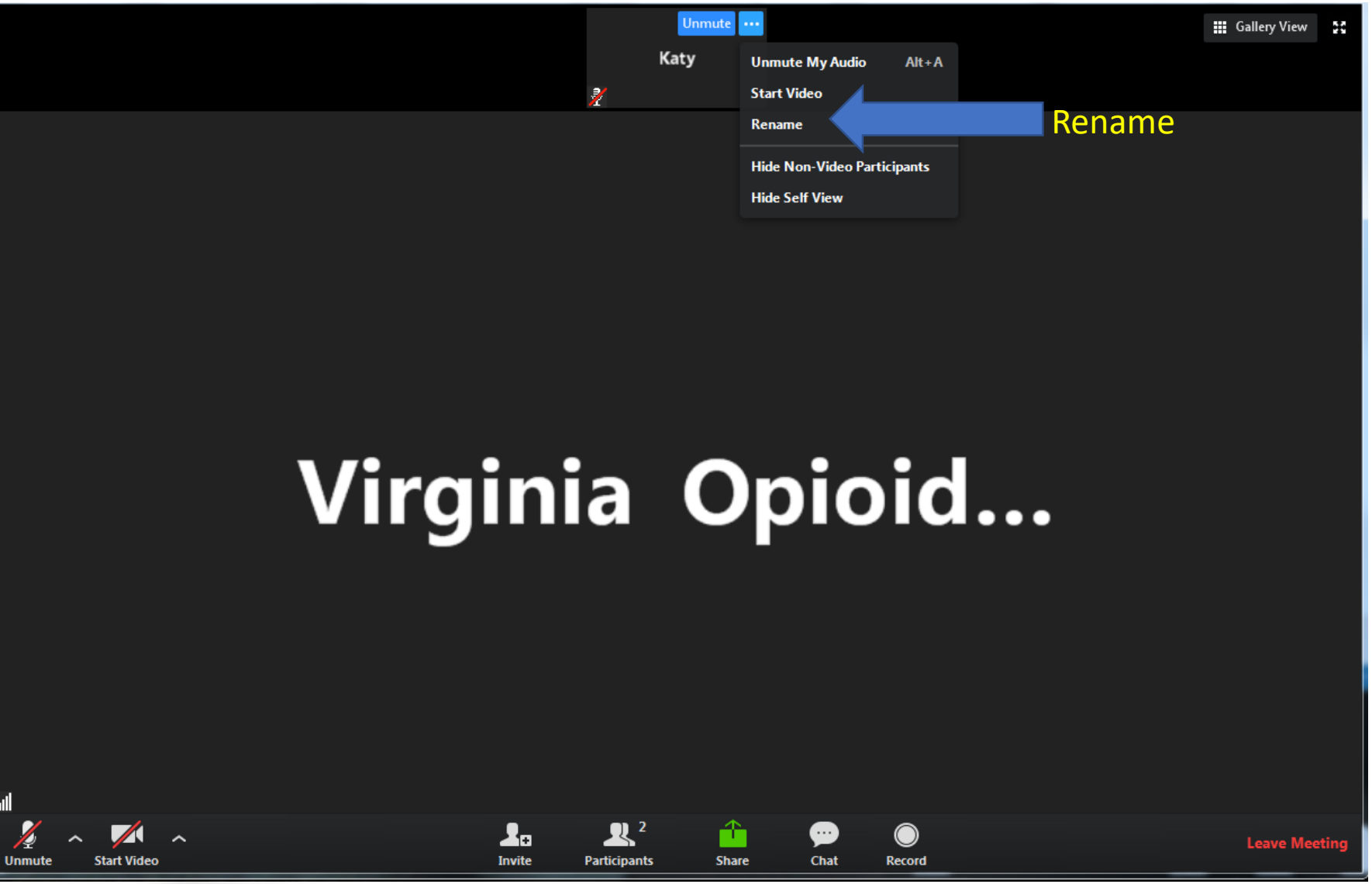
Virginia Opioid Addiction ECHO* Clinic

May 3, 2019

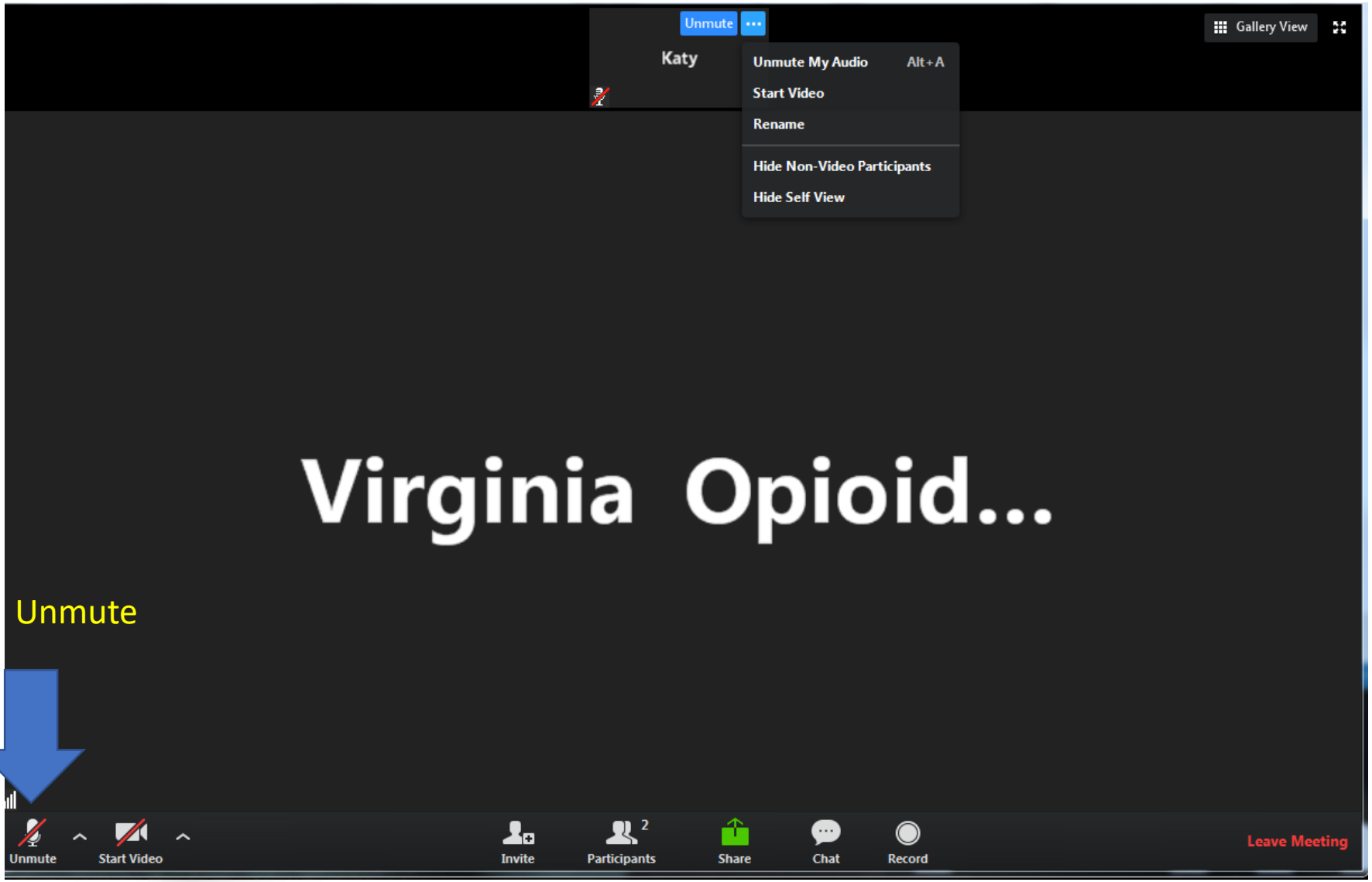
*ECHO: Extension of Community Healthcare Outcomes

Helpful Reminders



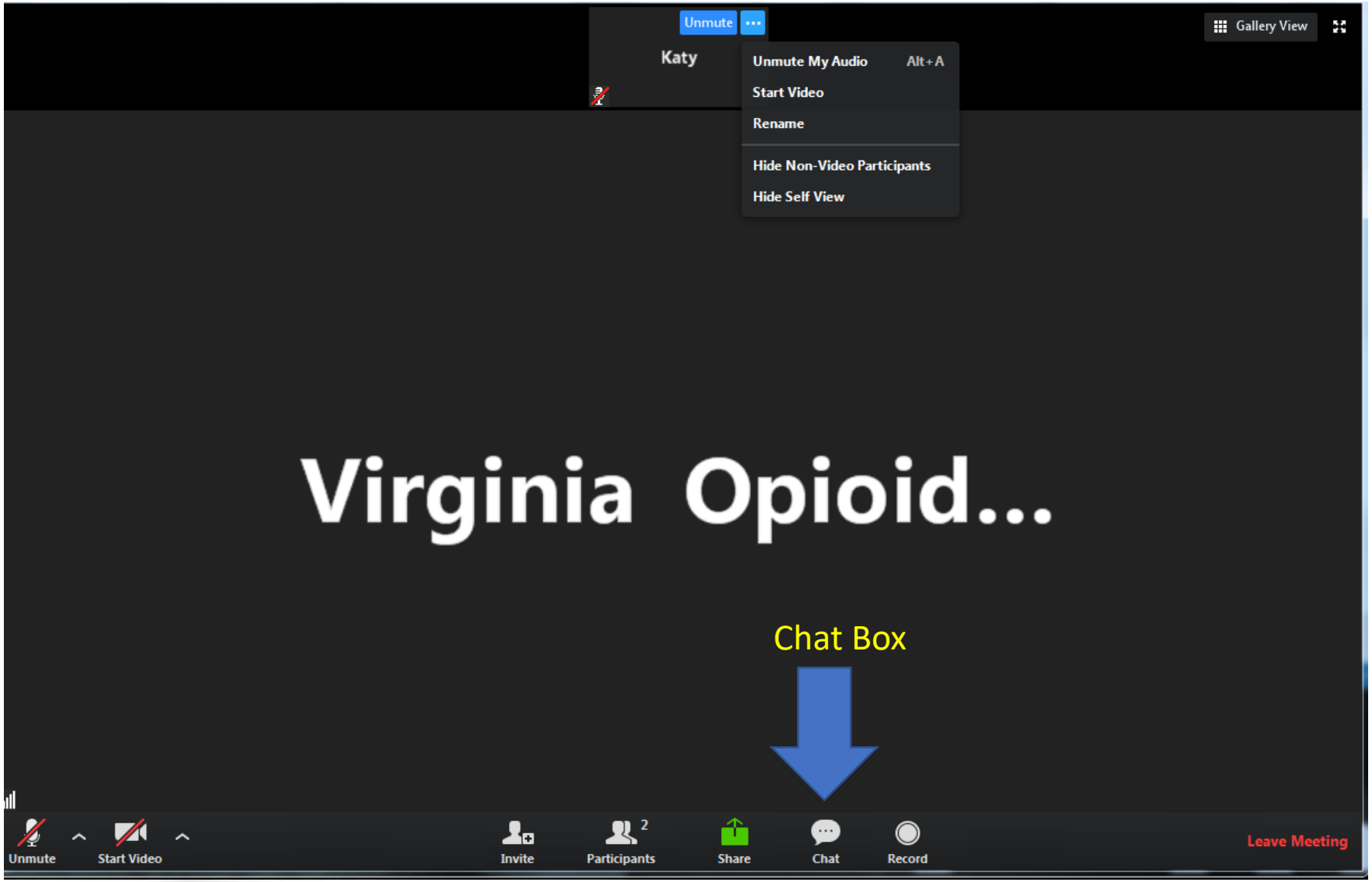
- Rename your Zoom screen, with your name and organization

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 Tom Bannard, MBA 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. **Peer Recovery and OUD: Not Just an Afterthought**
   II. **Tom Bannard, MBA**
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!

