UVM Project ECHO: Dental Series
Treatment of Oral Health-Related Pain

July 30, 2021

Course Director: Justin Hurlburt, DMD, MA
ECHO Director: Elizabeth Cote

Series Faculty:
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Amanda Kennedy, PharmD, BCPS
Hannah Hauser, MSW
Jeffrey Crandall, DDS
Natalia Chalmers, DDS, MHSc, PhD
Raymond Dionne, DDS, PhD
Sue Etminan, DMD, MPH
Thomas Connolly, DMD
• RECORDING OF SESSION TO BEGIN
Agenda

• Introductions
• Objectives
• Didactic Presentation (15-20 min)
• Case presentation
  • Clarifying questions
  • Participants – then faculty panel
• Discussion
• Recommendations
• Summary
• Closing Announcements
  • Submission of new cases
  • Completion of evaluations
Series Objectives

At the end of this ECHO series participants will:

• Understand the best practice approach to prescribing opioids for pain

• Be able to implement a workflow for the use of the Vermont Prescription Monitoring System (VPMS), including the use of delegates

• Understand the evaluation and management of patients with substance use disorder

• Identify and understand common causes of chronic orofacial pain and their connection to dentistry

• Understand effective non-opioid options for the management of pain in dental practice
CE Disclosures

The Vermont Office of Professional Regulation Board of Dental Examiners (BDE) designates this internet live activity (course ID CA-41774) for a maximum of 1.0 Continuing Education (CE) Credit. Participants should claim only the credit commensurate with the extent of their participation in the activity.

Interest Disclosures:

• As an organization sponsoring continuing education (CE) activities, UVM is required to disclose any real or apparent conflicts of interest (COI) that any speakers may have related to the content of their presentations.
Treatment Modalities (and Management Considerations) for Patients with Chronic Orofacial Pain

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I have no conflicts to disclose.
Treatment Modalities (and Management Considerations) for Patients with Chronic Orofacial Pain

Session Objectives:

1. Recognize the importance of the biopsychosocial model in the management of chronic Orofacial Pain (OFP) Disorders.

2. Understand that (so-called) TMJ disorders represent the musculo-skeletal element of OFP but that neuropathic pain and headaches are also in the realm of OFP.

3. Appreciate the complexity of OFP evaluation and management.

4. Understand the very limited use of controlled substances in OFP and that a very small percentage of these patients do have legitimate need for these medications.
Application for Specialty Approved by the National Commission on Recognition of Dental Specialties and Certifying Boards

- Effective in April, 2020, the National Commission on Recognition of Dental Specialties and Certifying Boards (NCRDSCB) has reviewed and approved the application from the American Academy of Orofacial Pain (AAOP) to make Orofacial Pain the 12th and newest specialty of Dentistry. The Commission is now reviewing the application of the American Board of Orofacial Pain (ABOP) to be the examining and certifying board for this specialty. Approval is anticipated in March, 2022.

- For more information go to:

Sequence for Evaluation of Orofacial Pain Disorders

1. History
2. Clinical Examination (Imaging, as indicated)
3. Diagnosis
4. Case Presentation and Patient Education
5. Then, Treatment Modalities
6. There is no substitute for the correct diagnosis! (i.e. Eagle’s Syndrome)
What do you think? (Scenario 1)
Dr. Kuchukulla has recently seen this patient. 30+ y.o. with complaints of R maxillary molar and sinus pain. Is the pain emanating from the impacted R maxillary third molar & dentigerous cyst in the sinus?
What do you think? (Scenario 2)

Dr. Kuchukulla has recently seen this patient. 30+ y.o. with complaints of L jaw pain and HA. Is the pain emanating from the left mandibular first molar implant?
What do you think? (Scenario 3)

Dr. Kuchukula has recently seen this patient. 30+ y.o. with complaints of R jaw pain and HA. Is the pain emanating from the periodontally involved right mandibular molar?
What do you think? (The reality)

70+ y.o. with L jaw pain and HA who has been aware of her dentigerous cyst for many years. This is actually a patient with OFP due to L TMJ osteoarthritis.
Classification of Orofacial Pains

