Substance Abuse Treatment Integration: Increasing Primary Care Capacity
Substance Abuse Treatment Integration:
Increasing Primary Care Capacity

Speakers

Moderator:
Constance Burke, NYS Office of Alcoholism and Substance Abuse Services, Division of Outcome Management and System Information

Panelists:
Dr. Hillary Kunins, NYC Department of Health and Mental Hygiene
Dr. Sandeep Kapoor, Northwell Health
Dr. James Anderson, Leatherstocking PPS
A Continuum of Substance Use Services for Primary Care

Hillary Kunins, MD, MPH
Bureau of Alcohol and Drug Use Prevention, Care and Treatment
Department of Health and Mental Hygiene

September 21, 2016
Why are we here?

• Opioid overdose deaths are a public health crisis in New York City
  – These deaths are preventable
• Unhealthy substance use often goes unrecognized
  – A variety of services delivered in primary care can be integrated and are effective
• We need your help!
The pyramid of use

- Substance use disorder treatment
- Substance use disorder
- Risky use
- Little or no use
Outline

• Substance use epidemiology in New York City
• Benefits of integration
• Variety of services/strategies that can be integrated
  – Judicious prescribing
  – Screening, Brief Intervention, and Referral to Treatment
  – Pharmacotherapy for substance use disorder
  – Harm reduction practices: naloxone and sterile syringes
  – Relapse prevention support
• Questions and discussion
SUBSTANCE USE EPIDEMIOLOGY IN NEW YORK CITY
Alcohol attributed to the deaths of nearly 1,800 New Yorkers in 2013

**Top 3 deaths**

- Alcoholic Liver Disease: 383
- Alcohol-related psychiatric disorders: 178
- Other Disorders: 150
- Homicide: 156
- Suicide: 125
- Motor-vehicle accidents: 91
- Any other accidents and poisonings: 366
- Liver Disease: 141
- High Blood Pressure: 76
- Cancer: 36
- Other Conditions: 34
- Heart Disease: 22
- Stroke: 36

**Note:** Rounding causes sum of specific causes to exceed total attributable deaths. In those cases, single deaths are eliminated from the non-direct causes with the highest frequencies to bring the sum in line with the actual total.

Alcohol consumption, New York City, 2014

Current drinking: Consumed at least one alcohol drink in past 30 days

Binge drinking: Consumed 5 or more drinks on one occasion for men or 4 or more drinks on one occasion for women in the past 30 days

Source: New York City Community Health Survey, 2014
Most NYC adults have not discussed alcohol use with a health professional

- Only 24% of NYC adults report a doctor, nurse or other health professional had asked or talked to them about their alcohol use in the past year

- Screening for alcohol use is not a routine part of clinical care for adults in NYC

Source: New York City Department of Health and Mental Hygiene Community Health Survey, 2011
Unintentional drug poisoning deaths, NYC, 2000-2014*

Number of unintentional opioid analgesic poisoning deaths

Age-adjusted mortality rate per 100,000

*Data for 2014 is preliminary and subject to change.
Source: New York City Office of the Chief Medical Examiner & New York City Department of Health and Mental Hygiene 2000-2014*
Unintentional heroin poisoning deaths increased 116% from 2010 to 2014*

Data for 2014 are preliminary and subject to change.
Source: New York City Office of the Chief Medical Examiner & New York City Department of Health and Mental Hygiene 2000-2014*
How did we get here?

• Opioid Analgesics
  – Increased prescribing
    • Opioid analgesic prescribing quadrupled from 1999 to 2010
    • Promotion of opioid analgesics for use in chronic non-cancer pain
    • Misperceptions related to efficacy
  – Risk for dependence and overdose underappreciated
    • By both patients and providers
    • Because it’s a prescription, people think it’s less risky (but just as dangerous as many illicit drugs)

• Heroin
  – Increased exposure to opioid analgesics
  – Decreased sense of risk associated with heroin
HOW CAN INTEGRATION OF SUBSTANCE USE SERVICES HELP?
Benefits of integration

- Improves access to treatment
- Improves patient outcomes (including treatment retention)
- Supports relapse prevention
- Allows to address coexisting health risks & illness
- Reduces stigma
Why treat substance use disorders in primary care?

