



## ACCEPT

### Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics

#### How to Join:

<https://iecho.org/public/program/PRGM1708646970665RHK0C7J5TR>

For attendance purposes please text the following code: **JULBAQ** to **608-260-7097**

**Session Date:** Friday, April 17, 2026

#### Didactic Topic and Presenter:

Building Systems of Care for Opioid Use Disorder and Overdose Across the Continuum of Care

Collin Michels, MD

Melissa Ricker-Bouche MD

#### Content experts: *Sheila Weix and Joe Galey*

- 
- 12:15 PM: Attendance text-in – Introductions
  
  - 12:25 PM: Case Presentation
    - Presenter: Melissa Ricker-Bouche MD - *Family Medicine & Geriatrics, Sun Prairie Family Medicine, Geriatrics Assessment Clinic*
  
  - 12:50 PM: Didactic Presentation
    - Presenter: Collin Michels, MD - *Chief of Emergency Medicine, William S. Middleton Memorial VA, Fellowship Director, ED Administration, Quality, and Leadership, Assistant Professor (CHS), BerbeeWalsh Department of Emergency Medicine, University of Wisconsin School of Medicine & Public Health | UW Health*
  
  - 1:15 PM End of Session

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**ECHO ACCEPT**

**Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics 2026  
Building Systems of Care for Opioid Use Disorder and Overdose Across the Continuum of Care  
4/17/2026**

**Didactic Presenter: Collin Michels, MD**

**Case Presenter: Melissa Ricker-Bouche, MD**

*Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)*

**Intended Audience:**

Nurses, Nurse Practitioners, Pharmacists, Physicians, Physician Assistants, Pharmacy Technicians, Psychologists, Social Workers, Patient/Caregivers, Students

**Objectives:**

1. Describe how paramedics can initiate buprenorphine initiation after overdose reversal or opioid withdrawal.
2. Explain how emergency departments can provide initiation and prescription for buprenorphine, including the use of decision support tools.
3. Discuss strategies for linking patients with opioid use disorder to community programs for follow-up care and long-term treatment goals across the continuum of care.

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<b>Name</b>	<b>Role</b>	<b>Financial Relationship Disclosures</b>	<b>Discussion of Unlabeled/Unapproved uses of drugs/devices in presentation?</b>	<b>COI completion date</b>
David Leinweber	RSS Chair/Reviewer	No relevant financial relationships to disclose	Yes	12/9/2025
Nada Rashid	RSS Coordinator	No relevant financial relationships to disclose	No	12/10/2025
Kathleen Maher	RSS Coordinator	No relevant financial relationships to disclose	No	12/9/2025
Randall Brown	Planner	No relevant financial relationships to disclose	Yes	12/10/2025
Ritu Bhatnagar	Planner	No relevant financial relationships to disclose	Yes	12/6/2025
Paul Hutson	Planner	usona (Independent Contractor - Consultant), Midwest Pharmacokinetic Consulting, LLC (Independent Contractor - Consultant), Otsuka America Pharmaceutical, Inc. (Independent Contractor - Consultant), Tryptamine Therapeutics (Independent Contractor - Consultant)	Yes	12/9/2025
Susan Mindock	Planner	No relevant financial relationships to disclose	No	12/8/2025
Sheila Weix	Planner	No relevant financial relationships to disclose	No	12/11/2025
Kellene Eagen	Planner	No relevant financial relationships to disclose	No	12/8/2025

Joseph Galey	Planner	No relevant financial relationships to disclose	No	12/19/2025
Cody Wenthur	Planner	Usona Institute (Grant / Contract)	No	3/30/2026
Megg Kohel	Planner	No relevant financial relationships to disclose	No	3/27/2026
Collin Michels	Presenter	No relevant financial relationships to disclose	No	4/3/2026
Melissa Ricker-Bouche	Presenter	No relevant financial relationships to disclose	No	4/13/2026

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# Building Systems of Care for Opioid Use Disorder and Overdose Across the Continuum of Care

**Collin Michels, MD**

Assistant Professor, Emergency Medicine

BerbeeWash Department of Emergency Medicine

University of Wisconsin School of Medicine and Public Health

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# Overview

- ▶ **Describe** how paramedics can initiate buprenorphine after overdose reversal or opioid withdrawal
- ▶ **Explain** how emergency departments can provide initiation and prescription for buprenorphine including the use of decision support tools
- ▶ **Discuss** strategies for linking patients with opioid use disorder to community programs for follow-up care and long-term treatment goals across the continuum of care



