University of Idaho
School of Health and Medical Professions

Project ECHO

CASE RECOMMENDATION FORM

ECHO Session Date: 6/25/26 **Presenter Credential:** LCSW

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: 34-year-old male with HIV-associated Non-Hodgkin lymphoma, significant psychiatric comorbidities (reported borderline personality disorder, bipolar disorder, social anxiety), and a complex substance use history, including past IV heroin and crack cocaine use in remission for 8 years, ongoing marijuana use, recent admission to methamphetamine use after repeated positive screens, and concerning dependence on prescribed clonazepam with early refill requests and agitation. He has a prior suicide attempt requiring hospitalization and is considered an unreliable historian, often providing inconsistent information. Socially, he lives with his mother (primary caregiver) in a strained, fluctuating relationship, is unemployed on disability, and demonstrates patterns of interpersonal instability with providers, including agitation and leaving care AMA. Despite strengths such as access to care and housing, his medication adherence is questionable, and his behavioral and substance use concerns currently limit eligibility for advanced treatments (e.g., bone marrow transplant). The care team is seeking guidance on appropriate community mental health and substance use supports, improving reliability of patient reporting, balancing pain management with concerns about drug-seeking behavior, and strategies to maintain therapeutic rapport.

Recommendations:

1. Transition to Buprenorphine
    - Strong recommendation to switch from Percocet (oxycodone) to buprenorphine (MOUD)
    - Buprenorphine is safer and may help with pain control and cravings across substances (opioids, possibly stimulant use patterns)
    - If patient resists buprenorphine, raises concern for active opioid use disorder
    - Evaluate whether current low-dose oxycodone is sufficient or if there is additional outside use
2. Therapeutic approach & engagement strategies
    - Use a nonjudgmental, harm-reduction approach:
        - Avoid ultimatums ("I'm taking this away")
        - Frame as: "I'll support you and give options whenever you're ready"
    - Emphasize alignment with patient's stated goals (living longer, family, health)
    - Be transparent:
        - "We can't achieve your goals without addressing substance use and mental health"
    - Focus on building honesty and trust, given unreliable self-report
    - Normalize ongoing use but shift toward safer use and gradual change
    - Reinforce: resources are available—it's not a resource problem
    - Encourage reflection on inconsistencies between stated desire for sobriety vs. actions
3. Address benzodiazepine + opioid risk
    - Avoid concurrent benzos and opioids
    - Recommend slow taper off benzodiazepine
    - Reassess anxiety treatment with safer alternatives
4. Optimize psychiatric and pain management
    - Clarify diagnosis and improve psychiatric medication regimen
    - Recommendation to switch Lexapro → Cymbalta (dual benefit for mood + pain)

CASE RECOMMENDATION FORM

- Address underlying pain drivers (e.g., edema/fluid overload)

5. Increase substance use treatment engagement
   - Offer MOUD
   - Encourage participation in IOP or structured SUD treatment
   - Recognize limited follow-through—may need higher-touch support
6. Harm reduction strategies
   - Strongly recommend:
     - Narcan availability
     - Fentanyl/xylazine test strips
   - Provide guidance for safer use practices
   - Continue engagement even during active use
7. Improve reliability of clinical information
   - Patient is a poor historian with inconsistent reporting
   - Focus on:
     - Objective data (tox screens, clinical findings)
     - Repeated, consistent messaging across team
     - Building trust to improve disclosure
8. Reinforce HIV and medical care priorities
   - Do NOT stop HIV medications, even with active substance use
   - Maintain coordination between HIV and psychiatric care
   - Psychiatric meds generally safe with current HIV regimen (monitor mood stabilizers)
9. Additional clinical/context considerations
   - Unclear drivers of methamphetamine use (new substance vs prior pattern)
   - Possible ongoing cravings contributing to polysubstance use
   - Monitor medical complexity (e.g., edema, prior subdural hematomas)
   - Assess motivation—patient verbalizes goals but demonstrates low behavioral follow-through

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

Shannon McDowell, Program Manager, 208-364-9906, sfmcdowell@uidaho.edu