Integrating HIV and Substance Use Disorder Treatment to Optimize Care for Vulnerable Patients

March 21, 2018

SAMHSA-HRSA
Center for Integrated Health Solutions

integration.samhsa.gov

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Health Resources & Services Administration

SAMHSA
Substance Abuse and Mental Health Services Administration

Moderators

Kristin Potterbusch, MPH, Director of HIV and Behavioral Health Integration, CIHS

Roara Michael, MHA, Senior Associate

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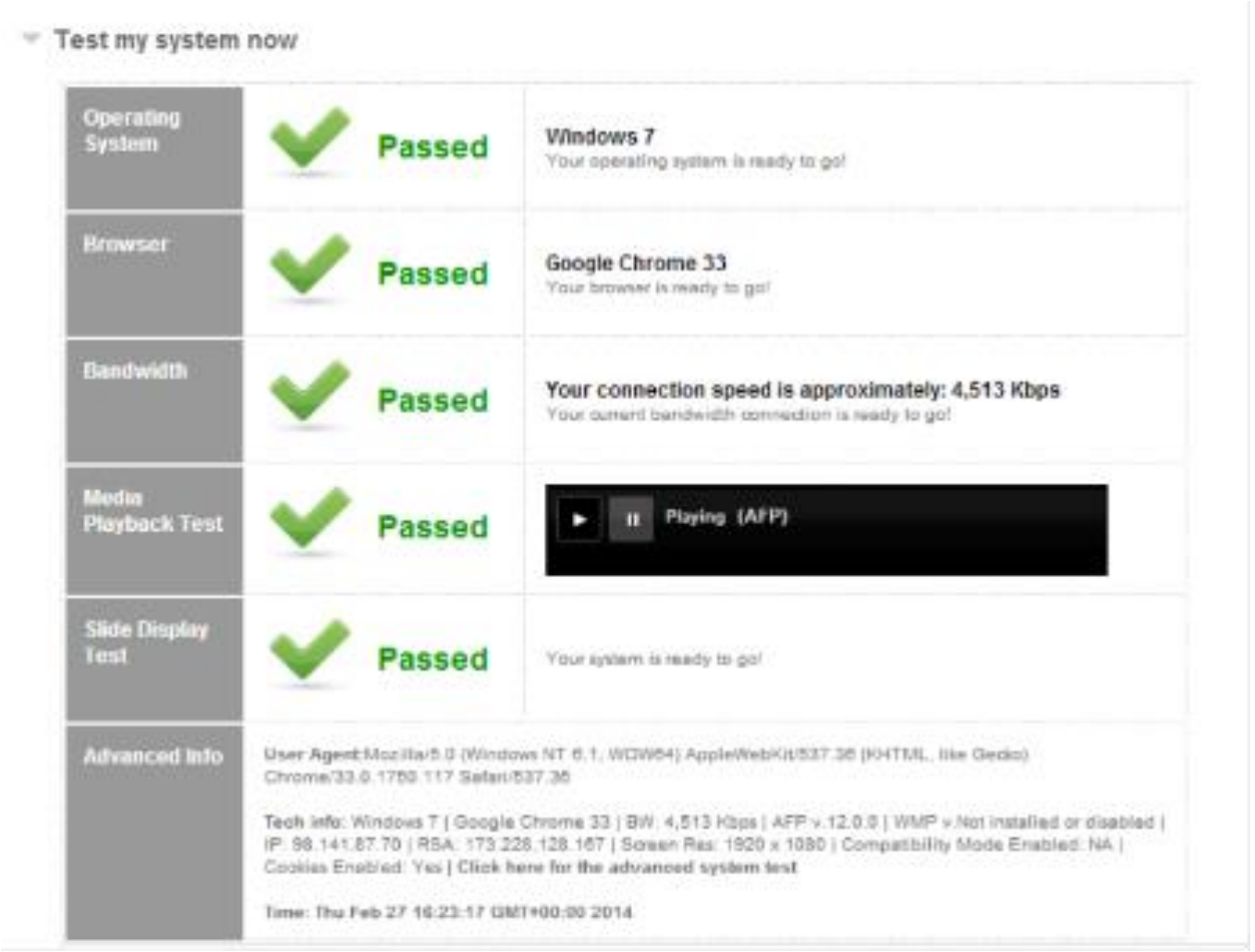

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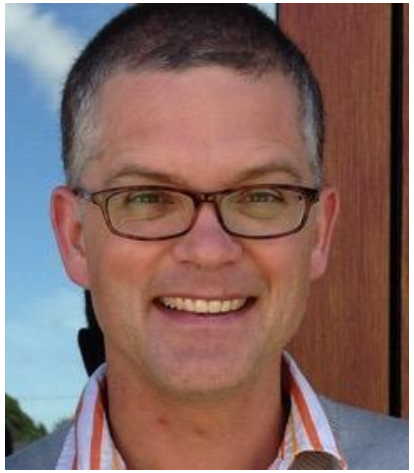
Today's speakers



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Director, Addiction Medicine Fellowship

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Joshua Blum, MD
Denver Health and Hospital Authority

Antigone Dempsey, MEd
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SAMHSA-HRSA Center for Integrated Health Solutions

WHO WE ARE

The **SAMHSA-HRSA Center for Integrated Health Solutions (CIHS)** is a national training and technical assistance center dedicated to the planning and development of **integration of primary and behavioral health care** for those with mental illness and/or substance use disorders and physical health conditions, whether seen in specialty mental health or primary care safety-net provider Settings across the country.

CIHS is jointly funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources Services Administration (HRSA), and is run by the National Council for Behavioral Health, the unifying voice of America's healthcare organizations that deliver mental health and addictions treatment and services.

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Integrating HIV and Substance Use Disorder Treatment to Optimize Care for Vulnerable Patients

Alexander Y. Walley, MD, MSc
Associate Professor of Medicine
Director, Addiction Medicine Fellowship
Boston University School of Medicine/ Boston Medical Center

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Learning objectives

At the end of this session, you will learn:

- How integration can support implementation of evidence-based practices and care teams in Ryan White HIV/AIDS Program provider settings to address substance use and HIV treatment needs;
- Opportunities to cross-walk SUD and HIV treatment approaches using the key concepts of integration; and
- Current organizational readiness to adopt and/or incorporate new strategies for client retention

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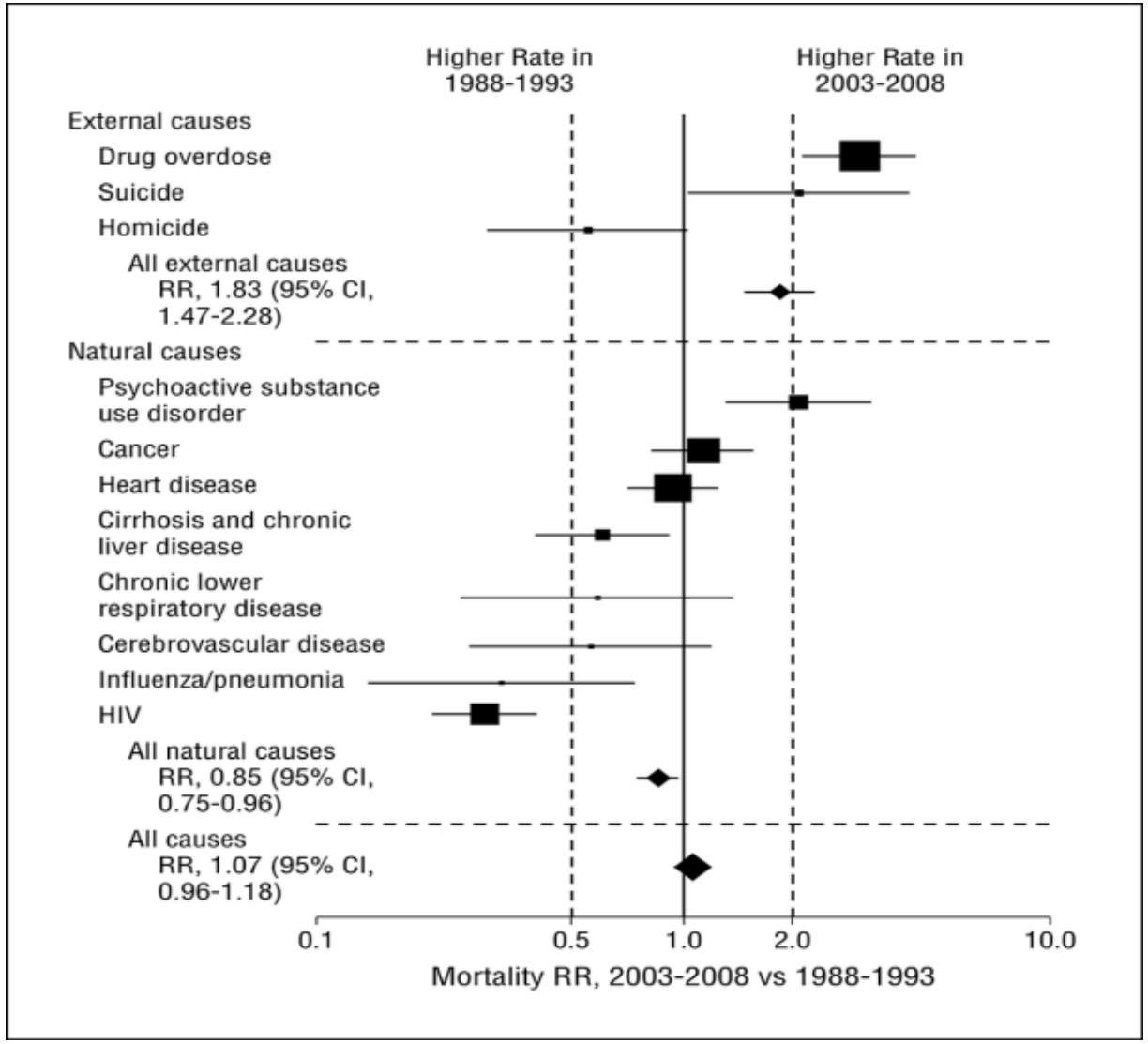
Focus