Megan Gussick, MD

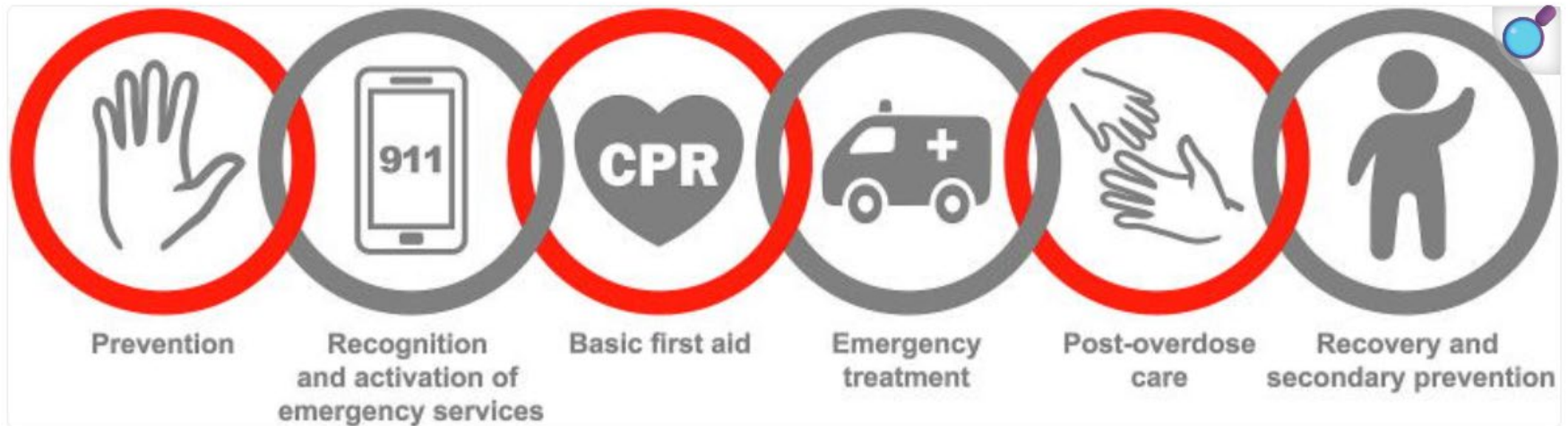


Elizabeth Salisbury-Afshar, MD MPH



Michelle Orellana-Lopez

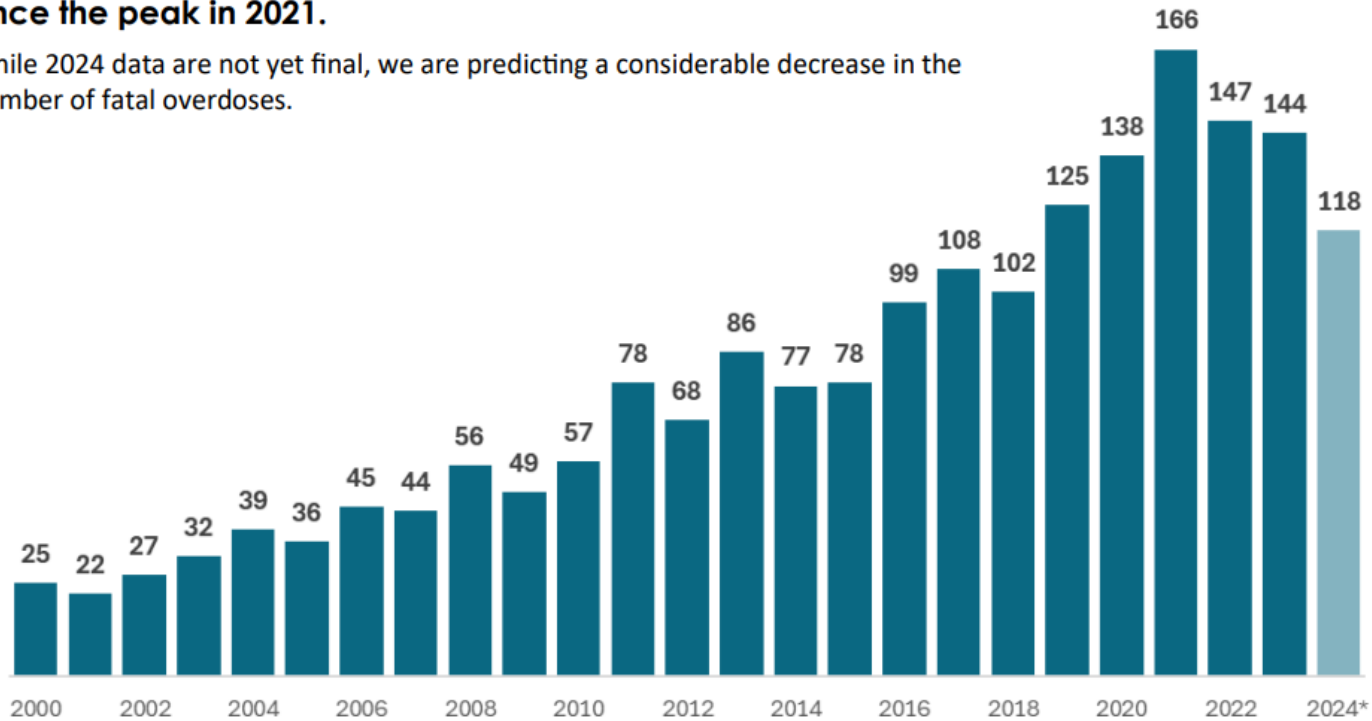
# Chain of Survival for Drug Overdose & Vision for Dane County Services



# Background– Overdoses in Dane County

The number of people who died due to a drug overdose in Dane County has decreased since the peak in 2021.

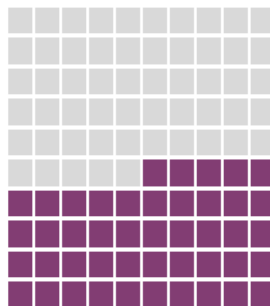
While 2024 data are not yet final, we are predicting a considerable decrease in the number of fatal overdoses.



\*2024 data are preliminary

# Contact with EMS and Hospitals in the Year Before Overdose Death Is Common

**45%** had an ED visit in the year before they died.



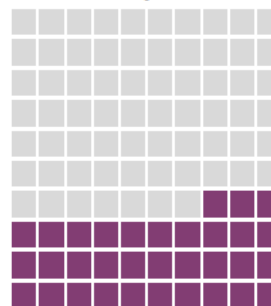
Of the 45% of people with an ED visit in the year before they died:

**24%** were for a non-fatal overdose.\*

**34%** occurred within 30 days of death\*

**45%** had 3 or more ED encounters in the past year.

**33%** had an EMS encounter in the year before they died.



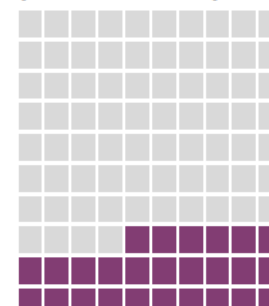
Of the 33% people with an EMS encounter in the year before they died:

**49%** were for a non-fatal overdose.\*

**26%** occurred within 30 days of death\*

**33%** had 3 or more EMS encounters in the past year.

**26%** had an overnight hospital stay in the year before they died.



Of the 26% people with an overnight hospital stay in the year before they died:

**14%** were related to substance use or mental health.\*

**25%** occurred within 30 days of death\*

**25%** had 3 or more overnight hospital stays in the past year.

# Why Buprenorphine in the Field



Studies have shown administration of buprenorphine by emergency medical services (EMS) providers in the field is **feasible and safe**



Studies have also shown paramedic-initiated buprenorphine results in significant **reductions in withdrawal scores and no cases of precipitated withdrawal with only minor adverse effects**

# What's The Cost?



Scene time by only **~6 minutes**

# What's The Benefit?



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Patients treated by EMS with buprenorphine are **5x more likely to engage in follow-up addiction care** within 30 days compared to those who do not receive buprenorphine

---

Treatment program retention rates for patients who receive buprenorphine from EMS in the field was **50% at 7 days** and **36-47% at 30 days**

# Madison Field Based Buprenorphine Initiation

- ▶ **Madison Fire initiated field Buprenorphine on March 1<sup>st</sup>, 2024**
  - All Madison Fire Ambulances carry Buprenorphine
  - All Community Alternative Response Emergency Services (CARES) paramedics carry Buprenorphine



# Training Madison Fire Paramedics



- ▶ Training lead by Addiction Medicine team
- ▶ Goals:
  - Familiarization of Buprenorphine including mechanism of action and safety
  - Understanding OUD and how Buprenorphine can help to treat this
  - Benefits of Buprenorphine initiation in the field vs ED vs outpatient

# Campaign to Local EDs



## Pre-Hospital Buprenorphine

**Planned launch: March 1, 2024**

### GOALS

- Aims to address the ongoing substance use crisis within our local community

### BACKGROUND

- Treatment with buprenorphine significantly reduces both all-cause and overdose mortality among individuals with opioid use disorder (OUD).
- Offering buprenorphine treatment to individuals that experience a non-fatal opioid overdose represents an opportunity to reduce opioid overdose fatalities.
- Although some emergency departments (ED) initiate buprenorphine treatment, many individuals who experience an overdose either refuse transport to the ED or are transported to an ED that does not offer buprenorphine

### PROTOCOL

#### Dosing

- Initial dose: 16 mg sublingual buprenorphine if Clinical Opiate Withdrawal Scale (COWS) is >7
- Repeat dose: after 10 minutes if symptoms remain, an additional 8 mg sublingual buprenorphine may be given
- Total maximum dose: 24 mg sublingual buprenorphine
- Please see the attached protocol for more detailed information