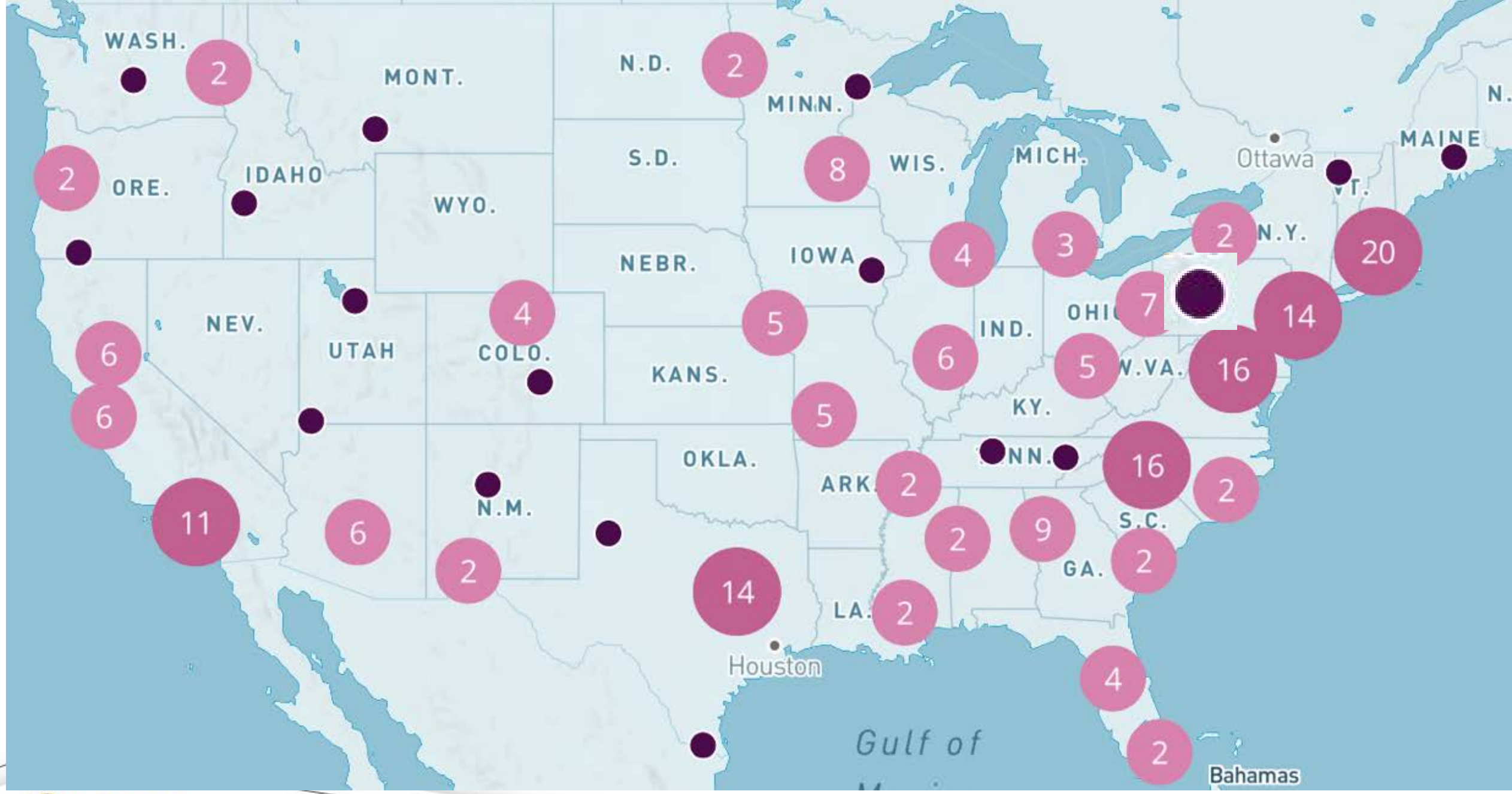
Didactic Presentation

Peer Recovery and OUD: Not just an afterthought

Tom Bannard, MBA, CADC

Program Coordinator, Rams in Recovery, Virginia Commonwealth University

Rams in Recovery, The Collegiate Recovery Program at VCU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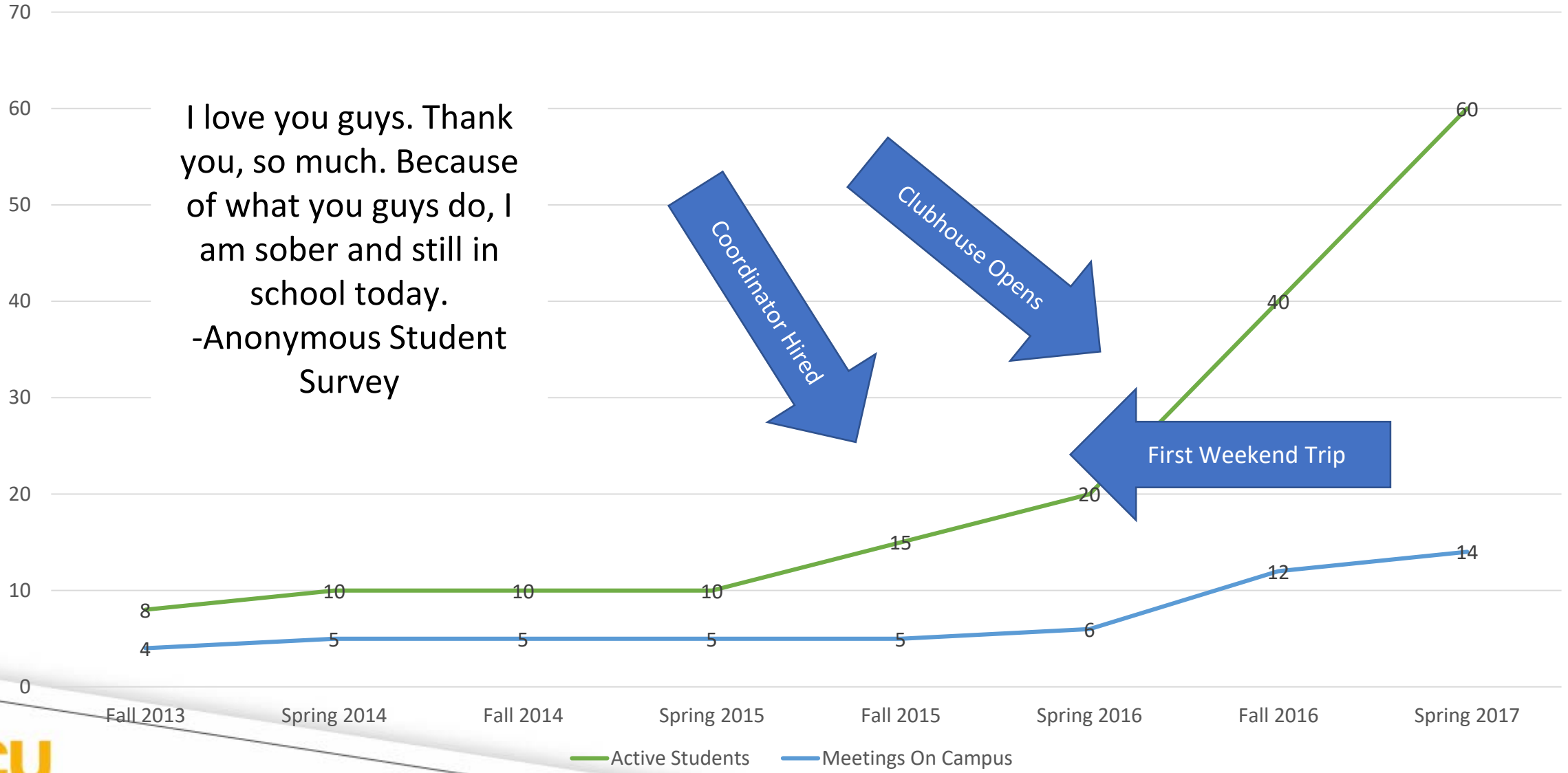
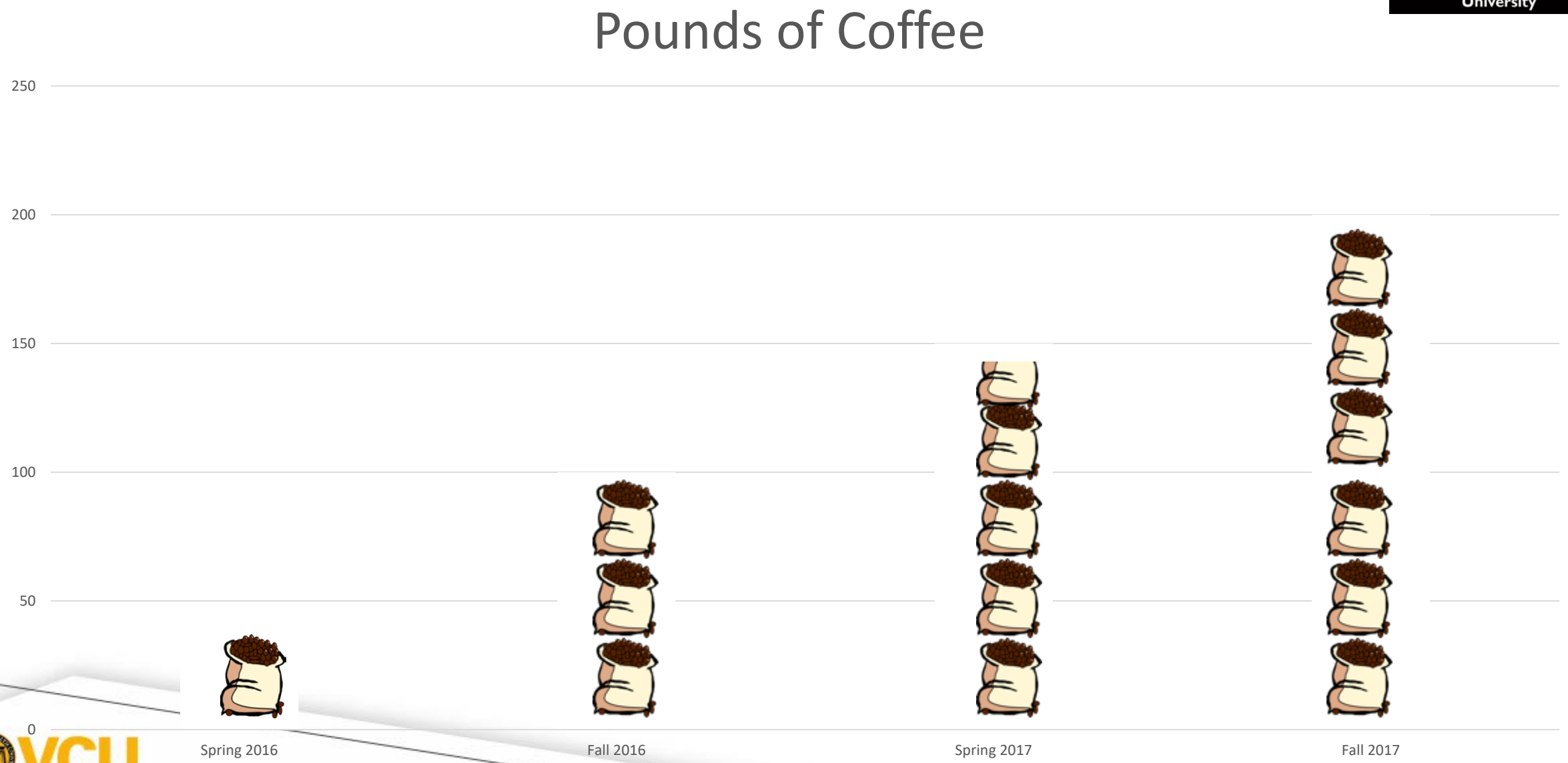
Rams in Recovery Growth 2013-17

I love you guys. Thank you, so much. Because of what you guys do, I am sober and still in school today.
-Anonymous Student Survey



Rams in Recovery Growth 2016-17



Objectives

1. Understand recovery competence as a form of cultural competence.
2. Consider ways in which what we know about physicians recovery programs might inform current practice with OUD.
3. Become familiar with different pathways of peer based recovery.