- HIV-Addiction Epidemiology
- Reducing harm – preventing overdoses and HIV
- Treating opioid use disorder

The HIV-Overdose syndemic?



Bagget et al. Mortality among homeless adults in Boston. JAMA Intern Med 2013.

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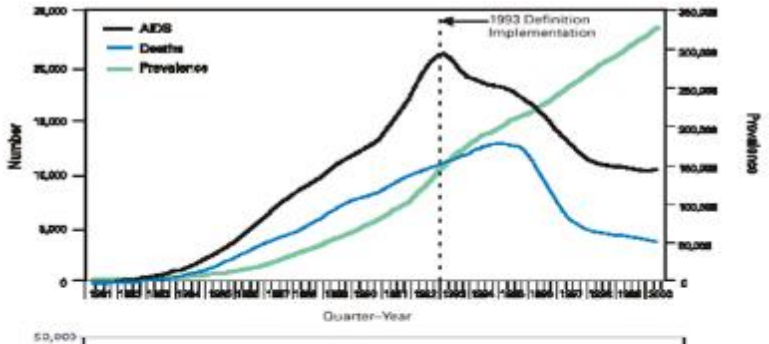
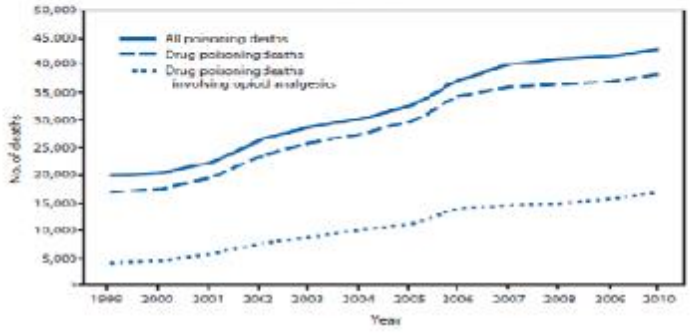
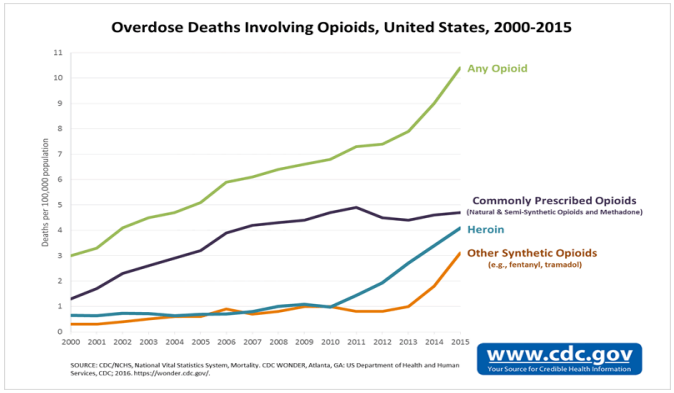
We've been here before







US 1981-2000

- AIDS incidence
- deaths
- prevalence

US 2000-2015

- Poisoning deaths by year and opioid analgesic involvement

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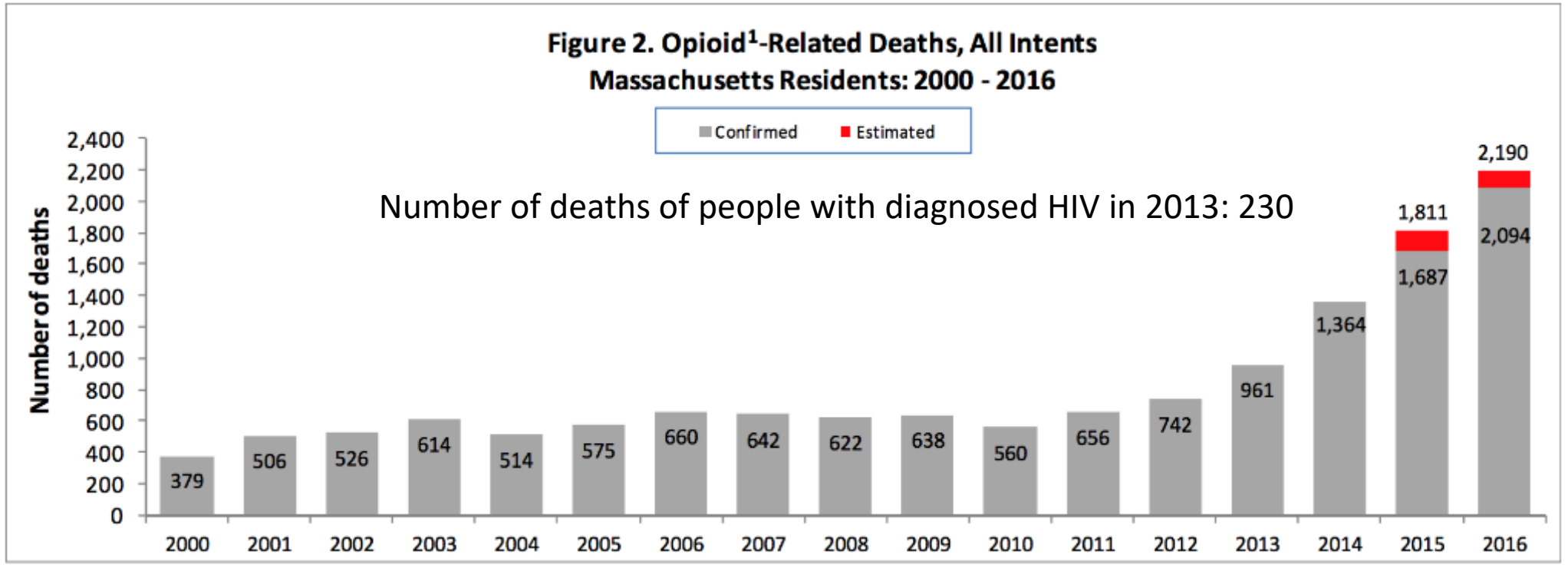
Opioid deaths in Massachusetts



Number of deaths of people with diagnosed HIV in 2013: 230

Romney Care
Naloxone via public health programs
Expansion of buprenorphine treatment

Police/Fire naloxone
Safe opioid education mandated

Pharmacy SO

www.mass.gov/files/documents/2017/11/13/sec1-od%20deaths%20mass%20residents%20Nov-17.pdf

Why overdose matters for HIV

- Overdose is a leading cause of death in HIV-infected PWIDs
- PLWH have greater risk of fatal OD
- OD prevention programs connect people to HIV prevention services and health services
- OD prevention empowers people who use drugs to reduce their risks
- OD and HIV infection are 2 risks particularly high in the peri-incarceration period
- OD is an issue that many people with HIV care about and likely have personal experience
- Open Society Institute and European Harm Reduction Network 2010

"The high rates of overdose and its association with HIV underscore the need for a syndemic approach that considers overdose on parity with HIV."

