Primary Care Bootcamp 6/21 References

- Whelton PK, Carey RM, Aronow WS, Casey DE Jr, Collins KJ, Dennison Himmelfarb C, DePalma SM, Gidding S, Jamerson KA, Jones DW, MacLaughlin EJ, Muntner P, Ovbiagele B, Smith SC Jr, Spencer CC, Stafford RS, Taler SJ, Thomas RJ, Williams KA Sr, Williamson JD, Wright JT Jr. 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Hypertension. 2018 Jun;71(6):e13-e115. doi: 10.1161/HYP.0000000000000065. Epub 2017 Nov 13. Review. PubMed PMID: 29133356.

- American Diabetes Association. Medical Management of Type 2 Diabetes. 7th ed. Burant CF, Young LA, Eds. Alexandria, VA, American Diabetes Association, 2019

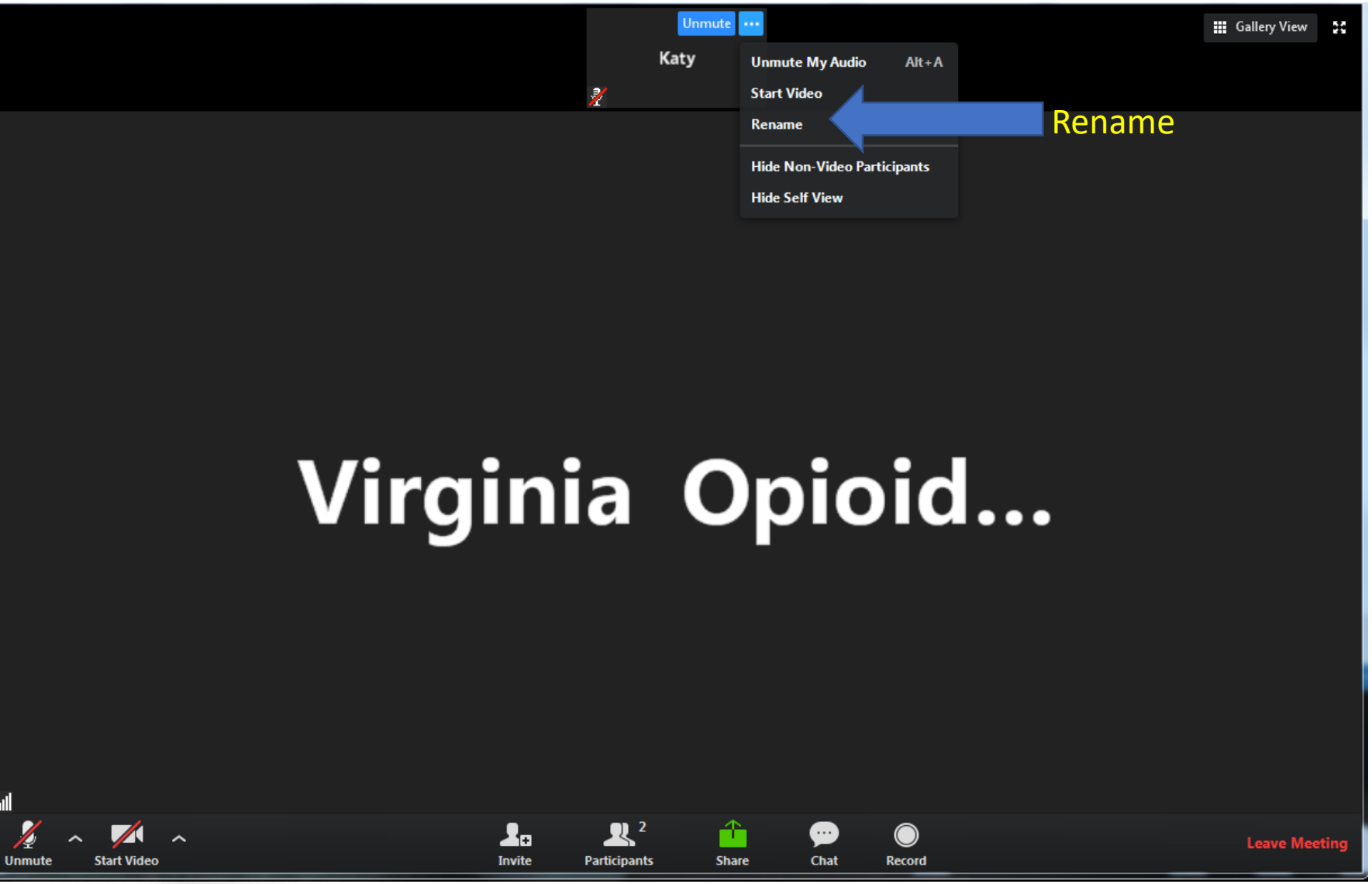
- ASCVD Risk Estiamtor: http://tools.acc.org/ASCVD-Risk-Estimator-Plus/#!/calculate/estimate/

Virginia Opioid Addiction ECHO* Clinic

June 21, 2019

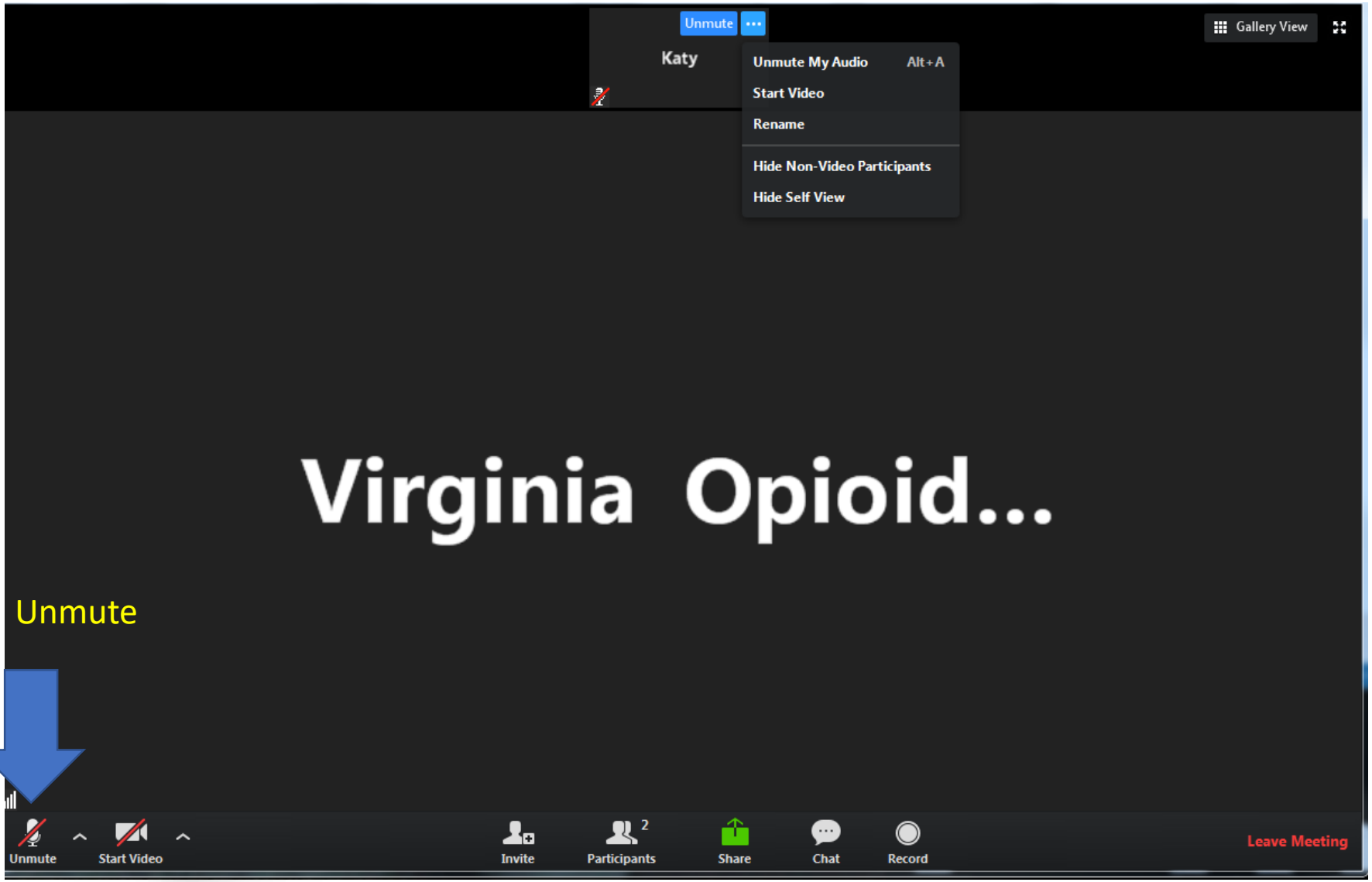
*ECHO: Extension of Community Healthcare Outcomes