### WHAT WE HOPE THE ED CAN DO

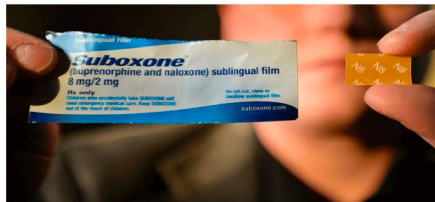
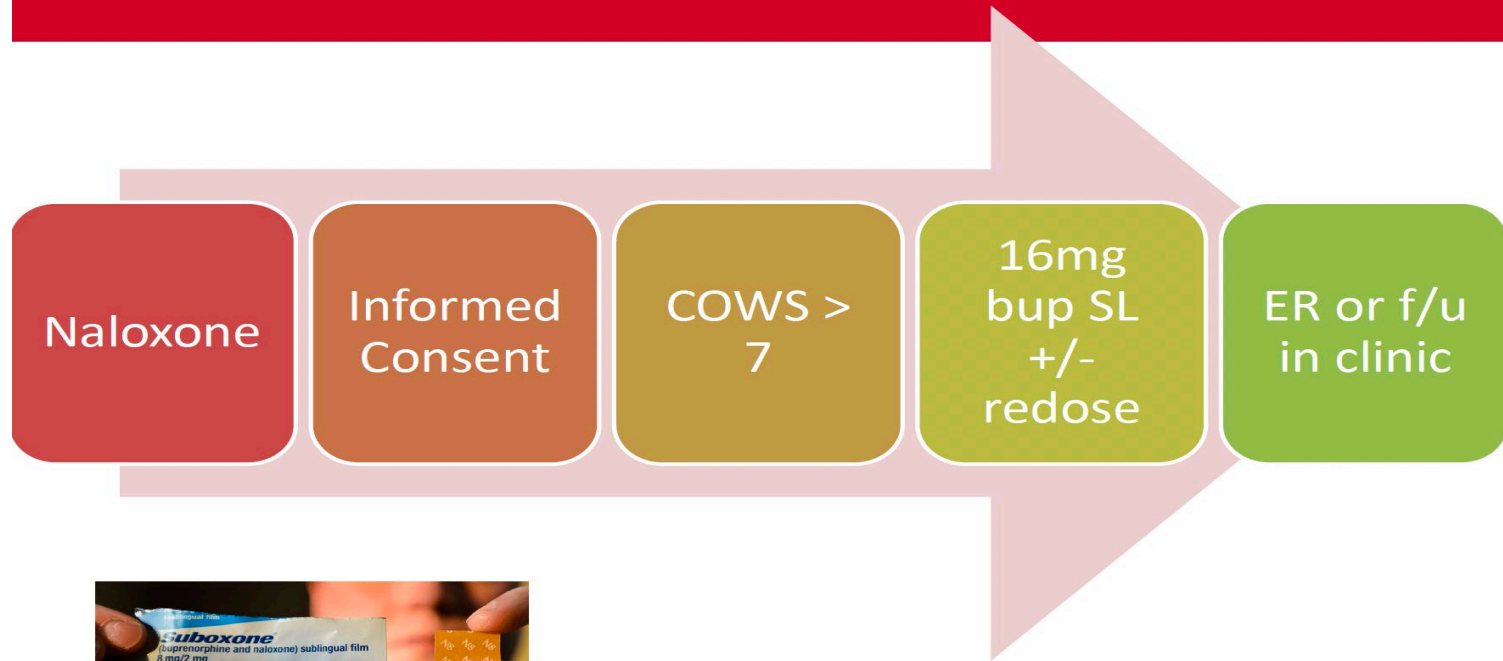
- Administer additional doses of buprenorphine if indicated
- Social work consult to connect patients with appropriate resources including connecting patient to clinics that can continue buprenorphine prescribing as well as other resources
- Prescribe buprenorphine upon discharge to help bridge patients to their follow up appointments with outpatient services

# Who Gets Field Buprenorphine?



1. Patient who is experiencing withdrawal after self-cessation of opiates
2. Patient who experiences an opiate overdose, received Narcan, and is now experiencing rapid opiate withdrawal

# EMS Workflow



# Transitioning Care

## Transport to local ED

- Patient can receive additional Buprenorphine as clinically indicated
- Buprenorphine prescription upon discharge
- Social Work consult for referral to outpatient resources

## Patient declines transport

- Patient receives hand-out
- Phone number obtained
- MFD Community Paramedics make follow-up phone call within 24-48 hours to help connect patient to outpatient resources

# Transitioning Care



**City of Madison Fire Department**



## You received buprenorphine

### What is buprenorphine?

It is a medication used to treat opioid withdrawal and addiction.

### How does it work?

It works on the same receptors in the brain as opioids but does not produce as strong of an effect as drugs like heroin.

### How can it help me?

By working on the same parts of the brain as opioids, it can immediately help decrease withdrawal symptoms. It can also reduce the frequency and intensity of cravings, plus provides protection against an accidental overdose in the next 24 hours.

### What are the next steps?

You should follow up at one of the clinics listed below. They will be able to provide you a prescription for the same medication, buprenorphine, that you were given today. They will also be able to connect you with other resources that you can access.

#### **Buprenorphine Treatment:**

##### **1. Compass Program**

1102 S Park Street, 4<sup>th</sup> floor Madison WI 53715

(608) 282-8270

8:30AM-4PM Tuesdays and Fridays

New patients seen Tuesday or Friday mornings between 8-11 AM on a first-come, first-served basis.

##### **2. Community Medical Services**

4802 East Broadway, Madison WI 53716

(608) 889-7500

7 am to 6 pm Monday-Sunday (7 days a week)

#### **Harm Reduction Services:**

##### **1. Dane County Syringe Service & Naloxone Program:**

2705 E. Washington Ave., Madison (Hours: Monday - Friday, 8:30 am - 4:30 pm)

2300 S. Park St., Suite 2010, Madison (Hours: Monday - Friday, 8:30 am - 4:30 pm)

##### **2. Lifepoint Syringe Services/Vivent Health:**

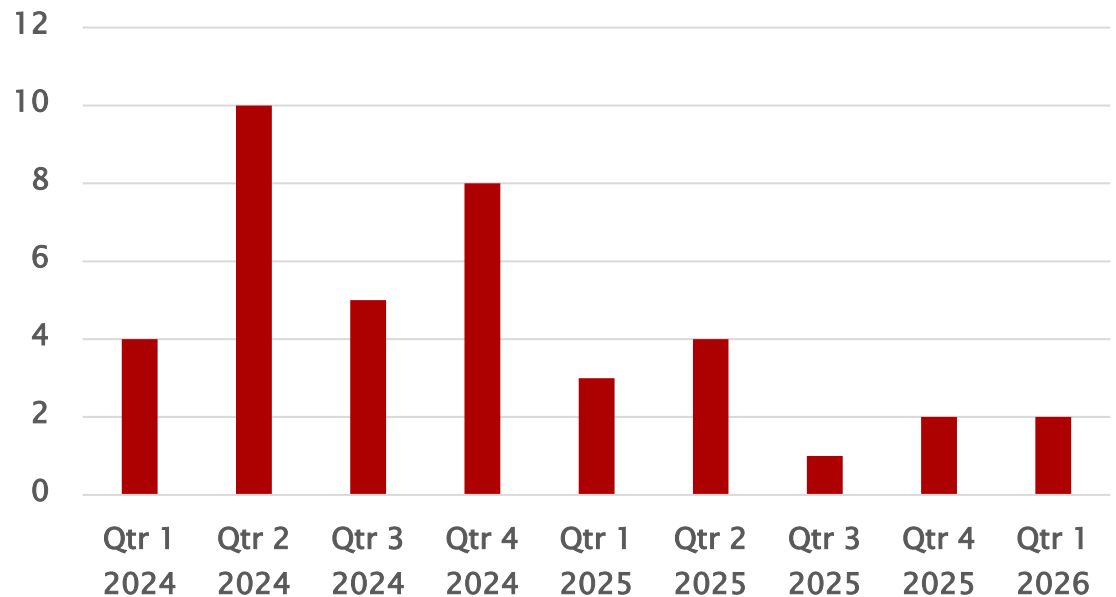
600 Williamson St., Suite H, Madison (Hours: Monday - Friday, 10:00 am - 5:00 pm)

Phone: (608) 332-6169

# MFD Early Outcomes

- ▶ Since March 1<sup>st</sup>, 2024  
MFD administered  
**Buprenorphine 39 times**,  
to 29 unique patients

