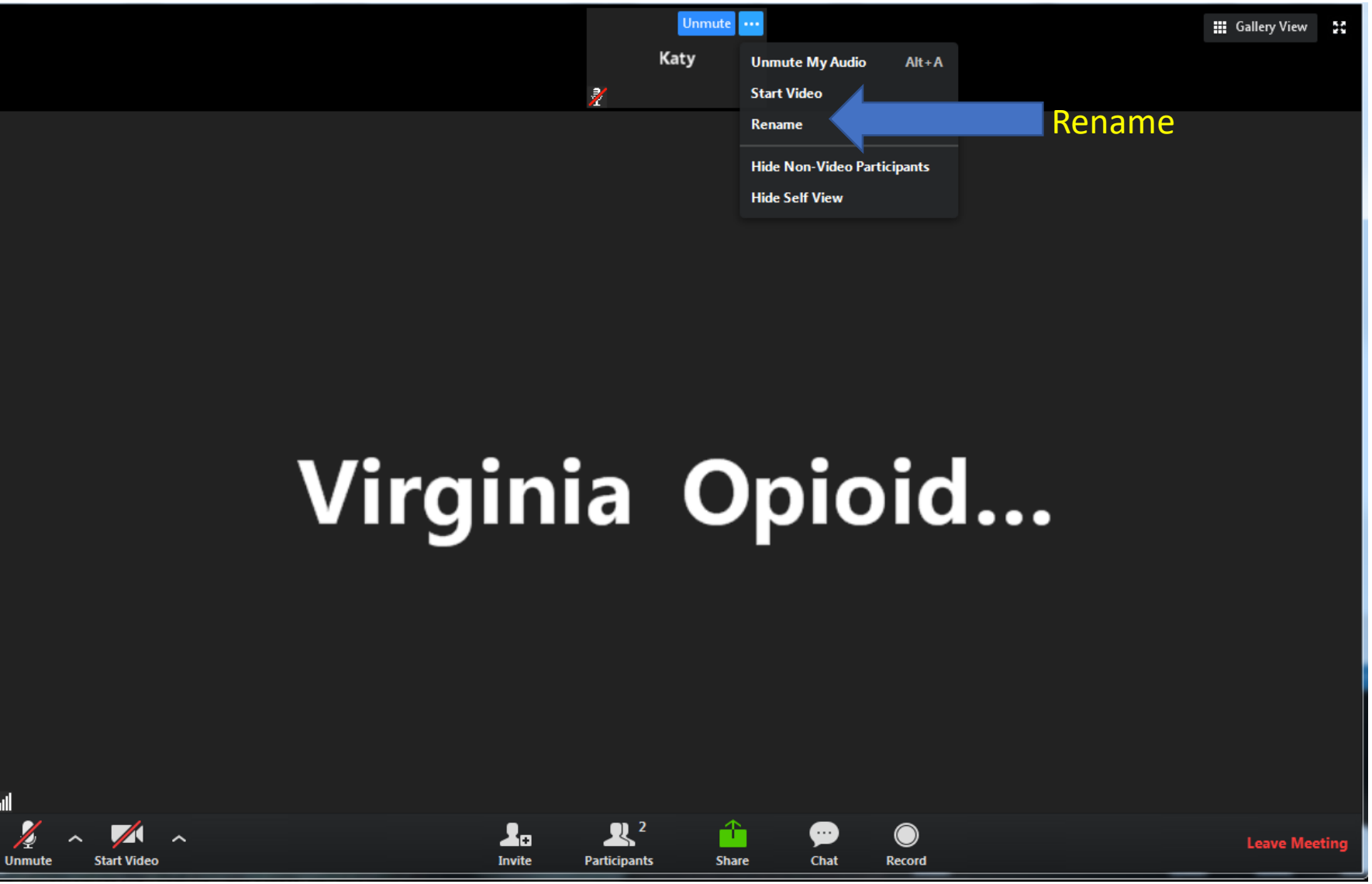
Virginia Opioid Addiction ECHO* Clinic

January 17, 2019

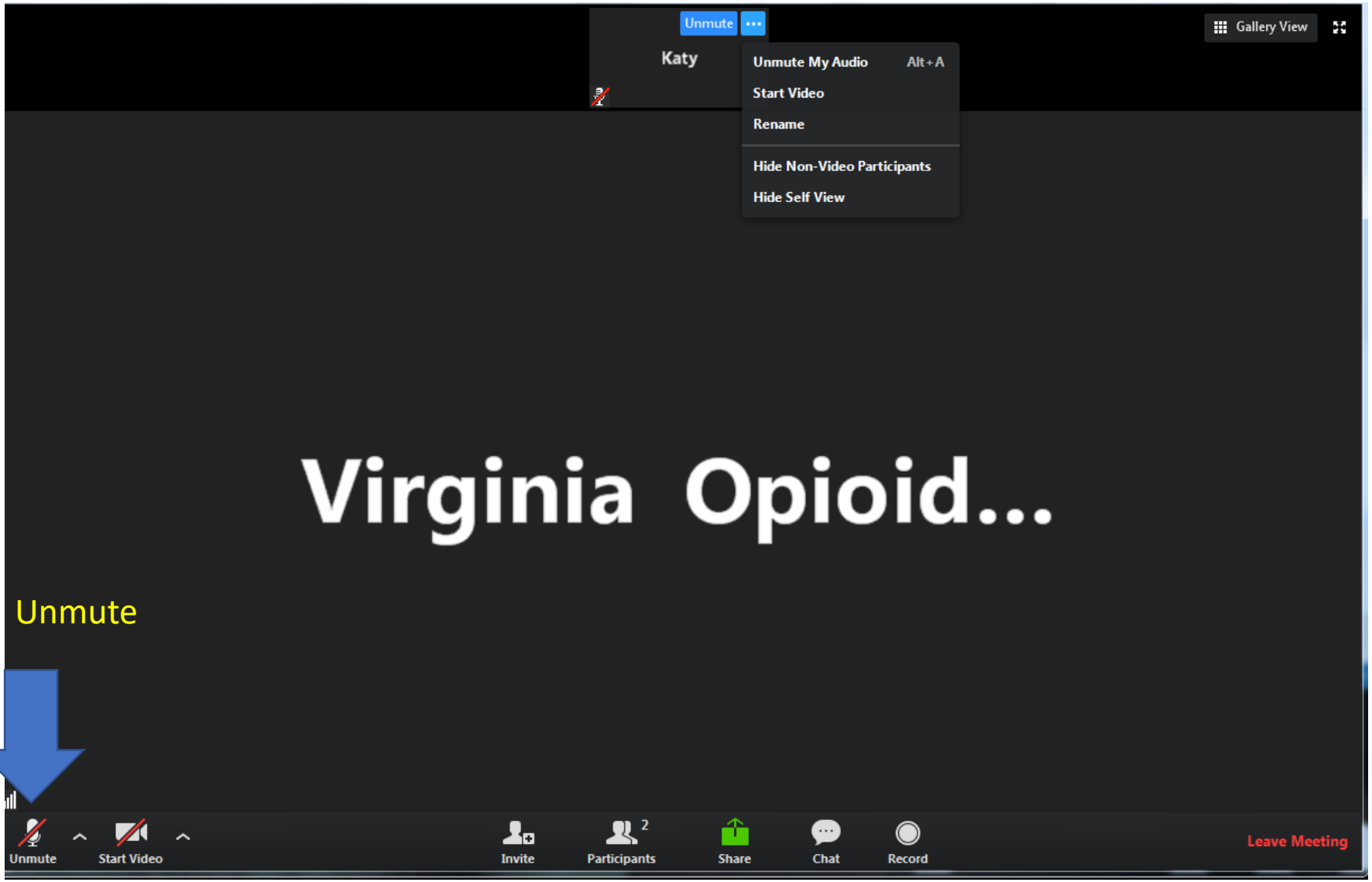
*ECHO: Extension of Community Healthcare Outcomes

