session

June 21: Prime Care Bootcamp: Common Medical Conditions and SUDs

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

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