• It works.
• Reduces substance use
• Improves overall health
  – Prevent death
  – Prevent and treat HIV, hepatitis C, other medical conditions
• Improves functioning
  – Employment, family and parenting
  – Decreases criminal activity
Why integrate substance use in primary care?

• Professional satisfaction. Really.
• Not everyone wants (or needs) to get treatment in specialized drug treatment settings.
• Primary care can make a difference in the opioid epidemic.
A word on stigma

• Significant stigma related to substance use and treatment for substance use disorder—pervasive in society

• Misconception of substance use disorder as a moral failing

• Consequences of stigma

• You will help by integrating substance use services into primary care practice
SERVICES AND STRATEGIES YOU CAN INTEGRATE
Services and strategies

1. Prescribe judiciously (opioids and benzos)
2. Screen and intervene
3. Treat or refer effectively.
   - Pharmacotherapy for opioid use disorders (buprenorphine)
   - Pharmacotherapy for alcohol use disorders
4. Prescribe naloxone for opioid overdose rescue
   - patients with opioid use disorder; patients on prescribed high-dose opioids
5. Provide relapse prevention/support
6. Offer sterile syringes
Judicious opioid prescribing

- Avoid prescribing opioids for chronic non-cancer, non-end-of-life pain
  - e.g., low back pain, arthritis, headache, fibromyalgia
- When opioids are warranted for acute pain, 3-day supply usually sufficient
- If dosing reaches 100 MED, reassess and reconsider other approaches to pain management
- Avoid whenever possible prescribing opioids in patients taking benzodiazepines
Total Daily MME = **180.0**

<table>
<thead>
<tr>
<th>Drug</th>
<th>MME</th>
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<tbody>
<tr>
<td>Fentanyl transdermal (in mcg/hr)</td>
<td></td>
</tr>
<tr>
<td>50mcg per patch</td>
<td><strong>120.0</strong></td>
</tr>
<tr>
<td>(each patch used for 3 days)</td>
<td></td>
</tr>
<tr>
<td>Hydrocodone</td>
<td></td>
</tr>
<tr>
<td>10mg (6 per day)</td>
<td><strong>60.0</strong></td>
</tr>
<tr>
<td>Hydromorphone</td>
<td></td>
</tr>
<tr>
<td>Methadone</td>
<td></td>
</tr>
</tbody>
</table>

**Add Additional**

NYC Health
Judicious benzodiazepine prescribing

• Increased risk of fatal overdose when benzodiazepines are taken with opioid analgesics, alcohol, or other CNS depressants

• If benzodiazepines are indicated, prescribe the lowest effective dose for the shortest duration—no more than 2-4 weeks

• Avoid co-prescribing benzodiazepines and opioid analgesics because of the risk of fatal respiratory depression
Screening, Brief Intervention, and Referral to Treatment (SBIRT)

- Reduces alcohol consumption and decreases health care utilization; ranked as one of the five most effective clinical preventive services
- Goal: Identify patients at-risk for unhealthy drinking
- SBIRT components
  - Screening using a validated tool
  - Brief intervention (if needed)
  - Referral to treatment (if needed)

Health Department SBIRT resources

City Health Information

Jan/Feb 2011, New York City Department of Health and Mental Hygiene, Vol. 30(1):1-8

Brief Intervention for Excessive Drinking

- Ask every patient about alcohol consumption using the 3-question AUDIT-C screening tool for adults and the CRAFFT tool for adolescents.
- Provide clear advice to moderate- and high-risk patients to reduce alcohol consumption.
- Provide regular follow-up to support efforts to achieve low-risk drinking levels.

