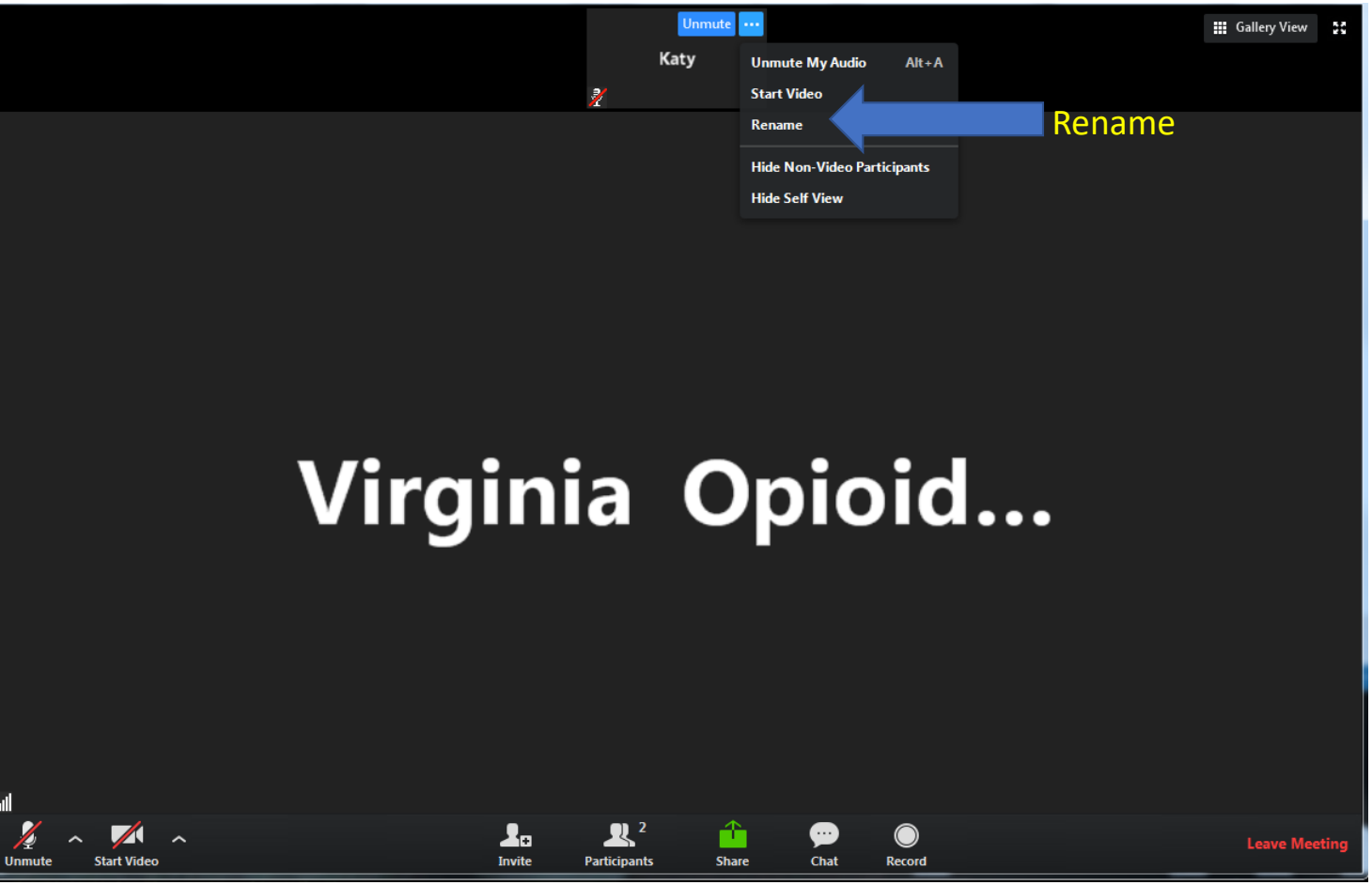
Virginia Opioid Addiction ECHO* Clinic

October 18, 2019

*ECHO: Extension of Community Healthcare Outcomes

Helpful Reminders



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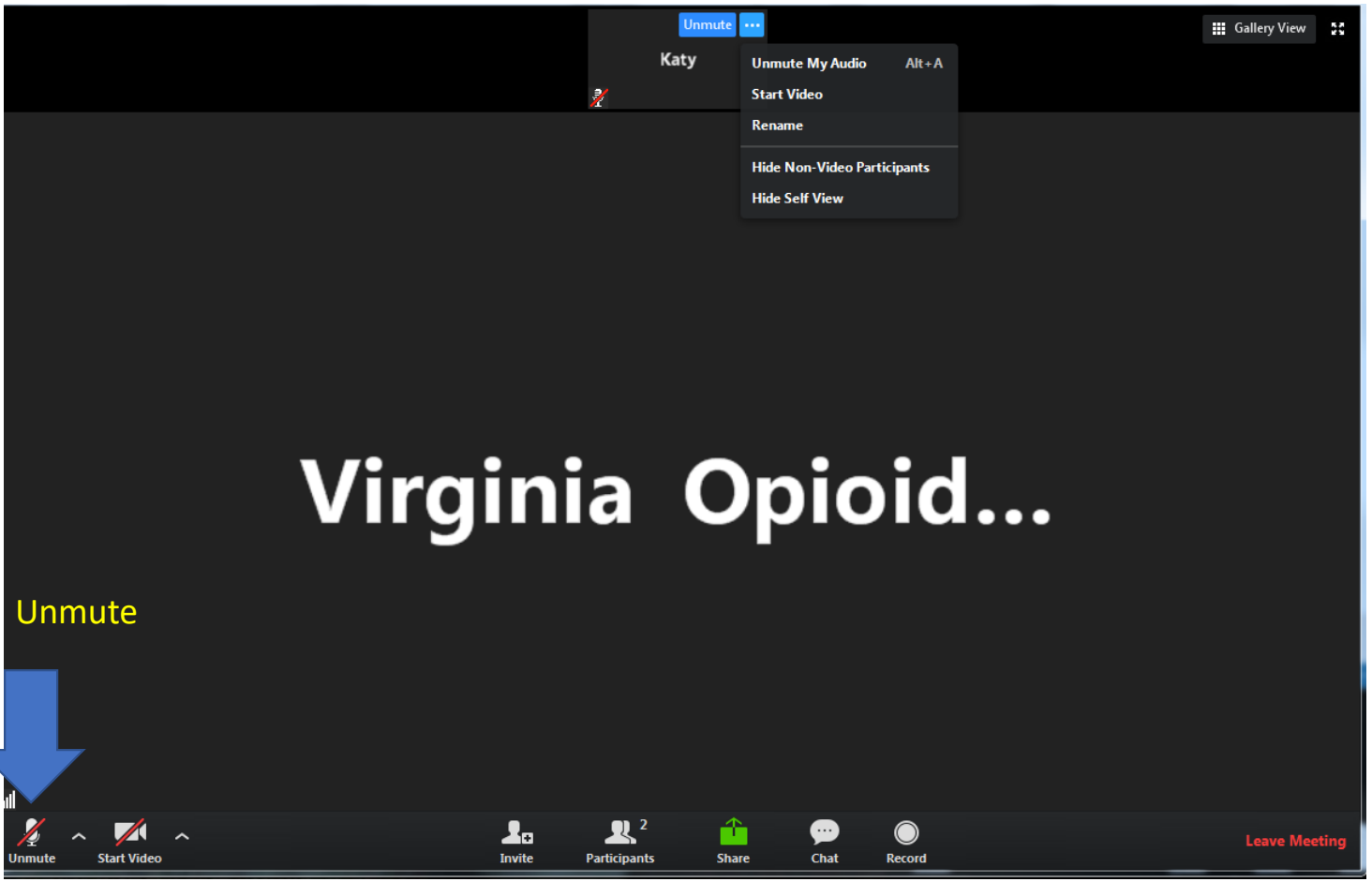
Helpful Reminders



