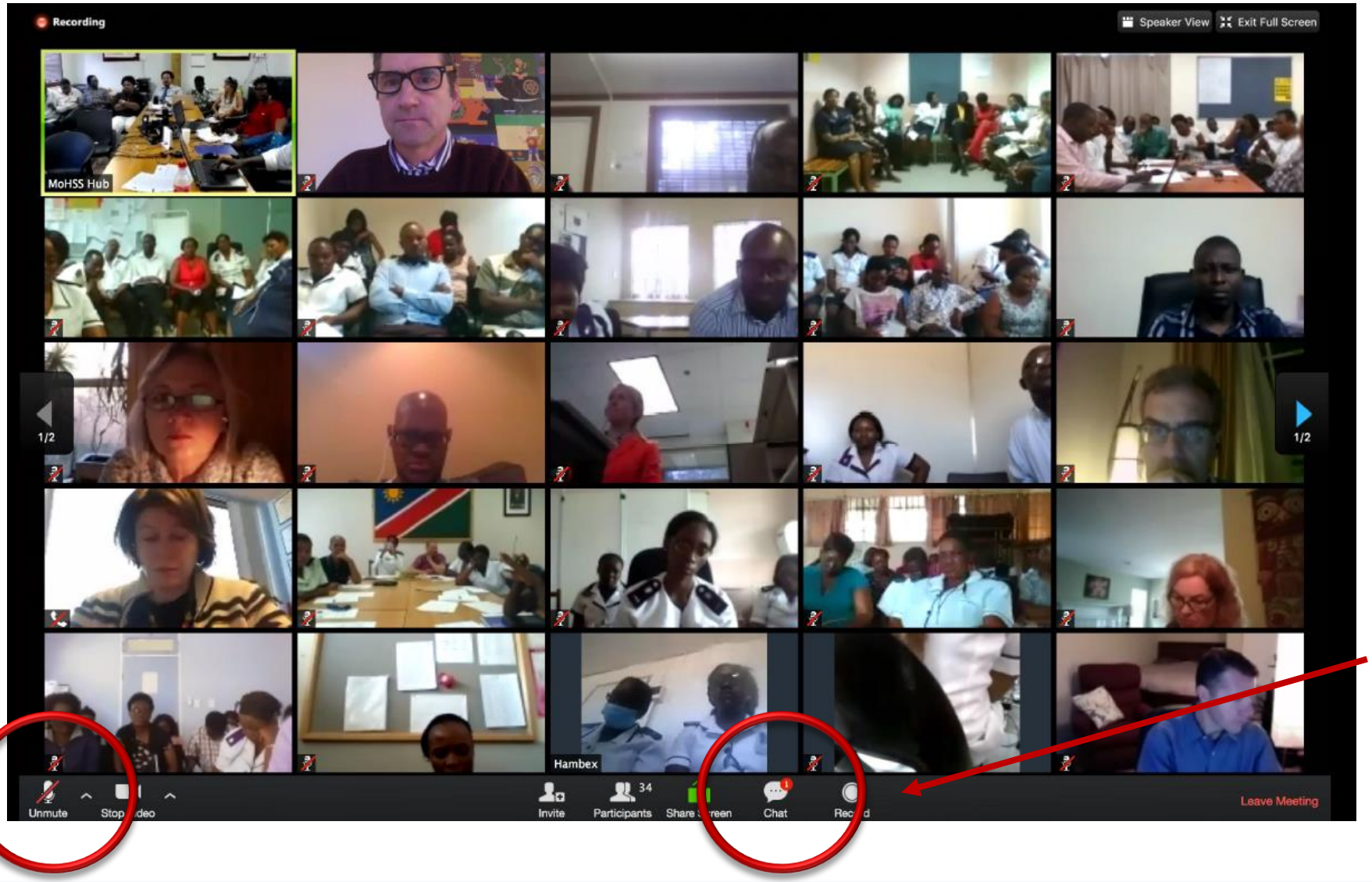
WELCOME to the

Substance Use ECHO

Session will start in less than 15 minutes

Some helpful tips:



Mute microphone when not speaking

Use chat function for comments and questions

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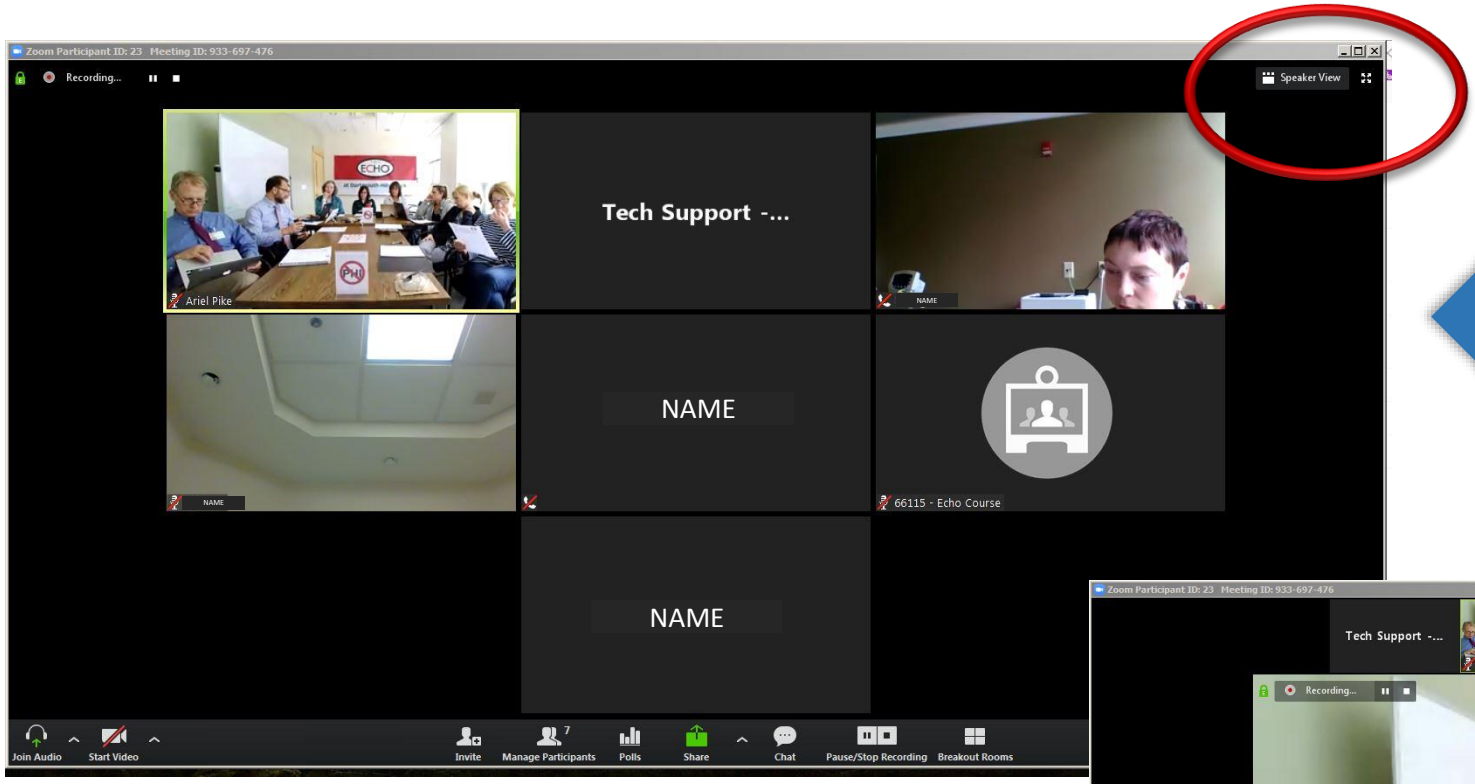
Change view to your preferences