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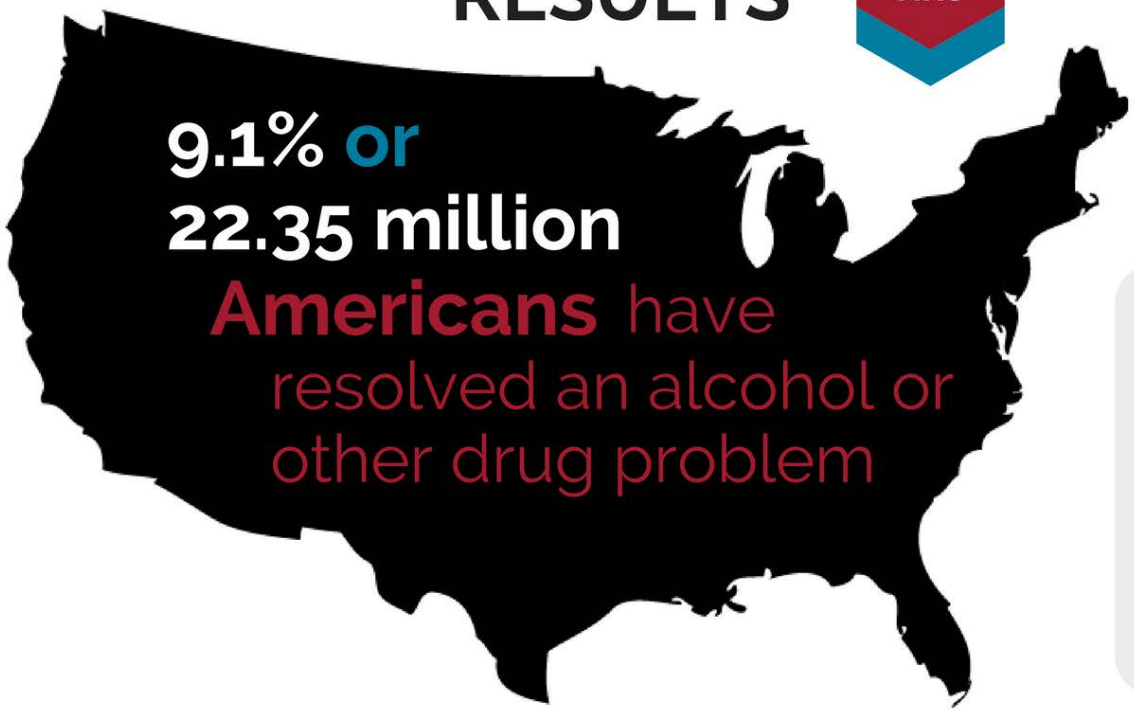
RESULTS

NRS



PRIMARY SUBSTANCE

51% alcohol
11% cannabis
10% cocaine
7% methamphetamine
5% opioid

SAMPLE

60% male, 45% aged 25-49 years of age,
61% non-Hispanic White, 14% Black, 17% Hispanic
48% employed, 46% living with family or relatives

Kelly, J. F., Greene, M. C. and Bergman, B. G. (2018), Beyond Abstinence: Changes in Indices of Quality of Life with Time in Recovery in a Nationally Representative Sample of U.S. Adults. Alcohol Clin Exp Res, 42: 770-780. doi:10.1111/acer.13604

NRS

28%

FORMAL TREATMENT

- 17% OUTPATIENT TREATMENT

9%

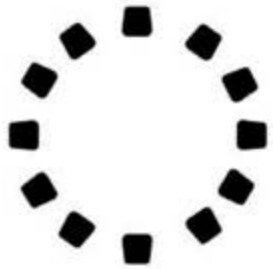
MEDICATION

Many Pathways

22%

RECOVERY SUPPORT SERVICES

- 9% FAITH-BASED
- 6% RECOVERY COMMUNITY CENTERS

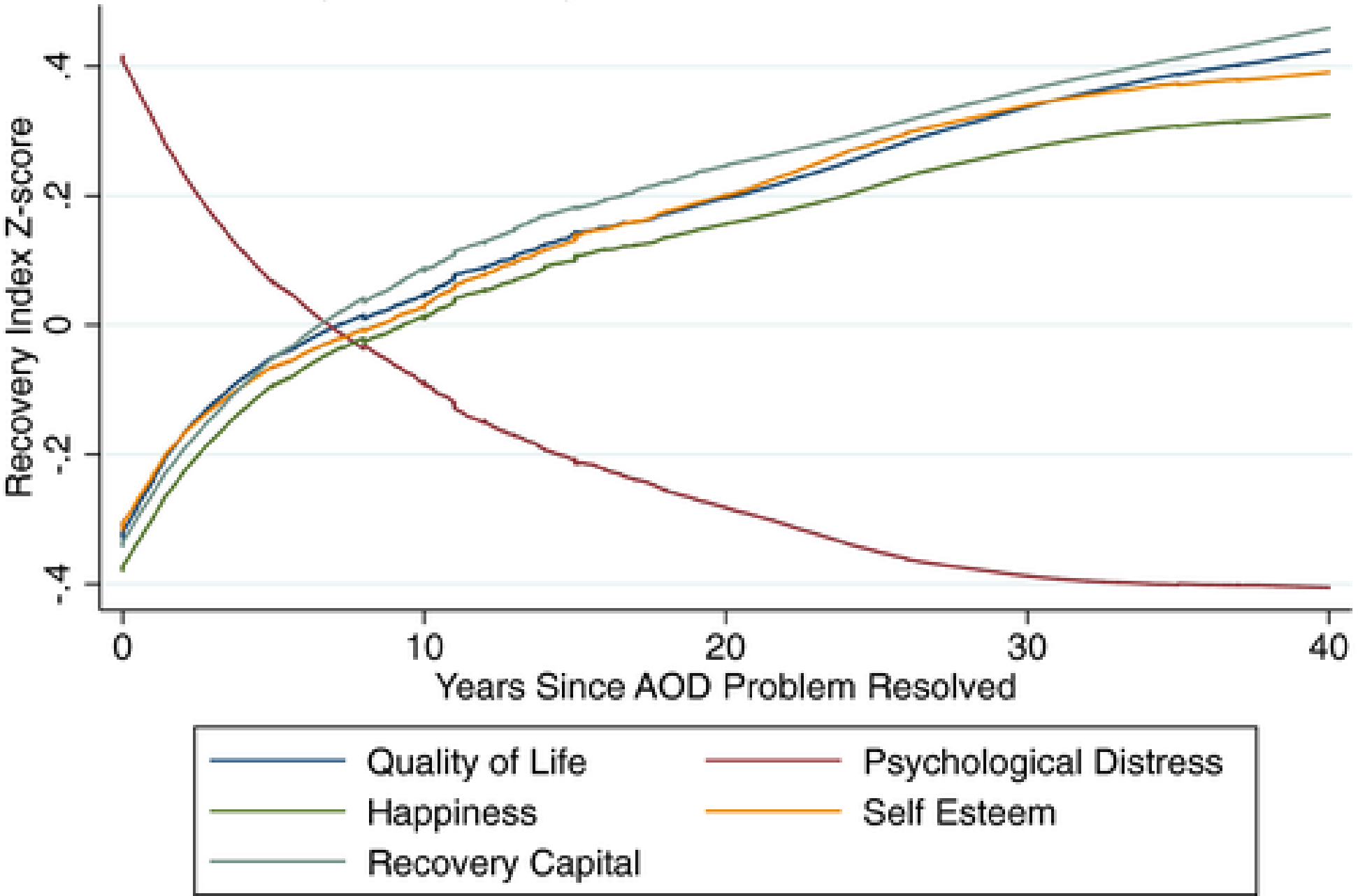


45%

SELF-HELP GROUPS

- 35% AA
- 18% NA

Recovery Indices by Years Since Problem Resolution



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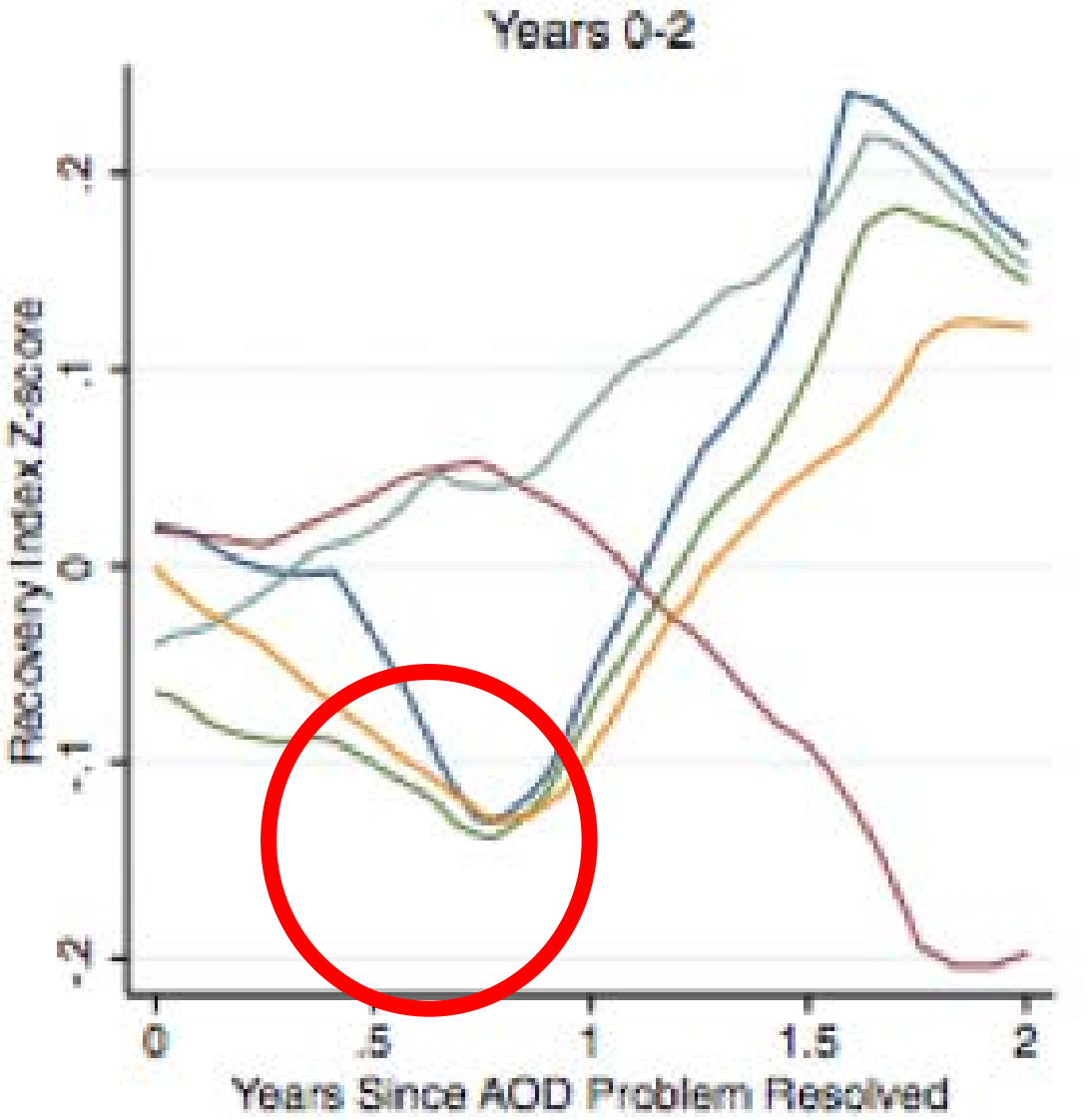
Kelly, J. F., Greene, M. C. and Bergman, B. G. (2018), Beyond Abstinence: Changes in Indices of Quality of Life with Time in Recovery in a Nationally Representative Sample of U.S. Adults. Alcohol Clin Exp Res, 42: 770-780. doi:10.1111/acer.13604

Recovery is not always smooth. Things often get worse before they get better.



Kelly, J. F., Greene, M. C. and Bergman, B. G. (2018), Beyond Abstinence: Changes in Indices of Quality of Life with Time in Recovery in a Nationally Representative Sample of U.S. Adults. Alcohol Clin Exp Res, 42: 770-780. doi:10.1111/acer.13604

November 2016

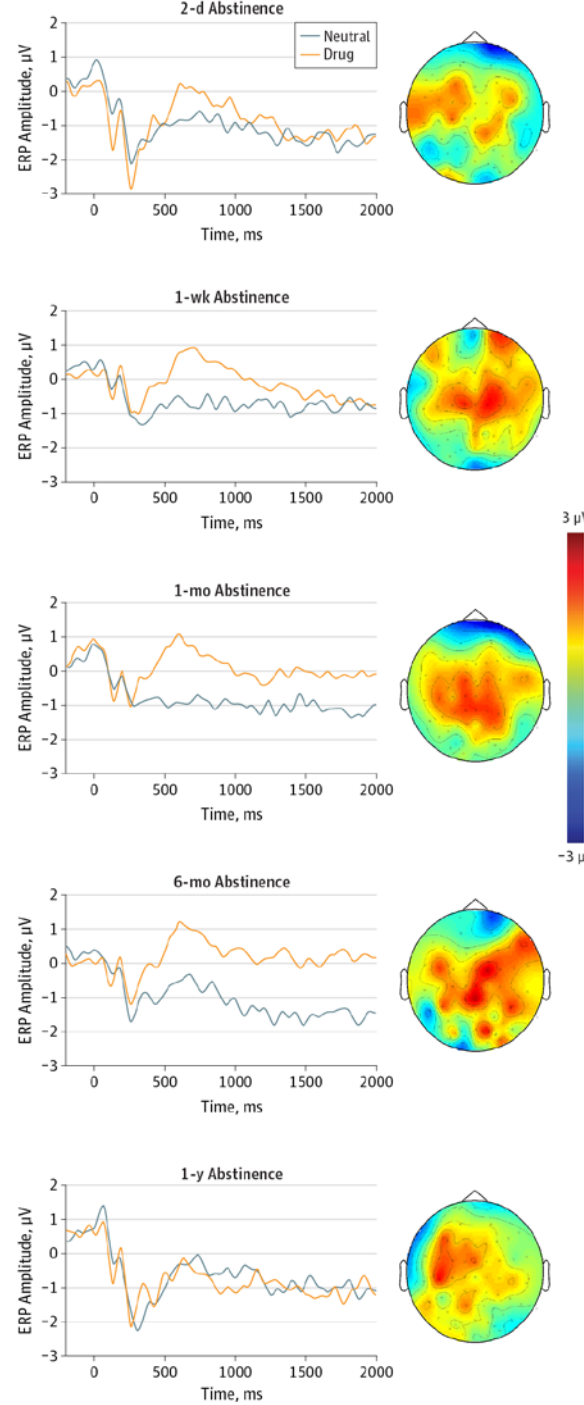
Incubation of Cue-Induced Craving in Adults Addicted to Cocaine Measured by Electroencephalography

