Virginia Opioid Addiction ECHO* Clinic

July 19, 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

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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. Didactic Presentation
   I. Virginia Mandated CPS Reporting Updates
      by: Valerie L’Herrou, JD

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
Disclosures

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

There is no commercial or in-kind support for this activity.
UPDATES TO VIRGINIA’S MANDATORY CPS REPORTING LAW: substance-affected infants

A PRESENTATION BY THE VIRGINIA POVERTY LAW CENTER

VALERIE L’HERROU
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VPLC

The statewide support center for legal aid in Virginia providing support in

ADVOCACY
TRAINING
LITIGATION

on the civil justice issues faced by low-income Virginians
Federal law re: substance-affected infants

- **Federal laws regarding states’ response:**
  - CARA (Comprehensive Addiction & Recovery Act)
  - PHSA (Public Health Service Act)
  - CAPTA (Child Abuse Prevention and Treatment Act)

- **2016: CARA amended CAPTA and PHSA**
  - Addresses state responses to substance use by pregnant women

- **PHSA:**
  - Federal funds for prenatal *family-based* treatment

- **CAPTA (1988; including 2016 amendments from CARA):**
  - Requires states to track/report data on infants born “affected by” substance abuse or withdrawal symptoms
  - Requires states to report such infants to CPS
  - Removes the term “illegal” as applied to maternal substance abuse affecting infants
  - Requires providing “plan of safe care” for *both mother* and infant
  - State monitoring system of referrals and delivery of appropriate treatment

Federal Administration for Children and Families program instructions to states:
https://www.acf.hhs.gov/sites/default/files/cb/pi1702.pdf
What does CAPTA require of states?

• “policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder....”

Federal Administration for Children and Families program instructions to states: https://www.acf.hhs.gov/sites/default/files/cb/pi1702.pdf
In-utero substance exposure: Virginia response

States thus must respond to and track the incidence of infants born affected by substance abuse.

- This resulted in a requirement that such situations mandate a report to Child Protective Services as part of the Child Abuse and Neglect statutes.
- Virginia law follows this requirement, and in response to the 2016 changes in CARA and CAPTA, amended the Child Abuse reporting statute (§63.2-1509).
- States must provide “plan of safe care” for both mother and infant.

→ Health care professionals are mandated to report to CPS when they are aware that an infant was born “affected by” substance use.

→ What happens when a report is made:
  - The CPS response to infants born affected by maternal substance use is to treat it as a red flag for risk of neonatal neglect and abuse; thus local CPS workers are supposed to assign a reported case to the assessment track (not the investigation track, though a case may be escalated to the investigation track).
  - (See differential response system, VA Code § 63.2-1504).
OLD Virginia law
(July 2017 through June 30, 2019)

- **Virginia’s Tracking and Reporting Law:**
  - In 2017, in response to CARA, language was changed:
    - Added prescription substances
    - Removed reporting exception for women receiving treatment
  - Language did not align with 22 VAC 40-705-40(A)(6)(h): “Facts solely indicating that the infant may have been exposed to controlled substances prior to birth are not sufficient to render a founded disposition of abuse or neglect...”
  - Did not mention continuing care related to Plan of Safe Care.
  - **DID** mandate CPS assessment track (vs investigation track)
  - Did not reference hospital responsibility to refer to community services board.

* §63.2-1509(B); ** §54.1-2403.1; ***§32.1-127(B)(6)
Virginia Code Section 63.2-1509(B): ‘For purposes of subsection A, “reason to suspect that a child is abused or neglected” shall, due to the special medical needs of infants affected by substance exposure, include (i) a finding made by a health care provider within six weeks of the birth of a child that the child was born affected by substance abuse or experiencing withdrawal symptoms resulting from in utero drug exposure; (ii) a diagnosis made by a health care provider within four years following a child’s birth that the child has an illness, disease, or condition that, to a reasonable degree of medical certainty, is attributable to maternal abuse of a controlled substance during pregnancy; or (iii) a diagnosis made by a health care provider within four years following a child’s birth that the child has a fetal alcohol spectrum disorder attributable to in utero exposure to alcohol. When “reason to suspect” is based upon this subsection, such fact shall be included in the report along with the facts relied upon by the person making the report. Such reports shall not constitute a per se finding of child abuse or neglect. If a health care provider in a licensed hospital makes any finding or diagnosis set forth in clause (i), (ii), or (iii), the hospital shall require the development of a written discharge plan under protocols established by the hospital pursuant to subdivision B 6 of § 32.1-127.’
In-utero substance exposure: child abuse?