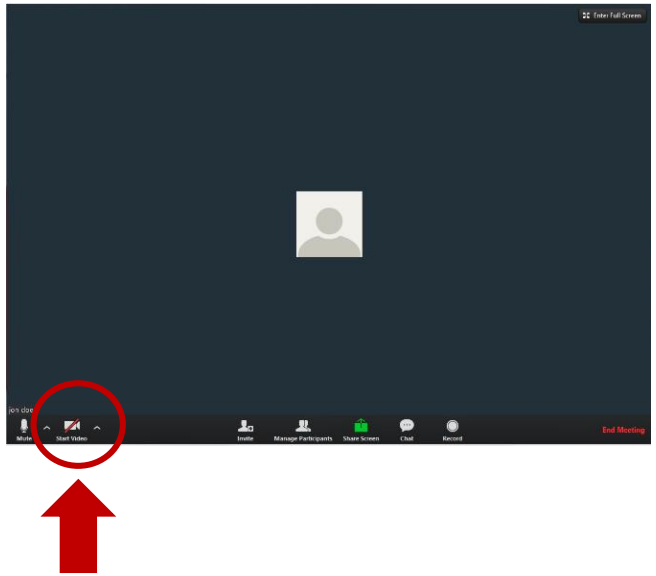
Gallery View

Speaker View

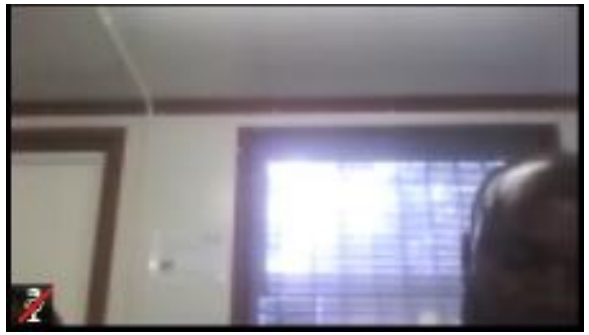
We want to see your face!

See tips below to create a better ECHO experience

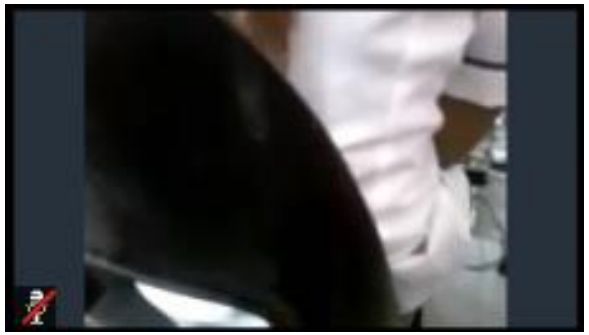
Start by turning your video on



Make sure you are in frame and aware of your background



Reduce your movement as to not cause distraction to others



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For educational and quality improvement purposes, we will be recording this video-session

By participating in this clinic you are consenting to be recorded –
we appreciate and value your participation

If you have questions or concerns, please email

ECHO@hitchcock.org

Attendance

- Spoke participants
- Hub participants

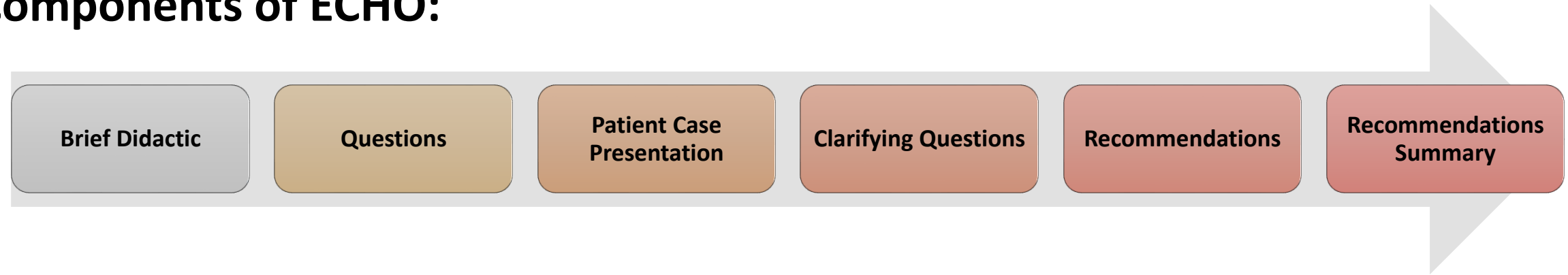
Please type your name, organization into chat

Please turn video on

Project ECHO (Extension for Community Healthcare Outcomes)

- ECHO is a telementoring model that uses virtual technology to support case-based learning and provide medical education.

Components of ECHO:



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Respect Private Health Information

To protect patient privacy, please only display or say information that doesn't identify a patient or that cannot be linked to a patient.

- **Names:** Please do not refer to a patient's first/middle/last name or use any initials, etc.
- **Locations**: Please do not identify a patient's county, city or town. Instead please use only the patient's state if you must.
- **Dates:** Please do not use any dates (like birthdates, etc) that are linked to a patient. Instead please use only the patient's age(unless > 89)
- **Employment:** Please do not identify a patient's employer, work location or occupation.
- **Other Common Identifiers:** Patient's family members, friends, co-workers, phone numbers, e-mails, etc.

