

CASE RECOMMENDATION FORM

ECHO Session Date: 5/14/26

Presenter Credential: DNP

After review of the case presentation and discussion of this patient's case among the ECHO Community of Practice, the following suggestions have been made:

Summary: This 60-year-old male Medicaid patient presents with complex medical, social, and behavioral health factors, including chronic pain, obesity (320 lb), significant orthopedic disease, and a history of complete heart block and acute kidney injury, along with long-term use of opioids (hydrocodone up to 6 tabs/day), benzodiazepines (temazepam 45 mg), and high-dose gabapentin (1800 mg). He reports nightly alcohol use (reduced from 6–12 beers to ~6) and denies other substances, with no formal psychiatric history but notable adverse childhood experiences (paternal abuse) and longstanding housing instability, currently living in crowded, resource-limited conditions. Despite these challenges, he is intellectually engaged, independent-minded, and medically adherent at a fair level, though he tends to challenge recommendations logically. The primary clinical question centers on how to approach gradual reduction of his opioids, anxiolytics, and gabapentin in a socially and psychologically effective manner, including prioritization of tapering while navigating his complex comorbidities, substance use, and interpersonal style.

Recommendations:

Start with GLP-1 optimization (semaglutide increase)

- Increase dose (if insurance allows) as first-line strategy
- Expected benefits:
 - Reduced alcohol cravings (supports AUD treatment)
 - Weight loss → improved pain, mobility, and sleep
 - May improve readiness for other medication changes

Address overall safety: high-risk medication combination

- Reinforce that alcohol + opioid + benzodiazepine + gabapentin = high overdose risk
- Set clear expectations: ongoing prescribing tied to demonstrated risk reduction (especially alcohol use)

Initiate opioid risk reduction

- Begin gradual hydrocodone taper now (frame as safety issue)
- Consider transition to buprenorphine (pain-dose, low-dose induction)

Treat Alcohol Use Disorder

- Use GLP-1 as above
- Consider topiramate if aligned with patient goals
- Link controlled medication prescribing to reduction in alcohol use

Plan benzodiazepine taper (temazepam)

- High-risk dose → gradual taper over 6–12 months
- Likely most resistant area; begin after initial engagement and small wins
- Refer for CBT-I / sleep psychology

Medication optimization (medical contributors)

- Stop pioglitazone (fluid retention risk)
- Reassess Bumex → taper if possible to preserve kidney function
- Evaluate amlodipine as a contributor to edema

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Stabilize before major multi-drug changes

- Hold gabapentin steady initially to avoid destabilization

Engagement strategy

- Use clear, non-argumentative, boundary-based framing
- Provide written evidence (aligns with his learning style)
- Reflect discrepancies in his statements about medication benefit

Sleep approach

- Reframe insomnia around weight, alcohol, and medication effects
- Consider contribution of prior head trauma
- Address within benzodiazepine taper plan

Continuity planning

- Develop a clear transition plan prior to provider retirement
- Set expectations that current regimen is unlikely to continue long term

Monitoring

- Obtain UDS
- Maintain close follow-up during medication adjustments

Consider presenting follow-up for this patient case or any other patient cases at a future ECHO Clinic session.

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