Helpful Reminders



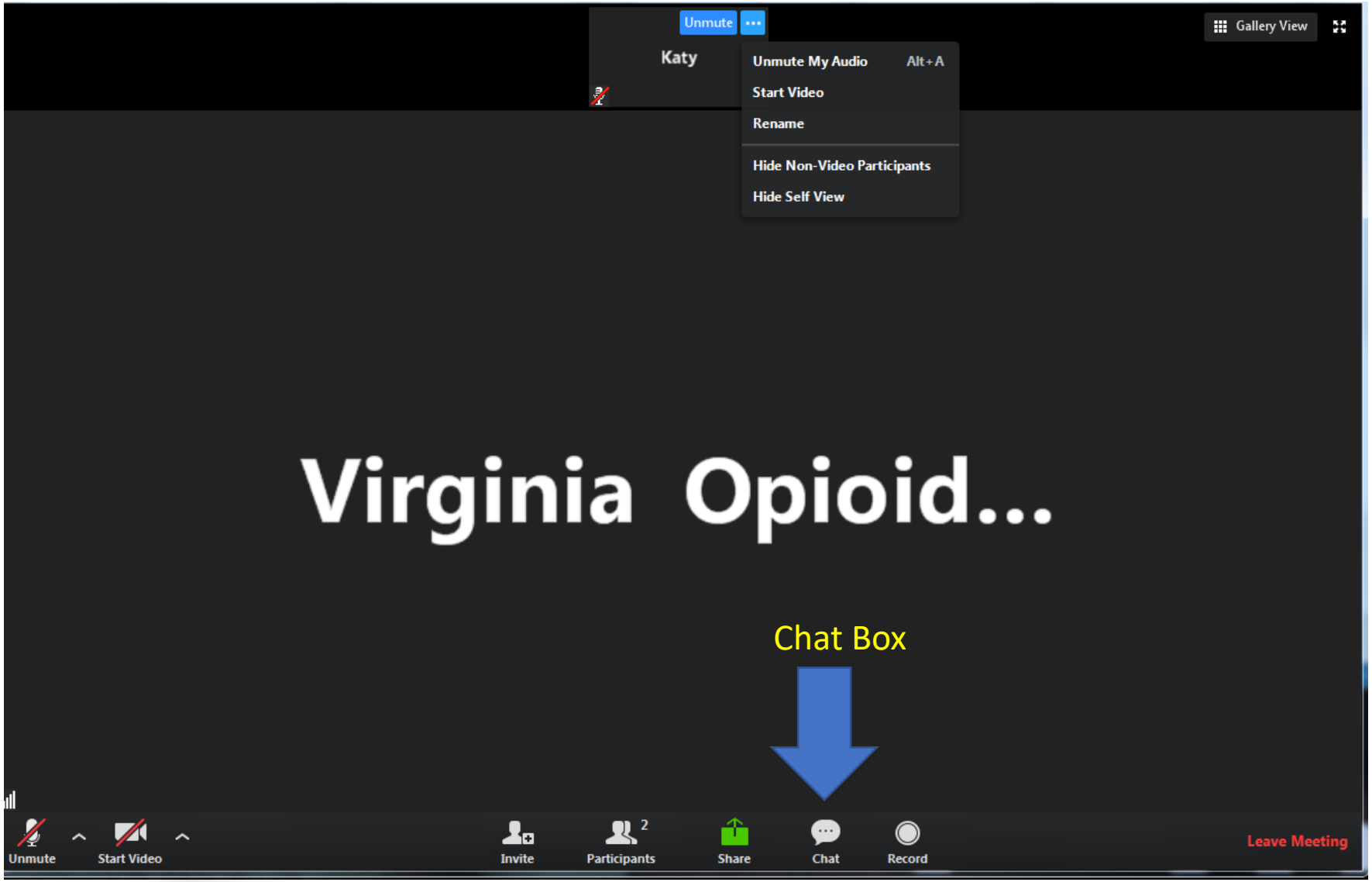
- Rename your Zoom screen, with your name and organization

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 Megan Lemay Bhakti Dave, MPH David Collins, MHA Vladimir Lavrentyev, MBA

Introductions:

- Name
- Organization

Reminder: Mute and Unmute to talk
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Use chat function for Introduction

What to Expect

I. Didactic Presentation
   I. **Megan Lemay, 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!

Primary Care Bootcamp:

Management of Common Medical Issues in Patients Presenting with Substance Use Disorders

Megan Lemay, MD
Project Echo
June 21, 2019

Objectives

- Understand the urgency of treatment of common medical conditions in patients presenting with substance use disorders

- Begin initial therapy for patients presenting with, hypertension, type 2 diabetes mellitus, hyperlipidemia, and opioid-induced constipation

Mr. H

Mr. H is a 48 year old man with a history of hypertension and opioid use disorder here to start buprenorphine therapy.

He has not seen his primary care physician in over 3 years since her practice closed. He previously got a prescription for his blood pressure medication from the emergency room, but has been out for 4 months.

He has no history of heart attack or stroke and is currently in withdrawal from a COWS of 16.

His blood pressure is 186/102.

What questions should we ask Mr. H regarding his blood pressure?

