Resources:

- Treatment Improvement Protocols. Enhancing Motivation for change in Substance Abuse Treatment. Chapter 3—Motivational Interviewing as a Counseling Style. SAMHSA. (1999, Rockville, MD)
- SAMSA-HSRA Center for Integrated Health Solutions website. Motivational Interviewing.

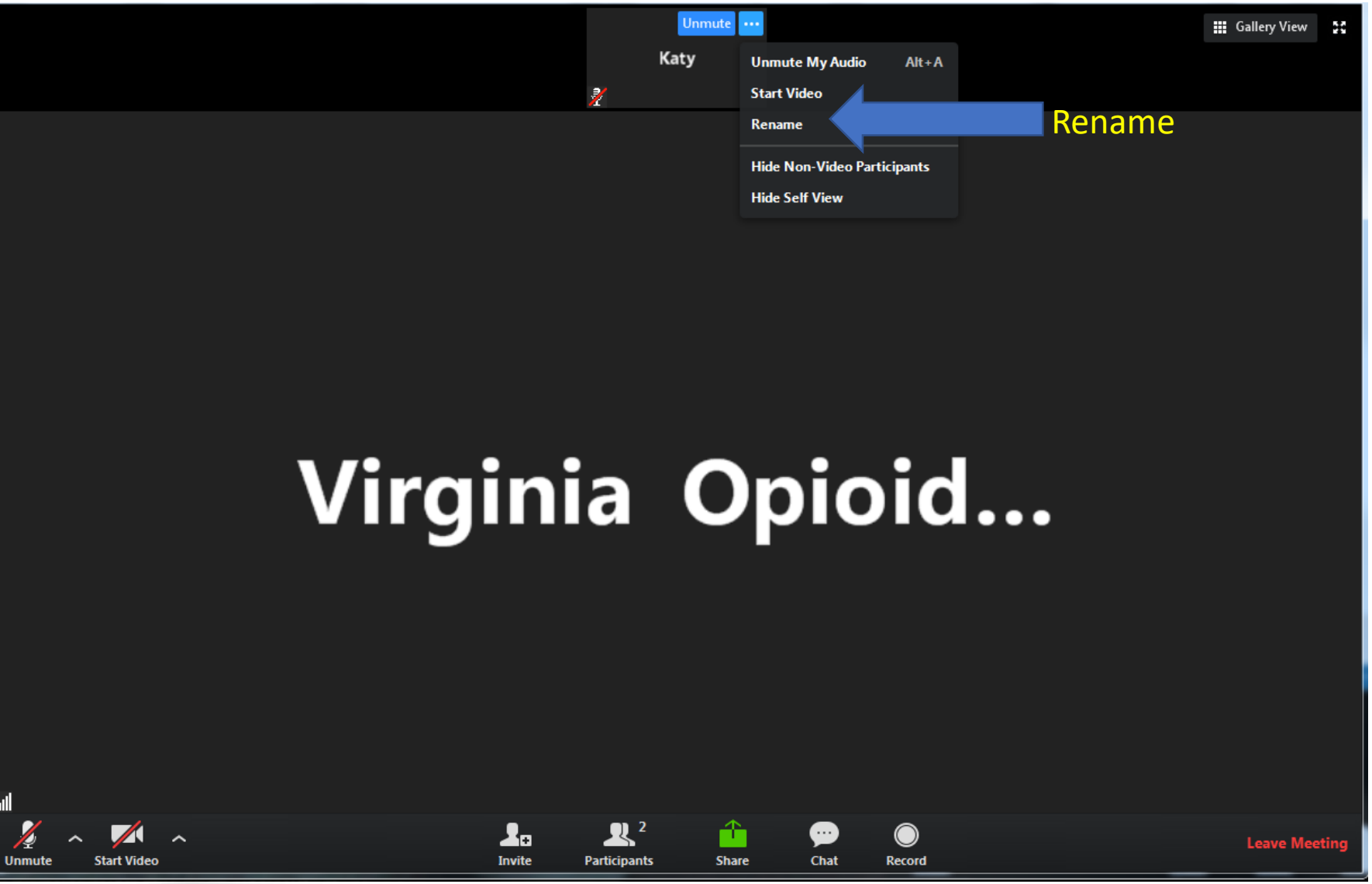
- Miller, W., & Rollnick, S. (2012). Motivational Interviewing: Helping People Change. Guilford Publications.