**Axis I (Physical Conditions)**
- Somatic Pain
  - Superficial Pain
    - Mucogingival Pain
  - Deep Pain
    - Muscular Pain
    - Myospasm
    - Central Mediated Myalgia
    - Myofascial Pain
    - Local Muscle Soreness
    - Protective Co-Contraction
  - TMJ Pain
  - Osseous Pain
  - Connect. Tissue Pain
  - Periodontal Pain
  - Visceral Pain
  - Musculoskeletal Pain
  - Visceral Mucosal Pain
  - Glandular, ENT Pain
  - Pulpal Pain
  - Vascular Pain
  - Neurovascular Pain
  - Capsular Pain
  - Arthritic Pain
  - Retrodiscal Pain
  - Ligamentous Pain
  - Neuropathic Pain
  - Episodic Pain
  - Continuous Pain

**Axis II (Psychological Conditions)**
- Mood Disorders
- Anxiety Disorders
  - Depression
  - Bipolar Disorder
  - Generalized Anxiety Disorder
  - Other Mood Disorders
  - Other Anxiety Disorders
  - Other Psychological Disorders

**Other Conditions**
- Psychological Factors Affecting Med Condition
- Malingering
- Hypochondriasis

**Somatoform Disorders**
- Conversion Disorder
- Pain Disorder
- Undifferentiated Somatoform Disorder

**Axis I**
- Diagnosis

**Axis II**
- Oakeson, 2005
The bio-psycho-social model of chronic orofacial pain.

What about the social determinants of health (SDOH)?

- Housing
- Food
- Transportation
- Utilities
- Child care
- Employment
- Education
- Finances

- Personal safety
  - Physical abuse
  - Insulting behavior
  - Threatening behavior
  - Verbal abuse
  - Cyber bullying
Classification of Orofacial Pains

**Axis I (Physical Conditions)**
- Somatic Pain
  - Superficial Pain
    - Cutaneous Pain
    - Mucogingival Pain
  - Deep Pain
    - Visceral Pain
    - Muscle Pain
      - Myospasm
      - Central Mediated Myalgia
      - Myofascial Pain
        - Local Muscle Soreness
        - Protective Co-contraction
      - Other Neuralgias
        - Capsular Pain
        - Ligamentous Pain
        - Disc Displacement Pain
- TMJ Pain
  - Capsular Pain
  - Ligamentous Pain
- Osteous Pain
- Periodontal Pain
  - Glandular, ENT Pain
  - Vascular Pain
  - Neurovascular Pain
  - Other Neuralgias
  - Neurovascular Variants
- TMJ Pain
- Osseous Pain
- Connective Tissue Pain
- Periodontal Pain
- Vascular Pain
- Neurovascular Pain
- Other Neuralgias
- Neurovascular Variants
  - Capsular Pain
  - Ligamentous Pain
- Disc Displacement Pain

**Axis II (Psychological Conditions)**
- Mood Disorders
  - Mood Disorder due to a Medical Condition
- Anxiety Disorders
  - Anxiety Disorder due to a Medical Condition
- Personality Disorders
- Generalized Anxiety
- Stress-Related Physiological Response
- Maladaptive Health Behavior
- Posttraumatic Stress Disorder
- Other Conditions
- Hypochondriasis
- Generalized Anxiety
- Somatoform Disorders
  - Hypochondriasis
  - Pain Disorder
  - Conversion Disorder
  - Malingering

**TMD**
- Central Mediated Myalgia
- Myofascial Pain
  - Disc Displacement Pain
  - Capsular Pain
  - Ligamentous Pain
- TMJ Pain
- Osteous Pain
- Connective Tissue Pain
- Periodontal Pain
- Vascular Pain
- Neurovascular Pain
- Other Neuralgias
- Neurovascular Variants
  - Capsular Pain
  - Ligamentous Pain
- Disc Displacement Pain

**Neuropathic Pain**
- Episode Pain
  - Paroxysmal Neuralgia
  - Continuous Pain
    - Trigeminal Neuralgia
- Peripheral Mediated Pain
  - Metabolic Polyneuropathies
  - Central Mediated Pain
    - Entrapment Neuropathy
    - Neuritic Pain
- Other Neuralgias
  - Capsular Pain
  - Ligamentous Pain
  - Arthritic Pain
  - Retrodiscal Pain
  - Other Neuralgias
  - Neurovascular Variants
  - Capsular Pain
  - Ligamentous Pain
  - Disc Displacement Pain

**Neuropathic Pain**
- Episodic Pain
  - Pain Disorder
  - Conversion Disorder
- Peripheral Neuritis
  - Herpes Zoster
  - Post Herpetic Neuralgia