Most adults in the United States (US) drink safely or not at all, but excessive drinking is common. In 2007 and 2008 combined, 23% of New Yorkers aged 21 years and older reported consuming 5 or more alcoholic drinks over a 2-hour period within the previous 30 days.1

Alcohol use is associated with high morbidity and use in pregnancy can cause miscarriage, premature birth, and developmental impairments, including fetal alcohol syndrome.13

Up to 20% of patients in primary care practices may be engaged in excessive drinking.14 Because patients are receptive to alcohol screening and counseling from their primary care physicians (PCPs) 17 and up to 40%...
Offer pharmacotherapy for substance use disorder

• Alcohol use disorder
  – Naltrexone and acamprosate are effective

• Opioid use disorder
  – Opioid agonists (buprenorphine or methadone) is the most effective form of treatment
    • Emerging evidence for long-acting injectable naltrexone
  – Buprenorphine can be offered in primary care
Treatment with opioid agonist medications – methadone and buprenorphine

• How these work: bind to opioid receptors in body
• Block effect of heroin or opioid analgesics
  – Prevent withdrawal and relieve craving
  – Block euphoric effects of other opioids
• Most effective treatments for addiction to heroin and opioid analgesics
Buprenorphine—An Office-Based Treatment For Opioid Use Disorder

- Buprenorphine treatment is a life-saving tool for patients with opioid use disorder.
- Learn to recognize opioid use disorder and recommend effective treatment.
- Incorporate buprenorphine treatment into your practice.
New initiatives to increase access to buprenorphine in NYC

1. Buprenorphine training for physicians, nurse practitioners, physician assistants

2. Practice support to help integrate buprenorphine treatment at your practice
Offer naloxone for opioid overdose prevention

• Prescribe naloxone to your at-risk patients:
  – High-dose prescription (≥100 MMEs/day)
  – Chronic opioid therapy (≥3 months)
  – Opioid misuse/illicit use
  – Family member or friend of at-risk individual

• NYC DOHMH prescribing guidance and patient materials on our website

• Alternatively, refer patients to harm reduction programs or pharmacies
>700 NYC pharmacies now dispense naloxone under standing orders (many across NYS)

Naloxone Available HERE

Opioids, like prescription painkillers and heroin, are risky drugs and can cause a person to stop breathing.

If you or someone you know takes opioids, ask about naloxone—it saves lives.

Visit nyc.gov/health and search for “Prevent Overdose” to get more information about opioid safety and naloxone.
Provide sterile syringe access

• Prescribe sterile syringes
  – Register with Expanded Syringe Access Program (ESAP)

• Refer patients to ESAP pharmacies or harm reduction programs
Provide relapse prevention support

• Help your patients understand that substance use disorders are chronic conditions; slips or relapses common

• Several frameworks can help
  – PRIMECare Model
  – Recovery management checkups

• Link patients to peer-based support
The pyramid of use

- Substance use disorder treatment
- Substance use disorder
- Risky use
- Little or no use
Concluding thoughts

• You can integrate a variety of effective substance use services into primary care
• Many services are simple and brief
• Small proportion of patients will need
• NYC DOHMH can help support you
• We need your partnership!
• Together we can address unhealthy substance use and overdose and improve the health of our community
Questions?
5 times more patients avoid relapse with buprenorphine maintenance than detox

3 phases of buprenorphine treatment

1. Induction:
   - Find optimal starting dose, without going through withdrawal; 2-3 days
   - Home inductions common, with close monitoring by physician during this period

2. Stabilization
   - Find minimum dose to prevent withdrawal and reduce/stop other opioid use
   - Dose ranges from 2-24mg per day

3. Maintenance
   - Continue to take prescribed dose at home
   - Regular medical appointments (variable interval)
   - Assess and offer/refer for counseling or other services
How long should a person take buprenorphine?

• Every person is different $\Rightarrow$ depends on individual

• Better outcomes with longer treatment

• Diabetes treatment analogy
Federal policy and buprenorphine prescribing

• Licensed physicians (MD or DO) with DEA waiver; NEW: NPs, and PAs

• Criteria for waiver
  – Complete 8 hours of buprenorphine CME OR subspecialty in addiction
  – Capacity to refer to counseling

• Maximum 30 patients during first year; can increase to 100 after first year; NEW 275 patients in year 3 for some physicians
My (former) patient

• 54 year old Bronx grandmother
  – Former bookkeeper
  – Foster mother to an 8 year old autistic girl
  – 3 adult children; divorced
  – High blood pressure and diabetes
My (former) patient

