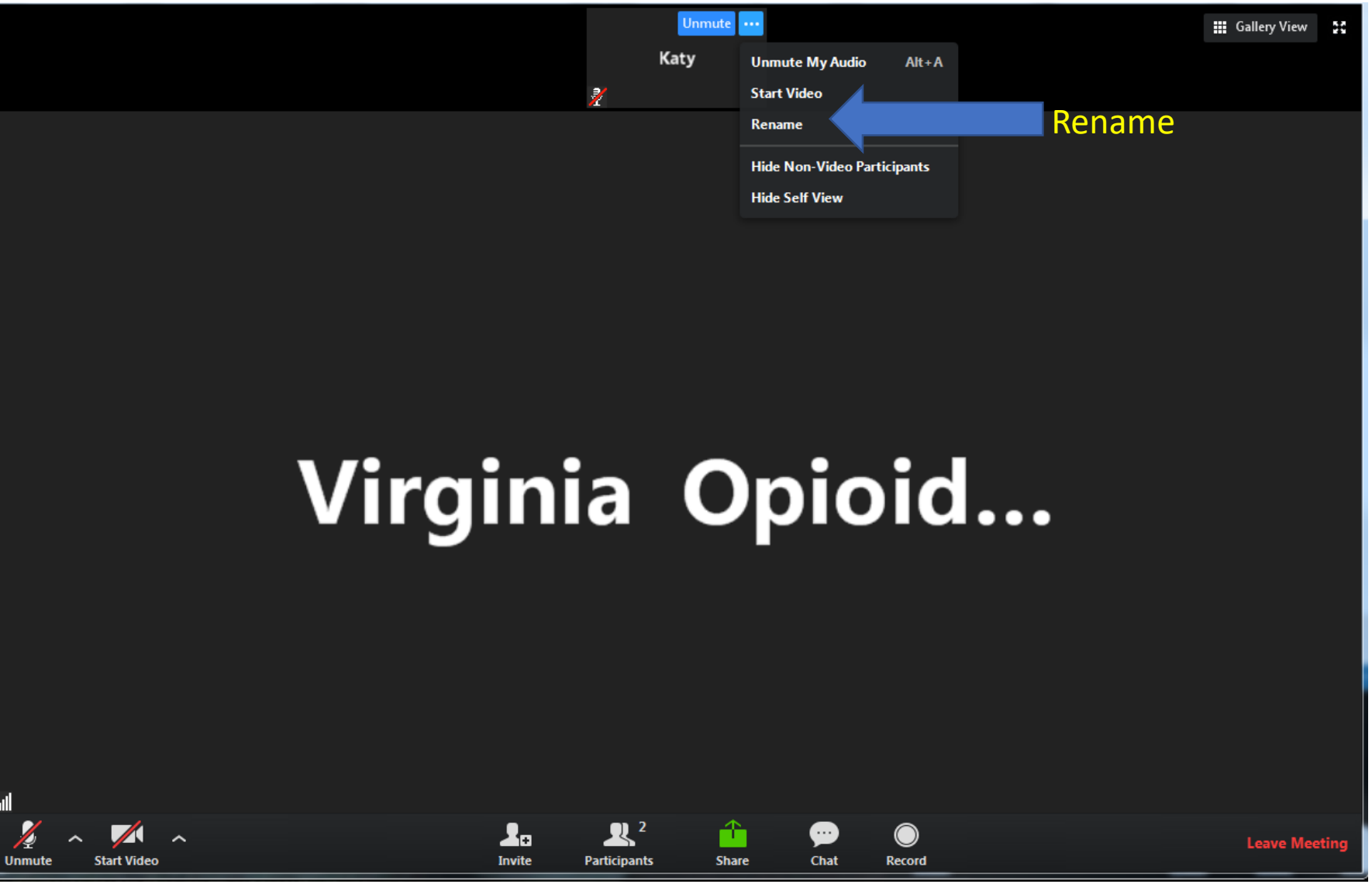
Virginia Opioid Addiction ECHO* Clinic

November 15, 2019

