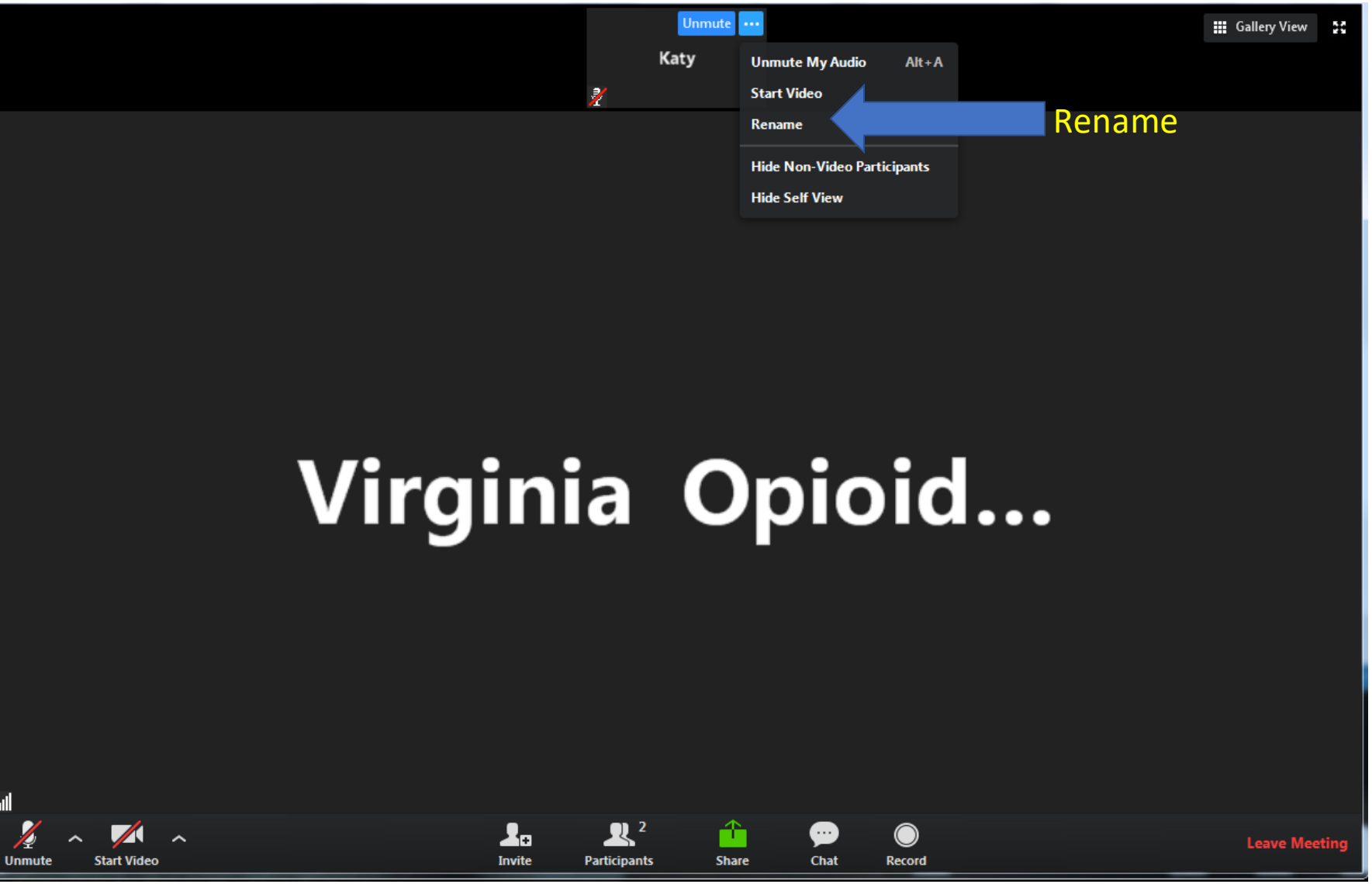
Virginia Opioid Addiction ECHO* Clinic

April 3, 2020

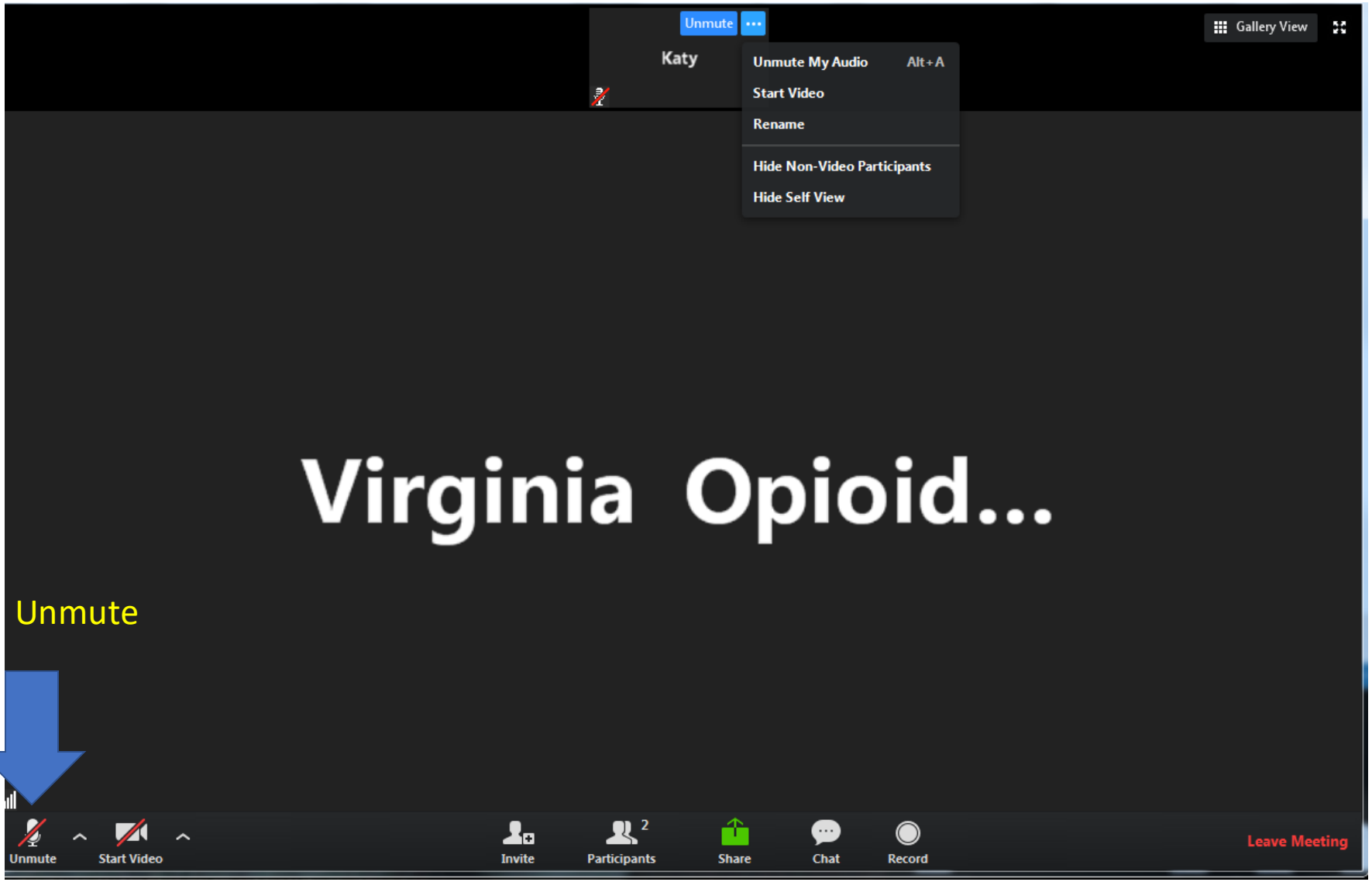
*ECHO: Extension of Community Healthcare Outcomes

Helpful Reminders



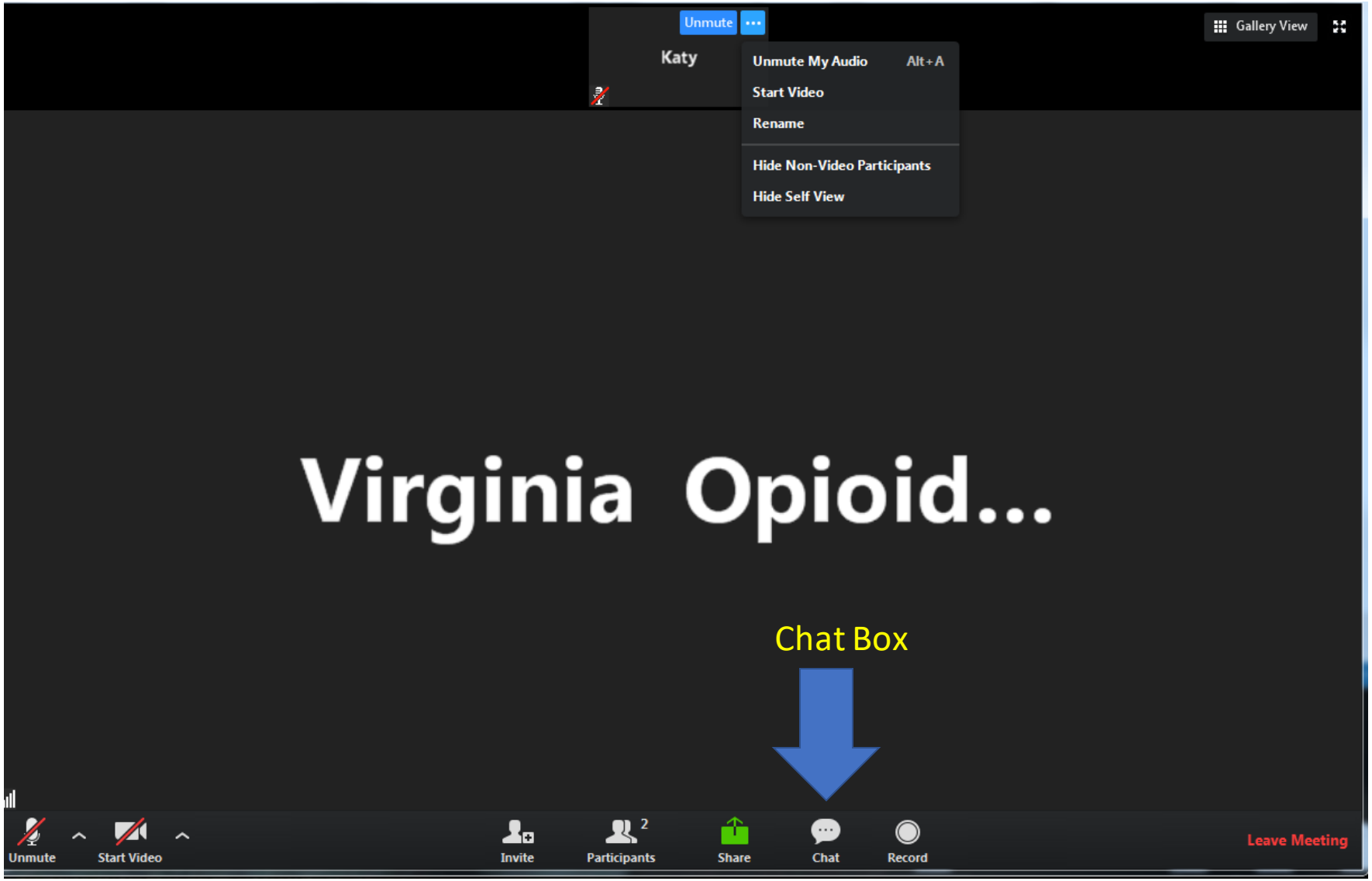
- Rename your Zoom screen, with your name and organization

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

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 Salim Zulfiqar, MD
Didactic Presentation	Richard Sterling, MD
Program Manager	Bhakti Dave, MPH
Practice Administrator	David Collins, MHA
IT Support	Vladimir Lavrentyev, MBA

Participant 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. **Richard Sterling, 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

Evaluation and Treatment of Hepatitis C in 2020

Richard K. Sterling, MD, MSc, FACP, FACG, FAASLD, AGAF
VCU Hepatology Professor of Medicine
Chief, Section of Hepatology
Fellowship Director, Transplant Hepatology
Virginia Commonwealth University
Richmond, VA

Conflicts of Interest in the last 12 months

- Advisory Board
  - Baxter, Pfizer
- Research support
  - Roche/Genentech, AbbVie, Gilead, Abbott
- Speaker
  - None
- Stock/Financial interest
  - None

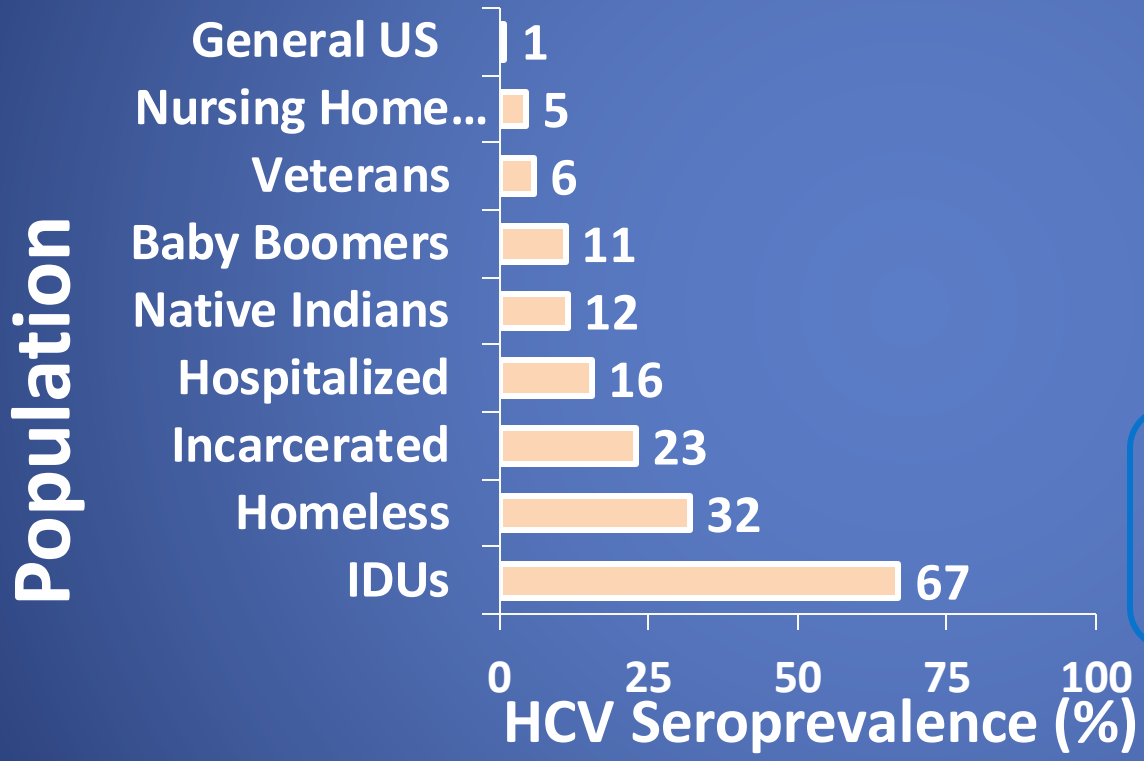
Learning Objectives

- To understand the epidemiology and burden of HCV
- Understand the evaluation of HCV
- To understand the current treatment for HCV

Overview of the Burden of HCV

- Approximately 30,000 new cases of HCV/year
- Acute HCV is rising (illicit drug use)
- Over 5 million in the US are infected (including prisons)
- <50% know they have it
- Over 75% who get HCV develop chronic disease
  - 25% will develop advanced fibrosis (scarring)
  - Increased scarring is associated liver failure and liver cancer
  - HCV remains a leading indication for liver transplantation

