E5: SBIRT to Enhance Recovery, Vitality, and Excellence (SERVE)

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Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

Conference Resources

Slides and handouts shared in advance by our Conference Presenters are available on the CFHA website at http://www.cfha.net/?page=Resources_2018

Slides and handouts are also available on the mobile app.

At the conclusion of this session, the participant will be able to:

Describe how evidence-based SBIRT and brief therapy intervention for substance use disorders can be utilized in the primary care setting as part of an interdisciplinary team.

- Define and explain various evidence-based interventions for substance use disorders (including opioid use disorders) that can improve patient outcomes in the primary care setting.
- Address the benefits and possible challenges of medical providers in the primary care setting utilizing medication assisted therapy (MAT).

NIDA. (April, 2017). Trends & Statistics. Retrieved from https://www.drugabuse.gov/related-topics/trends-statistics

- SAMHSA. 2015-2016 National Survey on Drug Use and Health National Maps of Prevalence Estimates, by State. Retrieved from https://www.samhsa.gov/data/sites/default/files/NSDUHsaeMaps2016/NSDUHsaeMaps2016.pdf
- Rocky Mountain High Intensity Drug Trafficking Unit. (October, 2017). The Legalization of Marijuana in Colorado: the Impact. Retrieved from http://www.rmhidta.org/html/FINAL%202017%20Legalization%20of%20Marijuana%20in%20Colorado%20The%20Impact.pdf
- Colorado Health Access Survey (2017 September). Colorado's New Normal. State maintains historic health insurance gains. Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/2017%20CHAS%20DESIGN%20FINAL%20for%20Web.pdf
- Dwinnells, R. (2015). SBIRT as a Vital Sign for Behavioral Health Identification, Diagnosis, and Referral in Community Health Care. Annals of Family Medicine, 13(3), 261-263. http://doi.org/10.1370/afm.1776.

Learning Assessment

A learning assessment is required for CE credit.

A question and answer period will be conducted at the end of this presentation.

Colorado Epidemiology

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Drug poisoning/overdose deaths in Colorado by involvment of specific drug type: Colorado residents, 1999-2017

Year	Opioid (prescription or illicit)	Non-opioid	Unspecified drug	Total
1999	73	219	51	345
2000	87	210	53	351
2001	118	221	67	406
2002	119	231	94	444
2003	118	245	133	497
2004	138	274	103	516
2005	179	299	123	601
2006	201	294	122	619
2007	269	276	182	728
2008	246	284	208	739
2009	279	254	227	764
2010	227	226	200	653
2011	304	272	260	838
2012	295	262	249	807
2013	295	331	212	839
2014	338	363	168	870
2015	329	378	173	880
2016	300	447	164	912
2017	372	484	151	1,010

Source: Vital Statistics Program, Colorado Department of Public Health and Environment

Local Substance Abuse Trends

- Benzodiazepines continue to be a big problem
  - Hospitalization rate in CO nearly identical to opioids
- Methamphetamine and meth/opioid combo continues to emerge as a growing problem
  - 22 deaths in 2001
  - 135 deaths in 2015
  - **196 deaths in 2016**
  - **298 in 2017**
- Cocaine making a comeback
  - **101 deaths in 2016**
  - **94 in 2017**

Denver Health patient rates of SUD/alcohol use disorder

Med Home	# Empaneled Patients	# Empaneled Patients with SUD Dx in last 3 years	SUD Pcnt	# Empaneled Patients with OUD Dx in last 3 years	OUD Pcnt
DH PAV G PEDS	11664	115	1%	9	0%
WESTSIDE PEDS	15827	263	2%	8	0%
EASTSIDE PEDS	8110	226	3%	3	0%
SCHOOL BASED	9307	279	3%	8	0%
MONTBELLO FAM MED	12124	414	3%	54	0%
DH PAV G LEVELONE PHYS	8584	433	5%	90	1%
LOWRY FAM MED	15928	889	6%	199	1%
EASTSIDE WOMENS CARE	869	53	6%	3	0%
WESTSIDE WOMENS CARE	1767	109	6%	10	1%
PEÑA PRIMARY CARE	16666	1241	7%	304	2%
WESTWOOD FAM MED	7486	568	8%	159	2%
DH PAV C WOMENS CARE	3250	264	8%	90	3%
PARK HILL FAM MED	7376	714	10%	140	2%
LA CASA FAM MED	8531	872	10%	173	2%
DH PAV G GERIATRICS	1269	138	11%	27	2%
WESTSIDE ADULT	8459	1211	14%	301	4%
EASTSIDE ADULT	9614	1557	16%	310	3%
DH PAV G ADULT	10977	1883	17%	471	4%
EIS PRIMARY CARE	662	212	32%	47	7%
MHCD ADULT	593	233	39%	33	6%
DH PAV G INTENSIVE OP	193	114	59%	31	16%
Total	**159256**	**11788**	**7%**	**2470**	**2%**