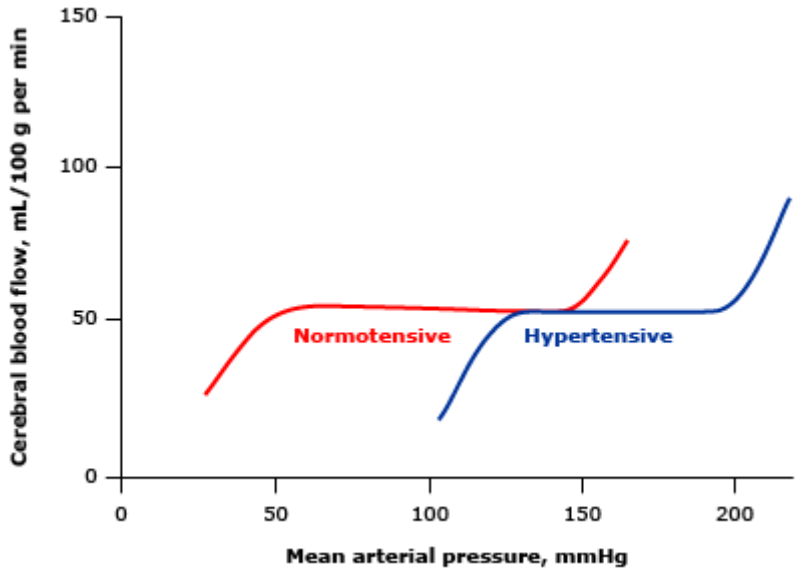
Hypertensive Urgency (Severe asymptomatic HTN) vs Emergency

-headache, vision changes, altered mental status, slurred speech, weakness, numbness
-chest pain, shortness of breath
-abdominal pain

Mr. H

Mr. H has a mild headache which he associates with his withdrawal, but no other symptoms consistent with hypertensive emergency.

He says his blood pressure is “always high” when checked



Redrawn from Kaplan, NM, Lancet 1994; 344:1335.

Treating Severe Asymptomatic HTN

- SLOW initiation of therapy to reach the goal
- Initial goal of <160/100, no more than 30% in the first several hours
  - Ex: clonidine may produce a faster reduction in BP and has the potential for rebound HTN

- My general approach:
  - Treat opioid withdrawal
  - Discuss ref flag features
  - Restart one anti-hypertensive if they have taken it before
  - Close follow

Mr. H

He returns for day 2 induction. He feels much better after initiation of buprenorphine. He could not remember the name of his blood pressure medications. He has no allergies

His blood pressure is now 168/98.

Management of Hypertension

- ACC/AHA definitions of HTN:

●Normal blood pressure – Systolic <120 mmHg and diastolic <80 mmHg
●Elevated blood pressure – Systolic 120 to 129 mmHg and diastolic <80 mmHg

●Hypertension:
•Stage 1 – Systolic 130 to 139 mmHg or diastolic 80 to 89 mmHg
•Stage 2 – Systolic at least 140 mmHg or diastolic at least 90 mmHg

How to choose an agent

- Choose what they have been given before

- If they cannot recall or have not been on therapy, consider amlodipine 5 mg
  - Calcium channel blocker without effect on kidney or liver
  - Most common side effect is benign lower extremity edema (most common at 10 mg dose)
  - Expect effect on blood pressure in 3-5 days

- Other good choices for initial therapy include
  - ACE-inhibitors/ARBs* (ex: Lisinopril 10 mg, losartan 50 mg)
    - Especially in diabetics
  - Thiazide diuretics* (ex: HCTZ 12.5 mg)
  - *Above options require checking of electrolytes before and 1-2 weeks after initiating therapy

Ms. D

Ms. D is a 56 year old woman with a history of opioid use disorder presenting to begin buprenorphine therapy. She completed induction last week and has stabilized on 16 mg daily. Her initial blood work shows a blood sugar of 329.

She has never been told she has diabetes, but she has not seen a doctor and over 10 years and her mother and sister have type 2 diabetes. She has symptoms of polydipsia and polyuria.

Her diet consists mostly of fast foods- burgers, pizza, French fries, chips, and sweets

Diagnosing Type 2 Diabetes

- Fasting Glucose >126
- A1C ≥ 6.5%
- Random Glucose >200 with symptoms of hyperglycemia (polyuria, polydipsia, polyphagia, blurred vision, weight loss)

Ms. D

What should prompt us to refer Ms. D for urgent treatment of her diabetes?

-Diabetic ketoacidosis (DKA) or Hyperglycemic Hyperosmolar State

-altered mental status

-abdominal pain

-in office tests-

-urine ketones in type 1 diabetics

-FSG >600 in type 2 diabetics (without access to self-management tools)

Ms. D

What further testing should we get?

-CMP- liver and kidney function

-A1C

-consider lipid panel

-a patient diagnosed as an adult, especially with other risk factors (obesity, poor diet), a diagnosis of type 2 diabetes can be assumed

Ms. D

- Labs showed normal liver and kidney function
- A1C 9.6%
- Lipid panel:
  - Total cholesterol: 243
  - HLD 36
  - LDL 170
  - Triglycerides 170

Ms. D

Ms. D has an appointment with a new primary care physician in 6 weeks, but asks if she can do something for her diabetes now.

Ms. D

- Lifestyle changes
  - Exercise
    - 150 min per week of moderate to vigorous aerobic exercise
    - 2-3 sessions a week of resistance exercise
    - Limit sedentary behavior
  - Nutrition
    - Focus on calorie reduction and weight loss
    - Carbohydrates are the enemy!
      - Limit or eliminate all grains (even whole grains including rice, pasta, cereals, oatmeal, breads), sugars (including most yogurts), limit fruits (berries and melon are the best choices if needed)
      - Fats and proteins do not raise blood sugar

Quick nutrition tips

- It’s not just plain salads!
- Burgers or sandwiches without the bun/bread (the middle is the good stuff anyway)
- Do not focus on low fat or diet-foods (ex rice cakes)
- Don’t forget liquid calories!

Medications for Diabetes Mellitus type 2

- Metformin
  - First line for type 2 diabetes
  - Start with 500 mg daily (ER formulation preferred to avoid GI side effects, covered by Medicaid)
  - Up titrate to 500 mg bid then 1000 mg bid
  - Will help with weight loss
  - Does not cause hypoglycemia
  - Avoid in advanced renal failure
    - Can initiate therapy if GFR >45
    - If someone is already on metformin, discontinue if GFR <30