Gilbert L et al. Redressing the epidemics of opioid overdose and HIV among people who inject drugs in Central Asia: The need for a syndemic approach. Drug and Alcohol Dependence 2013 Aug 13.

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Example successful strategies for HIV/AIDS and parallel opportunities for overdose reduction

Treatment <--------> Prevention

Examples of strategies for HIV/AIDS	Examples of parallel opportunities for overdose reduction
• HIV testing and risk reduction counseling	• Overdose risk assessment and reduction counseling
• Needle-syringe distribution	• Naloxone rescue kit distribution
• Targeted outreach /peer-driven interventions	• Targeted outreach /peer-driven interventions
• Anti-retroviral therapy and opioid agonist treatment	• Medication for opioid use disorders
• Comprehensive, collaborative, longitudinal care for individuals with HIV infection	• Comprehensive, collaborative, longitudinal care for individuals with addictions
• Coordinated prevention and treatment strategy across public health and the healthcare system	• Coordinated prevention and treatment strategy across criminal justice, law enforcement, public health and healthcare systems
• Major funding across public health and the healthcare system of evidence-based interventions	• Major funding across criminal justice, law enforcement, public health and healthcare systems of evidence-based interventions

Walley. A. (2015). HIV prevention and treatment strategies can help address the overdose crisis. Preventative Medicine, pg 2 Table 1
http://dx.doi.org/10.1016/j.ypmed.2015.04.004

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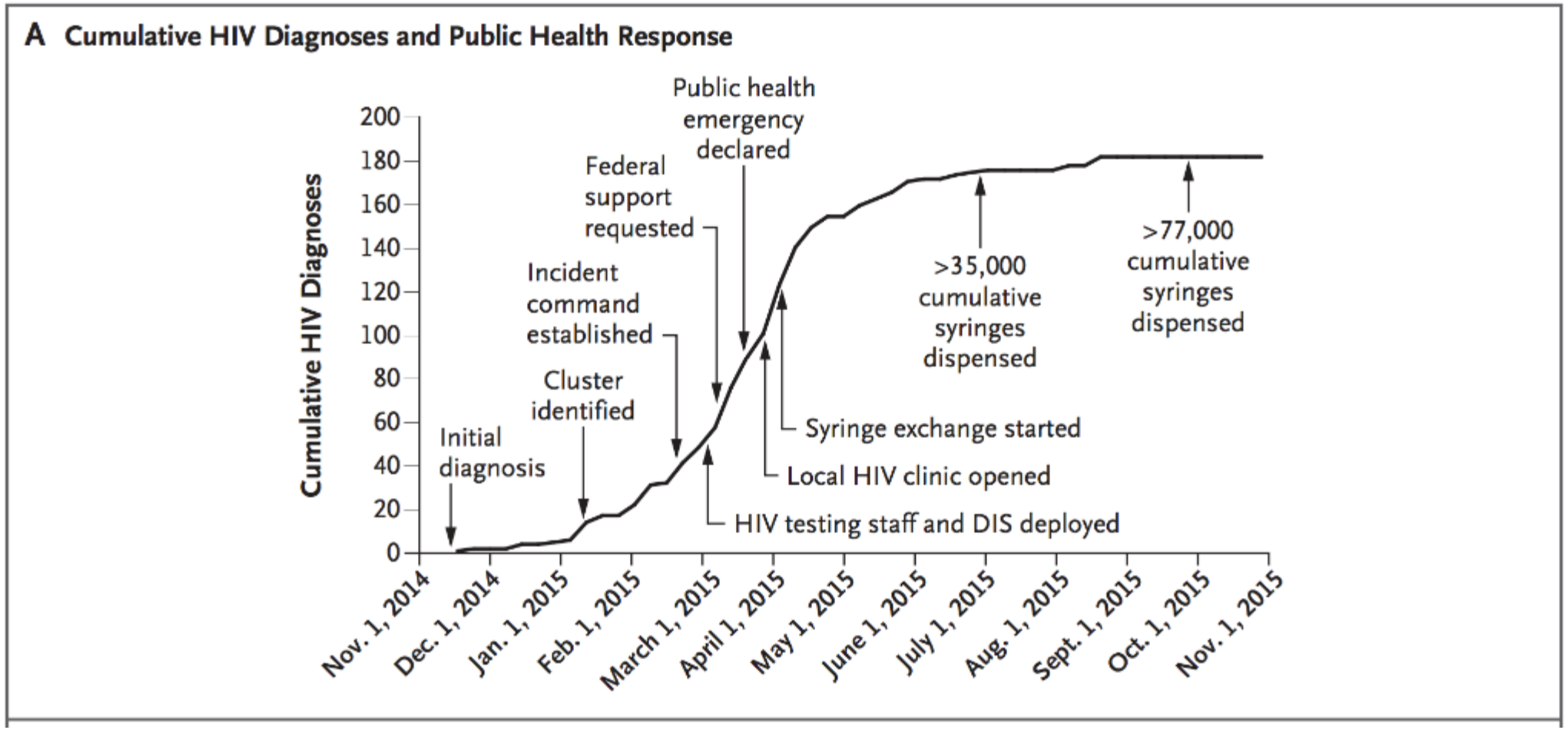
Scott County, IN HIV-oxymorphone outbreak 2014-2015