**Somatoform Disorders**
  - Hypochondriasis
  - Pain Disorder
  - Conversion Disorder
- Other Conditions
  - Hypochondriasis
  - Pain Disorder
  - Conversion Disorder

**Other Conditions**
  - Physical Conditions
    - Mood Disorders
      - Mood Disorder due to a Medical Condition
  - Psychological Conditions
    - Mood Disorders
      - Mood Disorder due to a Medical Condition
    - Anxiety Disorders
      - Anxiety Disorder due to a Medical Condition

**Okeson, 2005**
Classification of Orofacial Pains:
Musculoskeletal (TMDs)

Consider the following:

TMD and cervicogenic pain have many of the same qualities and are considered deep, somatic, musculoskeletal pains and include ligamentous pains like the PDL. These pains often contribute to Tension-Type Headache and can be triggers for migraine as well.
Clinical presentation of the chronic OFP (TMJ) patient.

<table>
<thead>
<tr>
<th>Contributing factors in chronic TMD &amp; orofacial pain</th>
<th>Bio- (Nociception)</th>
<th>Psycho- (Perception)</th>
<th>Social (Suffering)</th>
<th>Behavioral (Physical response)</th>
<th>Spiritual (Belief systems)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Predisposing Factors</strong></td>
<td>Dental neglect and caries</td>
<td>History of childhood physical abuse</td>
<td><strong>Childhood in a drug abusive setting</strong></td>
<td>Oral para-functional habits</td>
<td>Agnostic childhood</td>
</tr>
<tr>
<td><strong>Precipitating Factors</strong></td>
<td>A blow to the jaw &amp; damaged teeth</td>
<td>Terrorized by assault</td>
<td>Intrusive police investigation</td>
<td>Stress, dental Tx, trauma, etc.</td>
<td>External locus: “You did this to me.”</td>
</tr>
<tr>
<td><strong>Perpetuating Factors</strong></td>
<td>Irreversible tissue damage &amp; chronic pain</td>
<td>PTSD, anxiety &amp; depression</td>
<td><strong>Continued drug abuse for chronic pain control</strong></td>
<td>Sleep disorders, bruxism, chronic pain, etc.</td>
<td>Hopelessness: unable to improve</td>
</tr>
</tbody>
</table>
Clinical presentation of the chronic OFP (TMJ) patient (POMR or SOAP notes)
Clinical presentation of the chronic OFP (TMJ) patient.

How does a doctor manage this patient’s OFP?

• History (Subjective): This process shows the patient that the Dr. is both interested and cares about the patient’s (biopsychosocial) problems. Empathy is an essential tool.

• Should include medical history, global pain complaints, pharmaceuticals, psychological profile, behaviors, sleep, diet, etc. Even though you may not diagnose or treat these comorbidities, they can have a substantial impact on a patient’s OFP etiology and management. (e.g. SSRI induced bruxism, Ehlers-Danlos, auto-immune disorders, etc.)

• Attempt to identify the source of pain (e.g. HA, TMJ, ears, eyes, nose/sinus, mouth, teeth and neck) rather than the site of pain. (i.e. referred pain)
Clinical presentation of the chronic OFP (TMJ) patient.

How does a doctor manage this patient’s OFP?

• Physical examination (Objective): Helps to confirm the source of the patient’s pain.

• Defines the various sites of the patient’s pain.

• Validates the patient’s complaints.

• Educates the patient about the doctor’s knowledge about the patient’s condition.

• Therapeutic touch of the head and neck. “No one’s ever examined me like that before”.
Clinical presentation of the chronic OFP (TMJ) patient.

How does a doctor manage this patient’s OFP?

• Case presentation (Assessment): Communication with the patient about the findings.
• Enhances the patient’s understanding of his/her problem(s).
• Enhances the credibility of the caregiver.
• Identifying and acknowledging various comorbidities that can affect the outcome.
• Substantiates the need for the involvement of other health care providers.
Clinical presentation of the chronic OFP (TMJ) patient.

How does a doctor manage this patient’s OFP?

• Treatment (Plan): Elaboration of treatment options for the patient to consider.

• Sharing the responsibility for care with the patient.

• Understanding the prognosis

• Establishing realistic goals and expectations for the patient.
So under what circumstances are controlled substances indicated for chronic OFP?