HCV Burden Is Higher in Marginalized Populations



These populations experience:

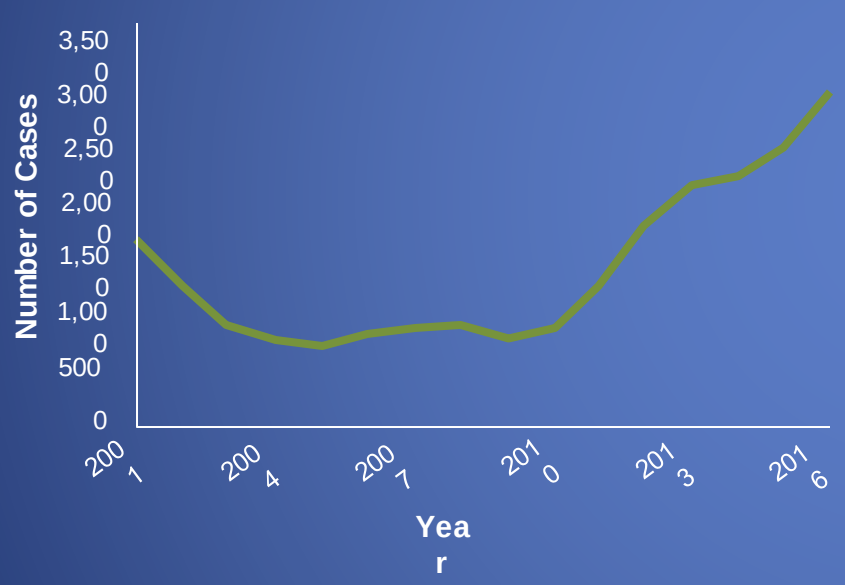
- High burden of comorbidities
- Inconsistency of HCV testing
- Limited access to HCV care

Implementation of research strategies and interprofessional collaborative efforts are essential to target these populations

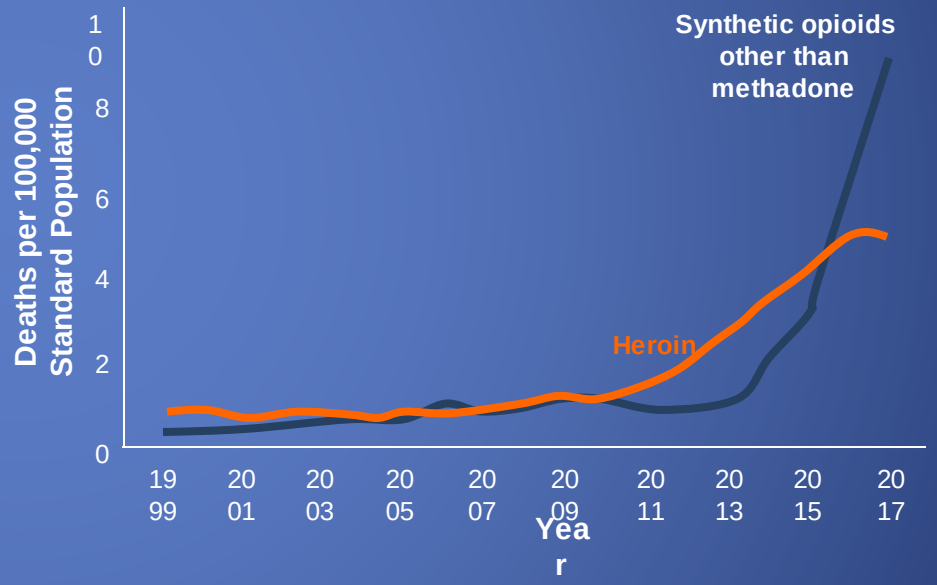
Denniston M, et al. *Ann Int Med*. 2014;160(5):293–300; Edlin BR, et al. *Hepatology*. 2015;62(5):1353–1363; Grebely J, et al. *Inl J Drug Policy*. 2015;26(10):1028–1038; Maier MM, et al. 2016;106(2):353–358; Galbraith JW, et al. *Hepatology*. 2015;61(3):776–782; Backus L, et al. *Fed Pract*. 2018;35(2):S8–S12.

US Trends for Acute HCV Cases and Drug Overdose-Related Deaths

Reported Cases of Acute HCV (2001–2016)



Drug Overdose Death Rates (1999–2017)

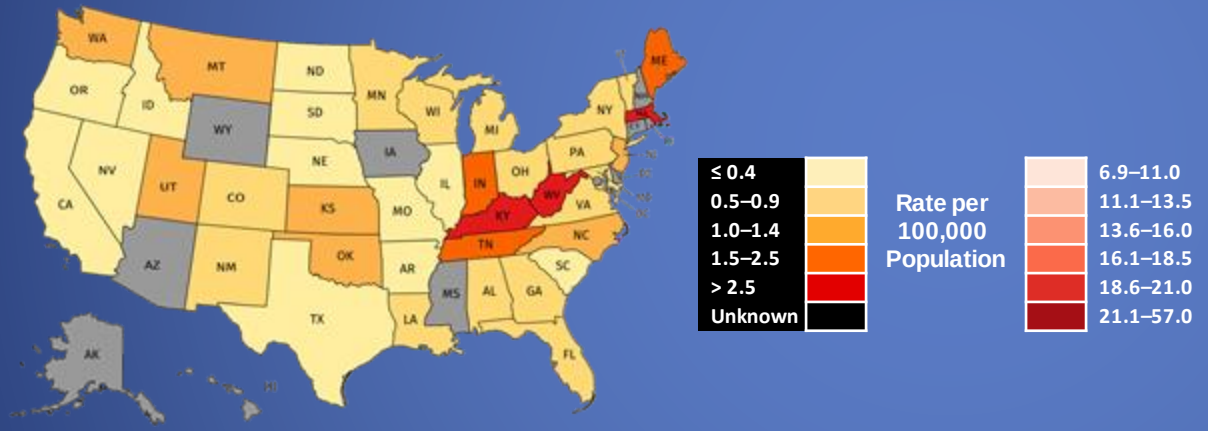


~69% of people with acute HCV infection reported injection-drug use

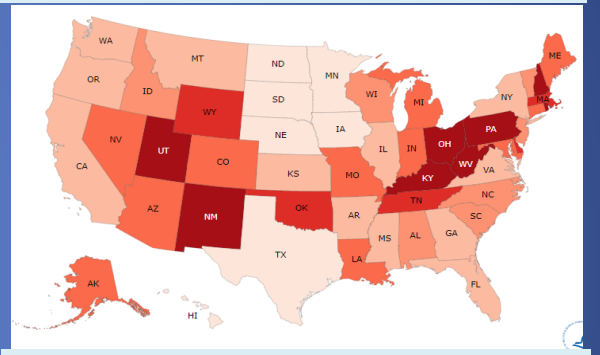
Centers for Disease Control and Prevention (CDC). Viral Hepatitis Surveillance – United States, 2016. https://www.cdc.gov/hepatitis/statistics/2016surveillance/pdfs/2016HepSurveillanceRpt.pdf. Accessed 5/8/2019; CDC. Drug Overdose Deaths in the United States, 1999–2017. https://www.cdc.gov/nchs/products/databriefs/db329.htm. Accessed 5/8/2019.

Acute HCV and Deaths From Drug Overdose

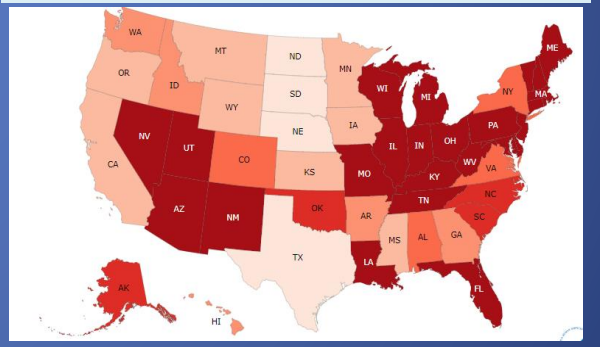
Acute HCV Cases (2014)



Deaths from Drug Overdose (2014)



Deaths from Drug Overdose (2017)

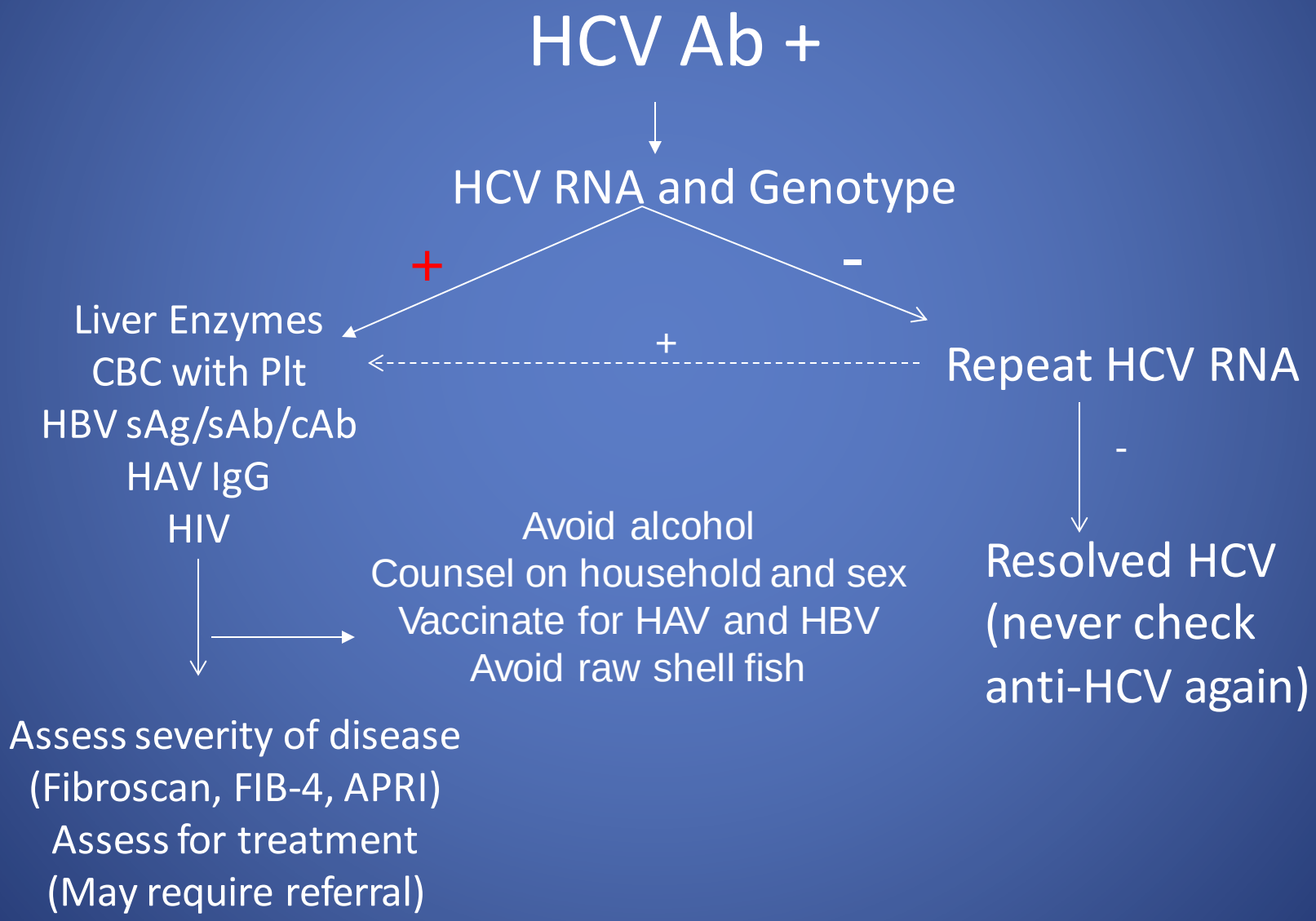


CDC. Surveillance for Viral Hepatitis – US, 2014. www.cdc.gov. Accessed 6/29/17; CDC. Drug Overdose Death Data. https://www.cdc.gov/drugoverdose/data/statedeaths.html. Accessed 05/08/2019.

Who to test for HCV

- Traditional risk factors
  - h/o illicit drug use (both IV and intranasal)
  - Tattoos and body piercing (especially if placed non-commercially)
  - Blood transfusion < 1991
  - HIV, HBV
  - Long term HD, Organ transplant recipient
  - Evaluation of elevated LFTs
- Non-traditional risk factor
  - 2/3 of those with HCV are those born between 1945-1965 “Baby Boomers”
  - All those 18-79 (new 2020)

Evaluation of HCV



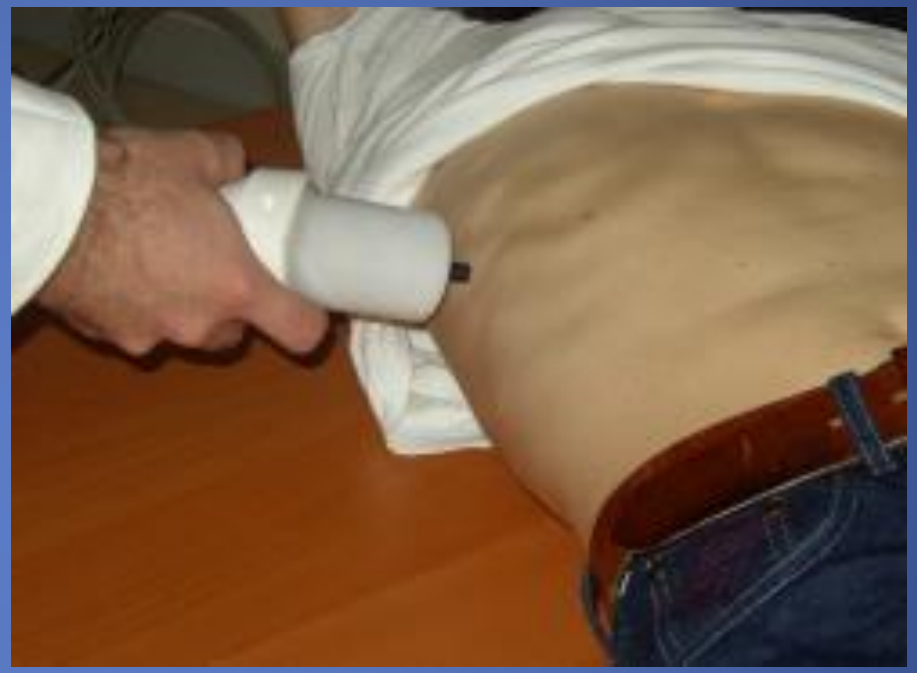
Potential Serum Fibrosis Markers

- Forns Index
- APRI
  - AST, Plt
- FibroTest / FibroSure
  - Bilirubin, A_2MG, Haptoglobin, GGT, globulins
- FibroSpect
  - HA, TIMP - 1, A_2MG
- ELF Test
  - HA, TIMP-1, PIIINP
- SHASTA Index - HIV specific
  - HA, AST, ALB
- FIB-4
  - Age, Plt, AST, ALT
- Lok Index
- eLIFT

All have excellent NPV (to rule out) advanced fibrosis but only moderate PPV (to rule it in)

