

Beyond SBIRT: Integrating Addiction Medicine into Primary Care

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Audience Participation!!

- If one of your patients screens positive via SBIRT for a drug or alcohol problem, what do you tell the patient and/or where do you refer the patient?

Available Treatments for Drug or Alcohol Dependence

- Detoxification (stopping use safely)
 - Inpatient or outpatient
- Inpatient or residential
- Outpatient
 - Cognitive Behavioral Therapy
 - Contingency Management
 - Motivational Enhancement Therapy
 - 12 Step Facilitation
- Medication Assisted Therapy (a.k.a. office-based treatment)
- What about Alcoholics Anonymous?
 - Self-help not formal treatment

MORE Audience Participation!!

- Raise your hand if you think there are any FDA approved medications a primary care doctor can prescribe to treat addiction.

FDA Approved Addiction Medications Available in Primary Care

- Alcohol Dependence
 - Naltrexone (Revia® and Vivitrol®)
 - Acamprosate (Campral®)
 - Disulfiram (Antabuse®)
- Opioid Dependence (heroin, Rx opioids)
 - Buprenorphine (Suboxone® and Subutex®): requires DATA 2000 Waiver to prescribe
 - Naltrexone (Vivitrol®)
- No approved medications for cocaine, methamphetamine, marijuana, ecstasy, etc. (refer patients to clinical trials!)

What about methadone?