Virginia Opioid Addiction ECHO* Clinic

March 29, 2019

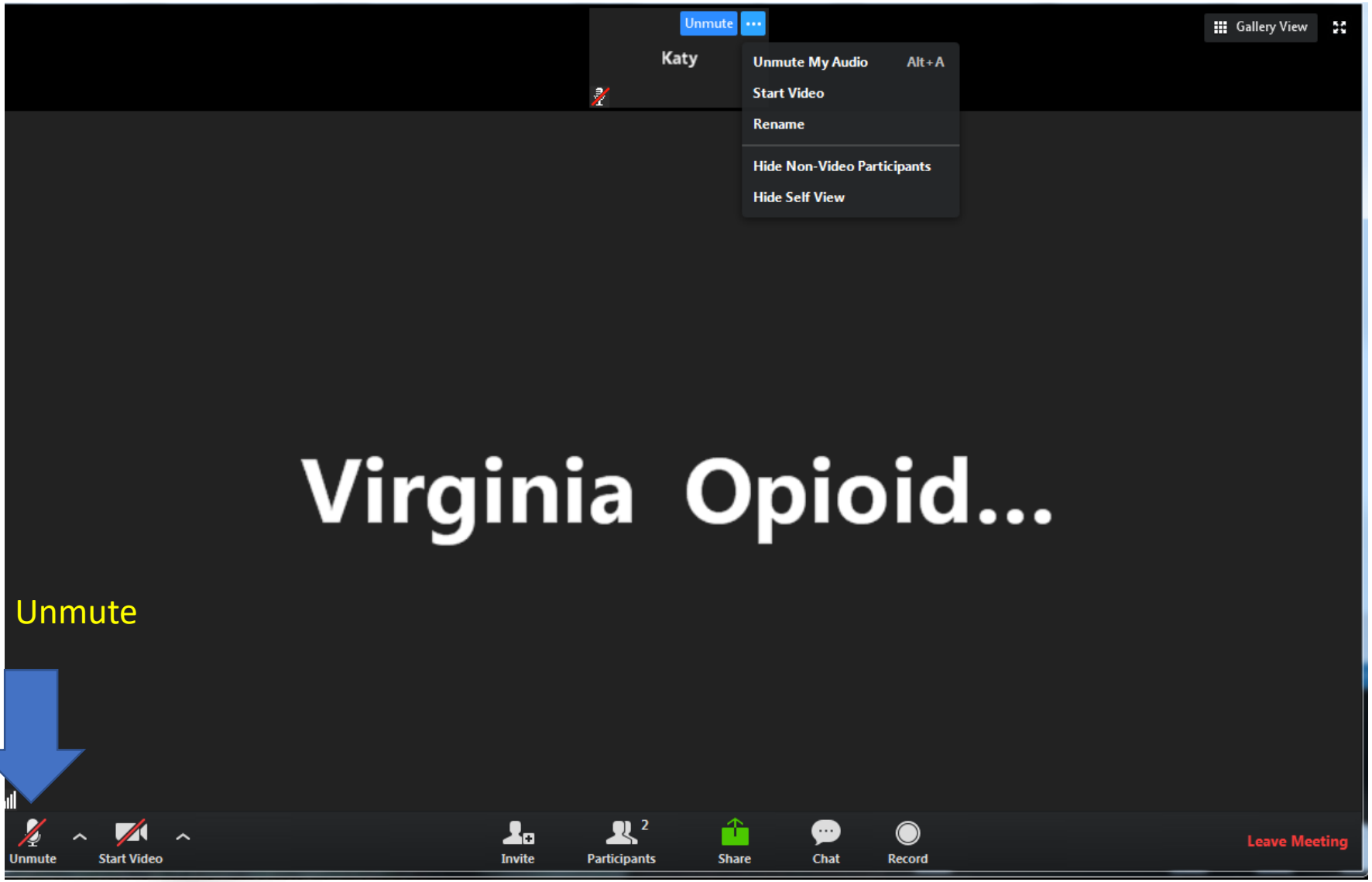
*ECHO: Extension of Community Healthcare Outcomes