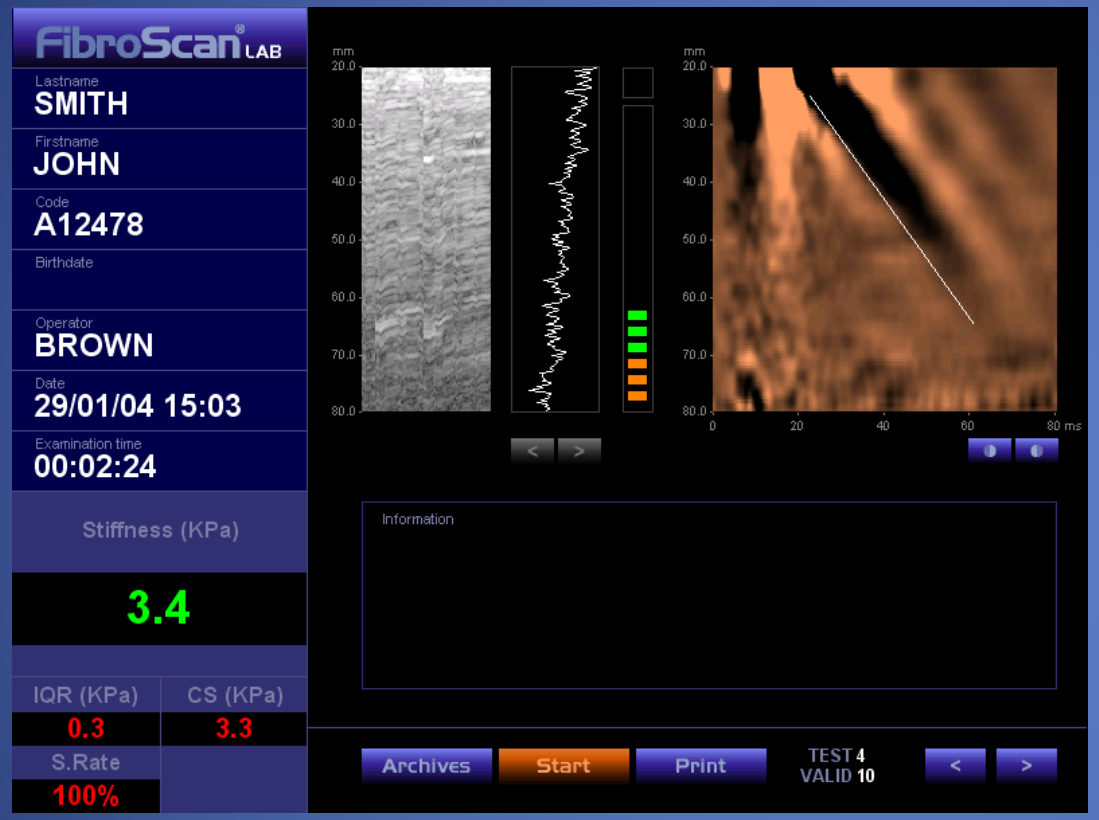
FibroScan®

Elastogram



- Examination duration varies between 2 and 5 minutes

Examination procedure

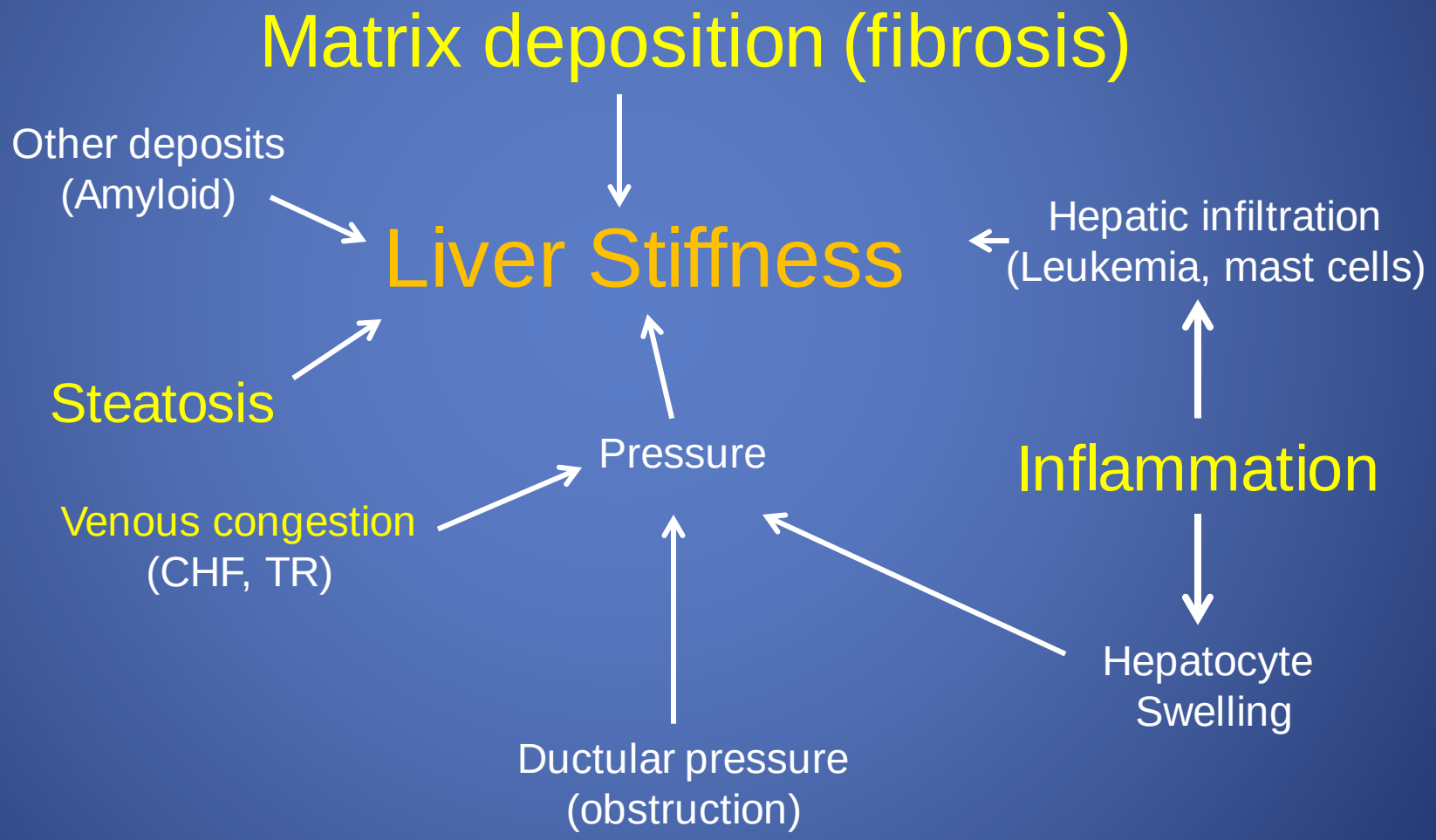


Area under the ROC curve (n=251)

(95% confidence interval)

- F≥2 : 0.79 (0.73-0.84)
- F≥3 : 0.91 (0.87-0.96)
- F=4 : 0.97 (0.93-1.00)

Factors that affect liver stiffness



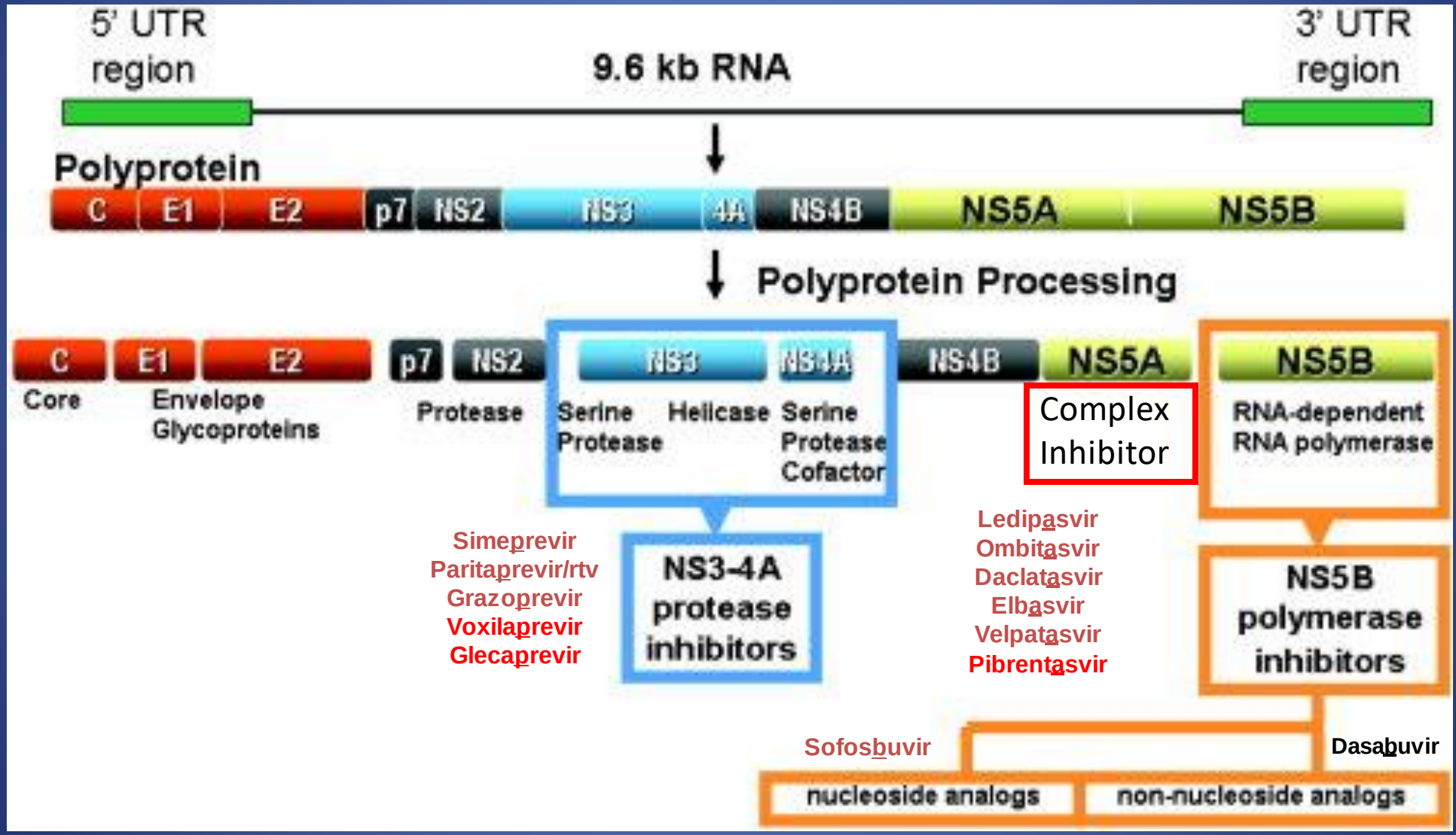
Bonder and Afdhal. Curr Gastro Rep 2014;16:372

So, now we know the patient has HCV, the genotype and the degree of fibrosis, how are we going to treat them?

Interferon free treatment

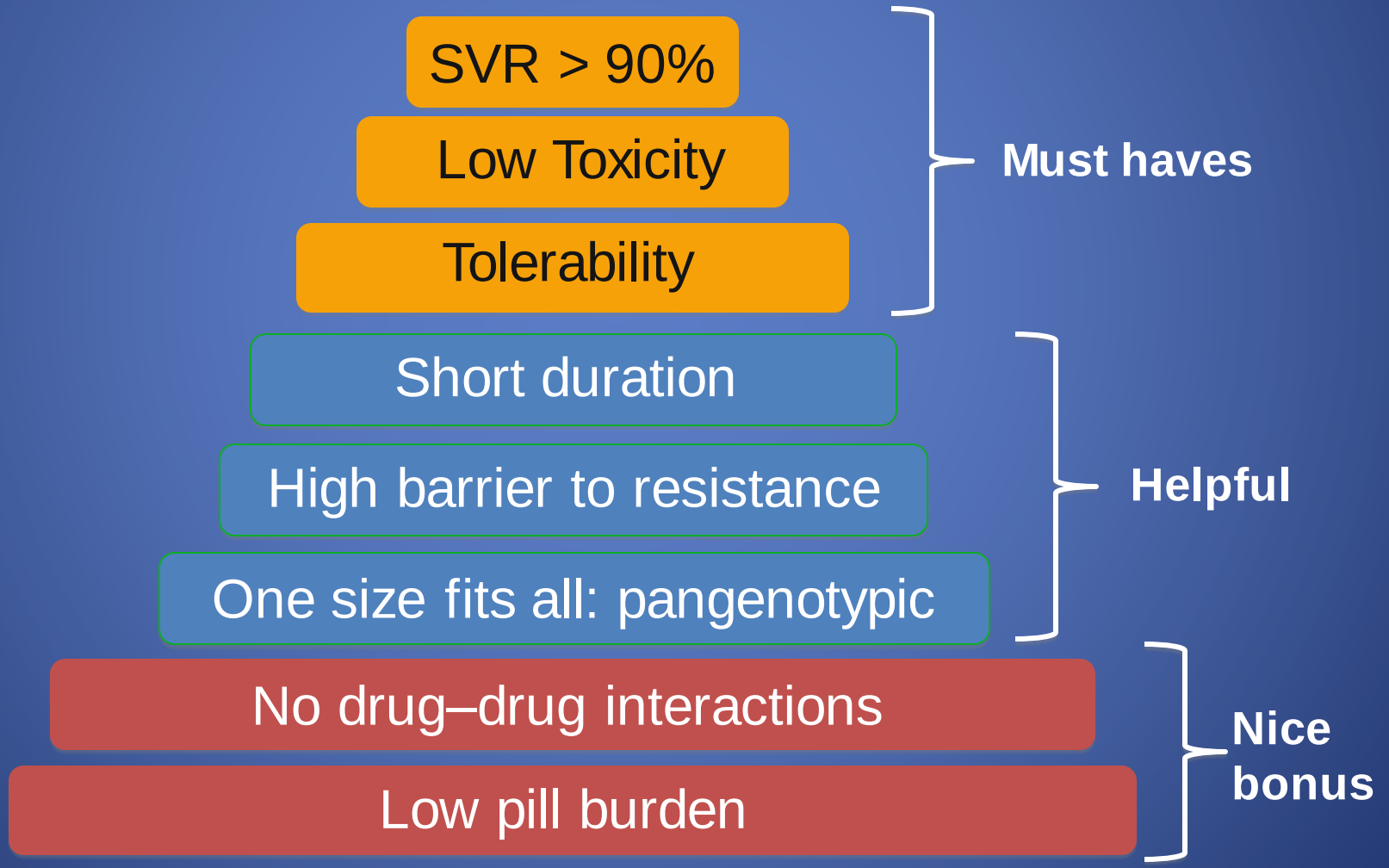
Holy Grail

HCV Polyprotein Processing and Viral Protein Function



Adapted from McGovern B, Abu Dayyeh B, and Chung RT. Hepatology. 2008; 48:1700-12

Requirements for HCV Therapy



Approved DAA for HCV 2020

DAA	GT	Duration (wks)	Tablets/day
Sofosbuvir + ribavirin (RBV)	2,3	12-24	1 + RBV
Sofosbuvir + Ledipasvir[&] +/- RBV*	1, 4-6	8-24	1 (+ RBV)
Sofosbuvir + Velpatasvir[&] +/- RBV^	1-6	12	1 (+ RBV)
Sofosbuvir + Velpatasvir + Voxilaprevir[&]	1-6	12	1
Sofosbuvir + Daclastasvir +/- RBV^	1,3	12	2 (+ RBV)
Sofosbuvir + Simeprevir	1,4	12-24	2
Elbasvir + Grazoprevir +/- RBV[#%]	1,4	12-16	1 (+ RBV)
Paritaprevir/ritonavir/ombitasvir/dasabuvir +/- RBV	1	12-24	4 (+ RBV)
Paritaprevir/ritonavir/ombitasvir +/- RBV	4	12	3
Glecaprevir + Pibrentasvir (G/P) [%]	1-6	8-16	3