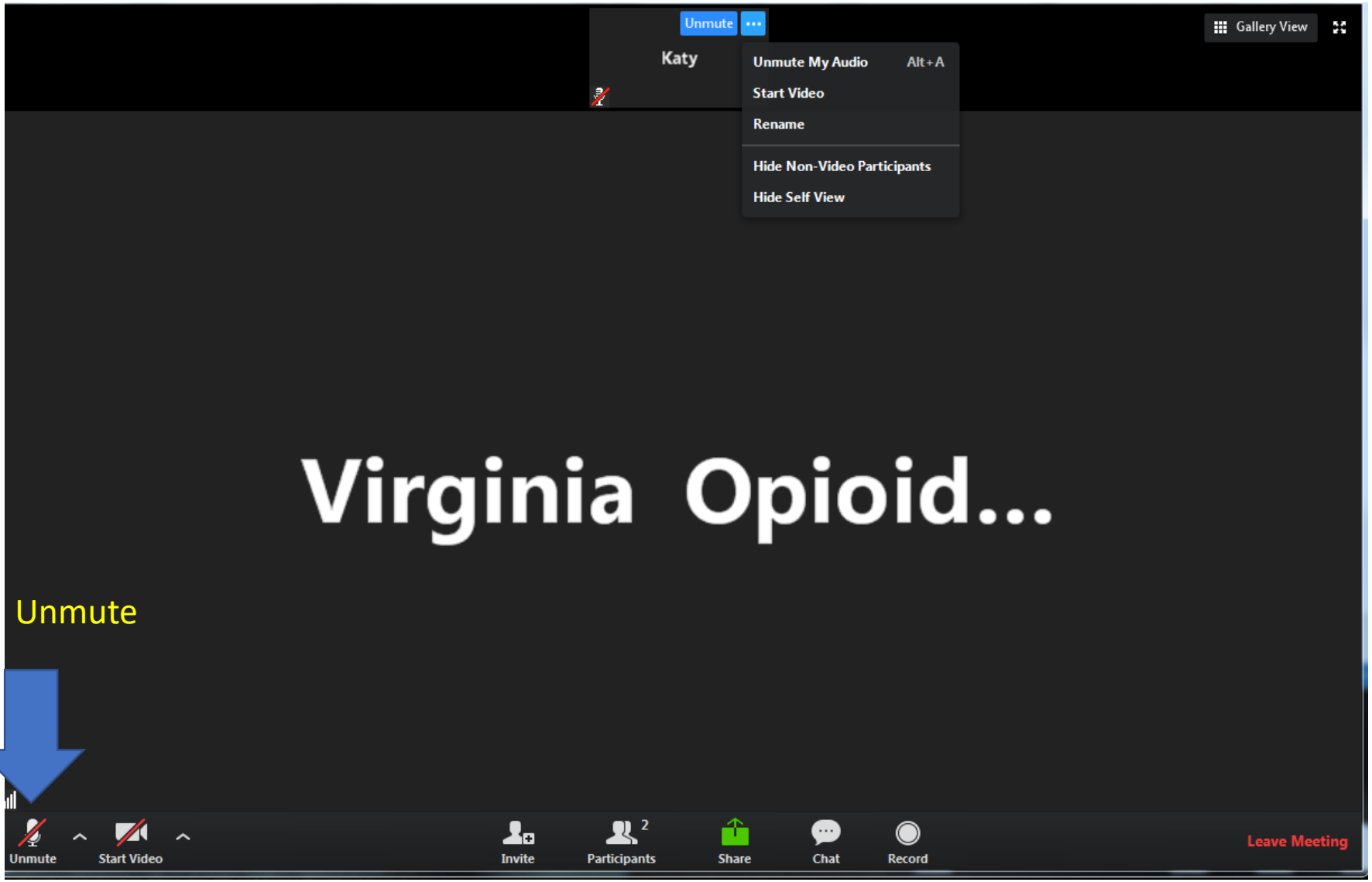
*ECHO: Extension of Community Healthcare Outcomes

