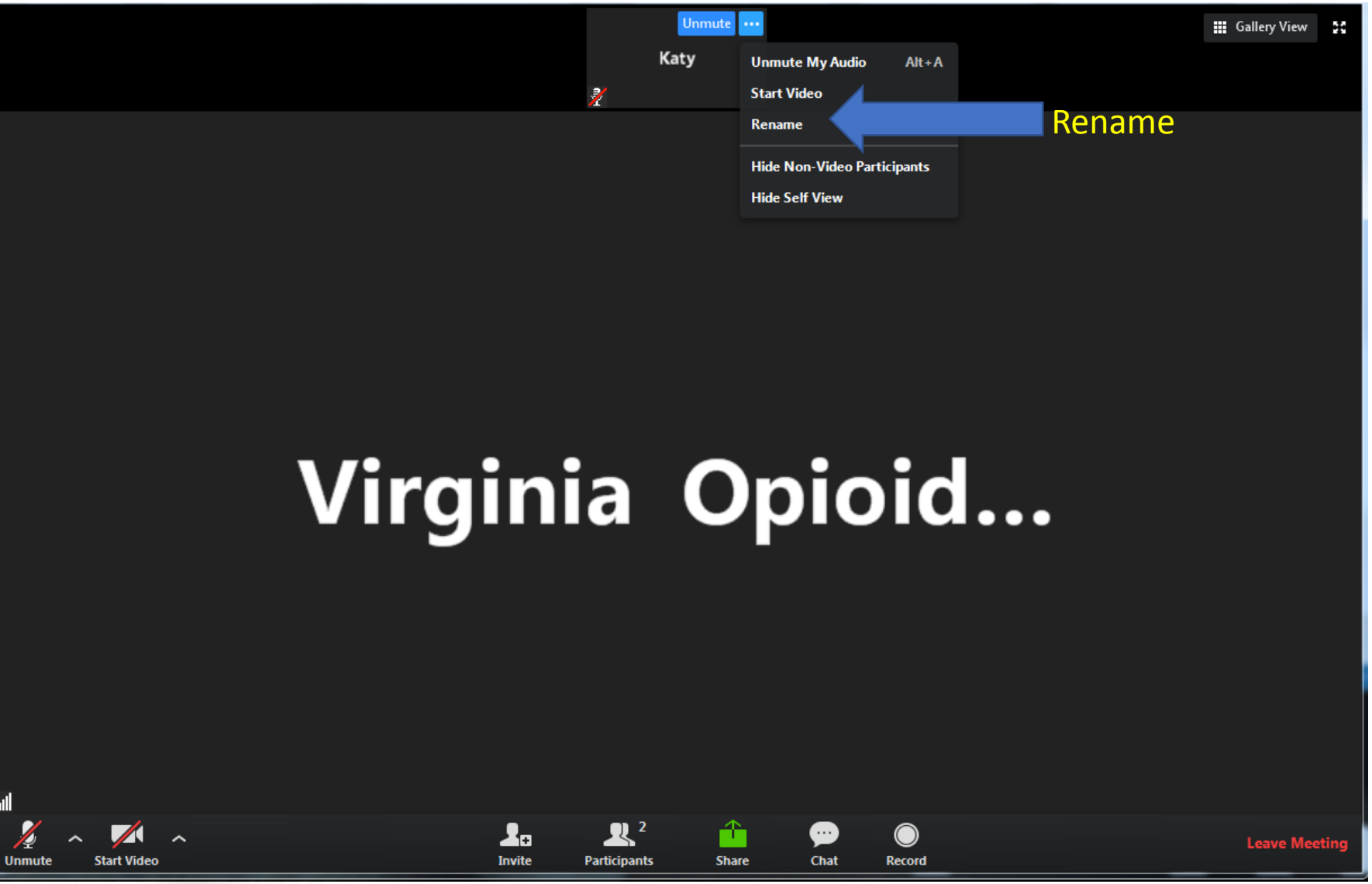
Virginia Opioid Addiction ECHO* Clinic

February 15, 2019

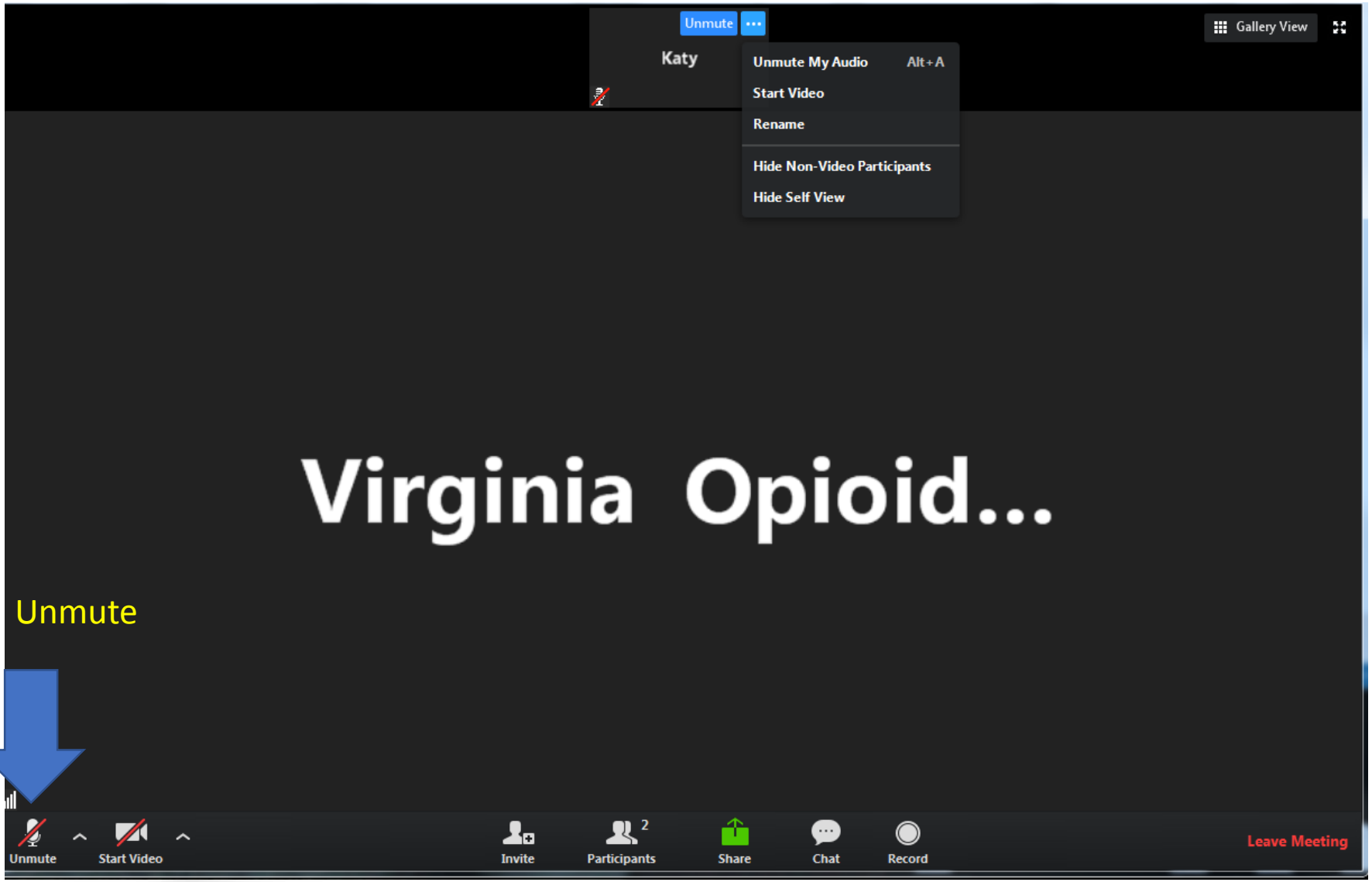
*ECHO: Extension of Community Healthcare Outcomes

Helpful Reminders



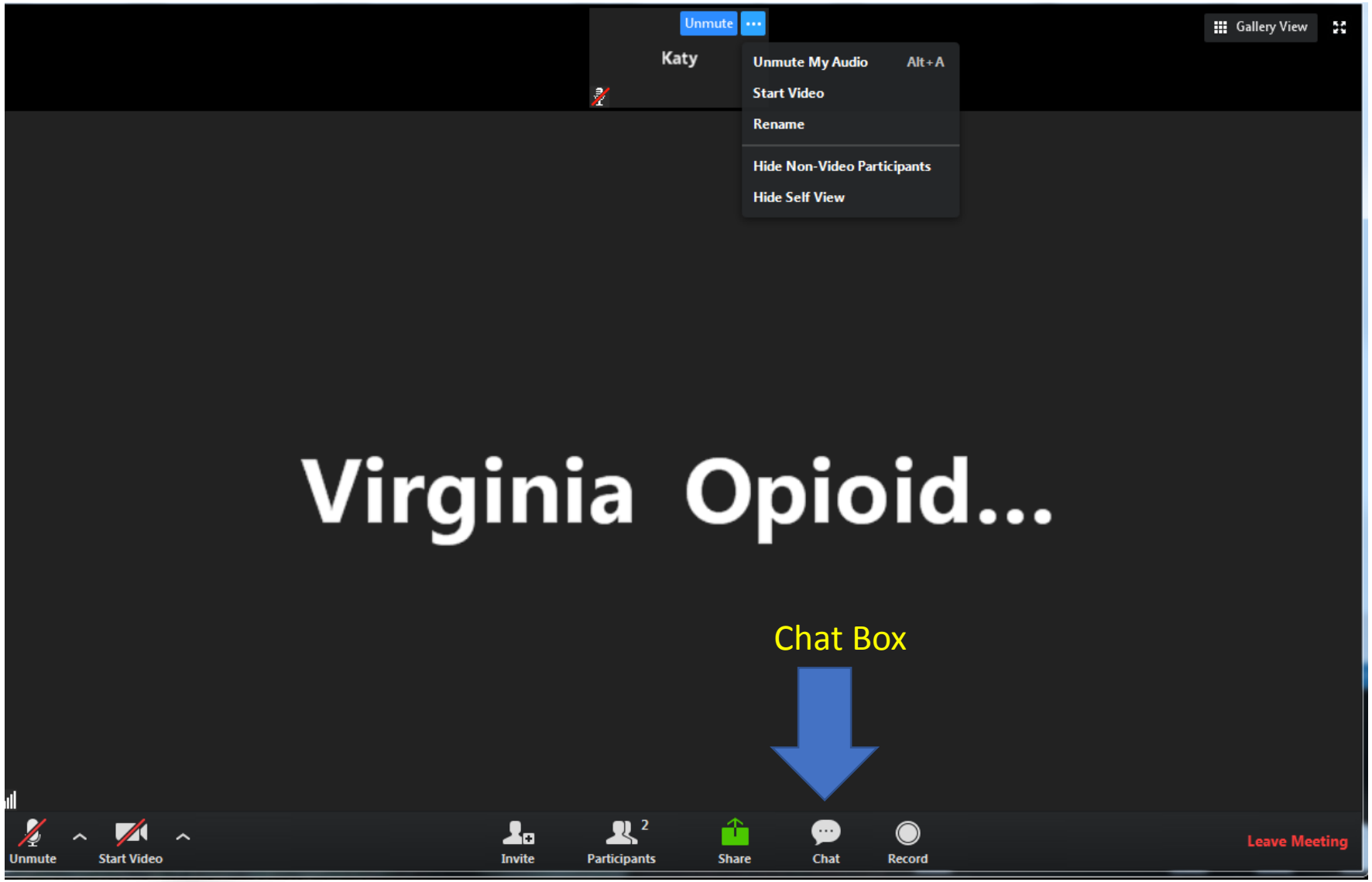
- Rename your Zoom screen, with your name and organization