Helpful Reminders



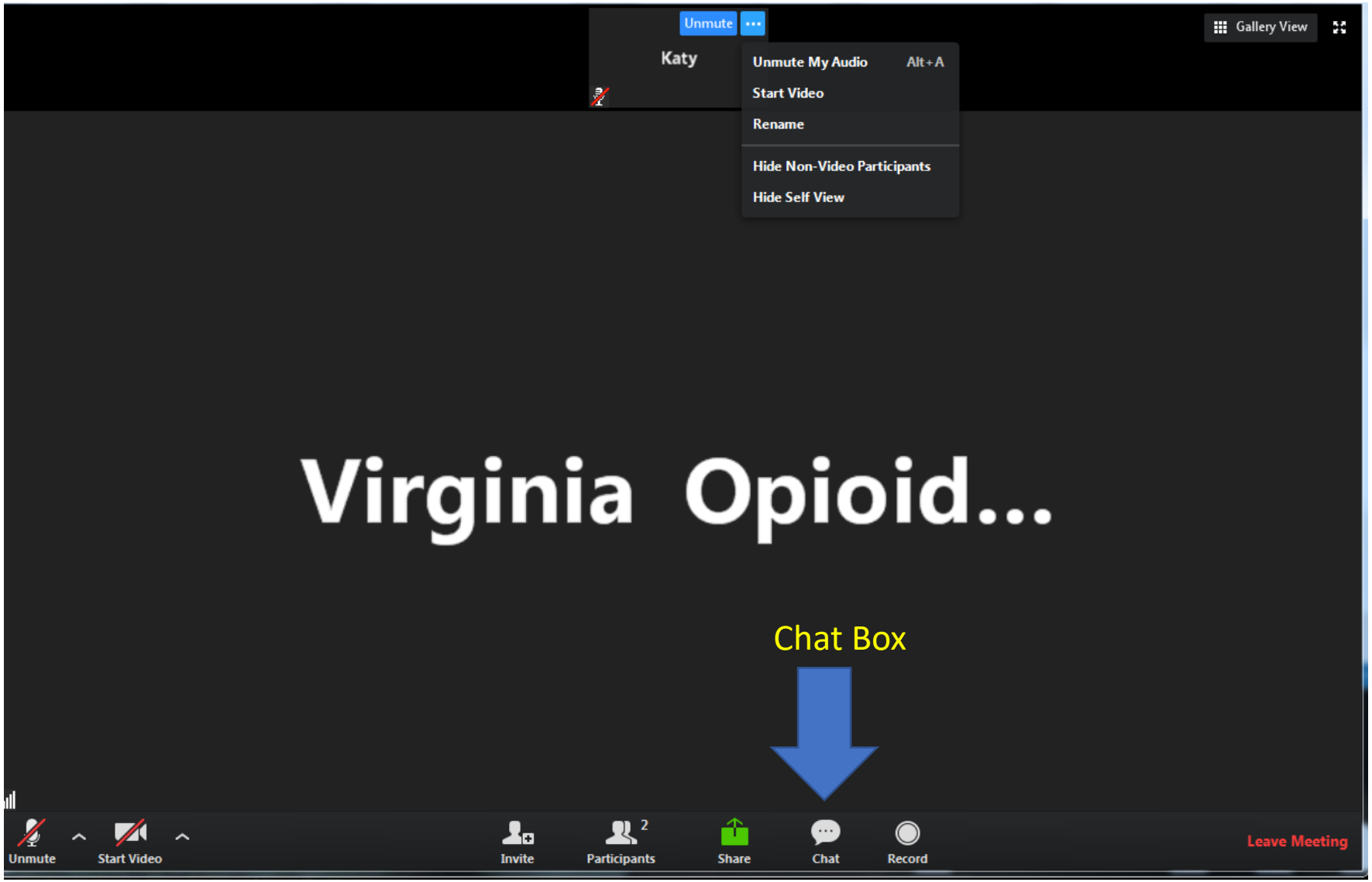
- Rename your Zoom screen, with your name and organization

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
- 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	Megan Lemay, 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

*6 for phone audio

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!

Didactic Presentation

Disclosures

Megan Lemay, MD has no financial conflicts of interest to disclose.

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

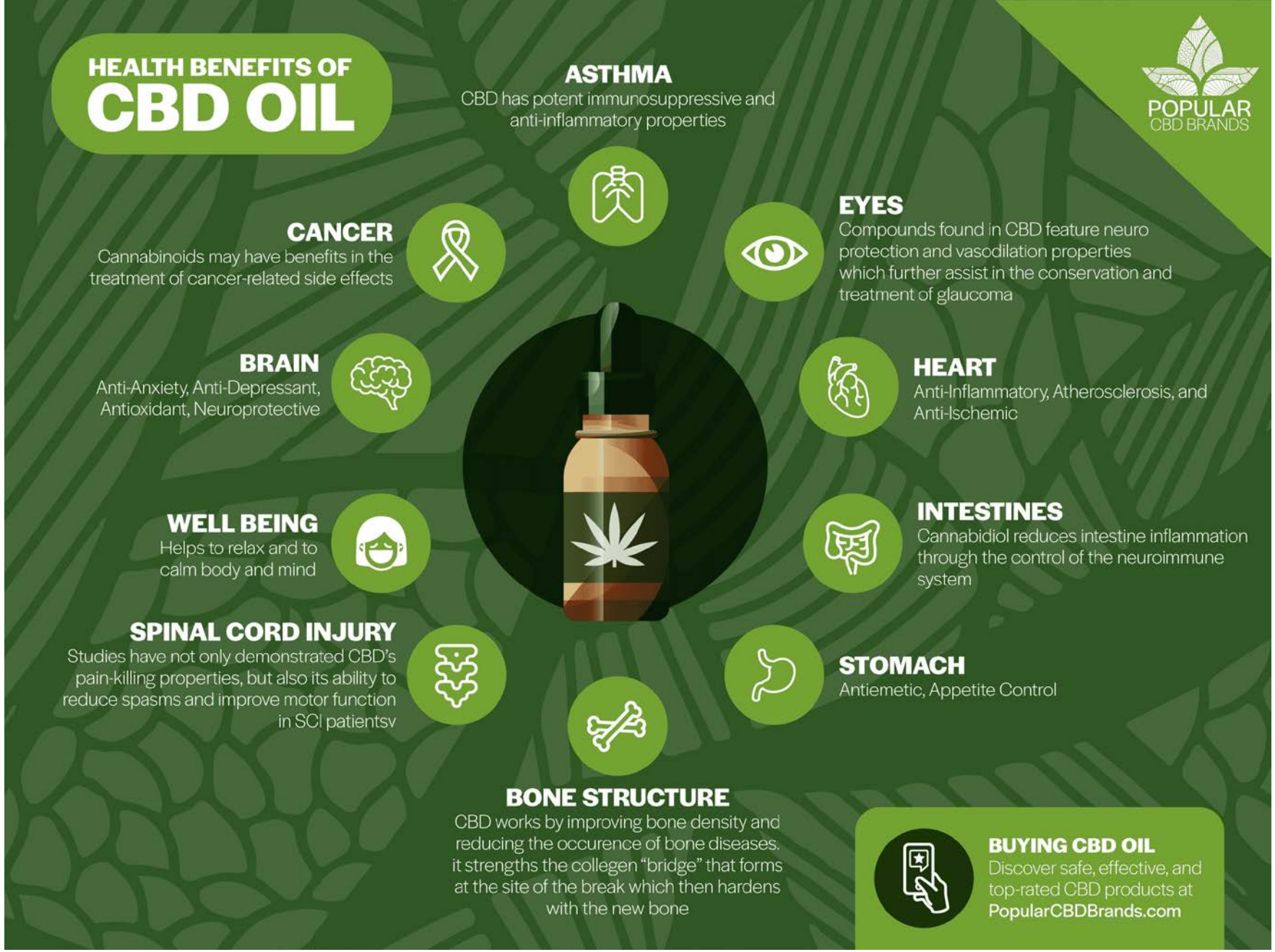
THC and CBD: Review of Evidence for Clinical Efficacy and Safety