- Know the patient (as described herein)!
- Review of prior Rx use (NSAIDs, APAP, etc.)!
- Informed consent!
- Controlled substance agreement!
- Prescription monitoring systems (VPMS)!
- Urine screening (GC-MS, e.g. Aspenti)!
- Timely face to face assessment and re-evaluation!
Examples of RISK ASSESSMENT TOOLS

**Self-Administered Questionnaire**

- **Alcohol Use Disorders Identification Test (AUDIT):** developed by the World Health Organization
  [http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf](http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf)

- **Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST):** developed by the World Health Organization
  [https://apps.who.int/iris/bitstream/handle/10665/44320/9789241599382_eng.pdf;sequence=1](https://apps.who.int/iris/bitstream/handle/10665/44320/9789241599382_eng.pdf;sequence=1)

- **Drug Abuse Screening Test (DAST)**

- **Substance Abuse and Mental Health Services Administration: Screening, Brief Intervention, and Referral to Treatment (SBIRT)**
  [https://www.samhsa.gov/sbirt](https://www.samhsa.gov/sbirt)
RISK ASSESSMENT TOOLS

Direct Interview (Face-To-Face) About

Substance Use & Abuse and Addiction Potential

• Which of the following drugs or substances, if any, have you used in the past? Check all that apply. Next to each drug or substance that you’ve circled, indicate if you used it occasionally (“O”), frequently (“F”), or continuously (“C”).

   Alcohol ______  Barbiturates _______  Cocaine _______
   Heroin _______  Amphetamines_____  Marijuana _______
   Fentanyl_______  Other_______________________________

• Are you presently using any of the drugs or substances below? Check all that apply and next to each indicate if you use it occasionally (“O”), frequently (“F”), or continuously (“C”).

   Alcohol ______  Barbiturates _______  Cocaine _______
   Heroin _______  Amphetamines_____  Marijuana _______
   Fentanyl_______  Other_______________________________

   (false negative answers?)

• Do you presently smoke cigarettes or use tobacco in any form? Yes_____ No_______

• If not, did you ever smoke cigarettes or use tobacco in any form? Yes_____ No_______

• How many packs do (did) you smoke a day? _____ For how many years? _____
VPMS monitoring of a 32 y.o. male from 04/09 to 10/09: (a former patient at VOPA)

- 4........... number of different addresses
- 13........ number of different pharmacies
- 17........ number of different controlled drugs
- 21........ number of different prescribers
- 76........ number of individual written Rx

Would you prescribe for this patient if you knew this information?

Can we consider this “keeping control over controlled substances?”

Could this patient become the next opioid abuse death?
Stratifying Patient Risk

Low Risk
- No past/current history of substance abuse
- Noncontributory family history of substance abuse
- No major or untreated psychological disorder

Moderate Risk
- History of treated substance abuse (inpatient), DUIs
- Significant family history of substance abuse
- Declines other Tx
- Past/comorbid psychological disorder
- Smoking
- Pain condition where opioids are contraindicated
- High –OH consumption

High Risk
- Active substance abuse
- Active addiction
- Major untreated psychological disorder
- Significant risk to self and practitioner
- Deception or failure to provide history
- Aberrant Behavior
- Pain or symptoms worse with opioids

Webster LR, Webster RM. *Pain Med.* 2005;6: 432-442. *(with additions: Dr. Ron Kulich)*
Housing
1. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?
   - Yes
   - No
2. Think about the place you live. Do you have problems with any of the following? (check all that apply)
   - Bug infestation
   - Mold
   - Lead paint or pipes
   - Inadequate heat
   - Oven or stove not working
   - No or not working smoke detectors
   - Water leaks
   - None of the above

Food
3. Within the past 12 months, you worried that your food would run out before you got money to buy more.
   - Often true
   - Sometimes true
   - Never true
4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
   - Often true
   - Sometimes true
   - Never true

Child Care
7. Do problems getting child care make it difficult for you to work or study?
   - Yes
   - No

Employment
8. Do you have a job?
   - Yes
   - No

Education
9. Do you have a high school degree?
   - Yes
   - No

Finances
10. How often does this describe you? I don't have enough money to pay my bills.
    - Never
    - Rarely
    - Sometimes
    - Often
    - Always

Personal Safety
11. How often does anyone, including family, physically hurt you?
    - Never (1)
    - Rarely (2)
    - Sometimes (3)
    - Fairly often (4)
    - Frequently (5)
COVID-19 + Addiction = “More than 93,000 people died from drug overdoses in 2020, according to provisional data released by the CDC's National Center for Health Statistics. That's a 29.4% increase from the 72,151 deaths projected for 2019.”