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

VCU Health
VCU School of Medicine

VDH Virginia Department of Health | VDHLiveWell.com | Virginia Department of Behavioral Health & Developmental Services

- 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

VCU

Hub Introductions

VCU Team	
Clinical Director	Mishka Terplan, MD, MPH, FACOG, FASAM
Administrative Medical Director ECHO Hub and Principal Investigator	Vimal Mishra, MD, MMCi
Clinical Expert Didactic Presentation Program Manager Practice Administrator IT Support	Lori Keyser-Marcus, PhD Courtney Holmes, PhD Mishka Terplan, MD Bhakti Dave, MPH David Collins, MHA Vladimir Lavrentyev, MBA

Introductions:

- Name
- Organization

Poll Question #1:

- What is your current comfort level with Naltrexone?

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

What to Expect

I. Didactic Presentation
   I. **Naltrexone**
   II. **Mishka Terplan, 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

Project ECHO Naltrexone

Naltrexone

- Opioid antagonist (at mu and kappa receptors)
- Can be prescribed by anyone
- Does not cause dependence or euphoria
- “Detox Hurdle” – precipitated withdrawal if not detoxed from opioids
- Oral formulation approved 1984 (OUD) and 1995 (AUD), SQ approved 2006 (AUD) and 2010 (OUD)
- Cost: 50 mg tablet=$0.74/day, 380mg Injection=$41.20/day
- Hepatic Metabolism

Injectable Naltrexone (XR-NTX)*

- Multicenter (13 sites in Russia) Funded by Alkermes
- DB RPCT, 24 wks, n=250 w/ opioid dependence
- XR-NTX vs placebo, all offered biweekly individual drug counseling
- Increased weeks of confirmed abstinence (90% vs 35%)
- Increased patients with confirmed abstinence (36% vs 23%)
- Decreased craving (-10 vs +0.7)

*No Black Box LFTs Warning Label for IM formulation

Krupitsky E et al. *Lancet.* 2011.

Oral Naltrexone Efficacy

- Oral naltrexone
  - Duration of action 24-48 hours
  - FDA approved 1984
- 10 RCTs ~700 participants to naltrexone alone or with psychosocial therapy compared with psychosocial therapy alone or placebo
  - No clear benefit in treatment retention or relapse at follow up
- Benefit in highly motivated patients
  - Impaired physicians > 80% abstinence at 18 months

Cochrane Database of Systematic Reviews 2006

Cochrane Library

Cochrane Database of Systematic Reviews

Oral naltrexone maintenance treatment for opioid dependence (Review)

Minozzi S, Amato L, Vecchi S, Davoli M, Kirchmayer U, Verster A

Analysis 1.2. Comparison 1 naltrexone versus placebo or no pharmacological treatments, Outcome 2 retention and abstinence, all patients.

Review: Oral naltrexone maintenance treatment for opioid dependence

Comparison: 1 naltrexone versus placebo or no pharmacological treatments

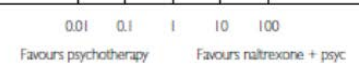
Outcome: 2 retention and abstinence, all patients

Study or subgroup	naltrexone n/N	placebo/no pharm n/N	Risk Ratio M-H,Random,95% CI	Weight	Risk Ratio M-H,Random,95% CI
Curran 1976	2/19	2/19		9.1 %	1.00 [0.16, 6.38]
Krupitsky 2004	12/27	4/25		17.8 %	2.78 [1.03, 7.49]
Krupitsky 2006	25/70	7/70		20.9 %	3.57 [1.65, 7.71]
Lerner 1992	9/15	8/16		22.8 %	1.20 [0.63, 2.28]
San 1991	4/28	8/22		16.8 %	0.39 [0.14, 1.14]
Schottenfield 2008	4/43	3/39		12.6 %	1.21 [0.29, 5.07]
Total (95% CI)	**202**	**191**		**100.0 %**	**1.43 [0.72, 2.82]**

Total events: 56 (naltrexone), 32 (placebo/no pharm)

Heterogeneity: Tau² = 0.42; Chi² = 13.40, df = 5 (P = 0.02); I² =63%

Test for overall effect: Z = 1.03 (P = 0.30)



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SUMMARY OF FINDINGS FOR THE MAIN COMPARISON *[Explan*

naltrexone versus placebo or no pharmacological treatments for opioid dependence

Patient or population: patients with opioid dependence
Settings:
Intervention: naltrexone versus placebo or no pharmacological treatments

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participan (studies)
	Assumed risk	Corresponding risk		
	Control	naltrexone versus placebo or no pharmacological treatments		
retention and abstinence, all patients	Study population		RR 1.43 (0.72 to 2.82)	393 (6 studies)
	168 per 1000	240 per 1000 (121 to 474)		
	Medium risk population			
	133 per 1000	190 per 1000 (96 to 375)		
abstinence at follow up	Study population		RR 1.28 (0.8 to 2.05)	116 (3 studies)
	340 per 1000	435 per 1000 (272 to 697)		
	Medium risk population			
	364 per 1000	466 per 1000 (291 to 746)		

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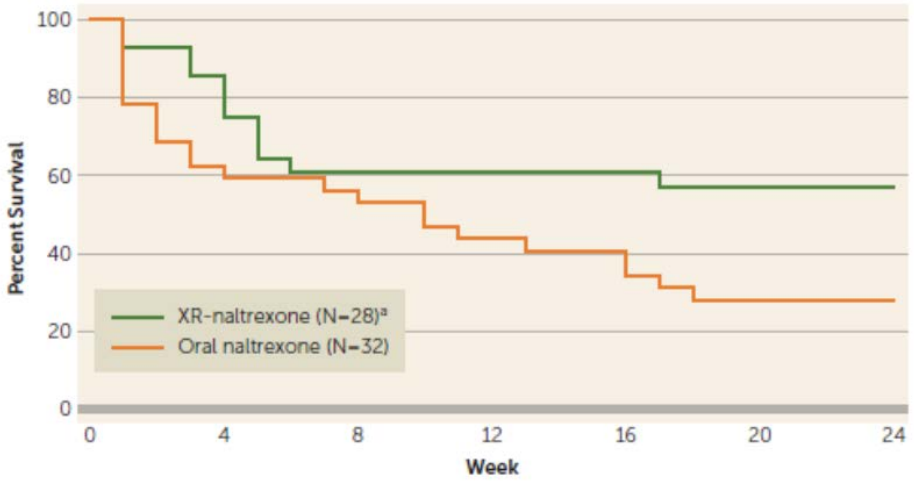
A Randomized Trial Comparing Extended-Release Injectable Suspension and Oral Naltrexone, Both Combined With Behavioral Therapy, for the Treatment of Opioid Use Disorder

Maria A. Sullivan, M.D., Ph.D., Adam Bisaga, M.D., Martina Pavlicova, Ph.D., Kenneth M. Carpenter, Ph.D., C. Jean Choi, M.S., Kaitlyn Mishlen, M.A., Frances R. Levin, M.D., John J. Mariani, M.D., Edward V. Nunes, M.D.