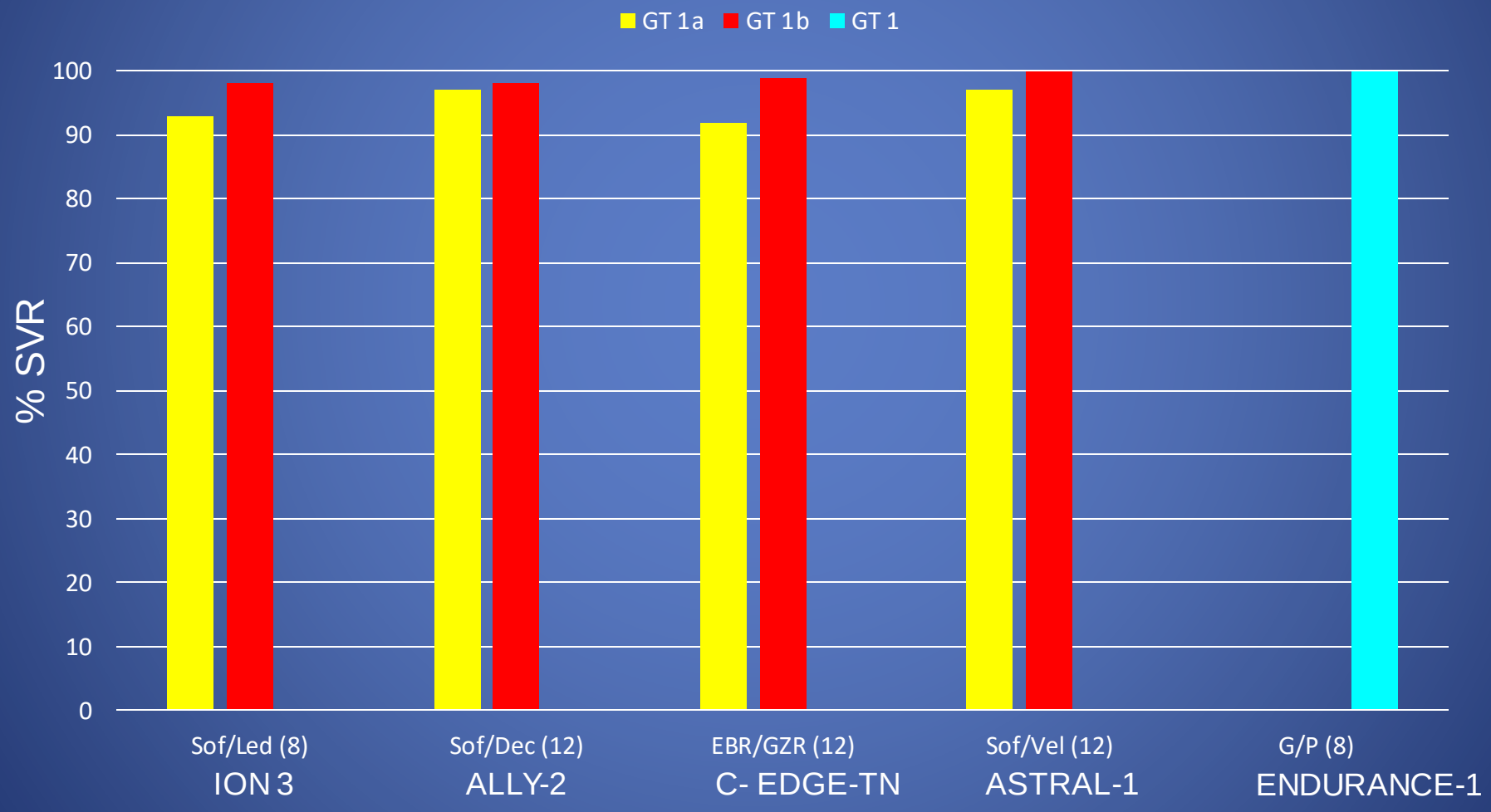
Mechanism: b NS5B inhibitor; a NS5A inhibitor; p NS3/4A Protease inhibitor
* Cirrhosis ^ GT3 with cirrhosis or Y93H [#] GT1a
[%] safe in renal failure [&] safe in decompensated cirrhosis

DAAs we use for HCV 2020

DAA	GT	Duration (wks)	Tablets/day
Sofosbuvir + ribavirin (RBV)	2,3	12-24	1 + RBV
Sofosbuvir + Ledipasvir +/- RBV* Harvoni	1, 4-6	8-24	1 (+ RBV)
Sofosbuvir + Velpatasvir +/- RBV^ Epclusa	1-6	12	1 (+ RBV)
Sofosbuvir + Velpatasvir + Voxilaprevir Vosevi	1-6	12	1
Sofosbuvir + Daclastasvir +/- RBV^	1,3	12	2 (+ RBV)
Sofosbuvir + Simeprevir	1,4	12-24	2
Elbasvir + Grazoprevir +/- RBV# Zepatier	1,4	12-16	1 (+ RBV)
Paritaprevir/ritonavir/ombitasvir/dasabuvir +/- RBV	1	12-24	4 (+ RBV)
Paritaprevir/ritonavir/ombitasvir +/- RBV	4	12	3
Glecaprevir + Pibrentasvir (G/P) Mavyret	1-6	8-16	3

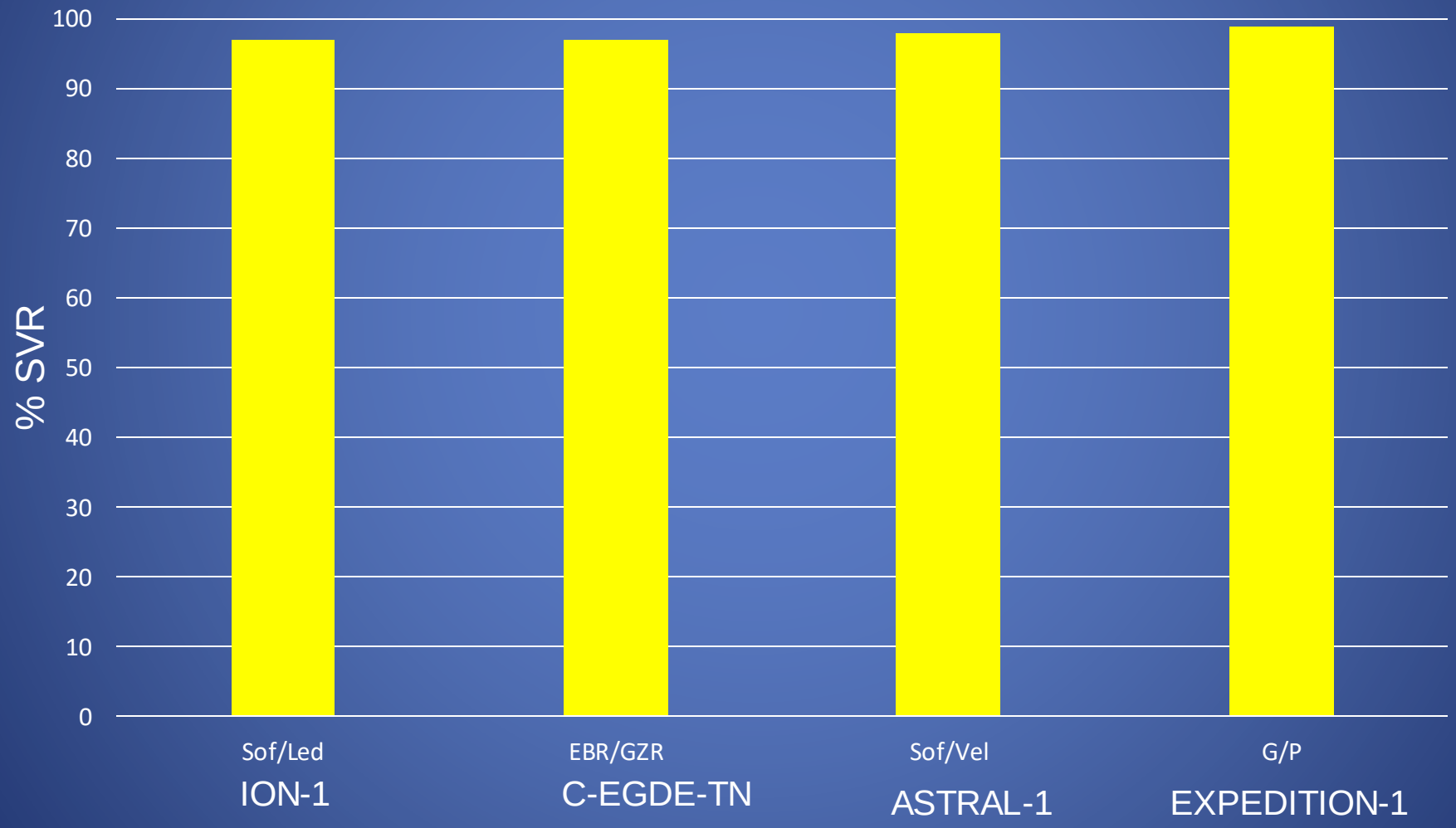
Mechanism: b NS5B a NS5A p PI
* Cirrhosis ^ GT3 with cirrhosis or Y93H # GT1a

Treatment of HCV Genotype 1 a/b
Treatment naïve, no cirrhosis (8-12 weeks)



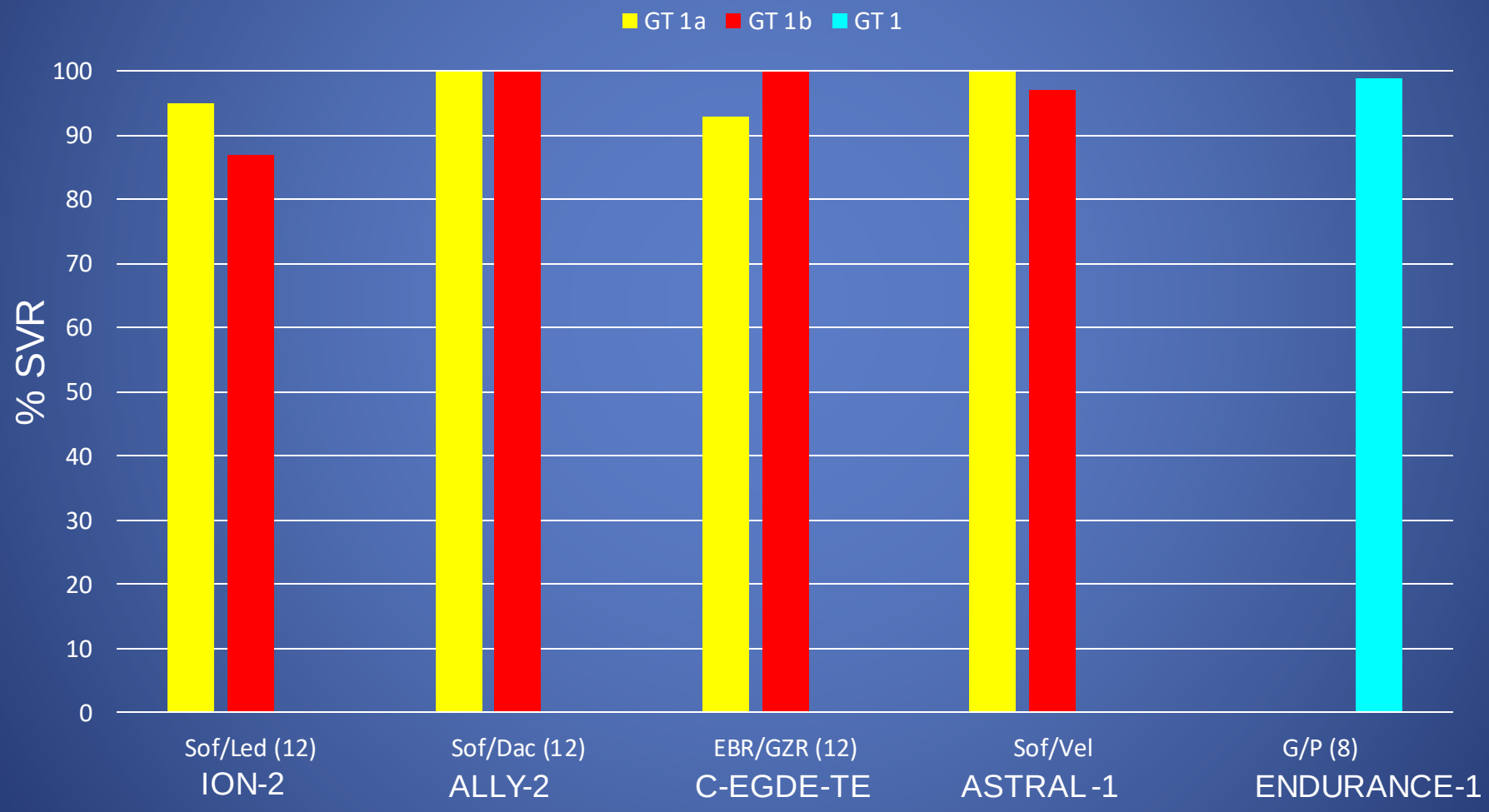
Kowdley KV, et al. *N Engl J Med.* 2014;370(20):1879-1888; Wyles DL, et al. *N Engl J Med* 2015;373(8):714-725; Ferenci P, et al. *N Engl J Med*. 2014;370(21):1983-1992; Zeuzeum S, et al. *Ann Intern Med*. 2015;163(1):1-13; Feld JJ, et al. *New Eng J Med.* 2015;373(27):2599-2607; Kwo P, et al. *Hepatology*. 2016;64(2):370-380; Puoti M, et al. IAS 2017. Paris, France. Abstract TUPEB0384.

Treatment of HCV Genotype 1 a/b
Treatment naïve, with cirrhosis (12 weeks)



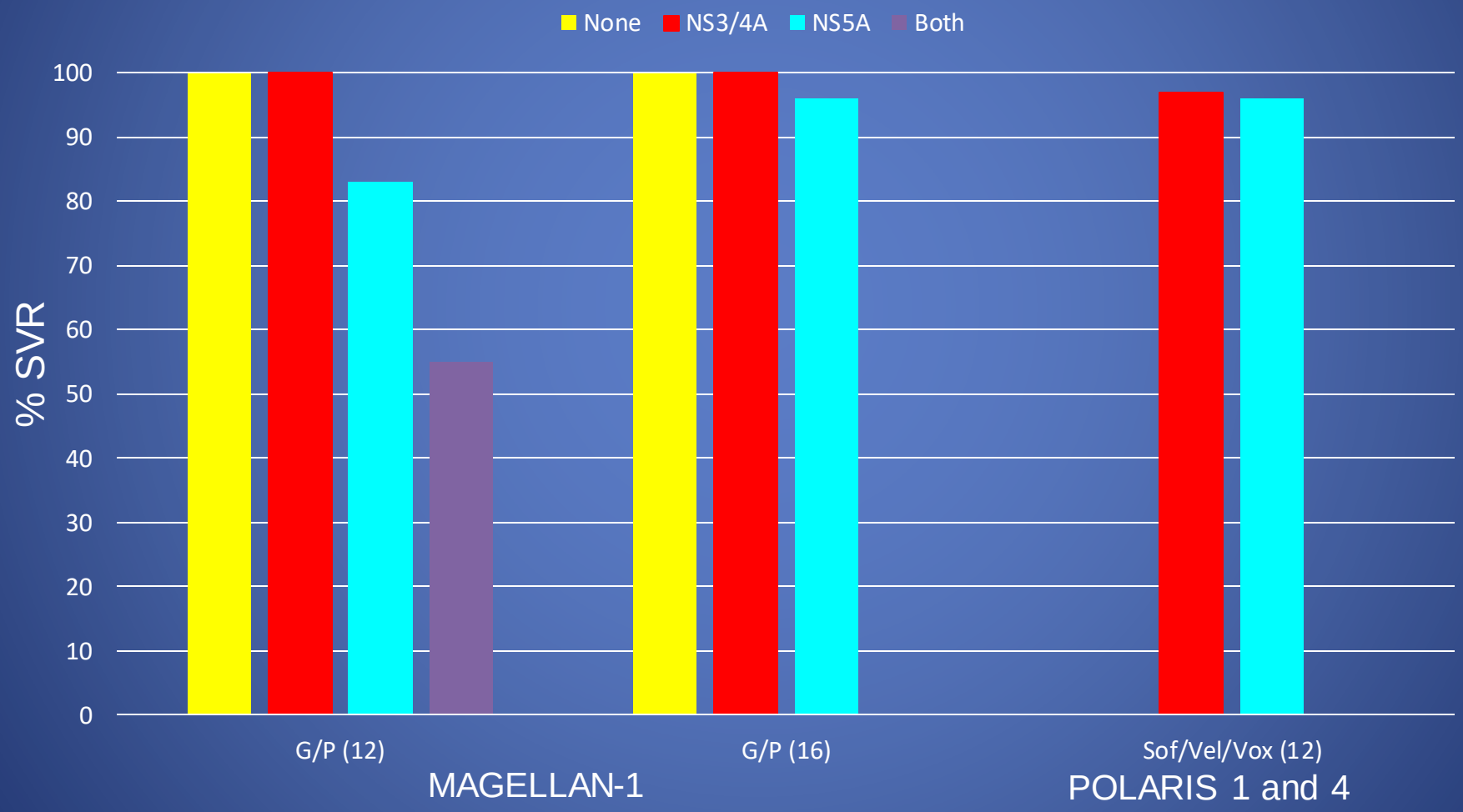
Afdhal N, et al. *N Engl J Med*. 2014;370(20):1889-1898; Feld JJ, et al. *J Hepatol*. 2016;64(2):301-307;
Zeuzeum S, et al. *Ann Intern Med*. 2015;163(1):1-13; Feld JJ, et al. *N Eng J Med*. 2015;373(27):2599-2607; Forns X, et al. *Lancet Infect Dis*. 2017.