Helpful Reminders



- Rename your Zoom screen, with your name and organization

Helpful Reminders



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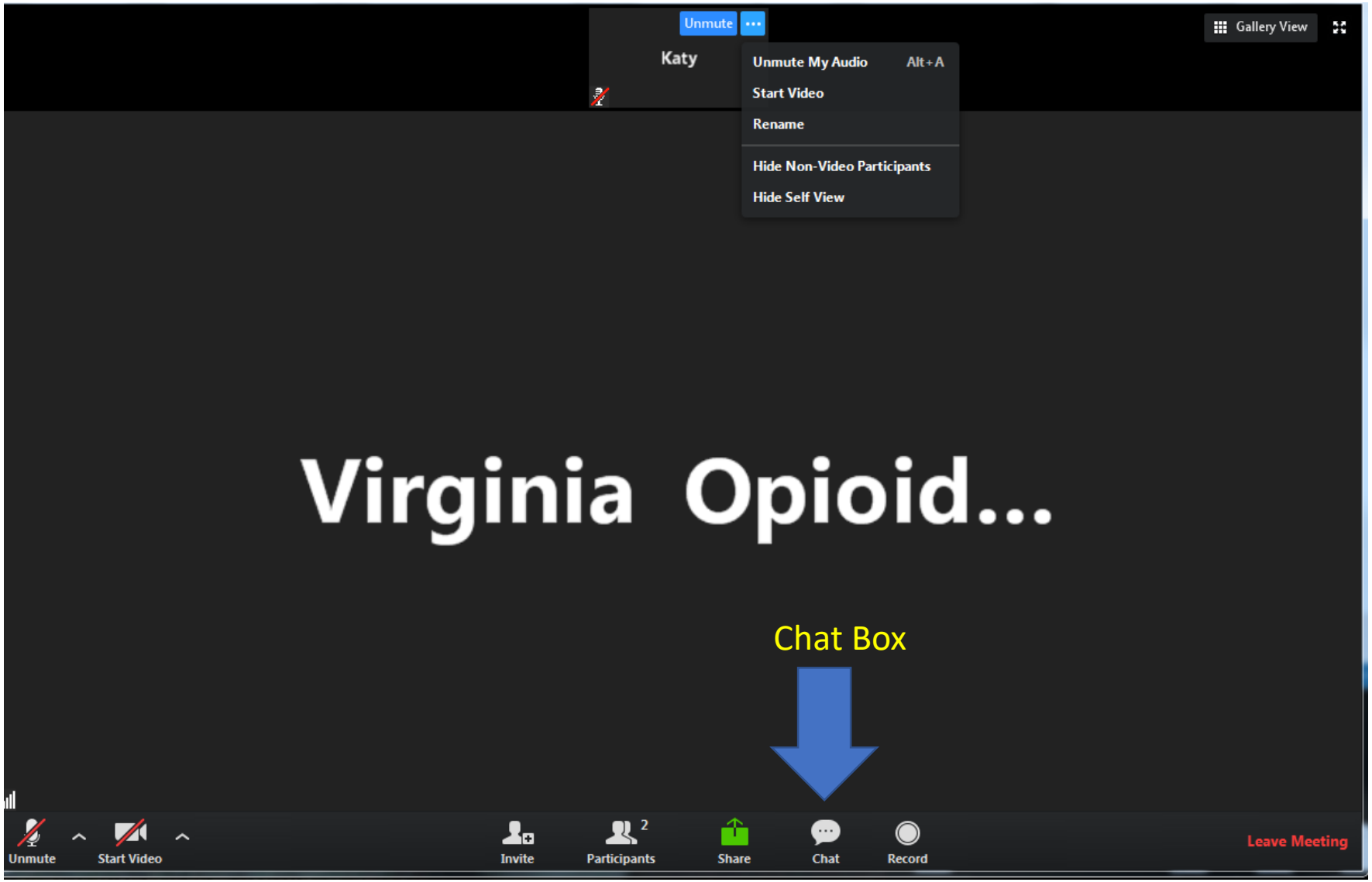
- If joining by telephone audio only, *6 to mute and unmute

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	Olivia Emerson
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. **Diversion Red Flags**
   II. **Olivia Norman**
II. Case presentations
   I. Case 1
      I. Case summary
      II. Clarifying questions
      III. Recommendations

III. Closing and questions

Lets get started!

Didactic Presentation

Disclosures

Olivia Norman has no financial conflicts of interest to disclose.

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

Diversion Red Flags

Olivia L. Norman

Assistant United States Attorney

What is Diversion?

- Diverting of controlled substances
- From their original licit medical purpose
- Examples:
  - Patient to others
  - Practitioner to Patient
  - Practitioner to Self
  - Pharmacist to Patient
  - Pharmacist to Self
  - Staff to Self/Others

Controlled Substance Act
21 U.S.C. § 801, et seq.

- Authorizes Attorney General to promulgate regulations for the registration and control of controlled substances (21 U.S.C. § 821)

- Attorney General delegated that authority to the Administrator of the Drug Enforcement Administration, that delegated administration to Diversion Investigators

Unlawful to Distribute Controlled Substances without Authorization

- Unlawful to distribute or dispense a controlled substance (21 U.S.C. § 841)
- Prescription for a controlled substance to be effective must be issued for:
  - Legitimate medical purpose
  - By a practitioner/registrant
  - Acting in the usual course of his professional practice

  (21 CFR § 1306.04)
  - Corresponding provisions for pharmacists

Current trends of illicit drug use

- 75 percent of opioid abusers started with prescription opioids (compared with the 1960s when 80 percent of opioid abusers got hooked on heroin first). JAMA Psychiatry 2014
- Prescription opioids are selling for $1/mg on the street (e.g., 30 mg Oxycodone pill is $30 on the street)
- As tolerance increases, buying pills on the street is cost-prohibitive
- Pills sold on the street could be counterfeit
- Options: get pills with a prescription or switch to heroin/fentanyl