Addiction Review

Addiction is…

A ***chronic, relapsing disease***

- Strong *genetic* component
- Results in *permanent changes in brain structure and function*

Characterized by *loss of control*

- Brain is literally hijacked by cravings to use drugs and prevent withdrawal symptoms

Very difficult to treat

- Detoxification ≠ Treatment!
- High rates of relapse
- Best evidence for treatment: counseling + replacement

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The cycle of addiction

Incentive Salience

Binge/ Intoxication

BASAL GANGLIA

DS

PREFRONTAL CORTEX

NAc

VTA

BNST

PFC

CeA

EXTENDED AMYGDALA

Dopamine
Opioid peptides
Corticotropin-releasing factor
Dynorphin
Glutamate

Withdrawal/ Negative Affect

Reward Deficit & Stress Surfeit

Preoccupation/ Anticipation

Executive Function Deficits

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Medication-assisted treatment

Primary Care Weaning and Detoxification Barriers

Opioid detoxification is difficult!

- Patients unsuccessful at following complex weaning schedules
- >70% relapse rate following detoxification

Depression and anxiety disorders common among opioid users

- Anti-anxiety
- Anti-psychotic
- Detoxification may exacerbate/unmask symptoms

Who are these nice people?
Why are they important?

Methadone: 1972
Buprenorphine: 2002
Naltrexone: 2006

http://atforum.com/interview-dr-vincent-dole-methadone-next-30-years/

Advantages of opioid maintenance

Reduced illicit drug use

Reduced euphoria

Decreased consequences from opioid use

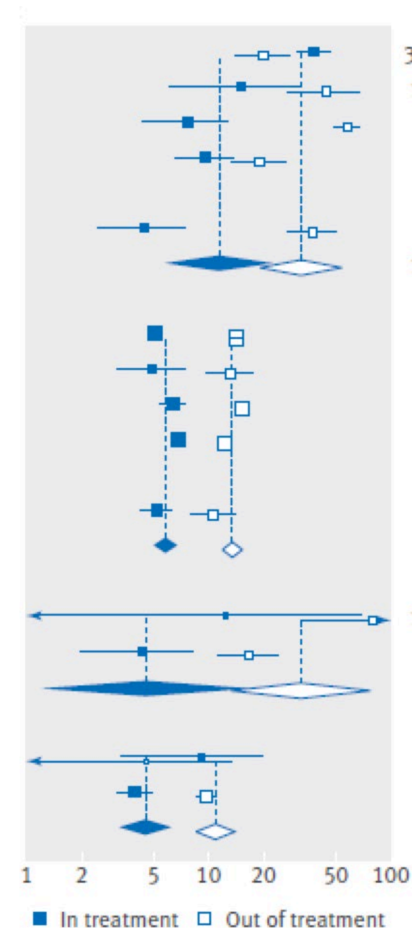
- HIV infection
- HCV infection
- Overdose
- Criminal behavior

Extinction of craving, priming, repeated pattern of binge use and withdrawal

Why? It saves lives

Methadone and buprenorphine reduce the risk of death substantially

- Methadone **11.3% vs. 36.1%**
- Buprenorphine **4.3% vs. 9.5%**
- All-cause mortality drops sharply in first 4 weeks of treatment
- **25 fewer deaths per 1000 person-years for those who continue tx!**