- Heroin use began in her 20s
- Addiction treatment
  - Entered methadone in late 30s
  - >20 years methadone treatment
  - Tapered off methadone ~4 years ago
- Approximately 2 years ago
  - Knee injury, prescribed opioid analgesics
  - Escalated dose
- Wants to obtain care for addiction
  - Now daily heroin use
My (former) patient

- We offered her buprenorphine
- She initiated treatment with buprenorphine
  - Heroin use ceased
  - Met with me regularly
  - Remained in treatment
  - Maintained an active relationship with grandchildren and family
Summary

1. Addiction is a chronic disease that may need long term treatment

2. Treatment works

3. Treatment with medications works best
   - Best evidence for methadone and buprenorphine; emerging evidence for injectable long-acting naltrexone

4. Treatment in primary care is possible and sometimes the only setting acceptable to the patient
   - DOHMH has resources that can help support you get started
SBIRT Implementation
Informing Statewide Dissemination based on Lessons Learned

New York State DSRIP Learning Symposium
September 21, 2016 130pm

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Northwell Health
Hofstra Northwell School of Medicine
Northwell Health
Center for Addiction Services and Psychotherapy Interventions Research (CASPIR)
Division of General Internal Medicine
Department of Emergency Medicine
Department of Psychiatry & Behavioral Health

The National Center on Addiction and Substance Abuse (CASA)

New York State Office of Alcoholism and Substance Abuse Services (OASAS)

Substance Abuse and Mental Health Services Administration (SAMHSA)
SBIRT Leadership

**Northwell SBIRT**

- **Jon Morgenstern, PhD**  
  Principal Investigator – Psychiatry
- **Joseph Conigliaro, MD, MPH**  
  Principal Investigator – Internal Medicine
- **Nancy Kwon, MD, MPA**  
  Principal Investigator – Emergency Medicine
- **Sandeep Kapoor, MD**  
  Director, NSLIJ SBIRT

**Northwell Dept. of Emergency Medicine**

- **John D’Angelo, MD**  
  Chairman, Emergency Medicine
- **Mark Auerbach, MD, MBA**  
  SBIRT MD Champion
- **Mae Ward, RN**  
  Administrative Director – Research
- **Karen Kline**  
  Senior Administrative Director II

**Northwell Department of Medicine**

- **Thomas McGinn, MD, MPH**  
  Chairman, Medicine
- **Jeanne Morley, MD**  
  SBIRT MD Champion – Internal Medicine
- **Lauren McCullagh, MPH**  
  Administrative Director - Research

**Northwell Department of Psychiatry**

- **John Kane, MD**  
  Chairman, Psychiatry
- **Bruce Goldman, LCSW**  
  The Zucker Hillside Hospital
- **Daniel Coletti, PhD**  
  The Zucker Hillside Hospital

**New York State Office of Alcoholism and Substance Abuse Services (OASAS)**

- **Connie Burke, MA**  
  NYSBIRT Project Director

**The National Center for Addiction and Substance Abuse (CASA)**

- **Charlie Neighbors, PhD**  
  Director
- **Megan O’Grady, PhD**  
  Associate Director
Northwell Sites for SBIRT Services

Emergency Department
Internal Medicine Practice

North Shore University
Zucker Hillside
The Feinstein
Long Island Jewish

Lenox Hill
Lenox Hill HealthPiex
(CASA Columbia
Strategic Alliance)

Hackensack
(STRATEGIC ALLIANCE)

Staten Island University (North)
Staten Island University (South)
To identify and effectively intervene with those who are at moderate or high risk for psychosocial or health care problems related to their substance use.

Services Delivered
*During SBIRT Health Coach Hours*
Dec2013 - Aug2016

<table>
<thead>
<tr>
<th>Completed PreScreens</th>
<th>PreScreen Positive</th>
<th>Brief Interventions</th>
<th>Referrals to Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>175,215</td>
<td>11%</td>
<td>6,264</td>
<td>1,281</td>
</tr>
</tbody>
</table>
1 IN 4
AMERICANS WHO FIRST SMOKED, DRANK OR USED OTHER DRUGS BEFORE AGE 18 HAS A SUBSTANCE PROBLEM

Compared to 1 in 25 Americans who first drank, smoked or used other drugs at age 21 or older