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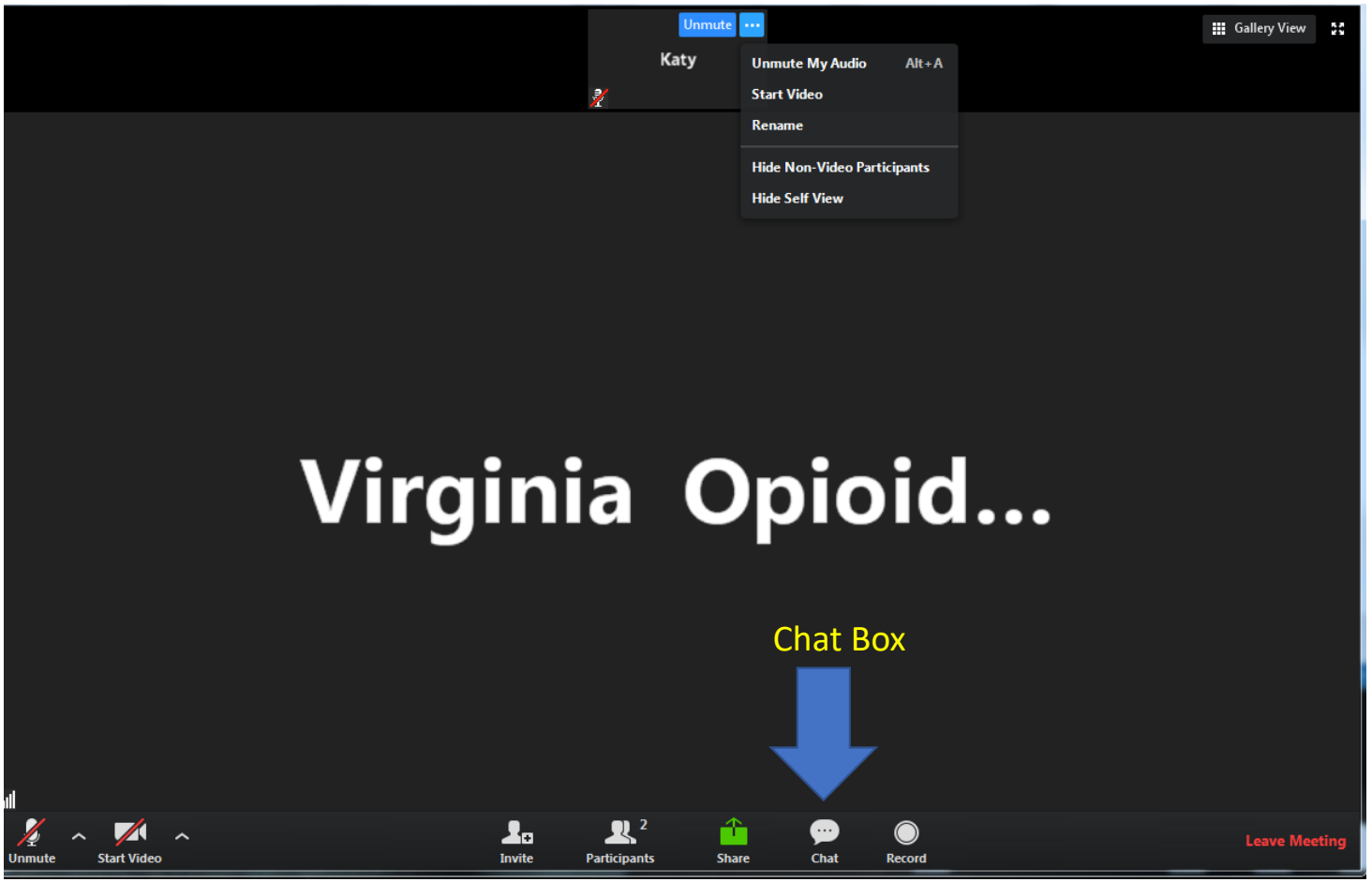
- If joining by telephone audio only, *6 to mute and unmute

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
- Website Link: www.vcuhealth.org/echo

Hub Introductions

VCU Team	
Clinical Director	Gerard Moeller, MD
Administrative Medical Director ECHO Hub and Principal Investigator	Vimal Mishra, MD, MMCi
Clinical Expert	Lori Keyser-Marcus, PhD Courtney Holmes, PhD Albert Arias, MD Kanwar Sidhu, MD
Didactic Presentation	Ben Fickenscher, MD
Program Manager	Bhakti Dave, MPH
Practice Administrator	David Collins, MHA
IT Support	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. **Chesapeake PROUD: ED Initiated MAT**
   II. **Ben Fickenscher, 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

Disclosures

Ben Fickenscher, MD: Pfizer Inc. and Portola Pharmaceuticals Inc.