Treatment of GT 1 non-cirrhotic Peg/RBV failures

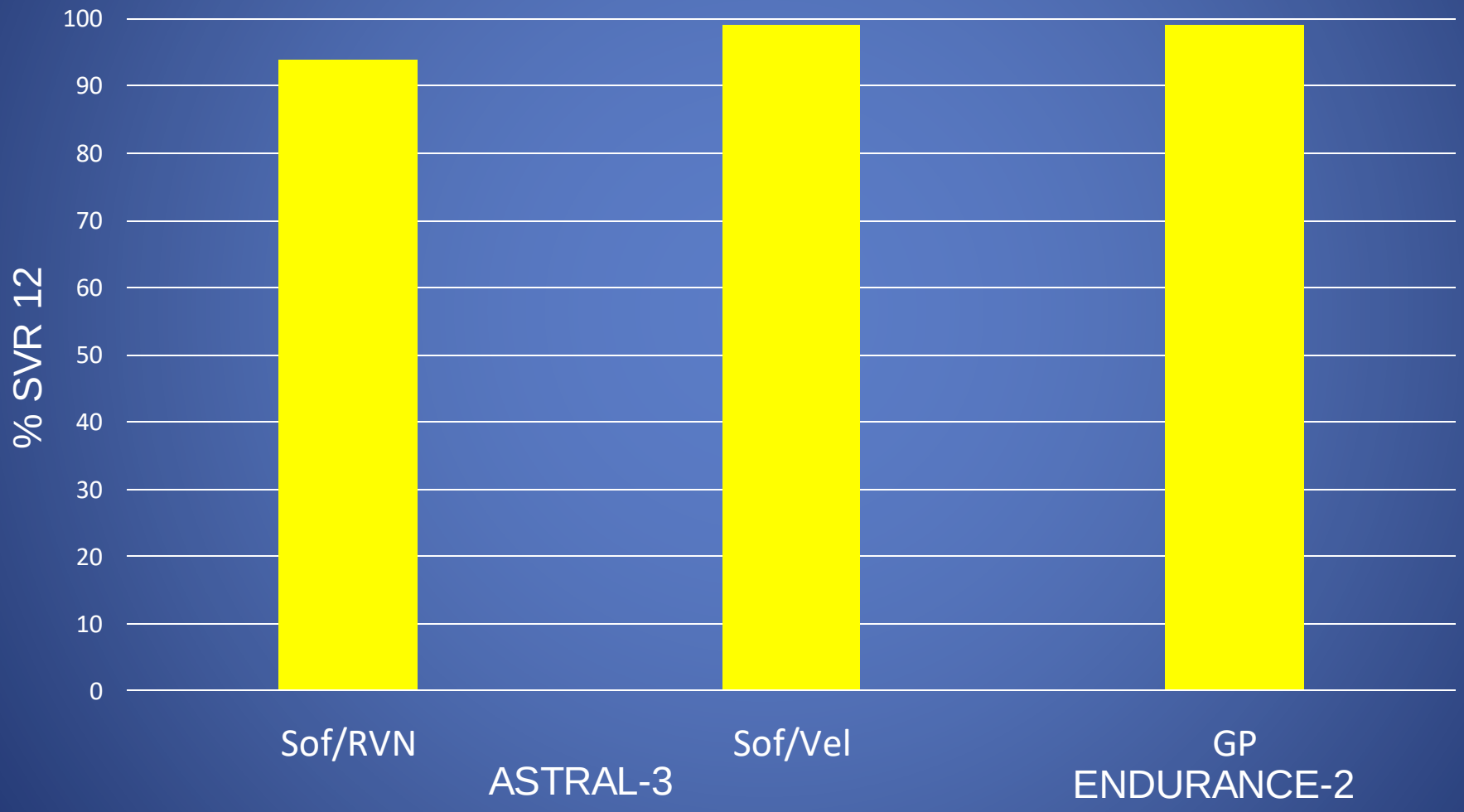


Afdhal N, et al. *N Engl J Med*. 2014;370(16):1483-1493; Wyles DL, et al. *N Engl J Med*. 2015;373(8):714-725; Afdhal N, et al. *N Engl J Med*. 2014;370(17):1604-1614; Andreone P, et al. *Gastroenterology*. 2014;147(2):359-365;Kwo P, et al. *Gastroenterology*. 2017;152:164-175; Feld JJ, et al. *N Eng J Med*. 2015;373(27):2599-2607; Kwo P, et al. *Hepatology*. 2016;64(2):370-380; Zeuzem S, et al. AASLD 2016. Abstract 253.

Treatment of HCV GT1
DAA Experienced

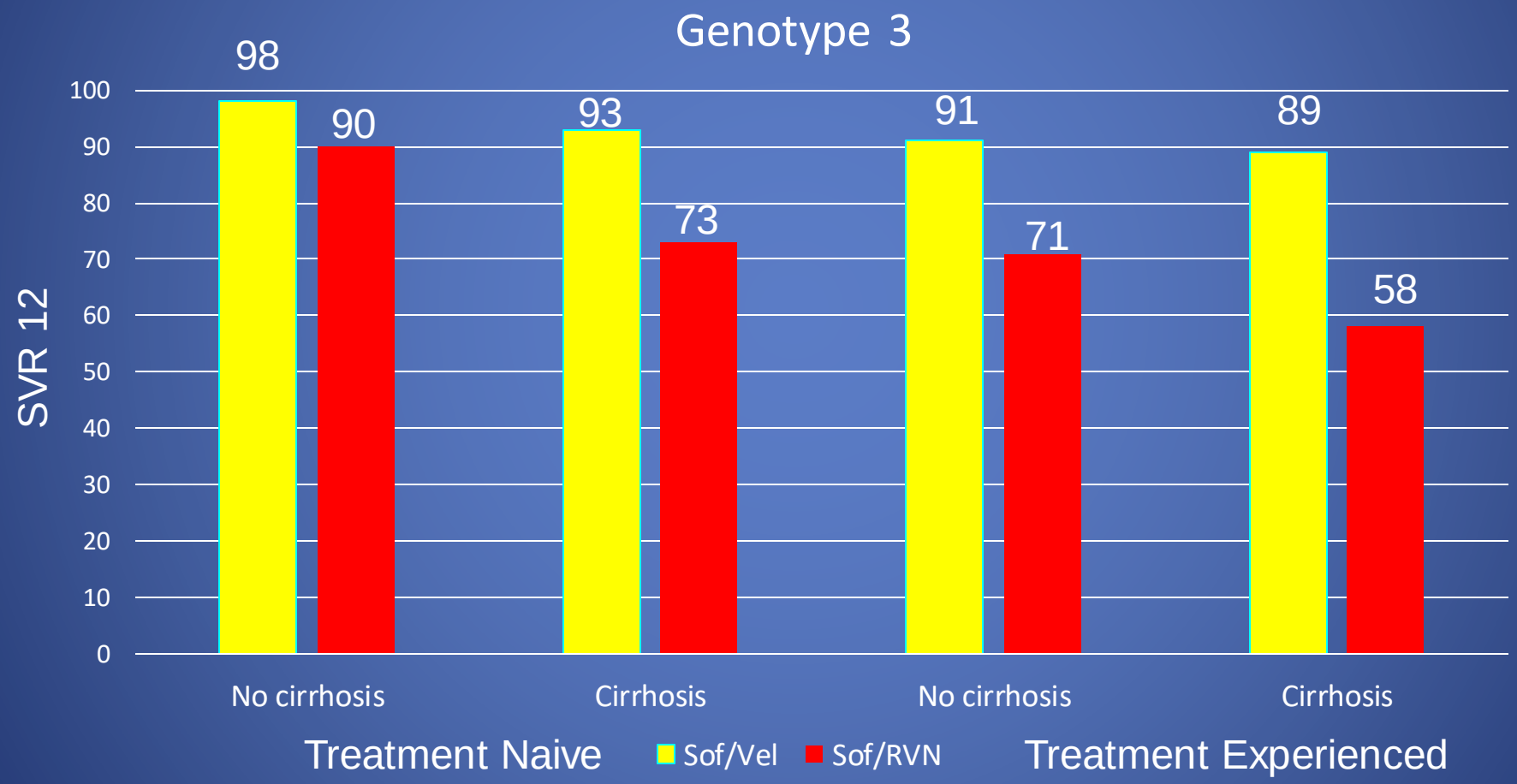


Treatment of GT 2
" A gift from God"



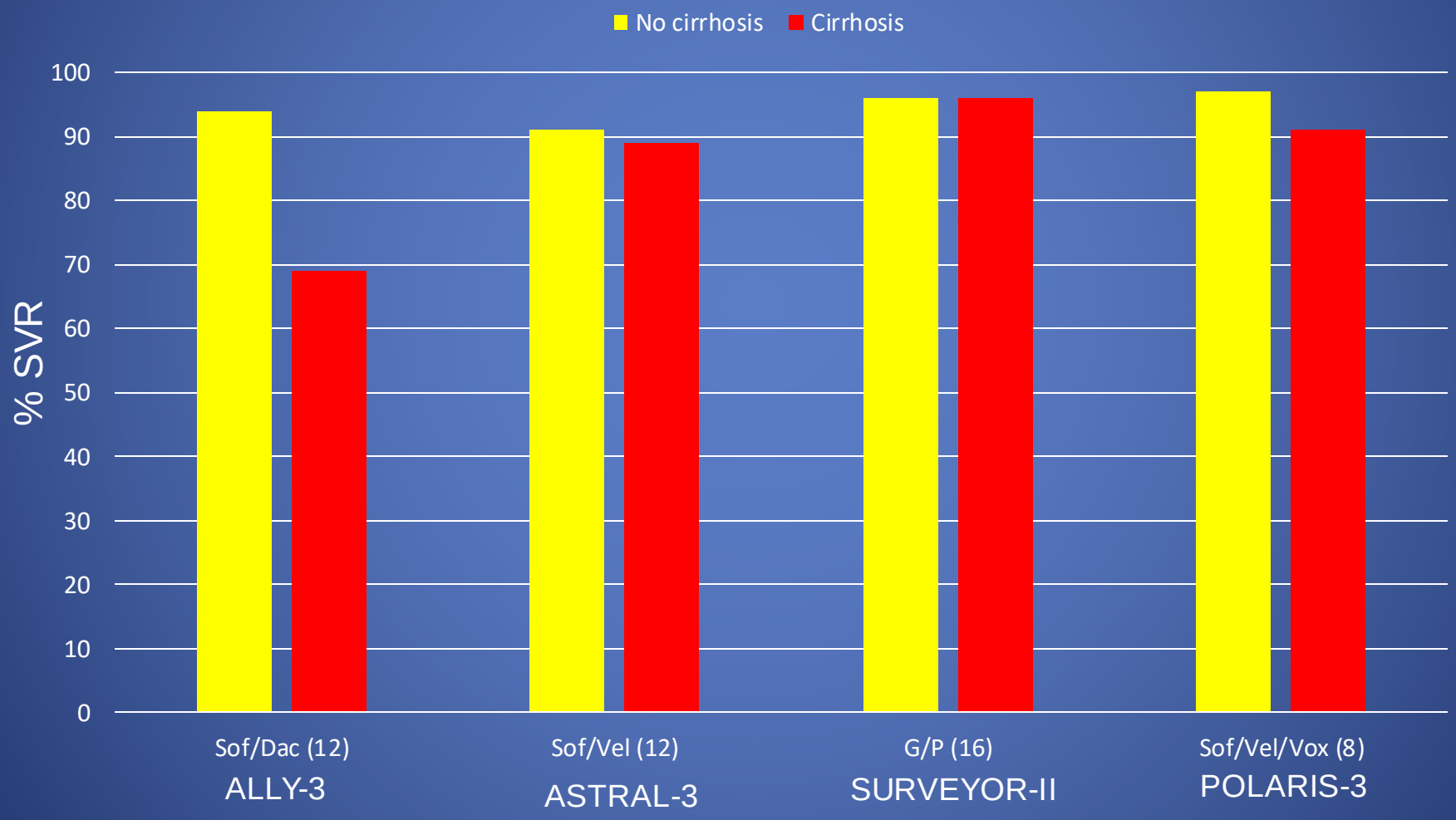
GR Foster et al. NEJM November 17, 2015. Kowdley AASLD 2016

Sofosbuvir + Velpatasvir (ASTRAL 3)