Megan Lemay, MD

1/17/2020

Objectives

1. Discuss the sources of evidence and formulations of cannabis which have been studied
2. Review the evidence for THC and CBD to treat specific conditions
3. Discuss the known safety and side effects of THC and CBD
4. Briefly review the state of medical cannabis in Virginia


HEALTH BENEFITS OF
CBD OIL
POPULAR
CBD BRANDS
ASTHMA
CBD has potent immunosuppressive and anti-inflammatory properties
CANCER
Cannabinoids may have benefits in the treatment of cancer-related side effects
EYES
Compounds found in CBD feature neuro protection and vasodilation properties which further assist in the conservation and treatment of glaucoma
BRAIN
Anti-Anxiety, Anti-Depressant, Antioxidant, Neuroprotective
HEART
Anti-Inflammatory, Atherosclerosis, and Anti-Ischemic
WELL BEING
Helps to relax and to calm body and mind
INTESTINES
Cannabidiol reduces intestine inflammation through the control of the neuroimmune system
SPINAL CORD INJURY
Studies have not only demonstrated CBD's pain-killing properties, but also its ability to reduce spasms and improve motor function in SCI patientsv
STOMACH
Antiemetic, Appetite Control
BONE STRUCTURE
CBD works by improving bone density and reducing the occurence of bone diseases. it strengths the collegen "bridge" that forms at the site of the break which then hardens with the new bone
BUYING CBD OIL
Discover safe, effective, and top-rated CBD products at
PopularCBDBrands.com


MUST BE 18 TO PURCHASE
MEGA MILLIONS
$252 MILLION
$199 MILLION
Did You Win?
JACKED POTS!
$40 MILLION
BIC Lighter
CBD GUMMIES
CANNABOMB
TRIPLE MEDICATED
VAPE TANK
R.I.P.
Marlboro
$490

VCU Health™

Mr. Jones

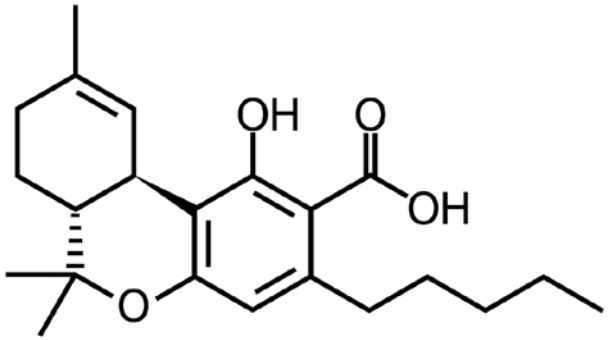
- Mr. Jones is a 35 year old man with no significant past medical history who presents to you for treatment of anxiety. He reports symptoms of anxiety affecting his work as a medical assistant and his relationships. He has had a few sessions of talk therapy free through his work which have helped his symptoms slightly.
- He has heard that THC and CBD oil can be helpful to treat all kind of things from diabetes to anxiety and asks you to certify him to receive this treatment

Formulations Studied

Nabiximols	Cannabidiol (CBD)	Cannabis	Dronabinol	Nabilone
Each mL contains 27 mg THC and 25 mg CBD, Oromuscosal Spray	Extracted from flowers and leaves of the C. sativa plant. Non-psychoactive	Numerous active cannabinoids including THC and CBD	Synthetic THC	Synthetic cannabinoid derivative mimicking THC

THC-A

- Tetrahydrocannabinolic acid
  - Precursor of THC (tetrahydrocannabinol) (activated by heat)
  - Non psycho-active



Key Reviews

Whiting, et al, JAMA 2015

- **Cannabinoids for Medical Use: A Systematic Review and Meta-analysis**
- 79 trials with 6462 participants evaluating Chemotherapy-induced nausea and vomiting, chronic pain, MS spasticity, HIV/AIDS, sleep disorders, psychosis, Tourette syndrome, anxiety, and glaucoma

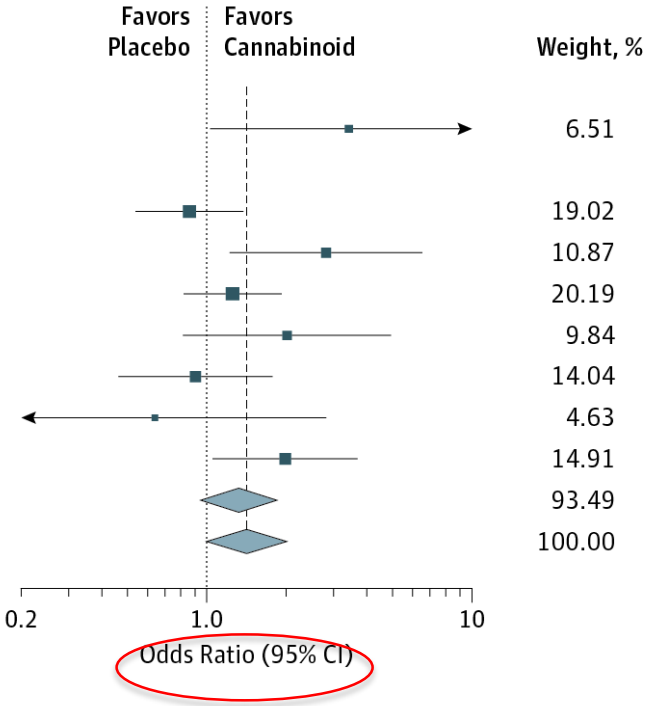
US National Academies of Sciences, Engineering, and Medicine, (NASEM) 2017

- **The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research**
- chronic pain; cancer; nausea and vomiting produced by cancer therapy; appetite stimulation in HIV/AIDS, cancer and anorexia nervosa; irritable bowel syndrome; epilepsy; spasticity in MS and spinal cord injury; Tourette syndrome; amyotrophic lateral sclerosis; Huntington's disease; Parkinson's disease; dystonia; Alzheimer's disease; glaucoma; traumatic brain injury and spinal cord injury; addiction; anxiety disorders; depressive disorders; sleep disorders; post-traumatic stress disorder; and schizophrenia

Chronic Pain

- Whiting Review
  - 28 trials with 2,454 participants
  - 13 studies used nabiximols and the remainder used THC or THC derivatives (none with CBD alone)
  - Conditions were almost all neuropathic pain conditions (one study for RA, one for MSK pain). Outcome was 30% reduction in chronic pain.

Improvement in Pain With Cannabinoid vs Placebo by Study	Cannabinoid Events		Placebo Events		Odds Ratio (95% CI)
	No.	Total No.	No.	Total No.	
Tetrahydrocannabinol (smoked)					
Abrams et al,[77] 2007	13	25	6	25	3.43 (1.03-11.48)
Nabiximols					
GW Pharmaceuticals,[22] 2005	54	149	59	148	0.86 (0.54-1.37)
Johnson et al,[69] 2010	23	53	12	56	2.81 (1.22-6.50)
Langford et al,[65] 2013	84	167	77	172	1.25 (0.81-1.91)
Nurmikko et al,[76] 2007	16	63	9	62	2.00 (0.81-4.96)
Portenoy et al,[67] 2012	22	90	24	91	0.90 (0.46-1.76)
Selvarajah et al,[70] 2010	8	15	9	14	0.63 (0.14-2.82)
Serpell et al,[88] 2014	34	123	19	117	1.97 (1.05-3.70)
Subtotal $I^2 = 44.5\%$, ($P = .0.94$)	241	660	209	660	1.32 (0.94-1.86)
Overall $I^2 = 47.6\%$, ($P = .0.64$)	254	685	215	685	1.41 (0.99-2.00)



Whiting JAMA 2015

Chronic Pain

- NASEM
  - Relied heavily on Whiting Review
  - Two studies published on inhaled cannabis since Whiting: One found a dose-related reduction in pain; the other did not.