There is no commercial or in-kind support for this activity.

PROUD

To offer Prevention and Recovery in Opioid Use Disorder

MEDICATION-ASSISTED TREATMENT FOR OPIOID USE DISORDER
CHESAPEAKE REGIONAL HEALTHCARE

10/24/2019

CHESAPEAKE REGIONAL HEALTHCARE

BEN FICKENSCHER MD

KURT HOOKS PH.D.

10/24/2019

CHESAPEAKE REGIONAL HEALTHCARE

Introduction

- Why CRH PROUD?
- Yale Model
- Buprenorphine/Naloxone (Suboxone)
- Protocols and Procedures
- Linkage and Partners
- Perils and Pitfalls
- Questions

CHESAPEAKE REGIONAL HEALTHCARE

Why CRH PROUD?

- Epidemic front-and-center in ED
- “Standard of Care” does not work

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MAT in the ED: Why?

- Treatment with Buprenorphine **decreases** mortality for patients with OUD
  - 50% reduction in mortality versus no treatment or psychosocial treatment alone
  - Injection Heroin users treated with Methadone or Suboxone had mortality rates of 6% compared to 25% in those without MAT
  - Mortality benefit seems INDEPENDENT OF the cessation of illicit opioid use

MAT in the ED: Yale Experience

- **Summary of the Yale ED MAT Study**
- "Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: a Randomized Clinical Trial," **JAMA 313 (April 28, 2015): 1636.**
  - **Lead Author:** Gail D'Onofrio, MD, chair, Department of Emergency Medicine, Yale New Haven Hospital
  - **Study Design:** Randomized clinical trial involving 329 opioid-dependent patients who were treated at the Yale New Haven Hospital ED from April 7, 2009, through June 25, 2013.
  - **Treatment Arms**
    - 1. Screening and referral to treatment (referral) [n = 104].
    - 2. Screening, brief intervention, and referral to community-based treatment services (brief intervention) [n = 111].
    - 3. Screening, brief intervention, ED-initiated treatment with buprenorphine/naloxone, and referral to primary care for follow-up within 72 hours

MAT in the ED: Yale Experience

- Buprenorphine regimen was 8 mg SL on the first day then 16 mg on days 2 & 3
- Buprenorphine was administered in the ED for patients in moderate to severe withdrawal. In patients with mild symptoms the three-day supply was prescribed for at-home unsupervised induction [n = 114].
- **Primary Outcome:** Enrollment in addiction treatment at 30 days.
- **Results Primary outcome:** 78% of the buprenorphine group were engaged in treatment at 30 days versus 37% in the referral group and 45% in the brief intervention group.

Buprenorphine/Naloxone

- Prescribing Laws
  - Drug Addiction Treatment Act of 2000
    - Prescribers of Buprenorphine for **Drug Addiction treatment and withdrawal** must have a special DEA "X" Waiver
    - Any provider with a normal DEA number can prescribe buprenorphine for the treatment of pain
      - Suboxone (Buprenorphine/Naloxone) and Subutex (Buprenorphine) are not approved for the treatment of pain
    - Any provider with a normal DEA number can **ADMINISTER** Buprenorphine for the treatment of addiction and withdrawal for up to 3 days
      - But cannot **PRESCRIBE**

Buprenorphine/Naloxone

- Prescribing Laws
  - Schedule III Narcotic
  - Can be electronically prescribed, called in, faxed in, etc
  - Telemedicine laws:
    - Controlled Substances Act, 21 U.S.C. §§ 802(52-54)(A): Under the Ryan Haight Act, at least one face-to-face encounter must occur before a controlled substance can be prescribed unless the encounter meets the federal definition of telemedicine. Because most EDs are registered with the DEA, this allows a buprenorphine provider to be consulted via phone or other form of communication (telemedicine) for an ED patient seen by another provider. The buprenorphine provider can then call in or fax a buprenorphine prescription

The Protocol

- Identification
- Selection
- Induction
- Discharge

Identification

- Potential candidate can be identified by anyone
- Physician
- APP
- Nurse
- Tech
- Care Manager/Social Worker
- Mental Health Screener
- Family
- Self Referral
- ESD Staff

Identification

PHYSICIAN OR APP CARING FOR PATIENT IS NOTIFIED OF POTENTIAL CANDIDATE

MAT ORDER PLACED IN EPIC

PROBING QUESTIONS AND DSM-V CRITERIA USED TO ASSESS LEVEL OF DEPENDENCE AND WILLINGNESS TO ENTER TREATMENT

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Identification

Nurse or Tech Supplies Patient with DSM-V Criteria Worksheet

Nurse or Tech Supplies Patient with Encouraging Informational Handout

Nurse, APP, or Physician gains verbal consent from patient to engage in further discussion/possible Medication Assisted Treatment

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Identification

- Nurse Enters MAT Panel Orders in EPIC:
  - Acute Hepatitis Panel
  - LFTs
  - EtOH
  - UDS

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Candidate Selection

Once LFTs, EtOH, and UDS are back:

- Potential Candidate completes COWS assessment to include Drug, Time, Route, Dose of last use
  - "Clinical Opioid Withdrawal Scale"

COWS Assesment

- Reviewed and verified with patient by Nurse
- APP/Physician notified when completed

Candidate Selection

- Physician or APP:
- Reviews COWS assessment
- Reviews the Patient Handout and answers questions
- Reviews Inclusion/Exclusion Criteria with Patient
- Obtains Patient Consent to proceed with MAT and referral for ongoing treatment and therapy

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MAT with Buprenorphine/Naloxone in the Emergency Department
Chesapeake Regional Healthcare