Substance Use & Addiction

Chronic Disease Model & Roles for Primary Care

Seddon R. Savage MD, MS

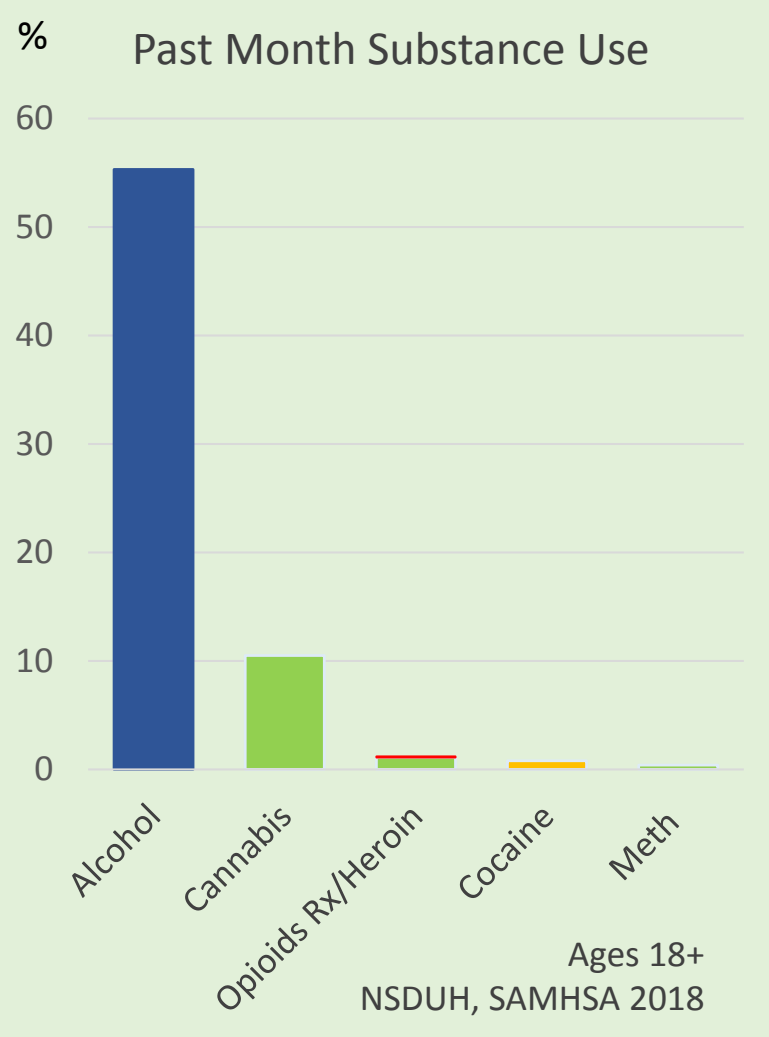
Advisor, Dartmouth Hitchcock Substance Use & Mental Health Initiative (SUMHI)

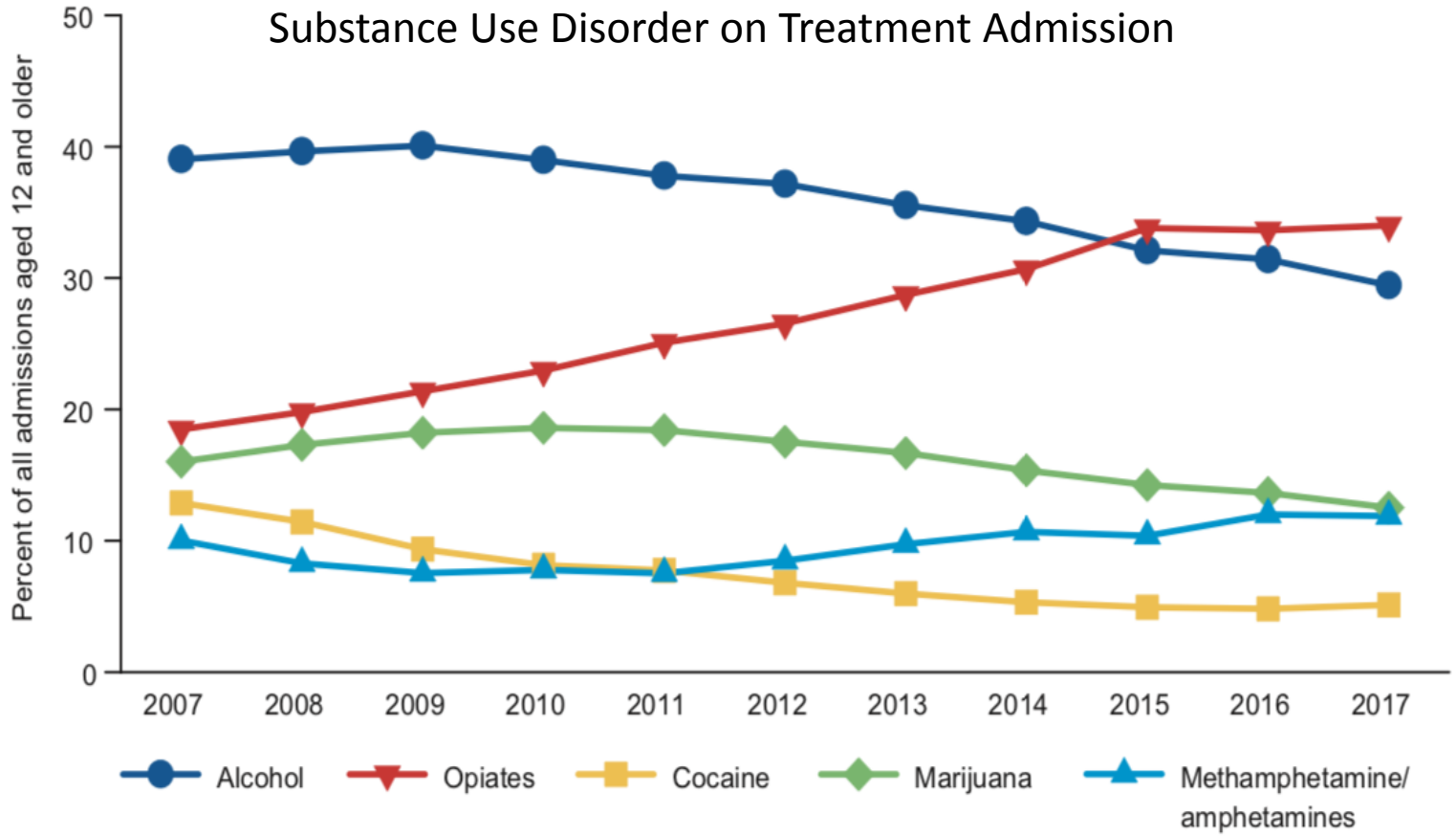
Adjunct Associate Professor, Geisel School of Medicine