MFD Buprenorphine Administrations

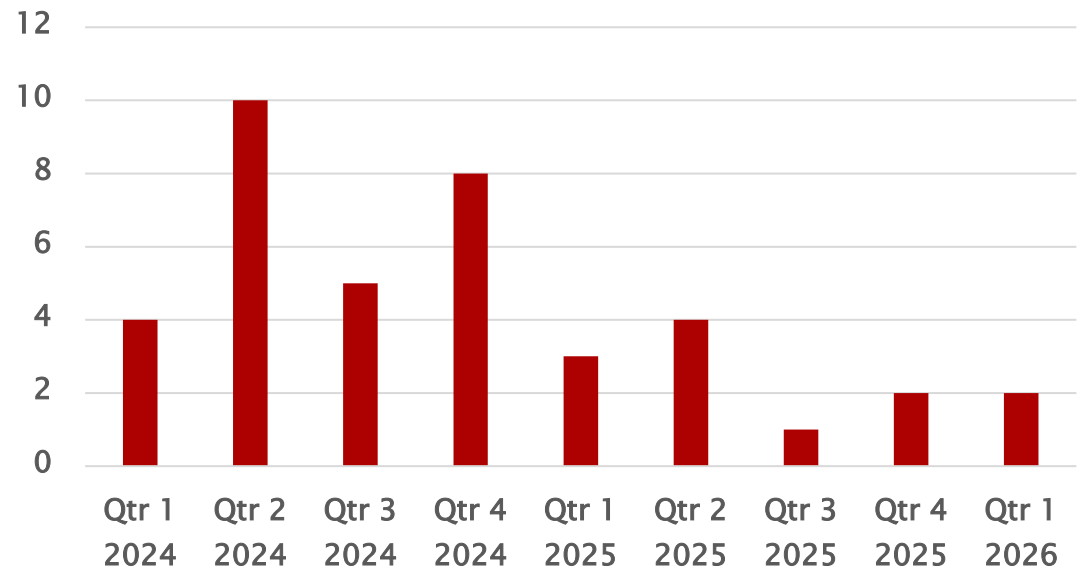


# MFD Early Outcomes

## ▶ 39 Encounters

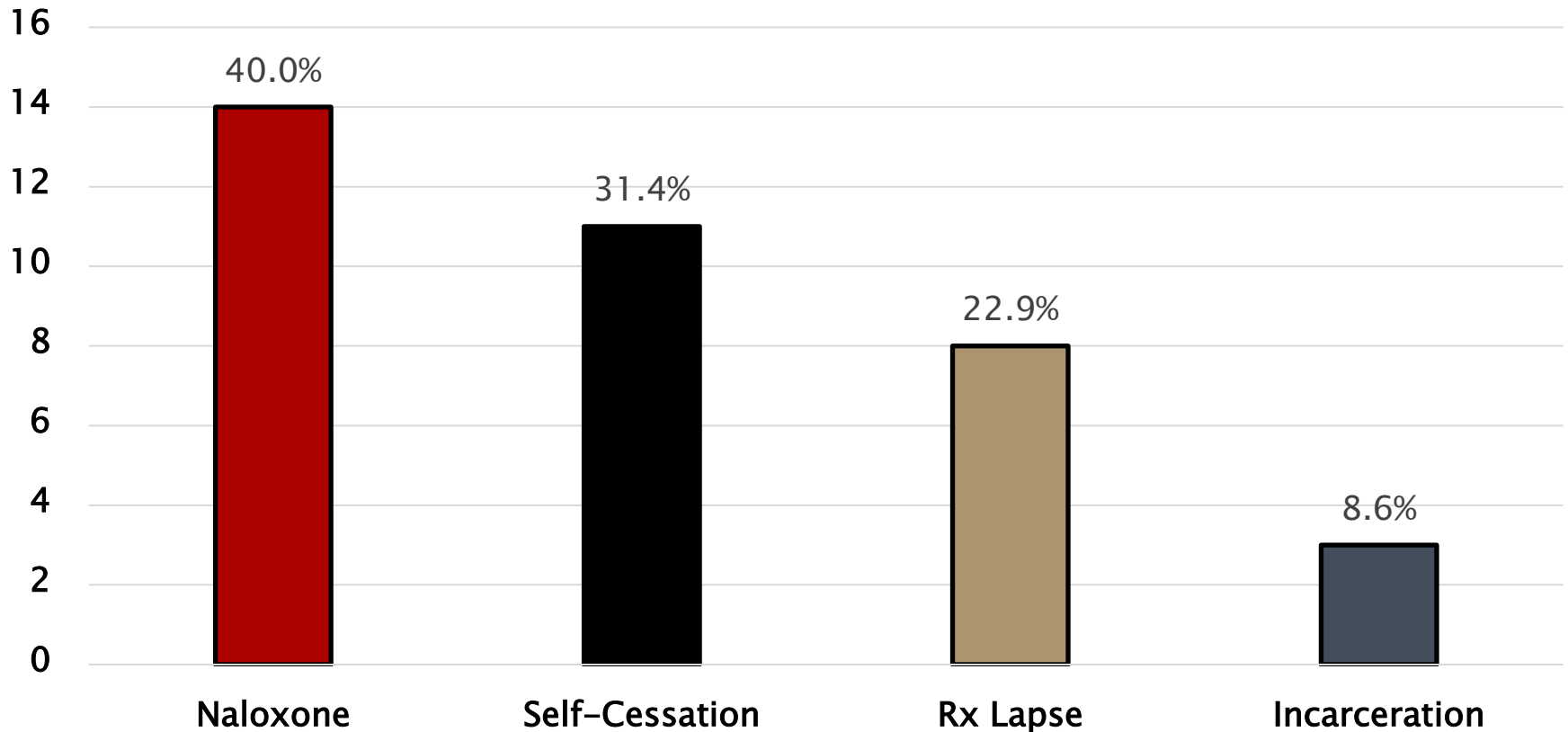
- Age (median):
  - 43 Years
- Sex:
  - 54% Male, 46% Female
- COWS (median):
  - 16
- Transport Rate:  
91.4%

MFD Buprenorphine Administrations



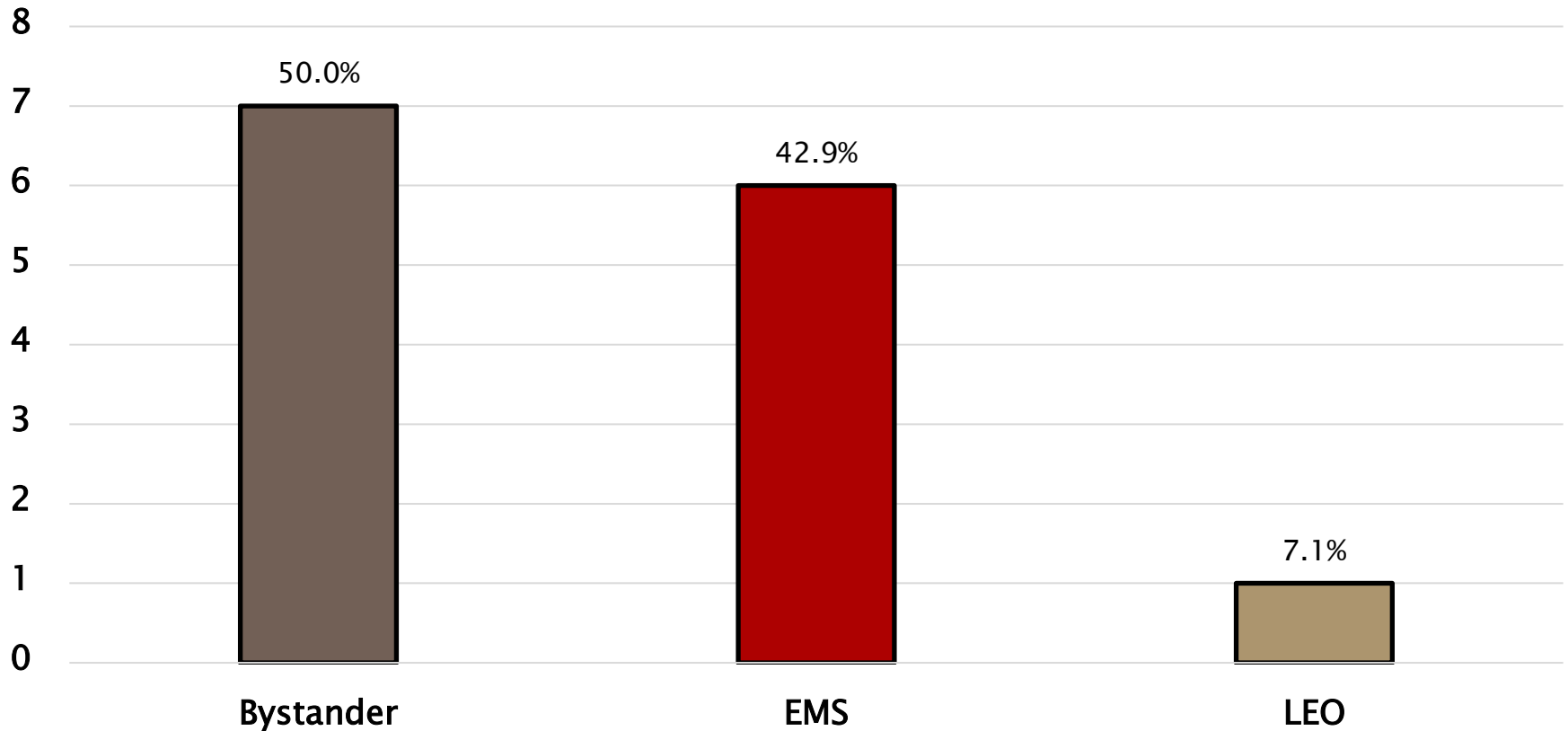
# For Patients Receiving Buprenorphine— Reason for Withdrawal