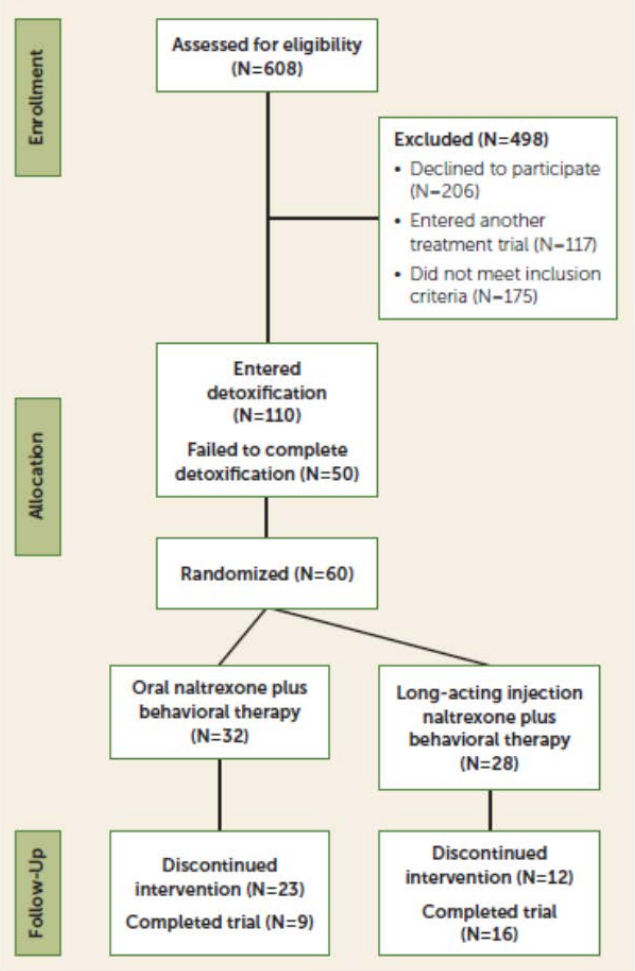
FIGURE 2. Time to Dropout for Participants Receiving Oral Naltrexone or Extended-Release Injectable Suspension Naltrexone (XR-Naltrexone)[a]



	Week						
Percent Survival (N survived)	0	4	8	12	16	20	24
XR-naltrexone (N=28)	100.0% (28)	85.7% (24)	60.7% (17)	60.7% (17)	60.7% (17)	57.1% (16)	57.1% (16)
Oral naltrexone (N=32)	100.0% (32)	62.5% (20)	53.1% (17)	43.8% (14)	40.6% (13)	28.1% (9)	28.1% (9)

[a] Time to dropout was significantly higher in the XR-naltrexone group relative to the oral naltrexone group (Kaplan-Meier nonparametric log-rank test, $\chi^2=4.64$, df=1, p=0.03).

FIGURE 1. CONSORT Diagram for a Randomized Trial Comparing Extended-Release Injectable Suspension and Oral Naltrexone, Both Combined With Behavioral Therapy, for the Treatment of Opioid Use Disorder



Injectable extended-release naltrexone for opioid dependence: a double-blind, placebo-controlled, multicentre randomised trial

www.thelancet.com Vol 377 April 30, 2011

Evgeny Krupitsky, Edward V Nunes, Walter Ling, Ari Illeperuma, David R Gastfriend, Bernard L Silverman

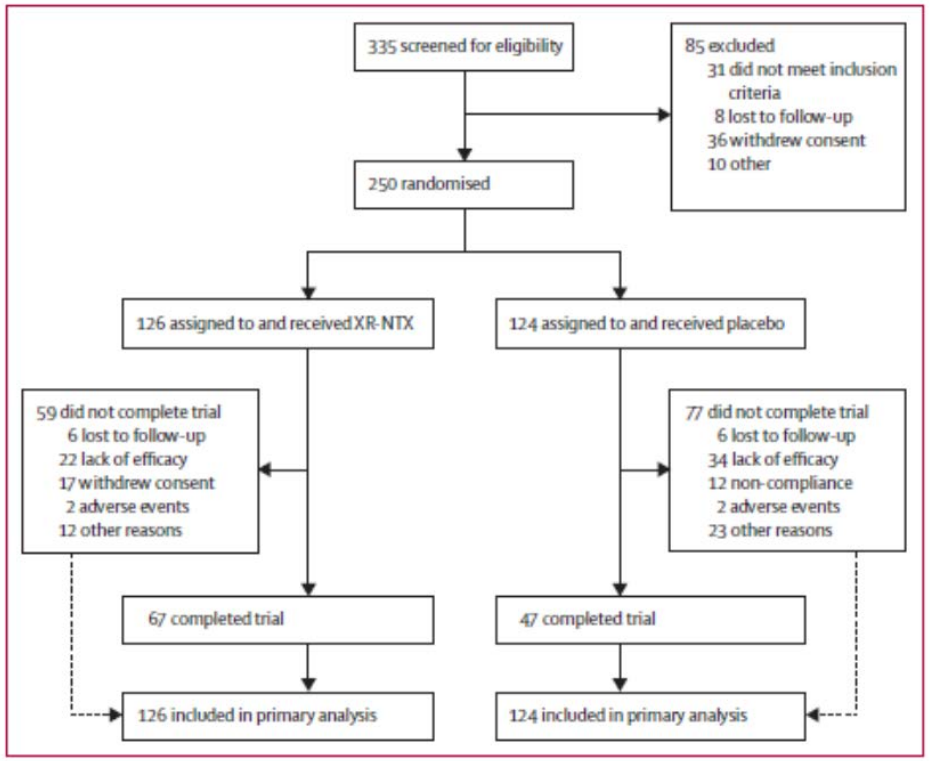


Figure 1: **Trial profile**
XR-NTX=extended-release naltrexone.

	XR-NTX (n=126)	Placebo (n=124)
Age (years)	29·4 (4·8)	29·7 (3·6)
Men	113 (90%)	107 (86%)
White	124 (98%)	124 (100%)
Duration of opioid dependence (years)	9·1 (4·5)	10·0 (3·9)
Days of pre-study inpatient detoxification	18 (9)	18 (7)
Opioid craving scale	18 (23)	22 (24)
HIV serology positive	51 (40%)	52 (42%)
Hepatitis C positive	111 (88%)	117 (94%)

Data are mean (SD) or number (%). XR-NTX=extended-release naltrexone.

Table 1: **Demographics and baseline clinical characteristics**

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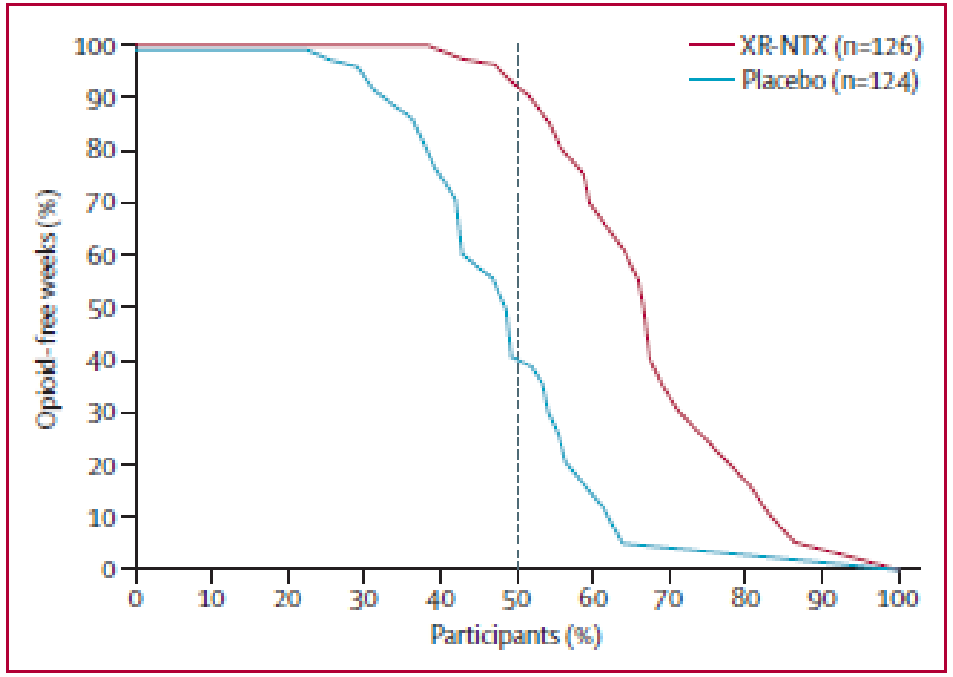

Figure 2: Percent of confirmed opioid-free weeks (cumulative) among participants treated with XR-NTX compared with placebo
XR-NTX=extended-release naltrexone

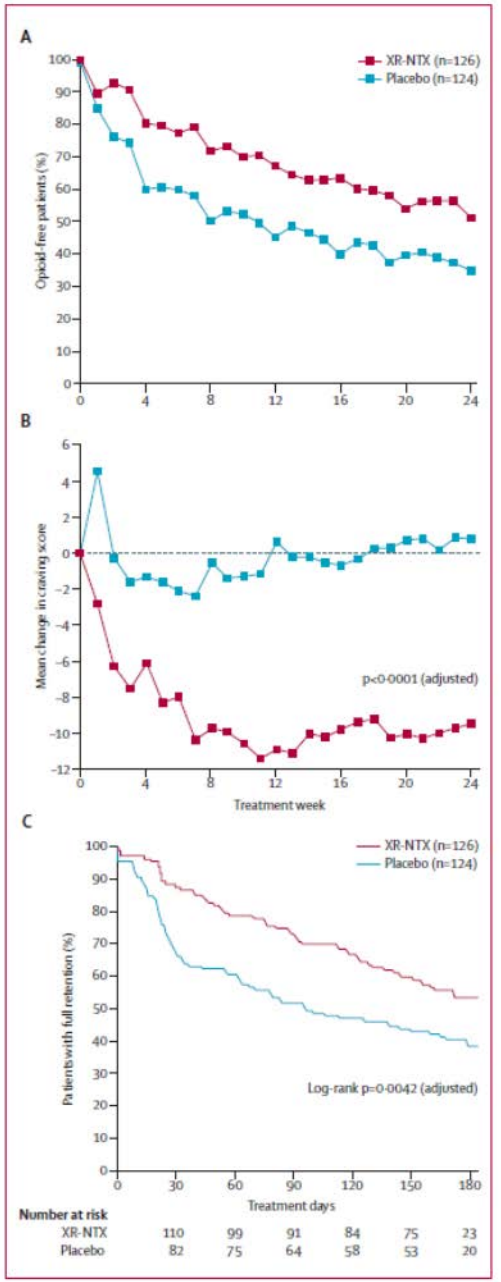

Figure 3: Key secondary efficacy outcomes
(A) Proportion of opioid-free patients by timeline follow-back self-report. (B) Mean change from baseline in craving. p value is based on a generalised estimating equation model assuming normal distribution and autoregressive correlation structure. (C) Time-to-discontinuation of study treatment. p values for analyses of craving (B) and retention (C) are adjusted for multiplicity. XR-NTX=extended-release naltrexone.