Sordo L, et al. *BMJ* 2017

Medication-assisted treatment options

Medication	Action	Usual effective dose	Frequency	Adverse effects
Methadone	Agonist	20-150 mg daily	Daily	Constipation, respiratory depression, dizziness, sedation, drug interactions
Buprenorphine	Partial agonist	8-24 mg sublingual	Daily- 3x/week	Constipation, headache
Naltrexone	Antagonist	380 mg IM	Monthly	Injection site reactions

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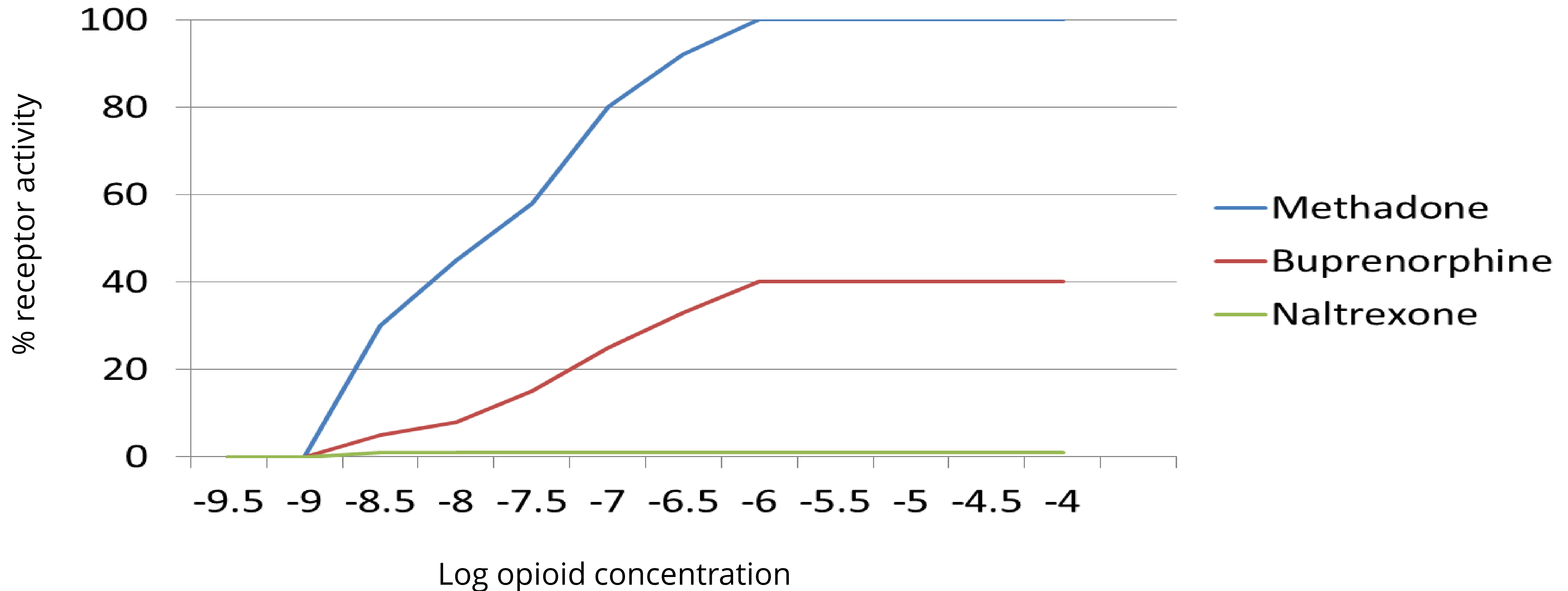
Mu opioid receptor activity



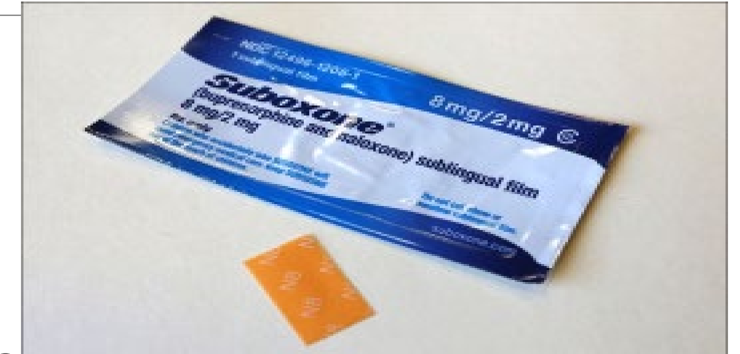
Why is buprenorphine a great choice?