Reason for Withdrawal



# For Patients Receiving Buprenorphine– Person Administering Naloxone

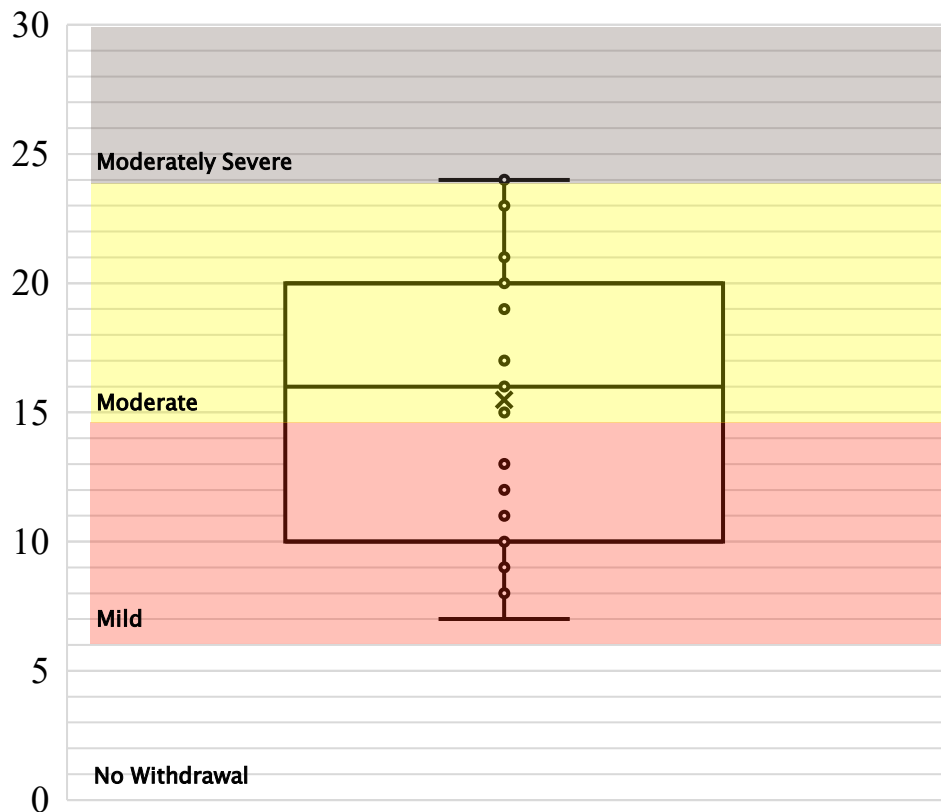
Person Administering Naloxone



Overall: 40% of encounters

# For Patients Receiving Buprenorphine- Clinical Opiate Withdrawal Scale (COWS) Score

COWS Score



Median: 16 (IQR: 10.5, 19.5)

# Where Do We Go From Here?



- ▶ Understand facilitators and barriers the program
- ▶ Focused on paramedic perception and training
- ▶ Interviewed 9 paramedics and developed survey tool

# Areas of Focus for Survey

1. Scene Dynamics
  - Law enforcement and bystander presence
2. Training and comfort
  - Efficient protocol and received training
3. Practical experience
  - Patient interest, barriers, sharing successes



# Key findings from Paramedic Surveys (N= 43)



## OVERALL

- 57% response rate
- Paramedics felt comfortable treating overdose, but less comfortable with referral to community care
- Most had buprenorphine training, though not all



## BARRIERS

### Patient factors

- Not meeting criteria
- Lack of interest
- Not disclosing opioid use

### Logistical factors

- Limited time
- Police presence



## FACILITATORS

- Education
  - How buprenorphine works
  - Next steps if patient refuses ED transport
- Follow-up planning
- Linkage to community care

# Lessons Learned for Field Buprenorphine

- ▶ Field Buprenorphine administration can be a great addition to chain of survival
- ▶ Paramedics can calculate COWS scores
- ▶ Opportunity for treatment post naloxone



# Next Steps for Field Buprenorphine



- Coaching to improve conversations with patient surrounding opiate use
- Creating safe environments for patients to disclose use
- Improving collaboration with law enforcement colleagues
- Resources and options for patients who do not desire transport to the ED

# Buprenorphine Initiation in the ED

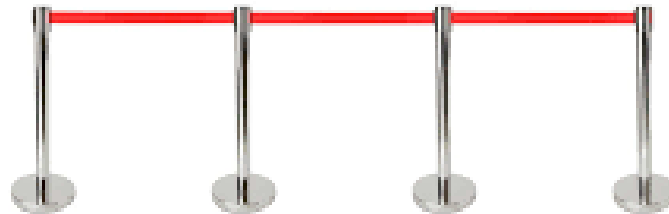
Previous: Evaluate, stabilize, discharge

Buprenorphine in the ED – ‘Yale Model’ 2009

Now Standard of care

# Caring for patient with OUD in the ED

- ▶ UW-Health ED 5/2022
  - Clinicians, nurses, social work on overdose education and naloxone distribution buprenorphine
  
- ▶ Attitudes, beliefs, barriers, facilitators toward buprenorphine and overdose education & naloxone



# Overdose Education & Naloxone Distribution

- Clinicians' attitudes towards naloxone were positive, while utilization was variable
- Barriers
  - Patient Cost
  - Bedside distribution
  - Pharmacy services
  - Nursing education and comfort



# Buprenorphine in the ED

- Clinicians' attitudes towards buprenorphine were positive, while utilization was low
- Barriers
  - Prescriber comfort
  - X-waiver
  - Time
  - **Lack of decision support**



**Background**

[Objective\(s\)](#)  
[Contributors & Reviewers](#)  
[References](#)  
[Legend](#)

**Adult patient presents to ED with suspected acute, uncomplicated opioid withdrawal**

- Obtain opioid history & make OUD diagnosis
  - Use smart phrase (.oudhxdsm)
- Discuss MOUD options
  - Proceed if patient interested in buprenorphine/naloxone

**This pathway does not address complicated withdrawal - consult Addiction Medicine as needed**

**Complicating Factors Include But Not Limited To:**

- Altered mental status
- Delirium
- Severe pain, trauma
- Methadone use
- Alcohol &/or benzodiazepine withdrawal
- Pregnancy

**Resource for Clinical Questions**

- UW Addiction Consultation Provider [Hotline](#) M-F 8am-5pm
  - Call 608-263-3260 or page Addiction Medicine provider on call (WI only)