Helpful Reminders



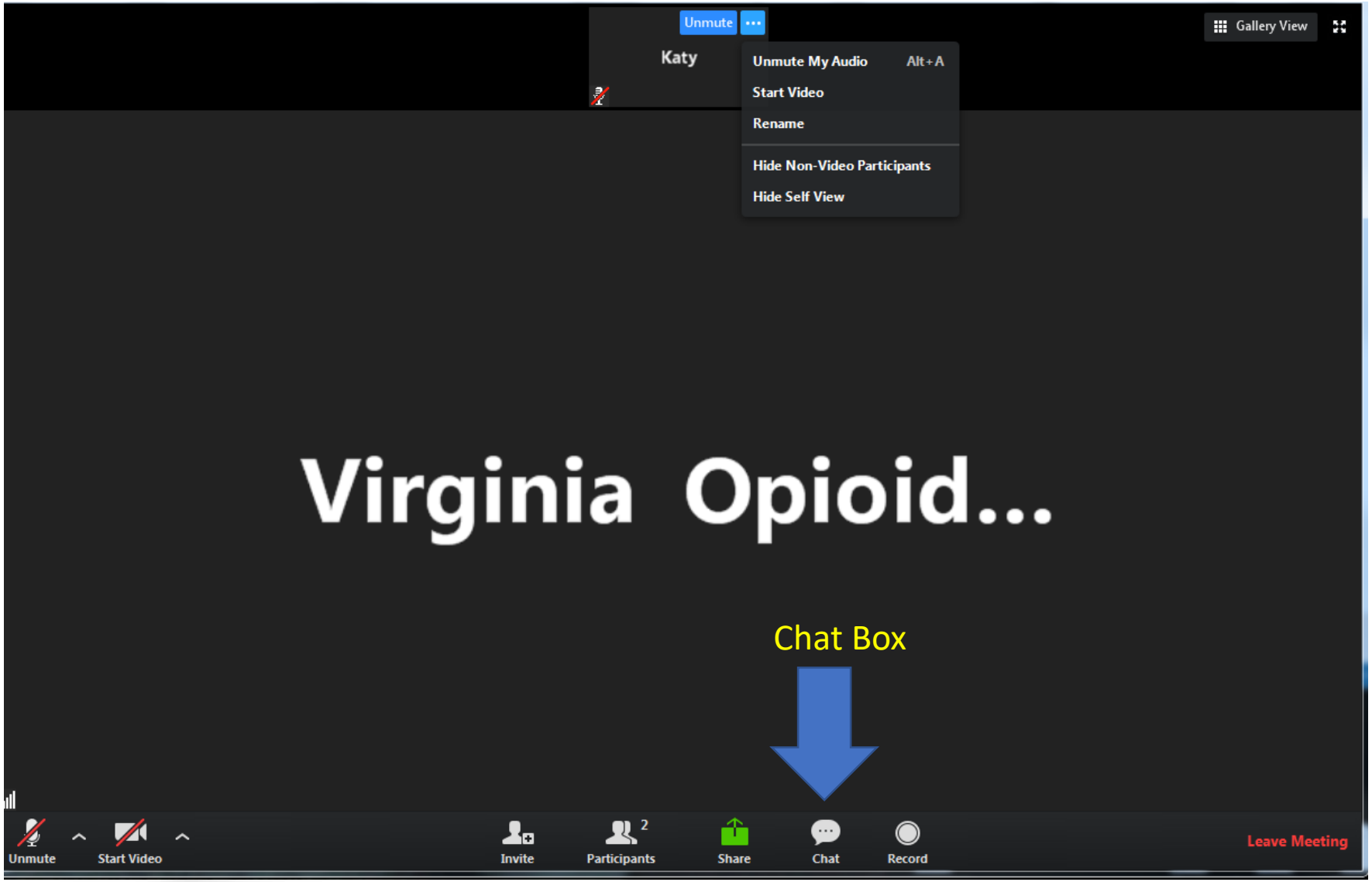
- Rename your Zoom screen, with your name and organization

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 Kanwar Sidhu, MD Lori Keyser-Marcus, PhD Courtney Holmes, PhD Bhakti Dave, MPH David Collins, MHA Vladimir Lavrentyev, MBA

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. **Motivational Interviewing**
   II. **Lori Keyser-Marcus, PhD**
   Courtney Holmes, PhD
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

Motivational Interviewing

Lori Keyser-Marcus, Ph.D.

&

Courtney Holmes, Ph.D., LPC, LMFT, CRC, NCC

Poll Question #1

How often do you use a Motivational Interviewing Lens in your practice?

- Every Day
- Sometimes
- Never

Poll Question #2

Who uses Motivational Interviewing in your practice?

- Doctors
- Nurses
- Other clinicians
- Admin staff
- Everyone
- No one

What we know from research

Treatment of addiction is as successful as treatment of other chronic conditions such as diabetes, hypertension and asthma

40%-60% success rates

Good outcomes are contingent on people staying in treatment for an adequate length of time.

What we know from research

Many people leave treatment before it has a chance to work.

Whether or not a client stays in treatment depends on:

- Motivation to change
- Degree of support
- External pressure (such as Criminal Justice System)

What we know from research

Effective and empathetic communication between practitioners and patients leads to

- Increased patient satisfaction
- Greater compliance with medication and treatment and attendance
- Reduced health care costs, and
- Greater likelihood of positive treatment outcomes

Motivational Interviewing

- A client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.
- The goal is to *create and amplify discrepancy* between present behavior and broader goals.
- Recognizes that MOST behavior has GOOD and LESS GOOD THINGS that maintain it
- MI is especially useful for engaging and retaining people in treatment.
- MI is well developed and researched.
- Effects of MI are significant and durable.

Assumptions of Motivational Interviewing

- Ambivalence is normal **and** an obstacle.
- Ambivalence can be resolved.
- Collaborative partnership—each has expertise.
- An empathic, supportive, yet directive, counseling style facilitates change.
- Direct argument/aggressive confrontation may **increase** defensiveness, **reduce** likelihood of change.

Motivation can be greatly influenced by YOU

- Provider/patient relationship is an often overlooked variable for predicting patient response to an intervention
- *Clinician characteristics* found to be stronger predictor of patient satisfaction/engagement than professional training or experience

MI Listening Method

- Reflective listening encourages disclosure and exploration.
- Listen carefully. “I’m all ears” approach
- Generate hypothesis about content, meaning, emotion
- Put your hypothesis in form of a statement
- Keep voice inflection neutral/down at end
- Listen to patient’s clarification
- Restate hypothesis about clarified content

Forming Reflections
Words to get you started:

- So you feel ..
- It sounds like you ..
- You're wondering if ..
- You …

A few minutes can go a long way.

- Allows you establish rapport and trust
- Putting treatment into context: Exploring events that precipitated treatment entry can help to clarify patient goals/expectations for treatment
- Affirmations: *It took a lot for you to be here today. I appreciate you coming.*

Handling Lapses

Your primary goal is to help the patient move beyond the slip and back into preparation and action stages of change.