Conflict of Interest Disclosure Statement

No Conflicts of Interest

Substance use is diverse

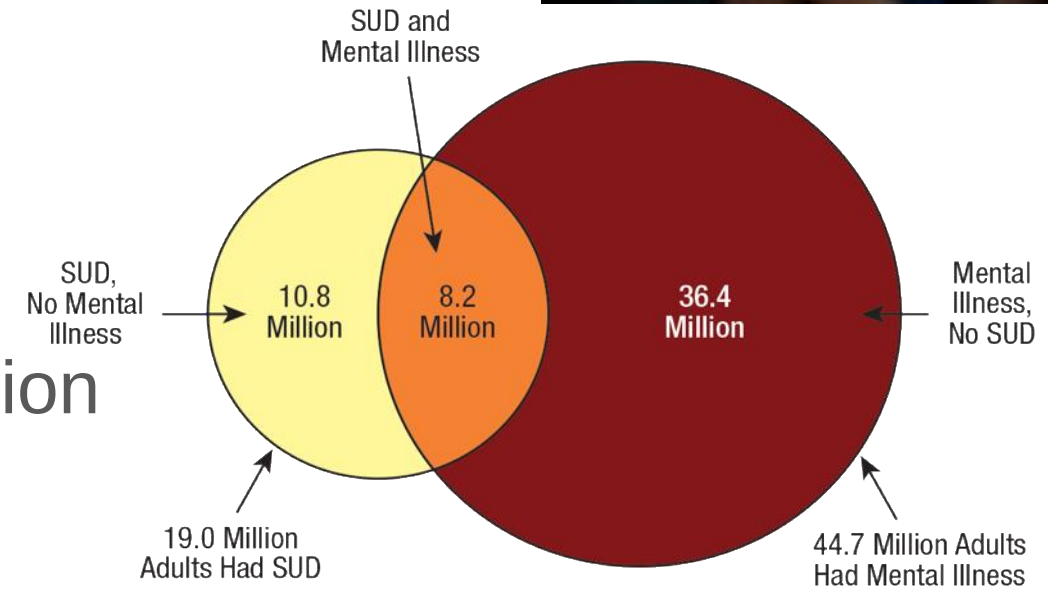




Primary Substance at Treatment Admission
Treatment Episode Date (TEDS) , SAMHSA, 2017

Why do people use substances?

- Curiosity/experimentation
- Elective use for euphoria/reward
- Symptom control
  - Mood, distress
  - Memories
  - Pain
  - Sleep
  - Withdrawal
- Compulsive use/addiction



NSDUH, SAMHSA
2016

Substance Use Spectrum & Intervention

Substance Use

Overdose

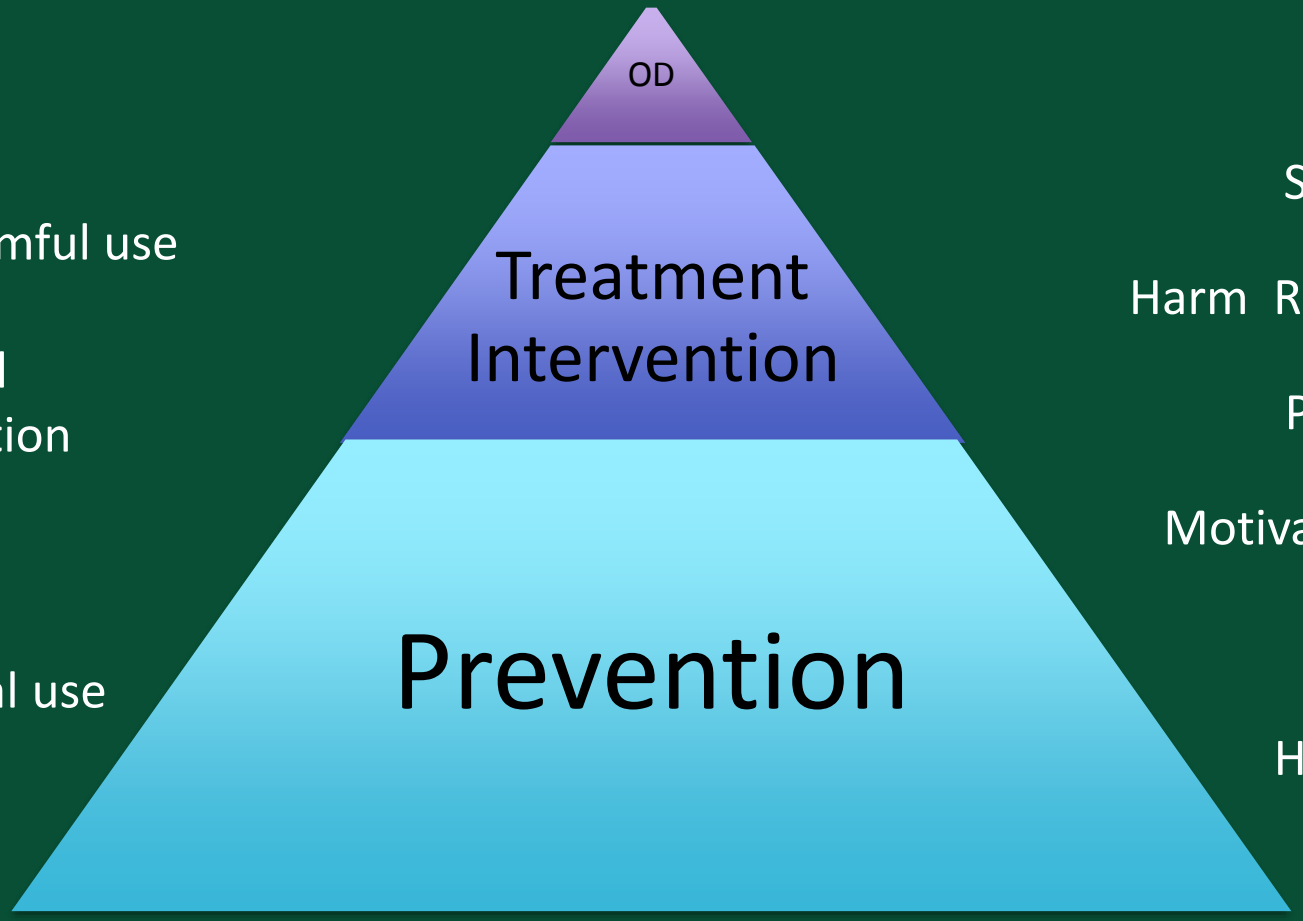
Potentially harmful use
- Addictive
- Recreational
- Self medication