Methods of Getting Prescribed Drugs

- Feign pain – often back, hip, shoulder, dental
- Exaggerate pain – with pre-existing/chronic condition
- Self-inflicted injury
- Doctor shopping
- ER visit at the end of shift
- Steal or replicate prescription pads
- Steal pills from clinics, hospitals, pharmacies

Drugs of choice - Opioids

- Oxycodone (Percocet®, Percodan®, OxyContin®)
- Hydrocodone (Lorcet®, Lortab®, Vicodin®, Tussionex®)
- Oxymorphone (Opana®)
- Hydromorphone (Dilaudid®)
- Morphine (Roxanol®)
- Codeine
- Fentanyl

Drugs of Choice - Benzos

- Alprazolam (Xanax®)
- Diazepam (Valium®)
- Clonazepam (Klonopin®)
- Loraxepam (Ativan®)

Drugs of Choice – Other

- Gabappentin (Neurontin®)
- Methadone
- Burprenorphine/Naloxone (Suboxone®)
- Amphetamine and Dextroamphetamine (Adderall®)
- Methylphenidate (Ritalin®)
- Zolpidem (Ambien®)
- Clonidine (HBP)
- Cyclobenzaprine (Flexeril®)
- Loperamide (Imodium®)

The “Holy Trinity” of Diversion

- Was: Opioid, benzodiazepine, muscle relaxant (e.g., oxycodone, alprazolam and carisoprodol)

- Trending:
  - Oxycodone or Hydrocodone
  - Alprazolam
  - Adderall XR (or other stimulant)

Red Flags that Patient Might be Diverting

- Using cash in lieu of insurance
- Traveling far distance to doctor's office
- Travel in groups
- Vague symptoms
- Resistant to alternative therapies
- Dictating the drug, strength, and/or quantity
- Seeking maximum doses
- Seeking replacement prescriptions

Red Flags that Patient Might Be Diverting (cont)

- Seeking early refills/ “lost” pills/prescriptions
- Using multiple pharmacies
- Filing multiple prescriptions
- Seeing multiple providers
- Claim drug type/strength not enough
- Urinalysis not positive for prescribed medication or positive for not-prescribed medication/illegal controlled substance
- Physical appearance or behavior indicative of substance abuse

Signs/Symptoms of Opioid Withdrawal

- Early signs include:
  - Agitation
  - Anxiety
  - Muscle aches
  - Restlessness
  - Increased tearing
  - Runny nose
  - Excessive sweating
  - Inability to sleep
  - Excessive yawning
  - Racing Heart

Opiate Withdrawal Timelines, Symptoms, and Treatment, American Addiction Centers.org

Signs/Symptoms of Opioid Withdrawal (cont)

- Later symptoms include:
  - Diarrhea
  - Abdominal cramping
  - Nausea and vomiting
  - Goosebumps
  - Drug Cravings
  - Rapid heartbeat
  - High blood pressure

Opiate Withdrawal Timelines, Symptoms, and Treatment, American Addiction Centers.org

Diversion by Practitioners

- Practitioners writing prescriptions outside the usual course of professional practice and not for legitimate medical purpose
  - For assisting another in the maintenance of a drug habit. *U.S. v. Tran Trong Cuong,* 18 F.3d 1132, 1137 (4th Cir. 1994)
  - For personal use
  - For personal profit
- Practitioners or employees stealing CS from clinics, hospitals, pharmacies

Good Faith

- Good faith is an exception where the practitioner can show actions were within:
  - The usual course of generally accepted medical practice;
  - Generally recognized and accepted in the United States; and
  - Prevailing standards of treatment
  - Objective standard

- But NOT willful blindness
  - deliberate ignorance
  - Take deliberate actions to avoid confirming suspicions of criminality

Red Flags that Practitioner Might Be Diverting

- Inordinately large quantities of CS prescriptions
- Large number of CS prescriptions
- No or inadequate physical exam
- Cash business
- Utilizes sliding scale for the cost based on quantity of pills
- Prescribes according to patient demand
- Ignore test results (both diagnostic and UA)
- Writing prescriptions to patients who appear to be selling their medications

Red Flags that Practitioner Might Be Diverting (cont)

- Fail to warn patients about the dangers associated with or instruct in the proper usage of the prescribed medication
- Warning patient to fill prescription and different pharmacies/drug stores
- Issuing prescriptions to patients known to distribute to others (i.e. “share”)
- Prescribing at intervals inconsistent with legitimate medical treatment
- Practitioner uses street slang to described CS

Red Flags that Practitioner Might Be Diverting (cont)