Strategies to help patients deal with lapses:

- Inquire about what lead to lapse of substance use.
- Review current treatment goals and plan: re-evaluate and modify if needed.
- Elicit change talk: reasons to get back on track

Strategies to elicit change talk

- **Evocative questions-** ask the patient directly for change talk
  - “In what ways does this concern you?”
  - “How would you like things to be different?”
- **Elaboration-** asking for examples of situations that illustrate change talk
  - “You said things were better then. Tell me about a time when you and he got along better. “
- **Using extremes-**
  - **“**What concerns you the most?”
  - “What would a perfect outcome look like?”

More Strategies

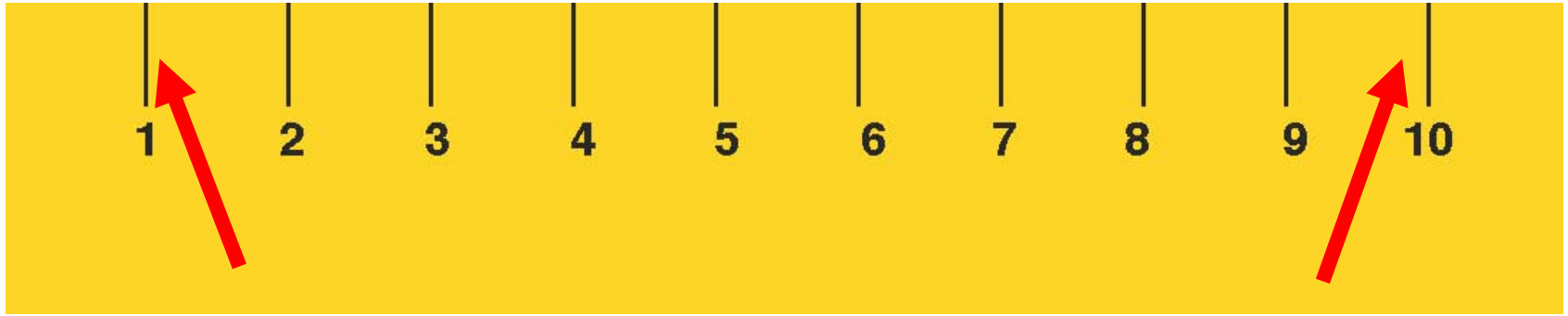
- **Looking back-**
  - "How was your life different before you started using alcohol?"
- **Looking forward-**
  - "If nothing changes, how do you think life will be for you in 5 years? If you decide to change, how might it be different?"
- **Exploring goals-** how target fits in with the values and goals of the client
  - "What things do you regard as most important? How does your drinking fit into that?"

Getting Back On Track

- What were “lessons learned”?
- Reframe lapse as a common and temporary part of the cycle of recovery
- Assess patient’s current stage of readiness for change
- Explore current patient goals—and move on toward a plan for renewed change

READINESS RULERS
Assessing Readiness to CHANGE

Combines readiness with techniques designed to elicit change talk.



Definitely NOT Ready To Change

Definitely Ready To Change

Simulated Patient Scenarios

First 2 scenarios with same patient

1st demonstrates non-MI interview

2nd demonstrates MI interview

In small groups discuss the following:

- what are the differences between the two videos

- can they identify things in their own practice from both videos

- what thoughts do they have about how they may change some of their interventions with patients

Role play demo #1

https://www.youtube.com/watch?v=80XyNE89eCs

Role play demo #2

https://www.youtube.com/watch?v=URiKA7CKtfc

Questions?

Case Presentation #1
Barbara Trandel, 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
Barbara Trandel, MD

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

Is patient appropriate for continued treatment with Suboxone in OBOT? Does his continued alcohol use when combined with his other physical comorbidities (untreated sleep apnea, hep C) make him too high risk for overdose? or is his risk for relapsing back to illicit opioids off Suboxone the bigger threat? Suggestions for addressing suspected alcohol use disorder? What are appropriate steps to take to ensure adequate care and safety of his dependent adult son?

Case Presentation #1
Barbara Trandel, MD

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.)

62 yo divorced Caucasian male who self-referred to CSB for Suboxone after being dismissed from local pain mgt office for UDS showing +methadone and absence of rx'd opiate (Roxicodone). Patient then began buying Opana off street to prevent withdrawal. Stated unable to quit opioids on own. Denied pain on presentation to Suboxone clinic.

Education included GED, some college. Previously worked as fisherman, moved to VA in 2012 from MA. Currently on disability for reported knee/ankle/back dysfunction/pain. Lives in home he owns. Primary caregiver for adult 26yo son with severe developmental disorder who is also on disability. Patient paid 30hr/wk to care for son through state. Son has case manager and sees psychiatrist at our facility. Local family include younger brother in assisted living with alcoholic cirrhosis.

Case Presentation #1
Barbara Trandel, 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.)