- **Inclusion and Exclusion Criteria**

- **Inclusion Criteria:**
  - Meets DSM-V criteria for Opioid Use Disorder
  - Desires to reduce or eliminate use of illicit opioids
  - Willing to enter long-term Suboxone maintenance therapy

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MAT with Buprenorphine/Naloxone in the Emergency Department Chesapeake Regional Healthcare

- **Exclusion Criteria:**
- History of Allergy or Adverse Reaction to Suboxone
- Unwilling/unable to not use Alcohol and/or Benzodiazepines while on Suboxone
- Comorbid diseases:
  - Chronic Pain requiring high-dose full opioid agonist medication
  - Psychiatric disease on benzodiazepine with history of misuse/abuse
- Psychiatric instability: Suicidal/Homicidal, psychotic. (Note: patients with psychiatric disease are among the most at-risk populations and may benefit most from MAT. Psychiatric illness alone should not be a contraindication)
- Inability/unwillingness to follow-up with community partners
- Pregnancy (refer to resources skilled in managing pregnant patients with OUD)
  - Precipitated withdrawal can be harmful to the fetus
- Age < 17

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Candidate Selection

- Consent
- Release of Information
- Referral Form
- Educational Materials

The Protocol

ED Induction

- If the patient has NOT recently used and is NOT in withdrawal:
  - MAT can still be beneficial to decrease the chance of relapse
  - OPTION #1: Refer to Community Partner for intake and treatment
  - OPTION #2: If immediate MAT desired:
    - 2 mg of Suboxone in the ED
    - Prescription for 4 mg of Suboxone (2, 2mg/0.5 mg tablets per day) for days 2 and 3
    - Referral to Community Partner for intake and treatment

ED Induction

- If patient is CURRENTLY using opiates and is NOT in withdrawal:
  - COWS Score of less than 8
  - OPTION #1: May wait in ED until COWS of 8 or greater and proceed with ED Induction
  - OPTION #2: May perform Induction at home
  - Patients are referred to Community Partner for Intake and Treatment no matter which OPTION is chosen

Home Induction

- Refer to Community Partner for Intake and Treatment
- May supply additional scripts as deemed necessary
  - Ibuprofen
  - Loperamide
  - Clonidine (0.1 mg q 4 prn)
  - Ondansetron
- Advise to return the ED immediately or call 911 if adverse reactions occur

ED Induction

- IF COWS score greater than 7
  - Give 4 mg of Buprenorphine
    - May give Ibuprofen, Ondansetron, Clonidine, Loperamide as necessary
  - Reassess in 1 to 2 hours
  - If withdrawal symptoms persist, repeat 4 mg dose
  - May repeat up to 16 mg
  - Prescriptions supplied
    - Four (4) 8mg/2mg Tablets of Buprenorphine/Naloxone used as per Home Induction Protocol for Day #2 and #3
    - Adjunctive prescriptions as deemed necessary
  - Refer to Community Partner

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Referral Procedure

- Patient is determined to meet inclusion criteria
- Induction procedure and related patient education
- Patient is counseled as to available service providers and matched based upon treatment service matching severity of need, in addition to:
  - Geographical, Financial, Transportation and client preference considerations
- ED initiates the preferred referral procedure of the selected provider
- Patient is met by CIBH peer provider as available, to assist with follow-up and transition

Media and P.R.

- Press Release
- Press Conference
  - DMAS
  - DBHDS
  - Partners
  - HROWG
  - Governor's office
  - Other Key Stakeholders

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Perils and Pitfalls

Perils

- Precipitated Withdrawal
- Suboxone Seeking
- ED as ongoing provider
- “Right” vs Service Option
- Complex Workflow

Pitfalls

- Medicaid Suboxone coverage
- X-Waiver issues
- Referral Partner fails
- Under-dosing

QUESTIONS?

BAFICKENSCHER@GMAIL.COM

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Case Presentation #1
Diane Boyer and Collete Neary

- 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

Case Presentation #1

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

In need of help in working with someone with a needle fixation. wondering if others have been working with a patient with needle fixation and what has worked and what has not. He is using his Suboxone as prescribed and not having cravings for heroine or any other substance Is Wellbutrin a safe choice for one with a needle fixation who has used heroine and cocaine in speedball method and started using Meth.

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.)

This patients is a 39 yo Caucasian male, legal charges as teenager, in detention, emancipated before 18 yo, completed GED, has worked doing construction and in food service. Is currently homeless after loosing be at shelter after being released from Prison. Preparing to enter residential rehab. Has no friends, has family (parents, sibling) about three hours away and feel they are his social support - has not seen them in years, contacts by phone intermittently. Has good working relationship with his boss in food service

Reminder: Mute and Unmute to talk
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Case Presentation #1

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.)

court ordered into treatment as teenager and seen either by a PCP or psychiatrist. Past medication trails included:
XANAX - it put him to sleep - and did not take anymore
Prozac, Zoloft - For a couple of weeks and he stopped taking it.
Vistaril - can't remember
Wellbutrin - only took for a little while
He feels there may have been more but her cannot remember he feels he has not been on Seroquel or Depakote or Lithium.
Clonidine - helpful with detox
Phenobarbital, Ultram, Quinine - For detox - Virginia Beach Detox
He did not want to be on medication.
He denies hx ov childhood He denies a history of trauma or abuse

Recent Psych hospitalization for Suicidal thoughts while wanting to stop using heroine and cocaine- shortly before entering OBOT
. Opioid use disorder (heroin, dependence)
Stimulant use disorder (cocaine, and less so Methamphetamine abuse)
Alcohol use disorder, mild
Residential Rehabilitation six times
Has had Hepatitis C treatment set up but could not complete due to returning to prison
Has not been willing to set up evaluation of current Hep C status due to need to work to be able to by a van and obtain housing
Is followed by Orthopedics for clavicle separation and receives cortisone injections q 3 months

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Case Presentation #1

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

He has been successful with Suboxone treatment - 3, 8mg/2,g sublingual film daily - never misses and appointment. Is engaging in weekly therapy, needs to start a group, had been relapsing on cocaine about every two weeks. More recently came in with numerous track marks on forearms and calves after using up cocaine while unsuccessfully finding veins and bought Meth. He is entering residential treatment. He agreed to try Lamictal to help with sleep. He does not like cocaine or meth and started talking about realizing he has an addiction to needles