Risky use

Elective/Clinical use

Non-use

STIGMA



Clinician Roles

Naloxone for OD

Support recovery

Harm Redux Counseling

Pharmacologic tx

Motivational Interview

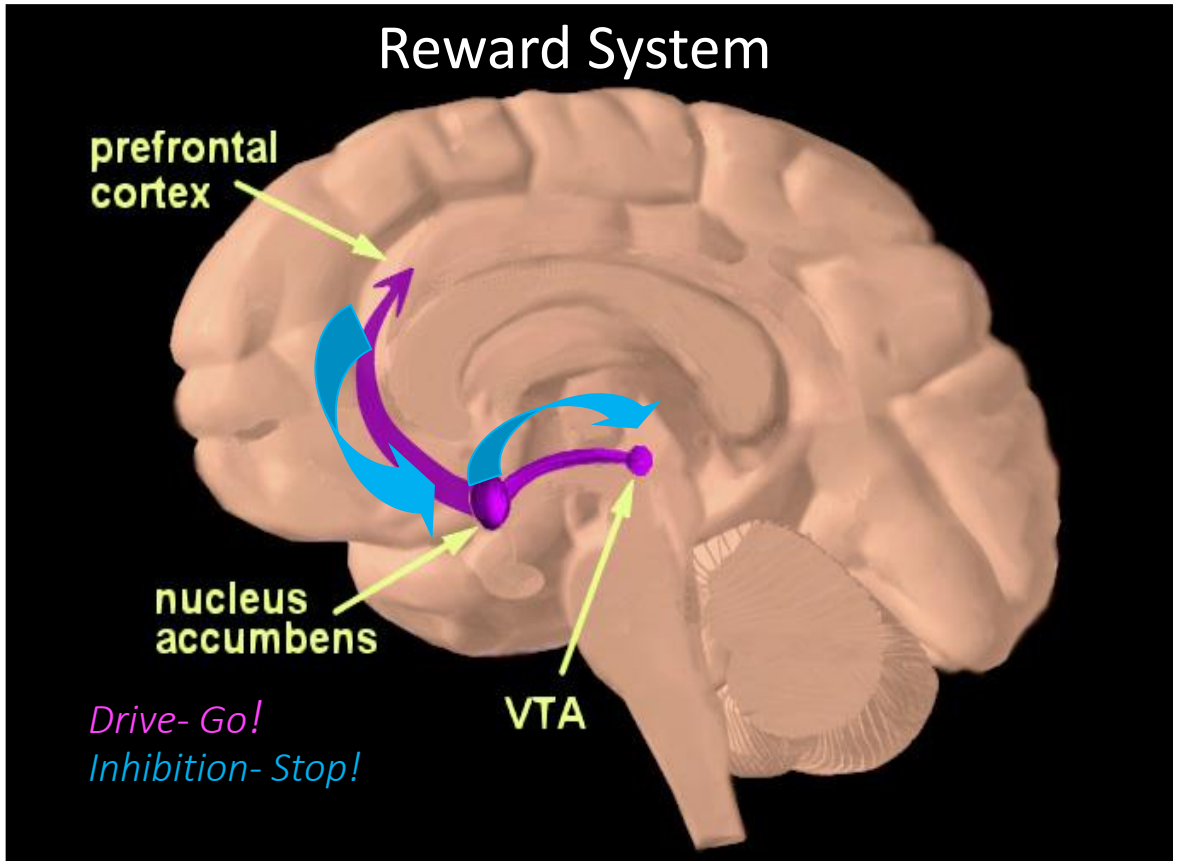
Routine SBIRT

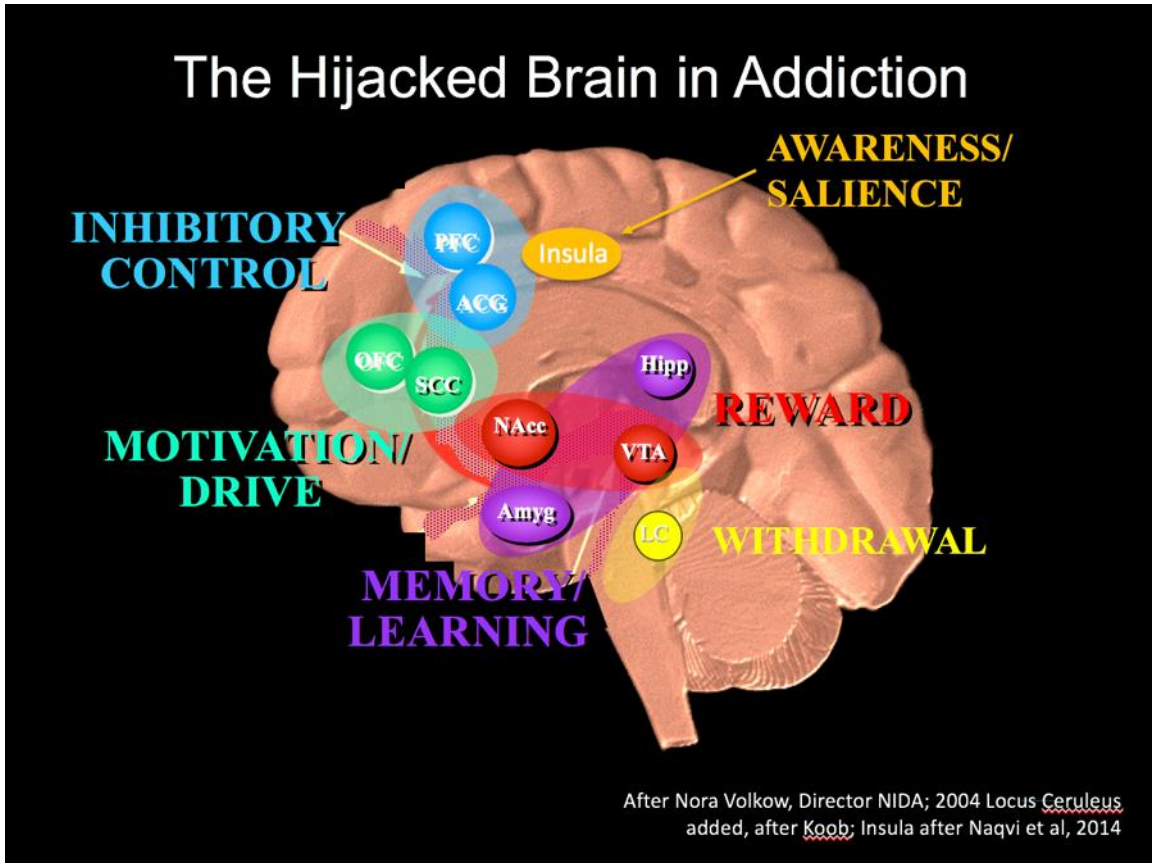
Health messaging