- No logical relationship between the prescribed drugs and the reported condition
- Writing more than 1 prescription to avoid detection/concern by pharmacy The vast majority of the doctor's patients are prescribed controlled substances over any other forms of treatment
- No individualized treatment plans – one size fits all
- Patients provide services or trade goods in exchange for prescriptions for CS

Red Flags that Practitioner Might Be Diverting (cont)

- Practitioner tells patient what to say about the CS if asked by the police
- Pre-writes prescriptions
- Lack of patient records, files, etc.
- Creation of false patient files
- Complaints of pain documented in patient medical files are for nebulous conditions (e.g., headache, nervousness)

Red Flags that Practitioner Might Be Diverting (cont)

- Prescribing inappropriate combinations of drugs to patients (i.e. ones that have an adverse effect when combined)
- “Lost” medication is frequently replaced
- Refills before prescriptions should have run out
- Patient deaths due to CS
- Prescribing CS without requiring an office visit
- Instructs patients cannot prescribe unless patient complains of pain

References

- Donald Sullivan, R.Ph, Ph.D., Professor of Clinical Pharmacy, Diversion of Prescription Drugs: A Pharmacist's Perspective,
- David Klein, History and Overview of Prosecuting Diversion Cases
- Simon Gaugush, AUSA, Prosecution Guide, May 1, 2012
- Opiate Withdrawal Timelines, Symptoms, and Treatment, American Addiction Centers.org
- JAMA Psychiatry 2014

Questions?

Case Presentation #1
Kayla Brandt, Case Manager

- 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

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

How do you motivate a young male with an opiate addiction and other substance use who is also the father of a 3 year old to get clean and motivated to become a productive citizen?

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.)

Individual is a white male, age 23, high school graduate. Individual is on disability and lives with his mother and younger brother. Individual has limited support and mother tends to be an enabler. Individual has been smoking marijuana since age 11 and continues use daily. Individual is also using opiates, heroin and basically any other drug. Individual's father is not in the area and divorced his mother several years ago. Individual has a toxic relationship with his father who also used (s) drugs.

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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.)

Individual is diagnosed with PTSD, Schizoaffective disorder, Bi-polar type, Cannabis use disorder Moderate, Anorexia Nervosa restricting type, Other unknown substance use disorder, severe. Individual began receiving opiates due to a back issues (Bulging discs) in his teens which eventually caused him to receive disability. Individual has attempted suicide four times by overdosing. Individual went to residential treatment in 2019 and only stayed 10 days until his mother picked him up because he said he could not take the noise of others there. Individual is currently receiving the following medications: Cariprazine 3 mg capsule, take one QD
Naltrexone 50 mg tablet take one tablet po q AM (which he recently started on) and
Aripiprazole ER 400 mg suspension, extended rel.intramuscular syringe. Individual has been in and out of services for several years for both mental health and substance use disorders with very little progress.
Administer 400 mg IM every 4 weeks

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

Inpatient, Individual therapy, Medication management, and Case Management services. Individual is very guarded in receiving help and always has an excuse for not following through. Individual is extremely intelligent but lacks motivation to make good choices.

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

Plans for future treatment include Naltrexone, peer support specialist services, individual therapy to address his estranged relationship with his father, assisting individual to obtain some form of work, obtain his driver's license and N.A. meetings for support and sponsor.
At this point, it is unclear what individual's realistic goals for treatment are other than he has his 3 year old daughter that he knows he needs to make changes or he risks losing her.

Other relevant information

Any help with this case to be able to help with the ambivalent stage with this individual would be greatly appreciated.

End Case Study

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Case Studies

- Case studies
  - Submit: www.vcuhealth.org/echo
  - Receive feedback from participants and content experts
  - Earn **$150** for presenting

Telehealth

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

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:

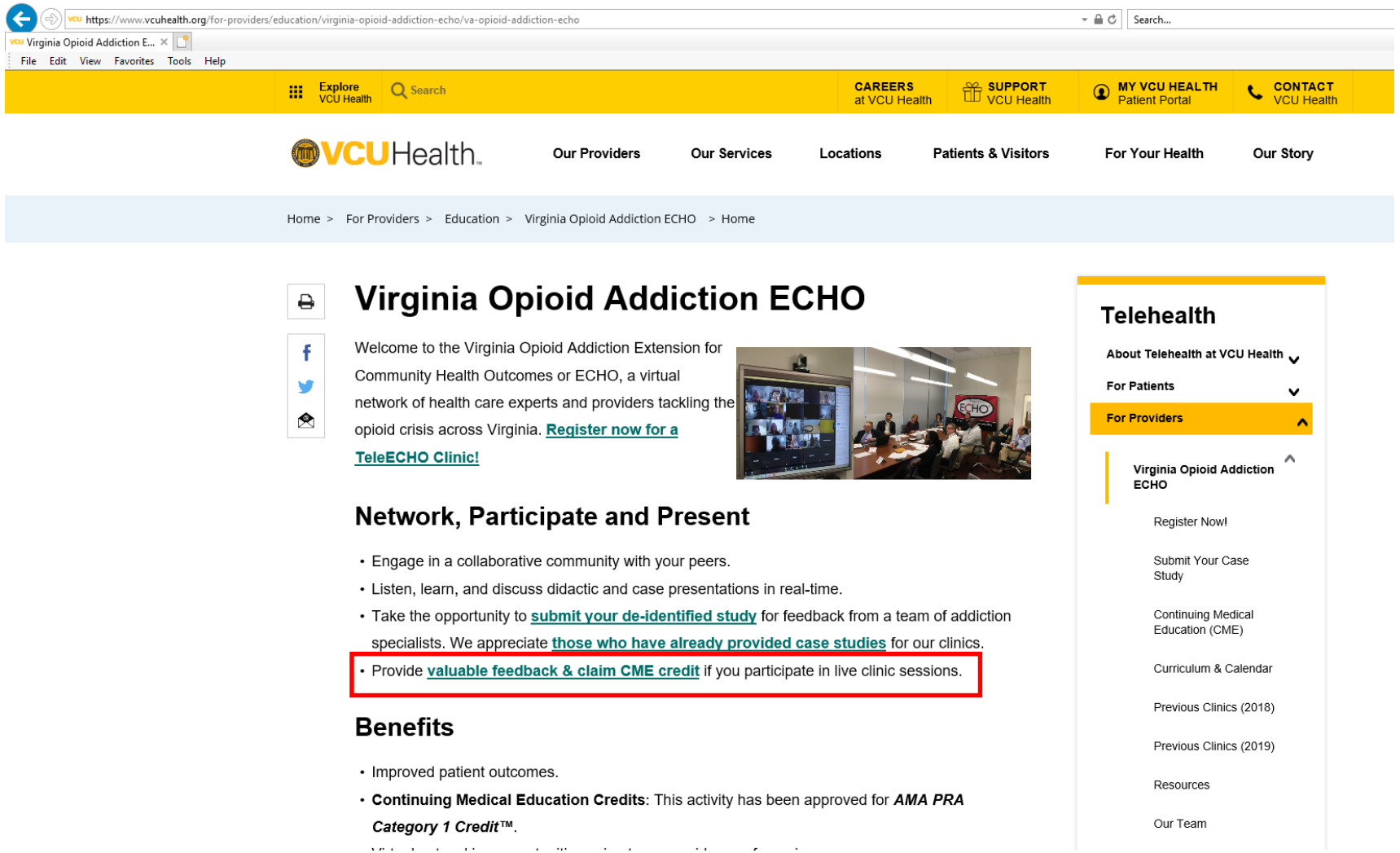
- **Ademola Adetunji, NP** from Fairfax-Falls Church Community Service Board
- **Michael Bohan, MD** from Meridian Psychotherapy
- **Diane Boyer, DNP** from Region Ten CSB
- **Melissa Bradner, MD** from VCU Health
- **Kayla Brandt, B.S.** from Crossroads Community Service Board
- **Susan Cecere, LPN** from Hampton Newport News
- **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
- **Manhal Saleeby, MD** from VCU Health Community Memorial Hospital
- **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
- **Ashley Wilson, MD** from VCU Health
- **Sarah Woodhouse, MD** from Chesterfield Mental Health