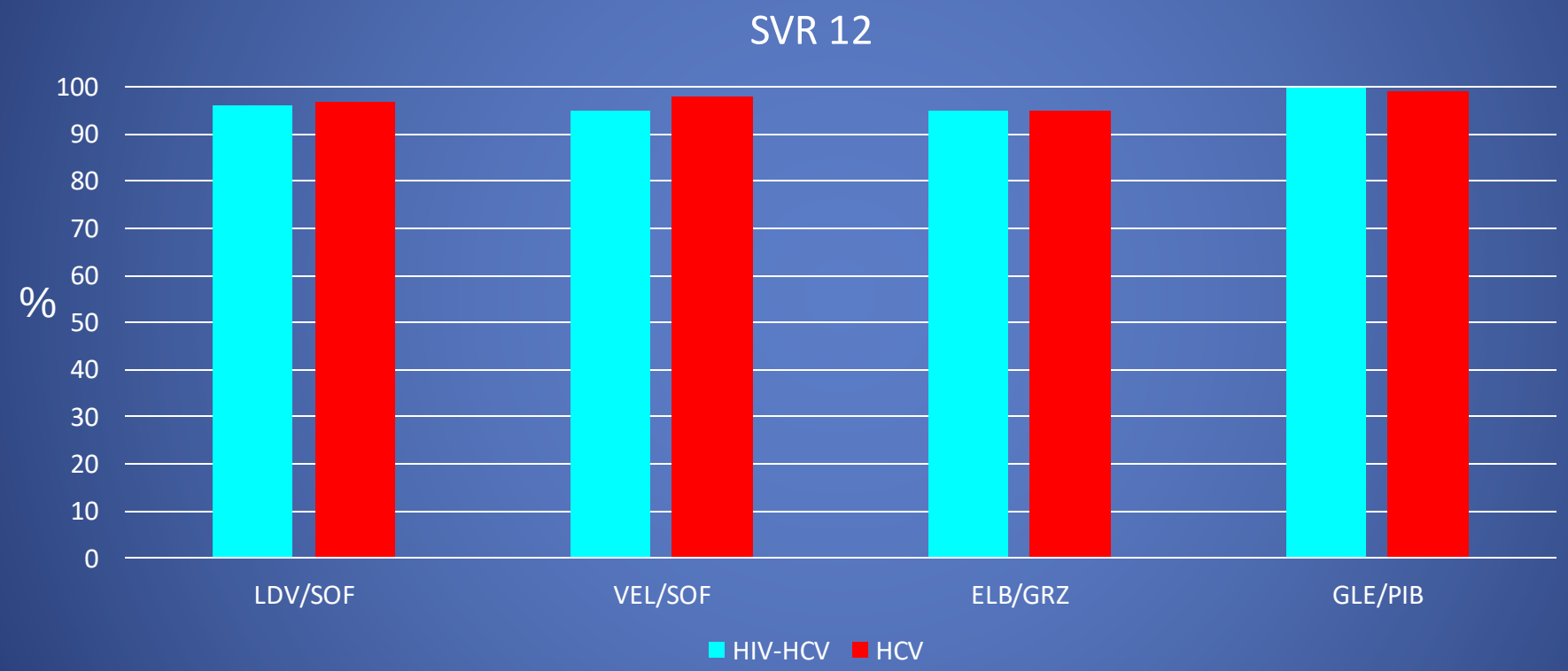
GR Foster et al. NEJM November 17, 2015

Treatment of HCV GT 3 (12-16 weeks)
Treatment Experienced

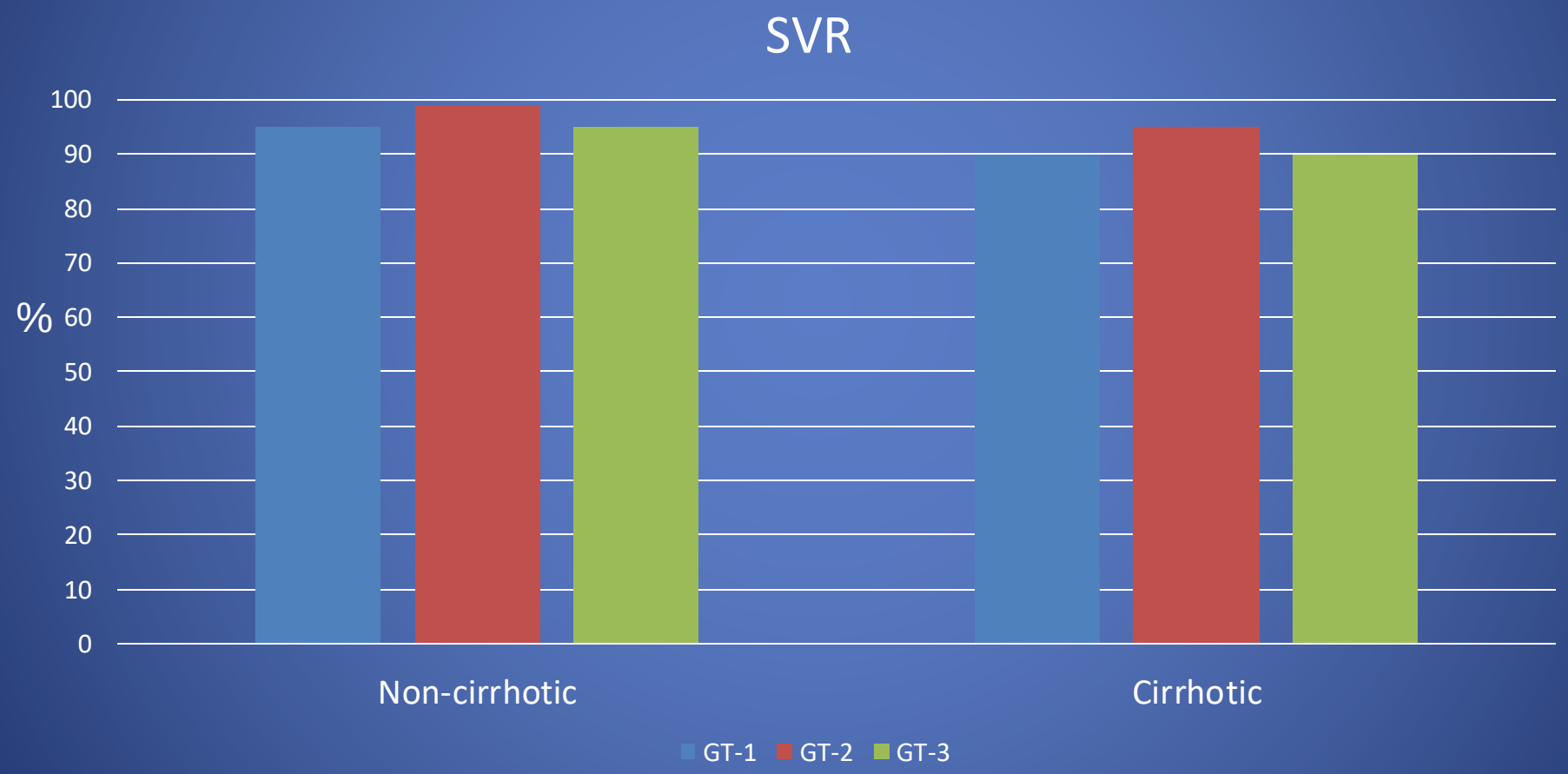


Nelson DR, et al. *Hepatology*. 2015;61(4):1127-1135; Leroy V, et al. *Hepatology*. 2016;63(5):1430-1441; Foster GR. *J Hepatol*. 2017;66(1)Suppl:S503-504; Foster GR, et al. *N Engl J Med*. 2015;373(27):2608-2617Wyles D, et al. AASLD 2016; Boston, MA. Abstract 113. Jacobson IM Gastro 2017

Summary of DAA in HIV-HCV vs HCV



Most with chronic HCV can now be cured



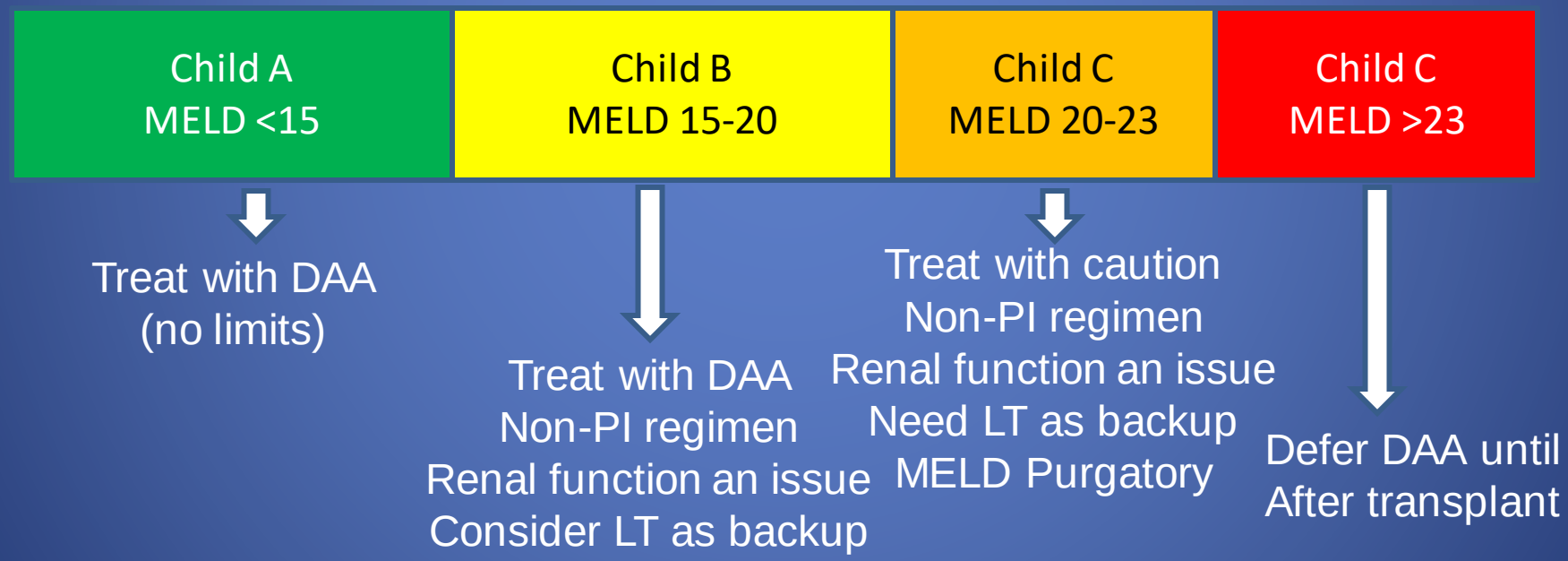
Remaining Challenges

- DAA failures
  - Depends on what DAA they failed
- Decompensated cirrhosis
  - Limited to non-PI containing regimens
  - MELD purgatory
- HCC
  - Increased risk of HCC (new or recurrent) debunked^
  - ? Lower SVR

^ Waziry R et al J Hep 2017 Ioannou GN J of Hep (in press) Waziry et al J of Hep 2016

How to proceed with difficult patients

EASL: recommends not treating MELD>18
ILTS: recommends not treating MELD>20

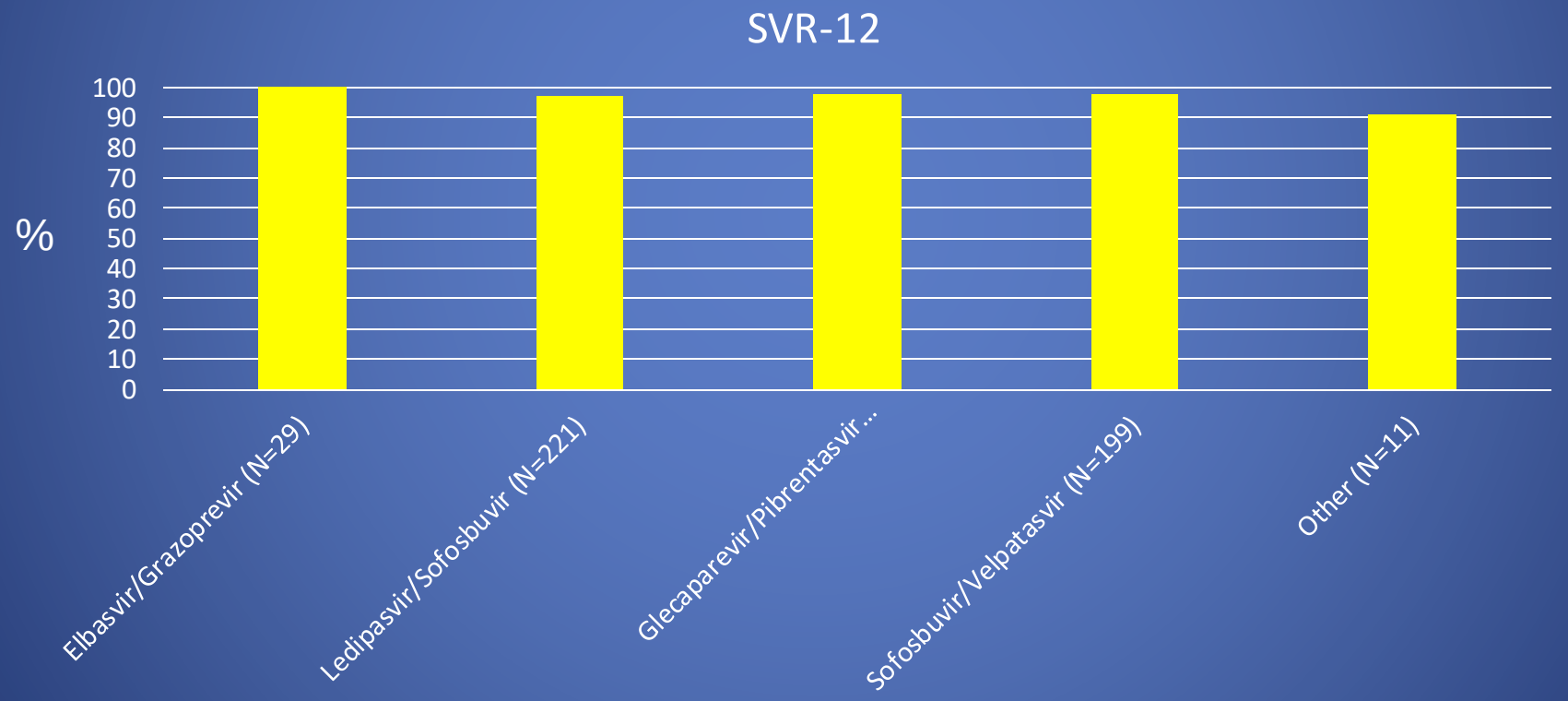


Treating HCV in 2020

#It's so easy, …

Perfect for ECHO

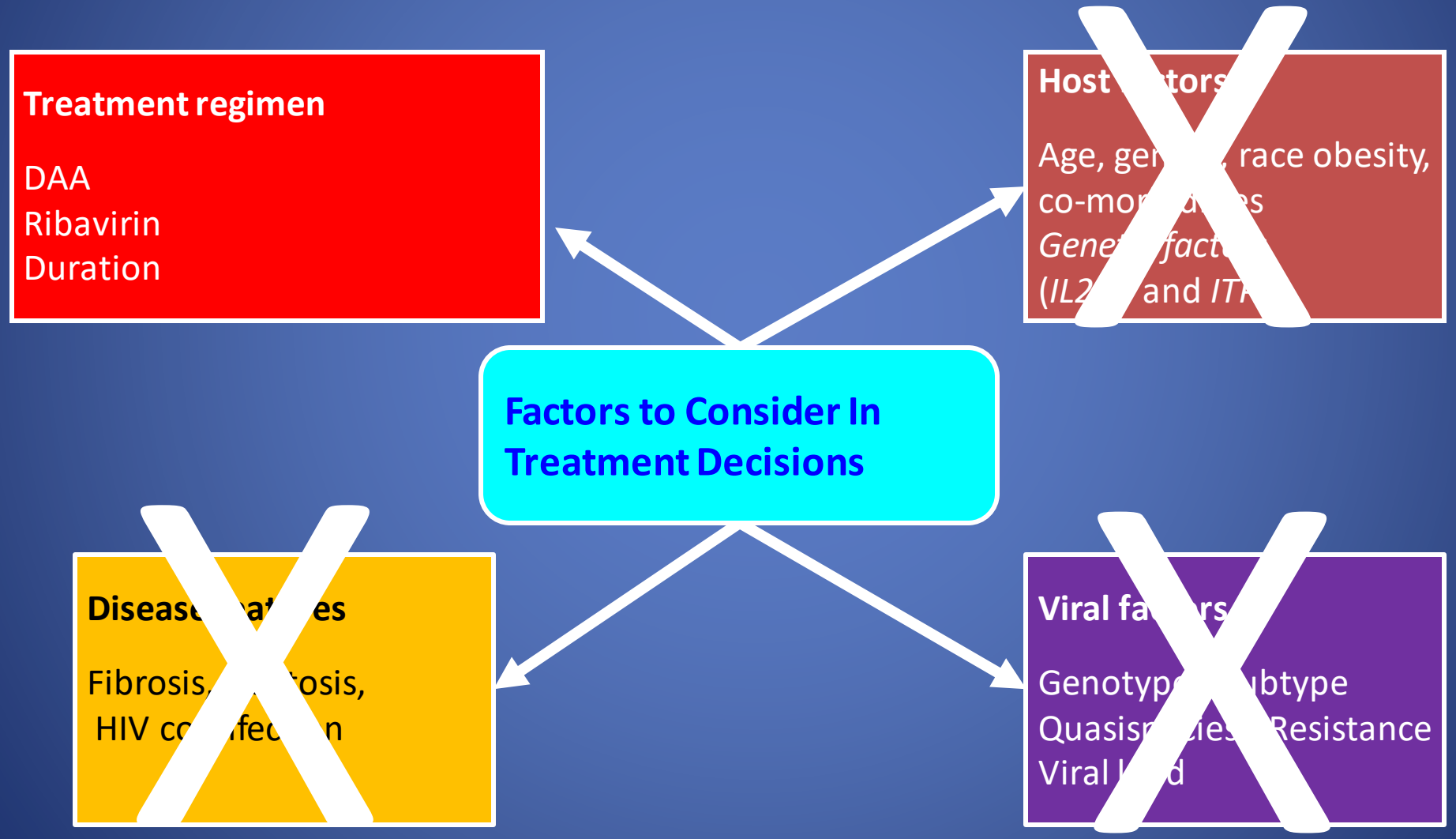
HCV Treatment in the VA DOC via Telemedicine