Peters et al. NEJM 2016

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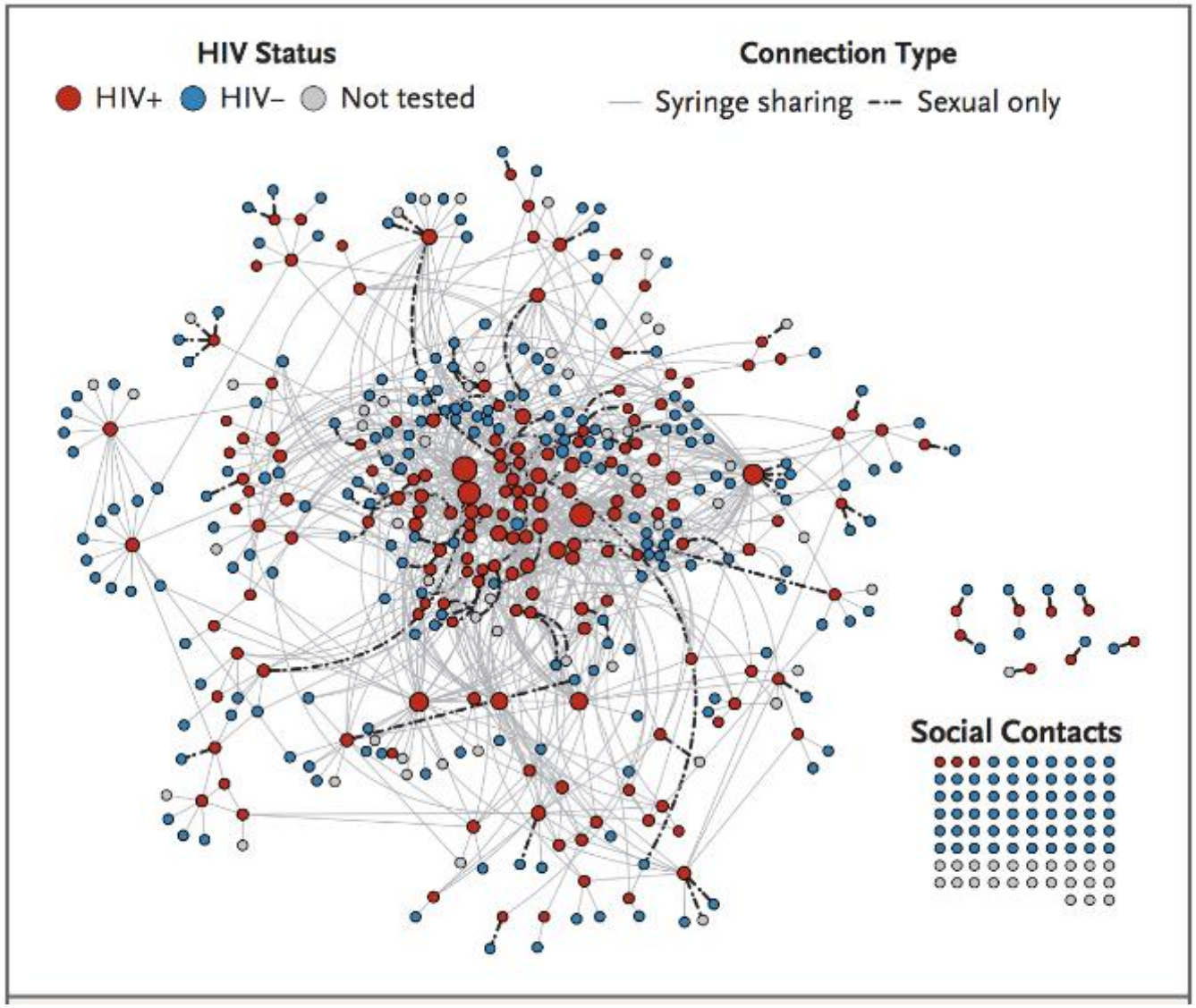
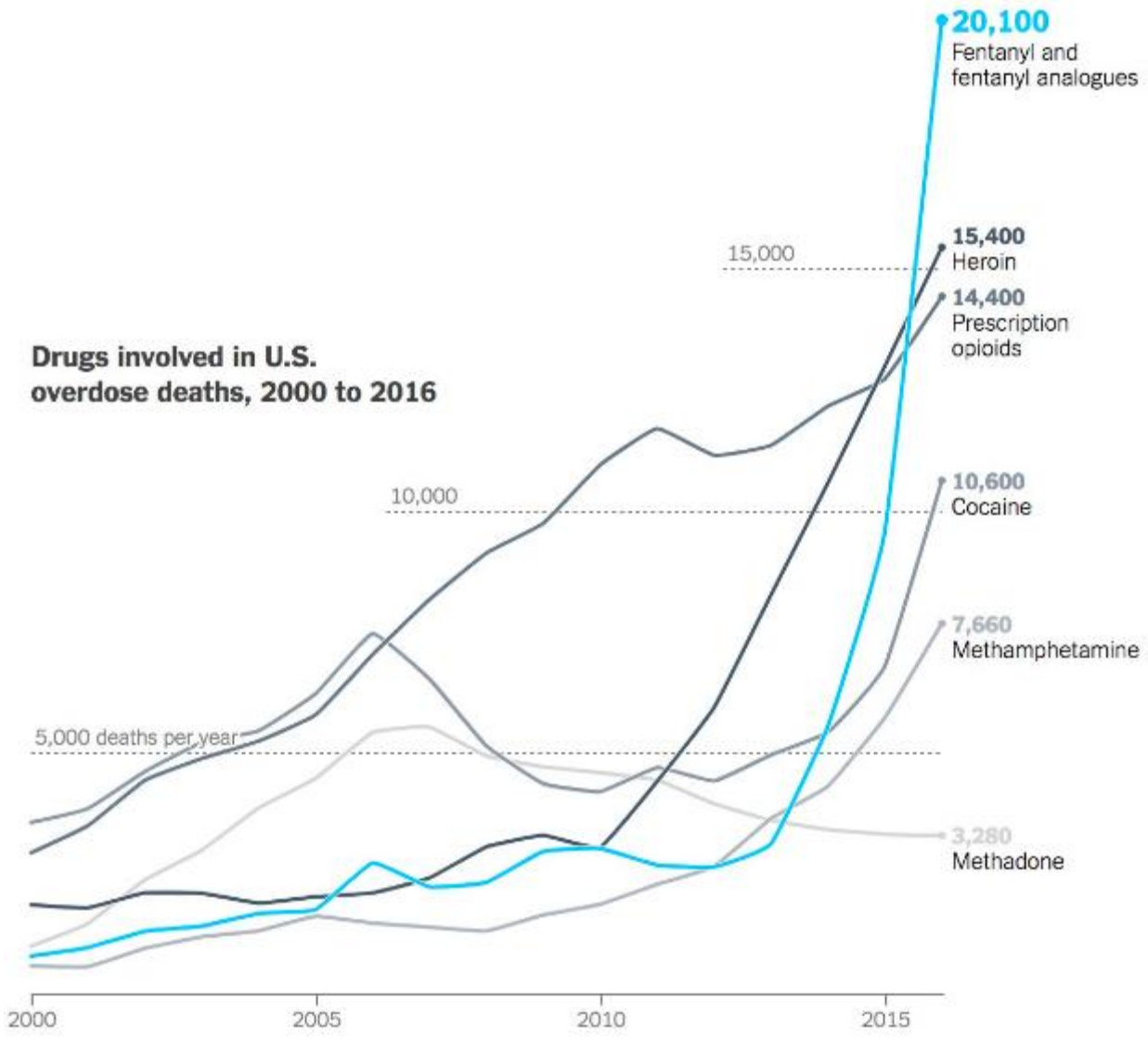


Peters et al. NEJM 2016

Fentanyl is driving the overdose surge



Katz, J. The First Count of Fentanyl Deaths in 2016: Up 540% in Three Years. NYT – The UpShot 9/2/2017.

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Strategies to address Fentanyl overdose deaths

A comprehensive public health response to address overdoses related to IMF

1. Fentanyl should be included on standard toxicology screens
2. Adapt existing harm reduction strategies, such as direct observation of anyone using illicit opioids, and ensuring bystanders are equipped with naloxone
3. Enhanced access and linkage to medication for opioid use disorders

"So, now what they [people selling illicit drugs] are doing is they're cutting the heroin with the fentanyl to make it stronger. And the dope [heroin] is so strong with the fentanyl in it, that you get the whole dose of the fentanyl at once rather than being time-released [like the patch]. And that's why people are dying—plain and simple. You know, they [people using illicit drugs] are doing the whole bag [of heroin mixed with fentanyl] and they don't realize that they can't handle it; their body can't handle it." **-- Overdose bystander**

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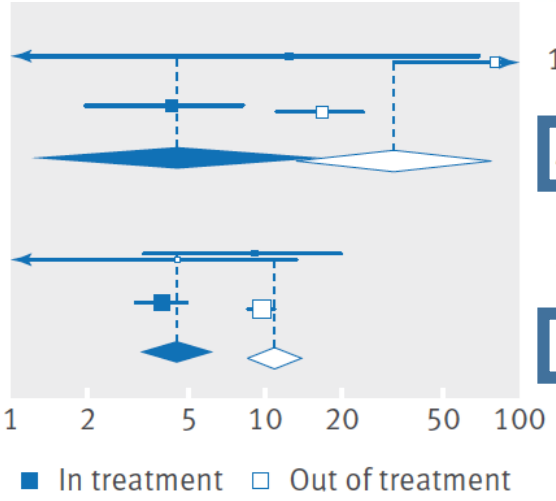
Medications for Addiction

Buprenorphine and Methadone reduce mortality

- Highly effective in reducing illicit opioid use
- Reduces overdose death rate
- Very low risk for overdose

	No of deaths/ person years		All cause mortality rate/ 1000 person years (95% CI)	
	In treatment	Out of treatment	In treatment	Out of treatment
Buprenorphine, first four weeks				
Cornish et al 2010	1/81	7/88	12.4 (0.3 to 69.2)	80.0 (32.2 to 164.8)
Kimber et al 2015	9/2094	28/1674	4.3 (2.0 to 8.2)	16.7 (11.1 to 24.2)
Overall			4.5 (1.2 to 16.8)	32.0 (13.2 to 77.5)
Buprenorphine, after four weeks				
Cornish et al 2010	6/659	3/663	9.1 (3.3 to 19.8)	4.5 (0.9 to 13.2)
Kimber et al 2015	78/19 842	286/29 565	3.9 (3.1 to 4.9)	9.7 (8.6 to 10.9)
Overall			4.5 (3.2 to 6.2)	10.9 (8.5 to 13.9)