1 IN 10
PEOPLE WHO NEED TREATMENT RECEIVE IT.

...THIS IS MORE THAN THE NUMBER OF AMERICANS WITH:

- **HEART CONDITIONS** (27 Million)
- **DIABETES** (26 Million)
- **CANCER** (19 Million)

The National Center on Addiction and Substance Abuse

The Issue

Major source of referrals to treatment are **NOT** healthcare providers, though most people see a doctor at least one time per year

*only 6.6%*

Rethinking Substance Use Problems From a Public Health Perspective

Dependent Users

At risk and binge drinkers
Clinical Practice
## The SBIRT Process

‘Starting the conversation...’

<table>
<thead>
<tr>
<th>SBIRT</th>
<th>Components</th>
</tr>
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<tbody>
<tr>
<td><strong>Pre-Screening</strong></td>
<td>Brief strategy to identify at-risk population using a valid, brief standardized questionnaire at the initial point of service</td>
</tr>
<tr>
<td>Audit-C/DAST-1/Tobacco</td>
<td>&lt; 1 minute</td>
</tr>
<tr>
<td><strong>Full Screening</strong></td>
<td>Valid extended standardized questionnaire administered with patient if they qualify based on the prescreen scores</td>
</tr>
<tr>
<td>AUDIT/DAST-10</td>
<td>&lt; 3 minutes</td>
</tr>
<tr>
<td><strong>Brief Intervention</strong></td>
<td>One or more discussions with health care professional focused on reducing or stopping unhealthy substance use:</td>
</tr>
<tr>
<td></td>
<td>1. Assessment &amp; feedback on substance use</td>
</tr>
<tr>
<td></td>
<td>2. Simple advice, goal setting, agree on plan</td>
</tr>
<tr>
<td></td>
<td>10-20 minutes</td>
</tr>
<tr>
<td><strong>Referral to Specialty Treatment</strong></td>
<td>Based on extent of substance use/abuse, patients may require more than a brief intervention</td>
</tr>
<tr>
<td></td>
<td>Every effort is made, in real-time, to provide a ‘warm handoff’ to community treatment providers and those within the NSLIJ Health System.</td>
</tr>
</tbody>
</table>
The Brief Negotiated Interview

A semi-structured interview process based on Motivational Interviewing that is a proven evidence-based practice and can be completed in 5–20 minutes.

Steps in the BNI

1. Raise the Subject
2. Provide Feedback
3. Enhance Motivation
4. Negotiate and Advise

Special acknowledgement is made to Drs. Stephen Rollnick, Gail D’Onofrio, and Ed Bernstein for granting permission to orient participants to the “brief negotiated interview.”
ED Workflow

Patient enters the Emergency Room

Patient is pre-screened by RNs after vital signs

Responses from pre-screen are documented into EMR
* Positive screen will elicit an ICON to the Health Coach.
* Negative screens will be tracked

Health Coach will perform full screen and provide brief intervention, brief treatment or referral to treatment for positive full screens

Health Coach will present to treating MD/NP/RN as needed

Interaction is documented with the EMR
SBIRT Team-Based Model @ Northwell Health

- Patient
- Nurses
- Medical Assistants
- SWs
- SUD Providers
- Physicians
- Health Coaches
Strategic Team-Based Approach

- Provide Information and Structure
- Elicit Feedback
- Tailor Service to Individual Site
- Provide Focused Training
- Pilot and PDSA
- ‘Go LIVE’
- Performance Monitoring, Training, continual PDSAs
Elicit Feedback

Gauge Interest and Buy-In
- Health System Leadership
- Site Specific Leadership
- Clinical Frontline Leadership
- Clinical Frontline Staff

Tailor Service

Workflows
- Evaluate existing
- Introduction of SBIRT
- Workarounds! (IT/Paperwork/Etc.)
- Clinical Frontline Staff Feedback Cycles
Timeline

- **3 months**
  - Identify/Hire Health Coach
  - Present to On-Site Leadership

- **2 months**
  - Present to On-Site Clinical Frontline Staff
  - NSLIJ Talent Acquisition and HR