Why the change?

- Confusion about whether such exposure constituted child abuse. Virginia law does not classify fetuses as children; thus prenatal exposure, regardless of any affect on the fetus, is not child abuse.

- Due to its inclusion in the child abuse code, law enforcement have sometimes treated such a case as criminal, even though prenatal substance exposure is not part of the criminal code; they argued that §63.2-1509(B) (civil child abuse) is evidence to prove § 18.2-371.1 (criminal child abuse).

- Women may come to the attention of law enforcement if they are arrested for possession of an illicit substance while pregnant, and were sometimes charged with criminal child abuse based on 63.2-1509(B).
In-utero substance exposure: pre- and neonatal care

- Virginia’s prenatal and neonatal care and SUDs:
  - **Prenatal**: Doctors required to advise women of potential for poor birth outcomes.*
  - **Prenatal**: No legal requirement to connect women with treatment options, but this should be considered best practice.
  - **Neonatal**: Doctors should discuss discharge with patient and make appropriate referrals.
  - **Neonatal**: Requires hospitals to notify, subject to federal law restrictions, the community services board of the jurisdiction in which the woman resides to appoint a discharge plan manager.**

* §54.1-2403.1  
**§32.1-127(B)(6)
Inconsistency / confusion for health and CPS workers?

The Virginia Department of Social Services July 2017 Child and Family Services Manual Section C: Child Protective Services, at 10.3.1:

“"The Code of Virginia requires health care providers to make a report of abuse or neglect when there is a reason to suspect that a mother exposed a newborn infant to controlled substances during the pregnancy." [emphasis added]

However, this is confusing as it is not entirely true, but is an oversimplification. The language of the law requires reporting in three circumstances:

Statute: §63.2-1509(B): “For purposes of subsection A, ‘reason to suspect that a child is abused or neglected’ shall, due to the special medical needs of infants affected by substance exposure, include (i) a finding made by a health care provider within six weeks of the birth of a child that the child was born affected by substance abuse or experiencing withdrawal symptoms resulting from in utero drug exposure; (ii) a diagnosis made by a health care provider within four years following a child’s birth that the child has an illness, disease, or condition that, to a reasonable degree of medical certainty, is attributable to maternal abuse of a controlled substance during pregnancy; or (iii) a diagnosis made by a health care provider within four years following a child’s birth that the child has a fetal alcohol spectrum disorder attributable to in utero exposure to alcohol.” [emphasis added]
Mandatory Reporting to CPS

- **CPS Manual: 10.3.1.1 First circumstance**
  - The first circumstance is a finding is made by a health care provider **within six (6) weeks of birth** that the child **is born affected by substance abuse or is experiencing withdrawal symptoms** resulting from in utero drug exposure. This includes dependency on **controlled substances prescribed for the mother by a physician** or an opioid treatment program (OTP).
  - Including Neonatal Abstinence Syndrome (NAS)

- **CPS Manual: 10.3.1.2 Second circumstance**
  - The second circumstance is **within four (4) years of a child’s birth**, a health care provider can **diagnose the child as having an illness, disease or condition** which, to a reasonable degree of medical certainty, is **attributable to in utero exposure** to a controlled substance.

- **CPS Manual: 10.3.1.3 Third circumstance**
  - The third circumstance is **within four (4) years following a child’s birth**, a health care provider can make the **diagnosis that the child has a fetal alcohol spectrum disorder (FASD)** attributable to **in utero exposure to alcohol**.