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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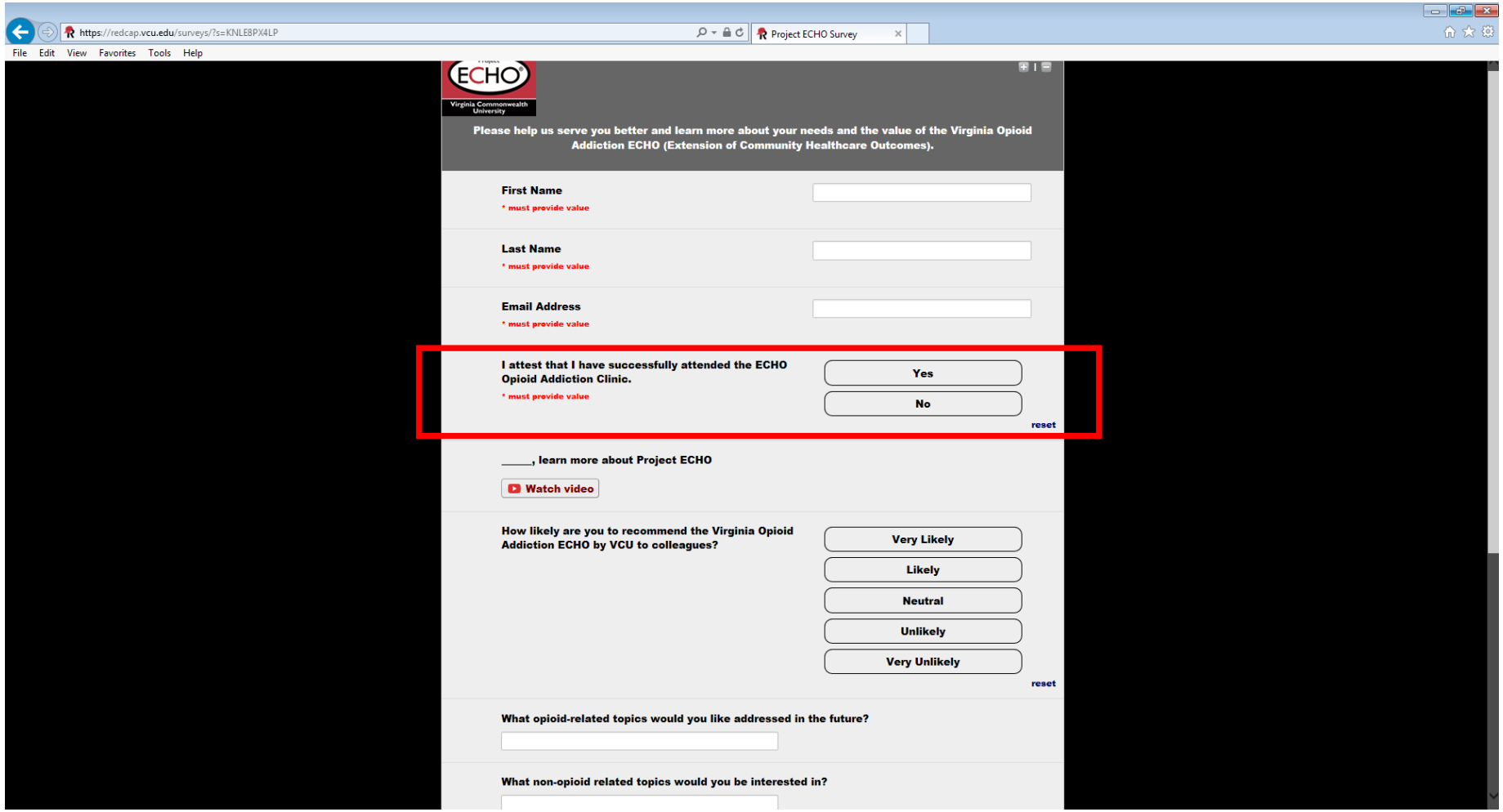

Access Your Evaluation and Claim Your CME

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

Access Your Evaluation and Claim Your CME

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

Virginia Opioid Addiction E...

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Virginia Opioid Addiction ECHO

Welcome to the Virginia Opioid Addiction Extension for Community Health Outcomes or ECHO, a virtual network of health care experts and providers tackling the opioid crisis across Virginia. **Register now for a TeleECHO Clinic!**

Network, Participate and Present

- Engage in a collaborative community with your peers.
- Listen, learn, and discuss didactic and case presentations in real-time.
- Take the opportunity to **submit your de-identified study** for feedback from a team of addiction specialists. We appreciate **those who have already provided case studies** for our clinics.
- Provide **valuable feedback & claim CME credit** if you participate in live clinic sessions.

Benefits

- Improved patient outcomes.
- **Continuing Medical Education Credits**: This activity has been approved for ***AMA PRA Category 1 Credit™***.

Telehealth

- About Telehealth at VCU Health
- For Patients
- For Providers
  - Virginia Opioid Addiction ECHO
    - Register Now!
    - Submit Your Case Study
    - Continuing Medical Education (CME)
    - Curriculum & Calendar
    - Previous Clinics (2018)
    - Previous Clinics (2019)
    - Resources
    - Our Team