COVID-19 and vaccination have become a substantial (and political) influence on SDoH and this is emphasized by the dramatic increase in OD deaths last year.
How to ask Sensitive Questions

• The right way to ask questions depends on the context…
  • How much time do you have?
  • How willing are patients to truthfully answer your question in this setting?
    • Important to keep privacy in mind
    • Explain to patient why you are asking these questions
How to ask Sensitive Questions

• The right way to ask questions depends on the context...
  • How much time do you have?
  • How willing are patients to truthfully answer your question in this setting?

• Have a Plan
  • Compile a list of local resources to offer patients
  • If resources are not available, where can they get more information?
Social Determinants Of Health in Vermont (SDOH-V) Vermont Community Resources for:

- **Housing:** [https://accd.vermont.gov/covid-19/housing-assistance-programs](https://accd.vermont.gov/covid-19/housing-assistance-programs)
- **Food:** [https://vem.vermont.gov/pods](https://vem.vermont.gov/pods)
- **Transportation:** [https://www.connectingcommuters.org/resources/community-resources/](https://www.connectingcommuters.org/resources/community-resources/)
- **Utilities:** [https://www.needhelppayingbills.com/html/vermont_assistance_programs.html#:~:text=A%20number%20of%20programs%20can%20help%20with%20paying,that%20can%20help%20residents%20meet%20their%20basic%20needs](https://www.needhelppayingbills.com/html/vermont_assistance_programs.html#:~:text=A%20number%20of%20programs%20can%20help%20with%20paying,that%20can%20help%20residents%20meet%20their%20basic%20needs)
- **Childcare:** [https://dcf.vermont.gov/cdd/cccsa](https://dcf.vermont.gov/cdd/cccsa)
- **Employment:** [https://humanresources.vermont.gov/](https://humanresources.vermont.gov/)
- **Education:** [https://education.vermont.gov/](https://education.vermont.gov/)
- **Finances:** [https://mymoney.vermont.gov/](https://mymoney.vermont.gov/)
Final thoughts?

• Time for discussion and Q & A.

• When are controlled substances necessary in dentistry? Acute vs. chronic pain?

• How does a dentist safely prescribe these medications?

• What are the risks associated with prescribing controlled substances?
Cases/HIPAA

• Names
• Address
• DOB
• Phone/Fax #
• Email address
• Social Security #
• Medical Record #

The discussion and materials included in this conference are confidential and privileged pursuant to 26VSA Section 1441-1443. This material is intended for use in improving patient care. It is privileged and strictly confidential and is to be used only for the evaluation and improvement of patient care.
• RECORDING TO BE STOPPED FOR CASE PRESENTATION
Case Presentation Format

Case presentation from a participant (a real-world case, from the field)
Then
Clarifying questions about the case from group to case presenter
Then
Ideas, suggestions, recommendations from participants
Then
Ideas, suggestions, recommendations from ECHO faculty team
Then
Additional discussion, if any (All)
Then
Summary of case discussion (course director: Justin Hurlburt DMD, MA)
# Case