Sordo et al. BMJ 2017

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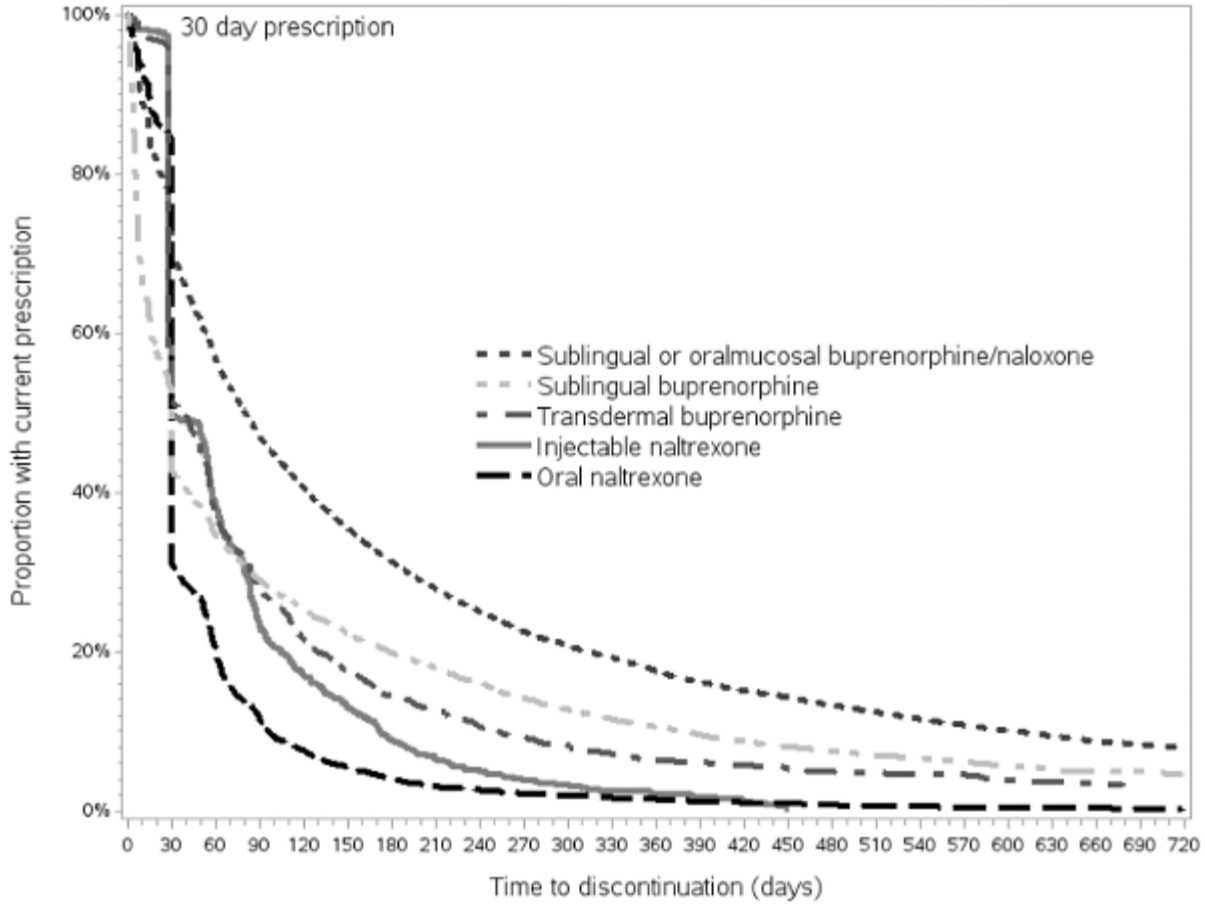
Treatment has not kept pace with incidence

2010-14 claims database of >200 million commercially insured in US

- 4-fold-increase in OUD dx
  - 0.12% → 0.48%
- BUT, proportion treated decreased
  - 25% → 16%



Morgan JR, Schackman BR, Leff JA, Linas BP, Walley AY. Injectable naltrexone, oral naltrexone, and buprenorphine utilization and discontinuation among individuals treated for opioid use disorder in a United States commercially insured population. JSAT. 2017 Jul 3.

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Matching patients to maintenance medications

The choice between methadone, buprenorphine or naltrexone depends upon:

- Patient preference - Past experience
- Access to treatment setting
- Ease of withdrawal
- Risk of overdose

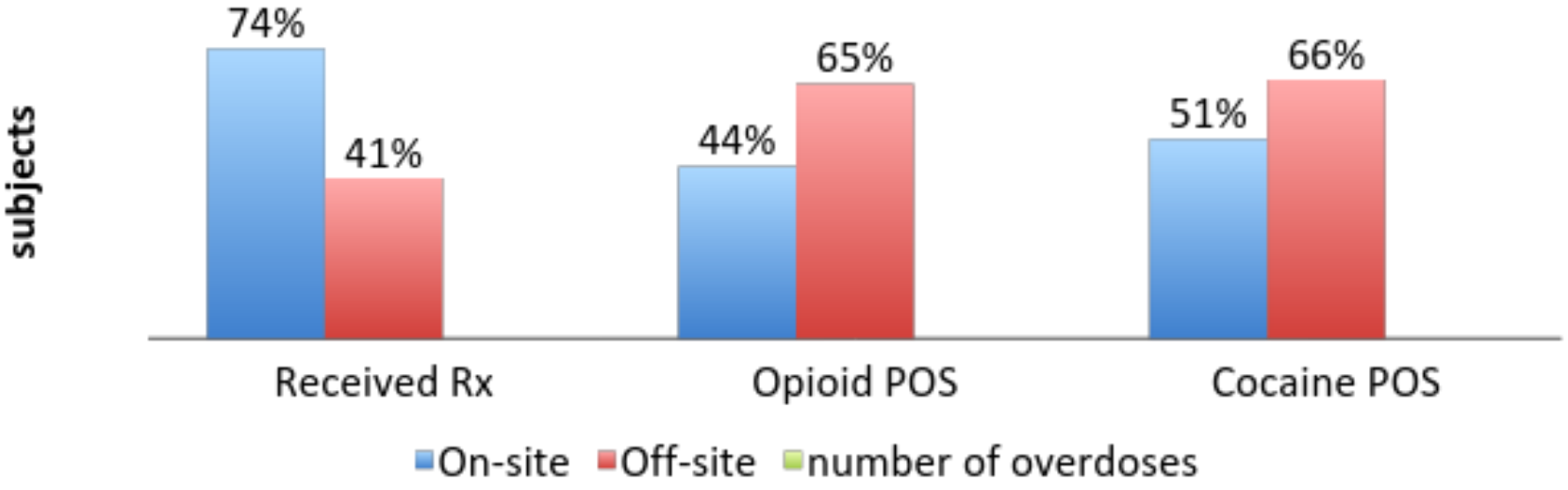
Should I prescribe or refer elsewhere?

93 patients with HIV and opioid addiction randomized

- On-site buprenorphine vs. referral to off-site buprenorphine

Outcomes at 12-months:

- HIV PC attendance - median: 3.5 vs. 3.0



Lucas et al. Ann Inem Med 2010

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Goals of medication treatment for Opioid Use Disorder

Relief of withdrawal symptoms	• Low dose methadone (30-40mg), buprenorphine
Opioid blockade	• High dose methadone (>60mg), buprenorphine, naltrexone
Reduce opioid craving	• High dose methadone (>60mg), buprenorphine, naltrexone
Restoration of reward pathway	• Long term (>6 months) • methadone, buprenorphine, naltrexone

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Opioid detox outcomes

Low rate of retention in treatment

High rates of relapse post treatment

- < 50% abstinent at 6 months
- < 15% abstinent at 12 months
- Increased rates of overdose due to decreased tolerance

"So, how long should maintenance treatment last?"

"Long enough"

O'Connor PG JAMA 2005
Mattick RP, Hall WD. Lancet 1996
Stimmel B et al. JAMA 1977

Example successful strategies for HIV/AIDS and parallel opportunities for overdose reduction

Treatment <--------> Prevention	Examples of strategies for HIV/AIDS	Examples of parallel opportunities for overdose reduction
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Here

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Integrating Substance Use Disorder Treatment Into Primary Care

Joshua Blum, MD
Denver Health and Hospital Authority

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Denver Health and Hospital Authority HIV Primary Care Clinic (HIV PCC)

- Vertically integrated urban health system serving underserved and immigrant populations
- 23% Black, 28.5% non-White Hispanic
- 74% <FPL, 94% <200% FPL

HIV PCC

- Focus on holistic, multidisciplinary care for PLWH
  - Primary care, mental health, substance use treatment, nutrition, medical case management, care navigation and outreach, linkage to care/EIS
  - PCMH III certification
- Services shared by Part A:
  - HIV-specific 340B pharmacy
  - HIV dental clinic
  - High resolution anoscopy-capable proctology clinic

Co-location of services

- First clinic besides Hepatology to offer HCV treatment
- Cooking Matters Classes
  - Teaches shopping for food and cooking; featured by Michelle Obama's "Let's Move"
- African Women's Group
  - Help navigating life in U.S., making connections
- Radiesse biofiller treatment of HIV-associated lipoatrophy
- PrEP
- Transgender education and care

Why SUD treatment integration?