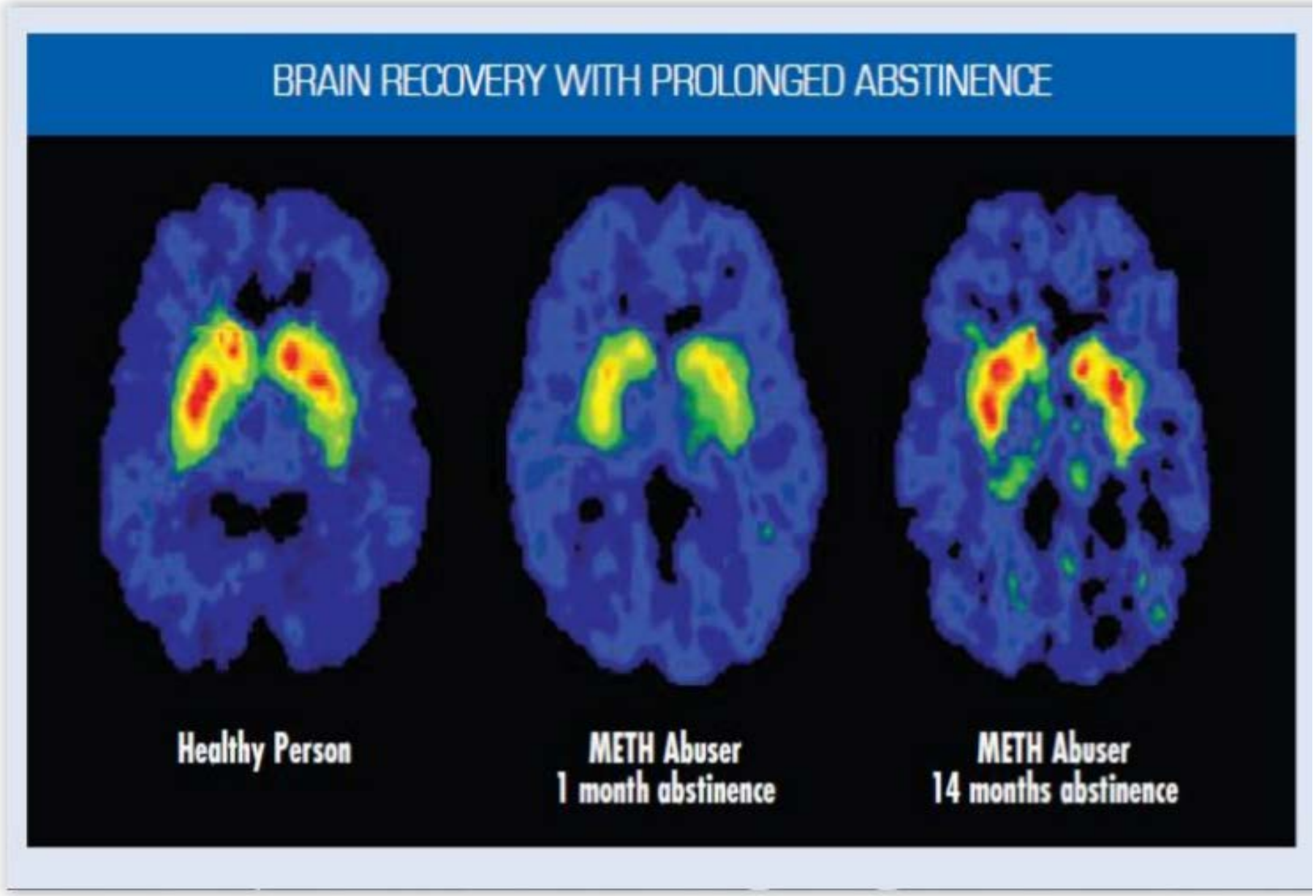
Muhammad A. Parvaz, PhD[1,2]; Scott J. Moeller, PhD[1,2]; Rita Z. Goldstein, PhD[1,2]

Author Affiliations | Article Information

JAMA Psychiatry. 2016;73(11):1127-1134. doi:10.1001/jamapsychiatry.2016.2181

Conclusions and Relevance The late positive potential responses to drug cues, indicative of motivated attention, showed a trajectory similar to that reported in animal models. In contrast, we did not detect incubation of subjective cue-induced craving. Thus, the objective electroencephalographic measure may possibly be a better indicator of vulnerability to cue-induced relapse than subjective reports of craving, although this hypothesis must be empirically tested. These results suggest the importance of deploying intervention between 1 month and 6 months of abstinence, when addicted individuals may be most vulnerable to, and perhaps least cognizant of, risk of relapse.





Volkow N et al. Loss of dopamine transporters in methamphetamine abusers recovers with protracted abstinence. *J Neuroscience* 2001;21(23):9414-9418.

Post-Acute Withdrawal Syndrome (PAWS): symptoms affecting persons in recovery

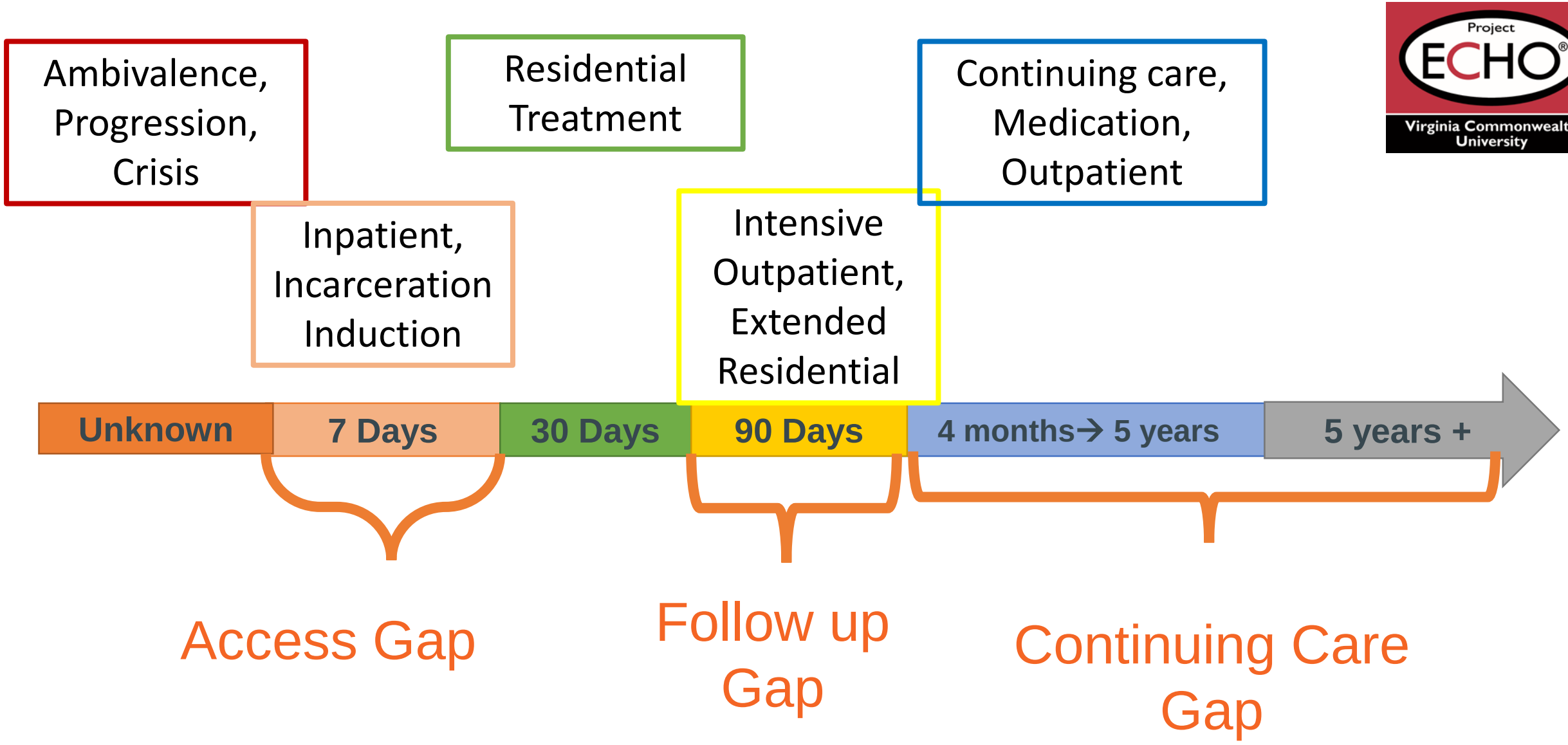
Anhedonia

Difficulty sleeping

Memory loss

Difficulty setting priorities

Stress sensitivity


Ambivalence, Progression, Crisis
Residential Treatment
Continuing care, Medication, Outpatient
Inpatient, Incarceration Induction
Intensive Outpatient, Extended Residential
Unknown
7 Days
30 Days
90 Days
4 months→ 5 years
5 years +
Access Gap
Follow up Gap
Continuing Care Gap

8 Keys to Physicians Health Programs

1. Use a motivational fulcrum
2. Share responsibility of reporting concerns with a focus on safety not punishment
3. Provide comprehensive assessment and treatment
4. Have high expectations of abstinence-based recovery

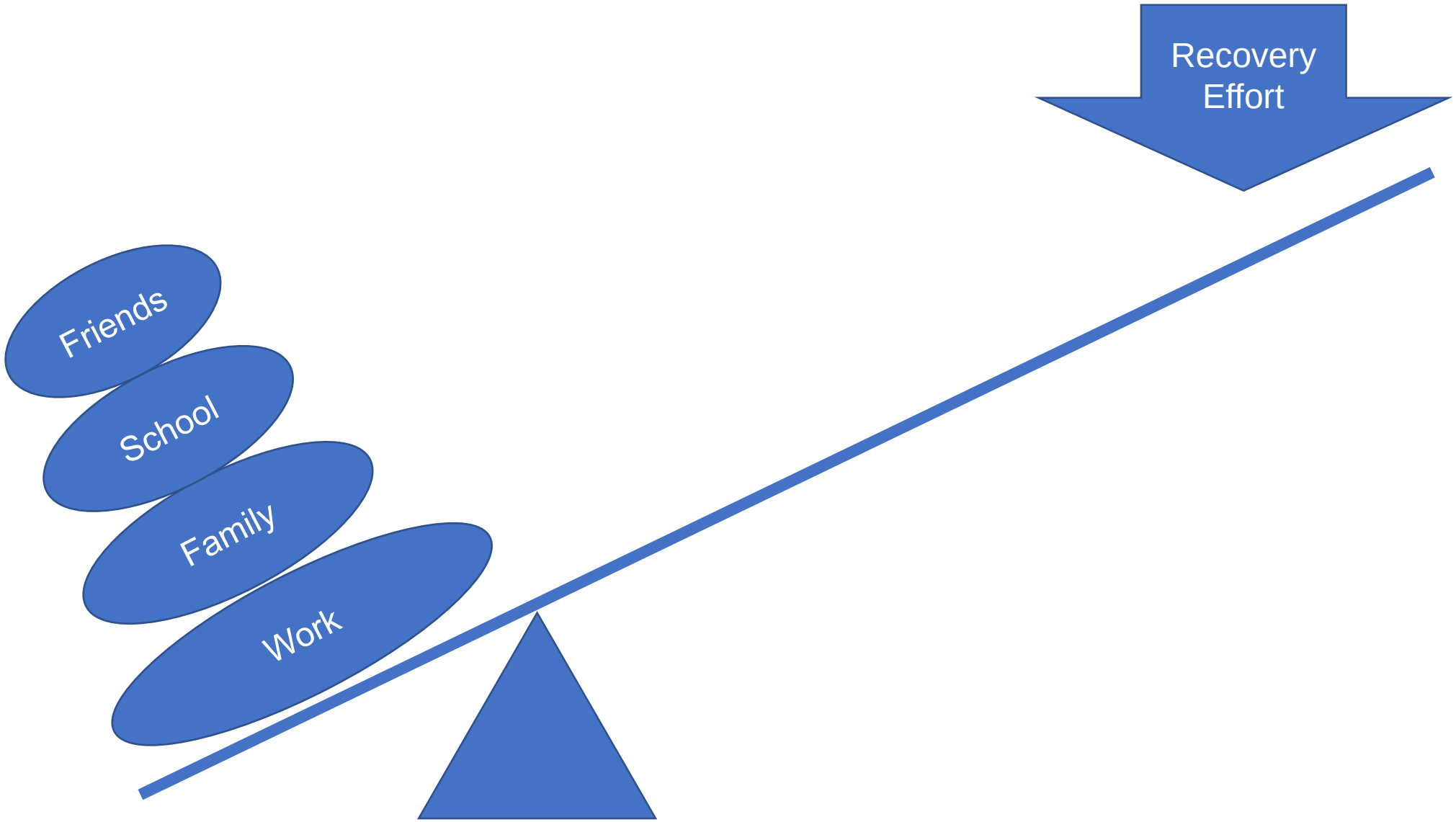
8 Keys to Physicians Health Programs

5. Assertively link to recovery support groups
6. Sustain monitoring and support
7. Re-intervene at a higher level of intensity when necessary
8. Integrate these elements and provide care management and oversight