Type 1 Diabetes

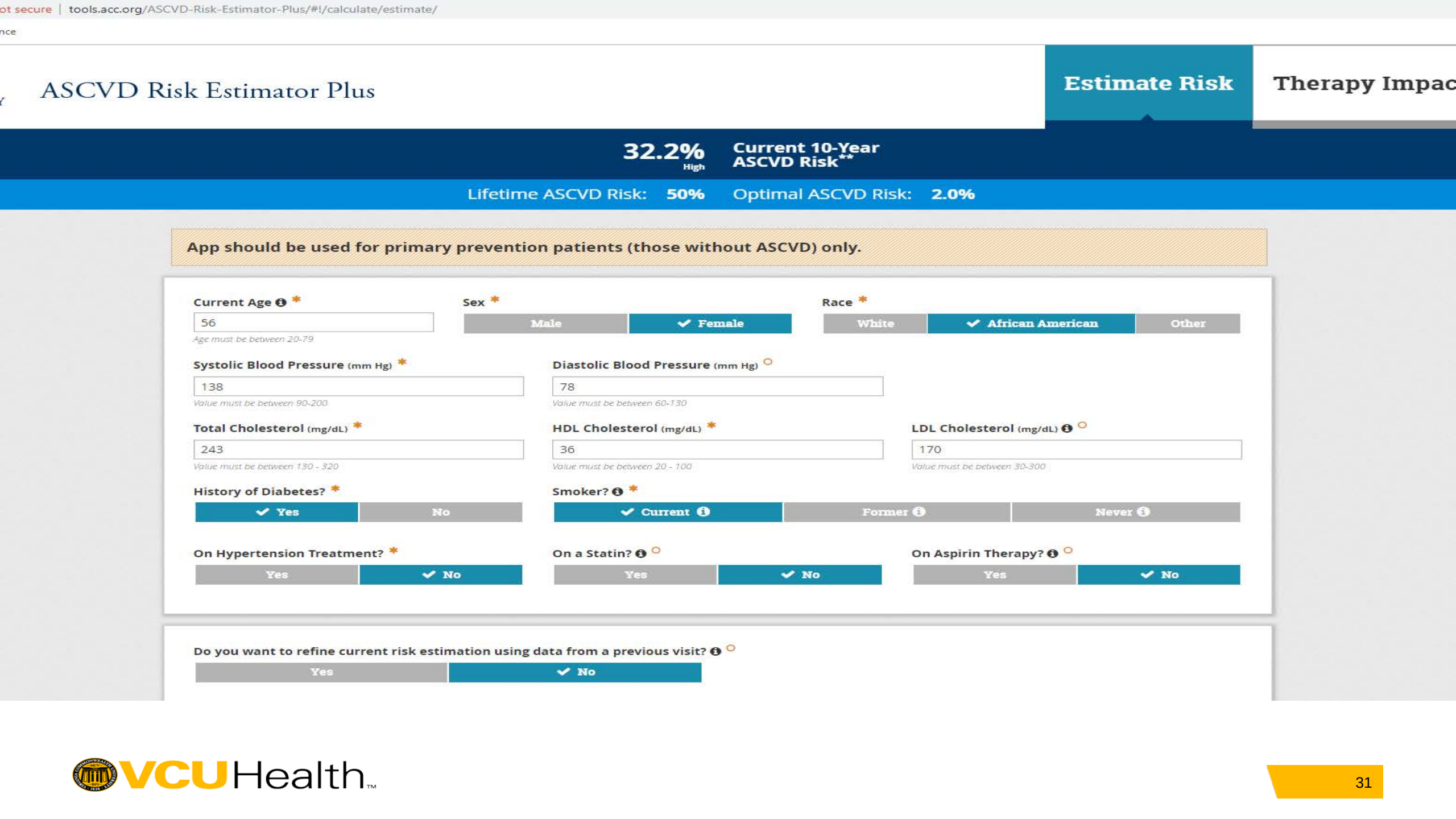
- Only medication is INSULIN
- Should be initiated by an experienced clinician, ideally seen by an Endocrinologist

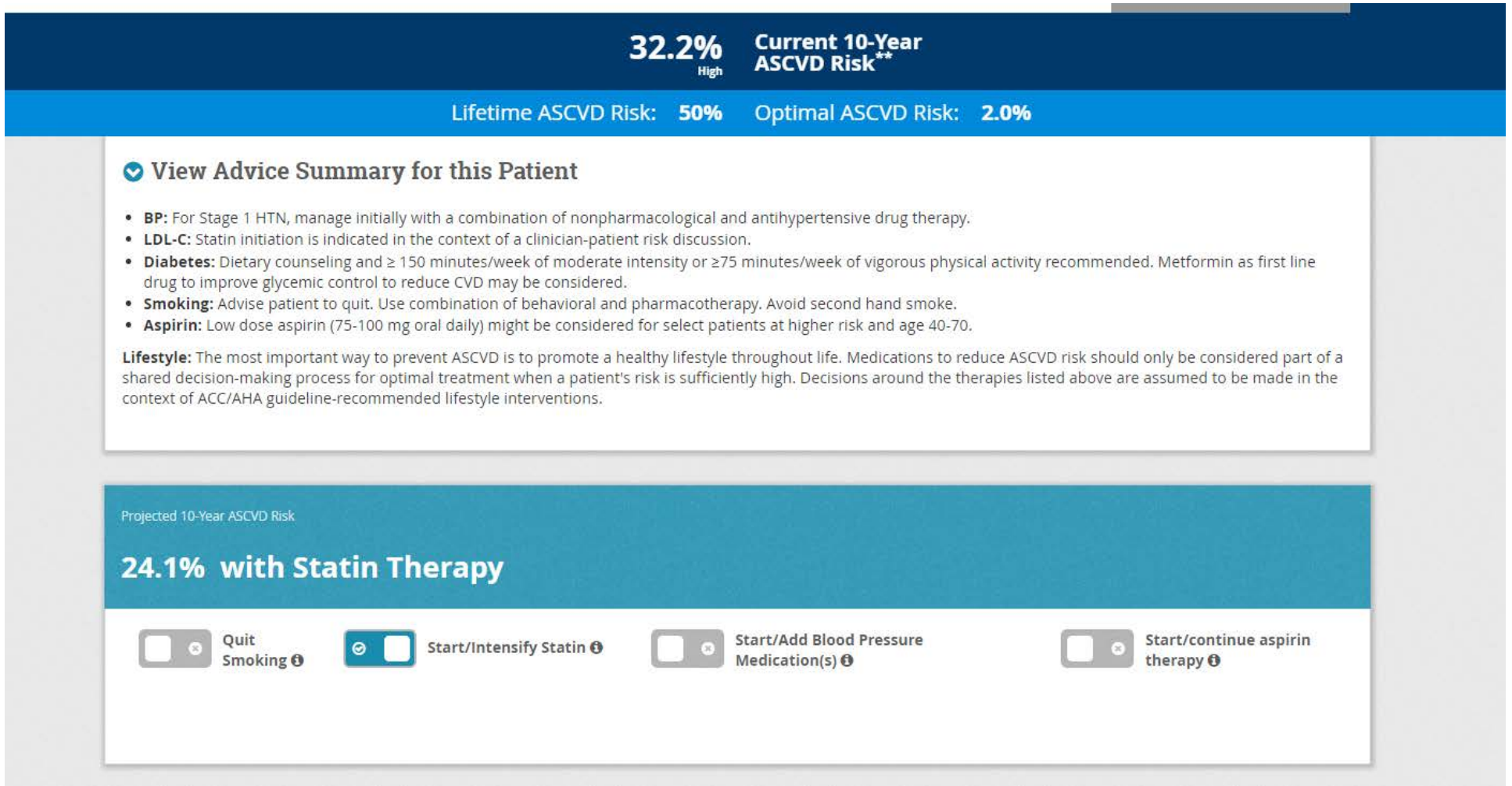
Ms. D

- A patient with type 2 diabetes which is poorly controlled has likely been poorly controlled for a long time. It is reasonable to focus on treating symptoms and establishing with a provider.