Complete [COWS](#) assessment

## Discharge



Discharge Orders - Prescriptions;  
Education & Resources for AVS

- [Buprenorphine/Naloxone SL 8mg/2mg BID](#)
- [Naloxone 4mg/0.1ml nasal spray](#)
- [Opioid Overdose Naloxone: General Info](#)
- [OUD Outpatient Resources](#)
- **PRINT & REVIEW with patient:**
  - [Buprenorphine Home Instructions](#)
  - [Outpatient Resource List](#) (view only for providers)



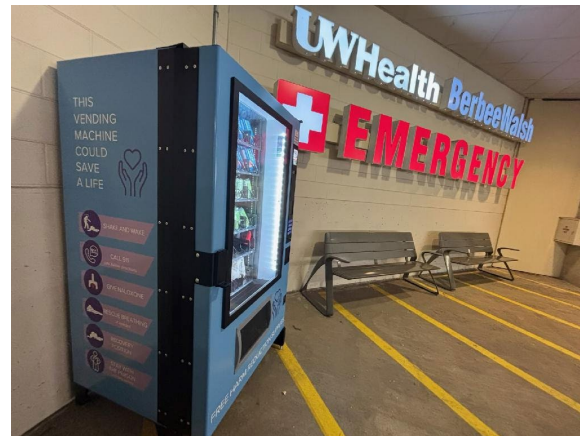
# ED-Based Buprenorphine Initiation Early Outcomes

- ▶ **March 2023 – May 2024**
- ▶ 46 Encounters, and 90% (n=38) had a prior documented OUD diagnosis.
- ▶ Buprenorphine was prescribed at discharge in 94% (n=29) of eligible discharges
- ▶ Naloxone was co-prescribed in only 52% (n=15) of encounters



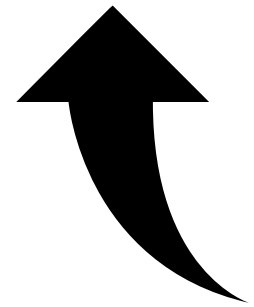
# Additional ED Interventions

- ▶ Clinical Pathway
- ▶ Overdose Response Kits
- ▶ Harm reduction vending machine (Dane Co Emergency Management)
- ▶ SAFE Communities Peers Support Services
- ▶ Dedicated nursing and provider education



# ED Post-Implementation Survey Key Findings

- ▶ Survey June 2025 (n=47)
- ▶ Re-survey of ED clinicians (physicians, residents, physician assistants)
- ▶ **Significant** increase in:
  - Comfort caring for patients with OUD
  - How much you feel you can do to help people with OUD
  - Comfort prescribing buprenorphine for treatment of OUD



# ED Buprenorphine Initiation Lessons Learned & Next Steps

- ▶ Continuing to partner with outpatient setting for transitions of care



# ED Follow Up & Next Steps

- Walk-in, low-barrier clinic, with same day access
- Ability to provide care regardless of insurance status.
- Offer a range of services
  - MOUD (buprenorphine & naltrexone)
  - HCV treatment
  - Wound care
  - STI testing and treatment
  - Housing assistance
  - Family planning and contraceptive access
  - Peer support services
  - Transportation assistance
  - Medical case management
  - Harm reduction education and naloxone



February 15, 2024

# Compass Program hopes to help fill care gap amid opioid crisis

About us

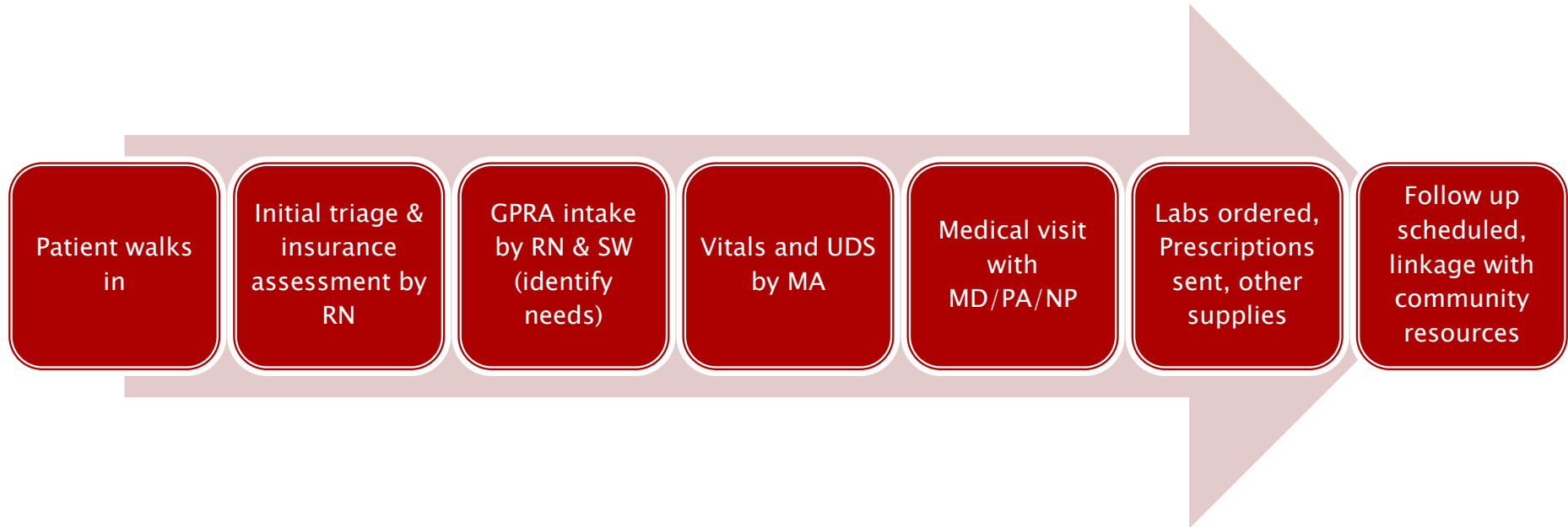


# UW Compass Program– Local Context

- ▶ Access to medications for OUD
  - PCP challenges
    - Access
    - Provider comfort
  - Cost / insurance
  - Most programs offer only "high barrier" care
  
- Provide additional care
  - Wound care, HCV treatment, reproductive health care



# Patient Experience



# Patient Volume & Referral Sources

## Patient Volume:

- 248 Unique Patients
- 1947 Total Visits

### Referral Sources:

Emergency Departments

EMS

Law Enforcement

Jail

Primary Care Providers

Community Agencies

Inpatient Hospitalization

Specialty Care Providers

Self-referred & current patients

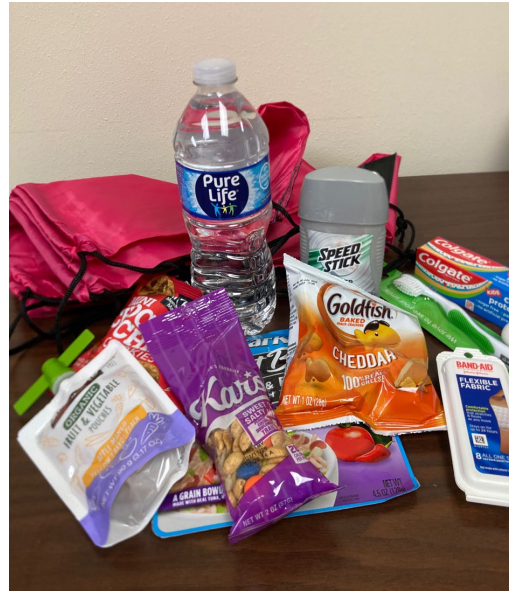
# Linkage to Community Programs

- ▶ Transportation
- ▶ Comprehensive Community Services (CCS)
  - collaboration with community case managers
- ▶ Food assistance
- ▶ Clothing vouchers
- ▶ Higher levels of substance use disorder care
- ▶ Recovery housing
- ▶ Crisis intervention and stabilization services
- ▶ Legal services
- ▶ Peer support