Safe prescribing

CHALLENGE STIGMA

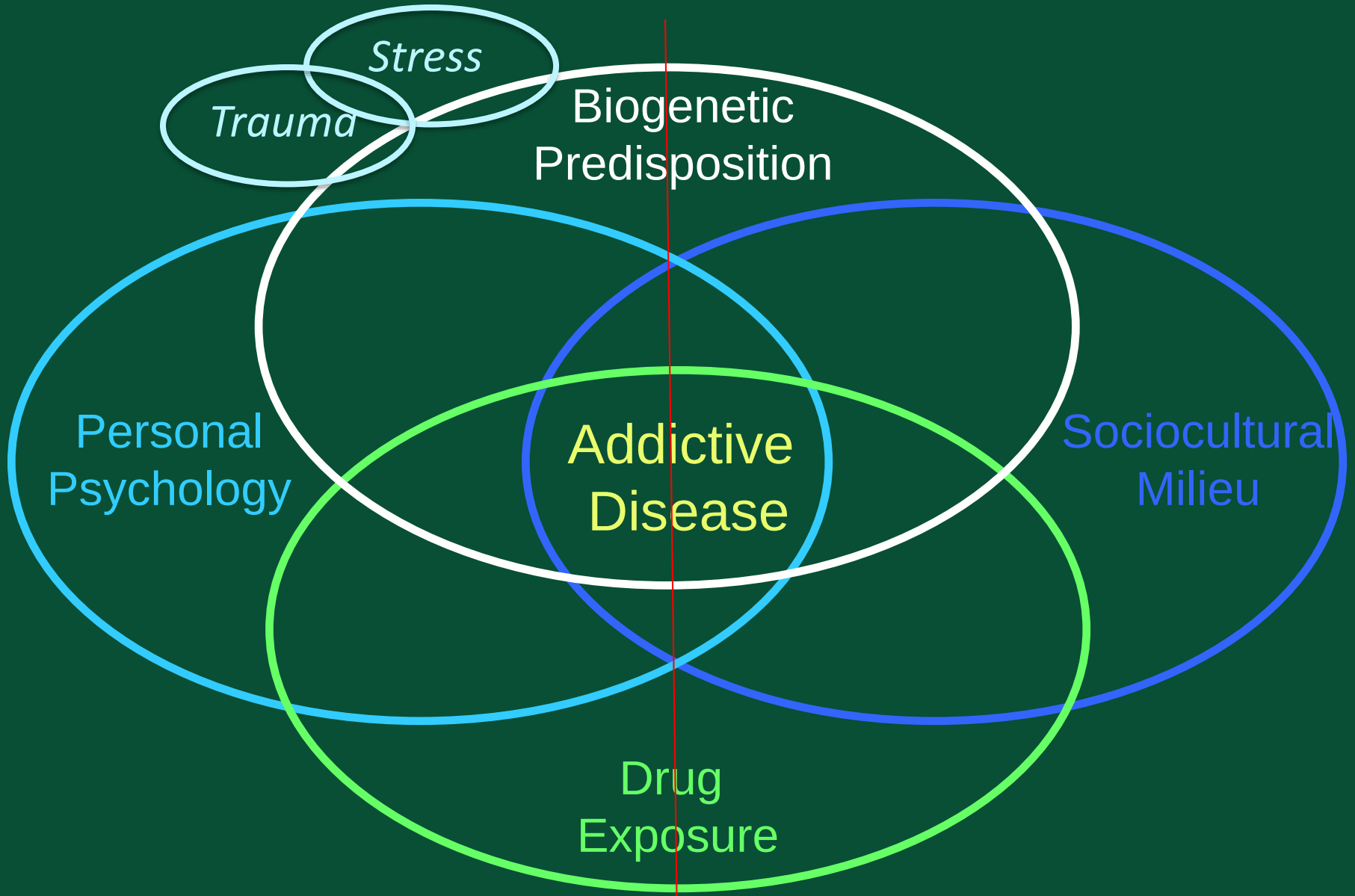
Understanding reward & addiction





We all enjoy different pleasures now and then. And we always have perfect control, right?

Why do some people develop addiction?



When does substance use become a disorder?