Ms. D

- Lipid panel:
  - Total cholesterol: 243
  - HLD 36
  - LDL 170
  - Triglycerides 170


ot secure | tools.acc.org/ASCVD-Risk-Estimator-Plus/#!/calculate/estimate/
nce
ASCVD Risk Estimator Plus
Estimate Risk
Therapy Impac
32.2%
High
Current 10-Year ASCVD Risk**
Lifetime ASCVD Risk: 50%
Optimal ASCVD Risk: 2.0%
App should be used for primary prevention patients (those without ASCVD) only.
Current Age *
56
Age must be between 20-79
Sex *
Male
Female
Race *
White
African American
Other
Systolic Blood Pressure (mm Hg) *
138
Value must be between 90-200
Diastolic Blood Pressure (mm Hg)
78
Value must be between 60-130
Total Cholesterol (mg/dL) *
243
Value must be between 130 - 320
HDL Cholesterol (mg/dL) *
36
Value must be between 20 - 100
LDL Cholesterol (mg/dL)
170
Value must be between 30-300
History of Diabetes? *
Yes
No
Smoker? *
Current
Former
Never
On Hypertension Treatment? *
Yes
No
On a Statin?
Yes
No
On Aspirin Therapy?
Yes
No
Do you want to refine current risk estimation using data from a previous visit?
Yes
No


32.2%
High
Current 10-Year ASCVD Risk**
Lifetime ASCVD Risk: 50%
Optimal ASCVD Risk: 2.0%
View Advice Summary for this Patient
BP: For Stage 1 HTN, manage initially with a combination of nonpharmacological and antihypertensive drug therapy.
LDL-C: Statin initiation is indicated in the context of a clinician-patient risk discussion.
Diabetes: Dietary counseling and ≥ 150 minutes/week of moderate intensity or ≥75 minutes/week of vigorous physical activity recommended. Metformin as first line drug to improve glycemic control to reduce CVD may be considered.
Smoking: Advise patient to quit. Use combination of behavioral and pharmacotherapy. Avoid second hand smoke.
Aspirin: Low dose aspirin (75-100 mg oral daily) might be considered for select patients at higher risk and age 40-70.
Lifestyle: The most important way to prevent ASCVD is to promote a healthy lifestyle throughout life. Medications to reduce ASCVD risk should only be considered part of a shared decision-making process for optimal treatment when a patient's risk is sufficiently high. Decisions around the therapies listed above are assumed to be made in the context of ACC/AHA guideline-recommended lifestyle interventions.
Projected 10-Year ASCVD Risk
24.1% with Statin Therapy
Quit Smoking
Start/Intensify Statin
Start/Add Blood Pressure Medication(s)
Start/continue aspirin therapy

Treatment Advice*

Collapse All

LDL-C Management (for this Patient)

At least moderate intensity statin initiation is indicated (I, A). High-intensity statin therapy is reasonable to reduce LDL-C by ≥50%. (IIa, B-R). Addition of ezetimibe to statin therapy is also reasonable to reduce LDL-C by ≥50%.

- Clinicians and patients should engage in a risk discussion that considers patient preferences for individualized treatment.
  Discussion checklist
- Clinician should evaluate for presence of risk enhancing factors that may favor statin initiation.
  Overall list of risk enhancing factors
  Additional risk factors for diabetes patients
  Race/ethnic specific factors in assessing and treating ASCVD risk
- If statin therapy is decided upon, clinician and patient should discuss risk and benefits before initiation.
  Statin types and intensities

Table 3. High-, Moderate-, and Low-Intensity Statin Therapy*

	High-Intensity	Moderate-Intensity	Low-Intensity
LDL-C Lowering§	≥ 50%	30% to 49%	< 30%
Primary Statins	**Atorvastatin (40†)-80 mg** **Rosuvastatin 20** *(40)* **mg**	**Atorvastatin 10** *(20)* **mg** **Rosuvastatin** *(5)* **10 mg** **Simvastatin 20-40 mg‡**	*Simvastatin 10 mg*
Other Statins	-	**Pravastatin 40** *(80)* **mg** **Lovastatin 40** *(80)* **mg** *Fluvastatin XL 80 mg* **Fluvastatin 40 mg BID** *Pitavastatin 1-4 mg*	**Pravastatin 10-20 mg** **Lovastatin 20 mg** *Fluvastatin 20-40 mg*

Hyperlipidemia Pearls

- Calculator is only used for ages 40-79
- Treating hyperlipidemia is not an emergency- it can often wait
- Fasting is no longer recommended
- Check LFT's before starting (and don't initiate if AST/ALT >3x ULN or cirrhosis)
  - No need for follow up LFT's

Ms. D

Ms. D returns for follow up 2 weeks after initiation of therapy.

She is taking metformin and atorvastatin and has not noted any side effects. Her glucose in clinic this morning is 152.

She has noted significant constipation since starting her buprenorphine. She has tried an over the counter stool softener, but still feels constipated and her last BM was 2 days ago.

Opioid-induced Constipation

- Prevention is key
  - Consider prophylactic rx for senna with any opioid prescription

- Before giving oral therapy, ensure no fecal impaction, consider enema or manual disimpaction if no BM in several days

- First line
  - Diet- increase water intake (especially warm liquids) and fiber intake
  - Use of laxatives
    - Polyethylene glycol (osmotic laxative)
      - Start with one cap in 8 oz fluid daily
      - If no effect in 24 hours, increase to 2 caps daily
    - senna (stimulant laxative, best not to use chronically)

Opioid-induced Constipation

- Second line
  - Opioid Antagonists
    - Methylnaltrexone
      - Peripheral-acting opioid antagonist
      - Discontinue laxatives and then start 450 mg po once daily
      - Dose reduce in renal disease
    - Oral Naloxone
      - 3% bioavailable, potential risk of precipitated withdrawal
    - Other options: naloxegol, lubiprostone (insurance coverage issues)

Conclusions

- In patients presenting with HTN
  - Assess for red flag symptoms which should prompt emergency care (severe headache, altered mental status, vision changes, chest pain, shortness of breath)
  - Correct blood pressure slowly in asymptomatic patients
  - Consider amlodipine as the initial antihypertensive

- In patients presenting with DM2
  - If presenting with significant hyperglycemia, screen for signs and symptoms of DKA or hyperglycemic hyperosmolar state (altered mental status, ketones in urine)
  - Focus on nutrition and exercise and consider starting metformin in type 2 diabetes

- In patients with hyperlipidemia
  - Use the ASCVD Risk Estimator to assess risk and decide on potential therapy

- In patients with opioid-induced constipation
  - Focus on diet changes, then laxatives then opioid antagonists

Thank you!
Questions?

References

- Whelton PK, Carey RM, Aronow WS, Casey DE Jr, Collins KJ, Dennison Himmelfarb C, DePalma SM, Gidding S, Jamerson KA, Jones DW, MacLaughlin EJ, Muntner P, Ovbiagele B, Smith SC Jr, Spencer CC, Stafford RS, Taler SJ, Thomas RJ, Williams KA Sr, Williamson JD, Wright JT Jr. 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Hypertension. 2018 Jun;71(6):e13-e115. doi: 10.1161/HYP.0000000000000065. Epub 2017 Nov 13. Review. PubMed PMID: 29133356.

- American Diabetes Association. Medical Management of Type 2 Diabetes. 7th ed. Burant CF, Young LA, Eds. Alexandria, VA, American Diabetes Association, 2019

- ASCVD Risk Estiamtor: http://tools.acc.org/ASCVD-Risk-Estimator-Plus/#!/calculate/estimate/

Case Presentation #1
Michael Bohan, MD

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

Reminder: Mute and Unmute to talk
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Use chat function for questions

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Case Presentation #1
Michael Bohan, MD

Project ECHO
Virginia Commonwealth University

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

How best to proceed with a patient who was dependent on high dose Alprazolam and is continuing to have withdrawal symptoms despite high dose agonist (Diazepam) replacement? The intention was to replace the Alprazolam with Diazepam and taper slowly.

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.)

The patient is a 40 yo unemployed male who is unmarried and lives with his mother in Chesapeake VA. He has the trade of tile setter but has been unable to work since starting the Diazepam taper. He has a girl friend who visits him occasionally. All his support comes from his mother. He does not drive.

VCU

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Use chat function for questions

Case Presentation #1
Michael Bohan, 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.)