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

Will continue to work with him while he is in residential treatment where he will get help with MD appointments , housing voucher for a place to live and he has his food service job waiting for him when he is ready to leave residential treatment
Will continue current Suboxone dosing, continue to titrate up on Lamictal according to patient response
Will discuss with therapist in residential treatment diagnosis of needle fixation

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Other relevant information

Have access to psychologist at local University hospital who work with individuals for treatment that includes improving adjustment to, and coping with, emotional and behavioral demands of acute, chronic, and life-threatening medical problems, Wishing there could be some sort of supervision/collaboration set up between University behavioral medicine psychologists and therapists in OBOT program

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End of Case Study

Case Presentation #2
Sunny Kim, NP

- 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

Case Presentation #2

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

I am holding a hot potato and no one wants to take it from me - managing pain in midst of opioid epidemic.

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.)

53 yo Caucasian female patient with high school diploma. Pt was a house wife all her life. Currently lives with her husband in Richmond. Two adult children all independent. No history of opioid or illicit substance use before the surgical complications

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

Case Presentation #2

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.)

Complicated surgical history started after gastric bypass in 2003

2015 Ischemic colitis resulted colectomy in January and ileostomy creation in May
2016 Total pancreatectomy with islet auto transplantation December
2017 Small bowel perforation December complicated with enterocutaneous fistula was on TPN until March 2018

July 2018 Gastric surgeon referred pt to pain management service. Nothing done by pain management then referred to MOTIVATE clinic. First seen in August 2018 by MOTIVATE provider who is a surgeon and determined that pt does not meet criteria for opioid use disorder. Started prescribing 2mg of hydromorphone every 6 hrs for pain management

Pt did not follow up with the other MOTIVATE provider and I ended up seeing her the second visit because she ran our of her hydromorphone 1 wk early. Called the other provider and discussed the plan. I was asked to continue with higher dose of hydromorphone. Hydromorphone increased to 4 mg every 6 hrs I was told that the plan is to continue hydromorphone to provide pain management until her fistula is repaired surgically.

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

Pt repeatedly going in and out of inpt service caused by severe abdominal pain due to obstruction. Pain minimally managed even with hydromorphone.

October 2018 (2 months after initial visit) surgery is still not done and the other provider attempts to transition pt to oxycodone but unsuccessful. He also attempt to transition pt to buprenorphine but also unsuccessful. Pt refuses patches (fentanyl, buprenorphine) as she had bad experiences in the past. Pt endorses that hydromorphone is the only opioid that works for her and the other provider increases dose to 8 mg every 4 hrs.

Case Presentation #2

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

December 2019 (4 months after initial visit) first fistula repair done but pt was told that she will need multiple surgeries on her fistula. No change on pain. Surgeons told pt that MOTIVATE will continue pain management. Hydromorphone 8 mg every 4 hrs continued

February 2019 (6 months after initial visit) Hydromorphone 8 mg every 4 hrs continued and surgical repair not done due to her poor albumin level. Pt continue going in and out of the hospital for abdominal pain caused by obstruction. The provider who completed initial assessment exiting the MOTIVATE and drops his working hours. I started seeing pt. pt started running out of hydromorphone early. Suggested pain log, appointment with pain psychologist but pt does not follow through.

June 2019 (10 months after initial visit) the other provider exited the clinic completely. Now I am acting as a primary provider. pt reevaluate by Dr. Arias. UDS never been positive for other substances +tolerance/withdrawal but still does not meet OUD diagnosis. Recommended to continue hydromorphone 8 mg every 4 hrs for now.

July 2019 (11 months after initial visit) spoke to her new gastric surgeon. The gastric surgeon reveals that pt is not compliant with the surgical team's requirement - refuses to be on TPN, sneaks out of her room while she is under NPO to eat at the cafeteria, refuses opioid desensitization with ketamin, and husband enables pt to refuse these suggestions. The surgeon also points out that pt is possibly avoiding these recommendations out of fear because all of her surgeries came with multiple complications. Agreed to explore options for opioid induce constipation to lessen her bowel obstruction, explore treatment for possible anxiety issues and to explore methadone and buprenorphine transition.

August 2019 (12 months after initial visit). We agreed to continue her hydromorphone 8 mg every 4 hrs while looking into methyl naltrexone. Pt also started looking for a second opinion from other surgeons

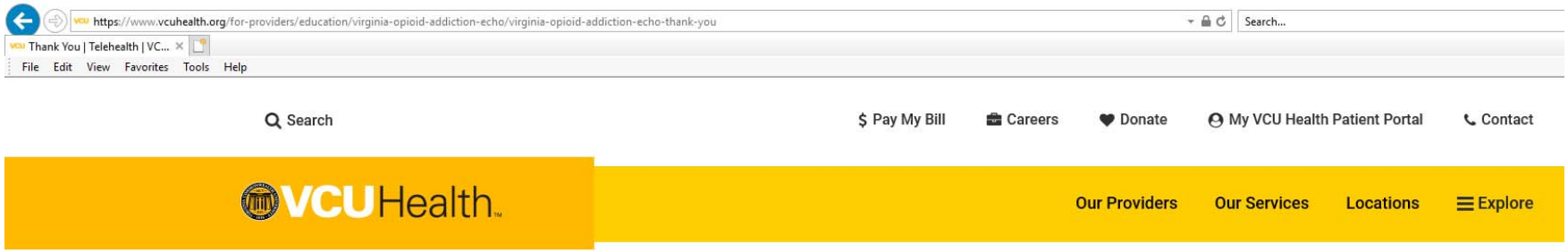
September 2019 (13 months after initial visit). Pt could not afford SQ methyl naltrexone and not interested in PO methyl naltrexone because she got an appointment with Mayo clinic for evaluation. Continued with hydromorphone 8 mg every 4 hrs as requested by Mayo clinic.