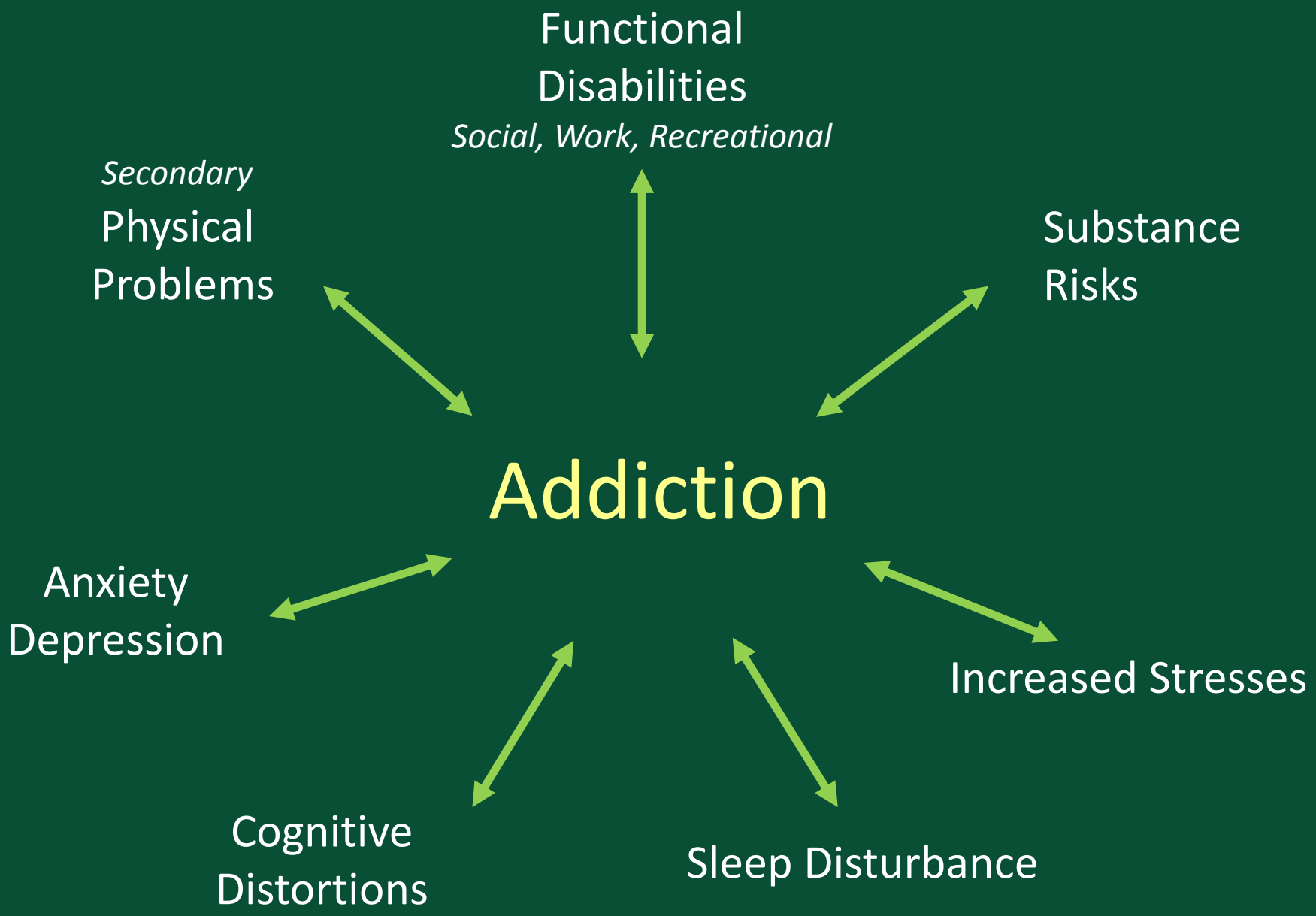
- Loss of control over drug
- Continued use despite harm
- Physiologic impact

1. Use larger amounts or longer period of time than intended
2. Persistent desire or unsuccessful efforts to cut down or control
3. Great deal of time spent to obtain ,use, or recover from effects
4. Craving, or a strong desire to use
5. Failure to fulfill major role obligations at work, school or home
6. Persistent or recurrent social or interpersonal problems
7. Important social, work or recreational activities given up or reduced
8. Recurrent use in physically hazardous situations
9. Persistent or recurrent physical or psychological problems due to use
10. *Tolerance (increased amounts or diminished effects)
11. *Withdrawal (withdrawal symptoms or use to avoid)

**Criteria not met if taking solely under medical supervision*

Mild 2-3 Moderate 4-5 Severe 6+

Diagnostic & Statistical Manual of Mental Health Disorders, 5th Ed
DSM V, American Psychiatric Association


Functional
Disabilities
Social, Work, Recreational
Secondary
Physical
Problems
Substance
Risks
Addiction
Anxiety
Depression
Increased Stresses
Cognitive
Distortions
Sleep Disturbance

SUD is similar to other Chronic Diseases

Substance Disorders, Diabetes, Hypertension, Heart disease

- Contributors
  - Biogenetic predisposition
  - Behaviors
- Course: remissions & exacerbations
- Life-threatening: treat, no cure
- Treatment & Recovery
  - Lifestyle changes
  - Counseling
  - Self awareness & regulation
  - Pharmacologic

Treatment Engagement

Substance Use

- 40-60% abstinent
- 15-30% some use

Diabetes, HTN, Heart

- 40-60% medication complaint
- <30% behavioral changes

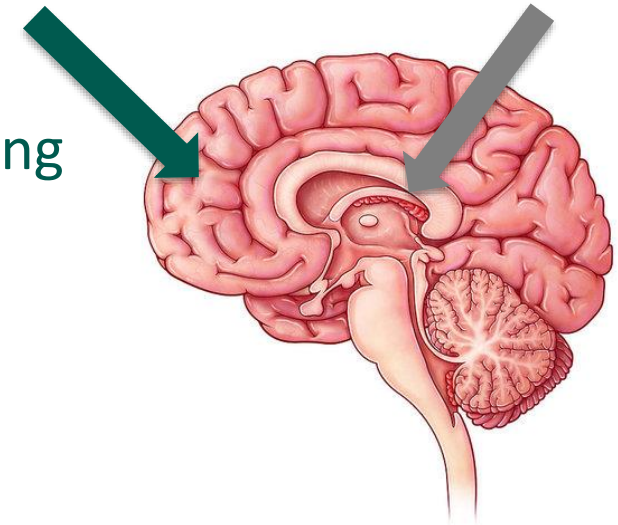
- Adherence most difficult
  - Low socioeconomic
  - Poor family/social support
  - Psychiatric co morbidity

McClellan, Lewis, O'Brien, Kleber, JAMA 2000

Paths to Recovery in Substance Use Disorders

Strengthen executive function

- Psychosocial interventions
  - Counseling (CBT, ACT)
  - Peer support
    - Group -AA, NA, RR
    - Peer recovery coaches
- Cultivation of personal well-being
  - Exercise, meditation
  - Healthy social networks
  - Meaningful engagement