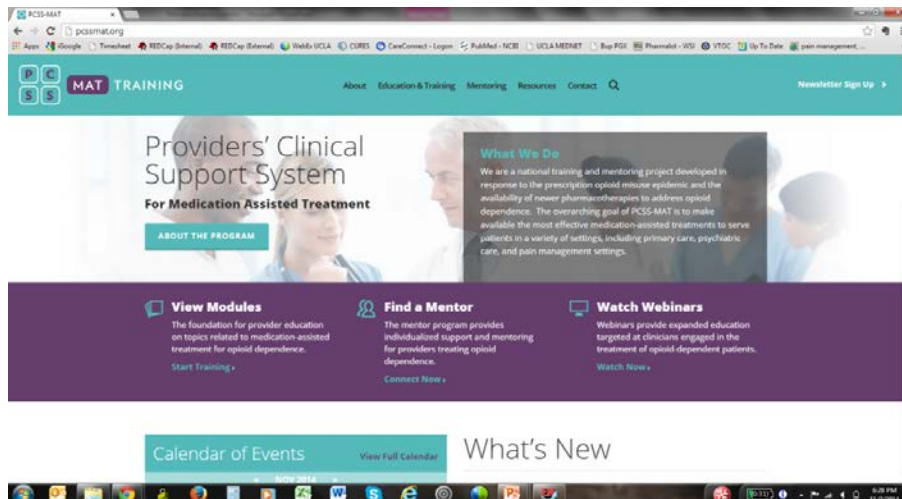


Limited to observed dosing at specialized Opioid Treatment Programs

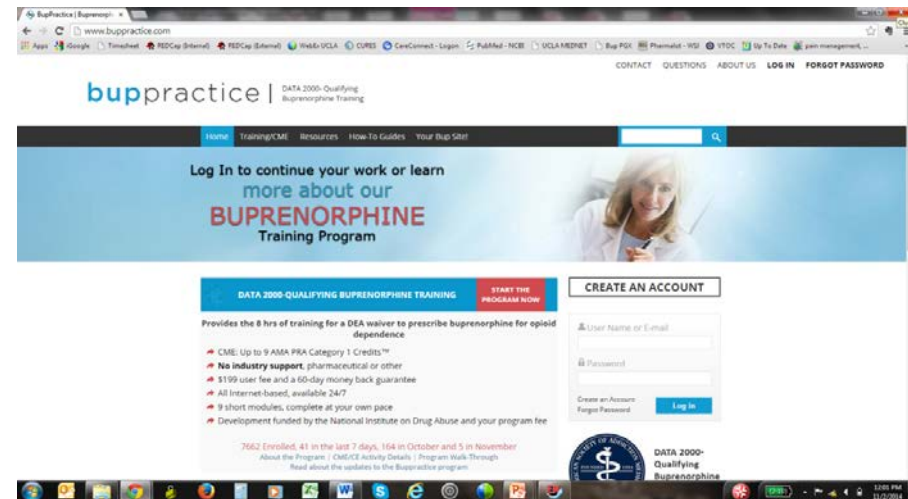


Drug abuse treatment act of 2000

- DATA 2000 waiver allows MD to prescribe office-based buprenorphine for addiction.
- Complete 8 hour CME and register with DEA.
- Limit on patients per MD (30 but can increase to 100 after one year) > keep a list of patients
- DEA inspects prescribing physicians



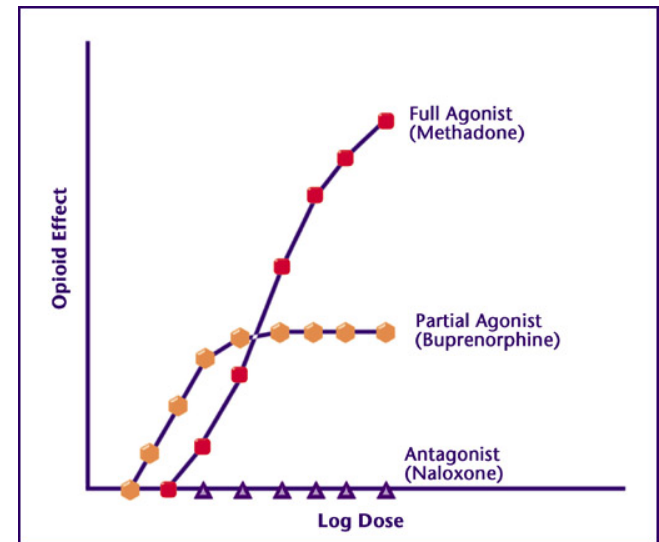
The screenshot shows the PCSS-MAT website. The header includes the logo and navigation links: About, Education & Training, Mentoring, Resources, Contact. The main content area features a large banner titled "Providers' Clinical Support System For Medication Assisted Treatment". Below the banner, there are three columns of information: "View Modules" (The foundation for provider education on topics related to medication-assisted treatment for opioid dependence. Start Training >), "Find a Mentor" (The mentor program provides individualized support and mentoring for providers treating opioid dependence. Contact Now >), and "Watch Webinars" (Webinars provide expanded education targeted at clinicians engaged in the treatment of opioid-dependent patients. Watch Now >). At the bottom, there are links for "Calendar of Events" and "What's New".



The screenshot shows the buppractice website. The header includes the logo and navigation links: Home, Training/CME, Resources, How-to Guides, Your Bup Site. The main content area features a large banner titled "Log In to continue your work or learn more about our BUPRENORPHINE Training Program". Below the banner, there are two main sections: "DATA 2000-QUALIFYING BUPRENORPHINE TRAINING" and "CREATE AN ACCOUNT". The training section includes a "START THE PROGRAM NOW" button and a list of benefits: CME: Up to 9 AMA PRA Category 1 Credits™, No industry support, pharmaceutical or other, \$199 user fee and a 60-day money back guarantee, All Internet-based, available 24/7, 9 short modules, complete at your own pace, and Development funded by the National Institute on Drug Abuse and your program fee. The account creation section includes a "Log In" button and a "Forgot Password" link. At the bottom, there is a "7662 Enrolled, 41 in the last 7 days, 164 in October and 5 in November" section and a "DATA 2000-Qualifying Buprenorphine" logo.