October 2019 (14 months after initial visit). Pt states that she does not plan to return to MOTIVATE as she will have her surgical repair at Mayo and will be in "pain rehab" afterwards. Requested last prescription of hydromorphone and she said good bye.

End of Case Study

Case Studies

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



Thank You

The success of our telehealth program depends on our participants and those who submit case studies to be discussed during clinics. We recognize the following providers for their contributions:

- **Michael Bohan, MD** from Meridian Psychotherapy
- **Diane Boyer, DNP** from Region Ten CSB
- **Melissa Bradner, MD** from VCU Health
- **Michael Fox, DO** from VCU Health
- **Shannon Garrett, FNP** from West Grace Health Center
- **Sharon Hardy, BSW, CSAC** from Hampton-Newport News CSB
- **Sunny Kim, NP** from VCU Health
- **Thokozeni Lipato, MD** from VCU Health
- **Caitlin Martin, MD** from VCU Health
- **Faisal Mohsin, MD** from Hampton-Newport News CSB
- **Stephanie Osler, LCSW** from Children's Hospital of the King's Daughters
- **Jennifer Phelps, BS, LPN** from Horizons Behavioral Health
- **Crystal Phillips, PharmD** from Appalachian College of Pharmacy
- **Tierra Ruffin, LPC** from Hampton-Newport News CSB
- **Jenny Sear-Cockram, NP** from Chesterfield County Mental Health Support Services
- **Daniel Spencer, MD** from Children's Hospital of the King's Daughters
- **Cynthia Straub, FNP-C, ACHPN** from Memorial Regional Medical Center
- **Barbara Trandel, MD** from Colonial Behavioral Health
- **Bill Trost, MD** from Danville-Pittsylvania Community Service
- **Art Van Zee, MD** from Stone Mountain Health Services
- **Sarah Woodhouse, MD** from Chesterfield Mental Health

Submit Feedback

Opportunity to formally submit feedback

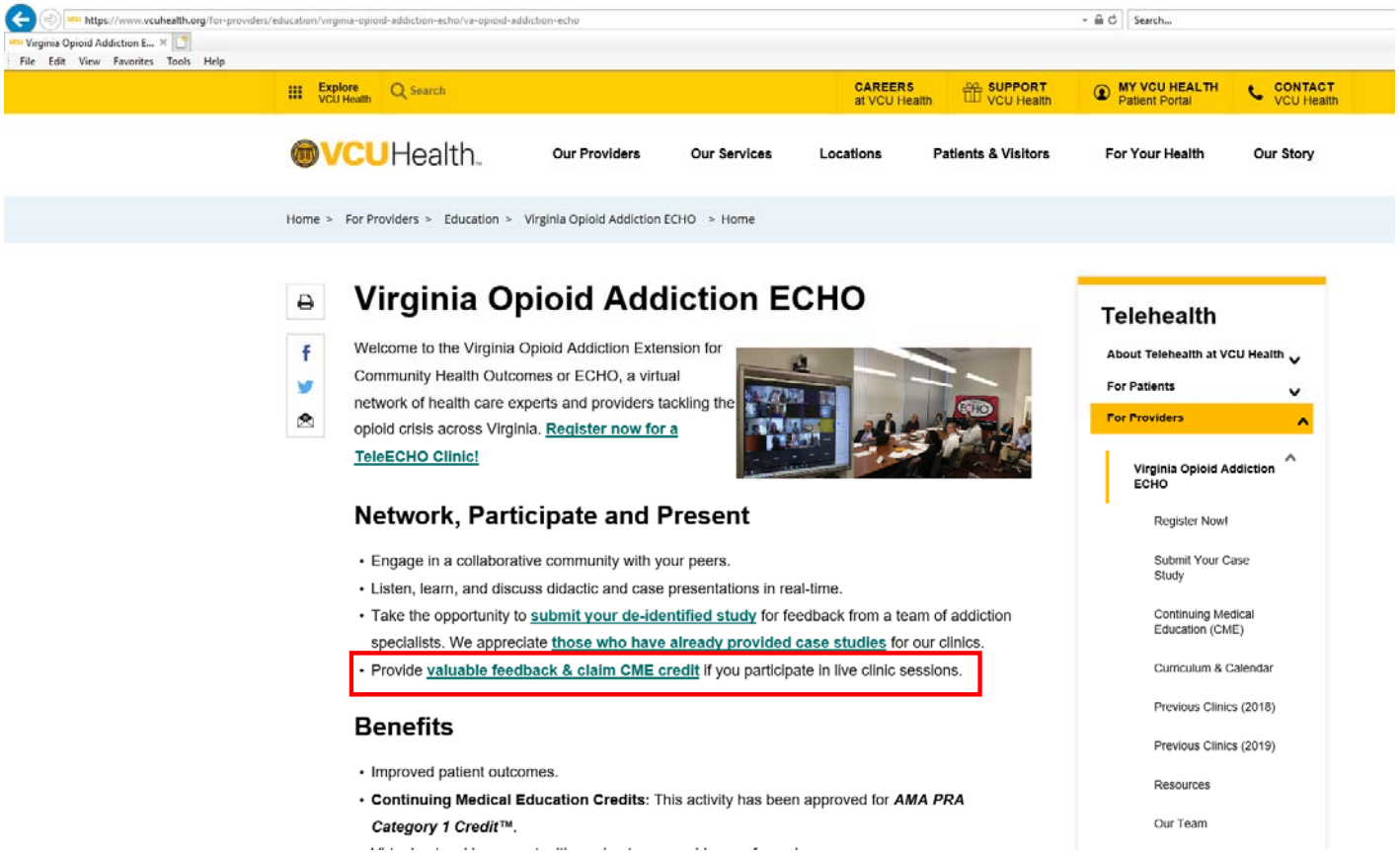
- Survey: www.vcuhealth.org/echo
- Overall feedback related to session content and flow?
- Ideas for guest speakers?