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JAMA Psychiatry | Original Investigation

Effectiveness of Injectable Extended-Release Naltrexone vs Daily Buprenorphine-Naloxone for Opioid Dependence

A Randomized Clinical Noninferiority Trial

JAMA Psychiatry December 2017 Volume 74, Number 12

Lars Tanum, MD, DMSci; Kristin Klemmetsby Solli, MSc; Zill-e-Huma Latif, MD; Jūratė Šaltytė Benth, PhD; Arild Opheim, MSc; Kamni Sharma-Haase, MD; Peter Krajci, MD, PhD; Nikolaj Kunøe, MSc, PhD

Figure 1. CONSORT Flowchart for Inclusion of Participants

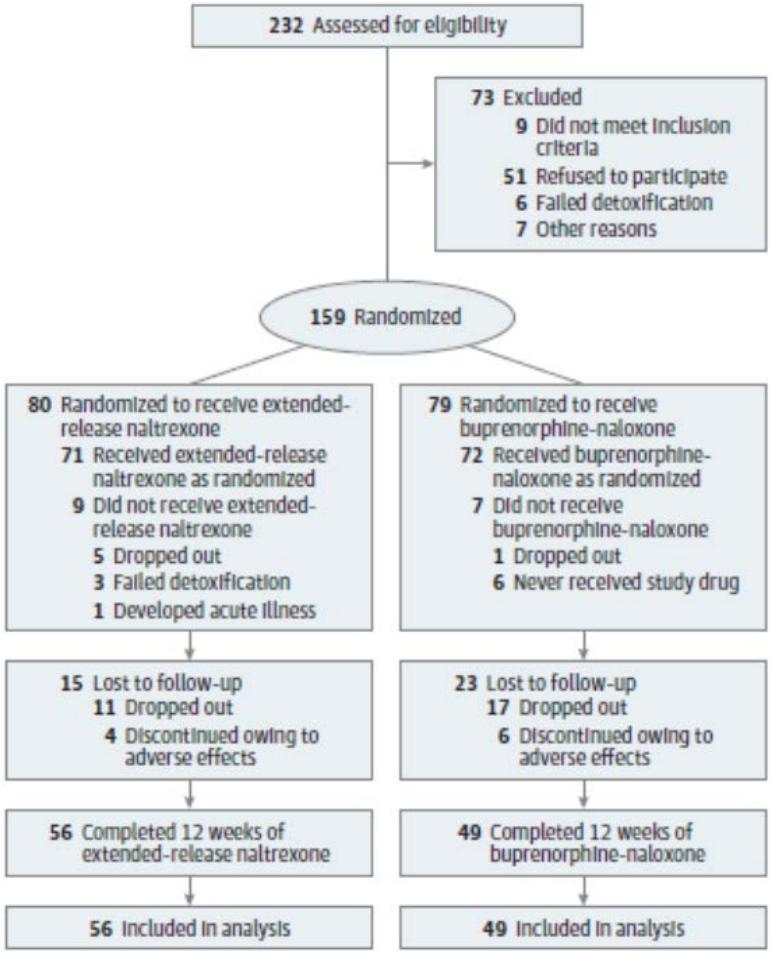

Table 1. Lifetime and Baseline Clinical Characteristics of Participants Randomized Into Treatment Groups[a]

Lifetime Characteristic	Extended-Release Naltrexone[b] (n = 80)	Buprenorphine-Naloxone[b] (n = 79)
Age, mean (SD), y	36.4 (8.8)	35.7 (8.5)
Sex, No. (%)		
Male	61 (76.3)	54 (68.4)
Female	19 (23.6)	25 (31.6)
White, No. (%)	72 (90.0)	70 (88.6)
Injecting (intravenous) users, No. (%)	72 (90.0)	64 (81.0)
HIV positive, No. (%)	2 (2.5)	2 (2.5)
Hepatitis C seropositive, No. (%)	44 (55.0)	42 (53.2)
Years of substance use, mean (SD)		
Heavy opioid use	8.9 (7.8)	9.6 (10.5)
Heroin	6.9 (5.8)	6.7 (5.2)
Other illicit opioids	2.4 (5.1)	3.2 (7.0)
Cannabis	9.0 (7.3)	10.2 (9.0)
Amphetamines	6.7 (7.3)	6.3 (6.6)
Cocaine	1.4 (3.1)	1.7 (2.8)
Benzodiazepines	5.1 (6.0)	5.9 (8.7)
Alcohol for intoxication	3.5 (4.8)	2.9 (4.1)
Use during past 30 d (baseline), mean (SD)		
Heroin	7.6 (11.0)	12.0 (12.9)
Other illicit opioids	8.2 (11.1)	14.5 (13.2)
Cannabis	8.2 (11.1)	10.2 (12.6)
Amphetamines	3.4 (7.4)	5.4 (9.1)
Cocaine	0.2 (0.7)	1.3 (3.9)

[a] Intention-to-treat sample, 159.

[b] Naltrexone, naloxone, and buprenorhine were all administered as the hydrochloride form.

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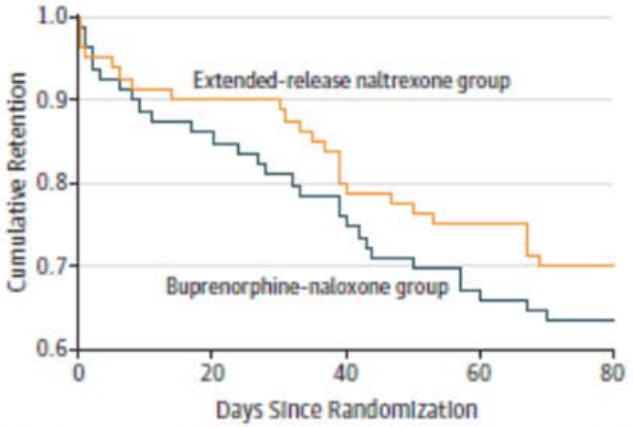
Figure 2. Survival Curves for Retention in Treatment and Estimated Mean Number of Days for the Use of Heroin, Other Illicit Opioids, and Major Secondary Outcomes



No. at risk

Buprenorphine-naloxone group	78	67	59	52	50
Extended-release naltrexone group	78	73	64	60	56

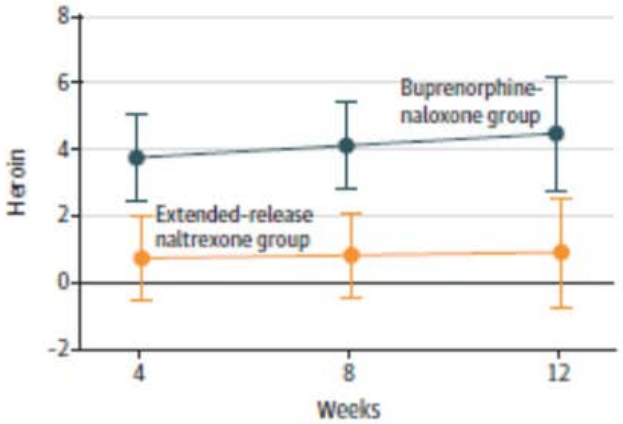


Table 2. Days of Use of Heroin and Other Illegal Substances Assessed at Weeks 4, 8, and 12[a]

	Extended-Release Naltrexone		Buprenorphine-Naloxone		Extended-Release Naltrexone vs Buprenorphine-Naloxone	
Time Point	No. of Participants	Mean (SD)[b]	No. of Participants	Mean (SD)[b]	Mean Difference (95% CI)[c]	*P* Value[c]
Heroin Use						
Week 4	63	0.8 (1.5)	65	3.7 (7.4)	−3.0 (−4.9 to −1.2)	.001
Week 8	59	0.8 (1.9)	55	4.4 (9.1)	−3.3 (−5.1 to −1.5)	<.001
Week 12	57	1.1 (2.3)	50	4.1 (8.4)	−3.6 (−6.0 to −1.2)	.003
Other Illicit Opioids Use						
Week 4	63	1.2 (2.2)	65	4.2 (7.9)	−2.9 (−4.8 to −0.9)	.004
Week 8	59	1.8 (4.7)	55	4.0 (8.5)	−2.6 (−4.6 to −0.7)	.007
Week 12	57	2.0 (5.0)	50	4.4 (8.7)	−2.4 (−4.9 to 0.1)	.06

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Table 3. Reported AEs Among 143 Participants Taking at Least 1 Dose of Study Medication[a]

Outcome	No. (%)		P Value[b]
	Extended-Release Naltrexone (n = 71)	Buprenorphine-Naloxone (n = 72)	
Deaths	0	0	
Nonserious AE	43 (60.6)	22 (30.6)	<.001
Serious AE[c]	6 (8.5)	3 (4.2)	.33
Pneumonia-related	2 (2.8)	0	
Withdrawal-related	3 (4.2)	0	
Acute pain	1 (1.4)	1 (1.4)	
Opioid overdose	0	1 (1.4)	
Planned surgery	0	1 (1.4)	
Insomnia	8 (11.3)	3 (4.2)	.13
Anxiety and depression symptoms	12 (16.9)	6 (8.3)	.14
Injection site problems	4 (5.6)	0	
Withdrawal-related AE[d]	28 (39.4)	10 (13.9)	<.001

Abbreviation: AE, adverse event.

[a] Naltrexone, naloxone, and buprenorhine were all administered as the hydrochloride form.

[b] Determined with Fisher exact test; empty cells indicate not applicable.

[c] Two participants reported 2 serious AEs each.

[d] Thirty-seven participants reported 2 or more withdrawal-related events.

Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): a multicentre, open-label, randomised controlled trial

Lancet 2018; 391: 309–18

Joshua D Lee, Edward V Nunes Jr, Patricia Novo, Ken Bachrach, Genie L Bailey, Snehal Bhatt, Sarah Farkas, Marc Fishman, Phoebe Gauthier, Candace C Hodgkins, Jacquie King, Robert Lindblad, David Liu, Abigail G Matthews, Jeanine May, K Michelle Peavy, Stephen Ross, Dagmar Salazar, Paul Schkolnik, Dikla Shmueli-Blumberg, Don Stablein, Geetha Subramaniam, John Rotrosen

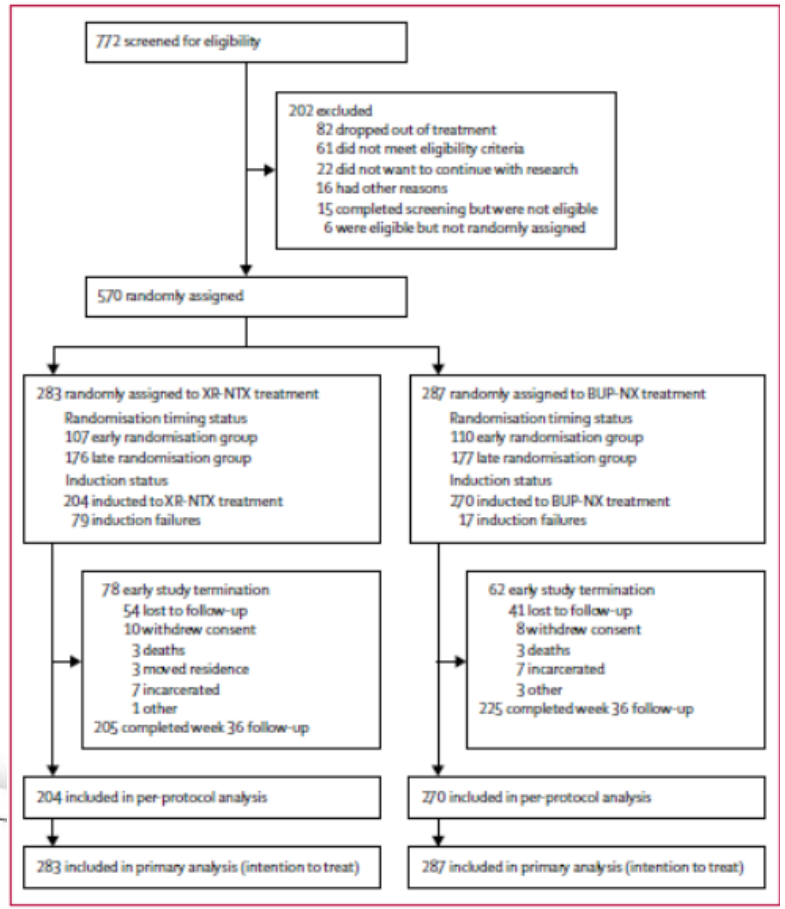

Figure 1: Trial profile
XR-NTX=extended-release naltrexone. BUP-NX=buprenorphine-naloxone.

	XR-NTX group (n=283)	BUP-NX group (n=287)	Treatment effect
Inducted to study medication			
Intention-to-treat group	204 (72%)	270 (94%)	OR 0·16, 95% CI 0·09–0·28; p<0·0001
Opioid relapse, weeks 3–24			
Intention-to-treat group	185 (65%)	163 (57%)	OR 1·44, 95% CI 1·02–2·01; p=0·036
Per-protocol group	106/204 (52%)	150/270 (56%)	OR 0·87, 95% CI 0·60–1·25; p=0·44
Relapse-free-survival (weeks), range 3–24			
Intention-to-treat group	8·4 (3·0–23·4)	14·4 (5·1–23·4)	HR 1·36, 95% CI 1·10–1·68; p=0·0040
Per-protocol group	20·4 (5·4–23·4)	15·2 (5·7–23·4)	HR 0·92, 95% CI 0·71–1·18; p=0·49
Total number of weekly opioid-negative urine samples, range 0–24			
Intention-to-treat group	4 (0–19)	10 (3–20)	p<0·0001
Per-protocol group	13 (3–21)	11 (3–20)	p=0·81
Total number of self-reported opioid-abstinent days, range 0–144			
Intention-to-treat group	39 (1–144)	81 (16–144)	p<0·0001
Per-protocol group	123 (18–144)	87 (20–144)	p=0·67

Data are n (%), n/N (%), or median (IQR). XR-NTX=extended-release naltrexone. BUP-NX=buprenorphine-naloxone. OR=odds ratio. HR=hazard ratio.

Table 2: Opioid treatment outcomes

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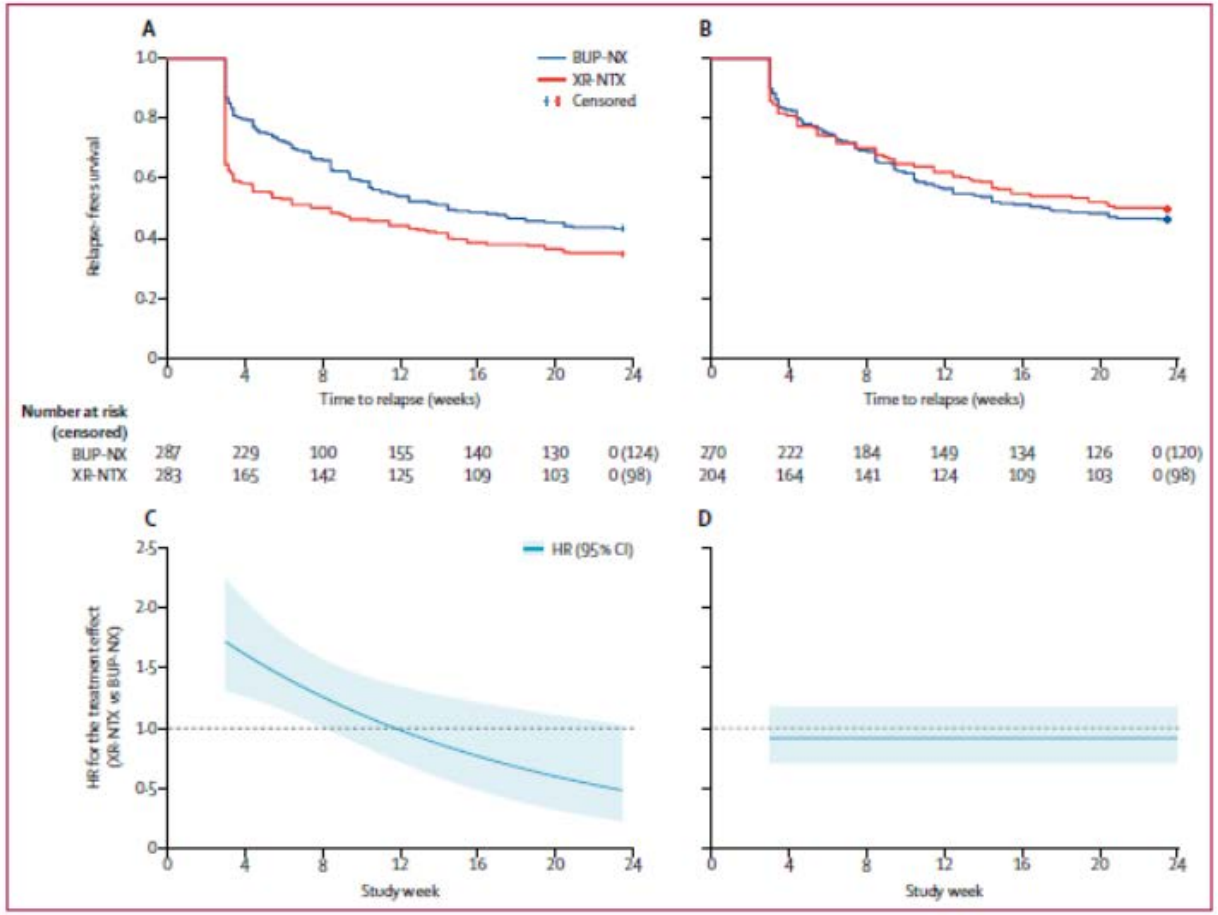

Figure 2: Relapse-free survival and treatment effect over time for the XR-NTX and BUP-NX treatment groups
Survival (A) and HRs and corresponding 95% CIs from the non-proportional hazards Cox model (time by treatment interaction included in the model; (C) assessed in the intention-to-treat population (n=570). Survival (B) and HRs by time (D) in the per-protocol population (n=474). XR-NTX=extended-release naltrexone. BUP-NX=buprenorphine-naloxone. HR=hazard ratio.

Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): a multicentre, open-label, randomised controlled trial

Lancet 2018; 391: 309–18

Joshua D Lee, Edward V Nunes Jr, Patricia Novo, Ken Bachrach, Genie L Bailey, Snehal Bhatt, Sarah Farkas, Marc Fishman, Phoebe Gauthier, Candace C Hodgkins, Jacquie King, Robert Lindblad, David Liu, Abigail G Matthews, Jeanine May, K Michelle Peavy, Stephen Ross, Dagmar Salazar, Paul Schkolnik, Dikla Shmueli-Blumberg, Don Stablein, Geetha Subramaniam, John Rotrosen

Induction Failure in naltrexone arm led to relapse in 70 of 79 (89%)

Overdose events not statistically different, however study not powered for overdose

	XR-NTX group (n=283)	BUP-NX group (n=287)
Treatment-emergent adverse events		
Participants with one or more treatment-emergent adverse event*	111 (54%)	141 (52%)
Number of treatment-emergent adverse events	247	334
Study medication discontinued due to adverse event	6	8
Type of treatment-emergent adverse event		
Injection site reaction, mild or moderate	46	NA
Gastrointestinal	34	59
Psychiatric disorders	30	29
Injury, poisoning, and procedural complications	23	25
Infections and infestations	22	27
Nervous system disorders	22	28
Treatment-emergent serious adverse events		
Participants with one or more serious adverse event	29 (14%)	29 (11%)
Number of treatment-emergent serious adverse events	39	35
Type of treatment-emergent serious adverse event		
Psychiatric disorders	9	11
Infections and infestations	5	6
Pregnancy	3	4
Death	3	4
Overdose events		
Participants with one or more overdose event (all)†	15	8
Participants with one or more overdose event (per protocol)‡	9	7
Number of overdose events (all)§	18	10
Number of overdose events (per protocol)	10	9
Fatal overdose events		
Number of fatal overdose events (all)	2	3
Number of fatal overdose events (per protocol)	2	3

Data are n (%) or N. NA=not applicable. XR-NTX=extended-release naltrexone. BUP-NX=buprenorphine-naloxone. *Treatment emergent is defined as any adverse events that occurred after the study day of induction for those participants inducted onto study medication. †p=0·14 (Fisher's exact). ‡p=0·31 (Fisher's exact). §Four participants reported more than one overdose event. Three of the four participants were randomly assigned to XR-NTX (two of these induction failures, one successfully inducted); each reported two overdose events. One of the four was randomly assigned to BUP-NX (successfully inducted) and reported three overdose events. None of these nine overdoses were fatal.