- **1 month**
  - Hands-on Training and Roll-Playing
  - Pilot Services
  - Heath Coach Training + Shadowing

Finalize Workflow, Logistics, EMR needs/changes
EHR Integration

PreScreen Questions and Scoring Algorithm
Automatic Tasking, Flagging, and Icons
Health Coach Documentation Note

Advancements
Automated Reports
‘Two-Way’ Handshake Data Transfer
Brief Internal Evaluation Results

- Implementation disrupted workflow: RN/MA 10%, MD 10%
- Implementation increased patient wait time: RN/MA 10%, MD 10%
- Favorable to SBIRT implementation at my site: RN/MA 80%, MD 80%
How Much Effort?
Team-Based Approach

Strategize  |  Organize/Implement  |  Maintain/Sustain

?? %  |  ?? %  |  ?? %
Take Away

• Strategic Approach – Sustainable?
• Truly a **Team-Based** approach for:
  • Implementation
  • Delivery of Care
  • Maintenance
• Closing loops of feedback, will go a long way!
• Just **BIG** enough, and just **SMALL** enough to use as a **Pioneer Project** to further integration
Thank You

For more information

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Director, SBIRT
Depts. of Emergency Medicine, Internal Medicine, & Psychiatry/Behavioral Health
Northwell Health

Assistant Professor of Medicine
Hofstra Northwell School of Medicine
Increase in Prescription Rates

Figure 1 - Opioid Prescriptions Dispensed by US Retail Pharmacies

Increase in Overdoses

![Graph showing increase in deaths per 100,000 population from 2000 to 2013 for Opioid analgesics and Heroin.](image)
SENATE MAJORITY
JOINT TASK FORCE ON
HEROIN & OPIOID
ADDITION

2016 REPORT & RECOMMENDATIONS

Co-Chair, Senator Terrence Murphy
Co-Chair, Senator George A. Amedore, Jr.
Co-Chair, Senator Robert G. Ortt
“Despite the success these drugs have in treatment, many providers have expressed concerns regarding the limited access to MAT due to a lack of programs…lack of education regarding the treatment”

(2016 report & recommendations, page 11)
Harm Reduction Philosophy

Concept of preventing or reducing negative consequences associated with certain behaviors

(WHO)
Principles of Harm Reduction

• Pragmatism
  ➢ Are we going to eliminate drug use?

• Humanistic Values
  ➢ Not approval, but not judgment

• Focus on damage
  ➢ Not the behavior itself

• Balance of Costs & Benefits
  ➢ Evaluation

• Focus on Immediate Goals
  ➢ Prioritizing
Office-Based Medication-Assisted Treatment for Opioid Addiction

- Requires a multi-disciplinary team
- Enables treatment of “whole person”
- Makes treatment more accessible
- Established efficacy for treatment of opioid-related disorders
# Team-based Care for Opioid Dependence

<table>
<thead>
<tr>
<th>Role</th>
<th>Tasks</th>
</tr>
</thead>
</table>
| Physicians, NPs, & PAs | • Assessing readiness  
                          • Dosing strategies  
                          • Drug screens  
                          • HepC/HIV  
                          • Discontinuing Tx  
                          • Cross-coverage |
| Nurses & MAs        | • Managing phone calls  
                          • Medication side-effects  
                          • Assessing mental health needs  
                          • Assessing Tx response  
                          • Pill counts & drug screens |
| Managers & Staff    | • Responding to Pt concerns  
                          • Addressing disruptive behavior |
| Behavioral Health   | • Counseling  
                          • Engaging families in Tx  
                          • Supporting prescribers |
|Whole Team           | • Opioid dependence as a chronic disease  
                          • Harm reduction  
                          • Role of Family in Tx |
Implementation Plan

• Identified 4 clinics interested in starting MAT
  ➢ More may join by start date
• Contracted with MAT experts (U of MA Med School)
• Will have two, four-hour live trainings
  ➢ CME credit
  ➢ Progress towards “X-license” for physicians
• Weekly ECHO consultation for one year after on-site training
• Hired board-certified addiction medicine psychiatrist to join our team
• Internal & external behavioral health support
• DSRIP funds for care management & patient navigation
Q&A and Discussion