Can be prescribed in primary care offices

Long half-life prevents roller coaster of withdrawal and craving

High receptor affinity prevents reinforcement in the event of a relapse

Partial activity prevents risk of death from respiratory depression



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Treatment gap

48 states with opioid abuse or dependence #s > MAT spots

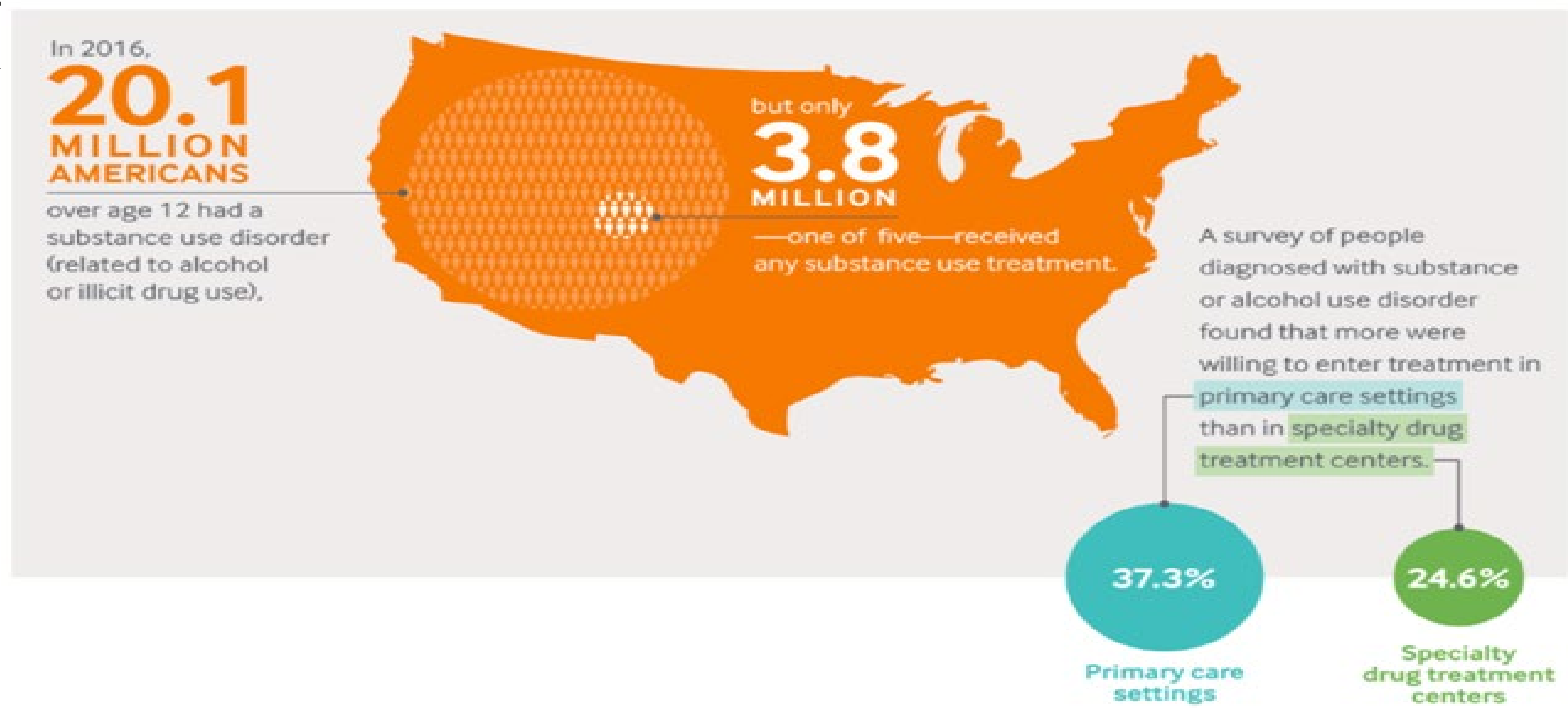
Gap of nearly 1 million assumes that all DATA-waivered physicians prescribing to their limits