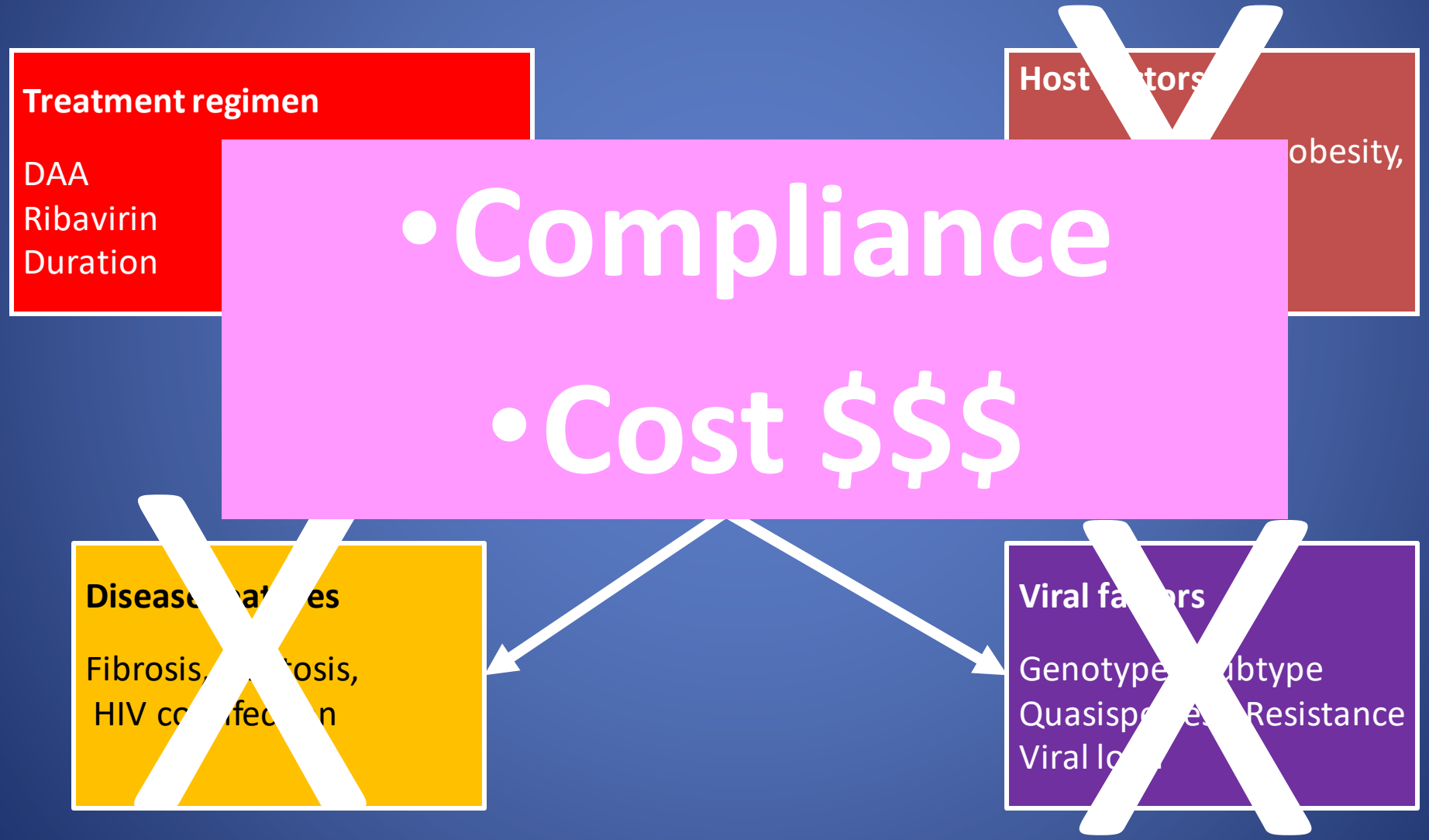
Ideal HCV Treatment: Is it Here Yet?

- Efficacy of IFN-free DAA treatment
  - >90% SVR in most patients
    - Treatment naïve or experienced
    - With or without cirrhosis (caution if decompensated, avoid PIs)
    - With or without HIV co-infection
    - Regardless of race, IL28B genotype, age, steatosis
    - Immunocompetent or immunosuppressed
    - Impaired renal function (2 regimens approved if CrCl <30)
    - Pan-genotype activity (GT1a, 1b, 2, 3, 4, 5, 6)
  - Treatment DAA failures still a challenge
- Safe (HBV reactivation), DDI
- Simple (1-3 pills/d), some may still need ribavirin
- Affordable ?

Identifying Candidates For Therapy 2020



Identifying Candidates For Therapy 2017



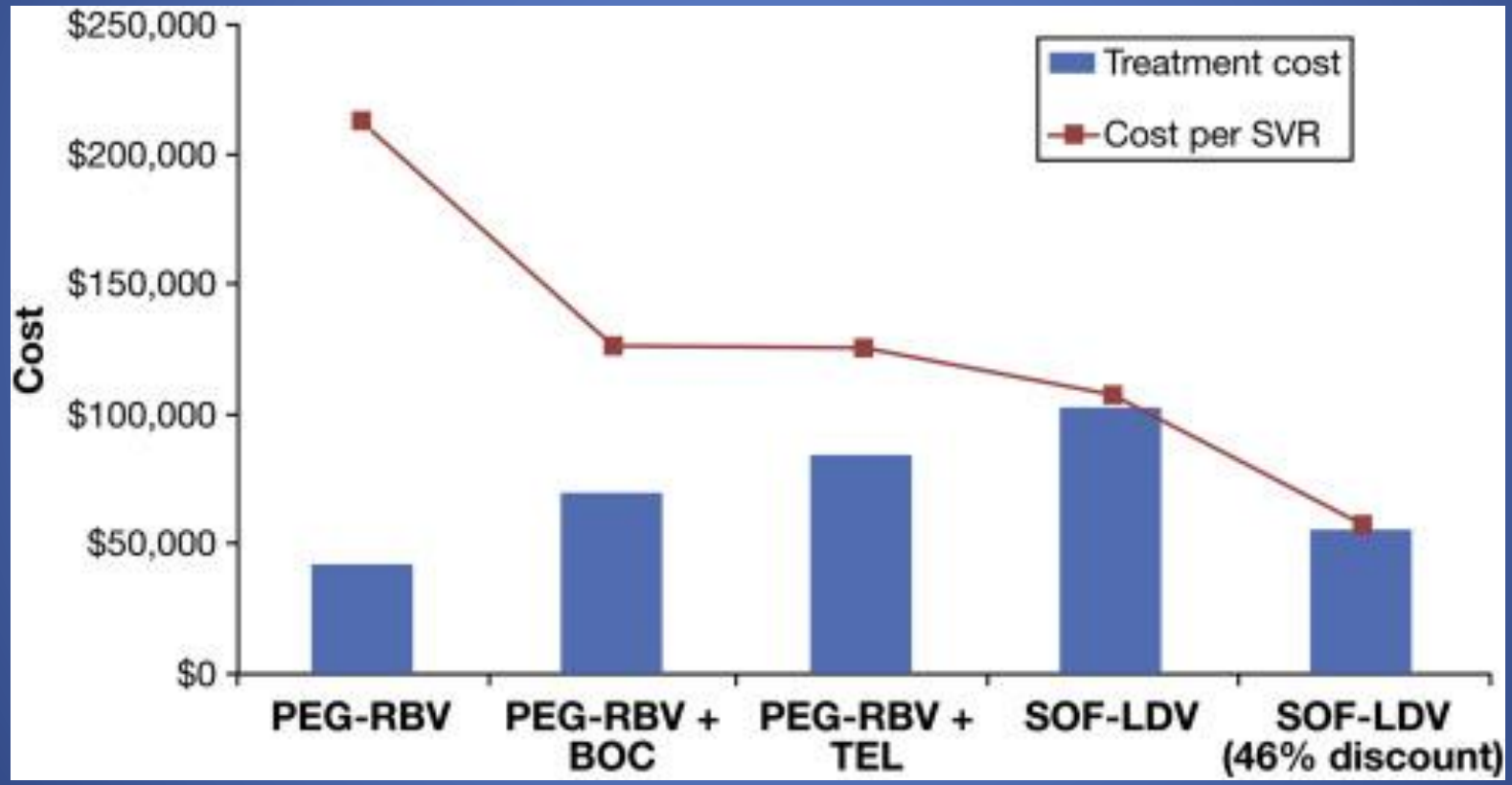
Risk of Relapse/Reinfection

Risk Group	Prevalence (5 yrs after SVR-12)
Relapse after SVR-12	0.2%
Risk of Reinfection (low risk)	1%
Risk of Reinfection (high risk)*	11%

* Ongoing illicit drug use

Jacobson et al. Gastroenterology 2017
Sarrazin et al. CID 2017

Cost and cost per SVR of different antiviral regimens to treat patients with hepatitis C virus genotype 1



Jagpreet C et al. CGH 2015;13:1711-1713

Life after cure

- Does my patient still need to f/u with hepatology?
  - F0-2: not unless they want (unless they have NAFLD or some other liver-related issue)
  - F4 or pre/post-treatment FIB-4 >3.25: yes (still need HCC surveillance, monitoring)
- Do I ever need to check for HCV again?
  - HCV antibody: no
  - HCV RNA (perhaps, but negative RNA 12 weeks defines SVR and one more at 24-48 weeks defines long term SVR)
- Can my patient drink alcohol?
  - F0-2: yes, but not to excess
  - F3-4: no, not unless we demonstrate fibrosis regression

Opportunities

- Identify all those with HCV (simple blood tests)
- Assessment of disease severity (non-invasive testing)
- Increased HCV treatment through ECHO to underserved populations and those remote from VCU (Telehealth)
- Combine with substance abuse programs to minimize reinfection
- Reduce the prevalence of HCV (elimination)

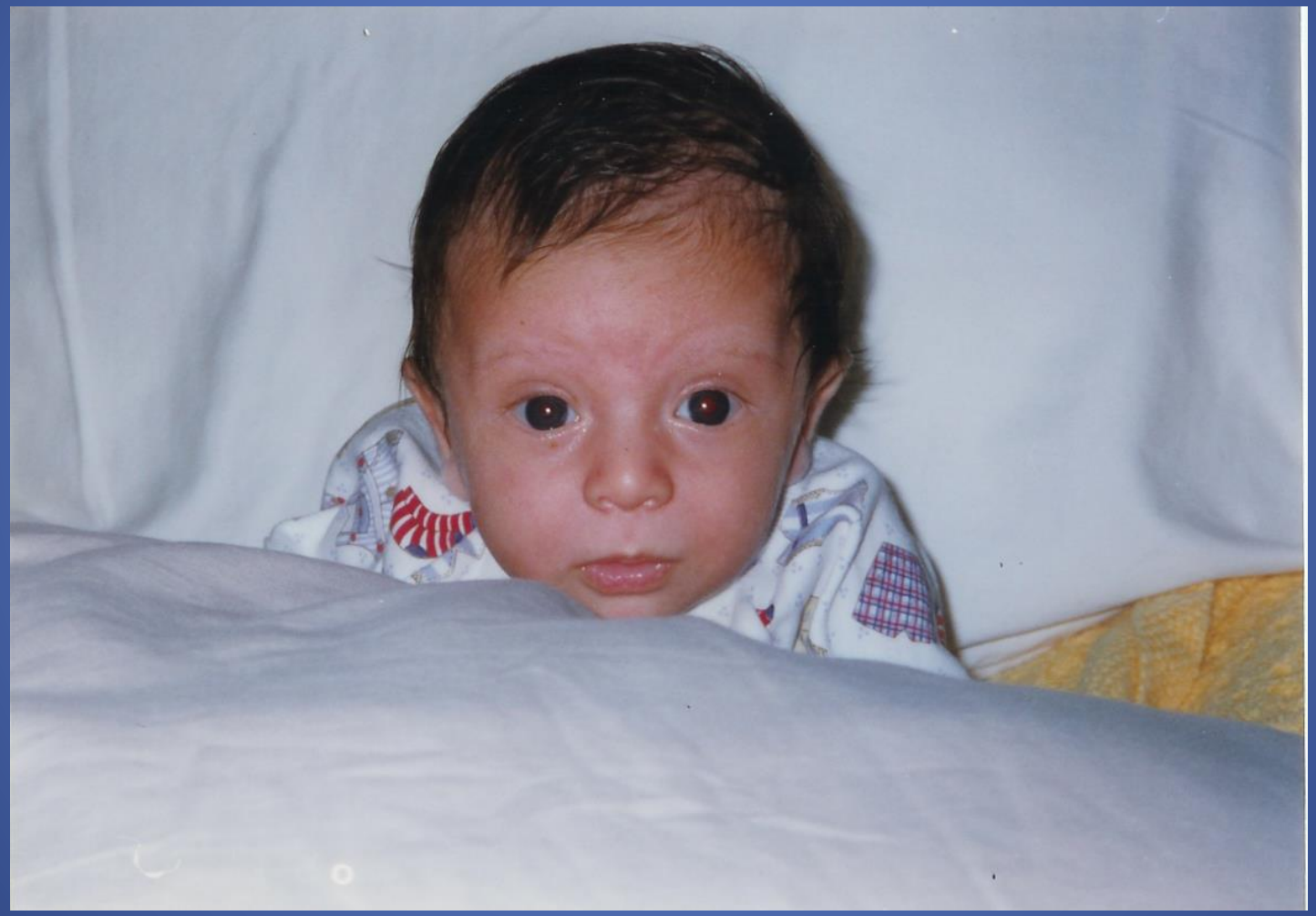
Ways to Practice Medicine

Evidence based

- PubMed
- Meta-analysis
- Systematic reviews
- Society Guidelines

Eminence based

Discovery Comes to the Prepared Mind



Thank you for your attention

804-828-9034
Richard.Sterling@vcuhealth.org
Twitter: RichSterlingMD

Questions?

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?

The dosage efficacy of Suboxone for maintenance

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.)

34y/o white male encounter for use of Heroin sniff 1g when using occasionally x 4 mths, first use of heroin 3 yrs ago.
Cocaine sniff 1-2g daily x 4 yrs, Alcohol 4-6 shots of Vodka 4-5 times per week x since age 16yrs old.
Rx suboxone 12mg BID
High school graduate, work as an HVAC technician. Living with wife and 2 kids in an apt.

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

Physical, Behavioral, and Mental health background information (e.g. medical diagnosis, reason for receiving opioids, lab results, current medications, current or past counseling or therapy treatment, barriers to patient care, etc.)

Dx: H/o Asthma
Opioid dependence.
Cocaine dependence.
Alcohol dependence.
H/o Chronic back pain (fell from ladder 3 yrs ago)
Medication: Suboxone 12mg film Sl BID (Starting receiving suboxone 1 yr ago due to heroin use after PCP stopped Rx narcotics). Client came to detox with 2 days suboxone Rx and some empty wraps of suboxone
Ventolin PRN
Advair inhale BID
Labs: UDS +BUP, OPI, COC, Alcohol, THC,
First encounter in detox center. Per client, he has being in two MAT detox and treatment program when he had Insurance. No INS now so what to link up with county.
Barriers to patient care are other substance (Cocaine and Alcohol) dependence.