15. The Physician Health Program: A Replicable Model of Sustained Recovery Management

Gregory E. Skipper[1] and Robert L. DuPont

(1) Medical Association of the State of Alabama, 19 S. Jackson St, Montgomery, AL 36104, USA


Recovery Effort
Friends
School
Family
Work

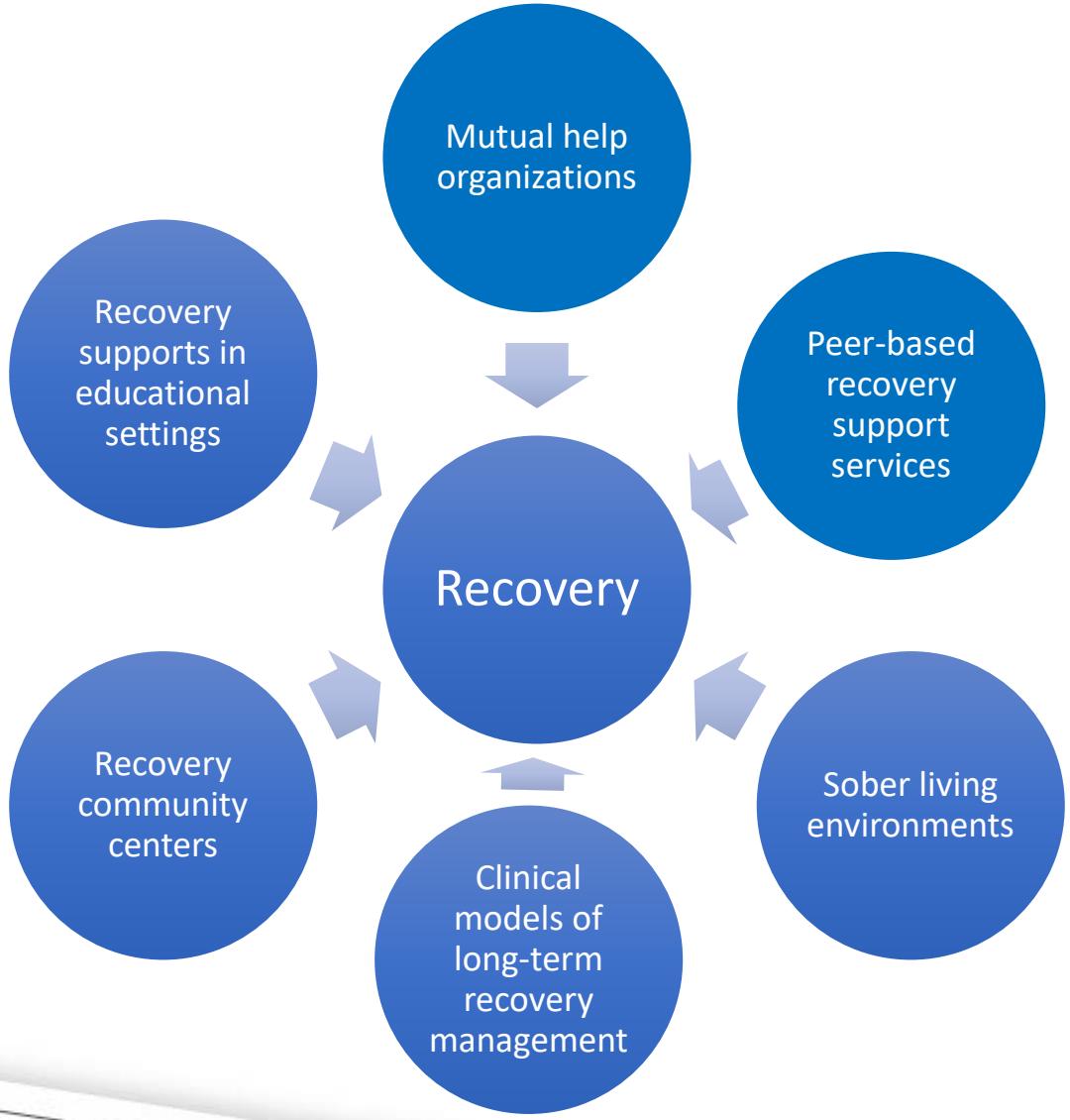
Use a motivational fulcrum

Project ECHO®
Virginia Commonwealth University

Informal, peer based & on-demand services are free and widely available

VCU

Recovery Support Services



Slides courtesy of John Kelly 2017

Mutual Aid Group Options

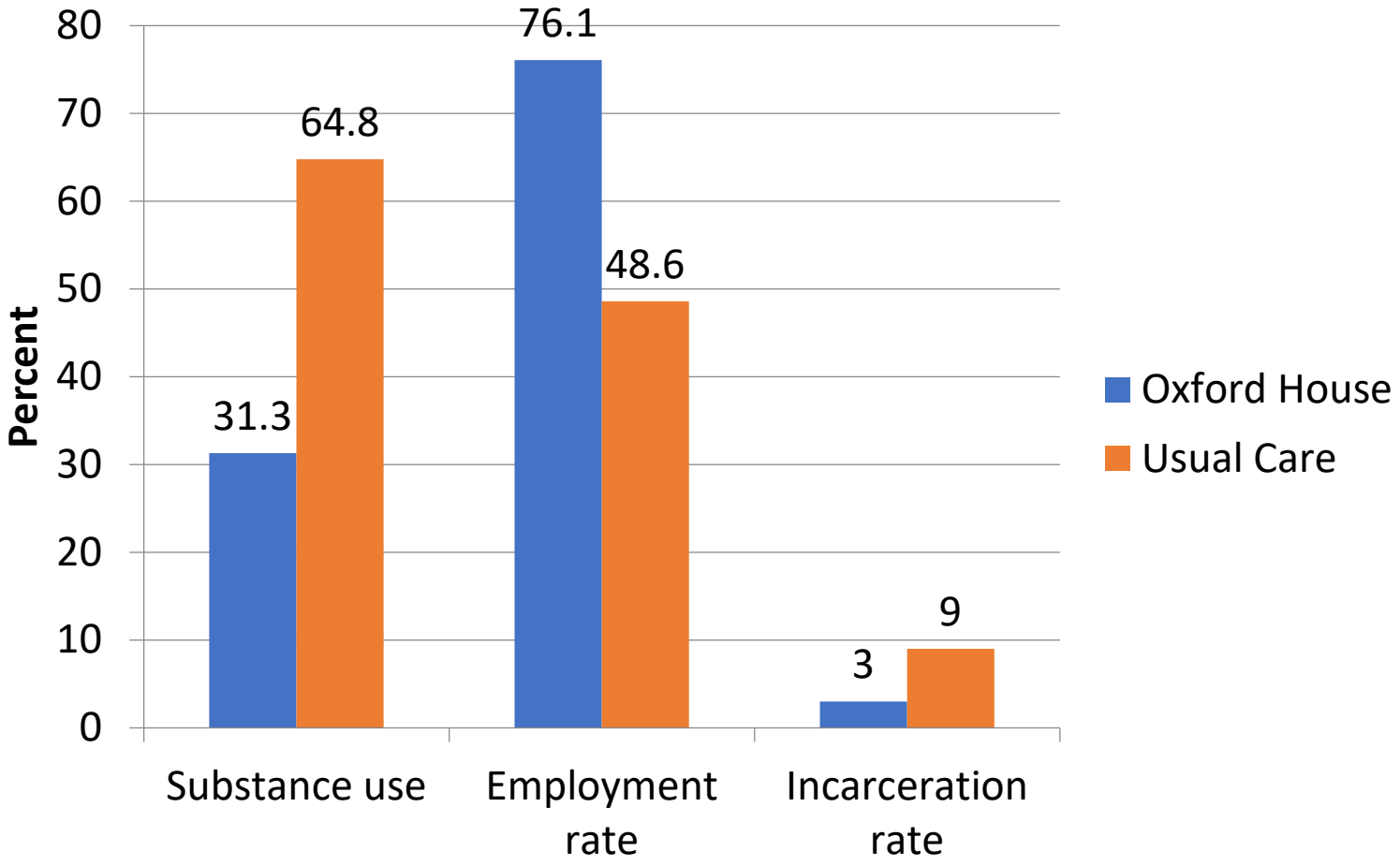
AA + NA (12 Step)

- More than 115,000 groups world wide (AA), 67,000 NA groups
- Approximately 2,000,000 AA members, Approximately 1,000,000 NA Members
- *Major challenge for some is spirituality/religiousity & demographic differences

SMART Recovery, Refuge Recovery, Life Ring

- 1500 SMART Meetings, ~150 Refuge Recovery meetings, ~600 Life Ring Meetings
- Unknown Membership size
- Celebrate Recovery and other faith based recovery ministries vary in size.

Oxford House vs. Usual Care



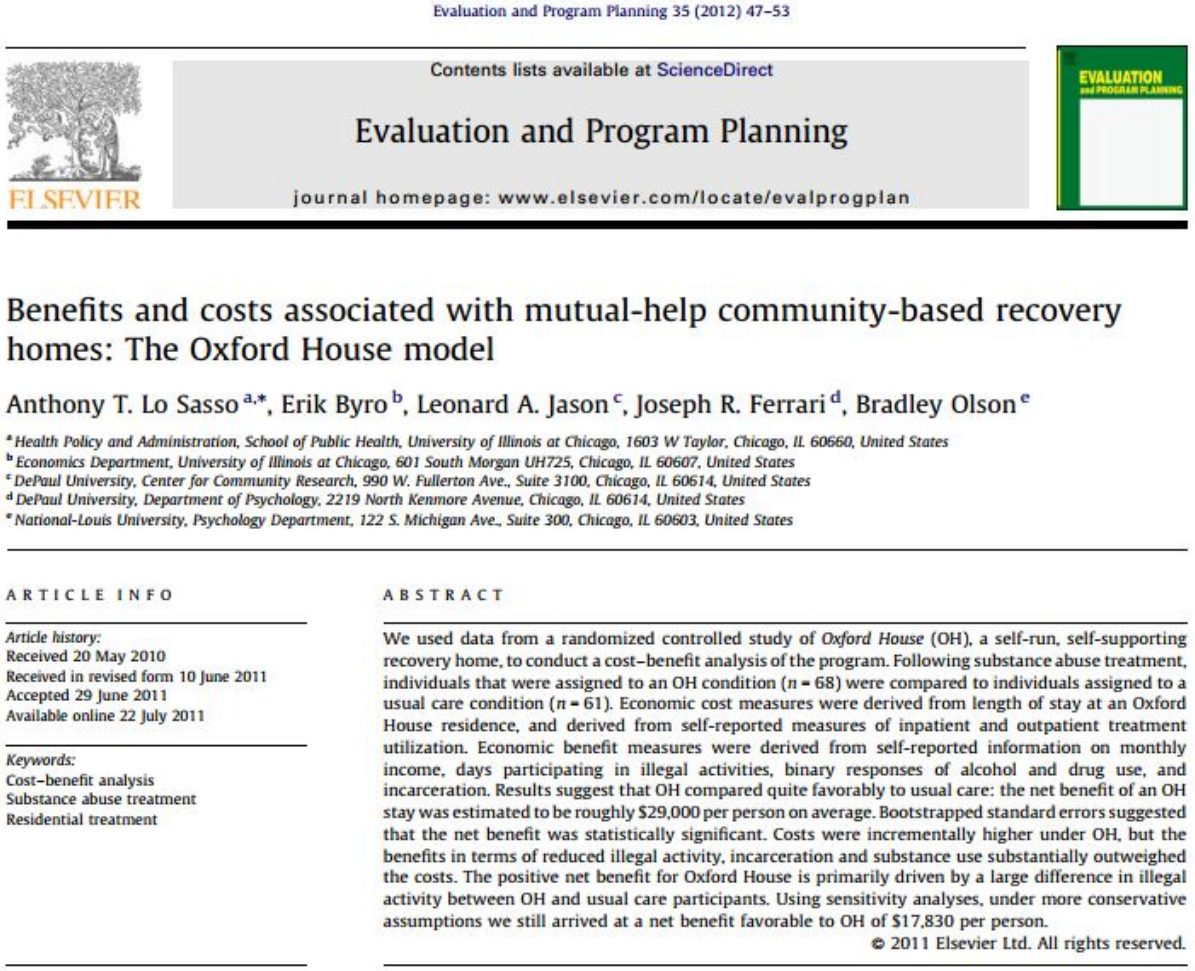
Sober living had –

- half as many individuals using substances across 2 yr follow up as usual care
- 50% more likely to be employed
- 1/3 re-incarceration rate