  - **Conclusion: conclusive or substantial evidence that cannabis or cannabinoids are effective for the treatment for chronic pain in adults**

Wallace et al., 2015, Wilsey et al., 2016, NASEM 2017

Chronic Pain

- Newer meta-analysis of 91 studies
  - Reduction of pain on 30% with OR 1.46
  - NNT 24
  - NNH 6

Individual AEs				
Dizziness	**23 (3879)** [1,4,8,14,19,40,49–51,54,56,66,68,72,74,80,83,86,90,98–100]	**OR 5.52 (4.47-6.83)**	**0%**	⊕⊕◯◯ **Low**
Depressed mood	**6 (1470)** [4,19,40,49,72,74]	**OR 1.60 (1.04-2.48)**	**0%**	⊕⊕◯◯ **Low**
Anxiety	2 (301) [1,72]	OR 2.45 (0.46-12.96)	0%	⊕◯◯◯ Very low
Cognitive or attention disturbance	**11 (1946)** [19,40,49,51,56,66,72,74,86,99]	**OR 5.67 (2.72-11.79)**	**0%**	⊕⊕◯◯ **Low**
Nausea	**14 (2381)** [8,14,18,40,49–51,54,56,66,68,72,80,83,86]	**OR 2.28 (1.73-3.00)**	**0%**	⊕⊕◯◯ **Low**
Vomiting	8 (1317) [8,40,49–51,56,66,72]	OR 1.57 (0.98-2.52)	0%	⊕⊕⊕◯ Moderate
Diarrhoea	10 (2099) [4,19,40,49,51,54,56,66,72,86]	OR 1.26 (0.90-1.76)	17%	⊕⊕◯◯ Low
Constipation	7 (1604) [4,8,19,50,72,99]	OR 1.32 (0.84-2.07)	0%	⊕⊕◯◯ Low
Drowsiness	**18 (2724)** [8,14,19,40,49–51,54,56,66,72,74,83,86,98,99]	**OR 2.18 (1.59-2.98)**	**42%**	⊕⊕◯◯ **Low**
Thought disturbance	**6 (539)** [49,51,72,74,98]	**OR 7.35 (1.95-27.72)**	**0%**	⊕◯◯◯ **Very low**
Insomnia	6 (582) [40,49–51,74,83]	OR 0.23 (0.07-0.76)	0%	⊕⊕◯◯ Low
Confusion and disorientation	**7 (984)** [19,49–51,72,74,86]	**OR 5.35 (2.31-12.39)**	**0%**	⊕⊕◯◯ **Low**
Intoxication	**10 (1476)** [40,46–51,66,72,74,83,86]	**OR 3.44 (1.74-6.83)**	**0%**	⊕⊕◯◯ **Low**
Appetite change	**7 (626)** [19,50,56,66,72,74,83]	**OR 3.00 (1.37-6.57)**	**0%**	⊕⊕◯◯ **Low**
Cardiovascular symptoms	4 (667) [8,49,66,72]	OR 0.80 (0.28-2.30)	0%	⊕⊕◯◯ Low
Respiratory tract infections	**7 (1384)** [40,49,50,54,56,66,72]	**OR 1.06 (0.63-1.78)**	**0%**	⊕⊕◯◯ **Low**
Dry mouth	19 (3117) [8,10,14,18,19,40,49–51,54,56,66,68,72,74,80,83,99,100]	OR 3.63 (2.61-5.05)	0%	⊕⊕◯◯ Low
Headaches and migraines	17 (2428) [8,19,40,49–51,54,56,66,68,72,74,83,86,98,100]	OR 0.86 (0.64-1.15)	0%	⊕⊕◯◯ Low

Chronic Pain

- CBD
  - CBD has been shown to be ineffective for Crohn’s colitis pain and chronic neuropathic pain
  - Could help with cancer-related pain (combined with THC)

Naftali 2017, Ben-Shabat 2006, Darkovska 2018

The bottom line for CHRONIC PAIN

- Cannabinoids have moderate to substantial evidence that they are effective in the treatment of chronic neuropathic pain
- Non-Neuropathic pain conditions have limited evidence
- CBD alone has limited evidence that it is ineffective in the treatment of some chronic pain conditions

Chemotherapy-induced Nausea and Vomiting

- Whiting Review
  - 28 trials of various mostly oral cannabinoids vs placebo or conventional anti-emetics
  - Most showed superiority to placebo and were as good or better than conventional anti-emetics

- Cochrane Review 2015
  - 23 trials, 19 of which were crossover studies
  - cannabinoids were more effective than placebo and similar in effectiveness to conventional anti-emetics
  - cannabinoids caused more adverse events, including dizziness, dysphoria, and euphoria

Whiting JAMA 2015, Smith et al 2015

Chemotherapy-induced Nausea and Vomiting

CBD

- No human studies evaluating the anti-emetic or appetite-stimulant effects of CBD alone

The bottom line for CHEMOTHERAPY-INDUCED NAUSEA AND VOMITING

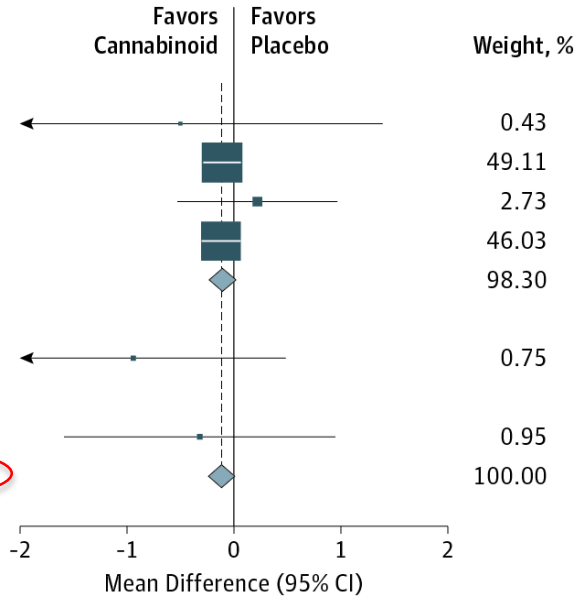
- **Cannabinoids have strong evidence that they are superior to placebo and at least as good as conventional anti-emetics for chemotherapy-induced nausea and vomiting**

- **There are no human studies evaluating CBD alone for chemotherapy-induced nausea and vomiting**

Multiple Sclerosis Spasticity

- Whiting Review
  - 11 parallel group studies of nabilone and nabiximols in patients with MS
  - associated with a greater average improvement in spasticity assessed using numerical rating scales (mean difference, −0.76 [95% CI, −1.38 to −0.14])
  - Insufficient evidence in spasticity from spinal-cord injuries
  - Objective physician-measured scales of spasticity did not reach statistical significant improvement

	Cannabinoid		Placebo		
Score Change With Cannabinoid vs Placebo by Study	No. of Patients	Mean (SD) Score Change	No. of Patients	Mean (SD) Score Change	Mean Difference (95% CI)
Nabiximols					
Collin,[125] 2010	156	-3.3 (9.25)	160	-2.8 (7.81)	-0.50 (-2.39 to 1.39)
Collin,[127] 2007	114	-.64 (.56)	63	-.53 (.58)	-0.11 (-0.29 to 0.07)
Wade,[129] 2004	73	-.37 (2.51)	70	-.59 (2.04)	0.22 (-0.53 to 0.97)
Berman,[87] 2007	40	-.13 (.43)	44	-.01 (.42)	-0.12 (-0.30 to 0.06)
Subtotal $I^2 = 0.0\%$, ($P = .0.82$)	383		337		-0.11 (-0.23 to 0.02)
Dronabinol					
Zajicek,[131] 2003	197	-1.86 (7.95)	207	-.92 (6.56)	-0.94 (-2.37 to 0.49)
Tetrahydrocannabinol/cannabidiol					
Zajicek,[131] 2003	207	-1.24 (6.6)	207	-.92 (6.56)	-0.32 (-1.59 to 0.95)
Overall $I^2 = 0.0\%$, ($P = .80$)	590		544		-0.12 (-0.24 to 0.01)



Multiple Sclerosis Spasticity

- Systematic Review 2014, Koppel et al, for selected neurologic disorders
  - 14 studies in patients with MS that oral cannabinoids and nabiximols
  - Cannabinoids are ‘probably effective in reducing severity of patient-rated spasticity but not physician-rated symptoms’.