Has prior history of Alcohol Use Disorder with serious withdrawal requiring treatment in an ICU. Later became dependent to Buprenorphine for which he used Alprazolam to taper but in turn became dependent to Alprazolam. Entered the Virginia Beach Psychiatric center in November 2018 for Alprazolam detox but had lingering withdrawal and sought outpatient help with me. I started Diazepam to taper off the Alprazolam but have not been able to reduce because of continued agitation with tremors, hand sweating, insomnia and agoraphobia. He remains at 150 mg of Diazepam. Alprazolam tolerance level was was around 8 mg . He has no physical illnesses.

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

Using the Heather Ashton MD Model for benzodiazepine withdrawal in which a long acting benzo is subsituted for a short acting one and in this case substituting Diazepam was substituted for Alprazolam at 20 mg for every 1 mg of Alprazolam. The starting dose was 170 mg/d and reduced slowly to 150 mg per day. The patient has not been able to break free of the withdrawal symptoms. Supplementing separately Tegretol 200 mg per day, later Abilify 10 mg per day and then Gabapentin up to 2400 mg per day provided no help. In fact he had profound withdrawal from tapering Gabapentin. He uses Melatonin to help with sleep which is of limited help. Psychiatric consultation has not been obtained because his symptoms prevented him from leaving his home, agoraphobia. He has been at high dose Daizepam for several months. The taper was hampered in part for the profound withdrawal he experienced from Gabapentin.

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

Case Presentation #1
Michael Bohan, MD

Project ECHO
Virginia Commonwealth University

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

We need to sort out his symptoms as far as the cause. He could have Anxiety or Bipolar disorder contributing to the agitation. The symptoms could be due to under medication with Diazepam. This is hard to believe because of the high dose of Diazepam he is on now. He acquired the Alprazolam on the street and seemed to have unlimited access for he had a lot left over when he came to detox. His tolerance level could have been 10mg of more of Alprazolam. I recommend inpatient assessment with Addiction Medicine specialists on an inpatient dual diagnosis unit where these issues can be sorted out.

Other relevant information

Not able to get to group therapy or NA meetings because of the fears which kept him at home. UDS have been positive for benzodiazepines except for the last one which was also positive for THC which he says comes from a single use of CBD oil. PMP reports consistent with the therapy he has been receiving.

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

VCU

Case Presentation #2
Jen Phelps, LPN

- 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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Reminder: Mute and Unmute to talk
*6 for phone audio

Use chat function for questions

Case Presentation #2
Jen Phelps, LPN

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

How do you determine when to discharge a client for continued heroin use and non compliance with 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.)

White male age 34 years old, he grew up with a middle income to upper income family. He has had behavioral problems through life and in and out of detention and jail since early childhood. He has limited and dysfunctional relationships with his family members. All peers are active substance users IV METH and Heroin, his father is an abusive alcoholic and sister was a crack user he has a hostile relationship with her. Client's father beat him up really bad when he was 12, and social services were called, and client went to live with his mother. Client did not talk to his father again until he was 17. Client states he was beat up by his Dad frequently. Has worked jobs in construction and factory over the years, recently unemployed.

Reminder: Mute and Unmute to talk
*6 for phone audio

Use chat function for questions

Case Presentation #2
Jen Phelps, 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.)

DX: Unspecified bipolar and related disorder (rule out), F90.2 Attention-deficit. hyperactivity disorder, combined presentation; F41.0 Panic disorder; F11.20 Opioid use disorder, F15.20 Amphetamine-type substance use disorder; He has been in and out of children's group homes & detention and jail since age of 14, he jokes that at age 17 the J&D judge got tired of seeing him in court and sent him to jail. True he went and served jail time at this age for drug related charges. He lacks insight into his addiction or mental health he struggles to see addiction as a disease. He often states, "I do this for fun" Client reports he has been using heroin on and off since he was 21. However he started using heroin regularly when he got with his last GF. Client states he was using a bundle (one gram/ten bags) a day but he stopped using heroin last summer (8/18) when he overdosed. Client states he was taken to the hospital and told they had to give him 2 shots to start his heart back up. Client asserts , crank, meth is his drug of choice, it helps him think clearer, feel better, etc. Client reports he went to the Methadone clinic for 2 years, 2014-2016, to help him get off of the meth . Client denies any other tx. Client denies any issues with marijuana, alcohol, or any other drugs, however has a DUI charge from alcohol use and a restricted driver's license related to this that impairs him for driving. Client has table on MAT before recently returning to work where money seems to be a trigger for his use, and recently starting using IV METH and Heroin again. Client is now unable to stop his use. He has continued to use Suboxone on and off during this time. housing is not stable, often has meds stolen, recently got a possession charge for heroin after bailing his ex out of jail.

LABS
metabolite UDS
6-4-19 results positive for BUP 167ng.ml; Norbup 138 ng/ml
AMP 781 ng/ml; (Adderall)
METh 1496 ng/ml; %D-METH >=20% (methamphetamine)
Norfentanyl 5.4ng/m; morphine 311 ng/ml (fentanyl)
6-actylmorphine 62 ng/ml (heroin)

Reminder: Mute and Unmute to talk
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Use chat function for questions

Case Presentation #2
Jen Phelps, LPN

Project ECHO®
Virginia Commonwealth University

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

Client is brought in weekly for MAT, Client has been referred to IOP completed this, client completed Cont Care, and attends AA on occasion. Client was referred to psych med management he has missed 3 appointments, he has never followed trough with a psych evaluation. Staff has processed this with him several times addressed his fears over this. Client continues to struggle with the term "addiction". Client has been offered in-patient treatment, failed to follow through with the referral. But does come in weekly for Case Management and MAT.

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

Client is seen weekly for MAT with weekly Metabolite UDS and DIP UDS onsite. Client has been referred for psych med management, in-patient treatment, staff has called 4 centers over the last 3 weeks trying to get him into treatment. Staff has reviewed REVIVE training and overdose risks, given Narcan script to client, encouraged client to follow up with the ED for Detox. Discussed possible discharge from program with client and possible referring client to another program for possible Methaodne treatment to manage heroin use as Suboxone doesn't seem to be holding client as client associates getting clean in the past with Methadone. Also just talk with client each visit about motivation for use and motivation for change and readiness for change.

Other relevant information

Client has court 6-24-19 may be getting jail time for possession charge.