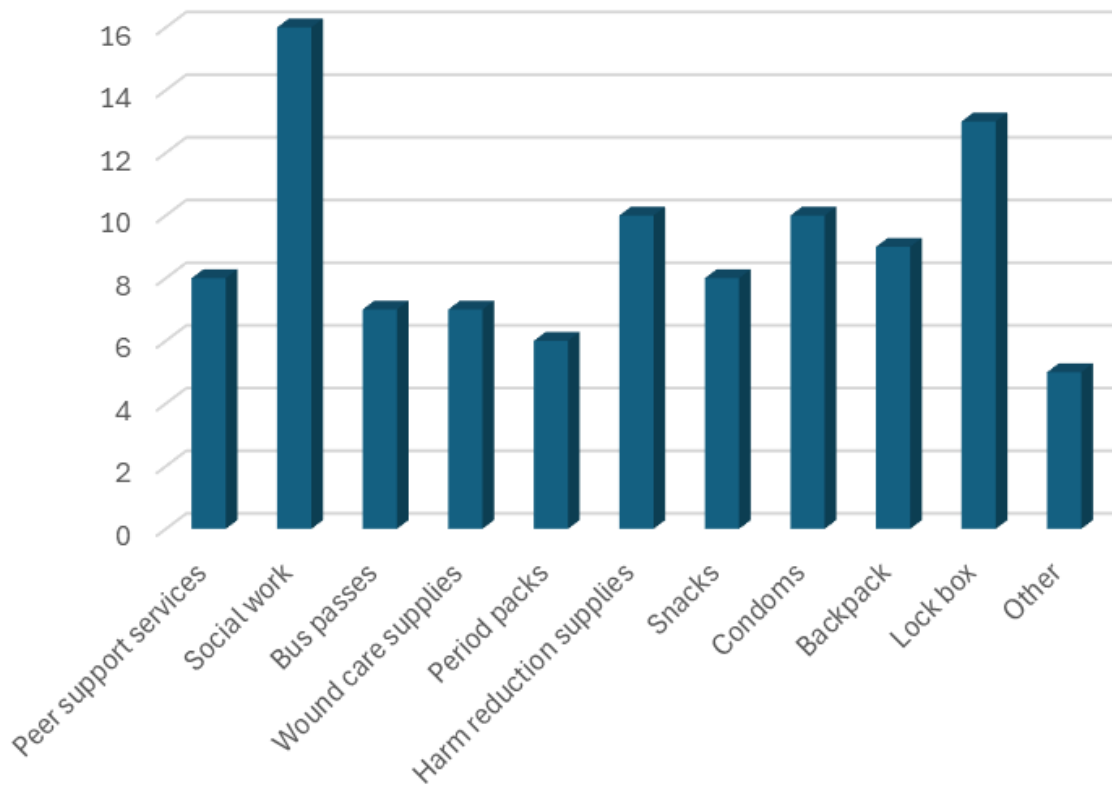


# Supplies

- Bus passes
- Backpacks
- Naloxone
- Test strips
- Basic wound care supplies
- Lock boxes
- Gun locks
- Hand warmers
- Menstruation packs
- Safer sex supplies
- Gloves/warm weather supplies
- Harm reduction supplies
- Snacks!



## What other support services or supplies have you received at Compass?





## Next Steps

- Upcoming Education Days with Madison Fire
- Automated referrals from ED to Compass with Peer Support Specialists doing outreach
- Expand hours to additional days of week, evenings, and weekends as volume grows.
- Patient evaluations and patient engagement sessions to identify areas for ongoing quality improvement

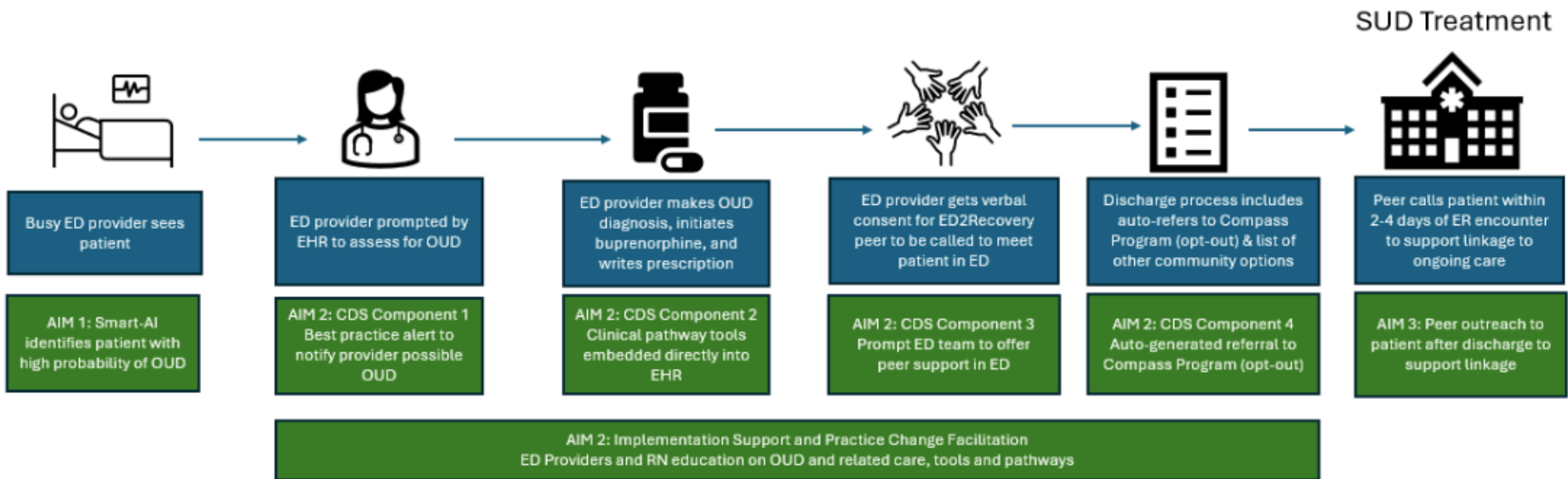
# UW–Madison receives \$1.6 million from CDC to strengthen opioid use disorder care

Posted on [November 24, 2025](#)

A new federal investment seeks to improve emergency care for individuals with opioid use disorder and strengthen recovery pathways across Dane County.

The Centers for Disease Control and Prevention has awarded \$1.6 million to a multidisciplinary team at the University of Wisconsin School of Medicine and Public Health to launch the Wisconsin Opioid Prevention and Treatment Research Network (WI OPTRN). The new initiative aims to reduce overdose deaths by better integrating evidence-based treatment for opioid use disorder (OUD) in the emergency department with reliable pathways to recovery in the community.

## Future State in the ED for Patients at risk for OUD



# Conclusions

- ▶ Our collaborative efforts in the field, ED and clinics is helping to provide lower barrier access to treatment for patients with OUD in Madison and Dane County
- ▶ Through on-going efforts, we hope to continue to expand these efforts and increase their impact

# Thank You!



# DSM-5 Substance Use Disorder ("Addiction")

- ▶ Tolerance
  - ▶ Withdrawal
- } **Physical Dependence ≠ Use Disorder**
- ▶ Larger amts/longer periods than intended
  - ▶ Persistent desire/failed attempts to quit/control use
  - ▶ Much time obtaining/using/recovering
  - ▶ Important activities sacrificed
  - ▶ Continued use despite known adverse effects
  - ▶ Failure to fulfill major obligations
  - ▶ Recurrent hazardous use
  - ▶ Craving
  - ▶ Ongoing use despite interpersonal problems

2-3 = mild

4-5 = moderate

≥ 6 = severe



# Case Presentation

Melissa Ricker-Bouche, MD

UW Department of Family Medicine & Community Health

Funding for this service was made possible by 435200-G-18-11448-285932-880 from Wisconsin Department of Health Services. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government or the State of Wisconsin.