Multiple Sclerosis Spasticity

CBD

There are no human studies of CBD alone for the treatment of MS spasticity, though there are some animal studies and proposed mechanisms that it may be helpful

The bottom line for MULTIPLE SCLEROSIS SPASTICITY

- There is conclusive evidence that oral cannabinoids improved patient-reported spasticity in multiple sclerosis
- There is insufficient evidence for cannabinoid use in other forms of spasticity
- There are no human studies to support the use of CBD alone for MS spasticity

Specific Seizure Syndromes

- Dravet Syndrome- FDA approved indication- Epidiolex oral solution
  - complex childhood epilepsy disorder that is associated with drug-resistant seizures and a high mortality rate
  - CBD 20 mg/kg oral solution in addition to standard AED's (n 120)
  - The median frequency of convulsive seizures per month decreased from 12.4 to 5.9 with cannabidiol, as compared with a decrease from 14.9 to 14.1 with placebo
  - Increase adverse events in CBD group: diarrhea, vomiting, fatigue, pyrexia, somnolence, and abnormal results on liver-function tests

Devinsky NEJM 2017, CBC News

Specific Seizure Syndromes

- Lennox-Gastaut Syndrome
  - rare, severe form of epileptic encephalopathy, are frequently treatment resistant to available medications
  - Decrease incidence of drop seizure attacks with CBD 20 mg/kg/day
  - Adverse affects slightly more common in the CBD group diarrhea, somnolence, pyrexia, decreased appetite, and vomiting

  - FDA approved

Anxiety

- Whiting and NASEM reviewed only one RCT of 24 patients with treatment-naïve social-anxiety disorder
  - Decreased anxiety in a simulated public speaking exercise with 600 mg CBD
- Other studies failed to show an effect on public-speaking anxiety with 150 or 300 mg of CBD
- Basic science research shows a potential physiologic basis for anxiolysis
- NASEM also notes a moderate probability of cannabis being associated with development of generalized anxiety disorder

Bergamaschi Neuropsychopharmacology 2011,
NASEM 2018

Additional Conditions with Limited Evidence

Condition	Evidence
Appetite Stimulation	Limited evidence in HIV/AIDS, little to no evidence to support use in other conditions
Sleep	Limited evidence primarily with Nabiximols improving sleep quality as a secondary outcome in studies for MS and chronic pain
Tourette Syndrome	Limited evidence (36 total patients) showing decreased tics with THC capsules

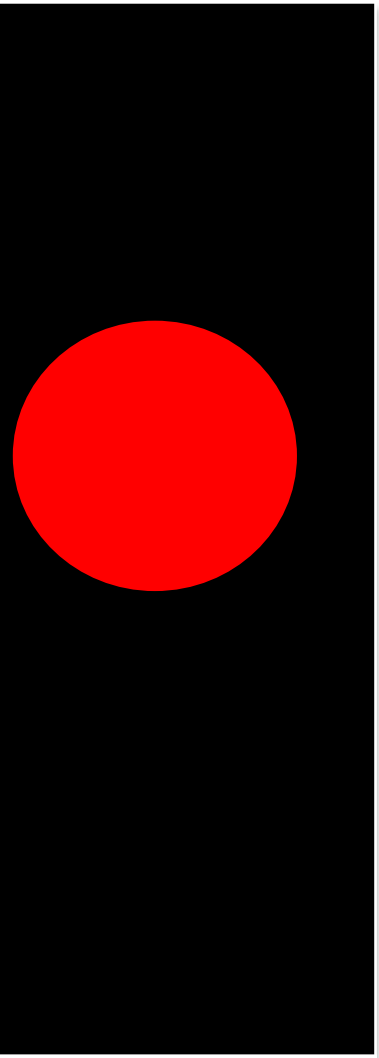
Additional Conditions with Insufficient evidence for Efficacy

Condition	Evidence
Epilepsy	Insufficient evidence for efficacy
Depression	Insufficient evidence for efficacy
Anxiety	Insufficient evidence for efficacy
Psychosis	Insufficient evidence for efficacy
Glaucoma	Insufficient evidence for efficacy

Condition	Evidence
Chronic Neuropathic Pain	●
Chemotherapy-Induced Nausea and Vomiting	●
MS Spasticity	●
Dravet and Lennox-Gastaut - CBD	●
HIV/AIDS Appetite Stimulation	●
Sleep Disorders	●
Tourette Syndrome	●
Other Chronic Pain Conditions	●

Conditions with insufficient evidence

Crohn's Disease, Diabetes, Dystonia, GVHD, Huntington's Disease, Parkinson's disease, smoking cessation, social anxiety disorder, epilepsy, anxiety, glaucoma, opioid withdrawal, Alzheimer's Disease



Adverse Effects of Short-Term Cannabis Use

- Impaired short-term memory
- Impaired Motor Coordination
- Altered Judgement
- Paranoia
- Psychosis

Adverse Effects of Long-Term or Heavy Cannabis Use

- Addiction
- Altered brain development/ Cognitive Impairment
- Diminished Life Satisfaction and Achievement
- Chronic Bronchitis
- Cyclic Vomiting Syndrome
- Association with depression, anxiety, and psychotic disorders

VCU Health

Volkow NEJM 2016

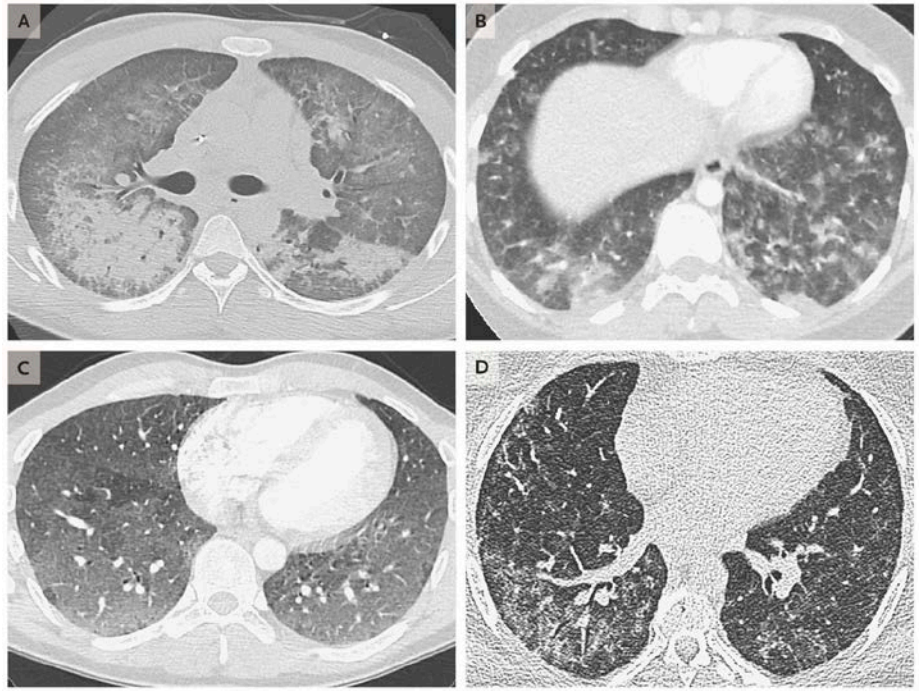
Table 2. Level of Confidence in the Evidence for Adverse Effects of Marijuana on Health and Well-Being.