Slides courtesy of John Kelly 2017

Cost-benefit analysis of the Oxford House Model

- **Sample**: 129 adults leaving substance use treatment between 2002 and 2005
- **Design**: Cost-benefit analysis using RCT data
- **Intervention**: Oxford House vs. usual continuing care
- **Follow-up**: 2 years
- **Outcome**: Substance use, monthly income, incarceration rates



Evaluation and Program Planning 35 (2012) 47–53

Contents lists available at ScienceDirect

Evaluation and Program Planning

journal homepage: www.elsevier.com/locate/evalprogplan

Benefits and costs associated with mutual-help community-based recovery homes: The Oxford House model

Anthony T. Lo Sasso [a,*], Erik Byro [b], Leonard A. Jason [c], Joseph R. Ferrari [d], Bradley Olson [e]

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[b] Economics Department, University of Illinois at Chicago, 601 South Morgan UH725, Chicago, IL 60607, United States
[c] DePaul University, Center for Community Research, 990 W. Fullerton Ave., Suite 3100, Chicago, IL 60614, United States
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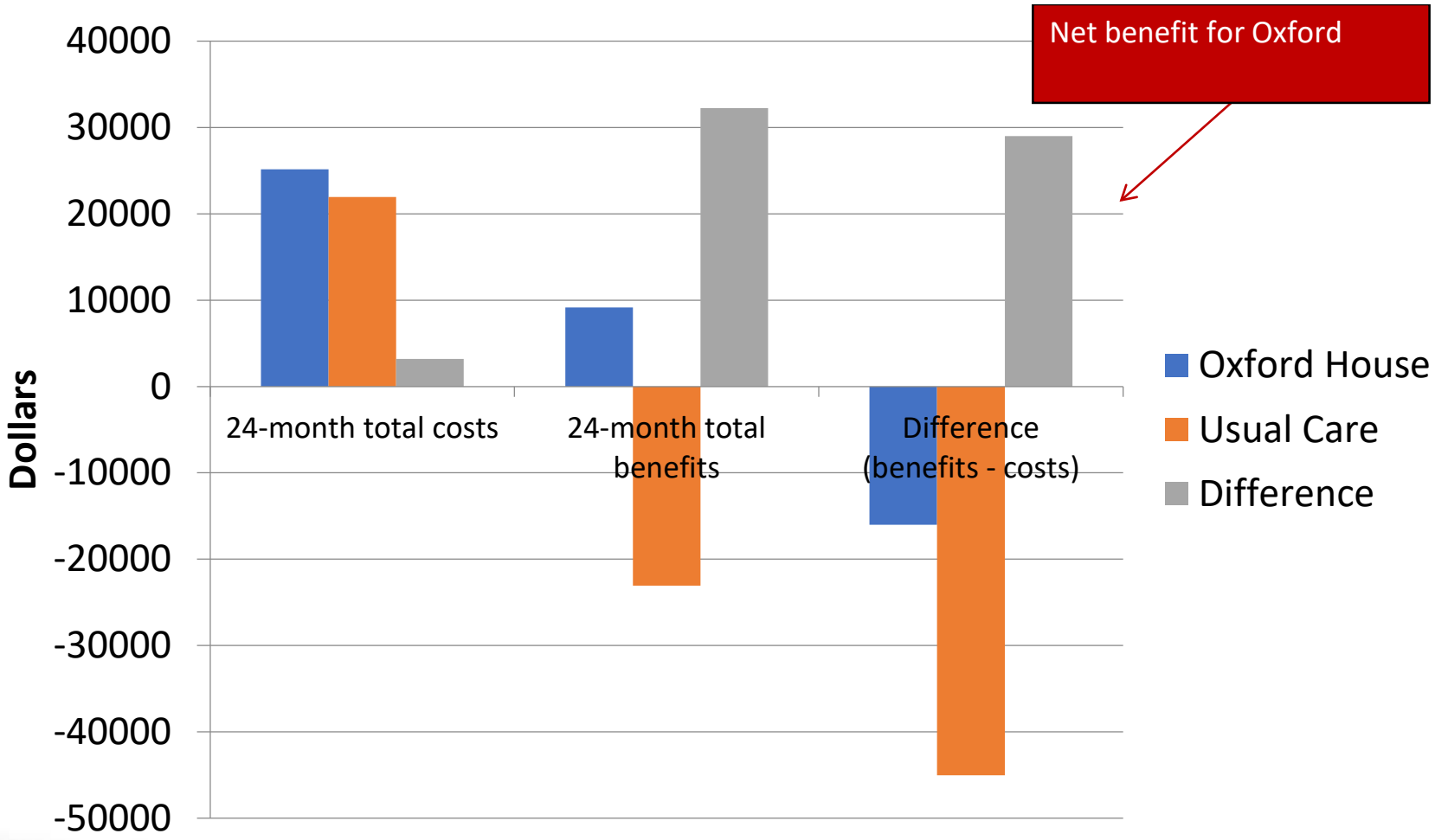
Substance abuse treatment
Residential treatment

ABSTRACT

We used data from a randomized controlled study of *Oxford House* (OH), a self-run, self-supporting recovery home, to conduct a cost–benefit analysis of the program. Following substance abuse treatment, individuals that were assigned to an OH condition ($n = 68$) were compared to individuals assigned to a usual care condition ($n = 61$). Economic cost measures were derived from length of stay at an Oxford House residence, and derived from self-reported measures of inpatient and outpatient treatment utilization. Economic benefit measures were derived from self-reported information on monthly income, days participating in illegal activities, binary responses of alcohol and drug use, and incarceration. Results suggest that OH compared quite favorably to usual care: the net benefit of an OH stay was estimated to be roughly $29,000 per person on average. Bootstrapped standard errors suggested that the net benefit was statistically significant. Costs were incrementally higher under OH, but the benefits in terms of reduced illegal activity, incarceration and substance use substantially outweighed the costs. The positive net benefit for Oxford House is primarily driven by a large difference in illegal activity between OH and usual care participants. Using sensitivity analyses, under more conservative assumptions we still arrived at a net benefit favorable to OH of $17,830 per person.

Slides courtesy of John Kelly 2017

Mean per-person societal benefits and costs



Slides courtesy of John Kelly 2017

Bottom Line

- The costs associated with Oxford House treatment are returned nearly tenfold in the form of:
  - ↓ Reduced criminal activity
  - ↓ Reduced incarceration
  - ↓ Reduced drug and alcohol use
  - ↑ Increased earnings from employment

Slides courtesy of John Kelly 2017

Recover Management Check-ups

4-year outcomes from the Early Re-Intervention experiment using Recovery Management Checkups

- N=446 adults with SUD, mean age = 38, 54% male, 85% African-American
- randomly assigned to
  - quarterly assessment only
  - quarterly assessment plus RMC
- Recovery Management Checkups
  - Linkage manager who used motivational interviewing to review the participant's substance use, discuss treatment barrier/solutions, schedule an appointment for treatment re-entry, and accompany participant through the intake
  - If participants reported no substance use in the previous quarter, the linkage manager reviewed how abstinence has changed their lives and what methods have worked to maintain abstinence

Source: Dennis & Scott (2012). Drug and Alcohol Dependence, 121, 10-17

Slides courtesy of John Kelly 2017

Recovery Management Checkups

- Participants randomized to RMC were significantly more likely than control participants to:
  - Return to treatment at all (70 vs. 51%)
  - Return to treatment sooner (by 13 months vs. 45 months)
  - Receive more treatment (1.9 vs. 1.0 admissions and 112 vs. 79 total days of treatment)

- RMC participants also:
  - Needed treatment for significantly fewer quarters (7.6 versus 8.9 quarters)
  - Had more total days of abstinence (1026 versus 932 of 1350 days)