Table 3: Adverse events and serious adverse events

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Drug Saf
https://doi.org/10.1007/s40264-018-0653-3

SHORT COMMUNICATION

Review of Case Narratives from Fatal Overdoses Associated with Injectable Naltrexone for Opioid Dependence

Roxanne Saucier[1] · Daniel Wolfe[1] · Nabarun Dasgupta[2]

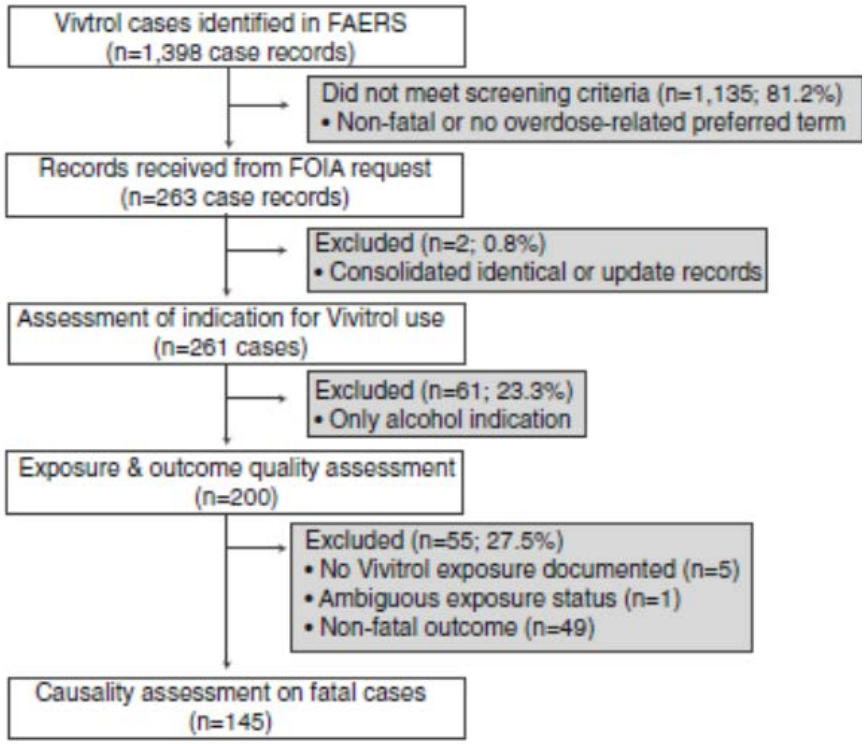

Fig. 1 Selection criteria schematic for case identification. Th figure represents the selection criteria and major data processin steps for identifying case records involving Vivitrol as a primar suspect drug from the US Food and Drug Administration Adver Event Reporting System (FAERS), 1 October, 2010 through 3 March, 2016. *FOIA* Freedom of Information Act

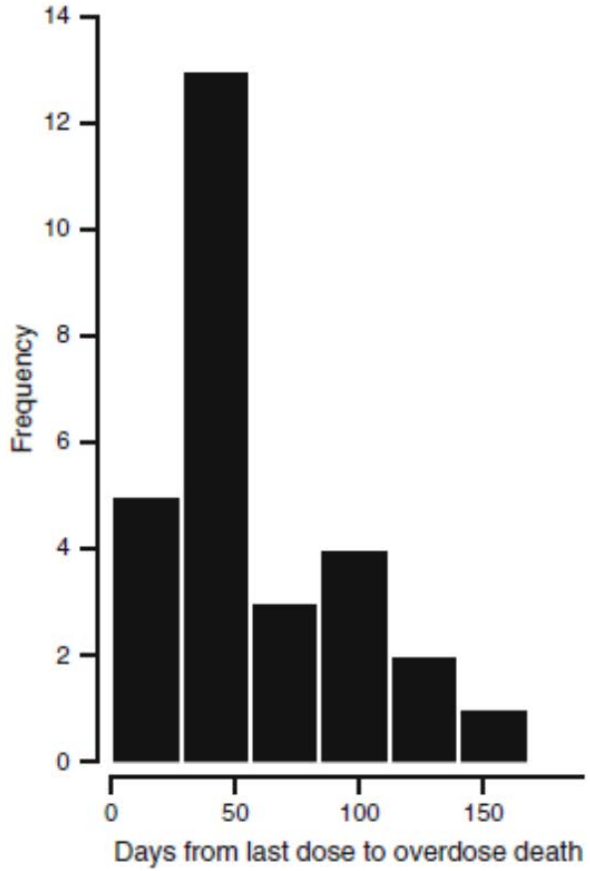

Fig. 3 Histogram of time from last known Vivitrol injection to opioid overdose death. Time to death was known for 28 out of 52 fatal overdose cases that were assessed for causality involving Vivitrol as a primary suspect drug from the US Food and Drug Administration Adverse Event Reporting System, 1 October, 2010 through 31 March, 2016. Bin width is 28 days because that is the labeled duration of effect

Conclusions

- “Induction Hurdle” for naltrexone – and high rate of relapse among induction failures
- However after induction both bupe/nal and xr naltrexone are similar
- Patient selection and ancillary supports to keep individuals engaged in care

Questions?

Case Presentation #1
Faisal Mohsin, MD

- 12:35pm-12:55pm [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 #1
Faisal Mohsin, MD

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

How can we help retain the patient in treatment? We would like for her to:
1. Give us negative urine screens
2. Take Suboxone as prescribed
3. Stay engaged in counselling
4. Make necessary lifestyle changes conducive to her 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.)

29 yr. separated, currently unemployed Caucasian female. Did not finish high school. No GED. Has 2 children but does not have custody. Lives with her father who drives a tow truck. Stays home much of the time.

She was referred to us for follow up from a local Psychiatric Hospital where she had been started on Suboxone for her opioid use disorder. She was on 8mg-2mg twice daily when she was initially enrolled into our OBOT program.

Case Presentation #1
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.)

History of Hepatitis C. Reports she was treated with Harvoni last year and virus was eradicated. Has not had any follow ups since.

Psychiatric Diagnosis include Recurrent Major Depressive Disorder and Generalized Anxiety Disorder. Is prescribed Venlafaxine XR 225 mg daily, Buspirone 10 mg three times daily and Trazodone 200 mg bedtime for sleep.

Substance Use Disorder:
Started abusing heroin around age 16. Has been using intravenously for the most part. Has "speedballed" as well. Using on average about 4-5 bags of heron daily. Presently prescribed a total Suboxone dose of 18mg daily; 8mg-2mg BID and 2mg-0.5mg in the afternoon.

Has a history of snorting cocaine and also i.v. use.
Alcohol: started drinking liquor regularly in her late adolescence. This had escalated to approximately a fifth of rum daily for the last 2 years. Has reportedly significantly cut back on her drinking since starting OBOT.

Urine screens are done weekly and randomly. UDS is usually positive for Oxys, Opi, Methamphetamines, Cocaine or THC. She has denied using Crystal Meth or any amphetamine based stimulants. Denies using any OTC medications such as decongestants, etc.

2 weeks ago, Buprenorphine level was 1 ng/ml and Norbuprenorphine level was 5ng/ml. The cutoff on LC/MS is 0.5 ng/ml.
Last week, on a random drug screen, UDS was positive for THC, Coc, Methamphetamines, and Oxys. However, negative for Buprenorphine.

Has been enrolled in weekly SA groups. Attendance has been inconsistent.

Case Presentation #1
Faisal Mohsin, MD

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

Medication Assisted Treatment includes Suboxone. Total dose at present is 18 mg-4.5mg per day. Attends weekly. Is offered counselling every visit.

Has also been referred to Peer driven Recovery groups. Has also been urged to attend AA and NA meetings.

Recommendations have also been made for her to seek employment or volunteer work to stay busy and structured throughout the day.

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

Patient's stated goal earlier in the treatment was to pursue full recovery from all substances. However, during the entire period of treatment, her mood has been apathetic and attitude passive. Is praised and positive reinforcement offered whenever she tests negative for Opioids and Oxys.

1. She is now on a Behavioral contract. Must give negative urine screens by the end of 2 weeks, after which a second and final contract will be instituted.

2. Increase counselling sessions to 2 per week.

3. Possibly increase the Suboxone dose to 20mg-5mg daily. But inconsistent compliance with this medication, repeated use of other substances and possibility of diversion, make this the least preferred option at this time.

4. Referral to the Methadone program or Residential based services is another option if unsuccessful in completing the Behavioral contract. We do not at the present time have an IOP.

Case Presentation #1
Faisal Mohsin, MD

Other relevant information

States she sometimes skips Suboxone for up to three days at a time during which she will use heroin and other substances. On some occasions she will take more than the daily prescribed dose. Cannot explain why.

Denies any diversion. December last year, on an LC/MS confirmation, she was negative for Norbuprenorphine, but Buprenorphine was measured at 6.0 ng/ml. Cutoff is 0.5 ng/ml.

Is uninsured. On a time limited SAMHSA grant which could be extended if it is shown that she has been compliant with her treatment and making progress in her recovery goals.