Buprenorphine/naloxone for opioid dependence

- μ -opioid receptor *partial agonist/antagonist*
- Reduces withdrawal and cravings (agonist); blocks other opioids (antagonist)
- Lower OD risk **UNLESS** combined with alcohol or sedatives (benzos)
- Carved-out to “Drug Medi-Cal” > submit TAR even for Medi-Cal managed care

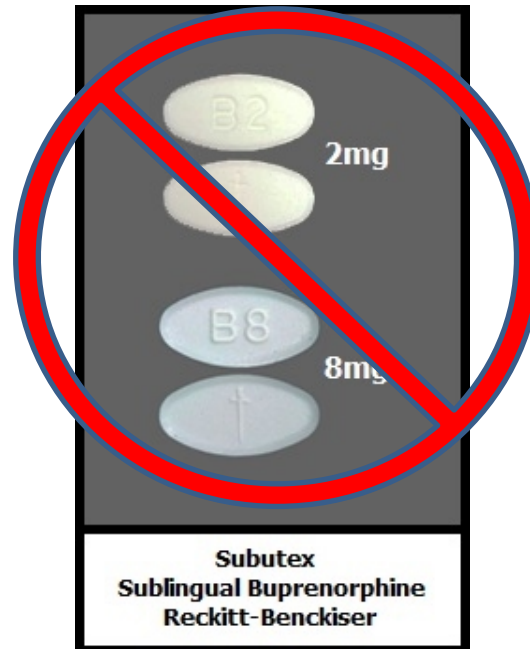


Buprenorphine formulations

ADDICTION



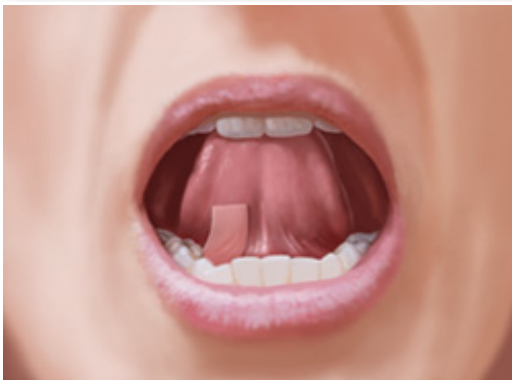
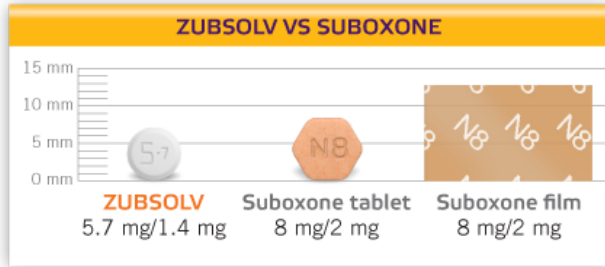
**DON'T USE:
ABUSED**