Only 55% of waivered providers listed on SAMHSA website's treatment locator

Estimated gap 1.4 million, real gap probably significantly higher

Jones CM et al. *Am J Pub Health* 2015

Primary care will fill the gap



Primary Care MAT

Providers and staff have long-term relationships with patients

No stigma to having your car parked at your primary care provider's office

PCPs are great at managing chronic conditions, like hypertension and diabetes

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Implementing MAT

Offer/initiate MAT in non-traditional locations and models

Emergency department

Inpatient service

Jails

Prisons

School-based clinics (children/adolescents)

Interim methadone/buprenorphine

Residential treatment facilities

Primary Care

Buprenorphine implementation models

Practice-based models

- OBOT
- BHIVES
- ”One-stop shop” model
- Integrated prenatal care/MAT

Systems-based models

- Hub-and-spoke (VT)
- Medicaid health home
- Nurse care manager (MA)
- Collaborative opioid prescribing model (MD)

Korthuis PT et al. *Ann Intern Med* 2016

Increasing access requires overcoming barriers

Clinic

Accessibility

Availability

Technical

Logistical

Reimbursement

Provider

- Communication
  - 42 CFR Part 2
- Workforce capacity
  - Addiction psychiatry/med
  - APPs
  - Addictions counselors

Patient

Stigma

Engagement & retention

Insurance coverage

Practice-based model: One-Stop Shop

Integrated model based in mental health clinic

- Provided integrated care for:
  - HIV/HCV
  - Mental Health
  - Primary Care
  - Syringe Exchange

Primary care provider embedded in mental health clinic

OUD treatment primarily naltrexone-based

Korthuis PT et al. *Ann Int Med.* 2016.

System-based model: ECHO

Primary care clinic performs initial screening, treatment, monitoring, and follow up

Mentored buprenorphine prescribing, including internet-based AV network for provider education

Korthuis PT et al. *Ann Int Med.* 2016.

Models of primary care delivery: OBOT

- Designated clinic staff member to coordinate prescribing
  - Typically nurse, SW
- Psychosocial services
  - Brief counseling on site
    - May be provided by physician, other staff
  - Off-site referrals
- Reimbursed by billable visits

Korthuis PT et al. *Ann Int Med.* 2016.

Necessary pieces

Assessment for OUD

Complete medical hx, assess for concomitant conditions

- HIV, Hepatitis, pregnancy, acute trauma

Physical exam & lab testing: Hep A,B,C and HIV, pregnancy, LFTs

- Offer vaccines, family planning

Determine appropriate site of care

Must be able to provide counseling or referral to counseling

Primary Care Medical Management
Critical Elements: Medical

Monitoring of compliance with buprenorphine maintenance

Monitoring of patients’ drug use, symptoms, and progress

Education regarding opioid use disorder and buprenorphine maintenance treatment

Encouragement to achieve abstinence from illicit opioids and to adhere to all treatment recommendations

Identification and treatment of medical complications of opioid use

Primary Care Medical Management
Critical Elements: Counseling

Encouragement to attend self-help groups

Provision of brief advice modeled on the education provided in standard drug counseling, such as encouraging patients to make lifestyle changes that support recovery, and to avoid potential triggers of drug use

Referrals to specialty services in the community (e.g., vocational, legal, housing or social services) if necessary

Maximize Collaborative Care

CARE RESPONSIBILITIES

Screening and intake

Pretreatment assessments

Treatment planning

Medication management

Monitoring (UDTs, pill counts, PDMP checks)

Individual and/or group counseling

Drop in groups

Family support

Relapse prevention

Recovery Monitoring

TEAM

Physician (waivered)

Nursing

Social worker

Counselor

Medical assistant

Administrative staff

Alford DP et al. *Arch Intern Med.* 2011.

Anticipate Insurance Issues

Is buprenorphine a covered benefit?
- What Tier? What Co-pays?

Is behavioral treatment covered?

Beware behavioral health carve outs!

Are lab services covered?

Restrictions on duration of treatment?

