University of Idaho
School of Health and Medical Professions

Project ECHO®

CASE RECOMMENDATION FORM

ECHO Session Date: 5/28/26 **Presenter Credential:** ADN

Summary: 64-year-old woman with Medicare and a long, complex history of substance use beginning in childhood (Valium exposure at age 7, marijuana in adolescence, and progression to prescription opioids and IV drug use in late teens) presents with opioid use disorder and recurrent methamphetamine relapses despite identifying opioids as her primary substance. Her course is marked by significant trauma, including early pregnancy, the death of her spouse at age 17, and multiple family losses related to substance use, as well as coexisting psychiatric conditions (anxiety, depression, bipolar disorder) and tobacco dependence. She experienced a life-threatening methamphetamine overdose in February 2026 requiring intubation and has had multiple documented meth relapses since 2021. She is currently treated with buprenorphine (8 mg QID) and adheres well to medications, participates in church-based recovery groups, and engages in personal recovery practices, but is not in formal counseling due to transportation and financial barriers. Her medical history includes hypertension, hepatitis C, chronic migraines, bulimia, and nerve damage from IV drug use. She lives in a rural area with limited support, relies on others for transportation, and travels long distances for care, though she reports strong spousal support. Her treatment history includes prior MOUD care, counseling, and incarceration for methadone distribution, and she seeks guidance on telehealth behavioral services and evidence-based treatments for methamphetamine use disorder.

Recommendations:

Expand access to behavioral health via telehealth

- Consider referral to programs offering full telehealth SUD treatment tracks (e.g., Thrive Community Services).
- Telehealth counseling, group therapy, and contingency management may help address transportation and cost barriers.

Reassess recent overdose and substance exposure

- Methamphetamine alone is unlikely to cause profound respiratory depression; strong suspicion for fentanyl or other adulterants.
- Counsel patient on risk of contaminated meth supply and consider harm reduction strategies (e.g., drug checking if available, overdose education).
- Review whether buprenorphine was taken consistently at the time of overdose.

Optimize MOUD (buprenorphine) strategy

- Current dosing (8 mg QID) is high but cumbersome—assess adherence, administration technique (e.g., swallowing vs proper SL absorption), and consistency.
- If emotional triggers are driving relapse, consider increasing buprenorphine dose to further suppress cravings.
- Strongly consider transition to extended-release buprenorphine (Sublocade):
    - Start at 300 mg monthly, with option to maintain higher dose if cravings persist.
    - Advantages: improved adherence, reduced misuse risk, more consistent plasma levels.

Assess medication safety and polypharmacy

- Gabapentin 4800 mg/day is very high and increases CNS depression risk—recommend gradual dose reduction.
- Evaluate overall sedating medication burden, especially in context of overdose risk.

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Review psychiatric medication regimen

- Amitriptyline 100 mg nightly: high anticholinergic burden and long-term cognitive risk.
- Consider transitioning to mirtazapine as a safer alternative (may also support sleep, mood, and appetite).

Clarify buprenorphine side effects and administration

- If patient is swallowing buprenorphine rather than allowing full SL absorption, this may:
  - Reduce effectiveness
  - Increase side effects (e.g., nausea potentially prompting promethazine use)
- Provide re-education on proper administration technique.

Address methamphetamine use disorder

- Reinforce that higher-dose MOUD can reduce stimulant use in some patients.
- Consider:
  - Contingency management (if accessible, including telehealth models)
  - Behavioral therapies via telehealth platforms
- Monitor closely for triggers and relapse patterns tied to emotional dysregulation.

Evaluate cardiometabolic regimen

- If Farxiga is being used for chronic heart failure, diabetes, or CKD, continue as appropriate.
- If obesity or cardiometabolic risk is present, consider GLP-1 receptor agonist as an alternative or adjunct, depending on indications.

Harm reduction and stability priorities

- Emphasize consistency with buprenorphine as critical to preventing overdose.
- Sublocade may be the most stabilizing next step given adherence concerns and relapse pattern.
- Continue leveraging her existing strengths (spousal support, church engagement).

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

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