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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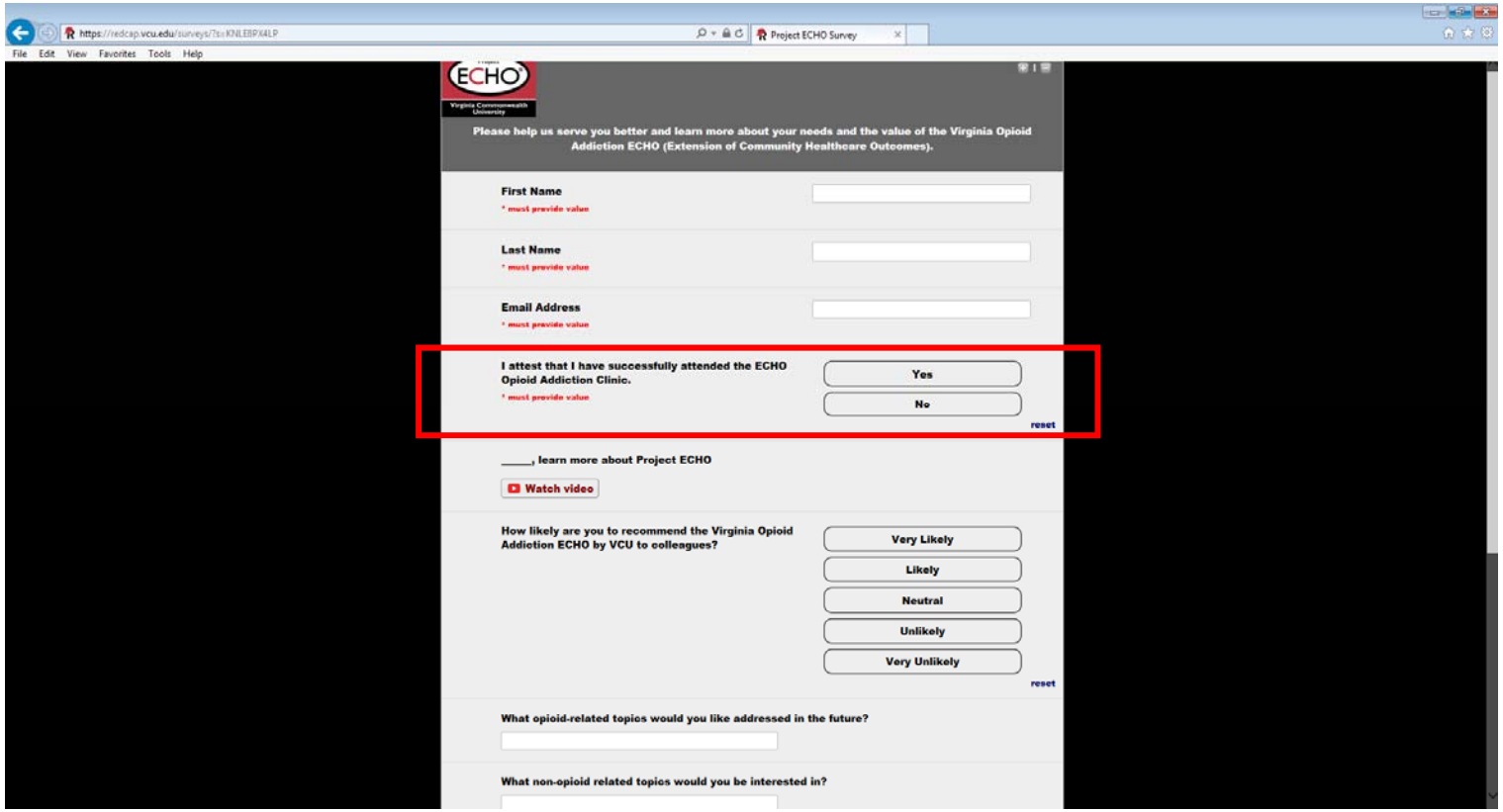
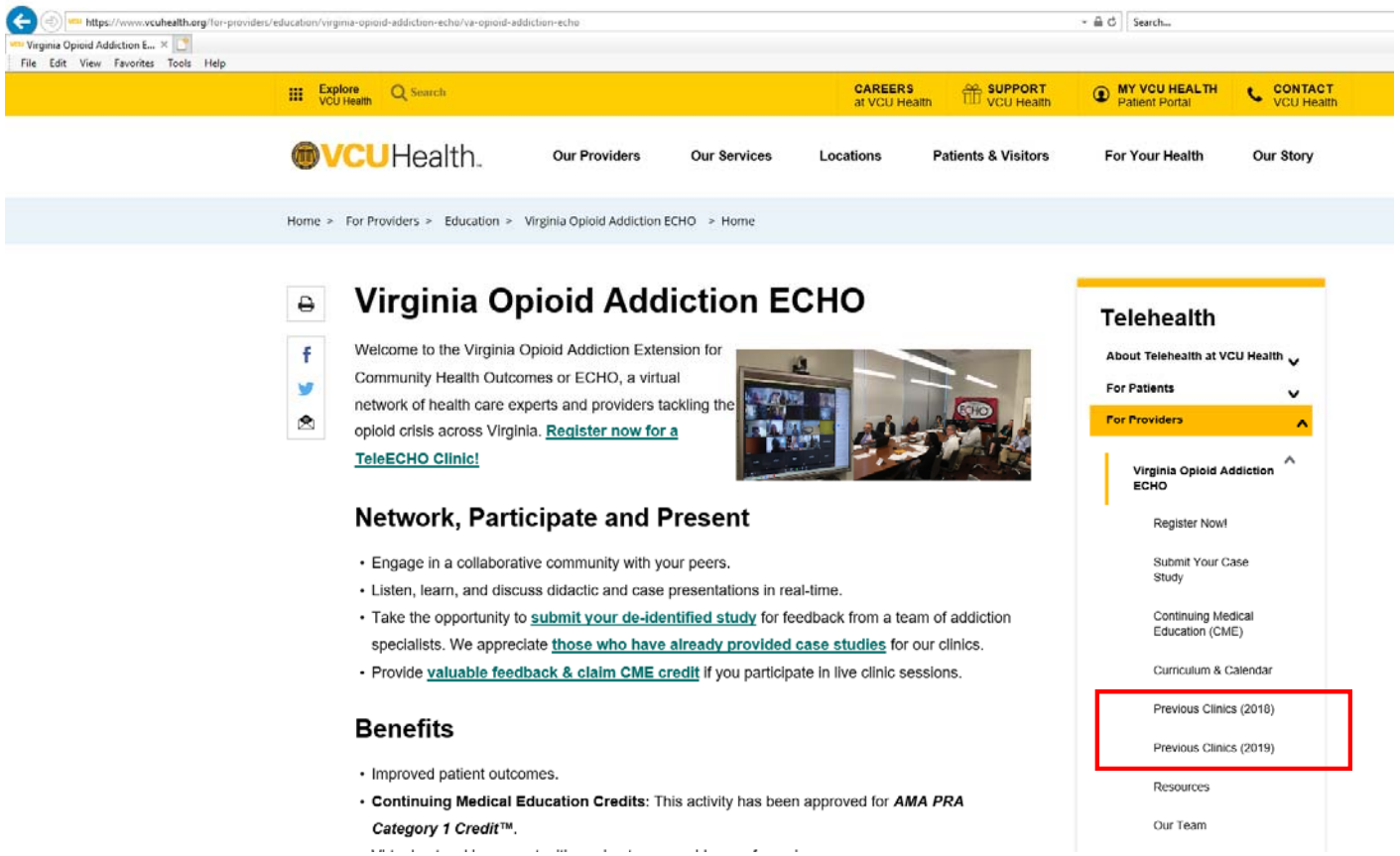