Effect	Overall Level of Confidence*
Addiction to marijuana and other substances	High
Abnormal brain development	Medium
Progression to use of other drugs	Medium
Schizophrenia	Medium
Depression or anxiety	Medium
Diminished lifetime achievement	High
Motor vehicle accidents	High
Symptoms of chronic bronchitis	High
Lung cancer	Low

* The indicated overall level of confidence in the association between marijuana use and the listed effects represents an attempt to rank the strength of the current evidence, especially with regard to heavy or long-term use and use that starts in adolescence.

Lung Injury Related to E-cigarette Use or Vaping (EVALI)

- 2,602 hospitalized EVALI cases, 57 deaths (as of 1/7/20)
- Link to vitamin E acetate
- Most patients reported a history of using e-cigarette products containing THC.
- CDC recommends that you consider refraining from using e-cigarette or vaping products (especially those with THC).



TS Henry et al. N Engl J Med 2019, CDC

CBD

-several in vitro and in vivo studies showing safety of CBD without effect on heart rate, blood pressure and body temperature, gastrointestinal transit, or alterations in psychomotor or psychological functions

-other studies have shown **possible orthostatic hypotension, dry mouth, diarrhea, vomiting, fatigue and elevated LFT's**

-may inhibit several cytochrome P450's enzymes

Naturalmedicines.com, Bergamaschi Curr Drug Saf 2012 , Medscape.com

Variations in Products

- 84 products purchased online (not from pharmaceutical dispensaries)
  - 42% of doses were under-labeled
  - 29% over-labeled
  - THC present in 21% of samples

Medical Cannabis in Virginia

- Information from the Virginia Department of Health Professions, Board of Pharmacy
- Adapted from *Caroline D. Juran, Executive Director*

"DISCLAIMER: The federal Controlled Substances Act makes it a crime to lease, rent or maintain a place for the purpose of manufacturing, distributing or using marijuana (21 U.S.C. § 856), to engage in financial transactions to promote illegal activities (21 U.S.C. § 1957), and to conspire to commit such a crime (21 U.S.C. § 846).

This educational material does not constitute legal advice and does not express the views or opinions of VCU Health CME, VCU Health System"

- The information in the presentation is not legal advice and is not intended to be complete. Refer to the DHP website for complete information

VCU Health™

Virginia Department of Health Professions

The State of Medical Cannabis in Virginia

- Virginia State Assembly laws passed in 2018-2019 (including SB 1557) effective 7/1/2019
- Allowed the creation of five medical cannabis processing facilities and dispensaries across the state
- enables Virginians to access therapeutic strength, Board of Pharmacy regulated cannabis THC-A and CBD OIL products after receiving approval by a certified doctor, physicians assistant or nurse practitioner.
- The drug is not prescribed in the Commonwealth because marijuana remains illegal on a federal level. Law creates an “affirmative defense” if a patient is found in possession of cannabis

Conditionally Approved Dispensaries

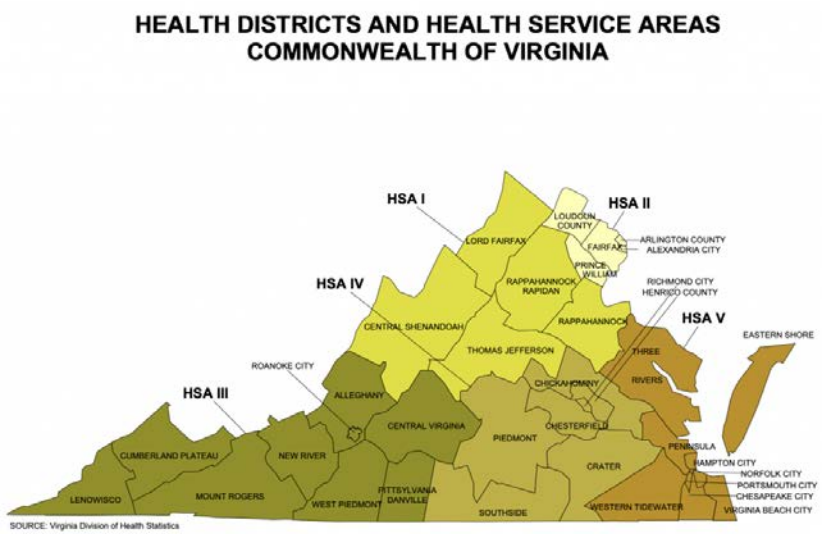
HSA I = PharmaCann Virginia LLC

HSA II = Dalitso LLC

HSA III = Dharma Pharmaceuticals

HSA IV = Green Leaf Medical of Virginia LLC

HSA V = Columbia Care Eastern Virginia LLC



Written Certification

- §54.1- 3408.3(B) “A practitioner in the course of his professional practice may issue a written certification for the use of cannabidiol oil or THC-A oil for treatment or to alleviate the symptoms of any diagnosed condition or disease determined by the practitioner to benefit from such use.”

- "Practitioner" means a practitioner of medicine or osteopathy, nurse practitioner, or physician assistant

Affirmative Defense

- Law provides for an affirmative defense for a patient, parent/legal guardian to possess CBD oil or THC-A oil as defined in §54.1-3408.3

….who has been issued a valid written certification from a Board of Pharmacy-registered physician

….and who maintains a current registration with the Board of Pharmacy.

Practitioner Requirements (an INCOMPLETE list)

- Conduct an in person history and physical, access the PMP, diagnose the patient, and be available for follow up
- Be of the opinion that the potential benefits of cannabidiol oil or THC-A oil would likely outweigh the health risks of such use to the qualifying patient
- Explain proper administration, potential risks and benefits, prior to issuing the written certification;
- Issue no more than 600 written certifications
- Do NOT provide samples or provide certifications for co-workers, friends, or family members

Certifications

- Register with the Department of Health Professions https://www.license.dhp.virginia.gov/apply/
- You then may provide certifications to a patient
- $50 initial fee and $50 annual fee thereafter
- Patients also register online for a $50 fee

What do we tell Mr. Jones?

Conclusions

1. There have been multiple formulations of cannabis studied with varied end points and outcomes
2. There is strong evidence for the use of cannabinoids to treat chronic neuropathic pain, chemotherapy-induced nausea and vomiting, and MS spasticity
3. Epidiolex is on oral CBD formulation which is FDA approved to treat Dravet and Lennox Gastaut syndromes
4. Cannabis use is associated with several adverse effects with short term and long-term use including addiction
5. CBD has limited evidence for safety in humans
6. Refer to the Virginia Department of Health Professions for additional information about medical cannabis in VA.

Questions?

References

1. Whiting PF, Wolff RF, Deshpande S, et al. Cannabinoids for Medical Use: A Systematic Review and Meta-analysis. *JAMA.* 2015;313(24):2456–2473. doi:10.1001/jama.2015.6358
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Case Presentation #1
Ademola Adetunji, NP

- 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

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

Should I give suboxone to this client even though her UDS is negative for Opioid?

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.)

35 years old Caucasian female. unemployed, separated with 3 adult children, living with aged mother that kicked her out. Presented to Detoxification clinic requesting for suboxone.

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.)

C/o using heroin and fentanyl about $200 worth daily. Period of sobriety off/on. last use of opioid the morning before seen at the detoxification clinic.
H/o Opioid use started at age 21 years old after discontinued from prescribed Oxycodone for neck injury in MVA at age 19 years old.
Current medication: None
Labs: Urine drug screening negative for all substances

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

Treatment: Placed on Vistaril 25mg po q6H PRN x 7 days
Clonidine 0.1mg po BID PRN x 7 days
Melatonin 3mg (1-5 tabs) po qHS pRN x 7 days
Referral to pain management via community clinic
Referral to residential patient psychotherapy (CBT)
Referral to housing assistance program (County housing assistance program, Shelter, Salvation army housing)

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

Follow up by phone call with patient, Community clinic provider, pain clinic.
Patient's goal for Treatment: Pain management without using Opioid

End of Case Study

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

Case Presentation #2
Saba Suhail, 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
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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?