## Accreditation Statement:

In support of improving patient care, the University of Wisconsin–Madison ICEP is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

### Credit Designation Statements

#### **American Medical Association (AMA)**

The University of Wisconsin–Madison ICEP designates this live activity for a maximum of 1 *AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

#### **American Nurses Credentialing Center (ANCC)**

The University of Wisconsin–Madison ICEP designates this live activity for a maximum of 1 ANCC contact hour.

#### **Accreditation Council for Pharmacy Education (ACPE)**

The University of Wisconsin–Madison ICEP designates this knowledge-based activity for a maximum of 1.0 hours or 0.1 CEUs of CPE credit. Credit can be earned by successfully completing the activity. Credit will be provided to NABP CPE Monitor within 60 days after the activity completion.

2026 Universal Activity Number (UAN): JA0000358-0000-26-008-L01-P

By completing the required components of this activity, you give UW-Madison ICEP permission to share completion data with the ACCME, certifying boards, and/or NABP.

#### **Medication Access and Training Expansion Act (MATE)**

This session is designed to meet the requirements outlined in the Medication Access and Training Expansion (MATE) Act. (Click [here](#) for more information.) Number of hours: 1.0

#### **ASWB Approved Continuing Education (ACE)**



As a Jointly Accredited Organization, the University of Wisconsin–Madison ICEP is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. Regulatory boards are the final authority on courses accepted for continuing education credit. Social workers completing this course receive 1.0 General continuing education credits.

#### **Continuing Education Units**

The University of Wisconsin–Madison ICEP, as a member of the University Professional & Continuing Education Association (UPCEA), authorizes this program for 0.1 continuing education units (CEUs) or 1 hour.

#### **Policy on Faculty and Sponsor Disclosure**

It is the policy of the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP) to identify, mitigate and disclose all relevant financial relationships with ineligible companies\* held by the speakers/presenters, authors, planners, and other persons who may influence content of this accredited continuing education (CE). In addition, speakers, presenters and authors must disclose any planned discussion of unlabeled/unapproved uses of drugs or devices during their presentation. For this accredited continuing education activity, all relevant financial relationships have been mitigated and detailed disclosures are listed below.

\* Ineligible companies are those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. The ACCME does not consider providers of clinical service directly to patients to be ineligible companies.

Detailed disclosures will be available prior to the start of the activity.

# Case Introduction

- ▶ One-liner (including age/sex):
  - 43 year old female with history of chronic lower back pain and lumbar radiculopathy, with a spinal cord stimulator
  
- ▶ Primary question for discussion:
  - Requesting assistance with further pain management while on suboxone

# Low Back Pain & Left Leg Radiculopathy History

- ▶ Started 2009
  - Felt like her back gave out after standing
  - Constant lower back and left leg pain since then
  - Impacts quality of life and functioning/mobility
- ▶ Most recent imaging:
  - Xray Thoracolumbar Spine 2025: "stable rightward convex scoliotic change of the lumbar spine. The vertebral body heights are maintained. No acute fracture is seen. There is **multilevel intervertebral disc space narrowing and disc spurring noted, most pronounced at L1-L2 and L4-L5**. These findings are stable in comparison to the prior exam. The sacroiliac joints are symmetric."
  - (MRI ordered)

# Medical & Behavioral Health Diagnosis:

- Chronic bilateral low back pain with degenerative disc disease/lumbar radiculopathy
- Bilateral lower extremity edema
- Anxiety
- Depression
- OCD
- PTSD
- Migraines
- Primary insomnia
- History of GI bleed, history of gastric bypass
- Primary sclerosing cholangitis vs AMA negative primary biliary cholangitis
- Tobacco use
- Obesity
- Fractured teeth, need for crown

# Current Medications:

- Buprenorphine-Naloxone 8-2mg (0.75mg every 6 hours)
- Aripiprazole 5mg once daily
- Gabapentin 300mg TID
- Fluvoxamine 25mg
- Zolmitriptan 5mg
- Lasix 40mg BID

# Previous Pain Management

- ▶ Topicals:
  - Lidocaine patches/diclofenac gel ineffective
- ▶ OTC:
  - NSAIDs contraindicated with history of GI bleed
  - Tylenol limited by liver enzymes
- ▶ Steroids:
  - Given prednisone by dentist for gingival manipulation/crowns (March 2026)
- ▶ Nerve-related medications:
  - Currently on gabapentin and fluvoxamine
  - Previously on imipramine; stopped when fluvoxamine was started due to concern for interaction
  - Duloxetine, amitriptyline, nortriptyline, topamax ineffective
  - Lyrica caused seizures

# Previous Pain Management

- Muscle relaxants:
  - Tizanidine was helpful, but contraindicated with fluvoxamine so recently discontinued
- Others:
  - Naltrexone ineffective

# Other interventions

- ▶ Spinal cord stimulator since 2024, with frequent adjustments
- ▶ Trigger point injections with Pain Clinic (ongoing)
- ▶ Osteopathic Manipulation Therapy 2024
- ▶ S/p physical therapy; not helpful. New order placed in 2023 but not completed
- ▶ Steroid injections (most recently in 2022)

# Mental Health

- ▶ Previously referred to Pain Psychology, Behavioral Health & Recovery
  - But has a strong relationship with current psychiatry provider, whom I am in frequent communication with

# Substance Use

## ▶ History:

- Oxycodone (10mg q6hrs PRN, not seen on UDS in 2017 but positive for benzodiazepines)
- Hydrocodone 10mg 4x/day and morphine 10mg qAM started in 2021
- **Accidental overdose in July 2022; fentanyl present in cocaine**
  - Incorrectly labeled as a "heroin overdose"
- **Denies subsequent substance use**
- **Started buprenorphine (butrans) 5/8/23**
- **Switched to buprenorphine-naloxone 9/22/23**
- **2026: Increased pain (spinal stimulator adjustments, dental procedures). Patient requested hydrocodone for breakthrough pain. I discussed with addiction medicine consult line. Recommended PRN for breakthrough pain. Considered decreasing dose of suboxone due to concerns for hyperalgesia. Hydrocodone without APAP not available; oxycodone available instead based upon insurance. Patient found benefit with functioning from taking daily; now requesting to take daily.**

# Substance Use

- ▶ Consequences of Substance Use:
  - Social/occupational/educational: accidental overdose in 2022 led to ICU admission for sepsis
  - Physical (including evidence of tolerance/withdrawal): tolerance; requiring escalating doses for pain management
- ▶ Past treatments:
  - Hydrocodone 2023 (1 fill)
  - Oxycodone intermittently since 2024
  - Tramadol intermittently in 2025 from dental team
  - Dilaudid while hospitalized

# Social History:

- Social Factors/History: two children and a partner
- Education/Literacy: former anesthesia tech/ nurse
- Income source: currently on disability

# Family History:

- Unknown

## Patient strengths & protective factors:

- Very engaged in care
- Willing to come in for visits and drug screening
- Frequent communication
- Strong psychiatric support

## Risk factors:

- Unclear substance use history
- Some early refills- but likely due to pain

# Labs

- ▶ UDS have been appropriate since 2023
- ▶ Most recently in November 2024

# Patient Goals & Motivations for Treatment

- ▶ Pain management to improve functionality

# Proposed Diagnoses

- ▶ Chronic lower back pain and lumbar radiculopathy

# Proposed Treatment Plan

- ▶ Update MRI
- ▶ Cyclobenzaprine or baclofen
- ▶ Re-engage with PT (but currently in too much pain)
- ▶ Integrative approaches

# Discussion:

- ▶ Primary question:
- ▶ If other treatment modalities aren't enough, what to do about suboxone/other opioid treatment with goal of improving function?

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- 2–3 = mild  
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By initialing here \_\_\_\_\_ you have acknowledged that Project ECHO case consultations do not create or otherwise establish a provider–patient relationship between any ECHO clinician and any patient whose case is being presented in a teleECHO clinic.