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

Intervention:
Start: Started with client suboxone 12mg SL BID x 2 days, then reduce to
Suboxone 8mg SL BID x 3 days. Then reduce to Suboxone 6mg BID x 3 days.
Client on days one of suboxone 8mg BID while in detox center or taper of suboxone if still in detox
Educating client
Referral:
MAT Residential/Out patient Addiction medicine clinic
Neighborhood clinic for PCP
Recommend Pain management f/u

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

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

Taper off suboxone if possible or Suboxone 8mg SL daily as maintenance.
Recommend Vivitrol shot once a month (Helps with Opioid and Alcohol craving) if taper off suboxone

Other relevant information

Possible use Clonidine 0.1mg BID and Vistaril 25mg BID PRN

Reminder: Main Question

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

The dosage efficacy of Suboxone for maintenance

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

Case Presentation #2
Tara Belfast-Hurd, PA

- 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

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

Additional resources for the individual?

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.)

21 year old African American Female. High School Graduate. Currently unemployed, but was employed at time I managed her case. Currently at a SUD residential facility, but was living with her parents at the time. Her mother is a good support. Currently seems to have good support, but at the time her 'friends' were a bad influence.

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

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.)

No medical issues/concerns. She became addicted to drugs at a very young age (approximately 15). She attempted counseling several times, but was unsuccessful. She was inconsistent with attendance, and had a difficult time trusting others. Currently, she is reportedly receiving therapy, and on an antidepressant.

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

At the time I managed her case, we attempted counseling, mental health skill building, MAT, detox, antidepressants

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

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

Her mother still reaches out occasionally to provide an update and/or acquire resources/guidance. She's currently at a SUD residential facility, but cannot stay there permanently. Reportedly the plan is to get her into an independent living situation, while managing her depression through medication and counseling.

Reminder: Main Question

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

Additional resources for the individual?

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

COVID Bolus: Rapid Advice for These Critical Times

Webinar Series

- More information: projectecho@vcuhealth.org
- 0.50 CE Hours : MD, PA, NP, SW, RN, PharmD, Pharm tech

- **Friday, April 3 at 4pm: Testing for COVID 19**
  Lilian Peake, MD, MPH, State Epidemiologist at VDH
  Denise Toney, PhD, (HCLD), Laboratory Director at Department of General Services

- **Monday, April 6 at 4pm: End of Life Conversations in the Time of COVID-19**
  Danielle Noreika, MD, FACP, Medical Director of Inpatient Palliative Care Services, VCU Health

Case Studies

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

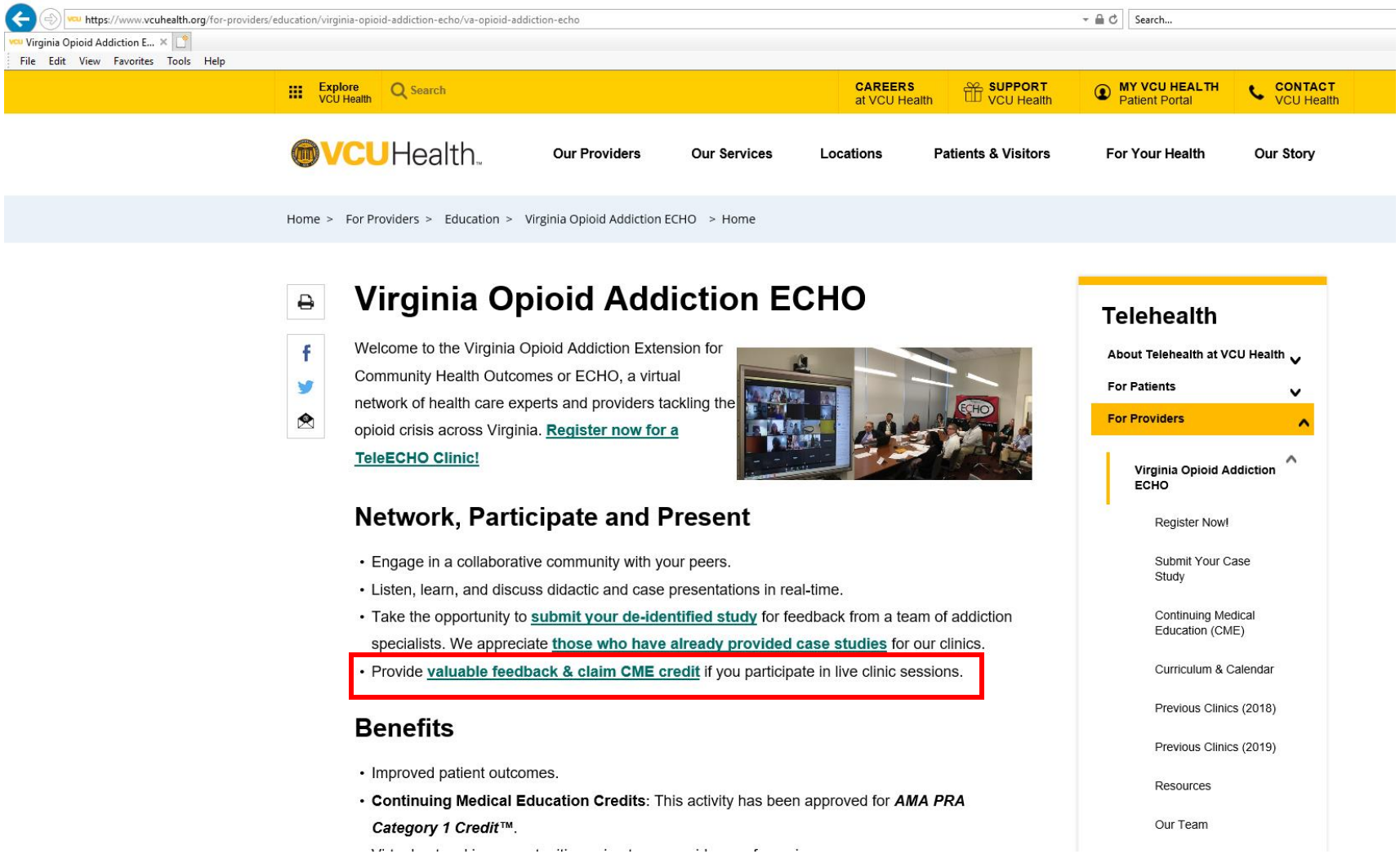
- **Ademola Adetunji**, NP from Fairfax County CSB
- **Michael Bohan, MD** from Meridian Psychotherapy
- **Diane Boyer, DNP** from Region Ten CSB
- **Melissa Bradner, MD** from VCU Health
- **Kayla Brandt, B.S.** from Crossroads Community Service Board
- **Susan Cecere, LPN** from Hampton Newport News
- **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
- **Maureen Murphy-Ryan, MD** from AppleGate Recovery
- **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
- **Saba Suhail**, MD from Ballad Health
- **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

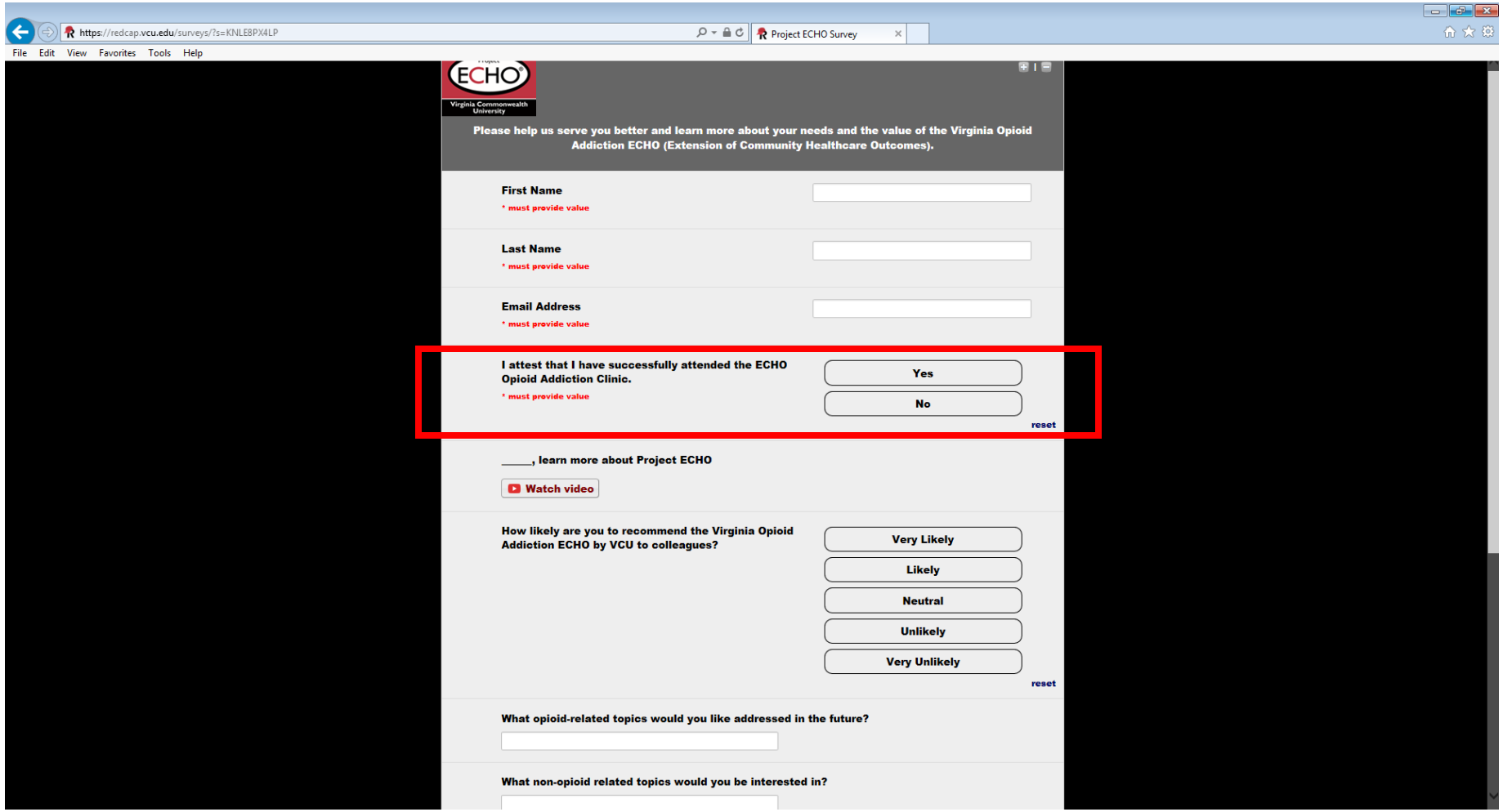
- www.vcuhealth.org/echo

- 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



Access Your Evaluation and Claim Your CME



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

Telehealth

- About Telehealth at VCU Health +
- For Patients +
- For Providers –
  - **Opioid Addiction ECHO** –
    - Register Now!
    - Submit Your Case Study
    - Continuing Medical Education (CME)
    - Curriculum & Calendar
    - Previous Clinics (2018)
    - Previous Clinics (2019)
    - Previous Clinics (2020)

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

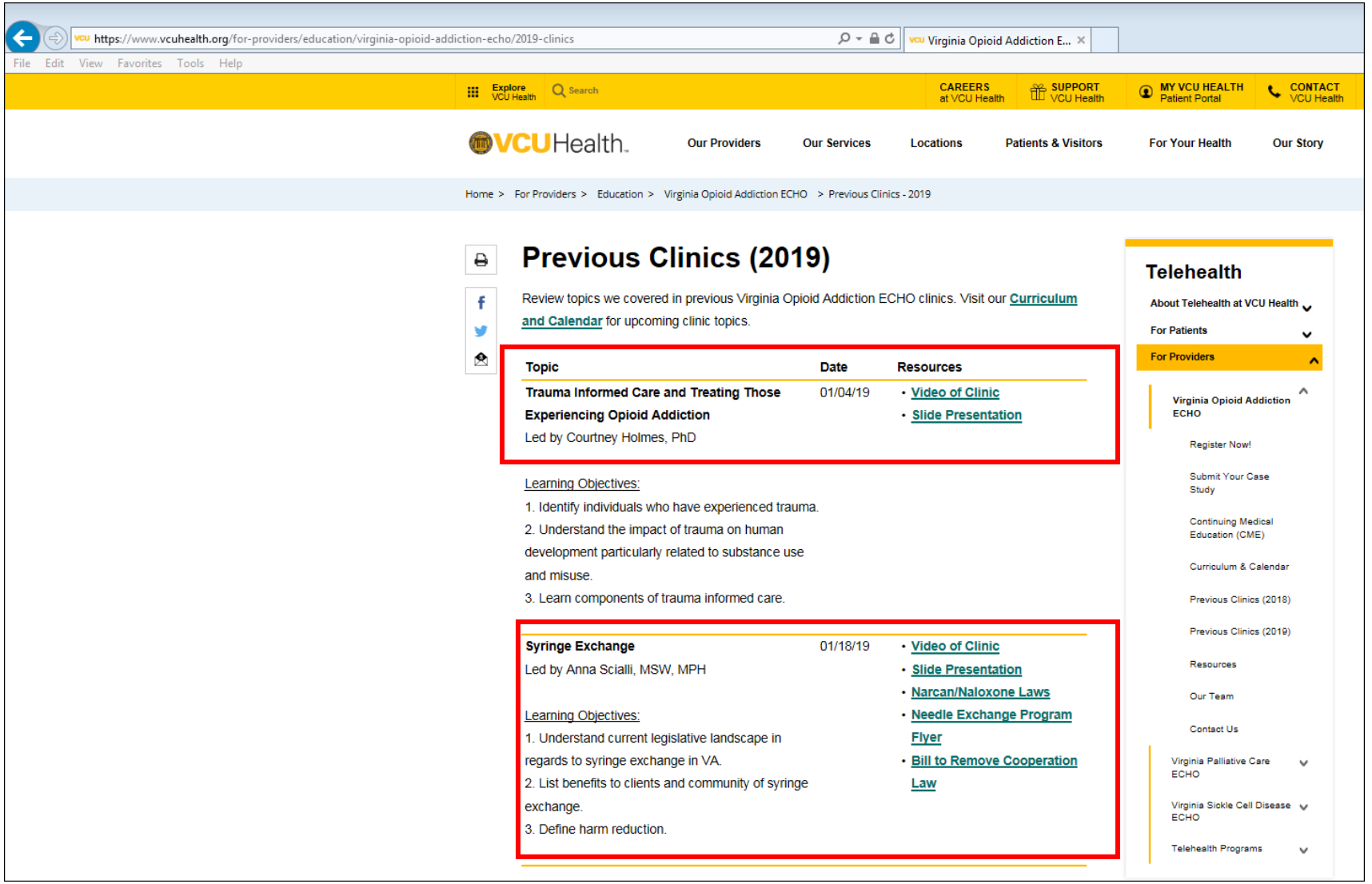
- Engage in a collaborative community with your peers.
- Listen, learn, and discuss didactic and case presentations in real-time.
- Take the opportunity to submit your de-identified study for feedback from a team of addiction specialists. We appreciate those who have already provided case studies for 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***

? Need help

Access Your Evaluation and Claim Your CME



VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

Mark Your Calendar --- Upcoming Sessions

April 17:	Special Populations and SUD	Aril Laoch, MS, LPC
May 1:	Synthetic Drugs	Ruddy Rose, PharmD, FAACT
May 15:	Advanced Motivational Interviewing	Denise Hall, LPC, NCC, CRC

Please refer and register at vcuhealth.org/echo

Project ECHO®
Virginia Commonwealth University

THANK YOU!

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

VCU