[emphasis added]

Mandatory Reporting to CPS

The manual provides more clarity when outlining the three circumstances that require reporting:

- **CPS Manual: 10.3.2 Health care provider responsibilities**
  - **10.3.2.1 Report to CPS** (22 VAC 40-705-40 A6). Pursuant to § 63.2-1509 B of the Code of Virginia, whenever a health care provider makes a finding or diagnosis, then the health care provider or his designee must make a report to child protective services immediately.
  - Whenever a health care provider makes a finding or diagnosis of one (1) of the three (3) circumstances... the health care provider shall make a report to CPS as soon as possible, but no longer than 24 hours after having reason to suspect a reportable situation.
  - Health care providers are required to release, upon request, medical records that document the basis of the report. Disclosure of child abuse or neglect information is also permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and federal Confidentiality of Alcohol and Drug Abuse Patient Information Regulations. (CFR 42 Part 2)

[emphasis added]

Mandatory Reporting to CPS

- **CPS Manual: 10.3.2.2 Report to the Community Services Board**
  - The Code of Virginia (§ 32.1-127 (B)(6)) “requires that each licensed hospital develop and implement a protocol requiring written discharge plans for identified, substance-abusing, postpartum women and their infants. The discharge plan should be discussed with the patient and appropriate referrals made and documented. The discharge planning process shall involve, to the extent possible, the father of the infant and any members of the mother’s extended family who may participate in the follow-up care for the mother and the infant. Hospitals are required to notify the Community Services Board (CSB) of the jurisdiction in which the woman resides to appoint a discharge plan manager for any identified substance-abusing postpartum woman. The CSB shall implement and manage the discharge plan.” [emphasis added]

- **2019 law change:** the above requirement from VA Code § 32.1-127 has been ADDED to the mandatory reporter section.

Discharge Planning: Plan of Safe Care

CPS Manual: 10.3.2.2.1 Hospital discharge plan

- Post-partum women with substance use disorders and their newborns may have multiple health care, treatment, safety and environmental needs. Their hospital discharge plans should include, but are not limited to:
  - A referral of the mother to the local CSB for a substance use assessment and implementation of the discharge plan.
  - Information and medical directives regarding potential postpartum complications and, as appropriate, indicators of substance use withdrawal and post-partum depression.
  - A follow-up appointment for pediatric care for the infant within two-four weeks.
  - A referral to early intervention Part C services for a developmental assessment and early intervention services for the infant.
  - A follow-up appointment for the mother for postpartum gynecological care and family planning.

(The CPS worker should obtain a copy of the hospital discharge plan and document the details in the automated data system.)

CPS Manual: 10.4.1 Who creates a Plan of Safe Care?

- A plan of safe care should begin when the mother is pregnant, initiated by her health care providers. After a report, CPS becomes part of this Plan of Safe Care.

CPS Response: Assessment vs Investigation

§ 63.2-1504. Child-protective services differential response system.
The Department shall implement a child-protective services differential response system in all local departments. The differential response system allows local departments to respond to valid reports or complaints of child abuse or neglect by conducting either an investigation or a family assessment.

  “Facts solely indicating that the infant may have been exposed to controlled substances prior to birth are not sufficient to render a founded disposition of abuse or neglect...”

  - A founded disposition of child abuse cannot be made based **ANY occurrence prior to birth**, since a fetus prior to birth is NOT an infant under Virginia law.

- **Family Assessment**
  - Assess child safety
  - Strengthen and support families
  - Assess risk of future maltreatment
  - Prevent further abuse

- **Investigation**
  - Assess child safety
  - Strengthen and support families
  - Assess risk of future maltreatment
  - Prevent further abuse
  - **Determine if abuse or neglect occurred**
§63.2-1509(B) does not distinguish between different types of circumstances when infants may be exposed to substances in utero, however, Group C creates the risks the Plan of Safe care and CPS assessment are designed to address.