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

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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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

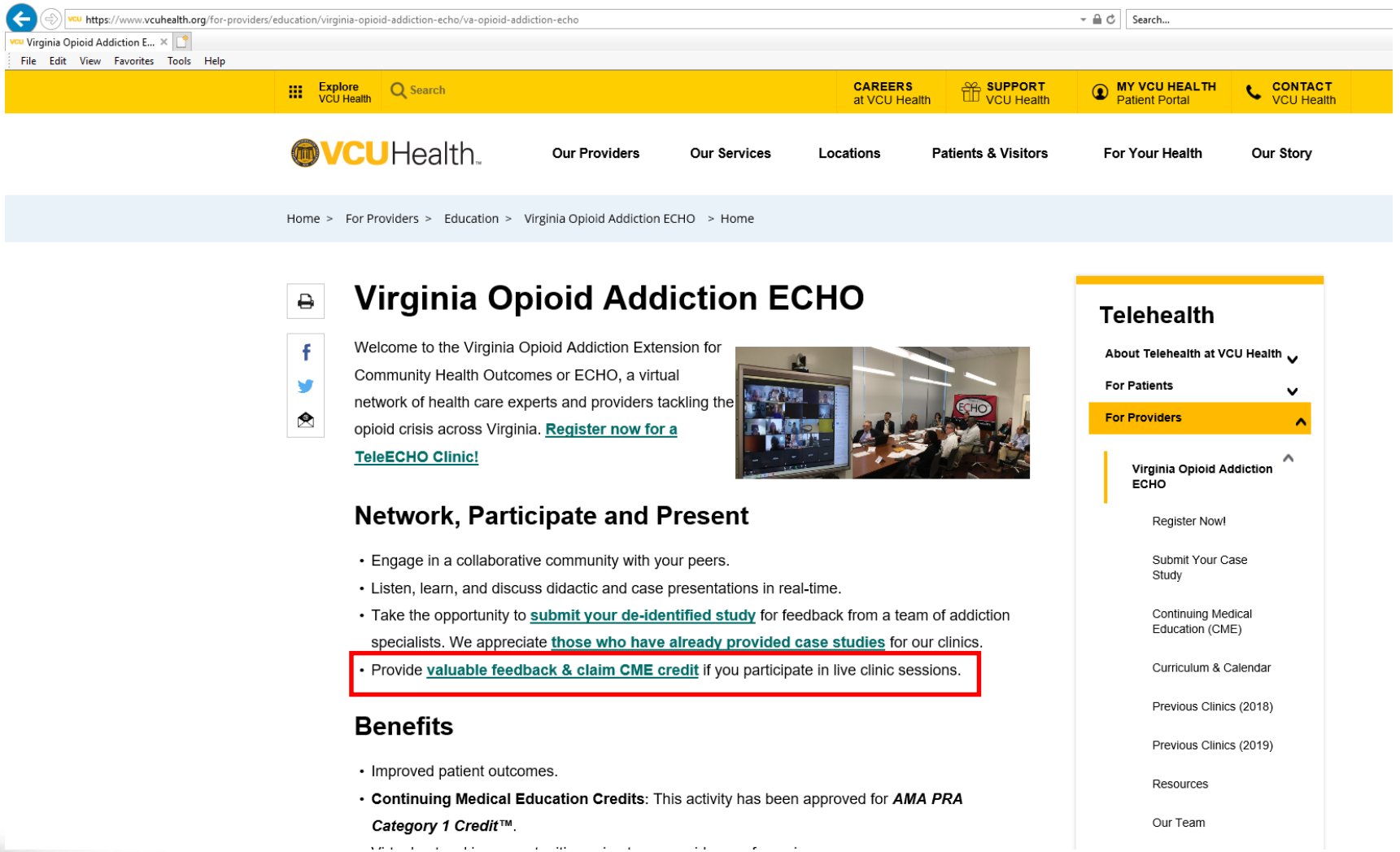
- Survey: www.vcuhealth.org/echo
- Overall feedback related to session content and flow?
- Ideas for guest speakers?

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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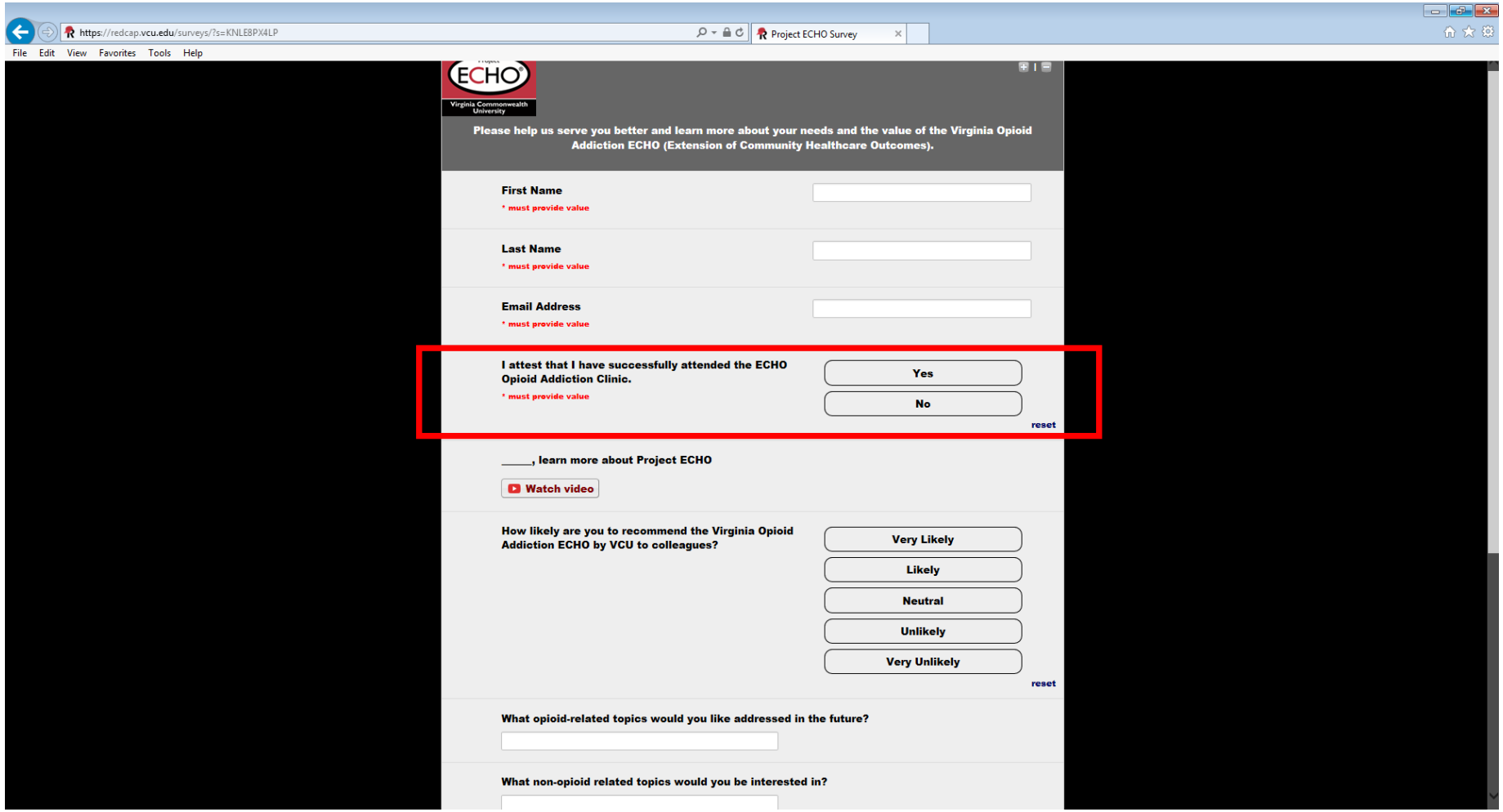
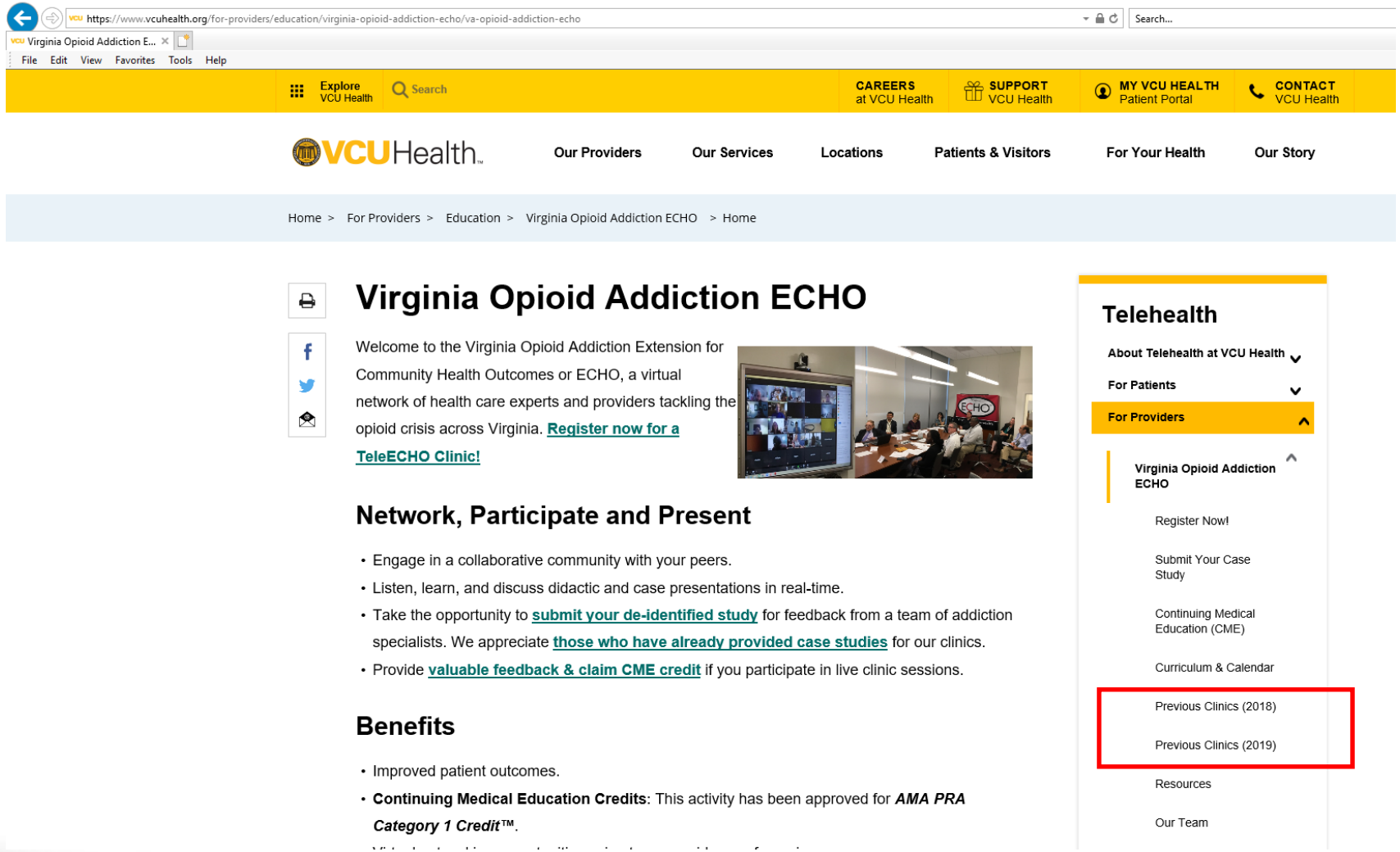