Med Hx: 1) h/o complex L ankle ftx req'ing mult surgeries 2) polyarthropathy -?rheumatoid arthritis - being seen by rheum 3) h/o gout on probenecid 4) chronic afib on oral anticoagulation (Xarelto) 5) HTN 6) hep C, chronic -sees GI 7) h/o kidney stones 8) asthma 9)sleep apnea, CPAP intolerant 10) low testosterone on replacement 11) morbid obesity.
Psych HX: 1) General Anxiety Disorder - prior on clonazepam- self-tapered on presentation to clinic

Substance Abuse Hx:
1) OPIATES - rx'd Percocet in 2011 for knee, ankle, back pain. Required increased dose. Referred to pain mgt in 2015. Given Roxicodone 30 qid until dismissal in July 2018. Began buying Opana 10mg oral/intranasal bid off the street until presenting to CSB in Nov 2018. No IV use. No heroin use. Denied h/o OD. Stated unable to quit on own. +withdrawal Spending up to $400/week. He had stated that opioids gave him "energy" to get things done - like "helping son with shower"; UDS: +oxy at intake.

2) TOBACCO - current user of smokeless tobacco. quit smoking tobacco cigs 30y ago.

3)ALCOHOL - first use 18y, beer drinker with progression to heavy use. 45day inpt rehab in 1985 followed by 10 year sobriety. DUI in 2012 with 30day inpt. During separate Psychosocial Assessment done at intake by CSB therapist he stated "drinking 2-4 light beers per day, about 4-5 days weekly" and "drank 20 of the past 30 days" Pt was told on intake to Suboxone Program that he could not drink alcohol while being prescribed Suboxone and he stated he could abstain. Breathalyzer neg. Urine ethanol neg. H/H, plts nml. MCV 97(high nml) Hepatic fxn panel within normal range. Pt reported abstinence from alcohol for first month of treatment but then reported return to drinking 1-2light beers a few times a week. One month later he reported drinking 3-4light beer/day up to 4 times a week. Random urine alcohol testing obtained. 2/19/19 : EtG >10,000ng/mL, EtS 2670ng/mL.
Further evaluation included AUDIT-10 score = 11. At present, patient meets criteria for mild Alcohol Use Disorder at a minimum. Pt does not currently acknowledge alcohol use as a problem. States drinking is a habit that he can quit that helps him "relax and relieve stress."

4) COCAINE- tried age 19, used intermittent until age 24yr
5) CANNABIS - age 13yrs - occ use of marijuana - last use over a year. Currently uses CBD OIL otc for "pain"
6) BENZOS - prior rx'd for GAD - self-tapered klonopin due to Suboxone Pgm requirement

Counseling- have been unable to engage in individual or group counseling due to adult son accompanies patient and is too disruptive. Patient has stated he has been attempting to arrange care for son but no success to date.

Case Presentation #1
Barbara Trandel, MD

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

1)Tapering to lowest effective dose of Suboxone (currently 4mg/day). Patient initially wanted to taper off Suboxone quickly but he struggled to follow through. Concerned about risk of relapsing back to illicit opioid use. Patient also rejected idea of tapering off Suboxone and transitioning to naltrexone or Vivitrol. We settled on current dose of Suboxone 8mg-2mg - 1/2 strip daily.
2)Patient counseled that he meets criteria for AUD. Reminded him that he agreed to abstain from alcohol when he entered Suboxone treatment and reviewed increased risk of overdose. Discussed adverse effect of alcohol on his multiple co-morbid conditions - including but not limited to chronic afib on anticoagulant, HTN, hep C, sleep apnea - along with harmful interactions with multiple meds.
2) Communicating with PCP, specialists
3) Reaching out to therapists/CM for help with finding solutions for him to attend counseling
4) Encourage patient attend NA/AA

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

Further taper down on Suboxone dose if possible
Work to have patient participate in counseling by helping find alternative care for his son
Engage son's case manager for her help in arranging care, evaluating conditions at home.
Consistently discuss concerns regarding alcohol use with patient during MAT visits to help move from pre-contemplation to contemplation stage of change
Continue to communicate with PCP, other specialists including GI

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
Cynthia Straub, FNP-C, ACHPN

- 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
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Use chat function for questions

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

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

Case Studies

- Case studies
  - Submit: www.vcuhealth.org/echo
  - Receive feedback from participants and content experts

https://www.vcuhealth.org/for-providers/education/virginia-opioid-addiction-echo/virginia-opioid-addiction-echo-thank-you

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Home > For Providers > Education > Virginia Opioid Addiction ECHO > Thank You