- SUDs kill!
- Prevalence
  - 43% of current clients have an active SUD excluding tobacco
- Co-location
  - Overcoming barriers
- Funding
  - IAHCT

Sherbourne CD et al. *Am J Psychiatry* 2000
Meyer JP, Althoff AL, Altice FL. *Clin Infect Dis* 2013

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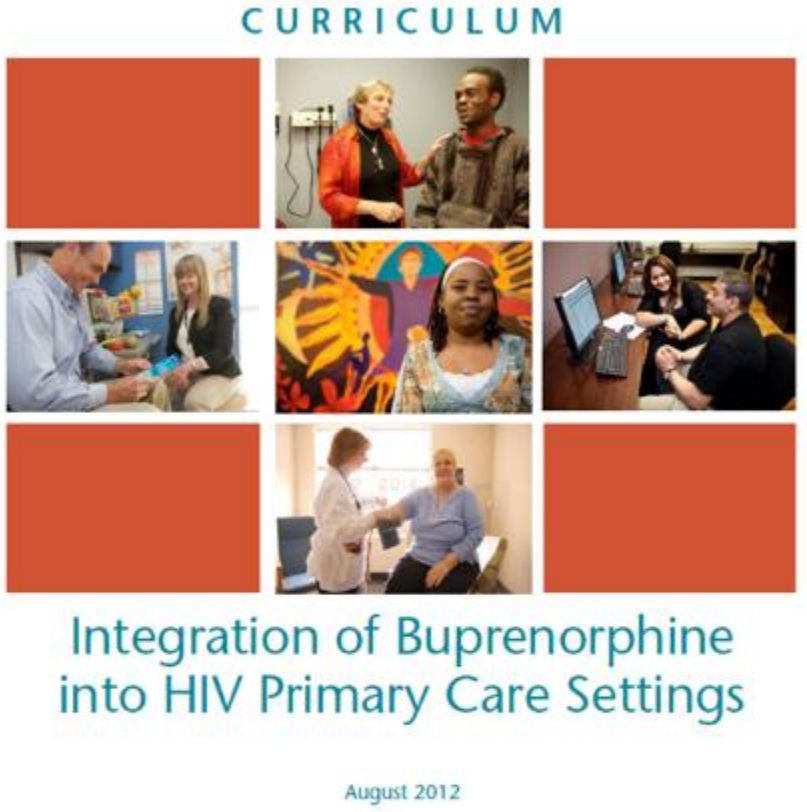
Organization

- Based on BHIVES model
  - SPINS
  - 10 sites
- Key points
  - Multiple providers, buprenorphine coordinator are keys
  - Persistent challenges include polysubstance use, dual diagnosis



U.S. Department of Health and Human Services
Health Resources and Services Administration
HIV/AIDS Bureau
Special Projects of National Significance Program

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Organization

- Single Certified Addictions Counselor joined staff
  - 0.4 FTE, increased to 1.0 FTE
  - SBIRT screening of new clients
  - Yearly SBIRT screenings on continuing clients
  - Additional counseling and/or referral for patients with moderate to severe disease

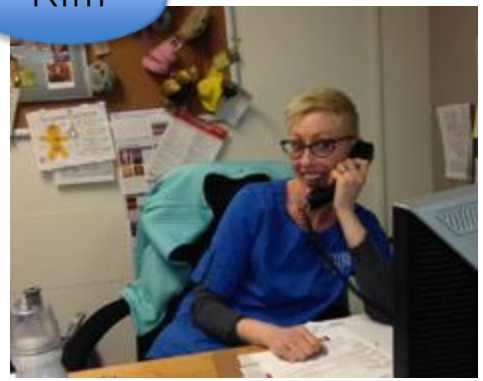
Lessons learned

- Hire great people
  - Flexible
  - Collaborative
  - Great attitude
- Everyone needs training
  - The x-waiver is just the start
- Clinic processes need a champion

Janice

Leon

Kim

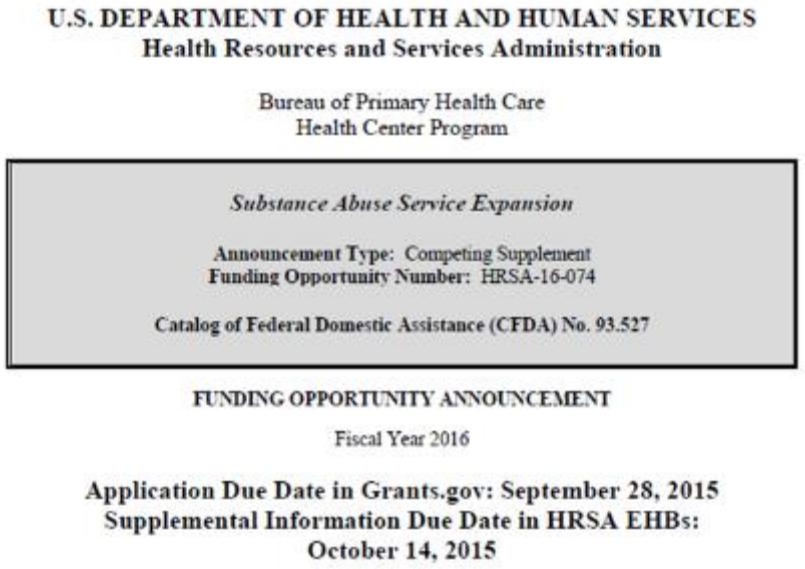


Lessons learned

- Clients don’t come in (just) for SUD treatment
  - “Piggybacked” visits more effective
  - Condition for ongoing therapy
- CAC needed a secondary role
  - Some days busy, others less so
    - Group visits
    - Outreach
- Knowledge of community resources crucial
  - CAC often served in a triage & referral role
  - Definitive therapy and treatment challenging

Substance abuse service expansion

- Integration of CACs into 4 DH primary care clinics
- Train at least 2 x-waivered physicians per clinic
- Technical expertise from addiction medicine physicians



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration

Bureau of Primary Health Care
Health Center Program

Substance Abuse Service Expansion

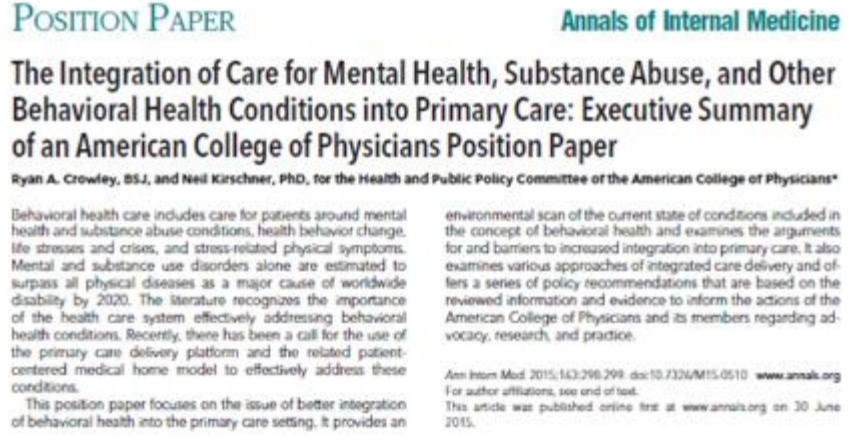
Announcement Type: Competing Supplement
Funding Opportunity Number: HRSA-16-074

Catalog of Federal Domestic Assistance (CFDA) No. 93.527

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2016

Application Due Date in Grants.gov: September 28, 2015
Supplemental Information Due Date in HRSA EHBs:
October 14, 2015



POSITION PAPER — Annals of Internal Medicine

The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: Executive Summary of an American College of Physicians Position Paper

Ryan A. Crowley, BS.J, and Neil Kirschner, PhD, for the Health and Public Policy Committee of the American College of Physicians*

Behavioral health care includes care for patients around mental health and substance abuse conditions, health behavior change, life stresses and crises, and stress-related physical symptoms. Mental and substance use disorders alone are estimated to surpass all physical diseases as a major cause of worldwide disability by 2020. The literature recognizes the importance of the health care system effectively addressing behavioral health conditions. Recently, there has been a call for the use of the primary care delivery platform and the related patient-centered medical home model to effectively address these conditions.

This position paper focuses on the issue of better integration of behavioral health into the primary care setting. It provides an environmental scan of the current state of conditions included in the concept of behavioral health and examines the arguments for and barriers to increased integration into primary care. It also examines various approaches of integrated care delivery and offers a series of policy recommendations that are based on the reviewed information and evidence to inform the actions of the American College of Physicians and its members regarding advocacy, research, and practice.