Transportation is sometimes an issue.

Has provided Buprenorphine only positive screens on two occasions only. This was earlier in the treatment.

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

Case Presentation #2
Jennifer Phelps, BS, LPN

- 12:55pm-1:25pm [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

Case Presentation #2
Jennifer Phelps, BS, LPN

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

How to manage or engage a client with high SI and continued polysubstance use and failed treatment recommendations in MAT?

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.)

22 yr old white male originally born in Russia history of was adopted twice in Russia and returned before finally getting adopted and came to the US to live. Lived in Delaware till this year, moved with parents to Virginia was court ordered into Substance Abuse treatment. Resides with his parents lives in the county rural area, transportations often an issue has limited social support and limited peer interaction. When he has mentioned dating often dates older women; by 10 or 15 years his senior. Has significant history of abuse from childhood, has high school education some trade skill training, has worked as a firefighter in Delaware, now works as a tele marker. Receives Medicaid, has applied for disability.

Case Presentation #2
Jennifer Phelps, BS, LPN

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.)

Has genetic and environmental; birth defect was born in highest pollution area in Russia, born without a leg, very defensive over this, and hides this very well, for first 3 months staff was not aware of this and actually got his physical from a PCP without notice of this. His mother is a nurse and came in shared this information with staff. Client was told he has a traumatic Brain Injury from childhood by the orphanage in Russia, has paperwork with limited information about this, there was signification physical and sexual abuse prior to age of 3. Client current diagnosis F31.81 Bipolar II disorder, F90.2 Attention-deficit.hyperactivy disorder combined presentation; F42.2 Obsessive-compulsive disorder; F11.20 Opioid dependence, F12.1 cocaine, abuse. Client has had individual therapy in the past, stated, "It doesn't help it's pointless". Client has SI daily and presents flat and struggles to find hope daily, client struggles to engage in groups or therapy, clients fights treatment and often is his own barrier to success and has insight to see this, but struggles to overcome this. Client has had multiple positive UDS screens 2-4-19 _ + BUP, + AMP (takes VAYVANSE) + THC 1-7-19 + BUP + COC + THC
MEDS: Suboxone 8 mg 2 mg SL place 2 film SL q D
VYVANSE 50 mg 1 po q AM
Rexulti 0.5 mg tab 1 po q am (took himself off this reported on 2-11-19)
Seroquel 200 mg tab 1 po q HS

Case Presentation #2
Jennifer Phelps, BS, LPN

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

Client was started on MAT 4-5-18, client is seen weekly and has been weekly since starting treatment due to non compliance with treatment and continue positive UDS for THC, COC. Client was recommended for IOP did not engage, Client was referred for Individual therapy did not engage, Client was talked to after repeated positive UDs screens, discussed psych med management, linked to a PCP for PX medically cleared. Client reported struggling with focus started on VAYAVSE. Client reported stressors of girlfriend and recent abortion as trigger for COC use, client has not relapsed on heroin during this time clients drug of choice is heroin. Client reports that it is a struggle daily to feel anything, a struggle daily to find a reason to keep going. Client continues to come weekly for MAT and Case Management.

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

Client is seen weekly for Case management
Client is seen weekly for OBOT MAT
Client is seen for psych med management to monitor his SMI
refer to therapy as needed
continues to asses client's willingness and motivation for therapy and link to services as client is ready to engage.

Case Presentation #2
Jennifer Phelps, BS, LPN

Other relevant information

Client present with SI daily, client has made significant progress in that he come to office weekly, he engages with Case manager and OBOT MD he talks with both for 20 mins each, weekly he is open and honest about his use and has reached a point of trust in that he listens openly to feedback from both. Case manager weekly redirects and encourages client to consider therapy and we discuss the importance and value of therapy and why it would help the client move past some of his issues that might beholding him back. Client has complied with every demand and treatment recommendation even if he has not fully engaged in the process. He did go to the therapy appointments that where required, he just did not engage and then he missed and cancelled several of them before being disagreed. Client continues to use COC and THC on occasion as coping skills.

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Case Studies and Feedback

- Case studies
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  - Receive feedback from participants and content experts
- Opportunity to formally submit feedback
  - Survey: www.vcuhealth.org/echo
  - Overall feedback related to session content and flow?
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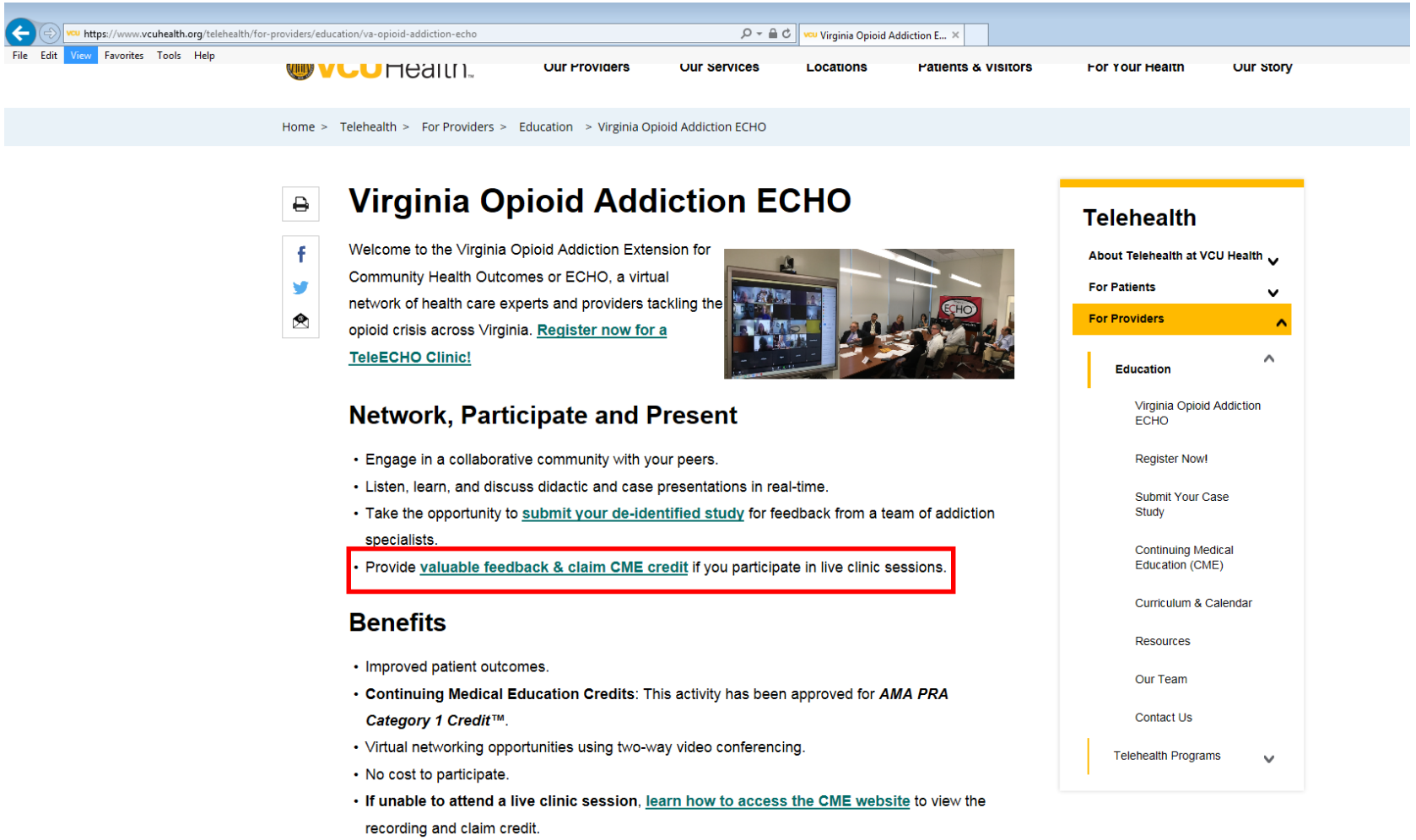

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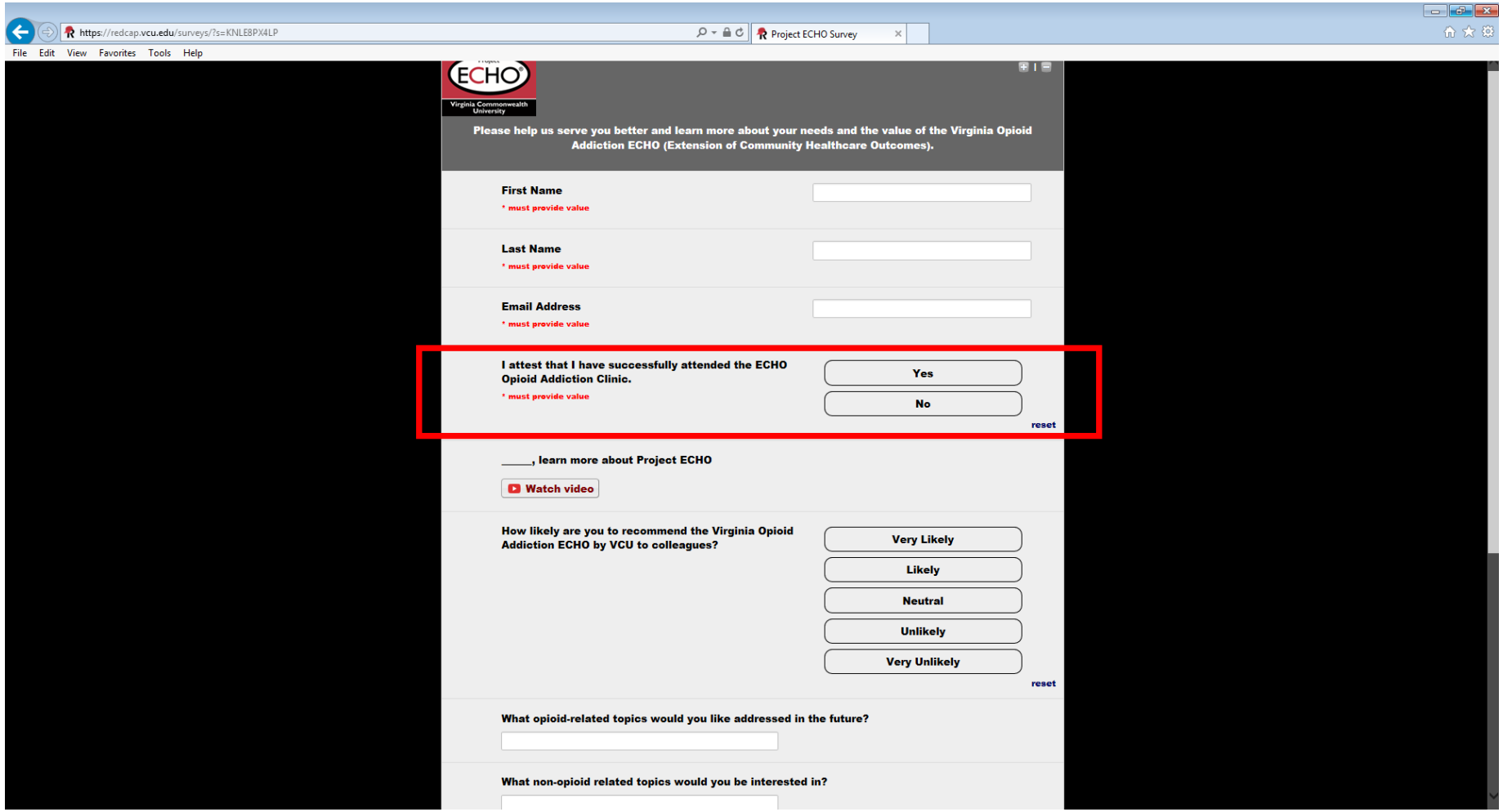