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

Telehealth

- About Telehealth at VCU Health
- For Patients
- For Providers

Project ECHO® Virginia Commonwealth University

VCU

Submit Feedback

Opportunity to formally submit feedback

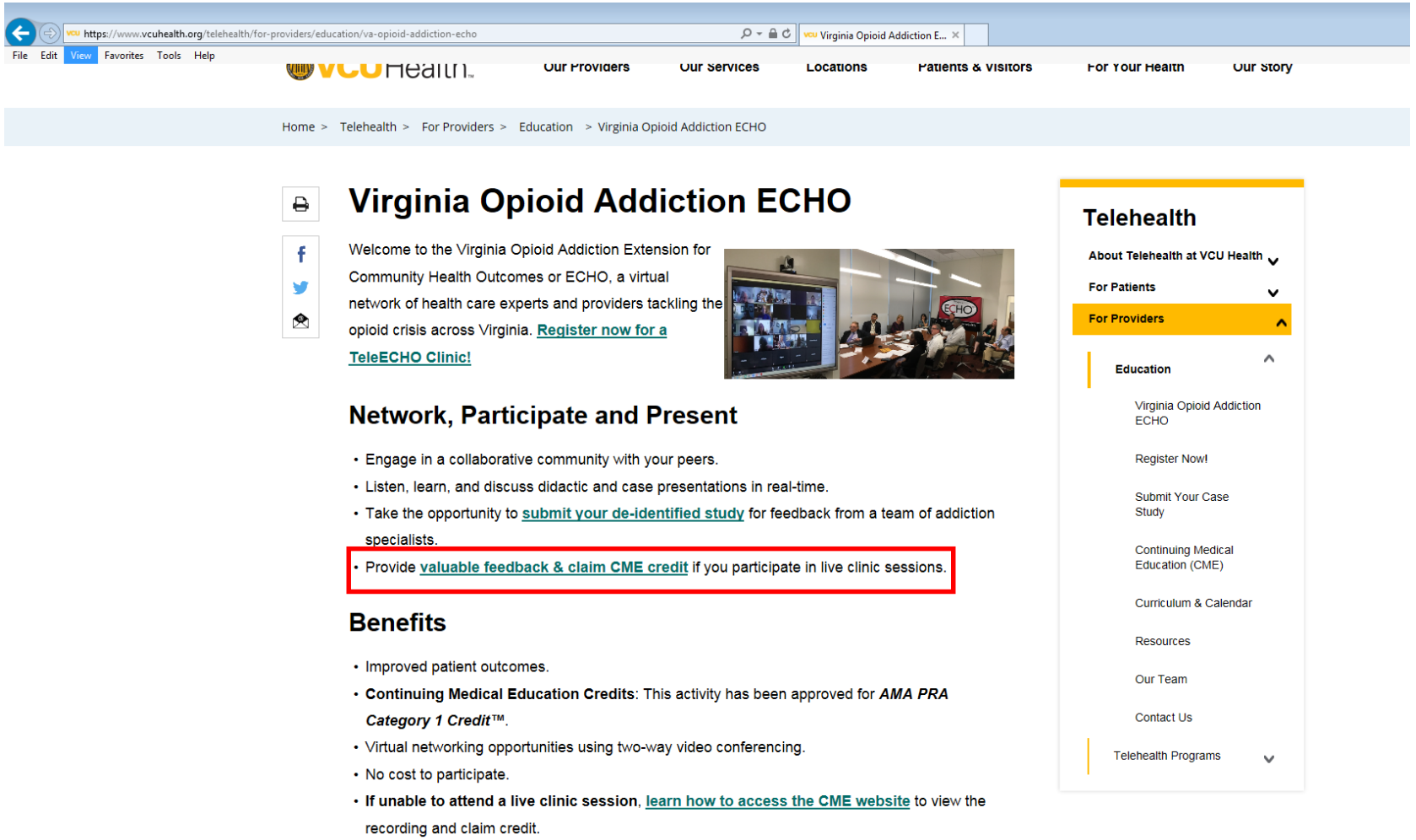
- Survey: www.vcuhealth.org/echo
- Overall feedback related to session content and flow?
- Ideas for guest speakers?