Ann Intern Med. 2015;163:298-299. doi:10.7326/M15-0510 www.annals.org
For author affiliations, see end of text.
This article was published online first at www.annals.org on 30 June 2015.

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Implementation

- Create referral and treatment guidelines
  - Constantly revised
- Overcome communication barriers
  - 42 CFR Part 2 legal questions
  - EMR limitations

- Processes to improve efficiency
  - Automated reports
  - EMR templates: standard intakes, transfer and discharge notes

SBIRT report

SBIRT Upcoming Appointments

nts with scheduled appointments in the next 3 days at HIV Primary Care

Enroll Date	Appt Time	Visit Provider	SBIRT in last 12 months
Jul-2002	8:20 AM	BLUM, JOSHUA	11/22/17 DH ED AUCC - Screen (+)
Oct-1995	8:40 AM	BLUM, JOSHUA	*No SBIRT in last 12 months
Jul-1991	9:00 AM	BLUM, JOSHUA	*No SBIRT in last 12 months
May-2001	9:00 AM	EIS FLOAT RN	9/25/17 DH ED AUCC - Screen (-)
May-2007	9:20 AM	BLUM, JOSHUA	*No SBIRT in last 12 months
	9:40 AM	BLUM, JOSHUA	*No SBIRT in last 12 months
May-2005	10:20 AM	BLUM, JOSHUA	*No SBIRT in last 12 months
	10:20 AM	EIS FLOAT RN	*No SBIRT in last 12 months
Dec-1996	10:40 AM	BLUM, JOSHUA	*No SBIRT in last 12 months
Dec-2015	11:00 AM	BLUM, JOSHUA	*No SBIRT in last 12 months
Sep-2010	11:20 AM	BLUM, JOSHUA	7/1/17 DH ED - Screen (-)
Sep-2003	11:40 AM	BLUM, JOSHUA	*No SBIRT in last 12 months

SUD report

Patients with Substance Use Diagnosis Upcoming Appointments

Patients with scheduled appointments in the next 3 days at HIV PRIMARY CARE

Appt Date/Time	Appt Type	Visit Provider	Substance Type
3/12/18 8:40:AM	EIS OV	BLUM, JOSHUA	Alcohol ; Cannabis ; Cocaine ; Opiod ; Other stimulant ; Other, mixed or unspecified
3/12/18 9:00:AM	EIS OV	BLUM, JOSHUA	Alcohol
3/12/18 9:20:AM	EIS OV	BLUM, JOSHUA	Other, mixed or unspecified
3/12/18 9:30:AM	EIS SW OV	BRAUER, ALEESA	Cocaine ; Other, mixed or unspecified
3/12/18 10:20:AM	EIS RN OV	EIS FLOAT RN	Alcohol
3/12/18 10:30:AM	EIS SW OV	BRAUER, ALEESA	Cocaine ; Opiod ; Other stimulant
3/12/18 10:40:AM	EIS OV	BLUM, JOSHUA	Alcohol
3/12/18 11:00:AM	EIS OV	BLUM, JOSHUA	Cocaine ; Other, mixed or unspecified
3/12/18 11:20:AM	EIS OV	BLUM, JOSHUA	Cannabis ; Other stimulant ; Other, mixed or unspecified
3/13/18 10:00:AM	EIS OV	ADAMS, JENNIFER E	Other, mixed or unspecified
3/13/18 10:40:AM	EIS OV	ADAMS, JENNIFER E	Alcohol
3/13/18 11:20:AM	EIS OV	ADAMS, JENNIFER E	Cannabis ; Cocaine ; Opiod ; Other stimulant
3/13/18 1:30:PM	EIS SW OV	BRAUER, ALEESA	Alcohol
3/13/18 1:40:PM	EIS OV	ROWAN, SARAH E	Opiod
3/13/18 2:00:PM	EIS OV	ROWAN, SARAH E	Alcohol ; Cannabis
3/13/18 2:20:PM	EIS OV	ROWAN, SARAH E	Other stimulant
3/13/18 2:30:PM	EIS SW OV	BRAUER, ALEESA	Alcohol ; Cannabis
3/13/18 3:40:PM	EIS OV	ROWAN, SARAH E	Cocaine ; Other stimulant ; Other, mixed or unspecified
3/14/18 9:00:AM	EIS OV	BLUM, JOSHUA	Alcohol
3/14/18 9:20:AM	EIS OV	BLUM, JOSHUA	Alcohol
3/14/18 10:20:AM	EIS OV	BLUM, JOSHUA	Alcohol
3/14/18 11:00:AM	EIS OV	BLUM, JOSHUA	Cannabis
3/14/18 11:20:AM	EIS OV	BLUM, JOSHUA	Alcohol

Primary care providers: just unlicensed mental health professionals?

- IM residents receive 0 months of behavioral health training
- Clinicians not adequately trained to work in integrated behavioral health and primary care settings
- The missing curriculum:
  - Motivational interviewing
  - Cognitive Behavioral Therapy
  - Mindfulness Training
  - MBSR, MORE
  - Psychiatric diagnosis and treatment

Hall J et al. *J Am Board Fam Med* 2015

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Keys to success

Communication & connection

- Relationships with other community providers, esp. specialized addiction treatment
  - Residential
  - IOP
- Facilitate referrals in and out of different organizations

Ongoing education

- Learning collaborative
  - Every other week meetings, modeled after Project ECHO
  - Didactic learning, followed by case presentation and discussions