**Group A**
- Responsibly using prescribed medications while pregnant
- Medications for seizure disorders
- Opioids for Pain Management
- Anxiety/Depression Medication
- Anesthesia administered for surgery while pregnant
- Anesthesia during labor (i.e. as part of epidural)

**Group B**
- Receiving Medically Assisted Treatment for Opioid-use Disorder
- Methadone
- Suboxone

**Group C**
- Using Prescription substances without the supervision of a doctor or not as prescribed
- Recreational, Illicit Drugs
- Alcohol
- Cigarettes

Source: Rockwell & Siddall, 2018

NOTE:
Virginia’s CPS Manual provides differentiation in its recommended Plans of Safe Care for each group, as well as who is responsible for creating/monitoring a Plan depending on typology, and whether pre- or post-natal.
Health Care Provider or CPS? Plan of Safe Care

Three populations of pregnant/post-partum women → who takes lead in creating/monitoring Plan of Safe Care?

1. **Using legal/illegal drugs**, on an opioid medication for chronic pain or on a medication that can result in dependency/withdrawal and **does not have a substance use disorder**.

*Prenatal*: Prenatal care provider in concert with pain specialist or other physician.

*Postpartum*: Maternal and Child Health service providers (e.g. home visiting provider, Healthy Families); CPS or community prevention services.

Three populations of pregnant/post-partum women → who takes lead in creating/monitoring Plan of Safe Care?

2. Receiving medication assisted treatment for an opioid use disorder (e.g., Methadone) or is actively engaged in treatment for a substance use disorder.

*Prenatal: Prenatal care provider in concert with Opioid Treatment Program or other therapeutic substance use disorder treatment provider/CSB.

*Postpartum: OTP or other therapeutic substance use disorder treatment provider/CSB.

Three populations of pregnant/post-partum women → who takes lead in creating/monitoring Plan of Safe Care?

3. Misusing prescription drugs, or is using legal or illegal drugs, meets criteria for a substance use disorder, not actively engaged in a treatment program.

*Prenatal*: Prenatal care provider or high-risk pregnancy clinic in concert with substance use disorder treatment agency/CSB.

*Postpartum*: Child Protective Services.

What’s included: Plan of Safe Care

CPS Manual 10.4.2: What is included in a Plan of Safe Care?

- A Plan of Safe Care should incorporate the mother’s (and potentially the other primary caregivers) need for treatment for substance use and mental disorders, appropriate care for the infant who may be experiencing neurodevelopmental or physical effects or withdrawal symptoms from prenatal substance exposure, and services and supports that strengthen the parents’ capacity to nurture and care for the infant and to ensure the infant’s continued safety and well-being.

- The plan should also ensure a process for continued monitoring of the family and accountability of responsible agencies such as substance use disorder treatment, home visiting, and public health and health care providers for the infant and mother.

CPS Manual 10.11 Appendix D: Sample Plan of Safe Care

→ Nota bene: I am not providing legal advice on when/what to report!

Federal law, the Family First Prevention Services Act, has created a new opportunity for treatment for new mothers with SUDs. Under the Act, states may use foster care funds to pay for the child’s portion of costs during a mother’s stay in in-patient treatment (Medicaid should cover a mother’s costs). The child will be in foster care but placed with the mother in the treatment facility.
Questions?
Case Presentation #1
Dan Spencer, MD

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

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions
Case Presentation #1
Dan Spencer, MD

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

Would like to become more familiar with policy/protocol that other hospitals are using when treating adolescents with substance use withdrawal concerns.

Case History

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

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

17 year old female, 8th grade. Stopped attending school for 1 1/2 years in 2016. Average IQ. Lives with mom, maternal grandmother, 2 siblings, a maternal aunt, 4 cousins. Biologic father lives close and spends time at the home. Few friends. Reports good relationships with family members. Reports her mother has a substance use problem. Mother currently on probation for heroin use. Identifies as bi-sexual.