Claim Your CME and Provide Feedback

- www.vcuhealth.org/echo

- 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



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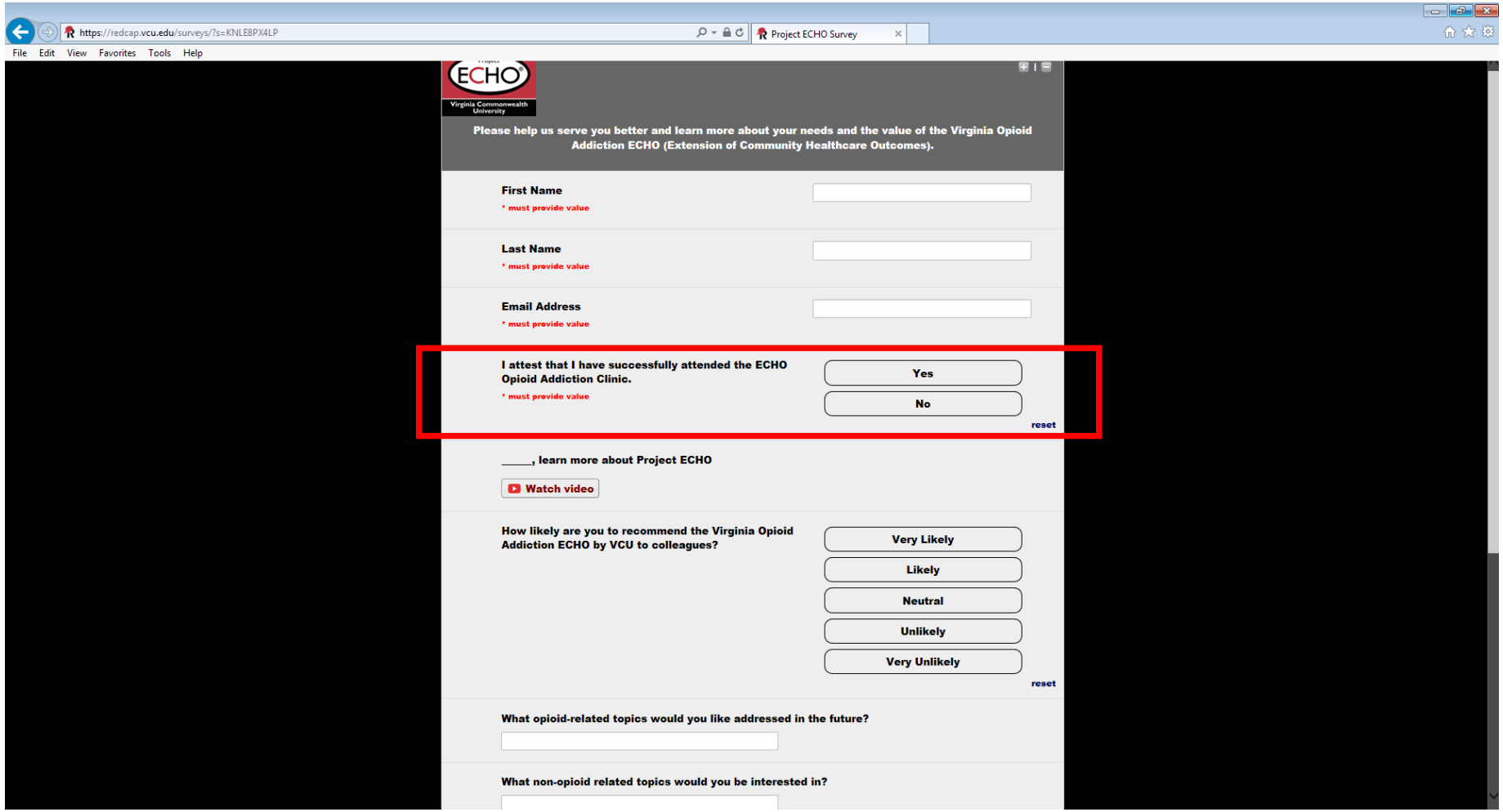
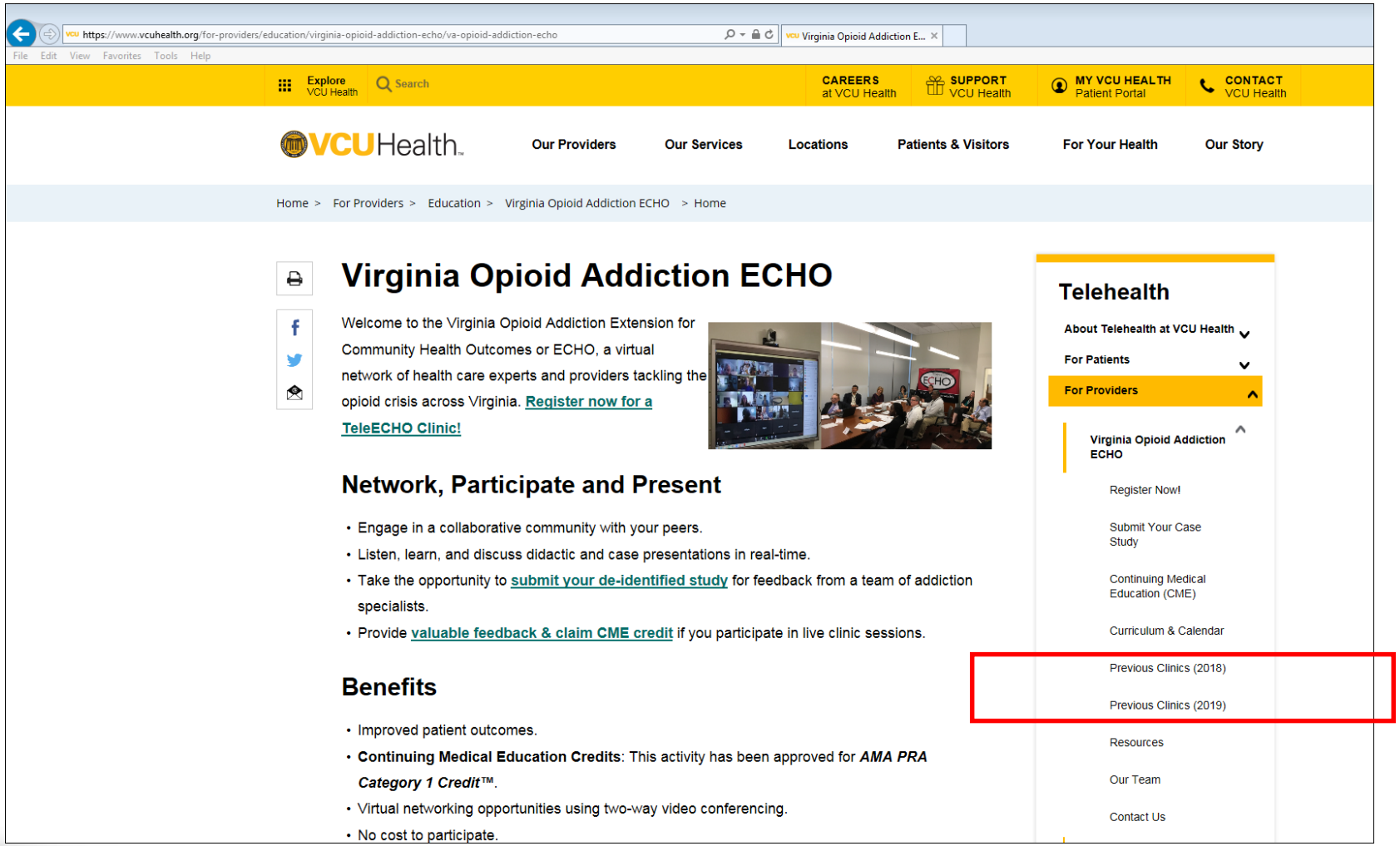