What, if anything, could have been done differently for this patient?
Should he have been immediately dismissed, or offered another chance?
I would also like to troubleshoot how best to treat patients with substance abuse while also suffering from comorbidities, particularly in an area where opioids (and other controlled substances) are heavily prescribed (currently number one in the nation). How can we, as the patient's PCPs, reasonably accommodate patient goals and expectations, when the majority of these patients expect (or in some instances demand) controlled substances?

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 is a 56 year old Caucasian male. He is currently unemployed, and is married. He lives in an apartment with another couple who manage his finances and ADLs. Social support includes his wife and father, as well as the other couple with whom he resides. He is without transportation.

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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.)

PMH:
-HTN, seizure D/O controlled, Bipolar disorder with depression currently well controlled, COPD, and chronic pain syndrome. He has a remote history of RCC with nephrectomy and prostatectomy.

Psych
- Bipolar disorder with depression.He is taking trileptal, saphris, depakote.
-Anxiety. He has been prescribed Klonopin, but is now on Xanax and Buspar
He denies inpatient psychiatric treatment. He does report a Family history of suicidal ideation without attempts.

Substance Abuse history:
ETOH: denies use
Heroin: denies use
Cocaine: denies use
Marijuana: denies use
Benzodiazepines: currently prescribed Xanax. Admits to taking Klonopin 5 weeks prior to PCP visit
Barbituates: denies use
Prescription meds: Pt is on norco for knee pain, back pain from injury when he was younger. He uses a cane due to knee issues. He has also been prescribed Neurontin
Tobacco:The patient has used tobacco for 40 years at a frequency of 1.5ppd.
Previously he was down to half pack a day using wellbutrin.

Labs results:
-PMP was checked at the last visit and was without concern--he apparently had his medication filled by the same provider consistently.
-Urine Drug Screen revealed methamphetamine, and additionally showed the absence/noncompliance of his chronic medications including hydrocodone, Xanax, wellbutrin

Barriers to patient care:
-lack of transportation
-lack of available resources (no pain management nearby, limited access to psychiatry in the region)
-ease of access to illicit substances

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

The patient had been prescribed klonopin, Xanax, and Buspar for his anxiety, and was receiving hydrocodone for chronic low back pain and knee pain. He had previously been on wellbutrin and Chantix for tobacco use, as well as nicotine patches, gum, and lozenges. He is currently on Wellbutrin. At the most recent visit, he was referred to psychiatry.

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

As a result of the patient's toxicology screen, he was dismissed from the facility and has subsequently found another PCP within the same health network.

End of Case Study

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Case Studies

- Case studies
  - Submit: www.vcuhealth.org/echo
  - Receive feedback from participants and content experts
  - Earn **$100** for presenting

Telehealth

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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:

- **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
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- **Jennifer Phelps, BS, LPN** from Horizons Behavioral Health
- **Crystal Phillips, PharmD** from Appalachian College of Pharmacy
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- **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

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- To claim CME credit for today's session
- Feedback
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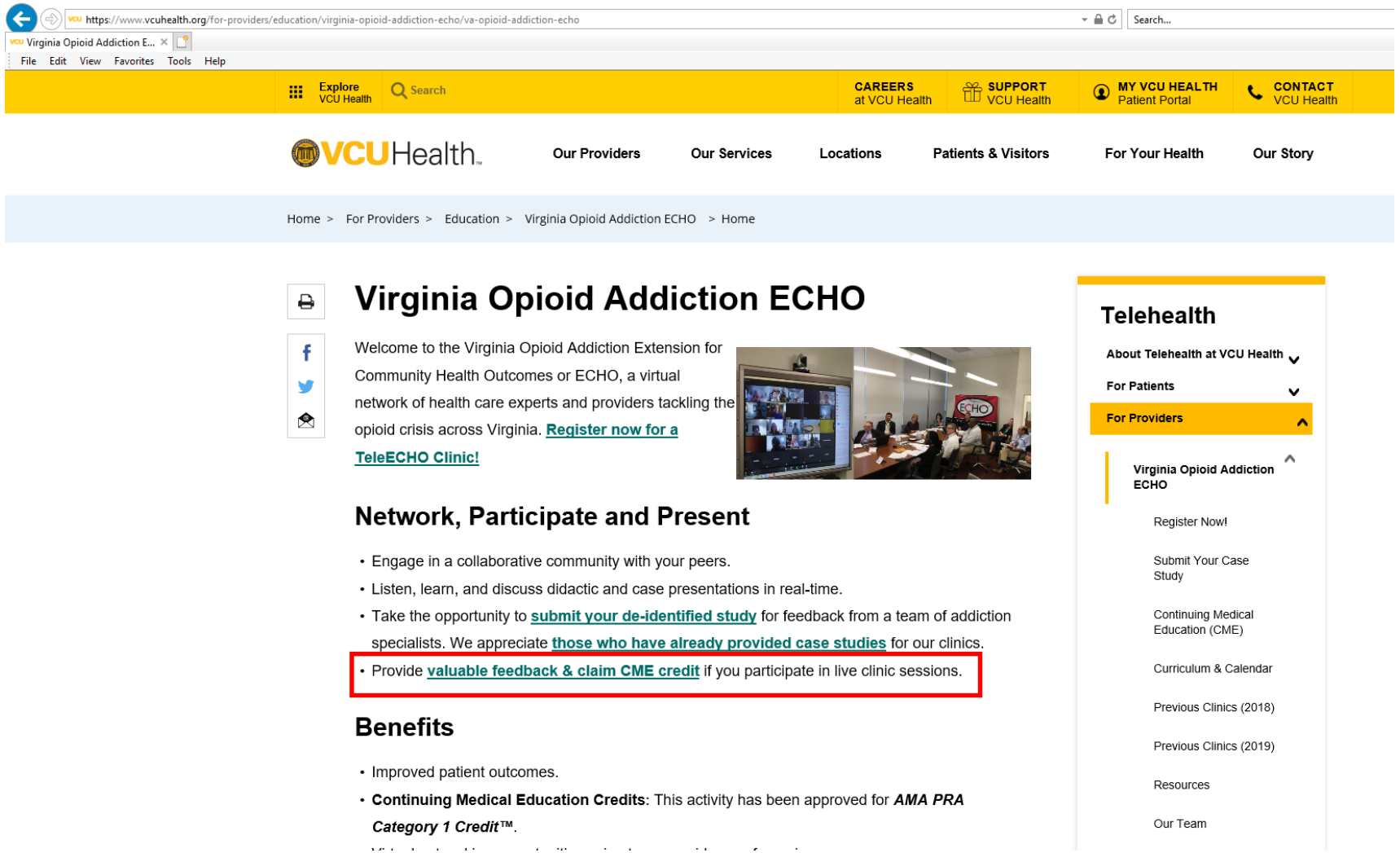