PAIN



Only in pregnancy or documented naloxone intolerance



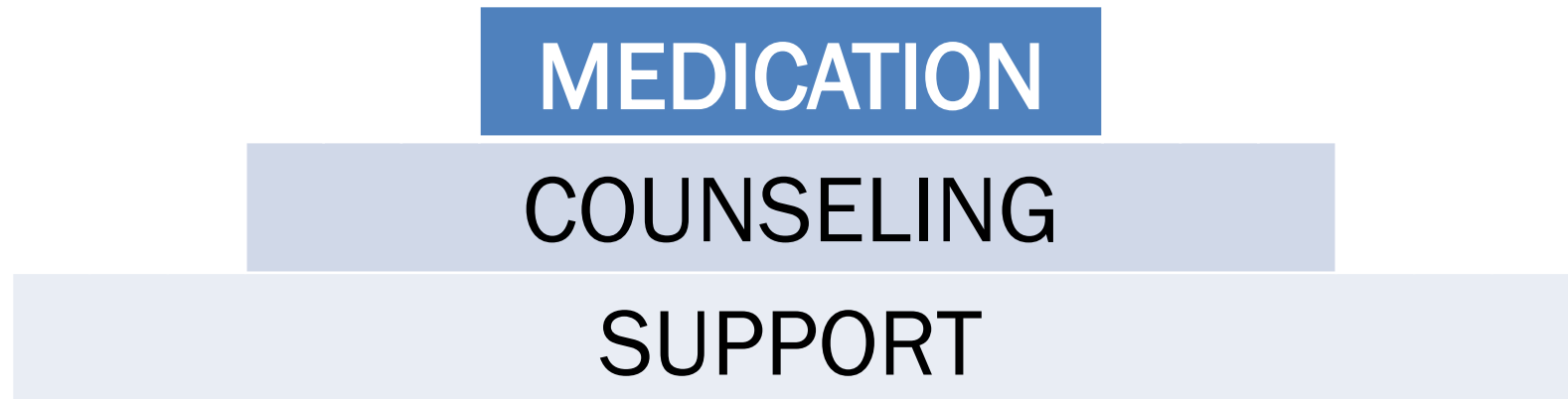
Injectable, Extended-Release Naltrexone

- Monthly intra-gluteal injection of extended release naltrexone 380 mg (Vivitrol®)
- Addresses non-adherence with oral naltrexone
- FDA approved for alcohol and opioid dependence
- Ethanol releases endogenous opioids > euphoria and reward
- Side effects: nausea, injection site reactions, precipitated opioid withdrawal, hepatotoxicity (RARE!), analgesic blockade
- “Buy and bill” for Medi-Cal except AB109 (criminal justice) > submit TAR



Model for treating drug or alcohol dependence in primary care

- Medication: reduce withdrawal or cravings, prevent relapse from stress, cues, priming
- Counseling: CBT, motivational enhancement, medication management; usually outpatient
- Support: Self-help groups (AA, SMART Recovery), family/friends, supportive environment (sober living)



RAND is collaborating with Venice Family Clinic (VFC) to study how to increase the delivery of SUD treatments in primary care

- VFC is a Federally Qualified Health Center (FQHC)
- 25 permanent medical providers and hundreds of volunteers and residents
- Fully integrated behavioral health care provided by LCSWs