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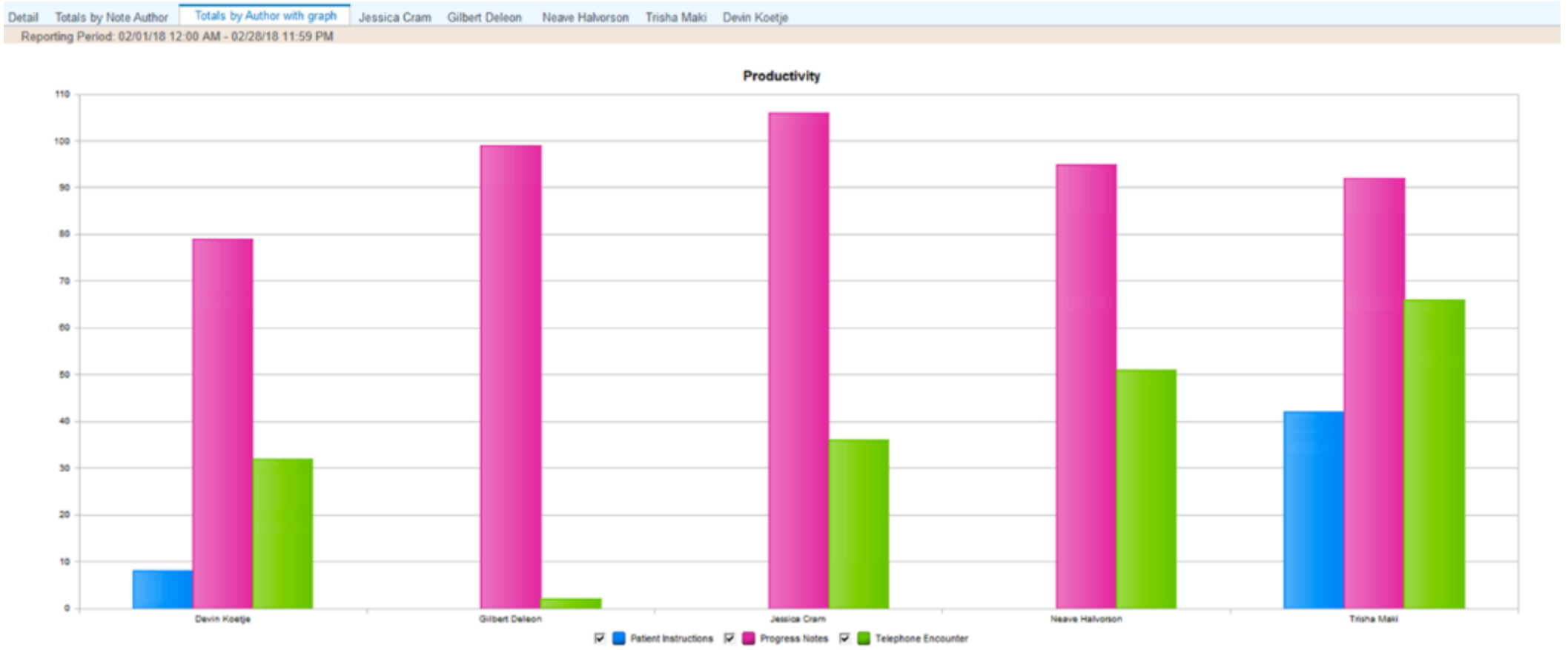
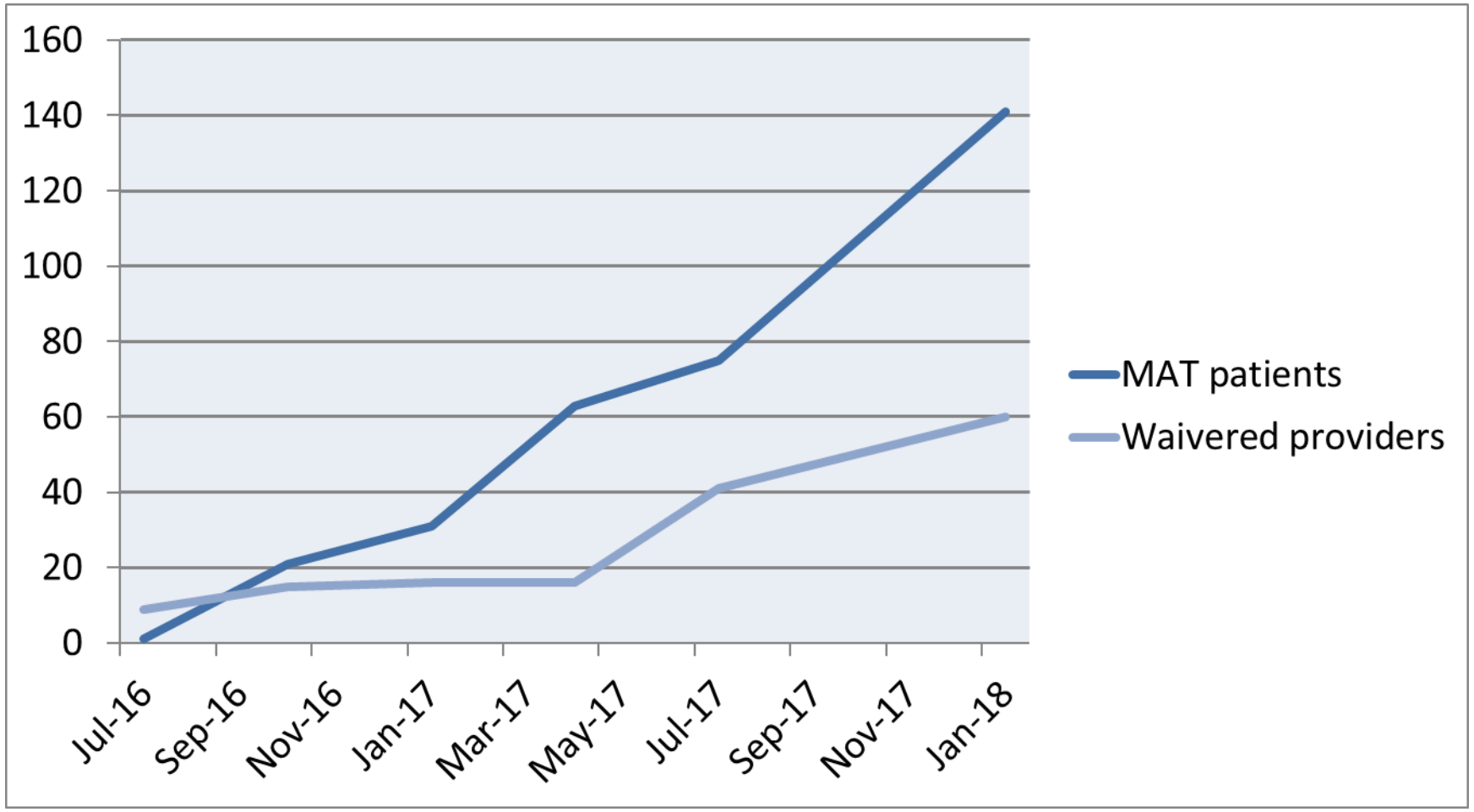
Measurement



MAT progress



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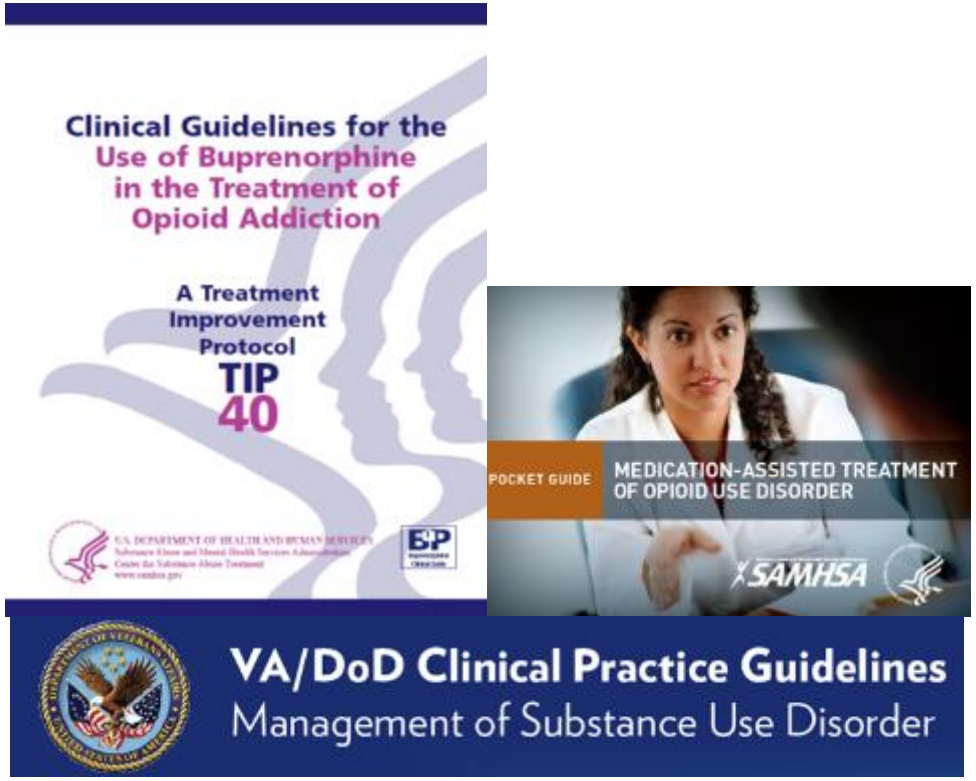
Lessons learned: Part 2

- Set the bar low for access, high for discharge
- High quality MAT resembles primary care
  - Overcome barriers to treatment
    - Transportation, housing
- “Abstinence only” model is less effective and not patient-centered
  - Harm reduction approach is natural to primary care

Technical support and resources



Websites:

- Providers Clinical Support System: www.pcssnow.org
- American Society of Addiction Medicine
- https://elearning.asam.org/
- SAMHSA TIP series

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Thank you

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Q&A: Facilitated by Antigone Dempsey

Antigone Dempsey, MEd

Division Director for Policy and Data, Health Resources and Services Administration's HIV/AIDS Bureau

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Substance Use Warmline:
Providing clinician-to-clinician consultation on managing substance use disorders

9 am – 8 pm EST, Monday – Friday

1.855.300.3595

The Clinician Consultation Center is pleased to offer free and confidential telephone consultation focusing on substance use evaluation and management for primary care clinicians.

With special expertise in pharmacotherapy options for opioid use, our addiction medicine-certified physicians, clinical pharmacists, and nurses provide advice based on Federal treatment guidelines, up-to-date evidence, and clinical best practices.

Learn more at http://nccc.ucsf.edu/clinician-consultation/substance-use-management/

CLINICIAN CONSULTATION CENTER

Translating science into care

Key Resources

- SAMHSA Tip 63
- SBIRT and Integration
- Screening Tools
- Integration Levels
- Organizational Readiness Assessments

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Integration-specific resources

- Integration Quick Start Guide
- Core Competencies for Integrated Behavioral Health and Primary Care
- Primary and Behavioral Health Integration: Guiding Principles for Workforce Development
- Building cultural competence in healthcare

CIHS tools and resources

Free consultation on any integration-related topic!

Visit www.integration.samhsa.gov or e-mail integration@thenationalcouncil.org

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Thank you.

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The mission of HRSA is to improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs.

www.hrsa.gov | www.samhsa.gov
integration.samhsa.gov

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Thank you.

Please take a moment to provide your feedback by completing the survey at the end of today's webinar.

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