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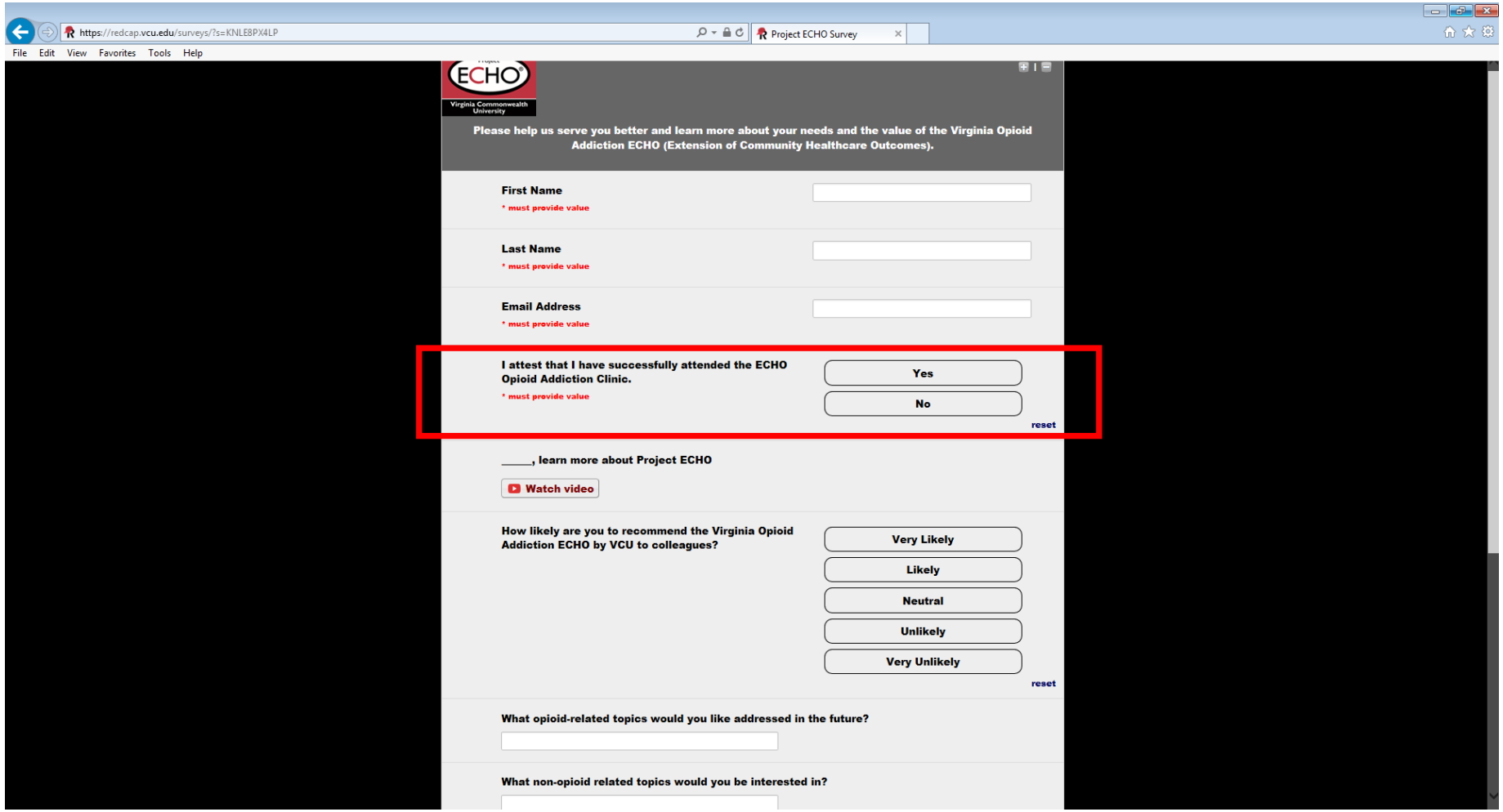

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    - Register Now!
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    - Continuing Medical Education (CME)
    - Curriculum & Calendar
    - Previous Clinics (2018)
    - Previous Clinics (2019)
    - Resources

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™***.
- Virtual networking opportunities using two-way video conferencing.
- No cost to participate.
- **If unable to attend a live clinic session**, learn how to access the CME website to view the recording and claim credit.

Content posted within the Virginia Opioid Addiction ECHO is made by possible, in part, by funding from the Virginia Department of Health.

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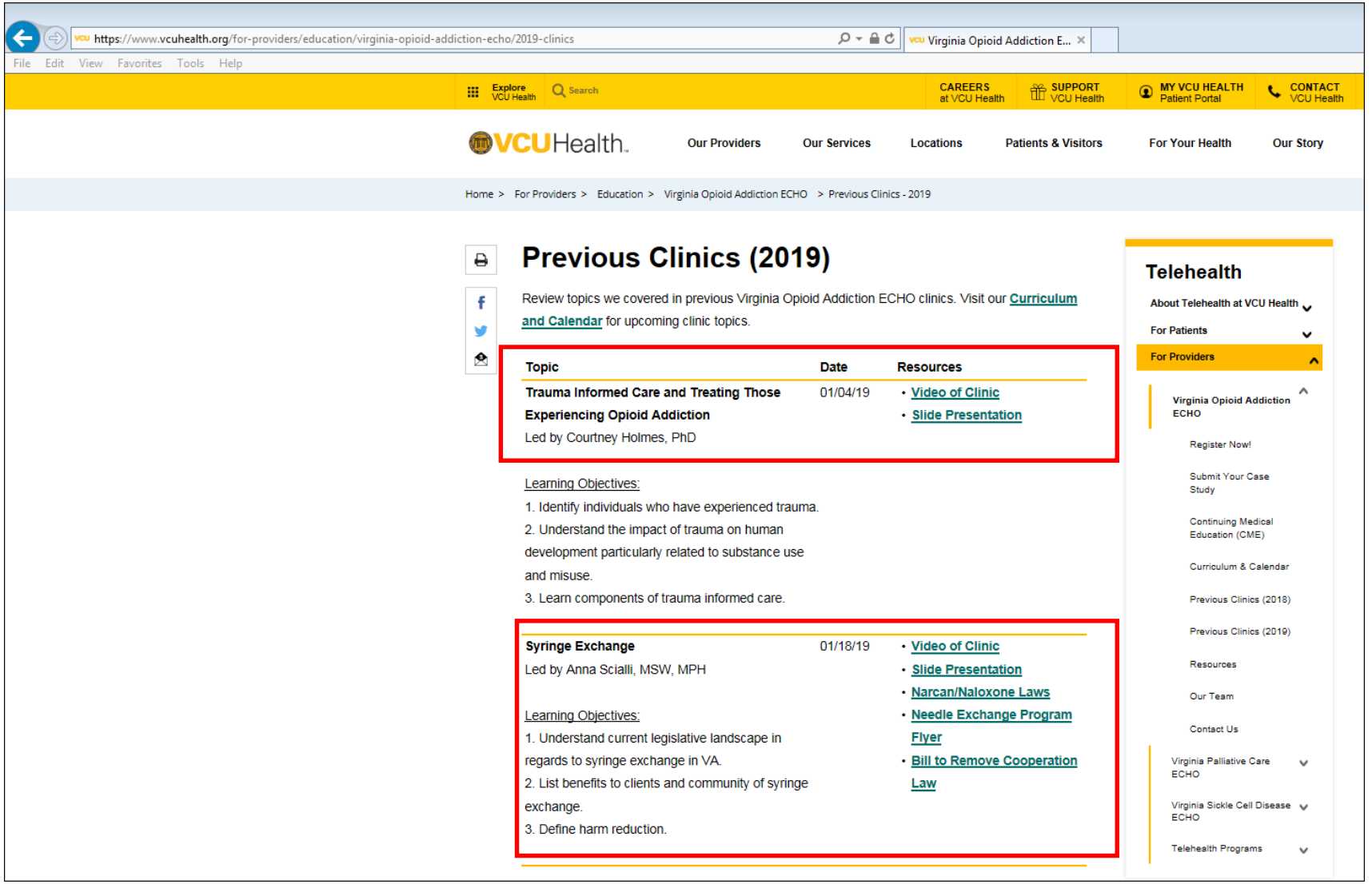

VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

Mark Your Calendar --- Upcoming Sessions

Jan 31:	Implementing Group Therapy	Courtney Holmes, PhD Lori Keyser-Marcus, PhD
Feb 21:	Pharmacotherapy for Methamphetamine Use	Gerry Moeller, MD

Please refer and register at vcuhealth.org/echo

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THANK YOU!

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Resources

1. Whiting PF, Wolff RF, Deshpande S, et al. Cannabinoids for Medical Use: A Systematic Review and Meta-analysis. *JAMA.* 2015;313(24):2456–2473. doi:10.1001/jama.2015.6358
2. The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research. 2017 Jan 12;. doi: 10.17226/24625. Review. PubMed PMID: 28182367.