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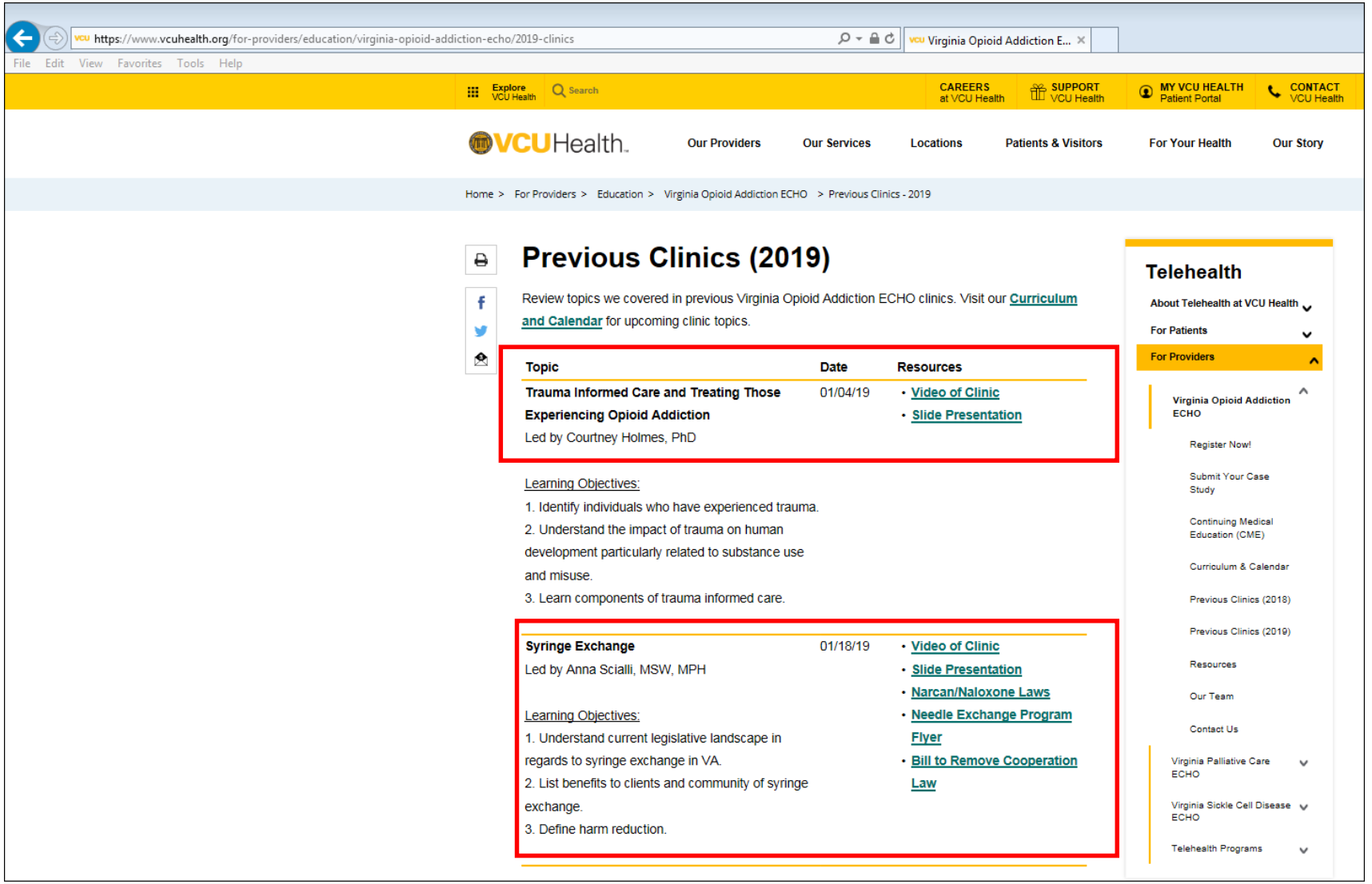

VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

Mark Your Calendar --- Upcoming Sessions

December 6	Managing Patient Trauma	Anika Alvanzo, MD

Please refer and register at vcuhealth.org/echo

Project ECHO®
Virginia Commonwealth University

THANK YOU!

Reminder: Mute and Unmute to talk
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VCU

Resources

1. Dasgupta N, Funk MJ, Proescholdbell S, Hirsch A, Ribisl KM, Marshall S. Cohort Study of the Impact of High-Dose Opioid Analgesics on Overdose Mortality. *Pain Med Malden Mass*. 2016;17(1):85-98. doi:10.1111/pme.12907
2. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. *MMWR Recomm Rep*. 2016;65. doi:10.15585/mmwr.rr6501e1er.
3. The Dangers of Using Adderall with Opioids, OpioidTreatment.net, June 13, 2018.
4. Donald Sullivan, R.Ph, Ph.D., Professor of Clinical Pharmacy, Diversion of Prescription Drugs: A Pharmacist's Perspective,
5. David Klein, History and Overview of Prosecuting Diversion Cases
6. Simon Gaugush, AUSA, Prosecution Guide, May 1, 2012
7. Opiate Withdrawal Timelines, Symptoms, and Treatment, American Addiction Centers.org
8. JAMA Psychiatry 2014