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions
Case Presentation #1
Dan Spencer, 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.)

Presented to our ED for acute treatment of heroin and benzo addiction. Using both consistently for approximately 1-year. Frequency, heroin 3-4 x /day and Xanax daily, up to 4 mg. Admits to snorting Xanax as well. Reportedly changed dealers a few months back and reports fentanyl use in place of heroin for 2-months. Has previously used methamphetamine, cocaine, and crack cocaine, but stopped approximately 1-year ago after a cocaine possession charge. Patient presented to multiple adult hospitals before coming to CHKD but was never admitted, only treated in ED and released resulting in return to use. History of depression and anxiety, not treated. Was attending group therapy for SUD prior to her inpatient admission. Patient on probation.

Recent diagnosis of STI's, genital herpes, prescribed medication, not taking regularly. No other known medical concerns or medication.
Case Presentation #1
Dan Spencer, MD

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

Patient managed on the inpatient medical unit for detox. Utilized consult with adult facility physician to manage her withdrawal over a period of 15-days. Once medically cleared she was transferred to a residential treatment program addressing SUD and Trauma out of state.

Continued on methadone with guidance from adult CL physician. She was started on 20 mg of methadone daily. She was weaned by 5 mg every 2-3 days. She was also started on Klonopin at 0.5 mg twice a day for 3 days, followed by 0.5 mg daily for 3 days, and then this was discontinued. She was placed on Depakote for seizure prophylaxis throughout the detoxification period. She tolerated weaning of these medications well and without complications. 7-day course of metronidazole for the bacterial vaginosis.
Case Presentation #1
Dan Spencer, MD

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

Patient to complete course of RTC and will likely return to the area with tight outpatient follow up. We don't anticipate an extended treatment relationship with this patient though she is being followed by our child advocacy center.

Other relevant information

Patient was voluntary for treatment. This is often not the case. How do others handle minors in this situation? Do folks have specific protocol's they follow? Policy around detox in a medical setting? We are interested in learning what others are doing as well.

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

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

How can we help the patient attain remission? Pt is struggling with Alcohol Use Disorder, and admits to lack of motivation and loss of control.

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.)

35 yr AAF, divorced, unemployed. Lives at home with her daughter. Has been unemployed for little under a year. Is being supported by family. High school graduate, some college credits. Has 4 children. 2 of her youngest are in high school. Middle son in Juvenile detention. Her oldest daughter is not enrolled in college and also unemployed. Patient's mother also appears to have an alcohol use disorder.

No known medical problems.
Case Presentation #2
Faisal Mohsin, 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.)

Previous diagnosis : Psychotic Depression and Alcohol Use Disorder, severe. Was being prescribed a combination of an injectable depot anti-psychotic, antidepressant and nighttime non-benzodiazepine sedative. Medication Compliance overall has been poor. Has not engaged in behavioral therapies. Often cancels appointments.

Until last year, reportedly drinking up to a liter of Vodka daily. Drinking for "years". Endorses blackouts+, Eye openers +, and needing a drink first thing in the morning. Has been fired from her last 3 jobs because of alcohol related issues. No DUIs but wrecked her car last year. Claims she was sober at the time. No reliable transportation at this time.

Was started on oral Naltrexone 50 mg/day, around last year for alcohol reduction. Poor compliance. Was started on Vivitrol 380 mg im monthly at the start of 2019. Has had 6 or 7 injections so far. No longer on any antipsychotic. Also prescribed Prozac 20 mg daily and Trazodone 100 mg bedtime. Has not taken these since her last appointment about 6 weeks ago.