<table>
<thead>
<tr>
<th>Patient Demographics</th>
<th>96-year-old female. Has 24/7 live-in care. Wheelchair bound</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CC:</strong></td>
<td>Presents to ED with severe jaw pain. Restricting her ability to eat and speak</td>
</tr>
<tr>
<td><strong>PMH:</strong></td>
<td>Atrial fibrillation, Hyperlipidemia, Hypertension, Alzheimer’s, osteoporosis, osteoarthritis. Pt wears Maxillary Complete and Mandibular Partial Dentures. Baseline: communication limited by hearing loss. Wears hearing aids. Able to speak short sentences</td>
</tr>
<tr>
<td><strong>HPI:</strong></td>
<td>No history of acute TMJ pain. No Trauma. Ate dinner and went to bed normally, woke up at 1:30 AM with severe pain and presented to ED. Pain 10/10, jaw still mobile, although painful</td>
</tr>
<tr>
<td><strong>Imaging, CT scan:</strong></td>
<td>Possible slight anterior and inferior dislocation of R mandibular condyle. Severe bilateral TMJ arthrosis. Ossific bodies likely within TMJ, suggestive of synovial osteochondromatosis</td>
</tr>
<tr>
<td><strong>Clinical Exam:</strong></td>
<td>Pt unable to communicate; did not have her hearing aids. Son provided history, and used pen/paper to complete exam. Patient extremely sensitive to light palpation of TMJ, cheeks, and intraorally. Flinches out of way when palpating. No deviation of jaw noted. No depression noted posterior to either jaw joint. Limited jaw opening ~20 mm. Grimaces when asked to close. Son thinks she may have kept her dentures in for 5 weeks straight. Gross debris on dentures. Painful to touch</td>
</tr>
<tr>
<td>Patient Demographics</td>
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<td>----------------------</td>
<td>----------------------------------------------------------</td>
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<tr>
<td>CC:</td>
<td>Presents to ED with severe jaw pain. Restricting her ability to eat</td>
</tr>
<tr>
<td>ED Medications:</td>
<td>Fentanyl 50 mcg IV, Morphine 2 mg IV. Improved pain minimally, but became lethargic and nauseous. Elevated Troponin levels, lung nodule</td>
</tr>
<tr>
<td>Clinical Exam:</td>
<td>Taking Oxycodone 2.5 mg and Tylenol 650 mg. Overall pain and demeanor improved. Had hearing aids and able to speak short sentences, “I’m in pain”. Family/caregiver communicate on her behalf. Confirmed dentures have only been in for about 3 days, due to some discomfort removing them. Pt able to take them out today with no issues. Pt is able to open and close teeth together, no deflection noted or depression posterior to jaw joints. Opening ~35 mm. Able to tolerate intraoral palpation. No ulcerations/swellings intraorally. Less pain upon extraoral palpation. Bilateral clicking and crepitus noted. Tender to R jaw palpation, painful L lateral movement. Flinches in pain when attempting. Able to tolerate liquid diet.</td>
</tr>
<tr>
<td>Day 2, in Baird</td>
<td>Transient dislocation of R TMJ during night (possibly from yawning) that spontaneously reduced. Pain from event coupled with bilateral arthrosis. Recommended soft food diet, pain management with Oxycodone and Tylenol, continue Tylenol upon discharge.</td>
</tr>
</tbody>
</table>
Questions and Discussion from the group....
Prep for Next Session

-Prior to each session, if you have specific questions for our faculty expert(s), please let us know and we will pass along ahead of time.

<table>
<thead>
<tr>
<th>DATES</th>
<th>SESSION</th>
<th>DIDACTIC TOPICS (in addition to case review)</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 9</td>
<td>TeleECHO Session 1</td>
<td>Managing Opioids Safely and within Vermont Opioid Prescribing Rules (Charles D. MacLean, MD and Amanda Kennedy, PharmD, BCPS)</td>
</tr>
<tr>
<td>July 23</td>
<td>TeleECHO Session 2</td>
<td>Overview of the Vermont Prescription Monitoring System (VPMS) for the Dental Team (Hannah Hauser, MSW)</td>
</tr>
<tr>
<td>July 30</td>
<td>TeleECHO Session 3</td>
<td>Treatment Modalities for Patients with Chronic Orofacial Pain (Jeffrey Crandall, DDS)</td>
</tr>
<tr>
<td>August 13</td>
<td>TeleECHO Session 4</td>
<td>Fundamentals of FDA Regulations of Oral Health Products and U.S. Trends for Opioid and Antibiotic Prescribing in Dentistry (Natalia Chalmers, DDS, MHSc, PhD)</td>
</tr>
<tr>
<td>August 27</td>
<td>TeleECHO Session 5</td>
<td>Pain Control to Prevent the Need for Opioid Prescriptions (Raymond Dionne, DDS, PhD)</td>
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<tr>
<td>September 10</td>
<td>TeleECHO Session 6</td>
<td>Dental Management of Patients with Substance Use Disorder (Sue Etminan, DMD, MPH)</td>
</tr>
</tbody>
</table>
Conclusion

• Slides are posted at www.vtahec.org

• Volunteers to present cases (this is key to the Project ECHO model)
  • Please submit cases to Justin.Hurlburt@uvmhealth.org

• Please complete evaluation survey after each session

• One your completed evaluation is submitted, CE information will be emailed to you.

• Please contact us with any questions, concerns, or suggestions
  • Justin.Hurlburt@uvmhealth.org
  • Elizabeth.Cote@uvm.edu