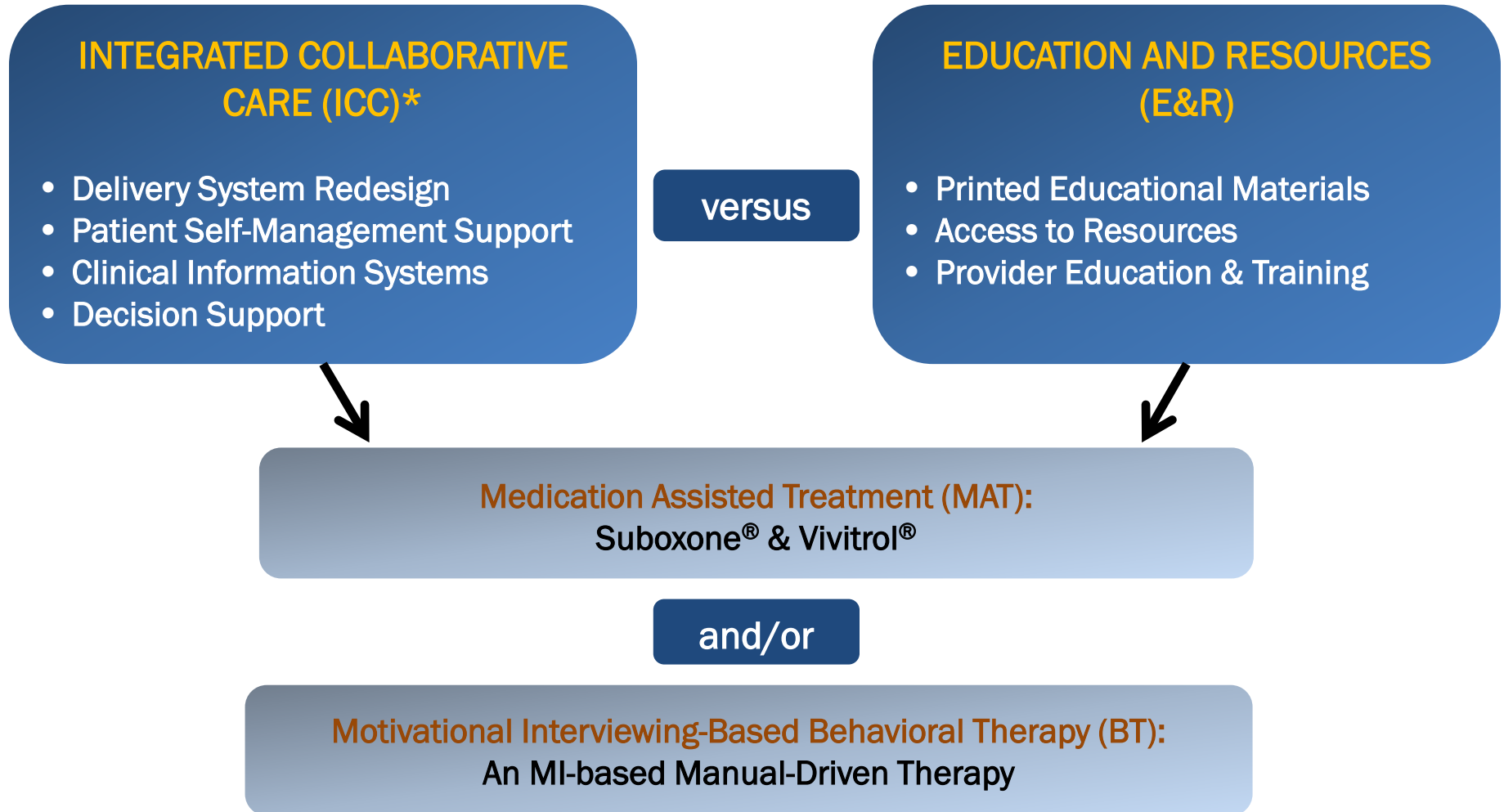


Substance Use, Motivation and Medication Integrated Treatment

Kate Watkins (PI), Allison Ober
Despina Kayichian, Karen Lamp



Study Compares Two “Implementation Strategies” for Delivering OAUD EBPs



Challenges: Screening not identifying patients

- We have only identified risky alcohol and/or opiate use at 3% of all adult patient visits
 - Providers identified many who don't answer the screening questions accurately
 - Patients usually NOT coming in for help with substance abuse issues and may not be ready to admit that they have a problem, much less be ready to quit
 - Screening is done by MAs and not always in a completely private space

Challenges: Back-up for complicated cases

- Patients with complicated medical and social issues
 - Polysubstance abuse (commonly test positive for opiates, amphetamines, and benzodiazepines)
 - Homeless and may have mental illness (dual diagnosis)
 - Complex comorbidities (other chronic illnesses, Hepatitis C, COPD, heart disease)
 - These are tricky patients even for addiction specialists; even more so for primary care providers new to treating addiction
 - *Limited access to inpatient detoxification/treatment*
 - High No Show Rates
 - Incentives? And Provider patience

Early anecdotal impressions on keys to successful integration

- Identify Provider Champions to combat potential provider ambivalence, skepticism
- Identify an accessible expert consultant until you develop in-house expertise
- Provide staff with simple, clear written protocols
- Get support from Senior Management (trainings, double visits, concerns about attracting new clientele)
- Integrate behavioral health and case management into the care team

The future?

- Increase access to anti-addiction medications via collaborations between community clinics and substance abuse treatment programs
 - Community clinic providers prescribe anti-addiction medications
 - Counseling and inpatient detoxification from substance abuse programs
 - Vivitrol[®] before inpatient or hospital discharge > follow-up in primary care

Questions?

- Feel free to contact me:
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