Diagnosis has now been amended to Major Depressive Disorder secondary to Alcohol Use Disorder and Alcohol Use Disorder, severe, continuous. No anti-psychotics being prescribed. No evidence of psychosis. Mood remains depressed, with low energy, amotivation, sleep disruption, etc. No h/o attempts at suicide.
Case Presentation #2
Faisal Mohsin, MD

Labs:
8.8.18  AST=116, ALT=80, CDT=4.2, GGT=168
11.7.18 AST=30, ALT=22, CDT=2.4, GGT=59, PEth=1718 ng/ml
12.12.18 AST=74, ALT=30, CDT=2.2, GGT=66, PEth=1503

[Vivitrol started around January 2019.]
4.24.19  AST=43, ALT=37, CDT=4.1, GGT=92, PEth (not done)
5.07.19  BAC 0.068
6.10.19  BAC 0.00
7.17.19  BAC 0.00. Labs scheduled for next week.

Presently:
Continues to drink 7 days per week. Since last few weeks, reports drinking 1/2 pint of Vodka daily. Last reported drink was the day before, around 7.00pm. States she now initiates her first drink around 2.00pm.

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

Presently only taking IM Vivitrol (Naltrexone) 380 mg. Was prescribed oral Topamax at her last 2 visits to assist with alcohol reduction. Non-compliant. Is also prescribed Prozac 20 mg daily and Trazodone for sleep.

Despite repeated recommendations has failed to participate in self help groups such as AA. Has not engaged in behavioral therapies such as individual or group therapies at the CSB. Most common excuse, "nobody called me" or lack of transportation.
What is your plan for future treatment? What are the patient's goals for treatment?

Patient's goal: "I want to drink socially only, not every day"

Treatment team plan:
Continue Vivitrol for at least another 6 months and monitor labs.
Goal is to lower her GGT to below 65 (high normal cutoff), lower the CDT to below 1.2 (1.6 and higher considered abnormal and indicative of heavy alcohol consumption).

A second option is to add oral Topiramate to her regimen for alcohol reduction. However, there is no evidence that combined therapy has been shown to work better than any one pharmacological treatment, plus she has consistently demonstrated poor medication compliance.

Scheduling follow ups more frequently.

Additional shared goals: resumption of steady employment, improved financial status, purchasing a vehicle with subsequent mobility and independence, leading to an improved quality of life.

Other relevant information

Continue to use Motivational enhancement. Identify the progress and positives.

Praise and encouragement every time she blows negative.

Continue to recommend engagement with individual and group therapies including initiating AA attendance.

Have asked her to bring her daughter with her at her next visit so we can have her daughter assist her with medication compliance and attend her therapy appointments.
Case Studies

• Case studies
  • Submit:  [www.vcuhealth.org/echo](http://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
- Melissa Bradner, MD from VCU Health
- Michael Fox, DO from VCU Health
- Shannon Garrett, FNP from West Grace Health Center
- Sharon Hardy, BSW, CSAC from Hampton-Newport News CSB
- Sunny Kim, NP from VCU Health
- Thokozani Lipato, MD from VCU Health
- Caitlin Martin, MD from VCU Health
- Faisal Mohsin, MD from Hampton-Newport News CSB
- Jennifer Phelps, BS, LPN from Horizons Behavioral Health
- Tierra Ruffin, LPC from Hampton-Newport News CSB
- Jenny Sear-Cockram, NP from Chesterfield County Mental Health Support Services
- Cynthia Straub, FNP-C from Memorial Regional Medical Center
- Barbara Trandel, MD from Colonial Behavioral Health
- Bill Trost, MD from Danville-Pittsylvania Community Service
- Art Van Zee, MD from Stone Mountain Health Services
- Sarah Woodhouse, MD from Chesterfield Mental Health
Claim Your CME and Provide Feedback

- [www.vcuhealth.org/echo](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 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™.

Telehealth

Virginia Opioid Addiction ECHO

Register Now
- Submit Your Case Study
- Continuing Medical Education (CME)
- Curriculum & Calendar
- Previous Clinics (2018)
- Previous Clinics (2019)
- Resources
- Our Team
Access Your Evaluation and Claim Your CME
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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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)

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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.
VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

Mark Your Calendar --- Upcoming Sessions

August 2: Mindfulness for Healthcare Professionals  Patricia Kinser, PhD, RN

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

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