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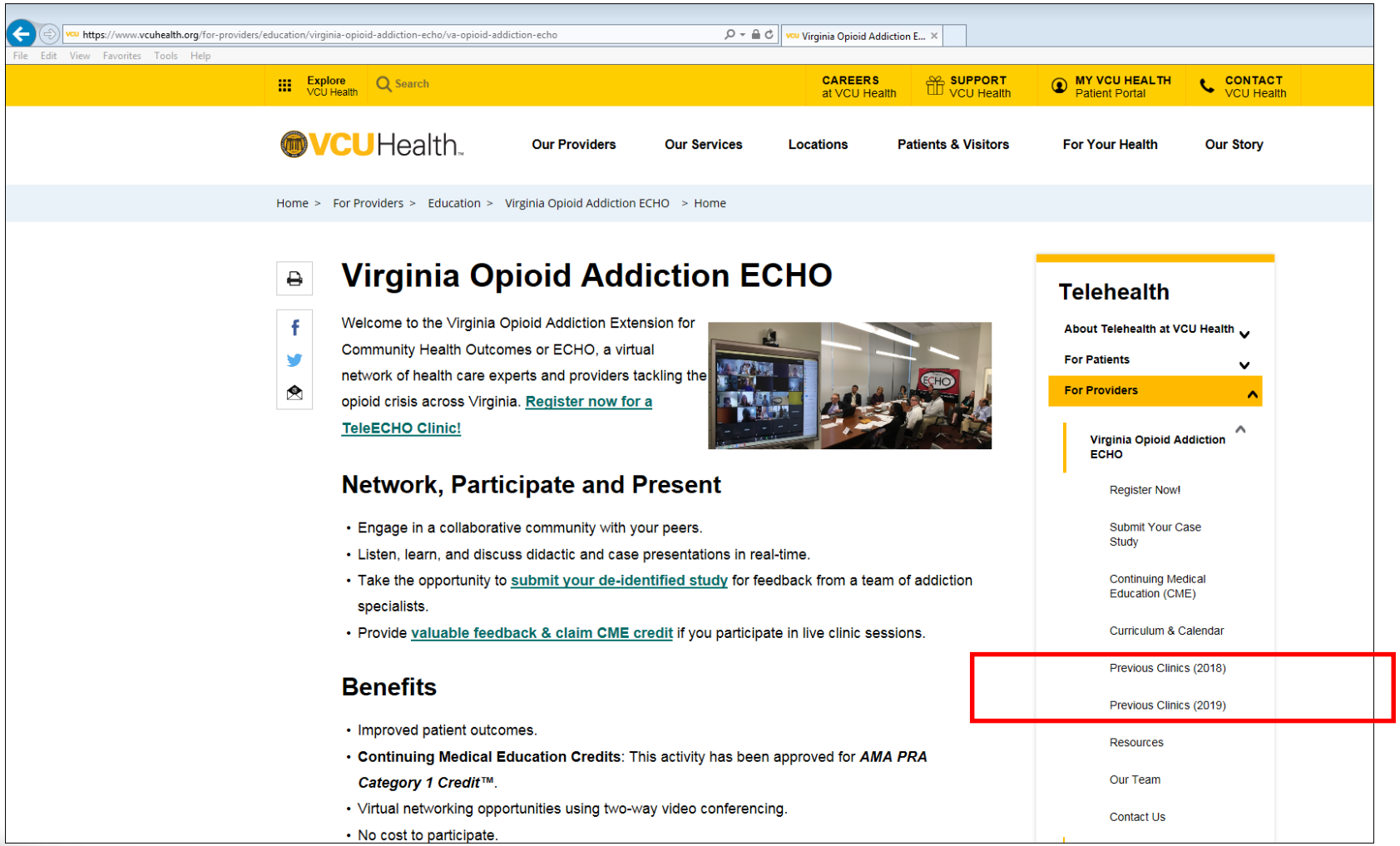

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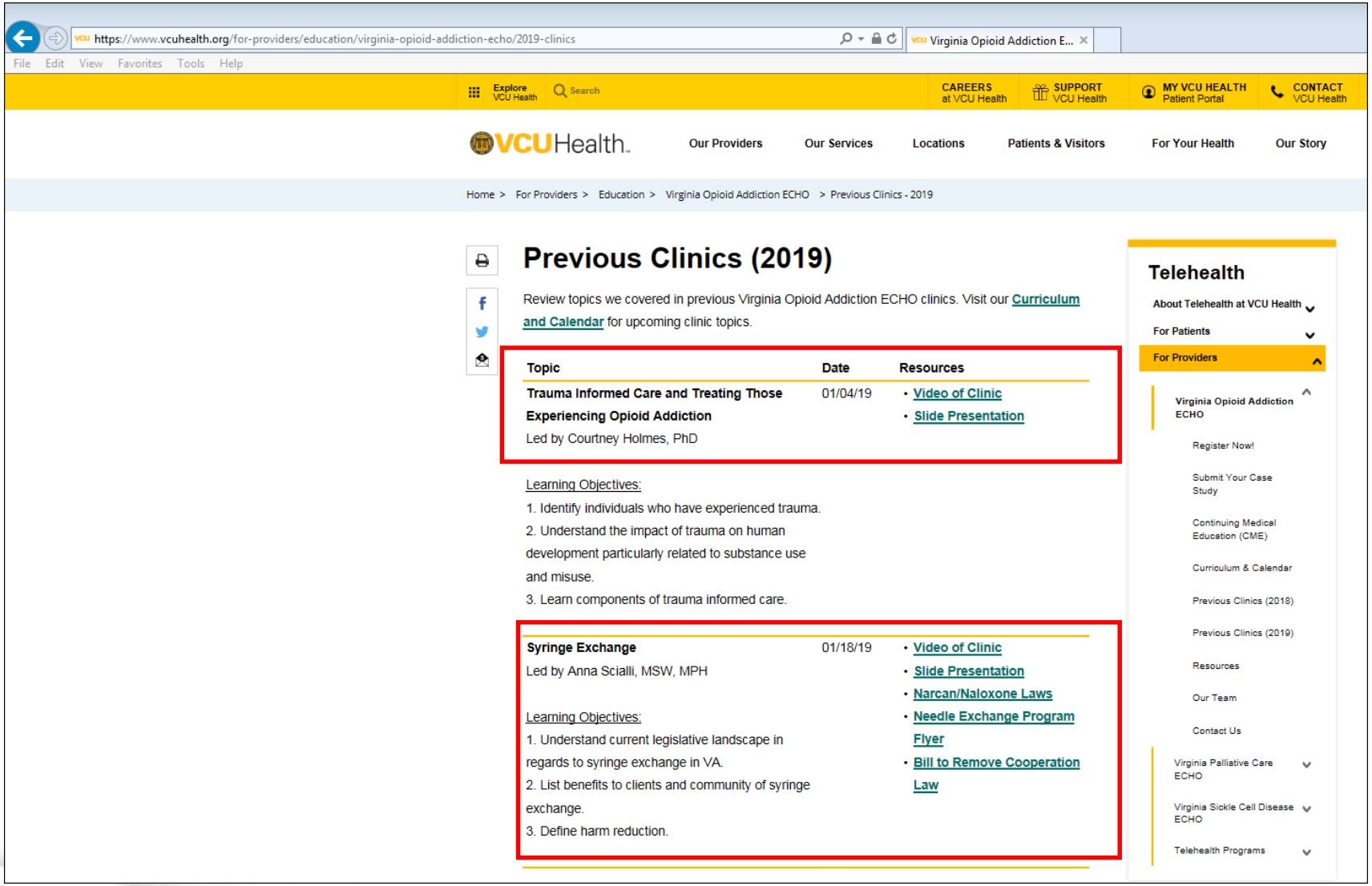

VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

Mark Your Calendar --- Upcoming Sessions

03/01	Pharmacotherapy for Co-Occuring SUD	Gerard Moeller, MD
03/15	Policy with Maternal Substance Use Disorder	Valerie L'Herrou, JD

Please refer and register at vcuhealth.org/echo

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THANK YOU!

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Resource Materials

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Author: Dr. Joshua Lee, et al

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5806119/