Access Your Evaluation and Claim Your CME

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

Access Your Evaluation and Claim Your CME



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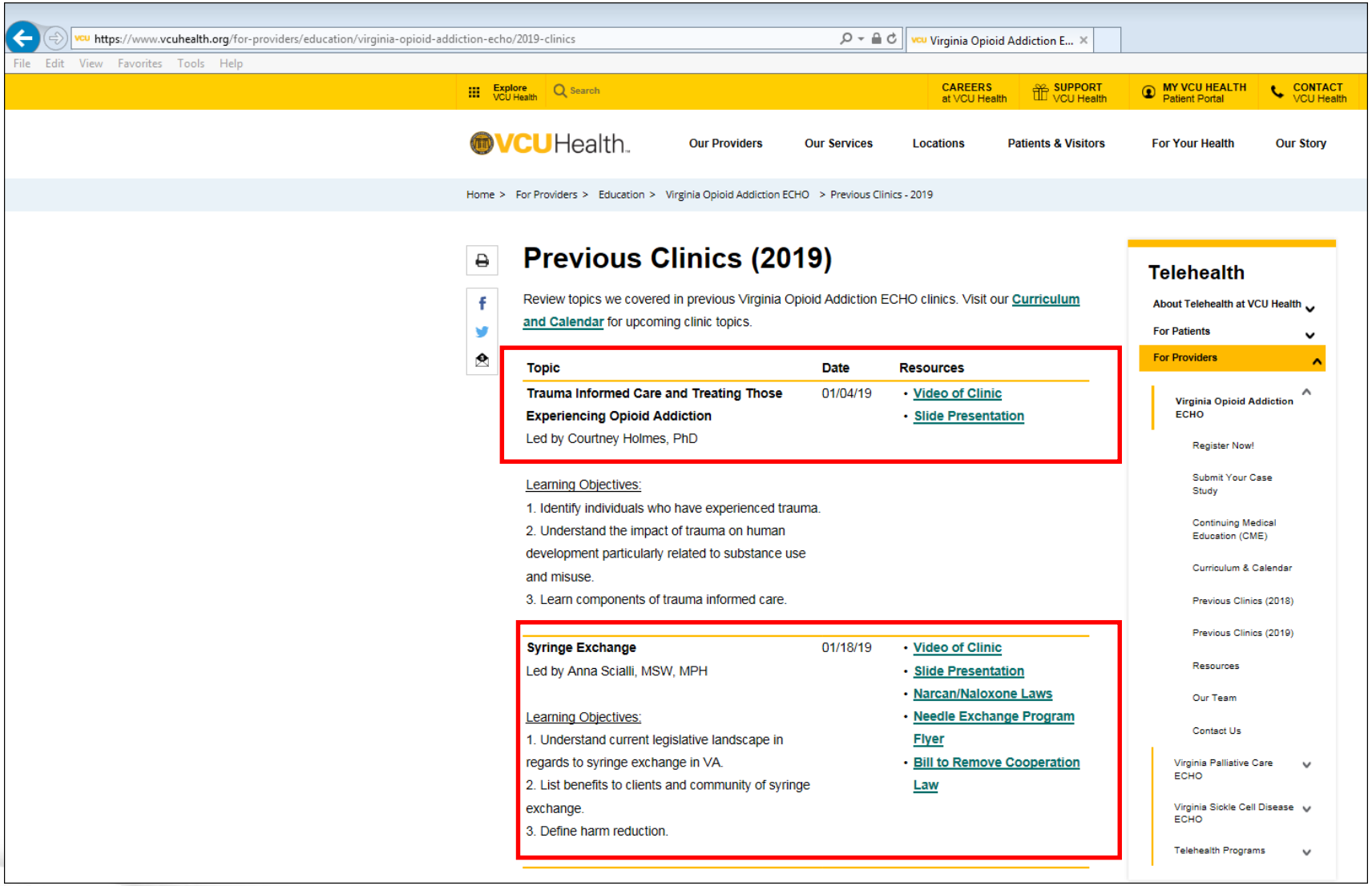

VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

Please refer and register at vcuhealth.org/echo

THANK YOU!