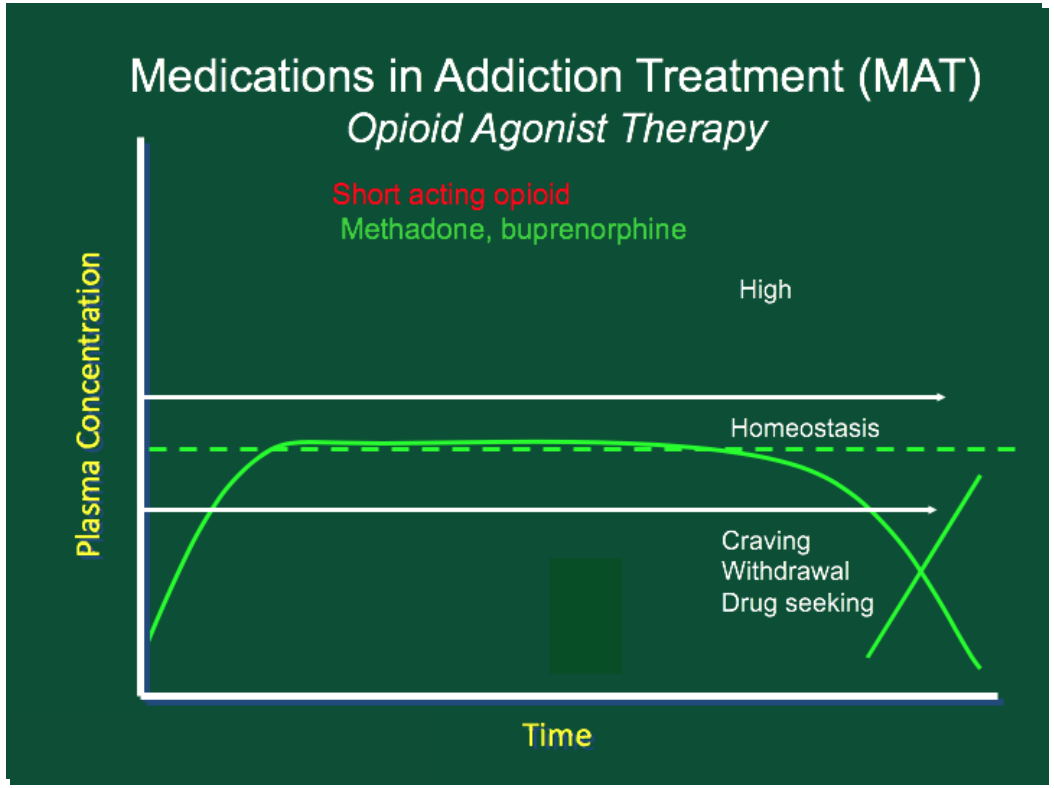


Extinguish demands from reward centers

- Avoid/limit rewarding drug use
- Pharmacologic treatments

Pharmacologic therapies

- Help with physiological stabilization so can focus on recovery
- Medications are used, but functional criteria of SUD resolve
- Options for OUD
  - Buprenorphine, partial opioid
  - Methadone, full opioid
  - Naltrexone, opioid blocker
- Options for alcohol
  - Naltrexone
  - Acamprosate
  - Disulfiram
- Other SUDs, less evidence



Stigma & discrimination are obstacles to care

- Stigma - *disgrace or disapproval associated with a certain circumstance, quality or identity*
- Common types
  - Social > informs responses to stigmatized persons
  - Internal > shapes stigmatized persons feelings about themselves
  - Institutional > shapes how systems engage with stigmatized people
- Leads to care avoidance & poor health outcomes
- Approaches to address
  - Realistic understanding
  - Language (person centered, health oriented)
  - Empowerment: support, resources, pathways to address

What might have shaped this person's journey from innocent infant to adult with a substance use disorder?

Primary Care Team Opportunities

- Challenge stigma: recognize, respect, language
- Prevent: health messaging, care in prescribing
- Screen regularly
  - Motivate healthy change
  - Intervene &/or refer
- Provide pharmacologic therapies
- Harm reduction: counseling, naloxone
- Support recovery

Resources: Education & Clinical Tools

- D-H Substance Use & Mental Health Initiative *https://med.dartmouth-hitchcock.org/sumhi.html*
- Physician Clinical Support System *https://pcssnow.org*
- NIDA Med *https://www.drugabuse.gov/nidamed-medical-health-professionals*
- NH Doorway portal to treatment *https://thedoorway.nh.gov/home*
- NH Recovery Hub for patient supports *http://nhrecoveryhub.org*

Case Presentation

- **Presenter Name: Caitlin Tilley**
- **Presenter Practice Location: Southwestern Vermont Medical Center**

- **Patient's age:** 40's
- **Patient's gender:** Male
- **Significant Medical History:** osteomyelitis
- **Prior psychiatric dx:** Alcohol Use Disorder, Substance Use Disorder
- **Prior psychotherapy/counseling:** Unknown
- **Prior inpatient psychiatric hospitalizations:** Brattleboro Retreat 2014?, Granville Center 2019

Case Presentation cont.

- **Current meds:** N/A
- **Current/past substance use:** Alcohol, Marijuana
- **Missing essential needs:** Financial strain, food insecurity, housing issues, transportation issues, unemployment
- **Relevant family psychiatric history:** Paternal history of alcohol abuse disorder, maternal history of depression
- **Assessments:** Suicide Screen (C-SSRS), PHQ-2 (screened only for feeling depressed)
- **Other Pertinent information:** Although patient denies history of suicide attempt, he has reported that when he was in his 20s he did hold a gun to his head but "didn't follow through with it." Has had multiple ED admissions with chief complaint of suicidal ideations while intoxicated and denies when sober.

Case Presentation cont.

- **Clinical Summary:** Patient presents frequently to ED with ETOH intoxication or concerns r/t left foot infection since June of 2019. Patient was admitted multiple times to the ED or inpatient unit with infection related diagnosis and usually left AMA prior to completing treatment. In August, left foot infection became so severe that patient was admitted with sepsis and required amputation of the left hallux. Patient did discharge to rehab facility after this admission. Relapsed sometime around October. Since then it has been difficult to coordinate care for this patient related to the fact that patient is persistently homeless despite multiple attempts made by healthcare advocate to find housing accommodations for him, compounded by the fact that patient continues to drink “from the time he wakes up until he goes to bed” which appears to be affecting his decision-making capacity regarding the severity of his situation.

Question:

- What approach should be taken with this patient to hopefully prevent further significant illness or injury r/t substance abuse disorder and social determinants of health?

Sign up for Case Presentations

1/28/2020	Screening, assessment, diagnosis	Case 1: Case 2:
2/11/2020	Brief intervention, med management counseling and relapse prevention	Case 1: Case 2:
2/25/2020	Psychosocial interventions	Case 1: Case 2:
3/10/2020	Pharmacotherapy for AUD	Case 1: Case 2:
3/24/2020	Pharmacotherapy of OUD	Case 1: Case 2:
4/7/2020	Use & misuse of cannabis	Case 1: Case 2:

Reminders:

- Next session January 28th – Screening, assessment, and diagnosis (Luke Archibald)
- Please type your name, organization, and email into chat
- Slides will be posted to the D-H ECHO Connect site