- Outcome Monitoring plus RMC generates less in societal costs than OM alone

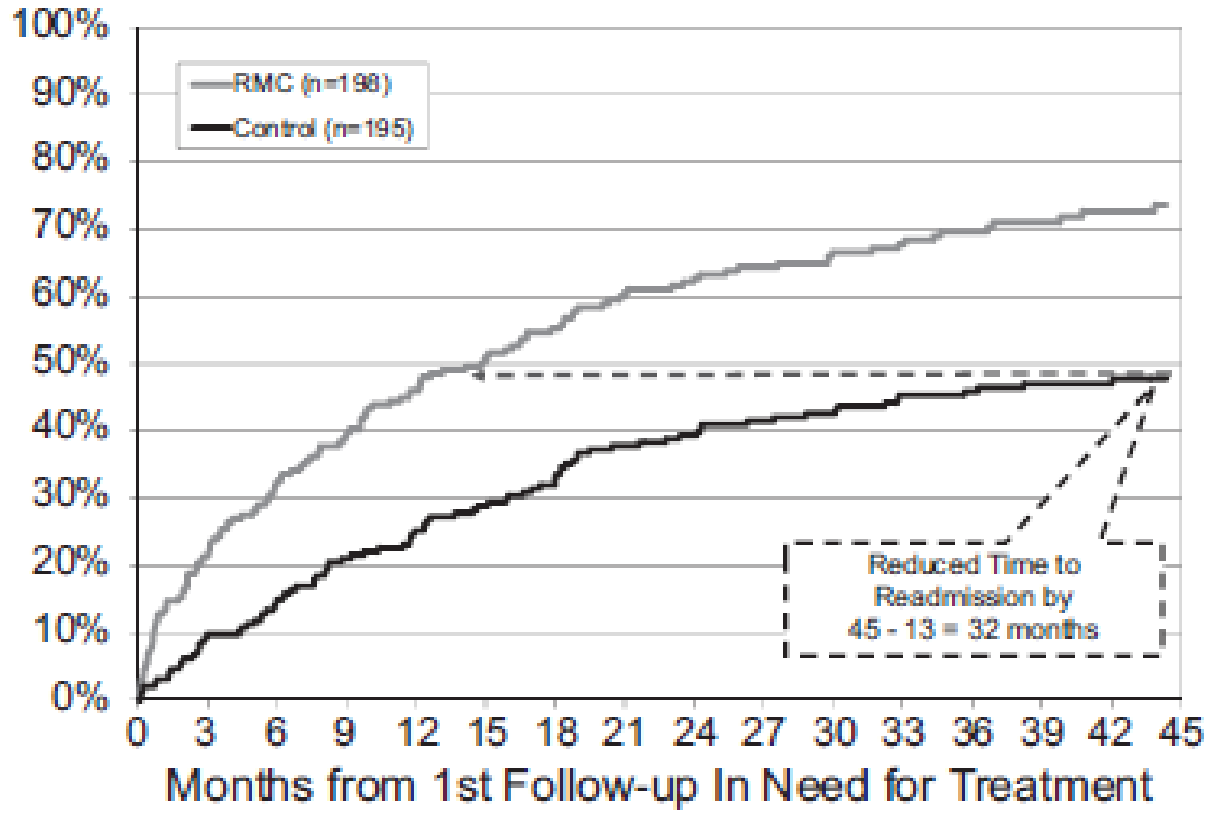
Dennis & Scott, 2012

McCollister et al., 2013

Slides courtesy of John Kelly 2017

Results 1
Return to treatment

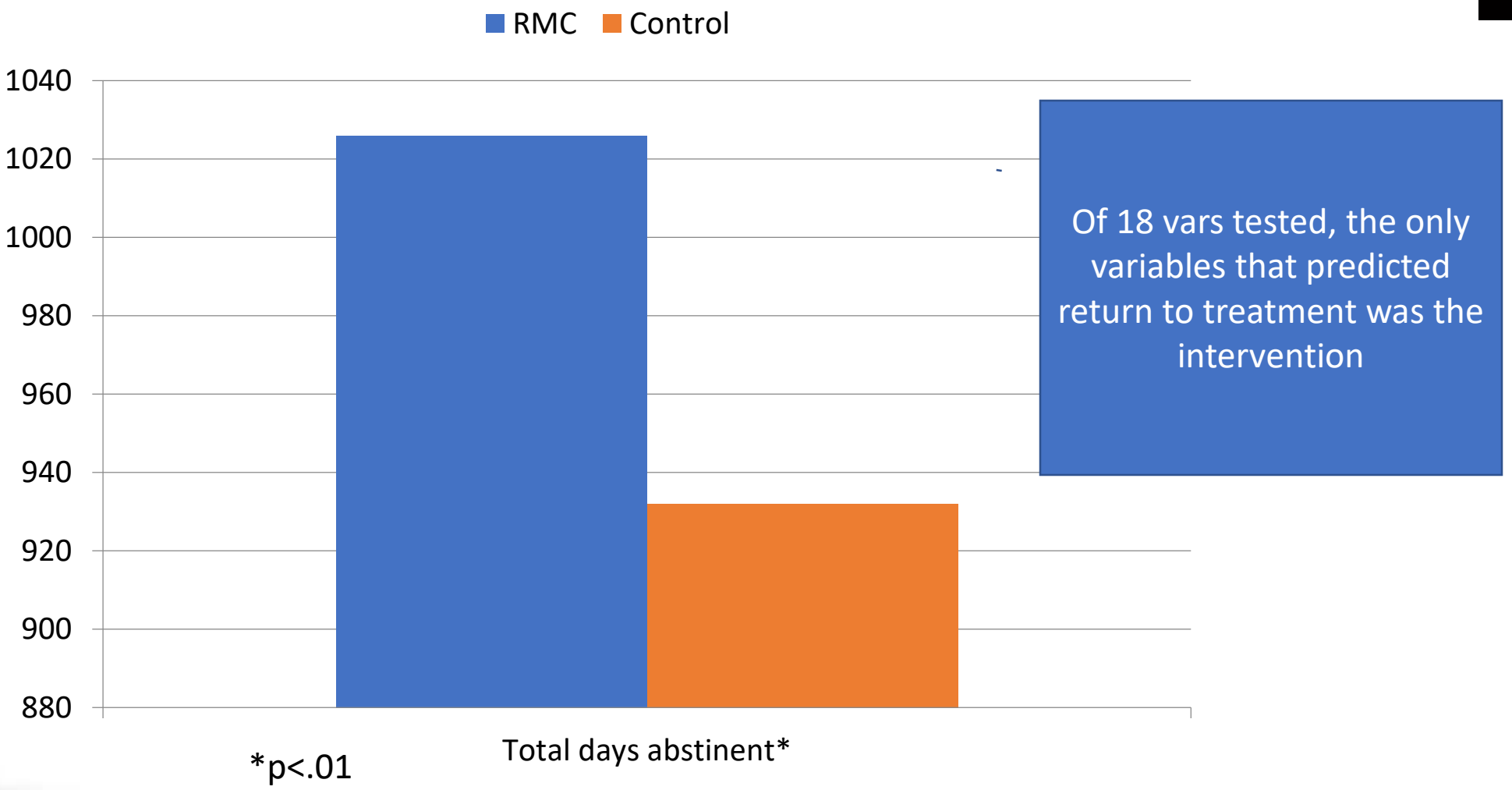
- Participants in RMC condition sig. more likely to return to treatment sooner



Source: Dennis & Scott (2012). Drug and Alcohol Dependence, 121, 10-17

Slides courtesy of John Kelly 2017

Results 4
Days abstinent (0-1350)



Of 18 vars tested, the only variables that predicted return to treatment was the intervention

*p<.01

Slides courtesy of John Kelly 2017

RCOs in the United States

There are currently more than 80 centers operating nationally

Slides courtesy of John Kelly 2017

Contact Me: Tom Bannard

Bannardtn@vcu.edu
8043668027

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?

1) What is best way to promote successful recovery in a co-dependent couple when both have opioid use disorder (and both on probation) when only one person could be retained in treatment and now suspect Suboxone diversion?
2) How to best use and interpret urine drug levels of buprenorphine/norbuprenorphine in regards to evaluating dose adherence? do levels correlate well to quantitative dose being taken?

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.)

39 yo single Caucasian female who was referred to CSB at end of 2018 by her parole officer after urine screen pos for opiates. Pt reported relapse to intranasal heroin. Had been taking "street Suboxone" when she could buy it. Patient's boyfriend - with similar history- entered treatment at same time. (He left program after 4 weeks stating he was "weaning himself off Suboxone")
Patient inducted on Suboxone 12/18. Maintenance dose 16mg daily. In March 2019 provider noted pt forgot empty packs or short several packs when counted.

Initial UDS on induction:+opiates,+THC. Urine testing after 1 week on maintenance dose Suboxone showed bup/norbup levels over 1000ng/mL. 3/19 random urine showed bup 12ng/mL and norbup 53ng/mL. Patient asked if complying with full Suboxone dose and was evasive. 4/19 UDS: +bup, +cocaine --but urine confirmation showed bup 2ng/mL, norbup 10ng/mL, creat 0. Patient again evasive about compliance but offered spontaneously that her boyfriend planned to return to the program to resume Suboxone treatment.
Patient enrolled in Suboxone Group therapy but inconsistent attendance. Frequent re-scheduled visits.

Patient had h/o heroin use beginning at age 17. Intranasal, stated no h/o IV use. Quick escalation to daily use. Abstinent for 1 yr at age 19 after participation in youth program. Treated on methadone from 2011-2015 but relapsed & left treatment. Entered residential program in 2016 w/ subseqt 8 month sobriety before relapse. Arrested at end of 2016 for petty larceny and served 1 year term.

Living with boyfriend in rented home along with her 18yo daughter.
Lost custody of 12 yo daughter with autism.
High school education, now working as a waitress.
Father died of heroin OD. Mother with heroin and cocaine use- died heart failure while pt in high school. Lived with grandparents.
Current social support include boyfriend, sister and grandparents

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

Use chat function for questions

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.)

SUBSTANCE hx: 1) heroin per above 2) marijuana beginning age 14y - uses "on and off" 3) tobacco beginning as teenager - current 1ppd. No reported h/o cocaine use
MED: 2 prior pregnancies. Children now 12 and 18. Recently obtained Medicaid w/ plan to est with PCP and discuss contraception. Hep C anti-body pos. GI referral pending.
PSYCH: h/o depression. ?bipolar d/o raised while incarcerated and treated with unknown medication. No current meds. Mother with h/o "mania" Patient hospitalized in 2015 for depression, heroin detox. Psych referral pending
MEDS: Suboxone only

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

-Multiple discussions regarding importance of honesty in recovery, increased risk of relapse with inconsistent med use, seriousness of med diversion, risk of return to jail due to current probation. Continues in individual and group therapy.

Encouraging boyfriend to return to treatment.

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

Referrals pending to PCP,GI and psychiatry
? Subblocade - haven't discussed with patient yet
?random call-backs for pack counts
? couples therapy
? information regarding co-dependent relationships

Patient states she is doing much better on Suboxone treatment with stable employment. Now able to pay off some bills. Reports significant anxiety around being on probation.

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

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

Use chat function for questions

Case Presentation #2
Diane Boyer, 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

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

Case Presentation #2
Diane Boyer, MD

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

How to address Substance induced Mood Disorder , Secondary primarily to cocaine/Crystal Meth abuse while pariticipating in Office Based Opiod Treatment recieving weekly medical apointments and individual therapy also case management -
Is anyone use the Addiction Severity Index to help guide treatment?

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.)

Rather than presenting one patient I want to discuss challenges and possible solutions in Office Based Opiod Treatment treatment for Several of our patients who also have a cocaine/Crystal Methamphetamine Use disorder. Demographics of these individuals vary in age, ethnicity, most are on medicaid and trying to work, some are on probation, some work full-time. Some have stable living situations some are in shelters, some are renting rooms where there is ample access to heroine and cocoane/Meth

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.)

opiod use disorder,
as above stimulant use disorder
some with co-occuring difficult to treat hypertension
Several who are HEp C - positive and finding it complicated to go to there Infectious Disease appointments, and to follow-up with the PCP

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

Case Presentation #2
Diane Boyer, MD

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

Weekly Medical appointments
Weekly Individual Therapy
Case management
Some have been back to residential treatment for relapse on heroine and cocaine

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

Figure out how best to support these individuals in their hard work to move towards a less chaotic life and start to experience at least momentary stability and contentment in their life
What is best treatment for Stimulant use disorder? Intensive cognitive behavioral therapy, DBT, individual or group?
Trauma therapy - More frequent Suboxone Clinic appointments? Peer Support?

Most of our consumers in this situation are trying to pay off court fines and make enough money to pay for rent. And keep from going back to jail. A big goal is to get dentistry services

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

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Submit Feedback

Opportunity to formally submit feedback

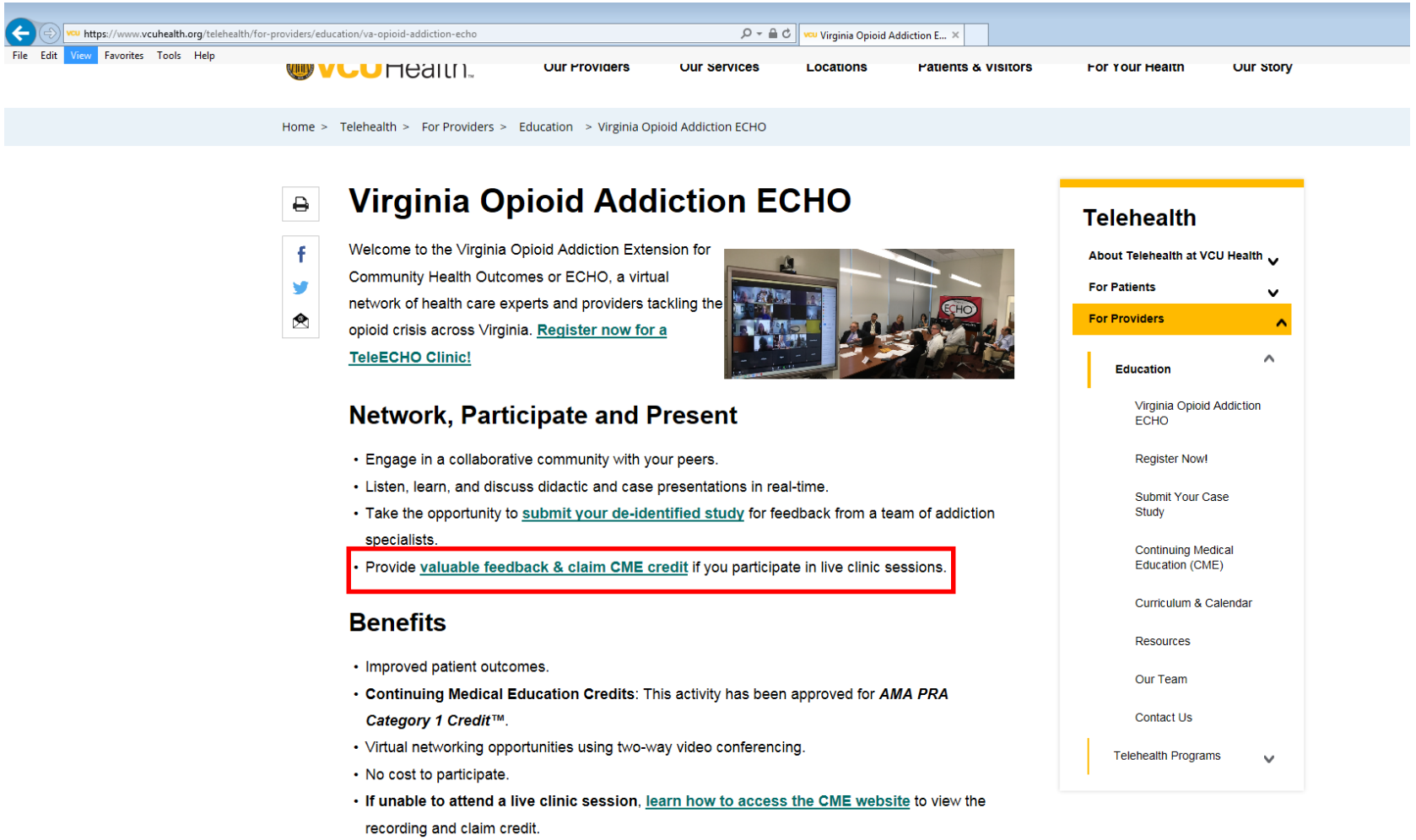
- Survey: www.vcuhealth.org/echo
- Overall feedback related to session content and flow?
- Ideas for guest speakers?