Access Your Evaluation and Claim Your CME

- www.vcuhealth.org/echo
  - To view previously recorded clinics and claim credit

Access Your Evaluation and Claim Your CME



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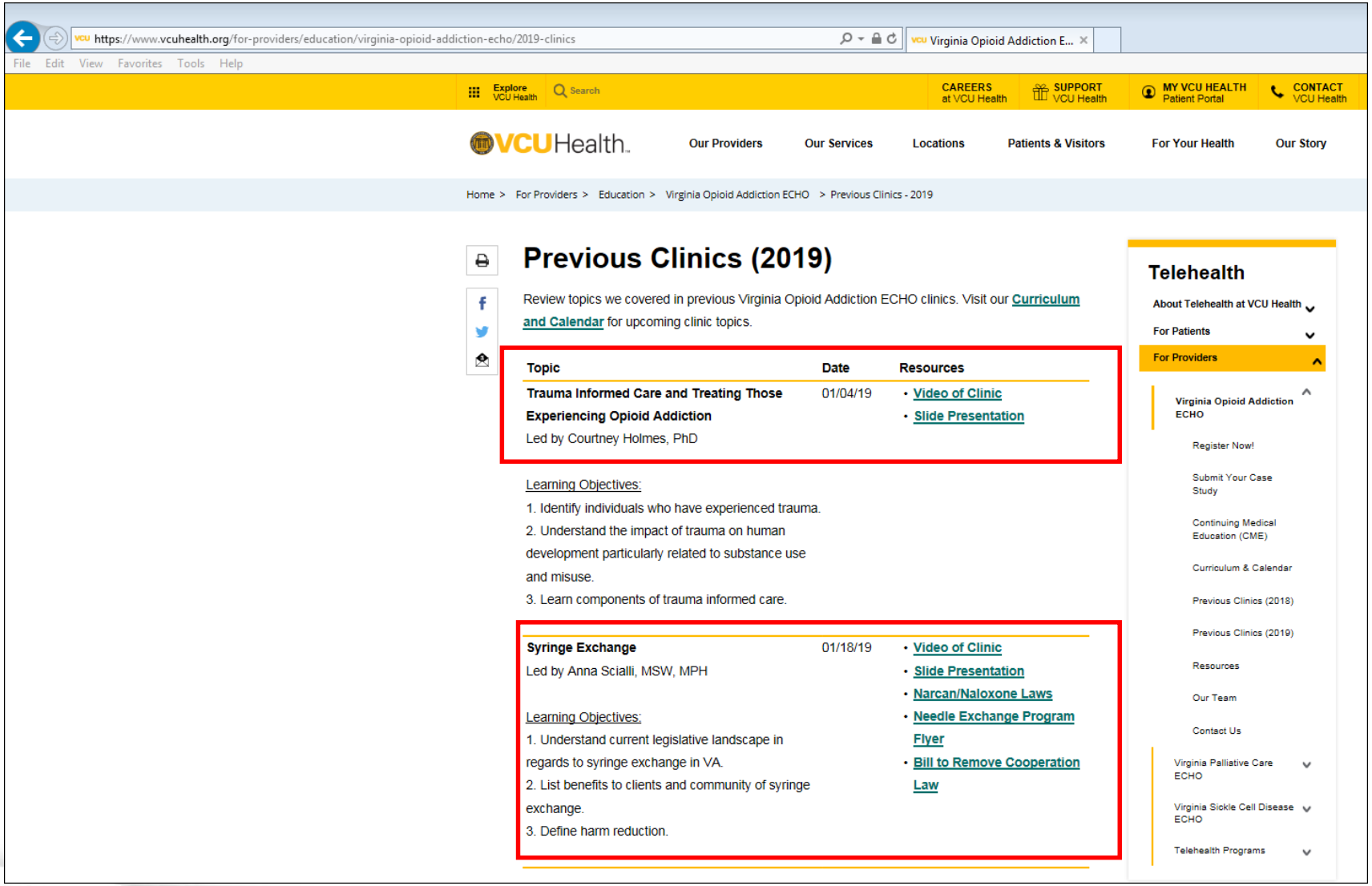

VCU Virginia Opioid Addiction TeleECHO Clinics

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

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Virginia Commonwealth University

THANK YOU!

VCU

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*6 for phone audio
Use chat function for questions