Anticipate prior approval procedures
- Collect forms from each payer
- Submit forms in advance of fill
- Consider cash for first few days supply
- Monitor patient's pharmacy benefits
- 340B coverage in some Community Health Centers

Billing for OBOT

OBOT is standard medical care: billing procedures are standard

The ICD-10 Code for opioid dependence is F11.20.

Physicians billing codes: (CPT) billing codes, accepted by all payers

No specific Addiction Medicine codes. Same codes as other ambulatory care services

More information provided in written materials

Local resources to help implement MAT

IT MATTTRS2 Colorado

- Offers on-site practice facilitation, waiver training reimbursement, MATerials
- http://www.practiceinnovationco.org/itmatttrs2/

Project ECHO

- Has a buprenorphine implementation series
- https://echocolorado.org/

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Denver health CHS addiction treatment services

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Denver Health Model

Hub and spoke model

- OBHS=hub=specialty, high intensity
- FQHCs=spokes=low-moderate intensity, stable patients
- “No wrong door” approach = wherever the patient accesses care they can be triaged and connected to the appropriate service

MAT inductions in all settings

- OBHS, primary care, emergency department, inpatient service

Denver Health Addiction Treatment

ADDICTION CENTER OF EXCELLENCE (OBHS)

- DATA & RESEARCH
- PREVENTION
- CORRECTIONS
- EDUCATION
  Provider, patient, public
- EMERGENCY DEPARTMENT
- RECOVERY COMMUNITY
- COMMUNITY HEALTH
- INPATIENT

Program Goals

Integrate addiction treatment in the primary care clinics to:

- Increase SBIRT screening to identify problematic use
- Expand access to Medication-Assisted Treatment for patients with opioid use disorders
- Provide substance use disorder and opioid use disorder counseling with referrals to higher levels of care as needed
- Break down traditional silos of mental health and substance use treatment and provide a team-based approach

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Progress to date

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By the numbers

5 CAC III/LACs in three GIM and two family medicine clinics

2 health educators focused on SBIRT and health behavior change

2 Behavioral Health Educators to support the CAC IIIs/LACs in connecting patients with resources and maintaining engagement in care

At least 5-6 DATA waivered prescribers per clinic

In 2017, 1664 unique patients had an encounter with the addiction counselor

Since 2016, approximately 2400 SBIRT full assessments have been completed

Over 300 patients prescribed buprenorphine-based MAT from 2016-present

Active patients & productivity

Clinic	# Patients receiving MAT
DH PAV G ADULT	46
DH PAV G LEVELONE PHYS	1
EASTSIDE ADULT	38
EIS PRIMARY CARE	1
LOWRY FAM MED	55
PEÑA PRIMARY CARE	18
WESTSIDE ADULT	41
Total	200

	2017	Jan-June 2018
Total Encounters	4969	3869 (x 2= 7,738; +56%)
Unduplicated patients	1665	1235

Individual CAC Productivity Over the Past Year

1400
1200
1000
800
600
400
200
0

Devin Koetje
Gilbert Deleon
Jessica Cram
Neave Halvorson
Trisha Maki

Addendum Note
Confidential Notes
Patient Instructions
Progress Notes
Telephone Encounter

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Successes and Lessons Learned

Enthusiastic, motivated addictions counselors quickly make themselves invaluable members of the care team

Modeling intervention after integrated behavioral health program (i.e. warm hand offs, close collaboration with team) helps to improve uptake in acceptance of program

Regular Zoom meetings (Echo lite) helpful for teaching/case discussions

On site trainings for providers made it easier to get sufficient numbers of prescribers

Hurdles and roadblocks

Collaboration with OBHS has taken effort and time

Staff turnover at OBHS can create bottlenecks

Privacy standards around addiction treatment (42 CFR Part 2) is a major obstacle

We continue to struggle with healthcare coverage
- PAR required for buprenorphine
- Long-acting injectable buprenorphine not accessible
- Depot naltrexone not covered under CO Medicaid
- Residential treatment not available

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Conclusions

The opioid epidemic rages on

MAT proven to reduce morbidity and mortality

Collaborative primary care will be the key to expanding access

Referral relationships crucial

Session Evaluation

Use the CFHA mobile app to complete the evaluation for this session.

Thank you!