Access Your Evaluation and Claim Your CME

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

Access Your Evaluation and Claim Your CME



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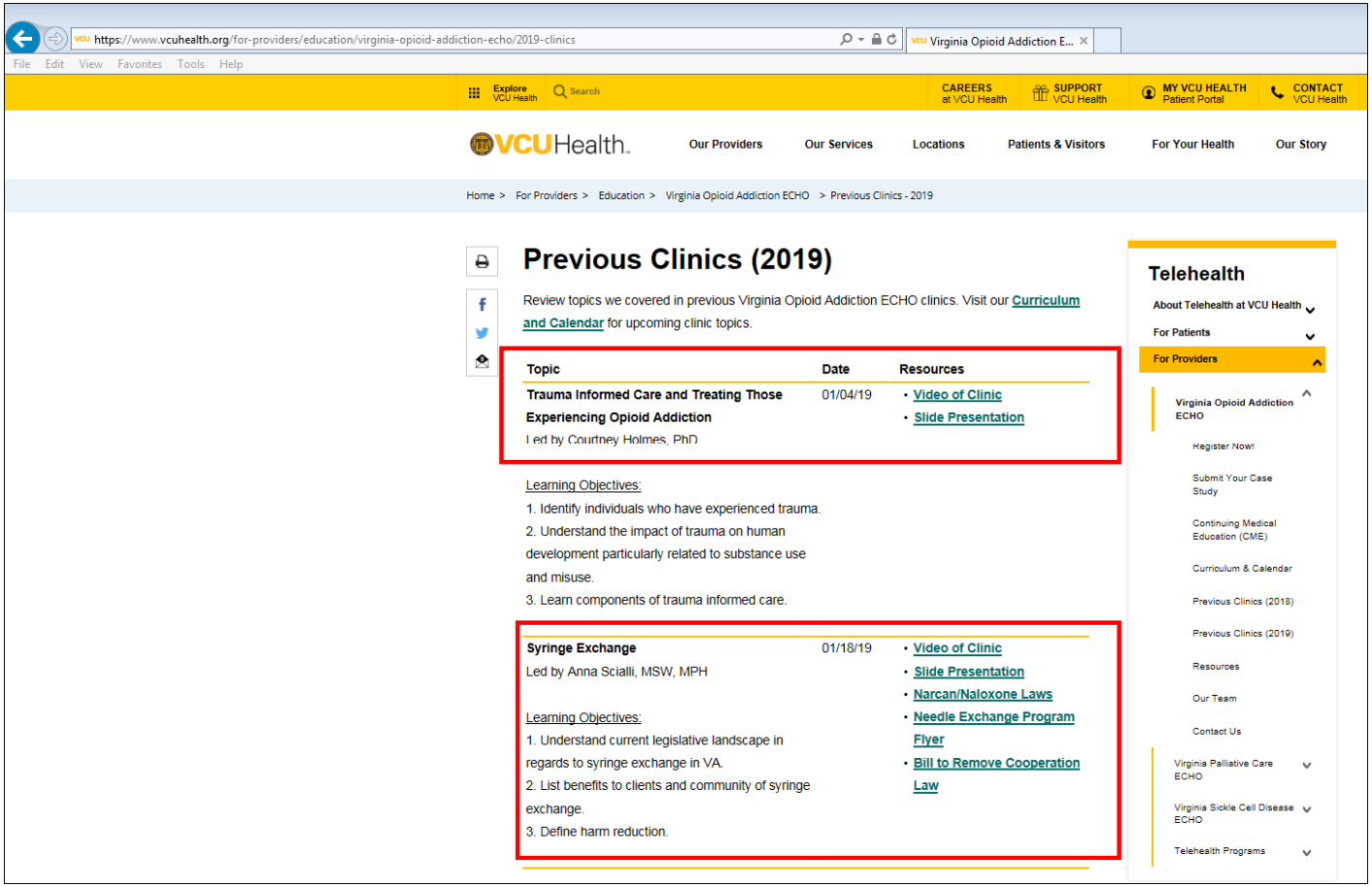

VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

Mark Your Calendar --- Upcoming Sessions

Nov 1:	Alcohol Use Disorders	Albert Arias, MD
Nov 15:	USDOJ Diversion Guidelines	Olivia Norman
Dec 6:	Managing Patient Trauma	Anika Alvanzo, MD

Please refer and register at vcuhealth.org/echo

THANK YOU!

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Use chat function for questions

Resources

1. "Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: a Randomized Clinical Trial," JAMA 313 (April 28, 2015): 1636.

a. Lead Author: Gail D'Onofrio, MD, chair, Department of Emergency Medicine, Yale New Haven Hospital

2. Drug Addiction Treatment Act of 2000

3. Controlled Substances Act, 21 U.S.C. §§ 802(52-54)(A)