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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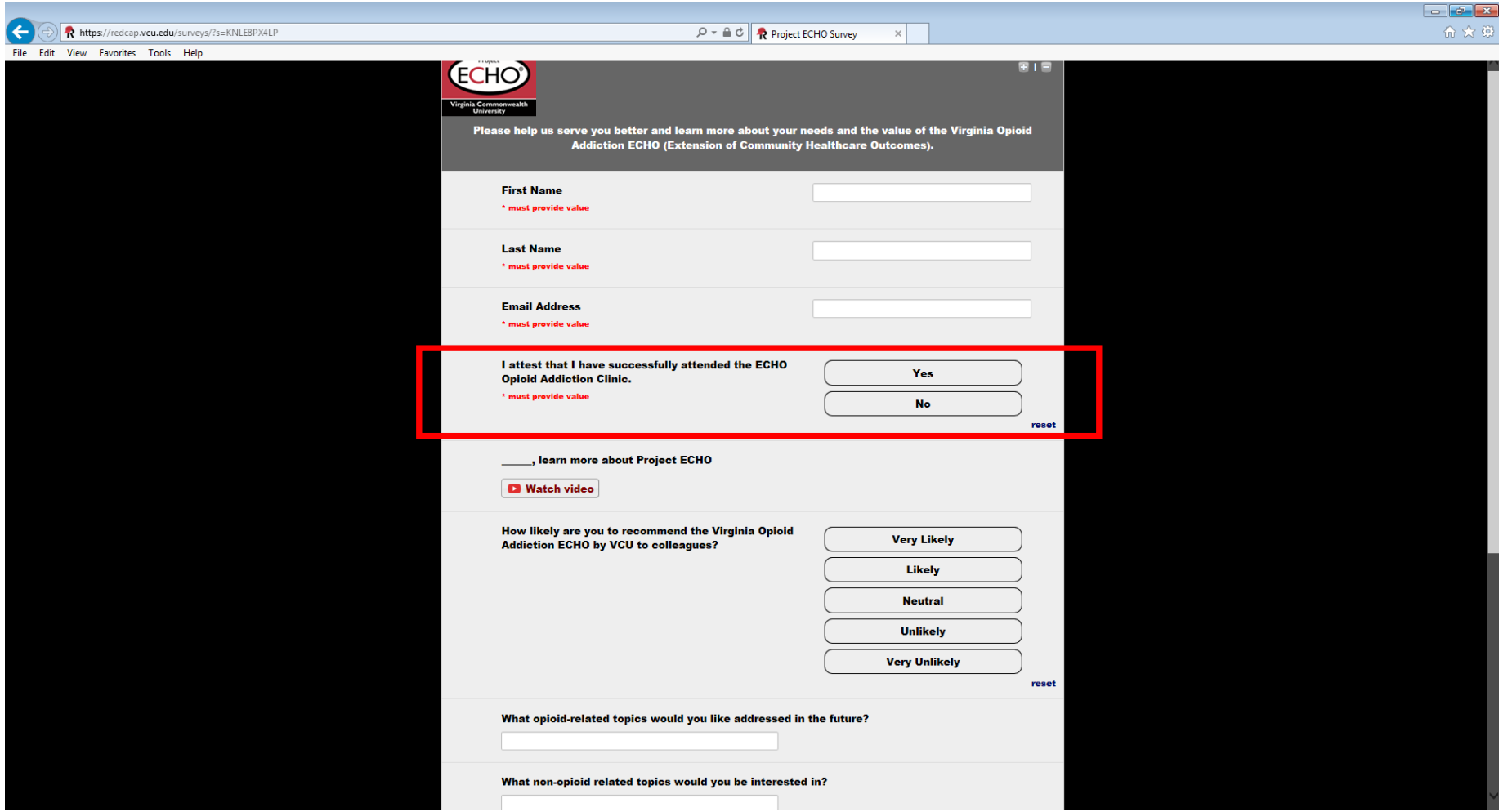
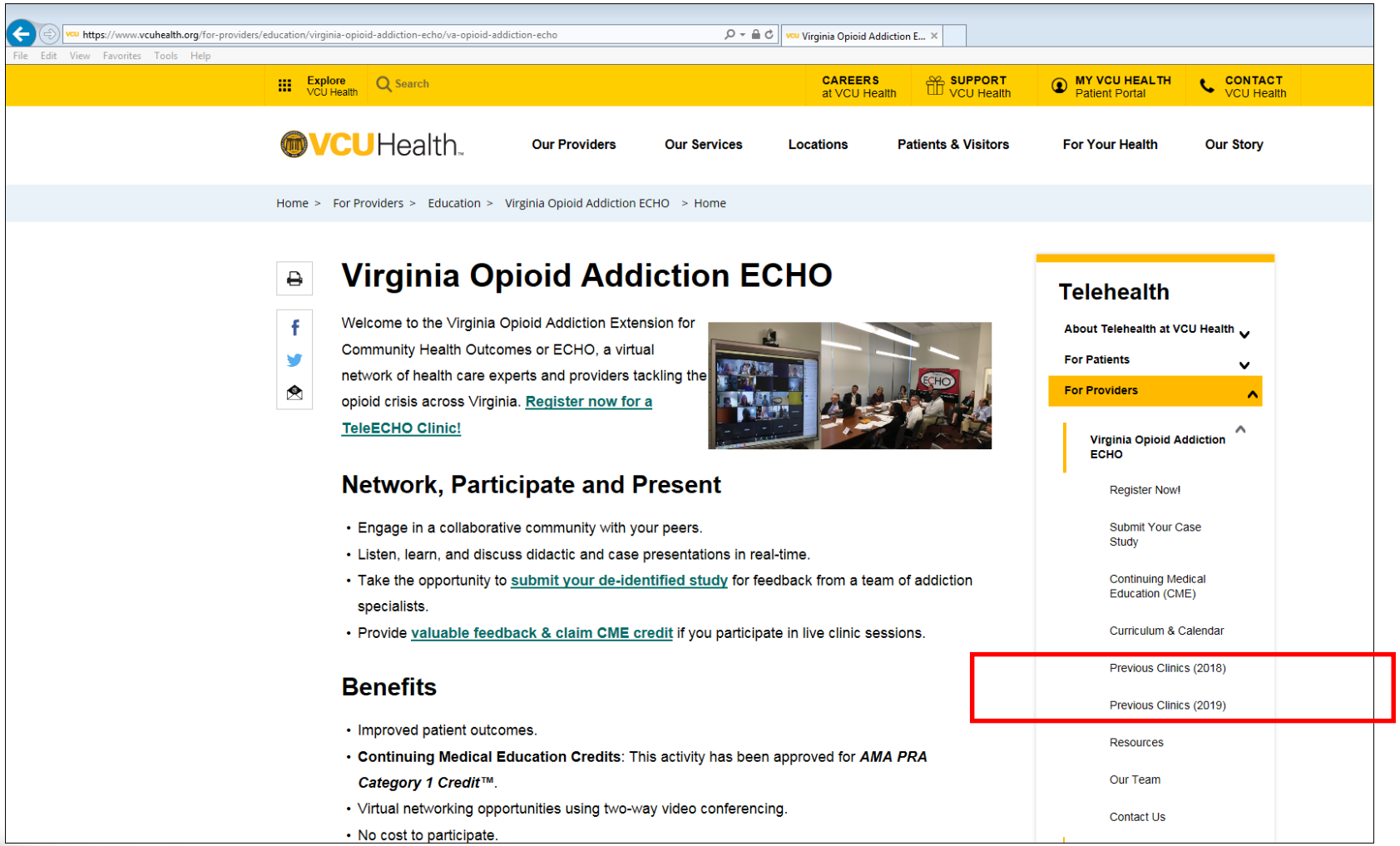


Access Your Evaluation and Claim Your CME

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

Access Your Evaluation and Claim Your CME



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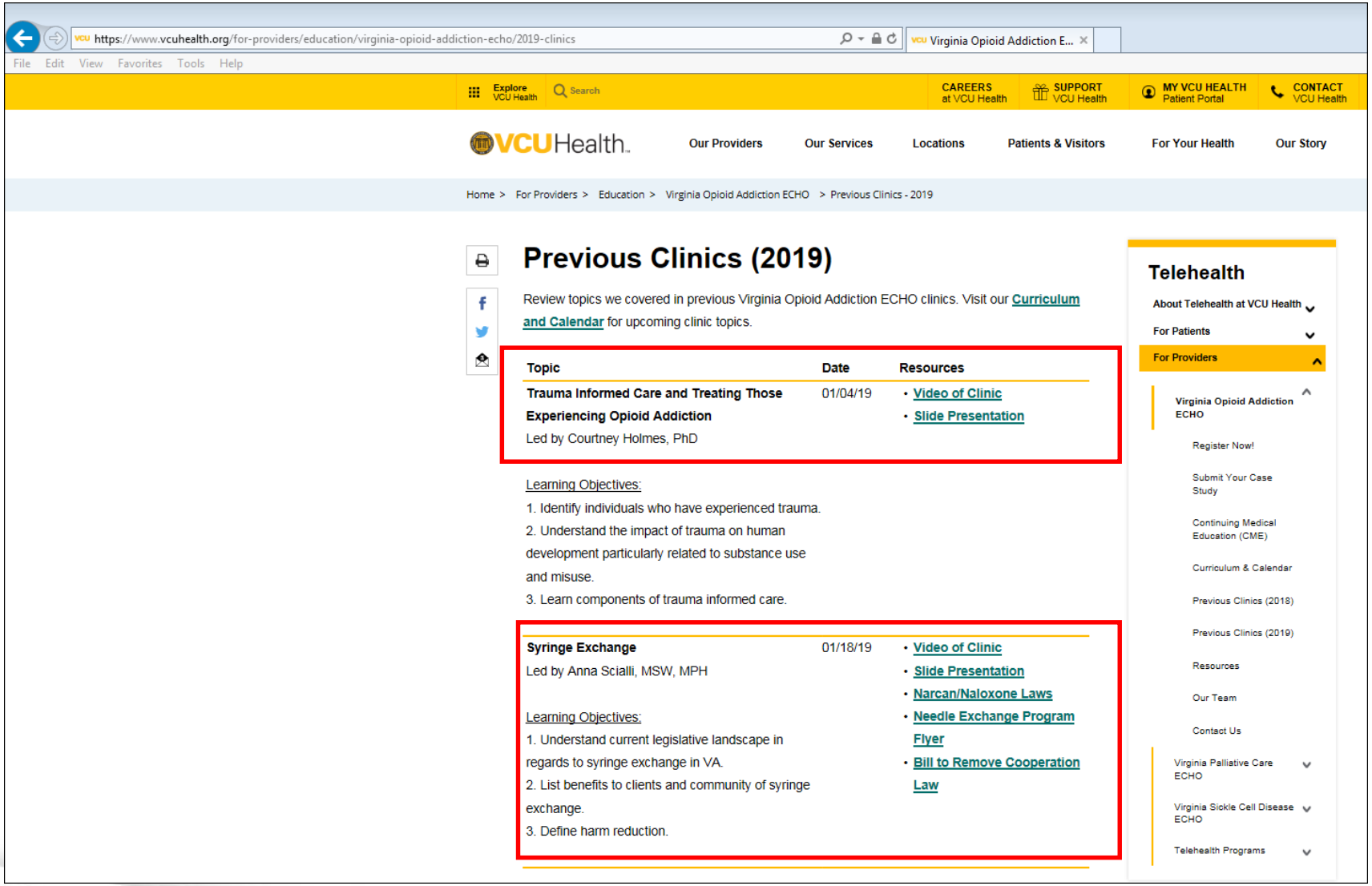

VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

Mark Your Calendar --- Upcoming Sessions

May 17: Chronic Pain Self- Management Program	Joyce Nussbaum
June 7: Relationship Centered Care and Share Decision Making	Lori Cathers, PhD
June 21: Primay Care Bootcamp: Common Medical Conditions and SUDs	Megan Lemay, MD

Please refer and register at vcuhealth.org/echo

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THANK YOU!

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

Peer Recovery Resources

1. Rams in Recovery: recovery.vcu.edu
2. Collegiate Recovery - collegiaterecovery.org
3. Quick family starting place: https://thewell.vcu.edu/recovery-support/families/
4. Recovery using Technology https://www.recoveryanswers.org/resource/recovery-technology/
5. Peer Based support platform: 7cups.com
6. App based follow up care: https://www.weconnectrecovery.com/analyze-monetize-aftercare/?gclid=CjwKCAjwk7rmBRAaEiwAhDGhxExV1AZXAHHonlIEHWZaxNuXJCf4Toc0-M5KepDiTDqNCy4HtxOWFhoCpbEQAvD_BwE
7. RVA Warm Line: https://www.saara.org/alive-rva
8. 12 step alternatives: https://www.thetemper.com/sober-communities-beyond-traditional-aa/
9. Women's Recovery: https://womensconnectshasta.com/finding-help-in-our-community/recovery-treatment-online-options/
10. Recovery 2.0 Global community on Facebook
11. For Richmond: RVA Recovery
12. Warm Line info: https://mhav.org/new-addiction-recovery-support-warm-line/
13. Recovery Research Institute: https://www.recoveryanswers.org/